Criminal Justice Coordinating Council (CJCC)
August 10, 2017
8:00 a.m.
VMCCCU-CC

CJCC Members Present: Angela Connolly, Judge Gamble, John Sarcone, Sheriff McCarthy, Susie Osby, Cory Williams, Gary Mikulec, Dana Wingert, Jerry Evans.

CJCC Members Absent: John F. Mauro, Chad Jensen, Valorie Wilson.

Others Present: Stacy Curtis, Tera Clement, London Usher, Justin Hyde, Greg Bellville, Roger Kuhle, Eric Kool, Anna Hyatt, Ron Berg, MacKenzie Elmer, Steve Johnson, Christopher Pattersen, Colleen Christopherson, Dillon Kraft, Betty Andrews, Melissa Ahrens, Teri Sommerlot, Tom Jackowski, Annie Uetz, Sarah Boese, Lori Baker, Rick Kozin, Clifford Leonard, Sara Lupkes, Patrick Coughlin, Arnold Woods, Marty Ryan, James Cornick.

Approval of June 8, 2017, Meeting Minutes
Moved by McCarthy Seconded by Sarcone to approve the June 8, 2017, CJCC Meeting Minutes.

Reports – Due to a change in the usual meeting format, presentation of reports will not be given, but handouts distributed will provide the data for the I-Leads Committee, Pretrial Release, and the Jail Diversion & Crisis Observation Center updates.

Angela Connolly, as acting Chairperson, requested that CJCC Committee members and guests participating in the meeting introduce themselves. After introductions, Angela explained the change in the make-up of the meeting was due to Polk County being accepted by the Data Driven Justice and Behavioral Health Design Institute to participate in a program that is part of, and paid for by, the Substance Abuse and Mental Health Services Administration (SAMHSA). This will be discussed in a demonstration call during today's meeting. Also, a Mental Health Community Services Plan, a requirement of the State, will be discussed.

LOOM Demonstration Call – Annie Uetz, Polk County Health Services; Lynn Overmann, Vice President of Data Driven Justice, the Laura and John Arnold Foundation
Annie stated that the goal of the Design Institute is to provide information, tools, and strategies to use data to improve care for individuals who are high-utilizers (those people who are touching all of the different systems) and how they can reduce the costs for those individuals, along with creating a better quality of life for them. Health Services staff will be going to Maryland to learn how to integrate the data between the service sectors; how to make the most efficient use of the limited behavioral health, criminal justice, and social support services and resources; and assist in understanding the legal framework of data-sharing across systems to ensure HIPAA laws and rules are being followed. They will create a work plan to see what can be done to be sure emergency and other high cost services are being utilized the way they should be, rather than for individuals who could be connected to the system to get the treatment and support they need to maintain in the community. This is all part of developing and participating in an 'open lattice' system, which will be discussed in the demonstration call with Lynn Overmann.

Formerly at the White House, when the Data Driven Justice (DDJ) Initiative moved to the John and Laura Arnold Foundation, Lynn, as Vice President of DDJ, moved there as well. The initiative began in October 2015, and was officially launched in June 2016. During that time, they spoke to Criminal Justice Coordinating Councils, since they are very effective at looking across different local systems to try and implement change. DDJ was interested in finding out what was going on in our local jail systems—Every year, 11 million people cycle through 3,100 local jails, costing over $22B in incarceration costs alone. The vast majority of those people (95%) stay in local jails, many with complex problems—64% have a mental illness; 68% have a substance use disorder; and 44% have chronic health problems. In speaking with Police Chief's and Sheriff's, what DDJ has heard is that they've begun to rely heavily on the criminal justice system to be a key provider of these social services; however, jail or police departments are not good places to solve these problems, but often treatment just isn't being provided in the community.

