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# Examining the Responses of Police when Interacting with the Mentally Ill: A study of Portland Police Bureau's Behavioral Health Unit

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**Examining the Responses of Police when Interacting with the Mentally Ill:  
A study of Portland Police Bureau's Behavioral Health Unit**

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## Table of Contents

|  |    |
|--|----|
| <b>Abstract:</b> .....                         | 3  |
| <b>Research Question:</b> .....                | 4  |
| <b>Introduction:</b> .....                     | 5  |
| <b>Literature Review:</b> .....                | 7  |
| Deinstitutionalization .....                   | 7  |
| Police Interaction with the Mentally Ill ..... | 8  |
| Criminalization of the Mentally Ill .....      | 9  |
| Trainings and Models .....                     | 10 |
| Crisis Intervention Teams (CIT) .....          | 11 |
| Mobile Crisis Units/Teams (MCU) .....          | 12 |
| Role-Playing .....                             | 12 |
| <b>Methodology:</b> .....                      | 14 |
| <b>Case Study:</b> .....                       | 15 |
| History of the Behavioral Health Unit .....    | 15 |
| Interview Introduction .....                   | 16 |
| Disclaimer .....                               | 16 |
| <b>Content Analysis:</b> .....                 | 18 |
| <b>Discussion:</b> .....                       | 24 |
| <b>Conclusion:</b> .....                       | 27 |
| <b>Appendix One: Interviews</b> .....          | 28 |
| <b>Bibliography:</b> .....                     | 38 |

### **Abstract**

Police interactions with the mentally ill have been a growing topic as of late in the United States, both in scholarship and in the news. The environment regarding policing is changing, and police agencies are now looking for ways to properly deal with sensitive populations. The information presented will outline and compare Portland Police Bureau's (PPB) Behavioral Health Unit (BHU) methods for working with the mentally ill, to similar methods around the country, to see what the differences were in police-based interaction with the mentally ill. Five interviews were conducted with staff from the Behavioral Health Unit, and a content analysis of those interviews was conducted to determine if the Behavioral Health Unit provides a platform for a successful evidence-based model for police and their interactions with people with mental illness around the nation. The findings suggest that the Behavioral Health Unit has the potential to be an evidence-based model, and a conclusion could be drawn that the tactics of resource connection and follow-up applied by the Behavioral Health Unit could be applied to other departments to lessen the issues that surround police interaction with the mentally ill.

### **Research Question**

How do the practices of the Portland Police Bureau's Behavioral Health Unit compare with those of other police-based practices when dealing with the mentally ill, and could it be a potential model for evidence-based practice?

## **Introduction**

Around 1960, deinstitutionalization became the most prevalent reform for the mental health system in the United States. Instead of housing the mentally ill in state hospitals, the idea was that community mental health centers would aid the mentally ill. However, due to a lack of funding and resources, the mentally ill were instead left to care for themselves (Etter et al., 2008). This led to an increase in police interaction with this population, and to an increase in the criminalization of the mentally ill (Raphael and Stoll, 2013). According to the National Alliance on Mental Illness (NAMI), “Approximately 20% of state prisoners and 21% of local jail prisoners have ‘a recent history’ of a mental health condition” (Mental Health by the Numbers, 2015).

Due to this increase in police interactions, better models were sought for training officers in how to properly interact with this specific population. Some of the more prevalent models include, but are not limited to, Crisis Intervention Teams (CIT) and Mobile Crisis Units (MCUs). In recent years, after a settlement with the Department of Justice (DOJ), the Portland Police Bureau (PPB) created the Behavioral Health Unit (BHU). The goal of this unit is to coordinate the response of law enforcement and the behavioral health system to aid people in behavioral crisis resulting from known or suspected mental illness and or drug and alcohol addiction.

The purpose of this thesis is to examine PPB’s BHU, and to determine if it can become an evidence-based model for other police bureaus or departments. To properly assess whether or not the BHU can be an evidence-based model, an extensive literature review will be conducted, to better understand the history of deinstitutionalization, police interactions with the mentally ill, the criminalization of the mentally ill, and the current police models and methods of training in responding to calls that involve people with a mental illness. A set of five interviews will then be conducted, with various staff of the BHU, to better understand the unit itself, how it works, and

what models and methods of training it employs, with the hopes of determining if the BHU has the potential to become an evidence-based model.

## **Literature Review**

Important contexts that influence the current state of mental health policing are, the history of deinstitutionalization, its effects on the interactions between the police and the mentally ill, criminalization of the mentally ill, and potential training and models to improve the interactions between police and the mentally ill. To answer the research question fully, a good grasp of the history, interactions issues, criminalization of the mentally ill, and potential solutions is needed. In general, most authors see deinstitutionalization as the root cause of the increase in police interaction with the mentally ill, and most advocate for the decriminalization of the population and trainings and models to help ensure a better understanding of this population.

