Recommendations for Improving Options and Outcomes for Persons with Mental Illness in Multnomah County's Criminal Justice System

May 2002

Persons with Mental Illness in the Criminal Justice System Working Group

Co-Chairs Commissioner Lisa Naito and Judge Julie Frantz

Sponsored by

The Local Public Safety Coordinating Council of Multnomah County, Oregon

PUBLIC SAFETY COORDINATING COUNCIL OF MULTNOMAH COUNTY

May 10, 2002

To Employees who work to meet the Needs of Persons with Mental Illness and to those that they serve:

Judge Frantz and Commissioner Naito have led a working group on Persons with Mental Illness in the Criminal Justice System which has created the report – *Recommendations for Improving Options and Outcomes for Persons with Mental Illness in Multnomah County's Criminal Justice System*. The Local Public Safety Coordinating Council is pleased to support the efforts of Judge Julie Frantz, Commissioner Lisa Naito, Sheriff Noelle, District Attorney Michael Schrunk, Chief Mark Kroeker, and Joanne Fuller, in their pursuits to address the needs of person with mental illness in our communities and within the criminal justice system.

An impetus to creating the report was the effort within Multnomah County, led by County Chair Diane Linn, to reform the mental health system. During Multnomah County's mental health redesign process, the criminal justice leaders saw an opportunity to decrease the numbers of persons who enter the criminal justice system and that in partnership there would be new options to improve services for those who do enter the criminal justice system.

The Local Public Safety Coordinating Council is proud to be able to assist in bringing together the criminal justice and mental health systems. I would like to sincerely thank the leaders in the criminal justice and mental health systems, including our employees and partners in these efforts, for their hard work and perseverance.

Sincerely,

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Serving Public Safety Agencies in Multnomah County

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Multnomah County Oregon

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Background

Two years ago, *The Oregonian* challenged readers to name metropolitan Portland's largest treatment center for the mentally ill. "No, it isn't the Oregon Health Sciences University. It isn't the Oregon State Hospital or the crisis triage center," wrote Robert Landauer in a March 2000 editorial. "It is the Multnomah County Jail." On an average day, Landauer cited, 13% of jail inmates are identified as seriously mentally ill. He listed reasons for this, including:

- Moving people from state hospitals to under-funded community treatment;
- Not connecting all people in need to treatment programs; and
- Criminalizing the behavior of the chronically mentally ill so they end up in jail.

While "the problem is national, most effective responses are local," wrote Landauer. In October of 2000, under the joint leadership of Commissioner Lisa Naito and Judge Julie Frantz, a working group on Persons with Mental Illness in the Criminal Justice System, concerned about these same issues, created the document *Options for Persons with Mental Illness in Multnomah County's Criminal Justice System*. Some recommendations from that report no longer apply, some have been accomplished, and others require more work or a new strategy. (See appendix G)

The working group has continued to meet and has been absorbed by the Local Public Safety Coordinating Council. They have worked to further improve service for adult persons with mental illness who come in contact with the criminal justice system. In February 2002, due to the opportunity provided by Multnomah County's mental health redesign, the group divided into three separate focus areas: pre-booking options, post-booking options (including community courts), and the Oregon State Hospital. Re-entry processes and services were not selected for work at this time. Committees provided recommendations on improving the system for persons who: do not need to be booked into jail; are cited and released by officers or booked for low level crimes; are booked for higher level crimes; or who need assessment or treatment by the Oregon State Hospital. (See Appendix F for a list of focus group members.)

Recommendations in this report will help develop more effective and humane ways to meet the needs of persons with a mental illness who have contact with the criminal justice system. Current budget difficulties only emphasize the need for a clear vision and structured steps to achieve the goal of fair and effective treatment for persons with a mental illness. Multnomah County, as part of its mental health redesign, has had a similar process that resulted in recommendations. Efforts made in children's mental health and cultural competency in the

system, and the availability of culturally specific services are particularly important to the outcomes of the criminal justice system.

This report provides detail as to the information obtained from each of the focus groups and their recommendations. The recommendations have also been placed in summary form for ease of reference. The report is divided into six sections: *Summary of Recommendations, Pre-booking Options, Post-Booking Options, Oregon State Hospital, Implementation Priorities and Responsibilities,* and an *Appendix*. There are recommendations that came out of each of the working groups, and are listed as themes.

Summary of the Recommendations

Themes – Recommendations Suggested by all Focus Groups

1. **Provide training on mental health** for law enforcement, judges, attorneys and parole/probation officers.
   a. Cover awareness of mental health issues, how the current mental health system works, how to interact to make it work better, available resources, and access to crisis services.
   b. Arrange for Continuing Legal Education credits (CLEs) for attorneys and others who attend this training.

2. **Improve information sharing and coordination** between the mental health and criminal justice systems for persons in crisis, to decrease the use of jails for detention and to increase diversion to services through the mental health system (rather than a person having to enter the criminal justice system to get services).
   a. Designate a point of contact for law enforcement persons within County Mental Health. Points of contact within each law enforcements agency should also be designated for County Mental Health and service providers.
   b. Contractually require each social service provider: to designate a person as liaison to the criminal justice community; to develop expertise in each agency; and to develop a list of criminal justice personnel to contact with questions, to learn about services, and to problem solve.
   c. Enable law enforcement officers to find out whether a person is being treated in the mental health system and has a responsible mental health provider or case manager, so that the officer can direct the person to these services instead of toward the criminal justice system. This would require 24/7 access to information and social service providers.
   d. Law enforcement officers need to be able to contact a probation officer 24/7. These probation officers need a high level of awareness of options available for persons in crisis with mental illness, so as to limit the use of jail detention just to get someone off the street and hold them until services can be found.
   e. County Mental Health should develop a plan to address complaints from the criminal justice system through their Quality Management team, with a goal of improving crisis avoidance and response.
   f. Improve coordination between the criminal justice community and developmental disabilities/brain trauma workers. Defendants who fall into this category often cannot get connected to the services that they need.

3. **Increase options for crisis assessment and placement.**
    a. Develop a secure treatment facility (such as a crisis triage center) as an absolutely necessary component of the local system.
    b. Develop mechanisms so that local hospital emergency rooms are properly staffed and able to deal with persons in a mental health crisis.

Recommendations for Pre-Booking Options

1. **Improve use of walk-in clinics.**
    a. Encourage use of these clinics.
    b. Provide clinics that are open 7 days a week, 24 hours a day.
    c. Create alternatives to police transports for Director's Custodies.
2. **Create alternatives for local transport of persons in crisis** who have not committed a crime, providing more appropriate transport while relieving police of this task.
    a. Research and implement a more cost-effective option with adequately trained personnel.
3. **Improve stability of persons with a mental illness** in the community.
    a. Assure adequate housing, food, employment, and access to family supports and services.
4. **Improve Crisis Response training.**
    a. Advocate with the legislature for DPSST to increase Crisis Response training requirements for officers (more than the current 4 hours, and up to 40 hours), and to add DPSST regional trainers to provide this training for all police agencies.
5. **Improve capacity within police agencies to utilize trained officers.**
    a. Create policies and operating procedures to support officers who are trained to assist persons in crisis and to assure that they are the officers dispatched to the scene.

