

## MINUTES

### Task Force for the continuing Study of the Treatment of Persons with Mental Illness Who are Involved in the Criminal Justice System

July 19, 2012

10:00 a.m. – 12:30 p.m.

Legislative Services Building

#### Call to Order – 10:05 a.m.

The Task Force for the Continuing Study of the Treatment of Persons with Mental Illness who are Involved in the Criminal Justice System meeting was called to order at 10:05 a.m. by Kathleen McGuire, Chair of the Task Force.

#### Introductions and Welcomes

Introductions were made around the room. Task Force members and guests introduced themselves.

#### Minutes Approval

Harriet Hall moved that the June 21, 2012 minutes of the Task Force for the Continuing Study of the Treatment of Persons with Mental Illness who are Involved in the Criminal Justice System be approved as provided. Melinda Cox seconded. Motion passed.

#### Not Guilty by Reason of Insanity (NGRI) Education Curriculum –Conditional Release and Oversight by Mental Health Centers

Bambi Creek with Forensic Community Service Programs, CMHIP gave an overview of forensic community based service programs. Under 1 % of felony criminal cases that apply for NGRI status are granted the status. Currently CMHIP has 150 inpatients and 150 outpatients under C.R.S. §16-8-10.5 statute. About 6,700 individuals go through Institute for Forensic Psychiatry for psychiatric assessments. The assessments focus on the risk factors and determine level of care and needs.

Forensic Community Service Programs' (FCSP) main goal is public safety, community reintegration and fostering highest level of independent functioning. The program includes psychiatrist, forensic psychologists, case managers, two regional CR coordinators and proactively works with Community Mental Health Centers (CMHC's) on reintegration into the community. Community placement can last from one year to eight-nine years. Patients have lots of oversight.

The community treatment is provided primarily by Community Mental Health Centers often in the county of commitment. Sex offender patients are often placed in Pueblo as it is where there were committed or it is a court preference.

Transition to the community progresses from on ground supervised to off grounds supervised and then to off grounds unsupervised. If a treatment team decides that a patient is ready to move to the community he then is referred to the disposition committee that gives recommendations to the superintendent and the court on how the patient is doing. Inreach process begins, a case manager gets assigned and the preparation for discharge begins. A temporarily physical removal (TRP) is granted by the court along with an agreement to the patient; very specific treatment plans are developed. Annual reports to the court are made. FCSP can require individual to return to the hospital.

Susan Drown reviewed the phase of a conditional release for the group. Individual can get to conditional release by a court order. State hospital will draft the conditions of release which serves as a guide for the court. If a court agrees to grant conditional release a copy of the conditions of release will go to the Community Mental Health Center (CMHC), the patient and CMHIP. CMHC provide the same level of services as Community Placement. Unconditional release granted by the court is voluntary, not guaranteed and includes follow up mental health services.

Currently all Mental Health Centers in Colorado have Forensic Community Based Services Programs but three (Centennial Mental Health Center, Midwest and San Luis Valley). Spanish Peaks Mental Health Center has conditional release individuals and no community placement.

Annual FCBS change in status graph was reviewed. Demographically population includes 86.73% male, average age 54.7, with 73% schizophrenia/psychotic disorder. 80% of crimes were violent offenses, 24.31 % are employed. Funding includes SSI, SSDI, SSI/SSDI, VA, and Indigent.

Kathy McGuire asked why some individuals don't qualify for Medicaid. Ms. Drown responded that some have conduct disorders and these disorders don't qualify. Ms. Creek added that postpartum psychosis that was a result of medications doesn't qualify.

The role of Division of Behavioral Health is the ongoing monitoring of NGRI compliance, oversight in CMHIP, monitoring of critical incidents, liaison between Mental Health Centers and CMHIP, tracking and monitoring. Gaps and challenges include resource intensive population, funding for services not funded by insurance, treatment planning, data, etc.

Dr. Clark gave an overview of Mental Health Center Denver (MHCD) that serves as a Community Mental Health Center. It is the 3<sup>rd</sup> largest provider for NGRI population that comes out on conditional release and community placement. Currently it has 20 people on conditional release and 7 on community placement. MHCD provides a full array of services, uses evidence-based practices. Housing can be a challenge, registered sex offenders can't be housed here.

