A Study of People with Mental Illness in the Criminal Justice System
March 2005 – Final Draft

PUBLIC SAFETY COORDINATING COUNCIL OF MULTNOMAH COUNTY

Executive Summary

The Public Safety Coordinating Council of Multnomah County has a history of leadership and partnership in its work to improve outcomes for people with mental illness in the criminal justice system. The Council has consistently promoted the position that treatment is both less costly and more effective in achieving positive outcomes both for public safety and for the mentally ill person. New connections between public safety and social service systems have been developed and strengthened through this work.

Multnomah County's many public safety and human services agencies, together with inter-jurisdictional partners and private providers, have cooperated to implement recommendations from past reports. The results are impressive:

- Services for offenders with a mental illness have been developed and coordination improved.

- The proportion of inmates in Multnomah County jails with a mental illness is below the national average, although this number remains higher than the 5% of the general population which has a mental illness.

In spite of this, the number of people with mental illness booked into the Multnomah County Jail has decreased only modestly from recent years.

This study examines a group of 469 people placed on a psychiatric alert at jail, who together have accumulated 18,000 bookings over the past 19 years. The reasons they continue to cycle through the criminal justice system and strategies to improve outcomes are explored.

A separate section looks at youth with mental disorders who enter the juvenile justice system, an issue which the Public Safety Council has not previously examined. This section offers strategies to reduce recidivism and improve outcomes for these youth.

An appendix lists the services targeted to or heavily used by people with mental illness involved with the justice system. This will help establish the connection between the Public Safety System and the Social Services System which needs to be strengthened if we are to succeed with the recommendations of this report.

Workgroups for adults and for youth met from November 2004 through January 2005 to examine data, identify accomplishments and make key recommendations, summarized as follows:

Conclusions and Recommendations from the High Booking Study:

1. **Mental illnesses should be managed like other chronic diseases.** Most people with a mental illness are able to adapt to their disability and lead healthy and fulfilling lives. Yet a group of 469 people with a mental illness have shown a pattern of repeated involvement with

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the criminal justice system. A workable strategy is needed to better support such individuals, including developing treatment readiness and adoption of a recovery approach.

2. **Co-occurring disorders form a persistent barrier to recovery.** When mental illness, alcohol or drug abuse, and chronic homelessness are all present, the likelihood of community complaints about a person's behavior increases, as does the chance for negative interaction with police and the criminal justice system. Treatment is difficult to initiate and hard to maintain.

3. **Housing is the key to successful treatment.** Supportive housing is often the first level of treatment that chronically homeless people with mental illness need to stabilize their living situation and medical condition, and to begin to develop the motivation to get well.

4. **Intervene before booking.** Alternate intervention at the earliest stage of contact needs to be strengthened, and critical community resources need to be readily available to provide police an alternative to taking mentally ill persons to jail.

5. **Reduce ethnic-over-representation in the high-bookings group.** African American males are greatly over-represented in the high-bookings group of people with a mental illness. More information is needed to understand why, and to develop interventions to change this pattern.

6. **Develop a shared information system.** First responders (police, crisis response teams, hospitals, jail and corrections health) need to know whether a person is receiving treatment (or has in the past), so they can make immediate contact with the appropriate provider.

7. **Measure outcomes.** Shared indicators of success are needed to determine what works to improve outcomes for the 469 people in the high-bookings group. Systems should collaborate on measurement criteria and protocols so progress can be monitored across the board in a consistent and useful way.

Recommendations for Youth:

1. **Move toward a family and home-based services model for treatment.** Because family involvement is critical for success, evidence-based family and home-based treatment models should be used for high risk youth and their families.

2. **Integrate and coordinate treatment in a "system of care."** Systems of care achieve better outcomes for high risk youth. Services for youth offenders should blend a corrections approach with mental health and alcohol and drug treatment.

3. **Engage high risk youth and families through outreach case management.** Reach out to identify and stabilize youth before they reach a crisis point. Make treatment more present and persistent for high risk, non-compliant youth and their families.

4. **Target services to higher risk youth.** Targeting criteria should be adopted for a portion of Mental Health funds to increase services to medium and high-risk youth and families through outreach case management, and family and home-based service models.

Process Recommendations:

The Persons with Mental Illness in the Criminal Justice System committee of the Public Safety Council should be expanded, and should conduct further analysis, guide development of these recommendations, and monitor progress toward implementation.

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The Study Report

The Issue: Over-representation of people with a mental illness in jail

Although approximately 5% of the national population is estimated to have a serious mental illness, a figure which holds across economical and racial groups, the prevalence of mental illness among the population in jail or prison is estimated at 16% nationwide.[1]

Multnomah County is ahead of the national average, with about 13.8 % of people booked into jail having a mental illness. In 2004:

- 24,759 people (unduplicated) were booked into the Multnomah County jail during the year, some more than once, for a total of 41,139 bookings.

- 3,413 of these people were placed on a medical psychiatric alert by Corrections Health at some time during the year. A psychiatric alert is placed when an initial health assessment reveals a history of mental illness, suicidal thought, or disruptive or bizarre behaviors.[2]

- These 3,413 people represented 13.8% of the total booked population.

- These 3,413 people were booked 5,009 times, representing 12.7% of all bookings.

Such over-representation of people with mental illness in jail illustrates the unfortunate fact that jails have become de facto treatment facilities. For most people with a mental illness, treatment is more effectively provided in community settings, ranging from secure facilities, to residential services, to supported or independent living.

Co-occurring substance abuse disorders are also a major concern, affecting an estimated three-quarters of people booked into jail nationwide who have a serious mental illness.[3]

In Multnomah County, the County Jail's drug-use forecasting data show that over half (54 to 76% of men and 51 to 88% of women) test positive for at least one illegal drug when booked, and that inmates with addiction issues are most likely to have frequent incarcerations.[4]

Federal Arrestee Drug Abuse Monitoring (ADAM) data gave similar numbers; 60% of arrestees from 1994 to 2002 tested positive for at least one illegal substance (heroine, cocaine, marijuana, methamphetamine or PCP), and since 1999, 25% tested positive for more than one substance.[5]

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[1] Criminal Justice/Mental Health Consensus Project, Council of State Governments, 2002, p. 4.

[2] Medical reviews of over 1,000 random cases conducted in both 1999 and 2001 found an 85 to 90% correlation between psychiatric alert designation and existence of a mental illness.

[3] Criminal Justice/Mental Health Consensus Project, Council of State Governments, 2002, p. 4.

[4] Department of Community Justice, Transitional Services Unit website.

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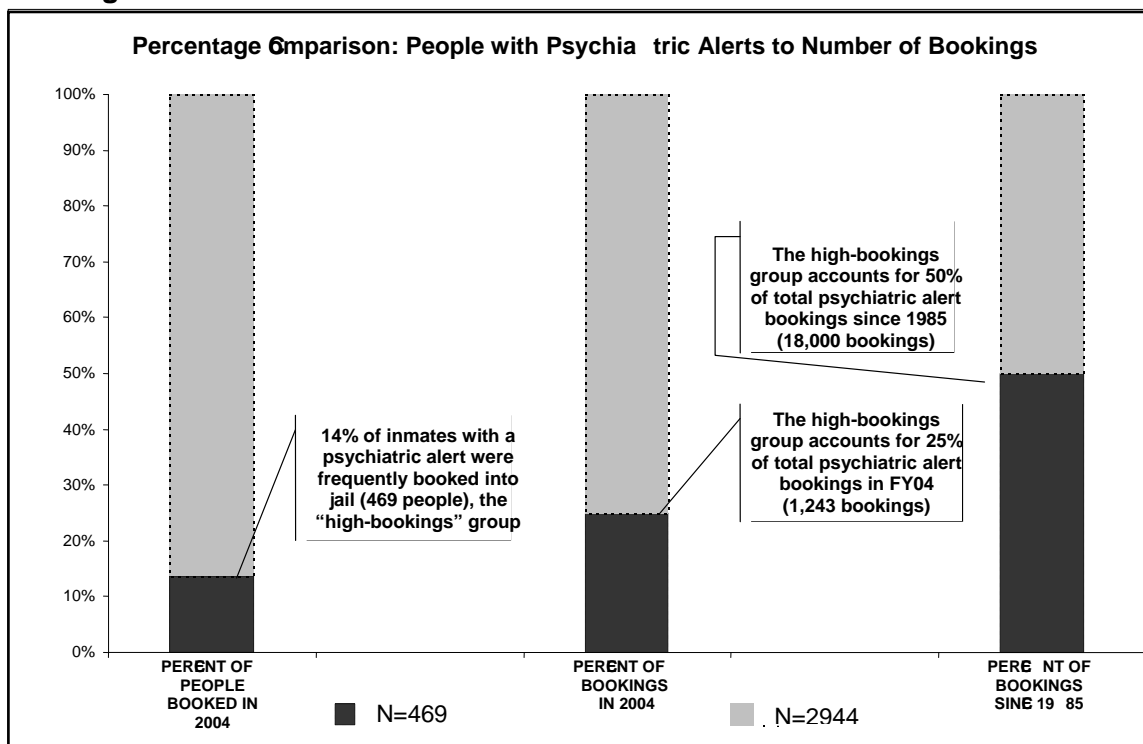*Public Safety Coordinating Council of Multnomah County, March 2005*

The Target Population: Who is frequently booked into jail?

Central "booking" is the front door into the Multnomah County Jail system. During the booking process, Corrections Health staff complete an assessment of immediate needs, and people who have a history of mental illness, suicidal thought, or disruptive or bizarre behavior are placed on a "psychiatric medical alert" to initiate further monitoring, assessment or treatment.

For this report, Corrections Health staff looked more closely at the 3,413 people placed on a psychiatric medical alert in 2004. They determined that these 3,413 people had been booked into the Multnomah County Jail close to 36,000 times over the past 19 years. A small "high-bookings" group of 469 people was found to have accounted for half of these bookings:

- The high-bookings group of 469 people represents only 14% of those placed on a psychiatric alert in 2004, but accounted for 25% of those bookings.

- The high-bookings group has accumulated 18,000 bookings over the past 19 years, or 50% of all bookings for people with psychiatric alerts since 1985.

- At least 88% of this high-bookings group had concurrent substance abuse issues, related to use of or addiction to alcohol or drugs, or both.

- This high-bookings group was slightly older, somewhat more likely to be male, and much more likely to be African American.

Figure 1: Percent Comparison, People with Psychiatric Alerts to Number of Bookings

Percentage Comparison: People with Psychiatric Alerts to Number of Bookings

14% of inmates with a psychiatric alert were frequently booked into jail (469 people), the "high-bookings" group

The high-bookings group accounts for 25% of total psychiatric alert bookings in FY04 (1,243 bookings)

The high-bookings group accounts for 50% of total psychiatric alert bookings since 1985 (18,000 bookings)

PERCENT OF PEOPLE BOOKED IN 2004

PERCENT OF BOOKINGS IN 2004

PERCENT OF BOOKINGS SINCE 1985

N=469   N=2944

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[5] "Local Trends in Illicit Substance Use," based on the National Institute for Justice's *Arrestee Drug Abuse Monitoring (*ADAM) research program, Multnomah County Budget Office, 2004.

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The most frequent charges for this high-bookings group were drug charges, holds from other counties, supervision violations and lower level property crimes. Very few charges were for person-to-person crimes.

People with psychiatric alerts are for the most part people with a mental illness, which can include a wide range of disorders. Case reviews found a very high correlation (85 to 90%) between psychiatric alerts and existence of a mental illness. Although diagnosis is difficult to complete in an often short stay in a jail setting, 43% were given a diagnosis in jail of a severe and persistent mental illness, and 2% a diagnosis of a personality disorder.[6]

A data-match research project was conducted in December 2004 to link the names of these **469 high-bookings group members** with the DCHS Mental Health client list. Matches were found in the Mental Health Raintree system[7] for:

- 385 people (82%) who are, or once were, eligible for the Oregon Health Plan, and thus eligible for Mental Health Organization (MHO) coverage to pay for treatment;

- 211 people (45%) who have contacted the Call Center at least once; and

- **178 people** (38%) who have, or once had, a primary authorization to a **mental health provider**.

Thus, fewer than half of the high-bookings group contacted any County-funded mental health service, and just over a third were assigned to a primary mental health provider, even though a large majority had OHP coverage that would pay for treatment.

A match of the high-bookings list with the County Addictions program's **Community Based Services** case management team found **101 names** (22%) of current or former clients.

The Department of Community Justice also matched the high-bookings list to their records, and found that **233** (49.7%) **are on parole and/or probation**.[8] Of these:

- 215 (93% of these) are supervised by the Multnomah County Department of Community Justice, including 33 (14.2%) in DCJ's Mentally Ill Offender Unit; and

- 12 people (5.1%) are supervised by a county other than Multnomah.

Cross-matching between the County agencies, or with community providers, was not completed in time to be included in this report, but would be useful.

Roadmap to Treatment: Accessing the direct route

For people with a mental illness, involvement with the criminal justice system begins with unacceptable behavior, often committed in a public setting, which leads to a complaint or notice by the police. Arrest more often than not initiates a lengthy and costly criminal justice process, with the resulting link to community treatment a possible – but by no means guaranteed – result.

