



## HUMAN SERVICES AND PUBLIC SAFETY POLICY COMMITTEE (HSPSPC)

November 18, 2016

12:15 P.M.

Walter A. Scheiber Board Room (3<sup>rd</sup> Floor)

### MEETING MINUTES

#### 1. WELCOME, ANNOUNCEMENT(S), AND APPROVAL OF MEETING SUMMARY

*Brenda Donald, Human Services and Public Safety Policy Committee Chair*

Chair Donald opened the meeting at 12:15 P.M., extended a welcomed to participants and invited everyone to self-introductions. In her absence, thanked Vice Chair Toles' for taking the lead with putting together this meetings' agenda.

Chair Donald requested and received a motion to approve the September 16, 2016 HSPSPC draft meeting summary. The motion was seconded and unanimously approved.

Jennifer Schitter, MWCOG Principal Health Planner, introduced the panel to speak about the "Health Indicators Project."

#### 2. HEALTH OFFICIALS COMMITTEE HEALTH INDICATORS PROJECT

*Dr. Steven Woolf, Director of the VCU Center on Society and Health*

Dr. Woolf presented an overview of last years' presentation to the HSPSPC that focused on social determinants related to healthcare in Metropolitan Washington. Research findings indicate that major drivers surrounding health disparities had to do with living conditions, the environment and social economic factors; he noted that policy decisions are not only based from these factors, but also on job availability, quality of education, and access to healthy foods, etc. It is these kinds of drivers that influence healthcare cost, healthcare availability and what is decided about clinics and hospitals.

The purpose of today's presentation is to brief the committee on a new initiative underway "Healthy Communities Index," a project geared to tracking census throughout the Washington Metropolitan area and takes an extensive look at healthcare disparities by location and outlines how those differences impact healthcare availability in various jurisdictions. The work being done with the Virginia Commonwealth University will connect the dots that help communities and policymakers better understand that policy decisions and access to providers should not be compartmentalized or ignored given the locale; these important decisions are interconnected and largely impact healthcare decisions.

The work Dr. Woolf did last year with the Northern Virginia Health Foundation examined census track for life expectancy throughout Northern Virginia, Fairfax and Loudoun counties; these areas were targeted for data collection because of affluent communities and for having a reputation for being relatively healthy. However, findings determined that even in these wealthy areas, there were still pockets of need and healthcare concerns. To assist policymakers and community leaders to stay engaged with what is happening in respective jurisdictions, an interactive tool was developed and put on the Northern Virginia Health Foundations website for easy access. This interactive tool allows for targeting any census track to ascertain not only life expectancy in a particular location, but also



demographic characteristics that are important to shaping health such as race, education, ethnicity, income, etc. The tool clearly shows dramatic differences across the map in life expectancy given the location and income levels.

Data evaluated thus far has prompted discussions on finding ways to draw intersections between the interest in life expectancy and the Region Forward initiatives. When thinking about the best way to collect and analyze information from a surface viewpoint, it made sense to extract information based on territories, which were outlined as part of the topical focus area for Region Forward; however, physicians reviewing the same data observed that health is at the center of the findings and is heavily influenced by factors such as one's income, neighborhoods, and lifestyles.

The Health Officials Committee is in the process of developing metrics to chart how the region is doing in terms of health outcomes by duplicating the life expectancy project done in Northern Virginia, but shifting the focus to the District of Columbia and Maryland; taking a broader look at what was initially thought of as quality of life and incorporating other factors that might influence life expectancy. The health officials have dialogued extensively over the past year with various committees and stakeholders, and have made a number of adjustments to the data collected and indicators to better serve the needs of Region Forward, and some practical needs for health officials that can be used in decision-making for advancing healthcare outcomes in respective jurisdictions.

