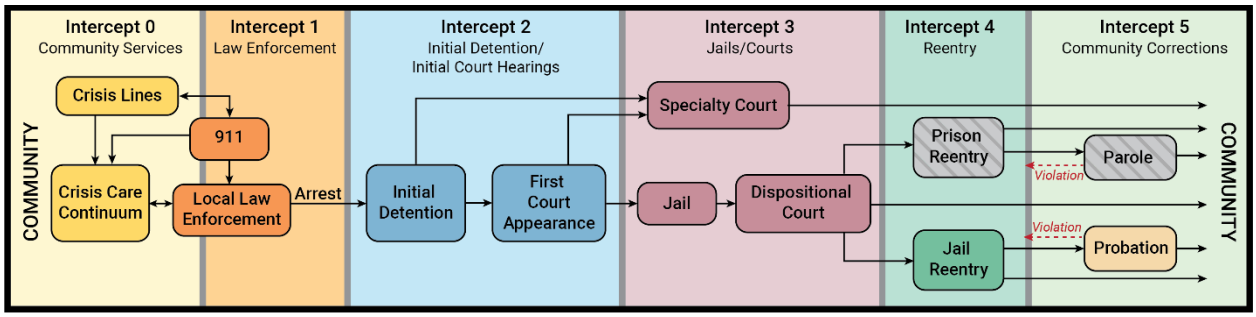
LPSCC

Local Public Safety Coordinating Council
MULTNOMAH COUNTY, OREGON

Sequential Intercept Model mapping (SIM)
Executive Summary
Connections with Portland Street Response pilot
October, 2019

Introduction

In 2010, Multnomah County's Local Public Safety Coordinating Council (LPSCC) brought together a diverse set of criminal justice and behavioral health partners to create a map of services provided for individuals who cross between those respective systems. To successfully accomplish that broad endeavor, partners met over the course of multiple days and used what's known as the Sequential Intercept Model (SIM), a tool developed by Policy Research Associates, Inc. The SIM identifies opportunities for diverting people with behavioral health conditions away from the criminal justice system whenever possible by analyzing resources and gaps at five intercepts, from law enforcement to community corrections.



Since that time, Policy Research Associates has added another intercept called "community services", which accounts for programs prior to law enforcement contact. A number of opportunities have arisen in the past year to examine this part of the system. They include:

1. **The MacArthur Foundation's Safety and Justice Challenge**: Beginning in 2015, Multnomah County Chair Deborah Kafoury helped lead a successful effort in partnership with local criminal justice agencies to apply for the MacArthur Foundation's Safety and Justice Challenge. The challenge focuses on decreasing over reliance on jail, particularly for those who struggle with behavioral health conditions. A recent part of the work has encouraged grantee sites to engage in a SIM mapping process.

2. **Multnomah County Mental Health System Analysis:** As part of an ongoing analysis of Multnomah County's behavioral health system, Commissioner Sharon Meieran expressed interest in mapping the criminal justice and behavioral health system at Intercepts 0 and 1 to better understand existing services and interventions.

3. **Portland Street Response:** And most recently, the City of Portland began developing ideas to increase non-police responses for certain 911 calls by creating a "Portland Street Response" (PSR) pilot project. At this time, the focus of PSR planning is to "provide a branch of first responders who are trained in behavioral health, crisis intervention and on-scene medical assistance; whereby enabling Portland Street Response to reduce Police, Fire, and EMS interactions with individuals who have not committed a crime, and who may be experiencing a mental health crisis or have an emergency health concern that does not immediately threaten their life, or the lives of individuals around them."

To meet all of the needs listed above, the Local Public Safety Coordinating Council worked with PRA to bring a site-specific mapping process to Multnomah County and the City of Portland. The mapping exercise was conducted on September 20, 2019 and this summary is a synopsis of the PSR-related areas discussed at the SIM.

This summary focuses on the areas covered in the SIM convening that directly pertain to gaps in the current system, which may inform PSR program development.

