Portland Police Bureau

Behavioral Health Unit Advisory Committee

Status Report April 2018

The mission of the Behavioral Health Unit Advisory Committee (BHUAC) is to provide guidance to the City of Portland and the Portland Police Bureau in the development and expansion of Enhanced Crisis Intervention Team (ECIT), Behavioral Health Response Teams (BHRT), Service Coordination Team (SCT), Bureau of Emergency Communication (BOEC) crisis call triage, and utilization of community-based mental health services.

The BHUAC is charged by the Department of Justice (DOJ) Settlement Agreement with "analyzing and recommending appropriate changes to policies, procedures, and training methods regarding police contact with persons who may be mentally ill or experiencing a mental health crisis, with the goal of de-escalating the potential for violent encounters."

Since its inception in 2013, the BHUAC has focused its efforts primarily on policies, procedures and training related to (the development and expansion of) ECIT, BHRT, SCT and BOEC crisis call triage as these areas were considered mission critical for affecting outcomes of police interactions with people in mental health crisis. Throughout our work, BHUAC members expressed repeated interest in working on the piece of our mission related to "utilization of community-based mental health services." With the upcoming opening of the Unity Center for Behavioral Health, the committee agreed the timing was right to shift its focus towards this broader aspect of our mission.

In December 2016, the BHUAC voted to make the following topics priority for 2017:

1) Intersection of Law Enforcement and the Community Mental Health System
2) Unity (including transport, police officer holds, how Unity fits into and impacts the greater mental health system, Providence and other ERs)
3) Effectiveness of the Memphis Model
4) BOEC (including dispatch protocols and crisis triage, direct dispatch of BHU, direct dispatch of MH providers)
5) Disengagement Policy

As time allowed, BHUAC also wanted to review Directives 850.20, 850.21, 850.22 and 850.25.

The Intersection of Law Enforcement and the Community Mental Health System is a broad and complex topic. After discussing how to approach this work, BHUAC committee members agreed to spend 2017 focusing on learning collectively as a group as much as possible about all aspects of the local community mental health system. The goal was to educate our committee as a

whole and then determine where and to whom it made sense for the committee to make informed recommendations.

Between January 2017 and January 2018, the BHUAC had presentations and discussions on the following topics:

- Behavioral Health Response Teams (January 2017)
- Supportive Transitions and Stabilization (STS) Program (February 2017)
- Multnomah County Mental Health and Addiction Services Division: Multnomah County Adult and Juvenile Mental Health Systems of Care (March 2017)
- Mental Health Providers: Cascadia Behavioral Health and Central City Concern (April and May 2017)
- Bureau of Emergency Communications: Training, Dispatch Protocols, Crisis Triage (May, July and August 2017)
- Joint Office of Homeless Services (June 2017)
- Unity Center for Behavioral Health (July 2018)
- Directive 850.20 Training Division Scenario Presentation (August 2018)
- Multnomah County Sheriff's Office: Jail Diversion Pilot Program in partnership with Cascadia Urgent Walk-In Clinic (August 2018)
- Peer Support Specialist Panel (September 2018)
- ECIT Officer Panel (October 2018)
- Directives 850.22 and 850.25 (December 2017)
- Multnomah Intensive Treatment Team (January 2018)

In the attached appendix, there is a summary of the findings, learnings, barriers/gaps and strengths and lessons learned by the BHUAC based on these presentations. This information is reported in the minutes submitted monthly but is consolidated in the appendix for easy review.

January 2017 – March 2018 BHUAC Recommendations

Because of the shift in the approach to the work, the BHUAC did not have as many recommendations as in previous years. Following is a summary of the recommendations made by the BHUAC between January 2017 – March 2018:

BHUAC Bylaws

The BHUAC voted to approve the following changes (underlined) to the BHUAC Bylaws:

Article 3:
The Behavioral Health Unit Advisory Committee membership is established and maintained solely by the Portland Police Bureau <u>with input from the BHUAC Chair</u> and shall include representation from…

Article 4:
Committee members shall serve for two years and may be appointed for an additional two-year term.
It shall be the responsibility of the Behavioral Health Unit leadership with input from the BHUAC Chair to select a replacement member.

