
Multnomah County Feasibility Assessment

Mental Health Jail Diversion Project

Prepared by

Lore Joplin Consulting

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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

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Project Participants		
<i>Key:</i>		
<i>I = Interviewee</i>		
<i>D = Data Group Participant</i>		
<i>P = Stakeholder Prioritization Meeting Participant</i>		
<i>O = Other Assistance</i>		
Individual	Organization	Role
Lauren Brown	Sr. Research Analyst, Multnomah County Local Public Safety Coordinating Council (LPSCC)	D
Katie Burgard	Lead Corrections Counselor, Multnomah County Sheriff's Office (MCSO)	I, O
Jean Dentinger	Manager, Diversion Courts, Multnomah County Mental Health and Addiction Services Division (MHASD)	I, D, P
Mark Douglass	Mental Health Evaluator, Lifeworks NW	I, P
Chris Farentinos	Director, Behavioral Health Services, Legacy Health System	I
Sharon Fitzgerald	Assistant Director of Supportive Housing, Central City Concern	I
Judge Julie Frantz	Chief Criminal Judge, Multnomah County Court	I, P
Dr. Nimisha Gokaldas	Medical Director, MHASD	D
Nancy Griffith	Director, Corrections Health, Multnomah County Health Department (MCHD)	I, D, P
David Hidalgo	Director, MHASD	I, P
Liv Jenssen	Criminal Justice Manager, Multnomah County Department of Community Justice (DCJ)	I, D, P, O
Chair Deborah Kafoury	Chair, Multnomah County Board of Commissioners	I
Gary Kissel-Nielsen	Service Director of Addiction Specialty Services, Lifeworks NW	P
Melissa Marrero	Attorney, Multnomah County District Attorney's Office	I
Shea Marshman, Ph.D.	Director of Planning & Research, Multnomah County Sheriff's Office (MCSO)	D
Ginger Martin	Deputy Director, DCJ	I, D
Bob McCormick	Sergeant, Portland Police Bureau Behavioral Health Unit	I
Colette McEldowny	Attorney, Multnomah County District Attorney's Office	I, P
Tim Moore	Undersheriff, MCSO	I, O

Neal Rotman	Community Mental Health Program Manager, MHASD	D
Kathleen Roy	Clinical Director, Old Town Recovery Center, Central City Concern	I, P
Judge Tom Ryan	Judge, Multnomah County Circuit Court	I
Eric Sevos	Senior Clinical Director, Cascadia Behavioral Healthcare	I, P
Commissioner Judy Shiprack	Commissioner, Multnomah County Board of Commissioners	I, P
Abbey Stamp	Executive Director, LPSCC	D, P
Don Trapp	Pretrial Supervision Manager, DCJ	I, D, P
Stu Walker	Mentally Ill Offender Unit Manager, DCJ	I, D, P
Scott Williams	Lead Mental Health Consultant, Corrections Health, MCHD	I, P
Linda Yankee	Chief Deputy, MCSO	I, D, P
Judge Youlee You	Judge, Multnomah County Circuit Court	O
Christina Youssi	Executive Assistant, LPSCC	O

Acronyms and Abbreviations

ACA	Affordable Care Act
ACT	Assertive Community Treatment
ALOS	average length of stay
AOD	alcohol and/or other drug
BJMHS	Brief Jail Mental Health Screen
CATC	Crisis Assessment and Treatment Center
CCO	coordinated care organization
CFR	Code of Federal Regulations
CIMS	Corrections Information Management System
CIT	Crisis Intervention Training
DCHS	Department of County Human Services
DCJ	Department of Community Justice
ECIT	Enhanced Crisis Intervention Training
ED	emergency department
FACT	Forensic Assertive Community Treatment
FTA	failure to appear
HIPPA	Health Insurance Portability and Accountability Act
IDDT	Integrated Dual Diagnosis Treatment
IMD	Institution for Mental Disease
LEO	law enforcement officer
LGBT	lesbian, gay, bisexual, and transgender
LPSCC	Local Public Safety Coordinating Council
MCHD	Multnomah County Health Department
MCSO	Multnomah County Sheriff's Office
MHASD	Mental Health and Addiction Services Division
MHC	mental health court; mental health consultant
MIO	Mentally Ill Offender
NAMI	National Alliance on Mental Illness
OHA	Oregon Health Authority
OSH	Oregon State Hospital
OSHU	Oregon Health and Sciences University
PAMC	Portland Adventist Medical Center
PO	parole/probation officer
PPB	Portland Police Bureau
PSP	Pretrial Supervision Program
PTSD	post-traumatic stress disorder
RIO	Release of Information
SAMHSA	Substance Abuse and Mental Health Services Administration
SMI	seriously mentally ill
SPMI	serious and persistent mental illness
WSIPP	Washington State Institute for Public Policy

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 estimates³), 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:

- Black¹² 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)	Court-ordered outpatient mental health treatment for people who have previously been in a psychiatric hospital, jail or prison
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)	

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 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.

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 forensic¹⁷ clients

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

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.

abuse, treatment status, and criminal justice data on individuals so that their 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

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.

the county's contracted mental health services currently are directed toward racial or 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.

Introduction

Project Origins

For some time the Multnomah County Board of Commissioners has been concerned about the number of people with mental illness who come into contact with the local public safety system and end up detained in county jails. Little reliable information has been available about how many such people there are, the reasons they are in jail, the costs associated with their detention, and whether they could be diverted to less expensive, community-based services and/or therapeutic facilities.

To fill this information gap, the Multnomah County Board of Commissioners included a note (proposed by Commissioner Judy Shiprack) in the county's 2015 fiscal year budget calling for a feasibility assessment focused on mental health jail diversion. The budget note followed a site visit to Bexar County, Texas, by a small group of county stakeholders, to observe and better understand Bexar County's nationally recognized jail diversion model. In response to the budget note, the Multnomah County Board of Commissioners requested that the Local Public Safety Coordinating Council (LPSCC) coordinate

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.

Most of them (up to 75 to 80 percent) also have substance abuse disorders.

with a facilitator who could convene stakeholders, collect relevant data, and assess the potential for diverting additional people with mental health issues out of Multnomah County jails and into other settings, such as community-based treatment. Although the assessment would be completed independently, it would supplement several broader county policy efforts related to mental health issues among defendants, inmates, and people on community supervision. These efforts include LPSCC's mental health prioritization process (which is identifying service gaps for a subset of very high need clients who have contact with the criminal justice system) and the work of the council's Mental Health Subcommittee. For more information on these efforts, see Appendix A.

Information Sources

This report summarizes work done in response to the Multnomah County Board of Commissioners budget note request. The report addresses the need for and feasibility of enhancing diversion opportunities and presents recommendations for initial actions to accomplish this. The content of the report is based on four primary sources of information:

- A review of current literature on such topics as people in jail who have a mental illness, relevant social conditions, the effectiveness of mental health jail diversion, and selected diversion programs around the country

- Interviews with local stakeholders, including representatives of the Multnomah County Sheriff's Office, Multnomah County Court, Department of Community Justice, District Attorney's Office, Health Department's Corrections Health, and Department of County Human Services' Mental Health and Addictions Services Division; Legacy Health; and community mental health service providers
- Data (demographic, medical, criminal, etc.) on a select group of detainees in Multnomah County jails who were possibly eligible for diversion and had been screened or assessed for release but who remained detained
- A facilitated process in which stakeholders reviewed summary-level data and interview findings and then identified their initial priorities for system improvements

Specific information sources and methodologies are described in more detail later in this report and in Appendixes B, C, and D.

Social Context

Multnomah County has a national reputation for being on the forefront of evidence-based decision making. Given the limited resources available in both the criminal justice and mental health systems, the county recognizes the need to use those resources in the most effective manner possible and in a way that treats individuals with mental illness humanely. The county's current examination of policies and practices related to diverting people with mental illness from jail supports those goals and is taking place against a backdrop of social conditions that may be unique in the country, at least in their degree:

- **Housing:** The Portland area is in the midst of a housing crisis, with a tight market generally and high demand for affordable, low-income, and low- or no-barrier housing.
- **Homelessness:** Oregon is tied with Hawaii for the highest rate of homelessness in the nation. The homeless population in general has higher than normal rates of mental illness (up to 25 percent, nationally).¹⁹
- **Suicide rate:** The suicide rate in Oregon is 35 percent higher than the national average.²⁰ In Multnomah County, suicide is the eighth leading cause of death.²¹
- **Number of suicides:** The suicide rate in Multnomah County actually is dropping. However, because of population growth, the number of incidents has gone up. From 2001 to 2011, the number of suicides in Multnomah County increased by one-third, the number of suicide attempts increased by nearly 13 percent, and

¹⁹ Homeless Research Institute (2012) as cited in Stewart et al. 2012. Report on Police Interactions with Person in Mental Health Crisis. March 21, 2012.

²⁰ Stone (2010) as cited in Stewart et al. 2012. Report on Police Interactions with Person in Mental Health Crisis. March 21, 2012.

²¹ Multnomah County Health Department. 2014. *2014 Report Card on Racial and Ethnic Disparities*. December 12, 2014. Available at <https://multco.us/file/37530/download>.

the number of suicide-related calls responded to by the Portland Police Bureau rose by 90 percent.²²

- **Civil commitment:** Over the two decades ending in 2003, the civil commitment rate in Oregon dropped by more than half, from 45 to 22 people per 100,000.²³
- **Police staffing:** There are fewer police officers in Portland now than there were in 2001.²⁴

Evidence suggests that contact between police and people experiencing a mental health crisis has increased in recent years.²⁵

At the Human Level ...

Sometimes it is hard to remember the human lives that lie behind the facts and figures in a report such as this. To help illustrate the reality and complexity of the situations of people in jail who have mental health disorders, we have compiled composites of hypothetical individuals, based on elements of many real cases in the jail. Michael, James, Rachele, George, and Robert are NOT real people. But the details of their “stories” are real and reflect the lives of many people in Multnomah County.

▶ Michael’s story

“Michael” is a 22-year-old white man. He was diagnosed with schizophrenia while in his teens and has multiple convictions for indecent exposure, most of them on public transportation. He was sexually abused as a child by a family friend and is now estranged from his family. Currently he is homeless. Michael often runs and hides when approached by law enforcement officers. His most recent booking was for a probation violation for failure to report to his probation officer after absconding from a residential treatment facility. He said that he left the treatment facility because he was afraid of the other residents.

▶ James’s story

“James” is a 28-year-old African-American man diagnosed with paranoid schizophrenia. James has frequent contacts with the police, often for malicious damage to cars. (He believed the cars were controlling his thoughts.) Recently, his mother contacted the police to report that James had destroyed his bedroom furniture and attempted to assault her. He was booked in jail and is awaiting trial on new charges. When interviewed for possible pretrial release, he indicated that he was willing to participate in residential treatment, but he is being held in jail pretrial until a treatment bed is available for him, which is estimated to be at least six weeks.

²² Stewart et al. 2012. Report on Police Interactions with Person in Mental Health Crisis. March 21, 2012.

²³ Bloom (2006) as cited in Stewart et al. 2012. Report on Police Interactions with Person in Mental Health Crisis. March 21, 2012.

²⁴ Stewart et al. 2012. Report on Police Interactions with Person in Mental Health Crisis. March 21, 2012.

²⁵ Ibid.

▶ **Rachelle's story**

"Rachelle" is a 32-year-old white woman who was booked into the jail twice in the last two months on probation violations for failing to report to her probation officer. She has a long history of mental illness and two misdemeanor convictions. Rachelle has a difficult time complying with her probation conditions because of her mental illness. Although she often has been referred for services, she hasn't followed through with either mental health or substance abuse treatment. She is disorganized and has difficulty completing the most basic activities of daily life. She takes medications while in custody and does become more functional, but when she is released back into the community she doesn't follow up with her aftercare. She is homeless. She reports that her medications get stolen, so she doesn't want to take them with her when she is released from jail. She doesn't meet criteria for dangerousness to self or others so is released to the streets when her time is served.

▶ **George's story**

"George" is a 38-year-old white man who has a 12th-grade education. He is employed part time and recently entered supportive housing, with the help of his probation officer. He is estranged from his former spouse and has a 9-year-old son from that relationship. This marriage has a documented history of violence. He has been diagnosed as a schizophrenic in the past. It is also notable that he is reported to have had episodes of violence when on medications. He was recently arrested and booked on a restraining order violation.

▶ **Robert's story**

"Robert" is a 51-year-old white man who is frequently in jail because of misdemeanor crimes and violations for failing to appear in court on his charges. He has schizophrenia and diabetes and is an addict. About half of the time he comes into custody he is released on his own recognizance. When he does stay in custody, it takes several days for him to detox enough so that he can talk with staff about his medications. Robert has significant difficulties taking care of his basic needs. His blood sugars are dangerously high, and he has sores on his feet, hands, and legs that won't heal because of his poor health. The only time he takes insulin is when he's in jail. When he is released from jail and not taking his medication, he is too disorganized to follow up on care.

Information from the Literature

This section provides brief background information on mental illness among people in jail, co-occurring disorders they commonly have, their experiences in jail, and what current evidence says about the effectiveness of mental health jail diversion programs. The information presented here is based on a review of recent literature, which is summarized in Appendix B.

People in Jail Who Have Serious Mental Illness

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.²⁶ This is three times the proportion among the general public.²⁷

People in jail who have serious mental illness typically have faced a variety of challenges in their lives well before they come into custody. Often they are poor and/or homeless, and many have a lifetime history of sexual and physical abuse.²⁸ Most of them (up to 75 to 80 percent, by some estimates²⁹) have substance abuse disorders in addition to mental illness. Medically, people with serious mental illness are prone to heart attack, stroke, hypertension, obesity, diabetes, metabolic syndrome, and other physical health problems, which together contribute significantly to a shorter life span (13 to 30 years shorter, on average) than among the general population.³⁰

Although people with serious mental illness often are stereotyped as aggressive, their criminality is usually 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.³¹ In those cases where offenses (violent or non-violent) are closely linked to symptoms of mental illness, the offenses most commonly are committed by people with bipolar disorder.³²

²⁶ 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.

²⁷ Kessler et al. (1999) as cited in Council of State Governments, 2002, *Criminal Justice/Mental Health Consensus Project*. Document No. 197103. June 2002.

²⁸ 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.

²⁹ Ibid.

³⁰ 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.

³¹ 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).

³² Peterson et al. 2014. "How Often and How Consistently Do Symptoms Directly Precede Criminal Behavior among Offenders with Mental Illness?" *Law and Human Behavior*. Vol. 38, No. 5, 439-449.

Once in jail, people who have a serious mental illness are vulnerable to assault or other forms of intimidation by predatory inmates. The jail environment tends to exacerbate symptoms of mental illness, especially since most jails lack comprehensive mental health treatment resources delivered in therapeutic environments. This leaves people who have serious mental illness at risk of harming themselves and others. They may act out or break jail rules, thus prolonging their incarceration.³³ They also have high rates of recidivism – more than 70 percent in some jurisdictions.³⁴

Jail Diversion and Its Effectiveness

Jail diversion is a means of “avoiding or radically reducing jail time by referring a person to community-based services.”³⁵ 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. Diversion programs can occur pre-booking, post-booking, or post-plea. Common elements of a diversion program include specialized training for staff (such as police officers), co-response of mental health service providers and police officers, 24-hour drop-off centers, release on own recognizance and pretrial supervision programs, and specialty courts.

Participation in diversion usually is voluntary. Often it is motivated by the prospect of the alternative (i.e., jail or hospitalization) or, sometimes, by making treatment a condition of housing.³⁶

Data on the effectiveness of jail diversion programs for people with mental illness are limited. What information is available appears to show better probation compliance³⁷ and reduced time spent in custody for people in mental health diversion programs. Although evidence is weak regarding the direct impact of diversion programs on recidivism, we know that there is strong

Pre-booking diversion: This occurs before an individual is charged with a crime. Pre-booking diversion usually involves community-based practices by law enforcement and clinicians that are designed to keep people out of jail altogether.

Post-booking diversion: This is the most common type of diversion. Defendants are assessed and screened for diversion after they have been charged with an offense. Often post-booking diversion involves treatment plans and allows charges to be waived after completion of the diversion program.

Post-plea diversion: Defendants plead guilty to the pending charges and participate in community-based supervision, treatment, or service programs. Once conditions are met, the charges and plea usually are dismissed.

³³ Council of State Governments. 2002. *Criminal Justice/Mental Health Consensus Project*. Document No. 197103. June 2002).

³⁵ 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.

³⁶ Monahan, J. 2011. “Mandated Psychiatric Treatment in the Community – Forms, Prevalence, Outcomes and Controversies.” In *Coercive Treatment in Psychiatry: Clinical, Legal and Ethical Aspects*. First Edition. Edited by T. Kallert, J. Mezzich, and J. Monahan. John Wiley & Sons, Ltd.

³⁷ Ibid. This finding relates specifically to probation agencies with small, exclusively mental health case loads where the focus is on problem solving rather than threats of incarceration.

evidence regarding the positive impact of decreased jail time on recidivism in the general population.³⁸

A relative newcomer to the mental health jail diversion world is Forensic ACT, or FACT, teams. FACT is an adaptation of the well-studied and highly effective Assertive Community Treatment (ACT) model, in which mobile, self-contained teams provide direct, 24/7 treatment, rehabilitation, and support services in the community to people who have severe mental illness, are functionally impaired, and have a high risk of inpatient hospitalization. FACT teams operate similarly but focus specifically on preventing re-arrest of justice-involved individuals with severe mental illness.

Additional work is needed to assess the effectiveness of FACT. However, initial findings are promising. They suggest that FACT programs can reduce arrests, jail days, hospitalizations, and hospital days, as well as improve psychiatric functioning and engagement in substance abuse treatment.³⁹ In one study, the increased outpatient costs of FACT were offset by lower inpatient costs. Another, earlier study also reported reduced average costs, per client.⁴⁰

For more on ACT and FACT, see Appendix E.

Client Attitudes Toward Jail Diversion

In one study, defendants with mental illness who chose mental health court reported less coercion and more satisfaction with the court process than did defendants with mental illness in criminal court. Afterwards the diverted defendants had fewer arrests and spent fewer days incarcerated.⁴¹

In New York state, 62 percent of people with mental illness involved in court-ordered treatment reported that treatment had been “a good thing” for them and that pressure or encouragement to engage in treatment helped them get and stay well (81 percent), gain control over their lives (75 percent), and made them more likely to keep appointments and take medication (90 percent). They also expressed confidence in their case manager’s ability to help them (87 percent) and said that they and their case managers agreed on what was important for them to work on (88 percent).⁴²

³⁸ Sirotych, F. 2009. “The Criminal Justice Outcomes of Jail Diversion Programs for Persons with Mental Illness: A Review of the Evidence.” *Journal of the American Academy of Psychiatry and the Law*, 37:461-72, 2009.

³⁹ Morrissey, J.P. 2013. Forensic Assertive Community Treatment: Updating the Evidence. SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation. October 2013.

⁴⁰ Ibid.

⁴¹ Monahan, J. 2011. “Mandated Psychiatric Treatment in the Community – Forms, Prevalence, Outcomes and Controversies.” In *Coercive Treatment in Psychiatry: Clinical, Legal and Ethical Aspects*. First Edition. Edited by T. Kallert, J. Mezzich, and J. Monahan. John Wiley & Sons, Ltd.

⁴² New York State Office of Mental Health. 2005. 2005. Kendra’s Law: Final Report on the Status of Assisted Outpatient Treatment. March 2005. Available at https://www.omh.ny.gov/omhweb/kendra_web/finalreport/.

Jail Diversion Models

An early step in this feasibility assessment was to conduct a brief review of the literature on current jail diversion programs around the United States, in an attempt to identify elements central to a successful diversion program. Although there are some studies that evaluate the effectiveness of individual mental health jail diversion program models in terms of mental health treatment and emergency room use, there are few that measure changes in recidivism or compare outcomes across program models. There also is limited evidence from systematic reviews. Based on the available studies, some individual programs appear anecdotally to be performing well. Below we summarize the highlights of several of these programs, to illustrate components and approaches that might be applicable in Multnomah County. We also summarize a conceptual model that maps the landscape of diversion activities.

The Sequential Intercept Model

In conjunction with staff from SAMHSA's GAINS Center, M.R. Munetz and P.A. Griffin developed a conceptual model of the points of intersection between the criminal justice and the mental health systems. For the purposes of this project, we have tailored that model to focus on mental health jail diversion, organizing diversion opportunities sequentially into five different categories or "intercepts," each of which represents a potential point of diversion:⁴³

- Intercept 1: Law Enforcement/Emergency Services – Crisis teams, law enforcement teams, citation & release, arrest & booking
- Intercept 2: Initial Detention and Court Hearings – Initial detention, first court appearance
- Intercept 3: Jails/Courts – Specialty courts, dispositional court, jail, prison
- Intercept 4: Reentry – Reentry from prison or jail
- Intercept 5: Community Corrections – Probation, parole, and post-prison supervision; includes specialty courts and community-based treatment services

The sequential intercept model is used here to help explain recommended principles for jail diversion, such as limiting penetration of people with mental illness into the criminal justice system and developing interventions and diversion opportunities at each

⁴³ Munetz M.R., and P.A. Griffin. 2006. "Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness." *Psychiatric Services*, 57:544-549. doi:10.1176/appi.ps.57.4.544).

intercept.⁴⁴ The model also can be used as a planning tool at the local level, to illuminate where in the system jail diversion already is occurring, where there may be additional opportunities for diversion, and which stakeholders may need to coordinate and/or commit resources in order to expand diversion opportunities.

Although this report does not rely heavily on the sequential intercept model, it does organize descriptions and discussions by intercept, focusing primarily on activities in Intercepts 1, 2, and 5.

Program Model Examples

Bexar County, Texas (San Antonio)

Bexar County's current jail diversion program grew out of a 2002 effort in which stakeholders took part in a collaborative process to remove barriers to diversion. Designed to offer a treatment alternative in lieu of arrest to public inebriates,⁴⁵ the program has garnered considerable attention nationwide.⁴⁶ The program's success has been attributed in part to expanded collaboration among key treatment, law enforcement, and criminal justice stakeholders and a strengthening of the crisis care system, so that there is adequate infrastructure in place to treat the diverted individuals.

The Bexar County program is noteworthy for its proactive outreach, multiple points of diversion, and 24-hour crisis care center, which houses co-located mental health, medical, and court services:

- **Outreach:** A police officer and a licensed counselor jointly meet individuals in the community and assess needs.
- **Diversion:** The system has three points of diversion: the 24-hour Crisis Care Center, release on commercial bond with mental health conditions, and a mental health docket.
- **Co-located services:** Collaborating agencies manage the 24-hour Crisis Care Center (CCC) which serves as a stabilization unit and provides "one-stop stopping" for mental and physical health screening, assessment, and treatment. The CCC is staffed by medical, psychiatric, and social work professionals who provide psychiatric assessment, case management, and monitoring, as well as medical treatment (e.g., medical clearance for the crisis and detoxification programs). Included at the CCC are a sobering area, detox/counseling area, and onsite mental health/drug court.

