JUSTICE & MENTAL HEALTH COLLABORATION PROGRAM

Outcomes Associated with the Creation of the Gresham Service Coordination Team

Multnomah County

Research & Planning
Community Justice

CITY OF GRESHAM OREGON

CASCADIA BEHAVIORAL HEALTHCARE
WHOLE HEALTH CARE™

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Executive Summary

This report was developed to outline the evaluation of the Gresham Service Coordination Team (GSCT) for justice-involved individuals who are experiencing mental illness in the City of Gresham, Oregon.

The Gresham Service Coordination Team

Funded through a Bureau of Justice Administration -- Justice and Mental Health Collaboration Program grant supported the implementation of the GSCT that:

- Uses a co-responder model to pair mental health clinicians and police officers, who respond to 911 calls for service with a mental health nexus.
- The team is responsible for both (1) de-escalating active mental health crises that have triggered a police response and (2) following up with the justice-involved individuals in the days and weeks following a police incident.

Outcomes

Success, for this team, was defined in the following manner.

Documenting Mental Health Related 911 Calls for Service

- Over the nine-month period of analysis, the Gresham police responded to 1,890 calls for service involving a mental health concern.
- This translates to approximately 3% of all 911 calls received.

Diverting Individuals with Mental Health Needs Away from Jail

- Only 6% of those mental health calls resulted in an arrest.
- If an officer trained in crisis intervention was present on the scene for a mental health call, the individual experiencing mental illness was significantly less likely to go to jail than if the responding officer(s) did not have crisis intervention training.
- Additionally, if a GSCT clinician was on scene, even fewer individuals were sent to jail. Only 2.1% of clients seen by the GSCT clinicians were sent to jail.

Providing Follow-Up Resources for Justice-Involved Individuals with Mental Health Needs

- Following a mental health 911 call, the team coordinated follow-up services for 180 clients in the nine-month window of analysis.
- On average, the clinicians on this team spent 2.3 hours coordinating services for each client and had an average of 10 unique contacts with the client, their families, or service providers.
- The GSCT spent the most time in direct contact with clients, but also frequently coordinated with the client's immediate family members, the client's primary therapist, and other police officers who were not on the Gresham Service Coordination Team.
- The GSCT also provided service referral information to clients. Most often, the GSCT informed clients about a 24-hour crisis line, walk-in medical clinics, and housing support services.
- Finally, the GSCT occasionally provided tangible goods as part of their service coordination efforts. Most often, the team provided food and drinks to clients who were experiencing food insecurity. Other tangible services included car rides to and from appointments, access to a phone, and various home goods (furniture, kitchen equipment).

Project Overview

Background

In 2017, a partnership was created between the Gresham Police Department (GPD), Cascadia Behavioral Healthcare (CBH), and the Multnomah County Department of Community Justice's (DCJ) Research and Planning Team (RAP). This collaboration was made possible through the award of a Bureau of Justice Assistance Justice and Mental Health Collaboration Project grant designed to advance criminal justice reform. The funds from this grant were used to implement a joint police and clinician response team that would be tasked with responding to 911 calls related to mental health crises in the City of Gresham, Oregon. The officers and clinicians on the Gresham Service Coordination Team (GSCT) would provide the dual roles of de-escalating the crisis situation and acting as a service coordinator in the days and weeks after the incident to provide additional support. This report explores the effects of the creation of the GSCT on diverting individuals experiencing mental illness away from the criminal justice system and on increasing these clients' access to community resources.

Methodology

Data was collected between 6/1/2019 and 3/31/2020. This time period was chosen as it contained complete months in which the GSCT was fully operational. Prior to 6/1/2019, the team was still in its pilot phase and data was inconsistently available. Furthermore, data after 3/31/2020 was confounded due to the COVID-19 pandemic. Quantitative data sources were combined using SQL. Data was checked and cleaned for reporting errors and missing values. Data analysis was conducted using R statistical software.

Four sources of data were combined for the evaluation.

911 Calls All incoming 911 calls in the City of Gresham were documented. This data includes both the 911 calls involving a mental health concern and 911 calls that were unrelated to mental health. This 911 call data included information about suspected crime type, priority, response time, clearance time, and number of officers at the scene.

Mental Health Mask After responding to a 911 call with a mental health nexus, Gresham police officers are required to complete an extra page of documentation before a call can be marked as cleared (i.e., a data mask). The data mask was not required for calls that did not involve a mental health concern. The mental health mask recorded information regarding the presence of social workers at the scene, officer use of force, the presence of weapons or drugs at the scene, and the result of the call (e.g., "criminal custody", "mental health hold"). The mask also served as an automatic referral system to connect the GMHT with clients in crisis.

GMHT Documentation Additional information was recorded by the GMHT clinicians on any client who was seen by the team. This data included client demographics, case notes, assessments, referrals, time spent with clients, and the reason clients exited the program (e.g., "successful completion", "client declined further services").

Interviews with GSCT Members Quantitative data was enriched through qualitative interviews with both clinical and police team members from the GSCT. Team members provided stories and details regarding their day-to-day work activities, successes, and lessons learned.