Methodology

Given the immense interest in examining the front end of the criminal justice and behavioral health systems, it was agreed that the best, most timely use of time and resources would be on an in depth analysis of the crisis/community system (intercept 0) and law enforcement (intercept 1).

On Friday, September 20th, over 40 people convened to discuss the services and responses available at both intercepts. City agencies, County Departments, community-based organizations, and people with lived experience with services attended the all-day event. With the support of PRA, participants mapped available services, responses, and system gaps for individuals struggling with behavioral health conditions who often have police contact.

It is important to note that the SIM process did not document how services are funded, nor did it thoroughly document the interactions, coordination, and communication pathways between many of these services.

Findings

The day long exercise mapped a wide variety of crisis and law enforcement services for this population provided by Multnomah County, the City of Portland, and other local partners. However, ongoing resource constraints and a lack of investment from State and Federal partners was a recurring theme.

The final SIM report and map will be available by the end of 2019. It will provide a detailed list of existing services and gaps that were discussed during the mapping exercise. Until then, the following is a preliminary list of services and gaps identified thought the SIM process that may be most informative in developing a PSR pilot program.

Current Services that align with Portland Street Response pilot planning

- Law Enforcement
- Project Respond
- Cascadia Behavioral Healthcare Urgent Walk-In Clinic
- Central City Concern Hooper Inebriate Emergency Response Service (CHIERS)/Sobering Station
- Portland Street Medicine
- Portland Fire & Rescue Community Healthcare Assessment Team
- Emergency Medical Services
- Other crisis lines/referrals, such as 911 and Lines for Life

Potential Gaps for Portland Street Response Consideration

Dispatch - Ensuring proper dispatch for the eventual PSR pilot is essential. The following system gaps were discussed for reference.

Crisis Call Lines

- 911, while an invaluable crisis resource receives too many non-crisis calls due to lack of knowledge of other crisis lines and resources.
- In times of severe weather, 211 has an up-to-date list of available shelter beds, but this isn't the case otherwise. Transportation to available beds is also a gap.

911 Response

- 911 could use more staff to answer calls.
- There is a need for additional public education on appropriate situations that warrant calling 911, as well as other available options.
- There has been an increase in mental health calls in East County.

Healthcare - There is a lack of appropriate health care options for this population in our community. There are a number of reasons, including insufficient resources from state and federal partners, as well as local health care systems.

- Other than at Unity Center for Behavioral Health and the two psychiatry clinics at Providence, hospital psychiatry services are limited or nonexistent.

- There is no psychiatric emergency service (such as the Unity Psychiatry Emergency Services) available to individuals who may be “highly agitated,” which often results in them being taken to jail or to sobering elsewhere. The PES is voluntary, which leaves a service gap for individuals with higher acuity who may not wish to engage.
- Transition from hospitals to the community is fragmented and uncoordinated at times. Hospital social workers rotate shifts, leading to communication breakdown.

Law Enforcement and First Responders

- Rates of AMR (American Medical Response, Multnomah County’s emergency medical service ambulance contractor) response to behavioral health-related calls are rising, as are transportation needs of individuals being held in a hospital for mental health evaluation.
- Law enforcement is called to arrest individuals for trespassing who have completed treatment at the emergency departments, but have not left the premises due to a lack of options (do not qualify for PES, etc.).
- The Portland Police Bureau has about 100 positions unfilled.
- Law Enforcement Assisted Diversion (LEAD®) only operates 10am-8pm Monday through Friday.
- Roughly 40-50% of homeless individuals who are arrested are arrested due to outstanding warrants.

