Oregon Statewide Summit

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Introduction:

The Oregon Health Authority contracted with Policy Research Associates (PRA) to provide a strategic planning workshop to inform the work of Oregon Health Authority's Justice and Mental Health initiatives and targeted Legislative appropriations for crisis services and jail diversion. The *Criminal Justice and Behavioral Health Statewide Summit* was held January 20, 2016 at the Salem Convention Center, Salem, Oregon.

Persons with mental illness and co-occurring disorders are over represented in the criminal justice system. Steadman, et. al. (2009) found that the prevalence of people with serious mental illness is 3 times higher than the general population.[1] Teplin, et. al. (1991) found that 72% of jail inmates have a co-occurring disorder.[2]

Other characteristics of justice involved individuals with mental illness are:

- They are less likely to make bail.[3]
- They are more likely to have longer pre-trial incarceration. [3]
- They are more likely to have serious disciplinary issues in jail or prison.[4]
- They are more likely to face technical probation violations. [5]
- Trauma lifetime prevalence rates for persons with mental illness are over 90% (unpublished TAPA data).
- Trauma incurred within the year prior to arrest is over 70% (unpublished TAPA data).
- They have higher rates of homelessness, unemployment, and substance abuse. [4]

Across the criminal justice system, persons with mental illness fare worse than those without.
In addition, incarcerated populations have higher prevalence rates of medical conditions and substance abuse: [6]

- Tuberculosis 4 times higher
- Hepatitis C 9-10 times higher
- HIV 8-9 times higher

It is not surprising then, that a study of Washington state prison releases found that within 90 days of release the mortality rate for the cohort was 3 times higher than the general population and within 2 weeks of release, the mortality rate was 12 times higher than the general population. [7]

Oregon has been addressing the over representation of persons with mental illness in the criminal justice system as a result of legislative interest and grass roots advocacy. In 2011, the OHA received a legislative directive to convene a statewide workgroup to identify the needs of people with mental disorders involved in the criminal justice system. This workgroup made specific recommendations which were aligned with Sequential Intercept

Model Intercepts and resulted in additional appropriations for jail diversion initiatives, enhancements for Aid and Assist Programs and enhanced services to drug courts.

This initiative is timely as Oregon seeks to improve social services to the justice-involved population in a fiscally responsible and efficient way. In addition, health care reform presents new opportunities to expand the population served, expand partnerships, and design resources specific to the needs of the population.

Summit Goals:

- To introduce the Sequential Intercept Model as a planning tool to strategically inform legislation, policy, planning, and funding;
- To identify opportunities for coordination and collaboration among state and local stakeholders;
- To inform state and local stakeholders about best practices in the behavioral health and correctional fields; and
- To consider the impact of health care reform and state behavioral health and criminal justice initiatives on justice-involved populations.

The following documents were reviewed and influenced this report:

- Oregon's Community Mental Health Services and Substance Abuse Prevention & Treatment Block Grant Application (2014-2015)
- Behavioral Health System Mapping Fact Sheet 10/15
- Oregon Health Authority 2015-2018 Behavioral Health Strategic Plan
- Multnomah County Feasibility Assessment Mental Health Jail Diversion Project. 2/2015
- Senate Bill 832

Background:

The Sequential Intercept Mapping workshop has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along five distinct intercept points: Law Enforcement and Emergency Services, Initial Detention and Initial Court Hearings, Jails and Courts, Re-entry, and Community Corrections/Community Support.

2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.

3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population

The participants in the workshops represented multiple stakeholder systems including mental health, substance abuse treatment, health care, human services, corrections, advocates, individuals, law enforcement, health care (emergency department and inpatient acute psychiatric care), and the courts. Dan Abreu, MS CRC LMHC, and Travis Parker, MS, LIMHP, CPC, Senior Project Associates at Policy Research Associates facilitated the workshop session.

Ninety-four (94) people were recorded present at the Oregon Summit.

