

**Final**  
STAFF SUMMARY OF MEETING

TREATMENT OF PERSONS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE  
SYSTEM

Date: 03/18/2016 ATTENDANCE

Time: **01:31 PM to 04:01 PM** Humphrey X

Place: HCR 0112 Lee X

This Meeting was called to order by Newell X  
Representative Singer Woods X  
Martinez Humenik X  
Singer X

This Report was prepared by  
Amanda King

X = Present, E = Excused, A = Absent, \* = Present after roll call

Bills Addressed:	Action Taken:
Call to Order	Witness Testimony and/or Committee Discussion Only
Status Update on Restoration/Competency Work Group Activities	Witness Testimony and/or Committee Discussion Only
General Overview of Advisory Task Force Recent Activities	Witness Testimony and/or Committee Discussion Only
Advisory Task Force Membership Update & Discussion of Vacancies	Witness Testimony and/or Committee Discussion Only
Status Update on Data Subcommittee Activities	Witness Testimony and/or Committee Discussion Only
Status Update on Housing Work Group Activities	Witness Testimony and/or Committee Discussion Only
Discussion of Future 2016 Leg. Oversight Committee Meeting Dates	Witness Testimony and/or Committee Discussion Only
Public Comment	Witness Testimony and/or Committee Discussion Only
Research Requests	Witness Testimony and/or Committee Discussion Only

**01:31 PM -- Call to Order**

Representative Singer called the meeting of the Legislative Oversight Committee Concerning the Treatment of Persons with Mental Illness in the Criminal and Juvenile Justice Systems (MICJS) to order. The meeting agenda (Attachment A) was distributed to the committee members.

**01:32 PM -- Status Update on Restoration/Competency Work Group Activities**

Sheri Danz, MICJS Task Force member as the representative of the Office of the Child's Representative, discussed the work of the Competency Restoration Subcommittee of the MICJS Task Force. She outlined the work that the MICJS Task Force has done in the past concerning restoration and competency issues. She referenced the MICJS Task Force retreat that was held on September 25, 2015. She stated that instead of focusing on the definition of juvenile competency, the Competency Restoration Subcommittee is now focusing on restoration services. She stated that the subcommittee meets monthly and listed the agencies that are represented on the subcommittee.

**01:36 PM**

Ms. Danz answered questions from the committee members about what currently happens to juveniles who are awaiting restoration services. She briefly discussed the curriculum that is used for juvenile restoration services. Ms. Danz referenced the delays that can occur in the court proceedings that involve juvenile competency issues. She discussed the comparative analysis with other states that the subcommittee has conducted regarding juvenile restoration services. Ms. Danz listed Florida, Maryland, and Virginia as states that could be used as possible models for juvenile restoration services. She explained that Colorado law does not clearly identify which entity is designated to provide restoration services. She discussed the potential underreporting of data concerning competency restoration services ordered in juvenile cases. She stated that the subcommittee is working to develop a survey to send to practitioners in the juvenile justice field concerning restoration services. She stated that it is possible that the subcommittee will come forth with a recommendation that Colorado list in state law the singular designated entity responsible for contracting for competency restoration services. Ms. Danz reviewed the guiding principles that could be outlined in state law for the delivery of juvenile competency restoration services.

**01:45 PM**

Ms. Danz answered questions from the committee about competency restoration services and how it is determined if someone is restored to competency. She referenced the Models for Change publication entitled *Developing Statutes for Competence to Stand Trial in Juvenile Delinquency Proceedings: A Guide for Lawmakers* by Dr. Kimberly Larson and Dr. Thomas Grisso.

**01:49 PM**

Amanda King, Legislative Council Staff, answered a question about a memorandum on juvenile competency statutes and model legislation that was prepared by Legislative Council Staff (Attachment B). Ms. Danz discussed the existing research the subcommittee has reviewed.

"

**01:50 PM**

Ms. Danz discussed the subcommittee's activities related to adult competency restoration services. She referenced litigation regarding adult competency evaluations. Ms. Danz stated the next step for the subcommittee is engaging the Office of Behavioral Health in the Department of Human Services. Ms. Danz answered questions about the involvement of the Department of Corrections in the subcommittee's activities. In response to a question, Ms. Danz further discussed the competency restoration services provided in Virginia and how that state could be a model for Colorado. Ms. Danz responded to questions about how many juveniles are referred for restoration competency services. She referenced the Joint Budget Committee's *FY 2016-17 Staff Budget Briefing - Judicial Branch* document. Ms. Danz emphasized the importance of including a data collection component in any subcommittee recommendations regarding competency restoration.

**02:06 PM**

Representative Singer referenced the MICJS Advisory Task Force Members list (Attachment C) that was provided to the committee members. He asked that the committee be provided a list of the subcommittee members. The committee discussed identifying Legislative Oversight Committee members to work with the subcommittee on restoration competency issues.

"

**02:09 PM -- General Overview of Advisory Task Force Recent Activities**

Susie Walton, MICJS Task Force Chair and Park County Department of Human Services Director, outlined the three focus areas for the task force of competency restoration, housing, and data. She discussed how some of the issues outlined in the task force's charge are being addressed by other entities, such as suicide and medication consistency. Ms. Walton said that she would provide the committee members with a list of subcommittee members.

**02:13 PM -- Advisory Task Force Membership Update and Discussion of Vacancies**

Ms. Walton stated that there are current three vacancies on the task force. The Task Force Membership booklet (Attachment D) was distributed to the committee members. She discussed Chris Johnson, Executive Director of the County Sheriffs of Colorado, whose appointment as a representative of local law enforcement is pending. Ms. Walton stated that the representative for the Colorado Mental Health Institute at Pueblo had recently resigned from the task force. She said the institute is currently looking for another representative to fill the vacancy. Ms. Walton discussed the vacancy of a judicial branch representative and stated that the appointment will be made by the Chief Justice of the Colorado Supreme Court once a representative is identified.

Ms. Walton discussed Jack Zelkin who was recently appointed to the task force as a member of the public who has an adult family member who has a mental illness and who has been involved in the Colorado criminal justice system. She also discussed Ms. Zelkin's experience in the housing sector.

Ms. Walton discussed the Department of Corrections representatives on the task force.

**02:17 PM -- Status Update on Data Subcommittee Activities**

Peggy Heil, MICJS Task Force member as the representative of the Department of Public Safety, provided an information packet (Attachment E) to the committee about the federal Bureau of Justice Assistance Second Chance Act Statewide Adult Recidivism Reduction Strategic Planning Program Grant. She stated that the first key collaborator steering committee meeting was held on March 14, 2016. She reviewed the background and process for applying for the grant and how the task force became involved. She discussed issues related to recidivism, increased percentages of jail detainees with mental illness, and psychotropic medication disruptions as individuals transfer between systems. Ms. Heil discussed the identified need to plan a statewide electronic justice and health information sharing system to improve continuity of care and to reduce recidivism of individuals with mental illness.

"

**02:21 PM**

Camille Harding, MICJS Task Force co-chair and Department of Health Care Policy and Financing, reviewed the Succinct Summary of 2015 Focus Group Responses (Attachment F). She stated that the focus groups were conducted through a partnership with the Colorado Regional Health Information Organization, Department of Health Care Policy and Financing, and the task force. Ms. Harding stated that the focus groups were conducted by phone. She stated that there was limited participation of eastern plains and no input from the health providers within the criminal justice organizations. In response to a question, Ms. Harding discussed why certain providers were not contacted for the focus groups. The committee dialogued with Ms. Harding about involving smaller counties and other various criminal justice organizations in future endeavors.

"

**02:30 PM**

Ms. Harding discussed the findings regarding the screenings that occur in criminal justice entities. She stated that very few criminal justice entities are currently using a standardized means of detecting inmates with mental and behavioral health issues. She said that most criminal justice entities conduct suicide risk assessments. Ms. Harding discussed the difficulties for jail staff in obtaining diagnoses and medication records from other entities. She reviewed the finding of the focus group research related to mental health treatment provided through the criminal justice entities. Ms. Heil answered questions about what happens in situations when a criminal justice entity is lacking health care providers. Ms. Heil discussed a survey that was sent out through the County Sheriffs of Colorado association to determine who the providers of certain health-related services are for the various county jails. Ms. Heil said that the survey results could possibly be made available to the committee.

**02:36 PM**

Ms. Harding discussed the focus group results concerning the attitudes towards the proposed health information exchange, which were mainly positive. She discussed the focus group results concerning the definition of "serious mental illness." Ms. Harding answered questions about the varying definitions of "serious mental illness" used by different entities. She responded to questions related to medication consistency throughout various criminal justice entities. Ms. Harding and Ms. Heil responded to additional questions about issues that can arise from different entities using definitions of "serious mental illness." Representative Lee discussed the need for a standardized screening tool for serious mental illness. In response to a question, Ms. Harding discussed some of the screening tools that are used in Colorado and the need for additional research regarding screening tools. Committee discussion about law enforcement training regarding the handling of persons with mental illness occurred.

**02:55 PM**

Ms. Harding answered questions about jail-based behavioral health services. Senator Newell discussed a possible research request on national information about definition for "serious mental illness" and the various screening tools for mental illness. Ms. Harding outlined the future directions listed in Attachment F for using the information gathered through the focus groups.

**03:01 PM**

Ms. Heil stated that the planning grant has been awarded for one year. She discussed the timeline for accessing implementation funds and the information exchange that could result if the implementation grant funds are received. Ms. Heil referenced the subcommittees that are involved in the planning grant structure. In response to a previous question, Ms. Heil discussed how medication consistency issues can arise when a person transfers facilities. She discussed the work of the medication consistency workgroup that the Behavioral Health Transformation Council formed. Ms. Heil referenced the other materials in the information packet she provided the committee.

**03:12 PM -- Status Update on Housing Work Group Activities**

Kathy McGuire, MICJS Task Force Member as the representative of the Office of Alternate Defense Council, discussed the background and work of the housing subcommittee of the MICJS Task Force. She listed the entities that are represented on the subcommittee. Ms. McGuire stated that a summer intern will be working on gathering information about prior and current legislation and other efforts that are underway to address housing for persons with a mental illness who are involved in the criminal and juvenile justice systems. She stated that the goal of the research is to develop a white paper. Ms. McGuire discussed the long-term goal of developing pilot projects to address housing issues in both the rural and metro areas.

**03:20 PM**

Representative Lee discussed the issue of inmates being released homeless. He encouraged the subcommittee to engage the Department of Local Affairs. Ms. McGuire stated that the subcommittee has identified 30 entities to engage in the subcommittee's efforts. Senator Newell discussed a possible research request of prior legislation concerning housing for persons with a mental illness who are involved in the criminal and juvenile justice systems.

**03:25 PM -- Discussion of Future 2016 Legislative Oversight Committee Meeting Dates**

Amanda King, Legislative Council Staff, outlined various scheduling matters for the committee to consider. She stated that Colorado law indicates that the committee is to meet a minimum of three times annually. Ms. King stated that the bill drafting and interim committee meeting guidelines will probably not be issued until June, but outlined a possible timeline for interim committee bill drafting. In response to a question, Ms. Walton stated she did not feel it was necessary for the committee to meet again before the end of the legislative session, but encouraged the committee members to attend the upcoming task force meetings. Committee discussion about a potential meeting in June occurred, but no specific date was determined.

**03:30 PM -- Public Comment**

**03:30 PM --** Lisa Mitchell, representing herself, discussed family's experience with juvenile and criminal justice systems. She expressed her concerns about the treatment her son received from various state entities. She discussed the use of psychotropic medications in state facilities and Medicaid fraud.

**03:45 PM**

Committee members made comments regarding Ms. Mitchell's testimony. Committee members continued to dialogue with Ms. Mitchell about her son and her possible involvement with the MICJS Task Force.

**03:54 PM --** Debbie Carroll, representing herself, discussed competency evaluations, the conditions of youth corrections facilities, and House Bill 16-1110, a Parent's Bill of Rights. Committee members commented about Ms. Carroll's testimony.

**03:59 PM -- Research Requests**

Representative Singer discussed potential research requests concerning a 50-state survey of definitions of "serious mental illness," screening tools for mental illness for people entering jails or prison, and prior legislation concerning housing for people being released from the criminal and juvenile justice systems. The committee discussed the potential research requests with Ms. King.

**04:01 PM**

The committee adjourned.

## AGENDA

**Legislative Oversight Committee Concerning the  
Treatment of Persons With Mental Illness in the  
Criminal and Juvenile Justice Systems**

Friday, March 18, 2016  
1:30 p.m.  
House Committee Room 0112

---

- 1:30 p.m. Call to Order**
- *Representative Singer, Legislative Oversight Committee Chair*
- 1:35 p.m. Status Update on Restoration/Competency Work Group Activities**
- *Sheri Danz, Advisory Task Force member*
- 2:05 p.m. General Overview of Advisory Task Force Recent Activities**
- *Susie Walton, Advisory Task Force Chair*
- 2:35 p.m. Advisory Task Force Membership Update and Discussion of Advisory Task Force Vacancies**
- *Susie Walton, Advisory Task Force Chair*
- 2:45 p.m. Status Update on Data Subcommittee Activities**
- *Camille Harding, Advisory Task Force Co-chair*
- 3 p.m. Status Update on Housing Work Group Activities**
- *Kathy McGuire, Advisory Task Force member*
- 3:30 p.m. Discussion of Future 2016 Legislative Oversight Committee Meeting Dates**
- 3:45 p.m. Public Comment**
- 4 p.m. Adjourn**



**Colorado  
Legislative  
Council  
Staff**

Room 029 State Capitol, Denver, CO 80203-1784  
(303) 866-3521 • FAX: 866-3855 • TDD: 866-3472  
[www.colorado.gov/lcs](http://www.colorado.gov/lcs)  
E-mail: [lcs.ga@state.co.us](mailto:lcs.ga@state.co.us)

**M E M O R A N D U M**

October 15, 2014

**TO:** Senator Linda Newell

**FROM:** Amanda King, Senior Research Analyst, (303) 866-4332

**SUBJECT:** Juvenile Competency Statutes and Model Legislation

**Summary**

This memorandum responds to your request for information about comparative language from other states concerning juvenile competency statutes. Specifically, this memorandum provides lists of juvenile competency laws identified by the National District Attorneys Association and the National Conference of State Legislatures; a summary of the National Center for Juvenile Justice's document on juvenile competency procedures in various states; an overview of the National Juvenile Justice Network's recommendations for policymakers on juvenile competency; and a discussion of the Models for Change guide for lawmakers on developing laws for competency to stand trial in juvenile delinquency proceedings. Additional information about any specific state is available from staff upon request.

**National District Attorneys Association**

In 2012, the National District Attorneys Association compiled a list of juvenile competency laws. The following 18 states were identified as having juvenile competency laws or court rules: Arizona, California, Colorado, Florida, Georgia, Idaho, Kansas, Louisiana, Maryland, Minnesota, Missouri, Nebraska, New Hampshire, New Mexico, Ohio, Texas, Vermont, and Virginia. The table of contents for the National District Attorneys Association document includes statutory citations for each identified state (Attachment A). The full document provides language from each identified states' juvenile competency laws and can be accessed at:

[www.ndaa.org/pdf/Juvenile%20Competency%202012.pdf](http://www.ndaa.org/pdf/Juvenile%20Competency%202012.pdf).

**Open records requirements:** Pursuant to Section 24-72-202 (6.5)(b), C.R.S., research memoranda and other final products of Legislative Council Staff are considered public records and subject to public inspection unless: a) the research is related to proposed or pending legislation; and b) the legislator requesting the research specifically asks that the research be permanently considered "work product" and not subject to public inspection. If you would like to designate this memorandum to be permanently considered "work product" not subject to public inspection, or if you think additional research is required and this is not a final product, please contact the Legislative Council Librarian at (303) 866-4011 within seven days of the date of the memorandum.

## National Conference of State Legislatures

The National Conference of State Legislatures (NCSL) also identified 18 states with juvenile competency laws or court rules. However, the same 18 states do not appear on both lists. Specifically, the National District Attorneys Association list includes Missouri, New Hampshire, New Mexico, and Vermont, but these states do not appear on the NCSL list. Alternatively, Arkansas, Maine, South Dakota, and Wisconsin appear on the NCSL list, but not the National District Attorneys Association list. It is unclear why there is a discrepancy between the information provided by the two organizations, but it does appear that all the states on both lists have juvenile competency laws or court rules in place. Table 1 lists the state laws or court rules identified by NCSL as addressing juvenile competency, and includes hyperlinks to the identified laws or court rule.

**Table 1**  
**Juvenile Competency Laws**

State	Statutory Citation
Arizona	<a href="#"><u>Ariz. Rev. Stat. § 8-291 et seq.</u></a>
Arkansas	<a href="#"><u>Ark. Code § 9-27-502.</u></a>
California	<a href="#"><u>Cal. Wel. &amp; Inst. Code § 709.</u></a>
Colorado	<a href="#"><u>§ 19-2-1301 et seq., C.R.S.</u></a>
Florida	<a href="#"><u>Fla. Stat. § 985.19.</u></a>
Georgia	<a href="#"><u>Ga. Code Ann. § 15-11-650 et seq.</u></a>
Idaho	<a href="#"><u>Idaho Code Ann. §§ 20-519A to 20-519D.</u></a>
Kansas	<a href="#"><u>Kan. Stat. Ann. §§ 38-2348, 38-2349, and 2350.</u></a>
Louisiana	<a href="#"><u>La. Children's Code Ann. § 832 et seq.</u></a>
Maine	<a href="#"><u>Me. Rev. Stat. Ann. tit. 15, §§ 33318-A and 3818-B.</u></a>
Maryland	<a href="#"><u>Md. Code, C. &amp; J.P. § 3-8A-17 et seq.</u></a>
Minnesota	<a href="#"><u>Minn. R. Juv. Del. P. Rule 20.01.</u></a>
Nebraska	<a href="#"><u>Neb. Rev. Stat. § 43-258.</u></a>
Ohio	<a href="#"><u>Ohio Rev. Code Ann. § 2152.51 et seq.</u></a>
South Dakota	<a href="#"><u>S.D. Codified Laws § 26-7A-32.1 et seq.</u></a>
Texas	<a href="#"><u>Tex. Fa. Code § 51.20.</u></a>
Virginia	<a href="#"><u>Va. Code Ann. § 16.1-356 et seq.</u></a>
Wisconsin	<a href="#"><u>Wis. Stat. § 938.295.</u></a>

Source: National Conference of State Legislatures.

## The National Center for Juvenile Justice

The National Center for Juvenile Justice (NCJJ) published a document in October 2013 on juvenile competency procedures (Attachment B).<sup>1</sup> According to the NCJJ, all but six states have procedures under which juvenile competency to stand trial is decided. Those six states are Alaska, Hawaii, Mississippi, Oklahoma, Oregon, and Rhode Island. Juvenile competency procedures can be outlined in state law, court rules, and case law. The NCJJ document provides an overview of the *Dusky* standard.<sup>2</sup> The NCJJ document discusses the *Dusky* standard related to the juvenile competency procedures in Arizona, Georgia, Kentucky, North Dakota, and Wyoming. Of particular interest might be the following definition that was recently enacted in Georgia:

*§15-11-651. Definitions. (3) "Incompetent to proceed" means lacking sufficient present ability to understand the nature and object of the proceedings, to comprehend his or her own situation in relation to the proceedings, and to assist his or her attorney in the preparation and presentation of his or her case in all adjudication, disposition, or transfer hearings. Such term shall include consideration of a child's age or immaturity.*

According to the NCJJ document, states use a variety of factors to determine whether or not a juvenile meets the *Dusky* standard, and outlines the factors in Arkansas, Idaho, Maine, and North Dakota law. In some states, such as Georgia, Idaho, Maine, Maryland, and Vermont, age is a factor in deciding whether a juvenile is competent or not. In other states, such as Arizona, Connecticut, Delaware, Montana, and Virginia, age alone does not render a juvenile incompetent. Other states, such as Arkansas, Michigan, and Ohio include age as a factor in certain circumstances.

The NCJJ document provides information on the application of juvenile competency laws to situations involving the transfer of a juvenile case to a criminal court. Specifically, Georgia, Kentucky, Louisiana, and Maryland are listed as states where this is a factor. Additionally, the document discusses the transfer procedures in Connecticut, Maine, Nevada, South Dakota, Texas, and Virginia.

The NCJJ document references recently enacted juvenile competency laws in Connecticut, Delaware, Georgia, Idaho, Maine, Michigan, Ohio, South Dakota, Utah, and West Virginia; recent case law in Colorado and Louisiana; and selected definitions in Delaware, Louisiana, and Maryland.

## National Juvenile Justice Network

According to the National Juvenile Justice Network (NJJN), every state except Oklahoma recognizes that juveniles in juvenile court must be competent to stand trial.<sup>3</sup> However, not all states have established competency standards for use in juvenile court.

---

<sup>1</sup>The National Center for Juvenile Justice is the private, nonprofit research division of the National Council of Juvenile and Family Court Judges.

<sup>2</sup>The *Dusky* standard is taken from a U.S. Supreme Court case. Under the *Dusky* standard, the defendant must have the ability to consult with his or her attorney and have a rational and factual understanding of the proceedings against him or her. *Dusky v. United States*, 362 U.S. 402, 80 S.Ct. 788, L.Ed.2d 824 (1960).

<sup>3</sup>The National Juvenile Justice Network is a membership-based organization promoting the reform of America's juvenile justice system.

