

Law Enforcement Response to People with Mental Illnesses in Benton County: Executive Summary

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Introduction

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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 illnesses¹ in recent years. In this context, this project (1) examined the prevalence of contacts between police² 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.

To achieve these goals, the research team conducted a review of existing research, conducted interviews with local stakeholders, and performed primary quantitative analysis of official police records.³ The review of existing research addressed extant policy responses to police contacts with the mentally ill in other jurisdictions, paying special attention to methodologically rigorous evaluations of their efficacy. The quantitative analysis of police records examined trends in the frequency of police contacts with mentally ill suspects and the disposition of such contacts. The quantitative analysis also sought to identify external trends (e.g., homeless counts, unemployment) that might explain the increase in police contacts with mentally ill suspects. Semi-structured interviews were conducted with individuals working in organizations that are either connected to the criminal justice system or that serve the community of people with mental illnesses, including law enforcement agents, mental health providers, and ancillary social service providers, among others. These data were used in an attempt to understand the potential causes of change in mental health contacts and what might be done to more effectively address these contacts in the specific context of Benton County.

We foreshadow the results in brief here before delving into more detail. The quantitative analysis of police records confirms that Benton County police contacts with mentally ill suspects increased dramatically in 2011 or 2012 (depending on the measure used). The increase does not seem to be driven by increases in homelessness or unemployment. Much of the increase in contacts is the result of an increased number of “Repeat Players” (RPs) – persons with multiple mental health related police contacts – since 2011. Most of these RPs did not have formal contact with Benton County law enforcement prior to 2012, indicating that they may be new to the community. While the cause of the increase in the presence of Repeat Players in the community remains to some extent unknown, a number

¹ It is important to note that throughout this report the term *people with mental illnesses* people *perceived* by law enforcement as exhibiting symptoms of a mental illness. The term should not be taken as an indication of a formal clinical diagnosis. Law enforcement agents have distinctive criteria and thresholds which they utilize to determine if a person has a mental illness. The specific criteria and thresholds may vary by agency, officer and even by contact, based on existing knowledge, or lack thereof, of the individual being contacted.

² We use the term “police” to refer to agents of law enforcement, which includes sheriff’s deputies.

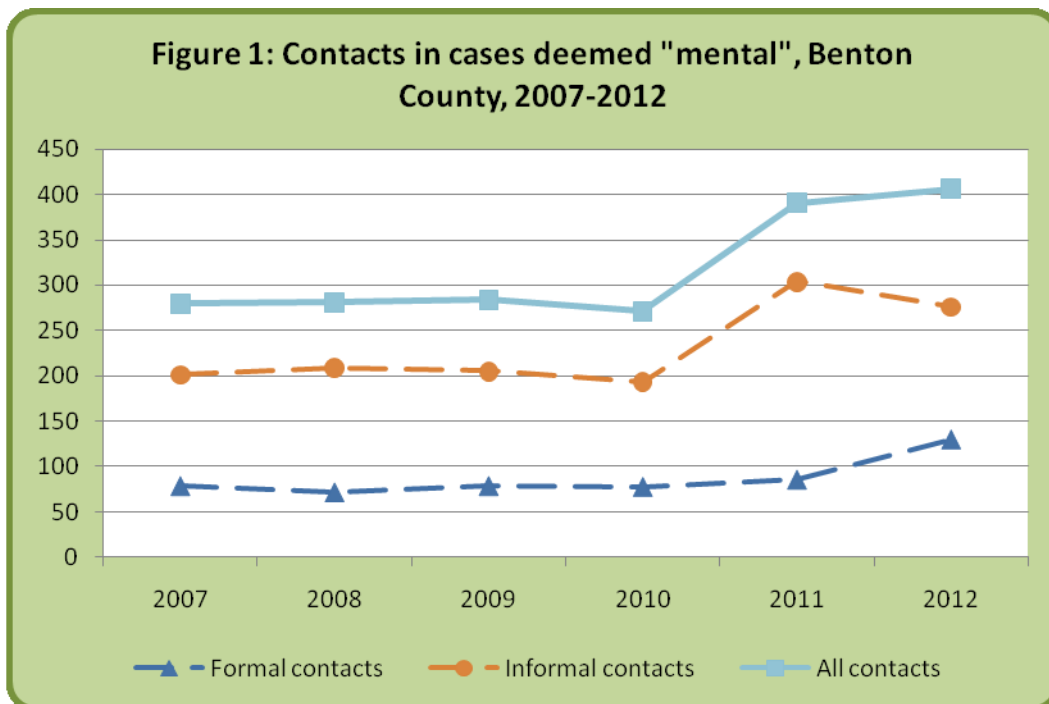
³ Appendix A contains an overview of the methodology used in the study. The full report contains a complete description of methodology.