Jay Flynn added that when someone comes to MHCD from CMHIP there are five levels of service available from high level intensity when a therapist is seeing 12 people to less intensive teams where the therapist is seeing 80 people. An electronic recovery needs level instrument is used to determine what level of service is needed for someone. It is used every 6 months. 94% of population that moves from higher level of service to the lower level stays in that lower level. Best practices include building close connection to the large treatment team. Disorders treatment, trauma recovery services are provided. Conditional release population vast majority has suffered significant trauma in the past in the course of their illness.

Behavioral therapy, motivational interviewing, work on eight criminogenic risk factors using cognitive approach to change criminal thinking and to reduce recidivism are used. The recovery is measured every 12 months using a 12 point scale. Teams see individual scores, use color coding, compare expected rate of recovery. The Center conducts hope training for staff.

Dr. Clark mentioned that primary care services are now available to consumers of Mental Health Center of Denver. A new facility was recently opened to provide medical care. Success in working with FCBS is the coordination of the monitoring process that is necessary for this population. Public safety is important for us. Some challenges include the liability issues, public safety and safety of our staff.

Mr. Flynn added that Community Mental Health Center of Denver is committed to seeing this population, however the liability issue is a challenge the Center faces. A need for legislative changes to address some gaps in the system that include permanently incompetent to proceed population was mentioned along the challenges the Center is facing. Dr. Clark added that we work very hard to create a smooth system for NGRI population that is coming back into the community. Michael Ramirez asked if the recommendations mentioned earlier could be provided to the Task Force members in writing. Mr. Flynn will share them in writing.

Susan Drown will send a chart with statistics concerning recidivism to Michele Manchester to distribute to the Task Force members. Most frequently committed crime is the escape - which includes not reporting, not living where supposed to, etc.

## **Subcommittee Updates**

### *Juvenile Justice Subcommittee*

Michael Ramirez provided a report from the Subcommittee that included three recommendations. He commended Anna Lopez, DCJ for her help consolidation of the information.

#### 1. Evaluation deadline

*Currently: 19-3-1302 (4) (d) (I) Thirty days after issuance of the order for the competency evaluation unless good cause is shown for delay, if the juvenile is held in a secure detention facility.*

*Recommendation: Add a language requiring youth to be released to appropriate community placement with mental health services when appropriate. Strengthen to evaluate within 30 days*

Discussion: The exception clause became a practice in many jurisdictions and not the exception. Youth are being held in detention awaiting a competency evaluation for upwards of 45 days in certain jurisdictions. This is both more costly to the system and detrimental to the juvenile's well-being.

Harriet Hall asked who is doing the competency evaluation and is the availability of resources a part of the issue. Michael Ramirez replied it is a part of a concern. Typically it needs to go to the forensic psychiatrist. When the case goes to court, you have to establish that level of competency, but does it have to be the case?

Dr. Kellermeyer cautioned that the quality of an evaluation might be affected by putting a deadline on them as juvenile evaluations take time as there are so many records and factors to consider. Kathy McGuire added that the adult evaluations can take 60-90 days. Gina Shimeall added that speed is not always the best way. It is hard to find competent juvenile experts. It is hard to determine if a juvenile has a mental health issue, and added that a thorough review of records from school, etc. is important.

Kathy McGuire asked if the chief concern was the use of detention while waiting for competency evaluation. Michael Ramirez replied it was a part of the issue. Another concern was the good cause language. The potential fix is defining the good cause language. Susie Walton added that the design right now is that the kids are housed without treatment. She is concerned with the length of time and cost associated with it.

#### 2. Clarification and Clean up to the language of competency language

A. *Currently: 19-3-1302 (2) A juvenile shall not be tried or sentenced if the juvenile is incompetent to proceed, as defined in section 16-8.5-101 (11), C.R.S., at that stage of proceedings against him or her.*

*Recommendation: define competency based on a juvenile definition not in reference to an adult statute.*

Kathy McGuire asked to clarify what it means. Michael Ramirez responded that the definition varies jurisdiction to jurisdiction.

