JAIL DIVERSION IN OREGON

PREPARED FOR OREGON HEALTH AUTHORITY

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Mandatory Disclaimer

The author conducted this study as part of the program of professional education at the Frank Batten School of Leadership and Public Policy, University of Virginia. This paper is submitted in partial fulfillment of the course requirements for the Master of Public Policy degree. The judgments and conclusions are solely those of the author, and are not necessarily endorsed by the Batten School, by the University of Virginia, or by any other agency.

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Glossary and Abbreviations

CIT: Crisis in Training

CMHP: Community Mental Health Partners

Jail: usually local facilities under the jurisdiction of a locality; generally considered a short-term holding facility for those who are newly arrested; can also be used to house individuals who have a shorter sentence (less than one year)

Mentally ill: defined by the National Institute of Mental Health as mental, behavioral or emotional disorder

OCBHJI: Oregon Center on Behavioral Health and Justice Integration

OHA: Oregon Health Authority

Prison: under the jurisdiction of the state or the federal government; generally used to house convicted offenders who are serving longer sentences

SAHMSHA: Substance Abuse and Mental Health Services Administration

SIM: Sequential Intercept Model, developed by SAHMSHA – describes how individuals come into contact with and move through the criminal justice system

Executive Summary

The United States incarcerates far too many mentally ill individuals rather than diverting them away from jail to appropriate treatment or community health services. This applied policy project seeks to address some of the root causes of America's high population of incarcerated individuals and provide three alternatives to address the problem.

America has the highest incarceration rate in the world, and at any given time has around 1.2 million individuals in jail or prison. Spending time in jail leads to poor outcomes later in life, including worse employment prospects for men, less earnings over a lifetime, and lasting psychological impacts that cannot be quantified. Individuals who enter jail or prison are not likely to continue receiving whatever care they previously had access to, since jails and prisons tend to have severely underfunded health services, particularly for people who require mental health services.

Jail diversion allows mentally ill individuals that have committed non-violent crimes to be diverted from jail and instead receive the treatment and support they need. Jail diversion can occur at various stages through a person's interactions with the criminal justice system. The goal is to divert people away from jail in the earlier stages, and possibly even before they encounter a police officer or get arrested.

The three alternatives are:

1. Crisis In Training (CIT): a police-based specialized training teaching police officers how to handle high-stress encounters with individuals experiencing a mental health crisis;
2. Community Mental Health Programs, specifically "Warm Lines:" a newer form of a help line that seek to fill a gap in mental health services and are usually staffed by peer volunteers, not to be used in crisis or emergency situations;
3. Mental Health Courts: although they are considered a newer form of jail diversion, mental health courts have generally proved be quite effective at diverting individuals away from jail in exchange for a commitment to abide by a court-ordered treatment plan or program

I used four evaluative criteria to judge the alternatives: cost, political feasibility, administrative feasibility, and equity. Oregon currently has a tense atmosphere due to essentially reversing a bill that largely decriminalized possession of a small amount of drugs. Based on that and the various criteria mentioned, I recommend that OHA pursue **CIT for police officers at the county level**. CIT is a renowned approach to jail diversion that is proven to be effective at reducing arrests and making officers feel safer when dealing with mentally ill individuals. Although it will require police training which takes police officers away from their normal duties, it is low-cost especially compared to mental health courts. CIT is also already present in Oregon across various counties, which makes it easier to significantly expand the program in counties that it already exists in, and bring it to counties that are completely new to CIT.

Since there is already funding allocated for jail diversion in a recent bill that was just signed by Oregon Governor Tina Kotek, the challenges of the implementation of CIT will mostly lie in getting small, rural counties on board. These counties tend to be more resistant of overarching programs that have a formal component since they are smaller and more tight-knit. There is generally favorable public sentiment in Oregon at the moment to have increased law enforcement presence and enforcement when it comes to individuals who are suffering from addictions or mental health problems.

Problem Statement

Not enough individuals with serious or persistent mental illnesses receive treatment under Oregon's jail diversion program, leading to an overburdened jail system in Oregon. Mass incarceration has enormous social, financial and personal costs to those who are incarcerated and society at large.

Client Overview

Oregon Health Authority (OHA) is a statewide government agency that runs the majority of Oregon's health programming, including public and behavioral health. OHA has overseen the majority of Oregon's health related programs since its inception in 2009.

OHA seeks to lower healthcare costs, while also improving the quality of and increasing access to healthcare for Oregonians. OHA's mission is to ensure all people and communities can achieve optimum physical, mental, and social well-being. OHA's core values are health equity, service excellence, integrity, leadership, partnership, innovation and transparency.

Background on the Problem

The U.S. has one of the highest incarceration rates in the world (Raphael & Stroll, 2013) There are approximately 716 people in prison for every 100,000 people (Walmsley, 2013). The prison population has skyrocketed in the past 50 years. The prison population in the U.S. has skyrocketed since the 1980s due to the roll back of social programs in the 1980s and started employing increasingly punitive forms of punishment (Craige et al, 2020).

The deinstitutionalization of mental hospitals in the 1970s is a key factor in the exponential growth of the prison population as it led to the release of individuals who were somewhat supported by a mental health system that no longer existed. It begets the question of whether the mentally ill have been trans-institutionalized, or simply moved from one institution to another – as in moved from mental hospitals to prisons and jails. The shutting down of mental institutes could possibly explain the increase the incarceration rates in the U.S. (Raphael & Stoll, 2023).