The *healthy community index* project will have two Phases (phase one and phase two) and will work to highlight and explain wide differences in healthcare outcomes. Phase one will be the planning phase where details are outlined and deliverables are generated, there will be continued collaboration with stakeholders, collection of raw data, detailed documenting, and mapping for the entire Metropolitan Washington and Maryland areas. Phase one will act as a narrative discussion that walks the reader through factors that shape health disparities and the project will provide explanations for health differences with the use of scientific calculations and schematic maps for an at-a-glance view. It is expected that reports for DC and the surrounding suburbs will show significant census tract level differences given population variances. The same type of interactive tool developed for Northern Virginia will be developed for Montgomery county, and anyone visiting the resource will be able to see a number of variables that makes it easier for jurisdictions to analyze respective data and zoom-in on specific areas of interest. The ultimate goal is for an easy drill-down briefing for public consumption and simple access to view demographic data.

Phase Two of the project, the *healthy community index*, will concentrate on a large number of well-defined data-points that can serve as a dashboard for tracking progress across jurisdictions that are important to health and can function as predictors for differences in life expectancy; some examples of data-points are social economic changes that exists at census tract level, housing, and access to transportation. The expectation is that about 100 maps will be developed to represent different jurisdictions and designed for an at-a-glance view of health disparities across domains to determine if pockets of need still exist; has there been a reduction in violence, crime and toxic stress, mapping will outline transformations and clearly summarize the work being done to address problem areas. Many locations have great needs, are aware of those needs and have been working on improvements overtime, the hope is that this project will bring visibility to success stories. Additionally, this project is designed to help policymakers appreciate the geographical issues that exist in different jurisdictions that can be used as a platform for collaboration, policy changes, encourage inter-relationships, and establish cross-sector strategies.

#### Discussion:

During the National Association of Counties Annual Conference held in July, a documentary was shown about resilience; adverse childhood experiences. Ms. Gross in-turn shared the same documentary at a committee meeting last week, which was well received. The documentary touches on research being done to combat hostile experiences children face and wondered if there were correlations to what is being done with the regional health indicator project.



- ACE (adverse childhood experiences) conducted its first study in 1998 followed by many additional studies that determined children exposed to two or more adverse childhood experiences such as substance abuse in the home, unstable families, or economic marginalization are at higher risk of developing acute health problems in adulthood. The research done has found a perfect correlation between adverse childhood experiences to chronic health conditions as adults.
- In hopes of improving health in adulthood, providers are attempting to identify ways to reduce exposure to toxic stress in childhood experiences. One hurdle is to first pinpoint which adverse childhood experience is being referenced; is it poverty, lack of social mobility, etc. (ages 0-3 are more critical)? Currently there is no census track level data on ACE exposure and to obtain such data systematic screening is required. Some jurisdictions are beginning to collect this kind of data, but are finding it to be too expensive and too difficult to manage. Information gathering is so layered and complex that the approach should be from different entry-points, a more global viewpoint aiming toward a largescale impact on improved policies and program changes; take the focus away from one-area-at-a-time.

### 3. MENTAL HEALTH DIVERSION PANEL

*Laura Yager, Director, Systems Transformation, Office of the County Executive, Fairfax  
Dr. Nicole Johnson, Director of Forensics, DC Department of Behavioral Health  
Dr. Raymond Crowel, Chief of Behavioral Health, Montgomery County*

*Laura Yager, Director, Systems Transformation, Office of the County Executive, Fairfax*

- a) Mental health illness is very common and studies show that those who suffer from mental illness end-up in the criminal justice system more frequently, and once in the system they are less likely to receive the appropriate treatment leaving them vulnerable to recycling through the system.
- b) Fairfax county has established an intercept model designed to identify common points when the mentally unstable initially comes in contact with the criminal justice system. Having knowledge of this kind of information is helpful to caregivers and providers because they can better ascertain the need for intervention followed with appropriate treatment.
- c) Fairfax received funding from a grant in 2006 to create a jail diversion team whose responsibility was to help people shift away from the criminal justice system; however, there was little success because of difficulty with identifying ways and programs for diversion. In 2015 there were a number of tragedies that occurred amongst people diagnosed with mental illness and from that a police ad-hoc committee was established assigned to make examine reports of excessive use of force in the criminal justice system toward those with mental health issues, which resulted in another push to focus on diversion related activities. Hence, Diversion First was created to develop a diversion system of care, and a stakeholders group was created in June represented by a community service board that consisted of providers, police chiefs, judges, court services, etc. who are engaged and collaborating on diversion programs for the mentally challenged.
- d) The Diversion First program was not competitive for state funding for diversion related activities because the crisis intervention training model for law enforcement was inappropriate, and it went against regulations for police officers to drop-off individuals to a mental health facility without first routing them through the justice system. Stakeholders worked to make necessary changes that would follow guidelines for evidenced based practices and revamped the training model to compliance. Shortly after the necessary changes were made the Merrifield Crisis Support Center was opened, a facility designed as an alternative to incarceration for those persons with mental health issues. Police officers are trained to recognize persons who are mentally unstable; they are now authorized to take them to a facility for appropriate treatment, bypassing incarceration.
- e) A Mental Health First Aid initiative has also been launched; training targeted specifically to first responders, fire and rescue personnel. A goal has been set to have all jail-based officers trained