With the philosophy that if there's a big problem, someone has already done something about it, they began looking around the country to see what steps have been taken that may be replicated. In Camden, N.J., the combining of hospital data and police arrest data helped to identify an overlap of individuals in both data banks--the 'Dual-System High Utilizers' or 'Super Utilizers' as they are called in the medical world. There were 205 individuals identified to be dual-system high utilizers (10+ ED visits & 6+ police encounters over five years). The data also showed how a disproportionate percentage of patients were responsible for costs (re: 10% of patients = 73% of costs, 5% of patients = 58% of costs; 1% of patients = 26% of costs).
A further breakdown of the numbers showed two things that Lynn feels demonstrates the value of looking at data, and encapsulates DDJ's goals. First, it validated what people that work in the system already know--how prevalent substance abuse, mental health, and homelessness is among high-utilizers. The other was a statistic showing that 60% of Police and Hospital High Utilizers have at least one substance-abuse related hospitalization prior to their first encounter with the criminal justice system. That opens up the possibility of being more proactive or preventative by intervening at the time of a substance abuse hospitalization, and before those people enter into the criminal justice system.

San Diego, CA, has taken a proactive intervention and realignment of existing services approach. Project 25: Housing First, Health Home for Serious Mentally Ill and Chronic Homeless. In 2010, 28 people were identified that had cost the community $3.5 million in public services. By providing that housing first intervention, there was a total cost savings of $3.7 million over 2 years as, while housing them is costly, public service expenses are even greater. All project 25 individuals are housed in their own apartments, have acquired health care insurance, and are receiving necessary supportive services and care on an ongoing basis.
Miami-Dade, FL, has taken an approach that involves de-escalation training to all of their first responders. Since police and EMT's are likely the first to be called when someone is in a mental health crisis, they are taught to identify the signs, how to effectively stabilize the situation, and create ways to divert them from jail and the criminal justice system. With de-escalation training, law enforcement responded to 50,000 calls, only made 109 arrests, and diverted 10,000 people away from the criminal justice system. Over five years, the jail population fell from 7,000 to 4,700 and saved $12 million a year. Miami-Dade has been able to close two facilities, and have not seen an increase in crime.

The sharing of data is not without its challenges. Some common problems stem from 'siloed data' [data from the same entity (i.e. police) being stored in separate systems], outdated systems, manual entry, and privacy issues. One of the biggest challenges is that there isn't an existing technology solution that's acceptable to most communities and local governments.

When first responders receive a call, typically they are just dispatched to a location or to a victim, with no knowledge of prior encounters. The sharing of data between police and EMS, for instance, can provide a great deal of insight into a situation when first responders are going out on a call. A crime analyst from the Cambridge Police Department pulled together actual police and EMS data from a 26-year-old female over the course of about 4 years, revealing a history of overdoses, domestic disputes, mental health episodes, etc. Just that simple data sharing revealed that the young woman was on a destructive path, and may not survive without intervention and treatment.

The goal of a case study in Johnson County, KS, was to identify high-utilizers of EMS & mental health services, plus law enforcement encounters in the County. They pulled together data from Paramedic transport logs, Jail bookings, Court records, Probation records, and Mental health case management on 200 individuals who had a high number of contacts. They were able to create a risk predictor tool that was about 52% accurate in determining which of those individuals were most likely to have a jail booking within the next year. They also used the data to identify individuals that had had mental health services but then had been disconnected. By working their way down the list and getting people reconnected to services, they were able to reduce the chance they would end up back in jail.

Johnson County also looked across other services to identify four individuals that had cost them about $2.16 million in services over 5 years, a low estimate based on data available from the courts. The time involved in crunching the numbers and gathering the data was 60-80 hours. While the cost for each person varied, with the lowest being $56,921, the average annual cost for services per person was $139,833. Even with the amount of money spent, and the services available, they still haven't been able to break the cycle of homelessness and high levels of interaction with jails and hospitals.

DDJ is committed to helping Polk County and all DDJ participants with an open lattice data sharing platform developed to bring data together from different systems. That shared data can help to see what their population looks like, who the high utilizers are, what may be driving the high level of cycling of individuals among services, what interventions are in place, and what might be more effective, while also saving money. The DDJ team will help with data integration and individualized data analysis.