Article 5:
The Chair term shall last two years and may be appointed for an additional two-year term.

Article 6:
A simple majority of the BHUAC's voting membership shall constitute a quorum.

Article 7:
The BHUAC Chair will submit a monthly report including any recommendations made by the BHUAC. The BHU Lieutenant will forward the monthly report to the appropriate parties as described in the Settlement Agreement and respond to the committee in writing regarding each recommendation.

Fall 2017 In-Service Training Scenario

The BHUAC voted to recommend approval of the Fall 2017 In-Service scenario as presented with the following two notes to be reviewed during the post-scenario debrief:

- Mental Health crisis is not dependent on diagnosis.
- Ensure the roll players participate in the debriefing process.

BOEC Crisis Call Triage

After providing advice and multiple reviews of BOEC's revised mental health crisis call triage process, BHUAC agrees BOEC is doing effective crisis call triage and utilization of resources. Therefore, the BHUAC does not recommend revising policies and protocols to directly dispatch BHRTs, NGOs or community-based mental health providers.

BOEC Direct Dispatch to Non-Emergency Services

BHUAC recommends the issue of direct dispatch to non-emergency services be added to the list of topics for the City and the DOJ to discuss for a potential amendment and to explore alternatives to the "second part" of Task # 113.

PPB Directive 850.22 Police Response to Mental Health Director's Holds and Elopement

After reviewing PPB Directive 850.22, BHUAC recommends clarifying the definition of director so that it correctly identifies as the person who can write a directors hold the director or a designee of the director, not any director of a mental health program. Using Multnomah County's definition of "Director" and "Director's Designee" would provide sufficient clarity.

Under Policy Item 3, BHUAC recommends changing "manage custody" to "manage a person in custody" to read, "A member's ability to manage a person in custody in a safe, constructive, and humane manner is of critical importance to the involved person, the involved person's support system, community members, mental health providers, and the Police Bureau. Member shall treat the individual with dignity and compassion at all times."

PPB Directive 850.25 Police Response to Mental Health Facilities

BHUAC recommends greater consistency and clarity throughout the directive in the terms used to describe mental health facilities. There seems to be a distinction at various points in the directive between facilities that are secure/non-secure, designated/non-designated, adult/non-adult and residential/non-residential. Our suggestion is that there be independent definitions for facilities that are "secure", "designated", "adult" and "residential".

Further, it appears that despite the application of the directive's policy section to all mental health facilities, there is no guidance for officers where the facility is non-designated or non-adult or non-residential. Therefore, BHUAC recommends procedures be added that describe police response to other mental health facilities referenced in the directive, including mental health facilities that are not designated residential sites, and also mental health facilities that serve people under the age of 18.

BHU SOP

When the BHU SOP is up for review, the BHUAC would like to add the following recommendation: “Any sustained force complaint is strong reason against acceptance into the ECIT program.”

Annual In-Service Training for 2018

The BHUAC approved the Annual In-Service Training for 2018 as presented at this meeting.

Mental Health and ECIT Dispatch Protocol

The BHUAC approves amending the Mental Health and ECIT Dispatch Protocol to include “The subject’s behavior is escalating the risk of harm to self or others” as a priority for dispatching ECIT officers.

The BHUAC recommends the COCL, working with behavioral health and advocacy organizations, interview community members who have had direct interactions with ECIT officers since the implementation of the Mental Health and ECIT dispatch protocol, prior to the COCL next report.

PPB Strategic Planning for ECIT

The BHUAC recommends the Portland Police Bureau develops a strategic plan in conjunction with feedback from ECIT officers and the community that:

1) improves ECIT officer recruitment and retention

2) increases ECIT officer availability and
3) promotes community engagement

For example, one option to explore would be having ECIT officers available precinct wide and not assigned to a particular district.

Reviewing Our Process

In February 2018, the BHUAC reviewed the previous year's work as well as the approach and the process. Overall, members expressed appreciation of the education component of 2017 and learning more about the intersection of law enforcement with the community mental health system. Members wanted to take this knowledge, build on it and turn that collective wisdom into more action in 2018. Members discussed how this committee can have impact on other parts of the mental health system, including more intentionality about exchanging and sharing information with other committees whose work may overlap with BHUAC's focus.

