The Portland Committee on Community Engaged Policing (PCCEP)

Behavioral Health Subcommittee October 6, 2020 Public Meeting Transcript

Amy Anderson:

And thank you, Laura and Barb, for coming. I really was hoping there'd be more folks, but it is what it is and it's Zoom. So we'll have to do the best we can. I'm going to start off with basically this is the behavioral health subcommittee for the PCCEP, big committee off the big committee. We meet every month to try to do a informal education and learning system about our services. So tonight I invited Laura and Jeannie to present on the crisis management systems, and some of Cascadia's forensic programs so that folks can be more aware of what exactly goes on and who manages what and a little bit of how the process works.

Amy Anderson:

So people can start maybe figuring out where to do referrals, or how to get people plugged in, those kinds of things, folks that need services. So I'm going to start off with introductions. My name is Amy Anderson. Welcome everyone. Claudia, you want to lead out and see who you see?

Claudia:

Yeah. Welcome everyone. My name is Claudia and I am the project assistant for PCCEP. Thank you guys for taking the time out of your evening to be here. I will go next with Judith.

Judith:

Hi everybody. I'm Judith Malorie. I'm a senior policy advisor for the office of equity and human rights. I spend part of my time supporting the staff and particularly this committee for the PCCEP. They can go to Barb.

Barb:

I'm on Amy's screen but with her little chatting thing in her hand. Hi everyone, my name is Barb Ranish. I'm a peer support specialist and a freelance advocate. But usually here I just say I'm a citizen. I'm Amy's right hand. She's left-handed.

Amy Anderson:

Yes. She's my right hand and I'm left-handed.

Judith:

Thanks Barb.

Amy Anderson:

Keeps me focused.

Judith:

How about Laura?

Amy Anderson:

Every peer needs a peer, so there we go.

Judith:

Yeah.

Barb:

Oh, I'm supposed to pick somebody though. I'm sorry. Jared, back at you.

Amy Anderson:

Oh, we're doing a pick?

Jared:

Hi. This is Jared Hagar. I'm with the US Department of Justice. And I'm here in my role as the monitor of the settlement agreement. And I will pass it to Trevi.

Trevi:

Hi, I'm having a bad hair day.

Amy Anderson:

I wanted Claudia to [crosstalk 00:02:46].

Trevi:

I'm Trevi Thomas and I am a community member.

Barb:

Another time Jared was on the call.

Amy Anderson:

It's cute.

Trevi:

And I'll pass it to Mary Claire.

Amy Anderson:

She may or may not be in the room.

Trevi:

Oh, okay. Let's see. Let me see who else is here. Is Anne here?

Amy Anderson:

No. Tom, you want introduce yourself? Are you there? Hello? Okay. Well, I guess if they come online and want to talk, we'll go from there, but I'm going to pass to Laura. Do you want to do a little introduction?

Laura Cohen:

Sure. Thank you. Thank you for having us. My name is Laura Cohen and I'm the senior director of diversion services at Cascadia. I have to say I had a little bit of anxiety as you all were going around and it felt like being the last selected for I don't know, kickball or something. Amy, thank you for calling on me. I appreciate that. And I'm going to pass it off to Barb Snow, colleague at Cascadia.

Barb Snow:

Thanks, Laura. Hi, my name is Barb. I am the clinical director of crisis services at Cascadia. So you all have invited me tonight to talk a little bit about crisis services, which I am more than happy to do. I do use she/her pronouns. Before I jump in, I think I see one name that hasn't introduced themselves yet. So Susan, I'm going to pass to you.

Susan:

I'm Susan Goddard, interested community member.

Amy Anderson:

Well Tom, are you online?

Barb:

Can you hear me now?

Amy Anderson:

Can you hear us? Okay. Well, I guess he's in the background being virtual. We're going to go ahead and get started. I invited Laura to come in and talk about some of the higher level programs or forensic diversion type programs that we typically don't hear about very much in the public. And one of the programs that I work on is the fact team, which is underneath Laura's purview. So that's the forensic assertive community treatment team at the Kerns building. I just feel it's really a good time for folks to learn a lot about our what I call quiet programs. You don't hear them much. So with that said, I'm going to turn this over to Laura and let you begin, I guess.

Laura Cohen:

Thanks Amy. I just want to make sure I'm following your agenda because I think Barb may have been first.

Amy Anderson:

Oh, Barb was first? Sorry.

Barb Snow:

It's completely arbitrary. So whatever you guys are comfortable with.

Laura Cohen:

I have a feeling that you all are going to be really interested in the crisis programs, because when I've looked at your past agendas and all of your work with the BHU and other programs, I [crosstalk 00:06:15] Barb's presentation is probably going to allow for you to ask a lot of questions, so I'll let her go and then I will follow up if that's okay.

Amy Anderson:

That sounds good. Thanks. Okay, Barb. I'm excited for the group to hear about the services.

Barb Snow:

Excellent. so I do have a PowerPoint and I'm going to try to share that in a second. Before I do that, you guys are small group and I would love for this to be as interactive as possible, because I would love to answer the questions that you have and not just kind of drone at you. Unfortunately Zoom for me, really assisted me droning on and makes it harder to have real interactive dialogue, but I will do my best to watch the screens or pay attention if hands are raised or if people throw something in chat, because I really do want to make this useful for you and not just me talking about stuff that I thought might be useful if it's not. So let me know, keep me on track, all those things.

Amy Anderson:

Now, Claudia, does she need shared screen privileges?

Barb Snow:

I do.

Claudia:

Yeah. I was just going to say that. I can go ahead and make you cohost, Barb, and then that way you can share your screen.

Barb Snow:

Awesome. Thank you. I didn't warn you ahead of time.

Claudia:

It's okay.

Barb:

I'm so glad Barbara's not here.

Barb Snow:

All right.

Amy Anderson:

Oh I love the way my teeth work.

Barb Snow:

And then let me know, are you seeing the first slide of a PowerPoint?

Amy Anderson:

Oh yeah.

Barb Snow:

Excellent. Okay. Sorry. I am simultaneously trying to make it so I can see all of you as well, which is helpful for me. So I have two screens going. So if I'm not looking at the camera, it's because I'm looking at the PowerPoint to make sure I'm staying on track. So crisis services for Cascadia entails a couple of different programs. One is our urgent walk-in and one is Project Respond, which has a number of programs underneath it. So I'm going to talk about both those individually. And then we can talk about the crisis line as well in relation to Project Respond and urgent walk-in also.

Barb Snow:

So this is our urgent walk-in clinic. It is open seven days a week from 7:00 AM to 10:30 PM. Those are its current hours and it is seven days a week. It's over there on 43rd and Division. It is part of a larger outpatient clinic for Cascadia, but it is its own separate standalone program as well. So the walk-in clinic serves anyone and everyone in Multnomah County who walks in the doors and says they want to see someone. So it doesn't matter what your age is, your insurance, any demographic you can think of, doesn't matter. It is a free service. Our goal is to provide that service in a really expedient manner as well. So if you walk in those doors, it looks slightly different because of COVID in terms of spacing and whatnot, but there's a front desk that's labeled urgent walk-in clinic. There are other things that go on in that clinic as well, but there's a very clearly marked front desk for the urgent walk-in clinic.