of plausible explanations are discussed. Regardless of cause, the contact figures confirm the existence of a significant and growing problem, which may negatively impact police resources and public safety outcomes. We review possible responses to the increased level of contacts and conclude with several recommendations suited to the local context of Benton County.

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

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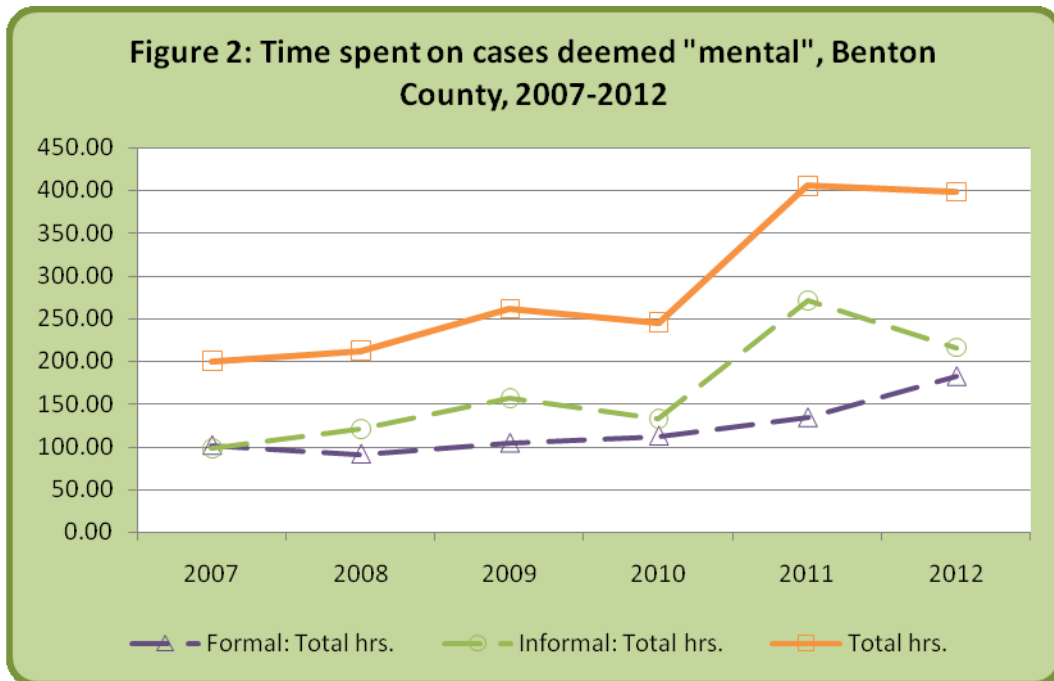
Quantitative analysis of official police records documents the changing amount of contact between law enforcement officers and mentally ill suspects. One way of assessing these contacts is by considering all police contacts in Benton County that were flagged as "mental" (or "12-60," the local law enforcement code for mental health crisis) either by responding officers or police dispatchers (on the basis of the call for service). Figure 1 shows the total number of such contacts ("All contacts") broken down by whether the contact was resolved formally with an official case number ("Formal contacts") or informally with no official case number ("Informal contacts"). 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.