In 2012, the NJJN issued a policy update entitled *Competency to Stand Trial in Juvenile Court: Recommendations for Policymakers* (Attachment C). The recommendations draw from another document, *Developing Statutes for Competence to Stand Trial in Juvenile Delinquency Proceedings: A Guide for Lawmakers*, which is discussed later in this memorandum. The NJJN policy update specifies the following factors as ones state policymakers should consider when developing competency statutes: defining competence; due process considerations; competence evaluation by mental health examiners; and remediation and legal disposition of incompetent defenders.

**Defining competence.** According to the NJJN, juvenile competency laws should instruct the court to consider a juvenile's mental illness, intellectual disability, and developmental maturity when determining whether a juvenile is competent to stand trial in juvenile court. While laws addressing adult competency usually declare someone incompetent on the basis of either mental illness or intellectual disability, juvenile competency evaluations often reveal developmental immaturity as a third reason for incompetence. Developmental immaturity restricts a juveniles ability to understand and reason, even in the absence of a mental illness or intellectual disability.

The NJJN states that state laws should include cognitive thresholds that juveniles must meet to be found competent. These may include factual understanding, rational understanding, the ability to assist counsel, and the ability to make decisions. The NJJN recommends using broad categories to allow judges discretion when deciding whether or not a juvenile satisfies the thresholds. It discourages referencing specific abilities, such as the ability to disclose relevant facts to his or her attorney.

**Due process considerations.** According to the NJJN recommendations, juveniles should be permitted to exercise their right to counsel prior to any competency evaluation and should be protected against the use of any self-incriminating statements made during the evaluation. The recommendation suggests using the protections afforded to adults in criminal competency evaluations for guidance, as well as protections afforded to juveniles undergoing other mental or behavioral health evaluations.

**Competence evaluations by mental health examiners.** The NJJN recommendations outline several factors for juvenile competency evaluations. The evaluations should be performed by an examiner with training and experience in child psychology or psychiatry. The evaluators should have appropriate training in forensic specialization, and states should provide continuing education to these professionals. The evaluations should be conducted in the least restrictive setting appropriate. Finally, the evaluations should be performed within a reasonable time period, and the recommendation suggests that evaluations can be appropriately completed by a qualified professional within two to three weeks of when the evaluation is ordered.

The recommendation states that the laws should provide guidance to the court and to the examiners on the competency evaluation report contents. Additionally, the laws should offer more direction than merely a list of the content areas, but should still leave some discretion to the courts and evaluators. The following five content areas for the evaluation report are specified in the recommendation:

- assessment of the juvenile's mental disorder and intellectual disability;
- assessment of the juvenile's developmental status;
- assessment of how the juvenile's mental disorder, intellectual disability, or developmental maturity affects his or her abilities associated with competence to stand trial;

- causes of the juvenile's deficits, if any, in his or her abilities associated with competence to stand trial; and
- potential for remediation of the juvenile's abilities associated with competence to stand trial.

**Remediation and legal disposition of incompetent defendants.** The NJJN recommends that state laws instruct the courts to determine the most appropriate placement or services for the juvenile based on the particular reasons underlying the juvenile's incompetence. It proposes that this time should be referred to as remediation, rather than restoration, because it does not imply that the juvenile was once competent and will over time be restored to that status. It also recommends that during the time of remediation, the juvenile should be placed in the least restrictive setting available. The recommendation also states that laws should provide a length of time allowed for remediation and include a periodic review of remediation progress. The recommendation suggests looking at a state's criminal code for guidance on the length of time permitted for remediation and advises that when incompetence cannot be remediated, a decision must be made about the legal disposition of the case that balances the interest of the juvenile, the state, and the public. Finally, the recommendation states that when a juvenile cannot be remediated and the case is dismissed, the laws should include provisions to allow a court to transfer a case to the state's child welfare system. This will allow the court to address public safety concerns and order appropriate services for the juvenile.

## Models for Change

In 2011, Models for Change published *Developing Statutes for Competence to Stand Trial in Juvenile Delinquency Proceedings: A Guide for Lawmakers* by Kimberly Larson, Ph.D., J.D., Thomas Grisso, Ph.D., and the National Youth Screening and Assessment Project.<sup>4</sup> This guide can be found at: <http://modelsforchange.net/publications/330>. As was stated previously, this publication was the basis for the NJJN policy update entitled *Competency to Stand Trial in Juvenile Court: Recommendations for Policymakers*. However, the full guide published by Models for Changes provides a more in-depth discussion of definitions of competence to stand trial and other related topics. Specific to the definitions, the Models for Change guide outlines the following factors: psychological predicates for incompetence; relation of the predicate of developmental immaturity to incompetence; functional ability associated with competence (incompetence); and degree of defendant ability required in delinquency proceedings.

**Psychological predicates for incompetence.** The Models for Change guide states that laws should offer a definition of the allowable predicates for incompetence to stand trial. It goes on to explain that a predicate refers to a psychological condition that accounts for or is the cause of a defendant's incapacities in areas that are relevant for competency determinations. The Models of Change guide discusses consideration of specifying allowable mental disorders in statutory definition, and whether developmental immaturity should be included among the allowable predicates. The guide includes examples from California, Florida, and Virginia on allowing or not allowing developmental immaturity as a predicate. Ultimately, the Models of Change guide recommends including developmental immaturity as a predicate for incompetence to stand trial in juvenile court. The guide uses the following California law from the California Welfare and Institutions Code as an illustration of this type of law:

---

<sup>4</sup>Models for Change is a multi-state initiative working to guide and accelerate advances to make juvenile justice systems more fair, effective, rational, and developmentally appropriate. It is funded by the John D. and Catherine T. MacArthur Foundation.

709. (b) *Upon suspension of proceedings, the court shall order that the question of the minor's competence be determined at a hearing. The court shall appoint an expert to evaluate whether the minor suffers from a mental disorder, developmental disability, developmental immaturity, or other condition and, if so, whether the condition or conditions impair the minor's competency. The expert shall have expertise in child and adolescent development, and training in the forensic evaluation of juveniles, and shall be familiar with competency standards and accepted criteria used in evaluating competence. The Judicial Council shall develop and adopt rules for the implementation of these requirements.*

**Relation of the predicate of developmental immaturity to incompetence.** The Models for Change guide states that if developmental immaturity is accepted as a predicate, states should consider how the predicate will be applied. It outlines the following three options: judicial discretion; age-based presumption of incompetence; and *per se* incompetence. After an analysis of the three options, the Models for Change guide recommends a multi-tiered system that combines all three options. It proposes that the division between the tiers be age-based, with juveniles in different tiers receiving different levels of protections.

**Functional abilities associated with competence (incompetence).** The Models for Change guide recommends that the degree of detail included in statutes concerning the definition of competence to stand trial be determined by the state. The guide goes on to explain that in most states, the definition of competence to stand trial describes the ability to assist counsel in a defense, and the ability to understand or appreciate the nature of the proceedings. However, some states have gone further in defining the abilities that are of concern in competency determinations, which provides more guidance to the courts and examiners. The Models for Change guide discusses various options, including specifically identifying the necessary functional abilities, outlining broad concepts, and not providing further refinement beyond the state's definition similar to the *Dusky* Standard.

After a discussion of the various options, the Models for Change guide recommends defining broader cognitive concepts, rather than functional abilities. The Models for Change guide points to the following Maryland's law as an example of this type of approach:

§3-8A-17.3. (3) *In determining whether the child is incompetent to proceed, the qualified expert shall consider the following factors:*

(i) *The child's age, maturity level, developmental stage, and decision-making abilities;*

(ii) *The capacity of the child to:*

1. *Appreciate the allegations against the child;*
2. *Appreciate the range and nature of allowable dispositions that may be imposed in the proceedings against the child;*
3. *Understand the roles of the participants and the adversary nature of the legal process;*
4. *Disclose to counsel facts pertinent to the proceedings at issue;*
5. *Display appropriate courtroom behavior; and*
6. *Testify relevantly; and*

(iii) *Any other factors that the qualified expert deems to be relevant.*

***Degree of defendant ability required in delinquency proceedings.*** The Models for Change guide encourages states to consider whether juvenile statutes should address the degree of ability required for competence. According to the Models for Change guide, most states' standards describe the types of abilities required, but few address whether the same or a lesser degree of those abilities is required in juvenile court in comparison to criminal court. The Models for Change guide discusses the following four options concerning this issue: same level of ability; lower level of ability; charge-related; and no guidance. After an analysis of the four options, the Models for Change guide does not make a recommendation on this issue, but merely states that the choice should be based on the state's sense of fairness, as well as practical considerations, such as the current state of their laws with regard to the consequences for juveniles who are adjudicated delinquent.



## U.S. States with Juvenile Competency Statutes

*Please note there may have been changes to this area of law since our last update. Please feel free to contact us at 703-549-9222 to discuss information included in this document.*

### TABLE OF CONTENTS

<b><u>ARIZONA</u></b> .....	<b><u>5</u></b>
ARIZ. REV. STAT. § 8-291 (2012). DEFINITIONS .....	5
ARIZ. REV. STAT. § 8-291.01 (2012). EFFECT OF INCOMPETENCY; REQUEST FOR EXAMINATION.....	5
ARIZ. REV. STAT. § 8-291.03 (2012). EXPERT APPOINTMENT; COSTS; IMMUNITY.....	6
ARIZ. REV. STAT. § 8-291.03 (2012). SCREENING REPORT .....	6
ARIZ. REV. STAT. § 8-291.04 (2012). EXAMINATION; COMPETENCY TO STAND TRIAL .....	7
ARIZ. REV. STAT. § 8-291.05 (2012). MISDEMEANOR CHARGES; DISMISSAL; NOTICE .....	8
ARIZ. REV. STAT. § 8-291.06 (2012). PRIVILEGE AGAINST SELF-INCRIMINATION; SEALED REPORTS .....	8
ARIZ. REV. STAT. § 8-291.07 (2012). MENTAL HEALTH EXPERT REPORTS.....	10
ARIZ. REV. STAT. § 8-291.08 (2012).. COMPETENCY HEARINGS; RESTORATION ORDERS .....	11
ARIZ. REV. STAT. § 8-291.09 (2012). RESTORATION ORDER; COMMITMENT .....	11
ARIZ. REV. STAT. § 8-291.10 (2012). REPORTS; HEARINGS .....	13
ARIZ. REV. STAT. § 8-291.11 (2012). RECORDS .....	14
<b><u>CALIFORNIA</u></b> .....	<b><u>15</u></b>
CAL. WELF. & INST. CODE § 709 (2012). INCOMPETENCY; SUSPENSION OF PROCEEDINGS; HEARING; APPLICATION; EXPERT OPINION THAT MINOR IS DEVELOPMENTALLY DISABLED; DETERMINATION OF ELIGIBILITY FOR SERVICES.....	15
<b><u>COLORADO</u></b> .....	<b><u>16</u></b>
COLO. REV. STAT. § 19-2-1301 (2012). MENTAL INCOMPETENCY TO PROCEED--EFFECT--HOW AND WHEN RAISED.....	16
COLO. REV. STAT. § 19-2-1302 (2012). DETERMINATION OF INCOMPETENCY TO PROCEED .....	17
COLO. REV. STAT. § 19-2-1303 (2012). PROCEDURE AFTER DETERMINATION OF COMPETENCY OR INCOMPETENCY .....	18
COLO. REV. STAT. § 19-2-1304 (2012). RESTORATION TO COMPETENCY .....	19
COLO. REV. STAT. § 19-2-1302 (2012).. PROCEDURE AFTER HEARING CONCERNING RESTORATION TO COMPETENCY.....	20
<b><u>DELEWARE</u></b> .....	<b><u>20</u></b>
BILL .....	20
<b><u>CONNECTICUT</u></b> .....	<b><u>24</u></b>
BILL .....	24

<b><u>DISTRICT OF COLUMBIA</u></b> .....	<b>29</b>
D.C. CODE § 16-2315 (2012). PHYSICAL AND MENTAL EXAMINATIONS.....	29
<b><u>FLORIDA</u></b> .....	<b>34</b>
FLA. STAT. ANN. § 985.18 (2012). MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL, SUBSTANCE ABUSE, AND EDUCATIONAL EXAMINATION AND TREATMENT .....	34
RULE 8.095. PROCEDURE WHEN CHILD BELIEVED TO BE INCOMPETENT OR INSANE.....	40
<b><u>GEORGIA</u></b> .....	<b>46</b>
GA. CODE ANN. § § 15-11-149 (2012). DISPOSITION OF MENTALLY ILL OR MENTALLY RETARDED CHILD .....	46
GA. CODE ANN. § § 15-11-150 (2012). LEGISLATIVE PURPOSE .....	46
GA. CODE ANN. § § 15-11-151 (2012). DEFINITIONS.....	47
GA. CODE ANN. § § 15-11-152 (2012). STAY OF PROCEEDINGS REGARDING CHILD WHO MAY NOT BE MENTALLY COMPETENT; EVALUATION OF CHILD'S MENTAL CONDITION .....	48
GA. CODE ANN. § § 15-11-153 (2012). MENTAL COMPETENCY HEARINGS; FINDINGS BY COURT .....	51
GA. CODE ANN. § § 15-11-153.1 (2012). FINDING OF MENTAL INCOMPETENCY; DISMISSAL OF PETITION; TRANSFER TO STATE COURT.....	52
GA. CODE ANN. § § 15-11-153.2 (2012). TRANSFER OF PROCEEDINGS; JURISDICTION .....	52
GA. CODE ANN. § § 15-11-154 (2012). PLAN MANAGER; MENTAL COMPETENCY PLAN.....	53
GA. CODE ANN. § § 15-11-155 (2012). DISPOSITION HEARING ON MENTAL COMPETENCY PLAN; COMMITMENT OF CHILD TO CERTAIN AGENCIES; CONTINUING JURISDICTION .....	55
<b><u>IDAHO</u></b> .....	<b>57</b>
IDAHO CODE ANN. § § 20-519A (2012). EXAMINATION OF JUVENILE--COMPETENCY--APPOINTMENT OF PSYCHIATRISTS, LICENSED PSYCHOLOGISTS OR EVALUATION COMMITTEE--HOSPITALIZATION--REPORT .....	57
<b><u>KANSAS</u></b> .....	<b>60</b>
KAN. STAT. ANN. § 38-2348 (2012). PROCEEDINGS TO DETERMINE COMPETENCY .....	60
KAN. STAT. ANN. § 38-2349 (2012). SAME; COMMITMENT OF INCOMPETENT .....	61
KAN. STAT. ANN. § 38-2350 (2012). SAME; JUVENILE NOT MENTALLY ILL PERSON.....	61
<b><u>LOUISIANA</u></b> .....	<b>62</b>
LA. REV. STAT. ANN. § ART. 832 (2012). HOW MENTAL INCAPACITY IS RAISED; EFFECT.....	62
LA. REV. STAT. ANN. § ART. 833 (2012). MENTAL EXAMINATIONS.....	62
LA. REV. STAT. ANN. § ART. 834 (2012). APPOINTMENT OF COMPETENCY COMMISSION; QUALIFICATIONS .....	63
LA. REV. STAT. ANN. § ART. 834.1 (2012). DOCUMENTATION OF COMPETENCY COMMISSION .....	64
LA. REV. STAT. ANN. § ART. 835 (2012). REPORT OF COMPETENCY COMMISSION; CONTENT; FILING.....	64
LA. REV. STAT. ANN. § ART. 837 (2012).. PROCEDURE AFTER DETERMINATION OF MENTAL CAPACITY ...	66
LA. REV. STAT. ANN. § ART. 837.2 (2012). REPORT OF RESTORATION SERVICE PROVIDER.....	70
LA. REV. STAT. ANN. § ART. 837.3 (2012). SIX-MONTH EVALUATION; HEARING.....	71
LA. REV. STAT. ANN. § ART. 837.4 (2012). TWO-YEAR EVALUATION; HEARING.....	72
LA. REV. STAT. ANN. § ART. 837.5 (2012). THREE-YEAR EVALUATION; HEARING.....	73
LA. REV. STAT. ANN. § ART. 837.6(2012). PROCEDURE FOR CHANGE OF PLACEMENT; COMMITMENT TO MENTAL INSTITUTION OR OUT-OF-HOME PLACEMENT.....	74
<b><u>MARYLAND</u></b> .....	<b>75</b>
MD. CODE ANN. § 3-8A-17.4. (2012). COMPETENCY HEARING .....	75
MD. CODE ANN. § 3-8A-17.5 (2012). COMPETENCY OF CHILD.....	76
MD. CODE ANN. § 3-8A-17.6 (2012). COMPETENCY ATTAINMENT SERVICES.....	76
MD. CODE ANN. § 3-8A-17.7 (2012). INCOMPETENT CHILDREN UNLIKELY TO ATTAIN COMPETENCY ...	77

<b><u>MINNESOTA</u></b> .....	<b>79</b>
MINN. R. JUV. DEL. P. 20.0: PROCEEDING WHEN CHILD IS BELIEVED TO BE INCOMPETENT .....	79
<b><u>MISSOURI</u></b> .....	<b>84</b>
Mo. S. Ct. R. 117.01: PHYSICAL AND MENTAL EXAMINATION OF JUVENILE.....	84
<b><u>NEBRASKA</u></b> .....	<b>85</b>
NEB. REV. STAT. ANN. § 24-258 (2012). PREADJUDICATION PHYSICAL AND MENTAL EVALUATION; PLACEMENT; RESTRICTIONS; REPORTS; COSTS; RESPONSIBILITY .....	85
NEB. REV. STAT. ANN. § 43-259 (2012). EVALUATION; MOTION FOR RELEASE OF JUVENILE IN CUSTODY .....	86
<b><u>NEW HAMPSHIRE</u></b> .....	<b>86</b>
N.H. REV. STAT. ANN. 169-B:20 (2012). DETERMINATION OF COMPETENCE. ....	86
N.H. REV. STAT. ANN. 169-B:21 (2012). MENTAL HEALTH AND SUBSTANCE ABUSE EVALUATION. ....	87
N.H. REV. STAT. ANN. 169-B:22 (2012). DISPOSITION OF A MINOR WITH A DISABILITY. ....	87
N.H. REV. STAT. ANN. 169-B:23 (2012). ORDERS FOR PHYSICAL EXAMINATION AND TREATMENT. ....	89
<b><u>NEW MEXICO</u></b> .....	<b>89</b>
N.M. CHILD. Ct. R. 10-242.....	89
RULE 10-242. DETERMINATION OF COMPETENCY TO STAND TRIAL.....	89
<b><u>OHIO</u></b> .....	<b>91</b>
OHIO JUV. R. 32(A) SOCIAL HISTORY; PHYSICAL EXAMINATION; MENTAL EXAMINATION; INVESTIGATION INVOLVING THE ALLOCATION OF PARENTAL RIGHTS AND RESPONSIBILITIES FOR THE CARE OF CHILDREN	91
<b><u>TEXAS</u></b> .....	<b>92</b>
TEX. FAM. CODE ANN. § 55.31 (2012). UNFITNESS TO PROCEED DETERMINATION; EXAMINATION.....	92
TEX. FAM. CODE ANN. § 55.32 (2012). HEARING ON ISSUE OF FITNESS TO PROCEED .....	93
TEX. FAM. CODE ANN. § 55.33 (2012). PROCEEDINGS FOLLOWING FINDING OF UNFITNESS TO PROCEED .....	94
TEX. FAM. CODE ANN. § 55.35 (2012). INFORMATION REQUIRED TO BE SENT TO FACILITY; REPORT TO COURT.....	95
TEX. FAM. CODE ANN. § 55.36 (2012). REPORT THAT CHILD IS FIT TO PROCEED; HEARING ON OBJECTION .....	96
TEX. FAM. CODE ANN. § 55.37 (2012). REPORT THAT CHILD IS UNFIT TO PROCEED AS A RESULT OF MENTAL ILLNESS; INITIATION OF COMMITMENT PROCEEDINGS.....	96
TEX. FAM. CODE ANN. § 55.38 (2012). COMMITMENT PROCEEDINGS IN JUVENILE COURT FOR MENTAL ILLNESS .....	97
TEX. FAM. CODE ANN. § 55.39 (2012). REFERRAL FOR COMMITMENT PROCEEDINGS FOR MENTAL ILLNESS .....	98
TEX. FAM. CODE ANN. § 55.40 (2012). REPORT THAT CHILD IS UNFIT TO PROCEED AS A RESULT OF MENTAL RETARDATION .....	98
TEX. FAM. CODE ANN. § 55.41 (2012). COMMITMENT PROCEEDINGS IN JUVENILE COURT FOR MENTAL RETARDATION .....	99
TEX. FAM. CODE ANN. § 55.42 (2012). REFERRAL FOR COMMITMENT PROCEEDINGS FOR MENTAL RETARDATION .....	99
TEX. FAM. CODE ANN. § 55.43 (2012). RESTORATION HEARING .....	100
TEX. FAM. CODE ANN. § 55.44 (2012). TRANSFER TO CRIMINAL COURT ON 18TH BIRTHDAY OF CHILD	101
TEX. FAM. CODE ANN. § 55.45 (2012). STANDARDS OF CARE; NOTICE OF RELEASE OR FURLOUGH .....	102
<b><u>VERMONT</u></b> .....	<b>102</b>
Vt. R. FAM. P. 1(i).....	103

RULE 1. PROCEDURE FOR JUVENILE DELINQUENCY PROCEEDINGS .....	103
<b><u>VIRGINIA</u></b> .....	<b>108</b>
VA. CODE ANN. § 16.1-356 (2012). RAISING QUESTION OF COMPETENCY TO STAND TRIAL; EVALUATION AND DETERMINATION OF COMPETENCY .....	108
VA. CODE ANN. § 16.1-357 (2012). DISPOSITION WHEN JUVENILE FOUND INCOMPETENT.....	110
VA. CODE ANN. § 16.1-358 (2012). DISPOSITION OF THE UNRESTORABLY INCOMPETENT JUVENILE.....	111
VA. CODE ANN. § 16.1-359 (2012). LITIGATING CERTAIN ISSUES WHEN THE JUVENILE IS INCOMPETENT .....	111
VA. CODE ANN. § 16.1-360 (2012). DISCLOSURE BY JUVENILE DURING EVALUATION OR RESTORATION; USE AT GUILT PHASE OF TRIAL ADJUDICATION OR DISPOSITION HEARING .....	111
VA. CODE ANN. § 16.1-361 (2012). COMPENSATION OF EXPERTS .....	112

# JJGPS JUVENILE JUSTICE GEOGRAPHY, POLICY, PRACTICE & STATISTICS STATESCAN

Linda A. Szymanski, Esq., Senior Attorney, NCJJ

October 2013

*Juvenile Justice GPS (Geography, Policy, Practice, Statistics) is a project to develop an online repository providing state policy makers and system stakeholders with a clear understanding of the juvenile justice landscape in the states. The site layers the most relevant national and state level statistics with information on state laws and practice and charts juvenile justice system change. In a landscape that is highly decentralized and ever-shifting, JJGPS provides an invaluable resource for those wanting to improve the juvenile justice system. We hope that the information will be used as a platform for inspiring change and finding solutions that have been applied in other places.*

## Juvenile Competency Procedures

Currently, all jurisdictions but the following six have either statutes, court rules or case law outlining the procedures under which juvenile competency to stand trial is decided: Alaska, Hawaii, Mississippi, Oklahoma, Oregon, and Rhode Island.