References:

1. Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60, 761–765.

2. Abram, K.M. & Teplin, L.A. (1991). Co-Occurring disorders among mentally ill jail detainees. *American Psychologist*, 46 (10): 1036-1045 http://www.pacenterofexcellence.pitt.edu/documents/PsySJailMHStudy.pdf

3. Council of State Governments Justice Center. (2012). Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Correction Systems. https://csgjusticecenter.org/wp-content/uploads/2013/05/CTBNYC-Court-Jail_7-cc.pdf

4. James, D.J. & Glaze, L.E. (2006). Mental health problems of prison and jail inmates. Washington, DC: United States Department of Justice, Office of Justice Programs. http://www.bjs.gov/content/pub/pdf/mhppji.pdf

5. Porporino, F.J. & Motiuk, L.L. (1995). The prison careers of mentally disordered offenders. *International Journal of Law and Psychiatry,* 18:29–44.

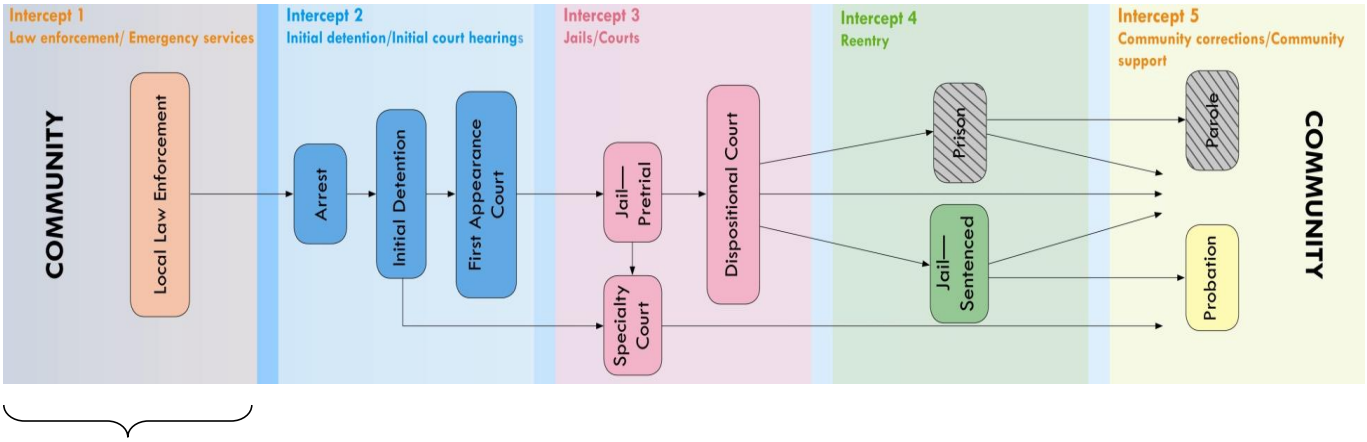
6.

Category	Condition	Prevalence Compared to U.S. Population
Infectious Diseases	Active tuberculosis	4 times greater
	Hepatitis C	9–10 times greater
	AIDS	5 times greater
	HIV infection	8–9 times greater
Chronic Diseases	Asthma	Higher
	Diabetes/hypertension	Lower
Mental Illness	Schizophrenia or other psychotic disorder	3–5 times greater
	Bipolar (depression) disorder	1.5–3 times greater
	Major depression	Roughly equivalent
Substance Abuse and Dependence	Alcohol dependence	25% fit CAGE profile
	Drug use	83% prior to offense; 33% at time of offense

SOURCES: NCCHC, "Prevalence of Communicable Disease, Chronic Disease, and Mental Illness Among the Inmate Population," *The Health Status of Soon-To-Be-Released Prisoners, A Report to Congress*, 2002; *BJS Special Report: Substance Abuse and Treatment, State and Federal Prisoners, 1997*, NCJ 172871, 1999.