Law Enforcement Response to People with Mental Illnesses in Benton County

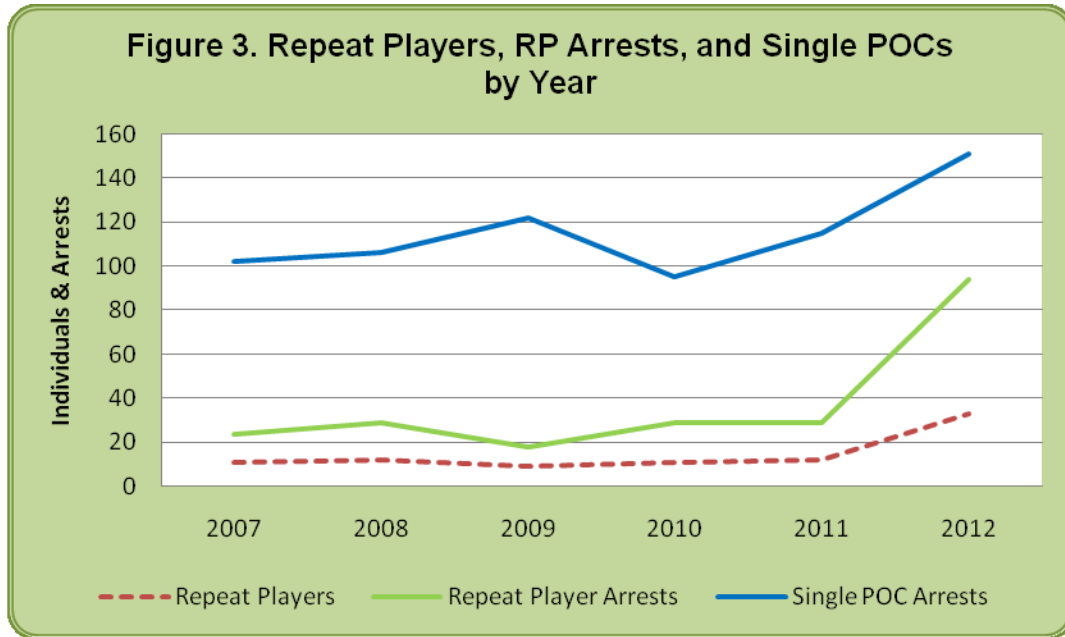
The police records contain information on the time spent during each police contact, which allows for analysis of the total amount of time Benton County law enforcement spent on "mental" contacts. Figure 2 shows a slight increase in time spent on all "mental" contacts from 2007 through 2010. This is 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" contacts, double the 200 hours spent on such contacts in 2007.

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The use of "Peace Officer Custody" provides a different measure of police contact with mentally ill suspects. A **Peace Officer Custody (POC)** is an arrest that occurs because an individual is believed to be a danger to himself or others due to mental illness.⁴ As seen in Figure 3, the number of POCs fluctuated between 124 and 144 each year between 2007 and 2011. In 2012, the number of POCs jumped to 245, more than 60 percent above than the previous high point. This rise in POCs is not a function of rising frequency of total arrests in Benton County, as the number of non-POC arrests declined slightly from 2010 through 2012.

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Much of this rise in POCs was attributable to "**repeat players**" (**RPs**), those who had at least two POC arrests in a given year.⁵ 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% (Figure 3). Most of the RPs arrested in 2012 were not arrested with POCs in prior years, indicating they 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 (see final report for details).

⁴ 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.

⁵ 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).

Possible Causes of Increasing Mental Health Contacts

These above figures confirm that Benton County has experienced a significant increase in the number of contacts between people with mental illnesses and law enforcement. The increase does not correspond to trends in homelessness, unemployment rates, or general arrest patterns in Benton County, and as such these factors are not likely to be causes of the rise in mental health contacts. As shown above, the increase has been driven disproportionately by a relatively small group of "repeat players", and an explanation of the trend in mental health contacts will likely involve a detailed examination of the identities of these RPs, which would require data not presently available to the research team. Although a clear statement of the cause is not possible with available data, we draw on interviews of local actors with knowledge of the mental health population, mental health policy documents, and existing studies on this topic to present several possible explanations of the rise in mental health contacts.

