COAB Meeting
Thursday, February 25, 2016
5:30-8:30pm
East West College of the Healing Arts
525 NE Oregon Street, Room 230
Portland, OR 97232

DRAFT MINUTES

Members present:
Se-ah-dom Edmo
Vince Elmore
Catherine Gardner
Avel Gordly
Tashia Hager
Jakhary Jackson
Jimi Johnson
Ime Kerlee
Sharon Meieran
Myrlaviani Rivier
Rochelle Silver
Tom Steenson
Philip Wolfe

Meeting commenced at 5:30 PM

1. **Welcome, housekeeping, updates**

2. **Presentation: Mental Health, Peers and Possibility**

Kathleen introduced Janie Marsh and Anne Casper. Janie has worked as peer support specialist, community support and integration teams coordinator for Yamhill County Behavioral Health. Anne has worked in teaching and refugee programs, as a peer support specialist, and has volunteered for years at several community mental health programs.

“Nothing about us without us.”

10 steps to recovery:

- Hope
- Respect
- Empowerment
- Self-direction
- Individualized and person centered
- Strengths-based
- Responsibility
- Peer Support
- Holistic
- Non-linear

Wellness:

- Professional care
- Education
- Spirituality
- Work
- Family
- Social network
- Relationships
- Community
- Mental “illness”

History of the Recovery Movement: Started in Portland in 1968 with the Insane Liberation Front and Tom Whittock. Anne said there have been three generations of peer leaders in Oregon. Her definition of “peer’ is someone who self-identifies with mental health issues and helps others in similar circumstances.

Janie discussed her background being dually diagnosed with both mental health and substance abuse disorders. She was in an out of the jail system. She discussed the cocktail of medications and their side effects, noting that no one warned her about them. It was hard to function and to feel because of the medications so sh went back to substances she knew in a 22-year cycle. Eventually she went to prison, where there were no drugs.

Ann said their depression started around 18. She slept 20 hours a day. In college, the opposite happened — she stopped sleeping and started to see things others didn’t see. She described her introduction to psychology as being forcibly hospitalized, and she didn’t know why she was there or drugged up. Things are more different now in hospitals. She has had years where she’s been fine and years when she’s not. She has been on 27 different medications. Ann talked about how her mania sometimes has been highly productive, not just “bad.” Her last seven hospitalizations have been related to coming off medications. She feels there isn’t good support

in jail systems for transitioning out of jail with or without medications, as well as making sure people can keep having access to those medications after they are released. She was committed two years ago and lost her civil rights. She later appealed and won, finding that she should have never been committed in the first place.

Philip was curious about Anne's interactions with the police — how has it been different for her in other countries?

Ann said that when she was in Italy she was connected with Italy Hearing Voices. Rome had only 150 psych beds, and yet it somehow worked, probably because they have good outpatient services. They had 35 psychiatrists. Instead of group homes, families housed people. She was in three different hospitals in Japan. Police were very gentle with her there. In a situation where she fire extinguished a hallway, she wasn't arrested, instead people worked to get her help.

Janie said recovery is not just possible, it's probable. Have hope for people when they don't have it. Our language (terminology) matters.

Myrlaviani asked about stigma, isolation and belonging.

Ann talked about her own isolation and the need to create community.

How do does Portland get the police to stop shooting people with mental health issues in Portland?

Janie said that process is getting started, especially with the Behavioral Health Unit (BHU). A place to start is get to know the police and be in situations where conversations are possible. Peer Apocalypse as a peer support conference that takes place in Astoria. Ann and COAB member Lt. Tashia Hager will give a presentation called "Peers, Police and Possibilities". (Not approved by the conference but organizers asked her to do an unofficial evening panel.) Peer Apocalypse is a part of Mental Health America (MHA) Oregon. People can learn more at **peerapocolypse.org**. Peer Apocalypse welcomes everyone, including clinicians, training on things like Emotional CPR. It will be at the Seaside Convention Center on 3/14-3/16.

Ann also feels like the police culture is changing; for example, the Hillsboro police teach mindfulness.

Ann said her experience at one of the first meetings of COAB didn't have a positive experience. COAB can change things by first building relationships with one another. Ann said to respect people where they're at.