In fact, Oklahoma has specific case law from the state Court of Criminal Appeals explaining that since juvenile proceedings are not criminal but rehabilitative, it was the intent of the legislature not to have the competency statutes apply to juveniles. (*G.J.I. v. State*, 778 P.2d 485 (1989))

### The Dusky Standard

Typically, both juvenile and adult competency statutes are based on the *Dusky* standard, taken from the 1960 United States Supreme Court case. Under that case, “the test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and whether he has a rational as well as factual understanding of the proceedings against him.” (*Dusky v. United States*, 362 U.S. 402, 80 S.Ct. 788, 4 L.Ed.2d 824 (1960))

However, the Wyoming Supreme Court warns that these standards should be applied in the light of juvenile norms. (*In the Interest of SWM v. State*, 299 P.3d 673 (2013))

As an example, Georgia’s new definition of juvenile incompetency, effective in 2014, reads: ‘Incompetent to proceed’ means lacking sufficient present ability to understand the nature and object of the proceedings, to comprehend his or her own situation in relation to the proceedings, and to assist his or her attorney in the preparation and presentation of his or her case in all adjudication, disposition, or transfer hearings.

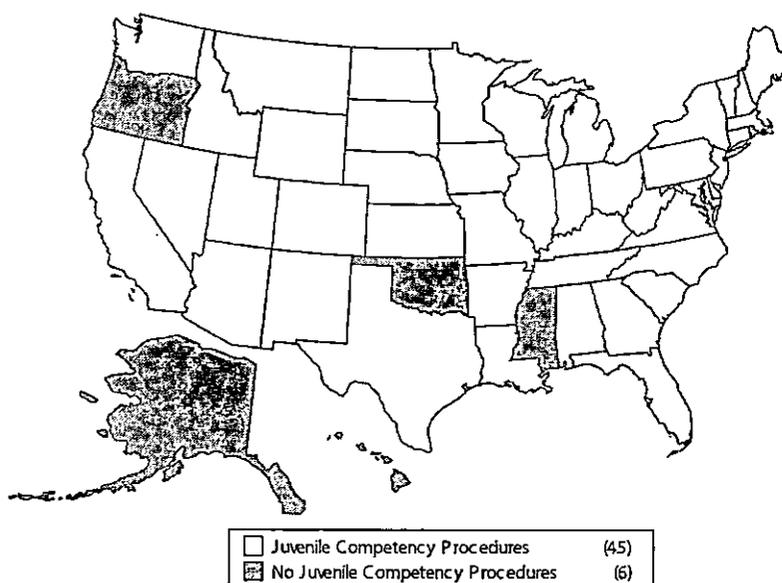
Under the Arizona version of the *Dusky* standard, a juvenile is incompetent if he or she does not have sufficient present ability to consult with the juvenile’s lawyer with a reasonable degree of rational understanding or who does not have a rational and factual

understanding of the proceedings against the juvenile.

In Kentucky, incompetency to stand trial under the *Dusky* standard means, as a result of mental condition, lack of capacity to appreciate the nature and consequences of the proceedings against one or to participate rationally in one’s own defense.

The test for determining an accused juvenile’s competency to stand trial in North Dakota is whether the accused has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and whether he has a rational as well as factual understanding of the proceedings against him.

States with Juvenile Competency Procedures



# NATIONAL JUVENILE JUSTICE NETWORK

## Competency to Stand Trial in Juvenile Court: Recommendations for Policymakers

POLICY UPDATE | NOVEMBER 2012

### ABOUT THIS DOCUMENT

Around the country, the question of whether a defendant is competent to stand trial is being raised more often in juvenile court proceedings. However, most states lack statutory guidance for how competence to stand trial should be applied in juvenile court. Instead, these states apply their adult criminal competence statutes to youth in juvenile court, resulting in frustration, confusion, and uncertainty among judges, prosecutors, and defense counsel. As a result, practitioners and policymakers have become interested in developing competency statutes for use in juvenile court.

To aid states in developing competency statutes for juvenile proceedings, the John D. and Catherine T. MacArthur Foundation's Models for Change initiative published *Developing Statutes for Competence to Stand Trial in Juvenile Delinquency Proceedings: A Guide for Lawmakers*. The 91-page guide provides a comprehensive analysis of statutory components, offering arguments in support of and against drafting options, and concludes with drafting recommendations. This brief policy update is intended to provide an overview of the juvenile court competency issue and to summarize the recommendations from Models for Change. However, in order to fully understand the range of statutory options and their implications, we strongly encourage readers to review the full guide.<sup>1</sup>

### INTRODUCTION

The United States judicial system is bound by the rights granted to the people in the Constitution. The right to due process and a fair trial, as guaranteed by the Fifth and Sixth Amendments respectively, are commonly thought of as cornerstones of the criminal justice system. However,

---

<sup>1</sup> The information in this document is drawn from the Models for Change guide, *Developing Statutes for Competence to Stand Trial in Juvenile Delinquency Proceedings: A Guide for Lawmakers*, from November 2011, available at <http://bit.ly/Tqp7sU>. For more information about Models for Change, visit [www.modelsforchange.net](http://www.modelsforchange.net).

the rights that embody these principles were not always granted to defendants in the juvenile justice system. Even today, youth prosecuted in the juvenile system are not constitutionally guaranteed all of the same protections afforded to defendants in criminal court proceedings.<sup>2</sup>

When juvenile courts were first established in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries, they were founded on the notion that youth in trouble with the law needed help and rehabilitative services, not punishment. As such, the courts were created within civil legal systems, rather than criminal systems, and lacked the majority of the due process protections guaranteed to defendants in criminal court—most notably, the right to counsel. Over time, the ideals of the juvenile justice system deteriorated. Youth were increasingly deprived of their liberty and subject to punishment instead of rehabilitation and treatment. The emerging harshness of the juvenile system began to raise questions about whether or not youths’ constitutional rights were being violated. In 1967, the Supreme Court responded to concerns about youth rights in *In re Gault*, and extended to youth defendants in juvenile court proceedings the right to timely notification of the charges filed against a defendant, the right to confront witnesses, the right against self-incrimination, and the right to counsel.<sup>3</sup> Although the Court extended other due process protections to defendants in juvenile court following *Gault*, the Court has yet to extend *all* due process rights to youth in the juvenile system. Among these protections is the requirement that a defendant be competent to stand trial.

Competency to stand trial dates back to English common law. Under common law, a defendant was required to have sufficient mental capacity to understand the proceedings against him and to participate in his or her defense. In 1960, the Supreme Court ruled in *Dusky v. U.S.* that competency to stand trial is a constitutional requirement, and a defendant is competent to stand trial if he or she “*has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and ... a rational as well as a factual understanding of the proceedings against him.*”<sup>4</sup> To comply with the Supreme Court’s holding in *Dusky*, states passed statutes to govern competency determinations in criminal court.

## COMPETENCY TO STAND TRIAL IN JUVENILE COURT

Defense attorneys did not begin to raise the question of competency in juvenile court until the 1990’s. As new laws were passed to treat youth more harshly and more like adult defendants, defense attorneys started raising competency to protect their clients in juvenile court. Since no juvenile competency standards existed, either in case law or statute, attorneys and courts frequently relied on their state’s criminal competency statute as the standard. Currently, all states except Oklahoma now recognize that youth in juvenile court must be competent to stand trial,

---

<sup>2</sup> For example, youth in juvenile court are not guaranteed a right to bail, the right to trial by jury, the right to a speedy trial, or the right to represent themselves.

<sup>3</sup> *In re Gault*, 387 U.S. 1 (1967).

<sup>4</sup> *Dusky v. United States*, 362 U.S. 402 (1960).

even though the Supreme Court has not formally extended this due process requirement to juvenile proceedings. However, not all states legislate or provide guidance on the competency standards to use in juvenile court. In fact, many states, if not most, still employ the same criminal competency statutes used to evaluate adult defendants for youth in juvenile court.

The use of adult competency statutes in juvenile court raises many concerns. Most importantly, criminal statutes were developed for use in determining the competency of adult defendants, and fail to recognize reasons for incompetence that are unique to youth. Criminal competency statutes typically include mental illness and intellectual disability as reasons for incompetence. However, when dealing with youth, a juvenile court should also consider a defendant's developmental maturity when assessing his or her competence to stand trial. These three reasons for incompetence—mental illness, intellectual disability, and developmental maturity—each present challenges when evaluating a youth's competence to stand trial. Moreover, they can also be interrelated, in that a youth's mental illness and/or intellectual disability may be further complicated by his or her developmental immaturity—an issue that is unique to youth.

## **Mental Illness**

---

Mental illness in youth is difficult to diagnose and treat, as symptoms of mental illness vary with age. A behavior that may be considered symptomatic in someone at one age, which would lead to a diagnosis of mental illness, may be considered normal behavior in someone younger or older, and would not result in a diagnosis. Young people's ongoing development makes it challenging to determine whether a symptom actually exists, or if it is just a behavior that will naturally subside with age. Moreover, a youth's mental illness may be more detrimental to his or her ability to understand the proceedings and participate in his or her defense—rising to the level of incompetence to stand trial—than it might to an adult with the same diagnosis.

## **Intellectual Disabilities and Cognitive Impairments**

---

Like adults, youth may have a low IQ, learning disability, and/or other neuropsychological impairment that affects their competence. However, some research has shown that youth are more frequently found incompetent based on intellectual deficits than are adults—finding that 58 percent of youth, and only six percent of adults, were found incompetent based on intellectual deficits.<sup>5</sup> In court, these youth may have problems with their memory, learning, and/or processing information, in addition to challenges with abstract reasoning and executive functioning. As a result, they may have difficulty satisfying the factual and rational

---

<sup>5</sup> Anette McGaha et al., "Juveniles Adjudicated Incompetent to Proceed: A Descriptive Study of Florida's Competence Restoration Program," *Journal of the American Academy of Psychiatry and the Law*, 29 (2001): 427.

understanding tests of the *Dusky* standard — even though they may not meet the full criteria for some of these intellectual and cognitive diagnoses.

## Developmental Maturity

---

While many adult criminal competency statutes refer to mental illness and intellectual disability as underlying factors for incompetence, none refer to a defendant's developmental maturity—a critical factor to consider when evaluating the competency of a youth to stand trial. The ongoing process of adolescent development can amplify mental illness or intellectual disabilities that are already affecting a youth's competence. And developmental immaturity alone can raise concerns about a youth's competence to stand trial. Neurological, cognitive, and psychosocial development all contribute to a youth's factual and rational level of understanding of the court process. During adolescence, youth may have an unstable sense of self, be emotionally impulsive, and have a decreased ability to make rational and reasonable decisions on their own. Their misperceptions of risk and sometimes faulty perspectives on others demand that courts consider developmental maturity when making a determination about a youth's competence. It would be foolish to neglect these major components of human development when making such determinations.

## RECOMMENDATIONS / FACTORS TO CONSIDER

To aid policymakers in this important work, this policy update summarizes a series of statutory factors to consider and drafting recommendations drawn from the Models for Change publication, *Developing Statutes for Competence to Stand Trial in Juvenile Delinquency Proceedings: A Guide for Lawmakers*.

### Defining Competence

---

**Juvenile competency statutes should instruct the court to consider a youth's mental illness, intellectual disability, and/or developmental maturity when determining whether the youth is competent to stand trial in juvenile court.**

- In criminal court, adults are usually declared incompetent for one of two reasons: mental illness or intellectual disability. Competency evaluations of youth however, often reveal a third reason for incompetence—developmental immaturity.

- Youth who are developmentally immature are restricted in their ability to understand and reason, even in the absence of a mental illness or intellectual disability. These limitations have been acknowledged by the Supreme Court on several occasions.<sup>6</sup>

**Statutes should provide guidance to the court by including cognitive thresholds that youth must satisfy to be found competent.**

- A juvenile competency statute should include cognitive thresholds to represent the concepts articulated by the Supreme Court in *Dusky*, mentioned above. For example, the thresholds might include factual understanding, rational understanding, the ability to assist counsel, and the ability to make decisions.
- Defining the categories broadly, as opposed to using specific abilities such as, “able to disclose relevant facts to his or her attorney,” protects youth who may have a factual understanding of the situation, but lack the ability to rationally apply the facts to the bigger picture. For example, a youth may know that he or she is in a courtroom, that there is a judge, a prosecutor, and a defense attorney, but may not comprehend the larger implications of a juvenile court proceeding. Since it is difficult to qualify rational understanding with specific abilities, using broad categories allows judges to use discretion when deciding whether or not a youth satisfies the thresholds.

## Due Process Considerations

---

**Youth should be provided a right to counsel prior to any evaluation of competence, as well as during the evaluation.**

- A competency evaluation in juvenile court is a critical stage of the proceeding and youth should be entitled to counsel before and during the evaluation under the Sixth Amendment, which guarantees defendants the “assistance of counsel for [their] defense.”<sup>7</sup> Similar to competency evaluations in criminal court, competency evaluations in juvenile court may affect the outcome of the case and result in a loss of liberty for the youth involved — hence the importance of counsel.

**Youth should be protected against the use of any self-incriminating statements made during a juvenile competency evaluation.**

- Self-incriminating statements made by youth during a juvenile competency evaluation, or information contained in the written competency report, should be prohibited from being used as evidence against the youth in future proceedings.

---

<sup>6</sup> *Roper v. Simmons*, 543 U.S. 551 (2005); *Graham v. Florida*, 130 S.Ct. 2011 (2010); *J.D.B. v. North Carolina*, 131 S.Ct. 2394 (2011); *Miller v. Alabama*, 132 S.Ct. 2455 (2012).

<sup>7</sup> U.S. Const. amend. 6.

- States may refer to the level of protection afforded to adults in criminal competency evaluations for guidance, or to the protections afforded to youth undergoing other mental or behavioral health evaluations in juvenile court.

## **Competence Evaluations by Mental Health Examiners**

---

**Evaluations of youth competency in juvenile court should be performed by examiners with training and/or experience in child psychology, or psychiatry with forensic specialization.**

- Mental health professionals conducting juvenile competency evaluations should have proper training and experience working with children and adolescents, and appropriate training in forensic specialization.
- States should provide continuing education to these professionals, to ensure up-to-date training and knowledge.

**Juvenile competency evaluations of youth should be performed in the least restrictive setting appropriate for the youth's psychological needs.**

- Youth should not be hospitalized in a psychiatric facility for a competency evaluation unless such psychiatric care is required for a reason separate from the competency evaluation.

**Juvenile competency evaluations should be performed within reasonable time limits.**

- A juvenile competency evaluation can be appropriately completed by a qualified professional within two to three weeks. States should consider this 14- to 21-day range in relation to the time limits they place on adult competency evaluations, and in light of both the youth's and the state's interest in avoiding unnecessary delay.

**Juvenile competency statutes should provide guidance to the court and to examiners on the content that should be included in the competency evaluation report.**

- Juvenile competency evaluations should include analysis in five content areas: assessment of the youth's mental disorder and intellectual disability; assessment of the youth's developmental status; assessment of how the youth's mental disorder, intellectual disability, and/or developmental maturity affect his or her abilities associated with competence to stand trial, such as what he or she understands about the trial process, assisting counsel, and making decisions about the proceedings; causes of the youth's deficits, if any, in his or her abilities associated with competence to stand trial; and

potential for remediation of the youth’s abilities associated with competence to stand trial.

- Statutes should offer more direction than merely a list of the content areas to be included in the evaluation report, but should still leave some discretion to courts and evaluators.

## **Remediation and Legal Disposition of Incompetent Defendants**

---

**Juvenile competency statutes should instruct the court to determine the most appropriate placement and/or services for a youth, based on the particular reasons underlying the youth’s incompetence.**

- While criminal statutes typically refer to “restoration”—the period of time it takes to restore an adult’s competence—juvenile competency statutes should refer to this period of time as “remediation.” Since some youth will be deemed incompetent to stand trial based purely on their developmental immaturity, remediation is a more appropriate label because it does not imply that the youth were once competent and will over time be restored to that status. Rather, it acknowledges that a youth may have never previously satisfied the competency-to-stand-trial benchmark.
- During the remediation process, youth should be placed in the least restrictive setting available.

**Statutes should provide a length of time allowed for remediation and should include provisions for periodic review of remediation progress.**

- States should look to their criminal codes for guidance on the length of time that should be permitted for remediation.
- Statutes should require periodic review of the remediation progress. Youth placed in inpatient facilities should be protected by more frequent reviews than youth placed in outpatient programs.

**When incompetence cannot be remediated, states must decide what should happen in the legal disposition of the case.**

- Juvenile competency statutes should balance the interests of the youth, the state, and the public when determining how these cases should be resolved.

**If an incompetent youth cannot be remediated and the state chooses to dismiss the juvenile charges against him or her, juvenile competency statutes should include provisions that allow the court to transfer the case to the state's child welfare system.**

- By transferring the case to the child welfare system, courts are able to address public safety concerns, and also order appropriate social or clinical services for the youth. States must determine the appropriate court procedure for such a provision.

## **CONCLUSION**

A competent defendant is a requirement for trial that derives from English common law. Incorporated under the due process clause of the Constitution, competence to stand trial protects defendants who cannot understand the proceedings against them or participate in their own defense. Despite states' acknowledgement that competence is a requirement in juvenile court, most states continue to rely on competence statutes that were developed for adult defendants and fail to consider issues regarding competence that are unique to youth. As competence to stand trial is increasingly raised in juvenile proceedings across the country, the need for statutory guidance is amplified.

Because this document is only intended to provide a brief overview of the issues raised by competency statutes in juvenile court and a summary of the Models for Change recommendations, we urge you to download the full document, *Developing Statutes for Competence to Stand Trial in Juvenile Delinquency Proceedings: A Guide for Lawmakers*, for more information.

## Factors Used in Determining the Dusky Standard

States use a variety of factors to reach the determination as to whether or not a juvenile meets the *Dusky* Standard.

For example, in Arkansas, in reaching an opinion about the juvenile's fitness to proceed, the examiner must consider and make written findings regarding an opinion on whether the juvenile's capabilities entail: an ability to understand and appreciate the charges and their seriousness; an ability to understand and realistically appraise the likely outcomes; a reliable episodic memory so that he or she can accurately and reliably relate a sequence of events; an ability to extend thinking into the future; an ability to consider the impact of his or her actions on others; verbal articulation abilities or the ability to express himself or herself in a reasonable and coherent manner; and logical decision-making abilities, particularly multi-factored problem solving or the ability to take several factors into consideration in making a decision.

In Idaho, the examiner or evaluation committee can employ any method of examination that is accepted by

the examiner's profession for the examination of juveniles alleged not to be competent, provided that such examination must, at a minimum, include formal assessments of the juvenile in each of the following domains: cognitive functioning; adaptive functioning; clinical functioning; comprehension of relevant forensic issues; and genuineness of effort.

To assist the court's determination of competency in Maine, the State Forensic Service examiner's report must address the juvenile's capacity and ability to: appreciate the range of possible dispositions that can be imposed in the proceedings against the juvenile and recognize how possible dispositions imposed in the proceedings will affect the juvenile; appreciate the impact of the juvenile's actions on others; disclose to counsel facts pertinent to the proceedings at issue including the ability to articulate thoughts; the ability to articulate emotions; and the ability to accurately and reliably relate a sequence of events. The juvenile being tested must also: display logical and autonomous decision making; display appropriate courtroom behavior; testify relevantly at proceedings; and

demonstrate any other capacity or ability either separately sought by the juvenile court or determined by the examiner to be relevant to the juvenile court's determination.