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- A partial closure of Oregon State Hospital beginning in 2008 and 2009 released some people with mental illnesses back to the community (Oregon Health Authority, n.d.). In November, 2011, the state division of Addictions and Mental Health began a long-term initiative ("Adult Mental Health Initiative") to move institutionalized persons with mental illness into lower levels of care, which in many cases has meant a transition to independent living in the community (Addictions and Mental Health Division, 2010).
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- Although the burden for treating these people was placed primarily on community mental health organizations, there are often insufficient resources for outpatient treatment. This problem exists in many places nationally.
 - Benton County, and especially Corvallis, has many community resources and characteristics that attract people who are homeless and may have unmet mental health needs.
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- The presence of the inpatient treatment facility in Corvallis' Good Samaritan Hospital likely brings people with mental illnesses to the area, and these people may not leave once they have arrived for the reason above.
 - Greater law enforcement awareness and training in dealing with people with mental illnesses may have influenced police procedures. For example, the rise in POCs could conceivably be a result of internal directives to treat suspects with mental illness in a more formal manner, perhaps as a means of reducing legal liability. Quantitative analysis of the available data on formal and informal contacts, as well as consultation with heads of law enforcement agencies on recording practices, suggest that changes in internal procedures have not occurred and cannot fully explain the observed rise in mental health contacts.
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Potential Responses to Increased Mental Health Contacts

We reviewed the research literature for several types of responses to increasing law enforcement contacts with mentally ill suspects in order to assess their potential efficacy in reducing such contacts in Benton County. Because prior research on these responses comes from diverse contexts, we also incorporated data from our interviews to assess the extent to which the responses are a realistic response in the context of Benton County. These responses fall into the following categories: 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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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, Steadman, Borum, Veysey, & Morrissey, 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.

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, Angell, & Watson, 2012; Tucker, Van Hasselt, & Russell, 2008). In most cases, officers volunteer to undergo the training (Lord, Bjerregaard, Blevins, & Whisman, 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 may:

- Reduce unnecessary arrests (Lord et al., 2011), although the research on this is not consistent (cf. Sirotych, 2009; Watson et al., 2010).
- Increase officer's ability and confidence to resolve encounters with people in crisis without using force (Canada et al., 2012; Lord et al., 2011; Morabito et al., 2010).
- Decrease time and costs of dealing with people with mental illnesses in the criminal justice system (Lord et al., 2011).
- Increase trained officers' ability to appropriately refer mental health services as opposed to hospitalization or arrest (Canada et al., 2012).

These findings on CIT should be treated cautiously, however, as many studies on this topic suffer from methodological weaknesses (Compton, Bahora, Watson, & Oliva, 2008; Geller, 2008; Sirotych, 2009). Two criticisms are especially important. First, 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. Consequently, we cannot be confident that the CIT training made any additional contribution to officer performance above and beyond what might be expected from officers already predisposed to volunteer for a mental health training program (Geller, 2008).

Interviews with police agents suggest mixed perspectives on implementing CIT training in Benton County. Some police officers felt that further training could be beneficial while others do not perceive that there is a need for further training. The latter view ad hoc health information sharing and field experience as more relevant for successful outcomes in resolving mental health call. Second, most agencies do not reward trained officers for completing additional training, which may depress voluntary enrollment in training.

Specialized Mental Health Responses (Co-Response Teams)

In the latter two responses—police-based specialized mental health response and mental-health based specialized mental health response—are similar in that both involve a collaboration between mental health responders and police officers, but they differ in whether the mental health responders are embedded within the law enforcement agency or external to it. Both of these approaches involve "co-response" teams, since law enforcement and mental health officers work collaboratively, either on-site or over the phone. The mental health component of the team is available to help police by ensuring the provision of immediate emotional aid, information, and of the best treatment to the person who is people with mental illnesses (Young & Brumley, 2009; Young, Fuller, & Riley, 2008). Co-response teams attempt to provide a smooth transition from crisis to

treatment, typically by employing a technique such as critical incident stress debriefing (CISD) (Young, et al., 2008).⁶

The police-based mental health response model is carried out by mental health professionals who work in conjunction with police departments to provide on-site and telephone consultations to officers. Finally the mental-health based specialized mental health response model involves the greatest involvement of mental health providers, typically as members of a mobile crisis team, to provide patient care at the scene (Hails & Borum, 2003; Reuland & Cheney, 2005). Often these models are hybridized in some way to tailor them to local need and resources.