The diversion system also includes a drop-in day center, a crisis hotline, 911 referral to a mental health crisis team, a mobile crisis unit, police officer CIT training, and a

⁴⁴ 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.

⁴⁵ Galbreath, R. 2014. The Restoration Center. Presented by C. Garfield and B. Berry at the PRA Meeting on Jails, Communities and Persons with Behavioral Health Disorders, Miami, Florida, October 15, 2014.

⁴⁶ Mann (2006) 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.

voluntary residential treatment unit. Additionally, the system ensures that clients have rapid access to psychiatric/mental health appointments.

A 2008 study of the Bexar County program showed that the cost of sending an offender to residential treatment is less than one-fourth that of housing a prisoner in jail.⁴⁷ More recent data indicate that much of the program's cost avoidance is related to sobering and injury care.⁴⁸ The program has significantly reduced law enforcement wait times for medical clearance/screening and psychiatric evaluation (from 9 hours and 12-14 hours, respectively, to 10 minutes and 20 minutes), thus making more effective use of law enforcement time.⁴⁹

Connecticut Criminal Justice Diversion Program⁵⁰

Connecticut's criminal justice diversion program provides comprehensive, court-based diversion services statewide. Clients generally have a serious mental disorder (i.e., schizophrenia, bipolar disorder, or major depression) and have been charged with misdemeanors or low-level felonies. The program provides clinical alternatives to arrest and incarceration, ensures continuity of care for those who are incarcerated, and facilitates reintegration for those who are returning from jail or prison.

Diversion typically occurs at arraignment, via the following program elements:

- **Cross-checking.** The arraignment list is faxed daily to clinical staff at the Department of Mental Health and Addiction Services (DMHAS). They check the list against their information system to identify current or recent DMHAS clients. The judge, sheriff, public defender, bail commissioner, or state's attorney may also identify potential candidates for diversion.
- **Diversion teams.** Diversion teams consisting of one to three mental health clinicians employed by the DMHAS or its contractors are located in the court, where they work to assist the client (not the court). Team members get permission from the client to work on his or her behalf and discuss the case with the court; specific information about the person's mental health diagnosis is kept confidential. Diversion teams do not coerce the client into treatment with threats of jail or promises of a lighter sentence. Instead, they act solely as mental health clinicians.
- **Assessment and treatment plans.** Once the diversion team members have the client's permission, they do a brief assessment to determine whether the person is having symptoms, taking medication, or being treated (in which case the team may contact the treating agency for additional information). They and the client

⁴⁷ 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.

⁴⁸ Galbreath, R. 2014. *The Restoration Center.* Presented by C. Garfield and B. Berry at the PRA Meeting on Jails, Communities and Persons with Behavioral Health Disorders, Miami, Florida, October 15, 2014.

⁴⁹ Ibid.

⁵⁰ Frisman et al. *Connecticut's Criminal Justice Diversion Program: A Comprehensive Community Forensic Mental Health Model.* Available at <http://www.ct.gov/dmhas/LIB/dmhas/publications/jaildiversion.pdf>. Originally published in *Community Mental Health Report*, (c) 2000 Civic Research Institute, Inc., 4478 US Route 27, Kingston NJ 08528.

then develop a treatment plan, which could involve hospitalization or community-based care.

- **Court decision.** At arraignment, the diversion team presents the treatment plan to the judge and describes the ability of the mental health system to meet the client’s needs. This is advisory information only, as it is the judge’s decision whether the client is diverted. There are no specific criteria for diversion. The decision to divert is based on such factors as the seriousness of the charge, the risk posed by the client, the extent to which the offense was related to the mental disorder, and the options presented by the diversion team. Typically the judge releases the defendant on a written Promise To Appear with the condition that the client participate in the proposed treatment plan and appear for another pre-trial hearing in a few weeks.
- **Follow-up appearances.** At subsequent hearings, the diversion team reports on whether the client has continued with treatment. If not, the case is returned to the regular docket, as if there had not been a diversion effort.

Diversion teams are not limited to assisting people at arraignment. They may become involved in all phases of their clients’ court cases, including pleas or sentencing, as appropriate.

Possible System Components

The review of selected jail diversion systems identified a variety of possible components, many of which already are in place Multnomah County.

Not all of these components are necessary for an effective system; in fact, some may be overlapping or duplicative. Stakeholder interviews and the experience of other jurisdictions suggest that taking a systemwide view, understanding the community, involving key stakeholders, and enhancing communication and coordination may be more important in developing an effective diversion system than including a particular component or program.

Component	Present in Multnomah Co.
Urgent mental health walk-in clinic	✓
24-hour 911 triage with crisis hotline	✓
24-hour mental health crisis hotline	✓
24-hour mobile mental health outreach teams (with mental health clinicians)	✓
Police officer CIT training	✓
Enhanced CIT training	✓
Police behavioral health response unit	✓
Combined police/mental health clinician teams	✓
Detox/sobering station	✓

Hospital commitment (acute)	✓
Crisis drop-off center (24 hour)	
Drop-in day center	
Co-located medical and behavioral health services	✓ (limited)
Psychiatric emergency room ⁵¹	
Triage of justice-involved people for mental health appts.	
Pretrial supervision	✓
Court-ordered outpatient mental health treatment for people who have previously been in a psychiatric hospital, jail or prison	
Co-located mental health services at arraignment	
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	✓
Culturally specific services	✓ (limited)

For brief descriptions of current system components in Multnomah County, see Appendix E.

⁵¹ Multnomah County does not currently have a psychiatric emergency room, but Legacy Health Services is working with Oregon Health and Sciences University to open one in late 2016, assuming that challenges such as funding and the use of special Medicaid crisis stabilization billing codes can be addressed. Meanwhile, the Multnomah County Department of Community Justice (DCJ) is contracting with Central City Concern (CCC) to open a 12- to 16-bed residential stabilization center for men who have mental health issues (and possibly also substance abuse and/or chronic medical conditions). Expected to open in early 2015, the stabilization center will serve DCJ clients on community supervision for up to four months, providing skill-building, treatment, and support services to prepare them for eventual transition to alcohol- and drug-free housing.

Potentially Divertible Individuals Being Held in Jail

To better understand who is being held in Multnomah County jails who might have been diverted but for their presenting mental health status, we worked with a project data group to collect information on three groups of detainees being held in jail during October 2014. These are people who were potentially eligible for diversion, had been screened or assessed for possible release, but remained detained. We examined data on a total of 80 people from three different groups:

- **PSP defendants**— 18 defendants who were screened by DCJ’s Pretrial Supervision Program (PSP) and met release criteria (charge and risk assessment score) but were not recommended for release because of mental health concerns.

The Pretrial Supervision Program (PSP) conducts release interviews and assessments to determine the release eligibility of arrested defendants, and makes a recommendation to the court. PSP also provides pretrial supervision for all defendants who are referred and released. PSP release recommendations are based on criteria established by statute and a validated risk assessment. Under PSP supervision, defendants are afforded the opportunity to maintain employment and/or school attendance, continue with health-related services (e.g., drug and alcohol counseling, mental health treatment) and reside in the community pending the resolution of their court matters)

- **CSS defendants**— 44 defendants who were screened by the Multnomah County Sheriff’s Office’s (MCSO) Close Street Supervision Program (CSS) but were denied program participation. Some of these denials may be because of mental health concerns, although the data are not definitive.

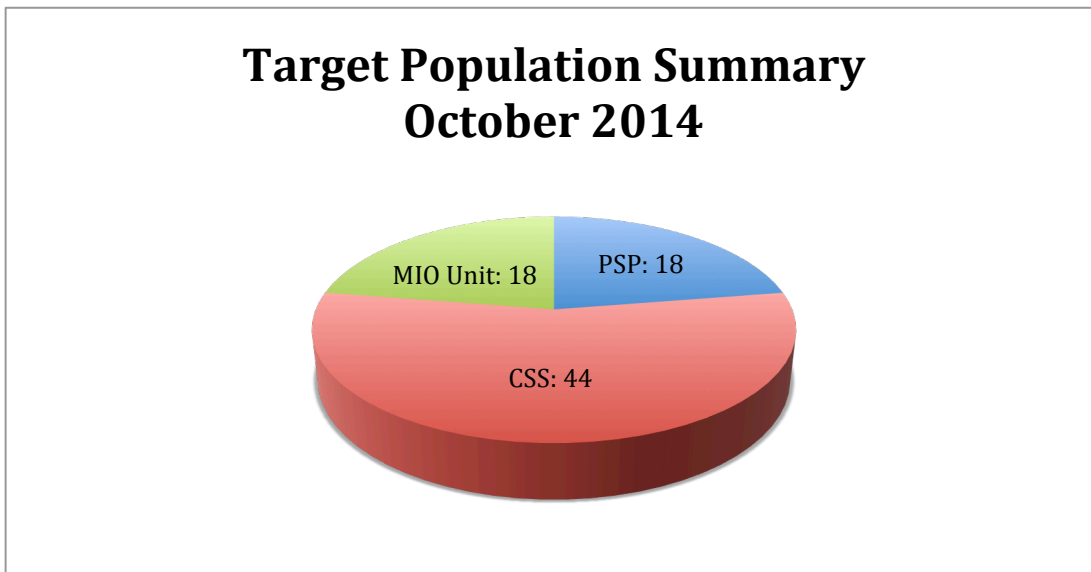
CSS is an intensive custody and supervision program that provides pretrial services to arrestees of Measure 11 crimes, domestic violence cases, and a select group of clients with mental health disorders. Deputies interview defendants and conduct investigations to present the Court with accurate, timely, and impartial information that assists the judge in making an informed release decision. This program supports both offender accountability and reentry of the offender into the community while increasing the number of available jail beds.

- **MIO Unit defendants**— 18 individuals who were on community supervision and had been placed on a jail hold by officers of the Multnomah County Department of Community Justice Mentally Ill Offender (MIO) Unit.

DCJ’s Mentally Ill Offender (MIO) Unit provides supervision services for probation, parole, and post-prison offenders who have been diagnosed with a severe and persistent mental illness. The MIO Unit works to divert offenders with severe mental illness from incarceration and hospitalization by treating them in the community. By connecting

these offenders to community-based treatment and providing them with supervision from specially trained parole/probation officers, the MIO Unit preserves community safety and minimizes offender contact with the criminal justice system. The goal of the MIO Unit is to reduce recidivism, enhance community safety, and support offenders with mental illness in achieving stabilization and improved functioning.

Data Collection Summary		
Population	Number	%
PSP	18	23%
CSS	44	55%
MIO Unit	18	23%
Total	80	100%



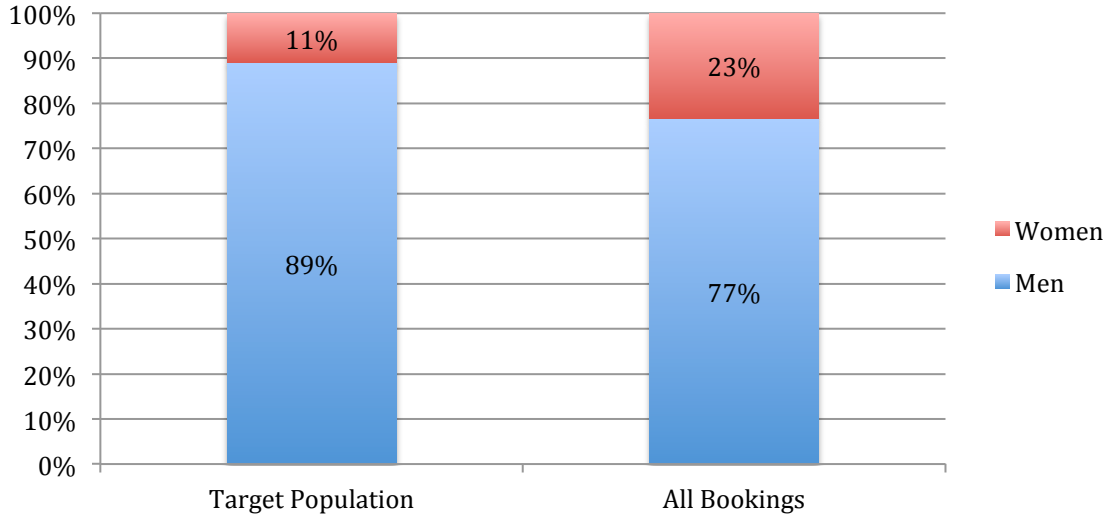
Results of the data analysis are summarized below and described in more detail in Appendix D, as are the data sources and collection methodologies, including those used to protect privacy. Demographic, medical, jail utilization, and criminal justice data are presented.

It is important to note that the data we collected do not represent all jail detainees with mental health diagnoses. Our analysis was limited to the specific target population of possibly divertible individuals, which, in the case of the Close Street Supervision program, may include people who do not have a mental health disorder.

Demographic Data: Gender, Age, and Race

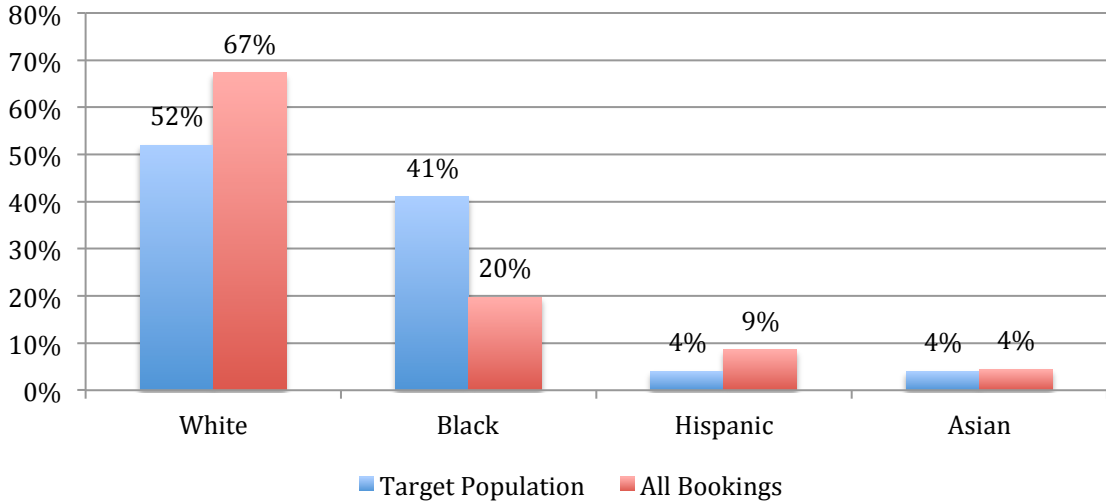
The individuals identified as the target population were mostly male (89 percent) and between the ages of 26 and 40, with the average age being 34.8 years. This is roughly comparable to numbers for the all bookings during the same time period (77 percent male and average age of 35.4 years).

Gender: Target Population & All Bookings October 2014



The most pronounced finding among the demographic data was the significant overrepresentation of black detainees, at 41 percent of the target population. This compares to 19.7 percent of all bookings during that time period.

Race: Target Population & All Bookings October 2014



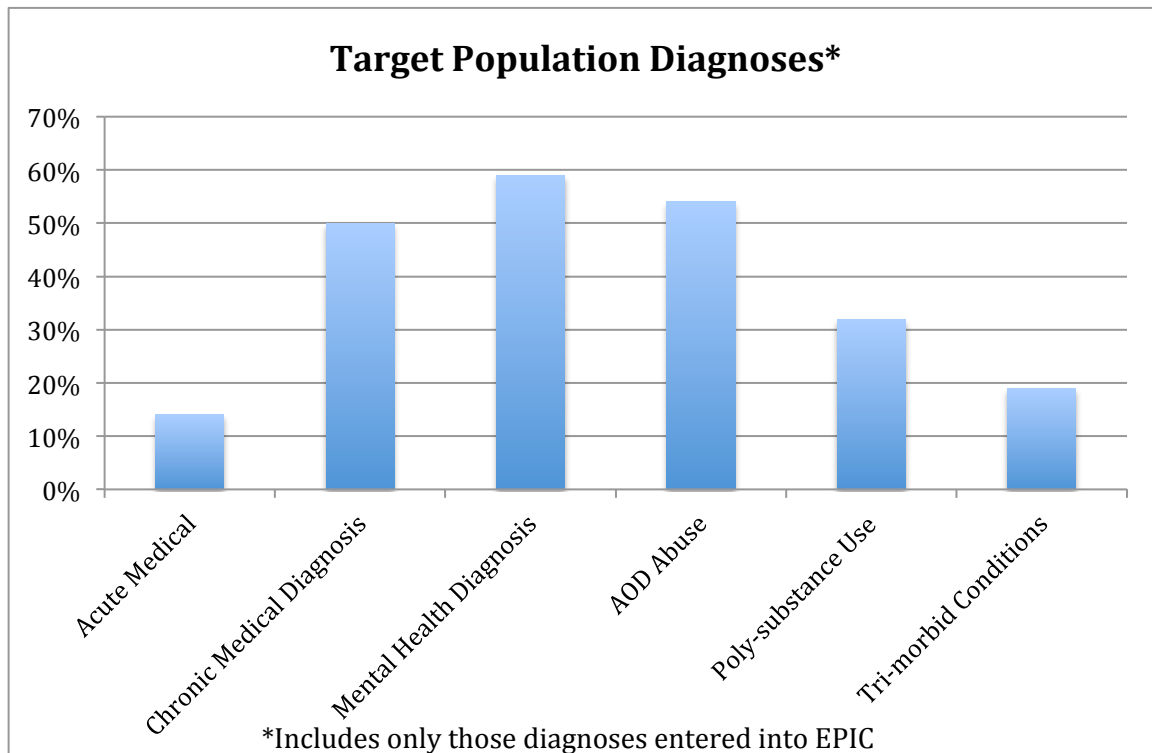
Race/Ethnicity of the Target Population					
	White	Black	Hispanic	Asian	Total
PSP	5	12	0	1	18
CSS	27	14	3	0	44
MIO Unit	9	7	0	2	18
Total	41	33	3	3	80
%	52%	41%	4%	4%	100%

Race/Ethnicity by % of Total Bookings in October 2014 ⁵²					
	White	Black	Hispanic	Asian	Total
%	67.3%	19.7%	8.6%	4.4%	100%

Health Data

The available health data for the target population include medical, mental health, and substance abuse diagnoses contained in Corrections Health’s EPIC database (which does not necessarily include all the diagnoses associated with these individuals).

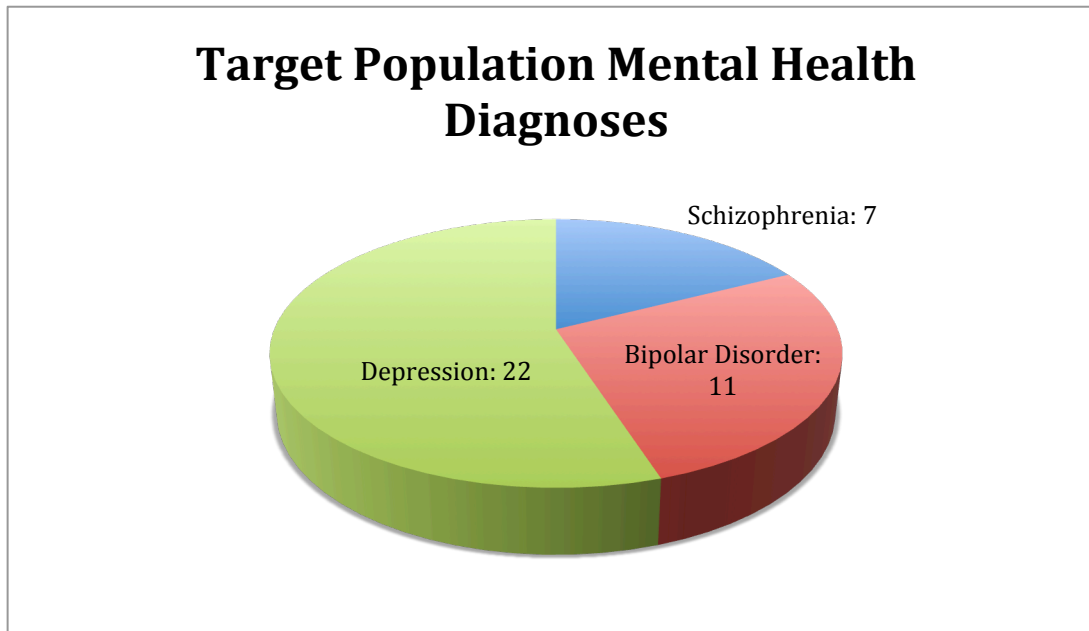
A total of 47 of the 80 individuals in the target population, or 59 percent, had diagnoses of mental health disorders, 50 percent had chronic medical conditions, and 54 percent had a diagnosis of alcohol or other drug abuse. Roughly one out of five people had a tri-morbid diagnosis, meaning mental health, chronic medical conditions, and alcohol or other drug abuse.



⁵² Multnomah County Sheriff’s Office. 2014. Monthly Jail Report, November 2014. Available at http://www.mcso.us/profiles/pdf/jail_stats.pdf.

