Mental Health Response Advisory Committee (MHRAC)
Meeting Minutes
Tuesday, June 16, 2020

In Attenance:
Co-Chair Danny Whatley, The Rock at Noon Day
Co-Chair Rick Miera, Executive Committee
David Webster, Bernalillo Country Behavioral Health
Laura Nguyen, Albuquerque Ambulance
Lea Harrison, Haven Behavioral Hospital of Alb.
Robert Salazar, NAMI/Peer Representative
Betty Whiton, NAMI
Gilbert Ramirez, CABQ-Dept. of Family & Comm. Services
Maxwell Kauffman, Law Offices of the Public Defender
Elizabeth Romero, M.D., UNM Department of Psychiatry
Lieutenant Matt Dietzel, APD CIU
Cassandra Bailey, Detective, CIU
Rosa Gallegos-Samora, Albuq. Health Care for the Homeless
Leyna Inberg, Albuq. Health Care for the Homeless
Nils Rosenbaum, MD., M.P.H., APD Behavioral Health Division
Paula Burton, Peer Representative
David Ley, New Mexico Solutions

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

Absent:
James Burton, Peer Representative
Rob Nelson, APD/C.O.A.S.T
Sarah Alires, St. Martin's HopeWorks

Meeting was called to order at 5:04 PM. A quorum was met at time of start.

Danny Whatley informed those present that this is the second Zoom meeting of the Mental Health Response and Advisory Committee. He stated that they would probably have another Zoom meeting in July. Danny Whatley will be out of town at that time but Rick Miera will take care of that meeting and Lt. Dietzel will put the meeting together. The plan is to hopefully resume meeting at the Rock in August.

Welcome first time guests:.
Guests were asked to put their information in the chat line due to the large number of meeting participants.

Mary Perez, UNM Psychiatric Hospital
Bob Gusch, saw meeting notice on Neighborhood site
Mariela Ruiz-Angel, Coordinator, Albuquerque Community Safety Department
Dr. Kimberle Pruett, AFR/EMS
Deputy Chief Jaramillo, AFR/EMS
B.C. Chris Ortiz, AFR/EMS
Nicole Duranceaux, Psychologist, President of New Mexico Psychologists Association
Michael Lucero, Lead Clinician, MCT, HopeWorks
Deputy Burch, BCSO, MCT

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Approval of meeting minutes

There was a motion made by Dave Ley to approve the minutes as written. The motion was second by Gilbert Ramirez. The minutes were approved as written.

Public Comment (two minutes per person, 15 minutes total)

Jim Ogle: I have a couple of comments; first of all; looking at what's been happening during the last couple of months; especially the last few weeks; when you look at the recommendations; Albuquerque Police Department has been following a lot of those and I think they should be commended on that. They are on the right path and they've made a lot of progress. My second comment is: looking at the composition of the MHRAC Board, you start wondering if it's diverse enough. No African Americans on the board; nor Native Americans or refugees. I would like the board to address to maybe address some of those issues.

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

- C: Danny Whatley: That has certainly been brought up before and we have discussed it and tried to figure out a way to accomplish that. I would say that those we would consider not having a voice in the community is certainly represented by the service providers and those who work daily in law enforcement also; service providers such as Health Care for the Homeless and also from HopeWorks who are dealing with those from that population every day. I think they are a good representation of those that don't have a voice. I certainly appreciate that and I wish there was a way; someone who would step forward. Right now we are sitting at somewhere around 18/19 members. So I wouldn't want to get much bigger. It would get unwieldy if it got too large.
- Q: Jim Ogle: Has there been outreach to the NAACP?
- A: Danny Whatley: There has not been. We have had folks from some of those organizations attend our meetings in the past to give their voice. And those groups are certainly represented by AMICII. The CASA is hearing from those folks in our community; it's just MHRAC, the committee itself, is not representative of those communities that you mentioned. We are certainly open to that. You have to realize too that the membership of MHRAC is pretty much spelled out in the CASA and with who the representation has to come from. There is a little bit of wiggle room but not a lot. Any other comments or questions.
- Q: Phyllis Patten: I have a grave concern over how people with mentally challenged issues, psychological issues, are being treated and put into the jail system because the police don't know how to handle them; they are not safe to others or to themselves; but putting mentally challenged people into jail is not the answer. Of course it takes a great amount of finances to find housing for mentally challenged people and I understand that; but I would like to know what your committee is discussing? Do they have plans, and if someone is already in the jail and has been there for close to a year now; what can parents of adult children who have psychological problems; and find themselves being held in a legal system in jail; postponing court decisions over and over for almost a year now. We need some help here.
- C: Danny Whatley: We certainly discuss those kinds of situations in MHRAC; but MHRAC was created by the Court Appointed Settlement Agreement and basically has a three prong responsibility. One is policy: the creating of policy, the writing of policy as it relates to interaction between those who are experiencing a mental health crisis and also those experiencing homelessness. So policy is one end of it. Training is another and information sharing is the third. We are limited and we have to stay on task. That is one of the reasons we are successful; we have a limited scope. This may not be the venue; there are other organizations that get involved in

those types of requests and those kinds of concerns. MHRAC is not really that group to address these issues.

