Multnomah County
Feasibility Assessment

Mental Health Jail Diversion Project

Executive Summary

Prepared by

Lore Joplin Consulting

January 2015

This project was completed by Lore Joplin Consulting, in collaboration with Ann Sihler.

Lore Joplin provides technical assistance to governmental and nonprofit agencies. Her expertise is in systems analysis, collaborative planning, and supporting the implementation of evidence-based practices.

www.lorejoplin.com

Ann Sihler specializes in conveying complex topics clearly—as a writer, editor, critical thinker, and communications consultant. Typically she works on large, collaborative projects that seek to address challenging human and environmental problems.

www.annsihler.com

Executive Summary

Project Background

This report was prepared in response to a Multnomah County Board of Commissioners fiscal year 2015 budget note to investigate the need and feasibility of enhancing diversion opportunities for people in county jails who have a mental illness. The budget note was proposed by Commissioner Judy Shiprack following a trip taken by a small group of county stakeholders to visit and observe the nationally recognized jail diversion program in Bexar County, Texas.

Nationally, an estimated 15 to 17 percent of people booked into jail have active symptoms of serious mental illness, such as schizophrenia, major depression, and bipolar disorder.[1] This is three times the proportion among the general public.[2] People in jail who have mental illness typically also have high rates of substance abuse disorders (up to 80 percent, according to some estimates[3]), they often are poor and/or homeless, and many have been repeatedly sexually and physically abused.[4] They commonly have chronic physical health problems that will shorten their lifespan (by 13 to 30 years).[5] Although people with serious mental illness often are stereotyped as aggressive, their criminality typically is limited to low-level nuisance crimes. When their behavior does include violent crimes, it is usually related not to their mental illness but to other factors, such as substance abuse.[6]

Once in jail, people who have a serious mental illness are vulnerable to intimidation and assault. Because the jail environment tends to exacerbate symptoms of mental illness, inmates with mental illness may act out or break jail rules, thus prolonging their incarceration.[7] They also have high rates of recidivism—more than 70 percent in some jurisdictions.[8]

Clearly, diverting more of these individuals from jail to community-based services has the potential to cut criminal justice system costs, reduce recidivism, and provide more effective mental health treatment for offenders. It also would represent a more humane response to individuals in jail who have a mental health disorder.

---

[1] Steadman, H.J. 2014. When Political Will Is Not Enough Jails, Communities, and Persons with Mental Health Disorders. White Paper 1, prepared for John D. & Catherine T. MacArthur Criminal Justice Reform Initiative: Reducing the Overuse and Misuse of Jails in America Initiative. Policy Research Associates, Inc. July 2014.
[2] Kessler, R.C. et al. (1999) as cited in Council of State Governments, 2002, *Criminal Justice/Mental Health Consensus Project*. Document No. 197103. June 2002.
[3] Steadman, H.J. 2014. When Political Will Is Not Enough Jails, Communities, and Persons with Mental Health Disorders. White Paper 1, prepared for John D. & Catherine T. MacArthur Criminal Justice Reform Initiative: Reducing the Overuse and Misuse of Jails in America Initiative. Policy Research Associates, Inc. July 2014.
[4] Ibid.
[5] De Hert et al. 2011. Physical Illness in Patients with Severe Mental Disorders. I. Prevalence, Impact of Medications and Disparities in Health Care. Educational module in World Psychiatry. Feb 2011; 10(1): 52–77.
[6] Monahan and Steadman, 2012 ("Extending Violence Reduction Principles to Justice-involved Persons with Mental Illness." In J.Dvoskin, J. Skeem, R. Novaco, and K. Douglas (Eds). Applying Social Science to Reduce Violent Offending (pp. 245-261). New York: Oxford University Press) and Fazel et al. (2009) and Steadman (1998) as cited in Monahan and Steadman (2012).
[7] Council of State Governments. 2002. *Criminal Justice/Mental Health Consensus Project*. Document No. 197103. June 2002.

