**Overview: Community-Based Programs, Services and System Approaches that Support Successful Jail Diversion**

**Table of Contents**

**Overview: Community-Based Programs, Services and System Approaches that Support Successful Jail Diversion**

**Module** – Local Public Safety Coordinating Councils (LPSCC)

**Presenter(s) –** Professionals with successful experience operating or managing diversion services in Oregon's system. Contact the Oregon Center on Behavioral Health & Justice Integration at 1-888-733-0454 or visit [www.ocbhji.org](www.ocbhji.org).

**Length – 3.5** hours

**Learning Outcomes:**

At the end of this unit, the participants will:

- Identify the need for implementing successful jail diversion strategies.
- Understand the Community Mental Health Program's role in providing the mental health safety net for the region within which it operates.
- Develop an operational understanding of community-based programs, services, and systems approaches that help divert people with serious behavioral health needs from jail and hospitalization.
- Become aware of how these programs and strategies relate to one another and how they might be applied in specific combinations to achieve desired community-level outcomes.
- Know where to go for additional resources that support implementing successful programs, services and systems approaches.

**Course Description**

This course will provide participants with information about the community mental health and behavioral health systems and how the various safety net services play a role in successfully diverting people with serious behavioral health needs from jail into these services. This course will also provide an overview of systems approaches that have been proven to successful divert individuals from jail while providing a structured and coordinated response to services and accountability (Stepping Up Initiative and Specialty Courts for instance). The presenter will use examples from regions in Oregon where successful models have been developed: Marion County's response to Aid and Assist/.370 and crisis intervention and mobile crisis services, Multnomah and Lane sobering facilities, and Harney County's rural response to jail diversion. The presenter(s) will highlight the various Centers of Excellence that support implementation and successful operations for the evidence-based programs such as Assertive Community Treatment, Supported Employment, Crisis Intervention Teams, and Early Assessment and Support Alliance (EASA).

Community coordination and shared outcomes will be a focus of this course and small group discussions will be used to solicit maximum participant interaction and dialogue.

**Suggested media**

➢ Power Point slide deck to keep the course on time and on target with the learning objectives
➢ Center on Behavioral Health and Justice Integration flyer
➢ List of diversion programs and strategies
➢ Handouts from other states with similar services

**Introduction to Topic**

Many people with behavioral health needs (mental health, substance use or co-occurring mental health and substance use disorders) who come in contact with the criminal justice system achieve recovery and become self-sustaining, contributing members of their communities. However, uncoordinated and inadequate treatment and support services inhibit the pursuit of recovery and may lead to criminal justice involvement. In order to successfully help improve the lives of people with behavioral health needs and enhance safety in the community, the mental health, substance use, and criminal justice systems must break through organizational barriers and collaborate in providing coordinated, integrated, and comprehensive services.

In trying to explain the rise in behavioral health diagnoses in the correctional system, many researchers point to the closure of state psychiatric hospitals in the late 1960s. The closures were meant to allow patients to return to their families and live independently. In the ensuring decades, men and women once housed in institutions found themselves incarcerated, often for minor offenses. (Kaiser Health News, May 2014, By The Numbers: Mental Illness Behind Bars).

**Problem Statement**

The number of people with mental illness in US jails has reached crisis levels. In counties across the nation, jails now have more people with mental illnesses than in their psychiatric hospitals (Stepping Up Initiative).

The majority of people in state prisons and local jails have an identified behavioral health diagnoses   as do over 44 % of people in federal prisons. Almost half (49.7%) of people in prisons are there for drug related offenses. The next highest reason for prison admissions is for weapons, explosives, arson at 15.7%. In addition, 80% of people in county jails test positive for drugs and 68% of jail inmates have been diagnosed with a substance use disorder or addiction problem (Bureau of Justice Statistics).

These data are compelling but do not convey the full impact on our communities. The correctional system, local hospitals, treatment providers, businesses, individuals with behavioral health
needs and their families, and the entire community deal with the physical, emotional, and financial effects of the growing numbers of these individuals in the correctional system.

Local law enforcement that are responding to crisis calls often encounter people experiencing symptoms of behavioral health diagnoses that are agitated and/or frightened.  These encounters can be unsafe for law enforcement, the individuals, and bystanders.

A 2011 analysis on cost avoidance in Douglas County found that people with behavioral health needs had an average of 14 admissions into the jail over a 12-month period. This is one example of a common problem – jails and prisons with a "revolving door" of individuals with behavioral health needs. Access to treatment for individuals with behavioral health diagnoses is often limited upon their release into the community; these individuals often struggle with managing their basic needs, often increasing their probability of returning to jail.

In addition:
- Inmates with untreated behavioral health needs remain in jail longer than other inmates
- Only one in six  jail inmates receive mental health services while incarcerated
- Incarcerating people with behavioral health needs is costly. According to the Vera Institute of Justice (2015) jails have become one of the most significant public safety expenditures a community makes every year. Per bed jail costs range generally from $100 - $160 per day (News Channel 21 report on county jail costs, April 2015).
- Jails and prisons are ill-equipped to manage people with active psychiatric symptoms, which often result in their isolation and separation from the general population.