7. Binswanger, I.A., Stern, M.F., Deyo, R.A., Heagerty, P.J., Cheadle, A., Elmore, J.G., & Koepsell, T.D. (2007). Release from Prison — A High Risk of Death for Former Inmates. *The New England Journal of Medicine,* 356:157-65. http://www.nejm.org/doi/pdf/10.1056/NEJMsa064115

Intercept 1



Resources

- Crisis Intervention Team (CIT) training/Steering Committee
- Crisis team
- Community outreach
- Crisis hotline
- Ride alongs
- Assertive Community Treatment (ACT) teams
- Alcohol and drug services
- Mental Health First Aid training
- Emergency Services (EMS) response
- Urgent psychiatric/crisis appointments
- Respite
- Detoxification center
- Stakeholder meetings
- Diversion case management
- Bi-lingual crisis worker/translation app available

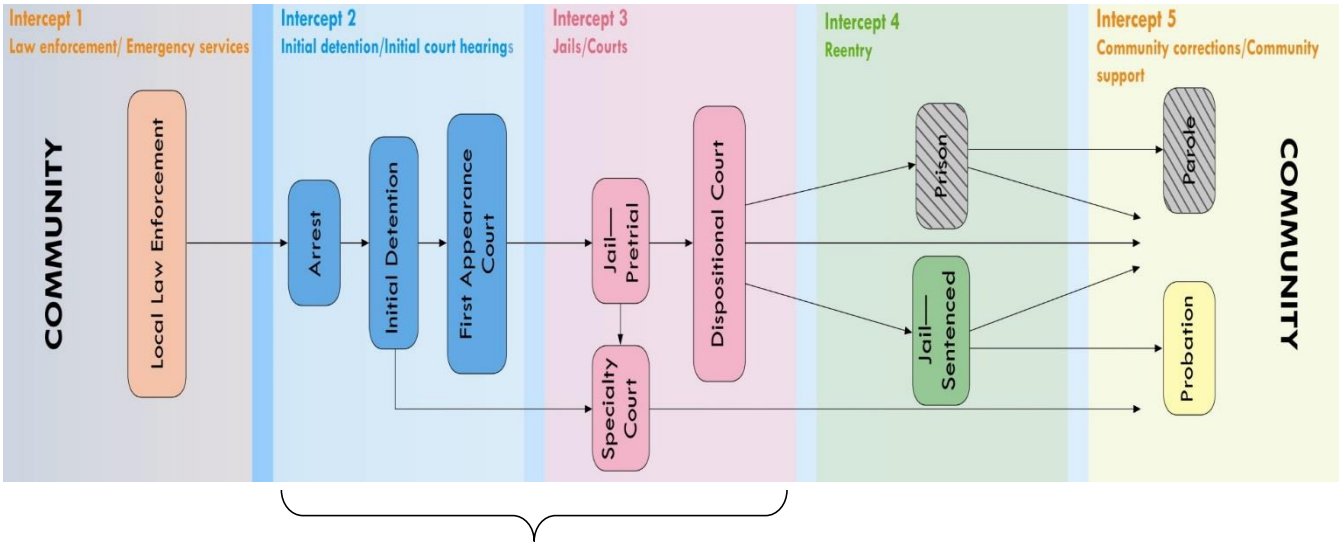
- Sub-acute
- Crisis walk-in
- Agency collaboration
- Peer-run organization
- Warm line
- Screening service
- Community Care Organizations partnership
- Veteran resource sharing
- Veteran Affairs Supportive Housing (VASH)

Gaps (with prioritization from the group)

- Housing/transitional (continuum of housing)- 14 votes
- Timely diversion- 8 votes
- Data tracking and outcomes- 8 votes
- CIT leadership support, direction, and guidance for law enforcement; crisis respite center- 8 votes
- Alternative payment methodology/reimbursement- 4 votes
- Inter-agency communication- 3 votes
- Training of court personnel- 2 votes
- Cross-discipline training- 2 votes
- Fidelity in training and policy- 2 votes
- Lack of detox centers- 2 votes
- Psychiatric prescribers- 2 votes
- Lack of mental health courts- 1 vote
- HIPAA- state interpretation expectations- 1 vote
- Behavioral health workforce- 1 vote