Recommendations for Post-Booking Options

1. **Assure access to mental health services** throughout the criminal justice system for persons who need these services.
    a. Expand the mental health program to cover more of the existing defendants in Community Court.
    b. Expand the Community Court's mental health program to serve persons with non-Community Court eligible misdemeanors.

c. Inform judges of pre-sentencing assessment procedures, so there is not a need for a judicial order for a mental health assessment or mental health probation officer.

d. Reduce caseloads for mental health probation officers by: decreasing court-mandated assessment and supervision required of them; increasing capacity of the mental health system; and/or adding more probation officers.

2. **Advocate with Kaiser to pay for mandated treatment** for their enrollees. If needed, advocate with the legislature to require such coverage.

Recommendations for Improving Services from the State Hospital

1. **Improve access** to the Oregon State Hospital (OSH) for mandated services.

   a. Advocate with the Legislature to reinstate the 7-day limit (and possibly advocate for a shorter 72-hour limit) on the length of time someone who is unable to aid and assist can wait in a jail to get admitted to the State Hospital.

   b. Increase mechanisms to assure that OSH follows existing statutes.

   c. Explore options for billing OSH for transport for mandated services.

   d. Encourage judges to require that, as a condition of release from the State Hospital, a person be released to a community placement, not to the jail.

2. **Expand the use of local pre-trial evaluations.**

   a. Obtain and process a list of local doctors, approved by both the District Attorney's Office and the Defense Bar, to do evaluations. *(This is in process.)*

   b. Bill OSH for local assessments to avoid cost shifting to the local jurisdiction.

   c. If OSH will not pay, due to the benefits of fewer jail bed-days, fewer transports, speedier process, and more humane and fair treatment for the person in custody, local assessments should continue.

3. **Develop further options for stable housing** for persons with a mental illness, which include monitoring and wrap-around services.

Pre-Booking Options

The first focus group looked at options available to the police and those that could decrease the number of people that are booked in jail. Persons who would benefit from increased pre-booking options are those who come to police attention who have not committed a crime and persons who have committed a low level crime that does not require booking. Increased efforts prior to persons entering the system would include adequate community services and better coordination with mental health in order to divert adults with mental health issues from the criminal justice system.

Focus Group Discussion and Learnings

Changes in Mental Health Services

Multnomah County Mental Health and Addictions Services is undergoing a major redesign. Services for persons experiencing a mental health crisis include the following. (See also Appendix A. Current Status of Mental Health Systems)

- The County-operated **Call Center** is available 24 hours a day, 7 days a week, providing crisis intervention, as well as information, referral, and access to services for families, individuals, and the community. The Call Center can serve as a central point of contact for law enforcement officers, providing information and accessing crisis resources as needed.
- A contracted **Mobile Crisis Response Team** is available to respond on-site to a crisis 24 hours a day, 7 days a week.
- **Walk-in Clinics**, or other types of **no-appointment-necessary** services to meet urgent needs, are required from every primary mental health provider; currently four walk-in clinics are in place, operating at specific hours in high-need locations.
- **Primary Provider Case Managers** work with enrolled clients and families in mild crisis when there is not a foreseeable risk of harm to self or others. This is a community-based approach that helps individuals and families to resolve a crisis and learn to manage the circumstances that precipitated it.
- **Intensive Community Services** are a new County staff capacity intended to provide a safety net for high-needs clients and families not associated with an outpatient provider. Functions include treatment readiness, harm reduction, and short-term intensive case management to stabilize a person in preparation for transition to an outpatient provider.

The mental health system is also working to develop cultural competency in all County and provider services, as well as to develop culturally specific services to assure that differing racial, ethnic, gender and cultural needs are met.

The Call Center's role as the central point of contact for law enforcement officers needs further development. Officers are not all aware of how the new mental health system works, and so may not contact the Call Center. Call Center staff are not able to access information about whether a

person has a parole/probation officer or Community Justice system case manager and the data system does not yet contain information on all of the clients in the mental health system.

The new crisis options are not fully utilized. Most walk-in clinics are underused. Mobile response teams did not work well initially for police officers due to understaffing and start-up issues; officers lost confidence and a new educational campaign is needed. Officers continue to want a secure evaluation unit; the closure of the Crisis Triage Center has had a tremendous negative impact on their ability to deal with persons in crisis.

Coordination and Information Sharing

The lack of connection and information sharing with mental health is a barrier to diverting people from the criminal justice system. Crisis responders from both criminal justice and mental health cannot readily find out when a person is involved with the other system and has a parole/ probation officer, case manager, or treatment provider. Information that is public record should be shared; however, advocates fear that further collaboration may lead to abuses.

The new mental health "Raintree" database will improve interdepartmental coordination by allowing Call Center employees and Acute Care Coordinators in Multnomah County to be able to quickly locate information on a person's eligibility, primary provider, and history in the mental health system.

Police Response and Transport

When police are called to the scene of a mental health crisis, they may have the opportunity to transport people to a person's desired care facility, but officers do not all understand the current mental health system's options well enough to assist with this choice. In the case of a person needing an involuntary emergency psychiatric evaluation, the police will simply transport to the nearest hospital emergency room capable of performing this evaluation.

Many Multnomah County law enforcement, corrections, and parole/probation employees have received the *Portland Police Bureau's Crisis Intervention Team* (CIT) training. The CIT 40-hour mental health crisis response training, conducted by local area mental health professionals, family members, and consumers has continued to be a model for best practices in public safety response to people in crisis. Since 1995, 248 public safety or related professionals have been trained.

In 2001, Portland Police Bureau officers were called to transport 1,862 persons to a local hospital or mental health clinic for a mental health evaluation. Of these, 910 were under Police Custody for an involuntary evaluation under ORS 426.228, 175 were under Director's Custody for an involuntary evaluation under ORS 426.233, and 777 were Voluntary Assists where the person requested assistance and was transported to a treatment facility of their own choice.

Police are frequently called to walk-in clinics to transport a person to a hospital or mental health facility under a Director's Custody. Police transports for Police and Director's Custody means that a person is transported to care in the same manner as people who are arrested and

transported to jail. They are handcuffed (even when no crime has been committed), put in the back of a marked patrol car, and escorted to the various care facilities by an armed police officer. A more suitable transport system for people in mental health crisis, and who have not committed a crime, should be developed and would relieve patrol officers to spend time on other public safety issues.

Other transport options could be developed, such as:

1. Contract with a current secure transport provider who would: come to the scene, take custody from the Police, transport and remain with a client until the evaluation is complete, and return the patient to place of contact, or home if needed.

2. Develop and fund the Chiers transport provider to be able to fulfill the transport and custody mission on involuntary mental health custodies.

3. Create a new secure transport program. One concept would use off-duty peace officers partnered with trained consumers as two-person teams to fulfill the transport/custody function, providing better all-around care skills.

4. Contract with a local police agency to provide all transport, paying for appropriate police staffing; use less restrictive vehicles (i.e., not regular police cars) and have officers wear less uniform-like clothes.

State training requirements for employees of non-police agencies who can provide such transport are not adequate for preventing harm to the employees or the person being transported; training should be enhanced if any of these transport options are to be used.