Many of the topics we discussed in 2017 involve Unity, emergency services and other aspects of the community mental health system, including end user experience. One member described the last few years as a "seismic system change." Members wanted to make sure we have the right people at the table to have conversations that lead to better collaboration between systems and increase positive outcomes for end users of these systems.

Looking Ahead

BHUAC agreed on the following topics for review and consideration for the rest of 2018:

- Disengagement policy and practice (including impact in the field)
- Transporting people in mental health crisis to Unity and Providence
- Gaps – education, systems, communication, what is the role of PPB/BHU/BHRT/ECIT?
- Work Group – identify "big picture issues" then problem solve, invite subject matter experts and other key stakeholders, share solutions.
- Creation of a tangible document/take away to share with community partners (re: holds, transportation, emergency services, roles, directives, etc.)
- Americans with Disabilities Act and how it affects the work of BHU
- Substance Use Disorder and Dual Diagnosis
- Multnomah County Commissioner Sharon Meieran and the Multnomah County Mental Health System Analysis
- Multnomah County Mental Health Court
- Multnomah County Local Public Safety Coordinating Council (LPSCC)
- State Mental Health System (as it relates to or impacts the Multnomah County MH system and including the metro area Behavioral Health Care Collaborative)

- Review of Directive 850.20 before the review process is opened so any future recommendations can be submitted during the open review period. How does this policy work in actual practice? How does the definition of mental health crisis affect interactions between PPB and mental health providers?

In March 2018, the Chair of the BHUAC announced the addition of new committee members, including representatives from Unity Center for Behavioral Health, AMR emergency services, HealthShare and Multnomah County's Office of Consumer Engagement. As these key new members come on board, the BHUAC will continue to focus its work on the greater system issues that directly impact interactions between people in mental health crisis and the police.

Appendix

In this appendix are the findings, learnings, barriers/gaps and strengths and lessons learned by the BHUAC based on the presentations since January 2017. This information is reported in the minutes submitted monthly but is consolidated here for easy review.

Behavioral Health Response Teams (January 2017)

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.

Supportive Transitions and Stabilization Program (February 2017)

Based on the presentation re: the Supportive Transitions and Stabilization (STS) Program, we captured the following identified barriers in the mental health system:

1) **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.
2) **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.

3) **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.
4) **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.
5) **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.
6) **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.
7) **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.
8) **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.
9) **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.
10) **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.

Aspects of the STS Program that are working well:

1) Utilizing Project Respond to assess an individual while in the program.
2) Coordination with jail mental health in order to assess and transport directly from jail to the program without interruption of services.

3) Educating DAs and Fire Marshalls about the barrier that Arson charges have on an individual and their future housing options.
4) 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.
5) Access to outpatient services and self-sufficiency programs within Central City Concern.
6) 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.
7) 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.
8) Increasing support and education for individuals connected to Medication Assisted Treatment.

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.

Multnomah County Mental Health and Addiction Services Division: Multnomah County Adult and Juvenile Mental Health Systems of Care (March 2017)

Based on the presentation re: Multnomah County Mental Health and Addiction Services, we captured the following identified barriers in the mental health system:

1) **Mental Health Shelter** – There is need for a mental health shelter that would be open 24/7 and provide medication support and meals. It would allow mental health professionals to engage with the individuals in the shelter and refer or connect people with treatment and other services. 60% of the folks going through Unity are homeless.
2) **Affordable Housing** – Due to affordable housing shortages, people served by the County's Residential Services are often reluctant to leave even after they no longer need the additional services provided by these programs. That results in long wait lists for Residential Services, which in turn makes it difficult to transition people from higher, more restrictive and more expensive levels of care such as the Oregon State Hospital. The systems gets backlogged and people get stuck in inappropriate levels of care, often to the detriment of their health. There is a need to move people through these residential programs (once they are ready) into more permanent housing so that more

people can ultimately be served. There is also a need to ensure we are providing people the right treatment at the right place at the right time.

