CITIZENS CRIME COMMISSION

Citizens Crime Commission Mental Health Task Force
June 2012

*Chair:*
Bill Barr

*Members*
DJ Wilson

Erin Hubert

Stan Sittser

Kari Stanley

Clark Cosart

Dave Williams

Julie Leuvrey

Mark Goodman

Jill Long

Andy Olshin

Dean Dordevic

Meg Garvin

Michael Balter

William Nunley, MD

## Staff:

Executive Director Suzanne Hayden

**Mission**: "Assure accurate timely and complete information is available for responders to persons experiencing mental health crisis in order to increase safety of police and other responders and persons experiencing the crisis"

**Goal**: Examine and evaluate public policy, laws and practice to advocate for coordination of community resources for mentally ill persons and persons in mental health crisis coming into contact with police.

**Desired Outcomes**: Clarity of the problem's scope; increased understanding of effective uses of community resources; AND increased coordination and information sharing among stakeholders.

**Preliminary Findings**: The task force used the work of Safer PDX examining the root causes of unnecessary police encounters with persons experiencing a mental health crisis. We found multiple studies conducted locally which also identified critical areas of system improvement. We determined information sharing and improved resource coordination should be the focus of our work. Committee members and staff made site visits to observe Portland's 911 dispatch center, Multnomah County Crisis Call Center, Project Respond, the LAPD mental health evaluation unit and LA mental health court, police "ride alongs" Multnomah County jail intake, Multnomah County Crisis Assessment and Treatment Center. We held discussions with crisis services providers, police officers, advocates, defense attorneys, district attorneys, and judges. During this process, we repeatedly encountered:

- a lack of consistent information sharing and coordination across agencies making up the mental health crisis system safety net; 911, Multnomah County call center, mental health treatment providers, Police, hospitals and jail.
- the crisis system stakeholders lack a uniform way to define, communicate and measure their role in responding to persons experiencing a mental health crisis.

- a consensus that inadequate community mental health treatment capacity is negatively impacting use of crisis services and resources of other stakeholders such as businesses, police, jails, courts and hospitals.

Inconsistent communication and coordination has resulted in a lack of accurate information about the various roles organizations play in this system, the population served, as well as the how dwindling public and private resources should best be used. Police officer time is not being optimized. We have been told a police officer's delivery of a person in custody to the jail staff takes 15 minutes versus admission to a hospital ED requiring at a minimum 1.5 hours. We heard many reports from officers and family members of people taken into custody indicating confusion about where to access immediate mental health assistance. Police officers related stories of taking someone to a hospital emergency room to be placed on an involuntary hold, spending hours transferring custody, only to see the person right back in the community in the same circumstances within 24 hours. We became concerned with the limited options for police officers when they are encountering persons in mental health crisis. We sincerely believe these lack of options may discourage police officers from engaging with mentally ill persons experiencing crisis.

We can best support improved outcomes for police, mentally ill persons, and use of public funds by advocating for a collaborative process identifying tangible community goals. Contacts with police indicate resources for mental health treatment have not been effective, available, accessed or appropriate. People with repeated contacts with police as a result of their mental illness are highly likely to enter the jail and criminal justice system or the emergency room where they receive the highest cost care. They are also at increased risk for a violent encounter with citizens and police.

<u>Preliminary Recommendations</u>:

1. The system must develop accurate measures of police encounters with persons with mental illness. The present dispatch system is an imperfect method for tracking the nature of the calls that come in as the

information is likely to contain factual errors until confirmed by a responder on site.