North Dakota case law identifies four, nonexclusive factors relevant to determining whether the evidence before the trial court should reasonably have raised a doubt as to the juvenile's competency: (1) the juvenile's irrational behavior; (2) the juvenile's demeanor before the trial court; (3) any prior medical opinions on the competency of the juvenile to stand trial; and (4) any questioning of the juvenile's competency by counsel before the trial court.

## Juvenile's Age as a Factor in Determining the Dusky Standard

Some states use the juvenile's age as a factor in deciding his or her competency. For example, the juvenile's age or immaturity can be used as one basis for determining the juvenile's competency in: Georgia, Idaho, Maine, Maryland, Vermont.

Juvenile Competency								
State	Legal Authority	Factors	Definitions	Dusky Standard	Age as Factor	Procedures	Recent Law	Transfer Procedures
Alabama	■	■		■				
Alaska								
Arizona	■		■	■	■	■		
Arkansas	■	■		■		■		
California	■	■		■		■		
Colorado	■		■	■		■		
Connecticut	■			■	■	■	■	■
Delaware	■	■	■	■	■	■	■	
Dist. of Columbia	■		■	■		■		■
Florida	■	■		■		■		
Georgia	■	■	■	■	■	■	■	■
Hawaii								
Idaho	■	■		■	■	■	■	
Illinois	■			■		■		
Indiana	■	■				■		
Iowa	■			■		■		
Kansas	■			■		■		
Kentucky	■			■				■
Louisiana	■	■	■	■		■		■
Maine	■	■		■	■	■	■	■
Maryland	■	■	■	■	■	■	■	■
Massachusetts	■			■				
Michigan	■	■		■	■	■	■	
Minnesota	■	■		■		■		
Mississippi								

Sometimes this is referred to as "Chronological immaturity," meaning a condition based on a juvenile's chronological age and significant lack of developmental skills when the juvenile has no significant mental illness or mental retardation.

On the other hand, age alone does NOT render a person incompetent in: Arizona, Connecticut, Delaware, Montana, and Virginia.

In Michigan, a juvenile 10 years of age or older is presumed competent to proceed unless the issue of competency is raised by a party. A juvenile younger than age 10 is presumed incompetent to proceed.

In Arkansas, if a juvenile is younger than 13 at the time of the alleged offense and is charged with capital murder or murder in the first degree there is a presumption that the juvenile is unfit to proceed and he or she lacked capacity to possess the necessary mental state required for the offense charged; to conform his or her conduct to the requirements of law; and to appreciate the criminality of his or her conduct. The prosecution must overcome these presumptions by a preponderance of the evidence.

In Ohio, if the juvenile who is the subject of the proceeding is fourteen years of age or older and if the juvenile is not otherwise found to be mentally ill, intellectually disabled, or developmentally disabled, it is rebuttably presumed that the juvenile does not have a lack of mental capacity. This presumption applies only in making a determination as to whether the juvenile has a lack of mental capacity.

### Juvenile Competency Statutes Applied to Transfer Statutes

A few jurisdictions specifically mention the applicability of their juvenile competency statute to their statute transfer provisions regarding the transferring a juvenile case to criminal court. The juvenile competency statute specifically applies to the transfer statute in: the District of Columbia, Georgia, Kentucky, Louisiana, and Maryland.

In Nevada, the juvenile court cannot certify a juvenile for criminal proceedings as an adult if the juvenile court specifically finds by clear and convincing evidence that the juvenile is developmentally or mentally

incompetent to understand the situation and the proceedings of the court or to aid the juvenile's attorney in those proceedings.

Under Texas law, a juvenile alleged by petition or found to have engaged in delinquent conduct who as a result of mental illness or mental retardation lacks capacity to understand the proceedings in juvenile court or to assist in the juvenile's own defense is unfit to proceed and must not be subjected to discretionary transfer to criminal court as long as such incapacity endures.

In Virginia, with certain statutory exceptions, if a juvenile 14 years of age or older at the time of an alleged offense is charged with an offense which would be a felony if committed by an adult, the court must, on motion of the attorney for the Commonwealth and prior to a hearing on the merits, hold a transfer hearing and can retain jurisdiction or transfer such juvenile for proper criminal proceedings to the appropriate Circuit Court having criminal jurisdiction of such offenses if committed by an adult. Any transfer to the appropriate Circuit

Juvenile Competency								
State	Legal Authority	Factors	Definitions	Dusky Standard	Age as Factor	Procedures	Recent Law	Transfer Procedures
Missouri	■							
Montana	■			■	■			
Nebraska	■							
Nevada	■			■				■
New Hampshire	■							
New Jersey	■	■		■		■		
New Mexico	■					■		
New York	■			■		■		
North Carolina	■			■		■		
North Dakota	■	■		■		■		
Ohio	■	■		■	■	■	■	
Oklahoma								
Oregon								
Pennsylvania	■	■		■		■		
Rhode Island								
South Carolina	■			■				
South Dakota	■	■		■		■	■	■
Tennessee	■					■		
Texas	■			■		■		■
Utah	■	■		■		■	■	
Vermont	■	■		■	■	■		
Virginia	■			■	■	■		■
Washington	■		■	■		■		
West Virginia						■	■	
Wisconsin	■		■			■		
Wyoming	■	■		■		■		

Court must be subject to the following conditions: the juvenile is competent to stand trial, the juvenile is presumed to be competent and the burden is on the party alleging the juvenile is not competent to rebut the presumption by a preponderance of the evidence.

Not-with-standing a finding by the juvenile court in Maine that the juvenile is competent to proceed in a juvenile proceeding, if the juvenile is subsequently bound over for prosecution in the Superior Court or a court with a unified criminal docket, the issue of the juvenile's competency can be revisited.

Likewise in South Dakota, not-with-standing a finding by the court that the juvenile is competent to proceed in a juvenile proceeding, if the juvenile is subsequently transferred to criminal court the issue of the juvenile's competency can be revisited.

In Connecticut, the juvenile competency statute does not apply to a transfer hearing.

### Recently Enacted Juvenile Competency Statutes

Recently, several states have enacted new juvenile competency statutes: West Virginia in 2010; Idaho, Maine, and Ohio in 2011; Connecticut, Delaware, and Utah in 2012; Michigan and South Dakota in 2013. New Georgia law will be taking effect in 2014.

### Juvenile Competency Definitions

Some state statutes provide valuable definitions. Delaware defines the term *Competency Evaluator* to mean an expert qualified by training and experience to conduct juvenile competency evaluations, familiar with juvenile competency standards, and familiar with juvenile treatment programs and services.

In Louisiana, *Insanity* means a mental disease or mental illness which renders the juvenile incapable of distinguishing between right and wrong with reference to the conduct in question, as a result of which the juvenile is exempt from criminal responsibility.

A *Competency Hearing* in Maryland means a hearing to determine whether a juvenile alleged to be delinquent is mentally competent to participate in a waiver hearing, an adjudicatory hearing, a disposition hearing, or a violation of probation hearing.

### Recent State Case Law

The issue in a 2010 Louisiana appellate court case was whether the juvenile court is divested of jurisdiction when a juvenile is indicted in criminal court at a time when competency proceedings are pending in the juvenile court.

In this case, after the indictment was filed and before the juvenile court held a hearing on the competency issue, the state objected to the juvenile court's exercise of jurisdiction and moved to dismiss the proceedings. The juvenile court denied the state's motion, and said a competency hearing would be conducted to determine the juvenile's capacity to proceed.

The Louisiana appellate court held that in those cases where the competency of the juvenile is raised in juvenile court before the state secures an indictment, the state has no authority to get an indictment until the juvenile has been found competent. If the juvenile is found competent in the juvenile court, trial in the criminal court is not prevented. Only those juveniles who are found incompetent would be shielded from criminal prosecution. (*State in the Interest of T.C.*, 35 So.3d 1088 (2010))

In 2013, the Supreme Court of Colorado held that the differing treatment of indigent juveniles and indigent adult defendants with regard to the entitlement to a second competency evaluation at state expense did not constitute an equal protection violation.

The Colorado high court went on to explain that the divergent purposes of the adult and juvenile justice systems can logically demand divergent procedures and procedural protections. Consequently, the competency procedures applicable in juvenile justice proceedings can validly differ in important ways from those used in the criminal context.

The state high court found that no

Equal Protection violation occurred here. The General Assembly's establishment of a comprehensive system for the rehabilitation of juvenile offenders—which seeks to provide care and guidance, in contrast to the punitive focus of the criminal justice system—provides a rational basis for denial of an initial and second competency evaluation as a right in the juvenile justice system, even though a criminal defendant would be entitled to both.

In order to protect an alleged juvenile offender's welfare in a juvenile justice proceeding, the state has a very different role than it does in a criminal prosecution: that of *parens patriae*.

In fact, the juvenile competency provisions—unlike the adult provisions—explicitly require the court, prosecution, probation officer, guardian ad litem, defense counsel, and parent or legal guardian to actively safeguard an alleged juvenile offender's right not to be tried or sentenced while incompetent to proceed.

The Colorado Supreme Court concludes that the General Assembly could reasonably and rationally view this arrangement as more conducive to achieving the less adversarial, more intimate, informal and protective proceeding the United States Supreme Court identified as the aspirational goal of the juvenile justice system. (*In the Interest of W.P.*, 295 P.3d 514 (2013))

Linda A. Szymanski, Senior Attorney with the National Center for Juvenile Justice prepared this document with support from the John D. and Catherine T. MacArthur Foundation. Points of view or opinions expressed are those of the author and not necessarily those of the Foundation.

© National Center for Juvenile Justice  
3700 South Water Street, Suite 200  
Pittsburgh, PA 15203-2363

The National Center for Juvenile Justice is the research division of the National Council of Juvenile and Family Court Judges.

Suggested Citation: Szymanski, Linda A. 2013. Juvenile Competency Procedures. JJGPS StateScan. Pittsburgh, PA: National Center for Juvenile Justice.

## MICJS Advisory Task Force Members

State or Private Agency	Representative(s) and Affiliation(s)	
Department of Public Safety (1)	Peggy Heil	Division of Criminal Justice
Department of Corrections (2)	Kerry Pruett	Mental Health Programs Administrator
	Susan White	Division of Parole
Local Law Enforcement (2) - one of whom will be in active service and one of whom shall have experience dealing with juveniles in the juvenile justice system	Commander Thomas DeLuca	El Paso County Sheriff's Office (active service representative)
	vacant	
Department of Human Services (5)	Jagruiti Shah	Office of Behavioral Health
	Ashley Tunstall	Division of Youth Corrections
	Melinda Cox	Division of Child Welfare
	vacant	Colorado Mental Health Institute at Pueblo
	Moe Keller	Mental Health Planning and Advisory Council
County Department of Social Services (1)	Susan Walton, chair	Park County Department of Human Services
Department of Education (1)	Michael Ramirez	Teaching and Learning Unit
State Attorney General's Office (1)	Cynthia Kowert	Assistant Deputy Attorney General
District Attorneys (1)	Tariq Sheikh	17th Judicial District - District Attorney's Office
Criminal Defense Bar (2)	Karen Knickerbocker	Office of the Colorado State Public Defender
	Gina Shimeall	Criminal Defense Bar
Practicing Mental Health Professionals (2)	Fernando Martínez	San Luis Valley Mental Health Center
	Lisa Thompson	Colorado Coalition for the Homeless
Community Mental Health Centers in Colorado (1)	Harriet Hall	Jefferson Center for Mental Health
Person with Knowledge of Public Benefits and Public Housing in Colorado (1)	Pat Coyle	Colorado Department of Local Affairs, Division of Housing
Colorado Department of Health Care Policy & Financing (1)	Camille Harding, co-chair	Clinical Services Office
Practicing Forensic Professional (1)	Richard Martinez, M.D.	Colorado Office of Behavioral Health/UCDSOM
Members of the Public (3)	Bethe Feltman	Member with a mental illness who has been involved in the Colorado criminal justice system
	Deirdre Parker	Parent of a child who has a mental illness and who has been involved in the Colorado criminal justice system
	Jack Zelkin	Member with an adult family member who has a mental illness and who has been involved in the Colorado criminal justice system
Office of the Child's Representative (1)	Sheri Danz	Deputy Director
Office of the Alternate Defense Counsel (1)	Kathy McGuire	Private attorney
Colorado Department of Labor and Employment (1)	Patrick Teegarden	Director of Policy and Legislation
Judicial Branch (4)	vacant	
	Judge K.J. Moore	1st Judicial District
	Susan Colling	Juvenile Programs Coordinator, Probation Services
	Tobin Wright	Chief Probation Officer in the 16th Judicial District

Updated: March 9, 2016

*Task Force Concerning Treatment of Persons with Mental  
Illness in the Criminal and Juvenile Justice Systems.*

## Task Force Membership

---



**Susan L. Walton, MSW**  
County Department Of Social Services Representative  
MICJS Chair

Park County Department of Human Services  
59865 Highway 285, 2nd Floor  
Bailey, CO 80421  
(303) 816-5930 | [susan.walton@state.co.us](mailto:susan.walton@state.co.us)

Susan Walton earned her Master's Degree in Social Work from the University of Denver in 1995. Since that time she has held several positions in the human services field, most recently as Director of Social Services in Elbert County from 2003 through 2009 and Program Manager in the Children, Youth and Families Division of the Jefferson County Department of Human Services. She is currently the Director of the Park County Department of Human Services and passionate about the quality and just treatment of individuals with mental illness.

**Camille Harding, LPC**  
Colorado Department of Health Care Policy & Financing Representative  
MICJS Vice Chair

Quality Health Improvement Unit Manager  
Clinical Services Office  
Colorado Department of Health Care Policy and Financing  
303-866-5879 | [camille.harding@state.co.us](mailto:camille.harding@state.co.us)

Camille Harding earned her Masters of Mental Health Counseling, and currently is employed with Health Care Policy and Financing managing the Quality and Health Improvement Unit. She previously worked in HIV/AIDS prevention and substance abuse and mental health treatment. Ms. Harding was in private practice for 12 years specializing in childhood trauma, abuse and neglect. She served on the Colorado Association of Play Therapy Board for five years and has conducted numerous trainings on treating young children with behavioral health needs, and working with families and parenting interventions.

**Susan M. Colling, MPA**  
Judicial Branch Representative  
Juvenile Programs Coordinator

Colorado Judicial Department  
CO State Court Administrator's Office  
CO Division of Probation Services  
1300 Broadway, Suite 1100, Denver, Colorado 80203  
(720) 625-5767 | [Susan.colling@judicial.state.co.us](mailto:Susan.colling@judicial.state.co.us)

Susan Colling received her Master's degree in Public Administration/ Criminal Justice from the University of Colorado in 1996. Ms. Colling is the juvenile probation specialist for the CO Division of Probation Service where she provides technical assistance, evaluation and analytical services and training. She is the current vice chair of the Governor's appointed Juvenile Justice and Delinquency Prevention Council and a member of the Statewide Senate

Bill 94 Advisory Board and on the Juvenile Justice Task Force of the CO Commission on Criminal and Juvenile Justice.

**Melinda Cox**

Department of Human Services Representative  
Division of Child Welfare Services

Office of Children, Youth and Families  
1575 Sherman Street, Denver, Colorado 80203-1714  
(303) 866-5962 | [Melinda.Cox@state.co.us](mailto:Melinda.Cox@state.co.us)

Melinda Cox serves as a Program Manager for Prevention, Intervention, the Core Services Program and Family Stabilization Services in the Division of Child Welfare with the Colorado Department of Human Services. Ms. Cox serves as the liaison between the Division of Child Welfare the Office of Economic Security/Colorado Works Program (TANF), and the Office of Behavioral Health (OBH). She serves on the CDHS Prevention Steering Committee, Behavioral Health Planning and Advisory Council, the Division of Youth Corrections Senate Bill 94 Advisory Board, and the Economic Security Policy Advisory Council. Ms. Cox has over twenty years in human services experience at CDHS, as well as in Denver and Adams County. She is a native of Colorado and University of Colorado alumna.

**Pat Coyle**

Public Benefits and Public Housing in Colorado Representative  
Colorado Department of Local Affairs

Colorado State Division of Housing  
[Pat.coyle@state.co.us](mailto:Pat.coyle@state.co.us)

Pat Coyle has over thirty years experience in business development and affordable housing finance. He has worked at all three levels of government and is currently the Director of the Colorado Division of Housing. Prior to his current position, Pat worked for the U.S. Department of Housing and Urban Development, was director of the Colorado Small Business Office for Governor Romer, and, most recently directed the housing programs for Denver's Road Home, Denver's Ten Year Plan to End Homelessness. He is a founding board member of Housing Colorado, Inc. the trade association for affordable housing in Colorado.

**Sheri Danz**

Office of the Child's Representative  
Deputy Director

1300 Broadway, Suite 320

Denver, CO 80203

(303) 860-1517, extension 102 | [sheridanz@coloradochildrep.org](mailto:sheridanz@coloradochildrep.org)

As Deputy Director of the OCR, Ms. Danz assists in managing the day-to-day operations of the agency and contributes to state agency's effort to improve legal representation of children by overseeing attorney services, providing substantive resources, training and support to attorneys, and informing policy and legal developments related to child welfare and the representation of children. Ms. Danz's legal advocacy on behalf of children and youth includes representing adolescents and young adults in child welfare and other civil matters as a Skadden Fellow/staff attorney at the Legal Assistance Foundation of Metropolitan Chicago; representing juveniles in delinquency proceedings as a staff attorney at the Colorado State Public Defender's Office; and representing youth in public benefits, child welfare, and protective order proceedings as a legal intern at the Door's Legal Services Program, a multidisciplinary youth services center in New York City. Ms. Danz has also worked on issues regarding parents' counsel at the Office of the State Court Administrator in Colorado and served as a law clerk to the Hon. Gene Carter, United States District Court Judge for the District of Maine. Prior to law school, Ms. Danz taught special education in rural North Carolina through the Teach for America Program. Ms. Danz is a graduate of New York University School of Law, where she received a Root-Tilden-Kern public interest scholarship and served as a member of the New York University Law Review.

**Commander Tom DeLuca**

Active service law enforcement representative  
El Paso County Sheriff's Office

[TomDeLuca@elpasoco.com](mailto:TomDeLuca@elpasoco.com)

Commander Tom DeLuca started his career with the El Paso County Sheriff's Office in 1988. He was promoted to the rank of Sergeant in September 1994. He was assigned to the Intake and Release Section. In 1998, he transferred to the Support Services Bureau as the Training Sergeant. In 2001, he transferred to the Law Enforcement Bureau as Community Support Sergeant which supervised School Resource Officers, DARE Officers, and Community Support Officers. He also supervised the POSSE Unit of volunteers that augmented the Law Enforcement function in the County. In 2002, he transferred to the Traffic Unit and managed the LEAF and Aggressive Driving Grant, as well as traffic enforcement for El Paso County. In January of 2003 he was promoted to the rank of Lieutenant. In September of 2010, he attended and graduated from the FBI National Academy Session 243, where he trained with agencies throughout the United States, as well as international Police Agencies. In February of 2011, he was promoted to the rank of Division Commander for the Detention Bureau. Commander DeLuca retired from the El Paso County Sheriff's Office at the end of June 2012. In August of 2012, he was hired by District 11 Security to be a Campus Security Officer for Coronado High School. In 2014, he was transferred as the Acting East Side Security Coordinator of School District 11 where he

supervised and responded to twenty five (25) Elementary, Middle and High Schools for security and investigative purposes.

**Bethe Feltman**  
Member of the Public Representative  
Member with a mental illness who has been involved in the Criminal Justice System  
[REDACTED]

Tragedy struck the Feltman family in 1998. Bethe committed two horrific crimes. Thankfully, the courts adjudicated her NGRI (Not Guilty by Reason of Insanity) and sent her to the state hospital in Pueblo. Bethe has since been diagnosed with Bipolar Disorder. Bethe was granted her Conditional Release status in January 2004. Currently Bethe receives services through JCMH (Jefferson Center for Mental Health). Bethe is a public speaker. She has shared her experiences with countless audiences ranging from students to professionals in the field.

**Harriett L. Hall Ph.D.**  
Community Mental Health Centers in Colorado Representative  
President & CEO, Jefferson Center for Mental Health  
4851 Independence Street, Suite 200, Wheat Ridge, Colorado 80033  
(303) 432-5001 | [HLHall@jcmh.org](mailto:HLHall@jcmh.org)

Harriett L. Hall has served as President and CEO of the Jefferson Center since 1984. She is currently the President-elect of the Colorado Behavioral Healthcare Council and has served numerous mental health agencies in both clinical and administrative positions. She has served as the Chair of the national organization Mental Health Corporations of America. In addition to being past-chair of this Task Force, she serves on the Jefferson County Community Corrections Board, the Jefferson County Criminal Justice Task Force and the Governor's Community Corrections Advisory Board. Dr. Hall is co-chair of the Health Plan Advisory Group for the Colorado Health Benefit Exchange Board.

[REDACTED]

**Margaret "Peggy" Heil**

Department of Public Safety Representative  
Colorado Division of Criminal Justice

Office of Research and Statistics  
(303) 239-4172 | [peggy.heil@state.co.us](mailto:peggy.heil@state.co.us)

Peggy Heil is a licensed clinical social worker with over 30 years of experience in criminal justice behavioral health administration, service delivery, and research. She is employed in the Office of Research and Statistics at the Colorado Division of Criminal Justice, Department of Public Safety. In her current job, she promotes effective interventions for justice involved individuals with behavioral health needs by facilitating policy and research development.