A Day on the GSCT

The GSCT consists of one certified mental health clinician, two police officers, and one police sergeant. The team works full time (40 hours per week) in the City of Gresham. The GSCT operates on a co-responder model, meaning that the officers and the clinician respond to 911 calls and provide follow-up visits together in the same vehicle. Below is a sample daily schedule for this team. However, please note that due to the highly agile nature of the job, the team often deviates substantially from this schedule.

8am: Team arrives and reviews notes and new referrals.

- Referrals are usually sent by other police officers who responded to a mental health crisis while the team was off work.
- Additionally, other service providers and clinicians in the Gresham area may refer clients to the GSCT if they feel their client is in need of additional service coordination

9am: Team meets as a group and creates a list of clients to contact that day.

- This list will combine new clients from the referrals with older clients who are in need of follow-up visits.

10am: Team begins contacting clients and service providers.

- This may be over the phone or in-person depending on the situation.
- If this is the first meeting, the clinician gathers information about service needs.
    - Does the client have a primary care physician? A mental health provider?
    - Are they in need of addiction services? Veteran services? Medication management?
- Team will then begin connecting the client to resources by:
    - Making client intake appointments with medical or mental health providers nearby.
    - Contacting existing providers to inform them of their client's current service needs.
    - Coordinating between various service organizations and familial supports to ensure that resources aren't duplicated or missing.
    - Driving clients to existing appointments if transportation is a barrier or sitting with clients through appointments if anxiety or communication are barriers.

Anytime: Team responds to crisis calls as they come in.

- Throughout the shift, the team listens for active 911 calls that may involve a mental health concern.
- If one comes in, the clinician and at least one officer will respond to the scene while it is in progress to assist in crisis de-escalation.
    - Once the scene is secured, the clinician will gather the same service needs information listed above.
    - The clinician will also call any current providers to inform them of their clients' current level of need.
    - The GSCT also responds to active calls for service that come in from mental health providers.
    - If current providers are worried that their clients are in crisis, the team will respond to that call as well.

Case Examples

The services provided by the Gresham Service Coordination Team are tailored to the individual needs of each client. Below are three real case examples that highlight some of the coordination efforts that the team typically employs. All names have been changed to protect the identity of the clients, but their stories are factual.

Peter

Peter was referred to the GSCT for two reasons: he had begun to call 911 repeatedly for non-emergencies, and he showed signs that he might be a risk of overdosing from his prescription medication. When the GSCT officers and clinicians reached him for a wellness check, Peter admitted that he had missed several meetings with his regular therapist. So many, in fact, that he was afraid he might have been dropped from their caseload. He also had concerns that he was eligible for veterans benefits, but did not know the steps needed to access them. Due to his lack of resources and support systems, he was struggling financially and living in a barren apartment.

The GCST offered to coordinate with Peter's mental health, veteran, and housing security services. When GSCT reached his therapist, it turned out that he was still enrolled and the team was able to schedule him a therapy appointment for the following week. Next, the GSCT reviewed Peter's eligibility for veterans benefits with the local VA hospital and determined that he was qualified. An appointment was scheduled for Peter to come to the VA to review his benefit package. Finally, the GSCT reached out to housing support services and obtained a food box donation of non-perishable food, plus plates, bowls, mugs, and utensils for Peter.

The team returned to Peter's apartment with the donations and reviewed the appointments that they had scheduled on his behalf. However, Peter was without transportation to get to the therapist or the VA hospital. So, the GSCT scheduled a taxi service to transport Peter to and from each appointment, and even called him one hour before to remind him of the plan. Then, they followed up with calls to both the mental health provider and the VA to confirm that Peter had kept his appointments. He knows now that GSCT remains available to help him, if he needs additional coordination.

Susan

Susan is an elderly woman living with cancer. Recently, her mental health symptoms had worsened and ultimately had resulted in an impending eviction from her apartment. She was utterly overwhelmed by the prospect of being evicted and finding a new place to live while maintaining her cancer treatments. While she was already connected to a mental health social worker and medical services when the GSCT got in contact with her, she had not been connected to any housing support services. She requested the help of GSCT with that transition.

GSCT provided her with a plan: first, with their guidance she would relocate her belongings in a nearby storage facility. Then, the team intervened with Susan's landlord and received permission for her to remain in the apartment for a few extra days, while they sorted out a housing plan. Their next step was to contact Adult Protective Services to explain the situation.

At the same time, GSCT also began calling services for the homeless, including outreach coordinators, fair housing council legal services, and women's shelters. When housing legal services and shelter services returned the team's call, they scheduled intake appointments for her. With that good news, the GSCT returned to Susan. They reviewed the plan for her to move her belongings to the storage facility. Lastly, they arranged for her to occupy in a long-term motel room until she would meet with housing services for her intake appointments.

Jack

After the Gresham Police was called to Jack's home due to a family dispute involving weapons, he was referred to the GSCT. The team arrived and spoke with Jack's mother, who also lives in the home. She informed them that Jack frequently suffers from persecutory delusions. So much so, that he rarely leaves his room.