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6 See Appendix C. Medical reviews of over 1,000 random cases conducted in both 1999 and 2001 found an 85 to 90% correlation between psychiatric alert designation and existence of a mental illness.
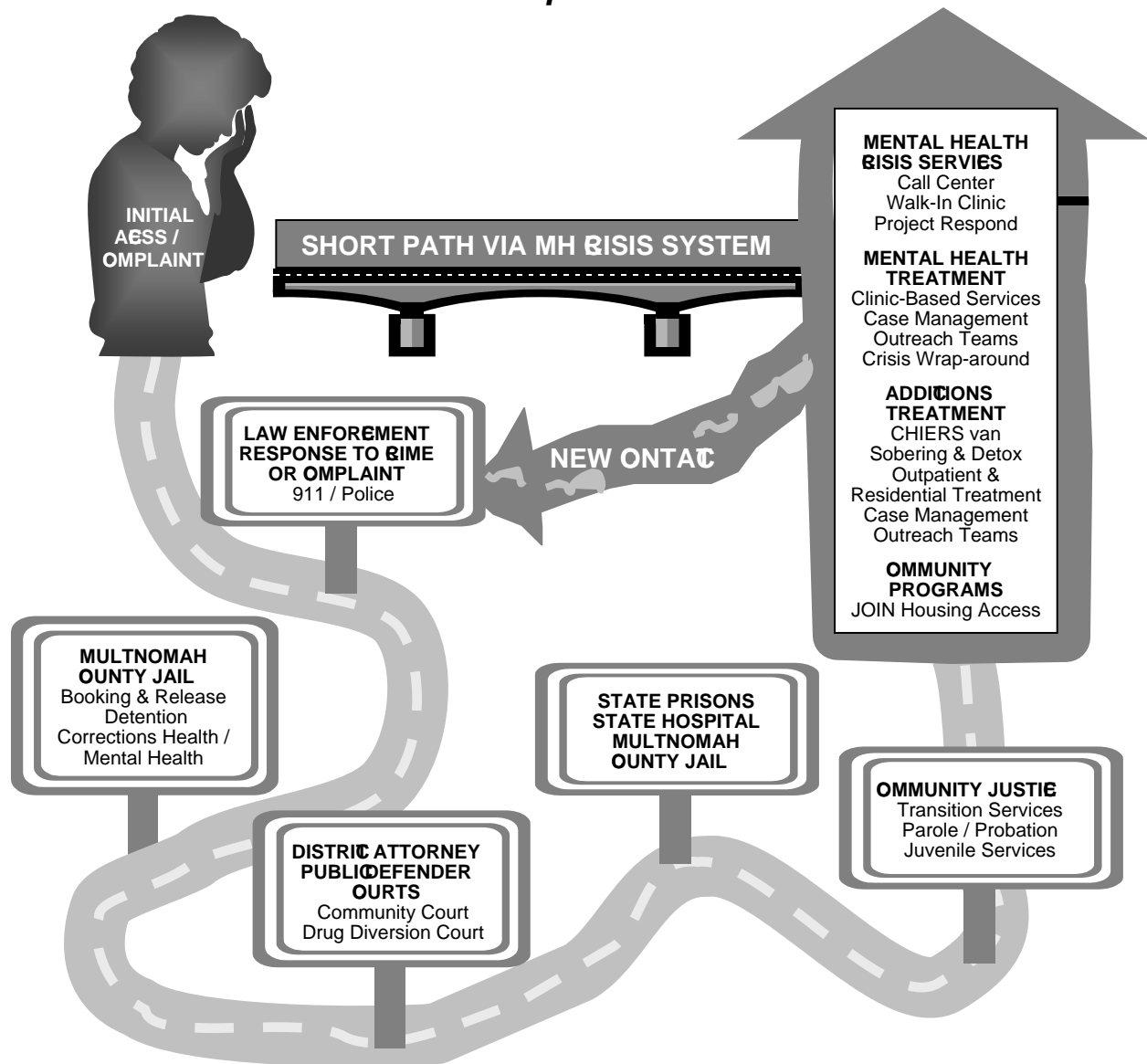
7 The Raintree data system has been in place three years; it does not contain earlier data, or data about private or non-profit services which are not funded by OHP and/or County Mental Health.

8 Data provided by the Department of Corrections, Mentally Ill Offender Unit, Jan. 2005

The criminal justice system route to treatment is complex, fragmented and expensive. As an individual is passed from one department or agency to another, the person can easily "fall off" and not stay with treatment. When a person leaves treatment, they may not meet the criteria to start again and may need to reach a crisis stage before they can re-qualify. Meanwhile, public safety agencies have provided costly services, but with only a limited ability to assist the person to manage their illness long-term and live successfully in the community.

The "direct route" which links the individual immediately to mental health crisis services, and from there into treatment, is more effective and less costly. This direct route is preferred for most people with mental illness, unless incarceration is required to assure community safety.

A Roadmap to Treatment

INITIAL ACCESS / COMPLAINT

SHORT PATH VIA MH CRISIS SYSTEM

MENTAL HEALTH CRISIS SERVICES
Call Center
Walk-In Clinic
Project Respond

MENTAL HEALTH TREATMENT
Clinic-Based Services
Case Management
Outreach Teams
Crisis Wrap-around

ADDICTIONS TREATMENT
CHIERS van
Sobering & Detox
Outpatient & Residential Treatment
Case Management
Outreach Teams

COMMUNITY PROGRAMS
JOIN Housing Access

LAW ENFORCEMENT RESPONSE TO CRIME OR COMPLAINT
911 / Police

NEW CONTACT

MULTNOMAH COUNTY JAIL
Booking & Release
Detention
Corrections Health / Mental Health

STATE PRISONS STATE HOSPITAL MULTNOMAH COUNTY JAIL

COMMUNITY JUSTICE
Transition Services
Parole / Probation
Juvenile Services

DISTRICT ATTORNEY PUBLIC DEFENDER COURTS
Community Court
Drug Diversion Court

Initiating treatment provides no guarantee against additional contact with the criminal justice system. New complaints about behaviors, parole or probation violations, or additional incidences

of crime can result in a new contact with law enforcement. Even here, though, intervention before booking by providing treatment alternatives remains an option.

Conclusions and Recommendations

1. Mental illnesses should be managed like other chronic diseases.

Most people with a mental illness are able to adapt to their disability and lead healthy and productive lives. With proper treatment, coping with mental illness is similar to dealing with a chronic heart disease or diabetes.

Yet as this study found, 469 people with a mental illness have shown repeated involvement with the criminal justice system. A workable strategy is needed to divert these people from the criminal justice system over the long-term, including fostering their treatment readiness and promoting a recovery approach for treatment providers.

Treatment Readiness: When an individual makes a personal choice to access the treatment, the intervention is more likely to be effective.

Strategies to assist a person to become treatment ready include: outreach to develop safe, frequent and positive contact with the individual; achieving a stable living situation (which may require accessing SSI, health benefits, employment, or housing); reducing barriers (e.g., allowing low-barrier or "wet" housing); developing motivation for recovery; and providing a high level of staff presence and persistence to stay with their clients and keep them in treatment.

Innovative models are being developed in our community to reach difficult-to-serve people, who do not access or stay with other types of treatment, including some in the high-bookings group.[9]

- Teams based on the Assertive Community Treatment (ACT) model[10] deliver comprehensive services to people where they live, including medical, psychiatric and addictions services, case management, housing, benefits and employment. These are:
  - Community Outreach and Engagement (CORE) in the Mental Health system; and
  - Community Engagement Project (CEP) teams, focused on people with addictions.

- The Community Based Services team (County Addictions) coordinates services and works toward treatment readiness for those not yet assigned to an outreach team or provider, including collaboration with jail and corrections health staff for those in jail who need services.

- The Neighborhood Livability Crime Enforcement program targets people who are frequently involved with criminal justice for livability crimes, and uses a model of repeated incarceration as an immediate consequence to motivate treatment.

All these treatment readiness programs are relatively new, and several have a built-in evaluation component to assess effectiveness.

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[9] Community Based Services has served 101 high-bookings group members, but the number served by other teams is not known.

[10] "Criminal Justice/Mental Health Consensus Project" report, p. 251, cites a 25 year history of research demonstrating effectiveness of ACT for clients who do not respond to less comprehensive approaches.

Only a third of the high-bookings group have (or have had) a relationship with a contracted mental health treatment provider. A fifth have been on the Community Based Services caseload, although the total number of the high-bookings group served by these teams is not yet known. A method is needed to be sure a connection with a case management team or a treatment provider is made before the individual leaves the booking center or jail.

A Recovery Approach: Increasingly, a recovery approach is being adopted for mental illnesses – even for chronic disorders such as schizophrenia and bi-polar disease – moving away from the acute care model that prioritizes crisis treatment, toward an emphasis on long-term management of the individual's conditions.

Adopting a recovery model for treatment is gaining momentum nationwide. In Illinois, the Behavioral Recovery Management Project found that: "Conditions of mental illnesses, alcoholism and drug addiction often resemble the course and pattern of chronic physical disorders, such as diabetes, coronary heart disease or arthritis. Such disorders are often characterized by alternating episodes of stabilization and symptom activation that require long-term strategies of disease management.[11]"

Oregon Partners in Crisis defines recovery as "having control over one's life and the ability to live, work, learn and participate fully in one's community."[12] For this goal to succeed, society will need to reject old stigmas. From a public health perspective, successful disease management requires public education about symptoms, behaviors and management strategies, so that people know what is normal for these diseases, and can correctly assess behaviors.

Parity of mental health with physical health in both private and public insurance coverage is critical to the success of the recovery approach, both to de-stigmatize mental illness, and to increase the availability of treatment.

Other critical components of this approach include involvement of family in providing a system of support for the individual's recovery, and finding other avenues for pro-social support – such as places to socialize that enhance recovery.

Recommendations:

a. Continue outreach case management team services to facilitate steps toward stabilization and treatment readiness for this hard-to-serve population.

b. Create a new mental health outreach team to actively connect with each individual booked into jail who is placed on a psychiatric alert but does not have a treatment relationship. Make this connection while the person is still at the booking center or jail, to immediately start to address the person's complex psychosocial needs, develop treatment readiness, and connect the person to a community provider.

c. Share evaluations of the different innovative treatment readiness models (as these are completed) among system partners to improve use of best practices.

d. Create options for pro-social interaction that promote recovery. This can be as simple as a place to play pool which is tolerant of a range of interpersonal skills and behaviors.

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[11] The Behavioral Health Recovery Management Project, 2000; Fayette Company & Chestnut Health Systems; sponsored by Illinois Department of Human Services, Office of Alcoholism & Substance Abuse

[12] "Priority Recommendations for Criminal Justice/Mental Health Collaboration," Oregon Partners in Crisis, 2004.

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e. Work toward developing a recovery approach to mental illness in treatment models and public attitude; educate the public about the range of mental illnesses.

f. Develop approaches to give neighbors and family members the support they need to help the person with a mental illness in their lives.

2. Co-occurring disorders form a persistent barrier to recovery.

When mental illness, alcohol or drug abuse, and chronic homelessness are all present, the likelihood of community complaints about a person's behavior increases, as does the chance for negative interaction with the police and the criminal justice system. Treatment is difficult to initiate, hard to maintain; long-term success of treatment in these circumstances is unlikely

No Way Out
Co-occurring disorders form a persistent barrier to recovery
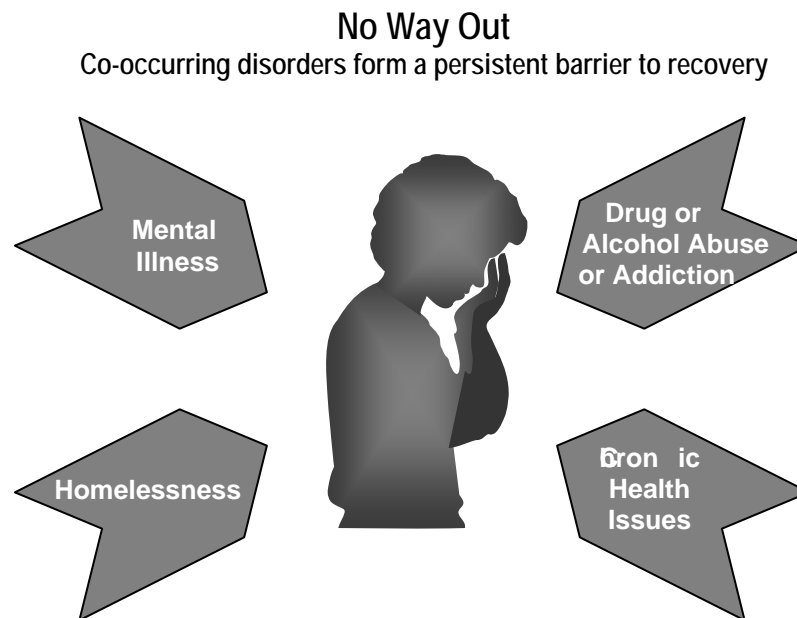
- **A mental illness** which is not being managed by treatment and/or medications can initiate or reinforce this cycle, leading to unaccepted behaviors, and possibly to negative outcomes such as the loss of work, housing or benefits. Lapses in health coverage can make it hard to access or continue treatment, and a person may instead self-medicate with alcohol or drugs.

- **Substance abuse or addiction** involves frequent periods of intoxication, reducing control of behavior, and increasing the likelihood of criminal activity to finance the addiction. Disturbing or criminal behaviors often lead to arrest, propelling the individual on the "long route" through the justice system. Addiction makes it difficult for a person to have an interest in long term goals, such as recovery, even when required by a court to receive treatment.

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The national GAINS Center estimates that 72% of people with serious mental illness admitted to US jails have a co-occurring substance abuse disorder.[13] In Multnomah County, an estimated 88% of the high-bookings group had substance abuse issues.

Substance abuse is cyclical based on the type of drugs available and their cost. When drugs are expensive, alcohol may be used more often. Of special concern to providers is methamphetamine, a difficult to treat component of drug addiction, which frequently involves users in criminal activity. Meth addiction can look like mental illness, compounding the difficulty of diagnosis. Providers say they are only beginning to learn how to deal with meth addiction, and that prevention of distribution and use of meth is especially critical.

Addictions treatment works to reduce repeat offenses. The Department of Community Justice studied a study of a sample of offenders who completed residential alcohol and drug treatment in 2001, and subsequent arrest patterns. They found a 51.2% reduction in felony arrests one year after residential treatment.[14]

- When **homelessness** results, living successfully in the community becomes more difficult. There is nowhere to receive messages or mail, it is hard to make and keep appointments, and termination of benefits can occur. It is difficult to seek or show up for work. Shelters can be full, or perceived as over-crowded or dangerous. Sometimes a person living on the streets is simply cold and tired, and will do anything to be taken care of for a few days, even in jail. Homelessness puts an individual into the public arena where behaviors are more likely to be noticed or offend, initiating calls to crisis services or law enforcement, and increasing the incidence of arrest.

- **Chronic health issues** often result from substance abuse and outdoor living. Many who are homeless do not have consistent health coverage, and may access County Health clinics or hospital emergency rooms only when there is a need for crisis medical care.

Most people with a mental illness who have an interaction with the criminal justice learn to modify their behavior to avoid arrest. But the barriers of unmanaged mental illness, substance abuse, health issues and homelessness interfere with this normal cycle of aversion and adaptation, interacting to reinforce each other, and increasing the likelihood of repeat interaction with the justice system.

Of the four barriers to recovery, county agencies and providers agree that homelessness is the most straightforward to address. Once a stable living situation is achieved, benefits can be restored, motivation to get well gradually strengthened, and treatment readiness developed.

County agencies and providers also agree that mental illness and addictions are often components of the same set of issues for an individual, and that to treat each separately is a fragmentation that does not benefit the client or further recovery. In recognition of this, the Departments of County Human Services and Community Justice now require providers to be

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[13] The National GAINS Center for People with Co-Occurring Disorders in the Criminal Justice System, TAPA Center for Jail Diversion website, Policy Research Associates, funded by the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration..

[14] Performance of the DCJ funded Residential Treatment System of Care, Department of Community Justice, 2004, based on 2001 data.

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certified in both mental health and addictions treatment, and are developing new models for integrated treatment.

Recommendations:

a. Further integrate DCHS Mental Health and Addictions Services divisions to provide leadership for integrated treatment. Strengthen links to public and private physical health to improve comprehensive services for shared clients.

b. Continue to work on integrating Mental Health and Addictions treatment services at the provider level, reducing the distinction based on the presenting issue, and addressing the person's entire set of needs. Assure that a range of services are available to meet different individuals' needs.

c. Maintain and expand team intervention services that address co-occurring disorders (ACT teams, like CORE and CEP) for this hard-to-serve population.

d. Provide residential treatment options (similar to RITS) for people with co-occurring severe mental illness and addiction disorders, who have not been successful in traditional treatment programs.