Mental Health Provider Agency Overview: Cascadia Behavioral Health and Central City Concern (April 2017)

Beth Epps, Chief Clinical Officer at Cascadia Behavioral Health, and Kathleen Roy, Director of Mental Health Services at Central City Concern, gave presentations about their organizations. (See April 2017 BHUAC Meeting Minutes for greater detail about those presentations.)

Discussion Summary (discussion held in May 2017)

- Having good care coordination is the key indicator to increasing positive outcomes for people with mental health issues.
- We are collecting a lot of information but systems are still very siloed.
- Navigating our mental health system is very complex, however resources like "211" and "Care for Us" and the Multnomah County Crisis Line can assist people and help connect to services.
- Mental health resources and services are not consistent across provider organizations and are impacted by insurance and program limitations and requirements.

Bureau of Emergency Communications: Training, Dispatch Protocols, Crisis Triage (May, July and August 2017)

BOEC's Spring 2017 In-Service Training Successes:

- Hearing about lived experiences from peers
- Hearing peers' perspective on what they want to hear, what they need and/or how they want to be treated when they call 911
- Engaging topics and speakers
- Clear objectives that were easy to communicate to different speakers
- Reinforced active listening skills
- More conversational than lecture which helped the learning process and participation goals
- Increased participation in facilitated scenarios
- Participants shared their own stories involving mental illness
- Deeper understanding of trauma
- Feedback indicated that people wanted more training
- Great feedback in reviews

Melanie thanked BHUAC members Leticia Sainz and Janie Marsh for their help and the time they volunteered to make BOEC's In-Service training a success. Having ECIT officers present was

also very helpful. It allowed the call takers to connect with those who are on the other end of the phone. It helped them understand where they fit in the system and understand more of the resources available to the caller once they were off the phone with the call taker.

What's Next for Future BOEC CIT In-Service Trainings:

- Redesign 16 hour course for new staff
- Vital to have peers and mental health professionals involved in the training
- Invite DOJ and COCL to review August training
- Develop 1 hour Continuing Education Development (CED) for follow-up and review of CIT course

The BHUAC discussed challenges to the DOJ recommendation of direct dispatch to BHU's BHRTs, Project Respond or any other or community-based mental health professional and are summarized below:

- There needs to be clinical-level triage and assessment done on calls to decide what happens next. BOEC does not have access to the databases that health care professionals use and 911 does not have the time, capacity or skill set to assess someone in mental health crisis.
- The main role of a Project Respond clinician on a mental health crisis call is to facilitate holds. Project Respond does not have the capacity to respond to all nuisance calls.
- The State of Oregon would need to change state laws in order for BOEC to direct dispatch to Project Respond or any other community-based mental health professionals.
- Project Respond is part of Cascadia Behavioral Health, a separate entity not subject to the DOJ Settlement Agreement. Cascadia would have to make the decision to let BOEC dispatch their employees and manage their workflows.
- BHRTs do not have the capacity to respond as a mobile crisis unit but are focusing efforts upstream on preventative efforts for high-risk individuals to keep them from future crisis situations.
- The "second part" of Task 113 seems to be asking BOEC and NGOs to have people, information and resources they do not have.
- The "second part" of Task 113 would divert the role of BHRTs away from prevention, which the BHUAC believes is highly important in keeping high-risk individuals out of crisis interactions with the police.

Joint Office of Homeless Services (June 2017)

Mark Jolin, Executive Director of the Joint Office of Homeless Services, gave a presentation on the housing crisis facing the city of Portland and Multnomah County. He provided an overview of the scope of the problem, factors that contribute to housing shortages, point-in-time counts

and surveys, efforts by the City and County to work together to address short and long-terms housing needs, and what is needed to continue to reduce the number of homeless people in our community.