- Cultural competency stigma- 1
- Resource sharing
- Siloing of services
- Lack of diversion programs
- Non-profit support (i.e., NAMI)
- Disparity of resources
- SSDI/SSI Access
- Civil commitment process
- Trauma-informed care training
- Transportation

Intercepts 2 and 3



Resources

- Communication between resources
- Mental health summit (Lane County)
- Working relationship with jail (embedded staff)
- Coordination between mental health court, mental health, and community corrections
- Communication across counties
- Specialty courts (Clackamas)
- State role in mitigation
- Mental health and veteran screening at booking
- VA participation (Clackamas)
- Community standard
- Forensic diversion (multi)
- Peer involvement/participation at all levels
- Medication availability

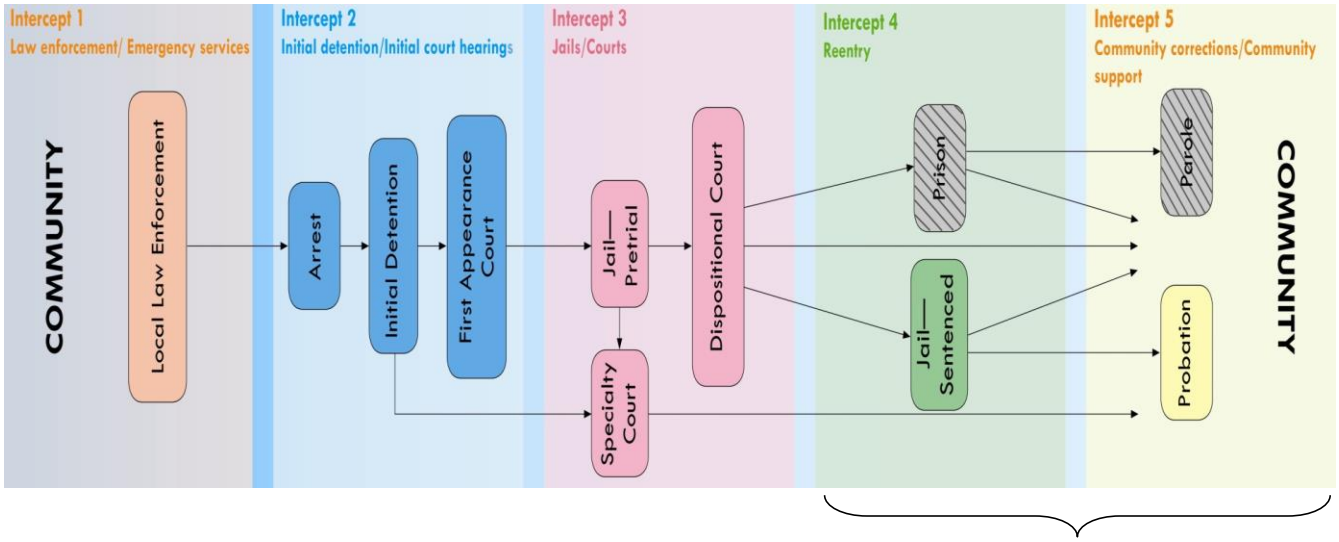
- Good assessment tools
- Dually credentialed staff
- Supporting people to attend community staff
- Peer-facilitated treatment
- Substance abuse treatment in jail and community corrections
- Flexibility/willingness of staff
- Jail staff are trained in CIT
- Medication Assisted Treatment (MAT)
- Telemedicine in local jail
- Assisted Outpatient Treatment (AOT)/Competency restoration
- In-home respite care

Gaps (with prioritization from the group)