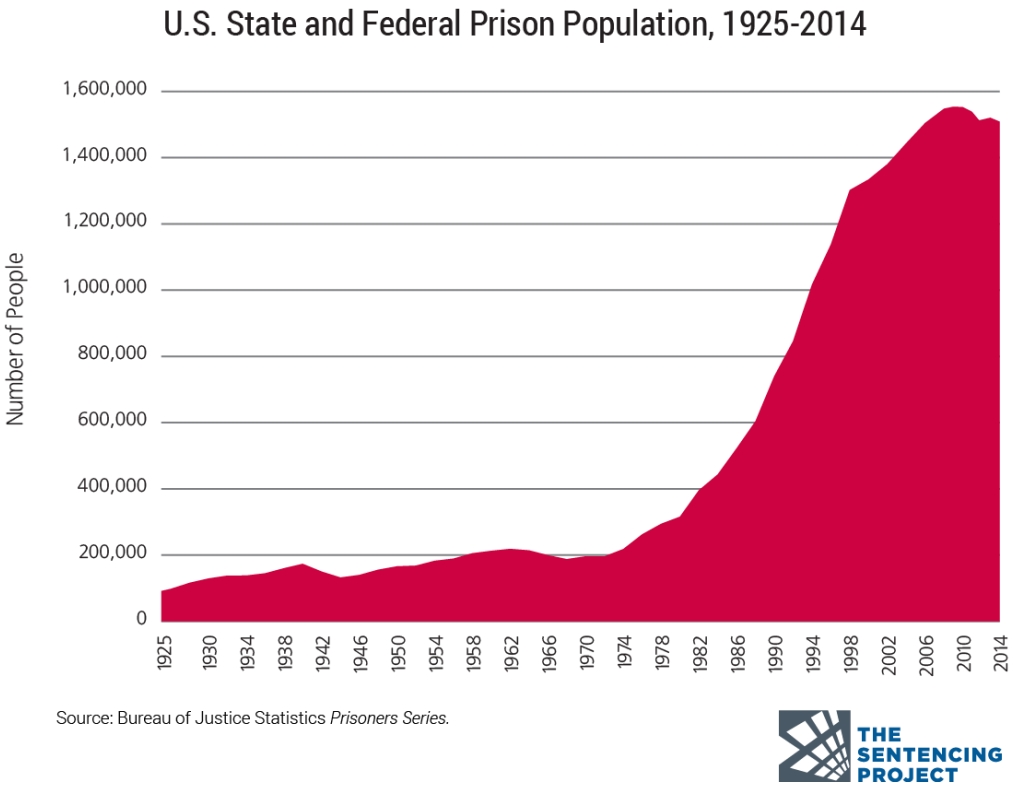


Figure 1: U.S. State and Federal Prison Population: 1925-2014

People with mental illnesses are gravely overrepresented in prisons (Raphael & Stroll, 2013; Cloud, 2014). An estimated 16% of men and 31% of women in jail have a serious psychiatric

condition, compared with a 5% occurrence in the general population (Cloud, 2014). Approximately 70 percent of Oregon jail inmates have some form of underlying or primary mental illness (Munetz and Griffin, 2006). Compared to the national rate of 16 percent of inmates having some form of mental illness, Oregon is in a much more dire position (Schaefer, 2005).

Oregon has also seen increasing incarceration rates in recent years, particularly the last 40 years. Oregon has an incarceration rate of 555 people per 100,000 people, which is considered very high. Not surprisingly, people of color are overrepresented in prisons and jails. Oregon's prison system has people cycle in and out of jail very quickly, so it's possible the rate is even higher than what is being reported (Sawyer, 2023).

Consequences of the Problem

Incarceration has a high cost on those who are incarcerated and on society at large. Health Services in prisons are notoriously under resourced and lacking (Cloud, 2014). Incarceration often leads to a disruption in health services, which can be harmful to mental and psychological health. Inhumane conditions such as overcrowding, solitary confinement and violent encounters all contribute to the last psychological impact of incarceration. In local jails, suicide is the leading cause of death, with death rates far exceeding those found in the general U.S. population (Sawyer, 2023).

Research has shown that high incarceration rates are linked to other negative outcomes such as lower employment, weaker familial ties, and poor health over a lifetime (Clear, 2007). Going to jail or prison also decreases wages earned by nearly $500,000 over a lifetime (Craigie et al, 2014). Having a criminal record is directly related to lower unemployment rates in men in their 30s (Bushway, 2022). Incarceration also has negative effects on families with a family member in jail. Parental incarceration can affect children in numerous ways, including shame, stigma, reduced parental support, conflict between caregivers and reduced family resources (Gifford, 2019).

Incarceration disproportionately affects certain populations, including minorities who are already disadvantaged by the criminal justice system. Prison and jail inmates are overwhelmingly male, with Latino and Black men overrepresented. Inmates also tend to be young and poor across all races (Apel and Ramakars, 2018). Incarcerated individuals' time in prison continues to affect them even after they have been released, leading to a poorer quality of life overall. Becoming a part of the criminal justice system and spending time in prison has long lasting effects on individuals that can be difficult to quantify.

What is Jail Diversion?

Jail diversion is a process that allows qualified individuals who meet a variety of conditions to be diverted away from jail and to get the support that they need. Jail diversion is largely geared towards individuals with mental illnesses who have committed low-level offenses who are not considered a danger to anyone else (Diversion programs explained, n.d.). Jail diversion programs may also be based on substance abuse or other contributing factors that may lead to an individual's encounter with the criminal justice system (Amell, 2022). In this document, diversion based on substance use will often be referenced alongside diversion based on mental illnesses since it can be difficult to decouple the two kinds of diversions.

Diversion programs in the U.S. started taking shape in 1940, when youth who had been charged with crimes were encouraged to be in probation instead of prosecution. After a few decades, the first federal program for jail diversion was established through the Pretrial Services Act of 1982. Today, 45 states have some form of jail diversion programs, but they tend to be experimental and underfunded.

Generally, there is reluctance to use the "insanity defense" in tandem with jail diversion tactics. However, the situation in Oregon is somewhat unique as it relates to insanity defense. Since 1978, insanity acquittees in Oregon who are considered dangerous and mentally ill have been placed under the jurisdiction of the Psychiatric Security Review Board (PSRB). While under the jurisdiction of the PSRB, insanity acquittees may receive treatment. This particular strategy could be considered a unique component of the jail diversion program if diversion is looked at more broadly (Schaefer, 2005). At this time, the only other states with Psychiatric Boards are Arizona and Connecticut.

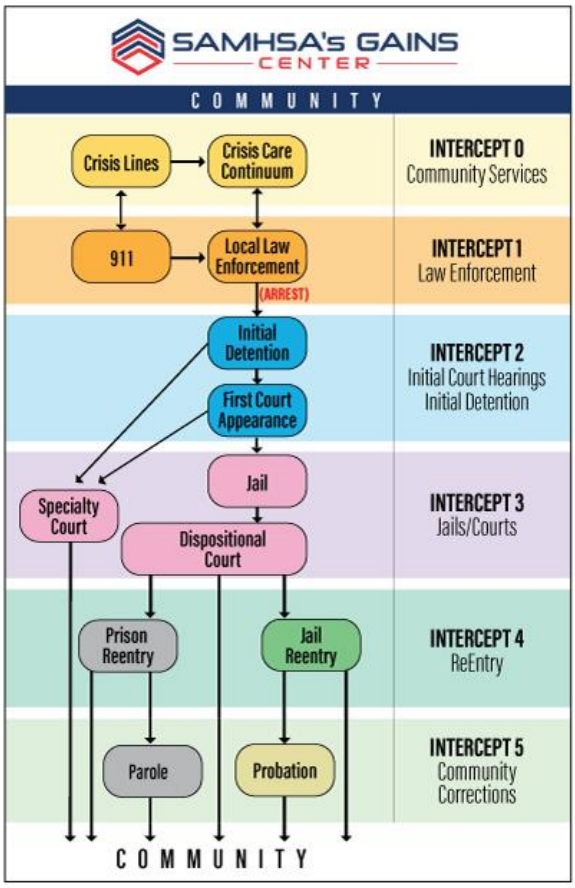
Some of Oregon's jail diversion programs have been held up as model programs over the past decade, including their program in Multnomah County which is the most populous county in Oregon and encompasses Portland.