Following are highlights from the presentation and the ensuing conversation with the BHUAC members:

- The scope of the housing problem is enormous and driven by affordability and lack of income.
    - In Multnomah County, 18,000 people receive Supplemental Security Income (SSI) which provides $773 per month.
    - On average, studio apartments in Portland rent for $1,156 per month, 1-bedroom apartments for $1,343 per month; 2-bedroom apartments for $1,450 per month.
    - Rents have increased more than 60% in the last 6 years, while SSI has only increased by 20%.
    - There are 185,000 households making less than 60% of median income.
- The number of people who are struggling with both mental health issues and homelessness increased between 2015 and 2017.
    - 70% of those who are chronically homeless have identified as having mental health, physical health or addiction issues.
- In terms of the total amount of people who are homeless, the overall number seems to have stayed flat, with an average of around 4,000 people in Multnomah County each year.
    - The chronically homeless tend to be most visible. Public conflict around tent communities, tent sleeping and parking RVs in public places has changed the perception of the crisis even though the numbers are fairly consistent.
- Every two years, Multnomah County and the City of Portland conduct Point-In-Time (POT) Counts surveys to get a better understanding of the issues, gather trend data and focus services
    - 11.6% fewer people were counted as sleeping without shelter in this year's survey because of 600 new shelter beds
    - Survey included questions about migration. The actual numbers are still being complied but migration seems to have been small. Less than 20% of the homeless migrated here, and an even lower number of that portion migrated here because of the services provided. Many of them come here because they have family or a job offer.

    - Going to try and capture data points in next survey to better understand increase in number of people self-identifying as having disabilities and mental health issues
    - Difficult to capture couch surfing data. Communities of color tend to be under represented in POT counts and many move from relative's house to relative's house or double up
- Other factors contributing to the housing crisis
    - Failure to provide affordable rent drives homelessness.
    - HUD changed the term of transitional housing (24 months) but you have to leave, HUD understood that when HUD pays rent they are now thought of as rapid rehoused.
    - There has been a decade long disinvestment by the Federal Government on low income housing. Many of the budgets are down from 2010, there are 40,000 fewer section 8 vouchers available.
    - The Oregon Health Authority has $1.2 million to maintain the people currently housed who have persistent mental health issues. As rents increase, it becomes more difficult to house the same number of people.
    - Failure to adequately invest in Community Based Mental Health & Addiction Services.
- Tax reform is needed
    - As a country, we subsidize lots of housing through mortgage deductions. If we capped the eligible mortgage deduction tax at $500,000, you could provide section 8 vouchers to everyone in need in the nation.
- What are the City and County doing?
    - They have combined their efforts into one to create the Joint Office on Homeless Services.
    - Efforts focus on prevention and housing placements
    - Combines budgets and staff for efficiency
- A Home for Everyone (AHFE) is a community-wide plan and initiative and served over 25,000 people with some level of housing support services in year two of the initiative
    - AFHE doesn't provide housing directly but manages the grants and other monies that come in and manages who gets the funds and how they are spent.
    - AHFE is made up of 35 different coordinating people who meet every other month. Smaller groups work on various issues, such as housing, mental health and street living.
    - AHFE has an executive committee, including the Mayor, County Commissioners, the Portland Business Alliance and others who can direct/push agendas and allocate/guide funds.

    - AHFE funds different programs, outreach workers, street outreach and nonprofits.
- Prevention efforts
    - AHFE is trying to get everyone off the street by prevention and intervention by attempting to expand stabilization and placement assistance.
    - The Joint Office now has $50 million budget and 96% of that goes to nonprofits to get people housed.
    - Aim is for prevention so less is needed for shelters. There are two new pilot projects to help prevent evictions and another to help pay for subsidized housing.
    - "Flip the Script" with Central City Concern looks at people who could become homeless and attempts to get in front of them before they wind up on the street.
    - More supportive housing services are needed to help people with mental health issues be successful in their housing placement
- Outreach Teams
    - JOIN is an outreach program that focuses on homeless camps, including social workers from Project Respond, peer support specialists and psychologists.
    - Permanent supportive housing teams will work closely with outreach workers to help people with mental health issues.
    - There will be mobile assessment to help find nontraditional homeless
    - Increasing # of outreach workers from 10 -12 to 30.
- Shelters and Permanent Housing
    - $15 million a year allocated for shelters, which will double the number of beds available.
    - All new shelters are 24/7. They are reservation based and that only applies to the year round shelters, not anything that opens for weather or during a temporary time.
    - The challenge will be to cycle people out and into permanent housing. Engagement is necessary.
    - The Royal Palm is no longer available, working on replacing it.
    - Short term sheltering at motels is expensive.
    - Unity has also talked about having permanent housing because so many of the people they see are homeless. They are looking at recuperative care.
    - The Henry will be more permanent and 122 and Burnside building will be a new facility.