3. Housing is the key to successful treatment.

Supportive housing is often the first level of treatment that chronically homeless people with mental illness need to stabilize their living situation and medical condition, and begin to develop the motivation to get well

The 2003 *Special Needs Housing Committee* report[15] identified specific housing issues related people with mental illness involved with the criminal justice system:

- There is a "hard to house" group of people with problematic behaviors, poor rental histories, multiple evictions, or criminal records; these are often people with psychiatric disabilities, frequently with co-occurring addiction disorders.

- A 2002 study of people frequently booked into the Multnomah County Jail found that 20% were homeless, and repeatedly cycled through jails, hospitals and shelters.[16]

- Of 1,010 offenders served by the DCJ Transitional Services Unit, 79% had a special need, which could be a mental health issue; 80% of these had alcohol or drug abuse disorders.[17]

- People with special needs, including mental illness, often require supportive services to succeed in housing. The Committee coined the term 'Housing + Services' to describe a range of permanent housing that incorporates supportive services provided by the housing provider or by others to meet residents' needs.

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[15] City of Portland Housing and Community Development Commission, Special Needs Housing Committee, June 2003, p. 10.

[16] Ibid, p. 12; Booking Frequency Pilot Project Report, Multnomah County's Sheriff's Office, Jan. 2002

[17] Ibid, p. 12; Multnomah County Community Justice Department's Transitional Services Unit (TSU) enrollment records.

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In the federal Arrestee Drug Abuse Monitoring (ADAM) research program, Multnomah County was found to have the lowest levels of stable housing among people arrested of any ADAM site in the nation.[18]

A 2004 survey of Multnomah County mental health, community services and justice providers found that lack of housing was the most frequently cited barrier to successful treatment. Major needs identified were for transitional as well as permanent housing, low barrier or "wet" housing, secure housing, and housing with support services.[19]

The Citizen's Commission on Homelessness has just released *Home Again, A 10-year plan to end homelessness in Portland and Multnomah County*. The plan directs a focus on the chronically homeless, recommends increasing the supply of permanent supportive housing, and adopts a goal that "175 chronically homeless people will move directly from the streets and institutions to permanent housing" within one year.[20]

Recommendations:

   a. Advocate for a portion of the high-bookings group to be among the first 175 chronically homeless people moved into permanent housing. Work closely with the City to make this happen.

   b. Assess specific needs for supportive housing to determine the quantity and type of housing needed for the high-bookings group, and prioritize these needs.

   c. Develop plans to provide the service and support component for housing units that can be built.

   d. Increase efforts to help people in the high-bookings group who currently have housing to remain in their homes.

4. Intervene before booking.

For people who commit non-serious offenses, alternate intervention at the earliest stage of contact needs to be strengthened, and critical community resources need to be readily available to avoid overuse of jail.

When a person displaying indicators of possible mental illness commits a non-serious offense, an assessment should be done as to whether an alternative other than jail might better meet the needs of the person. If a person is receiving treatment, the assessment process should connect with the case manager and care plan. The individual's case manager or other community services should support this assessment process, and help identify appropriate alternatives.

- **Intervene in the community:** County Mental Health has implemented services to make the "direct route" to treatment easy to access and simple to use. The Call Center has a dedicated line for police and jail staff to call, to determine whether the individual has a case manager or case management team, and will help make the link for appropriate

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[18] Local Trends in Illicit Substance Use, Multnomah County Budget Office, 2004; using 2002 ADAM data.

[19] Public Safety Coordinating Council for Multnomah County; Nov. 2004; see Appendix E for details.

[20] Citizen's Commission on Homelessness, "Home Again, A 10-year plan to end homelessness in Portland and Multnomah County," Dec. 2004, Summary, and Action Plan, p. 40.

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action. An officer may page Project Respond to help de-escalate a situation, or to transport a person in acute mental crisis to a hospital for evaluation and treatment.

- **Intervene at the jail:** Alternate services can be implemented even if the person is brought to jail. At the booking center, triage should occur for those with a mental illness to allow for an informed decision about whether the crime is based on criminality and should lead toward the justice system, or whether the person would be better served with a social service response. The response could include a secure psychiatric treatment at a hospital, placement in a crisis community treatment setting, return to a stable living situation with treatment, or medications or treatment while incarcerated. Involvement of the individual's case manager or case management team in the triage, or access to their diagnosis and treatment plan by Corrections Mental Health staff, would help staff at the jail make informed decisions and assure continuity.

- **Reduce parole/probation violations:** Almost a quarter of the high-bookings group's jail visits were due to supervision violations (18% parole and 8% post-prison supervision). A review of the types of violations for the high booking group, and an assessment of whether jail is an effective deterrent, and whether there are other appropriate alternatives would be helpful

Mental Health and Addictions staff and providers, who are increasingly involved in case coordination with corrections and probation/parole staff, including at booking, and in jail case staffings, discharge planning and community monitoring, should assist at all these stages.

Intervention to divert a person from jail can be bottlenecked if critical resources are lacking. Providers report that crisis hospital beds are frequently full, and that there are too few viable alternatives for crisis housing and treatment. Current needs include secure and non-secure crisis (less intensive than a hospital) housing, more respite, and expanded detox services. Funding for treatment and ongoing medications is needed for people who have lost or cannot access Oregon Health Plan eligibility, including for those with chronic (rather than crisis) needs.

Recommendations:

a. Create a new mental health outreach team (see 1.b.) to respond to the booking center or jail when a person arrives who has indications of a mental illness, but no treatment provider. The team would help assess the individual's community needs, identify alternate treatment options, and connect the person to community treatment, whether the individual is booked or not.

b. Assess the feasibility of a community-wide crisis plan for the 469 high-bookings individuals. Provide the major access points with the individual's name (only), and work through the Call Center to coordinate a pre-planned response led by a County worker or the individual's case manager. Use such incidents as part of a plan to motivate the individual toward treatment readiness.

c. Assess the types of parole and probation violations among the high-bookings group, and whether alternative strategies might better reduce violations.

d. Use case staffings among system agencies for both successes and failures with the high-bookings group, to discover any remaining issues or gaps, and develop improvements to the system.

e. Selectively expand resources to eliminate bottlenecks in the treatment system, in order to reduce use of jail as a substitute treatment facility. Include a complete spectrum of community based services, including some type of crisis residential placement (short of a hospital), where clinical monitoring, stabilization and assessment can occur for a temporary period.

f. Examine the criteria used for assignment to DCJ's Mentally Ill Offender unit, and determine whether people are properly assigned to the right supervision unit for appropriate follow-up and linkage to community treatment.

g. Assess the barriers that are keeping people from getting the treatment they need to avoid repeat bookings, and develop strategies to reduce those barriers.

5. Reduce racial over-representation in the high-bookings group.

African American males are greatly over-represented in the high-bookings group of people with a mental illness. More work is needed to understand why African Americans with a mental illness are more likely to end up in the high-bookings group, and to develop interventions to change this pattern.

The Public Safety Council's report on *Racial Over-representation in the Criminal Justice System* showed serious over-representation of African Americans, Hispanics and Native Americans throughout Multnomah County's criminal justice system.[21] African Americans are also over-represented among those placed on a psychiatric alert, making up 10% of this group. But this increases dramatically in the high-bookings group, where 31% are African American.[22]

African American mental health clients are 16.6% of Verity enrollments, but use only 14.2% of hospital bed days paid by Verity.[23] It is not known whether lower use of hospital services relates to the higher use of jail.

Recommendation:

a. Develop interventions to change the pattern of over-representation of the African American population with mental illness among the high-bookings population.

6. Develop a shared information system.

First responders (police, crisis response teams, hospitals, jail, corrections health) need to know whether a person is receiving treatment (or has in the past), so they can make immediate contact with the appropriate provider to assure coordinated and effective treatment.

Shared Client Data System: Sharing client identity and limited treatment information across agencies is crucial to improving outcomes for shared clients. Police should be able to connect a person with a mental illness to their case manager. Corrections Health staff should be able to

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[21] "Racial Over-representation in the Criminal Justice System," Public Safety Coordinating Council of Multnomah County, 2001, p. 6

[22] Corrections Health data on the high-bookings group, December 2004; see Appendix B.

[23] "Verity" is the payment system for Multnomah County Mental Health.

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determine whether a person is receiving Mental Health treatment, and if so, access the treatment and medication plan so these can be continued while the person is in jail.

Over the past few years, links between the jail, corrections health, community justice and mental health and addictions systems have been strengthened:

- Information sharing protocols have been developed and approved; Call Center and Community Based Services staff can share some clinical information with County Jail, Corrections Health, and DCJ staff.

- In January 05, the Call Center installed a dedicated phone line for police, booking, corrections and DCJ calls to provide immediate information on whether a client is "known" to the system. The Call Center will access the individual's case manager, provide essential history, and dispatch assistance if needed. Later this year, the Mental Health Raintree software will be installed in the booking facility so that selected information can be accessed by Corrections Health staff directly without a phone call.

- Key staff of outreach teams have received clearance to do "in-reach" for clients in jail.

- Case managers participate when feasible in case staffings at the jail when their clients are incarcerated, to provide continuity with community treatment.

However, barriers remain:

- There is no consensus view of acceptable and legal information sharing parameters. Especially since HIPAA, many programs are wary of sharing even client identity, and permissible information sharing varies depending on type and relationship of agencies.

- Client release forms, which could permit wider information sharing, are not consistently formatted or used; many clients are reluctant to sign such forms.

- Addictions client data is in a different data system than Mental Health records, and subject to stricter federal confidentiality protections, currently limiting linkage to these case managers and treatment plans.

- Speedy identification of a client's agency and case manager is not immediately available without a phone call. Even with a dedicated line, making a call in a field situation and listening to and writing down pertinent information takes time and is subject to error.

- Some in the high-bookings group give different names in different situations; use of aliases makes it difficult to find a match between mental health and justice data systems.

The Bureau of Housing is implementing a Homeless Management Information System (HMIS), a new web-based system for data collection and research on homelessness.[24] The tool will track outcomes for homeless people, and whether housing is being adequately planned for at discharge from institutions. Because of probable overlap with the frequently-booked population, coordination between Mental Health and Addictions systems and the Homeless Management Information System should be pursued.

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[24] A Federal Department of Housing and Urban Development grant is enabling the City of Portland's Bureau of Housing to develop and implement the HMIS in 2005.

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Recommendations:

    a. Resolve questions about data sharing by determining which communications are permitted vs. prohibited, and what opportunities exist for joint planning and case management for shared clients. Look at communications between County agencies, with County contractors, with city law enforcement, and with other agencies, such as hospitals.

    b. Create a shared data system so that staff in mental health, addictions and justice systems can quickly find out whether an individual is know to the other systems, and if so, determine how to contact the individual's case manager.

    c. Strengthen City/County partnerships to collaborate with the Homeless Management Information System. Coordinate information for both client management and research purposes with the proposed HMIS data system.

7. Measure outcomes

Shared indicators of success are needed to determine what works to improve outcomes for the 469 people in the high-bookings group. Research across systems should be collaborative, disciplined, and utilized as evidence-based practices.

SAMSHA's report on *Cost Effectiveness of Four Criminal Justice Diversion Programs* suggested outcome measures for successful diversion programs, including: reduced criminal behavior, reduced substance use, improved mental health status, and increased quality of life.[25]

Local programs and county agencies use a variety of indicators of success, based on careful research and available client data. Communication about measurement and outcomes across agencies would help improve these efforts.

- ▪ **Evaluation and Best Practices:** Shared data and a means of evaluation would reveal whether the multiple agencies involved are making progress to impact the problem of over-representation of people with mental illness in the criminal justice system.

  Several pilot projects have been recently started, or are beginning in 2005, to attempt to better reach and support "hard to serve" people with severe mental illness and/or substance abuse. Most expect that long-term or repeated contact will be needed to impact this population. Evaluations of these projects will help determine which approaches work best in this community.

- ▪ **Client Demographics and Location:** Mapping and case studies would provide a better picture of this cohort from all perspectives. The treatment community needs to know what services to provide, to what groups of people, and where to place their resources geographically.

  For example, although half or more of one mental health provider's clients who are involved in the criminal justice system are Downtown, over a quarter are in the Southeast

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[25] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2000.

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area, and a significant number in Northeast and Gresham. High-bookings individuals on Parole/Probation are assigned throughout the county, concentrated in N/NE Portland.[26]

Recommendations:

a. Develop shared indicators of success for increasing diversion from jail, and a monitoring strategy. Report quarterly on these indicators to the Public Safety Coordinating Council's committee on Persons with Mental Illness in the Criminal Justice System.

b. Review evaluations of the case management pilot projects at the committee on People with Mental Illness in the Criminal Justice System. Encourage application of this knowledge to program decisions. If I-Tax funded programs are found to make the difference in treatment success, determine means for continued support.

c. Map client arrest locations and home addresses for the frequently-booked group, to help treatment providers determine where to locate resources.

Focus On Youth

Youth, Mental Illnesses and Juvenile Justice

This section addresses the needs of youth ages 12 to 18 who have an underlying mental disorder which contributes to their contact with the criminal justice system.[27]

The Surgeon General's 2002 Report on Children's Mental Health found that approximately 20% of children and adolescents experience a mental disorder, and 10% experience a mental illness severe enough to cause impairment at home, in school or in the community.[28] Yet prevalence of mental disorders for youth in juvenile justice systems nationwide is estimated at up to 60%.[29]

Diagnosis of mental disorders for youth requires a careful and comprehensive assessment. "Juvenile offenders frequently have multiple difficulties that are complex and interrelated. Disrupted family relationships, poor peer relationships, school problems, exposure to violence and trauma, health conditions, genetics, and learning disorders may each play a role in the development of a youth's mental and substance abuse disorders."[30]

Up to two-thirds of youth with a mental illness who are involved with juvenile justice systems nationwide have a co-occurring substance abuse disorder.[31]

Common diagnoses among incarcerated youth include anxiety or mood disorders, post-traumatic stress disorders, and risk for suicide. Diagnoses for youth offenders are different than for adults,

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[26] Cascadia Behavioral Health Care; Department of Community Justice; see Appendix C.

[27] Children under age 12 are not addressed here, because issues for this age group are treated as a dependency, rather than criminal, issue. However, needs of this young age group should be explored; older youth have revealed that their drug and criminal behavior frequently started well below age 12.

[28] "Key Issues," National Center for Mental Health and Juvenile Justice, p.1.

[29] "Mental Health Treatment for Youth in the Juvenile Justice System: A compendium of Promising Practices," National Mental Health Association, 2004, p. 1.

[30] Ibid, p. 9.

[31] Ibid, p. 1.

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in part because common adult mental illnesses, such as schizophrenia and bipolar disorder, do not usually appear until the late teen or young adult years. In addition, many youth have learned to camouflage symptoms, and it can take some time to work through layers of defenses before needs can be identified and help given.

In Multnomah County, youth age 12 to 18 who are adjudicated for an offense are typically sent to community treatment. Breaking conditions of probation, continuing crimes, or victimizing others can result in the youth being moved to McLaren or Hillcrest for detention.