Barb Snow:

And you go on up there and you say, "I'm hoping to see someone today and talk," and they'll give you some forms to fill out. It's a front and back of a piece of paper that asks basic demographics and why you came in today and what you're hoping for, just to give our clinicians some basic information before their meeting with you about what you might be wanting to make sure, again, that we stay on track and are meeting your needs as the individual walking in. Once you turn those forms back into the front desk, then we hope to have a clinician sitting with you within 15 minutes of that. We are, because of COVID, doing things a little bit differently. When I say sitting with you, we have a whole like menu of options available to try to meet people where they're at and provide the best intervention while also trying to keep everyone safe.

Barb Snow:

So masks are required while meeting with a clinician or with anyone in the building or outside the building. We do have an outdoor tent that we're doing some meetings in, if people feel comfortable doing face-to-face space outside under a tent. That might not feel comfortable for everyone because it

is open air and you're talking about potentially sensitive mental health information. If that's not comfortable for you, then we certainly won't use that as an option. We have interview rooms set up with tele-health options. So we have these really cool screens now that you just, I haven't done it myself so sorry, but you basically just push a button on the screen and it pops up a WebEx. It's not even like a full computer. It's like almost like being at the ATM except your ATM is a WebEx meeting.

Barb Snow:

So we might have you do that in one room with a clinician in the other room or a clinician maybe even offsite. Or we also have some conference rooms we're using if we need to space out and be face-to-face, but want to make sure that we have more than six feet of distancing between us. There's some plexiglass up. So all these different options that we're doing to try to best meet with people. So the clinician who comes out to meet with you will figure out which of those options right now makes the most sense and set you up with that. And then do a brief meeting with you where they talk about what brought you in today, what your concerns are, what's happening. Our goal is to really address the immediate needs and the crisis that's occurring. Depending on what's going on and what needs you might have, the walk-in clinic does have peer resources available.

Barb Snow:

So we have a room that we refer to as the standing stone resource room, which is our peer part of urgent walk-in. So individuals that come in might get referred to the peers for a little ongoing peer support. You could go do that same day, and again, it's being done all different ways virtually or distance and whatnot because of COVID. You could potentially go see peers that same day, or you could say, "This has been a lot. I'm feeling talked out today and I'd rather come back tomorrow or the next day and see the peers then." And that's fine too. We'll keep your referral to the peer standing stone open for 30 days after that visit to the walk-in clinic.

Barb Snow:

The other piece that the walk-in clinic does offer is the potential of a visit with a licensed medical professional with regards to medications. We definitely have a philosophy that we really want to try to help support people as best as possible in the community and with natural supports and other supports that are identified by the individual and medication might be a part of that, but we are not looking to immediately go to medications or feel that medications are a solve for all of the situations that someone might be facing. At times it might be that an individual had a medication and their prescription is running out and they haven't been able to get in to see their new prescriber in time or they're new to town and they don't have a prescriber yet. And we want to make sure that prescription is carried over. So we'll assist with those things. We do at times start new prescriptions, but we really want to explore every other option first. Oh, someone raised their hand. Oh, this is very exciting to me, but I don't actually know what to do with that except to say, what's your question? Is there a question out there?

Amy Anderson:

Yeah.

Barb:

Yes there is. And it's coming from Barb and Barb can't come through her phone because I'm next to Amy and it will squeal.

Amy Anderson:

It'll squeal.

Barb Snow:

Excellent.

Barb:

Here's my question. If I am already a patient of Cascadia's, can I utilize that walk-in clinic?

Barb Snow:

So that's a really good question. Yes, although I will say that if it's during business hours and the clinic that you go to is open, we would definitely recommend that you contact that clinic first or your clinician or your case manager, whoever it is you're connected to at Cascadia. We would recommend that you connect with that person first. However, if it's after hours, it's the weekend, it's a holiday, those supports aren't available to you, then yes, you can certainly walk in and see someone at the urgent walk-in clinic.

Barb:

Excellent. Thank you very much.

Barb Snow:

You're so welcome. That was a great question. How do I want to say this? I wouldn't access the walk-in clinic to replace ... They're not going to start you on medications if you're already enrolled with Cascadia. They're going to refer you back to your primary care provider or your clinicians for that need. Does that make sense?

Barb:

Absolutely.

Barb Snow:

Fumbled over saying that, but.

Barb:

Thank you.

Barb Snow:

You're welcome. Yes. So it is open to anyone. There is no cost. There was something else I was just going to say. I totally lost it, but I'm sure it'll come back to me. That's the basic overview of the walk-in clinic. So then Project Respond. When people hear Project Respond in our community, they frequently think

about the mobile crisis team, which is our 24/7 mobile response. I'm going to talk a lot about that, but I'm going to cover other things first. But both Susan and Barb have their hands raised. I'm very excited about this hand raising function, by the way. Sorry, it's late in the evening, too, but I'm excited. So, Susan, what's your question?

Susan:

This is on the previous one. Is there an interaction with the police with this center?

Barb Snow:

Good question. No. For the most part sorry, sorry I went ahead a slide and I don't know how to go back, but for the most part, the urgent walk-in clinic is standalone. We don't have a lot of law enforcement interaction. It is possible law enforcement, any law enforcement agency at Multnomah County has the ability to bring someone if they want to voluntarily to our walk-in center. So sometimes we do have officers bringing in someone that they have come into contact with in the community, and they think would benefit from our services. And that person has said, :Yes, I would like to go there." And so they might show up. And that's really primarily the interaction that we have with law enforcement in terms of the urgent walk-in clinic. I briefly remembered what I was going to say before, and then I forgot it again, but Barb, you had a question as well?

Barb:

No, I just hadn't put my hand down. Sorry.

Barb Snow:

That's okay. Well, I'm having PowerPoint issues, so I wish I could figure out how to go back a slide, but I seem ... Oh, there we go. All right. Thought I had it there. All right, if I do it like that, you guys can see see that slide, I think. So the crisis team I'm going to talk about a little bit more after I go through the rest and I remembered what was the other thing I just wanted to say with the walk-in clinic is it is ... although we're part of Cascadia, it's a standalone function. So coming to the walk-in clinic also does not enroll you in Cascadia services. So if you're looking to enroll in Cascadia services, you need to go through the care and the intake line. You can certainly use the urgent walk-in while you're waiting for that enrollment to happen or at any point. But just to be clear, it doesn't enroll you in Cascadia.

Barb Snow:

So the other programs at Project Respond besides the 24/7 program is we do have peer wellness specialists throughout. So they're attached to our crisis team, but then they're also throughout some of our other programs. We are so grateful for them and they do amazing work. And I'll talk a little bit more about them when we talk about the crisis team as well. We have a family crisis stabilization specialist team. So that team takes referrals both from our crisis team and from the Multnomah County call center for kids and families that might be sort of a little pre crisis. So they don't need an immediate kind of response in the community. But there's concern that if someone doesn't support this kid or this family in the next 72 hours to the next week that they will be in a more serious crisis. So we want to try to get in there and support that family and offer some ongoing linkage and resources to try to minimize the crisis and help them maintain where they're at.

Barb Snow:

A lot of those referrals for us come through the school system. So Portland public schools is a big referral for us for that team. Our emergency department liaison team works closely with all the local hospitals and emergency departments. So including the Pez at Unity is considered an emergency department. We get calls from those departments, from the emergency room, when there's someone there who doesn't need inpatient level care and is going to be discharging back out to the community, whatever that that might be, but they're going to be out of the hospital. They could use some extra support in the community to try to prevent them needing to come back to the hospital again. So we'll go in and see them in the emergency room, do an initial assessment, meet and greet, and then make a follow up plan to see them out in the community.