Health Data on Target Population		
Diagnosis/Issue	# of People (out of 80)	% of Target Population
Acute medical issues that required attention (i.e., broken bones, lacerations, chest pains, and abscesses)	11	14%
Chronic health conditions such as hypertension, hepatitis, diabetes, asthma, osteoarthritis, and chronic obstructive pulmonary disease (COPD)	40	50%
Mental health diagnoses (according to Correction Health's EPIC database)	47	59%
– Schizophrenia	7	9%
– Bipolar disorder	11	14%
– Depression	22	28%
Alcohol and/or other drug (AOD) abuse	43	54%
Poly-substance use	27	32%
Tri-morbid (i.e., chronic medical issues, mental health diagnosis, and AOD abuse)	15	19%

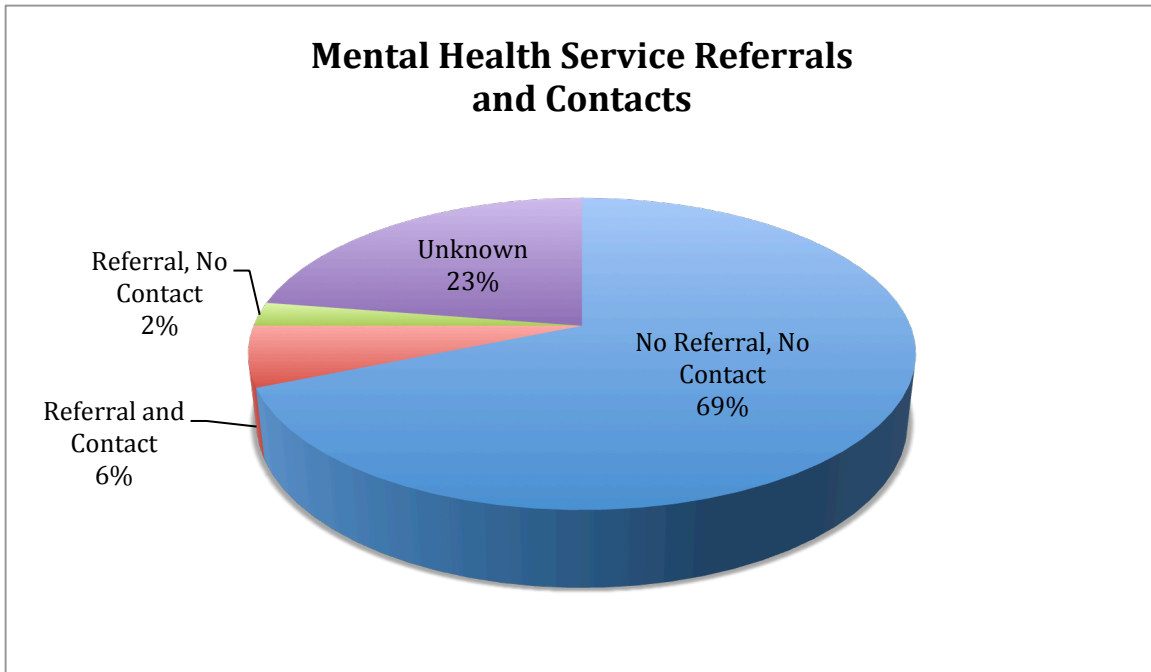
Note: Totals for numbers of people and percentages are not provided because individuals may have more than one of these conditions.



Following a January 2015 prioritization meeting for stakeholders in this project, staff from the Mental Health and Addiction Services Division's Decision Support Unit gathered additional data (enrollment, referrals, and service encounters) for the project's target population. Staff attempted to match the 80 individuals from the target population to case files in Electronic Health Records and/or Medicaid eligibility systems (CIM/MMIS). Of those detainees, exact matches were found in the databases for 25 (31.3 percent) of the individuals, possible matches were found for 37 (4.3 percent), and 18

(22.5 percent) had no match. None of the exact matches had a current mental health referral or a reported encounter with a mental health service provider in the past 120 days. Only five individuals (possible matches) had a current mental health referral and had received a community-based mental health service in the previous 120 days. Two people (possible matches) had an open referral but had had no reported contact with a mental health service provider.

Only five out of the 80 individuals in the target population had a current mental health referral and had received a community-based mental health service in the previous 120 days.



Target Population Mental Health Referrals and Service Encounters				
Match w/EHR and/or Medicaid eligibility data system	Current Health Referral?	Reported Encounter with Mental Health Services w/in Past 120 days	# of people	%
Exact match	No	No	25	31.3%
Possible match	Yes	Yes	5	6.3%
Possible match	Yes	No	2	2.5%
Possible match	No	No	30	37.5%
No match found	Unknown	Unknown	18	22.5%
Total			80	100%

Jail Utilization

On average, the 80 detainees in the target population spent more time in jail than other detainees, and they had frequent stays in resource-intensive units, such as suicide watch, disciplinary, and close custody.

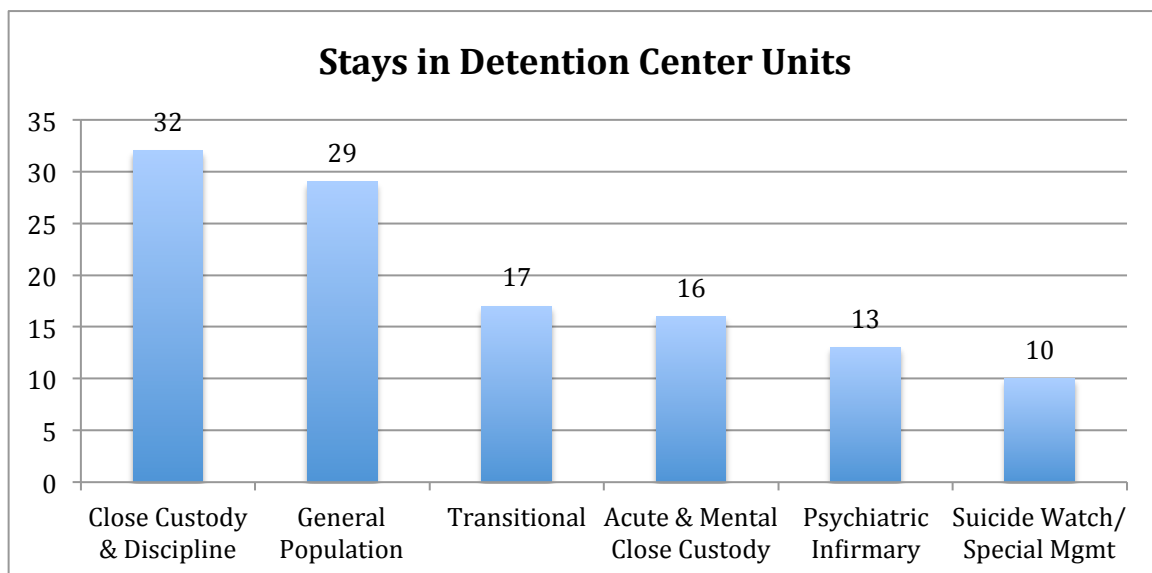
The 80 detainees in the target population spent an average of 18.27 days in jail during October 2014, which is longer than the 13.51 average length of stay (ALOS) for all jail detainees in October. During that month, members of the target population used approximately 1,352 bed days, in multiple units at both the Inverness Jail (MCI) and the Multnomah County Detention Center (MCDC).

We were able to collect housing information on a subset of the target population, i.e., 62 detainees who were being held based on decisions by PSP and CSS. Of those detainees, 42 spent one or more days at the Inverness Jail, 40 spent one or more days at the Detention Center, and some spent time at both facilities.

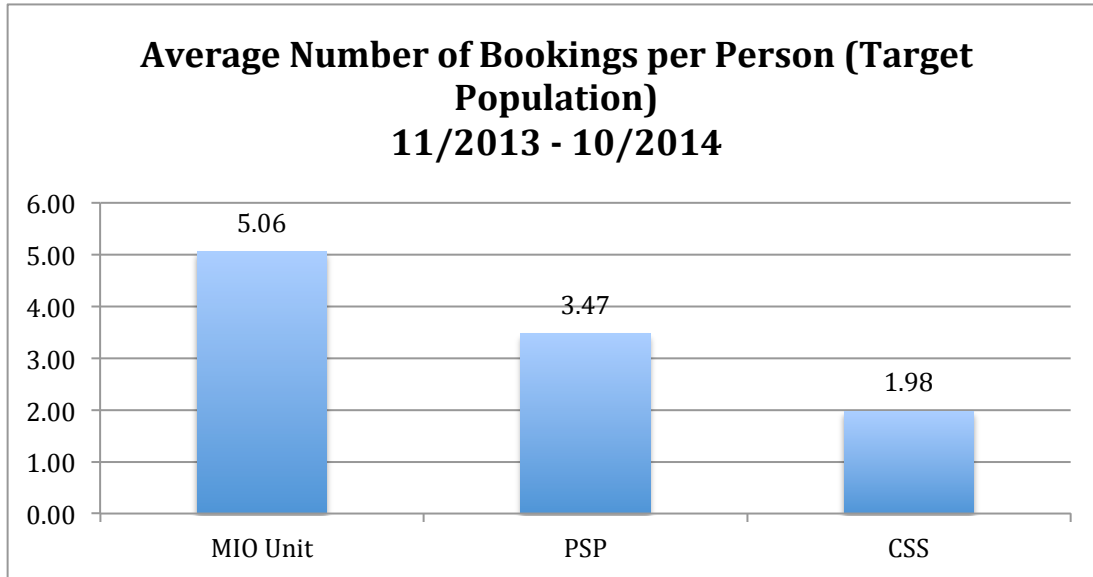
The 40 detainees at the Detention Center logged approximately 116 “stays” at various units within the center. (A “stay” is a discrete period of residence in a particular unit.) Those stays were as follows:

- 32 stays in close custody and discipline units (4f, 5a, 5b, 5c, 5d, 8a)
- 29 stays in general population units (6a, 6b, 6c, 6d, 8d)
- 17 stays in the transitional unit (7d)
- 16 stays in acute and mental close custody units (7a, 7b, 7c, 8b)
- 13 stays in the psychiatric infirmary (4d)
- 10 stays in the suicide watch/special management unit (8c)

The 42 detainees at Inverness Jail logged 131 stays at various units there.



Looking back at the previous year (November 2013 through October 2014), the individuals from the target population were booked into the jail an average of 2.98 times. The MIO Unit group had the highest average booking rate at 5.06 per person. One person from the target population was booked 14 times, two were booked 10 times and 11 were booked between five and nine times during that 12-month period.



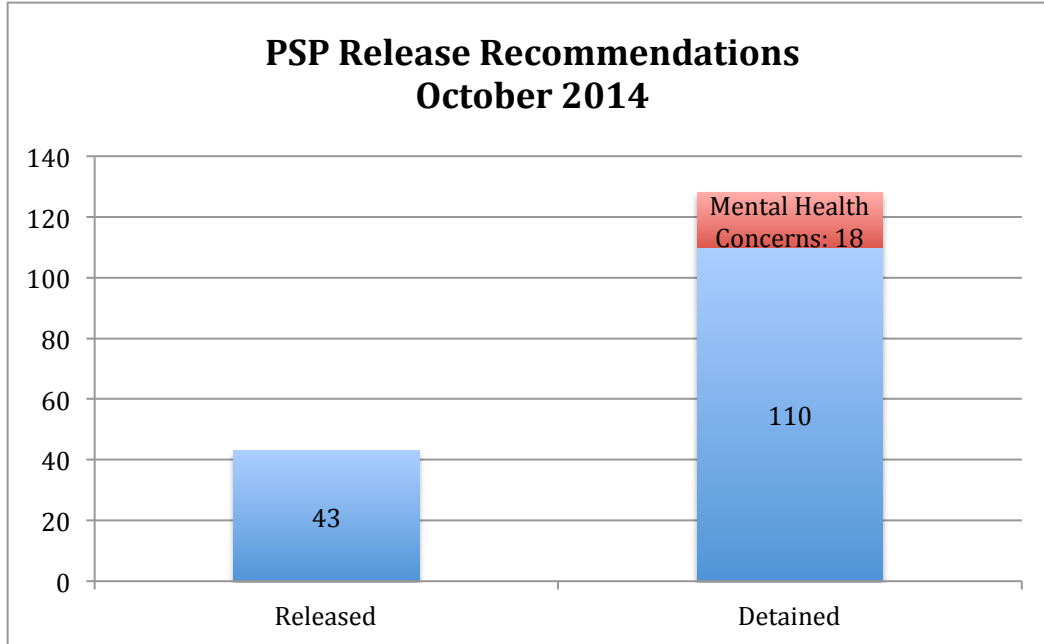
Criminal Justice Data

DCJ Pretrial Services Program (PSP)

The PSP makes recommendations to the court for release on pretrial supervision. These recommendations are based on state statute, an interview, and completion of a validated assessment tool (see Appendix D).

During October 2014, PSP conducted assessments on 171 defendants and the court released 43 (25 percent) based on PSP recommendations. Of the 128 people detained, 18 were detained because the PSP officers had concerns about the defendants' mental health status. These 18 people represent a subset of the 80-person target population that was the focus of data gathering for this report.

DCJ PSP	#	%
Total Referrals in October 2014	171	100%
Released	43	25%
Detained	128	75%
Detained because of MH concerns	18	11%



Primary charges for the 18 detained PSP defendants were as follows:

Charge ⁵³	# of Defendants
Possession of Cocaine or Meth	5
Restraining Order Violation	3
Domestic Violence-related Charges	3
Indecent Exposure	2
Robbery II	1
Theft I	1
Assault of an Officer	1
Resisting Arrest	1
Failure to Register as a Sex Offender	1
Total	18

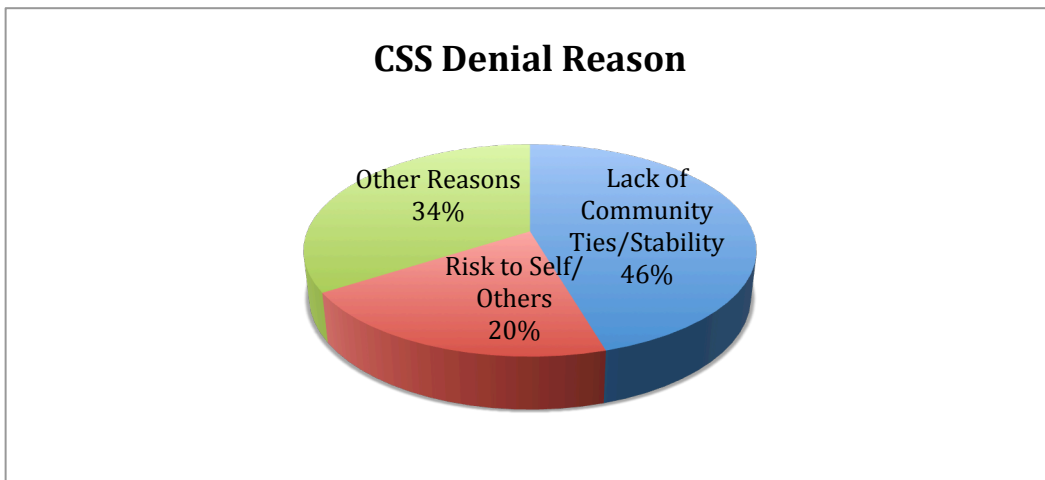
Close Street Supervision (CSS)

MCSO's Close Street Supervision provided data on 44 detainees who met the criteria for release on CSS but, upon being interviewed by CSS staff, were denied program participation. A manual review of the EPIC database indicated that at least 22 of these individuals had a recorded mental health diagnosis. Because the EPIC database does not include information from providers who do not use EPIC (i.e., most substance abuse and mental health treatment providers), it is possible that the rate of mental health diagnosis among our target population is higher than indicated in the EPIC database. For the purposes of this report, we included all 44 detainees in the analysis. We based this decision on a review of the separate, aggregate mental health diagnoses data received from Corrections Health and the CSS case notes, which include reasons for program denial.

⁵³ The charges listed are the most serious on file at the time of interview.

The 44 detainees were denied participation in the Close Street Supervision program for various reasons. Along with high-level pending charges, the most common reasons cited for denial were that the detainees lacked stability or ties to the community or were a danger to themselves or others.

Close Street Supervision (CSS)	#	%
Met criteria for release but were denied participation in CSS	44	100%
Denied because of lack of community ties/stability	20	45%
Denied because of risk to self/others	9	20%
Denied for other reasons	15	34%



Primary charges for those 44 defendants were as follows:

Charge ⁵⁴	# of Defendants
Robbery I, II, and III	12
Assault II, III, and IV (mostly DV)	10
Burglary I	4
Coercion	2
Kidnap I	2
Rape I and Rape I-DV	2
Sex Abuse I	2
Sodomy I	2
Attempted Assault I – DV	1
Attempted Conspiracy to Promote Prostitution	1
Conspiracy to Commit Aggravated Murder	1
Criminal Mistreatment I	1
Escape II	1
Manslaughter I	1
Menacing-DV	1
Parole Violation	1
Total	44

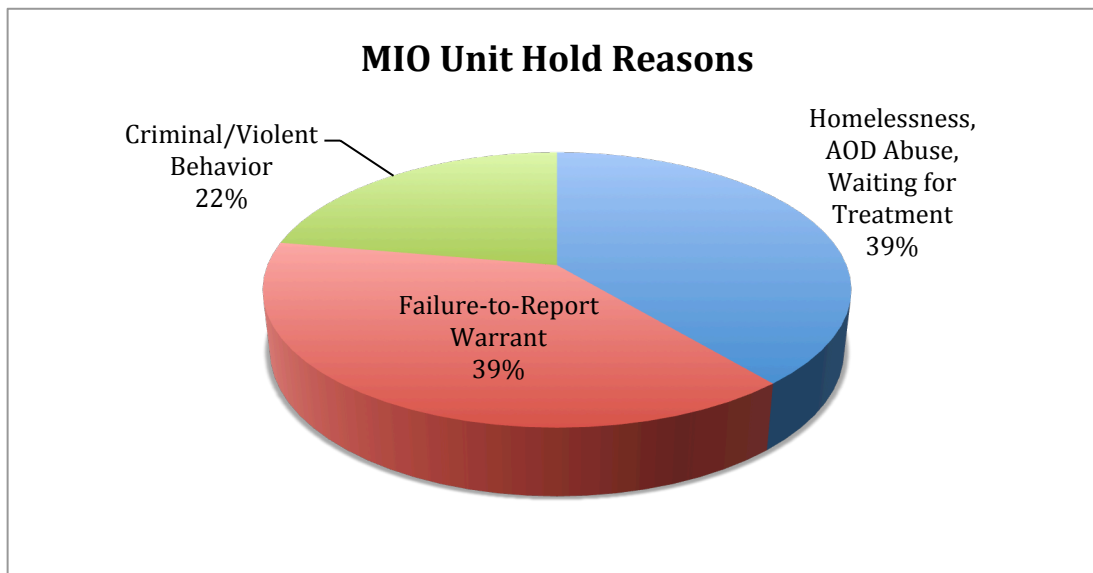
⁵⁴ The charges listed are the most serious on file at the time of interview.

DCJ Mentally Ill Offender (MIO) Unit

The DCJ Mentally Ill Offender (MIO) Unit provided a review of jail holds placed by MIO Unit officers during October 2014. Individuals supervised by this unit have been diagnosed with severe and persistent mentally illness.

The unit officers provided a case note for each of the 18 individuals sanctioned to jail time in October. According to the case notes, at least seven (39 percent) of the 18 detainees would be good candidates for diversion but were being held in jail because of issues related to homelessness, substance abuse (dual diagnosis), and lack of treatment availability (i.e., wait times). Another seven detainees (39 percent) were being held on a warrant for not reporting to their parole/probation officer; several of these individuals had also absconded from or failed to successfully complete community-based treatment programs. The remaining four detainees (22 percent) were identified as not “good candidates for diversion” because of the nature of their behavior (i.e., high level of violence and/or pending new charges).

Mentally Ill Offender (MIO) Unit	#	%
Total sanctioned to jail time	18	100%
Held because of homelessness, substance abuse, or lack of treatment availability	7	39%
Held because of warrant for not reporting to PO	7	39%
Held because of behavior (violence, pending new charges, etc.)	4	22%



Primary charges for those 18 detainees were as follows:

Charge⁵⁵	# of Defendants
Probation/Parole Violation	11
DUII	1
Indecent Exposure	1
Unlawful Possession of Meth	1
Robbery III	1
Theft of Services	1
Unlawful Delivery of Marijuana (DCS)	1
U.S. Marshal Hold	1
Total	18

⁵⁵ The charges listed are the most serious charge on file at the time of interview.

Section 5

Strengths and Weaknesses of the Current Multnomah County Jail Diversion System

To identify the strengths and weaknesses of the current system of mental health jail diversion, we interviewed 23 local stakeholders, which included Multnomah County elected officials, representatives of Legacy Health System and community mental health service providers, and employees of the Multnomah County Courts, Department of Community Justice, District Attorney's Office, Health Department's Corrections Health, Department of County Human Services' Mental Health and Addictions Services Division, and Sheriff's Office. Questions focused on the characteristics of the current system, service gaps, and potential system improvements, including necessary policy changes.

The following text summarizes key themes from the interviews. More complete information is available in Appendix C.

Strengths

There was general agreement on the diversity of the current mental health jail diversion system. Interviewees commented on recent enhancements to the continuum of system components. Relationships among stakeholders were characterized as good. Interviewees expressed appreciation for regular, multidisciplinary coordination meetings that are taking place (such as bimonthly meetings organized by the Portland Police Bureau's Behavioral Health Unit), and how actively partners are participating in these collaborative efforts. Most of these multidisciplinary meetings are focused on coordinating case management of specific people who are frequent users of system resources. The meetings help people understand the "global terrain" of the system and push people out of their institutional silos. Interviewees reported that new partnerships are emerging among stakeholders.

Interviewees have felt a renewed sense of energy and change recently. As one person said, "We've come a long way over the last two years!" Interviewees commented favorably on improved communication among stakeholders, an increased emphasis on transition planning, and recent support for elements such as Project Respond and the mental health call center that are critical components of the system of crisis services.

Summary of 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 focus on transition services

Opportunities for Improvement (Excluding Capacity Issues)

Interviewees identified potential system improvements in nine main areas, excluding capacity issues (which are discussed separately):

- Coordination across systems
- Information sharing, including confidentiality restrictions
- Sharing of electronic data
- Identifying defendants with mental illness at booking
- Timelines/wait times
- Staffing/training
- Funding structures
- Working with detainees
- Court/pretrial processes

Coordination across systems: The current mental health jail diversion system has many components, with multiple agencies doing similar work and, to some degree, co-managing the same people. For many interviewees, this complex system feels fragmented or lacking in continuity. Some interviewees are concerned about how well someone with a mental illness can navigate the system – especially if the interviewees themselves are not certain what other agencies are doing and how their own work connects with that (or doesn't).

Although interviewees appreciate the many significant instances of cooperation and relationship building with people from other agencies, they see a need for a forum or structure that could provide overall, high-level coordination of the mental health system (including jail diversion). It would be helpful for someone to “take the reins and set up a coordination structure,” one interviewee said. Funding might also be better used if there were stronger overall coordination. Currently funding for the mental health system comes from multiple sources, including Medicaid, state general funds passed through the county, project-specific grants from state and federal agencies, and county general funds. The table below lists some of the grant and county general fund resource streams for mental health services in the county. It is clear from the partnership descriptions in the table that these initiatives are complex and involve multiple partners. This highlights the need for enhanced coordination.