by end of June next year; they each will be well equipped and skilled in routing persons with mental health issues to receive the right kind of care.

- f) The intercept programs will continue to be data driven to show evidence of improved outcomes; positive return on investment.

*Dr. Nicole Johnson, Director of Forensics, DC Department of Behavioral Health*

- a) DC is invested in cross agency collaboration and has recently been awarded a grant from the Bureau of Justice Administration to work with the Metropolitan Police Department to create a screening tool in hopes of identifying persons with mental illness, offer assistance and provide support prior to the first court date, which is sometimes four to six weeks from the date of arrest.
- b) There are support systems set-up for those currently in the criminal justice system, trained staff are deployed at the pre-trial service agency, the department of corrections, and at the DC jail; they provide linkage support to inmates scheduled for release from incarceration.
- c) A team from New York visited in May 2016 to review services offered in the District of Columbia. From the mapping there were four pattern treatment areas highlighted for focus:
  - 1. Data Sharing – to address the need for agencies to communicate across systems about the same individual; one place of reference to reduce redundancy in information sharing.
  - 2. Housing for returning citizens – treatment and vocational resources. The District does not have a prison system and persons residing in the District and sentenced to prison actually serve-out those sentences in other states. Proper preparations need to be made for those returning to the District upon release from prison, they have to relearn the community, obtain housing, medical needs will have to be addressed, vocational training and other resources are needed to prepare those persons for re-entry to the workforce. Research has shown that those returning to the community want to be income-earning and productive citizens.
  - 3. Diversion opportunities such as appropriate housing for those with mental health issues. There are a large number of officers in the District who have been trained to recognize persons with mental health issues, but there needs to be alternatives to incarceration; avenues to get them the appropriate treatment. Resources need to be put in place that will guide and protect these individuals.
  - 4. Once the diversion opportunities are in place, there will then be a need to increase capacity of independent psychiatric emergency facilities to accept individuals for treatment.
- d) The District is serving as a pilot for the data driven initiative established by the White House. Collected data will be sent to the University of Chicago for study and analyzing. All agencies will be reviewed to target areas that service high volumes of persons with behavioral and mental health issues. Feedback will include suggestions for best methods to identify these persons and best ways to reroute resources or condense services to improve management of care, for example reduce visits to the emergency room through proper medical maintenance.
- e) While remaining within HIPPA guidelines, a universal consent form is being developed to allow for cross-agency information sharing.

*Dr. Raymond Crowel, Chief of Behavioral Health, Montgomery County*

- a) Montgomery county currently has approximately 2200 individuals coming through the criminal justice system, 20 percent of which have some form of mental illness, and the numbers continue to increase with more complex diagnosis, many related to substance abuse.
- b) Inmates with mental health problems are first housed in the jails critical intake unit for detoxing, monitoring and stabilization before being put into central population.
- c) Intercepts include the crisis intervention teams where 60 to 70 percent of law enforcement has been trained to identify citizens with mental/behavioral health issues. A new form of engagement has been put in place in Montgomery County this year called stop, triage, engage, evaluate, refer, and reprogram (STEER); this program is specific to helping law enforcement identify those who have substance abuse issues and provide them an alternative to arrest.