### **Deinstitutionalization**

Deinstitutionalization began around the 1960s with the Community Mental Health Centers (CMHC) Act of 1963 enacted by John F. Kennedy (Mechanic and Rochefort, 1990). Deinstitutionalization was the third type of reform according to Morrissey and Goldman (1986) with the first being asylums and the second being the psychopathic hospital. Deinstitutionalization was meant to move the care of the mentally ill away from state hospitals and into the communities, by creating the CMHC's. The CMHC's were supposed to "provide outpatient emergency, and partial hospitalization services for the mentally ill," (Raphael and Stoll, 2013, p. 190). However, a lack of funding and contention from the civil rights movement for the mentally ill made it hard to sustain the community mental health centers (Etter et al., 2008).

Resources for the CMHC's were scarce, which caused an increase in the numbers of mentally ill who were turned away. The mentally ill were aided by the civil rights movement in that it gave them the right to refuse aid if they could prove that they were not a danger to themselves or others. It therefore became easier to leave mental hospitals than to be committed to one



(Mechanic and Rochefort, 1990). Deinstitutionalization also led to an increase in the homeless population, and thus led to a greater level of interaction with law enforcement, due to an inability to receive treatment (Daniel, 2004). In summary, the articles used on deinstitutionalization suggest providing better trainings for officers and law enforcement personnel, as well as, developing a system to hold CMHC's accountable, (French, 1987) in order to improve interactions between law enforcement and the mentally ill.

### **Police Interaction with the Mentally Ill**

In addition to much of the research agreeing that there is a lack of funding for the CMHC's, many agree that deinstitutionalization led to an increase in police interaction with the mentally ill. Estimations of total police contacts have listed between 7-20% to be interactions with the mentally ill (Short et al., 2014). Due to deinstitutionalization, the mentally ill were left to care for themselves, which meant that many became homeless. The homeless account for a disproportionate number of the mentally ill, and more often than not, end up in jails or prisons for minor crimes because the officers are either unsure of how to deal with them, do not understand that they have a mental illness, or simply want to get them off the streets for safety reasons (Wacholz, 1993). Daniel (2004) even suggested that Labeling Theory might play a role in the interactions between officers and mentally ill individuals. He suggested that an officer's decision to arrest might have already been made before even approaching the situation due to the stigma that surrounds the mentally ill.

There is also a greater risk for use of force when policing the deinstitutionalized mentally ill (Mulvey and White, 2014). Someone with an illness could see an officer as a threat in himself and react negatively, or the police might not understand that there is an illness present and react negatively themselves. Gur (2010) stated that the first few seconds of interaction between an

officer and an individual with mental illness can determine how that interaction will end, either with de-escalation, exacerbation, or violence. Additionally, Mulvey and White (2014) found that “...individuals with a current mental health problem were nearly three times more likely to resist during the current arrest” (pg. 410-411) and while they also found that officers may be more likely to be understanding of certain aggressive or disruptive behaviors, there is a limit, and if that limit is reached, the officer might exacerbate their own response to become more forceful or coercive (2014).

In a study of the *Use of Nonfatal Force on and by Persons with Apparent Mental Disorder in Encounters with Police*, Kesic et al., found that police were two times as likely to use pepper spray against an individual with a perceived mental illness (Kesic et al., 2013). Since individuals with mental illnesses can have a heightened level of emotions, they may react violently which can lead to more arrests for this population.

### **Criminalization of the Mentally Ill**

In 2000, the estimated number of severely mentally ill individuals in jails and prisons was 310,000 (Lamb and Weinberger, 2005). Because of these arrests, the mentally ill have become criminalized making their crimes the focus instead of their mental illness (Wacholz, 1993). When thinking about the mentally ill population, the common beliefs are that they are dangerous and unpredictable (Watson et al., 2004), and once we label them as offenders and give them a criminal record, it is much harder to think of them as victims (Gur, 2010).

By introducing the mentally ill into the criminal justice system, officers had to take on the roles of mental health professionals without the proper training. In some cases, officers even provide counseling services. Research has suggested that to combat the criminalization of the mentally ill, a 24-hour care center should be made available to the mentally ill, as well as an

increase in the funding for the somewhat new Mental Health Courts (Lamb and Weinberger, 2005). These courts, instead of sentencing the mentally ill “offender” to jail or prison, work with a mental health professional to get them to a treatment facility. These courts could help to decriminalize the mentally ill. If officers could be trained on what mental illness is, it could potentially decrease the arrest rates, “...therefore, improving community attitudes by increasing knowledge and understanding about mental issues is an essential step in decreasing stigma,” (Daniel, 2004, pg. 388). Criminalization of the mentally ill and use of force are all reasons why the above listed authors advocate for better trainings and a forging of relationships between law enforcement and mental health professionals.

### **Trainings and Models**

There are various models for aiding the mentally ill, as well as, many training options for law enforcement. Many authors suggested trainings that involved educating the officers on mental illness and de-escalation practices (Herrington and Pope, 2014). It was found that two of the most prevalent models of mental health policing include Crisis Intervention Teams (CIT) and Mobile Crisis Units/Teams (MCU.) It was also found that role-playing trainings and Crisis Intervention Trainings (CITr) to be the most popular trainings among the research.