Research suggests that co-response teams may:

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- Provide pertinent information to police while ensuring the safety of the victim, thereby freeing the officer to conduct official business (Young & Brumley, 2009).
 - Reduce law enforcement officers' time spent on the scene (Kisely et al., 2010).
 - Provide improved access to treatment, crisis aversion, reduced hospitalization, and reduced jail time (Guo, Biegel, Jeffrey A. Johnsen, & Dyches, 2001; Scott, 2000).
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In Benton County, several law enforcement agents expressed a desire to work with mental health agencies in dealing with people in a mental health crisis. These agents said that mental health specialists are better suited to assisting people in a mental health crisis, and oftentimes law enforcement officers feel that they do not have enough knowledge about mental health services and programs to be of assistance. They opined that having a trained mental health professional on-site would be an asset, as they could direct the person to appropriate services and/or initiate contact with known treatment providers or others in a support network.

Research suggests that these teams work best when there is a strong partnership between police and mental health services (Reuland & Cheney, 2005). Such a relationship would require active cultivation in Benton County (see section on Inter-Agency Collaboration below). Additionally, co-response teams would require additional expenses. Some local mental health agents indicated that their current level of funding would not allow them to offer on-site assistance to law enforcement agencies.

Law enforcement-mental health collaboration may build upon existing practices. For example, if financial resources preclude on-site assistance (noted above), some mental health agents expressed an interest in assisting law enforcement via telephone, as is done by already in limited circumstances. Also, mental health agencies and law enforcement agencies may build upon other types of field-based collaborations that exist currently in Benton County. For example, OSU's mental health service (CAPS) has partnered with law enforcement agents in an multidisciplinary team working to prevent mental health crises

⁶ Several studies have shown that CISD can produce negative outcomes including worse psychiatric symptoms, travel anxiety, and higher levels of PTSD. For more information, see Kagee (2002).

and both parties indicate success. The context is distinct as the population at issue is included in a database via their status as enrolled students, but this may serve as a template that could be adapted to the degree allowed under constraints on health information sharing (discussed more below).

Mental Health Courts

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Mental health courts offer a specialized venue for engaging criminal suspects who suffer from a mental illness. Unlike pre-arrest diversion programs (like CIT or co-response teams), mental health courts attempt to divert the offender out of the criminal justice system and into appropriate treatment *after* being charged with a crime.⁷ 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; Sirotych, 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). Further, tailored responses enabled the better handling of those who have co-occurring substance abuse and mental health problems, a population that constitutes a sizeable portion of mental health court clients nationally (Council of State Governments, 2008). Arrestees participate voluntarily in the diversion program in order to avoid criminal sanctions (Castellano & Anderson, 2012; Miller & Johnson, 2011).

In the context of Benton County most individuals picked up on a POC are not charged with a crime, and thus would not be likely candidates for a mental health court. However, repeat players, who had a disproportionate impact on the growth in mental-health related contacts with police, were more likely to be charged with a crime. It is this sub-population of mentally ill offenders who, by virtue of repeated contacts with police, would make strong candidates for a mental health court, which could divert them from the criminal justice system into appropriate treatment.

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 (see Almquist & Dodd, 2009; DeMatteo, LaDuke, Locklair, & Heilbrun, 2013; Sarteschi, Vaughn, & Kim, 2011). 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; Sirotych, 2009). And while mental health courts would require new expenses (e.g., court staff, additional treatment expenses), there is some evidence that these costs would be offset by savings to the traditional criminal justice system, particularly in the

⁷ 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).

form of reduced frequency of jail stays for those with mental illness (Almquist & Dodd, 2009; Ridgely et al., 2007).⁸

While generally effective in improving outcomes for people with mental illnesses, because they respond only to those criminally charged some have criticized this approach as failing to address individuals with mental illness until they have penetrated relatively deeply into the criminal justice system (DeMatteo et al., 2013; Sims, 2009). There is also the concern of “net-widening,” which occurs if an individual who might otherwise be diverted out of formal criminal justice system processing is brought into a specialized program such as a mental health court because it is viewed to be in their best interest (Almquist & Dodd, 2009). Others criticize mental health courts to the extent that they require participants to cede their right to a formal criminal trial and (in post-adjudication models) require the participant to plead guilty to criminal charges (Almquist & Dodd, 2009; Sims, 2009).⁹

Although the evidence on balance suggests more positive outcomes relative to traditional criminal courts, the evidence base remains somewhat mixed (e.g., Sirotich 2009). Further, the features of mental health courts are highly variable, and there is not yet an accepted set of practices that have been conclusively shown to produce the desired criminal justice or mental health outcomes (Sarteschi et al., 2011; Sirotich, 2009). With respect to costs, some researchers fear that mental health courts may increase the demand for mental health services beyond the system's capacity to supply those services. In the absence of increased funding, this could reduce existing treatment quality or force mental health providers to discharge clients prematurely (Wolff, 2002). Finally, while there is evidence suggesting that short-term costs are minimal and long term savings are possible (Almquist & Dodd, 2009; Ridgely et al., 2007), there is not yet sufficient evidence to accurately forecast the economic costs and benefits of mental health courts.