Crisis Services

- Many crisis services are saturated, especially for individuals involved in the justice system.
- There is no low-barrier behavioral health drop-in center available currently.
- There is a lack of services for individuals who are not likely to be a danger to themselves or others, but still may be in sub-acute (or lower) crisis. They may be deemed “not ill enough” for the hospital, and become temporarily detained due to the lack of alternatives.
- The current crisis continuum does not address individuals with high needs but who are at low risk for committing crimes.
- There is a gap in secure treatment beds for individuals who have behaved violently.
- Some food banks will reportedly not serve individuals who are homeless.
- There is a gap in mental health services for elderly individuals, as well as those with traumatic brain injuries (TBI).
- There is a general lack of services utilizing a harm reduction approach.
- There is a reported lack of support for and high rate of turnover with behavioral health staff, especially at nonprofit organizations.
- There is not enough Assertive Community Treatment (ACT)/Forensic ACT team capacity, and there have been clients that ACT/FACT is unable to serve, due to high acuity. This may be an issue around fidelity to the model. There are also ACT eligibility limitations for individuals with justice involvement who have transitioned from the forensic hospital system.
- Central City Concern Hooper Inebriate Emergency Response Service (CHIERS)/Sobering Station reported not having enough resources to serve a growing

population of individuals with higher acuity needs. Their sobering center was not designed to treat individuals using substances other than alcohol, but they often see them as well. It is a “correctional-style” facility, with only cells and isolation rooms, and no access to beds or peers.

Detoxification

- There is a need for a specialized stabilization unit for individuals using methamphetamines and with co-occurring mental health needs. These individuals are currently often released to the streets or emergency departments.
- There is sometimes a waitlist for detox services.
- There is a gap in post-detox residential services for individuals with co-occurring significant mental illness in particular.

Housing

- There is a need for additional housing, especially supportive housing, and back-end resources for homeless response teams and systems.
- There are gaps in the coordination and overlap between the homeless response system and the Health Department and criminal justice system/set of outreach services. Behavioral health is not necessarily a focus of all of the efforts, specifically those around housing.
- There are about 2,000 people on the coordinated access list for recovery-oriented transitional housing, rapid rehousing and permanent supportive housing , which equals about six years of wait time.
- There are no shelters in Washington County, leading to more individuals coming to Multnomah County for shelter services. There is a specific lack of services available for non-publicly funded shelters.
- There is a need for a voluntary alcohol/opioid sobering shelter that would facilitate treatment engagement in the community.

Collection and Sharing of Data

- There are multiple behavioral health/homeless/crisis response systems working across the county, but without coordination or data sharing. Many see the same individuals repeatedly.
- There are multiple “high utilizer” lists housed at various organizations, such as OHSU and the Tri-County 911 Service Coordination Program, but there is a lack of coordination and efforts are likely duplicative.
- Portland Fire & Rescue’s Community Healthcare Assessment Team (CHAT) is unable to share data with the hospitals.
- Not all hospitals are included on the EPIC electronic medical record platform for data sharing, nor is LEAD.
- Kaiser’s new Unite Us resource identification and coordination platform will require an individual to have a case manager or other advocate to access resources, which is a barrier for individuals who are houseless.

Other considerations

- There is a general gap in coordination among community providers. There is a weekly (Friday morning) provider phone meeting, but it primarily focuses on “hot spot” campsite check-ins, as opposed to provider coordination. It was reported during the SIM that a model of improved coordination was utilized during Occupy Portland in 2011, which perhaps could be revisited.

Recommendations

Based on the gaps identified above, as well as the need for more permanent supportive housing, it is recommended that ongoing PSR planning incorporate these findings to ensure the new response adequately meets the needs of individuals in the community. Specifically, the pilot should articulate how the program will operate within and relative to other system responses and services outlined here.

One of the key gaps identified in the crisis response systems is a lack of information sharing, data integration, and cross-system evaluation to improve and create systems for the neediest members of our community. This gap is particularly pertinent to PSR program development to ensure downstream supports, services, treatment, and housing can help long term success of the program and the individuals it will serve.

Stakeholders should continue to engage in existing efforts to improve criminal justice and behavioral health systems. Cross-system and cross-jurisdiction mapping, service development, and policy recommendations would benefit from the structure and facilitation provided through the Local Public Safety Coordinating Council. PSR and other future efforts to divert individuals with behavioral health needs away from justice involvement should be championed together by the cities and Multnomah County.