4

- ➤ Individuals with serious behavioral health needs who become incarcerated and do not receive services are more likely to die by suicide
- ➤ They divert correctional resources – jail beds, law enforcement, etc. – from more violent offenders who may have engaged in more significant criminal activity to a typically lower level offender who is experiencing psychiatric or substance-induced symptoms
- ➤ More people with mental health and substance use diagnoses are entering prisons than ever before. Upon release, about 50% re-enter prisons within three years of release
- ➤ There continues to be an unsustainable number of people being referred to the state hospital under ORS 161.370 (Aid and Assist) at a cost of $859 per person per day, which equates to approximately $63,566 per episode, as the median hospital stay is 74 days.

Local or regional hospitals, who have a role in responding to the emergent needs of individuals experiencing a behavioral health related crisis, experience challenges effectively serving this population while maintaining adequate emergency department operations to meet the physical health needs for the general population. Law enforcement officers bring symptomatic individuals to the emergency department if the officer believes they are under the influence and need to detox or if other presenting problems indicate a need for medical release before admitting them to the local jails.  Hospitals that do not have psychiatric services, and most in Oregon do not, have to divert hospital staff and resources to provide services and ensure safety.

The courts also endure a multitude of issues as people with behavioral health needs move through the judicial component of the system. Some individuals with acute behavioral health needs may not be ready to aid and assist in their defense and the system needs to find the best resources to help them gain that competency. Court dockets are filled with people with primarily behavioral health needs and the courts do not always have information about how these issues impact corrections or treatment. The fact that there is a general lack of widespread utilization of diversion programs makes all these issues even more difficult.

Behavioral health treatment providers have dynamic opportunities and barriers as they work to provide effective care for their clients. In terms of the barriers, often they do not receive information regarding an individual's involvement in the justice system. The episodic way a person with behavioral health needs interact with the justice system and treatment staff makes it difficult to coordinate care and help individuals achieve recovery.

In each discipline (law enforcement, courts, local jails, hospitals, etc.), staff are diverted from their typical jobs to respond to the presenting needs and problems associated with individuals with behavioral health needs even when they are not part of the health care system.

Perhaps one of the most difficult issues is the lack of coordination and collaboration among key stakeholders who work with this population – law enforcement, first responders (emergency medical services, fire department personnel), community corrections, hospitals, jails, court personnel, probation and parole and treatment providers. Their individual work is more difficult, and less effective, because they work in isolation from each other.

## Community Programs

As stated earlier in this document, de-institutionalization and the closure of the state psychiatric hospitals in the late 1960s contributed to an increased prevalence of individuals with significant behavioral health needs coming into contact with the justice system.

The notion that state psychiatric hospitals, jails or other secure settings are the only options for rehabilitation is outdated. Significant advancements in community-based treatment of behavioral health conditions have been developed, tested, and successfully implemented over the past several decades.  The goal is to get the right person to the right option at the right time. There is a continuum of options for people with mild to significant behavioral health needs. Psychiatric hospitals are part of that continuum of care, but not should not be the default option.

5

Individuals with serious and persistent mental illness are protected by the Americans with Disabilities Act (ADA) and must be afforded opportunities to fully integrate into the community and participate in society. The Oregon Performance Plan (OPP) for Mental Health Services for Adults with Serious and Persistent Mental Illness (SPMI), a plan developed between the Oregon Health Authority and the United States Department of Justice (USDOJ) over the past three years, outlines service elements and targets "intended to better provide adults in Oregon with serious and persistent mental illness with community services that will assist them to live in the most integrated setting appropriate to their needs, achieve positive outcomes, and prevent their unnecessary institutionalization". The OPP and its' various components serve to resolve the USDOJ investigation of the State of Oregon's compliance with the integration mandate of Title II of the Americans with Disabilities Act (ADA) and *Olmstead v. L.C.*, 527 U.S. 581 (1999), as they apply to adults with serious and persistent mental illness. For more information on the OPP visit the following web page: http://www.oregon.gov/oha/HPA/CSI-BHP/Pages/Oregon-Performance-Plan.aspx

## Community Behavioral Health Services

Communities are encouraged to incorporate available community behavioral health services into system planning efforts associated with addressing needs among justice-involved populations. Each county (independently or through a consortia) is represented by a Community Mental Health Program (CMHP) (ORS Chapter 430). The purpose of a Community Mental Health Program is to provide a system of appropriate, accessible, coordinated, effective and efficient safety net services to meet the mental health needs of the citizens of the community (OAR 309-014-0010).

Following is a collection of community-based treatment options proven to be effective in advancing recovery and increased functioning for people with mild to severe behavioral health needs. Evidence-based practices associated with treatment and systems approaches can significantly reduce reliance on incarceration for individuals with behavioral health needs by providing appropriate services in the community.