These seven counties just received funding to implement additional or new jail diversion programs in 2024: Wallowa, Lake, Tillamook, Baker, Crook, Clatsop and Lincoln. These counties are mostly rural counties – some counties have not received jail diversion funding before and use more informal methods to divert people away from jail, including community partnerships and mental health services.

Jail diversion can happen either before or after an individual enters the criminal justice system or at various points after they have been arrested. Often times, diversion is referred to as pre-booking, post-booking or pre-trail diversion – the booking and/or trial diversion aspect is meant to identify whether or not an individual has been arrested or gone through a court trial. The Sequential Intercept Model (SIM) is often used to demonstrate each "intercept" or point at which an individual can be diverted away from jail (Munetz & Griffin, 2006; SAHMSHA, 2022).

The intercepts, in order of interaction with the criminal justice system, are

0) **Community Services** are intended to divert people with mental illnesses away from jail before coming into contact with law enforcement at all. They connect people with mental illnesses to Community Mental Health Services before they come into contact with the criminal justice system. Generally, this intervention occurs when an individual calls a crisis line or checks into a local crisis care service.
1) **Law enforcement and emergency services** involve diversion from law enforcement or emergency services who respond to an emergency situation, usually after 911 has been called. This can include police officers deescalating a situation with a mentally ill individual and deferring them to treatment instead of arresting them.
2) **Initial hearings and initial detention** is a post-arrest diversion – it occurs after an individual has been arrested and gone through an initial hearing, at which point it's determined that the individual would be better off being diverted to community-based services and treatment.
3) **Jails and courts** involve diversion after an individual has been arrested and booked. Diversion occurs through court or jail processes. This intercept also includes access to treatment and healthcare while an individual is in prison.
4) **Reentry** involves diversion when an individual is reentering the community. It encompasses transition planning, or organizing healthcare and mental health services around a prisoner's release. It involves medication and prescription access upon release, and a warm and coordinated handoff from corrections officers to either a social worker or case manager who may be taking on care for the newly released individual.
5) **Community corrections and supervision programs** involves community-based supervision, such as parole and probation programs to prevent violations that would lead to another stint in jail.



Source: Substance Abuse and Mental Health Services Administration
Figure 2: The Sequential Intercept Model

Generally, it's best to intervene as early as possible for these intercept points but in communities with poorly funded mental services, individuals are less likely to be intercepted early and will likely move past each intercept point. Funding for jail diversion programs can be acquired through Oregon Health Authority or Oregon's Justice Reinvestment Grant Program (Munetz and Griffin, 2006).

Being diverted from jail does not necessarily mean charges against the individual are dropped, but it some cases they are (Davis, 2012). Certain mental health courts will require a plea of no guilty or no contest while the individual participates in treatment. When mentally ill people stay in jail, their mental illness may become exacerbated if they are not receiving the care that they need. Additionally, continuing to allow mentally ill people in jail diverts attention and resources from more serious offenders and is not likely to reduce rates of recidivism for the mentally ill people in jail (Schaefer, 2005).

Acknowledgement of the Rollback of Measure 110

In 2020, Oregon became the first state to decriminalize/reclassify possession of small amounts of some drugs as misdemeanors which went into effect in February 2021. The decriminalization included fentanyl, cocaine, methamphetamine, and heroin. The move was lauded by racial justice experts, as the decriminalization was designed to reduce arrests of minority populations. Possession was punished with a citation and a maximum fine of $100. Since then, Oregon and specifically Portland have been hit with overdose deaths at an alarming rate. Portland declared a state of emergency in January 2024 due to increasing overdoses and deaths that were primarily driven by fentanyl usage in the public eye. According to Oregon state data, opioid overdose deaths increased over threefold from 2019 (280 deaths) to 2022 (956 deaths).

The measure to overturn decriminalization, HB 4002, earmarks $30 million for county-based diversion programs. The Oregon Criminal Justice Commission predicts that the bill will lead to a disproportionate amount of convictions for Black Oregonians (*Racial & Ethnic Impact Statement -HB 4002-24 Oregon Criminal Justice Commission*, 2024). On April 1, 2024 Governor Tina Kotek officially signed the bill into law, which will go into effect on September 1, 2024 (*Oregon Governor Signs a Bill Recriminalizing Drug Possession into Law*, 2024)

Policy Alternatives

In this section, I propose three policy alternatives on how to best approach jail diversion. The three policy alternatives are described in brief, with additional findings about them as related to the evaluative criteria in the "Findings" section. Since OHA has the ability to fund jail diversion programs, I am presenting these alternatives as various options that OHA can choose to take on in some capacity.

Alternative #1: Crisis in Training for Police Officers

Often, police officers serve as the first responders to mental health calls. Crisis in Training (CIT) is a police-based specialized response on how to handle high-stress encounters with individuals who are experiencing a mental health crisis. CIT was originally developed in coordination with the Memphis Police Department and the National Alliance for Mental Illness in the late 1980s after a mentally ill individual was fatally shot by police (Campbell et al, 2023, Rogers et al, 2019). The primary purpose of CIT continues to be less officer and citizen injuries; however, it is also used to divert individuals away from jail at the pre-booking stage to mental health services. The training process for CIT is 40 consecutive hours of training delivered five days in a row – that amounts to approximately one week of an officer being away from their normal duties.

CIT officers are considered liaisons to the mental health system (Franz and Borun, 2011; Rogers et al, 2019). CIT trained officers can also be deployed where there is no criminal activity at all, like in the case of a suicide attempt. CIT trained officers are not the only answer to diverting individuals away from jail – law enforcement should have a good rapport with mental health professionals and programs in their locality for CIT to be fully effective (Taheri, 2016).

Alternative #2: Mental Health Courts

Mental Health Courts (MHCs) are a newer form of jail diversion, but they are currently the second most common method of post-booking jail diversion after drug courts (Fox et al, 2021). MHCs divert individuals with mental illnesses away from incarceration in return for an agreement that the individual will comply with a court ordered mental health treatment plan (Honegger, 2015). MHCs are generally supervised by a sitting judge with a specialized docket where qualifying individuals are diverted to treatment and community services in lieu of being incarcerated. MHCs are only available to eligible individuals after an offense, arrest and booking have all taken place (Fot et al, 2021). MHCs are found to be fairly effective at diverting people away from jail, but have limited data about which parts of MHC are effective.