- Housing- 18 votes
- Medicaid cancellation while incarcerated- 8 votes
- Lack of funding- 6 votes
- 370 treatment in community- 6 votes
- DA resistance- 5 votes
- Peer-run respite- 4 votes
- Access to dual diagnosis treatment- 3 votes
- Inpatient treatment facilities- 2 votes
- Lack of trained workforce- 2 votes
- Dismissed drugs for misdemeanors- 2 votes
- Lack of consistency in access to resources- 1 vote
- Cannot blend funding/no re-allocation of funding/insecure funding- 1 vote

- Different formularies- 1 vote
- Jail segregation- 1 vote
- Suicide watch practices/inconsistencies- 1 vote
- Trauma-informed care- 1 vote
- Lack of court-imposed sanctions for Assisted Outpatient Treatment (AOT)- 1 vote
- Lack of case management during legal process- 1 vote
- Improved communication with mental health services- 1 vote
- Inconsistent terminology between counties
- Inadequate mental health treatment in jail
- Public defenders are uninformed
- Lack of providers for court support
- Bench parole with no mandated treatment
- Lack of mandated substance abuse treatment
- Unfunded mandates (inpatient detox)
- Mandated sentences for misdemeanors- unable to aid and assist
- Lack of basic life skills training
- Not enough early intervention
- Lack of communication between police and the DA

Intercepts 4 and 5



Resources

- Collaboration between community mental health providers and corrections/community corrections/Governor's Re-entry Council
- OSH relationship with community mental health providers
- PSRB model
- Strong laws regarding employment, housing, and anti-discrimination
- Evidence-based re-entry practices/in-reach (needs based)
    - Assessments, treatment planning, case management, clinicians on staff, electronic medical records, peers
- Community Care Organizations/Medicaid access
- Assertive Community Treatment (ACT) teams/supported employment
- Continuum of care

Gaps (with prioritization from the group)

- Lack of affordable housing (still segregated, lack of integrated housing)- 10 votes

- Lack of alcohol/drug residential services focus to adequately treat individuals with serious mental illness; end up in mental health with no coordination - 8 votes
- Lack of psychiatric beds (and variation, results in jail placement)- 4 votes
- Silo of developmental disability/intellectual disability/gerontology/Anti-social Personality Disorder
- Access to medication treatment is lacking for judges (corrections does not always support the education/cost)- 2 votes
- Cut-off of Medicaid while in jail- 2 votes
- Inadequate transportation-2 votes
- Lack of comprehensive community-based and culturally appropriate services- 1 vote
- VA- lack of communication/cooperation with SSA- 1 vote
- Lack of technology- 1 vote
- Lack of doctor/psychiatric nurse practitioner
- Communication/funding gaps between jail/community/Community Care Organizations
- Lack of first responders
- Funding/billing for peer support is cumbersome
- Never ending growth/demand for services
- Physical/dental care access
- Lack of preventative/trauma-specific services
- Lack of understanding about HIPAA
- Lack of diversity in rural areas; unable to use best practices
- Lack of sex offender treatment/housing
- Lack of qualified staff; high turnover due to burnout
- Too many initiatives

Gaps in Current Legislation (with prioritization from the group)

- Prosecution and defense-led deferred prosecution initiative- 6 votes
- Need for better crisis services in the community- 2 votes
- Inadequate civil commitment statute- 1 vote
- Medication override
- Need for probation officer support for treatment of misdemeanors

Intercept-Specific Priorities

Intercept 1	Intercepts 2&3	Intercepts 4&5
Housing (14)	Housing (18)	Housing Expand Housing Models (10)
Enhanced Police and Crisis Response (8)	Medicaid cancellation while incarcerated (8)	Lack of Co-occurring Disorder Treatment Lack of Integration (8)
Timely Diversion (8)	Community 370 treatment (6)	Lack of Continuum of Psychiatric Beds (4)
Data and Tracking Outcomes (5)	Funding (6)	Silo of systems (special populations include TBI/Intellectual Disability/Aging Population (4)