Mental Health Response Advisory Committee (MHRAC)
Meeting Minutes
Tuesday, May 19, 2020

In Attenance:
Co-Chair Danny Whatley, The Rock at Noon Day
Co-Chair Rick Miera, Executive Committee
Nils Rosenbaum, MD., M.P.H., APD Behavioral Health Division
Betty Whiton, NAMI
Gilbert Ramirez, CABQ-Dept. of Family & Comm. Services
Maxwell Kauffman, Law Offices of the Public Defender
David Ley, New Mexico Solutions
Paula Burton, Peer Representative
Cassandra Bailey, Detective, CIU
Lieutenant Matt Dietzel, APD CIU
Rob Nelson, APD/C.O.A.S.T
Robert Salazar, NAMI/Peer Representative
Sarah Alires, St. Martin's HopeWorks

Non-Voting Attendees:
Deputy Chief E. Garcia
Sergeant D. Dosal
Scribe: Lori Cruz, APD

Absent:
James Burton, Peer Representative
Elizabeth Romero, M.D., UNM Department of Psychiatry
David Webster, Bernalillo Country Behavioral Health
Laura Nguyen, Albuquerque Ambulance
Lea Harrison, Haven Behavioral Hospital of Alb.

Meeting was called to order at 5:05 PM. A quorum was met at time of start.

Welcome first time guests:.
Leyna Inberg, Psychiatric Nurse Practitioner, Albuquerque Healthcare for the Homeless
Rosa Gallegos-Samora, Albuquerque Healthcare for the Homeless
Quinn Donnay, FCS Gateway Project Coordinator
Rebecca Weatherford, APD, Compliance
Dr. Nancy Martin, Emergency Psychiatrist, Presbyterian

Approval of meeting minutes
There was a motion made by Betty Whitton to approve the minutes as written. The motion was second by Lieutenant Dietzel. The minutes were approved as written.

Public Comment (two minutes per person, 15 minutes total)
Danny Whatley asked Jim Ogle if he had anything to talk about. Jim Ogle stated not at this time.

New Shelter Update by Lisa Huval, Deputy Director, Family and Community Services:
Lisa Huval introduced herself. Stated she appreciates Danny continuing to give her a spot on the agenda to give updates on the Gateway Center. She then introduced Quinn Donnay, she joined Family and Community Services two weeks ago. She is the Project Coordinator for the Gateway Center. There was a need for the position. Quinn has lots of direct service experience. She worked for New Day family services in the Transitional Living Program and more recently she was at Catholic Charities. Having Quinn with her on the ground experience and running programs for individuals experiencing

homelessness, lots of connections and credibility with the community is really great. When Lisa Huval was with the Coalition to End Homelessness, Quin served in a leadership capacity the Continuum of Care and really understands a lot of the programs that are out there from a systems perspective. FCS is really excited to have her. Lisa Huval then asked if Quinn had anything to add. Quinn Donnay stated she was looking forward to this position and taking part in this. Lisa Huval stated that while Quinn is getting grounded in her position, Lisa will continue to attend MHRAC Meeting to provide updates on the Center. She stated that Quinn will sometimes be the representative.

Update on Gateway Center: back in February we released a report where we evaluated all possible sites. We went through 150 sites. After rigorous process of evaluating those sites, we came up with the top three potential sites and that report identified: the UNM owned property at I-25 and Lomas; Coronado Park and some of the adjoining area and the old Lovelace Hospital on Gibson. Soon after the City released the report, UNM did let us know that they were not interested in using that UNM owned property at I-25 and Lomas. So at this point we do have the remaining top two sites that we are considering for the Gateway Center. At the same time, the mayor convened a new group to try to develop a more comprehensive, collaborative framework for addressing homelessness in Albuquerque. The group is calling themselves the Homeless Coordinating Council. They consist of: a couple of county commissioners, city councilors, staff from Family and Community Services, staff member of the Mayor's office and staff from UNMH. The purpose of the Council is very high level but is trying to come up with some ideas on how best to address homelessness in the community. Part of their function does include the Gateway Center, but it is broader than just that as well. One thing that has come out of the Coordinating Council is the recognition that there is not really broad support for a large 300 bed shelter as we had been envisioning the Gateway Center for a period of time. So the option is doing several smaller shelters in more disbursed locations is still definitely still on the table but it was always on the table as we were working our way through the process. We were thinking of a 300 bed shelter but that was never set in stone no final decision was ever made. At this point the options of several smaller shelters, the options at both the old Loveless Hospital and Coronado Park are very much on the table but no decisions have been made. The City is still in the process of evaluating the two sites: getting appraisals to understand how much it would cost to acquire those properties. Certainly Loveless as an existing building would require some renovations: how much renovation, the cost of the renovations would all have to be determined. Therefore all is still in consideration at this time. Nothing is set in stone.

(Q) Questions, (A) Answers, (C) Comments:

- Q: Danny Whatley: Does anyone have any questions for Lisa?
- Q: Danny Whatley: Does the City have to go back to the voters or the legislature?
- A: Lisa Huval: We don't have to go back to the voters. We still have the $14Million that voters approved in the fall. But, yes, I think I understand what you're getting at. If we have to build several shelters at multiple locations, more than the one that was planned, then that increases the cost to build on multiple sites and the cost to operate at multiple sites. So we are going to need more than the $14Million. I think that's why it's helpful to have the Coordinating Council that involves UNM, City Council, the County Manager and the County Commissioners because if we are going to make these multiple locations work, there's the money question on how to pay for that both in terms of capital and operating. So I just want to make clear that there has been no commitment from any other those partners about what they are going to fund and how much. It's not at that point yet. The goal here is if we are going to want to do something at

Lovelace and Coronado Park, what is the cost of that and how can all these partners help fund it. Lisa Huval stated she has not heard any conversations about another G.O. Bond or question on the ballot and has not heard about any legislative action on this. Partly just because of the crisis we are in right now; question of what would be even be available the next legislative session.