There are three types of responses for police and their interactions with the mentally ill: mental health-based *mental health* responses, police-based specialized *mental health* responses, and police-based *police* responses. The first occurs when the police respond to calls involving a mental health component that are received by police, and then are diverted to a mental health facility. The second response utilizes non-sworn mental health professionals who are employed by the police department to attend to mental health related calls instead of officers. In the third

response type, police officers are trained to deal with mental health related issues. This is more commonly referred to as Crisis Intervention Teams (Browning et al., 2011).

### **Crisis Intervention Teams (CIT)**

Crisis Intervention Teams were created in Tennessee in 1988 following a fatal shooting of a schizophrenic individual who, upon being approached by police, ran at them with a knife (Browning et al, 2011). CITs consist of sworn officers who have completed Crisis Intervention Training and respond to mental health related calls in addition to general patrol duties (Herrington and Pope, 2014).

“CIT can best be described as a police-based pre-booking approach with specially trained officers that provide first line response to calls involving a person with mental illness and who act as liaisons to the mental health system,” (Morabito et al., 2013, pg. 423-424).

Perhaps the best aspects of the CIT are that they are trained to recognize mental illnesses, de-escalate situations, and can appropriately utilize crisis intervention when it is most needed (Walsh and Yun, 2013). In one study done by Morabito et al., they found that police have a positive perception of the program, and that “...the CIT training combined with opportunities for officers to put the innovations into practice, produced the strongest support for the program,” (Morabito et al., 2013, pg. 432).

CIT is a 40 hour long training that focuses on medications and their side effects, types of illnesses, de-escalation practices, and types of resources available to officers and the mentally ill (Browning et al, 2011). Additionally, CIT has been found to reduce the time spent on a single case, provide a better approach for de-escalating a situation, and helps officers to ensure that rather than simply addressing the immediate issue, they make sure that the individual receives all the help

they can (Herrington and Pope, 2014). Crisis Intervention Trainings are quite popular among police bureaus, and many even have created Crisis Intervention Teams from this training.

### **Mobile Crisis Units/Teams (MCU)**

Mobile Crisis Units are “...where civilian mental health professionals act as secondary responders to events when called on by police at the scene,” (Herrington and Pope, 2014, pg. 502). Their purposes are to diagnose, provide crisis intervention, and conduct pre-hospital screening with case management services (Lord and Bjerregaard, 2014). These units could be beneficial because it recommends working with a mental health professional, which can lessen the likelihood of physical restraints, and because the professional is there, instead of being introduced into the criminal justice system, the individual could receive aid (Lord and Bjerregaard, 2014). A similar article also suggested that police form a permanent relationship with the CMHC’s (Ruane and Cerulo, 1990). Through this relationship, officers could receive training from individuals that work with the mentally ill on a daily basis, and could create a permanent liaison which would help them build up resources to combat the issue of the mentally ill in the criminal justice system.

### **Role-Playing**

Positive Interaction Training was developed by Peter Silverstone. It utilizes role-playing methods to give officers a first-hand look at what types of situations could arise. There were six situations presented in this training: depressed female, alcohol intoxication with likely medical problems, possible psychosis, depressed and actively suicidal individual, mania with possible drug use and physical symptoms, and domestic dispute precipitated by problem gambling. To make these role-playing situations more realistic Silverstone suggested using actors.

After the role-playing the officers would receive feedback, which Silverstone found to be beneficial (Silverstone, 2013). Frierson (2013) commented on Silverstone’s Positive Interaction

Training stating that while many models fail to provide feedback and address police officer attitude, Silverstone's model does both. He stated that the role-playing helped develop certain essential skills such as active listening and body language interpretation (Frierson, 2013). Role-playing trainings allow officers to experience situations first hand in a safe environment which could lead to better interactions between law enforcement and the mentally ill, and subsequently, could lead to the decriminalization of the mentally ill population. "Training in de-escalation techniques can improve communication between officers and persons with mental illness and lead to improved handling of violent or potentially violent encounters," (Price, 2005, pg. 52).

Almost all contemporary research recommended better trainings for officers and potential mental health professional-law enforcement relationships. It is important to focus on what is currently in use to better address the research question of this thesis. There are multiple trainings available, as well as, different methods for implementing them. In addition, there are at least two types of responses that are working, CIT and MCU. The following information will compare these responses to the Behavioral Health Unit (BHU) and the responses that it utilizes, to combat the issue of negative police reactions with the mentally ill, in an effort to determine if the BHU can be an evidence-based practice.

### **Methodology**

This thesis will attempt to answer the research question: *How do the practices of the Portland Police Bureau's Behavioral Health Unit compare with those of other police-based practices for dealing with the mentally ill and could it be a potential model for evidence-based practice?* To accomplish this task, five interviews were conducted that examined the Portland Police Bureau's Behavioral Health Unit. A content analysis will then be conducted of these interviews, with the hopes of gaining a better understanding of the BHU and its practices and answering the research question.

This author expects to find that the Behavioral Health Unit's practices are productive so far, and that it could be a potential model for evidence-based practice. It is important to note that since the unit is new, quantitative data was unavailable for analysis.