Community Resources

There are too few placement options for a person with a mental health crisis. Even when a police officer contacts a person's probation officer for assistance with diversion, the probation office has few alternatives to detention in jail (where a person can be held for a maximum of 30 days). Inadequate housing, including a lack of long-term housing with supervision, also contributes to the number of people with a mental illness having contact with the criminal justice system.

Services are not always available to meet the needs of diverse cultures, and access to bi-lingual staff and an interpreter is sometimes difficult to arrange.

Training

All officers need enhanced Crisis Response training, as well as instruction on how the mental health system works. Agencies that do provide the training to their officers need to also have the appropriate protocols in place to support the officers' training.

The Portland Police Bureau (PPB) provides 16 hours of Crisis Response training in their advance academy; their Crisis Intervention Team (CIT) officers receive 40 hours of training.

The PPB's Crisis Intervention Team (CIT) Advisory Committee to the Chief of Police identified the need for training on the relationship between different cultures and the impact on someone in a mental health crisis. They suggested a cultural response panel be included in the 40-hour CIT training curriculum, which has been implemented. The Portland Police Bureau members have received general cultural sensitivity training during their annual officer in service trainings. Portland's CIT now appears to be the only one in the nation which self-identified the need for greater awareness in this area, and which has such training. The PPB CIT training curriculum has been provided to DPSST.

The State Department of Public Safety, Standards and Training (DPSST, which certifies Police Officers) requires and provides only four hours. More training is needed for officers across the state. DPSST should provide regional trainers to do in-house training for police officers. Within Multnomah County, PPB is one of six police agencies. PPB has trained many officers from the other police agencies; however, training through DPSST is still needed.

Recommendations for Pre-Booking Options

1. **Improve use of walk-in clinics.**
    a. Encourage use of these clinics
    b. Provide clinics that are open 7 days a week, 24 hours a day.
    c. Create alternatives to police transports for director's custodies.
2. **Open a secure evaluation unit.**
3. **Improve information sharing and coordination** between the mental health and criminal justice systems for persons in crisis, to decrease the use of jails for detention, and to increase diversion to services through the mental health system (rather than a person having to enter the criminal justice system to get services).
    a. Designate a point of contact for law enforcement persons within County Mental Health. Points of contact within each law enforcements agency should also be designated for County Mental Health and service providers.
    b. Require all mental health providers to designate a contact for police officers through provider agreements.
    c. Enable law enforcement officers to find out whether a person has a responsible mental health provider or case manager, so that the officer can direct the person to these services instead of towards the criminal justice system. This would require 24/7 access to information and social service providers.
    d. Law enforcement officers need to be able to contact a probation officer 24/7. These probation officers need a high level of awareness of options available for persons in crisis with mental illness, so as to limit the use of jail detention just to get someone off the street and hold them until services can be found.

e. County Mental Health should develop a plan to address complaints from the criminal justice system through their Quality Management team, with a goal of improving crisis avoidance and response.

4. **Create alternatives for local transport** of persons in crisis who have not committed a crime, providing more appropriate transport and relieving police of this task.
   a. Research and implement a more cost-effective option with adequately trained personnel.

5. **Improve stability of persons with a mental illness** in the community.
   a. Assure adequate housing, food, employment and access to family supports.

6. **Improve training** for officers, judges and attorneys in the criminal justice system.
   a. Advocate with the legislature for DPSST to increase Crisis Response training requirements for officers (more than the current 4 hours, and up to 40 hours), and to add DPSST regional trainers to provide this training for all police agencies. [The Portland Police Bureau has already developed a full and comprehensive curriculum that has been provided to the DPSST for such use.]
   b. Provide training for law enforcement, judges, attorneys, and parole/probation officers on mental health awareness, the current mental health system, available resources, and access to crisis services.
   c. Arrange for Continuing Legal Education credits (CLEs) for attorneys who attend this training.

Currently PPB trains officers from other jurisdictions in its CIT training. Jurisdictions who have trained officers need to develop necessary protocols and procedures to assure those officers are dispatched to the scene and supported.

Post-Booking Options

The second focus group discussed options for persons: who are in custody; who were booked and released; and who enter the court system and are cited and released for low-level crimes. Discussions about what is available to persons who enter the court system often centered around the types of crime people committed, and if the crime was committed *because* of factors relating to a mental illness (making the mental illness the treatment need) or if the person committed a crime and *has* a mental illness (requiring the criminality of the person *and* the treatment needs to be addressed).

Focus Group Discussion and Learnings

Community Courts

The Community Court is the main court for persons who commit non-person misdemeanor crimes. All misdemeanor crime and violations, with the exception of domestic violence and major traffic offenses, start out in Community Court for arraignment. However, only nonviolent, nonperson-to-person crimes are eligible for the Community Court program.

Of those persons who are eligible for the Community Court program, not all persons are able to receive mental health services, with those committing violations and some misdemeanors receiving lower priority. Those placed on the Mental Health Monitoring Program are followed for two to three months, with staff working as gatekeepers to services and other needs a person may have. The person reappears in front of the judge to discuss progress, with the case set over until the person completes the treatment plan.

A key role of the Community Court is to assist persons whose primary problem is with a mental health issue, not criminality. (See Appendix C, The Mentally Ill Defendant at Community Court, and D. Eligibility for Community Court and Mental Health Monitoring Program.)

Suggestions to serve more of the people with a mental illness who are involved with the criminal justice system include: expanding service to persons with misdemeanors currently not eligible for Community Court; and expanding the program to serve more of the Community Court defendants that are currently not entering the Mental Health Monitoring Program due to limited staffing.

All of the Community Courts have persons who connect and monitor people on the Mental Health Monitoring System. In one of the three courts (Westside Community Court), County Mental Health provides the staff for screening, linkage with resources, and monitoring. This employee also helps other partners (who are not County employees) do similar screenings at the other two courts. With anticipated Mental Health redesign improvements, this partnership should be duplicated. Such efforts prevent duplication within the criminal justice system to provide mental health coordination services.

People often misunderstand that a return appearance (more then one time) at Community Court means that the case will be discharged, not dismissed, and will thus show up on their record. Better communication is needed to prepare people for this outcome.

Portions of a Mental Health Docket Exist in the Clean Court and Community Court

In October of 2000, the working group identified the need for a Mental Health Court and suggested integrating a mental health docket into an existing court. Institutionalizing such a docket has not been fully completed. A portion of persons (those who commit non-person misdemeanor crimes) can be served through the Community Court, and others will soon be served in the Clean Court (persons with drug issues who can also be treated for co-occurring disorders). Both the Community Court and the Clean Court serve as excellent local examples of post-booking options for persons with mental illness. However, a significant percentage of persons with mental illness who enter the criminal justice system are not eligible for either Community Court or Clean Court. The need for a complete mental health docket still exists.

Department of Community Justice

Department of Community Justice (DCJ) services include: specialized mental health probation officers, transition services, and assessments.