2. Pursue a middleware platform for communication based upon protocols as determined by an oversight board as an initial step to achieve coordinated information. There exists disparate data bases and cultures of mental health treatment providers, 911 dispatchers, hospitals, police, fire, mobile crisis outreach workers, jails, and criminal justice personnel. We met with the creators of one of these communications solutions, Harris Logic. We feel this initial step will help focus strategies and communication particularly about individuals having repeated police encounters.
3. Add capacity to provide crisis triage site with "no refusal" police access. This triage location will help divert persons from jail and emergency rooms where appropriate.
4. Provide a clear message for the community and police to bring persons who are voluntarily seeking mental health assistance to the urgent walk-in clinic, including adding hours of operation if required to accommodate any increased volume. The urgent walk-in clinic provides bridge services to persons who need to see a mental health professional on an urgent basis.
5. Examine the feasibility and optimization of co-location and co-training of the County Call Center and 911. The County Call Center appears to be underutilized by persons experiencing a mental health crisis. 911 receives the vast majority of these calls. The task force felt better coordination between 911 and the call center will reduce unnecessary police response. There also exists opportunities to engage other crisis lines to help with suicidal callers.

The following Task Force Observations and stories highlight the police experience with mentally ill persons in crisis. These are very typical of the many stories shared with the Task Force.

***Jail – " a shower and a shave....15 minutes"***

In our observations at the Multnomah County Intake center and during our ride alongs, police officers are able to pull their vehicle into the secure sally port at the Multnomah County Detention Center, secure their weapon, bring their prisoner into the intake center, give the necessary information and property to the intake staff, and transfer custody of their prisoner to the sheriff's deputies. On average this process takes no more than 15 minutes, and the officer is back onthe street. During our tour, we were told prisoners who were brought in and were extremely dirty and soiled, were able to get a shower, a shave or haircut, delousing if necessary, clean clothes, and a medical evaluation.

We were told by various police officers about experiences taking someone to a hospital emergency room when they fit the criteria of a danger to themselves or others. The officers were not able to transfer custody of the person in less than an hour and many recounted much longer waits to transfer custody.

What if....A Police officer could transport someone in mental health crisis to a safe and welcoming place where the officer could transfer custody in the same amount of time it takes to book them into jail.

***"911...Man in the Middle... of the street"***

During our study, one of our members observed a man going in and out of traffic on a busy street, laying down in the street, pulling his hair out, gesturing, yelling and throwing things. 911 was called and the caller was told "Help is on the way" – no police officer showed up in the next 20 minutes and the man left the area. We followed up on the call with 911 and was told there were 4 callers to 911 during the time noted., We contacted the police officer who was dispatched. The officer indicated he had been dispatched earlier in the day to do a welfare check on the man. When he arrived on scene, the man appeared to be mentally ill, but said he lived nearby and promised the officer he would go home. The officer cleared the scene. The officer was again called to the scene

an hour later in response to a call of a man in the street, and was unable to locate the man. While he was looking, a call came over the radio regarding two shootings, so he cleared the scene. No report was written, no name was obtained, no other agency was contacted.

What if….The police officer was able to quickly access mental health assistance for the man in the street, and that "help was on the way".

*Hospitals – "The Girl Who Ate Glass"*

During a ride along, a member of our committee listened as an officer told his superior officer of a concern he had about a teenage girl that police were repeatedly called to deal with. He wanted a way to flag her name in the police records system to indicate she was violent, and fought with police. When the superior officer asked which girl this was, the officer replied, "this is the girl who ate glass…". Officers had been called multiple times on suicide attempts, and runaway reports. The officer related placing the girl on a police holds several times and taking her to the hospital because she was suicidal and doing dangerous things like eating glass, swallowing a nail, tieing something around her finger until it turned black., The officer related police being dispatched several times in a 24 hour period. This officer personally dispatched himself to a call when he recognized the girl's name. He found her in a pond, rolling around in the mud and the officer had to wade in to pull her out, and she fought with him until she was restrained, placed on a stretcher and taken to the hospital. He pulled four police reports and gave all the history to a doctor at the hospital, and they put her in a psychiatric room. The officer thought she was admitted. He later found the girls family had been called two hours later to pick the girl up at 3 a.m. from the hospital.