This report is intended to help Multnomah County better understand the population of people with mental illness in its jails and what opportunities there might be to divert more of them to community-based services. It explores topics such as how many people with mental illness there are in jail locally, what they are like, the reasons they are there, the strengths and weaknesses of the current jail diversion system, and the challenges of estimating the costs associated with detention and diversion. The report also presents recommendations that incorporate stakeholder input.

Information in this report comes from four sources: a literature review, interviews with 23 local stakeholders, records on individuals in county jails who have a mental health disorder, and the results of a prioritization process completed by a stakeholder group. A range of stakeholders participated in the project, including elected officials, representatives of the local medical and social service systems, and employees of many departments and divisions of Multnomah County. (For a complete list, see the Acknowledgements).

How Many People with Mental Illness Are in Multnomah County Jails?

This is a surprisingly difficult question to answer, for reasons ranging from the confidentiality of medical records to the presence of co-occurring conditions, such as substance abuse. For the purposes of this report, we narrowed the question down to "Who is being held in jail who might have been diverted but for their presenting mental health status?" To answer that question, we worked with a project data group to collect information on three groups of detainees being held in Multnomah County jails during October 2014:

- 18 defendants who had been screened by DCJ's Pretrial Supervision Program (PSP)[9] and met release criteria, based on their charge and risk assessment score, but were not recommended for release because of mental health concerns.

- 44 defendants who had been screened by the Multnomah County Sheriff's Office's (MCSO) Close Street Supervision Program (CSS)[10] but were denied program participation because of high-level pending charges and possibly also mental health concerns. (The data were not definitive.)

- 18 individuals on community supervision who had been placed on a jail hold by officers of the Multnomah County Department of Community Justice Mentally Ill Offender (MIO) Unit.[11]

These 80 individuals became our "target population": people who were potentially eligible for diversion, had been screened or assessed for possible release, but remained detained. Not everyone in this target population is presumed to have a mental illness (because CSS also works with people who do not have mental illness), but many of them do.

[9] The PSP makes recommendations to the court for release on pretrial supervision, based on state statute, an interview, and completion of a validated assessment tool.
[10] The Close Street Supervision Program is an intensive custody and supervision program that provides pretrial services to arrestees of Measure 11 crimes, domestic violence cases, and a select group of clients with mental health disorders.
[11] The Mentally Ill Offender Unit works exclusively with offenders with severe mental illness.

What Is This Potentially Divertible Population Like?

We collected demographic, medical, jail utilization, and criminal justice data on people in the target population, following protocols to maintain privacy, and found the following:

- Black[12] detainees are significantly overrepresented in the target population (41 percent compared to 19.7 percent of all bookings in October).
- At least half of the target population had a chronic medical issue or a diagnosis of mental illness or substance abuse (per Corrections Health's EPIC database). A total of 19 percent had all three.
- Very few of the target population (6 percent) appeared to have received a community-based mental health service in the previous 120 days.
- On average, members of the target population spent more time in jail than did other detainees: 18.27 days during October 2014, compared to 13.51 days (average length of stay, or ALOS) for all detainees. The target population used approximately 1,352 bed days in multiple units, such as the suicide watch/special management unit, psychiatric infirmary, and close custody/disciplinary units.
- The individuals in the target population were booked an average of 2.98 times between November 2013 and October 2014. MIO Unit detainees had the highest average bookings, at 5.06. One individual was booked 14 times, two were booked 10 times, and 11 were booked between five and nine times during that period.

Why Are They in Jail?

The top primary charges for which defendants from the target population were being held were as follows: [13]

Pretrial Supervision Program		Close Street Supervision		Mentally Ill Offender Unit	
Charge	**# of Defendants (out of 18)**	**Charge**	**# of Defendants (out of 44)**	**Charge**	**# of Defendants (out of 18)**
Possession of Cocaine or Meth	5	Robbery I, II, and III	12	Parole/ Probation Violation	11
Restraining Order Violation	3	Assault II, III, and IV (mostly DV)	10	DUII	1
Domestic Violence-related Charges	3	Burglary I	4	Indecent Exposure	1

Members of the target population were denied release from jail for the following reasons, among others (including high-level pending charges):

[12] We use the term "black" in this report because that is the designation in the Multnomah County Sheriff's Office database, which does not distinguish between African Americans and African immigrants.
[13] The charges listed are the most serious on file at the time of interview.