Mental disorders and substance abuse are both major issues for youth involved with Multnomah County Juvenile Justice. For the 957 children and youth on the Juvenile Justice caseload in 2004, initial screening identified 23% as having one or more mental health indicator (8% had two or more indicators), and 40% as having a substance use or abuse issue. With 47% enrolled in OHP at some time over the past two years, clearly almost half live in impoverished households.[32]

A snapshot of the 80 youth in Juvenile Detention in December 2004 showed that 32.5% had a serious mental health diagnosis, and 20% were on suicide watch.[33]

The goal of treatment is to redirect youth onto a healthy path to adulthood

Research shows that treatment for youth is effective. In fact, any treatment is better than no treatment. "Generally, regardless of the types of programs used or the youths' background, recidivism rates among those who received treatment are as much as 25% lower than the rates of children and teens in untreated control groups. The best research-based treatment programs, however, can reduce recidivism rates even more – from 25 to 80%."[34]

Principles of effective treatment for youth with mental illnesses in juvenile justice systems have been developed by the National Mental Health Association (NMHA), which stated that treatment systems should intervene early, target medium to high-risk youth, use community alternatives, deliver sufficient amounts of treatment, collaborate among agencies, and monitor progress.[35]

The NMHA identified that effective treatments are structured and intensive, community based, involve family members, and use integrated, multi-modal approaches. Promising practices included: Multi-Systemic Therapy, Functional Family Therapy, Integrated Systems of Care/ Wraparound Care, Cognitive Behavioral Therapy, and Multidimensional Treatment Foster Care. The NMHA recommended integrated treatment of mental health and substance abuse; effective practices for integrated treatment included the above, plus intensive case management.[36]

A key factor to keep youth moving down the path toward a healthy adulthood is a readiness for and commitment to treatment from both the youth and the family. Family must participate, as well as set expectations of success for their child. Where parents and family are not motivated, or

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[32] "JCP Assessment: Year 2002-03," based on the Oregon Juvenile Crime Prevention (JCP) Assessment, plus additional data provided by the DCJ Research and Evaluation Unit.

[33] Reported by Corrections Health for December 2004.

[34] "Mental Health Treatment for Youth in the Juvenile Justice System: A compendium of Promising Practices," National Mental Health Association, 2004, p.1

[35] Ibid, p. 5

[36] Ibid, p. 9, plus "Treatment Works for Youth in the Juvenile Justice System," NMHA Factsheet, pp. 1 & 2

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have their own mental health, addictions or criminality issues, or simply lack the skills to show up for appointments, traditional approaches to treatment are not usually effective.

Conclusions and Recommendations for Youth

1. Move toward a family and home-based services model for treatment.

Because family involvement is critical for success, evidence-based family and home-based treatment models should be used for high-risk youth and their families.

The medical model of short-term treatment of mental health and behavioral issues for youth has not worked well to improve outcomes for high-risk youth, in part because these are the youth and families who are not motivated toward treatment, have multiple problems that interfere with participating in treatment, or simply do not show up for appointments.

But family caring and involvement in treatment is critical, whether "family" is the natural or adoptive parents, relatives or others the child is living with, or foster parents. For high-risk youth, especially youth with parents and families that do not participate in traditional appointment based services, treatment should occur in the family's home.

The Multnomah County Department of Community Justice (DCJ) has implemented two successful programs that use this family and home-based model: Multi-Systemic Therapy (MST), and Assessment and Treatment for Youth and Families.

County Mental Health is currently developing a program that will be similar to MST, targeted to high-risk youth who have not been through the Juvenile Justice system.

Recommendations:

a. Use evidence-based family and home-based treatment models for high risk youth and their families, who are not likely to succeed with clinic-based services. Assign caseloads appropriate for this intensive, time consuming model of service.

b. Advocate with Child Welfare to recruit excellent foster parents, who can provide youth with stability, caring and quality parenting when they cannot remain with their family.

c. Advocate for "relative search" programs to link youth with other family members to provide a sense of caring and connectedness that may be lacking from the parents or family the child is living with.

2. Integrate and coordinate treatment, in a "system of care."

Systems of care have been found to achieve better outcomes for high risk youth. Services for youth offenders should blend a corrections approach with mental health and alcohol and drug treatment.

The National Mental Health Association found that implementing systems of care improved outcomes for youth. "Evaluations show reductions of up to 61% in the number of crimes committed by youth on probation who are involved in 'systems of care' programs." [37] NMHA

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[37] "Treatment Works for Youth in the Juvenile Justice System," Factsheet, National Mental Health Association, 2004, p. 2.

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also determined that multi-modal approaches were more effective than narrowly focused programs, and that integrated mental health and substance abuse treatment was 'state of the art' for youth with co-occurring disorders.[38]

For adolescent offenders, involvement in the juvenile justice system can provide the extra motivation youth and family need to participate in treatment, and the court counselor, probation officer or treatment provider can become a major supporter for the family in learning how to manage a difficult child or youth. The high correlation between youth in the juvenile justice system, and parents or family with mental health, alcohol or drug abuse disorders,[39] indicates a need for coordination with adult services to address family needs.

Unlike adults, homelessness has not emerged as a major issue for youth. Youth involved with the juvenile justice system who have mental disorders generally live with their families – but these families often have multiple problems and challenges. Addressing problems as early as possible with integrated treatment can allow the family unit to better raise healthy children.

Recommendations:

a. Emphasize funding for services for youth offenders to blend a corrections approach with mental health and alcohol and drug treatment.

b. Develop coordination mechanisms and protocols among Mental Health, Addictions and Juvenile Justice to assure coordinated service delivery for individual youth, and keep youth from avoiding or failing to complete treatment.

c. Develop a Mental Health, Addictions and Juvenile Justice data system so that providers can share allowed data, coordinate service methods and delivery, and assess outcomes.

d. To the extent possible, given diagnostic requirements for payment through Medicaid, move away from a symptom-based model to a strengths-based model of clinical assessment and intervention. Avoid labels which can interfere with addressing underlying mental health and environmental issues for youth.

e. Advocate with and involve private insurance and the Oregon Health Plan in the move toward integrated models of service, since health coverage drives (and unfortunately limits) what services are available. Seek parity in private coverage for mental health.

f. Support the family's engagement in their child's treatment, with a goal of helping the existing family provide the love and parenting that the child or youth needs.

3. Engage high risk youth and families through outreach case management.

Reach out to identify and stabilize youth before they reach a crisis point. Make treatment more persistent for high risk, non-compliant youth and their families.

In a traditional appointment-based service system, services are prioritized toward those who show up for their appointments, on time, and with accompanying family members when this is

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[38] Ibid, p. 2.

[39] Of youth in the RAD program, 88% had family with A&D issues, and 31% had family with mental health issues. "The Mental Health Status of Juvenile Offenders in Multnomah County Secure Residential Alcohol and Drug Treatment," DCJ Research and Evaluation Services, October 2002.

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part of the treatment plan. However, the highest risk youth are also the most likely to "shake off" treatment by being non-complaint. The system needs to respond by making treatment more persistent.

Recommendation:

    a. Provide outreach case management or in-home treatment services when high-risk youth and families do not, or are not likely to, engage in traditional clinic-based services.

4. Target services to higher risk youth.

Targeting criteria should be adopted for a portion of Mental Health funds to increase services to medium and high-risk youth and families through outreach case management, and family and home-based services models. Since these approaches require more staff time and thus lower caseloads, this will mean that fewer youth and families can be served overall.

County Mental Health is in the process of redesigning Children's Mental Health services, with changes effective with new contracts to be issued later this year. The new system plans to redeploy resources from routine child and family appointments to allow lower caseloads for some staff so they can go to homes and schools and serve the higher risk children and youth. Without this level of service, these youth are at risk of needing even more costly residential treatment programs, or appearing on the Juvenile Justice caseload.

The County Department of Community Justice (DCJ) already offers intensive services to some of its highest risk youth and achieves good outcomes, reducing recidivism and keeping the youth at home and in their community. National models for Multi Systemic Therapy (MST) achieve 25 to 70% reduction in re-arrests and 50 to 64% reduction in out of home placements from control groups.[40] For DCJ's MST program, 75% either successfully completed the program or were partially successful, 75% were either living at home or with another relative, and none were placed in a youth correctional facility. In December 2004, of the 81 youth who had exited MST at least 6 months ago, 62% had remained crime-free, and of those youth who completed MST successfully or partially successfully, 70% were crime-free.[41]

There is a "high-bookings" group in the County Juvenile Justice system as well. About 7% of youth each year account for 50% of Juvenile Justice referrals.[42] A review of a sample of records reveals a multi-problem profile for this group, including a high prevalence of substance use. Over a quarter have a history of mental health, alcohol and drug or residential treatment. DCJ staff and treatment providers share that this group of youth do commit serious crimes (not just status offenses), and seem to cycle through treatment programs with little change in behavior. The DCJ research report recommends earlier identification based on four risk factors (age of first criminal referral, number of runaway referrals, alcohol and drug use and school risk factors), and earlier involvement in treatment.

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[40] Multisystemic Therapy website, Research on Effectiveness, Results of Randomized Trials with Serious Juvenile Offenders, of four studies conducted 1992 to 1997.

[41] 2003 program data provided by Department of Community Justice.

[42] "Chronic Juvenile Offenders in Multnomah County," DCJ Research and Evaluation Services, 2003.

Recommendations:

a. Adopt targeting criteria to direct a portion of Mental Health funds to increase services to medium and high-risk youth and families through outreach case management and family and home-based services models.

b. Over the next year, conduct an in depth assessment for every youth with 3 or more referrals to the Juvenile Justice system. Evaluate the characteristics of this group of chronic youth offenders, determine their service needs, and develop appropriate interventions.

c. Target intensive integrated services to youth who fall into the 7% challenge population.

d. Look closely at the Cook County Clinical Evaluation and Services Initiative (CESI), a multi-disciplinary project which provides clinical coordination, assessment, and psychological evaluation for youth moving through the juvenile justice system as a potential model.

Process Recommendations

Success in improving outcomes for the high-bookings group will require ongoing attention, planning and monitoring by a representative, motivated group, with adequate data to assess needs and evaluate outcomes. The Persons with Mental Illness in the Criminal Justice System committee should be expanded, and charged with setting an agenda to conduct further analysis, guide development of these recommendations, and monitor progress toward implementation.

Recommendations:

a. Expand the Public Safety Council's committee on Persons with Mental Illness in the Criminal Justice System to represent all key interests in this issue. Charge this committee with responsibility for further analysis, developing strategies to implement this report, and monitoring progress and outcomes.

b. Provide adequate data support to the committee to assess needs of the high-bookings group, and assess outcomes.

c. Include youth issues in the committee's charge, or establish a youth subcommittee.

Appendices

A. Summary of Related Studies and Reports

B. Status Report: What Has Improved?

C. Profiles: Adults with Mental Illnesses in the Multnomah County Jail

D. Profile: Youth with Mental Illnesses in the Juvenile Justice System

E. Service Map: Services Targeted to or Used by People with a Mental Illness Involved with the Justice System

F. Survey Results: System Strengths, Successes and Barriers

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Workgroup Members: Adult Issues

Name	Position	Agency/Department
Kevin Bowers	Manager, Mentally Ill Offender Unit	Multnomah County Department of Community Justice
Leslie Ford	President	Cascadia Behavioral Healthcare
David Hidalgo	Program Manager, Multnomah County Call Center	Multnomah County Department of County Human Services, Mental Health
Ray Hudson	Program Manager, Addictions Services	Multnomah County Department of County Human Services, Addictions Services
Liv Jenssen	Manager, Transitional Services Unit	Multnomah County Department of Community Justice
Samantha Kennedy	Program Coordinator	City of Portland, Office of Neighborhood Involvement, ACCESS Program
Diane Luther	Housing Director	Multnomah County Housing Program
Seth Lyon	Program Manager, Adult Mental Health	Multnomah County Department of County Human Services, Mental Health
Bill Midkiff	Health Services Administrator	Multnomah County Health Department, Integrated Clinical Services, Corrections Health
Carol Nykerk	Program Manager	Multnomah County Sheriff's Office, Inverness Mental Health Treatment Team
Paul Potter	Vice President of Clinical Services	Cascadia Behavioral Healthcare
Mark Sanford	Public Guardian/Conservator	Multnomah Department of County Human Services, Aging & Disability Services
Judy Shiprack	Director	Public Safety Coordinating Council of Multnomah County
Lillian Shirley	Director	Multnomah County Health Department
Kathleen Treb	Assistant Director	Multnomah County Department of Community Justice

Workgroup Members: Youth Issues

Name	Position	Agency/Department
Amy Baker	Program Manager, Outpatient Services	Multnomah County Department of County Human Services, Mental Health
Bill Midkiff	Health Services Administrator	Multnomah County Health Department, Integrated Clinical Services, Corrections Health
John Pearson	Program Coordinator, Addictions Services	Multnomah County Department of County Human Services, Addictions Services
Judy Shiprack	Director	Public Safety Coordinating Council of Multnomah County
Dixie Stevens	Manager, Counterpoint and SRTP	Morrison Center
Wayne Scott	Clinical Manager, Juvenile Justice	Multnomah County Department of Community Justice

Report prepared by: Kamala Bremer, Consultant

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Appendix A:
Summary of Related Studies and Reports

Multnomah County Reports

In 2000, Commissioner Lisa Naito and Judge Julie Franz formed a workgroup of Public Safety Council members to develop options for people with mental illness who were involved with the justice system. In October 2000, the group produced a report, *Options for Persons with Mental Illness in Multnomah County's Criminal Justice System*, which suggested alternatives for: officers responding to a person in crisis, pre-booking disposition, diversion to a hospital, creation of a mental health crisis center, implementing mental health evaluation in jail, referral to a mental health court docket, training for parole and probation officers, linking released offenders to social services, and streamlining aid and assist evaluations to occur in a timely manner.

Following this initial report, the group continued to meet as the 'Persons with Mental Health in the Criminal Justice System' committee, and further developed their strategies. In 2002, they produced updated recommendations in *Recommendations for Improving Options for Persons with Mental Illness in Multnomah County's Criminal Justice System* followed with a May cross-system conference. In 2003, the group issued a *Progress Report on Bridging the Gaps between the Mental Health and Justice Systems*.

In the summer of 2004, it appeared that the number of people with a mental illness in the County Jail system was declining, reversing the sharp upward trend of 2003. Although this downward dip is again rising, committee co-chairs asked the group to revisit the issue in a report that forged into new territory. They requested a roadmap of services for this population, and an analysis of whether systems work together as well as needed, or whether gaps or fragmentation of services interfere with successful outcomes.

Governor's Mental Health Task Force Report

In September 2004, the Governor's Mental Health Task Force produced *A Blueprint for Action*, highlighting and reinforcing their concern for people with mental illness in the justice system. Their findings pointed to "an administrative and financing disconnect between the criminal justice system and the mental health system, such that no one is truly accountable for outcomes for individuals who are incarcerated or at risk of incarceration." The report was critical that "the State does not provide systematic funding for community services that might reduce criminal activity, prevent recidivism, or support diversion."

