Incarceration Prevention and Reduction Task Force
Behavioral Health Subcommittee
DRAFT Meeting Summary for July 28, 2016

1. Call To Order and Meeting Review

Committee Chair Anne Deacon called the meeting to order at 3:00 p.m. at the Health Department Lower Level Conference Room, 509 Girard Street, Bellingham.

Members Present: Anne Deacon, Susan Gribbin, Kelli Linville, Byron Manering, Randy Polidan

Also Present: Jill Bernstein, Peter Ruffatto (for Kelli Linville)

Members Absent: Julie Finkbonner, Greg Winter

Review March 31 and May 26, 2016 Meeting Summaries

There were no changes

2. Work Plan for Phase II

Deacon reviewed the Phase II requirements, which are specific to a triage facility.

The Committee discussed components of the Phase II report:

- Include a summary of what the Committee has been doing, including focusing on the front-door and back-door services that exist and that are planned
- More hours for the Crisis Prevention and Intervention Team (CPIT)
- A program similar to Law Enforcement Assisted Diversion (LEAD)
- Bellingham Police Department Behavioral Health Officer position
- Make program and service recommendations regardless of available funding, and allow City and County policymakers to decide which programs and services can be funded
- Realize efficiencies by coordinating services with Medicaid-funded behavioral health and the Behavioral Health Organization (BHO)
- They must communicate to a wide audience about what they are recommending and why, not just to the small group of people who decide funding
- First talk about what programs and services they want to recommend before talking about how to fund them
- The Committee should review how the Behavioral Health Tax funds are spent now.

Deacon described a recent statewide meeting she hosted to discuss Medicaid waiver money that would come through the BHO for housing, housing case management, and housing support services. They are working with partners to maximize those funds. The County is coordinating a pilot project to hopefully be funded from the waiver money. Funding will be also be available through the Accountable Community of Health (ACH). She will begin to draft the Phase II report and will bring it to the Committee at the next meeting.

Other Business

Manering presented a pilot program his agency will begin:

- It is proven to reduce criminal behavior by 50 percent
- Serves women with addiction issues and who are pregnant or have children up to the age of three
- Current services for the program participants include in-home, targeted, intensive case management, including behavioral health and child development services
- They will collect a variety of biographical data in partnership with the University of Washington Fetal Alcohol and Drug Unit
- This is a step toward becoming an evidence-based practice
- 70 mothers are enrolled in the program currently in Whatcom County, with capacity for up to 120 mothers
- Service is provided until the child turns three
- A goal is to have a baseline of information about recidivism rates by January 2017
- In January 2017, they will change the model to add components that are specific to reducing recidivism within the population
- This project is solely about keeping people out of jail, not solving mental health and substance use issues
- Further monitoring would be done until June 2019
- Annual status reports will be presented, with a final report after June 2019
- An possible incentive for the program participants is to somehow alleviate their outstanding warrants
- Dedicated supported housing, another possible incentive, is necessary throughout enrollment in the program
- The group they are working with now are the control group that has not received the special incentives
- This program also provides a better life for young children, which is a good early intervention program

The committee discussed how a warrant-forgiveness program may work and the lack of supported housing in the community.

Manering stated he is open to suggestions for other types of incentives for the program participants. He would like this committee to endorse his program.

The Committee concurred.

3. Update on County Health Department and North Sound Behavioral Health Organization (BHO) County Assessment and Proposed Response regarding Substance Use Disorder Inpatient Treatment

Deacon submitted a handout on Opioid Treatment Facts *(on file)* and described the Whatcom County Behavioral Health Facility Planning Report:

- 16-bed acute detox, medically-managed (pre-booking diversion at the triage facility)
- 16-bed mental health stabilizers (pre-booking diversion at the triage facility)
- Substance use disorder treatment in-patient facility:
  - Two levels of care
  - 30-50 beds
  - Medicare/Medicaid will pay for up to 14 days of care
  - voluntary
- 16-bed recovery house
- Funding
  - $2.5 million from the regional BHO
  - $2 million Department of Commerce grant
  - $3 million from local behavioral health fund
  - Possible State legislature capital budget allocation
  - The BHO will fund operational cost for the two 16-bed triage facilities
  - If they don't receive the Department of Commerce grant, they may see about bonding the $3 million from the behavioral health fund
  - If they get the $2 million grant from the Department of Commerce, they will need to break ground by June

The committee discussed the possibility of using the old St. Luke's property on Ellis Street or reusing another existing building, rather than buying property and building new. They will ask the status of Peace Health St. Joseph's plans for their facilities at the next Task Force meeting. Include capital facility funding for beds on the legislative agenda for the State.