Barb Snow:

So they do a lot of work with houseless individuals and housed individuals, but a lot of meeting people back at Starbucks and figuring out what is it that you could use to help stabilize and support you in the community. And that might be mental health resources, and it might be housing. It might be food, it might be anything you can think of. The shelter behavioral health team specifically serves individuals that are utilizing the publicly funded shelters within Multnomah County. So there are currently 15, although I think with the Mount Scott opening soon, we'll be at 16 publicly funded shelters in Multnomah County. So this team is called by those shelters to go see individuals who are there, who are having a hard time who are struggling. Again, not needing a crisis intervention Project Respond mobile response in that moment, but just needing extra supports and linkage. That team is made up of counselors and peer wellness specialists.

Barb Snow:

So they both do in the moment response and then do some follow up work, linkage, connection. And it might just be stopping by the shelter that they're staying at once a week or every other week to check in and say hi and see how someone's doing. I'm going to skip down to library crisis services, and then go back to the other two teams. But library crisis services is a small program we have that's typically embedded within the Multnomah County library system. So typically we have two staff that work various hours out of the downtown library. They're available for other branches as well as needed, but primarily work out of the downtown library, doing engagement and outreach to people at the library who are experiencing mental health issues. This has been on hold as the libraries have been closed, but we're excited because we're working with the library to get one of our staff back out there at Central library, at least a few hours a week while they're doing this hold/pickup table thing. I don't exactly know what to call it, sorry, at Central library.

Barb Snow:

I don't know. I just picked up a book today from my local library, but you just walk up and get your book, but at Central they definitely are having lots of individuals coming up who don't necessarily have a book to pick up, but are experiencing other stressors or needs. And so we're getting someone back out there to help address those. Barb, do you have another question?

Barb:

Why yes, I do. It's about the shelter behavioral health teams. Is that program funded substantially and who's funding it? Does that make sense?

Barb Snow:

I think so. It's funded by Multnomah County. It's funded enough for us to have ... so we have three counselors that rotate so that we have two of them on every day for an eight hour shift. So I hope that makes sense. So every day of the week, seven days a week, there are two counselors that can respond to the shelters from 2:00 PM to 10:00 PM. And then we have it's two FTE for peer wellness specialists. It's actually three peers because it's just the way we split it up. The peers work Monday through Friday from 11:00 to 7:00. So there's always two peers on, and then two counselors on the seven days a week. So that that's what they fund and that's what we are able to provide. Does that answer it? I'm going to hope that does.

Barb:

Yes, it does. Yes, sorry, use unmute. Needs a remote. I need a remote control.

Barb Snow:

I feel you. I'm horrible. If I mute myself, I will forget every single time and be talking away and have to be reminded that my lips are moving and no one can hear me. So the last two teams I'll talk about before delving a little bit more into Project Respond crisis team is our Portland Police behavioral health unit, and our Gresham police service coordination team. These are both co-location teams. So we currently have five clinicians that are embedded within Portland Police VHU. So you mentioned, Casey, I'm guessing you were talking about Lieutenant Headman. He's the Lieutenant over those units. So he and I know each other well, and we stationed basically five of our clinicians with him and his team to do those officer or clinician partnerships. So it's a co responder model. They have it kind of split up different ways, but they get all of their referrals internally from Portland police.

Barb Snow:

So police have had an interaction with someone somewhere and then make that referral to the behavioral health unit and they get assigned and go do work to try to, again, alleviate whatever crisis might be happening and to do a little bit of linkage and service provision to help people get what they need with the real goal of these individuals not running into having contact with law enforcement again. So it is a law enforcement program, but the goal and the benefit is to provide that mental health connection to people who are already having contact with law enforcement, with the goal of reducing that. Same for the Gresham police service coordination team. It's a much smaller team, it's one clinician. But it's similar work.

Barb Snow:

They get all of their referrals internally from Gresham police and do that work to try to reduce that interaction of law enforcement and people in crisis out in the Gresham area. So now we'll talk just a little bit more. I've referenced it a lot, but I'll talk a little bit more. And I think if I resume slideshow, yeah, we're on the right side now about our crisis team. So the crisis team is probably the biggest function of the services we provide outside of the walk-in clinic, but through Project Respond. It is 24/7.

It serves the entire county. I'll talk a little bit in the next slide about how you access it, but it is always teams of two QMHPs or qualified mental health professionals that respond to calls from service. Those individuals are trained to be director/designees, which means that they do have the ability to take someone involuntarily. We don't take them.

Barb Snow:

We have the ability to write a transport hold, which has someone taken in involuntarily to a hospital for evaluation. So that is our least favorite thing to do, the thing that we don't want to do ever, but is an option that we have available to us. Our goal, really, when we go out in the community and see anyone is to try to provide whatever we can in that moment to help stabilize and support and maintain someone in the community, because we do believe that is the best option for people to get the supports that they need to be successful in the community. Unfortunately, we can't always provide those things, and so we do have the ability to do that transport hold. And I can talk if you all are interested or want to know a little bit more about how that process works, I can come back to that and talk about it a little bit.

Barb Snow:

We do on that team have five clinicians ideally at any one time who have advanced training in child and family crisis. So that ideally if we do get a call on a family or a kid, we can make sure at least one of the clinicians responding has that advanced skill set in working with kids and families. Susan, you have a question?

Susan:

Yeah. And I don't know if it's appropriate now and if it's not, later is fine. I was wondering, when I think about all these services that you're talking about, I'm wondering about the street response and is this related to you?

Barb Snow:

That's a really good question. Let me hold on onto it. And I'll definitely speak to it. I think it's very timely and a very appropriate question, given everything going on in our community.

Susan:

Great. Thanks.

Barb Snow:

Yeah. So we do try to have those child and family specialists. We also just always are striving to have a diversity of staff amongst our crisis clinicians to try to best meet the needs of the community. So we would ideally like to have a staff that is composed of the racial and ethnic makeup of the community that we're serving as well as other cultural and diversity needs of the community that we're serving. So that is a constant thing that we are working on and we have been doing better at that in recent years. We're excited about that and we continue to strive to do that, to really be representative of the entire community.

Barb Snow:

So when that team is called out, and I'll go over how we're accessed in a minute, but when they're called out, we basically arrive on scene and then provide a similar assessment to what is done if you walk into the urgent walk-in clinic. It's really a basic risk safety planning kind of assessment, the difference being we're just doing it wherever you're at. So we're going to respond to you wherever the individual in need is. We will do assessments on the street corner. We'll do them in homes, in schools, at work, wherever it might be. Our goal, again, is to support individuals maintaining in the community and we do provide some short-term follow up and support and linkage. In order to do that, that's where our amazing peers come in frequently. We regularly refer individuals to our peers who we're seeing in crisis who maybe with that additional peer support we can offer can continue to help stabilize in the community.

Barb Snow:

This team does work with law enforcement. So two different routes, and I'll speak to that again in just a second, but one of the ways, and I'm going to just drop down to the bottom of the slide, but one of the ways we get called out onto a scene is through 911 or from law enforcement. So if law enforcement, again, anyone in Multnomah County, so we're talking Portland police, Gresham, the Sheriff's, Port of Portland. I feel like I might be missing someone, but I think that's most of them, they have the ability through BOEC through the Bureau of Emergency Communications, to page us and have us come join them in the field. Typically how that works is they've gotten a call through 911. They've gotten out, they've gotten there and they have made that assessment that it's not a legal matter or a police matter. It really is a more of a mental health or behavioral health concern, and they'll page us and we'll come out there.