- **Probation Officers:** Four specialized mental health probation officers have caseloads of about 60 people. They work to find structure for the person: in the community, from the family, or whatever may work for that individual based on their level of functioning. They help the person understand the court system and avoid further involvement. The goal is to help people become stable so they will not go back to jail, and to coordinate the multiple services people are involved with to assure they do not fall through the cracks.
- **At Intake:** A mental health screening and assessment at the intake process (jail) identifies offenders who have a history of mental instability/illness. Depending on the severity of the condition, an offender may be assigned to a regular or a mental health probation caseload. However, regardless of the caseload, if the offender is in need of services, they will be referred. Depending on the severity of the offender's criminal behavior, their current mental status, and resources available, offenders may be referred for services DCJ contracts from community providers. However, DCJ's first choice is to access services through the County Mental Health system.
- **Transition Services:** The Department of Community Justice provides various transitional services to offenders who are moving from prison, jail, or treatment, and returning to the community. These services include pre-release planning occurring within the prisons; centralized intake processing and referral; transitional support services for special need offenders, sex offenders, and gang offenders; and emergency, transitional, and permanent housing for offenders. [Please see Multnomah County Department of Community Justice Adult Offender Transitional Services APPENDIX D for more information on these services.]

Specialized District Attorneys, Judges and Defenders

There are regular assignments for civil commitments, and to the Community, STOP and Clean Courts; these attorneys and judges obtain a higher level of knowledge than others. Certain legal assistants and sentencing advocates in the Public Defenders office have a high level of knowledge and often recommend resources for people. There is, however, no system-wide training.

Accessing Mental Health Services within the Traditional Courts

- **Assessments Post-Conviction:** All persons who are sentenced to a crime and will be under the supervision of the Department of Community Justice are assessed. It is not necessary for the judge to order supervision by a mental health probation officer. If a mental health probation officer is not appropriate, the judicial order prevents shifting to a more appropriate caseload.
- **Bench Probation:** A person put on bench probation in the traditional court system (where the judge monitors and develops a one-on-one rapport with the person) does not have ready access to intensive case management or services. Only if the person commits a drug offense or goes through the Community Court will they likely be connected to services and monitored for success.
- **Awareness:** It is difficult for the Court to know that a person has a mental health issue without a past record of assessment and treatment. A self-report to the public defender cannot be easily shared with the Court, unless the defense presents a treatment option.

Coordination and Information Sharing

If information about participation in the mental health system were available to the criminal justice system, a defendant could be referred back to mental health instead of creating a duplicate system in criminal justice, or failing to meet a person's treatment needs due to a lack of knowledge. Court coordinators or "boundary spanners" are particularly helpful. The court coordinators in the Community, STOP and Clean Courts are key to these courts' success. However, persons with mental illness and addiction issues are in all of our courts, and many persons in need are not within the reach of the current court coordinators. The question is how to integrate a "boundary spanner" into the court system so that there are not such large gaps in who gets connected with treatment.

Training

More knowledge about mental health issues, treatment options, what to expect from the mental health system and how to connect with it, would be helpful for District Attorneys, defenders, judges and probation officers.

Private Treatment Coverage

There is concern that Kaiser will not pay for mandated treatment. This leaves government to cover the costs of persons mandated for treatment, who need such treatment, even though they have private insurance coverage.

Recommendations for Post-Booking Options

1. **Assure access to mental health services** throughout the criminal justice system for persons who need these services.
    a. Expand the Community Court's mental health program to serve persons with non-Community Court eligible misdemeanors.
    b. Expand the mental health program to cover more of the existing defendants in Community Court.
    c. Inform judges of pre-sentencing assessment procedures, so there is not a need for a judicial order for a mental health assessment or mental health probation officer.
    d. Reduce caseloads for mental health probation officers by decreasing court-mandated assessment and supervision by a mental health probation officer, increasing capacity of the mental health system, and/or adding more probation officers.

2. **Improve coordination and share information** between community justice and mental health.
    a. Enable the criminal justice community to know a person is being treated in the mental health system, and connect persons to mental health services through the existing mental health system and current providers.
    b. Contractually require each social service provider: to designate a person as liaison to the criminal justice community; to develop expertise in each agency; and to develop a list of criminal justice personnel to contact with questions, to learn about services, and to problem solve.
    c. Improve coordination between the criminal justice community and developmental disabilities/brain trauma workers. Defendants who fall into this category often cannot get connected to the services that they need.

3. **Develop training** regarding County Mental Health redesign, current services and mental health issues; obtain Continuing Legal Education (CLEs) for attorney attendance.

4. **Advocate with Kaiser to pay for mandated treatment** for their enrollees. If needed, advocate with the legislature to require such coverage.

Oregon State Hospital

Judge Julie Frantz has been involved for some time in improving Multnomah County's ability to streamline processes as they relate to the Oregon State Hospital. When there is a question as to whether a person can Aid and Assist in their own trial, the State of Oregon, through the Oregon State Hospital, is responsible to assess the person to see if in fact they cannot. If it is determined that the person cannot Aid and Assist, then they are required to get treatment until they are able to assist in their own defense; this is called *Treat Till Fit*. In these two areas – Aid to Assist and Treat Till Fit – the Oregon State Hospital, by law, has a responsibility and jurisdiction over the defendants. Persons who are in need of such assessments and treatment cause the most concern, as their condition often deteriorates in the jail and they are in most need of treatment and care.

Focus Group Discussion and Learnings

There are long delays in receiving required assessment and treatment support from the Oregon State Hospital (OSH). Delays in OSH admissions result in longer jail placement than necessary, with associated costs and negative effects on the person with a mental illness as well as on other inmates. Lack of proper treatment and lengthy detention in a jail setting can cause a person's condition to worsen. Jails were never designed with the intent of being a mental health treatment center.

OSH has told Multnomah County that the County is over-utilizing the State Hospital, because Multnomah County has 20% of Oregon's indigent population, but uses 40% of the hospital beds. There has been no assessment of this use, which could be due to Portland's urban nature, or a preference to not jail people who have a mental illness that causes them to need treatment.

Persons who need assessment or treatment from the Oregon State Hospital (OSH) include:

1. **Persons needing assessment pre-trial**

   People ordered for assessments to see if they can Aid and Assist in their own defense may wait for up to 240 days; Oregon Revised Statutes (ORS) require an evaluation within 30 days. It takes only one day to complete an evaluation (including transport time to Salem). Transport requires seven hours of corrections officer time to take a person to OSH and return the same day, at a cost of $400.

   Based on an agreement made in Multnomah County two and a half years ago when trying to address this ongoing crisis, the judge now receives an assessment summary via a telephone message, which is three to four minutes long. The attorneys are informed when the summary is available; they have 24 court hours to listen to the summary, after which a court date and disposition are set.

   Multnomah County has arrangements with three local doctors to do assessments, which result in a quicker assessment and lower transportation costs. However, this shifts costs from OSH to the State Indigent Defense Fund. The authorized doctors are now over-booked, with assessments being booked as much as three months in advance. If the individual eventually requires admission to the State Hospital, it is perceived that it is

better to have OSH do the assessment; OSH often does not accept the local assessment, and does another one, sometimes with differing results. The court ruling is not binding for the State Hospital.

2. **Persons deemed unable to aid and assist in their own defense, who are under the jurisdiction of the State Hospital to treat until fit until they can stand trial**

   In 2001, 32 individuals were court-ordered to OSH, to be treated until they were mentally competent to proceed in trial; the average time from court order to transport was 31 days, with 50% staying in jail more than 28 days after the order was received, and with the longest jail stay 111 days. Statues required transport to OSH within seven days (this requirement sunsetted last year and was not reinstated). This results in a cost for continued jail detention; the cost for jails to provide daily voluntary medications (the jail cannot require a person to take medication); the deterioration of a person who is housed in jail in need of treatment; and risk of safety to staff, the defendant, and other inmates. Of greatest concern are the deterioration of the person and the safety risks.