4. LEAD-like program recommendation: How do we coordinate this with the Legal/Justice Committee?

Review of CHART program in Everett

Deacon referenced the Chronic Utilizer Alternative Response Team (CHART) program information beginning on packet page 28 and described a recent meeting with the Everett CHART leadership team:

- The program includes the leadership team and the social services team
- This is the City's modification of a LEAD program
- The goal is that they cannot cost-shift among partners
- They can share protected health information as appropriate via agreements

Gockley stated this is one of two early-win projects according the North Sound Accountable Community of Health (ACH). They're trying to expand this program in the five-county ACH region.

The Committee discussed the lack of communication among all the agencies and jurisdictions about the new and different programs, such as Crisis Prevention and Intervention Team (CPIT), Law Enforcement Assisted Diversion (LEAD), the Homeless Outreach Team (HOT), and other programs. Organize a group meeting with everyone to make sure services are efficient and aren't duplicated.

Snohomish County Proposal for "embedded" Social Worker

Deacon described the proposed Snohomish County tax. Taxpayers would fund this LEAD-like program.

Deacon moved to recommend:

- Support for more mental health professionals for the CPIT program, as opposed to the 40-hour schedule they have now, and
- Support the Bellingham Police Department and encourage the Chief to move forward with their LEAD-like program, which will require an additional full-time police officer trained in behavioral health issues.

The Committee concurred.

5. Recovery Support Services

This item was not discussed.

6. Prevention & Early Intervention Efforts: Where do they belong in our work?

This item was not discussed.

7. Public Comment

The Committee discussed its meeting schedule, and agreed to meet monthly for a one-hour meeting. The Committee also discussed how to best facilitate communication on developing new programs and services among all the agencies and jurisdictions.

8. Adjourn

The meeting adjourned at 4:30 p.m.

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Ms. Ann Deacon, LICSW
Chair of the Behavioral Health Committee
Whatcom Incarceration Prevention and Reduction Task Force
311 Grand Avenue, Bellingham, Washington

August 19, 2016

Dear Ann,

The purpose of this communication is to request the Behavioral Health Committee review and support the Sheriff's Office plan to implement a "Crisis Response Team" (CIT) and forward the recommendation on to the full Incarceration Prevention and Reduction Task Force.

The greatest and most rapidly growing challenge to law enforcement and the criminal justice system involves the number of people suffering from the effects of untreated and dangerous forms of mental health and chemical dependency. The Sheriff's Office is the primary law enforcement service provider to the majority of Whatcom County residents who live within a geographical area that encompasses nearly 2500 square miles. It routinely and frequently encounters people suffering from behavioral health issues in both rural and urban growth areas who live many miles from existing services located within Bellingham.

As part of the 2017-2018 budget planning process, the Sheriff's Office requested funding for three deputy sheriff positions to form a "Crisis Intervention Team." C.I.T. deputies will be trained to defuse volatile situations and develop close professional relationships with behavioral health service providers. A major goal will be to work collaboratively to divert people from the jail and the criminal justice system to appropriate treatment and recovery resources.

After unsuccessfully attempting to access community-based behavioral health services, friends and family members of those in behavioral health crisis frequently turn to law enforcement as the social service agency of last resort. The absence of viable and reliable behavioral health services, particularly in rural areas, often leads to a pattern of arrest, jail, entanglement in the criminal justice system and unfortunately, often does not result in long- term successful outcomes.

C.I.T. deputies will receive advanced training in early intervention and accessing both the array of existing services and those envisioned by the Incarceration Prevention and Reduction Task Force. These deputies will be available to accept the referral of challenging cases from other law enforcement officers. The program is envisioned to be loosely modeled after a successful and highly acclaimed program in Memphis. However, the Sheriff's Office will work closely with the local behavioral health community to tailor specifics based on local needs and best practices.

I am more than willing to attend a Behavioral Health Committee meeting to describe this proposal more fully and to answer any questions.