- Mental health concerns (18 out of 18 PSP defendants)
- Lack of community ties/stability (20 out of 44 CSS defendants)
- Risk to self or others (9 out of 44 CSS defendants)
- Homelessness, substance abuse, or lack of treatment availability (7 out of 18 MIO Unit defendants)
- Not reporting to their probation officer (7 out of 18 MIO Unit defendants)
- Behavior such as violence, or pending new charges (4 out of 18 MIO Unit defendants)

Jail Diversion and Its Components

Jail diversion is a means of "avoiding or radically reducing jail time by referring a person to community-based services."[14] In a jail diversion program, charges often are reduced or dropped upon successful completion of appropriate community-based services, such as mental health or substance abuse treatment. Jail diversion typically is voluntary and can occur at pre-booking, post-booking, or post-plea.

Multnomah County already has many of the components commonly used in mental health jail diversion systems, but it lacks others.

Present in Multnomah County[15]	Lacking in Multnomah County
Urgent mental health walk-in clinic	Drop-in day center
24-hour 911 triage with crisis hotline	24-hour crisis drop-off center
24-hour mental health crisis hotline	Psychiatric emergency room[16]
24-hour mobile mental health outreach teams (with mental health clinicians)	Co-located medical and behavioral health services
Police officer Crisis Intervention Training (CIT)	Release on commercial bond with mental health conditions
Enhanced CIT training	Co-located mental health services at arraignment
Police behavioral health response unit	Supported housing
Combined police/mental health clinician teams	Peer-based program options
Detox/sobering station	
Hospital commitment (for acute care)	
Pretrial supervision	
Mental health court	
Drug and/or community court	
Forensic diversion	
Contracted forensic mental health treatment services (acute, subacute, and outpatient)	
Specialty mental health outpatient programs	
Limited culturally specific services	

[14] Steadman (2014) and Broner et al. (2005) as cited in Cowell et al. 2008. *A Cost Analysis of the Bexar County, Texas, Jail Diversion Program. Report 2: An Analysis of Cost-Shifting between the Treatment and Criminal Justice Systems.* Prepared for Leon Evans, President/Executive Officer, The Center for Health Care Services. RTI Project Number 0209991.000. May 2008.

[15] For brief descriptions of these programs, see Appendix E.

[16] Legacy Health Services is working with Oregon Health and Sciences University to open a psychiatric emergency room in late 2016. Meanwhile, the Multnomah County Department of Community Justice (DCJ) is contracting with Central City

There is no "silver bullet" in creating jail diversion programs, and no specific components that must be in place for a system to be successful. Much depends on community needs and coordination, as well as adequate levels of support services in the community (intensive outpatient treatment, housing, substance abuse services, etc.). Currently Multnomah County has approximately 40 contracts with at least 30 organizations that provide community-based mental health services. The data we received indicate that, together, these organizations provide (1) inpatient acute, subacute mental health, and respite services to approximately 1,900 individuals annually, and (2) lower level residential (group homes) and outpatient services to more than 16,000 adult clients. About 12 percent of these services are directed toward residential and intensive outpatient services, such as group homes, assertive community treatment (ACT), and a forensic ACT (FACT) team. Otherwise, very few of these services (less than 1 percent) are specifically targeted to forensic clients, including those participating in mental health court. This lack of treatment availability for forensic clients contributes to long wait times for appointments (up to four to six weeks) for defendants who otherwise might be diverted to residential or outpatient treatment.

What Are the Strengths and Weaknesses of the Current System?

We interviewed 23 local stakeholders about the current mental health jail diversion system and, based on their responses, identified the following system strengths and opportunities for improvement. (For fuller descriptions, see Section 5.)