The Task Force recommended that the State and counties fund and fully implement a community based system of care. Regarding the intersection with criminal justice, they proposed: increased training for criminal justice staff to understand mental illness and use community programs; more 24/7 acute care crisis centers; more facilities to serve individuals under Psychiatric Security Review Board supervision; and increased pre-release planning for those leaving jails. The report noted that the mental health system is significantly under-funded, and that cuts to other State services have negatively affected those with a mental illness who are also poor.

In Multnomah County, due to collaborative efforts on this issue over the past years, major progress has already been made toward many of the Task Force's recommendations.

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Oregon Partners in Crisis Report

During 2004, individuals and agencies from all aspects of Oregon's criminal justice and mental health systems convened to form a new coalition, Oregon Partners in Crisis (OrPIC), in order to jointly advocate for solutions to address the criminalization of people with mental illness.

In their fall 2004 report, *Priority Recommendations for Criminal Justice/Mental Health Collaboration*, the coalition found: "Oregon's jails and prisons have become, by default, mental health treatment centers – a role they are poorly equipped to play and one that pulls public resources away from their intended target: criminals. Individuals with mental illness stay in jail longer, are more expensive to maintain, are more likely to return to jail, and are at high-risk for suicide while there." They cited that 14% to 40% of jail inmates statewide have a mental illness, and many have additional co-occurring disorders.

The group recommended implementing those system improvements that would have the most effect on reducing placement of people with mental illness in the criminal justice system statewide. Specific recommendations spanned key issues: system collaboration, pre-booking diversion, pre-trial diversion, adjudication alternatives, sentencing options, care in custody, successful re-entry, and measuring outcomes.

To increase diversion from jail and reduce recidivism, Oregon Partners in Crisis recommends that the following key elements be present in each county or region:

- Crisis intervention training for police, to enable early identification and diversion.
- Local crisis resolution centers to handle psychiatric emergencies.
- "Boundary spanner" staffing to link mental health, substance abuse and criminal justice programs.
- Community Outreach Teams to provide intensive home-based services.
- Wrap-around and support services including medications, housing and skills training.

In order to achieve success, the coalition recommends measuring both immediate and long-term outcomes, to improve a program's ability to adapt to feedback, and allow for alteration of program design based on community changes.

Criminal Justice/Mental Health Consensus Project, Report and Website

Coordinated by the Council of State Governments, the Consensus Project is the result of requests from state government officials for help in improving the criminal justice system's response to people with mental illness. Policy makers, practitioners and advocates nationwide collaborated to produce an extensive report outlining issues and best practices in both criminal justice and mental health fields. The Consensus Project maintains a website to serve as a means of sharing their report and important papers on this subject at: http://www.consensusproject.org.

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Appendix B:
Status Report: What has improved?

Significant progress has been made in the past four years to improve services for people with mental illness who are involved with the criminal justice system.

Coordination & Collaboration

- Development of shared goals and cross-department coordination has improved operational systems and communications among agencies.

- Regular coordination meetings include the Department of Community Justice mental health network meeting, the County Mental Health and Addictions Services Advisory Council, and the Public Safety Coordinating Council's workgroup on Mentally Ill Persons in the Criminal Justice System.

Community Crisis Services

- The County's Mental Health Call Center has taken on new roles as a central hub to link people to both crisis and non-crisis services.

- A mental health crisis walk-in center has been created, which can be accessed 18/7.

- Mobile crisis services (through Project Respond), including secure transport, can be dispatched 24/7.

Community Case Management Strategies

- New evidence-based models are being implemented to attempt to reach the hardest to serve populations. These include Assertive Community Treatment (ACT) teams in both mental health and addictions, and several downtown/Old Town programs.

Links between Justice, County Human Services, and Community Services

- Corrections Health has expanded their Mental Health program.

- The Inverness Mental Health Treatment Team works to stabilize inmates, reduce self harm, manage symptoms, plan for continuity of care upon discharge to community. Safeguards assure releases of offenders with mental illness occur during daytime business hours.

- Community mental health case managers now have phone and visitation access with their incarcerated clients, and some have jail clearance for regular visits.

- Multidisciplinary treatment teams meet at the jails weekly; community case managers and discharge planners attend when possible.

- People with mental illness are diverted to Community Court where appropriate.

- County Mental Health staff are now assigned to the Community Court to facilitate linkage to treatment providers and other services.

- Department of Community Justice (DCJ) conducts joint treatment planning with mental health treatment providers

- The Transitional Services Unit, DCJ, provides support and services for successful integration into the community from prison/jail, especially for people with special needs including mental health, developmental disability, medical issues, or sex offense issues.

- Coordination with Social Security through the Joint Access to Benefits (JAB) program now allows for timely start up of benefits (such as SSI and Oregon Health Plan), and continuation or restoration of benefits when incarcerated over 30 days.

- The Department of County Human Services (DCHS) Mental Health and Addictions programs, and the Department of Community Justice (DCJ), have recognized the prevalence of co-occurring disorders in their service populations, and are requiring providers to be jointly certified.

- Culturally-specific treatment programs have been contracted to increase culturally appropriate services for the major racial/ethnic groups.

- A specialized Developmental Disability case manager is assigned to work with difficult DD clients involved in criminal justice, including those under PSRB.

- Training for the Mental Health Treatment Team at the County Jail includes continuum of care training with community partners, and cross-training with developmental disabilities staff.

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Appendix C:
Profiles: Adults with Mental Illnesses in the Multnomah County Jail

High-Bookings Inmates with a Psychiatric Alert

Multnomah County Corrections Health has identified a group of people, most of whom have a mental illness and many of whom have co-occurring substance abuse disorders, who have developed a chronic pattern of frequent bookings into the jail.[43]

Of the 3,413 people booked into Multnomah County Jails in FY04 (July 1, 2003 through June 30, 2004), 469 people accounted for 25% of the year's bookings of people receiving a psychiatric alert, and for 50% of these bookings since 1985.

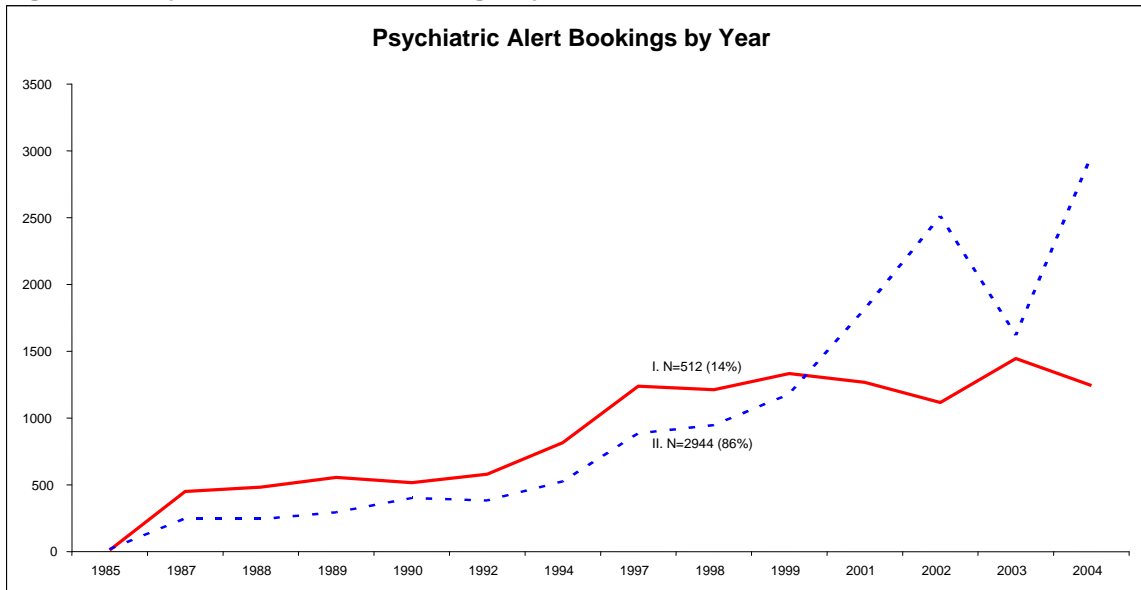**Figure 1: Percent Comparison**
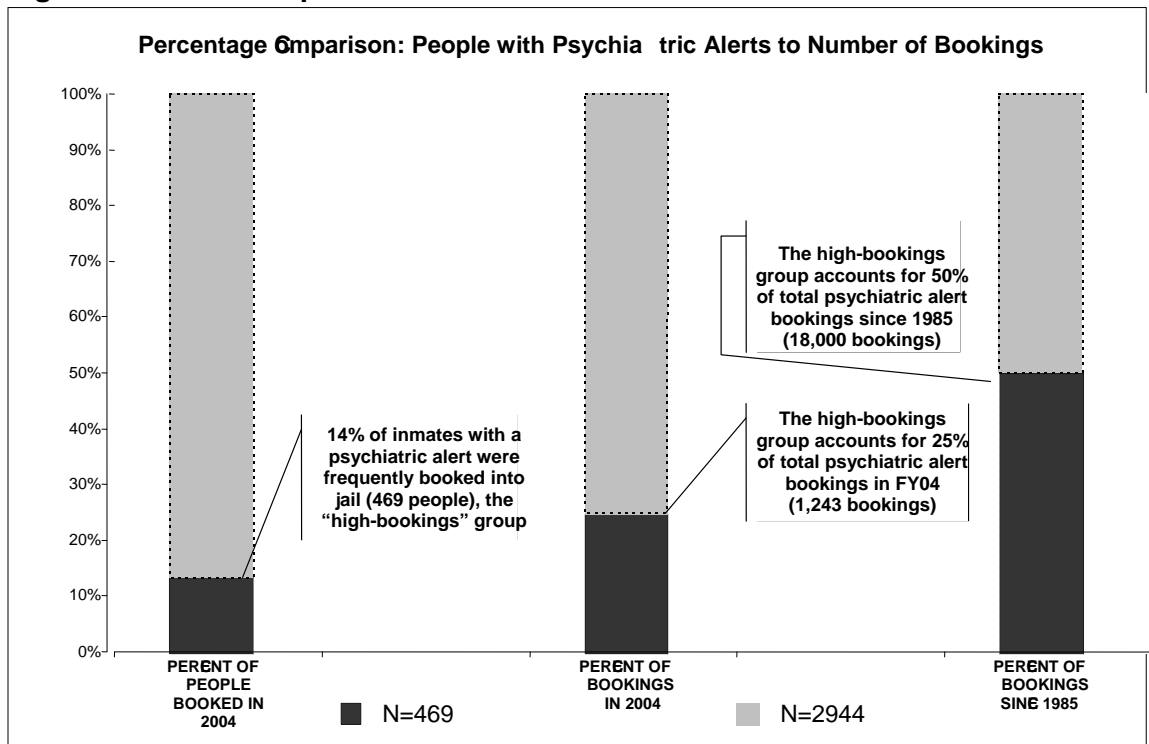
A psychiatric medical alert is placed by Corrections Health staff when a person booked into the Multnomah County Jail has a history of a mental illness, has suicidal thoughts, or disruptive or bizarre behaviors. Case record reviews have shown a high (85-90%) correlation between being given a psychiatric alert and having a mental illness diagnosis.

The less often booked group of 2,944 people with psychiatric alerts (shown in the lighter bar above) is used as a comparison with this high-bookings group of 469 people in the figures below.

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[43] Data and charts in this appendix prepared by Bill Midkiff, Health Services Administrator, Health Department, Integrated Clinical Services, Corrections Health, December 2004, based on the MC Jail SWIS (Sheriff, Warrant & Inmate System) data base data, and DSS-J (Decision Support System-Justice).

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**Figure 2: Psychiatric Alert Bookings by Year**

The high-bookings group (solid line) representing 14% of people on psychiatric alerts has accumulated 1,000 to 1,500 bookings in each year since 1997. The less often booked group (dashed line), with 86% of people on psychiatric alerts, has had a combined 1,500 to 3,000 annual bookings in recent years.

Table 1: Demographic Characteristics of Inmates with a Psychiatric Alert, FY04

Demographic Characteristics	High- Bookings	Less Often Booked	Total with a Psych Alert
Number of People	**469**	**2,944**	**3,413**
Age			
Average	40	36	36
Median	40	36	36
Range	44	64	64
Minimum	20	16	16
Maximum	65	80	80
Gender			
Male	330 (70%)	1,959 (66%)	2,289 (67%)
Female	139 (30%)	1,005 (34%)	1,144 (33%)
Race/Ethnicity			
Caucasian	306 (65%)	2,422 (82%)	2,728 (801%)
African American	144 (31%)	353 (12%)	497 (15%)
Hispanic	12 (3%)	87 (3%)	99 (3%)
Asian	1 (0%)	24 (1%)	25 (1%)
Native American	6 (1%)	58 (2%)	64 (2%)

The majority of the high-bookings group is male, with an average age slightly older than the less often booked people with psychiatric alerts.

Figure 3: Percentage Comparison, Race/Ethnicity
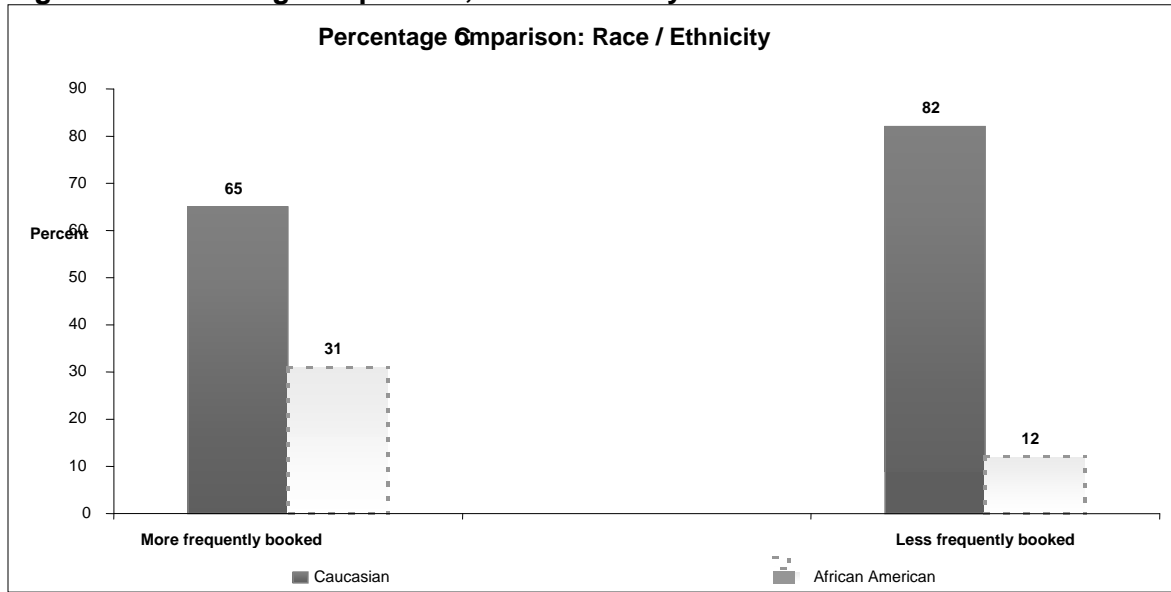
The percent of African Americans in the high-bookings group is 31%, compared to 12% in the less often booked group. In both groups, African Americans are represented above their 8% proportion of the County's general population.

