

# Law Enforcement Response to People with Mental Illnesses in Benton County

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## Introduction

The disproportionate arrest and incarceration of people with mental illnesses is a significant concern for police, policymakers, and academic researchers throughout the United States. Benton County (Oregon) law enforcement agencies have reported this very concern -- a significant increase in police contacts with people with mental illnesses<sup>1</sup> in recent years. In this context, this project (1) examined the prevalence of contacts between police<sup>2</sup> and people with mental illness; (2) examined some of the potential causes and consequences of the change; and (3) provided policy suggestions, based on the available research, for more efficiently and successfully addressing contacts between those with mental illnesses and the police.

## Methodology

The research team used official police records to document the trends in contacts with mentally ill suspects. Two sources of data were analyzed. First, **Peace Officer Custodies (POC)** were analyzed using a dataset of all arrests made by Benton County Sheriff's Office (BCSO) or Corvallis Police Department (CPD) from 2007 through 2012. A Peace Officer Custody is an arrest that occurs because an individual is believed to be a danger to him/herself or others due to mental illness.<sup>3</sup> The second dataset contains all police contacts in Benton County deemed to be related to mental illness. These data cover all law enforcement agencies in the County and span the years 2007 through 2012. A contact was deemed to have a mental illness component if (a) a police officer recorded "mental" or "12-60" in free-text comments about the contact, or (b) a dispatcher coded a call for service as "mental" based on information received from the caller. This second dataset includes contacts that generated an official case number as well as those resolved without a case number. Both types of contacts are recorded as a matter of law enforcement policy. While this measure of mental illness-related contacts is subject to some measurement error we have no reason to think that the tendency to identify a situation as "mental" increased over time. Law enforcement chiefs assured the research team that there have not been any systematic changes in protocol regarding how mental health contacts are

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<sup>1</sup> It is important to note that throughout this report the term *people with mental illnesses* refers to people *perceived* by law enforcement as exhibiting symptoms of a mental illness.

<sup>2</sup> We use the term "police" to refer to agents of law enforcement, which includes sheriff's deputies.

<sup>3</sup> Per ORS 426.228, a peace officer may take into custody a person who the officer has probable cause to believe is dangerous to self or to any other person and is in need of immediate care, custody or treatment for mental illness. As directed by the community mental health program director, a peace officer shall remove a person taken into custody under this section to the nearest hospital or nonhospital facility approved by the Oregon Health Authority.

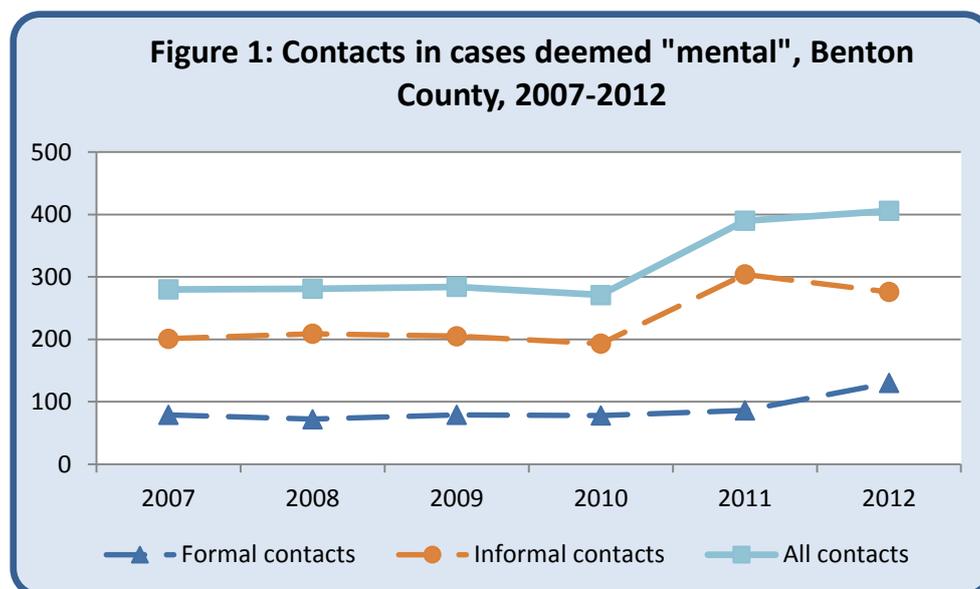
handled. As such, we are reasonably confident that the observed increases in mental health contacts are not a result of changes to internal policing practices.