System Strengths

- ✓ Good relationships and cooperation across the system
- ✓ Improvements in communication and support of elected officials in recent years
- ✓ Recently enhanced range of services and a focus on transition services

Opportunities for Improvement

- ❑ **Coordination across systems**—A need for better coordination of the current mental health system components and associated funding
- ❑ **Information sharing (confidentiality)**—Difficulties sharing relevant medical, mental health, substance abuse, and criminal justice data given local procedures and federal confidentiality restrictions
- ❑ **Sharing of electronic data**—Lack of a centralized data system or data sharing across the many existing databases
- ❑ **Identifying defendants with mental illness at booking**—Being able to prioritize individuals for diversion/reentry and connection with services
- ❑ **Timelines/wait times**—Long wait times (up to four to six weeks) for defendants to get treatment beds or outpatient appointments
- ❑ **Staffing and training**—Issues related to agency hiring in general, the availability of dually certified staff (for mental health and substance abuse treatment), and training to work with forensic[17] clients

---

Concern (CCC) to open a residential stabilization center for men with mental illness who are on community supervision. The center is expected to open in early 2015.

[17] Forensic is a term used within the mental health field to describe clients involved in the justice system. These clients may have been referred by the courts for mental health assessment or declared unable to aid and assist in their own

- **Working with detainees**—A need for more engagement with detainees, improved provider access to them, and better preparation for release
- **Court/pretrial processes**—Better information sharing and triage of people with mental illness before or at arraignment; better education among criminal justice partners about mental illness and the diversion system

Estimating Savings from Reduced Use of Jails

Although national data and anecdotal evidence suggest that jail diversion programs can be cost-effective, the level of cost savings (if any) hinges on the specific costs of the local criminal justice and mental health care systems. Reliably estimating cost savings requires not just a thorough understanding of and ability to break down jail costs, but also an understanding of (1) associated system costs, such as costs to law enforcement, local hospitals (from emergency room visits), and the courts, (2) the service delivery system available to people who are diverted, (3) costs associated with particular types of diversion programs and service activities, and (4) how costs vary depending on the size or nature of the diverted population or the time frame in which the costs are analyzed.

An important first step in estimating potential savings from reduced use of jails would be to determine how much it currently costs Multnomah County to house individuals with mental illness in jail, taking into consideration both fixed and variable costs (costs for booking, consumables, facility operations, debt service, Corrections Health, etc.), the difference in costs depending on which unit inmates are housed in, and the number of people who would need to be diverted to reach a meaningful threshold of cost-effectiveness. (For example, diverting just a few people from various units would not be enough to close an entire dorm.) Detailed analysis of the cost of prospective jail diversion programs also would be needed.

The scope of this project did not allow for this type of in-depth analysis, particularly since key information, such as detailed jail costing data, were not available. Collecting and analyzing cost data to evaluate potential savings from reduced use of local jails is one of the recommendations of this report.

Recommendations

The following recommendations for improving the current mental health jail diversion system are based on information collected specifically for this report, with the input of local stakeholders. Section 8 describes these recommendations more fully.

Recommendation A: *Implement high-priority enhancement opportunities identified by stakeholders.* Local stakeholders met in January 2015 to review information collected for this report and to prioritize potential system enhancements that emerged from the stakeholder interviews. The following system enhancements rose to the top:

- **A1. Improve information sharing (including confidentiality restrictions).** This issue concerns the challenge of appropriately sharing medical, mental health, substance abuse, treatment status, and criminal justice data on individuals so that their

---

defense. Some have been detained in correctional institutions, may be on probation or post-prison supervision, or otherwise be involved in the criminal justice legal process.

treatment needs can be understood, given current confidentiality restrictions (e.g., the Health Insurance Portability and Accountability Act, or HIPAA) and certain procedural challenges. A first step in addressing this issue would be to identify inconsistent interpretations of HIPAA across county departments. Stakeholders were mindful of the need to continue respecting clients' civil rights when addressing this issue.

- **A2. Coordinate better across systems**. Stakeholders at the prioritization meeting saw value in developing a forum or structure that could provide overall, high-level coordination of the local mental health system (including jail diversion), to improve service and make better use of available funding. Providing this function is beyond the scope of the Local Public Safety Coordinating Committee (LPSCC) Mental Health Subcommittee. Other jurisdictions, such as Miami-Dade, Florida, and Montgomery County, Maryland, could serve as models for overall system coordination.

