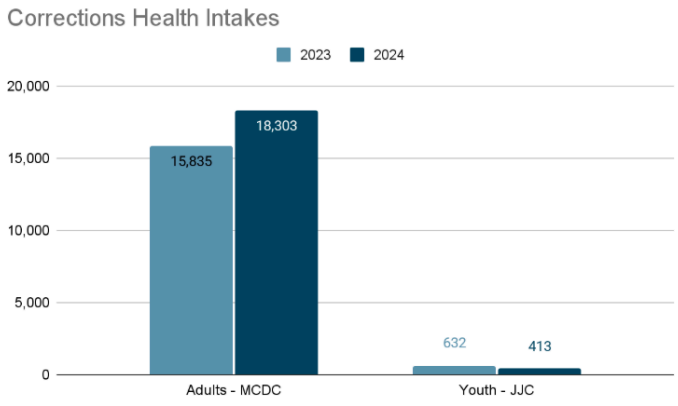
Multnomah County
FY 2026 Budget Work Session Follow Up

Corrections Health

May 20, 2025

Commissioner Brim-Edwards (District 3) - FUTURE FY 2026 BRIEFING The chart below shows year over year increases and we need to closely monitor. Please report back on the status of Corrections and Corrections Health capacity post the presiding judges orders and any other changing conditions for the public safety system.

Corrections Health: Who We Serve



18,716 community members served annually

For CY2025 there have been **6,083** Intakes for Adults & **149** Intakes for Youth

** Loss of Clackamas and Washington County contracts contribute to the reduction of youth intakes.*

MCSO/Corrections Health Response:

Corrections Health monitors intake trends and staff to meet the needs of our patient population. We make every attempt to hire and retain regular staff. We fill in with contracted agency staff as needed to meet the needs of the adults and youth we care for.

We will continue to track and monitor any legislative changes that may result in an increased population in corrections settings. Recent changes to illicit substance laws, for instance, may lead to an increase in carceral populations. While deflection options may mitigate this potential increase, we will continue to monitor this potential impact and will adapt as needed to ensure we maintain and provide the best quality of care possible.

As part of its role in our local justice system, the Multnomah County Sheriff's Office provides the Board of County Commissioners with updates related to carceral populations and capacity.

Commissioner Moyer (District 1) - What is our ADA process and policy(s) for accommodations in our corrections facilities for justice involved individuals? **FUTURE FY 2026 BRIEFING**

MCSO/Corrections Health Response:

There are several points in the process where people in custody may raise the need – during intake, through the nurse asking questions during the history and physical, and through the MRF (Medical Request Form) where Adults In Custody (AICs) can ask for what they need that may be medical, dental, mental health, or related needs. Additionally, AICs have access to an MCSO Corrections Counselor and/or the deputy assigned within the housing unit. These staff members serve as resources for requests related to medical support and/or ADA accommodations.

As we discussed during the worksession, we have tablets in each custody area for translation purposes for those using American Sign Language (ASL) or other languages to ensure that we can communicate effectively with them. These are also used if/as needed for translation during medical-related care/treatment. MCSO maintains access to teletypewriter (TTY) machines, which are available to AICs as needed. Further plans are underway to implement different tablets later this year, which AICs can use for phone calls. Corrections Health should be able to use these tablets for care visits when/if needed as well.

Commissioner Moyer (District 1) - FUTURE FY 2026 BRIEFING
How do we deliver mental health services for people who are in our custody? What does training look like and how does Corrections Health and MCSO coordinate on this work?

MCSO/Corrections Health Response:

In order to deliver care to clients, we first determine who needs care. All adults placed in custody are screened for mental health needs during a medical intake completed by a Registered Nurse prior to being booked into custody in accordance with the National Commission of Correctional Health Care standards. A team of Masters-level Qualified Mental Health Professionals (QMHPs) and/or licensed Counselors and Social Workers are hired into our Mental Health Consultant (MHC) role. The QMHP credential, LCSW and LPC all require a Master's degree and 12 hours or more of professional continuing education units annually. Additionally staff in the MHC role take at least 16 hours of training on suicide prevention. Qualified staff receive onboarding and extensive shadowing from senior clinicians after hire before working independently.