The research team also gathered data on the local mentally ill population from semi-structured interviews with key actors in organizations that interact with people with mental illness. This collection of data occurred in two phases. Phase 1 (April 2013-July 2013) focused on *procedures* regarding organizational goals, services, funding, interorganizational collaboration, and challenges in providing optimal service to the mentally ill community. Phase 2 (September 2013) focused on *perceptions* of key agents working with mentally ill individuals, asking about potential causes, solutions, and challenges to implementing reforms in Benton County.

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## Defining the Problem: Prevalence of Contacts between Law Enforcement and Mentally Ill Suspects

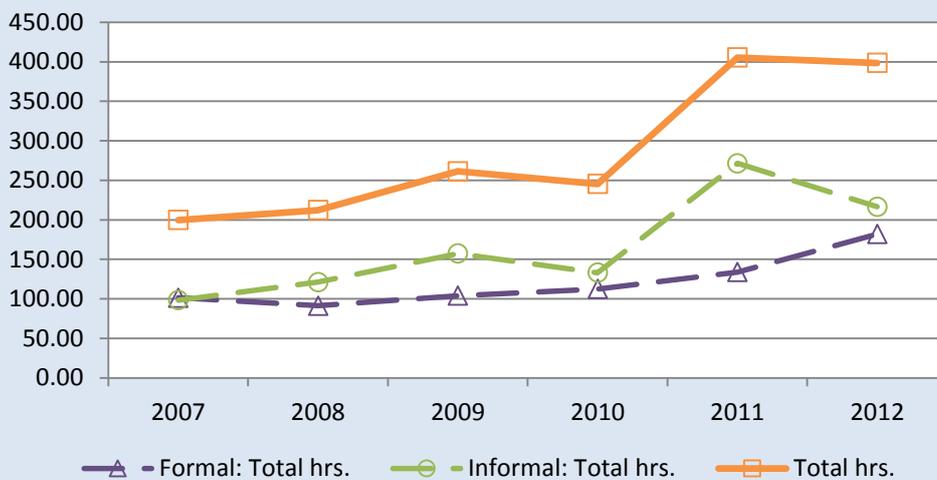
Quantitative analysis of official police records documents the changing amount of contact between law enforcement officers and mentally ill suspects. One way of assessing these contacts is by considering all police contacts in Benton County that were flagged as "mental" either by responding officers or police dispatchers. Figure 1 shows the total number of such contacts broken down by whether the contact was resolved formally with an official case number or informally with no official case number. The graph reveals stability in the overall number of such contacts from 2007 through 2010. The total number of "mental" contacts jumped in 2011, driven by a rise in informally resolved police contacts. The total number of contacts continued to rise through 2012, as law enforcement officials began to resolve more "mental" contacts formally.



Examining POC's (individual believed to be a danger to him/herself or others due to mental illness) provides another way to look at the problem. Notably, law enforcement experienced a significant rise in POCs, much of which was attributable to **"repeat players"**

(RPs), those who had at least two POC arrests in a given year.<sup>4</sup> The rise in RP arrests appears to be driven by growth in this population; the number of RPs in the community approximately tripled in 2012 while Single POCs increased 40%. Most of the RPs arrested in 2012 were not arrested with POCs in prior years, indicating these individuals may be new to the community. Although POC suspects are generally unlikely to be arrested on a non-POC charge, statistical analysis shows that RPs are more likely than the typical POC suspect to be charged with a non-POC crime

**Figure 2: Time spent on cases deemed "mental", Benton County, 2007-2012**



Another way to examine the data is to consider the amount of time police spent on calls prompted in response to a person that was perceived to be suffering from a mental illness (dispatch code 12-60 or "mental"), which allows for analysis of the total amount of time Benton County law enforcement spent on mental health-related contacts. Figure 2 shows a slight increase in time spent on all mental health contacts from 2007 through 2010. This is followed by a dramatic rise in 2011, driven largely by the increased number of informally resolved contacts and the time spent on them. By 2011, Benton County law enforcement agencies were spending more than 400 hours per year in mental health contacts, double the 200 hours spent on such contacts in 2007.