What if….there was shared information on persons who were coming into repeated contact with police and a multidisciplinary team of people met to find a better outcome for this person and for police.

*Civil Commitment – "The Business Community Mobilizes"*

A neighborhood based deputy district attorney received multiple community complaints regarding a profoundly mentally ill man coming into their

businesses, yelling, acting erratically, and appearing very disheveled and soiled, and hungry. These complaints dated back several years. Many times the man would wander into the street unaware of his surroundings. The man refused any help, housing or treatment and only occasionally would accept small handouts of food. He was given clothing and shoes, but would lose them. The police and Project Respond were called repeatedly to respond to complaints and welfare checks, sometimes multiple times in the same day. Officers repeatedly arrested the man for various low level offenses only to have him be released from jail within hours and return to the stretch of shops in the same neighborhood where he was arrested. Community members and police were worried that due to his untreated serious mental illness, leaving the man in the community placed him at risk of death. The man had been the subject of three commitment hearings and had either been discharged, had a commitment for only 30 days, or the commitment process was discontinued. The DA called a meeting, involved the civil commitment investigator from the County, community business representatives and police. Community members agreed to have a zero tolerance policy regarding the man. They called police and Project Respond every time they observed the man having an outburst or in danger. Police implemented a mandatory report flag on the man which required every call to be documented in a report. They collected information and presented testimony to a judge that showed a pattern of behavior of the man supporting civil commitment on the basis that he was a danger to himself and unable to care for his basic needs due to his untreated mental illness. If left in the community, he would be at risk of physical harm, victimization and possible death. The man was placed under involuntary psychiatric care. He was then transitioned into supported transitional housing and to date has had no further police contacts.

What if….there was more coordination to protect profoundly mentally ill persons who are in need of secure treatment and those efforts saved the community money, and provided a safe and better outcome for the mentally ill person.

## Testimony and Materials considered by the committee:

*Chief Mike Reese*
Portland Police Bureau

*Sgt. Troy King*
PPB Crisis Negotiation Team

*Captain Sara Westbrook*
PPB Central Precinct

*Dr. Liesbeth Gerritsen*
PPB Crisis Intervention Training Coordinator

*Jay Auslander*
Director, Project Respond

*Dr. William Nunley*
Psychiatrist

*Dr. Maggie Bennington-Davis*
Chief Medical Officer Cascadia

*David Hidalgo*
Interim Director of Multnomah County Mental Health and Addictions

*Melanie Payne*
BOEC Training and Development Manager

*Toni Sexton*
BOEC Operations Manager

*Honorable Julie Frantz*
Multnomah County Chief Criminal Judge

Consulted with:
Dan Staton, Multnomah County Sheriff
Sgt. Thomas Jacobs, Multnomah County Sheriffs office
Jeff Cogen, Multnomah County Chair
Joanne Fuller, Multnomah County Chief Operations Officer
Preston Looper, Chief of Clinical Innovations Harris LOGIC
Robert Bernstein, President and Director Bazelon Center for Mental Health Law
Steve Sutton, Multnomah County Mental Health Program Manager, Corrections Health
Terri Walker, NAMI Multnomah
Amber Kinney, Multnomah County Deputy District Attorney
Tom Von Hemert, Crisis Intervention Training Coordinator Thomas Jefferson area Virginia
Lt. Charles Dempsey, Los Angeles Police Department
Keith Breswick, Civil Commitment Director for the State of Oregon
Heesung Kang, Multnomah County Call Center Director
Kevin McChesney, Regional Director Telecare
Dan Clune, Telecare Multnomah CATC Administrator

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ORS 426.130 Court Determination of Mental Illness
ORS 426.228 Custody, Authority of Peace Officer
OAR 309-033-0230(6)(a)(A,B)(b,c)(A-C), "Custody of Persons Alleged to Be Mentally Ill Prior to Filing a Notification of Mental Illness"