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. One police agent said: *“the diagnosis really don't mean anything, just because I know you are paranoid schizophrenic it does not mean you are not a danger for me...”* (LE agent). Another agent expressed a desire for basic

⁸ 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).

⁹ Some models allow for criminal charges to be dismissed or convictions expunged after successful completion of the mental health court process (Almquist and Dodd, 2009).

descriptive information, as a means of learning about a person's behavioral (and perhaps criminal) past: *"If these people are dangerous, we need to know about them [...], I don't care about diagnosis, but if you can give me who they are, name and DOB, can you give me that? I can pull up criminal history on these guys and have an idea of what it is that they did in the past... and second tell me about their behaviors more so than their diagnosis [...] tell me how do these people act?"* (LE agent).

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 exceptions¹⁰, including in cases of imminent risk of harm (below), law enforcement may not receive PHI from a mental health provider without a person's prior authorization.¹¹ The information-sharing restrictions on mental health professionals is a source of frustration for some law enforcement agents, one of whom said: *"They [mental health professionals] are really worried about HIPAA, and I get that kind of stuff, but there are safety issues that is beyond that, in my opinion, and I think they are allowed, based on safety, to give us much more information than they give us"* (LE agent). 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.

HIPAA allows mental health agents to disclose PHI to law enforcement without prior authorization in cases of imminent risk of harm. A statement addressed to health care providers released from Leon Rodriguez, Director of the Office for Civil Rights at the Department of Health and Human Services January 15, 2013 indicated that "the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule does not prevent your ability to disclose necessary information about a patient to law enforcement, family members of the patient, or other persons, when you believe the patient presents a serious danger to himself or other people" (U.S. Department of Health and Human Services, 2013). Similarly, according to John Petrila (J.D., LL.M.) and Hallie Fader-Towe (J.D.), experts on health information law, such a disclosure 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). Interviews suggest that this type of information sharing occurs, albeit inconsistently. One mental health agent said, "it is a gray area of what we consider imminent risk" (MH agent).

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

¹⁰ These exceptions include locating a fugitive, missing person, suspect, or victim (Petrila & Fader-Towe, 2010).

¹¹ 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).

means of securely transmitting this information. If the legal interpretation proposed by Petrila & Fader-Towe (2010) above is considered legally valid in Benton County, we believe greater information sharing is possible.

In Oregon, one established means of communication is the Law Enforcement Data System (LEDS). House Bill 3466, enacted in 2010, ordered the Department of State Police to establish a medical database under LEDS and 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*. LEDS allows law enforcement officers to obtain personal health information about suspects who have consented to inclusion in the database. While promising, LEDS has not succeeded in providing law enforcement officers with pertinent mental health information. Both law enforcement and mental health agents say that few people consent to be included in the database and, consequently, police can rarely gain information about a person in crisis. According to one mental health agent, persons with mental illness do not consent out of a fear of stigma and a loss of rights: *"they feel like they are being branded as a person that has a mental illness, and they do not feel like they are being benefited by this [...] all the people in the psychiatric board [i.e., determined criminally guilty but mentally ill] are in the database, but again that has the component of losing rights"* (MH agent).

Other criminal justice agencies have greater access to mental health records. For example, Petrila and Fader-Towe state that HIPAA allows for "very broad disclosure of PHI without the person's authorization" (Petrila & Fader-Towe, 2010, p. 12) when it comes to correctional facilities receiving such information. Probation and parole officers may also have greater access to mental health records. Although HIPAA does not permit such disclosures without a person's authorization, such authorization may be required by the court as a condition of probation or parole, thereby enabling disclosure (Petrila & Fader-Towe, 2010). Interviews indicate that health information is transmitted relatively freely to the jail and to parole and probation services in Benton County.