Funding Streams Supporting Mental Health & Substance Abuse Services for Justice-Involved Individuals			
Funder	Program	Lead & Partners	Amount
Oregon Health Authority	FACT	Health Share (w/Cascadia & MHASD)	\$500k/1yr
	Jail Diversion Mental Health Services	Corrections Health (w/DCHS & Cascadia)	\$500k/15 months
County General Funds	Behavioral Health Triage for Adults in CATC	DCHS (w/MCSO, DCJ, Corrections Health, and Portland Police)	\$658,721/1 yr pilot
	Supportive Housing	DCJ	\$36k/1 yr pilot
	Mental Health Assessment & Suicide	MCHD/Corrections	\$385,820/1 yr pilot

	Watch Coverage in Booking & Jail		
Oregon Addiction & Mental Health Services	Forensic Diversion (base program)	DCHS/MHASD with DCJ, Sheriff, Pre-trial, Jail, Community Partners	\$277,241
	Mental Health Court	DCHS/MHASD with DCJ, Sheriff, Pre-trial, Jail, Community Partners	\$297,749
	Community Court	DA DCHS/MHASD	\$222,718
SAMHSA	Behavioral Health Treatment Court Collaboratives (BHTCC)	MHAS (w/MSC), Corrections Health, DCJ, DA, Court, Cascadia)	\$348k/yr – <i>10/1/14 to 9/30/18</i>
BJA	Drug Court Enhancement Project	DCJ (with Drug Court Partners)	\$200k/2 yrs

Information sharing (including confidentiality restrictions): Interviewees described challenges in getting information about the people they encounter in their work, particularly information from outside their own discipline (i.e., law enforcement, health care, criminal justice, behavioral health care). For example, when police officers encounter someone who appears to have a mental illness, it can be difficult to discover whether that person already is engaged with a provider or case manager. (This information would help the officer make an appropriate choice about where to take the person, or whether to involve the case manager in the situation.) Likewise, community treatment providers often do not know when one of their clients has come into contact with law enforcement or been taken to jail. Similarly, Corrections Health is prohibited from accessing a detainee’s hospital records (e.g., psychiatric ward stays) unless the detainee mentions the stay to Corrections Health staff; thus, Corrections Health does not always have a full picture of detainees’ medical and mental health needs.

Many of these information-sharing challenges relate to legal confidentiality restrictions, such as the Health Insurance Portability and Accountability Act (HIPAA), which limits the sharing of health information and medical records without signed Release of Information (RIO) forms. In some cases community service providers or county departments appear to be interpreting HIPAA restrictions narrowly, or differently, based on their legal counsel and degree of potential liability; therefore, they do not always share information that otherwise would be helpful. In addition, federal regulations further restrict discussion of a client’s chemical dependency⁵⁶ (which is a common co-occurring condition among people in jail who have mental illness).

Other information-sharing challenges are more procedural, and some have been overcome (such as by Corrections Health sending lists of jail mental health dorm inmates to providers every week, and DCJ sending lists of people on community supervision to Corrections Health). Yet interviewees repeatedly described a need for improvements in information sharing, so that people’s medical, mental health, and treatment status and needs can be better understood and there can be a well-coordinated

⁵⁶ 42 Code of Federal Regulations (CFR) Part 2 <http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2>.

response to people with mental illness who come into contact with the criminal justice system.

Sharing of electronic data: When it comes to electronic records, the lack of a centralized data system is a glaring challenge. The various acronyms – CIMS, SWIS, EPIC, EVOLVE – attest to the many different electronic records systems currently in use by DCJ, the criminal justice system, Corrections Health, and community providers to track detainees, inmates, and clients. The fact that these different systems generally do not communicate with each other has obvious implications for continuity of service. (Corrections Health, in particular, desperately needs to be able to share information with community providers, so that providers can better serve individuals coming into treatment from jail and vice versa.)

However, the issue of electronic data sharing goes beyond the treatment of individual clients or inmates. The lack of a centralized system curtails Multnomah County’s ability to collect data on the jail population overall. For the sake of efficiency, effectiveness, and equity, the county needs better data reporting on who is in jail, why, and for how long, and what detainees’ needs are. Improvements in electronic data sharing could help the county better understand, among other things, who is cycling rapidly in and out of the jail and why, the race and ethnicity of detainees, and the mental health needs of inmates – all of which is relevant to this report and any further exploration of jail diversion opportunities.

Identifying defendants with mental illness at booking: Defendants who have a mental health disorder are not necessarily identified as such at booking, in part because recognizance officers generally do not have mental health training, but also because the symptoms of mental illness can overlap with those of intoxication or drug use. In addition, there is no formal method of sharing information about potential mental health issues from one partner or desk in the booking process to the next (i.e., arresting officer, booking sergeant, recognizance officer, and Corrections Health). Unless defendants have a serious mental illness and are presenting symptoms at booking, they can end up in the general jail population, not be identified as having mental illness, and spend their tenure in jail without their mental health issues being addressed. Reliably identifying defendants who have mental illness when they enter the jail would decrease opportunity for victimization and allow these people to be prioritized for diversion/reentry planning and connection with services.

Interviewees’ ideas for addressing this issue included (1) having a credible point person in booking who can identify people with mental health issues, and (2) developing a system to better record and share observations and information about potential mental illness throughout the booking process. Another possibility is to use the Brief Jail Mental Health Screen (BJMHS)⁵⁷ to flag individuals for further mental health assessment as they come in the door. Using a screening tool such as the BJMHS at the booking desk would provide mental health data on all individuals passing through booking (including those released on their own recognizance), thus allowing for more in-depth analysis of the jail

⁵⁷ 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 takes an average of 2.5 minutes to administer.

population. In addition, using a screening tool would supplement self-harm data currently collected by Corrections Health during booking, to determine the need for suicide watch. More general mental health data collected through a screening tool such as the BJMHS would help flag detainees for follow-up with a mental health consultant within several days of intake.

Timelines/wait times: Many community mental health treatment providers have had difficulty handling the increase in demand for their services that has accompanied the increased numbers of insured related to the Affordable Care Act's (ACA) Medicaid expansion. This has resulted in long wait times for appointments for people transitioning out of jail – up to four to six weeks, according to interviewees. In some cases, this delay results in individuals being detained longer in the jail while they await treatment beds or appointments. DCJ's Pretrial Services Program and Mentally Ill Offender Unit both have described a lack of treatment availability as a contributing factor for initial and continued detainment of some people with severe and persistent mental illness.

Interviewees cited a need to more quickly link individuals to community providers when they transition out of jail, such as by using system navigators to make appointments for people and help them access treatment. Another suggestion was to get people started with treatment while they are incarcerated, as this would prepare inmates to enter treatment in the community and help them build relationships with providers before their release. Currently, although limited mental health services (crisis intervention services, one-on-one therapy, and transition planning) are available in the jail, they often are of short duration and not delivered in a therapeutic milieu (e.g., at times they are delivered through a locked door).

Staffing/training: Interviewees identified three distinct issues related to staffing and training:

- **Agency hiring and retention:** Local agencies are struggling to recruit, hire, and retain sufficient qualified staff to serve the large number of newly insured clients. Too often, providers are losing experienced staff to coordinated care organizations (CCOs) and the Veterans Administration, both of which pay more than providers can offer.
- **Dually credentialed staff.** Substance abuse is a common co-occurring disorder with mental illness, yet it is difficult to find staff who are dually credentialed and can treat both disorders simultaneously. In addition, it sometimes is challenging to find people who are dually credentialed and can also meet background check requirements (because of histories of substance abuse and related justice system involvement that led them to the field in the first place). Although academic institutions are increasingly producing graduates who are dually credentialed, recent graduates often need more on-the-job experience before they have the skills to successfully treat this population.

- **Training in forensic clients.**⁵⁸ The Portland area has few clinicians and agencies that are trained to and interested in working with forensic clients. At a minimum, agencies treating forensic clients need to understand the evidence-based practice models for working with this population, and staff typically need training on how to interface with the criminal justice system. Not every intensive case management provider has the skills and motivation to work with this population.

Funding structures: Interviewees brought up several issues related to the structure of funding for mental health assessment and treatment, such as a lack of funding for (1) infrastructure, and (2) the full continuum of mental health and especially substance abuse treatment (especially engagement), which long has been significantly under-resourced. A complicating factor is that, currently, Health Share of Oregon reimburses mental health services separately from addiction services, which makes it difficult to coordinate services. It would be helpful if these two types of benefits were combined. Another issue related to funding structure is that state and federal funds used to be funneled through county mental health agencies (the primary payer) to the providers. With the implementation of the ACA, the CCOs are now the primary payers (in addition to direct grants from the Oregon Health Authority). Consequently, the county mental health agencies have less leverage, according to some interviewees, to influence decisions about which services are offered locally.

Working with detainees: Interviewees described various opportunities to improve how people work with inmates with mental illness while they are in jail – to engage more with them, to increase provider access to them, and to better prepare them for treatment upon release. Most of these opportunities involve closer coordination between jail staff and providers, Corrections Health, or local hospitals, such as by communicating the timing of provider visits or inmate releases. Interviewees emphasized the importance of limiting trauma on people in jail, having smooth lines of communication, and easy access to detainees. They also spoke about placing less emphasis on medication when deciding whether to meet with someone (i.e., the person might be more amenable to taking medication after a positive interaction with jail, Corrections Health, or provider staff).

Some interviewees pointed out that housing people with mental illness in jail is resource intensive but sometimes necessary, especially for people who are on suicide watch or at risk of other types of self harm or acting out. These people’s behavior may make them more challenging for community-based treatment programs.

Court/pretrial processes. There are opportunities to improve identification and triage of people with mental health disorders during the pretrial release decision and arraignment processes. Interviewees believe that more information could be shared at the outset of cases, and better triage done before arraignment to identify individuals with mental illness. (Arraignment tends to be a favorable time to connect defendants with services because they often are more sober, rested, and calm than at booking).

⁵⁸ 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 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.

According to interviewees, more education is needed among criminal justice partners (including the District Attorney's [DA] office and the defense) about mental illness, how it presents, the process and criteria for participation in mental health court, and resources available for post-release supervision defendants. If the justice partners had this information, they would be more likely to ask judges to order participation in specific treatment programs.

Prominent System Gaps

It is clear from the interviews and data collected for this assessment that additional capacity is needed across the continuum of care – acute (inpatient hospital treatment), subacute (residential care outside of a hospital setting, such as at the CATC), outpatient, and specialty care (for co-morbid, tri-morbid, forensic, and racially and ethnically diverse clients). A lack of capacity contributes to the previously described long wait times for people trying to get mental health treatment appointments or placements.

Although mechanisms for referral to treatment are in place, long wait times can be an obstacle to diversion and release from jail. For example, for some members of the target population for this report, a lack of treatment availability was a contributing factor in the decision to not release them from jail; this was the case for some of the people being supervised by the Mentally Ill Offender Unit. Release recommendations by the Pretrial Services Program and Close Street Supervision are similarly influenced by the availability of timely community-based treatment options and positive support. If there were more community providers, one interviewee said, more people could be released.

The connection between treatment availability and release from jail, as seen in the information collected for this report, emphasizes points made by Taxman and Pattavina (2013; see Section 7) and others that the success of jail diversion programs is linked to the availability of appropriate mental health services in the community.

System Gaps

The following gaps in service are particularly pronounced and were repeatedly identified by interviewees:

- 24-hour drop-off center
- Dual-diagnosis treatment
- Residential dual-diagnosis treatment for women
- Outreach and engagement
- Adequate supplies of appropriate housing

These system gaps are discussed below. For more information on capacity issues, see Appendix C.

24-Hour Drop-off Center

The current jail diversion system lacks a 24-hour facility – separate from hospital emergency rooms and the jail – where law enforcement officers can drop off people needing acute or subacute care.

Having a 24-hour drop-off center that is convenient for police would allow some people with mental illness to be diverted from jail. Currently, when someone experiencing a

mental health crisis has committed a low-level crime, local law enforcement officers tend to avoid taking that person to a hospital emergency department. For the officer, an emergency room visit typically involves waiting for several hours, after which the individual may not even be admitted to the hospital. As an alternative, officers often take individuals to the jail, where their wait time to drop off the individual at booking is only 20 to 45 minutes.

Few other options are available. Cascadia Behavioral Healthcare operates an urgent walk-in mental health clinic that accepts voluntary law enforcement drop off. However, this clinic is not open 24 hours a day, is not a secure facility, and does not accept involuntary police transport drop off.

There also is the Crisis Assessment and Treatment Center (CATC). Although the CATC can accept referrals from law enforcement, it was not designed to be a 24-hour drop-off program. Referrals to the CATC program can come from community behavioral health providers, hospitals, crisis system programs, and law enforcement. The CATC's capacity is limited to 16 beds because of federal rules⁵⁹ that do not allow Medicaid reimbursement for services rendered in a facility with more than 16 beds. Most of the CATC's referrals come from emergency rooms, as a step-down from hospital psychiatric wards, and from DCJ. Because the CATC is not staffed to manage excessive violence and does not have medical capacity or a license for substance use detoxification services, its admission criteria and processes cause it to exclude many of the intimidating, violent, or alcohol- or drug-impaired individuals that officers are trying to place.

At one time, law enforcement officers had the option of taking such people to the Providence Crisis Triage Center, a 24-hour emergency mental health facility at Portland Medical Center that closed in 2001. The Crisis Triage Center reportedly was efficient and police friendly, but it also was expensive to run and was not designed to effectively transition individuals back to the community through connection with services. The City of Portland's 2012 agreement with the Department of Justice indicates that the "local CCOs will establish, by mid-2013, one or more drop-off center(s) for first responders and public walk-in centers for individuals with addictions and/or behavioral health service needs,"⁶⁰ but that has not yet occurred.

Any future 24-hour drop-off facility needs to be convenient for law enforcement officers and have a well-designed exit/transition strategy, so that clients are connected to ongoing outpatient treatment and wrap-around services as they transition back to the community. In addition, the facility must actively want and be adequately staffed to serve the forensic – and sometimes very challenging – people police bring to it.

Dual-Diagnosis Treatment

More than half (54 percent) of the target population for this assessment (i.e., potentially divertible individuals being held in jail) have substance abuse disorders, yet few local programs are set up to treat clients who are dually diagnosed. Although many county-

⁵⁹ The federal Institution for Mental Disease (IMD) Exclusion limits Medicaid billing to facilities with fewer than 17 beds. http://store.samhsa.gov/shin/content/SMA13-4773/SMA13-4773_Mod4.pdf.

⁶⁰ Settlement Agreement between US DOJ and City of Portland, 2012. <https://www.portlandonline.com/shared/cfm/image.cfm?id=417899>

contracted providers provide both mental health and substance abuse program services, the services usually are delivered in parallel and are not integrated. Only two county-contracted providers (Central City Concern and Luke Dorf, Inc., at Bridge City Recovery Center) are contracted for Integrated Dual Diagnosis Treatment (IDDT) for men – an evidence-based dual-diagnosis program. Central City Concern has an additional dual-diagnosis program that has connected housing for those enrolled in the program.

Most programs provide primarily mental health or substance abuse treatment services. According to interviewees, programs may not accept clients if the acuity of the “other” disorder is too high, or they may attempt to move clients through treatment too quickly, such that clients cannot meet program expectations. This is, in part, a staffing issue, as few mental health clinicians are dually certified in both mental health and substance abuse treatment; however, the situation is complicated by funding issues. Health Share of Oregon reimburses mental health services separately from addiction services, and the latter is more poorly funded than the former. Providers need more training and support in dealing with dually diagnosed clients. A higher rate of reimbursement for dually diagnosed clients would help build capacity for serving this subset of potentially divertible individuals.

Residential Dual-Diagnosis Treatment for Women

Information collected for this report indicates that dual-diagnosis treatment services (residential and outpatient) for women are severely limited, and possibly unavailable. For example, Bridge City Recovery Center, which is operated by Luke Dorf, Inc., has a 15-bed residential facility for men with dual diagnoses but no comparable facilities for women. Interviewees reported that inpatient substance abuse treatment programs for women lack the capacity to focus on mental health issues, resulting in frequent treatment failures among the female caseloads.

Outreach and Engagement

Outreach and engagement are crucial activities that lack support under current funding models.

Interviewees described people with mental illness (particularly those on the street) as a special population that can be difficult to engage in services. Successful engagement typically occurs as a result of repeated non-demanding, casual interactions (“step by step,” “on their own terms,” “where they’re at”) that take place well before the person with mental illness has enrolled in services and becomes a client; this allows the individual to build trust and develop an interest in treatment at his or her own pace. Such interactions currently are not directly funded. According to interviewees, funding outreach and engagement as a discrete treatment component could support a greatly needed expansion of these activities and improve treatment success.

Adequate Supplies of Appropriate Housing

Interviewees repeatedly mentioned the lack of supportive, transitional, low-barrier, and no-barrier housing for people with mental illness who are involved in the criminal justice system. Interviewees cited a number of housing-related issues that contribute to the lack of appropriate housing, including high housing costs in the Portland area

generally, the limited supply of physical units (single-room occupancy buildings, for example), and limited funding to subsidize non-traditional housing. There also are psychological and behavioral issues, such as the lack of housing readiness among some individuals (who need a “getting ready to get ready for housing” program), the need for housing for people who are still using drugs and alcohol, and the level of property damage landlords may need to accept in some cases (sometimes this population “has trouble following rules”). Additionally, federal fair housing regulations do not allow for the creation of specific housing solely for people with a mental health disability, and they limit the number of units that can be allocated for people with mental illness to 20 percent.

For some people in the target population for this report (i.e., potentially divertible individuals being held in jail), homelessness was a contributing factor in the decision to continue to hold the detainee.

County Contracts

The system gaps described above were apparent from the stakeholder interviews. Ideally, this information would be supplemented by detailed information about Multnomah County’s contracts with community-based mental health service providers (which is how much of the county’s mental health services are delivered), and which of those contracts are for forensic clients who are part of existing jail diversion programs. Instead, we were able to obtain only limited data about the county’s contracts with mental health service providers, most of which concerns general mental health services.

Based on information received for this report, the county has approximately 40 contracts with at least 30 community-based providers to deliver acute, subacute, and respite residential and outpatient mental health services. These contracts are not necessarily for services for forensic clients, nor do they include all of the contracts for services related to mental health jail diversion. The majority of the contracts are managed by MHASD; however, DCJ manages two contracts for services directed specifically toward forensic clients under community supervision. Funding for these services is braided together from multiple sources, including Medicaid, county general fund, and state general fund. Contracted providers include the following:

- Asian Health & Service Center
- Cascadia Behavioral Healthcare, Inc.
- Central City Concern
- CODA
- DePaul Treatment Centers, Inc.
- Lifeworks NW
- Luke Dorf, Inc.
- Lutheran Community Services NW
- NARA
- OHSU
- Outside In
- Portland DBT Institute
- Project Quest
- Telecare Mental Health Services of Oregon, Inc.
- Volunteers of America
- Western Psychological & Counseling

The following are examples of the types of services provided through these contracts:

- Adult General Outpatient Mental Health Services
- Assertive Community Treatment - Intensive Outpatient Mental Health Services
- Crisis Assessment and Treatment Center
- Crisis Respite Outpatient Services to Divert from Higher Levels of Care
- Crisis Walk-In Clinic and Mobile Response Team
- Culturally Specific Outpatient Mental Health Services - African and African American
- Culturally Specific Outpatient Mental Health Services - Asian/Pacific Islanders
- Culturally Specific Outpatient Mental Health Services - Eastern European
- Culturally Specific Outpatient Mental Health Services - Latino/Hispanic
- Culturally Specific Outpatient Mental Health Services - Native American
- Dialectical Behavior Therapy
- Dual Diagnosis Outpatient Mental Health Services
- Emergency/Jail Diversion Services
- FACT - Forensic Assertive Community Treatment - Intensive Outpatient Mental Health Services
- Outpatient Care Coordination & Psychiatric Medication Services
- Residential Mental Health Court Diversion Services
- Residential Mental Health Treatment
- Case Management Services for Individuals with Severe Mental Illness
- Intensive Case Management Service Programs for Individuals with Severe Mental Illness
- Transition Aged and/or Homeless Youth

Although contract amounts were not available for this report, we were provided with the number of clients served annually for fiscal year 2015 (although there is some variance in the way these numbers are reported, so this analysis is not definitive). Based on the data we received, contract providers provide inpatient, subacute, and respite mental health services to approximately 1,900 individuals annually and outpatient services to more than 16,000 adult clients.

The bulk (76.2 percent) of the outpatient services are targeted toward general mental health and severely mentally ill mental health services. About 12 percent of services are directed toward intensive outpatient services, such as ACT and FACT. About 10.5 percent of services are designed to be culturally specific and are targeted to Latino/Hispanic, Eastern European, Native American, African and African-American, and Asian/Pacific Islander clients. Only 0.4 percent of services are specifically targeted to forensic clients, including those participating in mental health court. No contracts appear to be targeted to LGBT (lesbian, gay, bisexual, and transgender) individuals.

Estimated Savings from Reduced Use of Jails

Although there are many reasons to consider implementing jail diversion programs for people with mental illness, the potential to significantly reduce criminal justice system costs is one of the most prominent. Yet actually estimating possible cost savings from jail diversion is challenging. Reliable estimates require 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) the 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. For example, in their book *Simulation Strategies to Reduce Recidivism: Risk Need Responsivity (RNR) Modeling for the Criminal Justice System*, Taxman and Pattavina described lessons learned from application of the Jail Diversion Cost Simulation Model⁶¹ in multiple jurisdictions:

- Jail diversion interventions alone may reduce jail days, but other desired outcomes depend on access to appropriate mental health services in the community.
- A basic level of cornerstone services (e.g., housing, assertive community treatment, substance abuse services) must be provided before jail diversion can be expected to improve client outcomes.
- It takes time for a jail diversion program to become cost-effective in a system providing appropriate services packages.⁶²

As to the latter point, the Massachusetts Department of Mental Health's Forensic Mental Health Services has described how the costs of jail diversion for people with mental illness can shift over time, with savings typically occurring only after what may be an initial increase in costs:

In the short term, nationally, data [have] shown that diversion programs shift costs from criminal justice to the community mental health system. Typically, more intensive services are needed when someone is in crisis, so that longer-term savings get realized over time as treatment need and costs decrease and future criminal justice involvements are reduced. Savings are also realized as targeted mental health services are provided and costly cycling between systems lessens.

⁶¹ The Human Services Research Institute, in collaboration with the TAPA Center for Jail Diversion (SAMHSA funded program), developed a Jail Diversion Cost Simulation Model that has been applied in several jurisdictions, including Chester County, PA and Travis County, TX. Accessed January 18, 2015, at <http://www.hsri.org/project/jail-diversion-cost-simulation-model/overview/>.

⁶² Taxman, F., and A. Pattavina, 2013. *Simulation Strategies to Reduce Recidivism: Risk Need Responsivity (RNR) Modeling for the Criminal Justice System*. Springer Science & Business Media, June 5, 2013. p. 262.

National data [seem] to point toward demonstrating that jail diversion programs have the potential to help alleviate jail and emergency room over-crowding, reduce the costs of incarceration, shrink court dockets and decrease unnecessary prosecution.⁶³

Although we are hopeful that jail diversion alternatives in Multnomah County will have a meaningful impact on the cost of jail operations, the scope of this project did not allow for the type of in-depth analysis necessary to determine the cost-effectiveness of diverting someone with mental illness from Multnomah County jails to community-based treatment, particularly since key information, such as detailed jail costing data, were not available.