The GSCT then spoke to Jack and conducted an assessment to determine if he currently was a risk to the safety of himself or others. Jack claimed he needed nothing more than additional food and drink, which the GSCT members provided. Jack agreed that he would attend an emergency session with his regular therapist if an appointment was scheduled for him. The GSCT reviewed that plan with Jack's mother, who quickly made Jack an appointment for the following week. The GSCT returned to Jack's house the day before his appointment to check-in and remind him of its scheduled time. Jack assured them that his mother would drive him to the appointment and he had no needs at that time.

However, Jack had two additional contacts with the police during the following week, which resulted in a non-voluntary hospitalization. Due to his escalating behaviors, the GSCT reached out to Jack's primary mental health provider to discuss getting him a higher level of care. The provider agreed that more care was warranted than she could provide alone. Therefore, the GSCT set up a schedule of phone meetings with that mental health provider, as well as with an intensive case management provider, and Jack's mother, so that all three might to organize wraparound care that was appropriate for Jack's needs.

Outcomes

During the creation of the GSCT, key members of both the Gresham Police and Cascadia Behavioral Healthcare settled on three quantifiable metrics of success for this project. Details regarding the early conceptualization of this team, the problems being addressed, and the creation of success metrics can be found in the JMHCP Key Informant Interview Report.

Success, for this team, was defined by:

- **Documenting Mental Health Related 911 Calls for Service**
- **Diverting Individuals with Mental Health Needs Away from Jail**
- **Providing Follow-Up Resources for Justice-Involved Individuals with Mental Health Needs**

Documenting 911 Calls for Service

The Mental Health Mask

A true analysis of the team's effectiveness at reducing 911 calls for service was not possible for this report due to the limited time in which the Gresham Police Department had been tracking calls with a mental health nexus. In June of 2019, the Gresham Police launched a mental health "mask," which requires every patrol officer to identify if a call for service involved a mental health concern before they can mark the call as complete (Figure 1). The creation of the mask coincided with the onset of the GSCT, and as such, no comparison could be made between 911 calls for service before and after the GSCT was operational. Therefore, this evaluation sought to capture baseline data, so that future research can examine the long-term impact of the GSCT at reducing 911 calls for service.

Figure 1: The Mental Health Mask

Over the nine-month period of analysis, the Gresham police responded to **1,890** calls for service involving a mental health concern. This translates to approximately **3%** of all 911 calls received in the nine-month period of analysis. Calls with a mental health nexus surged in the summer months, with **13.86%** of all mental health calls occurring in July 2019 (Figure 2). Mental health calls were lowest in the winter months. Only **10.11%** and **10.00%** of mental health calls occurred in December 2019 and January 2020 respectively.

Figure 2: Percentage of Mental Health Calls by Month

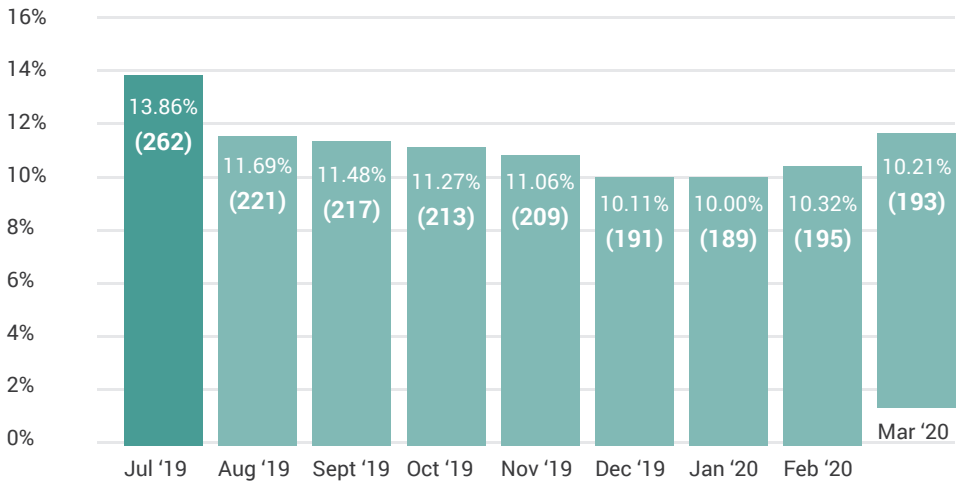
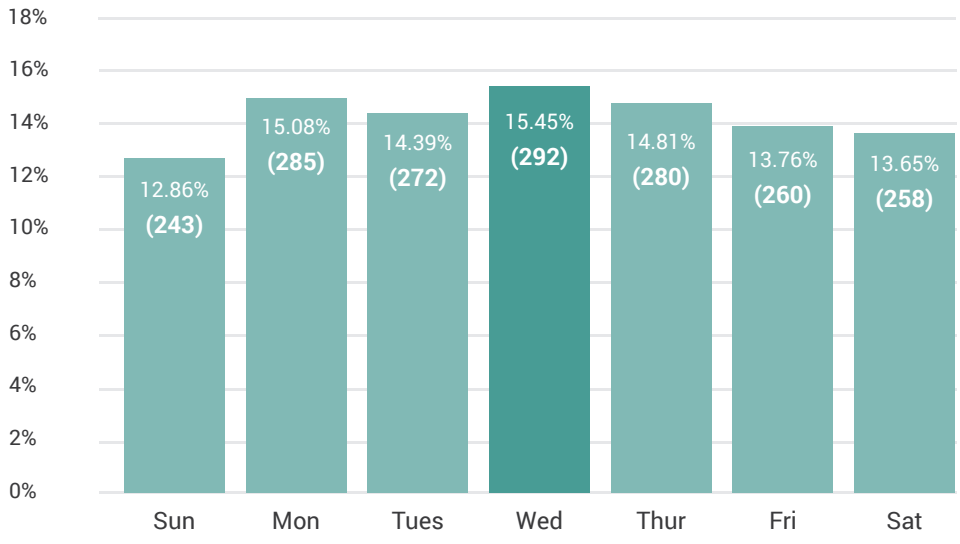