Table 2: Booking Frequencies for Inmates with a Psychiatric Alert

| Statistic	High-Bookings Group FY 04	High-Bookings Group Total since 1985	Less Often Booked Group FY04	Less Often Booked Group Total since 1985
Average	2.0	38	1.4	7
Median	1.0	35	1.0	5
Range	11	94	17	21
Minimum	1	24	1	1
Maximum	12	118	18	22

The high-bookings group had an average of 2 bookings each in FY 2004, and an average of 38 bookings each over the past 19 years combined. The number of bookings for the less often booked group is significantly lower, both for last year and over the past 19 years. Fewer than 10% of the less often booked group have more than 2 bookings total

Table 3: Length of Stay (LOS) of Inmates with a Psychiatric Alert, FY04

Statistic	High-Bookings Group	Less Often Booked
Average LOS	29	23
Median LOS	10	5
Range of the LOS	387	427
Minimum LOS	0	0
Maximum LOS	387	427
Sum of jail bed days (for all in group)	26,525	93,898
Average jail bed days per person	57	32

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Length of stay in jail is longer for the high-bookings group than for others who receive a psychiatric alert.

Figure 4: Percent of People with a Psychiatric Alert Released by Length of Stay
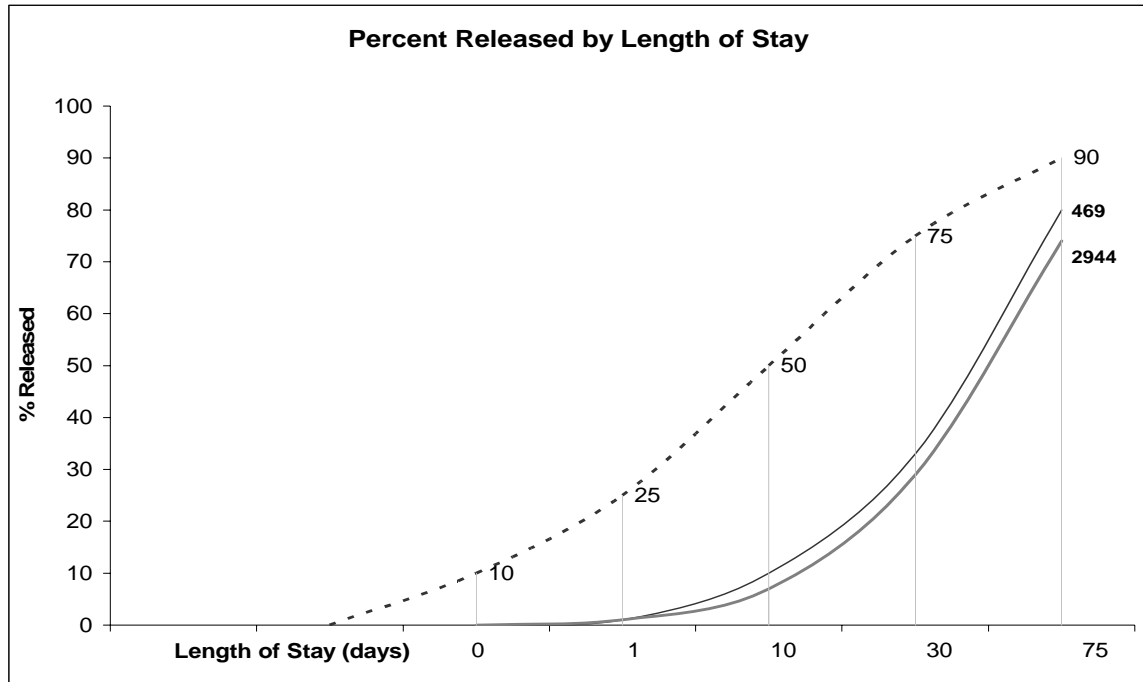
While only 10% of people with a psychiatric alert (dotted line) are immediately released, a quarter are released within one day, and half are released within ten days. Note that these short stays are generally far too brief for effective diagnosis or therapy to be provided in the jail setting. The solid lines mark the actual lengths of stay, and shows that there is no significant difference in length of stay between the high-bookings group and the less often booked group.

Table 4: Primary Diagnoses of High-Bookings Inmates with a Psychiatric Alert, FY04

Diagnostic Group[44]	High-Bookings Group	Less Often Booked
Severe - Persistent Mental Illness	202 (43%)	524 (17.8%)
Personality Disorders	9 (1.9%)	79 (2.7%)
Substance Use Disorders	178 (38%)	634 (21.5%)
No Diagnosis[45]	80 (17.1%)	1707 (58%)
Total	469 (100%)	2944 (100%)

For 43% of the high-bookings group, a diagnosis of severe and persistent mental illness was on record or was able to be arrived at during the often short stay in the jail. Note that this data records the diagnosis that is listed as "primary," however most of this group has co-existing disorders; 88% have a substance abuse disorder.

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[44] Primary Diagnosis only; co-occurring disorders exist for most of this group.
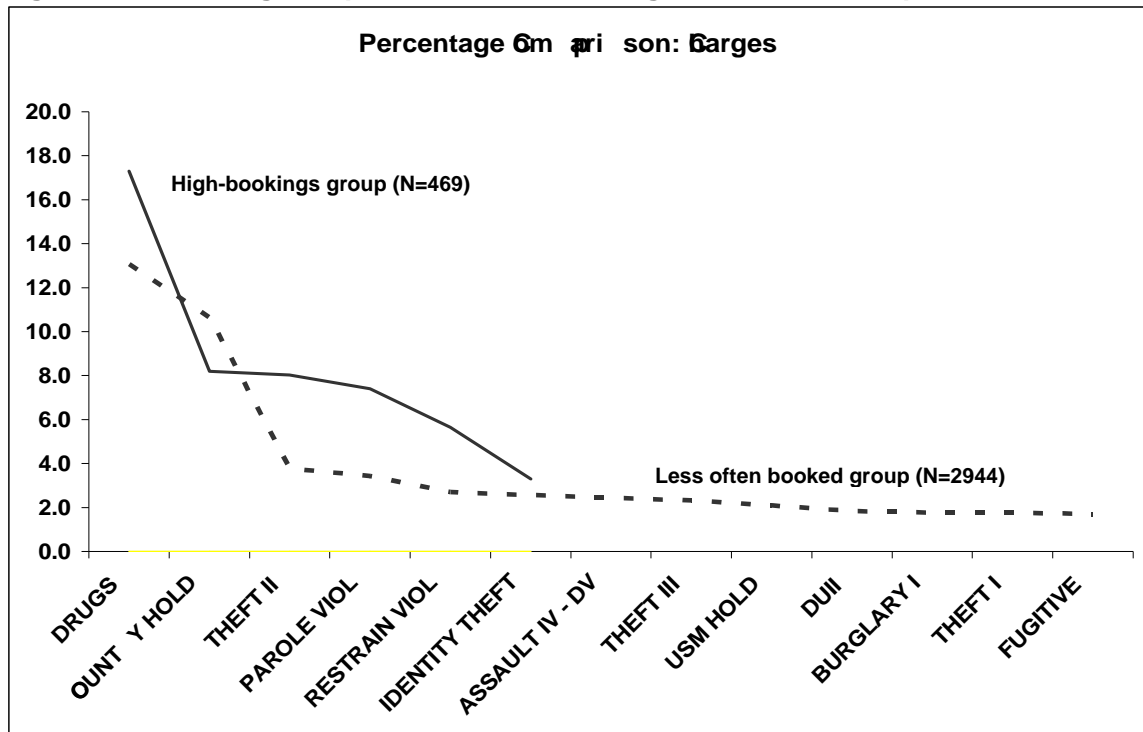
[45] Diagnosis is pending, or is other than those tracked in information system.

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Figure 5: Criminal charge summary for inmates with psychiatric alerts, FY04

High-bookings group (N=469)				Less often booked group (N=2944)		
Charge Description*	**Count**	**Pct**		**Charge Description**	**Count**	**Pct**
DRUGS	414	17.3		DRUGS	1280	13.1
VIOL VARIANCE DFZ	196	8.2		COUNTY HOLD	1042	10.6
COUNTY HOLD	192	8.0		THEFT II	370	3.8
PAROLE VIOL	177	7.4		PAROLE VIOL	336	3.4
THEFT II	135	5.6		RESTRAIN VIOL	265	2.7
POST PRISON VIOL	79	3.3		IDENTITY THEFT	252	2.6
THEFT III	76	3.2		ASSAULT IV - DV	240	2.5
INTERFER W PUB TRAN	45	1.9		THEFT III	228	2.3
FTA ON CITATION	40	1.7		USM HOLD	205	2.1
THEFT I	38	1.6		DUII	180	1.8
TRESPASS I	37	1.5		BURGLARY I	173	1.8
PROST	36	1.5		THEFT I	173	1.8
TRESPASS II	36	1.5		FUGITIVE	166	1.7
ASSAULT IV	32	1.3		UUMV	163	1.7
VIOL VARIANCE PFZ	29	1.2		ASSAULT IV	155	1.6
CRIM MISCH II	26	1.1		VIOL VARIANCE DFZ	147	1.5
UNLAW ENTRY OF MV	26	1.1		POST PRISON VIOL	147	1.5
DRINK PUBLIC PLACE	25	1.0		HARASSMENT	146	1.5
BURGLARY II	25	1.0		CRIM MISCH II	135	1.4
UUMV	24	1.0		MISD DUII	132	1.3
ASSAULT IV – DV=	23	1.0		FTA ON CITATION	129	1.3
USM HOLD (US Marshall)	23	1.0		HARASSMENT - DV	128	1.3
FUGITIVE	23	1.0		RESIST ARREST	110	1.1
DUII	22	0.9		FACILITY HOLD	109	1.1
IDENTITY THEFT	21	0.9		DISORDERLY CONDUCT	106	1.1
				MENACING - DV	106	1.1
ABBREVIATIONS				TRESPASS II	105	1.1
DV – Domestic Violence				POSS STOLEN MV	100	1.0
DFZ – drug free zone				SEX ABUSE I	97	1.0
County Hold – other co.				ASSAULT 4 DV-FELONY	93	0.9
FTA – failure to appear				FORGERY II	89	0.9
MISD – misdemeanor				TRESPASS I	89	0.9
MV – Motor Vehicle				BURGLARY II	82	0.8
PROST – Prostitution				MENACING	80	0.8
PFZ – prostitution free zone				ROBBERY II	78	0.8
RESTRAINing order				FORGERY I	75	0.8
UU – Unauthorized use				POSS FORG INST II	73	0.7
				DRINK PUBLIC PLACE	69	0.7
Total Charges	**2,393**	74.9%		**Total**	**9,793**	78.1%

* This table excludes charges significantly less than 1%. Possession, distribution and manufacturing of controlled substances are combined under "drugs." For county hold and parole/probation violations, it is not known what the hold or violation is for. The top 50% of charges, shaded in gray, are graphed below.

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Figure 6: Percentage Comparison of Criminal Charges Between Groups

This figure shows that for the high-bookings group, the top reasons for arrest are for drugs, holds from other counties, and parole violations (the type of parole violation is not known), with Theft II following, a lower level property crime. Very few of the charges for the high-bookings group are for person-to-person crimes.

Table 5: Cost per Arrest in Multnomah County, 1998[46]

Stage of Arrest	Cost per Arrest
Police	$1,850
Adjudication	$1,192
Jail (conviction)	$4,230
Supervision (conviction)	$2,117
Total Cost	**$9,389**

In 1998, the average cost for an arrest in Multnomah County was calculated at $9,389. This cost does not include the Health Department costs for Corrections Health, or the Corrections Mental Health program, or Department of County Human Services costs at the Community Court. It also does not factor in inflation since 1998, new programs which have been added or enhanced over the past six years.

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[46] Finigan, M. (January 5, 1998). An outcome program evaluation of the Multnomah County S.T.O.P. drug diversion Program. Portland, OR: Northwest Professional Consulting, and Finigan, M. (February, 1996). Societal outcomes and cost savings of drug and alcohol treatment in the state of Oregon. Portland, OR: Northwest Professional Consulting.

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Geographic location for the high-bookings group has not as yet been determined, but looking at mental health and probation/parole caseloads gives an indication that members of this group are distributed throughout the County.

Table 6: Cascadia Health – Clients involved with Corrections by Clinic [47]

Clinic	Number Served	Number of Clinic Clients Involved with Corrections	Percent of Clinic Clients Involved with Corrections
NE	530	80	15%
Downtown	820	400 to 600; 150 are mandated	50% +
Plaza (SE)	730	220	30%
Gresham	615	60	10%
Total	2,965	760 to 960 total	26 to 32% average

Although at least half of this large mental health provider's clients who are involved in the criminal justice system are in the downtown area, over a quarter are in the southeast area, and a significant number in northeast and Gresham.[48]

Table 7: High-Bookings Group in Probation/Parole, by Location[49]

Multnomah County District	Number Supervised	Other County	Number Supervised
North / Northeast District	61	Clackamas	8
Southwest District	44	Washington	6
Central	22	Columbia	1
East	19	Deschutes	1
Gresham	7	Jefferson	1
Drug Court	21	Marion	1
Reduced Supervision	13		
Local Control	5		
Domestic Violence	4		
Family Services	2		
DUII	2		
Intake Cases Awaiting Assignment	8		
Misc.	7		

This table is based on the data-match by the Department of Community Justice with the list of the high-bookings group. Supervision of these individuals is clearly distributed throughout the county, with about half located in NE and SW districts.

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[47] Estimated prevalence data provided by Cascadia clinic managers, Dec. 2004

[48] Estimated prevalence data provided by Cascadia clinic managers, Dec. 2004; see Appendix C

[49] Data provided by the Department of Corrections, Mentally Ill Offender Unit, Jan. 2005

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Appendix D:
Profiles: Youth with Mental Illnesses in the Juvenile Justice System

Initial Assessment: Department of Community Justice staff conduct an Oregon Juvenile Crime Prevention (JCP) Assessment for all youth coming into the Juvenile Justice system. JCP assessment data for 2003[50] showed that 23% of youth had at least one mental health identifier or need (15% had one identifier; 8% had two or more identifiers). These identifiers point out characteristics correlated by research to criminal offending, and suggest referral for further mental health assessment. The JCP assessed 40% youth as having a problem of substance use.