- Q: Danny Whatley: Who is giving technical advice to these leaders? Leaders may think they know about homelessness but they need input from community providers.
- A: Lisa Huval: The Department of Family and Community Services is represented on that group. Carol Pierce, our department director, is on the Coordinating Council. There is also several work groups on that Council; one is focused on services. Carol, Quinn and I are on that work group. It's services for free. There's also a group for funding and for government. This is just the first step towards this collaborative structure across the entities but it's not envisioned as the final end all be all what this looks like. I think all of us know that service providers, neighborhood representatives all have to have a place at the table as well. And as we build out what this formal collaboration look like there will be structures in place for some folks to be involved as well.
- C: Danny Whatley: Thank you Lisa. Anyone have any comments for Lisa? Any questions?
- C: Quinn Donnay: Just want to add that in this process I have been meeting with service providers, asking opinions, thoughts on what and how things should look. I've already met with some from HCH, St. Martins and a couple of other folks. If, Danny you would like to meet with me that would be great, I'd love to. I would like to meet with anyone who is interested. Because I know that it does matter what the providers have to say. So I'm very excited to have those conversations.
- C: Danny Whatley: Thank you. Anyone else have a comment or question?

IMR 11 and the Status of the Request for Partial Self-Monitoring by Danny Whatley:

Danny Whatley asked Lt. Dietzel or anyone from the City want to address this. Assistant City Attorney, Lyndsey Van Meter stated that the hearing was initially scheduled in February or March. The City pushed it back once due to COVID-19 with the hope that the May date would allow us enough time to not have any restrictions. That didn't work out. We are really not sure how much longer the restrictions will be in place so we talked to the Court about what the meeting could be like or the hearing could be like and in essence it would be a Zoom meeting with most likely being fifty to a hundred people on that line. So thinking through that the City decided that that would not be a good option for this type of hearing on this important issue. We agreed to ask the Court to push it back. Right now it is scheduled for August 28th. We are hoping that we will be able to do that in person at that time. We will see. We will keep everyone informed.

(Q) Questions, (A) Answers, (C) Comments:

- C: Danny Whatley: For those of you in the meeting on your first time, the agenda actually talks about IMR 11 (the Independent Monitors latest Report) and also the City's request for partial self-monitoring. MHRAC have whole-heartedly agreed with that move. There for a while we were in the minority, not too sure if we still are. But again that's exactly what the City is doing. He then asked if anyone had any questions for Lyndsey.

Mental Health Response Advisory Committee (MHRAC)
Meeting Minutes
Tuesday, May 19, 2020

Kaseman and UNMH updates during COVID-19 by Sgt. Dosal:

Sergeant Dosal stated that the biggest things they have learned during COVID-19 is the limited number of resources that are out there. With UNMMH, Kaseman and some of the other hospitals, there were some internal policy changes that we were not made aware of. But after having a meeting with Kaseman and Dr. Martin agreed to having a liaison to help the flow of information in regards to when there are policy changes like there was during COVID-19 and in reference to the handling of violent individuals who were uncooperative when coming in and that were being dropped off by officers. And in turn we were learning about incidents with officers regarding dropping off patients. We didn't have too many issues with UNMMH other than they had a person who had been tested for COVID but not allowing them to be admitted. That was hard for the officers to gage where they could go next. So it was if it didn't work out at Kaseman then the officers had to try UNMMH and vice versa. There was a meeting last week with Kaseman, Sgt. Dosal was hopeful about that. CIU met with the head nurse, the nurse manager, security and the doctors. We assured that we would meet often and that when there were policy changes they would notify us so that we could in turn left the officers know of any changes at the hospital. They would then have a heads up and not find out when they did the transport and then there would be a delay to the warm hand off. Continue to collaborate with Dr. Romero along with their head nurse. That's been great. We haven't had any problems at Lovelace that she knows of. Sgt. Dosal then mentioned that Dr. Martin was here tonight. Shows by being here tonight that they are willing to continue that information flow and work with APD.

During COVID there have just been limited resources regardless and this has put that strain and stress on our officers in the field on not knowing where to go; not being able to turn to the normal pool of resources that had longer hours or that were operational or were doing outreach. She stated this is issue that she would like to bring up for open discussion. Not now but at some time in the future. It would be nice for officers to have options. A lot of people were unprepared, how could they. However, in the future we do need to come up with better plan and have more resources that officers can utilize and that they are not being turned away by the hospitals. Because for now our officers were at that point where they didn't know what the next option would be.

Sgt. Dosal thanked Dr. Martin for being at this meeting. She stated that Dr. Martin has been great; she has been a great liaison, she has been helping with ECHO. She has gone out of her way with information sharing and helping CIU. She has done more than others who have been asked to sit on MHRAC.

(Q) Questions, (A) Answers, (C) Comments:

- C: Danny Whatley: We should segue from that into Fred Mowrer's letter. If you're a member of MHRAC you should have received a copy of Mr. Mowrer's letter. One of Mr. Mowrer's concerns was exactly what Sgt. Dosal mentioned namely officers not having a place or a clear place to take someone who is having issues with a mental health crisis. We have discussed as part of MHRAC, several occasions the transportation issue, as far as law enforcement transporting and the requirements for officer safety issues. Now would be a good time to discuss Mr. Mowrer's letter. Anyone want to jump in the middle of that?
- C: Robert Salazar: This has been a topic of concern since the beginning of MHRAC and putting officer at risk and individuals at risk and the big problem is institutions like UNMH turning people away and sending them back. That's unacceptable. That reflects more on the health care providers than APD but APD is the one that is catching the short end of it. Unfortunately, I do agree with the content of that letter. That person does not represent MHRAC but I do agree