- C: Lieutenant Dietzel: Sergeant Dosal sent up a meeting with NAACP for this coming Thursday. We will make sure to put out those kinds of invites for MHRAC in the future.
- Q: Danny Whatley: Anyone else? Anyone else with a public comment?
- C: Robert Salazar: I agree with Jim Ogle. This is an issue we have brought up in the past. We were flat out told racism does not exist. I consider racism and the elements involved in it to be a mental health crisis. We have brought this many times in the past and been told this is not an issue. I personally believe the only reason we have the consent decree is because James Boyd and the other lady were both white. I've personally experienced this with the department when I was not well; the darker the skin tone; the worse treatment they can get. This is something that needs to be addressed. Because if we continue to say it doesn't exist, the problem continues to continue on. I believe it is directly relates to mental health.
- Q: Danny Whatley: You have not heard it from MHRAC have you?
- A: Robert Salazar: No but I felt there were officers before that tried to bring it up early on and were told no it's not an issue and were told to be quiet about it. And in some instances it was actually laughed off. I think we can't address accordingly if we don't address it. I know we've worked a lot on the trainings and there is still a lot of work to be done.
- C: Danny Whatley: One of the things MHRAC might become involved in our scope is this new program that we are going to talk about. I think it's going to deal more with race relations and interactions with people with color. So maybe that's one of those things where we can address that in the Albuquerque Community Public Safety Department.
- C: Danny Whatley gave a background on how this came about and why the board received an email from him last week stating to look forward to what is going to come out on Monday. It really came about really quickly. Danny was notified that this was happening and APD did not want us to hear from the media about this program. That's the reason why he sent the email out and why there will be a discussion on this.
- C: Robert Salazar: One of the things we have been advocating for that licensed professionals are responding to these calls instead of putting law enforcement in that situation that they shouldn't be having to do. That's not fair to the officer or to the community. We've had these discussions in the past.
- C: Danny Whatley: There's not a lot of information right now. A concern I have personally, that MHRAC may not share, is where we paint the horse a different color and think it doesn't fall under the CASA anymore. Just because now all of a sudden law enforcement is not going to be directly involved in most cases involving mental health crisis doesn't mean the CASA doesn't cover that; doesn't mean that MHRAC is still not responsible for reviewing policy and looking at those things. We had the same thing with the homeless encampment situation. Trying to develop policy and still have not developed a policy; basically flying by the seat of our pants. MHRAC still has not reviewed anything on this. And so that's the other concern that I have; as we develop this new three prong concept; this new scope on mental health crisis and homelessness; MHRAC still has to be involved in that.

Albuquerque Community Safety Department

Mariela Ruiz-Angel introduced herself to the Committee. She has been with the City of Albuquerque for approximately 6 almost 7 years. She was hired by the previous administration to work on different projects ranging from education initiatives and economic development. She then transitioned a couple of years later to the Office of Immigrant and Refugee Affairs under the Office of Equity and Inclusion. As

she stated: so adhering right, bringing up very important issues, how boards are represented, how community stakeholders are represented; is pretty much the type of work she has been doing for a long time now. She was asked to help with the coordination of this office. According to Mariela Ruiz-Angel, it is very important that we do it well; that we bring all the right people to the table. She stated that she recognizing a lot of people on this call; and those that she has worked with on the blue torch and through our AFR Department. She stated that MHRAC was going to be crucial in this work. MHRAC has been the experts; they have been doing the work. She stated that Danny Whatley knows the CASA agreement inside out. Those are going to be things that will need to be kept in perspective. She stated that she did not have a lot of information at this point. She is in the gathering of data, the gatherings of what the departments are currently doing; what's working; what's struggling; and how can we uplift where we need to; where to redevelop where we need to. Key players? She stated that at this stage, she is open to any ideas; I'm open to receiving calls from those folks who want to be a part of those development conversations. She has already seen few folks who have reached out. She is really excited. It is definitely a big thing to take on and she stated that it will not just be her. Lots of folks will have input and help in this process. She then opened it up to questions or concerns or best wishes. As a department, she stated, they are just not there yet.

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

- C: Maxwell Kauffman: I do think it's a great step involving MHRAC. There are a lot of collaborative groups that work with the population that is being targeted. MHRAC is one; I think the CJCC, diversion re-entry sub-committee that Lieutenant Dietzel and I are a part of. This is right up our alley. I think the Achilles Heel in Albuquerque's progress is coordination and collaboration; which is why we're here and CJCC. MHRAC and CJCC are trying to collaborate together. But this new project is something that could unite projects. There are a lot of key stakeholders; a lot of players in the city who are in these groups; who have a wealth of wisdom. Practical help that could easily support these projects. I hope you can try to connect with either me or Lieutenant Dietzel to see how both CJCC and MHRAC can support this new project. So that we can ultimately benefit the community the best way possible.
- C: Mariela Ruiz-Angel: provided in the chat box the email address for her. Completely agree with everything you are saying. I'm excited about joining forces.
- C: Lieutenant Dietzel: I'd like to add to that too. CJCC's diversion re-entry sub-committee; we don't want to leave the county out of this. The three of us will be talking more.
- C: Lea Harrison: I am the Executive Director of Haven Behavioral Hospital and also on the MHRAC Board. One of the things I am concerned about, as well as some of my colleagues in the behavioral health industry; is the lack of communication. Max brought it up that we do have all these ancillary groups who are all trying to work together to do what's best for the community but I think sometimes, the left hand doesn't know what the right hand is doing; and I am very concerned that this new group; this improvement process; will fall into the men Usha of groups that start and are not communicating with other groups. So, I'm curious as to what you see that communication and what that collaboration looks like.
- A: Mariela Ruiz-Angel: So, I'm going to be really honest, as you get to meet me and my transparency; I don't necessarily give a lot of political run around. I work very in the community fashion; it's the only way I know how; to be honest. As a social worker; and as somebody who has a MBA; it's what I have found to be really successful. So, I've made it really clear to the Administration and I think everyone is on board with this and we are going to have to have community at this table but additionally we can't expect for us to start a new department and

then say hey Haven Behavioral Health; we're going to add this new thing to you; can you guys just do this now. We are going to have to figure out how to build more capacity as well with our partners and be able to have to have that constant communication. You already do the work well and we are not here to reinvent that. We are here to build capacity. I've been having this conversation with lots of behavioral health organizations and even the hospitals and we are already discussing; one, how do we continue to create potentially, what I see to be, an advisory group, stakeholders, who continue on through this work. And it might be that we don't have a massive stakeholders group; we might have behavioral health specialists; like yourselves; be part of one stakeholders group. Because we are going to have a lot of stuff that comes up. It is rare to encounter someone who's homeless, who is only dealing with homeless. Many times there is a dual diagnosis and I think lots of players and lots of people are going to have to be involved helping us work on some of these issues. So I just want to say that in my way of planning is to always to have transparency and to be constantly doing what is right. Even if it's bad news. I'm a big believer that it's better to be open and honest of where we are at. That's my commitment to the administration; to the stakeholders and as a social worker, the community who really needs to have this type of department.