Community Services Plan – Susan Osby, Executive Director, Polk County Health Services (PCHS); Facilitated by Rick Kozin, Director, Polk County Health Department

With Rick acting as facilitator, Susie and Annie will participate in the discussion on developing the Community Services Plan required by the State, to identify PCHS role, and get input from the involved parties. Susie began by giving a timeline of the development of PCHS and what they do:

1976—PCHS developed and incorporated due to people being brought back from Clarinda Mental Health Facility to Polk County. The Sands Center at Broadlawns was being built, and due to the use of federal funds, it was decided that PCHS would be the entity that would actually own that wing of the hospital.
1977—Supervisors appointed PCHS to oversee all the disability services.
1981—PCHS was called the 'Mental Health Coordinating Council'.
1993—The Department of Human Services (DHS) felt that every county should have an entity like PCHS that would be a central point of coordination.
2012—Legislation passed that counties would come together to become regions, and decide which counties would be in each region.
2013--Polk County felt that it was large enough to be its own region and submitted an application to become exempt.
2014—Exemption approved to allow Polk County to be its own region.
(A map in the handout shows the counties in each of the 14 MHDS Regions)

Senate File 504—Each region is mandated to develop a Community Services Plan. With input from the judicial system, hospitals, law enforcement, mental health & substance abuse providers, NAMI, crisis service providers, MCO's, etc., a Polk Community Services Plan will be created and submitted to DHS by 10/15/17. The plan will identify how to create ongoing cross-system collaborations, and create collaborative policies and processes relating to the delivery of, access to, and continuity of services and supports for individuals with complex needs.

Current Service Overview--All funding comes from tax dollars. Fund 10 is used only for mental health and disability services. As part of the regionalization, DHS decided each region should have different types of services. 43% of funds are spent on initial core services such as support of community, support of employment, transportation, etc. Having additional core services was also discussed, and although not necessarily required, Polk County felt they were necessary to help with high utilizers, and in FY14, developed the Crisis Observation & Crisis Stabilization Centers, and a Pre-Petition Screener. A small amount of money also comes from Fund 2 for prevention and treatment of Substance Abuse, and potentially where funding will come from for the Sobering Center that is being developed.

Susie turned it over to Annie Uetz to discuss a slide showing services in King County, WA, that PCHS would like to see in our community. The slide shows the 'familiar face' in the center and around them the services of Housing and a Case Management Team; the outside circle shows all of the community services they can connect to through their case management team (i.e., Transportation, Employment, Spirituality, Education, Legal Services, etc.) to help them remain in the community and work toward a better quality of life. To the right are Emergency Services (EMS, Fire, and Police) with Hospital, Jail, and the Courts beside that; above Emergency Services are Crisis Diversion Services. The key is good communication between providers of all services to see that people are diverted to the services that would be most beneficial to them. Along the bottom of the page are things that are needed when working with people to ensure all of those run smoothly—Be Person Centered; Use Motivational Interviewing Methods; Be Trauma Informed; Use Harm Reduction techniques; Be Evidenced Based; and work with Payors to make sure that everyone that need services receive them. Rick commented that the slide "looks complicated and busy because it is." He encouraged everyone to recognize that the relationships with the people are as important as the inventory of services when developing the Community Services Plan.

Current Polk County Community Services Plan Map—The next slide shows the services PCHS currently has in place [blue boxes] and those that are desired [yellow boxes]. When initially received from the White House, there were only six blue boxes on the chart to put in all of the services already in place in Polk County, a positive for PCHS, so they got permission to expand the number. The desired services [yellow boxes] include CIT Training (in process)—once all first responders are trained, that will become a blue box; a 24 Hour Crisis Line, which Broadlawns has but it will need to be expanded to meet the State's definition, therefore still in yellow; a Sobering Center (in process); and Crisis Aversion (a peer-run pre-crisis respite place where people can go if they just need to get away before a crisis develops). Annie wanted to show the chart so people could look at it and determine if there are services that PCHS hasn't recognized a gap in, things that are missing and need to be added. Angela Connolly asked if there were any questions about services that are already in place?

Steve Johnson from Broadlawns asked about Assertive Community Treatment? That program is included under Intensive Support Services, as not all programs could be listed separately. He wants to be sure that services focus on evidenced based practices.

Sheriff McCarthy asked "What are Motivational Interviewing Methods?" Annie explained that this came from the Substance Abuse system, and it is talking to and asking questions of an individual in such a way that it can be determined at what step they are in the process of making positive changes, thus deciding what direction to take from there, and motivating them to move forward.

What is Harm Reduction? Taking steps to minimize the negative consequences of an action when it isn't possible to prevent it entirely. An example would be providing clean needles to reduce or prevent the spread of disease.