with the content. We have been talking about that for a long time. I don't know what the solution is, but it comes down to the providers though, why are they turning away individuals. I have argued this many times in the past. It generally takes two to three weeks for psychotropic medication to take effect and be in your system and that only allows doctor to get a baseline. Once that's done that then gives the doctor the opportunity to even see if the medication is even working. Once that's done they can start adjusting the medication up or down depending on how the individual is doing. Here's the deal officers have to respond to. If I were to be in a crisis and APD has to transport me to a hospital, that means I have been off my medication and probably self-medicating. Then for the hospital to say they are going to hold me for 48 maybe 72 hours, depending on bad the individual is. Or if someone is taken to the hospital with suicidal ideations, the hospital is going to make that person give detailed plans for their suicide and if that plan is not detailed enough, the hospital is going to kick them out. Without a support system, that individual is left to wander around. Hospitals kicking them out; is not helping them. Hospitals are creating part of this problem. Officers should not be put in the line of fire. There's no excuse for that. Officers and our community deserve better than that. If the hospitals are not stabilizing them, how do they expect them to be well again? Officers should not be handling that; especially when they are continually seeing them and trying to do the right thing by taking them to the hospital and the hospital is basically saying good luck, figure it out. There is no training for that.

- C: Danny Whatley: Yes, and Robert, one the things we've talked about before and one of the concerns Mr. Mowrer brought up is the fact that the officers have to enforce a search and handcuff that person. That is policy and always has been and probably always will be. What are your thoughts on that?
- A: Robert Salazar: I think there are a lot of stigmas that those with a mental illness are unpredictable. If officers could actually see someone when they are not in crisis, they would be surprised on what they could learn and how much that individual would begin to trust you. When I started attending the training community meetings MHRAC started, I met a few officers, that I probably never would have met in my lifetime, and these officers, Matt Tinney being one of them, and these officers I got to know as a person and they got to know me as a person. And it was just through these community meetings. But when I had a crisis that would have probably resulted in a felony, these officers who responded, because I knew them and I knew they were here to help me, I did not have an adverse reaction. I listened to them. Dr. Rosenbaum responded to that call as well. Being that I got to know them, where I knew they were not out to get me, that changed the dynamics of the situation. I know it's not always provided for; but when officers are in their areas, there's nothing wrong with officers saying hi to them or getting to know them. Though in minority areas there is a distrust of officers. Have to change the dynamics. In mental health crises, never negate the training. The training comes first. And sometimes there are times when an officer cannot go against their training. They have to put handcuffs on the individual, but after that situation is done, when the officer is handing them off; maybe the officer can become their advocate; you might have seen something that is going on; something that you have concerns with; to whomever you are handing that person off to. Also explaining to the individual that handcuffing is a safety precaution. Be honest with the individual. Use your training. But I would never ask the officer to negate their training. Their training comes first. Pass along any concerns you have. Aftercare and follow-up care is very important. Handoff is very important.

- Q: David Ley: Thank you Robert. Danny has there been a change in policy that we had discussed previously, where it used to be the case that Albuquerque Ambulance would transport people to the hospital for suicide assessment; and then they stopped. I'm hearing from providers throughout the city that that issue is still up in the air.
- A: Lt. Dietzel: Spoke with Deputy Chief Jaramillo about this very issue. Just to give you guys the gravity of just how important this thing has gotten, so prior to April 2020, that shows how recently, the only provider authorized to transport in non-critical situations for medical care was Albuquerque Ambulance. They can't keep up with the demands of just normal accidents, heart attacks, strokes; so they just couldn't keep up with it. So AFR had to go ask if they could transport non-critical care given this circumstance. Back before then, the only time AFR was able to transport was for accidents that were critical. The person would die if they weren't transported. So because Albuquerque Ambulance was unable to maintain the basic level of what was needed; AFR now has the authority to transport in any situation. So that drove a lot of the decision for APD to transport across the board. Also, regardless of what Fred Mowrer says, I would stack our level of hours, our quality of training against anyone in the nation. But we don't train firefighters. Sgt. Dosal got with Deputy Chief Jaramillo at one point when I first started at CIU to discuss how we could we train firefighters? How much time would that take? It was determined it would take 5 years to train AFR and that would be if we stop training officers. It comes down to who has the most training in this area. We do right now. Is it a perfect situation? No. I do not like the idea that everyone who calls 911 for help, who needs to go to the hospital having to go in handcuffs. It's not great but it's the system we have for right now. And I do think it's important to point out that when an officer transports someone to the hospital by state statute. The state statute that requires us to transport someone, requires us to give a report to the doctor or the hospital they take them to. I don't know how you do that without having the officer involved in the transport.
- C: Danny Whatley: Any additional comments or questions regarding Fred Mowrer's letter. We have to realize to that now that he included us in the letter, he included the courts, department of justice, now we may have to come up with a standard response. I wouldn't attempt to do that in this meeting; but maybe in June we can sit down and put something together. This is something we can discuss anytime. Unfortunately, it's just a situation whether there isn't any good answer; the resources are just not there.
- Q: Jim Ogle: I have a question for Sgt. Dosal. Whether the hospitals have addressed how they will take care of people with mental illness and the COVID-19 together. Are hospitals working together? What I've heard has happened in other areas is that hospitals have taken whole units and set aside for COVID-19. I have no idea how many people are going to the hospital; how many that are transported have COVID-19. Something should be happening given that COVID-19 is going to be here for a while.
- Sgt. Dosal: I know we are doing our best to collaborate with the hospitals. What I would like to see and maybe Dr. Martin or Dr. Rosenbaum would like to speak to that is: are the hospitals speaking to each other. Collaborating. I don't know that. I do know that we are collaborating with the hospitals.
- C: Dr. Nancy Martin: I can speak for what Presbyterian is doing. This is week 3 now of Presbyterian, all of Presbyterian patients not just all behavioral health patients, the entirety of all Presbyterian Hospital admitted patients coming into Presbyterian are required to be tested for COVID-19. So our inpatient unit at Kaseman including our child and adolescent unit are COVID free. So every patient gets to COVID test and even if they leave and come back in 3 days,

they get tested again. So we are taking patients' safety while they are getting psychiatric care very seriously. I know community partners and other hospitals have followed suit in that requirement for COVID-19 testing and I'm the one that reviews all outside referrals requesting inpatient psychiatric care at Presbyterian Hospital and I know our community partners they want the tests resulted before they send us the referrals. Central Desert, a geriatric psychiatric care hospital, recently expanded (a few weeks pre-pandemic), they have a beautiful facility; they've be a great community partner because they have a positive COVID unit, so if you have a behavioral health issue and are COVID positive, provided you do not need medical care, you can go there. So we are talking a lot with our community partners about the appropriate place for our patients, certainly for long term care. We're not testing our staff right now but we are prioritizing the safety of our patients.