**Maryanne "Moe" Keller**

Department of Human Services Representative  
Mental Health Planning and Advisory Council

VP Public Policy and Strategic Initiatives  
Mental Health America of Colorado  
1120 Lincoln Street  
Suite 1606  
Denver, CO 80203  
(720) 208-2224

Moe Keller is Vice President of Public Policy and Strategic Initiatives for Mental Health America of Colorado. Before her work with MHAC, Moe served for eight years in the Colorado House of Representatives and eight years in the Colorado Senate, where she concentrated on legislation and policy for individuals who have mental health conditions and for individuals with developmental disabilities. Moe successfully sponsored mental health parity bills, legislation restricting use of seclusion and restraint and created the Children's Mental Health Treatment Act in state law. Prior to her work in the legislature, Moe was a special education teacher for deaf and hearing impaired children for 25 years. Moe has been married to Stephen Keller for 43 years and has two adult children.

**Karen Knickerbocker**

Criminal Defense Bar Representative  
Office of the Colorado State Public Defender

560 Golden Ridge Rd. Ste. 100, Golden, CO 80401  
303-279-7841 | [karen.knickerbocker@coloradodefender.us](mailto:karen.knickerbocker@coloradodefender.us)

Karen Knickerbocker is a Colorado native and Public Defender of 10 years. She is currently assigned to the Golden office after spending almost 8 years in Greeley. She attended the University of Denver College of Law as a public interest Chancellor's Scholarship recipient and graduated in 2003. Taking advantage of a dual degree program, she also graduated with a Master's Degree in Social Work from DU in 2002. Additionally, she has a Bachelor's

Degree in Social Work from Creighton University, graduating in 1997. Prior to the practice of law, she worked as a social worker, mental health therapist and case manager, serving diverse populations in Omaha, Chile, and Denver. She has also served previously as a Board Member and volunteer for Weld County Partners, a youth mentoring program. She is passionate about the fair and just treatment of persons with mental illness who are involved in the justice system and is honored to participate as a task force member.

**Cynthia Kowert**

State Attorney General's office Representative  
Assistant Deputy Attorney General

[Cynthia.Kowert@state.co.us](mailto:Cynthia.Kowert@state.co.us)

Cynthia is the Assistant Deputy for Criminal Justice at the Attorney General's Office. She is second in command in the Criminal Justice Section, which is comprised of 69 people. This includes attorneys, investigations and support staff. Cynthia supervises the First Assistant Attorney General's for CJS and also supervises three units: Foreign Prosecutions, the Marijuana Unit and Victim Services. Cynthia was with the 17th Judicial District, Adams and Broomfield Counties, for 18.5 years, spending about half of that tenure as Chief trial Deputy. She supervised several units during her time with the 17th, including: a District Court Unit, County Court, the Child Victim Unit and the Juvenile Unit. Cynthia prosecuted all types of cases from DUI's to First Degree Murder during her tie in the DA's office.

**Fernando A Martinez**

Practicing Mental Health Professional Representative  
CEO San Luis Valley Behavioral Health Group

8745 County Road 9 South, Alamosa, Colorado 81102

719-587-5609 | [fmartinez@slvmhc.org](mailto:fmartinez@slvmhc.org)

Fernando A. Martinez is the Chief Executive Officer of the San Luis Valley Behavior Health Group. He has a Masters in Guidance and Counseling from Adams State College and a Masters in Social Work Administration from the University of Michigan. He has extensive experience providing services in rural settings with over 30 years experience in substance abuse programming, twelve years in probation administration and 20 years in mental health services. He has supported the development of several programs that provide service to the State of Colorado's Department of Corrections and Judicial Department. Fernando is committed to fostering community collaboration and providing an accessible effective continuum of prevention, intervention, and treatment services to youth and families in southern Colorado.

**Richard Martinez, MD**  
Practicing Forensic Professional Representative  
Colorado Office of Behavioral Health/UCDSOM

Director Forensic Psychiatry Training  
3520 W. Oxford Avenue  
Denver, CO 80236  
[richardp.martinez@state.co.us](mailto:richardp.martinez@state.co.us)

Dr. Richard Martinez is the Robert D. Miller Professor of Psychiatry and Law at the University of Colorado Denver School of Medicine. He directs the Forensic Programs at Denver Health Medical Center and is Director of the Forensic Psychiatry Fellowship Training Program at UCD School of Medicine. After medical school and psychiatry residency, he completed fellowships in bioethics and professional ethics at Harvard Medical School and the Edmond J. Safra Center for Professional Ethics at Harvard University. His practice includes forensic expert evaluations and testimony in criminal and civil law. In addition to teaching at the UCD Medical School, he is an adjunct Professor at the Sturm School of Law at Denver University, and consultant to the Colorado Office of Behavioral Health Services and Colorado Department of Corrections. He has written on topics of professional ethics and social responsibility, organizational healthcare ethics, medical undergraduate education, boundaries in the patient-professional relationship, and topics in criminal law and psychiatry. His recent book, written with colleagues Phil Candilis and Robert Weinstock, is *Forensic Ethics and The Expert Witness*. He received the American Academy of Psychiatry and the Law "Best Teacher in a Fellowship Award" in 2013. He is on the Editorial Board of the *Journal of the American Academy of Psychiatry and the Law*. He is a Distinguished Fellow of the American Psychiatric Association.

**Kathy McGuire J.D., M.S.W.**  
Office of the Alternate Defense Counsel Representative  
Private Attorney

The McGuire Law Office, LLC  
7887 E. Belleview, #1100, Denver, CO 80111  
303-228-1611

[kmcguire@kathleenmcguirelaw.com](mailto:kmcguire@kathleenmcguirelaw.com)

Kathy McGuire received her law degree from the University of Denver School of Law in 1994 and a masters degree in social work from the University of Wisconsin in 1985. Ms. McGuire has a private law practice. Prior to this, she was a deputy state public defender for ten years in Golden and was the Office Head of the Castle Rock PD office for nine years. She has represented thousands of adults and juveniles charged with criminal offenses; a large number of her clients have serious mental illness. She has been a member of the Advisory Task Force for approximately seven years, holding the position of Chair of this task force for eighteen months.

**KJ Moore**  
 Judicial Branch Representative  
 1st Judicial District

Jefferson County Court, Division F  
 100 Jefferson County Parkway  
 Golden, CO 80401  
 720-772-2474  
 KJ.moore@judicial.state.co.us

KJ Moore received her Juris Doctor from Vermont Law School in 1995. She is currently a County Court Judge in Jefferson County handling primarily criminal cases and also presides over the Juvenile Mental Health Court. Previously, Judge Moore served as a District Court Magistrate handling domestic and juvenile matters. She was also a public defender for nearly ten years. Judge Moore is a member of the Board of Directors for CASA of Jefferson and Gilpin Counties, an appointed member of the Behavior Health Transformation Council, chair of the Jefferson County Court Services Advisory Committee, member of the Mental Health Court Advisory Council, member of the Problem Solving Courts Advisory Committee and as a member of the Recovery Court Advisory Council.

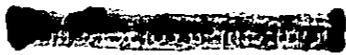
**Deirdre Parker**  
 Member of the Public Representative  
 Parent of a Child who has a mental illness and who has been involved in the Colorado  
 criminal justice system

Deirdre Parker's son had mental illness and passed away from suicide while under the care of the criminal justice system. This tragic event opened Ms. Parker's eyes to the issues many people with mental illness face when involved in the criminal justice system. For thirty years, Ms. Parker owned a small business and employed 30 staff. She has worked as a victim advocate for the Boulder Sheriff's Dept, a counselor at a Denver Battered Women's Shelter, a counselor for The Boulder Rape Crisis Team, a neighborhood activist, 4H leader, Volunteer coordinator at Waldorf and Dawson Schools and is active in NAMI, HOPE and a former board member of Second Wind Foundation.

**Kerry L. Pruett, LCSW**  
 Department of Corrections Representative  
 Mental Health Programs Administrator

Colorado Department of Corrections 2862 S. Circle Dr. Colorado Springs, CO 80906  
 719-226-4539 | kerry.pruett@state.co.us

Ms. Pruett is a clinical social worker with 30 years of experience specializing in mental health treatment and forensic social work in multiple settings. Her experience includes inpatient psychiatric treatment with the severely and dangerous mentally ill, and mental health treatment with juvenile and adult offenders. Ms. Pruett has also taught social work practice at a graduate level, and developed course work in social work in corrections. She has served as a field instructor for several graduate schools of social work, and implemented and



supervised social work internship programs in settings such as juvenile detention centers, county jails, probation and parole settings, and correctional facilities.

**Michael Ramirez, M.A.**

Department of Education Representative  
Teaching and Learning Unit

Colorado Department of Education  
201 East Colfax, Rm 409, Denver, CO 80203  
303-866-6991 | [ramirez\\_m@cde.state.co.us](mailto:ramirez_m@cde.state.co.us)

Michael Ramirez is currently a supervisor within the Office of Learning Supports, Teaching and Learning Unit at the Colorado Department of Education. Initially, Michael was hired by CDE in January 2000, as the Eligible Facilities Consultant and later became the Behavior Consultant for the Department. His career began when he started working with students with significant emotional and behavioral challenges in 1978. He initially worked with youth in a variety of Residential and Day Treatment Settings for over 20 years. Throughout his career he used education as a lever to empower students with social-emotional or mental health needs to achieve their life goals. His interest in addressing the educational needs of these youths is fueled by his opportunities to serve on a variety of boards and committees such as this Task force. Michael started on the task force as the CDE representative in 2005.

**Jagruti Shah, MA, LPC, CACIII**

Department of Human Services Representative  
Division of Behavioral Health

Manager, Offender Mental Health Programs  
Colorado Office of Behavioral Health  
3824 W Princeton Circle  
Denver, CO 80236  
303-866-7504 | [jagruti.shah@state.co.us](mailto:jagruti.shah@state.co.us)

Jagruti Shah, MA, LPC, CACIII is currently the Manager of Offender Mental Health Programs at the Office of Behavioral Health (OBH). She oversees the Offender Mental Health Services Initiative (SB 97) Programs, Continuity of Care with Transition Specialists Program and the Jail Based Behavioral Health Services Programs across the state. At OBH she serves as the clinical program expert for behavioral health services related to the offender population. She is currently appointed to the Justice Assistance Grant Board. Prior to OBH she worked at the Department of Health Care Policy and Financing, where she managed the Outpatient Substance Abuse Treatment and Mental Health Fee-for-Service benefits and also oversaw the benefit definition initiative- The Benefits Collaborative. She has also worked as the Program Coordinator at the Denver Women's Correctional Facility Therapeutic Community and at Independence House- Fillmore. She has a Master of Arts in Forensic Psychology from the University of Denver in Colorado and a Bachelor of Arts in Psychology from St. Catherine University in Minnesota

**Tariq Sheikh**

District Attorney Representative

Adams County District Attorney's Office  
Senior Deputy District Attorney, Juvenile Unit  
1000 Judicial Center Drive  
Brighton, CO 80601  
(303) 835-5575 | [tsheikh@da17.state.co.us](mailto:tsheikh@da17.state.co.us)

Tariq Sheikh is a Senior Deputy District Attorney in the 17<sup>th</sup> Judicial District. He specializes in juvenile crime and crimes against children. Tariq graduated from Temple University in 2005, at which point he joined the Philadelphia District Attorney's Office, where he tried several hundred cases. Tariq moved to Colorado in 2011 and joined the 17<sup>th</sup> Judicial District. He is in charge of the Juvenile Division and handles cases pertaining to juvenile crime, child abuse, and murder. Tariq has presented to various groups on a number of issues, including sex offenders, juvenile law, "sexting", domestic violence, and competency.

**Gina K. Shimeall**

Criminal Defense Bar Representative

Private Attorney

(303) 501-4703 | [gina.shimeall@shimeall-law.us](mailto:gina.shimeall@shimeall-law.us)

Gina Shimeall received her *Juris Doctor* from Washington University, St. Louis, Mo. in 1980. She was accepted to the Missouri Bar in 1980, Illinois in 1981, and Colorado in 1988. Ms. Shimeall presently works in private practice specializing in criminal justice related mental health cases and aiding jurisdictions in their collaboration and implementation of problem solving mental health courts. She is a volunteer for NAMI's (National Alliance for Mentally Ill) law line. She is a 25-year member of the 18th Judicial District's Community Corrections Board. As a board member she facilitated the design and implementation of the female dual diagnosis program "Arches." Her experience entails the planning and implementation of the mental health courts in Colorado's 18th and 4th Judicial District and the Aurora Municipal Courts. She is a retired 26-year veteran public defender.

**Lisa Thompson**

Practicing Mental Health Professionals Representative  
Colorado Coalition for the Homeless

Director of Housing First: ACT, CCH  
211 Champa, Denver, CO 80205

(303) 312-9684 | [lthompson@coloradocoalition.org](mailto:lthompson@coloradocoalition.org)

Lisa Thompson received her doctorate degree in nursing from the University of Colorado Health Science Center in 2008 and her master's degree in nursing with an emphasis in psychiatric mental health in 2006. She has worked in homeless health care since 2004 serving as a nurse manager, psychiatric nurse practitioner and currently as the Director of Housing First and Assertive Community Treatment Services for the Colorado Coalition for the

Homeless. She represents a practicing mental health provider on the Advisory Task Force and serves as an advocate for individuals with mental health disorders who are experiencing homelessness.

**Ashley M Tunstall, MPA, MA, LPC**  
 Department of Human Services Representative  
 Division of Youth Corrections

303-866-7967  
 ashley.tunstall@state.co.us

Ashley M. Tunstall has served as the Director of Behavioral Health & Medical Services for the Colorado Department of Human Services, Division of Youth Corrections since 2009 where she oversees the administration of assessment and treatment services for mental health, substance use, sex offense-specific, and medical services. The Division of Youth Corrections (DYC) provides a continuum of residential and non-residential services that encompass juvenile detention, commitment and parole, serving youth between the ages of 10 and 21. Ashley has 24 years of experience working in the criminal justice system. She has served in multiple roles working with both offenders and victims. She began her career providing emergency counseling and court accompaniment to rape victims while also conducting research on a domestic violence offender treatment program. Ashley has also worked in an emergency shelter for adolescent adjudicated males, as a county department of human services caseworker on the adolescent ongoing unit, and as the Program Director of a large metropolitan area Juvenile Assessment Center serving hundreds of youth per month. Ashley has expertise in the areas of family systems, risk assessment, mental health, and trauma. She has recently conducted research related to the revision of the treatment standards of the Domestic Violence Offender Management Board (DVOMB), and is leading the development of trauma-informed environments in the Division of Youth Corrections.

**Susan White**  
 Colorado Department of Corrections Representative  
 Division of Adult Parole

940 Broadway  
 Denver CO 80203  
 303-763-2470 susan.white@state.co.us

Susan has been with the DOC/Division of Adult Parole for 23 years. She began her career as a Parole Officer. Susan worked her way up through various management level positions. She is currently an Assistant Director with oversight of the Offender Reentry Programs which focuses on offenders release and planning. Susan is involved with connecting offenders to community resources upon release. She has a BA from the University of Colorado-Boulder majoring in both Psychology and Sociology (Criminology/Criminal Justice Emphasis).

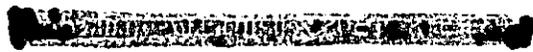
**Tobin Wright**  
 Judicial Branch Representative  
 Chief Probation Officer, 16th Judicial District

13 W 3rd St, Rm. 201, La Junta, CO 81050  
 719-383-7138 | [tobin.wright@judicial.state.co.us](mailto:tobin.wright@judicial.state.co.us)

Tobin Wright has served as the Chief Probation Officer in the 16th Judicial District (Bent, Crowley, and Otero counties) since 2006, after having been a Probation Supervisor in the 21st Judicial District in 2005. He is originally from Kansas, where he received his BA and MS degrees in Psychology. His MS is in General/Experimental Psychology, with an emphasis in Industrial/Organizational Psychology. Before coming to Colorado, Tobin was the Director of two Community Corrections programs. Additional job experience includes being hired as the Forensic Counselor when Kansas implemented their Sexual Predator Treatment Program, and he has been employed as a Psychologist at a juvenile correctional facility. Tobin also has years of experience working as a Probation Officer, as well as experience as an Intensive Supervision Officer in Community Corrections. In addition, Tobin created and facilitated an Alcohol/Drug Information Class for several years and served as adjunct Instructor at two community colleges - teaching Psychology and Sociology classes while in Kansas.

**Jack Zelkin**  
 Member of the Public Representative  
 Member with an adult family member who has a mental illness and who has been involved in the Colorado criminal justice system

Jack graduated from the University of Colorado with a BA in Marketing, Public Relations and Finance. He spent 45 years in relationship-building and consultative sales in the Airline, Public Utility, Energy, and Homebuilder fields. Jack chaired the original NAHB's Home Energy Rating System Task Force in Washington DC. He has spent 6 years as a Marketing Chair for the Colorado Association of REALTOR@s (CAR) State Convention. Jack has a family member with a mental illness and Jack is dedicated to helping others in similar situations. Jack is married to the "most patient woman in the world." They have been married for 46 years and have 4 children and 6 grandchildren.



## Grant Summary

**Grant:** Second Chance Act Statewide Adult Recidivism Reduction Strategic Planning Program

**Award Period:** October 1, 2015 to September 30, 2016

**Solicitation Overview:** This solicitation provides funding for a 12-month strategic planning process that targets recidivism reduction for a high risk adult population. Upon the completion of the Statewide Recidivism Reduction Strategic Plan, BJA will invite states to submit applications for implementation grants of up to \$1 million with the potential for two subsequent supplemental awards of \$1 million each.

**Vision:** All justice involved individuals with serious mental illness will be provided improved continuity of care in prescribed psychotropic medications and evidenced-based behavioral health services that incorporate Risk-Need-Responsivity principles, whether under criminal justice supervision or receiving community-based treatment services, to promote positive community adjustment, improved health, reduced recidivism and improved public safety. Closing continuity of care gaps will promote a quick and smooth adjustment whether the person is transitioning into the justice system or is being released back out to the community

**Mission:** To reduce recidivism rates among justice-involved individuals with serious mental illness through implementation of a statewide, electronic, criminal justice health information exchange (HIE) system. Thereby, improving care by enabling health care workers to access and securely share patient health information for psychotropic medications, assessment, treatment and continuity of care to appropriately address psychiatric and criminogenic needs and risks for each, whether the individual is incarcerated, in a mental health crisis system, or community reentry. Likewise, as justice-involved individuals re-enter the community, health care professionals and others responsible for their transition will have access to the appropriate level of health and justice information to make reintegration and aftercare successful.

**Proposal:** This grant will facilitate recidivism reduction of justice involved individuals with behavioral health needs by initiating an interagency planning process to develop a statewide justice to health information exchange infrastructure. Health providers in the community and criminal justice agencies will be able to access prior assessment and treatment data to ensure evidence based treatment and continuity of care as offenders transition to different systems. It is anticipated that this infrastructure will reduce gaps in service, facilitate evidenced-based treatment, and ultimately reduce recidivism of offenders with serious mental illness.

**Goal 1:** Define the grant high risk target population of offenders with serious mental illness, the majority of which have co-occurring substance use disorders

**Goal 2:** Identify electronic information exchange needs and opportunities for the statewide grant planning process

**Goal 3:** Develop a statewide justice to health information exchange system plan to improve triage, assessment, treatment and continuity of care for individuals with mental illness or substance use disorders whether they are in the criminal justice system, newly established mental health crisis system or community reentry.

**Collaborating Agencies:** Governor's Office, Department of Healthcare Policy and Finance (HCPF), Department of Human Services (DHS), Department of Corrections (DOC), Judicial Branch, Department of Public Safety (DPS), Colorado Integrated Criminal Justice Information System (CICJIS), County Sheriffs of Colorado, Colorado Regional Health Information Organization (CORHIO), Colorado Behavioral Healthcare Council (CBHC), National Alliance on Mental Illness (NAMI), Mental Health America, Prescription Drug Monitoring Program, Denver Crime Commission, and Adams County Criminal Justice Planner.