Barb Snow:

Our goal, when we come out there, is to relieve the officers and let them get on their way and let us take over. So that's one way that we're working with law enforcement. The other way that we get calls is through the Multnomah County call center. And I should've had that number on here, so I apologize, but that's 503-988-4888. That call center is a great number to have if calling any time for any reason to get resources and supports and connected to the right spot. They triage calls for us. So they determine if they think a mobile response is needed. They also do a lot of referral to the urgent walk-in clinic. So if someone doesn't need that mobile response and is willing and able to go somewhere, they might say, "Hey, go to that walk-in clinic," instead of sending out the mobile team.

Barb Snow:

But anyway, if they decided that we're necessary, then they page us, we call them back. We get the information from them about what the situation is. The majority of the calls that Project Respond crisis team is getting, it is not the individual who is in crisis calling for support. It is someone calling on behalf of that individual. So a family member, a loved one, a friend, a neighbor, a coworker, a concerned citizen on the street, you name it, it's typically someone else calling and saying, "I'm observing this individual and this behavior, and I'm very concerned about them." So we try to always call back the referral source to get that firsthand information once we've been given a call. Then we respond to the scene. We respond to the location and again, do that assessment.

Barb Snow:

Now in certain situations, and this is how law enforcement might come into it again, we prefer and we believe that the best response to a mental health crisis is for a mental health clinician or behavioral health clinician to respond and provide that assessment, and that's our goal every time. However, there are situations where the information we have, the concerns for the individual, the behaviors that are being described, are to a level of dangerousness and concern that we need law enforcement along in order to ensure the safety of that individual as well as the safety of the community and the safety of the clinicians that are responding. So again, we want to go without law enforcement, we try to go without law enforcement, we strive to go without law enforcement as much as possible, but there just are situations that occur with a level of concern and dangerousness is high enough that we need to work in tandem with them.

Barb Snow:

We are a hands-off ... I never know how to say that right, but we aren't trained to do a hands-on intervention in terms of safety. So if we're needing someone to be stopped from hurting themselves, then we need law enforcement there to help assist with that, or stopped from hurting someone else. So I think, yes. So this last slide Amy actually had seen in a different presentation, and it's just put it in there for you, Amy, a nice overview of all the services I just talked about. It just gives you a quick view of on the left hand side is the funding source, so where the money is coming from to pay for these services, the vast majority coming from Multnomah County, the self-initiated services versus initiated by others, that arrow at the bottom, that kind of continuum. Of course, this is a very nice boxed up black and white gridded version of something that is far more nuanced and complex than this shows, but it gives you that general oversight.

Barb Snow:

So Susan, you asked about the Portland Street Response. So that is not something we are providing. I'm very excited about it because I think it is something that will be hugely beneficial to the community. As you can see, we do all of these different services under the branch of crisis services to try to help connect people at different places or identify different needs. I feel like Portland Street Response is just one more program to help do that, which is excellent and needed, but more is better in terms of options and availability of supports for individual and community. I have thought about Portland Street Response as on-demand street outreach. So there are lots of calls that don't end up coming to Project Respond, that don't get triaged to us because of acuity or because of other reasons.

Barb Snow:

And I think that Portland Street Response can fit in nicely in terms of being another available option for individuals who are primarily houseless and out there. We're really excited to work closely with them too. I think we can actually have a real nice referral process back and forth. I think they're going to probably see individuals whose acuity is higher and they're going to want that Project Respond mobile team to respond. I think sometimes Project Respond mobile team is going to go out on something and think, "Oh, this is a great referral for Portland Street Response to know about and do potentially some follow up work with." So it'll be interesting to see as they come onboard, but I am excited about the possibilities of that. Jared, do you have a question?

Jared:

I do. Thanks for your presentation. I think it's very helpful and I appreciate your subject matter expertise. My question is about the behavioral health unit with the Portland police bureau. I know you mentioned the five co located teams. I was wondering if you could give a qualitative assessment of how you think that program, it works, and whether that's good, bad, or great, what your recommendations or what your ideas would be to make it better.

Barb Snow:

Ooh, that's a big question. So I mean, I'm biased. I've been working with that program since it started, so I will own my own I've been part of ... I mean, it started out as one clinician and grew to three and now five. So I definitely have a bias there in terms of thinking that it's a pretty great program. They are able to do work with individuals that otherwise I really think would not ... mental health clinicians would not be seeing these individuals because the level of acuity is so high. I think about clients that they have worked with who are armed, are threatening regular violence against others, threatening regular violence against themselves, but a lot of violence towards others. And a lot of scary scenarios where I wouldn't feel comfortable having just clinicians respond and the officer clinician partnership's ability to build relationships with individuals has really been phenomenal.

Barb Snow:

We were just talking about one individual who had in the last year a really, really scary and potentially very dangerous interaction with law enforcement in our community, and was luckily safely taken into custody and taken to a hospital and was there for quite a while. That individual recently now is back in the community and actually reached out to the officer that had been involved previously, and the clinician as well, but reached back out to that team. They've started working with them again with the hope of being able to provide some supports and some connections so that they don't get to the level of crisis that they were at before.

Barb Snow:

So it's definitely not a model that works for everyone out there. There are definitely individuals who don't want anything, and I understand why with law enforcement, or with a clinician to be fair too. There are definitely individuals who see me coming as a mental health clinician and tell me to go away in various ways because they they don't feel like they have a mental health concern and don't want a clinician in there, but back to the law enforcement piece, I mean there is. So I think we just try to be really open and honest and evaluate that on a regular basis. Think in terms of the second part of your question was what could they do better? I mean, I think all of us regularly throughout the crisis system are just continuously trying to do quality improvement and evaluation and see what we can do better.

Barb Snow:

I think throughout services right now, we have lots of opportunities to try to improve the services to people of color in our community. We're actively talking about how do we do that? How do we get greater diversity on our teams? How do we really maybe adjust or look at the services we're providing and how to do a better job of that. So I don't have a real specific answer right now, but it is definitely something that we're regularly talking about.

Jared:

Very helpful. Thank you.

Barb Snow:

Yeah, you're welcome. I was just going to say, you throw in the whole COVID thing too, and there's a whole nother layer of challenges to providing any work right now in our community. Susan, I think you were next and then Amy you're after Susan.

Susan:

Yeah, there was a concern during a review of an external examination by the OIR group of officer-involved shootings and in-custody deaths, where it was identified that one of these members of this behavioral unit actually performs the interrogation in a hospital. Do you have a comment about that?

Barb Snow:

I don't fully know what we're talking about, so I don't think I necessarily have a comment about it. We do on rare occasions see people in hospitals, but I wouldn't call it an interrogation. I don't know if there's a separate police incident that happened. So I guess actually I need to be ... I don't know, because I'm not sure.

Susan:

It was on a specific case.

Barb Snow:

I don't have enough details to speak to or really address that. I will say on the side, one of the things that has really been a benefit overall with our relationship with Portland police and my relationship work-wise with Lieutenant Headman and the sergeants is that the other thing that ... and also with Gresham police as well is we have developed relationships where we can give honest and good feedback to each other too. So one of the benefits of these relationships that we have is that I'll call up Lieutenant Headman or the Lieutenant at Gresham and say, "Hey, we had this interaction in the field and it just didn't feel good to us, or this happened and it probably shouldn't have happened that way." Sometimes they're more serious than that. And we do go through the complaint process if we've witnessed behavior that we believe is out of line or more serious than that.