   Once a person is admitted to OSH, they are not regularly evaluated as to whether they are ready to aid and assist in their trial; thus people stay in OSH longer than needed. Also, the processing of paperwork is very slow, so people stay there much longer then needed.

3. **Persons who are guilty except for insanity and are to be treated at the State Hospital.**

   Similar delays occur in admission for persons needing longer-term treatment.

Recommendations for Improving Services from the State Hospital

The goal of these recommendations is to decrease the time that people are in jail waiting for assessments, treatment, transport and admission to OSH, or to return to the community.

Desired outcomes are: for the State to follow existing statute; to increase awareness within the legislature of these issues; to reinstate legislation that sunsetted; to decrease the delay for transport and admission to OSH for required services; to increase the speed of processing of paperwork; and to increase the speed for release from the state hospital.

1. **Improve access** to the Oregon State Hospital for mandated services.
   a. Advocate with the Legislature to reinstate the 7-day limit (and possibly advocate for a shorter 72-hour limit) on the length of time someone who is unable to Aid and Assist can wait in a jail to get admitted to the State Hospital.
   b. Increase mechanisms to assure that OSH follows existing statutes.
   c. Explore options for billing OSH for transports for mandated services.
   d. Encourage judges in cases where a community setting might be appropriate to include in a judicial order that, as a condition of release from the State Hospital, a person can be placed in the community under supervision, not in jail, as they wait for trial.

e. More available beds through OSH are needed. Options to reach this recommendation could be accomplished by better turnaround, better processing of paperwork, and expanded state or local community treatment options; if the system cannot work more efficiently, then OSH should add more beds.

f. Full staffing at the State Hospital is needed, with adequate pay for employees who work there and who perform assessments.

2. **Expand the use of local pre-trial evaluations**.

   a. Obtain and process a list of local doctors, approved by both the District Attorney's Office and the Defense Bar, to do evaluations. [This is in process.]

   b. Bill OSH for local assessments to avoid cost shifting to the local jurisdiction.

   c. If OSH will not pay, due to the benefits of fewer jail bed-days, fewer transports, speedier process, and more humane and fair treatment for the person in custody, local assessments should continue.

3. **Increase options for crisis assessment and placement.**

   a. Develop a secure treatment facility (such as a crisis triage center) as an absolutely necessary component of the local system.

   b. Develop mechanisms so that local hospital emergency rooms are properly staffed and able to deal with persons in a mental health crisis.

   c. Increased capacity for the existing service providers is needed.

4. **Provide training** on how the mental health system works, and how to interact to make it work better.

   a. Obtain Continuing Legal Education credits (CLEs) for attorneys and others for attending.

5. **Increase communication** between the criminal justice and mental health systems.

6. **Develop further options for stable housing** for persons with a mental illness, which include monitoring and wrap-around services.

Implementation Priorities and Responsibilities

This report will be released at a conference on May 15, 2002. Some of the recommendations will be the focus of that day, such as court coordination, information sharing between the systems, and communication between front line workers. The outcomes of the conference and this report will assist the Persons with Mental Illness in the Criminal Justice System Working Group that is part of the Local Public Safety Coordinating Council, in staying focused, prioritizing, and making a work plan to meet the recommendations.

As is clear in the report, there are some recommendations, such as those pertaining to the State Hospital, that are largely out of the control of the leaders in Multnomah County. The elected officials can advocate for changes at the state level. Also, there has been continued coverage in the local newspapers on this issue.

One of the most important efforts that is underway is to get the front line employees of the police, sheriff, parole and probation, and county mental health and service providers together to begin to redefine their expectations of one another, create communication loops, and to institutionalize processes that allow for successful transition plans.

The Working Group will use these recommendations and the subsequent feedback to develop its priorities and work assignments.

Appendices

A. Current Status of the Multnomah County Mental Health System, April 2002

B. The Mentally Ill Defendant at Community Court

C. Cases eligible for Community Court and the Mental Health Monitoring System

D. Multnomah County Department of Community Justice Adult Offender Transitional Services

E. People Who Participated in the Focus Groups

F. Report on – Options for Persons with Mental Illness in Multnomah County's Criminal Justice System, October, 2000

Current Status of the Multnomah County Mental Health System

April 2002

Many changes are occurring in the mental health system during the upcoming year will create a different situation for police who come into contact with persons who are mentally ill.

I. Community Outreach

There is a need for more community outreach to get people treatment prior to a situation escalating to the point where an officer gets involved. The sooner the mental health system can intervene the better. While the concept is agreed upon, the practice will have to be expanded and improved upon over the next few years. This is simply because of the time it takes to recruit and retain the numbers of community-based staff necessary to make the system able to respond rapidly to any neighborhood in the county.

There are many kinds of community outreach services planned for the Multnomah County Mental Health system. These include outreach through providers and partner agencies (such as the Health Department and Community Justice), and streamlining entry into services at the point where a person makes their initial contact.

II. Call Center

The Call Center has been a priority for development, and is now working 24/7, integrating functions of a crisis line, information and referral, and member services.

The County-operated Call Center is the hub of the system, the place where the community-based components are coordinated. With one number, the community has access to mobile outreach, home based stabilization, acute care coordination, information and referral services, complaint reporting, and all aspects of information about the mental health system.

III. Crisis System

Components of the psychiatric crisis system are now in various stages of planning and implementation. The core of the mental health redesign plan is a shift of the main service elements, crisis care included, to a community-based model.

There will be three basic types of clinical teams responsible for community-based interventions for people in crisis.

A. The 24-Hour Mobile Crisis Service

While this team is understaffed at present, it is available. This team can be dispatched from the Call Center. It is for:

1. People who are unknown to the mental health system, who are perceived to be in crisis due to a possible mental disorder, and who cannot or will not come to a mental health center facility for screening or assessment.

2. Crises involving enrolled individuals or families that may involve the danger of harm to self or others, or could reasonably be foreseen to escalate to that level.

3. Outreach to anyone whenever called by law enforcement or emergency room staff.

This list is to be expanded over time as protocols are developed and training occurs with other agencies.

B. Primary Provider Case Managers

These case managers provide numerous types of community based mental health care, including work with people in mild crisis. Like the other elements of the crisis system, this group of case managers is only intermittently available, as this capacity will need to be built over the next few years.

As far as their crisis role is concerned, they will do the outreach to enrolled individuals and families in crisis when there is not a foreseeable risk of harm to self or others. Examples:

1. An eight-year-old child refuses to get into car for appointment to see therapist, prefers to watch TV, and remains on the couch. The foster parent becomes angry and calls mental health center for help.

2. A man misses an appointment for a medication refill and is reported to "not be taking care of himself again" by his brother.

The community-based approach to case management is all about empowering individuals and families to manage the circumstances that precipitated the crisis. The resolution of the reason for the call out thus becomes a vehicle for parenting skills, stress management, and other skill development.