**Proposal supported by the following Colorado policy planning groups:** Commission on Criminal and Juvenile Justice (CCJJ), Task Force Concerning Mental Illness in the Criminal Justice System (MICJS), and the Behavioral Health Transformation Council (BHTC)

There are five separate functions that will be considered during the planning process. Each of these functions must be designed in compliance with HIPAA, 42 CFR Part 2, and state law and will involve a different level of information access and permissions. These functions include:

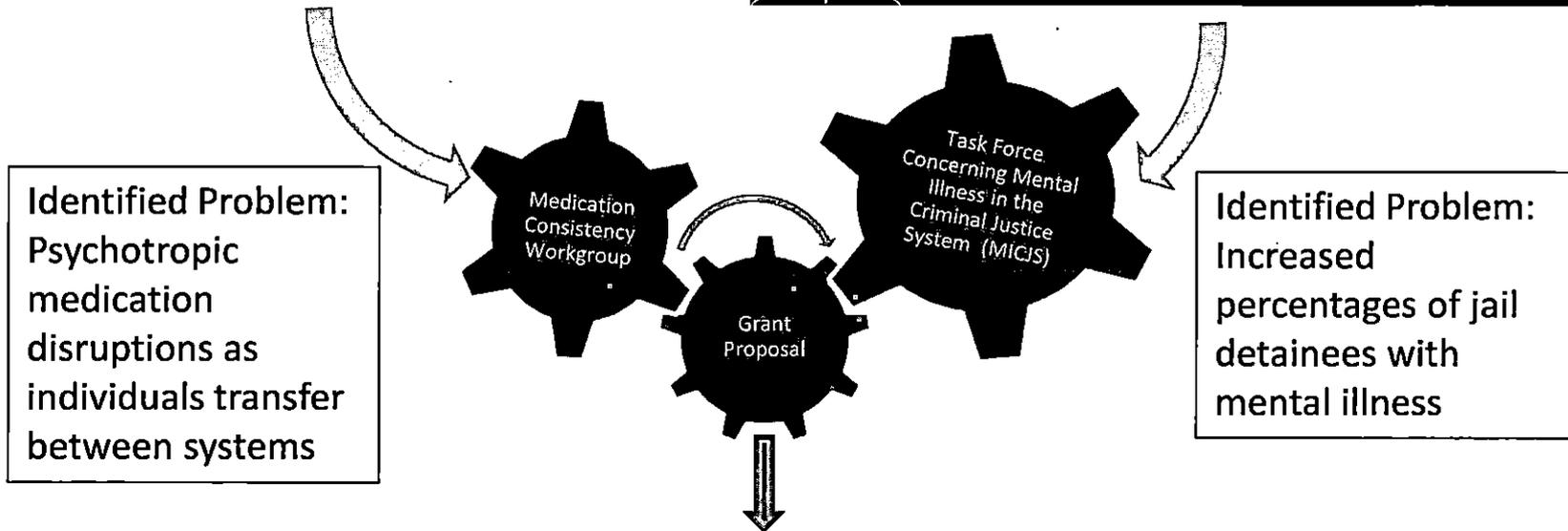
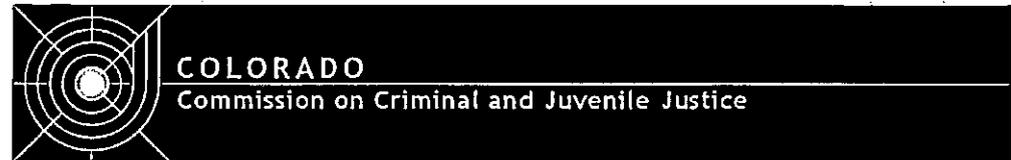
1. Criminal justice health provider and community health provider continuity of care information exchange
2. Information for program evaluation/data collection
3. Information for criminal justice supervision
4. Criminal justice status information for health providers
5. Information for law enforcement response to a crisis situation involving risk of imminent threat to the health or safety of a person or the public

The group will initially focus on the first priority involving criminal justice health provider and community health provider information exchange for treatment continuity of care. The group also needs to define two data elements to successfully complete the BJA planning grant process:

1. Develop a common definition for Serious Mental Illness (SMI) that can be used by all agencies that participate in the statewide information exchange system.
2. Develop a consistent recidivism measure that can be used across agencies to measure recidivism reduction progress.

For additional information please contact Peggy Heil at [peggy.heil@state.co.us](mailto:peggy.heil@state.co.us)

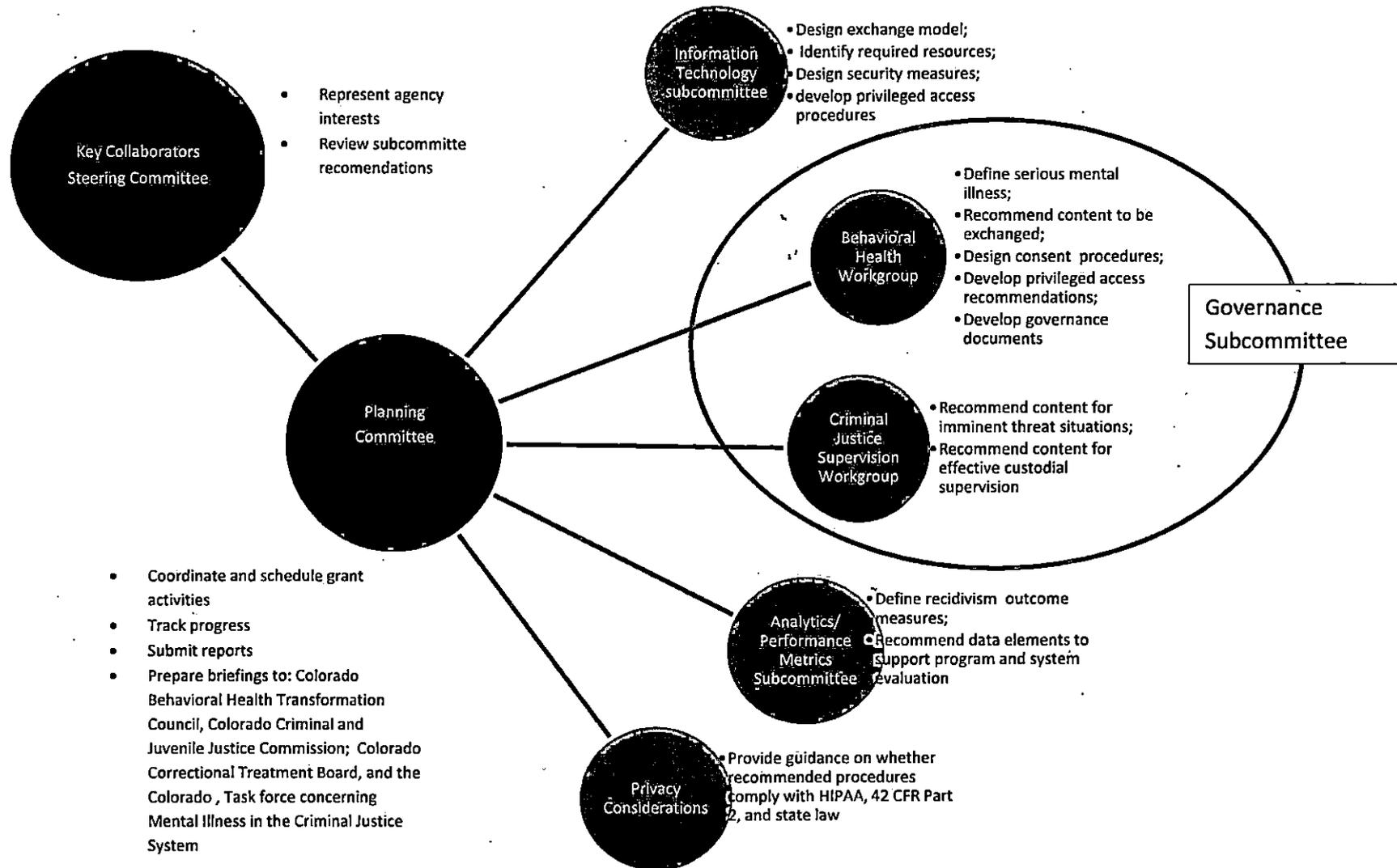
# Background



Plan statewide electronic justice and health information sharing system to improve continuity of care and to reduce recidivism of individuals with mental illness

# Reducing Recidivism of High Risk Offenders Through Improved Information Exchange

## Colorado BJA Second Chance Act Statewide Adult Recidivism Reduction Strategic Planning Program Grant Structure



Bureau of Justice Assistance Second Chance Act  
Statewide Adult Recidivism Reduction Strategic Planning Program Grant  
Reducing Recidivism of High Risk Offenders through Improved Information Exchange

Key Collaborator Steering Committee Meeting  
March 14, 2016

Agenda:

- Introductions
- Grant Background
  - CCJJ – Sheriff Joe Pelle
  - MICJS – Camille Harding
  - BHTC Medication Consistency – Regi Huerter
- Models for Justice and Health Information Sharing Systems – Bob May
- Focus Group Findings – Toria Thompson
- Planning Grant Details
  - Vision
  - Mission
  - Goals
  - Priority Functions
  - Data Requirements
  - Subcommittee Structure
  - Timeframes
  - Steering Committee Meetings
- Discussion

## Bureau of Justice Assistance Second Chance Act Statewide Recidivism Reduction Planning Program Grant

Reducing Recidivism of High Risk Offenders  
Through Improved Information Exchange



Key Collaborator Steering Committee Meeting  
March 14, 2016

---

---

---

---

---

---

---

---

## Welcome & Introductions

Permission to record

Agenda

- Grant background
- Grant details
- Discussion

---

---

---

---

---

---

---

---

## Background



psychotropic  
medications gaps  
as individuals  
transfer between  
systems



Increase % of  
detainees with  
mental illness

Plan statewide electronic justice and health information  
sharing system to improve continuity of care and reduce  
recidivism of individuals with mental illness

---

---

---

---

---

---

---

---

### Models for Justice and Health Information Sharing Systems

- Hampden County Sheriff's Department (2012)
- Maryland Dept. of Public Safety (2014)
- Alabama's ASSURE Project (2015 – Present)
- Behavioral Health Business Process Model

---

---

---

---

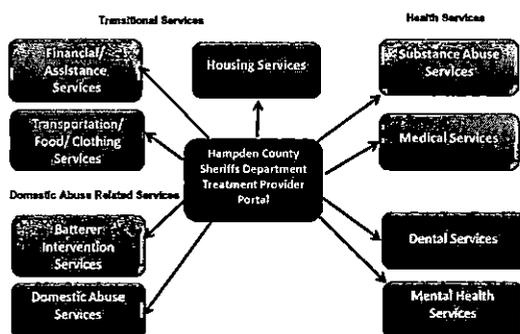
---

---

---

---

### Hampden County Service Provider Portal



---

---

---

---

---

---

---

---

### Maryland Project

Maryland Dept. of Corrections, State Parole & Alcohol and Drug Abuse Administration (ADAA)

- To implement electronic information sharing capabilities to share offender case file with 360 plus substance abuse treatment providers and to share offender treatment records with the DPSCS
- Built 42 CFR Part 2 Consent Management Module to enable sharing of treatment record back to Corrections

---

---

---

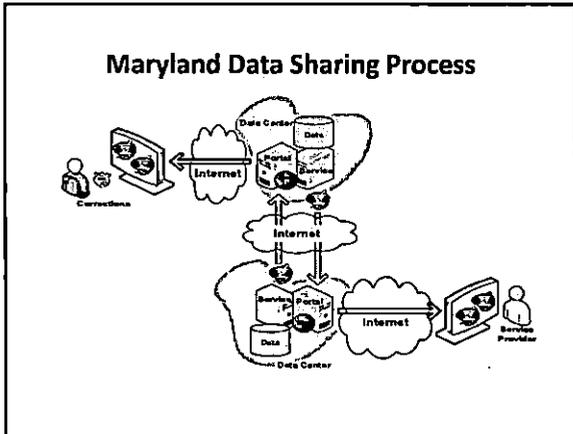
---

---

---

---

---




---

---

---

---

---

---

---

---

### Alabama Secure Sharing Utility for Recidivism Elimination (ASSURE)

**Problem:** Lack of information sharing relative to offenders' substance abuse (SA) and mental health (MH) diagnosis and treatment histories between the Department of Corrections, Board of Pardons and Paroles, Department of Mental Health and community-based SA/MH treatment providers

- Need to improve access to continuity of care for persons with SA/MH issues for offenders under probation supervision in the community
- Need to improve access to and continuity of care for persons with SA/MH issues released from Corrections into the community
- Lead Agency: Alabama Department of Mental Health (ADMH)

---

---

---

---

---

---

---

---

### Who is Involved

- Alabama Department of Mental Health (ADMH)
- Community Mental Health Centers (CMHC)
- ADMH Substance Abuse Contract Providers
- Alabama Board of Pardons and Paroles (ABPP)
- Alabama Department of Corrections (ADoC)

---

---

---

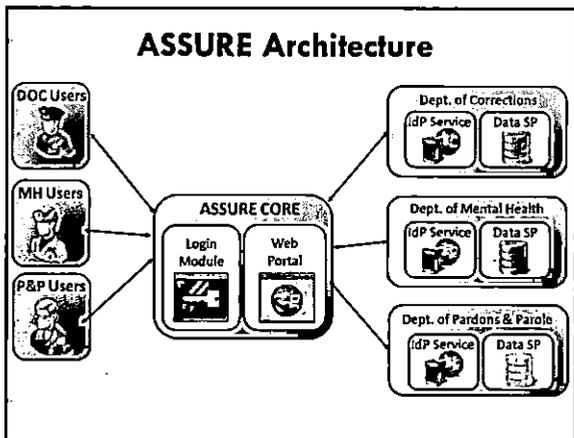
---

---

---

---

---



---

---

---

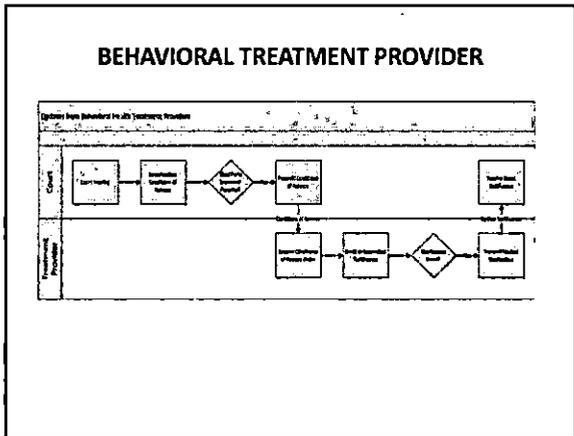
---

---

---

---

---



---

---

---

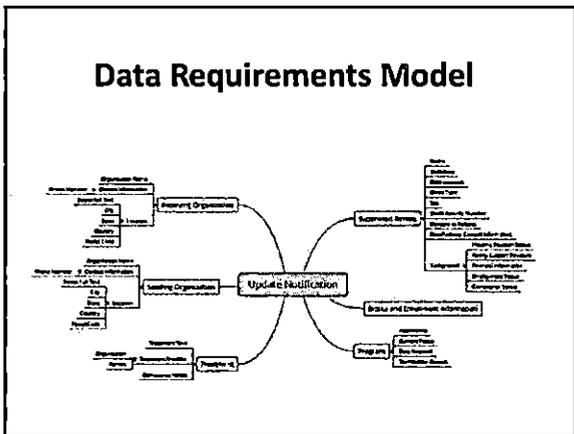
---

---

---

---

---



---

---

---

---

---

---

---

---

### Keys to Success

- Obtain Executive Sponsorship
  - Will not happen—and will not succeed—without buy-in and support at the very highest levels
- Establish Project Governance
  - Ensure that perspective and expertise from as many viewpoints as possible included in guiding the project
- Obtain Input and Support from User Community
  - Build a system with the needs and concerns of the system's users sought out and taken into account *before* the first line of code written
- Over-engineer by design
  - Have kept "The Big Picture" and future re-usability as the central theme right from the start
- Find the best resources and expertise available
  - Do not reinvent any wheels
  - Make use of proven standards and best practices

---

---

---

---

---

---

---

---

---

---

### Current Colorado Electronic Information Exchange Systems

- Colorado Integrated Criminal Justice Information System (CICJIS) - CDAC, DOC, DPS, DYC, Judicial
- Colorado Regional Health Information Organization (CORHIO) & Quality Health Network (QHN)

---

---

---

---

---

---

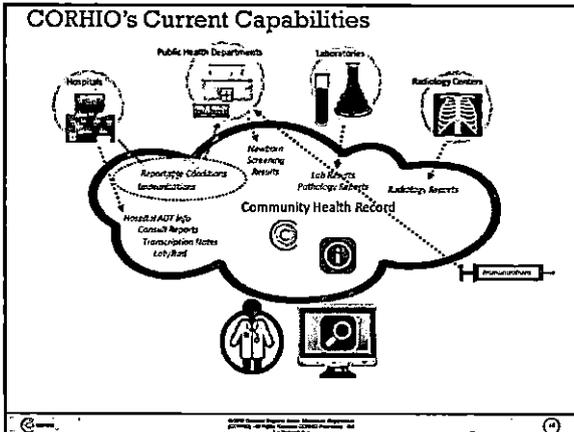
---

---

---

---

### CORHIO's Current Capabilities




---

---

---

---

---

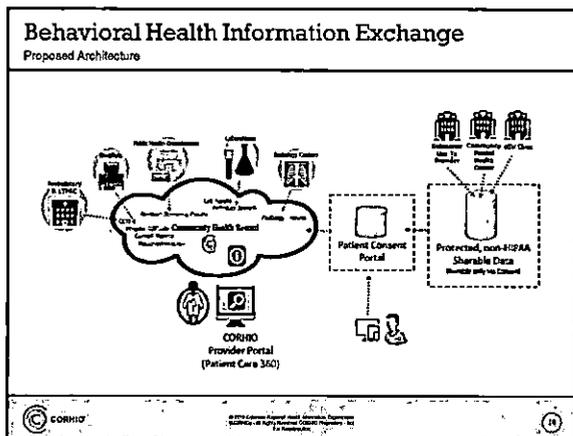
---

---

---

---

---




---

---

---

---

---

---

---

---

---

---

### Regional Focus Groups

Stakeholder interviews were conducted across the State to identify electronic information exchange needs and opportunities

1. Do you screen for mental illness and/or substance abuse among the population of people you serve?
2. Do you distinguish people with "Serious Mental Illness (SMI)" from others?
3. Do you keep general recidivism data?
4. Do you currently exchange health information with other state law enforcement and/or community mental/behavioral health entities?
5. What is your attitude about the inclusion of mental health and/or substance abuse information within existing Health Information Exchanges in Colorado (CORHIO & QHN)?

---

---

---

---

---

---

---

---

---

---

### Regional Focus Group

- Interviews conducted during five regionally focused stakeholder phone meetings.
- **Participants:**
  - Sheriff's Departments**
    - Alamosa County Sheriff's Dept.
    - Clear Creek Sheriff's Dept.
    - Custer County Sheriff's Dept.
    - Delta County Sheriff's Dept.
    - Pitkin County Sheriff's Dept.
    - Routt County Sheriff's Dept.
    - San Miguel County Sheriff's Dept.
    - Weld County Sheriff's Dept.
  - Behavioral Health Organizations**
    - Axis Health Systems
    - The Center for Mental Health
  - Jefferson Center for Mental Health**
    - North Range Behavioral Health
  - Payers**
    - Colorado Access
    - Colorado Health Partners
    - Community Care (RCCO 7)
    - Foothills Behavioral Health Partners
    - Rocky Mountain Health Plans
    - Value Options

---

---

---

---

---

---

---

---

---

---

### Findings – Criminal Justice Screening

- Very few criminal justice entities currently use a standardized means of detecting inmates with mental and behavioral health issues.
- Exception: Most conduct acute suicide risk assessments
- Most rely on patient reports of diagnoses and medications, which may be incomplete, mistaken, and/or willfully incorrect
  - Once issues are detected, in-house or contracted healthcare jail staff must spend a significant amount of time gathering information to verify diagnoses/past treatment/current medications is inconsistent and takes many hours to obtain (and therefore a lot of money)
  - Some smaller jails do not have any partnerships with mental health providers and do not actually have a means of obtaining this information

---

---

---

---

---

---

---

---

### Findings – Criminal Justice Treatment

- Medicaid loss upon jail entry means criminal justice entities struggle to provide adequate healthcare (physical or behavioral/mental).
- Piecemeal ways of funding in-house or contracted mental/behavioral health treatment
  - Some use grants (e.g. JBBS grant, McArthur grant, SB-97)
  - Some are about to lose funding
  - Some simply have to stretch their criminal justice budget
- Some criminal justice entities in smaller counties do not have specific contracts with mental/behavioral health entities (or in-house providers), so face severe limitations in ability to provide any type of treatment, including medications
- Unwillingness of many inmates to participate in mental health treatment
- Jails must put them on an M1 hold in order to force treatment (and sometimes in order to actually fund treatment).
  - Even then, not all hospitals will agree to see the patient

---

---

---

---

---

---

---

---

### Findings – Criminal Justice Attitudes toward HIE

- Mainly positive, given the difficulties of information gathering mentioned previously and potential cost savings that could occur if recidivism is reduced.
- Concerns about costs of information exchange:
  1. The cost of mental/behavioral health information exchange itself
  2. The cost of delivering appropriate treatment once inmates' diagnoses and medications are identified

---

---

---

---

---

---

---

---

### Findings – Behavioral Health Entities’ Attitudes toward HIE

- Mainly positive given opportunity to create more continuity/hopefully reduce recidivism.
- However, concerns about patients’ privacy - Slippery slope for secondary disclosure of health information
  - Notable hesitancy of mental/behavioral health entities to interact directly with criminal justice entities regarding their clients
  - Would need to have a very clearly defined flow of health information to prevent non-covered entities from accessing protected info
  - May need to build a basic dataset that would only provide the jail the minimum information necessary to do their job
- Adams County is already working on an infrastructure to share information between criminal justice entities and mental/behavioral health entities
  - Concerned about redundancy/creation of silos if our system did not take their pre-existing infrastructure into account

---

---

---

---

---

---

---

---

---

---

### Findings – SMI Definitions

- No clear consensus on how to define “serious mental illness”
  - Furthermore, many entities do not currently see a need to define this, given their organization’s functions and purposes
- Many criminal justice entities rely on a non-standardized combination of DSM criteria, evidence of functional impairment, and/or acute risk stratification
- Fundamentally different perspectives on mental/behavioral health issues:
  - Criminal justice entities tend to frame mental/behavioral health issues in the context of safety and acuity
  - Mental/behavioral health entities tend to frame these issues in the context of patient stability, medical needs, and need for community support to prevent re-entry into jails
- Difficulty of capturing mental illness data given that many behavioral issues that lead to incarceration are not necessarily driven by mental illness

---

---

---

---

---

---

---

---

---

---

### Findings – Recidivism Definitions

- No clear consensus on how to define recidivism
- Difficulty of capturing recidivism data (regardless of what ultimate definition is):
  - Many arrestees are transient between counties and states
  - Profound lack of information sharing between criminal justice entities in the state

---

---

---

---

---

---

---

---

---

---

### Findings - Information flow between criminal justice & behavioral health

- Varies significantly between counties: Counties with JBBS grants tend to have stronger partnerships with local community mental/behavioral health centers
- Some eligible counties are unaware of their current ability to get physical health information from CORHIO or QHN
- Many healthcare organizations refuse to give out health information to jails, even if requested by a HIPPA-covered provider—including recent ER visits.
  - Possibly lack of education about the laws surrounding this type of exchange
- Often jail providers spend hours trying to track down pertinent information on inmates: Consent process is currently cumbersome
- Many behavioral health entities receive a weekly or monthly census of current inmates in order to determine whether any of their clients have been recently incarcerated or will be released in the near future.
- Some shared information between behavioral health entities and parole offices, regarding legal obligation to keep health appointments and to mitigate risk factors

---

---

---

---

---

---

---

---

---

---

### Grant Vision - Accepted

"All justice involved individuals with serious mental illness will be provided improved continuity of care in prescribed psychotropic medications and evidenced-based behavioral health services that incorporate Risk-Need-Responsivity principles, whether under criminal justice supervision or receiving community-based treatment services, to promote positive community adjustment, improved health, reduced recidivism and improved public safety. Closing continuity of care gaps will promote a quick and smooth adjustment whether the person is transitioning into the justice system or is being released back out to the community."

