To: Lieutenant Tashia Hager
Portland Police Bureau, Behavioral Health Unit (PPB, BHU)

Captain Steve Jones
Portland Police Bureau, Compliance Coordinator

Dennis Rosenbaum
Compliance Officer and Community Liaison

Frank Ray
Chair, Bureau of Emergency Communications User Board

From: Shannon Pullen
Chair, Behavioral Health Unit Advisory Committee (BHUAC)

On: February 15, 2017

Re: January 2017 BHUAC Votes and Recommendations

The BHUAC met January 25, 2017 and reviewed the following agenda:

January 2017 Meeting Agenda

- Intros and Updates
- Discussion and Vote: December Minutes and Report/Recommendations
- Intersection of Law Enforcement and the Community Mental Health System Presentation and Discussion: Behavioral Health Response Team (BHRT)
- PPB Training Division Update

January 2017 Important Meeting Outcomes

In December 2016, the BHUAC voted to make the topic of the Intersection of Law Enforcement and the Community Mental Health System a priority for 2017. Although this topic is very complex, it is one the committee has been wanting to tackle for some time. In order to make informed recommendations, the BHUAC would like to have presentations from all aspects of the "system" and agreed on the following list of people/organizations to be scheduled as available over the coming months:

- BHRT – Clinician Officer Teams
- STS Program Update
- ECIT Panel
- County Mental Health Work – high level
- LPSCC
- Juvenile Mental Health

- Unity Center
- County Commissioner
- BHUAC Committee members
- Joint Office on Homelessness
- Peer Panel
- Judge Jones
- ITT Team (Multnomah)
- Forensic PEER Support
- State Mental Health System

Additionally, the following barriers to or gaps in services were identified during the BHRT presentation:

1) Working with people who only have Medicare because many providers do not take Medicare
2) Length of time from engagement to receiving actual services is too long: if a person is open to engaging a provider, they need to enroll with the agency and a particular program or service. That agency or organization needs to do its own assessment of what the person wants and needs. This process can take a while and in the meantime, the person may get worse or lose interest or be difficult to find once a program opens up.
3) Long waitlist for housing and treatment beds
4) Most people served by BHRT need a service provider to come to them. Providers need to start with engagement first and not show up with forms to be completed.
5) People don't want services at all or they don't want the ones available.
6) More dual diagnosis treatment options and services are needed, including the number of spaces available and timing/quicker access.
7) Difficult to find peer support service for someone who isn't enrolled in an agency.
8) More services are needed for people with both mental health issues and intellectual disabilities or mental health issues and Traumatic Brain Injuries (TBI).
9) Providers may not accept certain clients that are not an exact fit for a particular program even though they might benefit or be very successful in the program because it impacts fidelity scores.