ASSOCIATION OF OREGON COMMUNITY MENTAL HEALTH PROGRAMS

Addictions • Mental Health • Developmental Disabilities

Cherryl L. Ramirez, Executive Director, cramirez@aocweb.org
Diana L. Bronson, Executive Assistant, dbronson@aocweb.org
Andrew J. Smith, Legislative Liaison, asmith@aocweb.org
Sarah Jane Owens, Developmental Disabilities Spec., sjowens@aocweb.org

Informational Hearing on LEDS

House Human Services and Housing Committee

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Contact:
Cherryl Ramirez
Director, AOCMHP
(503) 399-7201
cramirez@aocweb.org

Dear Chair Tomei, Vice Chairs Gomberg and Olson, and Members of the House Human Services and Housing Committee,

This testimony is provided on behalf of Linn County Mental Health, Yamhill County Health and Human Services, and the Association of Oregon Community Mental Health Programs for informational purposes on the implementation of the Law Enforcement Database System (LEDS) for people with mental illness and other qualifying conditions.

Introduction – ***Frank Moore, Director, Linn County Mental Health***

Representatives of the Association of Oregon Community Mental Health Programs (AOCMHP) are testifying today on the implementation of the Law Enforcement Database System (LEDS) as passed in House Bill 3466 during the 2009 Legislative Session. As you are aware, the purpose of this bill was for the Department of State Police to create and maintain a medical health database within LEDS to provide law enforcement agencies with information to assist persons with qualifying illnesses or conditions in obtaining medical, mental health and social services.

In order to access accurate health information from an individual who comes into contact with law enforcement, the community mental health and developmental disabilities program (CMHP) director has

the permission to input and remove data from the health database with two prerequisites: 1) the individual has a qualifying illness or condition; and 2) the CMHP director has obtained the express written consent of the individual or a person authorized to make medical decisions for the individual, or a parent of an individual under 14 years of age.

So why hasn't broader acceptance and implementation of this Medical Database occurred?

Initially, I thought it was primarily due to passive resistance on the part of my peers to the intrusion of law enforcement into a therapeutic or clinical relationship and that they perceived it as rife with opportunity to be misused or, at its worst could be perceived as a coercive, unethical element to an otherwise trusting relationship. I was annoyed with my peer's lack of understanding of the potential good that could come from law enforcement's awareness of an individual's behavioral and/or physical disorder that could contribute to a safer interaction for the individual entered into the system, our law enforcement partners and obviously our communities. House Bill 3466 from the 2009 Legislative Session when implemented could truly save lives.

Why the medical database hasn't been further implemented could conceivably be about lack of funding, lack of trust of law enforcement or lack of understanding on the part of consumers of services or those of us who provide treatment services. As I self righteously reveled in my disappointment and annoyance with my peers, I suddenly realized that in Linn County, I've done a lousy job of implementing it, too. Why?

The Health Transformation, to be successful is not just about changing the culture of medical and behavioral health service provision and the way physicians, social workers, counselors, case managers and psychologists provide service to their customers, it's also about recognizing that those we provide services to have the right to choose how they receive services and their responsibility for their own health. To not make each potential enrollee in this system aware of their choices smacks of paternalistic discrimination or "We know what's best for you."

People with mental illness are not incompetent, nor are people with diabetes or developmental disabilities. We should fully inform them of their choices and let them decide.

I would suggest that these "barriers to implementation" are perceivably endemic to our healthcare system and to a behavioral healthcare system that has been grossly underfunded to the point that potential legal action through the US Department of Justice Settlement and/or the Olmstead decision has become a "driver" of system change.

All consumers of healthcare, whether for physical or behavioral disorders or both, must be fully informed, not only of their choices, but also of their responsibility for a change in how we define the relationship between the provider and the customer. For behavioral health, coupling the vision of Health Transformation with the transfer of much of the responsibility formerly held by community mental health programs to Coordinated Care Organizations creates an opportunity to further a concept and a resource that has the potential to truly save lives. It must be done however with a very different approach than many of us "experts" have used to this point.

Current Statewide Implementation of LEDS – ***Cherryl Ramirez, Director, AOCMHP***

In a recent poll of the Community Mental Health Program (CMHP) Directors, we learned that many counties are not implementing LEDS for people with a mental illness or other qualifying condition, usually because of the consent issues or because they are not aware of the program. Based on the feedback I have received, I believe the perception about the use of the information to punish, rather than assist, prevails among counties that do not use LEDS and the intent of the program is not viewed as a component in coordinating care and sharing health information. One respondent wrote that LEDS would be helpful for Abuse and Commitment investigations but staff are concerned about using the database for "security reasons". When probed further, it was not just the concern about sharing private information, but the perception that the process is cumbersome (e.g., checking office for security requirements, changing contact person). The most frequent response from those counties not implementing LEDS was that there is a basic distrust of law enforcement among individuals with mental illness and consent is difficult to obtain for this reason.

Those counties that are implementing LEDS also mentioned the difficulty of obtaining consent, both from staff/provider resistance and from individuals in contact with law enforcement or their families. The CMHP directors who responded reported a range of one to seventeen individuals with mental illness or another qualifying condition who are entered in LEDS. One respondent mentioned that initially the web form was not easy to use, but the county is now using an improved format.

