Behavioral Health Unit Advisory Committee
Meeting Minutes
January 25, 2017

Committee Members

Lt. Tashia Hager, PPB; PPB; **Sgt. Chris Burley**, PPB; **Sgt. Todd Tackett** PPB; **Ofc. Jason Jones**, PPB CIT; **Emily Rochon**, PPB SCT; **Shannon Pullen**, National Alliance on Mental Illness; **Bill Osborne**, Multnomah County Behavioral Health; **Cristina Nieves**, Commissioner Fritz's Office; ***Maggie Bennington-Davis**, Health Share of OR; ***Felesia Otis**, Volunteers of America; ***Floyd Pittman**, Community Representative; **Jan Friedman**, Disability Rights Oregon; ***Kathleen Roy**, Central City Concern; **Beth Epps**, Cascadia; **Cpt. Mary Lindstrand**, Multnomah County Sheriff's Office; **Mike Morris**, Oregon Health Authority Addictions & Mental Health Division; **Melanie Payne**, Bureau Of Emergency Communications; ***Hiroshi Takeo**, Peer Support Specialist; **Janie Marsh**, Mental Health America of Oregon**, Alex Bassos,** Metropolitan Public Defender's Office

Guest: Adrian Brown, US Attorney's Office; Brian Buehler, US DOJ; Cindy Hackett, BHU clinician/Cascadia, Leo Harris PPB Training Division

[* Indicates Committee Member was absent]

BHUAC would like to welcome its newest member, Alex Bassos. He works with the Metropolitan Public Defender's Office and is the director of training & outreach specializing in mental health cases.

December Report & October Minutes

The December minutes were reviewed and, for the benefit of the members not present at the last meeting, there was a discussion on how the committee determined the priorities for 2017. Jan Friedman wants to keep engagement of the community on the table.

Melanie Payne moved to accept the minutes. Captain Mary Lindstrand seconded the motion. Janie Marsh, Jan Friedman, Cristina Nieves & Alex Bassos abstained. The motion passed.

M/S/P

The December report was reviewed. Bill Osborn motioned to accept the December report, Mike Morris seconded the motion. Janie Marsh, Jan Friedman, Cristina Nieves & Alex Bassos abstained. The motion passed.

M/S/P

Priorities

The Chair discussed one possibility of how the committee may approach the first priority: intersection of law enforcement and the community mental health system/juvenile mental health. This is a large topic and before making any recommendations it would be helpful for the committee to become better educated on what the system entails. The committee discussed the option of having many presenters over the coming months, including the following people and/or organizations:

Behavioral Health Unit Advisory Committee
Meeting Minutes
January 25, 2017

- 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

BHUAC needs to review and discuss the bylaws in the next meeting. Many members are due to be replaced, which will make it difficult to get the above items done.

Mike Morris would like to be able to add what is going on the State level as topics come up. BHUAC members were encouraged to bring their knowledge and input into the discussion when possible.

Presentation on BHRT by Cindy Hackett

Cindy has worked with the BHU as a clinician since 2010. Things have changed and grown over the last 7 years. She is a clinician with Cascadia that partners with a PPB officer to work in the BHU. As a member of the Behavioral Health Response Team (BHRT), the main mission is to decrease police and person encounters. With the formation of the BHU and the support of the Portland Police Bureau, the BHRT program has been able to extend its reach within the City of Portland. Many of the Portland Police officers who have encountered BHRT find it to be a helpful program.

On a typical day, the BHRT reviews and assesses new referrals that have been assigned by the BHU Sergeants. The referrals come from patrol officers and Sergeants. The BHU Sergeants are responsible for assessing the referral and making assignments to BHRT.

As a clinician, Cindy can access certain information (such as medical records) and find out if the person has services. She can then help tie in the providers with the police. She and her partner will then attempt to coordinate with everyone involved. The team attempts to contact the person with the goal of connecting them to services.

The Portland Police Bureau is not a mental health provider and does not provide services, but the BHRT can help facilitate those connections. When contacting someone, the number one goal is safety. Then they assess the person's needs and why this person is having so many police encounters? It could be related to housing, work, mental health treatment or doctors. Building relationships is key and the team will do anything in their power to make that person feel comfortable.

