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: March 15, 2017

Re: February 2017 BHUAC Votes and Recommendations

The BHUAC met February 22, 2017 and reviewed the following agenda:

February 2017 Meeting Agenda

- Intros and Updates
- Discussion and Vote: January Minutes and Report/Recommendations
- Intersection of Law Enforcement and the Community Mental Health System: Supportive Transitions and Stabilization (STS) Program Presentation and Discussion
- Discussion of Bylaws

February 2017 Important Meeting Outcomes

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.