- Q: Jim Ogle: I guess my question is: if a person is brought in by police, what you are saying is if they have COVID-19, they are not being accepted by Kaseman? Do we have a place in Albuquerque where they are accepting them?
- A: Dr. Martin: It depends at what point they are found to be positive. Of the 3 weeks of doing this and I'm the staff psychiatrist in the ER Department, every day from 8 to 5; we've only had one case of all the patients we've tested who had no symptoms (and this happened today). So of course contact tracing will be done. This is an individual who came from the reservation, he did not come through APD, he was high risk already, but certainly, I empathize with the officers from the field who are transporting people and EMS who are transporting people around town, and not necessarily knowing they are COVID positive. I don't really have a suggestion for that. But we are in no way turning patients away because they have symptoms or a suspected issue with COVID or they happen to find out that they are positive. What I can tell you is a patient came in today with behavioral health issue, we determined he had psychiatric complications; we ordered a COVID test and were surprised it was positive. We sent a referral to either Central Desert if he gets declined he will come into our medical unit and be evaluated. But we are not turning patients away.
- Q: Jim Ogle: Has the hospital systems thought through the situation of bringing someone in who is violent and that sort of thing Sgt. Dosal. The individual who really needs care. Where do they put him without exposing other patients? A matter of discussion for the hospitals.
- A: Dr. Martin: I can answer that question even though it is not directed at me at least from Presbyterian. As Sgt. Dosal alluded we have a very good discussion between APD CIT, Presbyterian Psychiatry and Presbyterian Security. The policy Presbyterian came up with, driven both to protect patients and staff, when we have a violent situation, with the individual potentially hitting our staff, it would take 5 to 6 staff members to assist them or restrain them. If the medical or ER provider doesn't see a need for them to stay in the ER. Their threshold of letting them walk out is lower. And that is to protect the ER staff too. Certainly we had a few cases with individuals who were in crisis and required to be placed in restraints and then we were able to get the COVID testing completed. Luckily them came back negative but it really exposes all of our first responders. It's just not an easy time and it makes it harder to keep everyone safe.
- Q: Jim Ogle: Do you know what UNMH is doing?
- A: Dr. Rosenbaum: We spoke to Dr. Romero and they are doing something similar, they screen everyone for any symptoms for COVID-19 and then they test them. And I think what has to be what has to be kept in mind is that all psychiatric illnesses are medical first. You have to rule out all medical issues first. You have to put medical at the top of the pinnacle unless someone is

actively violent or suicidal and even then medical is key. Which is you have to go through the medical ward and isolate them do liaison. It's important that we don't vilify our hospitals, they are doing their best. They are overrun and it is hard for everybody.

- C: Rick Miera: My comment is literally in regards to the situation, so what I'm hearing from Lt. Dietzel is that AFR is going to be able to transport, is that correct? Is that what I heard.
- A: Lt. Dietzel: They are able to transport for non-emergency care.
- C: Rick Miera: So along with that are the rules and regulations that we've discussed many times with the police department that they have to be transported in handcuffs if they are going to be in the backseat of a car. My question is at what point are the handcuffs taken off. They are not under arrest but they are trying to take them to a facility and when the facility doesn't take them, does the police officer put them back in handcuffs to take them back to the car? The reason, this is the problem we used to have at the detention facility, when we took someone in the be seen in medical setting, if they came in with handcuffs, if made a world of difference if they were going to be accepted into the office or not. So I was just wondering if, as we go through this process, if we can find a common goal as well as a common solution to the fact that those individuals are not under arrest and that makes a significant impact on whether they are going to be accepted in any place, even in MDC. Tomorrow we will be having our meeting with MDC and this is going to be high on our agenda. The MDC Oversight Committee will be given this issue as well. MDC may say he looks like he may have COVID, they won't accept them there either even though they can. They prefer they go to a hospital. So do you think we may ever have a common solution to this problem?
- A: Lt. Dietzel: Lt. Dietzel put up, on the screen, the current policy on handcuffing. So basically an officer can find a reason not to handcuff someone. A lot of these things right here are physical limitations. They are unable to put their hands behind their back. So, yes you may or may not have to handcuff someone, but, like now I am doing a force review right now for a lot of use of force cases and I can tell you right now, if an officer decides to not handcuff a person, and that person fights with the officer, and that has to use force on that person, that officer is going to be forced to administratively regret not putting handcuffs on that person; because that argument will be, if you had put handcuffs on that person you would not have had a use of force on this person. I really do think we are stuck here. I don't want every person that calls for help to be handcuffed but if you don't do that as an officer, you may sorely regret that later with administrative action.
- C: Rick Miera: Thank you for that Lieutenant. I think that was where I was kind of going with my first part of my question. Everyone had their own rules and regs whether it is UNM or MCD. We will find out tomorrow night where MDC is at. Whether it's COVID or not or when they are accepting and when they are not. Just about a month or so ago they were not accepting individuals APD was bringing in. Specific to the mentally ill, just trying to see; would like to see from those here today, whether we are striving for the unattainable or should we continue to try to work something out where different people have different rules and regs they must follow and they don't all equate to a need to transport in a dangerous situation.
- C: Sgt. Dosal: I think it goes back to what Dr. Winograd used to say "officer can be the first responders but they shouldn't always be the only responders". And that's what we are looking for here, some assistance.
- C: Rick Miera: Thank you, thank you. Anyone else? I reason I opened this up is because we are going to have to address this ourselves because it was brought to us. I think we should at least have some, our suggestion as to how we deal with this.