- **A3. Identify defendants with mental illness at booking and engage them while in jail**. Unless defendants have a serious mental illness and are presenting symptoms at booking, they can end up in the general population, not be identified as having mental illness, and not be prioritized for diversion/reentry planning and connection with services. Options for implementing this recommendation include using the Brief Jail Mental Health Screen (BJMHS)[18] to flag individuals for further mental health assessment as they come in the door, and having someone in the jail who facilitates connections between detainees and service providers. Additionally, getting inmates started with treatment while they are incarcerated would prepare them to enter treatment in the community.

Recommendation B*: Collect and analyze data to better understand the actual costs of housing people with mental illness in the jail.* Although estimates exist of typical jail costs and the cost (and cost-benefit ratios) for various types of mental health interventions in other jurisdictions, a full local cost analysis is needed. Such an analysis should be based on data that were not available for this report—i.e., current, reliable data on the cost of housing people with mental illness in Multnomah County jails and specific costs related to the county's contracted mental health services.

Recommendation C: *Explore apparent racial disparities in the detention of people who have mental illness.* A striking finding from the data collection portion of this project is the significant overrepresentation of black detainees among the target population (40 percent compared to 19.7 percent of all bookings during the data period). The reasons for this disparity should be explored.

Recommendation D: *Evaluate the availability of culturally specific services*. Interviewees cited a need for additional culturally specific services for racial and ethnic minorities and LGBT (lesbian, gay, bisexual, and transgender) individuals. About 10.5 percent of the county's contracted mental health services currently are directed toward racial or

[18] The Brief Jail Mental Health Screen was developed by Policy Research Associates with funding from the National Institute of Justice and is available for free from the Substance Abuse and Mental Health Services Administration (SAMHSA), at http://gainscenter.samhsa.gov/topical_resources/bjmhs.asp. The screening can be conducted by corrections officers and takes an average of 2.5 minutes to administer.

ethnic minorities, but few of these programs focus on forensic clients, and none appear to be designed for LGBT offenders. Especially given the overrepresentation of black detainees in the target population for this report, it would be helpful to understand the current level of need for additional culturally specific services.

Recommendation E: ***Fill prominent system gaps.*** Interviewees identified the need for greater capacity across the continuum of care, but certain gaps in service were particularly pronounced (for fuller descriptions, see Section 6):

- **24-hour crisis drop-off center**. When an individual experiencing a mental health crisis has committed a low-level crime, there are few places law enforcement officers can take that person where he or she will be admitted for treatment. Often, because of the wait times involved for officers, the individual is taken to jail rather than the hospital emergency room. A 24-hour crisis drop-off center could help address this situation, especially if the drop-off center were designed to connect clients to treatment.

- **Dual-diagnosis treatment.** People in jail who have mental illness often also have substance abuse disorders, yet few local programs are designed to treat both diagnoses and/or have adequate numbers of dually certified clinicians.

- **Residential dual-diagnosis treatment for women.** The lack of these services has resulted in frequent treatment failures among the female caseloads.

- **Outreach and engagement**. Outreach and engagement to people with mental illness require special skills and approaches, but these activities lack support under current funding models, which emphasize reimbursement for enrolled clients who are actively participating in treatment.

- **Adequate supplies of appropriate housing.** Many people with mental illness who are transitioning out of jail require non-transitional housing (e.g., affordable, supportive, and low- or no-barrier housing), which is in short supply in Portland's tight housing market.

Interviewees praised the progress that Multnomah County and its partners have made in recent years to problem-solve gaps in the mental health system. Clearly these efforts have improved the system's response to justice-involved individuals with mental illness. Yet effective diversion of these individuals from jail will require additional efforts and resource investment to build a comprehensive continuum of services, with a specific focus on pre-booking and pre-trial community-based alternatives to jail. The recommendations presented above offer guidance on possible next steps for Multnomah County and its partners as they explore how to increase diversion opportunities for people in jail who have mental illness.