Although the obvious answer here would be to increase the presence of MHCs across Oregon, the implementation of this alternative could also look like increasing the efficiency and awareness of MHCs across the state. For example, Oregon already has MHCs in the state at the county level. Since those infrastructures are already in place, we could increase the capacity of those MHCs to handle more cases say on a monthly or annual basis. It may be less burdensome than creating entirely new courts in areas where they are not located, and perhaps people from outside of the county could be sent to these courts where they have the proper staff and resources to handle this sort of training.

This policy alternative may be the most complicated alternative just because it involves the intersection of so many different agencies at one point: OHA, community mental health programs, law enforcement, the judicial system, etc. It is difficult to parse out exactly the effect of a robust, well-organized MHC over anything else that a mentally ill individual may encounter. Mental health courts are also not standardized across counties, states or nationally so they vary wildly in capacity and implementation – there may not be one standard way even in the state of Oregon to shore up MHCs – it likely will need to be done on an ad hoc basis. The lack of standardization when it comes to the mental health system in the U.S. comes up repeatedly when it comes to jail diversion and supporting individuals with serious and persistent mental illnesses.

Alternative #3: Community Mental Health Services – Warm Lines

Involving Community Mental Health Services, or intercepts zero and two on the SIM, can also be considered a method to divert individuals away from jail. At intercept zero, this would be considered a pre-arrest diversion (Munetz & Griffin, 2006). Community mental health providers play a large role in supporting individuals who are diverted from jail, especially non-profit organizations and treatment facilities that facilitate treatment of rehabilitation of affected individuals. Community support services also may provide continued care to folks who do end up going to jail. Individuals who end up in jail and are released may also continue to interact with law enforcement and the public health system because they are on parole or probation and must be compliant in following a treatment in order to stay of out jail.

At intercept zero on the SIM, folks who are experiencing distress or an emergency situation may call 911 if they have no other options and urgently need help. Inappropriate use of emergency services is common when there are no 24/7 crisis lines or centers for people to turn to (Dalgin et al, 2018). Today, approximately 10% of all phone calls to police involve a mental health emergency (How do crisis teams, n.d.). In response to this shortage, communities have mobilized to provide warm lines, which are free phone service offerings by peers who have often been through mental health challenges of their own. Warm lines are not considered appropriate for crisis use (Dalgin et al, 2018). Lines are answered by trained staff or volunteers. Warm lines are available in over 30 states, as of 2018. Crisis lines are also more widely available now than they were previously. In fact, there is now a national suicide crisis line in the U.S. that was launched in July 2022.

In response to this crisis, there has been a renewed interest and move towards the implementation of warm lines, or free phone offerings by peers who have been through mental health challenges themselves. It's important to note that warm lines are not meant to be used during times of crisis – for crisis situations, folks should be calling a suicide line or a crisis-specific line. The effectiveness of warm lines and crisis lines is disputed, since the effectiveness of the call itself is judged by the change in distress of the caller throughout the course of the call (Hoffberg et al, 2020). However, they seem to be popular and have an increasing presence in the U.S., with warm lines being present in over 30 states.

Warm lines are not standardized nationally, so their availability varies wildly across the States. However, it seems like a great funding opportunity from OHA and lends itself to jail diversion if people can be helped at an earlier stage. Oregon already has crisis lines that are specific to counties, but perhaps increasing the prevalence of warm lines could help prevent things from reaching a point where an individual may need to contact a crisis line.

It wouldn't be enough to invest in the warm lines themselves – they would need to be advertised and folks would need to be made aware of the fact that they exist. A resource isn't useful unless the people who need them the most know that they can call on it if needed. Therefore, implementing this alternative would require a two-prong approach: beefing up existing non-crisis lines + creating new non-crisis lines where appropriate and doing some sort of information campaign that would make people aware of their existence.

Evidence on Potential Solutions

It is difficult to evaluate studies related to the efficacy of jail diversion because jail diversion is not standardized. It varies in implementation at state, county and local municipality levels. Jail

diversion's effectiveness is also heavily influenced by whether or not there is a robust community mental health program in the locality and the relationships between law enforcement, courts, mental and health providers. Given these factors, studies about the effectiveness of these approaches have been assigned to one of three categories: low strength, medium strength or high strength. Low strength is given to studies that are either more theoretical or small in size. Medium strength studies are correlational, and generally bigger in size as well as more recent. High strength studies are causal and highly reputable. These categories are meant to easily identify whether or not a study can be considered extrapolative and applicable to OHA's work in Oregon.

Alternative #1: Crisis in Training for Police Officers

A study conducted in 2000 showed that specialized police response in three different localities led to lower arrest rates across the board. The study looked at three different police responses in Birmingham, Alabama, and Memphis and Knoxville, Tennessee. The study compared 100 calls that may have involved a mentally ill individual in each city. Each of the three cities had their own type of response based on the resources available. Birmingham had a community service officer team which employs trained community service officers who are not sworn police officers but have received training on how to handle mental health emergencies. Those officers are not allowed to arrest people. Memphis had a police-based program that has specially trained officers and is also considered one of the most visible prebooking jail diversion program in the U.S. while Knoxville had a mobile crisis unit that responds to calls in the community and handles calls and referrals from jails.

In Knoxville, police expressed frustration with long wait times and delayed responses and only engaged with the mobile crisis team for 40 of the 100 calls studied. In Birmingham, understaffing was an issue as there were only six community service officers for over 900 police officers. The lowest rate of arrest was in Memphis, Tennessee due to the presence of a crisis drop-off center for persons with mental illness that had a no-refusal policy for police cases (Steadman et al, 2000). Although using specialized services reduced the likelihood of arrest in all three cities, Memphis' crisis center and robust training allowed for the lowest arrest rate – showcasing that training law enforcement is just one piece of the puzzle and that for CIT training to work as intended, there needs to be mental health services and facilities available to individuals as well. This study is considered medium strength since it did look at three different localities and three different approaches to police-based diversion. It's not high strength because the size of the study was relatively small at 100 calls per city, and it's bit dated.

Studies about the efficacy of CIT are mostly related to officer-related outcomes and readiness, such as whether CIT trained officers felt equipped to handle an encounter with an individual experiencing a mental health crisis. Many studies about the efficacy of CIT do not provide a conclusive result to whether CIT is able to reduce arrests in the police jurisdictions where

officers can opt to become CIT trained. Generally, CIT training is shown to lead to positive outcomes – which includes better preparedness for officers to deal with encounters with individuals experiencing a mental health crisis and reduced arrests (Compton et al, 2014; Taheri, 2016).