- Q: David Ley: Lt. Dietzel is that policy you showed us something that can be reviewed or commented on? I would note that in the language that says physical disabilities, if that language simply said disabilities, then it would include mental conditions, etc., then the officer could use their judgement with an individual suffering from mental challenges or developmental issues or psychiatric conditions to determine if they thought it was okay to transport without handcuffs. That would actually give some flexibility and freedom so the officers could make a compassionate decision.
- A: Lt. Dietzel: I am going to load the SOP recommendation form in the chat. I would encourage everyone on here if they feel strongly to fill one out with what your concern is. I brought these concerns and the policy is what it is. If you guys can help me out here, the recommendation form is first.
- C: David Ley: Yes, thank you. I think we could all certainly listen to some of the things Robert said and make suggestions.
- C: Sgt. Dosal: I just think those instances are few and far between. When we are talking about someone who is frail, where officers don't want to put handcuffs on but policy dictates that they do so. I just don't think those numbers are large. We still have to think of the big picture of the majority of the people officers are transporting that wouldn't apply. There are so many different scenarios officers are faced with, I think the general consensus is that it applies to anyone is a crisis that we can't afford anyone the opportunity to decide. I think any officer knows if it is someone who is having difficulty getting to the unit or if it is someone who is frail or anything like that, we encourage and ask Albuquerque Ambulance and AFR to help us and assist us with this but because there is not a medical component and it's behavioral health they will not help us with that. So again that puts it back on the officer to transport who in this one instance had to transport a 300 lb. individual in the back of the officer's Dodge Charger. AFR said they would help the officer get the individual in his unit. In another incident they told the officer you need to transport this frail 95 year old woman. Again, they said we will help you walk her into your unit but they will not transport her for us. We would like them to transfer for us because we would rather not handcuff them and put them in the back of our unit.
- C: Danny Whatley: I think one of the things we need to keep in mind is we need to go back to our roots. If we are going to look at something, as far as a standard response from MHRAC, we need to look at and evaluate other policies of other agencies and other areas. This is one of those things where we don't need to reinvent the wheel. Somebody out there has already answered these questions. I know the City has done that. Has looked at other departments. I think MHRAC may need to do some due diligence before we put together a response or even begin talking about a response to Mr. Mowrer's concerns.
- C: Max Kauffman: I have a comment about Mr. Mowrer's email. In fact I was wondering if you (Danny Whatley) and Rick Miera would be willing to update us on the meeting with MDC tomorrow; on what happens there. Because, I'm a little confused about that part. Maybe I'm missing something on how this work with COVID. It is my understanding that MDC will only take people with criminal matters and have been charged; booked; will have complaints filed within the next few days or so. And I'm checking the custody lists every day and I seeing those who have been booked the day before and I'm noticing that a lot of my clients are still being booked; even clients who are experiencing mental health episodes that roles into a criminal case. So I wondering if there is some data out there that can show how often people are they being turned away from MDC and how they are being selected. Because I don't think they are flat out denying everyone who is experiencing mental health crises also with criminal charges. I'm

looking at the custody lists every day. Now the numbers are low. I would say a lot of my clients getting books there are those I have not seen in a long time. So I don't know which way to go on this. They must be turning away some people because of these issues. But some are not being turned away; so I'm wondering if we can see some clarity from MDC on whose getting booked.

- C: Rick Miera: Mr. Kauffman, so (a) I would love to invite you to the meeting. We will be meeting about this same time tomorrow. I will get you online and anyone else who is online today. So we will be asking those kinds of questions and will be trying to get information and see how that information has changed from our last meeting. I am the chair of that oversight committee so, so that' how I know what is going to be on the agenda. So you can rest assured that those are some of the questions that will be asked. Move of a COVID issue now and I'm sure we will be receiving the letter from Mr. Mowrer as well. We will address this issue. I would love to share everyone exactly what happens and the official answers from the chief of MDC.
- Q: Danny Whatley: Any other questions or concerns on this topic?
- C: Detective Cassandra Bailey: Maybe more of a comment than a question. I feel that I am on the board more as a voice for our detectives and field officers that are transporting people to the hospitals and MDC and for lack of a better word, it's extremely frustrating. There have been quite a few incidents recently where we are transporting people who are clearly in crisis and they are not even being evaluated. I understand the whole COVID thing and I understand that the safety protocols take precedent but if these people are even being evaluated; and I, myself have taken someone twice to the hospital and the individual was clearly in crisis; the individual was homicidal and had suicidal ideations and the individual was not evaluated and was released from the hospital within hours; purchased and gun and attempted to kill someone. Luckily the gun malfunctioned and did not know how to clear the malfunction. She had driven herself to the neighbor's house; had him tie himself up and she tried to kill him. I think she should have been in the hospital at that point in time based on the multiple calls for service and the multiple times she was transported to the hospital. I understand, as officers, we are expected to deal with these kinds of situations, however, now we are talking about the community being in danger. The officers are doing their jobs, they're going; they're interviewing these people; they're transporting them; they are getting involved in use of forces because the individuals do not want to go to the hospital and officers are getting raked through the coals during use of force investigations just trying to take people to the hospital (not to jail). They clearly need help. But then they have to go back a few hours later to the house because someone almost got shot. And regarding MDC: I know of a situation where an individual was transported to the hospital quite a few times because she was clearly in crisis; released quickly; probably due to her drug use but she has an underlying mental health diagnosis. She ended up with 17 charges of battery on a peace officer; she was spitting at officers; kicking them. They finally get her to the jail and the jail turned her away because she refused to answer medical questions. So those officers then had to take her from MDC to UNM and got involved in another use of force because she was kicking at the officers as they tried to take her back. So all in all, this call lasted over 24 hours; all because the hospital wouldn't take her, MDC wouldn't take her. We are not getting help. I don't know where it needs to be fixed but it does because these field officers, who are already spread thin, to have to try to figure out how to deal with these people because the hospitals come up with policies that state no we are not going to evaluate them because they tested positive for meth. I had an individual last week who we took to the hospital who had three loaded guns; an assault rifle, shotgun and a handgun, fully loaded; making active