Figure 3: Percentage of Mental Health Calls by Day of the Week



Mental health calls were most frequently received in the middle of the week, and were least likely to be received on weekends (Figure 3). **Sixty percent** of all mental health calls for service were received on Monday-Thursday. In comparison, **30%** of calls with a mental health nexus were received on Friday-Sunday. Calls were most likely to come in during afternoon working hours, with **33.9%** of calls received between 12:00pm and 4:59pm (Figure 4). An additional **18.2%** of calls were received in the morning working hours of 8:00am to 11:59 am.

Calls for service involving a mental health concern

1,890

Calls for service responded to over 9 months of analysis

This is roughly **3%** *of all 911 calls*

Calls with a mental health nexus surged in the summer months to

13.86%

They were lowest in the winter months, down to

10.00%

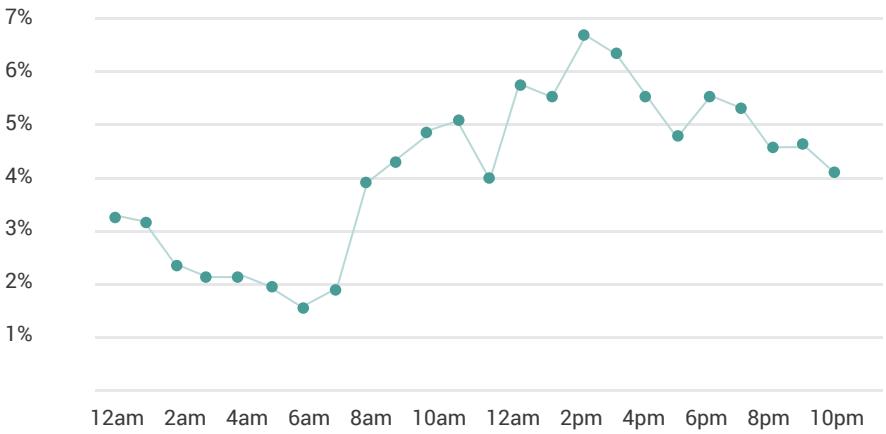
60%

of all mental health calls were received Mon-Thur

33.9%

of all mental health calls were received during afternoon working hours

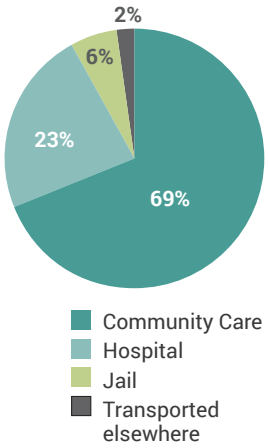
Figure 4: Percentage of Mental Health Calls by Time of Day



In total, Gresham police officers spent **1,376.6** hours responding to calls with a mental health nexus during our reporting period. On average, officers spent **44** minutes per mental health call. Of that time, an average of **30** minutes was spent actively responding on scene, with an additional **14** minutes spent on administrative tasks and transportation to the scene.

This data indicates that 911 calls for service that involve a mental health concern are a common part of the day-to-day work of the Gresham police force. Police responses to these types of calls are rather time-consuming and pull patrol officer resources away from other community policing efforts. The creation of the Gresham Service Coordination Team is one way in which these types of calls can be triaged to specially trained officers, simultaneously freeing up other members of the force.

Diversion From Jail



Of the 1,890 calls for service that involved mental health, only 6% of incidents (120 calls) resulted in an arrest. In comparison, 441 incidents (23%) ended with an intake at the local mental health hospital (193 non-voluntary, 248 voluntary). Citizens experiencing mental health issues were almost 4 times more likely to go to the hospital as they were to go to jail after having police contact in the City of Gresham.