Developing written Memoranda of Understanding (MOU) among all system partners outlining roles, responsibilities and common objectives is a best practice. An MOU also helps sustain partnership and operational efforts beyond individual leadership or staff tenure in the event people leave their positions. Two counties with robust, functionally developed MOUs are Yamhill and Marion.

## Mobile Crisis Services

Hank Steadman and colleagues (2000) said Mobile Crisis Services is "…the most visible pre-booking diversion program in the U.S." The goal of mobile crisis services is to help people resolve a psychiatric crisis in the most integrated setting possible and to avoid unnecessary hospitalization, inpatient psychiatric treatment, involuntary commitment, and arrest or incarceration. These services have been found to reduce injuries, use of force and increase healthcare referrals (Dupont & Cochran, 2000). Mobile crisis services are delivered by mental health practitioners who respond to behavioral health crises onsite at the location in the community where the crisis arises (individual's home, schools, residential programs, nursing homes, group home settings, hospitals, jails to name a few). These services include face-to-face therapeutic response. Response time requirements apply to this service and vary for urban, rural and frontier counties (OAR-019-0152).

- Urban response time – within one hour
- Rural response time – within two hours
- Frontier response time – within three hours

Mobile Crisis Services are not available in every county. Please have a conversation about the availability of mobile crisis services as a group(s) as this service is not implemented statewide. Communities who have implemented this model are finding good results (Marion, Multnomah, Washington).

**Crisis Lines, Hotlines and Warm Lines**

Each Community Mental Health Program is required to provide phone-based services that establish immediate communication links and provide supportive interventions and information for individuals in an urgent or emergent situation. For a listing of each 24-hour phone number, please check your local phone directory or search for your county mental health crisis number on the World Wide Web. The Oregon Health Authority maintains a list of crisis numbers on the following web page (please also check your local resource directories as numbers may change from time to time): http://www.oregon.gov/oha/ph/PreventionWellness/SafeLiving/SuicidePrevention/Pages/cntymap.aspx#klamath

Statewide, 24-hour crisis hotlines are available through private, non-profit organizations such as Lines for Life and Emergence. In Oregon, Lines for Life operates a suicide prevention line, drug and alcohol helpline, youth line and peer-to-peer counseling line for teens. Lines for Life handled nearly 78,000 calls during the fiscal year 2016/17.  Lines for Life also operates a military helpline with call or text capabilities. Visit Lines for Life on the web to learn more: https://www.linesforlife.org/

Below are the lines operated by Lines for Life:

| | |
|---|---|
| Suicide Lifeline: Call: 800-273-8255 Text: 273TALK to 839863 | Military Helpline: Call: 888-457-4838 Text: MIL1 to 839863 |
| Alcohol and Drug HELPLINE: Call: 800-923-4357 Text: RecoveryNow to 839863 | YOUTHLINE: Call: 877-968-8491 Text: teen2teen to 839863 |

Emergence Addiction and Behavioral Therapies operates the statewide 24-hour problem gambling helpline which is staffed with certified problem gambling counselors. The number to this helpline is: 877-MYLIMIT (or 877-695-4648). Live web chat with a counselor is available at: http://www.opgr.org/

The David Romprey Warm Line (1-800-698-2392), operated by Community Counseling Solutions, offers phone-based peer-to-peer support, helping people with mental health needs explore healthy ways to manage feelings and challenging experiences. The line is staffed by paid peers and is not available 24-hours a day. Please visit the web site to see available times of operation and to learn more about this service:  http://communitycounselingsolutions.org/warmline/

**Assertive Community Treatment (ACT)**

ACT is an evidence-based practice designed for individuals experiencing the most intractable symptoms of severe mental illness and the greatest level of functional impairment. This service is covered under the Oregon Health Plan. Team-based care and smaller caseloads are features of this model whereby a group of professionals assume direct responsibility for providing the mix of coordinated services. The disciplines represented on ACT teams include mental health specialists, psychiatrists, nurses, skills trainers, substance use disorder specialists, peer support specialists, and other professionals. The program is proven to reduce the need for hospitalization fewer interactions with law enforcement, and are able to maintain more stabilized housing.

For more information about ACT, please visit the Oregon Center of Excellence for Assertive Community Treatment at: http://oceact.org/

**Early Assessment & Support Alliance (EASA)**

EASA is an early intervention for individuals and their families who have experienced a first psychotic break.  EASA is funded by the Oregon Health Authority through agreements with Community Mental Health Programs (in a majority of

counties). An interdisciplinary team of providers offer wraparound services with a strong emphasis on education, skill building, natural and peer supports. Compared with patients receiving medication only, EASA participants demonstrated lower rates of treatment discontinuation, reduced risk of relapse, improved insights and quality of life, improved social functioning and obtained employment or accessed education. EASA participants went from 23% to 13% experiencing any legal involvement and from 13% to 1.9% with any arrest or incarcerations. This reduction was sustained over time. EASA serves teens and young adults.