Ann talked about the new Unity Center bringing peers to the table in the planning, and how welcoming that is. In one way, we are all peers.

Laquida and Catherine noted that at a COAB meeting there was an opportunity to identify as having lived experience by wearing blue construction hats. Nobody did. So the two of them decided to take this on. If people want to join, please do.

Kathleen read a message from Bud, Chair of the Executive Committee:

I'm sorry I can't make it tonight. You can put a hard hat out for me that says "gender dysphoria and clinical depression."

3. **Public Comment**

Brad Taylor read a note on behalf of Ann Brayfield. Ann asked that Keaton Otis and Michael Johnson be remembered because they, like Ann, had their civil rights violated. Although Ann survived, Keaton and Michael did not. Please find a way to look into these two cases before as you make decisions.

Laura talked about how important it is to have childcare at COAB meetings. She said people can't say quality childcare is only accessible ten days in advance. People in charge should be ashamed of themselves. Quality customer service because it goes hand in hand with quality childcare. She also said Police murder children, then read several names.

4. **Break**

5. **Presentation: Trauma-Informed Care**

The presenters:

- Josh Lathan, Qualified Mental Health Associate (QMHA), Community Mental Health worker.
- Dr. Sheryl Johnson, CADC III, LPC, Qualified Mental Health Professional (QMHP).
- Ms. Sin Kineye, MA in Education, QMHA becoming certified as a health worker.

Healing Hurt People Portland. Trauma and trauma-informed care: what is trauma, what does it mean to be trauma informed, and what is trauma informed care or treatment.

We need to expand our definition of what lived experience means. The presentation will focus on adverse childhood experiences (ACEs) for now.

For trauma and trauma-informed care there are two parts to keep in mind. Trauma can come from many places in childhood, including natural disasters, child neglect/abuse, school violence, traumatic loss and grief, and historical trauma that rarely gets dealt with, such as racism.

Definition of Trauma-informed care:

- Viewing trauma through an ecological and cultural lens.

- Recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether the trauma is acute or chronic.

People need to see others in the context of everything that has happened to them in their lives, not just how they present in the moment.

A lot of people who have experienced trauma are leery of authority figures, which is why it is so important to establish trust.

Trauma-informed principles:

- **Safety**: Ensuring the physical and emotional safety of consumers and staff.

- **Trustworthiness**: Making the tasks involved in service delivery clear. Ensuring consistency in practice. Maintaining boundaries, especially interpersonal boundaries, are appropriate for the program.

- **Peer Support**: Offering support by virtue of relevant experience: he or she has "been there, done that" and can relate to others who are now in a similar situation.

- **Choice**: Prioritizing consumer experiences of choice and control.

- **Collaboration**: Maximizing collaboration and the sharing of power with consumers.

- **Empowerment**: Prioritizing consumer empowerment. Recognizing consumer strengths. Building skills.

The Trauma-Informed Approach:

- Trauma Un-Informed:
    1. "What is wrong with you?"
    2. "What is your problem:"
- Trauma Informed:
    1. "What has happened to you?"
    2. "How have you tried to deal with it?"

3. "How can you and I work together to meet your goals for healing and recovery?"

Why is trauma informed care important?

- It causes a shift to happen in our perspectives/attitudes.
- The patients/clients has their strengths, and we value them.
- It teaches us to have helpful, trusting relationships.

Studies also show that 77% of patients who suffer physical injuries resulting from interpersonal violence have PTSD and 50% of that same population has had Adverse Childhood Experiences (ACEs).

ACEs and Trauma-Informed Care:

Objectives:

- Understand the Adverse Childhood Experiences Study.
- Understand what ACEs are.
- Understand the biological, emotional and social effects of ACEs.
- Understand the impact of race and ACEs.
- Understand resiliency.

ACEs was created by Dr. Felitti at Kaiser and Dr. Anda at the Center for Disease Control (CDC). This started after weight loss research. A number of people didn't come back after losing over 100 lbs. They wanted to know why people stopped, and found that it was usually related to past trauma in their lives. For example, many women felt that they would be powerless if they lost more weight, because of past sexual assault.

The purpose of ACE:

- Assess childhood exposure to multiple types of abuse.
- Assess an array of high priority health and social problems from adolescence to adulthood.