Alternative #2: Mental Health Courts

A meta-analysis on the efficacy of MHCs shows that there is a 74% reduction in the chances of reoffending among the individuals who went through MHCs compared to those who did not. Therefore, there is some basis to suggest that diverting people from jail through MHCs reduces recidivism, or a rearrest (Fox et al, 2021). The meta-analysis is considered a high strength study since it looked at over 30 different evaluations, all of which occurred from 1998 to 2020. The meta-analysis examined a large amount of studies itself, and was specifically looking at the effect of jail diversion on recidivism on adults and juveniles with mental illnesses. A study conducted in 2016 shows that the effects of MHC were consistent with other studies, in that participants who completed programs laid out by MHCs had spent fewer days in jail one year post release compared to individuals who had not gone through a MHC (Lowder et al, 2016). The 2016 study would be considered medium strength since it did follow individuals for one year post-release, but the sample size was relatively small at only 97 total participants.

Given those findings, there is a lot of scope for future research, particularly divided up by effects on adults versus juveniles and across different localities. Moreover, the studies are not randomized and likely will never be due to the requirement of funding sources for courts and the feasibility of not being able to employ a randomly assigned experimental design within the larger criminal justice system (Honegger, 2015). Despite the lack of robustness and methodology of some of these studies, MHCs are generally considered an emerging practice, continued research of their efficacy is required to hone their practice and implementation (Honegger, 2015).

It will continue to be challenging to access MHCs due to the nature of how they operate: although most courts share the same basic procedures, MHCs are unique and non-standardized across the U.S. For example, only certain mental health courts will allow individuals to appear before them if they have committed felonies; other MHCs will only accept nonviolent misdemeanor charges (Honegger, 2015).

Alternative #3: Community Mental Health Services – Warm Lines

A meta-analysis of the effectiveness of crisis lines showcases that they tend to be effective, however the results from these studies show that oftentimes the effectiveness is judged by the change in distress of the caller throughout the course of the call, and not by any other measure (Hoffberg et al, 2020). Due to these factors, a variety of these studies are considered biased and not highly reputable, giving them a low strength score. It's also important to note that these studies generally look at suicide prevention as a measure of success – it's difficult to say whether or not these folks would have been arrested if they had instead called 911 to get help.

However, it remains an intervention point worth looking into since mental crisis lines are becoming more widely available.

Criteria for Evaluation

All three alternatives were measured against four criteria: cost effectiveness, political feasibility, administrative feasibility, and equity. These criteria were selected because they are important factors of implementation, particularly both feasibility criteria. Since OHA is a

governmental agency, it must consider cost and administrative feasibility as a part of its calculus when it comes to implementing jail diversion solutions. Since OHA lists health equity as one of its core values, I selected equity as a criterion.

Criterion #1: Cost Effectiveness

In the context of jail diversion, cost effectiveness is gauging how expensive the implementation of an alternative would be compared to the status quo of carrying on without intervening. In *Policy Analysis for Social Workers,* efficiency is defined as "assessment of achieving program goals or providing benefits in relation to cost" (Caputo, 2014). I used various state resources, literature on CIT to figure out the baseline costs for each alternative.

I kept the following questions in mind while assessing cost effectiveness:

- Who is bearing the costs for the alternative?
- Are the costs of the alternative greater than the costs of the status quo?
    - This is directly related to the costs of housing people in jails and prisons.

This criterion will be measured on a low, medium, and high scale.

Criterion #2: Political Feasibility

Any policy alternative will inevitably have some sort of politics tied to it – whether it will even be implemented, how it will be implemented, whether it will be funded, can all be innately political decisions. Political feasibility is defined by Caputo as "the likelihood that a policy will be adopted, or the likelihood that elected officials will accept and support a policy proposal" (2014). Given that there can be political implications whenever a statewide agency takes action, I want to ensure that the proposed alternatives would not receive significant pushback, by either OHA itself or any of the partners they work closely with which includes law enforcement, courts, mental health community programs among many others. It should be noted that experimental policy that fails is more politically feasibly than policy that was touted as more likely to be successful (Caputo, 2014). I kept the following questions in mind while assessing alternatives for political feasibility:

- Will the alternative be adopted quickly?
- Does the alternative only benefit a specific population?
- Who is bearing the costs?
- Were earlier versions (if applicable) of this alternative successful?

This criterion will be measured on a low, medium, and high scale.

Criterion #3: Administrative Feasibility

Caputo defines administrative feasibility as "the likelihood that a department or agency can implement the policy or deliver the program well" (2014). Oregon Health Authority is a

statewide government agency, which means that it will encounter administrative burdens and red tape when it comes to implementing alternatives. It also may take additional time and effort to pull together a plan for a particular alternative and then implement it. Imbedded into administrative feasibility is a time consideration, and how long it will take for the alternative to be partially or fully implemented. I kept the following questions in mind while assessing alternatives for administrative feasibility:

- Does a version of this alternative already exist?
- How many actors will be involved in the implementation of this alternative?
- How long will it realistically take for this alternative to be fully realized?

This criterion will be measured on a low, medium, and high scale.

Criterion #4: Equity

Equity is difficult to quantify, so will be measured on a low, medium and difficulty scale. Some of the proposed alternatives are potentially biased, especially given that outcomes for racial minorities and men tend to be less favorable when it comes to encounters with law enforcement. Although an alternative may be appealing, when it comes to the actual implementation of the alternative, it must be carefully considered if it would affect everyone equally. To judge against this criterion, I carefully considered on how each alternative would affect minority populations specifically. This type of equity is called outcome equity, which refers to the "fair distribution of societal goods, such as wealth, income or political power" (Caputo, 2014). I kept the following questions in mind while assessing alternatives for equity:

- Will this alternative benefit a minority population?
- Does this alternative take special care to not be discriminatory towards marginalized populations?

This criterion will be measured on a low, medium, and high scale.

Findings

In this section, I review each of the three alternatives against the four evaluative criteria outlined earlier.

Alternative #1: Crisis in Training for Police Officers

Cost Effectiveness: Medium

The cost of administering the program versus housing an individual can be somewhat convoluted and difficult to figure out. The net financial effect of a CIT program is of modest benefit; however, much of this analysis is based on estimates and average length of stay. The costs of training officers are generally fairly low, although the exact cost may vary depending on the state and partner organizations. According to the National Alliance on Mental Illness, it can cost anywhere from $175 to $250 per officer to train them according to CIT standards. The cost of CIT training is low because it is developed through community collaboration, and often volunteers are willing to contribute their labor to train officers. Given that clear cost discrepancies exist between inmates with mental illnesses and those without, diverting people away from jail should generally be considered a cost-savings approach for taxpayers. The Department of Justice estimates that approximately $15 million of American taxpayers' money goes toward housing individuals with mental illnesses in prisons and jails, translating to $50,000 per inmate annually (Org, M.I.P., n.d.).