C. Intensive Community Services

The new provider contracts support intensive-case management of high needs clients and families. Yet the model does not assign all consumers to a provider and some people choose to have nothing to do with any provider of mental health services. The County is creating a new capacity called *Intensive Community Service*s, which will take on a number of roles including some aspects of the crisis system.

The purpose of the Intensive Community Services Team is to serve the community with a kind of safety net for clients and families who, for whatever reason, may not be associated with an outpatient provider, but who could benefit from, or clearly need mental health services and support.

Part of the role of this team will be associated with work that has been called "treatment readiness" or "harm reduction." This means that these outreach services can be focused on those consumers involved with other social service agencies, or who are in the community, who are not ready to avail themselves of mental health care, even though those who know them feel that they should.

As noted above, the Mobile Outreach Team will be available for those in crisis, by which we mean experiencing a mental health problem or situation that might rapidly deteriorate into an emergency. Also, case managers with the Primary Providers are available to work in the community with their caseload of clients and families who are open in treatment with their agency.

Intensive Community Service staff work with people in neither category (i.e., those people who are not in treatment with any agency and whose need for community-based services do not rise to the level of an emergency). These teams will carry small, temporary caseloads where intensive effort toward establishing safe disposition and removing access barriers of any kind is the goal.

IV. Walk-In Clinics

Walk-In Clinics are also an important resource. The four clinics currently in operation offer no-appointment-necessary services for persons who identify a need for immediate assistance. A person does not need to be an ongoing client enrolled in mental health services to receive screening and initial services at a walk-in clinic.

This option can support people who have difficulty keeping appointments or who have urgent needs that cannot wait for a scheduled appointment. It is also appropriate for a person with a mild crisis, even if they have no history with the mental health system.

Present Status

Right now, those persons without primary providers are taken to the emergency rooms of hospitals, or the Mobile Crisis Team is called and arrives if and when it can. This is because the other elements of the crisis system are under construction.

The Call Center (crisis line) is now working 24/7, and can be a resource for officers. The call center should work as the point of contact into the system for officers. Information needs to be available regarding if the person in crisis has a case manager or parole/probation officer.

The next important change will be the availability of the Intensive Community Service teams. Because police transports for emergency holds have been decreasing, the focus of development

will continue to be on reaching people before acute crises occur and offering effective alternatives to hospitalization.

People who have difficulty making scheduled appointments can get lost – currently there is little or no follow-up. But the system is moving to a "no appointment necessary" approach as one method to combat this problem.

The walk-in clinics are still underutilized. The community in general, and consumers and families in particular, need to be educated regarding walk-in clinics. These efforts, called "Social Marketing" nowadays, are part of the destigmatization of mental health care in general.

Police and others need to be educated on what they can expect from the system, as many things have changed.

The Defendant with Mental Illness at Community Court

Since the Westside Community Court opened in April of 2001, all three Community Courts have been addressing the needs of defendants with mental health issues through the "mental health monitoring program," administered by Heidi Grant, PhD.

I. Structure of The Docket

Defendants with cases in Community Court who have been identified as having mental health problems are either connected with mental health services or are monitored to ensure compliance with their existing treatment. Defendants with mental health issues are identified through the initial intake interview, by the judge, by the attorneys, or by law enforcement.

Defendants with identifiable mental health issues are connected to local treatment providers and are monitored while their cases are before the court. For a defendant who is already participating in mental health treatment, the court's social service staff obtains a signed release, and the defendant is monitored until his case is terminated.

II. Caseload

Defendants in the court's mental health program are typically supervised for an average of two to three months. During this time, the social service staff work with treatment providers to ensure that the defendants are fulfilling their obligations and report to the court on their progress. If a defendant has complied with all court-ordered obligations, the defendant is terminated from the program as "successful" and the case is dismissed. A defendant who does not complete his/her obligations – or who is having trouble following the court's orders – is brought back before the court to address the defendant's problems. A defendant who is ultimately unable to comply with the court's orders "fails" the program and is terminated with a conviction and receives the previously agreed upon jail time. Defendants who need additional time to comply with the court's orders after the initial further proceeding date remain "under supervision."

The following chart breaks down the mental health cases handled by the court's mental health monitoring program since its inception.

AREA	SUCCEED	FAIL	UNDER SUPERVISION	TOTAL
West	25	14	17	56
E/SE	16	6	11	33
N/NE	14	10	8	32

III. Limitations of the Current Structure

There are a number of limitations on the current system that have prevented the court from serving all mentally ill defendants at the court. Because one person is currently handling a majority of the caseload, not every defendant who comes to court is screened for mental health issues. Additionally, only the most serious mental health cases that come through community court are monitored and connected with treatment. Defendants who are already connected with a service provider and defendants charged with a violation are often not monitored.

IV. Expanding Community Court's Mental Health Program

There are a number of ways that Community Court's mental health docket could be expanded to meet the needs of all mentally ill defendants who come through the court. Many of these are already being pursued in a limited capacity. They include:

- **Handling non-Community Court eligible misdemeanors through Community Court's mental health program.** By allowing defendants who have been charged with non-community court eligible offenses, and have decided to plead guilty, to enter their plea in community court we can use the existing mental health resources available at the court to monitor defendants on bench probation and ensure they are compliant with court-mandated conditions.
- **Increasing the referral network to ensure that all cases get to the court.** By ensuring that the jail, Multnomah County Circuit Court judges, defense attorneys, prosecutors, and supervising agencies such as Close Street Supervision are all aware of the court's existence, more can be done to ensure that defendants with mental health issues are properly routed to community court.
- **Increase screening/monitoring of existing defendants.** An increase in the number of mental health staff would increase the number of defendants who can be screened and monitored and would enable the court to engage in more comprehensive monitoring of defendants already before the court.
- **Expanding existing partnerships.** By utilizing existing partnerships with parole/probation and PPB, the court can ensure that the most effective treatment plan is developed for the defendant.

Cases Eligible for Community Court and the Mental Health Monitoring Program

ELIGIBLE CASES:

1. Misdemeanors and misdemeanors treated as violations (i.e., Theft III) are eligible for Community Court when they occur in a precinct served by a Community Court.
   a. Eligible misdemeanor offenses include:

      Criminal Mischief II & III; Disorderly Conduct; Drinking in Public/Open Container; Misdemeanor Drug Offenses; Failure to Appear; Forgery II; Fraudulent Use of Credit Card; Furnishing Alcohol to Minor; Indecent Exposure; Interfering with a Peace Officer; Interfering with Pedestrians; Noise Offenses; OPDR Referrals; Obstruction of Public Sidewalk; Offensive Littering; Prostitution, Unlawful Procurement Prostitution Activities; Tampering with Evidence; Theft II & III; Trespass I & II; Unlawful Application of Graffiti; Unlawful Vending.

   b. All traffic misdemeanors and violations (infractions) that have an accompanying non-traffic misdemeanor arising out of the same transaction or criminal episode may be Community Court eligible (i.e., DUII plus a trespass).

2. Violations by law (i.e., MIP, < 1oz. Marijuana) are Community Court eligible and will be cited, arraigned and resolved in Community Court.

INELIGIBLE CASES:

1. Cases involving a domestic violence charge will not appear at Community Court.

2. Persons who are registered sex offenders will not appear at the North/Northeast or Southeast Community Courts. Registered sex offenders from any Community Court catchment area may be cited to and appear at the Westside Community Court.