This team receives electronic referrals for care from medical intake, phone calls, medical request forms from clients, and other referrals prompted by medical and MCSO to prompt care. MHCs respond to requests for care as soon as possible (often immediately) and must assess all AICs who present with mental health needs within at least 30 days to meet National Commission on Corrections Health Care (NCCHC) standards. Clients are typically seen much sooner. Approximately 42% of AICs present with a mental health or substance use diagnosis, so this is a significant caseload.

MHCs triage the order of daily client visits based on the severity of the clinical need presented with support from their licensed Mental Health Supervisors. MHCs are assigned to caseloads of clients based on unit assignment and are regularly physically present on units to see clients, offer care, and interact with MCSO staff.

Regarding communication between MCSO and mental health staff, weekly multi-disciplinary meetings and Management Plan meetings occur including mental health and corrections representatives and complex client needs regarding housing and treatment are discussed. Staff also heavily use electronic communication in Criminal Justice Administration Services (CJIS) systems. Corrections Health and MCSO staff communicate ongoing and openly in person and by phone to address daily client behavior concerns for clients entering custody, remaining in custody, and being released from custody, including discussing when care needs to occur so treatment staff have the security support needed to safely enter units and see clients.

After a client is provided a field standard bio-psycho-social, diagnostic assessment including risk assessment from an MHC, they

are provided care, including individual therapy, at a frequency based on assessed acuity. For instance, our most acute clients may be seen daily and more stable clients may be seen monthly based on the MHC assessment. Care often occurs on client modules or at client cells, which is common in this setting, but more private areas are used as much as possible. Care may also include behavioral support planning, psycho-education, and care coordination.

In providing ongoing care MHCs also actively coordinate with MCSO, medical teams, and transition services to see that clients receive medical care, medications, and case management support as indicated.

MCSO has a dedicated Sergeant who serves as the mental health leader for MCSO and provides support and training to deputies who have experience and/or an educational background in working with AICs that are navigating various mental health related challenges. Additionally, our Corrections Health mental health leadership team partners with MCSO to support training and education of both their civilian and sworn staff as it relates to AICs and their mental health needs.

As noted in the briefing by our Corrections Health Director of Nursing, mental health evaluations are conducted by Qualified Mental Health Professionals (QMHPs). In addition to these initial evaluations, any MCSO or Corrections Health staff can screen and determine a client's initial placement on suicide watch (for instance, if the client reports suicidal ideations, a plan, or is actively harming themselves). Afterwards a masters-level QMHP, who may additionally be independently licensed as a Social Worker or Counselor, assesses the client's ongoing needs.

The initial risk assessment provided by the QMHP contains 20 questions. This includes discussion of the client's history of dangerousness to themselves or others, recent treatment, relevant information from law enforcement reports, assessed risk factors, protective factors, a rating on the evidence-based Columbia-Suicide Severity Rating Scale (CSSRS), administration of other relevant assessment tools, education about suicide watch in the environment, safety planning, follow-up referrals and recommendations for other healthcare teams.

By field standards, this is a comprehensive method to inform client safety and need for suicide watch-specific observation, isolation, and restriction from items that could be used to harm or kill oneself. AICs are encouraged to engage in an initial, more in-depth, bio-psycho-social assessment by a QMHP in order to determine mental illness diagnosis and plan ongoing mental health care including individual therapy, case management, and transition planning. AICs on suicide watch are also referred to engage in medication management provided by a Psychiatric Mental Health Nurse Practitioner (PMHNP) if clinically indicated.

If desired, the Multnomah County Sheriff's Office can provide an overview of the Department of Public Standards Safety and Training requirements, with an overview of how the annual training plan and curriculum is developed.

Commissioner Brim-Edwards (District 3) - For slides 14-15 please provide any data that helps us understand if we are achieving our goals, comparisons to benchmarks, the total population we are trying to serve, where we have gaps in services.

Corrections Health Response:

As discussed during the briefing, Corrections Health (CH) is working to create the data needed to show our progress related to our goals and answer these questions. We do not have the depth of data needed at this time to properly depict the great work the CH team is doing.