## Case Study

### **History of the Behavioral Health Unit**

In 2013, after a settlement with the Department of Justice (DOJ), the Portland Police Bureau (PPB) created the Behavioral Health Unit (BHU) (DOJ Settlement, 2012). The DOJ settlement was facilitated to deal with perceived issues surrounding use of force against individuals with apparent mental illness. In the agreement, it was determined that PPB would create the BHU to combat use of force issues, as well as, to aid those that were suffering from mental illness by connecting them to resources. In addition, PPB needed to establish an “Enhanced” Crisis Intervention Team (essentially a Crisis Intervention Team as outlined above), and expand its Mobile Crisis Unit.

Approximately 7-9% of police calls involve the mentally ill in some way, so for Portland that would be about 27,000 calls. To improve the responses to these calls, PPB created the Enhanced Crisis Intervention Team (ECIT). The ECIT was formed in May of 2013, and is one of the main components to the BHU. ECIT officers receive the resources they need from the BHU to ensure that they are successful in aiding the mentally ill population. Currently, there are 78 officers who are a part of the ECIT who perform their regular patrol duties until they are called upon. The officers are an additional on-scene resource that aids in responding to mental health related calls. They are an immediate resource to deal with the most challenging calls. They are available to other officers and community members. ECIT officers are sent out if the call has a mental health component and any of these five conditions: (1) Upon the request of a responding officer or sergeant, (2) A subject is violent, (3) A subject has a weapon, (4) The subject is suicidal, and (5) the call is at a designated residential mental health facility.

In addition to the ECIT, in the BHU there are three Behavioral Health Response Teams (BHRTs) (BHU’s version of a MCU). The BHRTs are made up of an officer and a mental health



professional that work together to aid an individual that has high contact with PPB, to find them more appropriate resources.

### **Interview Introduction**

To better understand the BHU, interviews were conducted which consisted of eighteen questions. These questions focused on what the BHU does, how it helps people, and whether or not the interviewee believed the BHU to be effective. In order to comply with the Institutional Review Board, the researcher completed a “Review Not Required” application, to which the IRB stated that review was unnecessary. The reasons for this were that the interviewees would all be adults; the questions are non-identifiable because they are not personal, and the interviews would be completely anonymous.

In addition to not needing IRB approval, the interviewer wrote a disclaimer, outlined below, so that interviewees would know that it was completely anonymous. The interviewer also made a point of stating the anonymity of the interview to each individual. A total of five interviews were conducted (See Appendix One). Since there will be no quantitative data for the analysis, the interviews were purely for content analysis purposes with no firm conclusions drawn.

### **Disclaimer**

“My name is Marina Kabot-Sturos and I am an undergraduate student at Portland State University studying Criminal Justice. I am currently working on my thesis with the Behavioral Health Unit. I currently work for the Department of Justice in the United States Attorney’s office in a secretarial role. I am aware of the existing animosity between the DOJ and PPB due to the ongoing case regarding PPB and the response to people experiencing mental crisis

in Portland; however, I am only interested in learning more about our BHU. I would like to let you know that this will be completely anonymous, and voluntary. It is perfectly fine to opt not to participate in this interview. Please know, regardless of your participation, your name will not appear in any documentation whatsoever. Are you willing to participate in an interview with me that will assist me in the composition of my thesis?”

It was important to include that the interviewer worked for the DOJ due to the settlement agreement that is in place between the DOJ and PPB. The interviewer wanted to be completely transparent to ensure that the interviewees felt comfortable answering the questions.

### **Content Analysis**

After conducting the interviews, a content analysis was conducted to determine the main points that could be derived from them. In general, each interviewee enjoyed their job and believed that the BHU was working well. They did find limitations, which are outlined below.

#### **Question 1**

*How do individuals get into the BHU?*

This question was unanimous. There is only one way that individuals get into the BHU, and that is through an officer referral. The BHU has a form that officers fill out upon contact with an individual with an apparent mental illness. Once filled out, the form is sent to the supervisor (sergeant) who determines if they can be a resource for the individual. This is done by determining the risk level that the individual poses, and the level and complexity of the mental illness. Once the decision is made, the individual is assigned to the BHRT case load. Occasionally, the BHU will take referrals from other individuals, like the mayor or their community partners, but the mentally ill individual in question must have a fairly high level of risk.

#### **Question 2**

*What types of trainings did you have to complete?*

The trainings were fairly similar. All officers stated that they completed CIT and ECIT trainings. In addition, most had completed Applied Suicide Intervention Skills Training (ASIST) and Threat Assessment training. One officer suggested making the ASIST training required. Another mentioned that the Threat Assessment training is on its way to become mandatory. From the interviews conducted, it was understood that officers took every opportunity possible to get more training.

#### **Question 3**

*Are there specific requirements to be an officer with the BHU? (Schooling/Personal History)*

There was no degree requirement specifically for the BHU, but all interviewees mentioned a “no use of force” history requirement. Since the BHU works with a sensitive population and use of force was an issue within the settlement agreement, it is understandable that it would be a requirement. However, there are obvious instances where an officer with even a minor use of force history might be allowed. These would be cases where the use of force is not called into question. It would have been deemed an appropriate action in the situation.