Barb Snow:

But I guess I would say another benefit of these relationships is really making change from the inside as well, or I don't know about making change, but trying to influence or support change from the inside and through those relationships we've built. But, sorry, I don't think I can speak specifically to a situation that I don't have all the information about. I would probably misspeak. Amy, did you have a question?

Amy:

Yes, I did. I'm very interested in the data of numbers of contacts that Project Respond does as far as folks said they know how many times does one person get an interaction versus somebody who's never been contacted? I'm working on some theories about some things. The one thing I learned being a chaplain at MCDC was that the majority of the folks were known by their first name by all the police. So

it seemed that when an individual is so well known that they call them by their first name, they tend to be in more trouble than those individuals who are not as well known. So I'm kind of wondering if we keep a log of repeat ... how many times does one individual call versus different individuals? You know what I mean? That's my question.

Barb Snow:

I do know what you mean. I'm not going to have great numbers off the top of my head, because I don't have it in front of me. And I always worry that I'm going [crosstalk 00:44:07].

Amy:

No, you don't have to bring it. I'm just curious if they're available [crosstalk 00:44:11] you.

Barb Snow:

Yeah, well, one of the things, so we have a database and we keep records on everyone. It goes by the fiscal year. So when we start a fiscal year July 1-

Amy:

July.

Barb Snow:

... the database, I mean nothing changes in the database, but it resets a little bit. And the two pieces of data that I pull on a monthly basis is how many total people have we seen and how many of those individuals are unique, so unique to the fiscal year? Meaning we haven't seen them already this fiscal year.

Amy:

Oh.

Barb Snow:

So you can imagine, I mean, that number does go down. So number of unique individuals does go down over the course of a fiscal year when we're seeing someone ... potentially we saw them in July and then we saw them again in August and not a unique individual in August because they were seen in July. But I will say, and again this is where I don't have a good percentage off the top of my head. There are individuals we see and we will have multiple contacts with over the course of a year, but there are hundreds, if not thousands of individuals that we will just see one time. When I say one time, I'm talking about one episode of care. Not necessarily one visit but one ... it might be one visit or it might be multiple visits and some peer supports, and that's the one time, if that makes sense. So I don't know if that answered it fully for you. We keep numbers on all kinds of stuff.

Amy:

You just track the data differently. That's all. You just track the data in the method that you're accustomed to that makes sense and I'm just trying to figure out the number of times that individual

gets contacted before he goes to jail or before he is back in custody. That's what I'm trying to figure out is do people even use the services enough to prevent them from having to go to jail in the first place. That's what I'm trying to figure out, or do folks just not contact anyone and end up in trouble? That's something I've been trying to figure out.

Barb Snow:

That's complex and really hard to figure out too because the other thing that we struggle is we can't prove something that didn't happen. So I might have contact with someone and ... how am I saying this? I can't say for sure that me having contact meant that they then never went to the hospital that year. It might have. I'd like to think that we made ... but I can't track what doesn't happen. Does that make sense? I'm not articulating it very well right now.

Amy:

No, you're doing great because this is where healthcare gets a little gray area is the tracking that a lot of people are used to or the numbers, they want to see the ins, the outs, the positives, the negatives, and I'm just realizing that there's so many variables to this subject matter that you can't quantify it in a statistical format that makes sense. You just confirm what I've been working on is that it's not convertible, so to speak, to a numbers dollars and cents event versus well we saw him 12 times so that means he's more inclined to be going to jail. There's no way to track that. Okay thank you. Because that'll help me explain to folks more about why these numbers are not available. People want to know how much are we spending on this or that or whatever based on how many people we serve and it can't be quantified, and that's what I'm trying to just figure out how to explain to folks. So thank you.

Barb Snow:

Laura, do you have something to add to that?

Laura Cohen:

I do. Amy, if I could also just jump in and say that there are a number of other programs both that Cascadia works directly with and some of our other community partner agencies work with where we partner very closely with law enforcement so there's law enforcement assisted diversion or lead. There's our Intensive Street Engagement program where we work very closely with NRT officers, the Neighborhood Response Team Officers, where again similar diversionary way like Project Respond, we're trying to keep people from either going to the hospital but in this case most likely we're keeping them from going to jail. So there are other variables that are in the community that also impact that bottom line number. It may be that one person has connected with Project Respond, law enforcement assisted diversion. They may be homeless, so they may also be connected to ISEP, our Intensive Street Engagement Program. There's so many different things that overlap that it is very hard to get that unique identifier.

Amy Anderson:

I didn't even know those programs existed and I've been around a long time. That just tells me that there's so much good stuff out there, we just don't know about it, to promote it or to present it to someone who has questions and that's why I invited you ladies here was so that we could get more

informed and then have a better sense of how things are really working internally for an individual like you were just saying. Wow there's way more things going on than I ever considered. So yeah, that's awesome. Thank you.

Barb Snow:

Susan, do you have a question?

Susan:

Yeah, I was curious, if I remember correctly, we actually had a presentation from the behavioral health unit and they did say that they ... I don't know if they actively do it or they try to do it or they're working on doing it, where they're trying to identify multiple contacts of police and figure out if they can assist. Now I don't know how that works and maybe Barb can clarify that, but it does sound maybe something like what Barb's asking for in terms of that connection between multiple interactions with police and services associated.

Barb Snow:

I can't fully speak to what the Portland Police through the BHU data they're collecting. They have a data analysist. I don't know how to say that word. Analyst. Maybe that's what I was going for, data analyst with that unit. So I'm sure they're regularly looking at all kinds of things but I can't speak to it, sorry. Any other questions? I can certainly send my PowerPoint to whoever and make it available to you all.

Female:

Hey Barb, yeah, I went ahead and gave you my email so if you can give me a copy when you get a chance after this meeting or tomorrow, I'm happy to post it online.

Barb Snow:

Excellent. I will do that.

Amy Anderson:

Yeah, Barb, if you would like to come back to another meeting and do more trainings, I'd love to have you back because this information is valuable as we head into winter, because the season's changing and COVID's creeping and the flu bugs are already doing a million things. I think we'll be seeing a lot more people coming up.

Barb Snow:

For sure. I'd be happy to come back. I also would encourage you, if you haven't, to have someone from the Multnomah County call center take part because we have all of these amazing programs and they're accessed different ways, but for the crisis team, they're really our primary triager and referral. They're doing lots and lots of other things too besides referring to us, so they can speak to all of the other options out there too.

Amy Anderson:

That's a great idea. We'll send out some invite letters to some of these other folks. We'll start really bringing people on board to have great conversations.

Barb Snow:

Excellent.

Amy Anderson:

I think, Laura, you probably have a little bit of time, [crosstalk 00:52:43] any other questions. Thank you, Barb. That was awesome. It really, really helped.

Barb Snow:

I'm glad it was helpful. You're so welcome and I'll stick on for a little bit while Laura talks.

Amy Anderson:

Okay.

Susan:

Yeah, would you please, because I do have a question that's at the end might relate to all the stuff that you guys do so if you ... are you planning on staying to the end?

Laura Cohen:

How about you just ask now and that way Barb for sure can hear it if she ...

Susan:

Oh okay, all right. Yeah, one of the things that I'm thinking about while all this is going on, I totally agree that this is new information and it's very exciting. One of the things that's a recommendation, again from that same external examination of PPB, their recommendation is to develop a standard practice of meeting with family members and convening a community meeting within days of an officer-involved shooting or other critical incidents, to listen to concerns and explain investigative process. So that's a quote from one of the 28 recommendations. It feels like what they're looking for is this relationship with the community that you have developed in your work and maybe in association with other community based organizations or something, that we can provide services after a traumatizing incident that is community specific and supportive in a time where a lot of people don't feel like their interactions with police are supportive in any way. So are these type programs things that we can tag onto or is it something that we have to develop separately? Any opinion about that?