Conducting an in-depth, location-specific analysis is important because the cost-effectiveness of specific diversion program models can vary considerably. One study of the cost-effectiveness of diversion programs found that total cost savings or increases hinged on the costs of the criminal justice and mental health care systems (i.e., “domains”) in the individual jurisdictions:

After combining costs over all domains, there was considerable variation across sites... In Memphis, the greater inpatient mental health care costs exceeded the jail costs associated with diversion, resulting in diversion being associated with an increase in costs over all domains of \$6,576 [per diverted person over the 12-month study period]. The New York City jail diversion program was associated with total costs being \$6,260 lower.⁶⁴

To estimate savings from reduced use of Multnomah County jails, it would necessary to know how much it currently costs the county to house individuals in jail. From the data we collected on the 80 people in our target population, we can extrapolate the number of bed days used during the year for this type of population (i.e., 16,224 annual bed days). If reliable estimates were available of what it currently costs to house a person with mental illness in jail (i.e., the average cost per person per day), that figure could be multiplied by the number of annual bed days saved via diversion to yield a cost savings rate per person diverted. To be useful, this average per-person cost would need to be based on current and complete cost data, using a full cost-recovery model that includes costs for Corrections Health, booking, consumables, facility, debt service, etc.

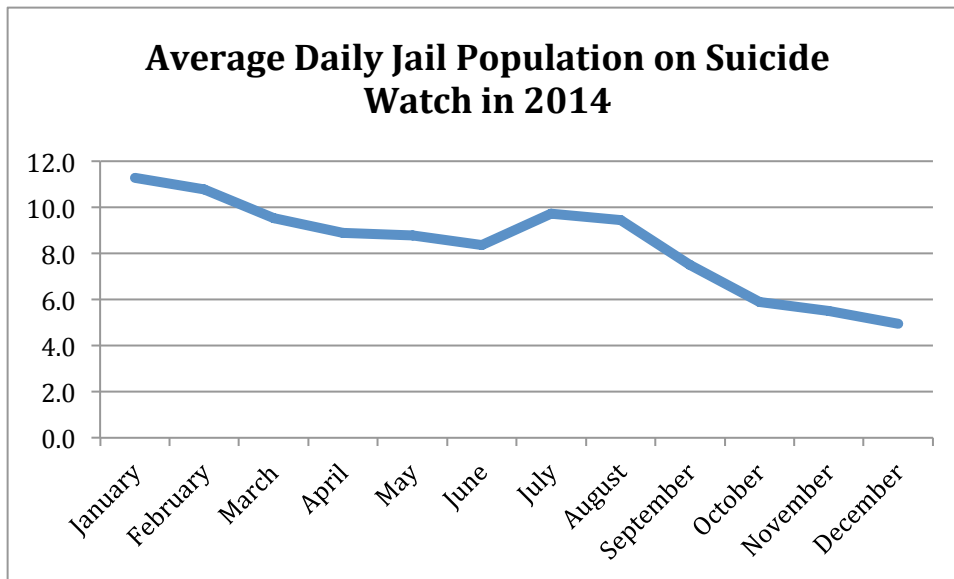
The average per-person cost would serve as the basis for analyzing potential cost reductions associated with diversion activities. Such an analysis would require additional, more detailed data on the target population, the amount of their use of specific jail units and services, and the costs and timing of the specific diversion components being considered.

For example, one consideration is whether the enhanced diversion were to occur pre- or post-booking. If the latter, costs related to the booking process (i.e., the jail, DCJ’s Recog,

⁶³ Massachusetts Department of Mental Health Forensic Mental Health Services. 2009. Report on DMH-Operated Pre-Arrest Jail Diversion Programs 7/1/06 to 10/1/09. October 2009.

⁶⁴ Cowell, A. J., et al. 2002. Assessment of the Cost-Effectiveness of New York’s Jail Diversion Program. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration. Research Triangle Park, NC: RTI International.

and Corrections Health) would continue to be incurred. As another example, a recent grand jury report quoted a rate of \$650 per day to hold inmates in a suicide watch unit.⁶⁵ (How that rate was determined is unclear.) Given that our target population had at least 10 stays of at least one day each in the suicide watch/special management unit, diverting this specific high-need population could reduce the use of the suicide watch unit and thus result in significant savings. In fiscal year 2015, the Board of County Commissioners invested \$385,820 in county general funds to add three shifts of Corrections Health mental health personnel to provide 24/7 support to inmates with mental illness who are at risk of being held in the suicide watch unit. Since January 2014, the number of inmates held under suicide watch has decreased by approximately 50 percent.



The number of diverted individuals is another important consideration in estimating the costs of reduced use of jails. As noted in Section 4, the target population resides throughout the jail system, in multiple types of units (mental health unit, suicide watch, general population, discipline unit, etc). Because the target population is relatively small and individuals are spread out across the jail system, it is unlikely that significant savings would be achieved in the short term unless a large number of additional people were diverted. However, it is possible that over time, as more individuals are diverted and treated in the community, recidivism and therefore bookings would be reduced to a point that an entire jail unit could be closed, resulting in corresponding savings.

In short, considerable additional analysis is needed, using current and reliable data, to estimate the short- and long-term savings potential of specific jail diversion opportunities and the critical mass of individuals that would need to be diverted to achieve significant cost savings.

⁶⁵ Multnomah County Corrections Grand Jury. 2014. *Conditions and Management of Correctional Facilities Within Multnomah County, Oregon October 2014-December 2014*. Found at <http://mcda.us/wp-content/uploads/2015/01/2014-Multnomah-County-Corrections-Grand-Jury-Report.pdf>.

In the absence of such data, we have surveyed current literature on the costs and cost-effectiveness of particular types of jail diversion programs, to give the reader an idea of the range of potential costs savings.

Pre-arrest Diversion Programs

Massachusetts conducted a cost analysis of its pre-arrest diversion programs in which emergency service clinicians are paired with police to co-respond to calls with mental health elements.⁶⁶ That study used the previously mentioned Jail Diversion Cost Simulation Model to identify the following cost savings:

Diverting 100 people from...	Savings
• Emergency room visits @ \$3,500/visit	\$350,000
• Ambulance rides @ \$500/ride	\$50,000
• Booking @ \$2,000/event	\$200,000
• Jail at \$130/day x average stay of 4 days	\$52,000
Total Savings	\$652,000

Forensic Assertive Community Treatment (FACT) Programs

Evaluations of two Forensic Assertive Community Treatment (FACT) programs (Project Link in Rochester, New York, and the Thresholds Jail Program in Chicago, Illinois) demonstrated cost savings of between \$39,518 and \$18,873 per participant, respectively.⁶⁷ A randomized trial of a California-based FACT programs showed that although providing intensive outpatient services was more expensive at the outset, such costs were subsequently offset by reduced jail and hospital stays.⁶⁸

Mental Health Court

In an evaluation of the fiscal impact of Allegheny County Mental Health Court (MHC) conducted by RAND, findings suggested that the MHC program led to an increase in the use of mental health treatment services in the first year after entry, as well as a decrease in jail time for the participants. However, the decrease in jail expenditures almost offset the increase in the outlays for treatment services.⁶⁹

The study's authors note that the mental health costs associated with the mental health court are primarily supported by Medicaid, so "when cost-sharing with the federal

⁶⁶ Massachusetts Department of Mental Health Forensic Mental Health Services. 2009. Report on DMH-Operated Pre-Arrest Jail Diversion Programs 7/1/06 to 10/1/09. October 2009.

⁶⁷ Lamberti J.S., R. Weisman, and D.I. Faden. "Forensic Assertive Community Treatment: Preventing Incarceration of Adults with Severe Mental Illness." *Psychiatric Services*. 2004; 55:1285-1293.

⁶⁸ Cusack, K., Morrissey, J., Cuddeback, G., Prins, A., & Williams, D. (2010). "Criminal Justice Involvement, Behavioral Health Service Use, and Costs of Forensic Assertive Community Treatment: A Randomized Trial." *Community Mental Health Journal*, 46, 356-363.

⁶⁹ Ridgely, S.M., et al. 2007. Justice, Treatment, and Cost: An Evaluation of the Fiscal Impact of Allegheny County Mental Health Court. Santa Monica, CA: RAND Corporation.

government is taken into account, the estimated extra costs of the MHC program for the Commonwealth are eliminated.”⁷⁰

Other Cost Analyses

In 2014, the Washington State Institute for Public Policy’s (WSIPP) identified a group of programs that treat mental illness (not limited to justice-involved clients) and meet WSIPP’s criteria for being evidence-based, research-based, or promising.⁷¹ Evidence-based programs or practices have been tested in heterogeneous or intended populations with multiple randomized and/or statistically controlled evaluations, or in one large multiple-site randomized and/or statistically controlled evaluation, and the weight of the evidence from a systematic review demonstrates sustained improvements in at least one outcome. “Evidence-based” means that a program or practice can be implemented with a set of procedures to allow successful replication and, when possible, has been determined to be cost-beneficial. Research-based programs or practices have been tested with a single randomized and/or statistically controlled evaluation that demonstrates sustained desirable outcomes, or the weight of the evidence from a systematic review supports sustained outcomes as identified in the term “evidence-based” but does not meet the full criteria for “evidence-based.” Promising programs or practices are those that, based on statistical analyses or a well-established theory of change, show potential for meeting the evidence-based or research-based criteria.

WSIPP’s analysis indicates that a limited number of mental health treatment program models meet the organization’s criteria for being evidence-based: cognitive behavioral therapy for anxiety, depression, and post-traumatic stress disorder (PTSD); collaborative primary care for anxiety and depression; mental health courts; and PTSD prevention following trauma for adults.

⁷⁰ Ridgely, S.M., et al. 2007. Justice, Treatment, and Cost: An Evaluation of the Fiscal Impact of Allegheny County Mental Health Court. Santa Monica, CA: RAND Corporation.

Recommendations

Mental health jail diversion in Multnomah County is a complicated system that occurs through the coordinated action of numerous public and private partners, supported by multiple funding streams. Given the complexity of the system and the general, ongoing need for additional mental health and addiction treatment services in the county, opportunities to enhance the mental health jail diversion system in Multnomah County are myriad. The recommendations we present are based on information collected specifically for this report, with the input of local stakeholders.

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. Stakeholders prioritized three areas as a focus for planning jail diversion enhancements (for additional description, see Section 5):

- **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 treatment needs can be understood, given current confidentiality restrictions (e.g., HIPAA) and certain procedural challenges. Participants in the prioritization meeting indicated that improving information sharing would require the involvement of stakeholders beyond the Local Public Safety Coordinating Council (“we need the right people at the table”) and recommended looking to other jurisdictions for possible procedural modules. A first step, though, would be to identify inconsistent interpretations of HIPAA across county departments, and to explore the boundaries of these legal restrictions within which improved information sharing could occur. Meeting participants were mindful of the need to continue respecting clients’ civil rights in attempting to address 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. Because establishing such a structure would involve many non-justice partners from the broader mental health and health care systems, the effort is beyond the scope of the LPSCC Mental Health Subcommittee. Additional consideration is needed as to who would drive the process of organizing a coordinating structure (local elected leaders, the Legislature, etc.). Again, meeting participants were interested in models used in other jurisdictions, particularly Miami-Dade, Florida, where the process is spearheaded by the chief judge, and Montgomery County, Maryland, where the process is led by the jail warden and a judge, with the participation of multiple county department directors.

- **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 spend their tenure in jail without their mental health issues being addressed. As a system enhancement, stakeholders prioritized identifying defendants with mental illness when they enter the jail, so that these people can be prioritized for diversion/reentry planning and connection with services. Stakeholders identified several options for addressing this issue, such as (1) placing a mental health professional in booking who can assess people for mental illness, using the Brief Jail Mental Health Screen (BJMHS)⁷² to flag individuals for further mental health assessment as they come in the door, and (2) having someone in the jail who facilitate connections between detainees and service providers. Additionally, getting people started with treatment while they are incarcerated would prepare inmates 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.

Additional data collection and analysis are needed to determine the cost-effectiveness of diverting someone with mental illness from Multnomah County jails to community-based treatment. Specific costs related to the county's contracted mental health services were not available for this report; neither were data on how much it costs to house people with mental illness in Multnomah County jails today.

Although estimates exist of typical costs (and cost-benefit ratios) for various types of mental health interventions and jail costs from other jurisdictions, a full local cost analysis of both would be beneficial. The cost analysis for the jails would need to consider 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.)

Understanding the true costs of housing people with mental illness in jail and treating individuals in the community would provide a foundation for a cost comparison and evaluation of the relative cost-effectiveness of particular diversion options.

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 (i.e., potentially divertible individuals being held in jail). During October 2014, blacks represented 19.7 percent of all bookings but 41 percent of the people who were potentially eligible for diversion, had been screened or assessed for possible release, but remained detained.

⁷² 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.

There could be many explanations for this discrepancy, but one that should be explored is the possibility of individual bias or institutional racism in policies and practices that result in a potentially divertible person being detained in jail.

Recommendation D: Evaluate the availability of culturally specific services.

Several interviewees mentioned the need for additional culturally specific treatment programs for racial and ethnic minorities and LGBT (lesbian, gay, bisexual, and transgender) individuals.

Currently Multnomah County lets contracts for culturally specific outpatient mental health services to the Asian Health & Service Center (130 treatment spots), Central City Concern (115 spots), Lutheran Community Services NW (325 spots), NARA (483 spots) and OHSU's Avel Gordly Center for Healing (674 spots) to provide culturally specific services for Asian/Pacific Islander, African, African-American, Eastern European, Latino/Hispanic, and Native American clients. However, with the exception of a Central City Concern contract to serve 48 African-American and Latino/Hispanic clients, most of these programs are not geared toward criminal justice clients. A review of current county contracts showed no LGBT-specific community-based mental health services.

In considering possible enhancement of diversion opportunities, it would be helpful to understand the level of need for additional culturally specific services, especially given the overrepresentation of black detainees in the target population for this report.

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 and mentioned repeatedly by many interviews:

- 24-hour drop-off center
- Dual-diagnosis treatment
- Residential dual-diagnosis treatment for women
- Outreach and engagement
- Adequate supplies of appropriate housing

These prominent system gaps are described in Section 6. Filling them would appear to address immediate needs that could result in additional people with mental illness being diverted from jail.

* * *

Multnomah County and its partners have made significant investments in both capacity and relationship building over the last several years. These improvements were noted by interviewees and during the several meetings convened for this project. In the midst of changes and system pressures related to ACA implementation, a severe housing shortage, and significant resource limitations, stakeholders have come together to

problem-solve gaps in the mental health system in a variety of ways, from emailing providers a list of the jail's mental health unit detainees every week to convening a bi-weekly meeting focused on coordinated case management of high-need individuals in the community. These efforts help to improve the system's response to justice-involved individuals with mental illness. However, effective diversion of these individuals from jail requires 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 here provide guidance on next steps as Multnomah County and its partners move to enhance the mental health system through existing initiatives and explore how increasing diversion opportunities may fit into those efforts.

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Appendix A: LPSCC Mental Health and Public Safety Prioritization Initiative

Local Public Safety Coordinating Council: Improving Mental Health and Public Safety

This illustration overviews the current distinct yet intersecting policy efforts to improve mental health responsiveness and outcomes for defendants, inmates, and probationers in Multnomah County while improving public safety.

Commissioner Shiprack FY15 Jail Diversion Feasibility Study Budget

Note:

- Bexar County follow up
- Contract with Lore Joplin
- Respond directly to the Budget Note Request
- Focus on mental health needs and service gaps that may increase the number of offenders potentially diverted from jail

Mental Health Prioritization process:

- Two meetings held to identify and prioritize the gaps in services for very high need clients.
- Target population: individuals and inmates with mental illness (who are often co/tri-morbid) who exhibit anti-social, violent behaviors and have contact with the criminal justice system
- Created list of priorities for policy makers.

Mental Health/Public Safety Subcommittee:

- Coordinating Council: Multnomah Behavioral Health Treatment Court Initiative, a DCHS grant which will help guide SAMHSA grant development (\$1.385M over 4 years).
- Reports to LPSCC executive committee
- Focus on information sharing and system improvement

Mental Health Prioritization: Making a Stronger Safety Net
DRAFT

On September 5, 2014, 30 County and partner agency operations and policy level staff* met to discuss the gaps in the mental health and criminal justice systems. The meeting was sponsored by the Multnomah County Local Public Safety Coordinating Council, Multnomah County Health Department, and Multnomah County Mental Health and Addictions Services Division. The purpose of the meeting was to align and prepare Multnomah County and community partners for future mental health system enhancement.

The group spent the afternoon focusing discussion on the needs of Individuals and inmates with mental illness (who are often co- and tri-morbid) who exhibit anti-social, violent behaviors and have contact with the criminal justice system. Our mental health and public safety systems are not built to address the needs of many of our community members who struggle with criminality, mental illness, and complicated health conditions. Deinstitutionalization and an underfunded system have left many without the care they need to stay safe, heal, and not pose a risk to public safety.

The group determined the top interventions and changes which will make our system more whole and responsive:

System enhancements (What we can do better)	System additions (What's missing)
Community based, not office based, treatment and engagement	More services and treatment for people with high acuity, but are not eligible for hospitalization
Centralized Assessment and Triage	Psychiatric Emergency Services
Warm handoff and navigation	Supported housing – housing first
Information sharing	Drop in center (meals, skills training, referral, peer mentors, services, and triage)
Better access from Emergency Department to alcohol and drug treatment	Dual diagnosis residential treatment for women and families
Flexible/fluid levels of care	

While the group focused on a narrow target population, other County and partner agency efforts complement this effort to improve outcomes for clients who struggle with mental illness and criminality:

- Commissioner Judy Shprack requested a jail diversion feasibility study. The study is underway, and recommendations are expected soon.
- HealthShare of Oregon launched four grant-funded programs that aim to better engage and appropriately serve their highest medical resource users. Many of these patients are co- and tri-morbid and have justice system contact.
- Multnomah County housing and mental health related grants and pilots.

At the local, state and federal levels, justice reinvestment and healthcare transformation efforts support efficient and effective use of public funds for evidence-based, community-based, and trauma-informed practices. These recommendations aim to assist policy makers and elected officials develop programming and budgets.

*Participants include:

First Name	Last Name	Agency
Erika	Armsbury	CCC
Jay	Auslander	Cascadia
Cliff	Bacigalupi	PPB
Devarshi	Bajpai	MHASD
Mary Claire	Buckley	PPB
Katie	Burgard	MCSO
Deena	Corso	DCJ
John	Custer	Adventist
Jean	Dentinger	DCHS
Chris	Farentinos	Legacy Health
Julie	Frantz	OJD
Joanne	Fuller	MCHD
Nancy	Griffith	CH
David	Hidalgo	MHASD
Nancy	Jackson	MCHD
Liv	Jenssen	DCJ
Bob	Joondeph	Disability Rights Oregon
Melissa	Marrero	MCDA
Ginger	Martin	DCJ
Truls	Neal	DCJ
Bill	Osborne	MHASD
Adam	Renon	District 3
Patrick	Sieng	AOC
Abbey	Stamp	LPSCC
Tam An	Tam	AMHS
Elizabeth	Wakefield	MPD
Caroline	Wong	MCDA
Linda	Yankee	MCSO
Christina	Youssi	LPSCC

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Appendix B: Literature Review Highlights

Multnomah County Mental Health Jail Diversion Literature Review Highlights

What is jail diversion?

- Jail diversion is a means of “avoiding or radically reducing jail time by referring a person to community-based services.”¹
- Diversion is not the same as discharge planning.²
- Charges often are reduced or dropped upon successful completion of a diversion program that links the defendant to appropriate community-based services.
- Program components vary. Common elements include specialized training for staff (such as police officers), co-response of mental health service providers, 24-hour drop-off centers, and specialty courts.
- Jail diversion is voluntary. Participation in community-based services often is motivated by the prospect of the alternative (i.e., jail or hospitalization) or by making treatment a condition of housing.³

Who takes part in mental health jail diversion programs?

- Diversion programs often focus on people with serious mental illness – i.e., schizophrenia, major depression, and bipolar disorder – who are subject to arrest for trespassing, disorderly conduct, public intoxication, and similar low-level crimes. Often these behaviors are related to untreated mental illness.
- Nationally, an estimated 15-17%⁴ of people booked into jail have active symptoms of serious mental illness. This is three times the proportion among the general public (5%).⁵
- Most seriously mentally ill people in jail (up to 75-80%, by some estimates⁶) also have substance abuse disorders. This “dual diagnosis” creates challenges because treatment programs usually focus on either mental illness or substance abuse, not both.
- Criminal violence by the seriously mentally ill usually is related not to the person’s mental illness but to other criminogenic factors, such as substance abuse or personal history.⁷ The majority of violent and non-violent offenses that are closely linked to symptoms of mental illness are committed by people with bipolar disorder.⁸

¹ Steadman (2014) and Broner et al. (2005) as cited in Cowell et al. (2008).

² SAMHSA’s Gains Center for Behavioral Health and Justice Transformation.

³ Monahan (2011).

⁴ Steadman (2014)

⁵ Kessler et al. (1999) as cited in Council of State Governments (2002).

⁶ Steadman (2014).

⁷ Monahan and Steadman (2012); Fazel et al. (2009) and Steadman (1998) as cited in Monahan and Steadman (2012).

⁸ Peterson et al. (2014).

- Seriously mentally ill people in jail often are poor and/or homeless, and many have a lifetime history of sexual and physical abuse.⁹ In some jurisdictions they are predominantly people of color.
- Nationally, approximately 6% of people with schizophrenia live in jails or prisons, and another 6% are homeless or live in shelters. Only 28% of people with schizophrenia live independently.¹⁰

Effects of jail on the mentally ill¹¹

- Seriously mentally ill people in jail are vulnerable to assault or other forms of intimidation by predatory inmates. The jail environment tends to exacerbate symptoms of mental illness, especially since most jails lack comprehensive mental health treatment resources delivered in therapeutic environments; this leaves seriously mentally ill people at risk of harming themselves and others.
- Seriously mentally ill people may act out or break jail rules, thus prolonging their incarceration. They also have high rates of recidivism – more than 70% in some jurisdictions.¹²

Medical problems among the mentally ill¹³

- The life expectancy of seriously mentally ill people is 13 to 30 years shorter than it is for the general population. This “mortality gap” has widened during recent decades. About 60% of the excess mortality is due to physical illness.
- People with serious mental illness are prone to heart attack, stroke, hypertension, obesity, diabetes, metabolic syndrome, and other physical health problems. The impact of these diseases on the seriously mentally ill is significantly greater than it is in the general population, in part because of disparities in health care access, utilization, and provision. For a variety of reasons, it is difficult for people with serious mental illness to access high-quality health care.