- d) Clinical Assessment and Triage Services is the second intercept that comes into play after an arrest and mental health assessment. This intercept assessment was launched after three suicides in one-year were related to mental health; the service has had great impact on reducing suicides. Additionally a program called CORP or Comprehensive Re-entry Program was initiated from a Bureau of Justice Administration grant designed for interaction between the jail and mental health facilities to better target those moving in and out of the system; those who are too psychotic to engage in treatment and do not comprehend the advocacy process, the program provides opportunity to address mental disorders, identify barriers to treatment, and better connect individuals to needed resources that will reduce chances for returning to jail.
- e) Drug Court is the third intercept level that has been in operation for about 10 years, and has begun a program known as JAS (jail addictions services) along with a crisis intervention unit for those who show signs of being acutely psychotic and in need of medical detoxing. There is also a behavioral health step-down unit designed for those individuals who are stabilized but are not quite ready for re-entry.
- f) CORP is revisited in the fourth intercept and helps individuals for re-entry to the community by linking them to appropriate resources such as first-stop community providers and alternative programs. The goal is to establish relationships and build intervention teams (i.e., housing, probation, law enforcement) that work together to ensure successful re-entry. The team is formed with persons positioned to cross boundaries and are trained take a more comprehensive look at what is happening with an individual providing frequent follow-up reducing the risk of re-arrest.
- g) The last level includes pre-trial, pre-release and re-entry services designed to divert from imprisonment. If someone is arrested, there is intervene to ascertain if the person is a CORP client and re-route them from jail back to the CORP services, if eligible.
- h) Montgomery County is rich in available resources. The Criminal Justice Coordinating Council has been in operation for approximately 12 years; a group of individuals from across disciplines such as criminal justice services, housing, behavioral health, healthcare providers, etc. collaborate to address criminal justice issues. To focus on behavioral health issues in the criminal justice system a subcommittee "Criminal Justice Behavioral Health Initiative" was established who helped with the adoption of the intercept model previously discussed, and in Y2014 Montgomery County went through the process of system mapping; advocating for a mental health court, and after 10 years the circuit court began seeing mental health cases, the District courts will begin seeing such cases in January.

Montgomery county continues to be challenged with reformation of the behavioral health system in terms of getting access to acute care facilities and diverting persons with mental and behavioral health issues, but will continue to collaborate and work across-systems to lower the bar for access to treatment so that law enforcement officers do not feel as though their only recourse is to arrest someone in order to get them the appropriate treatment. Although county, state and federal legislators should take a closer look at reforming the behavioral health system, however, there is a challenge in that there is no model legislation that has been developed to follow at present. There is a need for a system that is funded in ways that allow for clients to be dropped-off without having to get energy partitions to hold someone with mental illness for a period of time; this is something that should be looked at during the General Assembly.

Discussion:

1. At the point of arrest, recidivism in Montgomery County was about 20 percent of individuals going through the clinical assessment and triage service program, while law enforcement responds to a little more than 5,000 calls per year, persons with behavioral health issues recycling through the system are on the declined.
2. The District of Columbia is currently running data and do not have re-offense figures at present. There are attempts to inter-connect agencies and not just report-out numbers; the goal is to





- establish wrap-around services to reduce the number of reoffenders.
3. Fairfax stakeholders have agreed on a definition for recidivism as re-arrest or re-diversion where people are measured for three years. Stakeholders have input as to how data will be tracked, have begun a monitoring system, and is now a part of a new “Stepping Up” initiative in partnership with the White House Justice System. *Stepping Up* works to strengthen relationships between police and the community and work closely with government leaders to identify and review areas of concern such as:
    - Developing a plan for stable housing after discharge to avoid recycling through the system.
    - Improve linkage between mental health services and criminal justice system to include strong diversion efforts to treatment centers and away from criminal justice system.
    - Recent research data show that those who commit lesser crimes have a higher recidivism rate than those who commit greater crimes. The rates stagger because there is no successful re-entry system in place for those with lesser offenses because they are not in the system long enough for stabilized resources accompanied with limited follow-through. A program needs to be in place for at least 12-months from release to reduce the chances of re-offense.
  4. Housing is an important issue of concern because there are too many various ways in which housing is managed with most of the effort going toward the homeless families with little energy put to finding housing for homeless persons with mental, behavioral health and substance abuse issues; those who are mentally fragile.