Sincerely,
Bill Elfo
Bill Elfo, Sheriff

cc: Jill Bernstein, Chair, Whatcom Incarceration Prevention and Reduction Task Force
Jack Hovenier, Vice Chair, Whatcom Incarceration Prevention and Reduction Task Force
Whatcom County Executive Jack Louws
Whatcom County Council Legislative Analyst Forrest Longman

BEHAVIORAL HEALTH AD HOC COMMITTEE

INTRODUCTION

Since the Phase I report, the Behavioral Health ad hoc committee has focused its efforts in three areas:

1. Completing the Sequential Intercept Model mapping of existing programs, and identifying those that need improvement or expansion; also included are services that are in the planning phase but not yet implemented.

2. Researching the drivers of criminal thinking and behavior and understanding the program elements required of behavioral health programs that will likely reduce criminal justice involvement.

3. Prioritizing initial enhancement, expansion or development of programs and services that link to the Triage Facility programs, targeting diversion from arrest/jail to the Triage Facility as well as connecting individuals to support services upon discharge from the Triage Facility.

SEQUENTIAL INTERCEPT MODEL

The current map of our community's Sequential Intercept Model is attached. It depicts five points of intervention wherein behavioral health services can "intercept" a person who is involved with the criminal justice system and divert them away from that system and into services. The Whatcom community provides a robust set of services at all five intercept points. This map is a working document. As we enhance and expand services, the color-coding on the map will reflect that progress. And as we add new programs that bolster our continuum of care, we will include them on the map. In this manner we will be able to keep our focus and track our progress.

DRIVERS OF CRIMINOGENIC RISK

Research in the field of criminogenic risk in conjunction with behavioral health disorders has been evolving. Andrews and Bonta (2006) are some of the first researchers to identify distinct factors that increase a person's risk for criminal behavior. They outline eight "criminogenic risk factors". Their "Big Four" include

1. Criminal History ~ early and continuing behavior in a number and variety of anti-social acts in a variety of settings. They note that the earlier a person becomes involved in anti-social or criminal activity, and the longer it is continued, the more likely a person is to commit future crimes.

2. Anti-social Patterns of Behavior ~ certain behaviors that are predictive of a person's increased risk to engage in criminal activity. These behaviors include significant impulsiveness, adventurous pleasure-seeking, restless aggression, irritability, and a callous disregard for others.

3. Anti-social Thinking & Attitudes ~ values and beliefs that include a sense of entitlement, rationalizing poor behaviors, minimizing the reality of the impacts of poor behaviors, depersonalizing others, denying responsibility, and lacking empathy. These belief systems lend to a personal identity that is favorable to crime.

4. Criminal Associates ~ these relationships include both the association with pro-criminal others as well as the isolation from anti-criminal others. Over time, a person's circle of "friends" shifts one's perspective to the shared criminal mind-set.

These "Big Four" criminogenic risk factors have shown to be *predictive* of future criminal behavior. The researchers also identified four other criminogenic risk factors that are *associated* with future criminal behavior, but not necessarily predictive. They include:

5. Substance Use and Abuse ~ both legal and illegal substances. Research has shown that mental illness alone very rarely drives criminal behavior. However, when addiction coexists with mental illness, criminal behavior is three times more likely.

6. Dysfunctional Family/Marital Relationships ~ poor quality relationships that do not provide good behavior modeling, pro-social skills, appropriate displays of anger, or positive connectedness. This lack of positive experience combined with pro-criminal expectations has been associated with a higher risk of criminal behavior.

7. Poor School or Work Performance ~ minimal success in school or work creates a low level of rewards and satisfaction. One's identity and sense of worth is often tied to one's sense of competence. Low levels of performance can lead to low involvement is these pro-social settings. An emphasis on one's deficits as opposed to one's strengths may discourage attempts at pro-social activities.

8. Lack of Pro-social Leisure and Recreational Activities ~ similar to poor school and work performance, a low level of involvement and investment in positive activities creates opportunities for engagement in pro-criminal activities.

These second "moderate" four risk factors may not be predictive of future criminal behavior, but must be acknowledged as important issues to address in planning for programs and services.