#### **Question 4**

*What types of aid are provided to individuals in the BHU?*

Since officers are not doctors, they do not have the ability to prescribe medication or give counseling services. However, occasionally officers do act as non-professional counselors. The main type of aid provided to the mentally ill population by officers of the BHU is the connection to mental health resources. Officers assess the situation of the individual and point them to the right resources, whether that is a hospital because the situation is highly dangerous, or simply finding a community outreach center where the individual can be connected to a physician in order to receive treatment, medication, or even food and housing.

#### **Question 5**

*Is there an “expiration date” on how long someone can be in the BHU?*

No. Officers have a caseload, and according to one interviewee, they only close a case when an outcome is reached. These outcomes can include the connection to resources, criminal justice intervention and/or jail, the BHRTs cannot locate the person, or other (which may include death).

#### **Question 6\***

*Do you often see or come into contact with the same people?*

There was an almost unanimous yes to this question. Since the BHRTs receive a caseload, they are constantly working with an individual. Individuals that have reached an outcome and become a closed case, do in fact return when their behavior escalates again. The BHRTs carry a caseload of 12-15 individuals per week.

\*Interview 1, Question 6 presented an incorrect response. The correct response can be found in the appendix.

### **Question 7**

*How do you feel Portland's BHU program compares to other similar programs around the state?*

The interviewees felt that there was no real comparison to the BHU. The BHU focuses on follow-up with the individuals, while most other programs focus on reaction. Additionally, the BHU officers focus on connecting people to resources which is fairly unique.

### **Question 8**

*What made you want to work for the BHU?*

They wanted to create something innovative to help find a solution for this issue. Additionally, some of the interviewees felt that because of their interest in the field it would be a perfect fit.

### **Question 9**

*What do you believe is the best aspect of the BHU?*

The interviewees believed that the best aspects of the BHU were the team of coworkers, the ability to help someone in need, the combination of a clinician and an officer, the ability to be thoughtful, and the follow-up. All of the officers expressed gratitude for their coworkers and the leaders who give them the ability to be flexible. Many suggested that flexibility is one of the main

reasons why they enjoy their job. Two of the officers stated that it is because of the ability to be thoughtful that allows them to better aid the individuals on their caseload.

### **Question 10**

*Which aspect(s) could use some work?*

All of the interviewees stated that resources are lacking. They expressed a need for more people, cars, and even housing for individuals that they are following-up on. They also expressed the need for better communication with the community. Some of the officers also recommended forging better connections with mental health professionals so that communication can be more fluid and better aid can be provided.

### **Question 11**

*What do you enjoy most about your job?*

Most of the interviewees enjoyed having the ability to effect change. They liked helping those in need. Their jobs give them the flexibility to do what is necessary for the individuals on their caseload. Additionally, they enjoyed their coworkers. They felt that everyone was active in what they do, and that they are passionate about aiding those in need.

### **Question 12**

*What is your hope for the BHU?*

All officers expressed a hope for the BHU to continue to grow. They again recommended flexibility with timing and resources. Finally, most of the interviewees suggested making the laws more realistic. With the severity of some laws, various officers felt that the laws restricted them from aiding certain types of people. Some expressed frustration with the “danger to self or others” law. To quote one BHRT staff member, “If you can only hold someone when they are a danger to

themselves or others, you might be missing someone who may not have hit that point yet but very well could.”

### **Question 13**

*Do you feel that you have the appropriate tools to help those in need? (Knowledge/Skills)*

Most felt that they did. Some suggested more training opportunities. In addition, they felt that the mental health system should be worked on to improve it. They felt that if we can start working to fix the system, we could better aid the mentally ill population.

### **Question 14**

*What is your greatest obstacle in regards to your job?*

Most felt that the DOJ settlement requirements were a great obstacle. They felt that they are too strict without really understanding what actually works and what does not. Additionally, some felt that because of the strict laws surrounding mental health, people are falling through the cracks. Finally, they all expressed issues with the mental health system. Some believe that it is not working the way it should be to best aid those in need.

### **Question 15**

*Do you think there is a better/different way to aid the mentally ill?*

Many of the officers believed that investing in community support programs would be a better way to aid the mentally ill. If the BHU could get the community involved and educated, they may be able to better understand the population. Again, some of the interviewees recommended adjusting the laws to be less strict.

### **Question 16**

*What is your favorite thing to do at work? (Attend to a call; Paperwork; etc.)*

All of the officers stated that interacting with people, not just the mentally ill they come in contact with, but also their coworkers. They also enjoy the team that they are a part of.

### **Question 17**

*Do you think the BHU could be a model for other cities or states?*

The answer to question seventeen was a unanimous “yes”. Some believed that it should be a base model that is molded to fit the city it is being applied to. Others believed that it should be expanded. This model could be scaled up or down depending on the city. Most believed that the real benefit of the BHU was the layering. It focuses on multiple issues and has many teams. It is not the only way but it is a good model.