---

---

---

---

---

---

---

---

---

---

### Grant Mission - Draft

"To reduce recidivism rates among justice-involved individuals with serious mental illness through implementation of a statewide, electronic, criminal justice health information exchange (HIE) system. Thereby, improving care by enabling health care workers to access and securely share patient health information for psychotropic medications, assessment, treatment and continuity of care to appropriately address psychiatric and criminogenic needs and risks for each, whether the individual is incarcerated, in a mental health crisis system, or community reentry. Likewise, as justice-involved individuals re-enter the community, health care professionals and others responsible for their transition will have access to the appropriate level of health and justice information to make reintegration and aftercare successful."

---

---

---

---

---

---

---

---

---

---

### Grant Goals

**Goal 1:** Define the grant high risk target population of offenders with serious mental illness, the majority of which have co-occurring substance use disorders

**Goal 2:** Identify electronic information exchange needs and opportunities for the statewide grant planning process

**Goal 3:** Develop a statewide justice to health information exchange system plan to improve triage, assessment, treatment and continuity of care for individuals with mental illness or substance use disorders whether they are in the criminal justice system, newly established mental health crisis system or community reentry.

---

---

---

---

---

---

---

---

### Priority Information Exchange Functions

1. Criminal justice health provider and community health provider continuity of care information exchange \*
2. Information for program evaluation/data collection\*
3. Information for criminal justice supervision
4. Criminal justice status information for health providers
5. Information for law enforcement response to a crisis situation involving risk of imminent threat to the health or safety of a person or the public

\* 1<sup>st</sup> Priority

---

---

---

---

---

---

---

---

### Define Grant Data Elements

1. Develop a common definition for Serious Mental Illness (SMI) that can be used by all agencies that participate in the statewide information exchange system.
2. Develop a consistent recidivism measure that can be used across agencies to measure recidivism reduction progress.

---

---

---

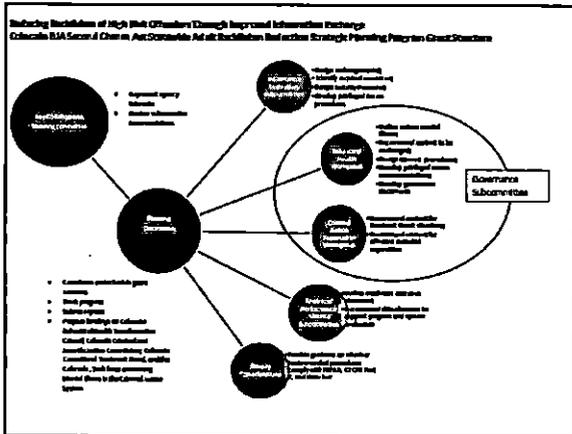
---

---

---

---

---




---

---

---

---

---

---

---

---

### Planning Process

- Substantial planning must be completed by June
- BJA Implementation Solicitation will be released ???
- Subcommittee Structure & Tasks
- Steering Committee Role & Future Meetings

---

---

---

---

---

---

---

---

### General Discussion

---

---

---

---

---

---

---

---

## Justice and Health



# Health Information Technology and the Criminal Justice System

**Advancing health information technology (HIT) is a key component of national healthcare reform efforts to improve the effectiveness and efficiency of delivery systems through better information sharing. By enhancing the ability of justice agencies and community healthcare providers to communicate, HIT can lead to more efficient and better coordinated healthcare, significant cost savings to health and justice agencies, and improvements in both public health and public safety.**

### What is health information technology?

Health information technology (HIT) encompasses a range of products and services—including software, hardware, and infrastructure—that enable the electronic collection, storage, and exchange of patient data. The goal of HIT is to increase the capacity for a patient's clinical information to flow seamlessly between treatment providers working in different settings, inform clinical decision making by supplying timely access to accurate information, and empower patients by giving them more control over their own health information. It can also improve the administrative aspect of healthcare delivery by improving workflow efficiency and clinical documentation to support appropriate billing.

### How is electronic health information used?

Converting paper medical records into a digital format can greatly increase the capacity for information sharing and may take a number of forms. This section defines some important terms describing technologies that can facilitate information sharing between health and justice systems.

- > Electronic Medical Records (EMRs) refers to both a patient's computerized medical record and the software system used to create, modify, and maintain these records. EMRs are digital versions of case notes on a patient's medical history. Providers can use EMRs for diagnosis and treatment. While EMRs can greatly improve workflow and service provision within one hospital, clinic, or correctional facility, they generally operate within a single organization and are not designed to connect with providers across treatment settings.
- > Electronic Health Records (EHRs) have the most potential for information sharing, as they allow providers to store and retrieve patient information over time and across care settings. EHRs are patient-centered records that follow people as they receive treatment in different places. The primary value of EHRs is that authorized providers and staff across health care organizations can create, manage, and access them. A person's EHR can include information from current and previous doctors, hospitals, community clinics, pharmacies, laboratories, and correctional health services.

- > Personal Health Records (PHRs) contain the same information as EHR/EMRs, but allow people to independently access and manage their records outside a treatment provider's office. PHRs typically include features that allow patients to review recent test results, renew prescriptions, schedule appointments, and contact healthcare providers.
- > Health information exchanges (HIEs) act as clearinghouses for clinical information, connecting multiple treatment providers at a regional and state level. By allowing multiple treatment providers who use incompatible proprietary information systems to share data in a variety of formats, HIEs enable electronic sharing of health-related information across organizational and jurisdictional boundaries. The goal of an HIE is to provide healthcare organizations access to important clinical information about a patient from across a network of healthcare providers to inform clinical decisions and administer services more efficiently. For example, a clinician working in a community healthcare setting could access diagnostic, treatment, and prescribing information from all participating hospitals, clinics, and other healthcare settings that have dealt with a patient. Treatment and administrative organizations can join an HIE by signing a contract that outlines the type of data that is shared. Once they join the HIE, they typically use a log-in portal to retrieve information submitted to the HIE by other providers in their network.
- > Telemedicine refers to the use of electronic communication and information technology to provide or support clinical care to remote areas that might otherwise not have access to an adequate range of health services. Telemedicine can make a critical difference in healthcare access, especially in rural areas where the patients may live many miles from the nearest healthcare provider.

**Telemedicine in Wyoming**

In Wyoming, where 75 percent of the population lives in rural communities or small cities with between 2,500 and 50,000 residents, state policymakers recognize that telemedicine is an essential tool for extending primary care, specialty care, and mental health services to people living in remote areas, including four state prisons.

Wyoming lawmakers established the Telehealth Consortium—a partnership among hospitals, physicians, and government agencies, including the Office of Chief Information Officer (OCIO) and Department of Corrections (DOC), and the Wyoming Health Information Organization (WyHIO)—with the mission of “facilitating the operation of a statewide interoperable telemedicine/telehealth network using existing internet protocol based communication and videoconferencing infrastructure and telecommunication services to the extent possible.”

[Click here to read the Telehealth Consortium's annual report.](#)

## Why is HIT a good investment for justice systems?

- > **Jails and prisons as healthcare providers.** HIT can improve health services in correctional settings in similar ways that it does for many hospitals and community clinics. On any given day there are more than two million people held in U.S. prisons and jails who rely on these facilities for their healthcare. Large city jails and prisons can serve the same number of people as a medium-sized hospital, often having their own clinics, labs, and pharmacies on site. For instance, each year healthcare providers working in the New York City jail system conduct nearly 750,000 medical and mental health visits and write more than 600,000 prescriptions.

As with people entering emergency rooms or acute care clinics, those booked into jails are often in a state of distress and commonly experience symptoms of unmet health needs. And the work of a patient discharge planner in a hospital developing continuity-of-care plans for patients who are returning home is analogous to transitional planning/reentry case-managers in jails and prisons. Professionals working in both of these environments can use reliable health records as a tool for linking their clients to appropriate services that keep them healthy and provide the support and treatment that they need in the community. A standardized record system can offer quicker access to reliable and comprehensive information on health needs and prior health system contact, improving the quality of treatment decisions, providing a reliable referral mechanism, and reducing the risk of erroneous treatment and/or prescribing decisions.

## What benefits can justice systems realize using technology designed for healthcare settings?

- > **More effective connectivity with community support networks.** Correctional health is an under-recognized and disconnected component of the safety-net healthcare system. The use of paper health records in jails, prisons, courts, and community corrections exacerbates this problem because it limits the capacity for communication with healthcare providers working in other settings. Investments in HIT can help link criminal justice agencies with the resources that exist in the community, promoting a model of continuous healthcare that does not lapse when someone enters or leaves a jail or prison. By improving access to essential behavioral healthcare, HIT can help address the mental health and substance use problems that lead many people into contact with justice systems.
- > **Improved quality of correctional healthcare.** If implemented correctly, EHRs can improve quality of care by increasing coordination, limiting unnecessary testing, lowering and containing costs, and decreasing medical errors, misdiagnosis, and other problems resulting from incomplete or illegible paper records.
- > **Enhanced opportunities for diversion.** Electronic health information can be used to verify a person's health needs before or immediately upon entering the justice system, thereby increasing opportunities for diversion or treatment alternatives to incarceration by providing timely access to accurate information on mental health or substance use needs.

- > **Smarter reentry planning.** It is well-documented that the first few weeks following release from incarceration is a period when people are susceptible to a range of health risks. Electronic health records are valuable tools to help treatment providers working in the community support people as they return home from jail or prison. The reliable transmission of important health information from correctional to community settings allows community-based providers to improve health outcomes for people returning from incarceration. For people with mental health and substance use problems, continuity of care that addresses behavioral health needs can significantly reduce the risk of recidivism.
- > **More comprehensive insurance coverage for transition planning.** The Affordable Care Act (ACA) requires local governments to develop strategies for enrolling vulnerable populations into health insurance plans and coordinated care. Jails can identify and engage under-served populations in health services. Transition planners can use EHR systems compatible with other electronic systems to manage applications for social benefits to ensure people have the necessary support when transitioning back to a community setting after incarceration. For example, Connecticut has created an interface between its jail management system (JMS) and the state's health insurance exchange (HIX), which allows demographic data from JMS to be electronically incorporated into a Medicaid application as a way of helping ensure that people have health insurance when leaving corrections settings.
- > **More cost-effective provision of treatment.** Between 9 and 30 percent of total corrections costs are allocated to healthcare for people in correctional facilities, depending on the jurisdiction. Increases in correctional healthcare costs are the result of several factors, including an aging incarcerated population, rising pharmaceutical drug costs, the prevalence of mental illness, and widespread need for substance use treatment. The need to control spiraling healthcare costs has prompted correctional systems to look for new models for managing healthcare services, including the use of standardized record systems.
- > **Better jail intake process.** Many correctional health EHRs are designed to interface with jail and prison management systems. By making detailed information on prior diagnosis and treatment accessible at booking, EHRs can help intake staff triage people to the appropriate health services and housing units.
- > **Improved sick call system.** HIT is currently used in some jails and prisons to manage inmate requests for healthcare. Inmates can use kiosks or phone systems to contact a sick call system and make appointments with medical staff.
- > **Reliable clinical decision making.** EHRs can ensure that treatment providers have appropriate and accurate client information at the right time to inform clinical decisions. Many EHRs come with features that provide clinicians with important clinical decision-making tools; such as alerts about medication allergies or side effects, or suggestions for treatment regimens based on clinical history.
- > **Greater compliance with legal and ethical obligations.** Jails and prisons have a legal obligation to provide people in the facilities with healthcare that is comparable to community

standards of treatment. HIT can help correctional institutions enhance the quality of care by reducing medical errors, strengthening clinical decision making, and documenting service provision.

- > **Increased patient support.** Individual health records are transportable and accessible across communication networks. Therefore, patients have greater access to their personal health information as they move between providers, their data is less likely to get lost, and there is less opportunity for medical errors.
- > **More robust capacity for data-driven policy.** Agencies can compile datasets to perform analyses for reporting and policy-making purposes and evaluate programs' effectiveness.

**What are some of the concerns with the use of electronic health records in correctional settings?**

- > **Privacy.** Concerns are frequently raised about the potential for EHRs to lead to security breaches, misuse of data, and loss of patient control over information. However, with proper controls on access and comprehensive policies that govern their use, EHRs can be more compliant with privacy laws and secure than paper records.
- > **Costs of implementation.** There are significant costs associated with installing, managing, and maintaining electronic record systems. Technical assistance, licensing fees, and the need to provide training to correctional personnel can all present barriers to implementation. Nevertheless, while investing in HIT is expensive in the short term, it can improve efficiency and yield long-term savings.
- > **Connecting with legacy data systems.** It is important to select an EHR that has the ability to connect with or supplement data systems that are currently in use. In some cases, it may be necessary to upgrade computer hardware and networks before introducing EHRs into a correctional setting.
- > **Challenges integrating physical and behavioral health information.** Substance use and mental health treatment providers typically rely on less well developed information systems when compared to those used by general healthcare practitioners. Although EHRs are designed to span disparate information systems, there may still be connectivity issues between physical and behavioral healthcare providers.

## What are the factors to consider if my agency is thinking about moving from paper to electronic healthcare records? How do I select a vendor for electronic health records?

There are a number of companies, such as e-Clinical Works, that market electronic health record systems, and several that have designed EHR systems tailored specifically to correctional settings. There are a few factors to weigh when selecting an EHR vendor:

- > **Does the EHR enhance interoperability?** A very important factor to consider is whether the technology you select enhances interoperability—the ability to conduct electronic information exchange within and across other systems.
  - *Will the EHR be able to connect to existing information systems within your agency?* You should be sure that the EHR product you choose has the ability to interface with existing data management systems in your facility. Exchanges between EHR and existing systems can help avoid duplicative data entry, increase efficiency, and ensure that both systems have up-to-date information on demographics, medical history, and custodial housing assignment;
  - *Will the EHR be able to connect with community systems?* Additionally, it is important to ensure that the technology you choose uses technical standards that are capable of interfacing with treatment providers in your community.
  
- > **Is the EHR certified?** Purchasing an EHR that has been certified by the Certification Commission for Health Information Technology (CCHIT) as meeting the requirements of “meaningful use” will maximize the potential for interoperability and information sharing. The Office of the National Coordinator for Health Information Technology (ONC) maintains a list of EHRs certified by CCHIT.

## Are correctional health providers eligible for financial incentives for using electronic health records?

- > The Medicaid EHR Incentive program, in the HITECH Act (2009), includes financial incentives for eligible healthcare providers demonstrating “meaningful use” of EHRs caring for patients covered by Medicaid. Payments can be used to support adopting, implementing, or upgrading EHR technology. Providers can receive annual payments if they continue to demonstrate compliance with current meaningful use standards.
  
- > As of 2012, correctional health providers are eligible for incentive payments if: (1) at least 30 percent of their patients are *enrolled* in Medicaid; and (2) they adopt an EHR that is certified by ONC. More providers practicing in jails and prisons are likely to satisfy the 30 percent Medicaid enrollment requirement following implementation of national health reform; especially in states expanding Medicaid coverage in accordance with the Affordable Care Act that also “suspend” rather than terminate Medicaid coverage upon incarceration.<sup>1</sup>

---

<sup>1</sup> Before August 2012, providers practicing in correctional facilities were not eligible to receive EHR incentive payments. The old rule required providers to have 30 percent of their patient volume to include encounters *paid* by Medicaid, and therefore

## Electronic Health Records in Jails and Prisons

An increasing number of correctional systems are converting paper records into digital format in an effort to improve the effectiveness and efficiency of healthcare delivery and enhance connectivity with community health systems. Below are examples of jurisdictions that have successfully adopted EHRs.

- > **Rhode Island.** The Rhode Island Department of Correction (RIDOC) introduced an EHR to manage health information across its seven correctional facilities. According to RIDOC staff, the technology has become a vital component of the state's correctional health delivery system that streamlines communication among medical, behavioral health, and dental staff. The EHR maintains a chronology of all healthcare admissions, diagnostic tests, and other events related to patient care. [Read how](#) RIDOC identified the core requirements of its EHR, selected a vendor, and developed a records system tailored to its needs and case flow.
  
- > **Kentucky.** Since 2004, the Kentucky Department of Corrections (KyDOC) has been using an EHR in its 13 state-operated prisons, and the department is currently planning to upgrade the system in accordance with meaningful use standards for EHRs promulgated by the Office of the National Coordinator for Health Information Technology (ONC). These changes will enhance the ability of KyDOC to communicate with treatment providers in the community that employ EHRs using similar standards. [Click here](#) to read a "positive but cautionary case study of how users assess components of an EHR in a relatively stable and controlled organized setting."
  
- > **New York City.** In 2008, the Bureau of Correctional Health Services (BCHS) of the New York City Department of Health and Mental Hygiene implemented an EHR, e-Clinical Works. [Click here](#) to read an article written by members of BCHS about their adoption and use of e-Clinical works to provide health services to people held in the nation's second-largest jail system.

---

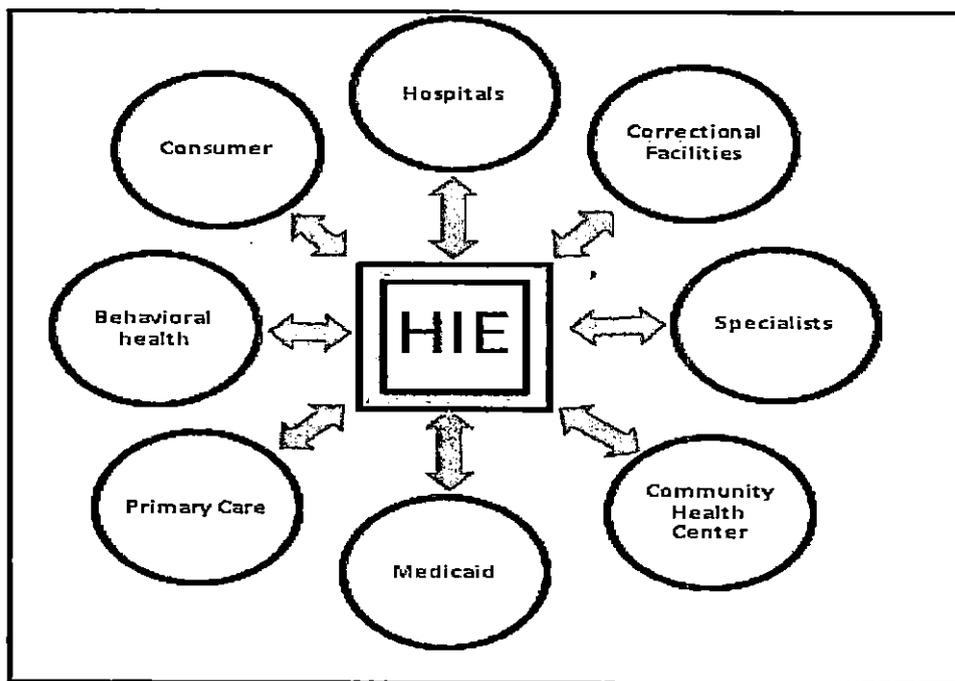
excluded correctional health because health services inside jails and prisons are not reimbursable Medicaid. The new rule only requires that 30 percent be *enrolled* as opposed to paid by Medicaid.

## How are jurisdictions currently using HIEs to build connectivity between health and justice systems?

- > Several states and city governments are actively working to develop bidirectional information flow between community health and justice systems through HIEs. For example, some jurisdictions provide professionals working in correctional facilities with access to health data maintained in the HIE. This allows a correctional health provider or authorized jail or prison staff person to view clinical information relating to someone that they are serving in their facility, from other providers in the HIE network. By linking correctional facilities into HIEs, clinicians working in a range of settings can access information on any medical treatment a patient receives while incarcerated, helping ensure continuity of care as people return to the community.