Barb Snow:

Well, my first thought was TIPS. Are you all familiar with the TIPS program? I'm probably not the best person to speak about TIPS, but TIPS is a volunteer group, amazing, amazing group of individuals that can get referred to directly from police or through 911 after a traumatic event has happened. And I don't fully know what their criteria is or how that works, which is why I'm probably not the best person to speak to TIPS, but I guess that's what I thought at first, that some of that actually sounds to me what

TIPS does in terms of not necessarily police-related incidents, but just sudden deaths. I know that they will go on-scene and help support the family and help them do all kinds of incredible work, like how you deal with a medical examiner and how you deal with funeral ... They're so knowledgeable and so amazing. So there might already be some things like that out there that are doing pieces of what you're talking about.

Susan:

Okay cool.

Barb Snow:

I don't fully know. I haven't read all of those. I mean it really probably would be about ... I'm thinking from the Project Respond lens, that sounds different than what we're doing now. It might be something to talk about or to look at, but it probably would be a new addition to what we're doing, if that makes sense. A little different.

Susan:

So potentially they could be a referral. They could refer people to your services, someone that was this liaison so to speak.

Barb Snow:

And anybody can refer to our ... yeah, so anyone who is concerned about the mental health of someone in the community can be a reference, make a referral to Project Respond.

Mary Claire:

Susan, if I could add onto that-

Susan:

Thank you, Mary Claire.

Mary Claire:

The TIPS program, I think, is going to be discussed at another subcommittee meeting as well. I had a conversation with Ann the other day and she was asking how the process for police to get TIPS involved, I mean as Bob says, it's an amazing program. It's been going for 28 years. It's a private nonprofit. It has over 205 volunteers right now they work in teams. They even have youths for all kinds whether it's suicide, homicides, accidental things, whatever. Either fire, police, or the emergency people know to call BOEC and there's always a team on call. So you'll be hearing it and I know you go to almost all of these subcommittee meetings, so I think it's going to be addressed at one of them in response to the recommendation that you're talking about.

Susan:

Cool. Thanks for the information.

Mary Claire:

You bet.

Amy Anderson:

Thank you, Mary Claire. It's always nice to hear the data, information. Then we all stay informed.

Mary Claire:

Amy, as long as you're asking, to your other question, BHU does keep some of those statistics you wanted, Amy, in terms of repeat individual clients or what have you, and we also keep data on whether people after leaving BHU's care, how long they might stay out of the system. So if you want some of that data, I'm sure we can get that to you as well.

Amy Anderson:

Yeah, and since everybody's working, now do you also work in the fiscal year from July to June or is it January to December?

Mary Claire:

July 1st to June 30th.

Amy Anderson:

Perfect. So the data will at least be the same. Thank you. That's what I'm trying to figure out.

Mary Claire:

Oh you mean for the data? We do it on an annual basis. Sorry. I thought you meant what our budget was.

Amy Anderson:

No, data.

Mary Claire:

The data will be an annual.

Amy Anderson:

So it's January to December?

Mary Claire:

Yep.

Amy Anderson:

Okay, okay. Another barrier to how we track things. Okay that makes sense. Or analyze data when you're only doing it in certain increments. Okay. Well, given that it's 7:35, if there's no final questions, I'm going to turn it over to Laura. Welcome, Laura and thank you for coming.

Laura Cohen:

Thank you. Do I also have permission to share my screen?

Amy Anderson:

You can arrange that. We've got great staff people.

Claudia:

Yeah, I can go ahead and make you cohost now.

Laura Cohen:

Okay. Then if I do that ...

Claudia:

You should be good to go, Laura.

Laura Cohen:

Okay. Let's see if I can do the beginning. There we go. Hi everybody. So as I said, my name is Laura Cohen. I'm the senior director of diversion services. I work both with Barb who oversees all the crisis services, and then I work with all of our forensic teams as well and our intensive service teams. Amy has asked me to talk a little bit today about our intensive services. So I am going to do that. I thought it would be important to start out with a really basic understanding before we dive into how we get to our intensive services. It's important to understand that all treatment really begins with an evaluation, whether that's at an urgent walk-in or at one of our clinics, or in a hospital setting. We do an evaluation as mental health professionals to really look at somebody's symptoms, their history, their level of function, their behaviors, and of course their safety.

Laura Cohen:

All of those factors really help us to figure out what level of care they need, which is really what's the right dose of treatment? That can be a whole variety of things. You can see that on the screen right now. Everything from the highest most restrictive level of care, which would be an inpatient setting. Within inpatient settings, the state hospital is the most restrictive, and then we have acute units. Underneath that, so as a step down from that, we have a residential level of care. That includes both secure, so locked facilities as well as non secure facilities. People are often discharged from residential to something called either a partial hospitalization program or an intensive outpatient program. So you'll hear people say IOP or PHP.

Laura Cohen:

And then the two that I'm going to really talk about today are assertive community treatment and intensive case management, which are the highest levels of care above traditional outpatient treatments. So going to a clinic maybe once a week, maybe once every other week. The two that I'm going to talk about today, like I said, are assertive community treatment, which is ACT, and intensive case management, which is ICM. So ACT is an evidence based practice that was developed in the 1970s after we de-institutionalized a lot of folks who had been in psychiatric institutions for many, many years. That occurred, of course, in the 1950s and 60s, and as a response to that we suddenly had all these people who were out in the community who had been institutionalized for so long that they really didn't know how to function very well in the community. Not because of their own fault but just because they had never lived in the community.

Laura Cohen:

So ACT, assertive community treatment, was designed specifically for people that had really high acuity. So their symptoms were very intense. These are folks who are most at risk for psychiatric hospitalizations, multiple hospitalizations. Oftentimes they have a long history of being justice involved and they are oftentimes the most challenging to engage with. These are folks who typically hadn't done well and continue to not do well in a traditional outpatient setting. We see this a lot in our own clinics at Cascadia where we make appointments for folks and they don't show up. This happens repeatedly so one of the really amazing things about ACT that I'm going to talk about in a minute is that it is very person-centered and it is very community based, which means we go like Project Respond, we go to wherever somebody is.

Laura Cohen:

As I indicated, this is an evidence based practice, which for those of you that don't know, that means that it's a practice that's been ... it's a model that's been able to be replicated in many different environments and different settings and different communities, but following some very similar practices. So we at Cascadia follow the evidence based practice of ACT. You can see, and Amy referred to this earlier, we have a forensic version of that as well called FACT. That is specifically for people who have high justice involvement. Uh oh now I did exactly what ... there we go. So the goal of ACT is really to help people stay out of the hospital. As I said earlier, it was really designed for people who had been in the hospital for a long time. Now fortunately we don't have people who are as institutionalized. So the whole purpose of ACT is really to keep people out of the hospital and jail, and really to help them develop the skills that they need in order to live in the community.

Laura Cohen:

In order for it to be an evidence based practice, there is a fidelity, which means there's a recipe that we follow in order to make sure that we're adhering to the model correctly so that we can have similar outcomes to the people that initially developed ACT and people that do ACT all around the country at this point. Actually, all around the world. So these are the basic ingredients for an ACT model. This is what makes it an effective model, and that is first and foremost it is a multidisciplinary team. So we have a part-time psychiatrist or prescriber, a full-time nurse, a full-time program manager, who is a master's level clinician, another master's level clinician. We have a peer [inaudible 01:05:47] specialist. We have a CADC, so somebody who specializes in alcohol and substance use treatment. Then we also have a supported employment specialist. That is a core component of an ACT team.