For more information about EASA, visit the EASA Community on the web at: http://www.easacommunity.org/

**Supported Employment**

The Individual Placement and Support model of supported employment (IPS) for individuals with serious mental illness has been designated an evidence based practice by the Center for Mental Health Services and the State of Oregon and meets the following criteria:

➢ The program model has been validated by rigorous research.

➢ Guidelines describe the critical components.

➢ A treatment manual and empirically validated fidelity scale are readily available.

➢ Successful implementations have occurred in a wide range of settings.

Supported employment services are closely integrated with mental health treatment services and are a covered service under the Oregon Health Plan. Employment specialists are assigned to one or two mental health teams from which they receive referrals. The employment specialists meet weekly with team members to think of strategies to help people with their employment and education goals.  The goal is to generate competitive jobs for adults with mental illnesses and help them connect to and sustain that employment. Thirteen of thirteen studies have demonstrated that SE achieves significantly better employment outcomes than other employment models (60% competitive employment vs. 22% without). Other benefits include better control of psychiatric symptoms, higher self-esteem and more satisfaction with finances and with leisure time.

Find more information and resources on Supported Employment by visiting the Oregon Supported Employment Center of Excellence at: http://osece.org/

**Choice Model**

The Choice Model Program (formerly known as the Adult Mental Health Initiative program - AMHI) is designed to promote more effective utilization of current capacity in facility based treatment settings, increase care coordination and increase accountability at a local and state level for helping people with serious and persistent mental illness remain as independent as possible and avoid institutional placements. The Choice Model is funded by the Oregon Health Authority through agreements with a set of eight regional contractors representing Community Mental Health Programs and Coordinated Care Organizations (statewide coverage is available).

The Choice Model is designed to promote the availability and quality of individualized community-based services and supports so that adults with serious and persistent mental illnesses who have either been civilly committed or are at risk of civil commitment to the Oregon State Hospital (OSH)are served in the most independent environments possible and use of long term institutional care is minimized.

For more information about the Choice Model, visit the Oregon Health Authority's website at: http://www.oregon.gov/OHA/pages/index.aspx and use the search engine to look for "Choice Model".

## Crisis Respite Services

Crisis Respite is a short-term community-based alternative to psychiatric hospitalization or other higher levels of care. This service is designed to help stabilize symptoms while the individual continues to work with his/her treatment team and other natural recovery support services in the community. Services are provided in safe, calm, home-like settings that have been licensed by the Oregon Health Authority subject to standards in OAR 309-035-0100 through 309-035-0225. Lengths of stay in crisis respite are generally short (one week or less) but may last up to 30 days.

While many counties have developed this resource, crisis respite services are not available in every community. Please discuss the availability and accessibility of this service with your community mental health program director.

## Sobering Facilities

A sobering facility operates for the purpose of providing to individuals who are acutely intoxicated a safe, clean and supervised environment until the individuals are no longer acutely intoxicated (ORS 430.260 – 430.425). Oregon recognizes addiction as a health condition, not a crime, and there are prohibitions on units of local governments from making public intoxication, public drinking, drunk and disorderly conduct, vagrancy or using or being under the influence of controlled substances a crime (ORS 430.402). Sobering facilities provide a public safety service and are not supported by Oregon Health Plan. Making appropriate referrals to substance use disorder treatment and ancillary supports is an important feature of sobering services. There are a handful of sobering facilities in Oregon (Eugene/Lane, Portland/Multnomah, Grants Pass/Josephine, Medford/Jackson) but more communities are motivated to develop this resource to divert people from the justice system and ensure their safely until they are no longer acutely intoxicated.

## Clinically and Medically Managed Detoxification Services

Two types of non-hospital detoxification services are available through regional centers: Clinically Managed and Medically Monitored Detoxification.

Clinically Managed Detoxification: Clinically managed detoxification is provided in a residential, non-medical or social setting and emphasizes peer and social support. This service is intended for individuals whose intoxication is sufficient to warrant 24-hour support or whose withdrawal symptoms are sufficiently severe to require primary medical nursing care services. In this service, medical evaluation and consultation must be available 24-hours a day to ensure appropriate stabilization and transfer practice guidelines if individuals need a higher level of care. Staff must be trained and competent to implement physician-approved protocols.

Medically Monitored Detoxification: Medically Monitored Detoxification is designed to serve people with more serious or complicated withdrawal symptoms who can be safely treated outside of a hospital setting as determined by a physician. This service is provided in an inpatient setting and staffed by licensed medical professionals (credentialed nursing staff and physicians) who are available 24-hours a day by telephone, available to assess patients within 24-hours of admission or earlier, and who provide on-site monitoring of care and evaluation daily. The level of nursing staff must be appropriate to meet the severity of patient needs and staff ratios apply to this service as specified in Oregon Administrative Rule (OAR) 415-050-0050.