### Possible Causes of Increasing Mental Health Contacts

With limited available data the quantitative section of this report examined a number of potential reasons for the rise in contacts with the mentally ill by law enforcement, including levels of homelessness and unemployment, and concluded that these variables cannot explain the increase in contacts. The qualitative analysis also shed light on potential causes for the increase in police contacts with the mentally ill, and the results

<sup>4</sup> This is a conservative measure of "repeat player" arrests, underestimating the number of arrests due to repeat players. The current measure will fail to capture individuals whose POC arrests are spread across multiple years, perhaps in close proximity (e.g., December 31, 2010 and January 1, 2011).

suggest a number of factors may be relevant. Among the most important are the partial closure of the Oregon State Hospital (OSH) beginning in 2008, the relative attractiveness of the Corvallis area for the mentally ill and homeless in terms of services and acceptance, and the presence of an inpatient treatment facility at Good Samaritan Hospital. We elaborate a bit more about these potential causes below.

“Deinstitutionalization” represents a policy of moving people out of state public mental hospitals and into more public community care facilities (Koyanagi & Bazelon 2007). There have been several, not always linear, phases to this movement, but most relevant to the present study is that in the 1990s there emerged a new philosophy of recovery from serious mental illness, which focused not on “cure” but rather living a normal life while also having a serious mental illness, and prompted increased rates of deinstitutionalization.

Oregon has seen such a push towards deinstitutionalizing those with serious mental illnesses. There was a phased closure of the Oregon State Hospital beginning in 2008<sup>5</sup> and, in November, 2011, the state division of Addictions and Mental Health began a long-term initiative (“Adult Mental Health Initiative”, or AMHI) to move institutionalized persons with mental illness into lower levels of care. In many cases this has meant a transition to independent living in the community (Addictions and Mental Health Division, 2010). This initiative has likely contributed to the growth in contacts between police and persons with a mental illness for a range of reasons.

Nationally, problems experienced as a consequence of deinstitutionalization included insufficient community mental health funding (Koyanagi & Bazelon 2007), a problem regularly expressed by our study respondents. In addition, Benton County has many community characteristics and resources that likely attract the homeless and mentally ill. The county and particularly Corvallis are relatively wealthy and progressive, with many resources serving populations in need (e.g. Stone Soup is a free-meal-assistance program that serves meals to anyone in need). Furthermore, the local law enforcement community has awareness in dealing with people who may have mental illnesses, which may serve to result in better treatment of this population. Finally Good Samaritan Hospital in Corvallis houses the regional inpatient mental health treatment facility. Its location in Corvallis attracts those needing treatment into the community and these individuals, particularly those that are homeless, may be likely to remain in the community once discharged from the mental health treatment facility for the reasons above among others.

## Potential Responses to Increased Mental Health Contacts

The literature has indicated that the following are potential responses to increased mental health contacts: specialized responses to mental health crises; mental health courts; protected health information sharing; and collaboration between law enforcement and mental health agencies.

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<sup>5</sup> There are replacement facilities—one in Salem, completed 2011 and one in Junction City as yet unfinished—but these facilities are not intended to house as many patients.

## Specialized Responses to Mental Health Crises

Specialized responses to mental health crises attempt to respond to such crises with respondents specially trained to deal with mental health crises. Specialized responses come in three forms: (1) police-based specialized police response, (2) police-based specialized mental health response, and (3) mental-health based specialized mental health response (Deane et al., 1999). These types of response vary according to who the trained responders are (mental health agents or law enforcement officers) and where they are based operationally (law enforcement agency or mental health agency). They share in common a desire to divert mentally ill offenders out of the criminal justice system and into a mental health treatment program. In the context of Benton County (size of population, magnitude of the problem in terms of annual contacts, available resources and institutions, etc.) it was determined that only specialized police response would be appropriate so we limit our discussion to this<sup>6</sup>.

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### Specialized Police Responses (Crisis Intervention Training)

The police-based specialized police response model involves training police officers to provide crisis intervention and to act as liaisons to the mental health system. Crisis Intervention Training (CIT) is the most prominent example of this model. CIT has two primary components. First, training for law enforcement officers, in which mental health professionals educate officers about mental illness, substance abuse, psychiatric medication, and techniques for identifying and responding to a mental health crisis (Canada et al., 2012; Tucker et al., 2008). In most cases, officers volunteer to undergo the training (Lord et al., 2011), which generally lasts 40 hours. Second, CIT requires a strong partnership and close collaboration between mental health and police. Many places pair CIT training and response with a no-refusal drop-off site (or possibly a mobile crisis team; described below) enabling officers to drop individuals in a mental health crisis (Lord et al., 2011). The drop-off site is designed to quickly insert the individual into treatment and to allow the law enforcement officer to return to policing duties (Tucker et al., 2008). This typically occurs in relatively large places where the magnitude of the problem demands it, and resources are available to facilitate it.