What has happened to these people that they are so emotionally attached to their habits? The ACEs is only ten questions long, and you rate your answers from one to ten.

The ACE study- Definitions:

- Emotional
    - Parent or other adult swearing at child
    - Being insulted/put down by an adult
- Physical
    - Being pushed, grabbed or slapped
    - Throwing something at a child
    - Hitting a child hard enough to leave marks or injury
- Sexual
    - Adult or person at least 5 years older
    - Touching or fondling in sexual way
    - Having a child touch them in sexual way
    - Attempting oral, anal or vaginal intercourse
- Neglect (emotional)
    - Not feeling loved, special, protected, supported or having a sense of strength
- Neglect (physical)
    - Not having enough to eat
    - Having to wear dirty clothes
    - Not having someone to take child to doctor
- Household Dysfunction (mother/stepmother/female caregiver)
    - Slapped, pushed or grabbed
    - Had something thrown at her
    - Ever kicked, bitten, hit with fist or hard object
    - Ever repeatedly hot over a few minutes
    - Threatened with a knife or gun
- Household Substance Abuse
    - Lived with anyone with a drinking problem
    - Lived with anyone who used street drugs
- Household Mental Illness
    - Depression, mentally ill household members
    - Attempted/completed suicide

The study was done in San Diego — look at the population of that place and it is pretty representative of the country.

San Diego results:

- 17,000 people from San Diego were surveyed.
- Men were less likely to self-report emotional neglect.
- Women reported four or more on their ACEs more than men.
- There were several factors not taken into consideration.

After the ACEs study was done, a new study called the Philadelphia Urban ACEs study was created, factoring in several considerations not in the original. It is a bit longer than the original. It gives credit to the original study, but added experiences that kids have in an urban setting.

Philadelphia ACE Survey:

- Used telephones to contact and survey people.
- Contacted people over the age of 18.
- Added several questions including: witnessing violence, living in an unsafe neighborhood, experiencing racism, bullying, etc.

Effects of ACEs:

People who have experienced multiple ACEs are less likely to go from fight or flight mode to calm after a stressful experience, something people should be able to do.

Three types of stress:

- **Positive stress**: moderate, short-lived stress responses.
- **Tolerable stress**: more intense stress responses that allow enough time to recover, or occur in a relatively safe environment with the presence of supportive adults.
- **Toxic stress:** strong, frequent or prolonged activation of the body's stress management system, without access to supportive adults in a safe environment.

Implications of toxic stress:

- Interferes with neurobiological development.
- The capacity to integrate sensory, emotional and cognitive information into a cohesive whole.

Long-Term effects of traumatic stress:

- Automatic response:
    - Brain function
    - All major body systems
    - Social functioning
    - Risk of re-victimization
    - Stability of relationships, homelessness
    - Performance in the work force
    - Mental health

- Emotional effects:
    - Inability to process emotions through language
    - Diminished capacity for empathy

- Hypersensitivity to the trauma of others
- Diminished range of emotions: terror or rage
- Diminished aesthetic and spiritual experiences
- Feelings of worthlessness and shame

Epigenetics

Definition:

- Changing our genes without changing our DNA
- Altering our body's response to toxins
- Delaying our brain's natural development process
- Diminishing our brain's capacity for plasticity

Implications:

- Potential for in-utero developmental change
- Determinants of predisposition to resiliency
- Determinants of predisposition to PTSD
- Responsible for body's inability to heal (cell destruction or overproduction)

Philip asked about people who have PTSD and are hardwired to that fight or flight behavior all of the time; how bad is that for their bodies?

Sin said it was a case by case basis. Some people may have five cups of resiliency, while others may only have three. When you arrive at a stressor, some would use less of their reservoir than others.

Myrlaviani brought up the concept of "nature versus nurture" with fight or flight.

Avel noticed spiritual life is not on the list of resiliency, and asked why that was.

The presenters encouraged the audience to take the Aces and resiliency questionnaires and share them with people. Start to have conversations about trauma and healing.

Alisha said trauma impacts every person; it doesn't happen in a vacuum. It manifests in different ways and we need to understand the impact it has on systems and on organizations.

Meeting adjourned at 8:30 PM.