## Affordable Housing

Housing is affordable for the purposes of defining "Affordable Housing" when an individual or household spends no more than 30% of gross monthly income on housing (including utilities). Stable, affordable housing is one of the most significant factors in recovery from mental illness or substance use disorder, and affordable housing in Oregon is in short supply. The Oregon Health Authority and Oregon Housing and Community Services have partnered to increase the availability of affordable housing, including supportive and supported housing and rental assistance, through investments made by the Oregon Legislature in the past three Legislative Sessions.

For additional information about affordable housing in your area, reach out to your local housing authority or contact Oregon Housing and Community Services:  http://www.oregon.gov/ohcs/Pages/index.aspx. The Oregon Health Authority maintains an inventory of affordable housing on the web at http://www.oregon.gov/oha/HSD/AMH/Pages/Affordable-Housing.aspx.

## Supportive and Supported Housing

In Oregon, two terms are used to define the types of housing that include affordability, clinical and social supports for individuals with serious behavioral health and other special needs: Supportive and Supported Housing. The Oregon Performance Plan, mentioned earlier, provides these definitions as summarized in the table below:

| SUPPORTIVE HOUSING | SUPPORTED HOUSING |
|---|---|
| Permanent<br><br>Tenant maintains tenancy as long as meeting occupancy obligations (e.g. pay rent). | Permanent<br><br>Tenant maintains tenancy as long as meeting occupancy obligations (e.g. pay rent). |
| Affordable<br><br>Tenant pays no more than 30% of income for housing costs. | Affordable<br><br>Tenant pays no more than 30% of income for housing costs. |
| Integrated<br><br>Opportunity to interact with non-disabled neighbors readily available. | Integrated<br><br>Opportunity to interact with non-disabled neighbors readily available. |
| Access to Services<br>• Participation in support services is voluntary; services cannot be mandated as a condition of obtaining tenancy; tenants cannot be evicted for rejecting services.<br>• Tenants are offered choice and range of flexible services that are available as needed, desired; level of services are adaptable as needs may change without losing home.<br>• Services designed to promote recovery, enable tenants to attain and maintain housing.<br>• Provision of housing and provision of services are distinct activities. | Access to Services<br>• Participation in support services is voluntary; services cannot be mandated as a condition of obtaining tenancy; tenants cannot be evicted for rejecting services.<br>• Tenants are offered choice and range of flexible services that are available as needed, desired; level of services are adaptable as needs may change without losing home.<br>• Services designed to promote recovery, enable tenants to attain and maintain housing.<br>• Provision of housing and provision of services are distinct activities. |
| Housing<br><br>Private and secure with same rights and responsibilities as any other member of community; enables individuals with disabilities to interact with individuals without disabilities to the fullest extent possible. | Housing<br><br>Private and secure with same rights and responsibilities as any other member of community; enables individuals with disabilities to interact with individuals without disabilities to the fullest extent possible. |
| Siting | Siting |

| SUPPORTIVE HOUSING | SUPPORTED HOUSING |
|---|---|
| Number of rental units in any building or complex occupied by individuals with SPMI is not restricted. | • **For a building or complex with 2-3 units, not more than one unit may be used to provide supported housing for tenants with Serious Mental Illness (SMI) who are referred by OHA or its contractors.**<br>• **For buildings or complexes with 4 or more units, no more than 25% of units in a building or complex may be supported housing for tenants with SMI, referred by OHA or its contractors who shall make good faith, best efforts to facilitate the occupancy of those units by individuals with SMI.**<br>• **The remaining housing is available to all individuals in conformance with Fair Housing and other laws.** |
| Occupancy<br><br>Comparable to other housing in market; no restrictions or provisions specific to psychiatric disability. Applies to:<br><br>• Lease provisions;<br>• Lease term with option to renew (as long as in compliance);<br>• Occupancy rules;<br>• Unit options per tenant preferences, range of choices affordable to income level for housing market. | Occupancy<br><br>Comparable to other housing in market; no restrictions or provisions specific to psychiatric disability. Applies to:<br><br>• Lease provisions;<br>• Lease term with option to renew (as long as in compliance);<br>• Occupancy rules;<br>• Unit options per tenant preferences, range of choices affordable to income level for housing market.<br>**Additionally:**<br><br>• **No more than 2 tenants per unit, each with own bedroom.**<br>• **If two tenants in unit, must be able to select roommate.**<br>• **Cannot be rejected for occupancy due to medical needs or substance abuse history.** |

**Rental Assistance**

Rental assistance is designed to address this gap in resources, and is designated for individuals with a serious mental illness. Rental Assistance Programs are operated by contracted providers who applied for OHA funding to operate Rental Assistance Programs in specific counties in Oregon for eligible individuals.

➢ Eligible individuals receive barrier-removal and move-in assistance costs, as well as monthly rent subsidies based on HUD Fair Marketing Rates (which are set at the time of the original funding).