3. Cases involving a major traffic offense charge or violation that are not otherwise associated with a Community Court charge arising out of the same transaction or criminal episode will not be Community Court eligible (i.e., DUII or Hit and Run standing alone or only accompanied by traffic violations (infractions)).

4. Felonies.

5. Cases where egregious circumstances relating to the defendant's conduct or record are present at the time of issuing.

6. Cases where the defendant has failed to appear at Community Court two times after his or her first appearance on the underlying charge.

Multnomah County Department of Community Justice
Adult Offender Transitional Services

I. The Need for Transitional Services

Every month about 200 offenders return to our communities from prison, jail or treatment facilities. While the average length of stay in Oregon prisons is three to four years, Measure 11 continues to increase that length of time.

The first 90 days following release are the highest risk time for relapse to criminality and/or addiction. Roughly 17% of offenders have severe mental illness, and 80% have a history of drug or alcohol addiction. Currently, 75% of the prison population has been convicted of committing a crime against a person.

Ninety-five percent of prison inmates return to their original communities. In many cases, during their incarceration, an inmate's living arrangements, significant relationships and job situations have disintegrated. It is not uncommon for recently released offenders to have only temporary living arrangements or to be homeless. Recently released offenders often have no financial reserves.

II. The Research

Best practices, combined with research data, clearly indicate the need to provide case management, safe and secure housing, assistance with employment, aftercare and ancillary services for those offenders transitioning into our communities.

A recent statewide study indicates that criminal activity decreased by approximately 40% with stable housing and supportive supervision.

III. Transitional Services in Multnomah County

The Multnomah County Department of Community Justice works with system partners to enhance the continuum of transitional services available to offenders transitioning from prisons to the community. This continuum of services includes: pre-release planning occurring within the prisons; centralized intake processing and referral; transitional support services for special need offenders, sex offenders and gang offenders; and emergency, transitional, and permanent housing for offenders.

A. Pre-Release Planning (Reach-in)

- **Work collaboratively with the state prison system** to: identify targeted inmates; collect diagnostic, treatment, and criminal history information; and provide intensive pre-release case planning and transitional support 120 days or more prior to release. Targeted inmates include predatory / high risk sex offenders, gang offenders, African American offenders, MRDD, low-functioning adults, medically disabled offenders, offenders with mental health disorders, and elderly offenders.
- **Interview offenders and meet with institutional counselors** to collect information on targeted offenders. This information is subsequently used during the intake process to determine the appropriate placement of the offender upon release.
- **Develop transitional plans** that are appropriate for the risk and needs of the offenders and which include an array of community services including housing, mental health services, and substance abuse assessment. Plans are finalized 30 days prior to release.
- **Conduct visits with gang offenders** 30 days prior to release to finalize re-entry plans. Parole / Probation Officers, accompanied by a law enforcement officer and an outreach worker, visit gang offenders to emphasize the interagency collaboration and the importance of post-release surveillance, law enforcement response, and available resources for gang-affiliated youth.
- **Conduct visits with high-risk sex offenders** to develop conditions of supervision that meet the safety needs of the community, arrange for access to appropriate services and treatment within 48 hours of their release, and develop plans for community notification when appropriate.
- **Provide a system orientation for family and friends of offenders** within six months of an offender's release from prison. This program is currently under development and will provide an orientation to the supervision system, including five to six weeks of programs, such as resource and referral information, traumatic incident reduction, housing options, victim advocacy, and parenting.

B. Centralized Intake and Referral

- Receive all new probationers and those offenders coming directly from jail or prison.
- Orient to probation and parole supervision expectations.
- Conduct intake and needs assessment with all offenders.
- Refer offenders for full A&D assessment, services and/or treatment.
- Refer offenders for employment and educational services.
- Match offenders with Parole and Probation Officers.
- Report to the court regarding service referrals for low and limited offenders.

C. Transitional Services

- **Provide support, case management and housing resources** to assist targeted offenders in their successful reintegration into the community from jail, prison or treatment.
- **Support all offenders in transition** by providing services and referrals to meet their immediate needs and connect them with services to meet their long-term needs. Services and referrals include medical, mental health, housing, transportation assistance, clothing, food, and Oregon Health Plan application.
- **Visit gang offenders** in their homes within the first week of their release. A Gang Unit Parole / Probation Officer, accompanied by a law enforcement officer and an outreach workers visit the gang offender in the home to enforce conditions of probation and re-emphasize the interagency collaboration.
- **Manage high-risk sex offender cases** during their first six months following release. The Parole / Probation Officer (PPO) assigned to sex offender re-entry provides intensive case management to these offenders for this time period, monitors the offender's participation in appropriate services and treatment, and assists with the coordination of community notification.
- **Conduct *Daily Solutions* groups** for offenders with mental health issues who are in transition or crisis, providing an opportunity every morning for daily check-in, breakfast, and service referral.
- **Refer non-targeted offenders** whose incarceration period was greater than 12 months to the Day Reporting Center for highly structured and intensive stabilization, substance abuse treatment groups and urinalysis testing.
- **Provide educational assistance**, including basic skills, life skills and GED instruction through the Londer Learning Center.
- **Provide a continuum of alcohol- and drug-free housing options** for offenders to assist in their successful integration back to the community:
  - The County recently completed a planning process in collaboration with Central City Concern to manage 60 additional units of downtown housing.
  - The Department has, in collaboration with Network Behavioral HealthCare and the City of Portland's Bureau of Housing and Community Development, obtained a cooperative Housing First grant to assist 20 shared clients each year in obtaining and succeeding in permanent housing.
  - The Department contracts with local housing providers for an additional $1.1 million dollars in emergency, transitional and long-term housing options for offenders.
  - The Department is working to develop permanent group housing for MRDD and / or mentally ill offenders.

IV. Needs/Barriers

The following are the chief barriers that offenders face:

- 75 to 80 percent use or have used an illegal substance (data from random drug tests)
- Lack of education and job skills
- A criminal record
- Many offenders are unable to maintain employment due to the lack of safe and secure housing.

Criminal history in itself is a key barrier for offenders accessing safe, secure, and affordable housing. Even if an ex-offender has the ability to pay rent, a tenant background check by the landlord often screens out the ex-offender. Additionally, without the benefit of transitional housing, it is almost impossible for an offender to work on obtaining the necessary credit and rent payment history necessary to live independently and maintain permanent housing.

These individuals are at high risk of homelessness and recidivism. Affordable housing, and for some, supportive housing that is drug-, alcohol-, and crime-free is critical if treatment and services are to be effective in assisting the offender to integrate successfully into the community.

Working Group on Persons with Mental Illness in the Criminal Justice System and the Focus Groups

Members of the Local Public Safety Coordinating Council Persons with Mental Illness in the Criminal Justice System Working Group (WG) and persons who participated in the focus groups – Pre-Bookings (Pre), Post-Bookings (Prost), and State Hospital (OSH) – are given below. (LPSCC stands for the Local Public Safety Coordinating Council.)