- C: Lea Harrison: Thank you so much Mariela. It was an amazing response and obviously you have put a lot of thought into it and I do appreciate that.
- C: Mariela Ruiz-Angel: Lea, I would love to get your contact or whoever heads your behavioral health section so I can touch base on that.
- C: Lea Harrison: That's me and I will send that to you now.
- C: Rosa Gallegos-Samora: I'm a therapist at Health Care for the Homeless and I am on the MHRAC Board as well; I would also like to be part of this discussion. I've been in discussion with people from other states about their existing systems and how it's working for them and just because I have a vested interest in the experiences of my clients and of the people I serve and so I would like to set that up and try to work together with all the contacts I have. They have some really awesome information and they have been doing really good work for over 30 years. So I think we can learn something and implement some things that they are already doing.
- C: Mariela Ruiz-Angel: I would love that Rosa. That's the best part of; the City is being innovative about creating a department; which I think is a big step forward. There are a lot of programs and there are even programs within our own APD and AFR and I finding also in the Metro Securities division that there are already all types of programs that are really working well. So, how do we take from what we already have the infrastructure we already have, and adopt it and grow it into a bigger department? So I am very interested in gathering any information you may have and as well to include. I may have already had a conversation with potentially one of your directors but I would love to meet with you as well.
- C: Rosa Gallegos-Samora: I know some of my colleagues are worried that there will be a very rapid response because of everything that is going on in the public and that it's not going to be sustainable; that they are only going to put a band aid on it; rather than a long term solution and so I know that many of us are aware of that and we just serving our community well.
- C: Mariela Ruiz-Angel: I agree and you are right it can't be just a band aid. There needs to be change and it can take years. You are talking about changing a culture of how we are dealing with behavioral health and addiction and even domestic violence; all of those pieces fall into an idea of what we had has to change. It won't happen overnight. It won't even happen by the end of the year. I have been doing this with Immigrant and Refugee Affairs and working with communities and it has taken me years to build trust and how to figure out processes that work

for them and then to incorporate them. We are creating a new system, within a system and we going to have to figure out how to phase it so that it is sustainable. How to grow it small and then grow it to capacity.

- Q: Jeremy Lihte: I think we have something in place already that can be expanded and I don't know where we are at with our chaplains right; but when we are talking about our chaplains; expanding that unit; expanding what we have in the chaplain community; and their efforts; we can kind of insert far more social workers, we can insert far more advocates into that area. Chaplains are not only to announce deaths; they are there to counsel. I think that's how it was in the past. What our state is; and as far as our chaplains; what role they can play in dealing with mental health and especially faith?
- A: Danny Whatley: The Crisis Intervention Unit sort of assumed that role that you are talking about. The faith community is still certainly involved as far as counseling. But as far as triage and first responders; and those developing a plan to help those experiencing a mental health crisis in our community is now a CIU responsibility. All of our officers (or at least 97% or 98%) are already trained in crisis intervention and a lot of our officers have been trained eCIT. So there are trained officers out there to respond to those calls. The chaplains program is still important; there are times it would work well, however, there are times it wouldn't work because the faith community would not be well received in certain circumstances. So we have to keep that in mind. But I appreciate that.
- Q: Jeremy Lihte: Do the chaplains necessarily apply to the faith community?
- A: Danny Whatley: I would think so. I might not understand your question?
- C: Jeremy Lihte: I believe the chaplains are there for more than that. I mean they could be. I guess I'm proposing that we have a proponent of the police department that can be expanded; maybe set as counselors; maybe not officially in capacity of mental health or substance abuse but we can use that department to expand into those other capacities.
- C: Danny Whatley: I think one of the things that we would run into if we did something like that would be standardization of training. Making sure that our chaplains have been trained in the same areas. One of the problems we came across when we first started; was that training was all over the place. There were different levels of training; different divisions in APD were trained by different people and finally we've established that standardization. If we did that with the chaplains, and that became part of the response to those in a mental health crisis, I would think the standardization of training would have to be one of the things to look at.
- C: Jeremy Lihte: My proposal is just simply that we have a department set up to where we could expand rather than having to establish a new department: which we know how many loopholes and how much work that would be. Expanding the chaplain roles to include LCSWs or any other qualified clinicians to kind of fill this role. We could really put under that department of chaplain.
- C: Danny Whatley: I think the plan that has been proposed; that is being talked about; and there are not a lot of proposals out there yet; not a lot of specifics; I think it is one that MHRAC wants to be on board with but there's just not enough information for us yet to say that yes this is the way to go. I think anybody's there yet. I know that the mayor is sold on it and administration is sold on it but nobody really knows yet what we are going to see around the corner as we start looking for the missions to take those spots. Trying to figure out who those folks are and what they look like. It's an exciting opportunity. It's like starting all over again. Handing that ball off to someone else.