➢ Currently over forty Rental Assistance Programs are operating by over twenty different contracted providers with a total of 1,154 housing units.

➢ As of the latest reporting quarter 72% of these housing units were occupied by individuals.

These programs focus on at least one of the following priorities for these individuals:

➢ Transitioning from the Oregon State Hospital

➢ Transitioning from a licensed residential setting

➢ Without supportive housing are at risk of reentering a licensed residential treatment or hospital setting
➢ Homeless
➢ At risk of being homeless

Please discuss the availability of rental assistance with your Community Mental Health Program Director or his/her designee on housing as this service is available in many, but not all, areas of Oregon.

## Peer Delivered Services

Peer Delivered Services (PDS) are an important and evidence-based component of the service array for people with serious behavioral health needs. These services are provided by people with lived experience. This means the individual offering peer delivered services has experienced life as a consumer of mental health and/or substance use disorder services and is now at a point in his/her recovery that they are able to help others within the scope of services that are provided by peers. Please note that peer delivered services are an essential component of several programs described above: ACT, EASA, Supported Employment, Choice Model and Rental Assistance. Peer delivered services are tailored to the populations needing access to these supports. Certification and training is offered for individuals seeking credentials to serve people with mental health needs and people with substance use disorder recovery needs. Peer services are a covered benefit under the Oregon Health Plan. Some examples of the types of services provided by peers include:

- *Emotional support* is characterized by the demonstration of empathy, caring, or concern to bolster a person's self-esteem and confidence. This support is provided by a peers both through individual peer contact and peer-led groups.
- *Informational support* is shared knowledge and information and/or providing life or vocational skills training. Connections to this kind of support are made through peers delivered by community service providers offering parenting classes, the early learning hub, childhood learning programs, wellness events and classes.
- *Instrumental support* provides concrete assistance to help others accomplish tasks. This includes child care, transportation, help accessing community health and social services.
- *Affiliational support* facilitates contacts and connections with other people to promote learning social and recreational skills, create community, and acquire a sense of belonging. This includes connections to the broader recovery community, sports league participation, alcohol and drug free socialization opportunities and the like.

<u>**Systemic Approaches**</u>

Evidence-based programs offer important tools that help individuals with behavioral health needs live with higher quality of life and work towards recover. But this alone will not turn the tides on the flooding of the correctional system with people experiencing behavioral health needs. System based approaches are also needed to turn the tides on over reliance on justice responses for individuals with significant behavioral health needs.

When people from various systems work together to address community challenges related to individuals and families experiencing significant behavioral health needs, a broader set of strategies and resources are brought to bear on the issues. Systems need to work together in new ways to a) prevent people with behavioral health needs from entering the system and b) manage them in more effective ways when arrests occur. Several system-wide approaches exist and some are also considered "evidence-based".

## Community Restoration and Support Services (for "Aid and Assist/.370")

This set of services includes competency restoration and periodic assessment of a defendant's capacity to stand trial as required in ORS 161.370 while the defendant resides in the community. These services are required to restore an individual's ability to "aid and assist" in his/her own defense, before the person can stand trial. Forensic evaluations are performed by specially trained and qualified professionals for the purpose of evaluating competence to "aid and assist" in Oregon. A list of evaluators may be found at: [http://www.oregon.gov/oha/HSD/AMH-FE/Documents/FEC%20Court%20Lists.pdf](http://www.oregon.gov/oha/HSD/AMH-FE/Documents/FEC%20Court%20Lists.pdf)

Restoration services include:

➢ Providing a defendant with education necessary to best facilitate the defendant's return to capacity including skills training regarding courtroom procedures, roles, language and potential outcomes of the court process
➢ Incidental support (basic needs, clothing, food, transportation)
➢ Linkages to benefits and community resources such as housing/shelter, Oregon Health Plan enrollment, case assistance and Supplemental Nutritional Assistance Program (SNAP)
➢ Coordination and consultation with the court (including mental health court) or other designated agencies within the justice system and the Oregon State Hospital
➢ Participation in mental health and law enforcement collaboration meetings
➢ Communication of court ordered requirements, limitations and court dates
➢ Assisting defendants in accessing community supports that promote recovery and community integration (case management, therapy, substance use disorder treatment, medication and medication management)
➢ Administrative activities related to tracking and reporting all of the above
➢ Voluntary mental health treatment

Counties with the highest number of patients referred to OSH under the .370 statutes have received targeted funding to provide community restoration and support services to individuals with mental illness so they may be able to aid and assist in their own defense. These counties are: Douglas, Lane, Marion, Klamath, Washington and Multnomah. A pool of other funding for the balance of Oregon counties is managed by the Oregon Health Authority, Health Systems Division.

## Crisis Intervention Teams (CIT)

Mobile crisis services and crisis respite services provide time-limited, on-demand services in the community. The primary goal of these investment resources is to divert individuals from unnecessary presentations at local psychiatric emergency rooms and to provide them the services they need to remain safely in the community.