Relevant social context¹⁴

- **Suicide:** The suicide rate in Oregon is 35% higher than the national average, and suicide is the eighth leading cause of death in Multnomah County.¹⁵ Although the suicide rate actually has been going down in the county, the number of incidents has gone up, because of population growth. From 2001 to 2011, the number of suicides in Multnomah County increased by one-third, the number of suicide attempts grew by nearly 13%, and the number of suicide-related calls responded to by the Portland Police Bureau rose by 90%.
- **Homelessness:** Oregon also has high levels of homelessness, tying with Hawaii for the highest rate in the nation. Nationally up to 25% of homeless people suffer from mental illness. In Multnomah County, 50% of homeless people report having a

⁹ Steadman (2014).

¹⁰ Torrey (2006).

¹¹ Council of State Governments (2002).

¹² Ventura et al. (1998) as cited in Council of State Governments (2002).

¹³ De Hert et al. (2011).

¹⁴ Stewart (2012).

¹⁵ Multnomah County Health Department (2014).

physical, cognitive, or development disability or a substance abuse or mental health issue.

- **Victimization:** People with serious mental illness are victimized at a much higher rate than the community at large.
- **Service levels:** In less than a decade, the number of individuals provided with mental health services in Multnomah County nearly doubled, from 5,292 in 2004 to 10,062 in 2011. (This change reflects a variety of factors, not just demand.)
- **Holds and civil commitments** Over the two decades ending in 2003, the civil commitment rate in Oregon dropped by more than half (from 45 to 22 people per 100,000). Between 2005 and 2011, nearly one-quarter of the individuals placed on holds in Multnomah County annually had two or more holds in a calendar year.
- **Police contact.** There are fewer police officers now in Portland than there were in 2001. Evidence suggests that contact between police and people experiencing a mental health crisis has increased.

Effectiveness of jail diversion programs

- Data on the effectiveness of jail diversion programs for the mentally ill are limited.
- Better probation compliance has been observed with probation agencies that have small, exclusively mental health case loads and that focus on problem solving, rather than threats of incarceration.¹⁶
- A review of 21 case studies in the United States did not demonstrate that jail diversion programs reduced recidivism among the seriously mentally ill. However, there was a correlation between participation in jail diversion programs and reduced time spent in custody. This correlation was strongest with (1) pre-booking programs, and (2) court-based post-booking programs, where mental health clinicians work within the courthouse.
- In one study, mentally ill defendants who chose mental health court reported less coercion and more satisfaction with the court process than did mentally ill defendants in criminal court. Afterwards they had fewer arrests and spent fewer days incarcerated.¹⁷
- In New York state, 62% of mentally ill people involved in court-ordered treatment reported that treatment had been “a good thing” for them and that pressure or encouragement to engage in treatment helped them get and stay well (81%), gain control over their lives (75%), and made them more likely to keep appointments and take medication (90%). They also expressed confidence in their case manager’s ability to help them (87%) and said that they and their case managers agreed on what was important for them to work on (88%).¹⁸

Effectiveness of ACT and FACT teams

- **ACT:** Assertive community treatment teams are mobile, self-contained teams that provide direct treatment, rehabilitation, and support services in the community to

¹⁶ Monahan (2011).

¹⁷ Monahan (2011).

¹⁸New York State Office of Mental Health (2005).

people who (1) have severe mental illness, (2) are functionally impaired, and (3) have a high risk of inpatient hospitalization. ACT team members include psychiatric, nursing, addiction counseling, and vocational rehabilitation professionals who are available to clients 24 hours a day, seven days a week.¹⁹

- ACT teams have been well studied. They repeatedly have been shown to reduce psychiatric hospitalizations and promote housing stability.²⁰
- ACT teams are not consistently effective at reducing arrests or jail time, reducing symptoms, or improving clients' social adjustment, substance abuse, or quality of life.²¹
- An ACT team with a caseload of 60 people can cost \$1 million a year. ACT is most cost-effective for clients who have had at least 48 days of psychiatric hospitalization in the previous year.²²
- **FACT:** Forensic ACT is a relatively new adaptation of the ACT model that focuses on preventing the arrest and incarceration of people with severe mental illness.
 - FACT "add-ons" include:²³
 - Enrolling only people with prior arrests and jail detentions
 - Making re-arrest prevention an explicit goal
 - Accepting referrals from criminal justice agencies
 - Recruiting criminal justice agency partners
 - Using court sanctions to encourage participation
 - Engaging probation and law enforcement officers as members of the treatment team
 - Adding residential substance abuse treatment units for people with dual diagnoses
 - Current evidence on the effectiveness of FACT is considered "moderately strong." However, research has been limited and additional studies are needed that are randomized and controlled, involve more sites, and use more similar client profiles.
 - Findings so far point to the following possible outcomes of FACT programs:²⁴
 - Significant reductions in arrests, jail days, hospitalizations, and hospital days
 - Improvements in psychiatric functioning and engagement in substance abuse treatment
 - Fewer jail bookings, greater outpatient contacts, and fewer hospital days
 - Higher probability of avoiding jail in the post period

¹⁹ Morrisey and Meyer (2008).

²⁰ Morrisey and Meyer (2008).

²¹ Morrisey and Meyer (2008).

²² Morrissey (2013).

²³ Morrissey (2013).

²⁴ Morrisey (2013).

- If jailed, spending the same number of days in jail as people not in a FACT program
- In one study, the increased outpatient costs of FACT were offset by lower inpatient costs. Another study (from 2004) also reported reduced average costs, per client.²⁵

Principles and implications for practice

- Limit penetration of the seriously mentally ill into the criminal justice system.²⁶
- Develop interventions and diversion opportunities at each intercept, with a focus on early arrest, pretrial, and community supervision.²⁷
- Tailor treatment, support, and supervision to individuals' needs and risk levels. There's no "one-size-fits-all" approach to recovery from mental health disorders for people being supervised by the criminal justice system.²⁸
- Examine the issue of coercion and, when possible, offer choices.²⁹

Common themes (in the literature and program models)

- Collaboration – cooperation and coordinated problem solving among partners
- Specialized training – of police, corrections staff, other criminal justice partners, and providers
- Information sharing – to identify the target population and provide relevant data (e.g., medical records, prescriptions)
- Motivation for participation – navigating the issue of coercion vs. choice
- Capacity – ensuring that treatment is available for diverted individuals, especially those who have a dual diagnosis

Program Model Examples

Bexar County, San Antonio

- **Proactive outreach:** A police officer and a licensed counselor go into the community to assess those at risk and determine what they need.
- **Three points of diversion:** (1) 24-hour Crisis Care Center, (2) release on commercial bond with mental health conditions, and (3) mental health docket.
- **Crisis Care Center:** Collaborating agencies manage a 24-hour crisis stabilization unit that serves as "one-stop stopping" for mental and physical health screening, assessment, and treatment. The center is staffed by medical, psychiatric, and social work professionals who provide psychiatric assessment, case management, and monitoring, as well as medical treatment. Included at the

²⁵ Morrisey (2013).

²⁶ Steadman (2014).

²⁷ Monahan (2011).

²⁸ SAMSHA's GAINS Center for Behavioral Health and Justice Transformation and the Council of State Governments Justice Center. 2012.

²⁹ Monahan (2011).

center are a sobering area, detox/counseling area, and onsite mental health/drug court.

- **Challenges:** Historically, two issues were the main obstacles to jail diversion in Bexar County:
 - o Inadequate collaboration between key treatment, law enforcement, and criminal justice stakeholders
 - o Limited hours at the downtown crisis intake center (weekdays, 8-5)
- **Cost analysis:** The cost of sending an offender to residential treatment in Bexar County is less than one-fourth that of housing a prisoner to jail. (This does not include the additional costs associated with housing a prisoner with mental illness in a separate unit with increased supervision and medical care.)³⁰
- **Compared to Multnomah County ...**
 - o As of 2010, only 19% of the police force in Bexar County had taken Crisis Intervention Training (CIT). In Multnomah County, all police officers have had CIT training, and at least 78 officers have had an additional 40 hours of Enhanced Crisis Intervention Training (ECIT).
 - o Multnomah County's crisis response system shares many elements with Bexar County's: a crisis hotline, 911 referral to a mental health crisis team, a mobile crisis unit, police officer CIT training, a voluntary residential treatment unit, and a sobering station/detox unit.
 - o The Bexar County system includes some elements currently lacking in Multnomah County:
 - A drop-in day center
 - Quick police drop-off (at the crisis center, or a hand-off to the mobile crisis team)
 - Co-located physical and mental health treatment
 - Rapid access to psychiatric/mental health appointments

Connecticut Criminal Justice Diversion Program

- **Comprehensive program:** This community forensic services program provides clinical alternatives to arrest and incarceration, ensures continuity of care for those who are incarcerated, and facilitates reintegration for those who are sentenced.
- **Diversion teams:** Mental health clinicians are located in court during arraignment of people with mental health disorders. They obtain permission from the court to work on the client's behalf, assess the client, develop a treatment plan, suggest options to the judge, and communicate whether the client is continuing treatment.

³⁰ Cowell et al. (2008).

Los Angeles County: Third District Diversion and Alternative Sentencing Program

- **Demonstration program:** September 2014 marked the start of a new program to provide social services as an alternative to sentencing. The target population is adults who are chronically homeless, have serious mental illness, and commit specific misdemeanor and low-level felony crimes. The initial program budget is upwards of \$750,000, to serve up to 50 adults, including 20 veterans.
- **Supportive services:** Services include provision of bridge and permanent supportive housing, medical and mental health care, group and individual treatment and support, and employment and vocational services.
- **Pre-plea diversion.** This is a pre-plea program that lasts at least 90 days for misdemeanor offenders and 18 months for felony offenders. Once offenders have completed the program, charges may be dismissed and/or probation terminated early.

Seattle Law Enforcement Assisted Diversion (LEAD) Program

- **Pre-booking diversion:** LEAD diverts low-level drug and prostitution offenders into intensive, community-based social services.
- **Police referral.** Officers have a high degree of discretion and can divert people to a LEAD case manager without making an arrest. The case manager does initial screening at the precinct.
- **Intensive “hands-on” work:** Case managers meet the client “where they’re at,” provide social services, use motivational interviewing to help clients identify their personal goals, and support clients as they work toward their goals.
- **“Harm reduction approach”:** LEAD provides emotional, practical, and financial support without requiring abstinence. Services and benefits are not time limited, and there are no punitive sanctions for non-compliance.

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Appendix C: Interview Summary

Multnomah County Mental Health Jail Diversion Interview Summary

Overview

To gather information regarding the status of the current jail diversion system for individuals with mental illness, stakeholder interviews were conducted. This document summarizes the comments made by interviewees. A total of 19 interviews were conducted with 23 stakeholders (three were group interviews). Interviewees are listed in Appendix A. Interviews lasted from 30 to 60 minutes, and most were conducted by phone; one was conducted in person. Two interviewers participated on each interview to ensure record-keeping accuracy. Interviewees received the list of questions and a system intercept map in advance of the phone interview.

Time limitations prohibited all questions being asked of every interview, so questions were selected from the following:

1. What opportunities are there currently to divert individuals with mental illness from jail?
 - a. Where on the intercept do they fall?
 - b. What population do these programs serve?
2. What are the main strengths and weaknesses of the current programs?
3. What are the biggest service gaps you see for diversion, and who do they affect?
4. What suggestions do you have for filling those gaps, or improving the system overall?
5. Are there policy changes that would improve this system?
6. What outcomes do you hope to see from this project?
7. Do you have any concerns about the project?
8. Is there anything else you would like to share?

In addition, interviewees were asked to consider the following when responding to questions:

- Collaboration between agencies
- Information sharing
- Infrastructure needs
- Operational responsibilities
- Obstacles

Strengths

- We have a diverse system, with a wide array of services that can meet a range of needs. ✓✓✓
- We've come a long way over the last two years! ✓✓
- Improved communication. ✓✓

- Good relationships and emerging partnerships, including regular coordination meetings (Corrections Health, jail mental health, providers, law enforcement officers) and active participation. ✓✓
- Appreciation for the coordinated effort to get together; provides a better understanding of the “global terrain” and moves us away from silos. ✓✓
- Increased emphasis on transition planning.
- Recent support for a robust system of crisis services, including Project Respond, the mental health call center, etc. (although we still need more).

Opportunities for Improvement

Coordination across Systems

1. We need a forum/structure for overall, high-level system and funding coordination. We have multiple groups working on similar issues. It would be helpful for someone to “take the reins and set up a coordination structure.” ✓✓✓✓
 - a. There’s a lack of continuity. The system can be fragmented.
 - b. Many agencies are doing similar work and co-managing people with mental health disorders.
 - c. Not sure what everyone else is doing.
 - d. Funding might be better used if the system were better coordinated.
2. Navigation is an issue. The overall system has to make sense from a consumer’s perspective.
3. We need a commission or board to conduct formalized reviews of system failures and hold each other more accountable.

Information Sharing—Confidentiality Restrictions

4. We need to improve information sharing opportunities. What are the “achievable changes” and how can we move beyond the challenges of Health Insurance Portability and Accountability Act (HIPPA) and the need for Release of Information forms to better serve these clients? ✓✓✓✓✓✓✓✓
 - a. When someone comes into the criminal justice system, we need adequate information about his or her mental and medical health needs.
 - b. We need to be better able to share information to achieve a truly coordinated response.
 - c. Currently, Corrections Health (CH) is sending lists of jail mental health dorm inmates to providers every week, and the Department of Community Justice (DCJ) is sending lists of probationers to CH.
5. Lack of information sharing between law enforcement officers (LEO) and providers. ✓✓✓✓✓
 - a. LEO doesn’t know that an individual is engaged with a provider or case manager, including an assertive community treatment (ACT).

- b. LEO needs this information to make an appropriate choice about where to take a person.
 - c. Providers need improved notification of when people are in contact with LEO or taken to jail.
6. We need to better align the confidentially restrictions for chemical dependency¹ with those for mental health. (There are more stringent restrictions on talking about addiction.) ✓

Information Sharing—Electronic Data

7. Lack of a centralized electronic data system. ✓✓✓✓
- a. Criminal justice, Corrections Health, and providers all use different systems that don't connect.
 - b. Corrections Health desperately needs to be able to share information with providers (EPICS vs. EVOLVE).
8. We lack data reporting capacity to identify who is in jail, why, and what their needs are. ✓✓✓✓
- a. We need the ability to regularly report on who is cycling rapidly in and out of the jail and why (“frequent flyers”).
 - b. We need better data on race and ethnicity.
 - c. We need more information on the mental health needs of detainees.

Identifying Mentally Ill Defendants at Booking

9. We need to be better able to identify mentally ill defendants when they enter the jail so that they can be prioritized for diversion/reentry planning and connection with services. ✓✓✓
- a. At booking, we need to better record and share observations and information about potential mental illness. There is no formal method of sharing information from one desk/partner to the next (arresting officer, recog officer, corrections health, booking sergeant).
 - b. We need a credible point person in booking to identify mental health issues.
 - c. Could we use the Substance Abuse and Mental Health Services Administration (SAMHSA) assessment tool to flag people as they come in the door?
 - d. Unless defendants are seriously mentally ill and/or presenting symptoms, they may end up in the general jail population, not be identified as mentally ill, and go through the standard process without their mental health issues being addressed.

Timeliness / Wait Times

10. Wait times for assessment and treatment are too long. ✓✓✓✓✓✓
- a. Wait times for community treatment are four to six weeks or longer.

¹ 42CFR Part 2 <http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2>

- b. Agencies (including the walk-in clinic) have not been able to handle the increase in numbers and level of care needed.
 - c. We need to more quickly link individuals to community providers when they transition out of jail.
 - d. Pretrial release is less likely to recommend release because of the delay in getting a mental health assessment and access to treatment.
 - e. How can we bridge the time from arrest to intake (use of system navigators to make appointments and access treatment)?
11. Getting started with treatment while incarcerated would better prepare inmates to enter treatment in the community. Currently there are only crisis intervention services available in the jail.

Staffing / Training

12. Agencies are struggling to recruit, hire, and retain sufficient staff to serve all these newly insured clients. ✓✓
- a. The community care organizations (CCOs) / Veterans Administration are creating care teams and paying more than the providers can offer. Agencies are losing experienced staff to the CCOs.
 - b. The Crisis Assessment and Treatment Center (CATC) had everything in place, but opening was delayed because of hiring challenges.
13. We lack staffing with dual diagnosis credentials and training. ✓✓✓
- a. It's difficult to find staff who are dually credentialed and who can treat disorders simultaneously.
 - b. It's difficult to find dually credentialed staff who can pass the background checks.
 - c. People increasingly are being trained in dual diagnosis in schools, but they lack experience and it takes time for them to become qualified.
14. We lack clinicians and agencies that are trained and understand how to work with forensic clients. ✓✓
- a. Often there is a mix of criminal, mental health, and substance abuse issues.
 - b. Staff need training on how to interface with the criminal justice system.
 - c. Agencies need to understand the evidence-based practices models for working with forensic clients.
 - d. Not every intensive case management provider has the skills or motivation to work with this population.

Funding Structures

15. Funding for mental health services has shifted from the county to Medicaid as primary payer. When combined with direct grants from the state, the county's leverage for influencing the types of services delivered locally has somewhat diminished. ✓✓✓
- a. Lack of funding for infrastructure.
 - b. Lack of funding for a full continuum of services for addiction treatment.

16. Health Share's mental health services currently are separate from its addictions benefits, making it difficult to coordinate information. It would be helpful if these were combined.
17. Mental health is under-resourced, but funds for substance abuse treatment are even less available. We have been able to braid together various funding streams for mental health, but we've never had sufficient funds for substance abuse treatment to build an effective continuum of care.

Working with Detainees

18. We need to do a better job of engaging inmates in the jail, maintaining connections with providers, and preparing inmates for treatment upon release. ✓✓✓✓✓✓
 - a. We want to limit trauma on people in jail and increase engagement.
 - b. There's not a very smooth line of communication or easy access to detainees.
 - i. If providers know their client is in the jail, they connect with Corrections Health. Most provider clinicians don't have direct access to the jail themselves.
 - ii. Providers that visit detainees need an escort into jail by the Multnomah County Sheriff's Office (MSCO) corrections counselors, but under HIPPA, providers can only share info with the Corrections Health mental health consultants.
 - iii. If providers could work more closely with the mental health consultants, the providers could help move people out of the jail more quickly.
 - iv. We need to improve coordination between providers and jail staff, (i.e., give advance notice of when providers are coming and whom they are coming to see). For example, Forensic Diversion comes in on Thursdays. If they provided an advance list of whom they're going to see, jail staff could identify the floor that the inmate is on and prepare that person for the meeting.
 - c. Don't focus solely on whether the person is taking medication to determine whether or not to meet with them. After they meet with you, they might be more amenable to taking medication.
19. We need improved transition and release planning/coordination ✓✓✓✓
 - a. There's a lack of transitional case management from jail to the community.
 - b. We need better release planning coordination between MCSO and Corrections Health. CH needs to know when someone is being released, and MSCO needs to refrain from nighttime discharges.
 - c. Director's holds and transports to hospitals are not always effective. If a person is deemed too ill for release, the jail can place a director's custody hold and secure-transfer them to the hospital. The hospital is resistant to keeping those people and often doesn't keep them very long (doesn't give credibility to the jail assessment). The hospital then releases them to the community, where they get arrested again and are sent back to the jail.

20. Housing the mentally ill in jail is resource intensive but sometimes necessary. ✓✓
 - a. There will always be a population of mentally ill in custody, on suicide watch, etc.
 - b. There is a high cost associated with self-harm prevention and suicide watch. A lot of these folks are not going to be acceptable to community-based programs. They are actively acting out, self-harming, committing arson, etc.

Court/Pretrial

21. We need to improve communication and triage during our pretrial release decision protocol and arraignment process. ✓✓✓✓✓
 - a. We could do more at arraignment to identify individuals with mental illness and connect them with services (they're more sober then than at booking).
 - b. We need more information sharing at the outset of a case.
 - c. There are a couple categories of defendants and offenses that pretrial treats differently simply because of the charge. Would like to shift the focus to more risk-based decisions and hold on to people who pose a significant risk.
 - d. Corrections Health has been helpful in terms of assessing defendants before release. This has resulted in hospitalizations and treatment entry.
 - e. The District Attorney's (DA) office needs more information about the resources available for post-release supervision (PRS) defendants. If DAs had this information, they could then ask the judges to order specific treatment participation.
 - f. The timeline to access programs is too long to work for pretrial. Unless a person's illness is very acute, it can take two months to get an appointment.
 - g. We need to provide more education to the criminal justice partners about mental illness. Often it is difficult to make clear observations about how the defendant is presenting. We need a way to do a credible triage.
22. We need to provide more education to partners about alternative courts. ✓✓
 - a. We need to educate partners on criteria and process.
 - b. There is concern that the DA sometimes objects to cases going to mental health court instead of jail because mental health court does not result in as much offender accountability as incarceration. Providing more information about the services available to mental health court participants might help to lessen this concern.

Capacity Issues

Crisis Intervention / Acute Care

23. The county lacks sufficient acute care. ✓✓✓✓
 - a. Hospital emergency rooms are tired and frustrated with LEO bringing dangerous, violent people to them. Emergency rooms (ER) are not set up deal with the associated safety issues. ✓

- b. The Portland Oregon State Hospital (POSH) will be closing next year, when the Junction City facility opens.
 - c. Cedar Hills recently added more beds. Can Multnomah County contract for those beds?
 - d. We need a forensic ER with specially trained staff and incentives. ✓
 - e. The Legacy/Oregon Health and Sciences University (OHSU) psychiatric ER will come on board in two years but will not serve as a drop-off site for LEO.
 - f. Individuals often don't meet the hold criteria for hospital intake.
24. LEO need a 24/7 drop-off center separate from hospitals and the jail. ✓✓✓✓✓✓✓✓
- a. LEO tends to avoid taking individuals to the hospitals because that involves waiting for several hours, after which the hospital refuses to admit them. LEO will instead take individuals to the jail, where they know the individual will be booked and the officer's wait time is only 20 to 45 minutes.
 - b. Crisis/acute care needs to be convenient for police.
 - c. Any crisis/acute care facility needs a well-conceptualized and developed back door, meaning that it connects individuals with services. It has to be a place where the providers WANT to serve the people we're bringing to them.
 - d. The former crisis triage center, which shut down several years ago, was set up to for LEO drop off. It was efficient and police friendly but also expensive to run and the "back door didn't work." ✓
25. We need mechanisms that support increased field sorting. ✓✓
- a. LEO doesn't feel like they have easy, round-the-clock access to information regarding provider/case manager (although in crisis situations they can call the mental health call center and potentially access the name of the provider).
 - b. Is it possible to use the Disability Accommodation Registration to push out information to LEO?
 - c. If we decide that this level of crime shouldn't be transported to jail and the ER is not appropriate, field sorting is more effective.
 - d. We miss a huge opportunity to cite and release in the community.
 - e. Citing and releasing doesn't help with failure to appear (FTA) rates. If a person is in crisis, a piece of paper doesn't help. If you cite, you can't re-arrest until after their court date. LEO is forced to wait until the person gets so bad that they commit a crime or is hospitalizable.