B. *Currently: 19-2-1302. Determination of incompetency to proceed. (1) Whenever the question of a juvenile's competency to proceed is raised, the court shall make a preliminary finding that the juvenile is or is not competent to proceed. If the court feels that the information available is inadequate for making such a finding, it shall order a competency examination.*

*Recommendation: Add language related to what criteria is used by competency evaluator in their examination to determine competency. Use definition based on juvenile justice system not adult system and not based on age or other non-mental health criteria.*

Harriet Hall asked if the group was looking at developmental disabilities along with mental illness as a reason for incompetency. Michael Ramirez responded that the subcommittee wanted to make it more uniform. Melinda Cox asked if the work done by the group led by Michael Dohr was considered by the subcommittee. Michael Ramirez confirmed it was.

Kathy McGuire commented that the group might need time to review the whole document and then reconvene with questions as a group to discuss.

### 3. Restoration Structure

*Currently: 19-2-1303 (2) If the court determines pursuant 19-2-1302 that the juvenile is incompetent to proceed, but may be restored to competency, the court shall stay the proceedings and order that the juvenile receive services designed to restore the juvenile to competency, based upon recommendations in the competency evaluation unless the court makes specific findings that the recommended services in the competency evaluation are not justified...*

*Recommendation: There needs to be some structure for the restoration processes and details about services and payment as well as definition of roles and responsibilities for overseeing and implementing the restoration plan.*

How many kids are we impacting through competency? In 2011 - 17, inpatient and 119 outpatient youth were affected. District attorneys presented the numbers for their jurisdictions.

Kathy McGuire commended Michael Ramirez for his work. Mr. Ramirez commended Anna Lopez, DCJ for her work on the report. Anastasiya Schomaker will send an electronic copy of the report to all MICJS members and members will be able to send their questions/comments to her by August 2 to be discussed at the next Task Force meeting. Michael Ramirez will send a list of all members of the subcommittee who prepared the presented report.

Where there any mental health professionals that participated? Mental health professionals participated, but not someone who does the evaluations for CMHIP.

#### *Medication, Health Care, and Public Benefits*

Susie Walton updated the Task force members on several projects the subcommittee worked on:

- Disincentive for employment for NGRI persons living in the Medicaid certified alternative living facilities.  
Ad hoc group put together recommendations with examples how this is effecting people, outlining the costs to go back the state hospital. Jay Berry and Libby Stoddard are pursuing several avenues to get this heard and acted upon. The subcommittee's goal is regulation change.
- Free ID discussion  
It is a valuable resource that could be utilized more by jails. Need help from Kathy McGuire to ask Michael Kardasian, CCI to make a brief presentation to the Task Force or the subcommittee.
- Medication – no update.

#### **Behavioral Health Transformation Council Update**

Jeanne Smith reported the council is in the process of reorganizing. In August there will be an all day meeting to discuss the organizational structure. The group asked the Cabinet for recommendations on reforming its mission. After August Jeanne Smith will report on the new directions of the Council.

### **Other Updates**

Kathy McGuire reminded that the creating legislation directs the Task Force to elect Chair and Vice Chair by August 1st.

Harriet Hall moved the Chair and the Vice Chair are reelected by affirmation, Michael Ramirez seconded, motion passed unanimously.

Once we complete our study of NGRI, Kathy McGuire inquired whether it would be valuable have a strategic meeting of the Task Force? Susie Walton commented it will be great to have a retreat meeting. Michael Ramirez will value such meeting scheduled a few months out as it takes time to plan. Kathy McGuire commented that if we have clear goals as a Task Force, the goals for subcommittees will be clear as well.

Jeanne Smith recommended inviting legislative members to the meeting and scheduling it before December. It is also critical as the landscape has changed after the legislature was done and it will be helpful to know where legislature wants us to head. Kathy McGuire would like to have a professional facilitator for the meeting and is asking for ideas and suggestions.

Regular November 15<sup>th</sup> MICJS meeting is cancelled, the strategic meeting will be November 29<sup>th</sup>, 9:00 am-4:00 pm. The location is to be announced.

### **What is happening in your agency?**

Libby Stoddard announced that Federation is bringing a train the trainer for family advocates to Colorado last week in August. It is done in conjunction with the Mental Health Block Grant and Juvenile Justice Mental Health Subcommittee.

Lenya Robinson mentioned that Division of Behavioral Health and the Division of Children Youth and Family identified a need for a position who will champion the child adolescent family issues, we are in the process is getting the position filled.

### **12:03 p.m. – Adjourn**

The Task Force for the Continuing Study of the Treatment of Persons with Mental Illness who are Involved in the Criminal Justice System was adjourned at 12:03 p.m.