Laura Cohen:

In order to have an ACT team, you have to have all those pieces to the puzzle. As I said, as an evidence based practice, what we know from research is that that's what makes this a very effective way of keeping people out of the hospital, keeping people out of the jail, that this is full on wrap around service. We have everybody that we need on that team to provide everything that they need, that person, all the time. Barb, yes I see you're raising your hand.

Barb:

Crap that means I have to dive for the mute button because we moved the computer. My bad. Aren't there peers on these teams?

Laura Cohen:

Yes, I'm sorry. So I thought I had said that there's a peer [crosstalk 01:06:47].

Barb:

Well maybe I missed it. Thank you.

Laura Cohen:

Yep. Absolutely. And please, I should have said what Barb did, and please interrupt me as I go along. Sometimes we speak in an alphabet soup, so if I use acronyms that folks are not familiar with, please do interrupt me or stop me. So again, what's really unique about this model is that instead of having a specific case load, we all share the cases. We work with everybody on the team. Everybody on an ACT team in terms of professionals, they all have equal responsibility. Now that doesn't mean that I as a social worker am ever going to actually prescribe medicine to somebody. That's going to save that for the prescriber. But it does mean that I may take the medicine to somebody. It may mean that I help somebody get a job. It also may mean that the supported employment specialist takes somebody to the social security office. So there's a real shared responsibility and as I said earlier, that's something that is one of the things that makes this team very effective.

Laura Cohen:

One of the other elements is that we are available 24/7. So as Amy can attest to, everybody on the team gets to carry the phone. Usually most teams carry it for a week at a time. So instead of calling Project Respond, if somebody ends up having a crisis or they need to talk to somebody on the team, or they end up in a hospital, there are flags in our system to let people know, "Hey, Laura Cohen is a client on the ACT team. So go ahead and call the ACT team and maybe Amy will be on call that night and will talk to me and make sure that I'm doing okay." As I said earlier, one of the things about ACT is that we are community based. So one of the things that we are graded on is how often we provide, and what percentage of service we provide out in the community as opposed to providing it in the office.

Laura Cohen:

This is a very low barrier model, which means that we really try hard not to make it complicated for clients who are already struggling sometimes with organization, sometimes with some other symptoms. We try to make it really easy for them to engage in this service. We also have a very low client to staff

ratio. So in order to be an ACT team, we are only allowed to have 10 clients per one staff. So if we have a treatment team of five people, we can have up to 50 clients. No more. We can have less, but no more than that. One of the other elements of ACT is that it is time unlimited. So as long as somebody wants to continue receiving ACT services, technically they're allowed to do so. There's a little challenge with that in terms of our funders because oftentimes if somebody has done so well on ACT with that, our funders may want them to move along. But historically and traditionally, to be an ACT team means that if somebody says, "I want to be on ACT forever and ever," that they should be able to do so.

Laura Cohen:

Then I would say the secret sauce, and Amy, you can correct me if I'm wrong, but I think the secret sauce of an ACT team is that every morning an ACT team starts its day with a staffing where they talk about every single one of the clients so that everybody has a sense of what happened yesterday and then what are they going to do today. Everybody takes turns. Somebody will say, "Oh I'll go out and see Laura Cohen," or, "I'll take Laura meds today," or whatever it is, and that's a unique element and one of the things that is specific to an ACT or a FACT team. These are the diagnoses that are covered under ACT or FACT. So people have either a diagnosis of schizophrenia or schizoaffective disorder, bipolar disorder, or major depressive disorder.

Laura Cohen:

Then there are a number of other elements that we as an ACT or FACT team have to prove up to our payer, which in this case is Care Oregon, to show that this isn't somebody who just has bipolar disorder, but they also have functional impairment or they have intractable symptoms. Maybe they have delusions that just won't go away or hallucinations that just even with medication won't stop. We have to be able to show that they've had a series of hospitalizations and a documented inability, as I said before, to engage in traditional outpatient services. And then finally most clients on ACT have a high degree of criminal justice involvement. To be on FACT, you have to have even more extensive justice involvement.

Laura Cohen:

I'm going to talk a little bit about intensive case management, which is like the step down sister child or step down sister to ACT. So there are a lot of similarities between ACT and ICM. ICM is also focused on helping folks to engage and people who really have had difficulty maintaining contact with again traditional outpatient services with the goals of reducing hospitalizations and improving outcomes. ICM, or intensive case management, evolve from the ACT model and something that we call the traditional case management model. The difference is that we focus on much smaller caseloads with a high intensity input. So unlike a case management model where somebody may have ... a case manager may have, I don't know, 50 clients on their case load. In this model each clinician has up to 20 clients on their case load.

Laura Cohen:

Similar to ACT, this is community based. So we see people wherever they are, just like ACT does. We'll go on the streets, under the bridges, into shelters, into the hospital, in their homes, wherever they might be, we will go and work with them wherever that is, wherever they want us to. A very similar list of diagnoses, and as I said, it's sometimes a step up or a step down from ACT. I get to work with both

our ACT, FACT, and ICM teams at Cascadia. I see a lot of movement back and forth where somebody starts out in ICM and because their acuity is just too high, they need much more intensive wraparound treatment than what ICM can offer. They will often transition to ACT. Same thing with ACT. Sometimes from ACT, once somebody has done so well and they've stabilized but they're not quite ready to go to an outpatient setting, they will transfer to an ICM team. So those are some of the similarities between ACT and ICM, and these are some of the differences.

Laura Cohen:

So as I just said, the acuity and the functional impairment is often less intensive on an ICM team, and that's often how we in the behavioral health world determine which is a better placement for somebody when we're screening them. Sometimes it looks like on paper they might be better for ACT and after assessing them we really determine that maybe ICM is a better level of care. We are not 24/7 on ICM and we don't have as many contacts per week as we do with ACT. ACT and FACT have a minimum of two times a week that we see each client, and oftentimes, as Amy can attest to, we see clients sometimes two and three, sometimes four times a week. ICM does not have that same level of contact. As I said, there's a higher client/staff ratio and this team, unlike an ACT team, has only master's level clinicians. They provide really both case management and more of a counseling therapeutic role. So we don't have people that provide. We don't have a nurse. We don't have supported housing or a supported employment specialist.

Laura Cohen:

We don't have our own prescriber. We don't have our own substance use counselor. So it's a much more focused program. One of the things I often see on ICM is that we know that with this population, there are a lot of comorbidities, so not only do people have mental health issues and oftentimes substance use issues, but they also have a lot of overlapping physical health issues. So a big thing that our ICM team does is they provide a lot of care coordination. They make sure that clients get to and from primary care doctors. We at Cascadia have primary care so sometimes clients come to see us there, but they can also have their own doctors elsewhere.

Laura Cohen:

So I know one of the things Amy wanted me to talk a little bit about was how to access these services. These are, like I said, intensive level services, so it's not like I could call up as a community member and say, "I'd like to get my son in ACT." These referrals often come through hospitals, other community providers, even within Cascadia, oftentimes the Department of Community Justice, Unity, the state hospital. They're the ones who typically refer into these intensive programs. The way that it happens is they either contact us directly and because they've worked with us before, or they may go through Care Oregon, which is our primary care. I should have mentioned this early on, and I completely forgot, and Amy, I'm super sorry I forgot to say this, but we are the only FACT team in the entire state of Oregon.