### **Question 18**

*What, in your opinion, is a potential solution to the crisis of the mentally ill?*

The interviewees believe that if we could fix the broken mental health system it could potentially solve some of the issues. They also suggested better access to the system for the mentally ill. They suggested that outreach programs become more available so that they can go to the mentally ill rather than the mentally ill worrying about how to get to their appointments. The bottom line is flexibility. We need to be more flexible with this population.



### **Discussion**

After conducting an extensive literature review and interviews with members of the BHU, it was found that many similarities and differences in the models used do exist. The BHU utilizes a system of both the CIT model and the MCU. While the PPB's CIT Training is not an exact replica of the traditional model, the ECIT mimics the traditional model closely. CIT officers of the traditional model are meant to deal with the situation in the moment and get the individual where they need to be, whether that is a hospital or jail. Furthermore, the BHRTs utilize a referral based form that leads to a focus on follow-up. Most models in use now do not focus on the "long term", but the BHU does. They are attempting to reduce the number of police contacts with mentally ill individuals through their program.

The trainings were also reflective of the trainings currently in use. All PPB Officers receive a minimum of 40 hours of Crisis Intervention Training (CIT). The Oregon State Police Academy provides 8 hours of classroom and 4 hours of scenario-based training on the core competencies of Crisis Intervention, which include explaining what mental health disorders and developmental disabilities are, explanations of common medications used, the civil commitment process, and an introduction to the crisis cycle. PPB Officers then attend the PPB Advanced Academy and receive an additional 22 hours of classroom/role-playing training and 6 hours of scenario-based training on the mental health system. Additionally, they learn about the City of Portland specific resources, policies and procedures, crisis communication, risk assessment, veterans, and substance abuse. PPB Advanced Academy training builds upon the State Academy training. PPB Officers receive annual updates in crisis intervention training during annual in-service which have included working with veteran's, introduction of the BHU, updates on involuntary civil commitments and crisis intervention scenarios.

ECIT training builds on Department of Public Safety Standards and Training (DPSST) and the Portland Police Advanced Academy Crisis Intervention Training core competencies. Training is focused on ECIT officers being the interim response tool before Crisis Negotiation Teams/Special Emergency Response Teams (CNT/SERT.) ECIT officers assist primary officers and supervisors by providing them with resources available and by doing whatever can be done to assist in a CNT consult / call out. ECIT officers attend 40 hours of training with the four key topics: (1) Resources, (2) Risk Assessment, (3) Crisis Response, and (4) Patrol Tactics. BHRT officers start with 80 hours of Crisis Intervention and Enhanced Crisis Intervention training. The BHU then seeks training opportunities from community partners for the officers and clinicians. The BHU sends its BHRTs to four standardized trainings, the ASIST training put on by Lines for Life or the Multnomah County Crisis Line to which some officers and clinicians then volunteer at the Lines for Life crisis line taking crisis calls, Multnomah County Investigator/Civil Commitment training to better understand the commitment process and where the BHRT can impact the process when working with people in crisis, Trauma Informed Care put on by Volunteers of America, and officers and clinicians have also attended training in threat assessment.

From the interviews it was learned that the officers of the BHU believe that it can become an evidence-based model. While it was found that ECIT officers and the BHRTs are effective, it was suggested that they could do more with additional resources. Many of those interviewed believe that if more people were added to the BHU, they could better aid the population. They all stressed how necessary it was to have the flexibility of time to analyze and advocate for the individuals on their caseload. If there were more officers, capacity would not be so much of an issue. Instead of limiting the number of individuals that can be on a caseload due to capacity, there would be more officers to aid and connect those in need to resources.

Another constraint that was discovered in the content analysis was the limitations of the mental health system. While the BHU does a decent job of connecting people to the necessary resources, all of those interviewed stressed the difficulties they have when dealing with the system. This ranged from the lack of community outreach programs that are willing to go to the mentally ill, to the issue of a lack of housing. Additionally, some of those interviewed believed that the mental health system needs to be held accountable. One person interviewed mentioned how police officers “Cannot say no; however, the mental health system can. If we could forge relationships between these two systems, the criminal justice system and the mental health system, the potential for help could be much greater.”

The final limitation recognized by those interviewed were the unyielding laws that the BHU has to negotiate. Some of those interviewed felt that, due to the strictness of the laws, people were falling through the cracks. Some believed that they could be missing those that may not be at the height of danger, but nonetheless need help connecting to resources. This will be harder to remedy. Police officers do not create laws; they simply enforce and negotiate them.

### **Conclusion**

When used separately, the current models and trainings work well. However, what makes the Portland Police Bureau's Behavioral Health Unit (BHU) unique is that they use a layered approach that blends each model together. The ECIT officers respond to 9-1-1 calls, and the BHRTs conduct follow-up on people with mental illness. Thus, the BHU provides both an in-the-moment response, and a long-term follow-up plan when interacting with people with mental illness. The goal is to reduce the contacts they have with the police, thereby freeing up resources for the community.