threats in his car as he was driving to his mom's work to kill her and blow his face off. He was released in three hours. Yes, the guns were confiscated, but guess what, I received a call from his mom later stating that he was going to go buy a gun on Friday and blow his face off. So, I don't know, what are the officers supposed to do; driving around for 24 hours, being kicked and spit at; and MDC says no she's not answering medical questions; we're not going to take her and then the hospitals are saying, no she tested positive for meth, we're not going to take her. She was in handcuffs on and off for 24 hours; and yes I know she was one of the combative ones and not what we are talking about (the non-combative ones; the elderly or frail ones). My heart goes out to those officers right now who are on the frontlines and hospitals and jails are coming up with these policies and putting them back with the officers. And the officers don't know where to take these people. Officers don't know what to do. Are there any suggestions from the board?

- C: Max Kauffman: From my end, I don't see that. I can only see the charges from my end; so I think the most important thing you can do is get the stories out as you just mentioned. Otherwise, no one knows that that is going on. I have no idea what's going on, I don't know which of my clients are experiencing that. Either I don't see a charge or they don't come up on my radar. So I think it's important that you be as vocal as you just were.
- A: Detective Cassandra Bailey: Thank you for that.
- Q: Danny Whatley: Anyone else?
- C: Dr. Martin: Detective Bailey, I'd like to add to that. I appreciate you sharing, just listening to those scenarios, it's all very frightening. So I'm not sure which hospital systems you are talking about. We are not turning away people. So we evaluate people regardless of what their urine drug screen shows positive for and I have to tell you our units here at Presbyterian are staying full. We had seven beds today and I filled every single one of them; and probably half of the patients I admitted had more than two substances they were positive for. So, I am stressed to hear as a taxpayer, that when someone commits assault on a police officer, that our intake facilities would decline them. I also want to assure you from an ER side, we have been busier than ever. We live in a state, though, where if someone is using drugs, and I as their psychiatrist evaluating them in the ER recommend some type of treatment and they don't want that; I can't force them into it. So the clinical scenarios you are talked about are very distressing. If I would have heard any of that presentation that meets the involuntary hold criteria: the access to firearms, threatening to kill themselves, the threat to kill another person. Those are all involuntary hold criteria. So I don't know where the mismatch of that communication is but I do want to assure you that we don't, and it's a violation of federal law, for us to turn away someone based off their urine drug screen. Certainly we all know on this network, the community has a problem. Our system does not refuse care based on the urine drug screen.
- C: Detective Cassandra Bailey: The majority of the cases I presented today are cases I have been involved in. I have heard the Crisis Intervention discuss that it is coming from both hospitals, Presbyterian and UNM. The female who gained access to the gun and tried to kill her neighbor, she was having homicidal and suicidal ideations, claiming trolley systems were running underground all night long and that her neighbor was holding people hostage. She was transported to Kaseman after an incident where she drove to the Foothills substation and was driving her car erratically and the officers had to stop her there in the parking lot of the substation. She informed Detective Bailey the next day when Detective Bailey made contact with her, that she was there for a few hours but that she had been positive for meth. It was a day or so after that that she purchased and gun and tried to kill to same neighbor. The incident

with the guy with all the guns was UNM. We transported him to UNM after spending a long time with him. It's mainly coming from both UNM and Presbyterian. One detective told me, he hadn't even left the hospital; someone he transported was already leaving. I don't mean to be disrespectful, it's just scary when a field officer called me and said, and your female almost killed someone today, good thing the gun malfunctioned. It just scared me that these people who are in crisis and need help and are turned away for whatever reason. I don't know all the criteria about involuntary hold. But that was UNM and I don't know if we have a representative from UNM; but when I brought that individual in with the three loaded guns and a suicidal plan in place and he was let out in just a few hours, even he was disappointed. He told me "I need help, I need a diagnosis, I need to get on medication." He was let out and even he doesn't know why. It's just scary.

- C: Robert Salazar: Detective Bailey, that experience you are describing is very common in the peer community. That is a common response. Many times when we are self-medicating, our concerns are immediately dismissed as a substance abuse issue. I had that happen to me more times than I can count. All these experiences I am sharing are well before COVID 19. So this is not the virus, this is a global response that we've dealt with for a long time and I've been a big proponent of changing this for a long time. Where can we go to change the laws that would require hospitals to keep a person until they are stabilized not just release them because sedation is not the answer. It breaks my heart that I have heard more than one peer break down because they are not getting help. These are valid concerns and are coming from the peer community as well.
- Q: Danny Whatley: Anyone else? This is one of those topics again that are hard to handle on Zoom. No doubt it is a very real issue. But I certainly think this is one of those issues we can hopefully address in our June meeting. Everything seems different in our world today. It is something that is scary for sure. Anything else, anyone else?
- C: Gilbert Ramirez: Thank you everyone who shared their stories. I will say during this time of COVID it's heightened what type of gaps we have in our system or lack of services. We've been in an ongoing conversation with the county and UNM and the Crisis Triage Center. Where do you go when not mandatory for acute placement? Where are the gaps how do we address them? What opportunities do we have to make improvements? A lot of people were affected by losing access to their primary care physician for a continuum of care, being monitored by case managers. So we learned a lot in the first two months. With the homeless population, we don't have a system in place for those individuals who we consider are PIU, people who are under investigation for COVID testing. Where do you go to isolate for the 14 days while awaiting the results for COVID testing and still receive the mental health and/or substance use treatment that is needed? Those are some of the gaps we have been facing. There are no places right now. We have been placing those individuals in hotels for isolation but we have not been able to get them treatment for mental health or substance use. I think we can learn a lot from what happened in McKinley County where they had a huge outbreak and how it is spreading. I don't think anybody was prepared for this pandemic, I think we've given it a good place and done the best we can but there is still a lot we need to do. I think we've had some breakdowns and I do sit on the CJCC and we have talked about the MDC positives, so I will be able to share some of these issues and continue to grow. We are not out of the clouds yet and it will continue and there may be a resurfacing of COVID. Adaptable to change.
- C: Danny Whatley: Thank you Gilbert. Anyone else?