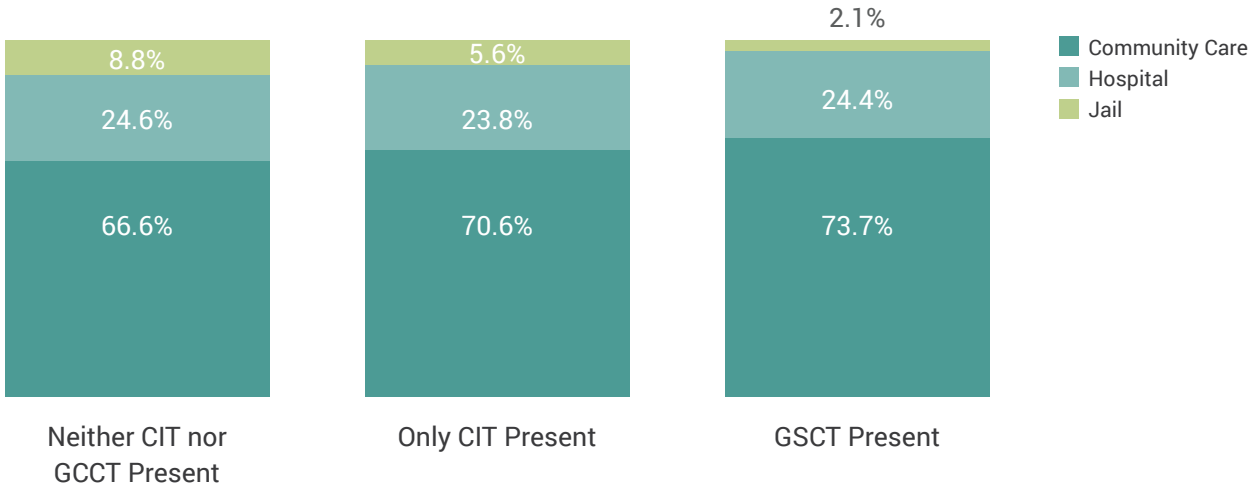
In order to better understand the impact of the GSCT on diversion from jail, a statistical model[1] was conducted. Dichotomous variables (yes/no), indicating (1) the presence of an officer who has received special crisis intervention training (CIT) and (2) GSCT clinician's presence on scene, were used as the predictor variables. Final disposition of jail, hospital, or community care was the outcome variable. Community care captures dispositions in which the GSCT either reconnects a client to their existing mental health/medical providers or sets up intake appointments for the client with community service providers. Clients who receive community care are then added to the GSCT caseload and are eligible for follow-up visits with the team members in the days and weeks after the 911 incident.

This model was significant[2], indicating that both CIT presence and GSCT presence had a notable impact on the final disposition for 911 calls for service. As seen in Figure 5, if an officer trained in crisis intervention was present on the scene for a mental health call (but the GSCT was not present), the individual experiencing mental illness was significantly less likely to go to jail (5.6%) than if the responding officer(s) did not have crisis intervention training (8.8%). In addition, the presence of a GSCT clinician on scene reduced jail dispositions to an even greater degree than did simply having a responding officer who was trained in crisis intervention (2.1%). In either circumstance, individuals who were diverted from jail were instead provided community care. No significant differences in overall rates of hospitalizations were reported in this model.

[1] A forward stepwise multinominal logistic regression.

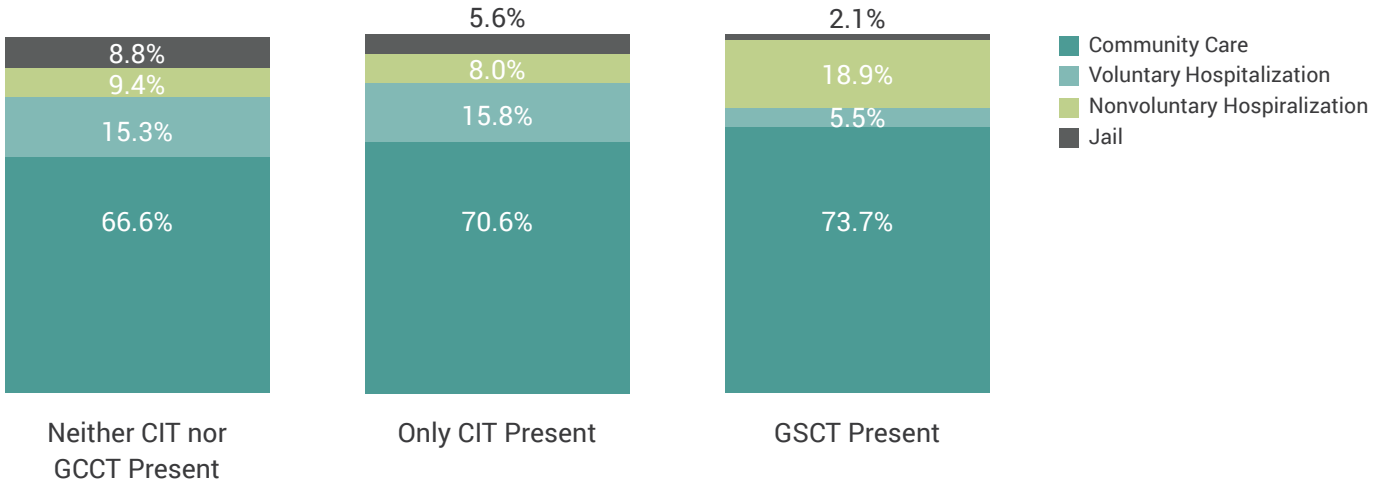
[2] X^2 (3) = 23.48, p < .001. Nagelkerke's pseudo R^2 = .016. Goodness-of-fit statistics indicate that this model had acceptable fit, Pearson X^2 (2) = 4.226, p =.10

