Behavioral Health Unit Advisory Committee
Meeting Minutes
February 22, 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, **Janie Marsh**, Mental Health America of Oregon, ***Alex Bassos,** Metropolitan Public Defender's Office;

Guest: Adrian Brown, US Attorney's Office, Jennifer Kelly & Medina Kearney

Introduced: Leticia Sainz with the Multnomah County Mental Health & Addiction Services. She oversees the prevention, access to legal means, emergency preparedness & behavioral health response to disaster, Multnomah County call center and contracts.

[* Indicates Committee Member was absent]

Notes:

We did not have quorum at this meeting so the January minutes & report and the discussion on BHUAC's bylaws around term limits was put on hold.

How police interact with the system is one of the biggest discussion we want to tackle this year and having the bylaws decided and the people in place for these discussions is very important.

Supportive Transitions and Stabilization (STS) Program Presentation and Discussion

Emily Rochon, Jennifer Kelly and Medina Kurney were present to give an overview on the Supportive Transitions and Stabilization (STS) Program, which is run by Central City Concern (CCC). Emily Rochon is the Program Manager for the Portland Police Bureau/Service Coordination Team and oversees the contract with CCC. Jennifer Kelly is the Case Manager for STS and Medina Kurney is the Assistant Manager.

STS has 6 beds specifically for individuals who are working directly with the Behavioral Health Response Teams who are experiencing unstable housing and in need of mental health or co-occurring services. This allows the individual to attain transitional housing in a single room occupancy unit and programming. Jennifer Kelly reviewed a typical day at STS, which includes groups and individual case management. Groups include life skills and daily check-ins. Peer Mentors help give extra support by addressing basic needs, transporting to appointments and community activities. STS is staffed 24/7.

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STS has been functioning for about a year and is consistently evolving. It is a short-term program, initially proposed as a 30 - 90 day transitional program, but it depends on the barriers and needs of the individual being served. The program is flexible and community-based. Being part of Central City Concern (CCC), the program has access to outpatient services, community volunteer work, and employment/income services. This is crucial in addressing the needs of the individuals in a timely manner. Outside providers can take 4 - 6 weeks to get intake appointments, which can impact a person who is experiencing crisis and instability.

Identified barriers in the mental health system:

- Insurance. Individuals may be prescribed medication when at the hospital or sub-acute, but upon discharge it is discovered the medication is not covered by their insurance. Switching medication increases risk of crisis.
- Navigation vs. Networking. Navigation of the mental health system is challenging/confusing and the wait time for services is too long. In order to get services for individuals, it is based more on networking. Services should be available to individuals in the moment and not based on, "who you know." Networking only works for individuals who are connected to support or case management.
- Lack of housing resources. Individuals may be denied access to housing because they do not meet "chronic homelessness" criteria, they are not dual-diagnosed, their mental health is not acute enough, and/or they do not identify as having a mental health diagnosis.
- Lack of coordinated care. Individuals need long-term support because homelessness and mental health are not the only barriers. For long-term success and stability, many individuals need intensive case management to teach life skills, medication management, track appointments, transport to appointments, secure income/pay bills. The system is not set up for long-term care and wrap around services.
- Referrals. Some referral sources fail to divulge certain key factors in order to get an individual into services. This is not fair to the individual or program and it highlights the need for more resources.
- Access to sub-acute services. When an individual starts to decompensate, the program tries to find appropriate resources. On multiple occasions, the individual is unable to access sub-acute for a variety of reasons, which ultimately leads to further decompensation and the person either leaves the program or is terminated.
- Communication. If an STS individual does get admitted into the hospital or sub-acute for stabilization, STS staff will inform medical staff of a plan to return to program upon discharge/stabilization. Unfortunately, the individual is discharged without STS having knowledge and then the individual is at risk of returning to homelessness.
- Waitlist. STS only has 6 rooms available. This is not enough and is very challenging for someone to maintain on the waitlist. Typically if someone has to wait more than 2 weeks, they give up and, "fall through the cracks," again.

- Detoxification. We are seeing an increased use of benzodiazepines, especially used while in Medication Assisted Treatment, which can be lethal. There are no options for our individuals to safely detox from benzodiazepines, because of the liability issues.
- Education. There is a lack of education about an individual's specific diagnosis. There is power in knowledge. This is much different from addiction treatment, which emphasizes education as a key to recovery/change. Committee members also commented there is misinformation among mental health professionals and the continued stigma of having a mental health diagnosis.

What has worked:

- Utilizing Project Respond to assess an individual while in the program.
- Coordination with jail mental health in order to assess and transport directly from jail to the program without interruption of services.
- Educating DAs and Fire Marshalls about the barrier that Arson charges have on an individual and their future housing options.
- The Behavioral Health Response Teams building rapport with the individual, connection to the program, and continued support of the individual while they are in the program.
- Access to outpatient services and self-sufficiency programs within Central City Concern.
- On-site Housing Specialist working directly with individuals to decrease housing barriers and identify appropriate housing. The program also has access to Shelter-plus-Care vouchers, as long as the individual meets criteria.
- Continuing to offer support once an individual transitions from STS to another program or housing. STS staff understand the importance of continuing the relationship and services, since most transitions lack the intensive care that is needed.
- Increasing support and education for individuals connected to Medication Assisted Treatment

Brainstorming/questions from committee members:

Is there a comprehensive list of housing options? What would ideal housing look like?

- There is not a comprehensive list and what is provided lacks clear, identified criteria. Research, experience in the field and networking is how to gather information about available housing/resources. The committee brainstormed about other possible resources, which will be shared and keep the committee updated on new/updated resources.
- Ideal housing would be a co-located, longer term transitional/permanent housing with intensive case management and peer mentors, staff available 24/7, support to build life skills and continue to work on breaking down barriers. For example, an individual can be in Service Coordination Team services for two years, which include low-barrier housing, alcohol and drug free housing, intensive case management, employment/income support, peer support, help with legal barriers, housing barriers, and continue all services once they move to permanent

housing. It is expensive up front, but leads to long term success and not returning to the criminal justice system.

How do you get someone help who doesn't acknowledge they have a mental health issue?

- STS staff supports the person, "where they are at," and encourage the individual work on other goals. Staff may share their own personal experience, provide Peer support, connect with support groups in and out of the program, and build on life skills. We are not here to force anyone to acknowledge or identify as someone who struggles with mental health. Committee also discussed how individuals may never get to this point, may have had bad experiences with hospitals/doctors before, or wrongfully diagnosed.

The next BHUAC meeting will be on March 22nd, 2017 at 2:00 PM at the Portland Police Bureau's Central Precinct, 11th floor BHU Meeting Room.