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

Minutes

December 13, 2018, 1:30PM-4:30PM
710 Kipling, 3rd floor conference room

ATTENDEES:

TASK FORCE MEMBERS
Joe Pelle, Chair, Boulder County Sheriff
Abigail Tucker, Community Reach Centers
Jamison Brown, Colorado Jail Association
Megan Ring, Publilc Defenser's Office
Cynthia Grant, AllHealth Network
Nancy Jackson, Arapahoe County Commissioner
Patrick Costigan, 17th JD District Attorney's Office (on phone)
Benjamin Harris, Department of Healthcare Policy and Financing (on phone)
Frank Cornelia, Colorado Behavioral Healthcare Council (on phone)
Tina Gonzales, Beacon Health Options

ABSENT
Jagruti Shah, Office of Behavioral Health
Norm Mueller, Defense Bar
Charles Smith, Substance Abuse and Mental Health Services Administration
John Cooke, State Senator, District 13
Judge Chris Bachmeyer, District Judge, 1st Judicial District

STAFF
Richard Stroker, CCJJ Consultant
Kim English, Division of Criminal Justice
Laurence Lucero, Division of Criminal Justice
Stephane Waisanen, Division of Criminal Justice
Peg Heil, Division of Criminal Justice

ADDITIONAL ATTENDEES
Vincent Atchity, The Equitas Project

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. Sheriff Pelle informed the group that the agenda would be slightly out of order and asked for an update from Dr. Werthwein.

Issue/Topic:	Discussion:
Update from Dr. Werthwein	Dr. Werthwein, Director of CDHS/Office of Behavioral Health (OBH), presented information on the announcement by the Capitol Development Committee regarding the repurposing of the Ridgeview Academy Campus that is used by the Division of Youth Services and has a capacity of approximately 500 beds. He stated that the campus has been underutilized and is at a 20% capacity rate. The layout of the academy has seven cottages for sleeping, a main administration building, a gym and a trade building. The goal according to CDHS was to build a hospital adjacent to the campus but that has not been successful due to the cost of $400 million whereas renovating the existing facility will cost $34 million. CDHS officials have proposed to merge this campus by March 2022 with a secure treatment facility with an additional 210 beds that would be used primarily for restoration. This facility will be funded over several phases and the first phase of construction will have funds in place by July 1. Two additional budget requests are also underway. The first is to reconstruct two cottages at Fort Logan with 44 beds, and to add 42 beds to the State Hospital in Pueblo. The focus of the new beds proposed by CDHS are primarily for competency restoration.

Issue/Topic:	Discussion:
Dr. Tucker's Workgroup and Finalizing Recommendation	Dr. Tucker directed the group to a draft recommendation that has been updated with the elements from the discussion at November's meeting. Dr. Tucker reminded the group that the focus is on the behavioral health emergency needs. The Working Group is asking the Task Force whether there should be an attempt to estimate a dollar amount necessary to establish such model. Several members of the Working Group reached out to hospitals, including Denver Health and a rural hospital in Chaffee County. The hospitals were asked what capital costs they would foresee to implement this model, and what barriers might pose challenges. Denver Health's response focused more on the process, the custody and

Issue/Topic:	
Dr. Tucker's Workgroup and Finalizing Recommendation (continued)	transfer agreements. Their primary concern is that people may get permanently placed in the hospital and so emphasized the importance of establishing processes to prevent this from occurring. The hospital located in a smaller rural jurisdiction had more concerns around capital costs to build the required space, and also the need to recruit qualified staff. Sheriff Pelle mentioned that, in the majority of these cases, the thing that will prevent the patient from becoming a permanent resident of the hospital is the shift from emergency stabilization to competency evaluation. Ben Harris indicated that he was also able to talk to another critical access hospital in Salida whose representative echoed the concern expressed by the hospital in Chaffee. However, this hospital has an established relationship with their community mental health provider and the implementation of such model seemed feasible. The primary concern was about the infrastructure costs and having the necessary resources. The idea of a rural mobile team to come to the hospital was discussed. It was mentioned that if the model is restricted to facilities eligible for Medicaid reimbursement, this reduces considerably the number of available facilities in the state. Ben added that he and Abigail talked to hospitals that are very community minded. Denver Health, for example, is the safety net for the county. We talked to two critical access hospitals and they are the primary community provider for their respect regions and communities. These hospitals may have been responsive because they have an organizational culture responsive to individuals using public health insurance.

Issue/Topic:	Discussion:
Size of target population estimate for recommendation	Richard discussed the need to estimate the size of the target population for the recommendation. That is very difficult question for us to answer. We see that 79 beds were closed in the past 9 years. We see the experience of the Boulder Jail and we see the experience of the Denver Jail. We have requested a lot of information from people. We don't have a lot of data to quantify the need that we are talking about. Kim English suggested that the group use the total jail population as a baseline; the jail capacity statewide is approximately 13,000-14,000 beds, and our numbers hover around somewhat less than 1% of that. We can add this as a footnote in the recommendation. Abigail added that, since OBH is projecting that they need almost 300 new beds, this could also be a footnote. Sheriff Pelle mentioned that if CDHS/OBH resolved the competency evaluation and restoration backlog, it would definitely impact the numbers here. Abigail noted that it would likely impact the numbers in a downstream way.