Figure 5: Final Disposition for Mental Health Calls



Although rates of hospitalizations didn't differ significantly, there were differences between voluntary and nonvoluntary hospitalizations depending upon who was present at the scene. When the GSCT was not present, only between 8.0% - 9.4% of final dispositions were nonvoluntary hospitalizations (Figure 6). This percentage more than doubles when the GSCT are present at the scene (18.9% of dispositions). Therefore, the results of this analysis indicate that the presence of the GSCT is both effective at diverting individuals with mental health needs away from jail resources and that clinicians have different diagnostic criteria than police officers for instituting a nonvoluntary hospitalization.

Figure 6: Hospitalization Dispositions for Mental Health Calls



Service Coordination

Population Served

Following a mental health 911 call, the team coordinated follow-up services for **180** clients in the nine-month window of analysis. The team saw both juveniles and adults with mental health concerns, with the youngest client at age **8** and the oldest client at age **79**. The average age of the clients was **40** years old. The GSCT served clients of all genders. In this sample, **51%** of clients identified as male, **47%** identified as female, **1%** identified as transwomen, and **1%** declined to state a gender identity. The racial and ethnic composition of the clients was as follows: **77%** White, **10%** Black, **3%** Hispanic/Latinx, **2%** Native American or Pacific Islander, **2%** Asian, **2%** Other, and **4%** Unknown. For reference, the City of Gresham is predominantly White **(64%)**, followed by **20%** Hispanic/Latinx, **5%** Black, **4%** Asian, **1%** Native American or Pacific Islander, and **6%** Mixed Race (US Census, 2019). At initial intake with the GSCT, **70%** of clients lived in private residences, such as apartments or houses. An additional **15%** of clients reported that they were houseless or living in motels. Another **8%** lived in supportive housing facilities, such as group homes, Oxford houses, or assisted living. The remaining **7%** of clients' living situations were unknown.

Time Spent Coordinating Services

Once an active incident had been resolved, the primary duty of the team was to coordinate follow-up services for the clients. These follow-up meetings primarily occurred in the days and weeks after a police incident. However, as the team developed rapport with clients, some would call the team directly and ask for additional support due to a new or ongoing issue (e.g., threat of eviction, substance abuse relapse). On average, the clinicians on this team spent **2.3** hours coordinating services for each client. However, time spent coordinating services varied greatly, with one client receiving **30** hours of coordination assistance. Clinicians spent a minimum of **15** minutes on coordination per client. On average, the GSCT had **10** unique contacts with the client, their families, or service providers (range = 2 to 34 contacts). A contact was defined as either a face-to-face meeting or a conversation via the phone. Additionally, GSCT attempted an average of **3** unsuccessful contacts per client (range = 0 to 7 unsuccessful contacts). Attempted contacts occurred when the team was either unable to locate the client or the client refused to engage with the team.

2.3 *Average hours coordinating services for each client*

10 *Average unique contacts with each client, client family or service provider*

3 *Average unsuccessful contacts with each client*

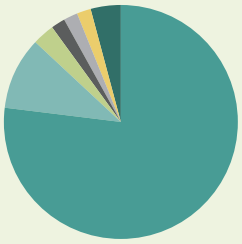
180

Clients in the nine-month window of analysis

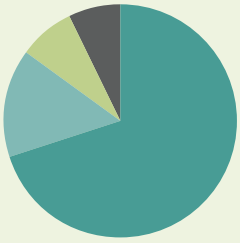
8yrs	40yrs	79yrs
Youngest Client	*Average Age*	*Oldest Client*

Identified as male	*Identified as female*
51%	47%

1% *Identified as transwomen and* 1% *Declined stating gender identity*



White 77%
Black 10%
Hispanic/Latinx 3%
Native American 2%
Asian 2%
Other 2%
Unknown 4%