Research suggests that CIT<sup>7</sup> may reduce unnecessary arrests (Lord et al., 2011), increase officer's ability to resolve issues without force (Canada et al., 2012; Morabito et al., 2010), decrease time and costs when dealing with the mentally ill in the criminal justice system (Lord et al., 2011), and increase officers' ability to refer people with mental illnesses to treatment rather than hospitalization or arrest (Canada et al., 2012).

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<sup>6</sup> Please see the Full Report for a more thorough coverage of police-based specialized mental health response and mental-health based specialized mental health response.

<sup>7</sup> CIT training programs are multi-faceted, highly variable, and context-dependent (NAMI, 2013). As a result, it is not yet possible to identify precisely which components of CIT are most effective or whether effective programs will be equally effective in other jurisdictions (Compton et al., 2008). Second, CIT training is often done on a voluntary basis.

## Mental Health Courts

Mental health courts offer a specialized venue for engaging criminal suspects who suffer from a mental illness. Unlike pre-arrest diversion programs (like CIT), mental health courts attempt to divert the offender out of the criminal justice system and into appropriate treatment *after* being charged with a crime.<sup>8</sup> Mental health courts generally have a specialized docket of cases involving those with mental illness and feature a collaborative and non-adversarial team, comprising a judge, prosecutor, defense attorneys, and representatives from parole and probation and a mental health agency (Almquist & Dodd, 2009; Sirotich, 2009). These parties can tailor a response plan to fit the needs of the defendant, which may involve a referral to the local mental health system and compliance monitoring (Wolff, 2002). Arrestees participate voluntarily in the diversion program in order to avoid criminal sanctions (Castellano & Anderson, 2012; Miller & Johnson, 2011).

Reviews of research on mental health courts provide reason for optimism. Although the body of work on mental health courts is limited in terms of the number of studies and their scope, some studies have found that participation in mental health courts reduces recidivism or re-incarceration (Almquist & Dodd, 2009; DeMatteo, LaDuke, Locklair, & Heilbrun, 2013). There is also some evidence that mental health courts have positive mental health consequences for participants (see Almquist & Dodd, 2009; DeMatteo et al., 2013), although the evidence here is not definitive (Sarteschi et al., 2011; Sirotich, 2009). In addition, while mental health courts would require new expenses, there is some evidence that these costs would be offset by savings to the traditional criminal justice system, particularly in the form of reduced frequency of jail stays for those with mental illness (Almquist & Dodd, 2009)<sup>9</sup>.

## Health Information Sharing

In interviews, all police agents expressed a desire to gain more personal information about suspects in a mental health crisis. In the current regime, police officers are typically the sole-responders to a mental health crisis; they do not have on-site assistance from a mental health professional or caregiver. Without personalized information about a suspects' prior health history, current treatment plan, or support network, responding police officers may feel ill-equipped to handle a mental health crisis.

Police do not necessarily believe that diagnostic or clinical health information would be helpful. In some cases, it may be sufficient to know some basic background information about the person's known behaviors and/or contacts. Police did express a desire for basic descriptive information, as a means of learning about a person's past behavior.

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<sup>8</sup> Post-adjudication diversion models direct the offender to treatment after a guilty plea, while pre-adjudication models direct the suspect to treatment before legal guilt is established (Almquist & Dodd, 2009).

<sup>9</sup> One might also consider the extensive literature on other problem-solving courts, most notably drug courts, which supports their efficacy both in terms of reduced recidivism (Mitchell, Wilson, Eggers, & MacKenzie, 2012) and cost-savings (Downey & Roman, 2010).

There are legal restrictions on the type and amount of information a mental health professional can share with law enforcement officers, and interviews suggest this is the crux of the issue in Benton County. The federal Health Insurance Portability and Accountability Act (HIPAA) provides a broad framework for maintaining the privacy and security of protected health information (PHI). While HIPAA allows for some exceptions<sup>10</sup>, including in cases of imminent risk of harm, law enforcement may not receive PHI from a mental health provider without a person's prior authorization.<sup>11</sup> The information-sharing restrictions on mental health professionals represent a source of frustration for some law enforcement agents. Other law enforcement agents acknowledged the challenges HIPAA presents to mental health agencies in terms of information sharing, but also voiced their desire for improved information sharing in whatever manner was possible.<sup>12</sup>