Additionally, I asked how LEDS could be improved for the counties that are using the system. One county that reported no barriers suggested increased funding for the office that implements LEDS. Another county recommended additional training for the staff who use the system and to ensure that staff members know how information will be used and understand the purpose of the system. One limitation of LEDS mentioned is that it does not include crimes handled in Municipal Court.

For counties that use LEDS, the database is treated as a component of the system of care for individuals with mental illness and other disabilities. It serves as an instrument to divert people

from jail, reduce recidivism, and to improve health outcomes by helping individuals access appropriate health care more quickly. Assuming that Medicaid Expansion will be implemented in Oregon, an estimated 45% of the individuals involved in the criminal justice system will be newly eligible for Medicaid and have a behavioral health condition. I predict that Coordinated Care Organizations will be interested in effectively coordinating the care for this population and I anticipate that the health information of people who come into contact with Law Enforcement will be included in the exchange of health information among participating systems. Public Safety entities should become partners in sharing health information with CCOs, Counties, and behavioral health providers if we hope to make a positive impact on treating individuals with mental illness and substance use disorders in the community as directed by the USDOJ settlement agreement requirements.

County Implementation of LEDS - ***Silas Halloran-Steiner, Director, Yamhill County Health and Human Services***

Yamhill County Health and Human Services (HHS) developed a policy to comply with HB 3466. The goal is to allow greater choice for individuals living in our community who recognize the value of entering medical information into LEDS. The policy and lessons learned to date are available for any interested parties across the state.

Currently, we have 17 individuals entered through a voluntary process. It has been well received by local law enforcement partners and our Yamhill County chapter of the National Alliance on Mental Illness (NAMI), but only after discussions about how the information will be used and what constitutes consent.

The 17 individuals range in age from 7-56 and include:

- 6 self-enrolled individuals with serious mental illness, 5 of whom have some history of interface with the criminal justice system
- 11 individuals who were referred by a parent/guardian or caregiver and enrolled in our county's developmental disabilities program

It is important to note that under our policy individuals or their guardians can remove their information at any time with written notice.

Our Presiding Circuit Court Judge uses a phrase to describe our over-arching goals with the local criminal justice system that I want to borrow for today's testimony. He says we want: "better outcomes, sooner."

Having the LEDS medical database information available for law enforcement follows the spirit of "better outcomes, sooner," by allowing:

- Criminal justice system diversion for persons whose primary issues are mental health challenges or developmental disabilities, not criminal conduct
- Quicker engagement and possible entry into needed services if, and when, individuals are not taking medications, or are disorganized or symptomatic
- Improved safety for individuals and law enforcement personnel by preparing officers and deputies before entering a crisis situation
- Access to emergency contact information of family or caregivers for some of our most vulnerable populations

There are, however, some implementation challenges to identify at this time, such as:

- Easy entry of the data into LEDS
- Cultural barriers within the mental health workforce
- Interestingly, staff have been more resistant than parents and caregivers, citing ethical dilemmas, confidentiality laws and fear that the information could be misused

In order to overcome obstacles to implementation we have:

- Spent time identifying the value with staff, as well as with local NAMI chapter
- Worked with the director of LEDS to enter information until we had a Memorandum of Agreement in place with our local Sheriff's Office

The opportunities for increased health and safety are significant but it requires a comprehensive approach that includes:

- Crisis Intervention Training (CIT) for law enforcement – for example, our Sheriff Jack Crabtree has really invested in CIT and has sent 26 deputies and 7 sergeants for training – and it makes a difference in how we work together on a daily basis
- Increased outreach efforts by community mental health professionals who work in tandem with local law enforcement
- Immediate access to information and, again, trust, that it will be used solely for "better outcomes, sooner"

Although successes are anecdotal at this time, earlier this week I talked with the Patrol Captain from Newberg Police Department. He reported an officer used the database last week to resolve an issue without incarceration or hospitalization.

I believe we can significantly improve our response to persons with disabilities and mental health challenges with greater use of the LEDS medical database.

At the core of this system change is the needed investment by community leaders, policy makers, practitioners, advocacy groups and others. This is hard work that must be done over time and with community cohesion and partnership as guiding principles.

In summary, in order to achieve "better outcomes, sooner" I recommend the following four actions:

1. Fund crisis outreach specialists who are embedded with local law enforcement since current crisis funds are stretched thin with triage and assessment for acute care hospitalization, civil commitment and alternatives. to hospitalization like crisis respite and rapid psychiatric evaluation
2. Invest in CIT for law enforcement so that agencies do not have to choose between enforcement activities and mental health training for officers and deputies.
3. Continue voluntary consent for enrollment in LEDS, but make participation mandatory for Community Mental Health Programs if, *and only if*, funds are identified to support this activity since some communities cannot implement it without additional resources.
4. Require Community Mental Health Programs to partner with Sheriff's Offices or Oregon State Police to enter information into LEDS to avoid the administrative burden of full LEDS certification.

Thank you for your interest in this topic and please contact us if you would like more information.