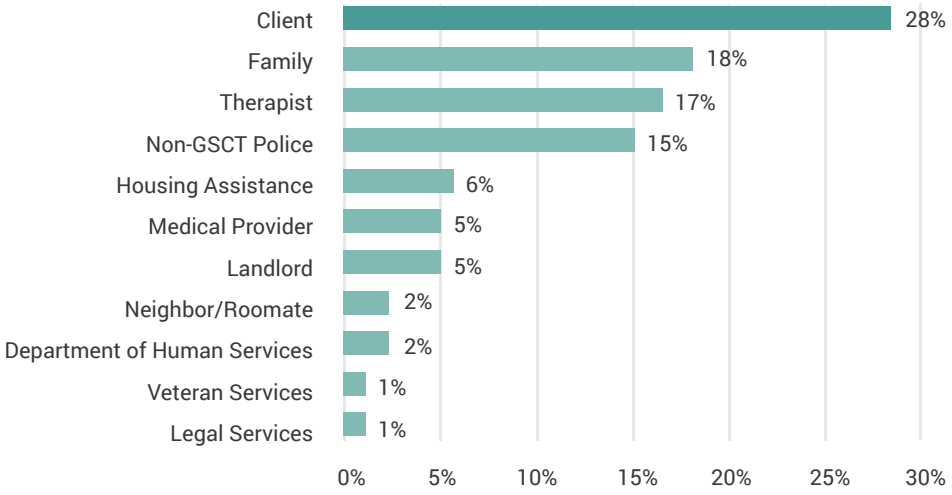


Private Residence 70%
Houseless/Hotels 15%
Supportive Housing 8%
Unknown 7%

Most Common Services Coordinated

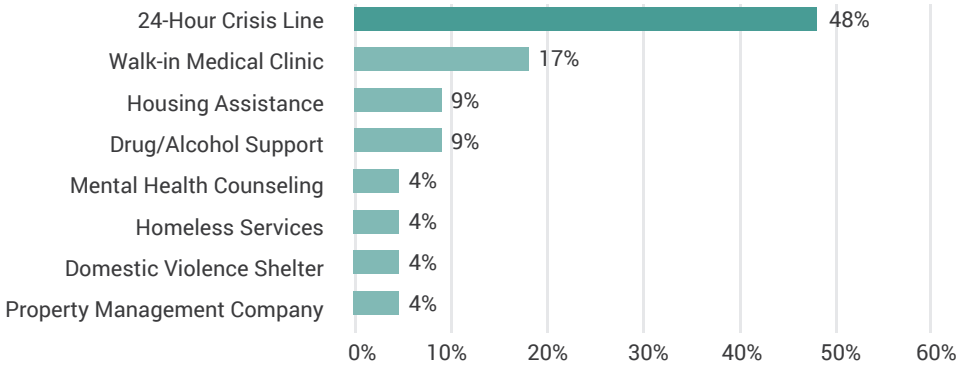
In order to examine the specific services that the GSCT provided, case notes from a randomly selected 10% subsample (18 clients) were analyzed. Results from this subsample (Figure 7) indicate that the GSCT spent the most time in direct contact with clients (28% of all contacts) but also frequently coordinated with the client's immediate family members (18% of all contacts), the client's primary therapist (17% of all contacts), and other police officers who are not on the GSCT (15% of all contacts). Depending on the unique needs of the clients, the GSCT also regularly coordinated with housing services, medical services, veteran services, human services, and legal services. Finally, the GSCT occasionally contacted other collateral individuals (e.g., landlords, neighbors, roommates) who may have provided additional information or support for the client.

Figure 7. Most Frequent Types of Contacts for the GSCT



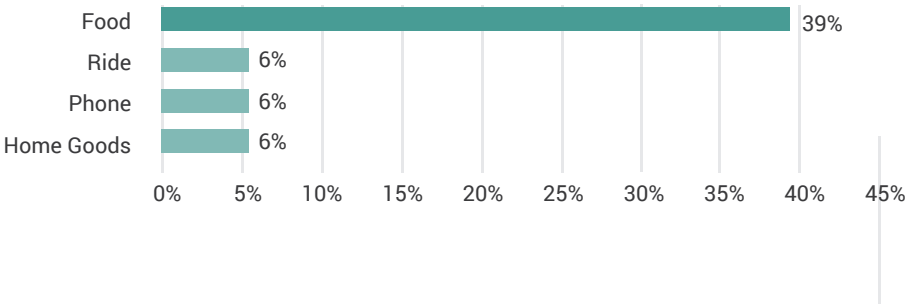
Additionally, the GSCT provided a wide variety of service information to clients Figure 8). In our subsample, service information was coded if the GSCT gave the client contact information and a description of the service, but did not directly contact the service themselves. Most often, the GSCT informed clients about a 24-hour crisis line (48%) that could be accessed anytime the client felt that they were in need of additional support. The team also frequently recommended that clients utilize walk-in medical clinics (17%), housing assistance (9%), and drug/alcohol support services (9%).

Figure 8. Most Frequent Service Information Provided by the GSCT



Finally, the GSCT occasionally provided tangible goods as part of their service coordination efforts (Figure 9). Tangibles were provided based on the individual needs of each client. Most often, the team provided food and drinks to clients who were experiencing food insecurity (39%). Other tangible services included car rides to and from appointments (6%), access to a phone (6%), and various home goods (furniture, kitchen equipment; 6%).