Mental Health Response Advisory Committee (MHRAC)
Meeting Minutes
Tuesday, May 19, 2020

Extreme Risk Firearm Protection Orders by Lt. Dietzel:

In about six hours, the Extreme Risk Firearm Protection Order law will go into effect. I've trained all the detectives who are going to interface with this. In terms of how it will interact with mental health, these are essentially gun restraining orders, an officer has to have probable cause to believe if they leave the guns with the individual or allow a person to buy a firearm, they are going to fire them. But these require a couple things: one of which is a reporting party, so somebody that has a relationship with the individual who we are trying to restrict from having a gun. The person needs to come to the police and say this person is dangerous, I am related to the person in this way or are in a personal relationship with the person, will you file an order for me. In terms of mental health, CIU will be handling all that deal with people in our case load. The reporting party fills out an affidavit. The officer files the order. This is a civil order not criminal. It is a gun restraining order. When these come up, clearly mental health related will be handled by CIU. I'm not sure how often this is going to come up.

(Q) Questions, (A) Answers, (C) Comments:

- C: Day Ley: Lieutenant, obviously this wasn't part of this process but, New Mexico Solutions actually had a patient who about 2 to 3 weeks ago, that had a gun had a plan, we go the police involved, she surrendered the gun to the police and we are thankful. Obviously my team is saying that that involvement and frankly the corona virus quarantine and isolation is the reason this lady is alive because the restrictions prevented her from getting access to other means. So we are thankful you guys are out there. My team wanted me to give you thanks for APDs and CIUs involvement. They have been very supportive and we have a woman who is alive because of everyone working together. Thank you.

Criminal Justice Coordinating Council and the City/County MOU by Max Kauffman

Max Kauffman stated that both he and Lt. Dietzel are on the same subcommittee and that there is a product they are working on that really does involve MHRAC. What they are working on right now is creating a universal ROI which encompasses many criminal justice partners and providers that someone could sign that would allow for free flow of communication for purpose of coordination of care. Have drafted an MOU and have discussed it with City legal and County legal for approval. Have received a thumb up so far and right now it is being further reviewed by the Criminal Justice Council. Still in the formative stage. We are ready to accept input on this ROI. This could be a really important thing. We've had a lot of clients on my end falling through the cracks because no one knows what is going on; or I can't track them down and everyone is hitting roadblocks when they are trying to find out what is going on with this individual. So there are obviously some very touchy parts to this. We need to respect people's privacy and ensure that the ROI is being used solely for the purpose of helping them and not for a law enforcement tool or for compliance for probation or things like that. Mainly there to just open the door to community providers. Max Kauffman stated that where he sees MHRAC coming into this is: we already have a lot of big players in MHRAC who could benefit from a universal ROI. He and Lt. Dietzel have already discussed the possibility of bringing in COAST in a very limited fashion though that may be a little bit more complicated and possibly even bringing in HopeWorks clinicians. Given the COVID crisis right now there is a big demand for this because we really all need to communicate right now. At this point there are some roadblocks. Wanted to inform everyone about what the subcommittee is doing. If anyone from MHRAC is interested in being involved in the process, I'd like to use this as a way to invite you to be a part of the next subcommittee meeting or if you would like be listed on the universal ROI, because we are targeting the high utilizers of the services and those who are

booked on a frequent basis at MDC. And at the same time coming up with a list of the high utilizers and target the people who need the help the most. Any questions?

(Q) Questions, (A) Answers, (C) Comments:

- C: Danny Whatley: Questions? Comments? Max, as far as meetings, you can notify Lori and she can put out the information to MHRAC.
- C: Max Kauffman: It's really just an open invite. I kind of volunteered because Lt. Dietzel and I are both on MHRAC and both on the subcommittee, so it's very easy for us to relay the information together and work together on it. Even if it's even independent of MHRAC that you want to be a part of it, I can certainly pass that information on to Lori. If anyone wants to reach out to me, please feel free.

Report and update from CIU, APD and Dr. Rosenbaum:

Dr. Rosenbaum mentioned that Peer Support will have MHRAC look at the SOP. He doesn't believe it is essential that MHRAC look at the SOP but felt it would be nice if they did. He then asked that everyone please look over the list of providers for behavioral health services which he had submitted. He has already received a lot of feedback. If anyone else has any additional feedback please share it with him.

Assistant City Attorney, Lyndsey Van Meter was present to answer any questions, if needed.

Report and Update from C.O.A.S.T.

- C.O.A.S.T. during COVID-19 by Xochitl Campos-Biggs and Rob Nelson
  COAST has been temporarily reassigned to Family and Community Services acting as case managers for the homeless people being tested and the ones in quarantine because they tested positive. We have two sites. Both sites are providing pretty much wrap around services for those people.