    - The big question that always comes up is “Where?” There is a domino effect when one building is redone or taken out of the equation. There is a push to put new units out there, but where?
- Funding
    - Joint Office goes through both City and County budget processes. It’s all public money. Working on the housing bond, construction tax and the State DOJ agreement. Federal funding is possible, but currently unknown.
- What is needed?
    - Permanent Supportive Housing is needed
    - Study after study proves that permanent housing works and per person cost savings is around $6,000 a person. Reduction of other services also happens.
    - Partnerships between law enforcement and outreach teams is needed and pushing everyone to a higher level of engagement is a must.

Unity Center for Behavioral Health (July 2018)

Julianna Wallace gave a presentation on the Unity Center for Behavioral Health (Unity). Unity is a collaboration between Legacy, OHSU, Adventist Health and Kaiser to provide behavioral health crisis services to the region. Some of the goals of Unity are: providing 24/7 access to psychiatric care; using trauma informed care; implementing culturally competent care, including peer support; removing police from transporting people to its facility; and providing an alternative to jail.

Unity includes 102 in-patient beds (80 adult and 22 adolescent) along with Psychiatric Emergency Services (PES). The model also includes collocating services such as Lifeworks, Moda, Care Oregon and Hooper Detox on site.

Currently the average length of stay for people in the PES is 26 hours. Unity has noticed a higher number of walk in patients then it expected. EMS is not able to drop off at Unity 24/7. There were 796 total people seen in June. Out of that number 21% were admitted to in-patient beds.

Unity Presentation Follow-Up Discussion Summary (discussion held in October 2017)

The committee discussed challenges to the new transportation protocols for getting people in behavioral health crisis to Unity, including:

- Lack of training among emergency services staff around communication with people in behavioral health crisis and de-escalation skills
- Difficulty in transitioning from police to emergency services
- Need for strapping someone down fully in order to be transported by emergency services vs. being handcuffed in a police car

- Some emergency services staff are being assaulted by more combative clients
- Lack of buy-in across the board by all emergency services staff re: new protocols
- Lack of clarity for who is responsible to go on and during calls
- Lack of input from emergency services about the rules that were adopted by the PPB
- Lack of option to go to the hospital or Unity on hold with a police officer
- If they are going on director's hold, they have to go via emergency services
- "The system" is used to police officers playing a certain roll during these calls, and it seems to be having issues adjusting to the change
- Does the person being transported end up with a bill? Who's paying?
- Data is being lost in transit. When the officer hands the client to the AMR employee, and then that employee hands the person to Unity, it's like a long game of telephone. Doctors aren't always seeing what the police officer saw. Emergency services is not willing to go to court to testify at hold hearings.

One member noted that AMR has to transport people in restraints on a gurney. This system is more hands on and possibly more traumatic than being driven to the hospital in the back of a police car. Another committee member noted the new transportation method was thought to be more humane than having a police officer do the transport. However, the restraint issue did not come up when the rule was written. Finally, one committee member suggested we invite a representative from the Unity Transport Group to attend a future BHUAC meeting and discuss these issues outlined above.

Directive 850.20 Training Division Scenario Presentation (August 2018)

Lt. Leo Besner from PPB Training Division brought a scenario for the upcoming In-Service Training. They would like to have this scenario reviewed by the BHUAC so it can be used during the fall 2017 In-Service training. The scenario uses ROADMAP and covers Directive 850.20 Police Response to Mental Health Crisis and will last about 15-20 minutes. They are looking to have officers utilize ROADMAP during the scenario.