- C: Mariela Ruiz-Angel: I would be really curious what the chaplain's program looks like and who it falls under. Maybe Lieutenant Dietzel knows about that. We will see; if there is a good model to it. But here's the thing, with the new department piece of this, I think it allows for a lot of run for multiple divisions. It doesn't limit us to a division of social workers who are doing one thing, right. I think there is room for there to be multiple divisions who are working collectively to address different issues. So I think, as I'm gathering information, that could be considered. So send it our way.
- Q: Danny Whatley: Any questions, comments? It's pretty hard to come up with questions when we don't have a lot of information.
- Q: Leyna Inberg: I work at Albuquerque Health Care for the Homeless; I'm a psychiatric nurse practitioner. I have just have a curiosity about this new branch of professionals. Will they be volunteers? City employees?
- A: Mariela Ruiz-Angel: They will probably be either City employees or contractors. And we are looking at pretty much the highest levels: LMSWs or LCSWs potentially. Therapists, psychologists; depending on what our money situation looks like. I think there will be multiple levels even all the way down to BSWs or case managers; that can help with things like follow-ups right. That's one of the things we don't have; don't have the capacity for, right, people doing follow ups. You get called to a down and out and you drop them off and that's it, right. And that's kind of how it ends. We need have the ability to connect those people to services. We're going to need people at all levels and there will need to be supervision and all that. Licensing. So I think we haven't really discussed how that will be a city position or if we will end up using contractors and they themselves can supply the licenses.
- C: David Ley: I'm the executive director of New Mexico Solutions. I will just point out that New Mexico has a tremendous work force crisis issue when it comes to behavioral health clinicians; particularly high level and independent level clinicians. So my very strong recommendation, as the city moves forward in this, is to incorporate a flexible and evolving kind of approach to hiring clinicians because that is how we all make it work. So when you set the expectation to hire independent clinicians, they are not really out there or they are working for me and if you need to hire them, you are going to take them away from me and that deprives people who are receiving services currently.
- C: Mariela Ruiz-Angel: That is one of the things we are considering. I talked to a number of clinicians recently who work for the courts and the courts at this point also are using contractors. One of the good things are you can have multiple jobs and contracts. Yes, you are right. We do not want to take away any employees from our partners. That is not something we are in to doing. The other thing I haven't mentioned is that we are looking at creating a pipeline right with social workers. We have two fantastic schools right here in our state and we know that we have a hard time retaining social workers. We don't pay them enough and we struggle with keeping them on and a lot of them leave. So we are trying to figure out how we start right at a BSW level and create a pipeline so that eventually they would be able to potentially be city employees or even if they got trained by the city and understood the system; and be vetted and go out to other partners. I think this is going to be another component of this as well.
- Q: Jeremy Lihte: So I will say we have this sitting pool of CPSWs (certified peer support workers) that are trained and are not being utilized. Some private corporations, some non-profit providers here and there but ultimately sitting there with no job after certification. So these are peers who have gone through mental health training, substance abuse training, and many other

issues regarding behavioral health. They are not being utilized and they do not have any positions available to them. So we have this sitting pool of individuals who have been trained and sure they do not have LCSWs or LMSWs but they are certified as peer support workers that can be utilized and should be utilized. I think my major question is, we are looking at this. We are in crisis mode right now. We don't know how to deal with this. We have to be honest about that. I think number one is the question to my friend Gilbert Ramirez: is it easier to open up a new department or to expand on an already existing department and how can we do that? And who can we utilize? LCSWs lets be honest; they are expensive and they are in private practice or they are already employed full time with another organization. We do have CPSWs who are certified to be peers but do not have a job opportunity. They are spending that money to become peers. How can we train them further and the ultimate question is where do we place them? Do we create a new department here; which I don't know how much it takes or do we expand on an already existing department? So I guess that question can be geared to either you Mariela or Gilbert Ramirez. And I definitely want to hear from Gilbert Ramirez.

- C: Robert Salazar: I'd like to add on to that, I can personally attest to that. I have had my CPSW for two years and am going through the process of getting it renewed. I have yet to utilize that outside of the volunteer work I do for MHRAC and NAMI.
- C: Jeremy Lihte: Absolutely and I think that's an avenue to be explored and as far as the county and city's situation is; I think it is the most affordable option and a really great option. But we need to figure out how and where to place these people because we are talking in circles. We have to have a department that is either established or not established to create and place individuals in. We have to choose those individuals, where we pull them from and where to place them. So CPSWs are ideal. I brought up chaplains earlier because that's what came to mind. I feel like that could be expanded upon and so those are my points and I do want to hear from Gilbert.
- C: Gilbert Ramirez: The work that has to be done is across all levels of skill sets and backgrounds. I see huge need for ongoing jobs for CPSWs and I'm a LCSW and I'm bilingual and I'm rare and I'm a male and yet I am no longer in the direct practice arena because we are at this level now trying to create change. So understanding that, I don't think I can empathize, one level of training or background over another. I think we need the entire spectrum of professionals out there to be able to respond accordingly. I do agree there is an opportunity to expand in other levels of professionals. I do agree that the state needs to invest more to keep the clinicians here. I'm bilingual; I have a degree in Spanish. I don't get paid any more than colleagues that have the same licensure that I have. There's no value in that. We do have to address some of the inequities that exist. We are going to need individuals who can diagnose, provide that level of prevention; just like we are going to need peers. I don't want to get into the splitting of teeth. And we have had these issues for a number of years. I agree there the jobs are not necessarily there. We do look at that with our behavioral health services contract. I also believe the landscape of how we provide behavioral health services in our community is evolving and changing and we need to partner with our universities to be able to prepare our next practitioners. We are seeing a change; on how to respond; culturally sensitive to the community we are serving. Believe we can grow our own in our city. The policies will be established. It's a matter of how effective it will be and how do we go off of what we have.
- C: Danny Whatley: Remember, MHRAC's responsibility is policy, training and information sharing; so even though this discussion has run the gamut; it needs to; that is the MHRAC role in this. Just to bring you back to it.

- C: Carol Pierce: Would like to build on one aspect of Gilbert's comment because I think the question was raised about building a department as opposed to added to an existing department. As the Director of Family and Community Services, I am supportive of the new department because I think it raises this to the kind of level and attention that is needed to have a different kind of response system. And I imagine it will include people who are currently at Family and Community Services but I think the availability and resources out there; I think they will have that focus and have that one department, I think that will have a benefit. So I did want to weigh in on that from a departmental level.
- C: Danny Whatley: We have to realize as well that the clinicians are just one level of this whole process; talking about advocates for homelessness and those that are dealing in that situation. A large portion of this department, this new wing is only one piece of it; there's still a lot more to it. Anyone else? Questions? Comments?
- Q: Jeremy Lihte: My ultimate question here is expanding a department versus creating a new department; what's the difference on time line?
- A: Danny Whatley: Listening to the mayor's press conference, seeing the release, it's something that is going to take a while either way. We are going to continue operating as we have operated; CIT unit and COAST unit remaining pretty well where they are at and Carol's shop staying where they are at and continue what they are doing. I don't think anything is going to change any time soon. As far as a timeline, I don't think anybody has a firm grip on that. Gilbert, do you have anything?
- C: Gilbert Ramirez: Predictability is going to be a bit hard. Given COVID situation. That's going to take until August. It's going to take a lot of work. What's it going to take; what's the timeline; what's the whole budget going to look like. I will say short-term, let's just get to August as to what's this department is going to look at and the budget and it will have to go through the approval process. I wish I could give you something more than that but with COVID; cuts in the gross receipts tax. Have a lot to look at and exam in regards to what expenditures are we not going to have because of cut in gross receipts tax. Our goal is to get something by August.
- C: Danny Whatley: I think job descriptions, policies, procedures; there's a lot of framework that has to be put together. As we go through those policies and procedures and trainings in their interactions with law enforcement, that's going to be MHRAC's forte as far as looking at what that looks like. There's so many policies already out there. There can't be conflict, they have to mesh. And even though APD does an amazing job with their policies, it's going to take time. Mariela, one of the things I want to let you know is that we allow the Gateway Center folks a slot at every MHRAC Meeting. I don't believe Lisa Huval is here tonight. We allow them; actually ask them to provide us with an update every meeting. Carol may speak to it tonight. We would appreciate that from your folks as well.
- A: Mariela Ruiz-Angel: Sounds good and I thank you all for your time and listening and openness and I look forward to being more involved in this meeting.