Finally, it is worth noting that law enforcement officials are not "covered entities" bound by HIPAA, and they may share PHI information with mental health officials. (There are limitations to such disclosure; see Petrila & Fader-Towe, 2010.) This communication channel may assist mental health professionals with diagnosing or treating a person in a mental health crisis.

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 (e.g., Almquist & Dodd, 2009; Council of State Governments, 2002; 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:

- 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.
- Mental health service providers may work with police to offer specialized officer training, such as CIT.
- Law enforcement and mental health agencies may develop an ongoing relationship for managing individual cases of mental illness.
- Law enforcement and mental health professionals may create a co-response team for jointly responding to mental health crises.
- 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 LEDS.
- 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. One law enforcement agent notes that collaboration with mental health agencies has happened in the past, but it has been highly variable: *“I would say our communication with Mental Health over the years goes cyclical, kind of depending on who the supervisors are”* (LE agent). The literature suggests that partnerships should be institutionalized and not dependent on certain authority figures (Thompson, Reuland, & Souweine, 2003). Another law enforcement agent echoes the previous sentiment, while also expressing hope for future collaboration: *“The challenge is [...]to get all organizations talking, sitting down on a table. We did that for a while, I don’t know what happened. [...] So I think that...That would be a tremendous start, just to go back to the table”* (LE agent).

A desire for more information about mental health services extends beyond the police. One judge said: *“What would be helpful to the court is if we had a list of some agencies with a brief summary of the services that they provide so that when we are dealing with people, particularly in the civil arena, where I cannot necessarily order them to do something, but if I see that someone needs to have something addressed I have it on my bench. I can say well this looks appropriate for this agency so I can suggest that they go there and try to hook them up with services.”*

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

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 collaboratively address the problem.

This MOU should formalize a collaborative relationship to address the problem that extends beyond the individuals in leadership in any of the organizations. This recommendation is low cost but has the potential to yield significant benefits as parties brainstorm ways to more effectively address the problem. The topics covered below may be among those addressed in such meetings.

2. Seek **legal consultation regarding the HIPPA threshold for personal health information disclosure**.

As noted above, HIPPA poses substantial challenges to personal health information (PHI) sharing between police and mental health agencies. HIPPA provides exceptions to be made in cases where there is imminent risk of harm. As observed by interviewees this is a “grey area,” and interviewees interpret what is “sharable” differently—this was the case both across and within agencies. However, the sharing of such information with police is allowed according to USDHHS. Given the legal risk posed to Benton County Mental Health in particular, we recommend legal counsel be sought to determine the extent of restrictions posed by HIPPA. A protocol should be developed and vetted with legal counsel regarding what can and cannot be shared in particular circumstances and the most appropriate means of securely transmitting this information.

3. Institute a **mental health court** (or mental health docket) in Benton County.

Mental health courts are a type of problem-solving court that can engage criminal suspects who suffer from a mental illness. Tailored responses that fit the needs of the defendant can be developed and may involve a referral to the local mental health system and compliance monitoring. As many of those who appear before mental health courts nationally have co-occurring substance abuse and mental health problems, the tailored responses offered by such courts are better able to address the needs of such persons. We see this option as being particularly useful for addressing the “repeat players”, those individuals who have multiple POCs annually, are more likely than single POCs to also be charged with crimes (and thus eligible for handling in a mental health court), and who disproportionately affect total mental-health related contacts with police and associated resource expenditures. These individuals are relatively small in number (N=33 in 2012) and thus it might be that a docket of these cases can be handled by an existing court/judge on an as needed basis. The available research on mental health courts is promising but not unequivocal. In part this is

because such courts take many forms. The development of this court/court docket should be done according to research informed best practice. Although there is much literature available to inform the creation of such a program¹², contracting an expert in the creation of such programs should be considered.

4. We recommend that law enforcement and mental health agents **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.

CIT training may improve officer confidence in handling such situations, and some positive outcomes have been identified by research, but there is also a need to interpret findings on the efficacy of CIT training cautiously. Two primary issues of concern are that what is regarded as CIT-training, and thus empirically assessed, is multi-faceted, highly variable, and context-dependent (NAMI, 2013) making it impossible to determine what parts of the trainings may be effective. Additionally such programs often involve training officers who volunteer for the training, and thus may be predisposed to handle such encounters in a unique way.