ROADMAP stands for:

Request specialized units
Observe or use Surveillance to monitor subject or situation
Area Containment
Disengage with a plan to resolve later
More Resources/Summon Reinforcements
Arrest Delayed
Patience (Use time and communication to attempt to de-escalate the subject)

This particular scenario is comprised of a Domestic Violence (DV) situation with a mental health (MH) component. Lt. Besner covered what the scenario entailed (In-Service has not occurred so

the particulars of the scenario will not be released). They will be looking at the officers to see if they are using their resources such as ECIT or CIT officers.

There was discussion about whether or not having a diagnosed mental illness would be a factor in an officer's decision-making during the scenario. Lt. Besner explained how officers work their way through the scenarios and the debriefing process that follows.

Multnomah County Sheriff's Office: Jail Diversion Pilot Program in partnership with Cascadia Urgent Walk-In Clinic (August 2018)

Stephanie Prybyl from the Sheriff's office gave an overview of the Mental Health Diversion (MHD) program that the Multnomah County Sheriff wants to implement in the next coming months.

The MHD model focuses on low-level misdemeanor crimes. When an individual is arrested for an offense such as Disorderly Conduct or Criminal Trespass II, and the behavior is likely attributable to mental health challenges – instead of being taken to jail, the individual in crisis may volunteer to be diverted to the MHD program for assessment and services.

This program partners with Cascadia Behavioral Healthcare. Participants will be taken to the 24-hour urgent walk-in clinic run by Cascadia instead of jail. The charges will still be reviewed by the DA, but under most circumstances, the charge would be dropped.

At the time of arrest, the officer will assess for any danger the individual may pose to self or others. The officer will run a records to check to assess the individual for eligibility criteria. Basis for exclusion includes:

- felony charge(s)
- crimes against person(s)
- vehicle citation(s)
- outstanding warrants

This program will be piloted initially in the downtown Portland area and will be assessed after one year to determine its effectiveness and possibly efficacy in other areas of Multnomah County. This program does not require additional funding at this time. It is a new option for officers that furthers efforts to de-criminalize mental illness while at the same time maintaining the goal of keeping the community safe.

Peer Support Specialist Panel (September 2018)

As peer support specialists, O'Nesha Cochran and Tonya Jones have had a significate impact on the systems they work in. They provided the following information about strengths, opportunities and challenges:

1) You have to be "kick-ass" advocates.

2) Having people who champion you and know what needs to happen makes all the difference.
3) There needs to be someone with privilege to break down barriers.
4) Having a conduit to someone who is in charge matters.
5) Having Peers who are passionate and have the attitude needed for Peer support matters.
6) Peer supervision piece is KEY. There is currently an issue with the Health Authority and how payments are made, but they are working on it.
7) Getting peer supervisors in rural areas will be more difficult. The Health Authority is using the Peer support network for training and support of more Peers.
8) Have you thought of integrating the Peer program in BHU?
   BHU is always changing and growing and they have looked at including Peers but have not reached that point yet.

ECIT Officer Panel (October 2018)

Three ECIT officers discussed their backgrounds and what drew them to becoming an ECIT officer. Following are some highlights from the discussion:

- These officers saw significant improvement in the curriculum in the last round of ECIT Training, in terms of its impact on their daily work.
- These officers have seen a significant cultural shift in the Portland Police Bureau over the last five years, with the changing focus of police work and officer attitudes about police work.
- The disengagement protocol was cited as an example of how change has occurred. Officers noted there is more focus on what is causing the issues that have brought police to the scene.
- These officers believe the voluntary aspect of the ECIT program is important as not every officer is interested in being an ECIT officer and not everyone has the skill set to do the tasks needed.
- These officers believe every officer should have the basic skills needed to be an officer in today's Bureau and noted there are many tools and resources all PPB officers receive through In-Service trainings, but being an ECIT officer takes more in-depth knowledge of the system.
- Officers spend significant time on crisis calls and believe there is an increase in the number of these calls. The increase over the last few years could be due to the increase number of houseless people living on the street or the fact that we now recognize someone is in crisis and officers are not just addressing the criminal issue.