New Shelter Update by Lisa Huval, Deputy Director, Family and Community Services:

Carol Pierce provided the update. Lisa and Quinn were not present. Quinn was introduced as the new gateway manager at MHRAC's meeting last month. FCS is delighted to have her. Last night at City Council Zoom Meeting legislation was introduced to create the Homeless Coordinating Council. And this

is a council that will have city councilors on there, county commissioners on there, UNM representation on there. And you will see similar legislation go through the County Commission soon and UNM as well.

2019 CIU Annual Data Report by Lt. Dietzel:

Lieutenant Dietzel started off by saying that he had obligated CIU into giving MHRAC a data report two times a year. He wants to do that in a way that is helpful to MHRAC; maybe it's not giving MHRAC a PowerPoint Presentation or maybe it is. He asked that MHRAC to help him think of ways to do this better. He asked that they please stop him if they have any questions during the presentation. It was a lot of work. This is the last data book he will have to do. He stated that the city is in the final stages of getting a contract with UNM's Institute for Social Research to basically take this over. He further stated that he is not the person to do this. He should not be doing this; it is not an appropriate fit for him to be doing for him to be doing his own data as the representative of a mental health unit. But here we are. Lieutenant Dietzel stated that he could not have done this without the assistance of Katharine Jacobs, Program Data Analyst, IA Force Division. She does all the use of force stuff; he does all the behavioral health stuff.

We are continuing to see a downward trend in purely mental health calls; these are calls that just behavioral health or suicide. They are coded as 10-40 or 43-1 in the CAD system. They have continued to drop in 2019. He is very curious what COVID-19 is going to do to the numbers in 2020. He expects it to drop but he's still not sure what we will see. One of the first things he would like to do when UNM comes on board is to look at the data. A mini data book; maybe this is what it looked like last year between April and June versus what it looked like this year between April and June. Lt. Dietzel then went over the contact sheet. APD is required to fill one of these out anytime they go to a call that has a behavioral health component. It captures everything the CASA requires and a little bit more in terms of the narrative and who actually responded. He pointed out the portion of the contact sheet that is highlighted in red. "If this is a referral, please email worksheet and report to apdcit@cabq.gov". That's how CIU does its referrals. Officers initially thought just filling out the contact sheet were enough for a referral. We really want them to know they need to email it to us. He then went on to the next slide showing the number of contact sheets over time. This increase is not because calls have increased; it's because APD implemented a new policy and procedure change that basically started sending out automatic emails to officers who went out to a 10-40 or 43-1 calls and did not fill out a contact sheet. It sent out a reminder that a contact sheet needed to be completed. So we went from 3,000 to around 8,500. So the automated emails are working. It's not that officers don't want to do them; it just adds to the paperwork they are already doing but we are looking for ways down the road to make it easier.

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

- Q: Lea Harrison: Are those sheets available, so that lets say hypothetically, you guys went to a call and you bring a patient to Haven, would that information be available to us if we needed to look at that?
- A: Lieutenant Dietzel: I can find that for you. But I will get to that slide where I actually mention Haven. But if you guys needed that I could definitely get if for you.
- Q: Rick Miera: Before you go on, could you go back to the contact sheet itself? On the bottom left hand corner, with regards to the Mental Health Transport, the where and the transported by who; can that information be extrapolated in the future by UNM. Would like to know what those numbers look like given the last subject matter. It's really all about, for creation of a new

department, the highlight has been as we now know, as we have discussed this at MHRAC a number of times; how much do you need police officers to clear the scene because that was the issue for so many years because no, we can't have somebody else doing this. So where the new department is going, there is still a lot more to that; but that's pretty much the highlight of that. So that little area at the bottom really helps the subject matter; we needed to clear the scene or not; or whether the individual needed to be transported or not. Do you think that's going to be available that we could take a look at it for the new UNM community program?

- A: Lieutenant Dietzel: Sure, we will get to that scene security issue in a little bit. That's really a big part of the data book coming up. But I do send all the contact sheet information to the UNM but it's more for the MCT side of it, they are contracted by the county to do the data for the mobile crisis team project. As we end up with a contract with UNM, I have a slide that going talk to which calls are we give away and what criteria will be needed for this third response. So I will get to that later.
- Q: Jim Ogle: Can you go back to one of the first slides? Is the MCTs included in this?
- A: Lt. Dietzel: Yes, sir. This is all cads, everybody responding, CIU, MCTs, everything that has those codes.
- Q: Jim Ogle: Do we have any idea why it's been going down?
- A: Lt. Dietzel: So I have a couple theories, my strength is not in data analysis. The hospitals are doing better; we are doing better, MCT launched. As that number drops it means Albuquerque as a whole is doing better responding to calls; getting them treatment and follow-up services. It's a great thing when that number goes down. I'm encouraging my guys to log on to those types of calls because it's important that I am being honest when giving this kind of presentation. It's a pat on the back for MHRAC, APD and the city as a whole that these numbers are getting lower. This is my favorite slide in the whole thing.
- Q: Jim Ogle: So it's saying all the work we have put into the Behavioral Health Initiative for the last 4 or 5 years, is showing up?
- A: Lieutenant Dietzel: Yes. We are all collectively doing a better job.
- C: Jim Ogle: Thank you.
- C: Jeremy Lihte: So what you are saying is when you are getting these calls where are these people being referred to? Do they have a resource guide?
- A: Lieutenant Dietzel: So we do have a resource card that they do use. Those calls end up coming to CIU at some point; especially if they are a frequent caller. I will get to that slide in a little bit. But generally once they come to us in CIU, I would love to believe that officers are out there handing out resources and offering all this stuff and some of them do but that's a lot to ask when you have 73 calls holding and needing your help. So that's a conversation that this third tier may be able to handle but for now we don't have a whole lot of options available: the hospitals, jail when it's appropriate; or do nothing. So hopefully this third response tier will not only be another option an give better referrals; MCTs are very good at referring but they have a clinician with them whose sole responsibility is doing that kind of thing; aftercare; that kind of moving things along; what happens tomorrow type of thought. Field officers, everything is today; what do I have left on this shift. Every day is fresh. With the exception of CIU, it's not how APD is designed. Does that answer your question?
- C: Jeremy Lihte: It does. So with this third option, with the new department it can be improved? We do have resources guides out there, I have one right in front of me; it has 80 pages; which is New Mexico Leaders in Recovery; which is my organization. So I see all these numbers on the screen and my concern is I don't even know where they are actually being sent. And I think the