**Action:**

Over the next year or two, perhaps COG can develop a research protocol to find ways to best identify and address problems surrounding homelessness in the region. Collaborate with other states to learn of some of the challenges faced and how they are working to address housing and other programs to support persons with mental and behavioral disorders.

It is noted that HSPSPC had visited the topic of homelessness at a previous meeting; there is overlap which drives regional dynamics to include families who are transient.

**4. OPIATE ADDICTION PANEL**

*Dr. Raymond Crowel, Montgomery County Department of Health and Human Services  
Lyn Tomlison, Assistant Deputy Director, Fairfax Falls Church Community Services Board  
Dr. Marquitta Duvernay, DC Department of Behavioral Health*

Jennifer Schitter, MWCOG Principal Health Planner, introduced the panel on opioid addiction, and noted that the National Capital Region Compact to combat opioid addiction was signed by Mayor Bowser and Governors Hogan and McAuliffe. “It is impressive to have these three leaders collaborate on bringing attention to opioid addiction that not only affects our region, but also Nationally”.

The National Capital Region Compact will convene a regional opioid and substance abuse summit in Y2017 to share best practices and strategies amongst public healthcare providers, public safety officials and residents. The date for the summit has not yet been determined, but anticipate sometime in the Spring.

The presenters addressed the opioid epidemic in their respective jurisdiction and efforts are underway to enhance community awareness. There was an overview of the current impact opioid abuse is having in Metropolitan Washington and surrounding areas.

- Community education, increasing awareness, and messaging will be key to controlling the opioid epidemic. Establishing relationships and collaborating closely with policymakers will assist with putting together the necessary policy changes needed to assist with regulating the laws

surrounding distribution and use of such drugs. Additionally, more focus is needed on increasing the number of prevention programs such as medical treatment facilities with more available beds, access and distribution of medicines that respond to drug overdoses, and working with providers on prescribing the appropriate pain medication to avoid the potential for addiction.

Dr. Raymond Crowel, Montgomery County Department of Health and Human Services

- There is increased use of substance abuse in middle school-aged youth, which mostly begin with the use of prescription drugs and carryover to illegal drug use.
- This year the Maryland State's Attorney's Office launched an initiative "Speak-up Save-a-Life Program" and spoke to over 10,000 students about the dangers surrounding opioid use, and introduced them to the new "Good Samaritan Law" that allows someone in the presence of a person who is using/abusing drugs to call ER and anonymously report that there is someone in need of help, without being detained for being in the immediate vicinity of drugs or paraphernalia.
- There is a collaboration of "Many Voices with Smart Choices" where parents are actively involved where different states and law enforcement work together on strategies for community messaging around opioid and substance abuse. PSA's and social media are being used for messaging across the board.
- There is a plan in place for prescriber education to include a prescription drug monitoring program at the state level, and peer-to-peer education.
- Maryland has a drug take-back program that allows for drugs to be dropped-off for safe disposal.
- STEER was created to do work targeted to substance abuse followed with a referral process. The biggest success stories are in ER recovery as many patients are in agreement to engagement.
- Virginia has major issues with oxycodone and opioid use, and heroin is cheaper and more easily accessible.
- Fentanyl use is trending and causing more overdoses and deaths.

## 5. ADJOURN

With no further business, Chair Donald adjourned the meeting at 2:15 P.M.

There will be no meeting in December. The next meeting will be held February 17, 2017.

Committee documents can be obtained at:

<https://www.mwcog.org/events/2016/11/18/human-services-and-public-safety-policy-committee/>

### Attachments/Handouts:

1. Agenda
2. Draft Meeting Minutes of September 16, 2016
3. Regional Health Indicators Project Overview
4. Behavioral Health Intercept Chart
5. Mental Health and Criminal Justice in DC
6. Montgomery County Action Against Opiate Addictions and Overdoses
7. Montgomery County Behavioral Health Diversion Efforts
8. Fairfax County Diversion First Fact Sheet
9. HHS Opioid Initiative: One Year Later
10. HSPSPC Draft 2016 Work Plan
11. HSPSPC Draft 2017 Meeting Schedule