Political Feasibility: High

Oregon is known to be a progressive state that is working on its overdose and drug problem. Previously, Oregon had decriminalized the possession of all drugs, to divert individuals with drug problems away from jail and towards treatment programs. Although this was recently overturned after Portland officials declared a 90-day state of emergency in Oregon's largest city after a high amount of public drug use and overdoses (Corkery, 2024). Given the public's changing opinion on the nature of addiction and recent events that have transpired in Portland, it's certainly possible that ordinary folks will want to see law enforcement more closely involved in the oversight of addiction. Given the popularity of repealing Measure 110, it's also highly likely that Oregon Governor Tina Kotek will go ahead and sign the bill repealing the measure. Given that CIT training is already widely available in the state, it shouldn't take an unreasonable amount of time to shore up existing programs and spread CIT to counties where it doesn't already exist. Relatedly, since CIT has already proven to be fairly effective, it should be a popular alternative among the public and politicians alike.

Administrative Feasibility: High

Oregon Health Authority already has an existing contract with the Oregon Center on Behavioral Health and Justice Integration (OCBHJI) which administers CIT programs across the state. Oregon also has a Crisis Intervention Team Center of Excellence that provides structure, support and technical assistance to Law Enforcement agencies and their local Behavioral Health agencies in the development of a local CIT program (Oregon Knowledge Bank, n.d.). Although there are no requirements for police officers to be CIT trained in the state of Oregon, there is a recommendation that police officers in Oregon undergo at least three hours of training every year dedicated to interactions with persons experiencing a mental health crisis. It's also important to note that Oregon has 174 law enforcement agencies, which makes a state-

mandated CIT training requirement unlikely. However, the existing infrastructure of CIT should make it easier for local jurisdictions to take up CIT.

Equity: Medium

CIT training can generally be considered a step towards equity (University of Richmond Police Department, n.d.). CIT training allows officers to become more sensitive to the needs of individuals who are experiencing a mental health crisis. This is based on preliminary findings, although generally research around equity tends to be emerging and not totally sound. Oregon Health Authority also explicitly mentions health equity as one its core values, with it being the first one to appear in a list of its seven values (Oregon Health Authority, n.d.).

Alternative #2: Mental Health Courts

Cost Effectiveness: Low

The average cost for psychiatric treatment in a community hospital ranges from $3,616 to $8,509, depending on the type of illness being treated. A simple calculation reveals that for an adult, the cost of 35 to 83 days in prison would provide the financing of a hospitalization that would have a better chance of bringing about recovery (Strensland, 2012). Given that on average, it costs $116.91 per day to house an inmate in a prison, it is of course more expensive (in the short-term) to send an individual to prison. However, it could be argued that diverting someone away from jail and to treatment instead would save the individual all the effects of incarceration and any future costs of housing them in jail in the future (*Federal Register :: Request Access*, 2023).

Political Feasibility: High

Since the previous citation method of handling drug use has become extremely unpopular, using mental health courts may be a more feasible and well-received approach by the community. Judges continue to hold power over sentencing even with the newly passed criminalization over illicit drugs. Judges can sentence individuals to probation and divert them to treatment even if the person indicates they would rather serve time in jail (Gebel, 2024). The costs of institutionalizing individuals, however, remains extremely high and could serve as a disincentive when it comes to deploying a solution to the overpopulation of mentally ill individuals in the criminal justice system. The system already exists, which means that it would not require a complete overhaul of an old system or creation of a new system which is attractive to politicians and the public, since it will inevitably cost less. Again, the atmosphere in Oregon is charged at the moment because of the failed decriminalization attempt therefore solutions that are more active and tried + tested will be more popular at this point in time.

Administrative Feasibility: Low

Mental Health Courts already exist in several Oregon counties, so the concept is not unfamiliar to Oregon. Several mental health courts list out key characteristics of mental health courts on their websites, such as Multomah, Josephine, etc. However, there have been instances of

overworked staff and lack of capacity being reported that make the administration of mental health courts arduous. It's also important to note here that Oregon State Hospital, Oregon's public psychiatric hospital, only has 705 beds, and that often times they are completely full. Often, even folks who are in trial in local courts are sent to Oregon State Hospital, especially if they are unable to aid and assist in their own defense. It's unlikely that the hospital will increase its capacity in conjunction with the increased use of mental health courts therefore the administrative feasibility is low.

Equity: Low

There is considerable evidence that the behavioral health system disproportionately punishes people of color and low-income individuals. Therefore, it's fair to say that any system existing in this structure would perpetuate that cycle, even if the court is specifically designed to divert individuals with mental illnesses away from jail.

Alternative #3: Community Mental Health Services – Warm Lines

Cost Effectiveness: Low

It remains extremely difficult, if not impossible, to discern, whether or not an individual calling a warm line or seeking treatment is actually being diverted away from jail. There is no true way to know what would've happened if they had not called the warm line. According to a Crisis Text Line, it costs around $1,000 to train volunteers. The cost of actually administering a warm line – which is distinct in nature from a crisis line – is difficult to procure.

Political Feasibility: Low

Given that Oregon is facing a massive mental health crisis along with an overdose problem, these community health programs may be unpopular as the state becomes harder on crime and less lenient on non-violent drug charges. Given how poor the rollout of the drug decriminalization was, and how that involved a hotline for troubled folks to call, it's not likely that this alternative will be popular with the public or with politicians as not many individuals who received citations called the number they were given. Over 7,000 citations were issued, and only a few hundred people called the number, and even fewer people than thought sought treatment. This alternative is also not tried and tested, which therefore may impede its pursuit by any authorities. There is still much to be studied about warm lines – and even crisis lines – which ultimately makes it unattractive.

Administrative Feasibility: Medium

Even though a lot of these administrative mental health programs operate outside of OHA and the criminal justice system entirely, they are still somewhat connected as community partners to various local jurisdictions. There is a warm line already operating in Oregon that is accessible 24/7 in English and Spanish. Given that the infrastructure already exists, it wouldn't be as difficult to shore up the resources being allocated to this warm line. However, the level of care

that warm lines provide continue to be disputed and it's unclear how and when a fully staffed and efficient warm line could be fully realized.