major priority here needs to be, if someone is struggling with behavioral health, we need more specific answers than Kaseman, Presbyterian or this or that. Of course, Lea has walked away from her screen; of course Haven is always a good option but we have hundreds and hundreds of resources; or maybe not hundreds; we are definitely lacking; but any case worker that's answered these phone calls or any officer on the street needs to have those resources. And I want to figure out how we can do that. How can we provide that? As the founder of New Mexico Leaders in Recovery, we are just a coalition of behavioral health providers. How can we contribute when it comes to APD and those needs for resources?

- A: Lt. Dietzel: I do think the third tier is a good response for this. Because I will be honest the field officers are not the right mechanism for long term kind of what's going to happen tomorrow or the next day, they are very myopic; what calls are holding; what do I have in front of me; what's the next call after this going to be; it's not perfect; but it's the reality of 85 calls holding on a Saturday, in the Southeast. They are certainly not going to have the time for this. That is the reality of the job. And you do have pressure from your sergeant on why they have all these calls holding. So that gets lost in the shuffle and that's not okay but we are really short staffed and it does kind of manifest it in that way. With that third tier; people may be getting help that they have not had before.
- C: Jeremy Lihte: So I will say this, my organization, New Mexico Leaders in Recovery, we print out resource booklets with every possible behavioral health provider, every month and we update it every month. So send me your information and I will drop off 1,000 of these things if you need them.
- C: Lieutenant Dietzel: That's excellent. Thank you, sir. That's perfect.
- C: Officer Dorian Dixon, APD, MCT: There was a response that I think was worth sharing, to that sentiment, that it would be great to take people to someplace other than one of the local area hospitals, because that's not a lot of times getting them connected to other resources. As you mentioned, sir, our goal is to get them treatment today, from an officer's perspective, and then their follow-up is up to the people we connect them with. I think it's worth noting, that as a police officer, I am certified law enforcement in the state of New Mexico. Beyond first aid training, I have no formal medical training, I'm not educated or trained in, outside of the department doing extra training; doing any kind of behavioral health assessments or offering aid and so I, through experience, can recognize behavioral health crisis as opposed to a medical health crisis, but we are required to make sure that they are medically safe and sound and going to the hospital before taking them anywhere else. And so I hope it's not misunderstood that we are not taking them there because I don't want to try to get them help with other resources; we are required to. I am not medically trained or able to certify that they are medically sound and have to go to the hospital for me before I can have them go anywhere else. I just wanted to make sure that was pointed out.
- C: Jeremy Lihte. No I get that completely. And thank you for giving that input. That absolutely makes sense. And that's why we need that third tier. And that's why we need those other responders to be able to correlate with and consult with and for them to establish and say okay there's a need for this level of care. We have put enough on our officers. You don't need to be assessing and evaluating people that you are dealing with. You don't need to be a clinician. I was just speaking specifically about people calling in and saying that they have behavioral health needs and when you pick someone up you take them to a hospital or whatever you need to do. I'm not talking about APD or that was not my intention at least. I'm speaking of what we are doing about the people calling in and saying they are having behavioral health problems and we

need to advocate our partners when you do get them to these health facilities where they should be referred to. So as far as boots to the ground, such as you, no criticism was intended.

Lt. Dietzel then continued his with his presentation. So one of the things we have to look at is where these calls are coming in at. So he likes to generate contact sheets by area command rather than just calls by area command. Because remember contact sheets encompasses, in theory, way more of the behavioral health interactions than all that APD does. So as you can see, Northeast is always number one, it's surprising that Foothills is lower than Southeast. Usually Foothills is where we struggle to find officers who are willing to do with eCIT program with us. I always take our unit out of it because we do follow-ups, so there are people we could have contact with 12 times per year. So it's only field officers. MCTs were left in because they are responding to calls. He then went over the next slide it shows the top ten beats where the majority of the contact sheets are generated. Beat 431 had the most. 431 is a very populated beat in the Northeast Area Command. Lots of apartment complexes so it's not surprising that this would be way above everywhere else. Lt. Dietzel said he would love to incorporate into the officer bid somehow, he would love the opportunity to stage officers at seats are being assigned by their supervisors, express if you have thinking of going to beat 431, you should strongly consider becoming eCIT trained and here's why; we have been getting a ton of behavioral health calls there, so it's best to have that extra level of training because you are going to be running into these things. The bid is coming up probably in August, and I'm still trying to figure out how I can get myself involved in that without running into contract issues. It's a difficult process so far but I think we are getting closer to having it put in. Next, Lt. Dietzel talked about the training. 100% of uniformed officers (P1/C rank) are CIT certified. So when you see on the news that they want to increase the number of officers trained in CIT; APD is already at 100%. It's really hard for us to run the CIT training right now because it is such a community taught class and a lot of people on this call right now teach this class, and logistically, it is a nightmare to get all of you on Zoom at different times of the day; there are two site visits in the training. We can't do site visits during this time. This is the only training we have had to put on hold. He is hoping they will be able to run this training at some point again or finding some way to hold it online with having to water down to the point where it is not the same. He then outlined the 40 hour CIT Training classes. He stated that Sergeant Dosal and the coordinators have done a phenomenal job with trainings. He then moved to the next slide concerning Enhanced Crisis Intervention Training and the Mobile Crisis Teams. So when the Settlement Agreement came up, APD had already committed to training 100% of its field officers in CIT. So we had to come up with a new level of training and that's the Enhanced Crisis Intervention Team Training. It's an 8 hour class and it's really based on what the officers need out there and what training that they feel that they need. There was a needs assessment completed; there's new training being developed every two years in response to what the trends are. He then discussed the mobile crisis teams. The mobile crisis teams are available from about 9ish in the morning until 11:00 at night. The next slide was eCIT response to behavioral health calls. It shows how often our eCIT officers are going to behavioral health calls. The goal is to always increase these numbers. We are pretty much 70% across the board. He then went over demographic data. Contact sheet by Age: the majority are between the ages of 20 and 40. He would be interested in seeing it that shifts as those individuals age. We do occasionally get calls regarding those experiencing dementia. And I don't necessarily think that we are the right response for those experiencing dementia.