A great aspect of the BHRT is that the team does not have any constraints on what kind of treatment they can connect someone to. There is no program restriction or needs that they have to meet. They can also take the time to build rapport with the person. Another benefit is that building a relationship with a police officer helps the next time they have an encounter with police.

There were a few questions on how they respond to someone in immediate crisis. In general, immediate crises are responded to by Project Respond (BHRT has gone out on many crisis calls; it is just not their main focus). BHRT focuses on follow up after a crisis call. How many times are people in crisis? That depends, they do try to respond if the crisis call is someone on their referral list, but it's not always possible. Do these typically end in hospitalization? Some people don't rise to the level of hospitalization; they might be in a state of crisis but are not in eminent danger. What is crisis? That is difficult. Many times the police or Project Respond can't take the person to the hospital, that is why disengagement is part of the plan and BHRT contacts them when the danger/crisis is over.

What are the gaps you are seeing?

Working with people who only have Medicare is an issue. Many places won't accept patients with Medicare. Another issue is when the person is willing to engage in services but not currently enrolled with an agency. Enrollment is a difficult process for those who are in crisis. Does the person want to go to the provider for service? Many need the provider to come to them. Slow engagement is necessary and time is needed. There are big gaps in services offered because many mental health providers are limited by the confines of billing codes and program restrictions. Homeless outreach programs exist but if there is a safety issue involved then these teams are not able to meet with the person. Refusal of service by the person is another issue. Many who come in contact with the police aren't aware of/ or refuse to acknowledge that they have a mental health issue. Timing of service is an issue. Long wait list for housing/ beds is an example.

Are there services no one is providing?

Dual diagnosis is a big missing piece. Having mental health and addiction as two separated silos is detrimental to care. Many programs only manage one or the other. There are few programs that will tackle both, there are not enough spots available in them, and the enrollment process is difficult. When you have someone struggling to get help and they have to wait 6 weeks for an appointment, you will lose those people.

Responsive services are difficult. Improvement is happening but it's slow. Many of the things needed to provide good care are not billable hours for a mental health provider (such as having coffee with the person).

Peer services are amazing. BHRT would love to have access to peers to work with people who are not connected to a provider or program.

Intellectual disability and mental health or Traumatic Brain Injuries (TBI) and mental health are other areas that are lacking in services. Again, there are places that can handle one issue, but not the other.

Finally, some organizations may not want to take difficult clients that may negatively impact their success rates for a particular program or may turn away clients that don't meet exact program guidelines because of program fidelity requirements. Some clients who are turned away for this reason may, in fact, be well served or very successful if allowed to participate.

The Chair then recapped the barriers to or key gaps in services that 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.

Training Update

Officer Leo Harris is preparing training for all officers regarding the unique risks in responding to calls of a suicidal person in an elevated position, such as a bridge or tall building. This training has already been reviewed by the committee as it is part of the ECIT training. ECIT officers will be dispatched to these kinds of calls however the Training Division recognized that patrol officers may have to deal with these calls if an ECIT officer was not readily available. Officer Harris wanted to discuss this with the committee to see if there were any additional recommendations.

The training will be in the form of a roll call video that sworn members will watch. The training video would cover the risk of going "hands on" with someone in an elevated position. Currently the policy allows for an officer to go hands on but it is important for officers to understand the risk as they

evaluate the totality of the circumstances. The video would discuss things like the risk of the subject falling and the risk of the officer of being pulled over during a physical struggle to keep someone from jumping. It will also discuss the challenge of trying to disengage from a physical encounter once you have gone hands on. There have been examples of close calls by Bureau members in the past.

Roll call videos push out training to all PPB members instantly, instead of waiting for yearly in-service to happen. A committee member asked if there is a way to provide additional answers to questions or have mentors for people to go to if they wanted to talk about the situation? Training has asked officers who have experienced this situation if they would be a part of the video.

Although not vote was taken, there was general agreement among the BHUAC members that this roll call video was an important training tool for the safety of all officers.

The Chair will email the bylaws and list of presenters early so BHUAC members can think of the topics for the next meeting.

The next BHUAC meeting will be on February 22th, 2016 at 2:00 PM at the Portland Police Bureau's Central Precinct, 11th floor BHU Meeting room.