Subacute Care

26. There's a lack of treatment capacity for the subacute population. ✓✓✓✓✓✓
- a. These are people with high levels of mental illness. They are co- or tri-morbid, anti-social, and/or violent and have frequent contact with the criminal justice system.
 - b. We need more intensive case management / ACT teams. Currently we have only one forensic ACT team but need 3 to 4 teams. ✓
 - c. We need increased contracting to develop alternatives to jail.

- d. CATC is good, but it's difficult to get people in there. It's capacity is low, and its criteria eliminate a fair number of candidates. It's supposed to be a secure facility, but if you're too mentally ill, they won't take you.
27. We need to identify providers who are willing and want to work with this acute population. ✓✓
- a. This is a challenging population, with people who might want to leave or might cause damage to buildings.
 - b. Providers want to "do the right thing." We need to develop a team that can respond to people and not be afraid. Providers have to WANT to work with these clients.
28. We need more of a focus on a continuum of long-term, wrap-around services. ✓✓
- a. There's an unfortunate cycle of crisis, case management, drop in, people starting to do well, then they drop down in services and spin out and end up back in jail.
 - b. We should improve the range and scope of our mental health services to (1) prevent this person from being booked, or (2) prevent this person from recidivating because of their mental illness, if they get an effective discharge plan with mental health services.
29. East County is not well represented at collaboration meetings or in terms of county funding. The type of police intervention in the field is different in East County than it is in Portland.

Intermediate Need

30. We need more intermediate/lower level care, i.e., services targeted at those with low-level mental illness who usually manage to function okay and/or are transitioning from residential care back to the community. ✓✓✓
- a. Should be voluntary (not locked) and available 24/7. (Cascadia's urgent walk-in clinic has limited hours.)
 - b. Many of these people end up in hospital, even though they don't rise to the level of subacute care – they know what to say to get admitted. As a result the acute units struggle. They have people that don't need to be there and lack beds for those who really need it. There's no intermediate level of care. We end up admitting people who could have done better in a lower level of care.
 - c. We have a large population of acute people. We have more beds for acute care (the most expensive beds) than we have for subacute and respite.
 - d. When people complete residential treatment, they leave without continuing support or connection with the next step of treatment.
31. We need a centralized pharmacy/medication distribution center where people can check in and get their meds on a daily basis. ✓✓
32. We need more respite care services. ✓
- a. Some people in crisis can't access a respite facility – someplace where they can stay and get some case management, so they can get reorganized and ready to go back to the community.

- b. Peer-led respite houses are much less costly than standard residential treatment. Short-term small group homes (10-14 days) can provide transitional support while in crisis.

Co- and Tri-Morbidity

- 33. We lack dual diagnosis services in general. ✓✓✓✓✓
 - a. Depending on a person's acuity, providers won't take them. We need a higher rate of reimbursement to build capacity for serving dually diagnosed patients.
 - b. Providers need more training and support for dealing with these clients. They often move them through too quickly and the clients can't meet their expectations.
 - c. Providers need to be more flexible about who they serve.
 - d. The two systems – substance abuse treatment and mental health – don't work together very well.
- 34. We lack dual diagnosis services for women. ✓✓✓
 - a. We have a 15-bed facility for men, but nothing for women.
 - b. There are several in-patient services in Portland for women, but they can't focus on mental. There have been many treatment failures for the female caseloads.
- 35. We lack resources that serve both medical and mental health needs.

Culturally Specific Programming

- 36. We need more culturally specific programming. ✓✓
 - a. We need more training in culturally responsive services for communities of color, and more attention paid to racial disparities.
 - b. Agencies have differing levels of skills and abilities in this area.

Forensic-focused Services

- 37. Provider services are not focused on serving forensic clients, and not all providers have the skill set or motivation to serve this population. ✓✓✓✓✓✓✓
 - a. Providers are concerned about the health and safety of their staff when accepting referrals.
 - b. Forensic clients may not be ready to engage, but are faced with the pressure of external motivation – “legal teeth to motivate engagement.”
 - c. Providers must persuade forensic clients to sign consent forms.
 - d. Our interventions aren't geared toward serving those with a history of violence or traumatic brain injury, and it's not our skill set.
 - e. Providers have high turnover. They need to be able to retain staff who want to serve this population.
 - f. The Forensic Diversion program has developed a great team of individuals to work with this population.
 - g. Should Multnomah County bring additional dollars to the table (the state dictates much of the rate amount) as incentive for serving this population?

- h. Should Multnomah County build its own teams and bill Medicaid?

Engagement

- 38. We need resources focused specifically on community-based engagement as a separately funded, valued, and billable activity. ✓✓✓✓
 - a. Providers need to get better at engaging clients to prevent escalation.
 - b. We need system navigators or peers who can engage clients and then connect them to services.
 - c. We need to hold providers more accountable for front-end diversions. It's their responsibility to help keep people stable and out of jail. Most detainees were or are connected with community-based services.
 - d. We need to do a better job of meeting clients where they are and moving at their pace, in their world.
 - e. Medicaid billing requirements (regarding productivity) limit what providers can do. How are we defining medical necessity? If we're not able to show that we're reducing symptoms with engagement activities, we can't afford to spend time on those tasks. This is a systemic problem that needs to be overcome.
 - f. We need people actively out and engaging with people on the street. Once someone is signed up there are teams that work with them, but it's hard to get people signed up. It takes a relationship and it takes time.
 - g. When House Bill (HB) 2594 passed in 2013, there was a lot of hope that we would be able to use assisted outpatient treatment to court-order people to treatment without having a criminal case. However, there was no enforcement mechanism in the bill and counties had a resource-based opt-out provision. Similar programs in New York and Florida have been successful; they have a mechanism to put someone on a two- to three-day hospital hold if he/she is not compliant with treatment. Such a system here could provide leverage for staying in treatment, with LEO and provider partnership to support stabilization.
 - h. Sometimes the criminal justice system is the only way to connect people to services. People's acuity is such that they don't have the insight to change their behavior and they won't, on their own, access care. If we can't engage with someone and they are continuing to break the law, we need to use jail as leverage for treatment.
- 39. We need a voluntary, 24/7 drop-in/stabilization center that provides a supportive environment, helps people prepare for treatment and/or housing, and gets them around other people. ✓✓✓
 - a. People need pro-social engagement activities where they can go during the day to get fulfillment. Most of these people lead very lonely lives. They are cut off from their families and they don't have good connections with other people.
 - b. A living room environment that provides peer support in a comforting environment would help people learn how to be social and prepare to engage in treatment.

- c. The only facility that currently provides 24/7 hospitality is Portland Rescue Mission, which is privately funded and faith-based.
40. We need increased focus on engagement while in jail and as part of release planning, to prepare people for a warm hand off to treatment in the community. ✓✓✓✓
- a. We need more reach-in programs through forensic diversion.
 - b. Some people get released who are ambulatory but could benefit from treatment. The handoff is weak between recog, pretrial, and Forensic Diversion.
 - c. The legal process doesn't allow us the time to sit with a person before their release, do an assessment, and connect them with treatment and medication. We need more continuity between custody and the community, regardless of a person's legal status.

Housing

41. Housing for the mentally ill is in especially short supply. ✓✓✓✓✓✓
- a. Portland is in a housing crisis. The current stock of affordable housing is low.
 - b. Federal rules don't allow for the creation of specific housing for people with a mental health disability. (Only 20% of units can be allocated for people who are mentally ill.)
 - c. We have to be creative and find other places where people can go.
 - d. There is a need for low- and no-barrier housing.
 - e. As the state was pressured by the Department of Justice to reduce the census at the state hospital, state dollars shifted toward mental health and away from homelessness.
 - f. Many hotels and single-room occupancy buildings (SROs) are not willing to accept the mentally ill. We need housing connected with our programs.
42. We need a "getting ready to get ready for housing" program that would support people who are motivated to get housed but aren't able to get organized (show up, fill out the application, etc.).

Appendix A: Interviewees

The following individuals were interviewed in November and December of 2014:

Katie Burgard	Lead Corrections Counselor, Multnomah County Sheriff's Office (MCSO)
Jean Dentinger	Manager, Diversion Courts, Multnomah County Mental Health and Addiction Services Division (MHASD)
Mark Douglass	Mental Health Evaluator, Lifeworks NW
Chris Farentinos	Director, Behavioral Health Services, Legacy Health System
Sharon Fitzgerald	Assistant Director of Supportive Housing, Central City Concern
Judge Julie Frantz	Chief Criminal Judge, Multnomah County Circuit Court
Liv Jenssen	Criminal Justice Manager, Multnomah County Department of Community Justice (DCJ)
Nancy Griffith	Director, Corrections Health, Multnomah County Health Department (MCHD)
David Hidalgo	Director, MHASD
Deborah Kafoury	Chair, Multnomah County Board of Commissioners
Melissa Marrero	Attorney, Multnomah County District Attorney's Office
Ginger Martin	Deputy Director, DCJ
Colette McEldowny	Attorney, Multnomah County District Attorney's Office
Bob McCormick	Sergeant, Behavioral Health Unit, Portland Police Bureau
Tim Moore	Undersheriff, MCSO
Kathleen Roy	Clinical Director, Old Town Recovery Center, Central City Concern
Judge Tom Ryan	Judge, Multnomah County Circuit Court
Eric Sevos	Senior Clinical Director, Cascadia Behavioral Healthcare
Commissioner Judy Shiprack	Commissioner, Multnomah County Board of Commissioners
Don Trapp	Pretrial Supervision Manager, DCJ
Stu Walker	Mentally Ill Offender Unit Manager, DCJ
Scott Williams	Lead Mental Health Consultant, Corrections Health, MCHD
Linda Yankee	Chief Deputy, MCSO

Appendix D: Data Collection Summary

Multnomah County Mental Health Jail Diversion Project

Data Collection Summary

January 23, 2015

Overview

The project data group was tasked with collecting and analyzing data on individuals who were being held in jail and who might otherwise be eligible for diversion except for their presenting mental health status. The group met twice, first in November to discuss the target populations and data elements and then in early December to review the preliminary data. Additional information exchange and conversations occurred by email and telephone. Participants in the data group are listed in Appendix B.

Target Population

Data collection focused on detainees who were potentially eligible for diversion and had been screened/assessed for possible release but who remained detained. Three groups of detainees were identified:

- Defendants screened by the Multnomah County Department of Community Justice (DCJ) Pretrial Supervision Program (PSP) who met release criteria (charge and risk assessment score) but were denied release because of mental health concerns.
- Defendants screened by the Multnomah County Sheriff's Office's (MCSO) Close Street Supervision Program (CSS) but were denied program participation. Some of these denials may be because of high-level pending charges and possibly also mental health concerns, although the data are not definitive.¹
- Individuals on community supervision who were placed on a jail hold by the Multnomah County Department of Community Justice Mentally Ill Offender Unit (MIO).

The Pretrial Supervision Program (PSP) conducts release interviews and assessments to determine the release eligibility of arrested defendants, and makes a recommendation to the court. PSP also provides pretrial supervision for all defendants who are referred and released. PSP release recommendations are based on criteria established by statute and a validated risk

1

CSS Mental Health-specific Referrals: It was noted during data collection that CSS began tracking mental health referrals from the court on 9/8/10 (that is the first recorded date of a mental-health-specific referral). CSS has a deputy specifically assigned to mental health referrals. Mental health referrals from the court have significantly declined since 2011, with only nine referrals in 2014 and no mental health referrals during the month of October. During that month, no one with a mental health referral was denied participation in CSS.

CSS MH Specific Referrals*	
Year	# of Referrals
9/8/10 – 12/31/10	14
2011	50
2012	16
2013	12
2014	9

assessment. Under PSP supervision, defendants are afforded the opportunity to maintain employment and/or school attendance, continue with health-related services (e.g., drug and alcohol counseling, mental health treatment) and reside in the community pending the resolution of their court matters.)

MSCO Close Street Supervision (CSS) is an intensive custody and supervision program that provides pre-trial services to arrestees of Measure 11 crimes, domestic violence cases, and a select group of clients with mental health disorders. Deputies interview defendants and conduct investigations to present the Court with accurate, timely, and impartial information that assists the judge in making an informed release decision. This program supports both offender accountability and reentry of the offender into the community while increasing the number of available jail beds.

The DCJ Mentally Ill Offender (MIO) unit provides supervision services for probation, parole and post-prison offenders who have been diagnosed with a severe and persistent mental illness. The MIO unit works to divert offenders with severe mental illness from incarceration and hospitalizations by treating them in the community. By providing these offenders with community-based treatment and with supervision from specially trained parole/probation officers, the MIO unit preserves community safety and minimizes offender contact with the criminal justice system. The goal of the MIO unit is to reduce recidivism, enhance community safety, and support the mentally ill offender in achieving stabilization and improved functioning.

It is important to note that the data presented here do not represent all jail detainees with mental health diagnoses. This analysis was limited to the specific target population of possibly divertible individuals, most of whom have been diagnosed with mental illness.

Data Source and Timeframe

Data were extracted by county staff from a variety of sources, including the MSCO's Corrections Information Management System (CIMS) and the Sheriff's Warrant Information System (SWIS), DCJ's E-Recog and the PSP Information System (Caseload Explorer), Corrections Health EPIC records, and the Decision Support Software for Justice (DSS-J) data warehouse supported by the Local Public Safety Coordinating Council (LPSSC). Data were pulled electronically and through manual file review. To protect privacy, health information was collected independently by Corrections Health staff and provided for analysis without any identifying information. This allowed us to summarize the health information in aggregate, but not to make direct connections to the individual criminal justice data.

Because almost none of the data needed for this report are currently contained in a networked system that allows easy extraction and comparison, the data group chose to collect a limited sample of data that is representative of the current population. The sample includes activity that occurred during the month of October 2014. The activity during that month included individuals who were booked, released, or detained in the Multnomah County jails during that time period.

Demographics

Records

The group found 80 individuals that met the identified criteria.

Data Collection Summary		
Population	Number	%
PSP	18	23%
CSS	44	55%
MIO Unit	18	23%
Total	80	100%

Gender, Age, and Race

MCSO provided demographic data on all 80 cases based on data extracted from MCSO's CIMS and SWIS systems.

Gender

- The individuals in the target population were predominately (89%) male and 11% female.
- By comparison, males represented 76.6% of all bookings during the same time period.²

	Male	Female	Total
PSP	13	5	18
CSS	42	2	44
MIO Unit	16	2	18
Total	71	9	80
%	89%	11%	100%

Gender % of Total Bookings in October 2014 ³			
	Male	Female	Total
%	76.6%	23.4%	100%

Age

- The majority of individuals in the target population (49%) were between the ages of 26 and 40.
- The average age of the target population was 34.8.
- The average age of individuals at booking in 2014 was 35.41.

	<26 years	26-40 years	>40 years	Total	Average Age
PSP	6	6	6	18	34
CSS	10	23	11	44	35
MIO Unit	3	10	5	18	35
Total	19	39	22	80	34.8
%	24%	49%	28%	100%	

² Multnomah County Sheriff's Office (MCSO) Monthly Jail Report, November 2014.

³ MCSO Monthly Jail Report, November 2014.

Race and Ethnicity

- Black⁴ detainees were highly overrepresented, at 41% of the target population. This compares to 19.7% of all bookings during that time period.
- White detainees were underrepresented, at 52% of the target population. This compares to 67.3% of all bookings.
- Hispanic detainees were slightly underrepresented, at 4% of the target population and 8.6% of bookings.

Race/Ethnicity of the Target Population					
	White	Black	Hispanic	Asian	Total
PSP	5	12	0	1	18
CSS	27	14	3	0	44
MIO Unit	9	7	0	2	18
Total	41	33	3	3	80
%	52%	41%	4%	4%	100%

Race/Ethnicity by % of Total Bookings in October 2014 ⁵					
	White	Black	Hispanic	Asian	Total
%	67.3%	19.7%	8.6%	4.4%	100%

Health Data

Health data for the target population were manually extracted from the EPIC data system by Corrections Health staff. The following is a summary of the medical, mental health, and substance abuse diagnoses found in those records. Because this information includes only data from the EPIC database, it may not represent all of the diagnoses associated with these individuals.

Medical Diagnoses

- 11 detainees (14%) from the target population had acute medical issues requiring attention, including broken bones, lacerations, chest pains, and abscesses.
- 40 detainees (50%) were diagnosed with chronic health conditions, such as hypertension, hepatitis, diabetes, asthma, osteoarthritis, and chronic obstructive pulmonary disease (COPD).

Mental Health Diagnoses

- 47 detainees (59%) from the target population had mental health diagnoses recorded in EPIC.
- Of those diagnosed with mental health disorders:

⁴ 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.

⁵ MCSO Monthly Jail Report, November 2014.

- 7 (15%) were diagnosed with schizophrenic disorder.
- 11 (23%) were diagnosed with bi-polar disorder.
- 22 (47%) were diagnosed with depression.

Alcohol and Other Drug (AOD) Abuse Diagnosis

- 43 detainees (54%) from the target population had a diagnosis of AOD abuse.
- 27 (63%) of those were identified as poly-substance users.

Multiple Diagnoses

- 27 detainees (34%) from the target population had both a mental health and AOD abuse diagnosis.
- 15 (19%) had diagnoses for chronic medical issues, mental health, and AOD abuse.

Referrals and Treatment Encounters

Staff from the Mental Health and Addiction Services Division’s Decision Support Unit gathered additional data on enrollment, referrals, and service encounters for the project’s target population. Staff attempted to match the 80 individuals from the target population to case files in Electronic Health Records and/or Medicaid eligibility systems (CIM/MMIS). Of those detainees, exact matches were found in the databases for 25 (31.3 percent) of the individuals, possible matches were found for 37 (4.3 percent), and 18 (22.5 percent) had no match. None of the exact matches had a current mental health referral or a reported encounter with mental health service provider in the past 120 days. Only five individuals (possible matches) had a current mental health referral and had received a mental health service in the past 120 days. Two people (possible matches) had an open referral but had had no reported contact with a mental health service provider.

Target Population Mental Health Referrals and Service Encounters				
Match w/EHR and/or Medicaid eligibility data system	Current Health Referral?	Reported Encounter with Mental Health Services w/in Past 120 days	# of people	%
Exact match	No	No	25	31.3%
Possible match	Yes	Yes	5	6.3%
Possible match	Yes	No	2	2.5%
Possible match	No	No	30	37.5%
No match found	Unknown	Unknown	18	22.5%
Total			80	100%

Jail Utilization

- The 80 detainees in the target population used approximately 1,352 bed days during October. This represents approximately 4% of the jail utilization for that month.⁶
- The target population spent an average of 18.27 days in jail during the month of October.⁷ The average length of stay for all jail detainees during October was 13.51 days.

⁶October Average Daily Population (ADP) of 1,164 x 31 days = 36,084 total available bed days.

- Detainees were housed in multiple units in both the Inverness Jail (MCIJ) and the Multnomah County Detention Center (MCDC). We were able to collect information on the 62 detainees who were held from PSP and CSS decisions. Those detainees logged “stays”⁸ of one or more days in the following units:
 - 42 detainees logged 131 “stays” at various units at Inverness Jail (most of these detainees also had stays at the Detention Center).
 - 40 detainees logged approximately 116 stays at various units at the Detention Center. Those 116 stays were in the following units:
 - 32 stays in close custody and discipline units (4f, 5a, 5b, 5c, 5d, 8a)
 - 29 stays in general population units (6a, 6b, 6c, 6d, 8d)
 - 17 stays in the transitional unit (7d)
 - 16 stays in acute and mental close custody units (7a, 7b, 7c, 8b)
 - 13 stays in the psychiatric infirmary (4d)
 - 10 stays in the suicide watch/special management unit (8c)

Criminal Justice Data

DCJ PSP

The PSP makes recommendations to the court for release on pretrial supervision. These recommendations are based on a case review that includes completion of a validated assessment tool (see Appendix A).

- PSP conducted assessments on 171 defendants during the month of October.
- 43 defendants (25%) were released based on their charge and their risk score.

DCJ PSP		
Total Referrals	171	100%
# Released	43	25%
# Detained	128	75%
# Detained w/MH Concerns	18	11%

- 128 (75%) were detained.
- Of those detained, 18 (11%) were included in this study because they met the criteria for release but were detained because the PSP officers had concerns regarding the defendants’ mental health status.
- Primary charges for those 18 defendants were as follows:

Charge ⁹	# of Defendants
Possession of Cocaine or Meth	5
Restraining Order Violation	3

⁷ This does not represent average length of stay because detainees’ booking date might occur prior to 10/1/14 and they might have continued being detained as of 10/31/14.

⁸ A “stay” is a discrete period of residence in a particular unit.

⁹ The charges listed are the most serious on file at the time of interview.

Domestic Violence-related Charges	3
Indecent Exposure	2
Robbery II	1
Theft 1	1
Assault of an Officer	1
Resisting Arrest	1
Failure to Register as a Sex Offender	1
Total	18

Close Street Supervision (CSS)

MCSO’s Close Street Supervision provided data on 44 detainees who met the criteria for release on CSS but, upon being interviewed by CSS staff, were denied program participation. Our ability to definitely state whether all of these denials were correlated with mental health diagnoses was limited because the corrections and health data were two separate databases and confidentiality restrictions limited the sharing of health information for detainees. However, for the purposes of this study, we included all 44 detainees in the analysis. We based this decision on a review of the separate, aggregate mental health diagnoses data received from Corrections Health and the CSS case notes, which include reasons for program denial (in addition to high-level pending charges). These reasons included:

- 20 detainees were denied program participation in part they “lack ties / stability.”
- 9 detainees were denied program participation in part because they were a “danger to self or others.”
- Primary charges for those 44 defendants were as follows:

Charge¹⁰	# of Defendants
Robbery I, II, and III	12
Assault II, III, and IV (mostly DV)	10
Burglary 1	4
Coercion	2
Kidnap I	2
Rape I and Rape I-DV	2
Sex Abuse I	2
Sodomy 1	2
Attempted Assault I – DV	1
Attempted Conspiracy to Promote Prostitution	1
Conspiracy to Commit Aggravated Murder	1
Criminal Mistreatment I	1
Escape II	1
Manslaughter I	1
Menacing-DV	1
Parole Violation	1
Total	44

¹⁰ The charges listed are the most serious on file at the time of interview.

DCJ MIO Unit

The DCJ MIO Unit provided a review of jail holds placed by MIO Unit officers during the month of October. Individuals supervised by this unit have been diagnosed as severely and persistently mentally ill. The unit officers provided a case note for each of the 18 individuals sanctioned to jail time.