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

- C: Danny Whatley: We are also seeing a lot more dementia cases in homelessness. We are seeing tons. It is one of those things that are out there. We actually have a nursing home,

rehab center in Albuquerque where that is their focus; is homelessness and those with very low income. So we are seeing it and it's real. There's no doubt about it.

- C: Lieutenant Dietzel: I do expect those numbers between 60 and 70 + to increase over time.

Lieutenant Dietzel went on to state that those present may notice that at the bottom of the slides mentions missing data. That does happen because of the contact sheets are filled with "ifs" and "then" so you can't do something like "I arrested the person for this but then I transported him UNMH for a mental health assessment." So as you make corrections to a form other fields open and other fields close. The slide on "Self-Disclosure of a Diagnosis during a CIT Encounter" is a very impactful on how our training is developed. As you can see, depression, schizophrenia (schizoaffective), bipolar and PTSD are the top four. When he did this slide, the coordinators were working on updating the CIT book. So he sent them the slide saying as you guys look at things to cover, these four diagnoses should be at the top of the hour. Cover these four first because the field is seeing more of them. CASA requires us to track veteran status. The vast majority of the time they state no. The next slide was about repeat encounters. CIU is not a part of this. The number has improved (40 down to 26). The number of contacts is going down. Another important slide is outcome data. No action taken on 3363 of the calls. So that goes back to what calls the third tier can take, probably those calls. But we will get back to that later. In regards to mental health transport destinations 2019 transports were outlined in the next slide. UNMH is always number one, Kaseman is creeping up there, and Presbyterian is on there and then it just drops off really fast. This is kind of a training issue. Do officers know that they can take individuals to smaller behavioral health hospitals (clinics)? The location on a certificate for evaluation will be Haven and he will get a call saying what is this place and can I transport them there. The answer is yes. Again it's the training.

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

- Q: Rick Miera: It does not have MDC there, why is that?
- A: Lieutenant Dietzel: That's because officers do not consider MDC a mental health transport. That is going to be an arrest. We have that data it's just not on this slide. Because for whatever reason, the charge was say a felony, or protect someone by making an arrest. Those are going to be tracked elsewhere. On the pre-booking sheet, if the individual does have behavioral health issues, there is a box on there that says Psychiatric Services and they will check that.
- Q: Danny Whatley: Would it be a good time to interject Sgt. Dosal's concerns and others' concerns about hospitals turning officers away as far as transports? I know we have talked about this in the past. And we have seen additional documents concerning that. Is that still an issue? Is that still a problem? We are seeing a lot of media attention around that and editorials; there have been several for being turned away. Just wondering if now would be a good time to talk about that.
- A: Sergeant Dosal: Well, I think it's just the same, yes that issue is still ongoing. I'm getting emails from officers in the field, often, at least a handful about being turned away from the hospitals. I think there is also a learning curve there, the officers need to understand that the hospitals are assessing, they are evaluating, and sometimes if the person is not going to be compliant and volunteer to do into the hospital and go into a program; they, the hospitals, can only do so much. So I think that, giving them that information about the process is helpful. I know it's hard for UNM having 6 beds, but they are working on that. They are definitely in a partnership. I can say that much now. We are talking weekly now. Especially with UNM and Kaseman. So it's been extremely helpful. And we have been great about showing Lea support

from Haven. Those are partnerships we have never had before. So I think the more that we educate officers about certificate for evaluations and hospital protocol that will be helpful. Nonetheless, even the MCTs are experiencing this as well. It's a hit or miss.

- C: Danny Whatley: I think Matt froze.
- Q: Danny Whatley: Is this a training piece where we could talk about the procedures and maybe, I know we have UNMH and the VA and Kaseman, involved in our training. Could we involve some of these other folks in the training piece just to talk about the process and the procedure for the intake of the transport situation?
- A: Sergeant Dosal: I think logistically that would be very hard to get a lot people to come on at a certain time when that class is happening. I think I just need to do a better job; just trying to make sure we are up to date with the protocols and any new policies and procedures. So one thing I have been trying to do with Kaseman and UNMH, is if there is some new policy or procedure, they let us know and we can then relay that to the field. But we can also start doing that in the classes as well. I just think logistically it would be hard for them to come and speak. But I'm confident we can that we can do that through our training and just constantly staying in contact with the hospitals. And it has been working really well with Kaseman, Lovelace and UNMH; better than it ever has. We are just still trying to figure out why our officers are being turned away; more so nights during our graveyard shifts. I'm just trying to figure out why that is happening. That's the current topic I'm trying to figure out.
- C: Lea Harrison: I have a presumption as to why that is ……. Computer froze. Unable to capture; got kicked out of Zoom meeting.
- C: MCT Officer Dorian Dixon: …… for identifying purposes, we had an issue where the patient before us, they brought someone in from their lobby, PES, that person who was a voluntary walk in became disruptive and they had to deal with that situation, and then they had a COVID issue where they had to do mass testing of everybody. So we sat there for 2 hours waiting for the intake. But stuff like that happens, you get those EDs where if something happens, they better focus on that before taking new patients. And so I think one of the things that is helpful is if the staff communicates with us, it helps the officers to know why we are waiting and do we need to divert to other hospitals but I don't know if there is a specific reason why the hospitals have these issues; I think a lot of it is just their volume; how busy they are, and then the communication between officers where they are not preceded as a flight ???? and there are things they should talk about.