Figure 9. Most Frequent Tangible Services Provided by the GSCT



Conclusion

Summary of Findings

At its conception, the GSCT sought to accomplish three agendas:

- **Documenting Mental Health Related 911 Calls for Service**
- **Diverting Individuals with Mental Health Needs Away from Jail**
- **Providing Follow-Up Resources for Justice-Involved Individuals with Mental Health Needs**

Based on this preliminary data from the first nine months of the program, it appears that the creation of the GSCT has made a number of notable impacts on 911 calls for service that involve a mental health concern. First, the Gresham Service Coordination Team spearheaded the development and deployment of a mental health data mask, which is now required to be completed by all Gresham police officers following every 911 call. This data-capturing tool counts the number of 911 calls that involved a mental health concern, a metric that was previously undocumented. Furthermore, the ongoing use of the mental health mask will allow for more in-depth analyses of the time, effort, and ultimate result of such calls. Already, the nine months of mask data that has been collected has allowed us to demonstrate that mental health calls are a daily part of the Gresham Police's work, making up approximately three percent of all calls for service. Furthermore, these calls appear to be rather time consuming. Each call lasts approximately 45 minutes before it is closed. Finally, the mask allows for easy identification of peak days and times in which the Gresham Police may expect to devote increased resources toward individuals with mental health concerns. Our pilot data indicates that mental health calls for service are most likely to occur in the middle of the work week, and peak in the afternoon.

Furthermore, the results relating to jail diversion indicate that the presence of a mental health clinician on scene was effective at diverting individuals with mental illness away from jail and toward community resources. This effect was found even when accounting for the presence or absence of a trained crisis officer on scene. In this data, the presence of the GSCT clinicians translated to a 76% reduction in jail dispositions for individuals experiencing mental illness compared to instances in which officers who have not been trained in crisis intervention responded to the scene and a 62.5% reduction in jail dispositions compared to incidents in which crisis-intervention trained officers responded without clinicians.

[...] the presence of a mental health clinician on scene was effective at diverting individuals with mental illness away from jail and toward community resources.

Overall rates of hospitalization dispositions did not significantly vary between types of first responders. However, significantly more nonvoluntary hospitalizations were performed by the GSCT than the two groups of police. This finding may be partially explained due to the team's ability to initiate a "director's custody hold", a special form of nonvoluntary hospitalization that allows highly trained clinicians to make a judgment about the client's future risk to themselves or others. In contrast, a Gresham police officer may only perform a nonvoluntary hold when the individual poses a clear and immediate danger to the well-being of oneself or others.

Finally, this evaluation found that the GSCT provided a wide breadth of follow-up services in the days and weeks after a 911 incident. On average, the team made ten additional contacts with either the client, their family, or other service providers after an incident. These follow-ups were individually tailored to the needs of the client and ranged from finding affordable housing, to providing food boxes, to enrolling in veteran's benefits.

[...] GSCT provided a wide breadth of follow-up services in the days and weeks after a 911 incident.

Over a nine-month period of analysis, these services were provided to 180 individuals in Gresham and consisted of over 580 hours of coordination. The GSCT spent the most time in direct contact with clients but also frequently coordinated with the client's immediate family members, the client's primary therapist, and other police officers who were not on the Gresham Service Coordination Team. An additional critical function that the GSCT performed in these follow-up visits was the provision of service information to clients. Most often, the GSCT informed clients about a 24-hour crisis line, walk-in medical clinics, and housing support services. The team would even go so far as to provide rides to and from appointments, provide phones to help these individuals stay in contact with their providers, and gather food and kitchen supplies for individuals who were living with hunger. The combination of follow-up services employed by the GSCT is a strong effort to encourage wraparound care for justice-involved individuals who have mental health concerns.

How to Move Forward

While the GSCT pilot program has made tremendous strides toward providing trauma-informed care for justice-involved individuals with mental health concerns, that work is not finished. For instance, in addition to tackling jail diversion, co-responder teams ought to work at reducing repeat hospitalization stays for justice-involved individuals with mental illness. Information presented in the Key Informant Report indicates that the hospital services in Gresham and the surrounding areas are often at capacity. This means that clients whose well-being is truly in danger are sometimes unable to access hospital resources. Promoting community care is the only sustainable tactic for freeing up both jail and hospital resources for those extreme cases.

An additional element not measured in this evaluation is the team's impact at reducing repeat 911 calls for service on the same individual. Clients who are in the throes of an acute mental health crisis often have repeated encounters with the police in a narrow period of time. Given that individuals experiencing mental illness are more likely to have force used against them during a police incident, each additional encounter puts that individual at increasing risk (Morabito, Socia, Wik, & Fisher, 2017[4]). Police departments would do well to investigate the impact of their co-responder team at reducing the overall number of police use of force incidents per individual.

Finally, based on the findings from this evaluation, the police-clinician co-responder model should be expanded to provide 24/7 availability. One of the largest program limitations identified by the Key Informants is that this team operates part time due to budgetary constraints. The results presented above indicate that this team is using their limited resources efficiently and are providing services that cannot be replicated by other providers. Future work will be able to measure the cost savings that the team generates because of the service coordination efforts being provided here. Expanding the GSCT to full-time service may only improve the extent to which individuals with mental health concerns are able to access the resources they need to remain in the community.

[4] Morabito, M. S., Socia, K., Wik, A., & Fisher, W. H. (2017). The nature and extent of police use of force in encounters with people with behavioral health disorders. *International Journal of Law and Psychiatry*, 50, 31-37.

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