(Q) Questions, (A) Answers, (C) Comments:

- C: Danny Whatley: Rob you mentioned homeless folks testing positive? I'm not sure that's correct.
- A: Rob Nelson: Let me correct that. I had one person that was placed because he was from out of town and had no place to stay. He tested positive, the hospital had nowhere to put him so we took him into one of our hotels and he was placed in quarantine and then assisted him in getting back to New York.
- C: Lisa Chavez: We are also assisting someone from the Navaho Nation
- C: Xochitl Campos-Biggs: I am with Family and Community Services. So COAST has been temporarily reassigned to Family and Community Services and I would just like to go over what Rob and Lisa said. They've done a very phenoniam job adapting to what has been a very changing landscape as far as how we adapt to protecting people experiencing homelessness from being exposed as well as giving them a place to stay in isolation while they are people under investigation. The project did start as what we called to hotel voucher program where we could get individuals from hospitals around the city and we would place them the hotels. For example, Rob would go out and educate the hotels on how to clean the rooms. Our team members like Lisa would take food to them, monitor them. We have a biotype social

assessment that we would use to assess their wellbeing. So this is the type of work we have been doing. We've worked with over 60 people that started at MDC and now we are at the Hotel Garden In and the Super 8. We are working very closely with our service providers and the system has changed, it changes weekly. We don't only work with people experiencing homelessness, we understand that case management is very important and it's really important to people especially people who are ill and they are working with all people who are going through HGI and Super 8. Gilbert Ramirez might want to speak more to this.

- C: Gilbert Ramirez: So the larger picture, the City runs the largest shelter, as we saw COVID coming, we had to kind of work to ensure that we had enough pods, TIU, perform investigations, and in the event people tested positive, we had to have a safety net. We secured hotels. We integrating having to move people into those hotels while awaiting test results or if they were positive; then had to get tested again to be sure they were negative before being returned. One huge piece that was needed was case management coordination for those being taken from the shelter and/or we have a partnership with the emergency department both with Presbyterian and UNM know that individual is identified as homeless, they know they can work with one from our team work to move them to one of the two hotels and if that case management is as well as medical care with our partner, Health Care for the Homeless or First Nations. So it's been a wonderful collaborative of nonprofits, City, County. We are lending to other counties outside of Bernalillo. We have had some people transferred from the tribes lodged in the hotels. Happy to say we have had zero positive tests at the shelter. Compared to other states, we are seeing, it's been a phenomenal process. And of course the behavioral health needs of those in quarantine, it's been a lot of work to keep stable during this time.
- C: Danny Whatley: Gilbert, you guys have done an amazing job and it's been one of those things too that once this is over, the heartbreaking stories and the successes will need to be shared.
- C: Lt. Dietzel: Just one more thing. I know all behavioral health training goes through MHRAC and that is how it's supposed to be but I just want you all to know that three o'clock Friday, I'm on PowerDMS and there's a video on there that said basically how to interact with the mentally ill. The academy put together a video based on the state mandated course and put that on PowerDMS. CIU did not know about it. MHRAC didn't know about it. We are going to put into place a way to avoid this ever happening again. Just as SOD has been rolled into the Training Sub-Committee, we are trying to get that to include the Academy as well, that way the next time one of these comes up, we all know about it. The video wasn't horrible; I am trying to get a copy of it from YouTube for the Training Sub-Committee so that they can review it. There was also a test attached to it. The reason the Academy did this was because it was state mandated training and they felt that they couldn't add or subtract from it. It's part of the yearly maintenance of training effort (MOE). It came out, we are going to try to fix that going forward.
- C: Detective Bailey: I wanted to point out that our Home Visit Detectives have continued to conduct their home visits throughout the community to those individuals in crisis. We haven't stopped helping people; making sure that they are staying connected to services; taking them to the hospital if needed. Even with the COVID going on, we have taken the precautionary measures with our PPE and only contacting them outside their homes. We haven't stopped the home visits and a lot of them are appreciative of that.

Report and update from sub-committees:

Information Sharing/Resource Sub-Committee:

Mental Health Response Advisory Committee (MHRAC)
Meeting Minutes
Tuesday, May 19, 2020

Training Sub-Committee:
David Ley: Training Sub-committee did meet a couple of weeks ago on Zoom. We talked about a variety of issues including a lot of pretty positive progress that has been made with CNT. I am really very excited to see a very nice collaboration between CIU and CNT around training, behavioral health, for CNT officers; it is exactly what I had envisioned and hoped for a few years ago. I'm thrilled that we are there and I want to acknowledge Lieutenant, Sergeant and Dr. Rosenbaum for their collaboration in getting there. I am happy to see it. He then asked Dr. Rosenbaum if ECHO had some success with funding. Dr. Rosenbaum stated no, in fact it was the exact opposite. David Ley then thanked Sgt. Dosal for reminding him about trainings. He stated that CIT and eCIT had actually gone gang busters in doing Zoom trainings for officers. The really nice thing is that amid this pandemic, that condition has not really even had a speedbump in terms of continuing the training they are providing. I am impressed by this and thank you.

MHRAC Final Discussion:
Danny Whatley: One thing we need to discuss. You should have received two resumes from Rosa and Leyna. Replacement for George Mercer who is no longer on the board. Want to hear from them really quickly. I would like to make a motion, that we accept them, they would basically be two alternates, one vote; that they will both serve, in case one of them can't be there, there will be some nights that both of them will be there, again they would have one vote but like everyone else, they will have the ability to make comments. So once again I make a motion that we accept them. Rick Miera second the motion. David Ley stated that he is on the board for Health Care for the Homeless and George has retired and so we just wanted to fill this with a representative from that organization. He also second that motion.

Leyna Inberg: I would like to say that I have been to one MHRAC meeting. The time I came was on behalf of my client and how the process of them being transported when they are suicidal. I've worked with suicidal prevention for many years. I've serve on a board for suicide prevention. It's a passion of mine. I've been a therapist for 6 years. I work for HCH. I've done so work with MDC with childhood family therapy. I've done some case management work but my passion is working with those that are most underserved. I love working with the homeless population and many of my clients are severely mentally ill so they are rotating between all of our organizations; between MDC, the hospitals and us. So I just want to add as many ways as possible.

Danny Whatley: So we have a recommendation and a second. We won't do the all in favor. Any opposed. Hearing none, you guys are now members of MHRAC. I apologize for the length of the meeting. Our next meeting is June the 15th. I'm in hopes of being able to do social distancing and having our meeting at the Rock. Thanked Matt for hosting this.

Adjourn
Meeting adjourned at 6:54 PM