There is a slide on how often are we enforcing things against homelessness people. 95% of the time there is zero enforcement action. When it is compared with the general population it is 94%. So 1% more of the time APD is warning, arresting, etc. a homeless individual. I looked at this and said it should be the same. But when I went back to my experience in the field; there were times somebody experiencing homelessness, in cold, wet, nasty weather; they didn't want to go to Joy Junction, they wanted to go to jail because they knew they could stay there awhile. That probably accounts for a lot of that. I don't know that; but based on my experience in the field that's what I think is happening.

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

- C: Danny Whatley: I would think that it's more related that 95% of my guys have warrants.
- C: Lieutenant Dietzel: And that's the other issue. In between warrants and I want to go somewhere warm and good food. I'm still not happy that it's the same as the general

population. We're getting there. The settlement agreement is a good thing. We probably never would have done this.

The question early was what calls the third option could take. This isn't everything and it shouldn't be all these calls but if only 8% of individuals were armed during these encounters it kind of gives you how big a scope of this third option really could be. The criteria are very important. The work sheet is very open; taken as a very broad base. This is interesting data. The next slide detailed what weapon the individuals were armed with.

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

- Q: Jim Ogle: Do you know how many of these were determined during the 911 call versus just when they showed up? Do you have any way of telling that?
- A: Lieutenant Dietzel: I do not. Remember that question is very broad in scope. It's basically was the individual armed. In looking back at some of the calls dispatch did make a reference

Finally, and this is the big one, one the big reasons the DOJ was investigating us. We were using too much force too often. This is 1% of the time which is consistent with other departments. This to me is destigmatizing for people experiencing mental illness. They are not more likely to be violent than anyone else. We are at 1% across the board. So we are where we should be. Force was used 42 times out of 5,779. This is important to me because I want eCIT on scene if possible if force has to be used. You want the highest trained level of response there to give the most room for de-escalation. There are times you get there and force has to be used and eCIT is not available. There are those instance decision making has to make on some of those calls and there is no time for APD to call someone else; you have to stop what is going on. He then went over the different types of force and the injuries as a result of force and 2019 CIU stats.

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

Lieutenant Dietzel: This probably Lori's last MHRAC meeting with us. Lori Cruz has been our admin for the last two years. He presented her a plaque. We can't keep Lori for the next 90 days as a result of city rules. I'm hoping she can come back at the end of 90 days; so that might not be goodbye. Just wanted to say thank you for everything you have done for APD, MHRAC and FIC. You have been there for us and you are amazing. She will be here for another week but this is the last for MHRAC.

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
  No update

Report and update from sub-committees:

Information Sharing/Resource Sub-Committee:

I had to cancel the Info Sharing/Resources Sub-Committee meeting with month because it was scheduled on the same day as the monitors visit. We will meet next month.

Training Sub-Committee:

Mental Health Response Advisory Committee (MHRAC)
Meeting Minutes
Tuesday, June 16, 2020

MHRAC Final Discussion:

Danny Whatley: Most of you that read the journal; I just wanted to let you know; when I was contacted last week about making some comments about the direction the city was going I made some comments as a representative of MHRAC and individually. If I ever say anything or any of us say that you disagree with as an MHRAC member don't hesitate to let us know. I tried to make comments that were appropriate and most of those we have discussed before. So again, what we are going to see is a lot more media folks contacting us. MHRAC is trying to stay secretive; non-media connected. That's probably not going to happen going forward. So we are going to see a lot more media attention. So again, we don't really have much in the by-laws about media. When you speak to the media or are asked for a comment if you will just couch it in your opinion you will be okay.

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

- C: Jeremy Lihte: I would like to be a part of this if that's ok with you Danny and the rest of the group. I never did introductions: I'm Jeremy Lihte; I'm the founder of New Mexico Leaders in Recovery which is great coalition of faith and health providers and other organizations. If you guys are open to welcoming me to this committee it would be an honor.
- C: Danny Whatley: Jeremy, of course the committee is open to the public and you are certainly welcome to attend but right now we do not have any slots available. By the bylaws we are at 19. The meetings are certainly open and we enjoy having meeting in person at the Rock at Noon Day. Jeremy's dad was the founding director at the old Noon Day ministry. So Jeremy certainly grew up around that. It's good to see you.
- C: Robert Salazar: If and when we do have an opening, Jeremy would be a great asset. I don't know him personally but I have heard of him. Part of the network he has where he reaches out to help link providers so that they can share not information but such as they have bed space or need a certain provider. Even during this period he has been a beacon of light on Facebook and other places; keeping people connected.
- C: Danny Whatley: Jeremy, you couldn't get a better recommendation that Robert Salazar. The next meeting is July 21st. I will be out of town and Rick is going to take care of that meeting and Matt is going to put it together. Hopefully in August we will be able to hold the meeting at the Rock. Rick I appreciate you doing this. I will be gone the entire month. I will be in God's country in Alabama. They have a little football team there I think Lea.
- C: Lea Harrison: It's a real small team; very little
- C: Sergeant Dosal: I have a comment; in this meeting we have over 70 people, it would be amazing if that number of people started showing up to MHRAC more often; we need that involvement and we need to get their ideas and their thoughts. I like the large attendance today and I would like for it to continue. This is the biggest showing we have had.
- C: Danny Whatley: Thank you Diane. And remember the monitor keeps referencing MHRAC as the shining star as far as the CASA. I appreciate those that have served in the past and those that are serving now.
- C: David Ley: Great meeting; thank you for the participation. I agree with Sergeant as to the level of community involvement and look forward to next month.

Adjourn

Meeting adjourned at 6:56 PM