It is the opinion of the author that the BHU is a viable method for aiding the mentally ill community. Based on the information gathered in this study, it is believed that the BHU has the potential to be an evidence-based practice. Data will be needed to support this opinion, however. But from the knowledge gained so far, it seems to be working in aiding the mentally ill population. The complex issues surrounding police interactions with the mentally ill will always be present. Mental illness is not something that can necessarily be cured. However, strides can be made to better aid this population by giving officers proper training, having a layered approach when contacting individuals with mental illness, and connecting them to the proper resources.

## Appendix One: Interviews

### #1:

1. How do individuals get into the BHU?  
*Through an electronic referral system. It is from all over the area and gives updated list of issues associated with a particular person.*
2. What types of trainings did you have to complete?  
*There are 3-4 mandatory trainings: ECIT, Volunteer Assist Trainings, threat assessment, and Suicide Help.*
3. Are there specific requirements to be an officer with the BHU? (Schooling/Personal History)  
*The individual should be CIT trained, they need commander approval, and there should be no use of force history.*
4. What types of aid are provided to individuals in the BHU?  
*The BHU has no ability to prescribe meds or distribute them, but officers act as counselors. They take the mentally ill to appointments, meetings with family, grocery shopping, and they check in with them.*
5. Is there an “expiration date” on how long someone can be in the BHU?  
*Officers are allowed to stay as long as they would like in the BHU as long as they are not a negative influence on the mentally ill.*
6. Do you often see or come into contact with the same people?  
*Not too often. They use a low, medium, high chart to determine who is a danger and who should be kept track of.*
7. How do you feel Portland’s BHU program compares to other similar programs around the state?  
*There is nothing similar to the BHU in the nation. Many agencies ask questions about the BHU, but there is nothing similar.*
8. What made you want to work for the BHU?  
*Help people and serve.*
9. What do you believe is the best aspect of the BHU?  
*Helping those that cannot help themselves.*
10. Which aspect(s) could use some work?  
*There are not enough resources. The system is broken for the mentally ill.*
11. What do you enjoy most about your job?  
*Helping people who cannot help themselves. It is exciting, the co-workers are amazing, and they liked having the ability to help.*
12. What is your hope for the BHU?  
*That the importance is recognized when the mentally ill are not a political issue. They want it to keep working and growing to improve lives.*
13. Do you feel that you have the appropriate tools to help those in need? (Knowledge/Skills)  
*They are working well with what they have.*
14. What is your greatest obstacle in regards to your job?  
*Letting other officers down and letting people falling through the cracks.*
15. Do you think there is a better/different way to aid the mentally ill?  
*They should adjust the mental health hold laws so that officers do not have to be afraid of getting sued or fired.*
16. What is your favorite thing to do at work? (Attend to a call; Paperwork; etc.)

*Interacting with people.*

17. Do you think the BHU could be a model for other cities or states?

*Yes, it could be model. It sort of already is due to the DOJ settlement.*

18. What, in your opinion, is a potential solution to the crisis of the mentally ill?

*Take non-police matters out of police hands and place them into the hands of the health care system. There should be no transporting with cuffs, and police should not be involved unless it is dangerous. Professionals need to be more available.*

*\*\*Upon completion of the research, it was found that the comment made by interviewee one in question six was incorrect. There is no high, medium, low scale. Instead, there is an arbitrary scale that the sergeants use when assigning people to the BHRT caseload. If an individual has a high level of mental illness and are a high risk to others they are most likely going to be assigned to the BHRT caseload.*

**#2:**

1. How do individuals get into the BHU?  
*Through a referral process. Officers respond to crisis events and when they do they provide intake, they respond, they de-escalate, and they assess the individual. If the officer does not believe that the individual meets the hold requirements for a hospital (danger to themselves or others) then they are referred to the BHU.*  
*Also, ECIT Officers when responding to a crisis call, fill out an ECIT form that is read by officials of the unit. If a person is the frequent subject of the ECIT forms, they have a higher likelihood of being assigned to one of the BHRTs.*
2. What types of trainings did you have to complete?  
*There are 40hr CIT trainings, de-escalation trainings, 40hr Enhanced CIT trainings, and 2 day ASIST trainings (optional.) They believed that the ASIST training was the best training because it was scenario based.*
3. Are there specific requirements to be an officer with the BHU? (Schooling/Personal History)  
*There are no degree requirements, but there can be no use of force history, and no history of discipline. They should have a reputation for good communication, and they should be people who have an interest in the mentally ill.*
4. What types of aid are provided to individuals in the BHU?  
*Due to HIPAA laws, the officers are not allowed to look at medical records, so they perform the intake and then proceed to call in a doctor who can then assess the individual properly. The officer tries to figure out what is causing the crisis. They may also call in professionals from Project Respond.*
5. Is there an “expiration date” on how long someone can be in the BHU?  
*There isn't an expiration date for individuals on a caseload, however, there is a 72 hour limit on how long an individual experiencing a crisis may be held in the hospital unless they are released early or are brought to court. Usually, individuals only stay for 24 hours.*
6. Do you often see or come into contact with the same people?  
*Yes, repeatedly. Although they do see some new people.*
7. How do you feel Portland's BHU program compares to other similar programs around the state?  
*There is nothing similar to it. It is the best model out there. It will be an evidence-based practice.*
8. What made you want to work for the BHU?  
*They had Mental Health probation officer history, and they love the subject. It is a natural fit since they are good at communicating.*
9. What do you believe is the best aspect of the BHU?  
*The fact that there is follow up. Most police officers are good at reaction but not follow up, which makes the BHU unique.*
10. Which aspect(s) could use some work?  
*Resources, there are simply not enough. Also, they should better integrate with clinicians.*
11. What do you enjoy most about your job?  
*Meeting new people, effecting change, interrupting/arresting a human misery, making something better, and treating those with dignity/respect that do not usually receive it.*
12. What is your hope for the BHU?