There are many ways in which PHI might be transmitted from mental health service providers to law enforcement: over the telephone, in on-site consultations, or via an electronic database. We advise mental health agencies (perhaps collaboratively with police) to consult legal counsel to determine the extent of restrictions posed by HIPAA, what can and cannot be shared in particular circumstances, and the most appropriate means of securely transmitting this information.<sup>13</sup>

### Inter-Agency Collaboration

Collaboration between law enforcement agencies and mental health agencies is an important step in thoroughly addressing the rise in law enforcement contacts with mentally ill suspects (Almquist & Dodd, 2009; Deane et al., 1999; NAMI, n.d.). Inter-agency collaboration is not so much a discrete policy intervention, but rather an overarching philosophy that informs and facilitates various possible interventions. Collaboration may occur in various forms, some of which already exist in Benton County:

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<sup>10</sup> In addition to "imminent harm" these exceptions include locating a fugitive, missing person, suspect, or victim (Petrila & Fader-Towe, 2010).

<sup>11</sup> State laws may be more restrictive, and if so they govern. Oregon law authorizes the disclosure of health information "as permitted by federal law," thereby adopting the HIPAA standards (Pritts, Lewis, Jacobson, Lucia, & Kayne, 2009).

<sup>12</sup> According to John Petrila (J.D., LL.M.) and Hallie Fader-Towe (J.D.), experts on health information law, disclosure on the basis of imminent risk of harm is allowed if the mental health agent deems it "necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and if the disclosure is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat" (Petrila & Fader-Towe, 2010, p. 6)

<sup>13</sup> In Oregon, one established means of communication is the Law Enforcement Data System (LEDS). House Bill 3466 authorized community mental health and developmental disabilities program directors to enter and remove personal health data *after receiving express written consent from the individual or his/her guardian*. However, LEDS has not succeeded in providing law enforcement officers with pertinent mental health information.

1. Law enforcement agencies may schedule regular presentations at which community mental health service providers educate officers on the services they provide to the mentally ill population.
2. Mental health service providers may work with police to offer specialized officer training, such as CIT.
3. Law enforcement and mental health agencies may develop an ongoing relationship for managing individual cases of mental illness.
4. Mental health service providers and law enforcement may work together to improve the sharing of protected health information, perhaps through increased use of voluntary disclosure authorizations via LEDDS.
5. Law enforcement and mental health agencies may write and sign a memorandum of understanding, in which both sets of parties acknowledge the problem of increased mental health-related criminal justice contacts and brainstorm appropriate courses of action for minimizing the problem.

In Benton County, there is both a history of collaboration to build on and a desire for more collaboration between law enforcement and mental health agencies. The literature suggests that partnerships should be institutionalized and not dependent on certain authority figures (Thompson et al., 2003). Local law enforcement agents also expressed hope for future collaboration.<sup>14</sup>

One mental health professional reported that his agency tries to meet regularly with law enforcement to hear about the problems that certain persons with mental illness are creating for the police and the community. This new information can then spur mental health outreach to the persons involved.

In sum, collaboration between criminal justice agencies and mental health service providers represents a positive first step toward minimizing the problem of mental health-related police contacts. While collaboration is not a specific policy intervention in its own right, it allows the involved stakeholders to craft a broad-based set of reforms tailored to the local community.

## Recommendations<sup>15</sup>

1. Develop and sign a **memorandum of understanding**, in which law enforcement and mental health acknowledge the problem of increased mental health-related criminal justice contacts, and agree to meet regularly to address the problem collaboratively.
2. Seek **legal consultation regarding the HIPPA threshold for personal health information disclosure**.

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<sup>14</sup> For more detailed information see our final report.

<sup>15</sup> For more information about our recommendations access our full and final report.  
<http://www.co.benton.or.us/da/wcjc/documents.php>

3. Institute a **mental health court** (or mental health docket) in Benton County.
4. Convene law enforcement and mental health agents to **discuss the possibility of providing training such as CIT** assessing the feasibility and potential benefit of these options as part of a larger collaborative effort.
5. Continue **aggressive pursuit of grant funding** to assist Benton County in developing the infrastructure (implementation of mental health courts, treatment for people with mental illnesses who are incarcerated, community reentry services, and training for local law enforcement on how to identify and safely resolve encounters with people with mental illnesses) to better manage this problem.
6. Any policy changes made should be subject to **research evaluation**.
7. **Systematic monitoring** of the number of POC's and "mental" calls should continue.

## Further Reading

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