Name	Organization	WG	Pre	Post	OSH
Heather Ackles	**Metropolitan Public Defenders**		x	x	x
Frances Baker	National Alliance of the Mentally Ill	x			x
Dr. Bigelow	Or. Health Sciences University	x			
Darcy Bjork	Multnomah County Sheriff's Office	x			
Kevin Bowers	Department of Community Justice			x	
John Bradley	Senior Deputy District Attorney	x	x	x	x
Rebecca Child	Advocate	x			
Charlotte Comito	Commissioner Naito's Office		x	x	x
John Connors	Metropolitan Public Defenders	x	x	x	x
Peter Davidson	Office of Mental Health and Substance Abuse	x	x		x
Judge Jim Ellis	Presiding Judge	x			
Judge Julie Franz	Chief Criminal Judge	x		x	x
Joanne Fuller	Department of Community Justice	x			
Heidi Grant	Department of Community Justice	x		x	
Robyn Gregory	District Attorney's Office			x	
Cliff Jensen	Portland Police	x			
Bob Joondeph	Oregon Advocacy Center	x		x	
Judge Dale Koch	Presiding Judge as of April 1, 2002	x		x	x
Ethan Knight	District Attorney's Office	x	x		x
Frederick Lenzser	District Attorney's Office	x			
Kathleen McCullough	Sheriff's Office	x			
Bill Midkiff	Corrections Health				x
Pam Mindt	Department of Community Justice			x	x
Commissioner Lisa Naito	Co-Chair; Multnomah County	x	x	x	x
Valerie Owen	Sheriff's Office	x		x	x
Dale Rector	Advocate	x			x
Ed Riddell	Portland Police Bureau, Crisis Intervention Team	x	x		
Carol Wessinger	Commissioner Naito's Office/ LPSCC		x	x	x
Kathy Wilt	Oregon Advocacy Center				x
Christine Kirk	LPSCC		x	x	x

Options for Persons with Mental Illness in Multnomah County's Criminal Justice System

October 2000

I. Alternative Dispositions for Persons in Crisis

Person has come to the attention of the police and may or may not have committed a crime (*e.g.,* person is on the street and yelling at others for no specific reason).

Responding police officer may:

- Respond and take no specific action (i.e., choose not to make an arrest, tells person to "move along");
- Defuse situation by using specialized skills acquired in Crisis Intervention Training or other like training;
- Call mental health response service (e.g., Mobile Outreach, if mentally ill; treatment provider, if known; the Chiers project, if intoxicated); or
- Use skills acquired through specialized training to refer person, and/or family and friends of subject, to appropriate social services.

Recommendations:

1. Expand community-based services for referrals (i.e., Urgent Care, shelters, round the clock mental health drop in centers, alcohol and drug treatment, etc.).

2. Streamline referral processes.

3. Develop a database that would allow officers to access certain information to assist with problem solving, referral and care, such as information regarding caseworkers and/or PO etc., subject to current confidentiality restrictions and availability of services.

4. Enhance Crisis Intervention Training for public safety officers.

II. Pre-booking (Non-Criminal) Alternative Dispositions for Persons in Crisis

Person poses an immediate danger to self and others warranting a civil police hold (e.g., person threatens suicide).

Responding officer may transport person to Crisis Triage Center, or other hospital, if diverted from CTC.

Recommendations:

1. Increase Crises Triage Center's capacity to shorten wait time to be seen for evaluation, treatment and referral.

2. Increase referral options (better access to acute care hospital beds, more sub-acute facilities, or crisis respite facilities).

3. Following hospitalization, sub-acute placement, or crisis respite placement, increase follow-up referral services (i.e., housing, transportation, alcohol and drug services, community-based services).

Note: All three of these recommendations have also been made in the Crisis Team Work Group report to the Design Team.

III. Non-Custody Alternative Dispositions for Persons in Crisis Who Are Issued a Citation for a Misdemeanor Crime

Responding officer may:

- Transport person to Crisis Triage Center or other hospital if diverted from CTC; or
- Make referral to social services.

Recommendations:

1. Increase Crises Triage Center's capacity to shorten wait time evaluation, treatment and referral.

2. Increase referral services.

3. Implement Mental Health Court docket program (particularly for those defendants who fail to appear on the misdemeanor citation). [See IV.2 below]

IV. Alternative Dispositions for Persons in Custody, Who Have Committed Non-Violent Offenses

These include: all misdemeanors, excluding domestic violence, or a non person felony for which the presumptive sentence under sentencing guidelines is not a penitentiary sentence; person has no pending person felony charges, and is not currently on post prison supervision or probation for a person felony.

Currently, all inmates are assessed by corrections health for all health related matters and corrections classification for a determination as to appropriate treatment and housing based on

individual needs and circumstances. For persons with mental illness, there is an extensive and system-wide protocol in place for care and treatment.

Recommendations:

1. A joint team approach as to evaluation of mental health status by corrections health, corrections classification unit, and specially trained recognizance officers for a more immediate determination of mental health status and recommendations which can be conveyed to the Criminal Court, District Attorney's Office, and Defense Bar by the time the defendant makes his/her initial appearance.

2. Referral to Mental Health Court Docket (if defendant meets criteria for acceptance). A defendant may opt in or out of the Mental Health Court program (when and if the defendant has the mental capacity to make such a decision). [Refer to VII. below.]
    a. If opting in, a treatment plan will be implemented by a team which includes an identified judge, caseworker, public defender, district attorney, court coordinator, Corrections Health, Sheriff's Office, and Community Justice personnel, which will divert the person from custody to community-based treatment programs with community oversight and supervision provided by an interdisciplinary case management team. The treatment plan would be flexible and adapted to the individual conditions and circumstances presented by the defendant. It may include secure residential in-patient treatment or a day program, electronic monitoring, etc.
    b. If opting out, the defendant will proceed through the regular criminal court process.

V. For All Persons in Custody Not Addressed in Sections I-IV Above

Currently, all defendants charged with any level of crime may be considered by the criminal court for pre-trial release.

Recommendation:

For defendants whose sentence includes probation, post-prison supervision or probation, it is recommended that there be Community Justice supervision with a dedicated team of specially trained probation officers, with reasonable officer-to-client ratios, with attached dedicated services (i.e., local services, day treatment, adequate housing, job referral and placement, accessing entitlements, etc.).

VI. For Adjudicated Persons Currently Serving Post-Prison Supervision

See above recommendation.

VII. Person is Unable to "Aid and Assist" and is Transferred to the Oregon State Hospital under a "Treat until Fit" Order from the Court

This is applicable to any defendant for any criminal charge.

Recommendations:

1. Streamline the aid and assist court referral process.

2. Increase the number of local evaluators and shorten the time between referral for evaluation and final evaluation report.

3. Increase the number of available beds for treatment at the Oregon State Hospital level.

4. Create a mechanism for access to emergency (crisis) level of care to meet treatment needs of acutely ill persons.

VII. Persons Who Are Adjudicated Guilty Except for Insanity

These individuals may be placed under the supervision of the Psychiatric Secure Review Board (PSRB)

Recommendation:

Increase the number of treatment providers and the capacity for community placement.

Further Recommendations

1. As the group did not address the needs of juveniles with Mental Illness in the Juvenile Justice System, it is recommended that a group be formed to develop recommendations for this population.

2. This group should continue to meet to calculate the necessary resources to implement the recommended mental health and criminal justice system changes and identify potential sources of new and existing revenues.