JCP Assessment Data for all Juvenile Justice Youth for 2003

Assessment Indicators	Percent of Youth (N=1213)
1 mental health indicator or need	15%
2 or more mental health indicators or needs	8%
Substance use problem	40%

Detention: Looking at a group of youth in a more intensive setting gives a slightly different picture. Of 80 youth in detention in December 2004, Corrections Health identified that one-third (26 youth) had a serious mental health diagnosis (i.e., an Axis I diagnoses); the most common diagnoses were depression, post-traumatic stress disorder, and anxiety disorders. One-fifth of these youth (16 youth) were on a suicide watch at detention.[51]

Snapshot of Youth in Detention – December 2004

Number of Youth In Detention, 12/04	Number/ Percent with Serious Mental Health Diagnosis	Number/ Percent on Suicide Watch
80	26 (32.5%)	16 (20%)

RAD Treatment: DCJ operates the Residential Alcohol and Drug (RAD) treatment program, a secure setting for high-risk youth, in cooperation with Morrison Child and Family services. An analysis of case records was conducted for the 51 clients served between March and May of 2002, 31 males and 20 females.[52] A high proportion of these youth were found to be diagnosed with serious disorders, including 88% with Disruptive Behavior Disorder and 82% with Substance Abuse/Dependence.

Perhaps as critical as the specific diagnosis for youth are the risk factors from their family history and environment. For the 51 RAD youth, 88% had a family history of alcohol and drug use; more than half had a history of family criminality, and as many had a history of physical or

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[50]"JCP Assessment: Year 2002-03," DCJ Research and Evaluation Unit, and additional data provided by DCJ.

[51] Reported by Corrections Health for December 2004.

[52] "The Mental Health Status of Juvenile Offenders in Multnomah County Secure Residential Alcohol and Drug Treatment," DCJ Research and Evaluation Services, October 2002.

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sexual abuse. This demonstrates the complexity of the multiple diagnoses and risk factors that often exist for these youth

RAD Diagnoses and Risk Factors
March to May, 2002

Youth Diagnoses	Number	Percent		Youth Risk Factors	Percent
Disruptive Behavior Disorder	45	88%		Family history of alcohol and drug use	88%
Substance Abuse/ Dependence	42	82%		Family history of criminality	57%
Depressive Disorders	21	41%		Physical or sexual abuse	57%
Adjustment Disorders	18	35%		Family history of abuse	45%
Anxiety Disorders	15	29%		Suicidal ideation	45%
Alcohol Abuse/ Dependence	14	27.5%		History of out of home placement	39%
Other disorders (duplicated)	12	NA		Violent in past 6 months	35%
Total Served	51	100%		Family history of mental health	31%
				Suicide attempt(s)	31%

In a snapshot of 15 youth currently in the RAD treatment program, 13 have Axis I diagnoses and are receiving psychotropic medication. The common disorders for this group include: Depression, Post-Traumatic Stress Disorder (PTSD), Attention Deficit/ Hyperactivity Disorder (AD/HD), Bipolar Disorder, and Disthymic Disorder (depression).

Repeat youth offenders: DCJ research shows that 7% of juvenile criminal offenders comprise a "problem population" of chronic offenders, who together accounted for 50% of criminal referrals during 2003[53]. In a random sample of these high recidivators, a multi-problem profile of youth emerged, including:

- First criminal referral at a young age,
- A dependency referral history,
- A runaway history,
- High prevalence of alcohol and drug use,
- A negative peer group,
- Serious family problems, and
- School risk factors.

The four factors that were most predictive of youth who would become chronic referrals are in bold. A quarter had a history of community mental health, alcohol and drug, or residential treatment. This study recommended increasing early identification of potential problem youth based on these indicators, increasing capacity to provide early intervention, and targeting services specifically to this group.

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[53] "Chronic Juvenile Offenders in Multnomah County," DCJ Research and Evaluation Unit, August 2003.

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Appendix E:
Service Map
Services Targeted to or Used by People with a Mental Illness Involved with the Justice System

This list of services is based on a November 2004 survey of County agencies and community providers. Only targeted or major services used for this population are listed, rather than all services that may be available. Services are dynamic and expected to change over time.

Community Access

Key community access points are listed below, representing the officers and staff who have either initial or repeat contact with people in crisis who have a mental illness. Ongoing training for staff in these programs is essential to help them identify and understand mental illness, to know how to link to the Mental Health Call Center to determine whether a person is in treatment, and to link to the individual's case manager, case management team or community resources.

COMMUNITY ACCESS	PRIMARY AGENCY; PARTNERS
Bureau of Emergency Communications (911) – Serves as primary switchboard for taking and sending the appropriate responder to emergency calls.	**City of Portland**
Crisis Intervention Teams (CIT) – Police officers regularly deal with issues involving people with mental illness and intoxication. CIT officers are dispatched to calls specifically involving a person with suspected mental illness or an unusual situation. Officers provide mediation, link to resources, often contact Project Respond for support, and may transport to the emergency room for an emergency hold, or to other options.	**Portland Police Bureau; Fairview, Gresham and Troutdale Police Departments; Multnomah County Sheriff's Office**
Neighborhood Livability Crime Enforcement – Works with 35 designated repetitive offenders; uses short periods of detention (immediately following the crime) coupled with community service sentences & social services to reduce recidivism. Bookings are often made on a community safety exemption.	**Portland Police Bureau**
ACCESS – A new pilot program, aims to reduce livability crimes in the Old Town/China Town Area, and thus reduce financial burden on police & emergency services. A case manager works with 90+ people who are public safety concerns as a danger to themselves or others, and for whom normal routes to MH treatment or rehab have not worked. Services include linkage to MH treatment, health care, emergency shelter, job placement and housing.	**City of Portland, Office of Neighborhood Involvement, Downtown Crime Prevention Program**; County departments, Portland Police Dept., Bureau of Housing & Community Dvpm't., Emergency Shelter Providers
Hospital Emergency Rooms – Have again become the primary medical provider for those ineligible for the Oregon Health Plan. Hospital staff can refer inappropriate and high users to more appropriate MH crisis and treatment resources.	**Hospitals**

MENTAL HEALTH ACCESS AND TREATMENT SERVICES

Mental Health treatment has evolved significantly in recent years, including:

- Providers have increasingly used evidence-based practices – those that have been demonstrated to work for particular populations – to guide their work. This is now required by State and County contracts.

- On-demand service has been recognized as an important part of the treatment continuum, with implementation of a Walk-In Clinic, and open-access appointments at all major clinics contracted by County MH.

- For those who are not likely to access clinic-based services, outreach teams based on the Assertive Community Treatment (ACT) Team model have been implemented. Teams address the comprehensive set of issues for an individual: mental illness, substance abuse or addiction, medical needs, housing, employment, and motivation for improved stability and/or recovery. Both Cascadia Behavioral Health Care and Central City Concern have teams in place to reach high utilizers of services with multiple diagnoses including mental health (Cascadia) or addictions (Central City Concern). Teams operate 24/7, and have staff with jail clearance so they can do "in-reach" for their caseload when incarcerated.

- "Wrap-Around Services" are now seen as an essential part of treatment success to help a consumer deal with a crisis and maintain a stable living situation.

- It is now accepted that a mental illness and co-occurring substance abuse or addictions issue should be treated as a combined disorder, rather than as separate issues by different programs. Multnomah County Mental Health and Addictions Services, as well as the Department of Community Justice, now require all providers to be certified for delivery of both services.

- Providers report that the next step is to develop a recovery model for mental illness, borrowing from A&D models and based on the belief that consumers should be able to meet all their life goals despite their psychiatric disabilities. Consumers would learn to self-manage symptoms and transcend their disability.

- Culturally specific services are available through specialized providers

MENTAL HEALTH SERVICES	PROVIDER; PARTNERS
ACCESS SERVICES	
Mental Health Call Center – A 24/7 phone center serving as the hub of the mental health system. Provides access for crisis and non-crisis callers. Dispatches Project Respond, refers to providers, links to case managers when a client is in crisis. Conducts problem solving with consumers and providers. Has flexible funding to prevent or remediate crises.	**Multnomah County, Department of County Human Services (DCHS) Mental Health Services**
Walk-In Clinic – An 18/7 clinic for people in crisis who are not in services, or in need or medication assessment or urgent need to see a therapist , Link to ongoing provider and other community program s. Provide immediate access to services. Near SE 39 and Div.	**Cascadia Behavioral Healthcare**; DCHS Mental Health Services

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MENTAL HEALTH SERVICES	PROVIDER; PARTNERS
Project Respond – A 24/7 mobile outreach and engagement team for people not yet in MH services. Respond to crises from County MH Crisis Line or police. Travel to site, assess, de-escalate to avoid hospitalization; if cannot, place the individual on a director's custody hold, transport to a hospital (either by Cascadia secure transport, or by police). Nurse practitioner & prescriber can prescribe medications. Provide follow-up until "loop is closed," connecting to case management or other services, or crisis has abated. 140 new clients and 900 total contacts a month; est. 10% involved with corrections.	**Cascadia Behavioral Healthcare**; co-funded by Multnomah County DCHS Mental Health and Portland Business Alliance
Hospital Emergency Room/ Psychiatric Ward - Hospital ERs complete a psychiatric evaluation and make a decision about whether an individual meets the MH hold criteria. If so, are placed on the psychiatric ward for medication and stabilization. Due to shortage of beds, some are transferred to another hospital or held in the ER for an extended period until a bed becomes available.	**Area Hospitals**
TREATMENT SERVICES	
Primary Provider – Clinic based services for people referred by self or others (e.g. courts). Initial appointment or open access clinic visit leads to a plan to work on resolution of client's issues, averaging 6 months, with 1 -3 times/week of individual & group sessions. If person has an "Axis I diagnosis" (severe mental illness), the process is longer, up to multiple years. Behavioral interventions are used first, along with skill building, symptom management, housing, employment & case management. When needed, a medical evaluation may result in prescription of medications. An estimate of 26 to 32% of Cascadia's clinic services clients are involved with corrections.	**Cascadia Behavioral Healthcare, Lifeworks, Oregon Health Sciences University** (OHSU), and 8 smaller providers.
Crisis Wrap Around Services – An add-on function that helps consumers deal with crises that could interfere with the success of treatment. Includes help to keep their housing, or negotiate a remedial contract with the tenant & property manager; or a personal care assistant – often another consumer – hired to help with shopping or keeping the terms of their housing contract.	**Cascadia Behavioral Healthcare**, and other treatment providers
Respite Care - A voluntary diversion alternative for short-term stabilization of consumers in crisis and at risk for incarceration or inpatient psychiatric admission. The group home facility is non-medical, staffed by mental health professionals 24/7, and links with medication consultations, services and benefits.	**Cascadia Behavioral Health Care**
SPECIALIZED TREATMENT SERVICES	
Case Coordination Program - Intensive assessment, case planning, referral, and care coordination for offenders with a mental illness on DCJ Parole/Probation community supervision. Cases are transitioned into standard case management services once stabilized. Serves 160-180 medium and high-risk adult male and female offenders with severe symptoms, who may have co-occurring disorders.	**Cascadia Behavioral Healthcare**; funded by Multnomah County DCJ
Community Outreach and Engagement (CORE) - Based on an Assertive Community Treatment (ACT) team model, delivers comprehensive services to people with a severe mental illness through outreach teams. Provides psychiatric & addictions services, case management, and linkage to housing, benefits and employment. 119 of 340 served (35%) have significant corrections involvement	**Cascadia Behavioral Healthcare**

MENTAL HEALTH SERVICES	PROVIDER; PARTNERS
Community Partners Reinvestment - Provides outpatient treatment and case management, with incentives for participation for young male offenders 18-25 incarcerated for over a year who are coming back to Multnomah County; all have experienced trauma and depression; all have drug arrests.; Metropolitan Family Services provides family support; SE Works funds up to 3 months housing assistance; Better People does work placement for people with criminal backgrounds.	**Volunteers of America**; funded by Jeht Foundation, Meyer Memorial Trust; Multnomah County Department of Community Justice
Conquest Center - Recovery oriented treatment services for persons with severe mental illness. Includes case management, medication management, and integrated dual diagnosis individual and group skills training/ therapy. Serves 300 adults with serious mental illness; over 40 % are African American.	**LifeWorks Northwest**
Culturally Specific Providers, e.g. NARA Outpatient & Residential - Comprehensive outpatient and residential treatment services, focusing on Native American culture, family and community strengths. Serves 323 adults a year in outpatient, 190 in residential; 80% are dual diagnosis and involved in justice system. **Additional culturally specific providers serve other targeted groups.**	**NARA NW**; funded by Indian Health Service, SAMHSA, HRSA, State of Oregon, OHP, Multnomah County, Private Pay, City of Portland, philanthropic organizations.
Mental Health Evaluations – Prioritized evaluations for DCJ clients who are medium or high risk, and where mental illness is suspected or there has been a problem with supervision.	**Tualatin Valley Mental Health**
Project Network – Culturally specific residential and out-patient mental health and alcohol & drug treatment program. Serves 100-120 pregnant and post-partum African American women, partners and children; includes women involved in criminal justice system.	**LifeWorks Northwest**
Treatment Not Punishment (TNP) – Outreach and treatment for African American adults who would not access traditional MH or A&D services. This new program currently serves 25 people with outreach, intensive case management and non-traditional services.	**Cascadia Behavioral Healthcare**; funded by Mult. Co. Department of Community and Family Services
Treatment Readiness Intervention & Prevention (TRIP) – Seeks integration of MH and A&D services with primary health care by placing a dually certified therapist in County Health Clinics. Reaches out to those who seek help from a physician when the issues are MH or A&D related. This new program currently serves 20 difficult to reach individuals who would not come to site-based MH services.	**Cascadia Behavioral Healthcare**

ADDICTIONS TREATMENT SERVICES

DCHS Addictions Services works with the target population which a co-occurring addictions disorder. In some cases, Addictions Services contractors are the primary provider for an individual, or provide case management to link the individual to needed services. As with Mental Health, culturally specific services are available through specialized providers.

- County Addictions Services staff are collaborating with the development of homeless services in downtown, especially the new outreach teams.

- The most critical development over the past year is the requirement, along with Mental Health and the Department of Community Justice, for all treatment providers to be dual certified for both alcohol/drug and mental health treatment.

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- The County has received a three year grant from SAMSHA (the federal Substance Abuse and Mental Health Services Administration), to test effective strategies for meth treatment. This grant will involve many of those working together now on the downtown homeless issue.

- Clark County also received a meth treatment grant, to look specifically at clients with co-occurring disorders. Multnomah County Addictions Services staff will be following the results of this closely.