Equity: Low

Gauging the equity of a warm-line is difficult, given that warm lines are generally serviced by volunteer peers who have experienced mental health crises themselves. A panel of technical experts on peer-operated warm lines spoke candidly about how peers who are volunteering on the warm lines may have trouble connecting to the people who are calling in, and would require further training across racial, demographic and socio-economic lines in order for the services provided by warm lines to be truly considered effective (Peer-Operated Warm Lines Technical Experts Panel, 2023).

	Crisis In Training	Community Mental Health Programs (Warm Lines)	Mental Health Courts
Cost Effectiveness	Medium	Low	Low
Political Feasibility	High	Medium	High
Administrative Feasibility	High	Medium	Low/Medium
Equity	Medium	Low	Low

Figure 3: Outcomes Matrix

Recommendation

When jail diversion programs are implemented successfully, it allows individuals to identify their maladaptive behavior and get the help they need for it, thereby reducing the likeliness of committing an act that will land them in jail again. Based on what has been found regarding the alternatives and criteria**, I recommend OHA continue CIT programming for police officers and**

work to improve the delivery of CIT to counties that do not have active programs. CIT is the most sound and feasible alternative for Oregon at this time. Given that an infrastructure already exists for deploying CIT training across the state, it would be administratively feasibly to expand its services into other counties that have less robust or no existing CIT programs. OHA also has an existing contract and relationship with OCBHJI, a specialized division within Greater Behavioral Health, Inc. Given the backlash to Oregon's 2020 decriminalization of drug possession and the recent recriminalization, increasing and creating new CIT programs could be viewed favorably by politicians and the public alike.

Even though the equity aspect of CIT is not clear and may perhaps be low like the other two alternatives, it's important to understand that CIT still comes out ahead in both feasibility criteria even though it is not as low-cost as community mental health programming. It's important to consider the temperature in Oregon at the moment, as tensions between the state and the public remain unusually high over this subject.

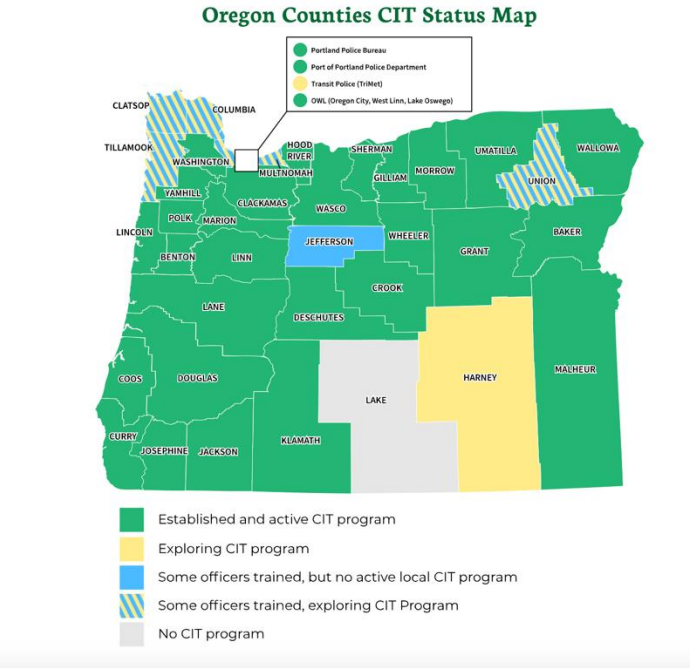


Figure 4: Oregon Counties CIT Status Map
Source: Oregon Center on Behavioral Health and Justice Integration

There is potential to further improve CIT by implementing it in the counties that it doesn't already exist in by using other Oregon counties as models. Out of the seven counties that have received new funding from OHA, three (Lake, Tillamook and Clatshop counties) either have no CIT program at all or only have some officers trained. These three counties could take cues from the other four counties (Wallowa, Baker, Crook and Lincoln counties) that also received the new funding, while the four counties that have CIT programs already can use the monies to

further improve their existing programs. Decision makers may also use the findings to help prioritize one type of diversion over another, although at the time it seems most politically amenable and feasible to invest any additional funding into law enforcement programs that have shown to be moderately successful.

Focusing on CIT doesn't mean that other jail diversion funding cannot be used to fund warm lines, or even crisis lines. Funding can continue to be invested into building more robust community mental health services, which are also part of the court system network and in turn part of the mental health courts alternative. In reality, a single approach to jail diversion can only go so far – ideally, some components of each alternative will be built up and each actor in the criminal justice system will have sufficient resources and training to be able to divert away qualified people from jail to the help that they so desperately need.

Implementation

Stakeholders

The main stakeholders involved in the implementation are OHA, OCBHJI, local law enforcement agencies and county officials. Each stakeholder represents a different aspect of what needs to be in place for CIT to be successful. OHA needs to provide the funds to train officers to become

CIT certified. OCBHJI needs to train officers. Law enforcement agencies need to be willing to allow their police officers to take time off from regular duty in order to be trained. County officials need to be on board and understand the benefits of CIT in order for the trainings to move forward. An overlooked stakeholder could be the general public, as people in Oregon and in Portland specifically have been increasingly unhappy with more lenient policies towards low-level offenses, even if the offense that was committed was non-violent. Community mental health partners will also be important to the implementation of CIT.

Worst Case Analysis

Based on some of the initial conversations I have had with county officials, some folks may not be as interested in pursuing CIT as an effective means of jail diversion since their counties are relatively small and don't have large police departments. The county may be resistant to CIT since it also represents a more heavy-handed, urban approach to jail diversion that rural, frontier counties may not see as suited for a smaller population. Relatedly, folks who are in and out of the jail system in those smaller counties are usually known entities to local law enforcement and they may not be willing to divert them to treatment if they have not already been amenable to it in the past. Police officers may also not be able to take time away from their normal duties, particularly in frontier counties, to do the training which requires officers to do the 40 hour training in one week's time.

General Takeaways

Jail diversion has reduced the amount of time mentally ill people spend in jail, which also reduced the burden on the jail. Jail diversion implementation should ensure that people who have committed low-level violent crimes can avoid prison time to receive the care that they need. CIT implementation is contingent on having readily available mental health services for individuals to be diverted to – it is not enough to be referred to treatment, the treatment needs to be accessible and robust in nature. This doesn't happen in a vacuum – success depends on strong collaboration efforts from the various stakeholder groups and also with good professional, working relationships among the staff that are supporting work on these programs. Law enforcement should also have a strong relationship with mental health professionals and services in their jurisdiction for CIT to be effective (Taheri, 2016). Jail diversion implementation will ultimately depend on the coordination and work of many different organizations and health intervention services, not just Oregon Health Authority.

Implementation is not a one and done battle – it must be endured and won, repeatedly.