Issue/Topic:	
OBH recommendation for new forensic beds	Richard identified three potential issues. One is the backlog competency and restoration work, and OBH is seeking funding to impact that. The second issue is what we have been trying to deal with, these emergency situations and the need to stabilize people using this hospital-jail collaboration approach. Then there may be a third issue that involves trying to bolster resources in the community to provide a variety of mental health services that make the person's placement in the jail unnecessary or impact it in other ways, such as re-entry. We need to figure out how to tackle each of these topics and not make the recommendation overlapping and confusing. Megan Ring stated that she is troubled by the OBH response that is focused on beds and not on other community resources. The Public Defenders' Office filed 64 lawsuits the last couple weeks to get people into beds, and this is in part because there are no other resources. She noted that this one size fits all approach is troubling and makes the in-out-jail cycle worse. Individuals go to the hospital and go back to the jail and when they get out there are no services. We are not giving people services in the community and for this reason the problem is going to get worse. Patrick noted that most of the people he sees requiring competency restoration are held without bail. Usually they are on serious charges, such as murders and attempted murders; things that require extensive prison sentences. Patrick said he sees a lot of competency work that is done out of custody and a lot of evaluations done by contracted licensed clinical psychologists. Abigail said perhaps it would be helpful to review that data because she does not see the cases that Patrick is referring to. Instead, a lot of people who are getting restoration have low level misdemeanor charges. She also mentioned that Richard's identification of the three issues was helpful but, in terms of the first issue, Abigail said she doesn't see it as the role of the task force to have a position statement of how the state is managing the expansion of forensic beds. Sheriff Pelle agreed with Abigail and mentioned that, as a task force and a subdivision of CCJJ, we should be careful about what we advocate for as a group. We certainly wear our own hats and have opinions but as a subcommittee we should probably not take a position on how the state addresses the lawsuit and how they handle the backlog. We need to stay focused on emergency stabilization. Sometimes these are the result of a suicide attempt which may not have anything to do with competency. We need to keep competency and restoration separate. Abigail asked the group for its perspective on the budget request in the recommendation. Should we address jail transport costs? Eligibility for Medicaid? Medicaid screening processes? Sheriff Pelle noted that security needs to be in place and on-site before the plan is implemented, and this is part of the costs. He added that if we are at a point where we have sufficiently narrowed the scope of the recommendation, how do we fund this? Richard summarized that we want to tailor the current recommendation to make it clear that we are talking about the provision of emergency services and not talking about competency and restoration, to give the recommendation more clarity. He also noted that, regarding the work going on to expand competency beds, the task

Issue/Topic:	
Task Force Recommendation: should it include cost estimates? Identification of Oversight Entity?	force doesn't feel the need to speak to that in any way. If we want to speak to the issue of community services at a later date, we want to keep that an option. That could be another area this task force could explore. Finally, what do we want to say about money? The counties are ultimately responsible for the cost. What we are recognizing that this is an unfair burden on the counties. There is this Medicaid reimbursement. What is left is the need for state funding to help support the creation of these things: 1) Some state oversight entity, perhaps within OBH, to assist with contracting and the identification of potential service providers; 2) Money to assist with individual hospitals with renovation and costs above what Medicaid reimbursement allows after the first 24 hours; and 3) Other cost associated with the jail such as transport and security. Tina noted that the upfront capital costs and the bed costs remain unknown. Ben added that, in addition to upfront costs, there will be costs associated with actually developing infrastructure to care for these individuals, plus supplemental operating costs. Just doing the quick math and I have heard a ballpark estimate of 2-3 supplemental staff ranging from clinical to security. If you did a per diem hourly rate for a four-day episode, that would give you an estimated supplemental operating cost that Medicaid would not reimburse and would have to be covered with additional funds. Ben continued to explain: What we heard from hospitals is that funding concerns have two parts. The first is, can we build the actual facility or renovate the facility into an acute care model. Operating that care model would have a higher costs than Medicaid would cover. You would need additional funding for the security staff, additional nursing staff, and additional behavioral health staff. Additionally, we should clarify that the startup money is a one-time expenditure. Once you build the infrastructure, that component is done. The budget item would be higher in those first few years, and then it drops down to basic operating costs. Frank suggested phasing the implementation, or developing a pilot with the intent of eventually reaching 100 beds. Ben agreed and reiterated that the problem is the number who of jail detainees who experience a behavior health crisis. Medicaid is agnostic to diagnoses and covers these episodes. Are we telling hospitals that these funds are only for members that are experiencing a behavior health crisis? What happens to those members who present with the same set of circumstances with physical health crisis? Are we creating a restriction on access to treatment, reserving these beds only for behavioral health?

Issue/Topic:	**Discussion:**
Finalizing the Recommendation	Sheriff Pelle asked the group if the recommendation should move forward as a pilot. Richard added that perhaps that would cost less money. Tina mentioned that pilot programs would allow us to collect information on actual demand and other related costs. Abigail told the group that she made some edits to the recommendation based on the conversation today. Richard mentioned completing the draft recommendation for the next meeting, in January. If the Task Force approves the recommendation in

	January, it could go the Commission on January 11 for the preliminary review. Sheriff Pelle agreed that the group should get the recommendation to the CCJJ soon, for a vote in February while the legislature is early in the session.

Issue/Topic: Next Steps and Adjourn	Abigail will send the updated recommendation to the Working Group for final input, and Abigail and Kim will finalize the wording in the recommendation. The Task Force will review the recommendation at the January meeting and, if approved by the Task Force, the recommendation will go to the Commission on January 11 for preliminary review, and a final vote by the Commission in February.

Next Meeting

February 7, 2019/ 1:30pm – 4:00pm 700 Kipling, 4th Training Room