ADDICTIONS TREATMENT SERVICES	PROVIDER; PARTNERS
Community Based Services – Team members coordinate components of the service continuum for individuals, and work on treatment readiness for those not yet assigned to an outreach team or provider. Work with jail and corrections health to coordinate services for those who have been arrested and need services. Russian and Spanish capability.	**Multnomah County DHS Addictions Services**
Community Engagement Project (CEP) - Based on the Assertive Community Treatment (ACT) team model, delivers comprehensive medical, psychiatric & addictions services, case management, and linkage to housing, benefits and employment to people where they live. Serves160 severely addicted people with mental illness, including chronically homeless and high medical users.	**Central City Concern**; 3 CEP teams funded by: Mult. County; HERSA/ HUD/ VA/ SAMSHA; Dept. of Labor/ HUD; partner with JOIN, VA, Housing Authority, Co. Health Dept.
Hooper Sobering and Detox – Provides therapeutic sobering and detoxi-fication for inebriated individuals. Serve as a key "front door" to services as many are more treatment ready immediately following their stay. The **BIERS van** provides transport of inebriated individuals to the facility.	**Central City Concern**
Outpatient & Residential Treatment– An array of drug and alcohol outpatient and residential treatment programs serve both general and specific needs.	**County Addictions Services** contracted providers
Residential Integrated Treatment Services (RITS) - Integrated care for individuals who have mental health, addictions, and criminal issues in a community residential setting. Serves 40 medium and high risk adult male offenders on parole or probation who have co-occurring disorders.	**Cascadia Behavioral Healthcare**; funded by Multnomah County Department of Community Justice and Medicaid

RELATED PROGRAMS

These include other County departments who serve small numbers of people who fit the target population definition, and community non-profits that provide key services needed by this group.

RELATED PROGRAMS	PROVIDER; PARTNERS
Developmental Disability Services – Provides case management, protective services, limited residential, vocational, crisis diversion, protective services for people with developmental disabilities, including some in target population. A specialized case manager works with DD clients involved with justice, including under PSRB	**Multnomah County Developmental Disability Services**
Public Guardian; Adult Protective Service Program – The Public Guardian acts as legal guardian or conservator for incapacitated adults 18+. Protective Services provides protection and intervention to older adults and people with a disability at risk of harm by abuse, neglect and exploitation, including self-neglect. Up to 5% of referrals are for people	**Multnomah County Aging and Disability Services**

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RELATED PROGRAMS	PROVIDER; PARTNERS
with mental illness and justice involvement.	
Public Health Clinics – Provide comprehensive medical services and link people to mental health and addictions treatment.	**Multnomah County Public Health**
JOIN - Uses a "housing first" model to place a person into housing, obtain an income, transition to permanent housing, and retain that housing. Part of stabilization is connecting people to MH & addictions. 5 outreach workers, one per precinct, contacted 2000 homeless last year and housed 436 in mostly private housing. About half have a mental illness; a third have both MI and criminal justice involvement.	**JOIN**; funded by Portland Police Bureau; active in Bureau of Housing and Community Development-led effort to end homelessness in 10 years.

MULTNOMAH COUNTY JAILS

Corrections Mental Health staff play an important role in designing and implementing a treatment plan while the individual is in the jail setting. Health Division staff are augmented by six OHSU psychology doctoral graduate practicum students, and assist with evaluation, assessment and individual and group therapy.

Multidisciplinary staffings in the jail help with the management of people with mental illness in the institutional setting. The discharge planner attends, and the community mental health worker is invited if know. Access to the MH Raintree data system will facilitate finding out whether the individual is in services, and if so, the name and agency of the case manager.

JAIL	PROVIDER; PARTNERS
Booking and Release – In downtown Justice Center. Accepts new prisoners, fingerprints/photographs, and provides physical search, initial medical screening and secure transport between facilities. Only slight increase in bookings in past 5 years.	**Multnomah County Sheriff's Department**
Corrections Health - Acute and chronic medical, mental health, dental care for all adults and juveniles incarcerated in jail; clients have high incidence of health problems affected by psycho-social factors, economic status, community MH care access, and complications of their criminality. **Corrections Mental Health** focuses on crisis intervention, stabilization, management in the jail setting, continuity of care when incarcerated, release planning, and suicide prevention. Practicum students add assessment and therapy capacity.	**Multnomah County Health Department**; George Fox graduate school of psychology
Inverness Mental Health Treatment Team– Located in medium adult security jail in NE Portland, serves average of 130 adult male offenders at a time with mental health or protective custody issues, within the jail setting. Work to stabilize inmates and move from close-custody single cell housing (dorm 14) to open dorm setting (dorm 14), and then to general population housing, work crews & community programs. Focus on reduction of self harm, symptom management, planning for continuity of care upon discharge to community.	**Multnomah County Sheriff's Department**; Health Department, Corrections Health

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ADJUDICATION

The Oregon Judicial Department 4th Judicial District is responsible for primary court functions in Multnomah County.

ADJUDICATION	PROVIDER; PARTNERS
Oregon State Hospital – Provides evaluations of whether a defendant is able to "Aid & Assist" in their own defense, and thus us able to stand trial or requires treatment. Also later provides treatment for those judged 'Guilty but Insane' by the court.	**Oregon State Hospital**
Community Court – Adjudicates low-level offenders amenable to treatment; those with mental health or drug/alcohol issues are screened by DCHS mental health consultant attached to the court, who refer to needed social services. Mental health/ A&D treatment services are linked and monitored under court supervision. 250 new arraignments per week; disposes of 6,000 cases per year.	**Courts, District Attorney, County Human Services, Department of Community Justice**; Portland Business Alliance
STOP Court – Engages addicts charged with a drug related crime into treatment. InAct (a non-profit agency) counselors complete assessments, provide treatment and case management, and make recommendations to the STOP Court judge.	**Courts, District Attorney, Department of Community Justice Defense Attorneys, InAct**
Civil Commitment Court – Judge decides whether a person alleged to be mentally ill is required to go to a psychiatric hospital or accept other mental health treatment. The community mental health program investigates the need for commitment following specific guidelines.	**Multnomah County: Courts, DCHS Mental Health, Sheriff's Office Civil Department**

COMMUNITY SUPERVISION

Community supervision promotes public safety and strives to reduce recidivism for defendants and offenders released to the community, through a balance of supervision, services and sanctions.

- Along with Mental Health and Addictions Services, the Department of Community Justice, now require all providers to be certified for delivery of both mental health and addictions services.

COMMUNITY SUPERVISION	PROVIDER; PARTNERS
Close Street Supervision – A highly supervised pre-trial release program, staffed by corrections deputies. Provides an alternative for defendants who cannot obtain pre-trial release through bail or personal recognizance; many present a variety of special needs. Goal is to maintain dependant in community without additional violations, and ensure appearance at all court hearings.	**Multnomah County Sheriff's Office**
Joint Access to Benefits (JAB) – Initiates application for Social Security benefits for incarcerated individuals prior to release so they can receive benefits sooner after release, such as stable housing and medical benefits.	**Multnomah County Department of Community Justice**, Sheriff's Office, Aging & Disability Services; Social Security Administration

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OMMUNITY SUPERVISION	PROVIDER; PARTNERS
Probation and Parole – Provides supervision for parole, probation and post-prison offenders, including many of those who have been diagnosed with a severe and persistent mental illness. Attempts to decrease or prevent future contacts with criminal justice.	**Multnomah County Department of Community Justice**
Mentally Ill Offender Unit – Provides supervision for parole, probation and post-prison offenders who have been diagnosed with a severe and persistent mental illness. Diverts from incarceration or hospitalization into community based treatment and services; attempts to decrease or prevent future contacts with criminal justice.	**Multnomah County Department of Community Justice**
Transitional Services Unit – Provides comprehensive services to prepare, equip & sustain offenders upon re-entry to community from prison or jail (first 90-180 days). Links to short & long-term housing. . Focus on offenders with special needs, incl. mental, developmental or physical disability, elderly, and predatory sex offenders. Serves 273 per month. 73% have special needs; a third identified a mental health need.	**Multnomah County Department of Community Justic e**; DCJ also contracts for 225 beds in a variety of settings. Builds partner-ships with community organizations for ongoing support and structure.
PSRB Monitoring & Supervision – Serves 87 men and women from Oregon State Hospital following treatment (for crimes from felonies to misdemeanors), deemed ready for conditional release to community. Provide case management; monitoring; day treatment, work or volunteer opportunities; residential & housing options. About half are in licensed beds (with plans to expand). Monitoring continues to maximum length of original sentence. Release may be revoked because of increase in symptoms or non-compliance. County Mental Health staff must review case and accept for County placement.	**Cascadia Beha vioral Healthcare, Providence Healthcare, Multnomah County DHS Mental Health**; funded by Psychiatric Security Review Board (PSRB)

YOUTH TREATMENT SERVICES

Collaboration in the treatment of youth has increased dramatically in recent years.

- ▪ DCHS Mental Health and Addictions services programs, and the Department of Community Justice, have adopted requirements for all providers to be dual-certified in mental health and addictions treatment.

- ▪ Addictions Services is working to implement family and culturally specific models for youth drug and alcohol treatment – for example, Leo Ni Leo and Kojo House, for African American youth – recognizing that it takes time and ongoing support to create such models.

- ▪ Mental Health is in the process of redesigning its contracted services to increase the focus on higher risk youth and expand family and home-based services.

- ▪ Mental Health is implementing a Family Checkup model, which may help shorten treatment for some families and free up resources to serve some families more intensively.

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YOUTH TREATMENT SERVICES	PROVIDER; PARTNERS
CRISIS SERVICES	
Children's Mobile Outreach - For children and youth who are experiencing a mental health crisis such as suicidality or very concerning behaviors to self or others, this team performs community based assessments and then links youth and families to appropriate services. The Mobile Outreach comes to the juvenile detention facility to assist with children who are presenting with acute mental health symptoms.	**Department of County Human Services, Mental Health program**
Children's Prevention Team - Responds to urgent requests for evaluation and intervention. CPT does outreach to children and families who cannot wait or will not go to a mental health appointment. The CPT is the first line of contact for the juvenile detention facility during day time hours. The mobile outreach responds during off hours.	**Department of County Human Services, Mental Health program**
OUTPATIENT SERVICES – Cascadia Behavioral Health, Lifeworks Northwest, Morrison Family Services, Trillium Family Services and the Kerr Center are the major providers for outpatient mental health treatment services for youth. Some programs are highlighted below.	
Adolescent Day Treatment (Nickerson/NE and Tigard) - highly structured setting with individual, family, group, psychiatric treatment and an academic program. Serve 130 Multnomah and Wash. Co. youth ages 12-18 experiencing serious psychiatric difficulties.	**Lifeworks Northwest**
Assessment and Treatment for Youth and Families (ATYF) - For severely delinquent youth who cannot be mainstreamed into the mental health system. Provides in-home clinical assessment and treatment to 200 probation youth per year who pose a high risk of committing new crimes, and have serious mental health, substance abuse and behavioral problems. Therapists administer the Global Appraisal of Individual Needs (GAIN), a state-of-the-art clinical assessment that provides a comprehensive picture of a youth risks and needs, and thus can link youth to appropriate treatment. Outpatient – and sometimes in-home – treatment focuses on changing anti-social behaviors, with active family involvement. ATYF has served 174 youth in its first year.	**DCJ, Juvenile Services**
Child Evaluation Clinic - Comprehensive psychological evaluation services for 58 children ages 3-18. Specialized evaluations for risk assessments, sex offenders, and fire-setters are available.	**Lifeworks Northwest**
Child & Family Outpatient Services – Provide wraparound treatment and support to meet the specific mental health, addiction and other social service needs of 400 children and families.	**Lifeworks Northwest**
Counterpoint Outpatient Treatment - Provides specialized sexual offender treatment to adjudicated Multnomah County adolescent males and females and their families using individual group, family and intensive case management.	**Morrison Child & Family Services**; DCJ and County MH
Early Intervention Unit (EIU) - When police get involved with an out-of-control child under twelve years old, the Early Intervention Unit provides immediate clinical intervention to keep the child from further penetration into the juvenile justice system. Therapists specially trained to treat delinquent children provide services in the family's home, on the family's terms.	**DCJ, Juvenile Services**

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YOUTH TREATMENT SERVICES	PROVIDER; PARTNERS
Multi Systemic Therapy (MST) –Therapists provide intensive, in-home family therapy for adolescents whose behavior places them at risk of out-of-home placement, who have significant substance abuse problems and/or are gang involved. Intensive home- or school-based services address the whole family, including younger siblings. MST will serve 50 families in FY05. Success is high: 75% completed the program or were partially successful in 2003; and 75% lived at home or with another relative. No MST youth were placed in a youth correctional facility, and 62 to 70% remained crime-free.	**DCJ, Juvenile Services**
Outpatient & Residential Treatment– An array of drug and alcohol outpatient and residential treatment programs serve both general and specific needs.	**County Addictions Services** contracted providers
RESIDENTIAL SERVICES	
Counterpoint Day & Residential Treatment – A statewide resource that provides specialized sexual offender treatment to adjudicated adolescent males and females and their families using individual group, family and intensive case management. Includes education and living environment for boys 13-18 years old; 9 of 35 are from Multnomah County.	**Morrison Child & Family Services**; Oregon Youth Authority
RAD Residential Alcohol and Drug Unit - RAD treats high risk teens under DCJ supervision who have serious substance and mental health issues and delinquent behaviors. RAD is a last-chance resource for teens facing commitment to a state facility because of past treatment failures. Staff provide clinical assessment, individual, family and group treatment and transition planning. 50-75% of RAD's 35 clients are gang members.	**DCJ, Juvenile Services;** Morrison Child & Family Services provides the A&D treatment
Rosemont Treatment Center and School - Provides comprehensive, highly structured secure residential mental health treatment and alcohol and drug treatment for psychiatrically disturbed and addicted adolescent females ages12 through 17. Of 99 served, 26 are from Multnomah County.	**Morrison Child & Family Services**; funded by Oregon Youth Authority and OMHAS
STRP Secure Residential Treatment Program – The only secure intensive residential treatment program in Oregon for high risk adolescent male sex offenders who are currently inappropriate for community placement. The average juvenile sex offender in SRTP has had 4.5 victims, usually younger children; half have serious alcohol and drug problems, and more than half had a mental health diagnosis. Clients receive intense individual, group, and family therapy in a setting where they cannot hurt anyone. Research on effectively treating juvenile sex offenders. Specially trained treatment staff, polygraphs, and medical and nursing care. SRTP serves fourteen males at one time, approximately 40 youth annually.	**Morrison Child & Family Services**; funded by DCJ Juvenile Services. Works closely with Juvenile Court Counselors and Judges.
Temporary Treatment Foster Care – added to MST in 2002, TFC serves 25 youth, significantly increasing the success rate of MST.	**DCJ, Juvenile Services**

Appendix F

Survey Results: System Strengths, Successes and Barriers
In Serving People with Mental Illness Involved in the Criminal
Justice System

Responses to LPSCC Survey, December 2004

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... who ... involved the ... justice system ...
November 2004. Responses ... small ...

1. STRENGTHS: What currently works well in the interface between the mental health and criminal justice systems?

Adult System

System Coordination

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Treatment Collaboration

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Youth System

Treatment Collaboration

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2. SUCCESSES: What evidence based practices are most effective in working successfully with offenders with a mental illness (and often a co-occurring addiction) offenders?

Adult System

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Discharge & Parole/Probation

Treatment & Community Services

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Youth System

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3. BARRIERS: What are the main barriers to success with this population?

Adult System

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Mental Health and Addictions Resources

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Youth System

Youth and Family Factors

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Coordination

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Community Services for Youth

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