Laura Cohen:

So when other entities, whether it's Department of Community Justice or other people like providers who know that a person in front of them has a very long history of justice involvement and that they are currently justice involved and they have all these symptoms, they often will refer directly to us and then we go to Care Oregon, which is our primary payer, and ask if they would authorize this level of care. So

really the thing that I would just want to stress is that for the most part, these two levels of care, ACT, FACT, and ICM, currently in the county are really four people who have Oregon Health Plan or what we call Medicaid. And for folks that either don't have Medicaid or who have let's say Medicare, both Multnomah County and Clackamas County, where we have teams in each of those counties, do have a couple of slots that they have contracted with us for those folks.

Laura Cohen:

But for the most part, these are paid through by Care Oregon or through the Oregon Health Plan. So I'm going to stop sharing my screen. Oh actually I have one more slide and that's just my contact information, which I'm happy to send to you all. I'm happy to answer any questions. I know I went through that quickly but I know our ending time is at 8:00 and I wanted to make sure that I was respectful for the rest of your evening. I'm happy to take questions if you have them. We have another whole suite of teams that work specifically with justice involved folks besides FACT. I'm happy to talk about those as well some other time, or tonight if you want, but Amy had asked if I would just focus on these three teams.

Amy Anderson:

No, that's enough. That's a lot of information between with what was shared earlier and what you shared now to let a gel in and set. I'm excited that we're the one and only but I wonder if there isn't room for an FICM program. I'm sitting here trying to figure out what separates the ACT from the FACT other than is they're both criminal justice engaged folks, I would think that both ... I'm confused. So that's all I was trying to figure out.

Laura Cohen:

I think I heard two questions in there.

Amy Anderson:

Yeah, you did. Barb had one about the differential between the criminal justice piece being in ACT and FACT and what differentiates those two programs, if the individual is engaged in criminal justice.

Laura Cohen:

So that's a great question. So just very quickly FACT means that somebody is currently involved in the justice system. They're either on probation, whether it's [crosstalk 01:19:48] probation. For somebody who is in ACT, most likely they've had some contact and oftentimes a lot of contact with probation, with jail, with he justice system, but they don't necessarily have to be under supervision and oftentimes people who are on our regular ACT team don't have that. They can have it, but they don't have to have it. To be on FACT, you have to currently be on probation or on paper or supervision or something like that. So that's the primary difference.

Barb:

That's good enough for me.

Laura Cohen:

What's that?

Amy Anderson:

That's perfect. That is exactly the answer to the question. It's active versus inactive so to speak, or off parole and probation or on parole and probation.

Laura Cohen:

Right.

Amy Anderson:

So wow, that's amazing.

Laura Cohen:

You had asked about [crosstalk 01:20:43] program. So the forensic intensive case management team. That's actually something that Cascadia had a number of years ago. It was before my time. I'm not sure what happened to that funding or what happened to that program, but I do think it's a great model and it's something that we probably can and should consider. And in terms of your question about should we have more FACT teams or more FACT slots, absolutely. I think that's what the data shows us is that there's plenty of people who would benefit from this kind of model and that's continued to help Care Oregon and our funders understand.

Amy Anderson:

Yes, that's what I try to do is help folks understand how to raise money to get awareness so we can have more services that actually meet the needs of the populations that everyone is currently talking about, which would probably qualify for a FACT model. So yeah, that's why it's critical that everyone learn about all these different program variations. I'm excited. I love doing what I do. It's like dream job of a lifetime. It's so unique. Yeah.

Laura Cohen:

It's really good work. It's hard work, and one of the things that the research shows is that ACT and FACt, because they are so effective, not only help clients improve their quality of life and their housing stability and keep them out of jail and the hospital, but it actually is really helpful for the staff that provides that service, because this is a very intensive group of clients that we work with. So seeing people do well actually reduces burnout. That's something that I think from a clinician standpoint is also important for us to keep in mind that these are models that work not only for clients and for the community but also for clinicians. Not that it should be about us, but we want to keep people employed. We want to keep people engaged in this work. In order to do so, it has to be fulfilling and meaningful and people have to see that there's hope at the end of the day. I think with ACT and FACt, Amy, and you can attest to that, we do see that people can do better and do better. That's really important for clients and for clinicians.

Amy Anderson:

Yeah, I've seen folks graduate. That's what I call it. I like to refer to it as a graduation when they reach levels of connectivity to the community and don't need us. I go, "Look, we're not dumping you. You're graduating. There's a totally different concept." So yeah. It's something that people can actually achieve and I've seen it. So that's what I'm working towards. So does anyone else have any further questions before we sign off?

Laura Cohen:

I saw Susan asked a question about are we looking for money to expand. I would just say that we, in the last four months, got an additional 10 slots funded, five by Care Oregon and five by the county. So that's huge. We're going to continue to show, through Amy's good work, that this is important that we need more and more slots and [inaudible 01:23:57] with this.

Amy Anderson:

Yes.

Laura Cohen:

We're constantly on the lookout for proving up the concept that this is a model that works and that we need more of.

Female:

Well I think in this fall bump where we have just again and again identified that we're not going to get any relief from PPB, to me the alternative is to support those that are not being equitably treated by the system in general. This is perfect timing to have ... the five million that was supposed to go to street response, they can't even take it because they're just trying to get up and running. Why aren't we spending every extra penny we have to try to support something that we clearly have evidence that it works?

Laura Cohen:

Yes. I agree 100%.

Female:

[inaudible 01:25:03] to the fire, huh?

Laura Cohen:

Absolutely. And I will certainly share that PowerPoint with Claudia. Barb and I both really appreciate you all inviting us, and if there are other things that you would like for us to come and talk about, we work with a lot of different teams and a lot of different programs and services. We'd be happy to share what we know or answer questions as they come up.

Amy Anderson:

Yeah, the hardest part for me is I wouldn't know what to ask because I don't know what all exists beyond what I know, if that makes any sense.

Laura Cohen:

Absolutely.

Amy Anderson:

I wouldn't even know what to ask for because I'm not even sure what's out there. So if you might have lists of things you think are important to this work that we can bring forward, I can share the list with my group and see what they'd like to listen to or learn from. Because I like to ask folks, "What are you interested in learning about and what more do we really want to talk about?" So I'll let you ladies think about it and then you can send me a list of ideas and then we'll see where we go from there. So Judith, did you have any final questions or anything?

Judith:

I just wanted to say thank you. My nephew was having a crisis and said the division street clinic was our first stop and it was tremendously important to him and Cascadia really was fantastic. So I just wanted to give you a personal thank you for the important work that you do.

Barb Snow:

Thank you. Thank you for sharing that. That is always so nice to hear and I hope he is doing better and I'm glad we were able to be part of that recovery for him.

Judith:

I think it totally changed his life, so thank you.

Barb Snow:

Oh thank you. Thank you all just for having us tonight. I really appreciate the opportunity always to come and talk about the work that we're doing.

Judith:

It's so great. Thanks, everybody.

Jared:

Thank you.

Amy Anderson:

And on that note we're going to say goodnight. Goodnight to everyone and thank you.

Jared:

Great job, Amy. Thank you.

Judith:

Stay well. Take self care.

Female:

Great job, Amy. Loved everyone. Love and peace.

Female:

Thank you all for tonight. I will go ahead and ...