What does Irrelevant of Payor mean? Ensuring that all people in the community have access to services based on need, not whether you can access funding. There are a number of funding streams available, and PCHS wants people to know they are there to support them regardless.

James Cornick asked about the role of probation and parole officers, and if they receive CIT training? Jerry Evans answered that they don't get CIT training, however, there is a mental health unit within the Fifth Judicial District with officers that have mental health training, and they meet every other month with P.C. Mental Health staff to discuss mental health issues. They also have licensed dependency counselors at the Fort Des Moines facility. A probation officer also meets regularly with the Forensic Assertive Community Treatment (FACT) team through Eyerly Ball, and PCHS works closely with them.

Rick Kozin posed the question "Is it important to continue doing what you're doing?" [in reference to the services currently in place]. In response, this question was posed: With the number of individuals that PCHS covers, rather than 'painting such a broad brush' with the services they provide, should some of those be scaled back and dollars shifted away from them to other areas?

As far as substance abuse treatment, are there any projections or preparations for an influx of opioid and/or heroin addiction that could occur here, as has been reported in other areas where services have been overwhelmed and communities devastated? Susie believes that definitely should be looked at, and that mental health and substance abuse providers need to begin working together. Regardless of the payor, or who provides the services, they need to look at the needs of the individual. As seen in Lynn Overmann's presentation, the percentage of people in jail with mental health and substance abuse issues is alarming. Chief Wingert said data from EMS and law enforcement should be able to be pulled together quickly to see if there has been an uptick in the overdose cases they respond to, which may help prepare for any possible influx in the future.

Angela Connolly asked if many of these individuals have dual diagnoses? That isn't known based on the reports he sees; and with overdoses, normally they give them a dose of narcan to revive them, take them to the hospital, and their involvement ends there. Rick Kozin said it's very possible there are a fair amount of dual diagnoses, given the anxiety, stress, and depression that often goes along with pain management strategies, and he believes this is one place that data gets siloed. Dana added that the Des Moines Fire Department has had to give the same person a dose of narcan on seven different occasions since February. Ron Berg with Prelude Behavioral Services said the number of patients they've seen with opioid as a primary issue has doubled, from 3% to about 6 or 7%, but the number of deaths are disproportionately higher than the increase in addiction cases. He believes rapid rehousing is important, and that having a safe place to go enhances the recovery and support process. Looking at the long term picture, John Sarcone believes an education component in the plan is necessary. Funding for the opioid crisis is available from SAMMS, and first responders will be contacted to do a needs assessment.

Justin Hyde, Parole Officer, said a large percentage of his caseload strictly have substance abuse charges. He has read some research on Portugal where they have decriminalized low-level possession and use of narcotics. Rather than being arrested, they have to appear before a dissuasion commission who determines to what extent the person is addicted to drugs, then refer them to a voluntary treatment program, fine them, or impose other administrative sanctions, and have had some good results. He wondered if something like that has ever been considered in this area. Miami-Dade, FL does a pre-screening before booking when someone is arrested to determine if they have substance abuse or mental health issues. If they haven't committed a crime, and are willing to go into a treatment program, there's no jail time; if they're unwilling, or if they don't follow thru with treatment, they go straight to jail. San Antonio, TX is also starting a similar program.

PCHS will incorporate the comments made this morning, or others they may receive in the near future and send those out.

There are some steps to be taken now such as identifying misalignments in the laws that don't support diversion practices, identify who the high utilizers are, and where the gaps are in data sharing, communication, services & supports. In order for the plan to work, it'll be necessary to get the hospitals and MCO's, etc., on board, as well as those present at the table this morning. Finding creative ways of working together is important. Gary Mikulec brought up the issue of combining law enforcement and health information, and the legal aspects of that i.e., taking someone to the Sobering Center, especially from the suburbs. If the person isn't in custody, they may demand to be dropped off in route. Who is responsible then if the person steps out into traffic and is hit? Also asked was who 'owns' the data once combined? These are issues that will be discussed when they go to Maryland.

The Community Services Planning Timeline can be found in the handout; a draft will be available by the time of the next CJCC meeting on 10/5/17.

Meeting adjourned: 8:58 a.m.