## How can my agency become a member of the HIE?

- > In order to get access to your local HIE you will need to enter into contractual agreements with the entity that oversees the exchange and other partners. Once you have joined the HIE, you will be able to share data with other members to coordinate care for your shared patients. As a first step, you should contact your state or local health department to determine who oversees the HIE. [Click here](#) to find out more about HIEs in your state.



**Health Information Exchange.** The image above depicts how an HIE serves as a data hub permitting bidirectional information sharing across a number of distinct entities.

## Linking Justice and Health through Health Information Exchange (HIES)

Health information exchanges (HIEs) enable the electronic sharing of health-related information across organizational and jurisdictional boundaries, connecting treatment providers at the regional and state level. Below are some examples of jurisdictions that are using HIEs to enhance connectivity between their criminal justice and healthcare systems. While the potential for HIEs to increase access to healthcare for justice system-involved populations is considerable, most jails, prisons, and probation and parole agencies do not currently participate in their local HIE. There are a number of factors that may explain the lack of integration of justice agencies, including technology requirements (agencies need to have an EHR system in order to participate), the siloed nature of agencies, and concerns about releasing sensitive health information to justice agencies. These concerns notwithstanding, connecting health providers in justice settings with their local HIEs presents enormous potential for increasing access to essential healthcare services for underserved populations.

- > **Salt Lake City, Utah.** Health officials in Utah are pursuing a vision where the state HIE will serve as an informational hub that can be used to streamline enrollment into Medicaid or other health insurance plans offered in Health Insurance Exchange (HIX), and track clinical encounters with the justice system and treatment community. Utah plans to use the HIE to support people as they transition between correctional settings and health services in the community. The HIE will also help improve the effectiveness of existing alternatives to incarceration programs by providing clinical information to case managers, advocates, judges, and others working in the courts.
- > **Pima County, Arizona.** In 2010, Arizona established the Health Information Network of Arizona (HINAZ), which recognizes 29 HIE stakeholders across the state, including hospitals, community health centers, and health plans. Pima County is the only county in the state to join the board of HINAZ and advocate for including correctional health systems to achieve optimal use of the state HIE. Nearly 40,000 people enter the Pima County Adult Detention Complex (PCADC) each year. More than half of people booked into the facility have previous involvement in the public mental health system, and a large percentage have received treatment for a chronic health condition. Connecting PCADC to the state HIE will dramatically improve the booking process by providing intake specialists with critical medical histories necessary to provide continuity of care, reduce medical error, and triage people to appropriate services. [Click here](#) to read a memorandum from Pima County officials making the case to link the detention facility to the state HIE.
- > **Camden, New Jersey.** The Camden county jail has joined the local HIE alongside hospitals and community clinics increasing the connectivity between correctional and community health systems. Through the HIE, staff at the jail are now able to log in to an online system and access important clinical information for people in the jail. This information can help the jail provide appropriate care while someone is in the facility, as well as informing reentry plans and referrals to community healthcare providers for people when they leave. [Click here](#) to view a PowerPoint presentation about Camden's HIE.

**What if it is not financially feasible for my jail or prison to invest in electronic health records? Are there less expensive technological solutions?**

- > **Secure e-mail messaging.** While an interoperable electronic health record that can interface with community health systems is ideal, there are technical solutions available that do not require a large investment of resources.

ONC's Direct Project provides a low cost alternative to fax machines and paper records by pushing clinical summaries between providers via secure e-mail exchanges.

- > **Cloud Computing.** Uses remote technology servers that can be located anywhere and accessed via the internet. This may be a viable option for smaller jurisdictions that cannot afford to invest in expensive technological infrastructure within their agency.

*"In-house systems are incredibly expensive to develop, require additional information, technology staff, and, once they are built, are difficult to expand or change. Cloud computing, on the other hand, is flexible, expandable, and you pay as you go with no upfront investment and only for what you use."*

—Paul Wormeli, the IJIS Institute on cloud computing

## Additional Resources

### *Websites*

The American Health Information Management Association (AHIMA)  
<http://www.ahima.org/resources/default.aspx>

Healthcare Information and Management Systems Society (HIMSS)  
<http://www.himss.org/library/topics?navItemNumber=13211>

HealthIT.gov  
<http://www.healthit.gov/>

IJIS Institute  
<http://ijis.org/>

### *Fact Sheets*

The Healthcare Information and Management Systems Society (HIMSS), "The Legal Electronic Health Record," [http://www.himss.org/content/files/legalemr\\_flyer3.pdf](http://www.himss.org/content/files/legalemr_flyer3.pdf) (accessed June 3, 2013).

National Commission on Correctional Healthcare, "Telemedicine Technology in Correctional Facilities," <http://www.ncchc.org/telemedicine-technology-in-correctional-facilities> (accessed June 3, 2013).

New York eHealth Collaborative, "Introduction to Electronic Health Records (EHRs)," [http://www.nyehealth.org/images/files/File\\_Repository16/ganda/Intro\\_to\\_EHRs\\_Final\\_121009-4.pdf](http://www.nyehealth.org/images/files/File_Repository16/ganda/Intro_to_EHRs_Final_121009-4.pdf) (accessed June 3, 2013).

### *Publications*

Community Oriented Correctional Health Services (COCHS). "Challenges of Bringing Connectivity to Jails via Health Information Technology: Three Case Studies." April, 2012.  
<http://www.cochs.org/files/hieconf/CHALLENGES.pdf> (accessed June 3, 2013).

Silow-Carroll, Sharon, Edwards, J. N., and Rodin, D. "Using Electronic Health Records to Improve Quality and Efficiency: The Experiences of Leading Hospitals." July 2, 2012. Commonwealth Fund.  
<http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/Jul/Using-EHRs-to-Improve-Quality-and-Efficiency.aspx> (accessed June 3, 2013).

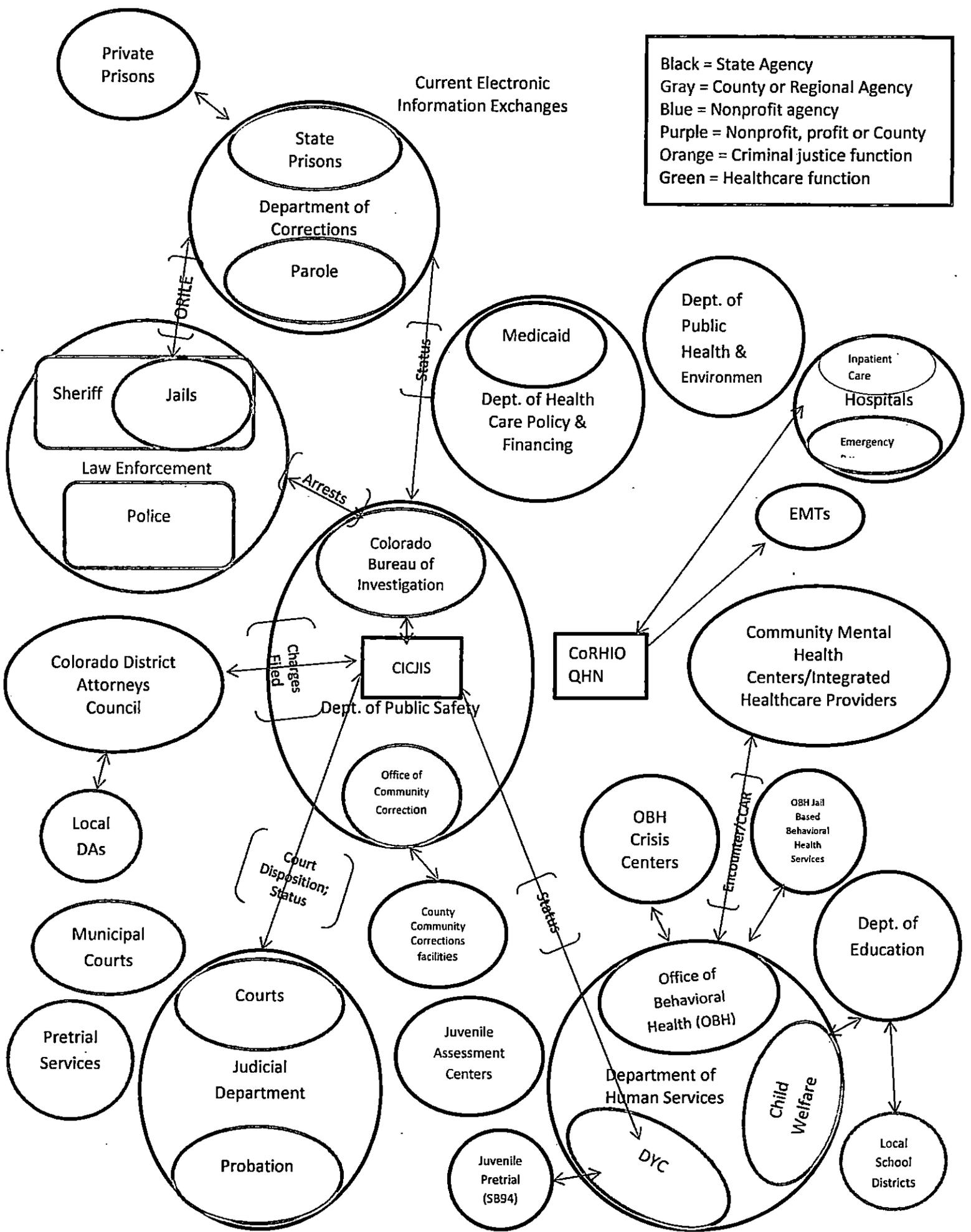
Stazesky, Richard, Hughes, Jennifer, and Venters, Homer. "Implementation of an Electronic Health Record in the New York City Jail System." April, 2012. Community Oriented Correctional Health Services (COCHS). <http://www.cochs.org/files/hieconf/IMPLEMENTATION.pdf> (accessed June 3, 2013).

Wisdom, Jennifer, Ford, James, and McCarty, Dennis. "The Use of Health Information Technology in Publicly-Funded U. S. Substance Abuse Treatment Agencies." *Contemporary Drug Problems* 37, no. 2 (2010): 315-339.

Woodward, Ralph P. "Electronic Health Records Systems and Continuity of Care." In *Public Health Behind Bars*, edited by Robert Greifinger . New York: Springer, 2007.

Marocco, Joseph R. and Marcussen, Pauline M. "Rhode Island Streamlines with Electronic Health Records." *Correctional Health Perspectives*.  
[http://www.mrccq.com/media/1637/rhode\\_island\\_streamlines\\_with\\_ehr.pdf](http://www.mrccq.com/media/1637/rhode_island_streamlines_with_ehr.pdf) (accessed June 3, 2013).

Gates, Madison L. & Roeder, Phillip W. (2011). "A Case Study of User Assessment of a Corrections Electronic Health Record." *Perspectives in Health Information Management* 8 (2012)  
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3070231/> (accessed June 3, 2013).



Black = State Agency  
 Gray = County or Regional Agency  
 Blue = Nonprofit agency  
 Purple = Nonprofit, profit or County  
 Orange = Criminal justice function  
 Green = Healthcare function

Current Electronic Information Exchanges

Private Prisons

State Prisons  
 Department of Corrections  
 Parole

Sheriff  
 Jails  
 Law Enforcement  
 Police

Medicaid  
 Dept. of Health Care Policy & Financing

Dept. of Public Health & Environment

Inpatient Care  
 Hospitals  
 Emergency

EMTs

Colorado District Attorneys Council

Colorado Bureau of Investigation  
 CICIS  
 Dept. of Public Safety  
 Office of Community Correction

CoRHIO QHN

Community Mental Health Centers/Integrated Healthcare Providers

Local DAs

Municipal Courts

Pretrial Services

Courts  
 Judicial Department  
 Probation

County Community Corrections facilities

Juvenile Assessment Centers

Juvenile Pretrial (SB94)

OBH Crisis Centers

OBH Jail Based Behavioral Health Services

Dept. of Education

Office of Behavioral Health (OBH)  
 Department of Human Services  
 Child Welfare  
 NYC

Local School Districts

ORILE

Status

Arrests

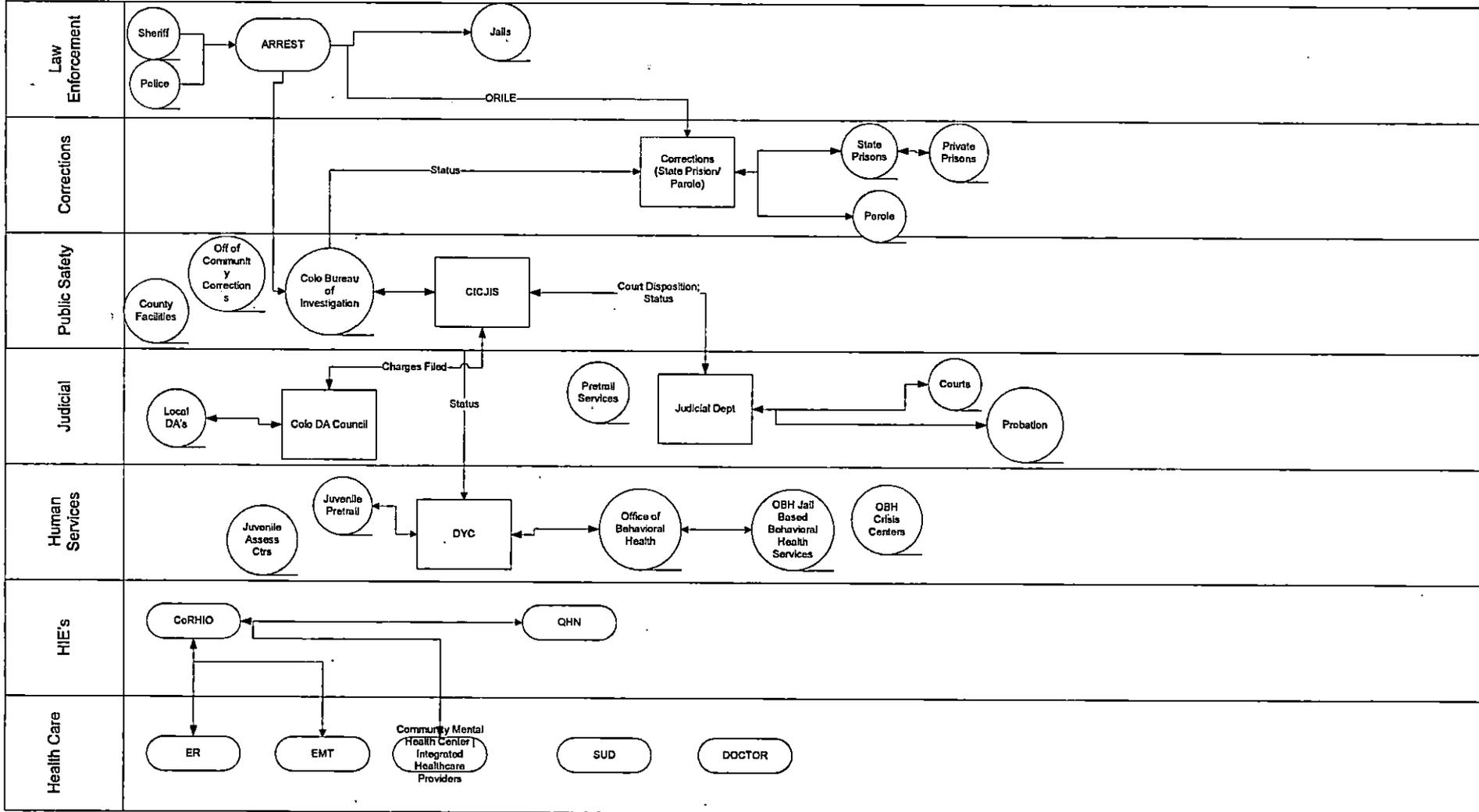
Charges Filed

Court Disposition; Status

Status

Encounter/CAAR

Info Exchange



## Succinct Summary of 2015 Focus Group Responses

### Caveats:

- Virtually no input from Eastern Plains (2 of the 3 Eastern Plains focus group participants were from the Custer County Sheriff's office which is Southcentral)
- No input from the health providers *within* the criminal justice organizations even though these people were continually mentioned

### Criminal Justice Entities: Screening

- Very few criminal justice entities currently use a standardized means of detecting inmates with mental and behavioral health issues.
  - *Exception:* Most conduct acute suicide risk assessments
  - Most rely on patient reports of diagnoses and medications, which may be incomplete, mistaken, and/or willfully incorrect
    - Once issues are detected, in-house or contracted healthcare jail staff must spend a significant amount of time gathering information to verify diagnoses/past treatment/current medications is inconsistent and takes many hours to obtain (and therefore a lot of money)
      - Some smaller jails do not have any partnerships with mental health providers and do not actually have a means of obtaining this information

### Criminal Justice Entities: Treatment

- Medicaid loss upon jail entry means criminal justice entities struggle to provide adequate healthcare (physical or behavioral/mental).
  - Piecemeal ways of funding in-house or contracted mental/behavioral health treatment
    - Some use grants (e.g. JBBS grant, McArthur grant, SB-97)
    - Some are about to lose funding
    - Some simply have to stretch their criminal justice budget
  - Some criminal justice entities in smaller counties do not have specific contracts with mental/behavioral health entities (or in-house providers), so face severe limitations in ability to provide any type of treatment, including medications
- Unwillingness of many inmates to participate in mental health treatment
  - Jails must put them on an M1 hold in order to force treatment (and sometimes in order to actually fund treatment).
    - Even then, not all hospitals will agree to see the patient

### Criminal Justice Entities: Attitudes toward proposed health information exchange

- Manly positive, given the difficulties of information gathering mentioned above, and costs to society of untreated individuals reoffending as a result of their mental illness or substance abuse issues
- However, concerns about costs:
  - 1) The cost of mental/behavioral health information exchange itself
  - 2) The cost of delivering appropriate treatment once inmates' diagnoses and medications are identified

### **Mental/Behavioral Health Entities: Attitudes toward proposed health information exchange**

- Mainly positive given opportunity to create more continuity/hopefully reduce recidivism.
- However, concerns about patients' privacy
  - Slippery slope for secondary disclosure of health information
    - Notable hesitancy of mental/behavioral health entities to interact directly with criminal justice entities regarding their clients
    - Would need to have a very clearly defined flow of health information to prevent non-covered entities from accessing protected info
      - May need to build a basic dataset that would only provide the jail the minimum information necessary to do their job
- Adams County is already working on an infrastructure to share information between criminal justice entities and mental/behavioral health entities
  - Concerned about redundancy/creation of silos if our system did not take their pre-existing infrastructure into account

### **Definitions of "Serious Mental Illness"**

- No clear consensus on how to define "serious mental illness"
  - Furthermore, many entities do not currently see a need to define this, given their organization's functions and purposes
- Many criminal justice entities rely on a non-standardized combination of DSM criteria, evidence of functional impairment, and/or acute risk stratification
- Fundamentally different perspectives on mental/behavioral health issues:
  - Criminal justice entities tend to frame mental/behavioral health issues in the context of safety and acuity
  - Mental/behavioral health entities tend to frame these issues in the context of patient stability, medical needs, and need for community support to prevent re-entry into jails
- Difficulty of capturing mental illness data given that many behavioral issues that lead to incarceration are not necessarily driven by mental illness

### **Definitions of "Recidivism"**

- No clear consensus on how to define recidivism
- Difficulty of capturing recidivism data (regardless of what ultimate definition is):
  - Many arrestees are transient between counties and states
  - Profound lack of information sharing between criminal justice entities in the state

### **Information flow between criminal justice entities & mental/behavioral health entities**

- Varies significantly between counties
  - Counties with JBBS grants tend to have stronger partnerships with local community mental/behavioral health centers
- Some eligible counties are unaware of their current ability to get physical health information from CORHIO or QHN
- Many healthcare organizations refuse to give out health information to jails, even if requested by a HIPPA-covered provider—including recent ER visits

- Possibly lack of education about the laws surrounding this type of exchange
- Often jail providers spend hours trying to track down pertinent information on inmates
  - Consent process is currently cumbersome
- Many mental/behavioral health entities receive a weekly or monthly census of current inmates in order
  - To determine whether any of their clients have been recently incarcerated
  - To determine whether any of their clients will be released in the near future
- Some shared information between mental/behavioral health entities and parole offices, regarding legal obligation to keep health appointments and to mitigate risk factors

#### **Future Directions?**

- Elicit input from Eastern Plains entities (both mental health and criminal justice)
- Verify when exactly new arrestees lose their Medicaid coverage
- Speak directly to contracted and in-house mental/behavioral health providers who work within jails to get their opinions on this proposed information exchange system
- Identify funding sources (grants, etc.) used by all criminal justice entities to fund their in-house or contracted healthcare providers
- Reach out to Adams County to understand exactly what kind of restructuring they're undergoing, to prevent redundancy with their new system
- Clarify exactly which entities already use CORHIO or QHN
- Conduct more detailed survey of which jails use which information systems
- Provide education regarding current physical health HIPPA regulations. Many entities (especially healthcare organizations that we haven't heard from directly) do not seem to realize that criminal justice healthcare workers are considered covered providers and are allowed to receive physical health information without inmate consent.
- Consider building a proposed minimum dataset that would give jails the minimum amount of mental/behavioral health information to be able to do their jobs.
- Consider analysis of all of the definitions of SMI: P5, P6, DOC, OBH, Medicaid (regarding medical necessities)