The University of Memphis Crisis Intervention Team (CIT) is an innovative training model which provides training to law enforcement officers. CIT trains officers to effectively assist individuals in their communities who are in crisis due to behavioral health or developmental disorders. CIT relies on a strong community partnership and a crisis system that understands the role and needs of law enforcement. It encourages officers to appropriately redirect individuals in crisis away from the criminal justice system and into the behavioral health system. Benefits Include:

➢ Immediacy of response

➢ Increased officer safety

➢ Reduced officer / citizen injuries

➢ Increased jail diversion

➢ Increased chance for consumer to connect to mental health system

➢ Increased officer confidence in skills

➢ Decreased injury by 40%

➢ Reduced need for "SWAT-like" responses by 50%

Oregon's Crisis Intervention Teams Center of Excellence (CITCOE) develop and maintain partnerships with Oregon criminal justice and behavioral health agencies, organizations and service providers in order to develop and maintain a network to criminal justice and behavioral health professionals, behavioral health advocates, and consumers to promote excellence in law enforcement behavioral health training throughout Oregon.

For more information about this resource, please visit: http://gobhi.org/citcoe

**Sequential Intercept Model (SIM) Mapping**

The goal of SIM is to improve responses for individuals with primarily behavioral health needs who are involved in the correctional system while enhancing public safety. Individuals are diverted from the correctional system to the extent possible and into treatment.
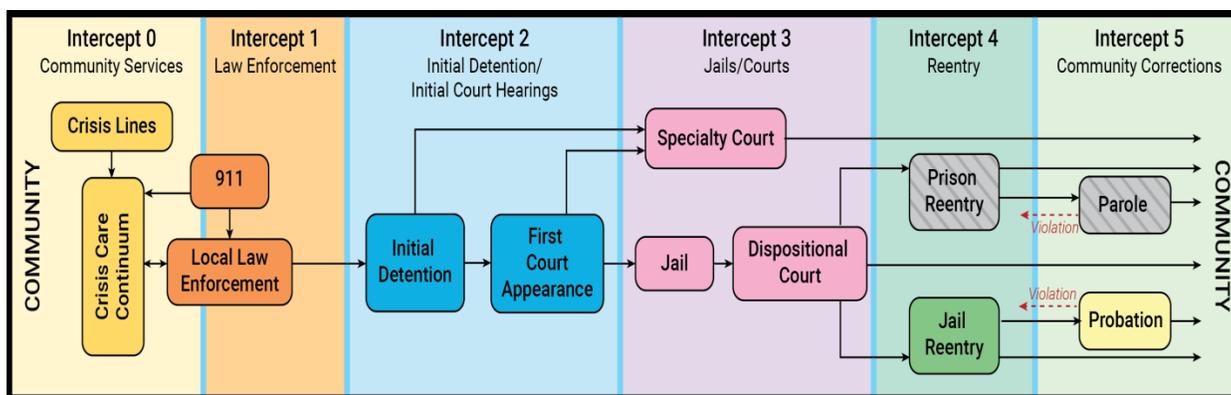


© 2016 Policy Research Associates, Inc.

This interdisciplinary team looks at each intercept of the criminal justice system and creates a list of what is working and barriers, or gaps. From that they develop priorities and an action plan. The plan leaves the team with follow-up activities to implement over the subsequent year. It improves outcomes for individuals and also enhances cross-system collaboration and partnerships.

SIMs brings together people from:

➢ Behavioral health professionals

- ➢ Criminal justice system personnel - law enforcement, jail staff, court personnel, probation and parole, defense and district attorneys, Judges

- ➢ ER staff

They attend a 1.5 day facilitated meeting where they:

- ➢ Identify resources

- ➢ Identify gaps

- ➢ Develop priority areas

- ➢ Develop an action plan

The Oregon Center on Behavioral Health and Justice Integration is available to help communities conduct SIM. In addition, the GAINS Center offers training that helps educate criminal justice professionals about the impact of trauma and how to develop trauma-informed responses. Find more information at the Substance Abuse and Mental Health Services Administration (SAMHSA), GAINS Center for Behavioral Health and Justice Transformation at: https://www.samhsa.gov/gains-center

**Stepping Up Initiative**

Stepping Up is an initiative sponsored by the National Association of Counties, the Council of State Governments-Justice Center, and the American Psychiatric Association aimed at reducing the number of people with serious mental illness who become incarcerated in local jails. The initiative involves a county level commitment from the county commissioners to reduce the number of people with mental illnesses in jails.

The framework for this initiative is an excellent complement to the community action plans created through the SIMs process to include measurable outcomes that impact the local criminal justice system. Communities must utilize data driven decision making and measure the efficacy of their local diversion work. According to the Stepping Up resources toolkit on the Web, six suggested questions county leaders need to ask themselves before signing up for the initiative are:

- ➢ Is your leadership committed?
- ➢ Do you have timely screening and assessment?
- ➢ Do you have baseline data?
- ➢ Have you conducted a comprehensive process analysis and service inventory?
- ➢ Have you prioritized policy, practice and funding?
- ➢ Do you track progress?