5. We recommend against the creation of an onsite co-response team housed with law enforcement.

Despite the significant increase in contacts between police and those with mental illness, there were 406 such contacts in 2012, equating to just more than one per day. This number is insufficiently large to warrant the resource expenditure on such a position housed within a local law enforcement agency. A partial FTE position, potentially assigned additional duties, within a mental health agency may be a possibility, though resources would need to be available to support such a position. Law enforcement and mental health agents should discuss the possibility of co-response efforts, assessing the feasibility and potential benefit of these options as part of a larger collaborative effort.

6. We recommend the **aggressive pursuit of grant funding** to assist Benton County in developing the infrastructure to better manage this problem.

Perhaps indicative of the national nature of this problem, there are funding sources provided by the federal government to assist state and local governments in managing police contacts with those with mental illnesses. This includes programs such as Justice and Mental Health Collaboration Program, created by the Mentally Ill Offender Treatment and Crime Reduction Act of 2004. The stated purpose of the program is “to increase public safety by facilitating collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems to increase access to treatment for this unique group of offenders.” Funding from these grants may be used for, among other things:

¹² For example: A Handbook for Developing a Mental Health Court Docket (N.d) (<http://www.supremecourt.ohio.gov/JCS/specDockets/MHCourts/handbook.asp>)

- Mental health courts;
- Mental health and substance abuse treatment for incarcerated individuals with mental illnesses;
- Community reentry services; and
- Training for local law enforcement officials on how to identify and safely resolve encounters with people with mental illnesses.

<http://csgjusticecenter.org/wp-content/uploads/2012/11/JMHCP-Brochure.2012.pdf>

Efforts to pursue funding such as this have been made already and should be prioritized.

7. Any policy changes made should be subject to **research evaluation**.

Empirical assessment of any policy change can be used to improve future outcomes and are often required as part of any significant grant funding.

8. **Systematic monitoring of the number of POC's and "mental" calls should continue.**

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Appendix A: 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 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. These data include agency-reported arrestee sex, age, race, date and time, arresting agency, and statute associated with the charge. These data were also integrated with data on homelessness and unemployment obtained from the state of Oregon (Oregon Employment Department, 2013; Oregon Housing and Community Services, 2012) to analyze the impact of changes in these variables on arrests. The second dataset contains all police contacts in Benton County deemed to be related to mental illness. This data covers 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 resolved formally (i.e., generated an official case number) as well as those resolved informally (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 (due to variability in dispatchers' tendencies to categorize a call as "mental" and individual officers' tendencies to report and code an event as "mental"), 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 to protocol regarding how mental health contacts are 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.

For confidentiality purposes, interviewees are categorized as Law Enforcement Agents, Criminal Justice Agents (besides police), Mental Health Agents, and Community Organizations. The table below indicates the numbers of interviewees (along with their affiliations) conducted in each phase of data collection.

<i>Categories</i>	<i>Home organization (Phase 1)</i>	<i>N</i>	<i>Home organization (Phase 2)</i>	<i>N</i>
LE Agents	Philomath Police Department, CPD, Albany Police, and Campus Police	5	Sheriff's office, Philomath Police Department, Corvallis Police Department, Albany Police, and Campus Police	5
CJ Agents	Juvenile Center, Benton County Circuit Court, The District Attorney, and BC Jail.	6	Benton County Circuit Court, The District Attorney, Parole and Probation, Defense Attorney, and BC Jail.	6
MH Agents	CAPS, Good Samaritan (ER), Pastoral Counseling, and BCMH.	5	Good Samaritan (Psychiatric unit), Linn County Mental Health, and BCMH.	5
Community Organizations	Stone Soup, CARDV, NAMI, COI, Corvallis City Hall, and Veteran's Services	6	--	0

The interview data were coded using an Inductive Thematic Analysis (ITA) approach. It draws from inductive analytic methods in order to identify and code emergent themes within data (Guest, MacQueen, & Namey, 2012). In the coding process, the themes emerged organically from the transcriptions. Then the researchers performed a theoretical coding, connecting the codes that emerged in the context-based analysis to the theoretical literature on best practices in order to better provide policy recommendations.