The behavioral health ad hoc committee has recognized that any consideration for criminal justice diversion programming must include attention to addressing these risk factors. The

committee has reviewed the intervention framework known as “Risk, Needs, Responsivity” (RNR). Programs are effective when the following principles are applied:

RISK: match the intensity of a person’s intervention to their criminogenic risk of reoffending

NEEDS: address dynamic risk factors (those that can be changed) to meet the person’s specific criminogenic needs identified

RESPONSIVITY: tailor the interventions to the learning style, motivation, culture, demographics, and abilities of the person, and address challenging issues of mental illness and addiction.

Research is clear: mental health treatment alone is ineffective in reducing criminal behavior. Effective interventions must include the focus on changing criminogenic thinking and behavior.

PROGRAM EXPANSION AND ENHANCEMENT

The county ordinance that created the Incarceration Prevention & Reduction Task Force (IPR Task Force) highlighted the expansion and program enhancement of our Crisis Triage Facility. Given this high priority focus, the committee chose to prioritize services that would serve as a “front door” as well as the “back door” to the Triage Facility. Front door services are those that can divert individuals pre-arrest to the Triage Facility for treatment, diverting jail booking. Back door services serve to connect people to recovery support services and treatment upon discharge from the Triage Facility.

“FRONT DOOR” SERVICES

Initial efforts have focused on programs that combine the expertise of law enforcement with those of a behavioral health specialist. Such programs include:

- The LEAD (Law Enforcement Assisted Diversion) program in Seattle. LEAD is a pre-booking diversion program that allows police officers to redirect low-level offenders engaged in drug or prostitution activity to community-based services instead of jail and prosecution.
- The CHART (CHronic Utilizer Alternative Response Team) program in Everett, which takes a collaborative approach that brings emergency medical response, law enforcement, human services on others together to create individualized plans to minimize the impact of individuals identified as having a very high impact on the system.
- The Behavioral Health Unit (BHU) of the Portland Police Bureau. The BHU includes a number of programs focused on behavioral health intervention by teaming specially trained police officers with behavioral health specialists.

Support was given to the Bellingham Police Department in their effort to seek grant funding to launch a local program similar to the Portland model.

The current CPIT (Crisis Prevention and Intervention Team) offered locally by Compass Health Whatcom and funded by the North Sound Behavioral Health Organization employs a full-time behavioral health specialist working with the Bellingham Police Department as a pilot project. The project has experienced success in managing difficult residents. These "front door" programs can divert people to treatment at the newly expanded and enhanced Triage Facility, and prevent or reduce incarceration. The committee is hoping to expand and enhance these or similar services throughout our community.

"BACK DOOR" SERVICES

Once a person is discharged from treatment at the Triage Facility, the priority focus is to ensure connection and engagement with a set of services that can provide continued support for stabilization and recovery. This is what we have referred to as the "back door" to the Triage Facility. Addiction, especially to illegal substances, has been shown to lead to criminal behavior and continual recidivism. Our community's capacity to provide adequate access to treatment for addiction is challenged. Recently, the Health Department has completed a report with recommendations on increasing the number of treatment facilities in our community.[1] These recommendations include the following:

A. Establish two residential treatment units for adults suffering from addiction

B. Expand our current Triage Facility to create two 16-bed units. One unit will be dedicated to providing acute detox services and initiation of medication assisted treatment. The other unit will be dedicated to mental health stabilization that can also be utilized for jail diversion as a pre-arrest/pre-booking alternative placement. Please see the Triage Subcommittee section for a more thorough discussion of this recommendation.

C. One or more Recovery Houses, which are facilities with on-site treatment services focused on promoting ongoing skills in maintaining recovery from addiction.

The committee will continue to pursue additional programs and services that can provide stabilization and recovery support services.

NEXT STEPS

[1] Whatcom County Heath Department. "Whatcom County Behavioral Health Facility Planning Report: Envisioning a New Substance Use Disorder Continuum of Care," June 2016.

In addition to the three focus areas discussed, members of the BH ad hoc committee as well as members from the Legal & Justice subcommittee met to discuss the merits of including other focus areas in the work of the IPR Task Force. Adverse Childhood Experiences can lead to an increased risk for substance abuse, mental illness, academic and learning problems, and even criminal behavior. There are many coordinated efforts in our community that address these issues effectively, and a dedicated set of professionals that ensure the delivery of evidence-based practices. Continued discussions about the scope of the IPR Task Force will help to set the parameters of our reach.