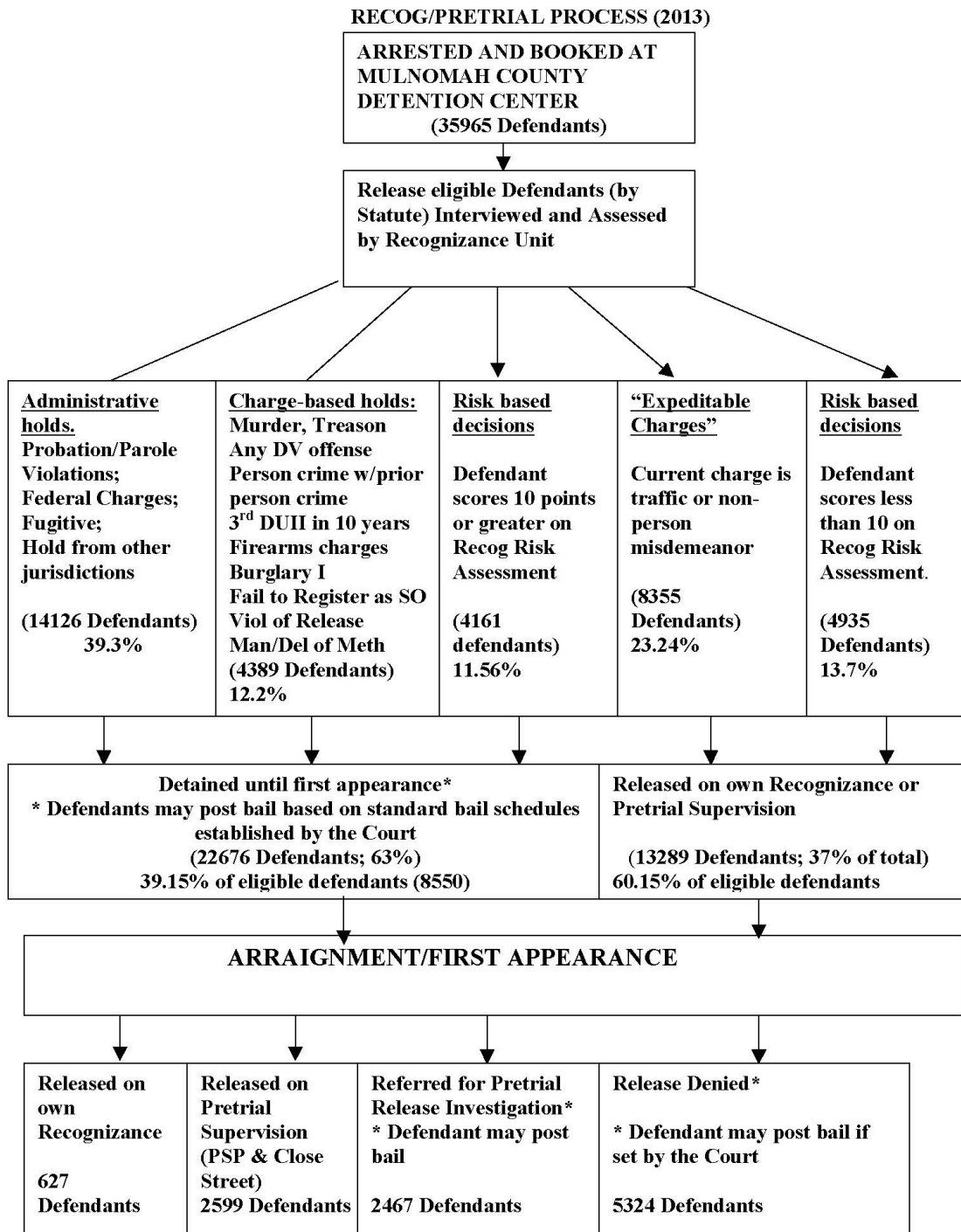
- Officers indicated that at least seven (39%) of those detainees would be good candidates for diversion, but because of issues related to homelessness, substance abuse (dual diagnosis), and lack of treatment availability/wait times, they were being held in jail.
- Seven (39%) of the detainees were being held on a warrant for not reporting to their parole/probation officer. Several of these individuals had also absconded from or failed to successfully complete community-based treatment programs.
- Four (22%) were identified as not “good candidates for diversion” because of the nature of their behavior (i.e., high level of violence and/or pending new crimes).
- Primary charges for those 18 detainees were as follows:

Charge¹¹	# of Defendants
Parole Violation	11
DUII	1
Indecent Exposure	1
Unlawful Possession of Meth	1
Robbery III	1
Theft of Services	1
Unlawful Delivery of Marijuana (DCS)	1
U.S. Marshal Hold	1
Total	18

¹¹ The charges listed are the most serious charge on file at the time of interview.

Appendix A

Recog/Pretrial Process



Appendix B

Data Group Participants

- Lauren Brown, Sr. Research Analyst, LPSCC
- Jean Dentinger, Manager, Diversion Courts, MHASD
- Nancy Griffith, Director, Corrections Health
- Liv Jenssen, Criminal Justice Manager, DCJ
- Shea Marshman, PhD, Director of Planning & Research, MCSO
- Ginger Martin, Deputy Director, DCJ
- Dr. Nimisha Gokaidas, Medical Director, MHASD
- Neal Rotman, CMHP Manager, MHASD
- Abbey Stamp, Executive Director, LPSCC
- Don Trapp, Pretrial Supervision Manager, DCJ
- Stu Walker, MIO Unit Manager, DCJ
- Linda Yankee, Chief Deputy, MCSO

Appendix E: Program Summaries

Program Summaries

Intercept 1: Law Enforcement/Emergency Services

911 Triage

911 Triage has developed protocols for mental health (MH) issues if there is not an imminent risk of harm to self and others. Modeled after a project by the Bazelon Center for Mental Health Law, in Washington, D.C. 911 operators triage callers and provide a warm transfer to the MH call line for stabilization and de-escalation. Alternately, the call line can send out Project Respond. Interviewees noted that there has been a reduction in the number of police calls for these situations.

Mental Health Call Center (Multnomah County)

The Mental Health Call Center is a 24/7 call line that provides stabilization and de-escalation. The center provides MH crisis/suicide counseling by phone, sends mobile outreach for in-person assessment, and refers to MH community services, including low-cost, sliding scale, and culturally/linguistically appropriate services. It also manages admissions to the Crisis Assessment and Triage Center (CATC) and works with police and local hospitals to triage people to the most appropriate service location, such as MH walk-in clinic, the hospital, or subacute services. The call center takes “warm hand-off” transfers from 911 operators.

The number of calls has been rising, from 70,000 in 2013 to an estimated 77,000 in 2014.

Project Respond (Cascadia)

Project Respond is a mobile MH crisis response team of 35 staff that provides 24/7 crisis intervention. Accessed through Multnomah County Call Center, Project Respond provides assistance to the police during a crisis and conducts MH assessments. The response team has better access than the police do to information about whether someone is already connected to services, such as a case manager or ACT team, and can aid officers in directing the person appropriately (i.e., to the case manager). This team is not usually called out for low-level MH situations.

BHU (PPB Behavioral Health Unit)

The BHU is a relatively new (April 2013), multidisciplinary, 11-person police unit, with a lieutenant, sergeant, program manager, five officers, an analyst, and three MH clinicians. The BHU targets high-risk people in the community with serious mental illness (SMI) – people who may have stopped taking their medications, recidivate at a high rate, and may be violent. The BHU convenes biweekly meetings with partners to coordinate case management of these individuals.

The BHU provides an additional 40 hours of enhanced crisis intervention training (ECIT) (beyond the standard 40 hours of CIT received by all officers). At least 78 officers so far have been trained as ECIT; they volunteer to be first responders on 911 calls involving MH crisis calls.

Behavioral Health Response Team (BHRT) (formerly Mobile Crisis Unit/MCU)

The Behavioral Health Response Teams are teams of a paired officer/MH clinician (subcontracted from Cascadia) that work proactively with individuals who have multiple contacts with police, in an attempt to connect them with appropriate services in advance of a mental health crisis. The Portland Police Bureau currently has three BHRT cars. Officers or the BHU refers people they are concerned about (who struggling and not connected to services), then BHRT follows up. This is a coordination function focused on keeping people out of jail. The acuity levels of these individuals tend to be high – they often end up in the hospital.

Urgent Walk-in Clinic (Cascadia)

This is a seven-day-a-week clinic where people can access an emergency psychiatric assessment outside of a hospital setting, plus additional MH support, such as counseling, medication-gap prescribing, and referrals to affordable MH treatment. This clinic (located at SE 43rd and Division) serves as a gateway path to services. It is an outpatient clinic, and NOT a 24-hour facility. (It is closed from 10:30 p.m. to 7 a.m.). Clinic services are available to anyone in Multnomah County, regardless of insurance, age, or income.

Crisis Respite (Cascadia)

This short-term, voluntary respite facility serves as an alternative to hospitalization. It offers a home-like setting where people can stay for five to seven days and get assistance in stabilizing symptoms of mental illness. The facility is operated by Cascadia. It has 10 beds contracted to Multnomah County and five beds contracted to Clackamas County.

Forensic Assertive Community Treatment (FACT) Team (Cascadia)

The Forensic Assertive Community Treatment (FACT) Team provides intensive community-based treatment for up to 35 clients over a 12-month period. FACT is an adaptation of the traditional assertive community treatment (ACT) model that focuses on people with serious mental illness who are involved with the criminal justice system (Lamberti et al., 2004). (ACT is a psychosocial intervention that was developed for people with severe mental illness (a subset of serious mental illness, marked by a higher degree of functional disability) who have significant difficulty living independently, high service needs, and repeated psychiatric hospitalizations [Stein & Santos, 1998]).

CATC: Crisis Assessment and Treatment Center (county funded, operated by Telecare)

The CATC, which opened in 2011, provides subacute mental health services for people experiencing a mental health crisis who cannot manage their symptoms on their own and do not need a hospital stay to become stable. The CATC is a 16-bed secure, locked facility where people can stay from four to 14 days as their mental health symptoms stabilize. The CATC has a multidisciplinary team of clinical, psychiatric, nursing, drug and alcohol, rehabilitation, recovery, and peer support staff. The program provides stabilization, medication adjustment, and psychiatric services, among others, all from a recovery model.

Multnomah County's 24-hour, seven-day-a-week Mental Health Call Center manages admission to the CATC. The police contact the Mental Health Call Center on a dedicated

line if they encounter someone who appears to be in crisis because of symptoms of a mental illness. (They may also contact Project Respond mobile crisis outreach.) The Mental Health Call Center then manages admission to the facility. When providers from mental health agencies have someone they believe is ill enough to need care at the CATC, they contact the Mental Health Call Center. Staff then work with providers to assess the person's need and manage admission to the CATC if it is an appropriate placement. Referrals are made by community outreach workers, emergency departments at area hospitals, community walk-in clinics, and Verity, the Medicaid-managed care provider for The Oregon Health Plan.

The CATC is not designed to function as a drop-off center for police. According to OregonLive, "the Police Bureau hasn't encouraged officers to bring people they encounter there, largely because it doesn't allow for drop-offs." "Police say the center simply isn't practical for patrol officers. In a March 2012 report, they said they can't take people straight there and that the center doesn't accept patients who are a danger to themselves or others, combative or assaultive, high on drugs or drunk."

"They must have a diagnosed mental illness, be referred from either a community care provider, an emergency room or acute hospital unit. They also must have stable medical vital signs on arrival. Upon discharge, they leave with a plan for follow-up treatment."

"To be admitted to the center, a person must first undergo a mental health assessment at a hospital, a walk-in clinic or in the field, said Kevin McChesney, regional director of operations for Telecare, the private corporation responsible for running the center."¹

As of May 2013, "the center has treated 1,300 people. Of those, 942 patients came from emergency departments, where police likely took them initially, county officials said. Another 358 came from community referrals through social service agencies and the county jail. Of those referrals, 82 came from Project Respond staffers, who police regularly call out to mental health emergencies."²

Justice Triage Center (operated by Telecare)

The Justice Triage Center opened in September 2014 and is funded by MHASD. Located on the first floor of CATC, it is open from 10 p.m. to 2 p.m. The program is designed for adults involved with the criminal justice system who have an Axis 1 diagnosis. The Justice Triage Center features rapid response/access to clinical staff, which include a qualified mental health professional (QMHP), a registered nurse (RN), and a recovery specialist – in addition to CATC's psychiatrist, during normal business hours). Services provided include stabilization, assessment, and medication support, problem/resolution assistance, supportive counseling, and discharge planning (i.e., intensive planning and implementation of integrated aftercare services in the community, including assistance with obtaining entitlements, community housing, community treatment resources, and referral to appropriate medical services).

¹ OregonLive. June 2011. Available at http://www.oregonlive.com/portland/index.ssf/2011/06/new_mental_health_center_in_ne.html.

² Ibid.

Referrals to the Justice Triage Center generally come from mental health staff at the Multnomah County Jail, the Mentally Ill Offender (MIO) Unit of the Department of Community Justice, Mental Health Court, or Community Court.

Hospital Emergency Room/Department

Police officers can drop off individuals at emergency rooms (ERs) for assessment and potential admission into the hospital's psychiatric unit. For people with mental illness, emergency room staff conduct an assessment to determine whether they meet the criteria for admission to the hospital's psychiatric ward and if so, what the length of the hold should be. Sometimes the individual is released directly from the ER, without being admitted and before the end of the police officer's shift.

Police officers report that it can take hours to process individuals in an emergency room, and that they sense that emergency rooms are resistant to admitting individuals with mental illness or who are experiencing a mental health crisis while intoxicated. Both police officers and mental health professionals have stated that "most emergency rooms inform first responders that use of emergency departments for intoxicated individuals regardless of mental health status is not appropriate" (Stewart 2012).

Hospital Psychiatric Unit Admissions

Cedar Hills Hospital

Cedar Hills is a free-standing psychiatric hospital located in southwest Portland. Cedar Hills serves adult patients who are in need of treatment for a psychiatric disorder or substance abuse detox. The hospital added 10 beds in September 2014, for a total of 89.

Legacy Health System

Legacy Health System has three acute psychiatric units: one juvenile/adolescent unit (with 16 beds), and two adult units (with 10 and 17 beds).

Oregon State Hospital

Oregon State Hospital provides physically secure, 24-hour care. At Holladay Park Hospital, Oregon State Hospital has leased four floors until 2015, when it will move to Junction City. Depending on the nature of their crime, patients in forensic commitment programs are under the jurisdiction of either the Psychiatric Security Review Board or the Oregon State Hospital Review Panel

The following information is available on the Oregon State Hospital website:

- **Crossroads (a civil program).** The Crossroads program provides services for adults who have been civilly committed or voluntarily committed by a guardian. They have been found by the court to be a danger to themselves or others, or unable to provide for their own basic needs, such as health and safety, because of a mental disorder. Patients each have an individual treatment care plan and attend the treatment mall every weekday. The primary focus of treatment mall programs is to prepare patients to return to the community. Groups help patients learn how to manage their symptoms and medications, develop coping and recreational skills, budget and manage their money, and plan and prepare meals. Community reintegration is the focus of weekly group trips to community

settings. Separate programs provide educational support, psychotherapy and help for alcohol and drug abuse. The Crossroads program has units at both the Salem and Portland campuses.

- **Archways (a forensic program).** Patients in the Archways program have been charged with but not convicted of a crime. They have been sent to OSH by a court order under Oregon law (ORS 161.370) because they have been found unable to participate in their defense due to their mental illness. The goal of Archways is to stabilize patients and help them achieve a level of legal competency so they are able to understand the criminal charges against them and work with their attorney.
- **Pathways (a forensic program).** Patients in the Pathways program have been convicted of a crime related to their mental illness; however, due to their mental illness at the time of the crime, a court has found that the person did not have the capacity to understand the criminality of their conduct.
- **Bridges (a forensic program).** Bridges is the community transition program for patients who have been found guilty except for insanity and are nearing the point where they no longer need hospital-level care. In addition to four traditional living units, Bridges includes six cottages on the hospital campus that provide a treatment setting much like a group home, where patients cook their own meals and share other household responsibilities. Bridges' goal is to help patients achieve their highest level of health, safety and independence as they prepare for discharge or conditional release to a less-restrictive community setting. Individuals work on living skills through daily treatment mall activities and classes as well as approved outings. They also participate in discharge planning with their treatment team members.

Intercept 2: Initial Detention & Court Hearings

Pretrial Supervision Program (DCJ)

The Pretrial Supervision Program (PSP) conducts interviews and assessments to determine the release eligibility of arrested defendants and makes a recommendation to the court. PSP also provides pretrial supervision for all defendants who are referred and released. PSP release recommendations are based on criteria established by statute and a validated risk assessment. Under PSP supervision, defendants are afforded the opportunity to maintain employment and/or school attendance, continue with health-related services (e.g., drug and alcohol counseling, mental health treatment), and reside in the community pending the resolution of their court matters.

Close Street Supervision (MCSO)

Close Street Supervision (CSS) is an intensive 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. Close Street Supervision provides intensive, individualized supervision and management of multiple-need pretrial arrestees who would otherwise be ineligible for pretrial release.

Deputies interview defendants and conduct investigations to present the Court with accurate, timely, and impartial information that assists the judge in making an informed release decision. This program supports both offender accountability and reentry of the offender into the community while increasing the number of available jail beds.

Supervision occurs through visits to the home and workplace, and through use of technologies such as electronic monitoring and GPS. Close Street Supervision's primary objectives are to ensure that clients come to all scheduled court appearances, do not re-offend while in the community, and adhere to the conditions of their release – and that victims are comfortable that the release does not pose a risk to them personally.

Intercept 3: Jails/Courts

Jail Detention (MCSO and Corrections Health)

MCSO provides stepped housing for people in jail who are mentally ill, at three levels: acute, subacute, or general population:

1. Acute – This unit is staffed by corrections officers and medical staff. A multidisciplinary team (corrections counseling, nursing staff, etc.) works there daily. They provide assistance with activities of daily living (ADL), such as showering, self-care, and eating. Staff work to connect individuals with community providers to share information about treatment, transition, and other housing options.
2. Subacute – This unit is the same as above but less intense. Inmates tend to stabilize more quickly. They may be willing to take medications and be more open to engaging.
3. General housing – People with mental illness who are housed among the general jail population may or may not have revealed their illness. They are able to advocate for themselves and navigate through jail and court proceedings without needing assistance.

If a jail inmate with mental illness is at imminent risk of harming themselves or others, the Corrections Health staff can write a directors' custody hold and transport the inmate to an emergency room. The hospital has discretion to determine whether or not the person meets criteria for admission. Corrections Health staff work closely with the jail diversion team to identify inmates with mental illness and arrange for release of appropriate inmates for whom treatment connections in the community are available.

Mental Health Court (Courts and MHASD)

Mental Health Court (MHC) provides offenders who have a mental illness an opportunity to stabilize, engage in treatment, and avail themselves of other social services. Participation in the program is a voluntary option to a traditional prosecution of criminal cases. Participants, as a result of their stability, tend to re-offend less and stay out of jail. By sharing their accomplishments with the court and the other MHC participants, every participant receives encouragement and increased support in the community from the entire court team.

Each participant is assigned a court monitor that will meet with the participant to put together a plan of action, which could include mental health treatment, substance abuse treatment, and/or obtaining benefits and housing. The monitor works with the participant in a supportive manner, with the intention of establishing new contacts and community supports, identifying resources and services that promote mental health/sobriety and stability in the community, or solidifying connections already made in the community. The monitor has regular contact with community supports in order to report back to the court.

The MHC capacity is currently 65, with 61 individuals currently on supervision. There are two court monitors, who have caseloads of 25 to 35 each. Additional capacity is being added through the SAMHSA grant, including peer counselors and an additional court monitor.

Forensic Diversion (MHASD)

Coordinated diversion includes three jail and/or hospital diversion programs for people who have a serious mental illness. Qualified mental health professionals staff the Community Court, Mental Health Court, and Forensic Diversion Programs. All three programs provide assertive, short-term support, with the goal of connecting people to appropriate community treatment options. A primary goal of all the programs is to divert people with mental illness from lengthy jail stays and to promote stability in the community.

The three coordinated diversion programs target people in the criminal justice system with serious mental illness who are at risk of lengthy stays in jail or hospitals unless they receive additional treatment, support, and resources. The programs address the needs of residents with a mental illness who can be safely diverted from jail and/or Oregon State Hospital, provide support for successful completion of court directives, and provide linkage to community services that provide stability. Initial case management and coordination protects the legal and civil rights of these individuals, ensures the appropriateness of resources, and decreases the unnecessary expense of time in jail or at Oregon State Hospital.

- The Community Court Program addresses quality-of-life crimes with a focus on restorative justice. Clients are able to participate in a variety of social services as an alternative to jail or community service.
- Mental Health Court provides time-limited intensive case management services to people involved in the criminal justice system, while connecting them to community treatment, housing, and financial and medical entitlements. Staff provide ongoing monitoring and support for people enrolled in Mental Health Court. Staff initiated services to 66 people in FY13.
- The Forensic Diversion Program focuses on diversion from the criminal justice system for persons charged with misdemeanors and ordered to undergo evaluation/restoration at the Oregon State Hospital. Staff provide mental status evaluations, as well as linkage to basic needs in the community; time-limited coordination/linkage to treatment services, housing, financial and medical entitlements, and social services. In addition, Forensic Diversion provides

community restoration as an alternative to being placed in the Oregon State Hospital. This option is less restrictive and provides the client with continued stability and services while maintaining safely in their community.

Multnomah Behavioral Health Treatment Court Collaborative (MHASD w/SAHMSA Funding)

The Multnomah Behavioral Health Treatment Court Collaborative supports and enhances current diversion court programming for disadvantaged, hard-to-serve individuals currently involved with the county criminal justice system who suffer from serious and persistent mental illness, a substance abuse issue, or a co-occurring disorder. The program includes trauma-informed care training for the entire MH court team.

Expected Future Programs

Residential Stabilization Center (DCJ)

The Multnomah County Department of Community Justice (DCJ) is contracting with Central City Concern (CCC) to open a 12- to 16-bed residential stabilization center for men who have mental health issues and possibly also substance abuse and/or chronic medical conditions. Expected to open in early 2015, the stabilization center will serve DCJ clients on community supervision for up to four months, providing skill-building, treatment, and support services to prepare clients for eventual transition to alcohol- and drug-free housing. DCJ will be in touch with the police Behavioral Health Unit so that officers know who is in residence at the stabilization center and should be guided back there if they stray.

Psychiatric Emergency Room (Hospitals)

Legacy Health Services is working with Oregon Health and Sciences University to develop a 24-hour psychiatric emergency room staffed by psychiatrists, nurses, and social workers. Modeled after a program in Oakland, California, the facility would serve 40 to 45 people a day on an outpatient basis, for up to 23 hours. A physician would make the decision whether to discharge or admit someone, and the facility would have a robust "back door" that would connect patients with community services. The psychiatric emergency room could open in late 2016, assuming that obstacles can be removed to using a Medicaid crisis stabilization code that pays providers by the hour, rather than by the service.