The National Alliance on Mental Illness (NAMI) has an extensive list of resources on how to go about implementing CIT programs. There is also a state-based arm of NAMI that can work with OHA and other stakeholders to figure out how to best implement CIT in counties across Oregon. There are unique challenges to improving upon an already existing program. The most difficult part will be tailoring each iteration of CIT for each county, particularly the counties who don't have any existing CIT programming. That requires hours of meeting and consulting with all local

departments who play a role in jail diversion and CIT. However, it seems like a worthwhile up-front investment to make at this moment in time while other programs are being heavily scrutinized and there is a public aversion to being lenient with people, even if they are committing low-level non-violent offenses.

CIT is almost always voluntary, so it may be worthwhile to explore whether or not it could be further incentivized. Offering a monetary incentive or a faster promotion by taking the training could perhaps encourage officers to take on the training. According to research, motivating police officers can be complicated. Extrinsic motivators like pay raises and longevity + educational pay are considered effective motivators, although intrinsic rewards can sometimes be more rewarding than pay raises or promotions (Fortenbery, 2015). If it's not possible to offer monetary incentives to officers to undertake the CIT training, perhaps there could be local/state or federal rules made to standardize the program and have a requirement that a CIT trained officer must be on duty at all times – therefore a CIT officer is available 24/7 whenever someone in distress calls 911 or has 911 called on them.

Conclusion

Jail diversion appears to be a sound approach to the overrepresentation of mentally ill people in jail. However, it has proven to be difficult to fully understand its efficacy given that there cannot be any randomized control trials or studies done in the criminal justice system. In that same vein, it's difficult to parse out the exact effects of a particular intervention done at an

intercept since various groups work together in tandem when it comes to institutionalizing a person.

The success of jail diversion programs requires the coordination and cooperation of many different stakeholders across organizations, governments, communities, etc. Jail diversion is inherently complicated because it involves the criminal justice system (which is also filled with a multitude of actors) and folks at a very difficult time in their lives. Out of the three policy alternatives that I proposed, CIT is the best solution for overcrowded jails that disproportionately house individuals with mental illnesses. CIT implementation will require coordination among law enforcement, community mental health partners, courts, the people who are being diverted away from jail, and possibly even more actors. According to a report by the Substance Abuse and Mental Health Services Administration, collaboration between community providers and law enforcement officers is key to effective jail diversion (Principles of Behavioral Health Services, 2019).

However, given the existing infrastructure in Oregon, implementing CIT should prove easier than the other two proposed policy alternatives. CIT is shown to be effective in reducing officer and citizen injuries and deaths, and is fairly low-cost. It's also present in almost every county in Oregon already, which makes it easier to expand and improve existing programs, and lend way for new programs.

Appendix

Figure 1: U.S. State and Federal Prison Population: 1925-2014

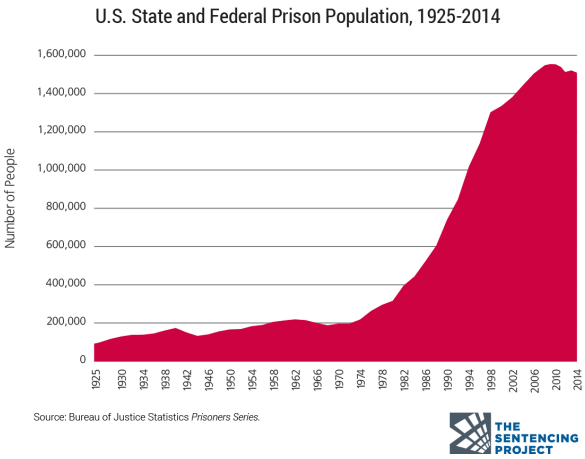


Figure 2: Sequential Intercept Model

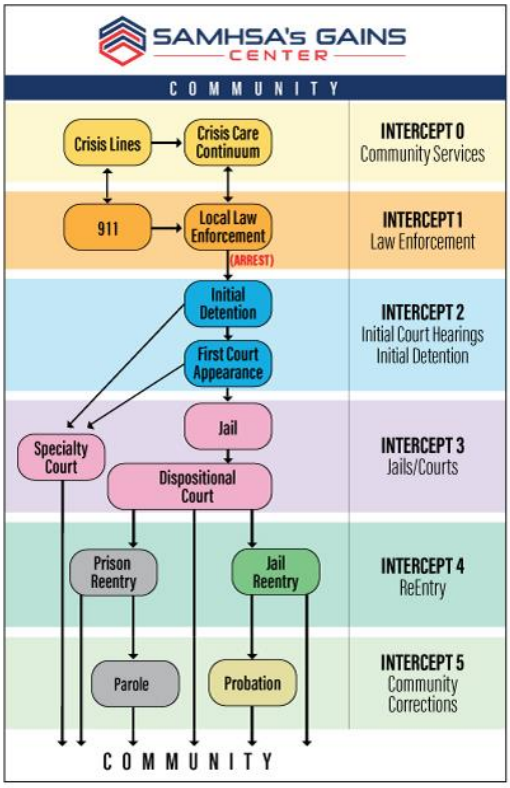
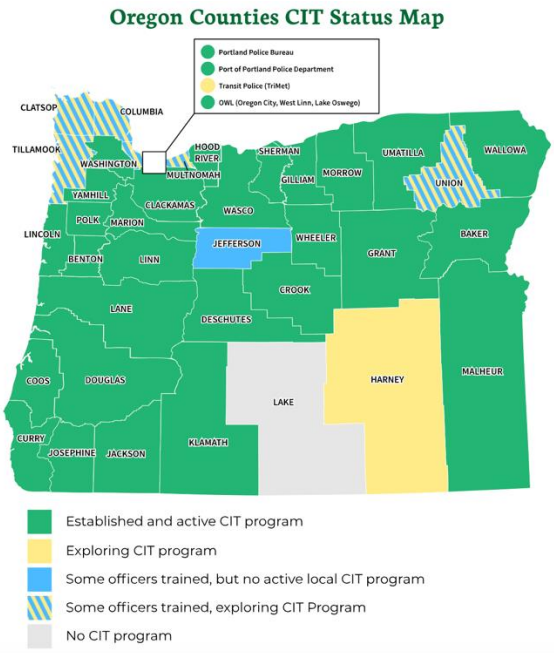


Figure 3: Outcomes Matrix

	Crisis In Training	Community Mental Health Programs (Warm Lines)	Mental Health Courts
Cost Effectiveness	Medium	Low	Low
Political Feasibility	High	Medium	High
Administrative Feasibility	High	Medium	Low/Medium
Equity	Medium	Low	Low

Figure 4: Oregon Counties CIT Status Map



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