- One member noticed an overall positive change in the way officers address the clientele at their mental health treatment facility.
- There was a discussion about interactions between ECIT officers and staff at mental health service provider organizations. This discussion included a conversation about expectations, rationale for why staff call for police assistance, legal limitations and restraints on the part of the officers, and ways for those interactions to go as well as possible even during difficult situations.
  If an interaction with an ECIT officer is going poorly despite everyone's best effort, it is possible to request another ECIT officer if one is available or ask for a Sergeant.
- There was a discussion about the duties of ECIT officers. All ECIT officers are also street officers, and therefore are responsible for handing calls within their district during their shift. If they are on an ECIT call for 3 hours, the officers in the neighboring districts try to help, but with the current volume of calls vs. staffing ratio, the calls can stack up and response time suffers. The last class of ECIT officers helped the call load, especially on the weekends. At times there was only one ECIT officer in the City during certain shifts.
- There was a discussion about the challenges and disincentives for being an ECIT officer. There is no pay increase and there is a large increase in the amount of paperwork required of an ECIT officer. These officers agreed that keeping the voluntary nature of this program is still important for attracting the right officers with the right skills for the job. Being primary on calls and the requirement to write a report on every call with a mental health component are the biggest challenges. Many officers who are ECIT feel overwhelmed. It is also disheartening when an officer does everything possible and 3 hours later that officer sees the same person on the street again.
- One committee member asked if the proposed CSO (Community Safety Officer) program could take some of the report writing duties off the ECIT officers. Unfortunately, the officers have to cover so many data points and write reports in such detail there is no easy way for another person to write their firsthand account of what occurred.
- These ECIT officers wished the community at large understood that the police are not actually a part of the mental health system. They also noted that PPB is on the cutting edge of dealing with people in crisis but there is a large disconnect with how the public views what PPB is doing.
- These officers believe finding ways to decrease paperwork and the amount of report writing would encourage more officers to apply as well as maintain their status as an ECIT officer.
- One idea discussed is having specific cars marked as ECIT cars instead of district officers, although it was noted they would require better staffing.
- ECIT officers wear a small pin that says ECIT on it, but there is not a large badge or patch to easily identify them as such.

Directives 850.22 and 850.25 (December 2017)

See Recommendations on pages 3 and 4 of the Status Report.

Multnomah Intensive Treatment Team (January 2018)

Rachel Phariss and David Sant from the Multnomah Intensive Treatment Team (M-ITT) gave an overview of their program. M-ITT is run by Cascadia and serves people who do not have a mental health provider. In 2017 they used a metric of 7 days from the point of contact to having someone connected with a provider, 2018 is changing. They will still work with the same people and get referrals but their 6 clinicians will have a shared case load and decide who needs to be seen that day. They usually work with those who are in the hospital and in-patient care, but are now expanding to others. It will be interesting to see how that change works for them. You still have to meet the criteria: Must have a diagnosis (any diagnosis), must be willing to engage, have a high risk of no follow up, be 18+, no neural cognitive disorder, need to know where they can be found and only uninsured patients. They work closely with all sorts of providers.

They meet with the client and discuss how they got referred. Primary focus is getting folks connected to mental health services – they do not do housing case management, but can refer to others. They can help patients get many different services and will do what needs to be done to get them to engage. Bus tickets, coffee, wheelchairs, etc. They advocate for the patient and make sure the mental health provider fits the situation and that they connect with each other. They are designed to be robust.

There have been conversations on connecting to more peers but there is no funding at this time. Will be taking community referrals in the future, but not there yet. Only taking referrals from psych units.

They only have 30 days authorization, the hope is that the patient gets connected by then. They currently have leeway in how long they hold a case but that could change with all the changes they are implementing in February. They can take re-referrals, there is no limit to the number of times they work with someone. There is also no official capacity yet. M-ITT is modeling itself after the ACT teams and want the 6 clinicians to handle 10 cases or less. Over that number becomes difficult.

Do you have or are you part of the discharge plan? Yes, M-ITT works closely with the hospital social workers and they support each other in making a discharge plan that will work for the patient. “How do you know when to step out?” It varies depending on the patient. Usually when they have made it to their appointment once or twice or when we are asked to stop.

M-ITT is unsure how many people will be transferring from FamilyCare or how that change will impact them. FamilyCare had 70,000 members.