Stepping Up resources are available through the Stepping Up Initiative website located at: https://stepuptogether.org/.

**Mental Health First Aid (MHFA)**

Mental Health First Aid is a day-long course providing lay-people with practical skills to help someone who is developing a mental health problem or experiencing a mental health crisis. Just like CPR training helps a person with no clinical training assist an individual following a heart attack or other physical health emergency, MHFA training helps a person assist someone experiencing a mental health crisis such as contemplating suicide. In both situations, the goal is to help support an individual *until appropriate professional* help arrives.

Mental Health First Aiders learn a single 5-step approach that includes assessing risk, respectfully listening to and supporting the individual in crisis, and identifying appropriate professional help and other supports. Participants are also introduced to risk factors and warning signs for mental health or substance use problems, engage in practice activities

that build understanding of the impact of illness on individuals and families, and learn about evidence-supported treatment and self-help strategies.

The evidence behind MHFA demonstrates that the course builds mental health literacy, helping the public identify, understand, and respond to signs of mental illness including substance use disorders.  MHFA was created in Australia in 2001 by Betty Kitchener, a nurse specializing in health education, and Tony Jorm, a respected mental health literacy professor. More information on the history of the course is available at [Mental Health First Aid™ Australia](#).

Over 18,000 Oregonians have been trained in Mental Health First Aid by certified trainers. For more information on this practice or to locate a trainer, please visit the Mental Health First Aid official web site at: [https://www.mentalhealthfirstaid.org/](https://www.mentalhealthfirstaid.org/) or the Association of Oregon Community Mental Health Programs Mental Health First Aid page at: [http://mhfaoregon.org/](http://mhfaoregon.org/)

## Trauma-Informed Care

The majority of people who have serious behavioral health needs and are involved in the justice system have significant histories of trauma and exposure to personal and community violence. Involvement with the justice system can further exacerbate trauma for these individuals.

Trauma-informed care is an approach used to engage people with a history of trauma. It recognizes the presence of trauma symptoms and acknowledges the role that trauma can play in people's lives. Trauma-informed criminal justice responses can help to avoid re-traumatizing individuals. This increases safety for all, decreases the chance of an individual returning to criminal behavior, and supports the recovery of justice-involved women and men with serious mental illness. Partnerships across systems can also help link individuals to trauma-informed services and treatment. (SAMHSA, GAINS Center)

Oregon is pioneering efforts to increase awareness of the impact of psychological trauma on individuals and communities. In addition, Oregon has expanded resources for practitioners and system collaborators wanting to improve their practices across physical, mental, behavioral health and justice systems.

For more resources on implementing trauma-informed care, visit Trauma-Informed Oregon at: [https://traumainformedoregon.org/](https://traumainformedoregon.org/) or the SAMHSA GAINS Center's Trauma Training for Criminal Justice Professionals at:  [https://www.samhsa.gov/gains-center/trauma-training-criminal-justice-professionals](https://www.samhsa.gov/gains-center/trauma-training-criminal-justice-professionals)

## Treatment Courts

According to the Criminal Justice Commission, treatment courts are defined as "problem-solving courts that operate under a specialized model to provide court-directed supervision and mandated treatment to nonviolent individuals with substance use or mental health needs underlying their criminal behavior." Treatment courts serve a specific and target population, rely on consistent judicial interaction throughout the program, and require collaboration among a multi-disciplinary team comprised of judicial, treatment, supervision, legal staff and others.

Oregon has implemented a number of treatment courts including: Adult and Juvenile Drug Courts, Family Drug Courts, and Mental Health Courts. Other treatment courts are in the development or early implementation stages in Oregon include DUII and Veterans Treatment Courts.

The 10 Key Components, originally outlined by the US Department of Justice, Drug Court Programs Office and modified for other problem-solving courts include:

1. Drug Courts integrate alcohol and other drug treatment services with justice system case processing.

2. Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process due process rights.

3. Eligible participants are identified early and promptly placed in the drug court program.

4. Drug courts provide access to a continuum of alcohol, drug and other related treatment and rehabilitation services.

5. Abstinence is monitored by frequent alcohol and other drug testing.

6. A coordinated strategy governs drug court responses to participants' compliance.

7. Ongoing judicial interaction with each drug court participant is essential.

8. Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.

9. Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.

10. Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness.

For more information on planning, developing, implementing and funding treatment courts, please visit the Criminal Justice System web site at: http://www.oregon.gov/cjc/specialtycourts/Pages/default.aspx, or the National Association of Drug Court Professionals at: http://www.nadcp.org/learn/what-are-drug-courts, or the National Institute of Justice, Office of Justice Programs at: https://www.nij.gov/topics/courts/drug-courts/Pages/welcome.aspx