- That it will continue to grow with support and gain stabilized resources.*
13. Do you feel that you have the appropriate tools to help those in need? (Knowledge/Skills)  
*They believe that a 4 hour monthly training could be highly beneficial. It should focus on case studies and technique.*
  14. What is your greatest obstacle in regards to your job?  
*The DOJ requirements. They believe that there are too many hoops to jump through and that they are being unreasonable because they do not really understand how the unit works.*
  15. Do you think there is a better/different way to aid the mentally ill?  
*Investing more in community providers, and making the system easier to access. Also, reforming the state law to make it easier for those in crisis to access services or be held before reaching a danger to self. It should be a tier system with more capacity for holding/treating individuals. There should also be transitional housing because typically, individuals are placed in the hospital, and then upon release left alone. A 30-day-hold would help the individual to get stabilized, give them access to meds, find housing, and can transition and gain life skills.*
  16. What is your favorite thing to do at work? (Attend to a call; Paperwork; etc.)  
*Building relationships and seeing the individuals again. The recognition of "I know him, I trust him." Repeated contacts help with an interaction. They begin to think of you as their officer.*
  17. Do you think the BHU could be a model for other cities or states?  
*Yes, it should be expanded, there should be more officers/clinicians, maybe 30 more of each, and make some available 24 hours.*
  18. What, in your opinion, is a potential solution to the crisis of the mentally ill?  
*Reforming the law to make fewer barriers to services. There should also be varying degrees of institutionalization. It should not be all or nothing. There should also be better treatment management.*



**#3:**

1. How do individuals get into the BHU?  
*Through a referral form for the BHU. A sergeant who gains a contact while on patrol opens the BHU Referral Program and inputs information related to the call, e.g. name, gender, race, age. Then, the officer in charge of the unit reads all of the referrals and disperses them to the Behavioral Health Response Team's (BHRT.) Since only so many referrals can be acted upon, the officer determines those that are urgent based on the individuals level of risk to others and the number of contacts they have had with the BHU.*
2. What types of trainings did you have to complete?  
*Suicide Assessment (ASIST), Threat Assessment, ECIT, ATAP (4 days), CIT when available, and Involuntary Commitment Training.*
3. Are there specific requirements to be an officer with the BHU? (Schooling/Personal History)  
*There is no degree requirement. Additionally, no use of force history, no history of discipline, a reputation for good communication, and people who have an interest in the mentally ill are preferred. They are not expected to be experts.*
4. What types of aid are provided to individuals in the BHU?  
*There are referrals to resources, and the BHU coordinates connections between the individual and the resources that they need. They do what is helpful.*
5. Is there an "expiration date" on how long someone can be in the BHU?  
*There is a police officer hold, which ends when the individual is dropped off at the hospital. There is also a 5 day limit for the hospital, either the individual is release or they go to a hearing.*
6. Do you often see or come into contact with the same people?  
*Yes, repeatedly. The only real time a case closes is when an individual dies, unfortunately. Their purpose is to manage the individual, not fix them.*
7. How do you feel Portland's BHU program compares to other similar programs around the state?  
*Other models are crisis based, while the BHU focuses on follow-up. That is why it is more effective.*
8. What made you want to work for the BHU?  
*1: They began with Project Respond, and then moved to the BHU. Thought the idea of pairing an officer and a clinician was great. They wanted to be a resource.  
2: They enjoy working with the population, and it is nice to effect change. They think it is nice to do something preventative.*
9. What do you believe is the best aspect of the BHU?  
*The pairing of a clinician and an officer. The BHU would not be able to do what they could without such a team. The team is given free rein to do what they believe is the most impactful, they can actually be thoughtful about the process.*
10. Which aspect(s) could use some work?  
*There should be more access to housing. Individuals need safe, warm places to get back on their feet. They also believed that there should be better connections to mental health professionals. They also had issues with the criteria for holding individuals. They believe that it is too high so they end up waiting long periods of time to get an individual the help*

*they need since the capacity is overflowing. They would also like the ability to jump to the front of the list.*

11. What do you enjoy most about your job?  
*1: The flexibility to do what the individual needs. They also like working with the police.  
2: They like making meaningful changes, and enjoy the ability to be creative. They also like that they have the time to help the individuals get what they need.*
12. What is your hope for the BHU?  
*They hope that housing will become a regular part of the BHU. Additionally, they would like to see the DOJ settlement requirements become more realistic so that officers will actually want to work with the mentally ill.*
13. Do you feel that you have the appropriate tools to help those in need? (Knowledge/Skills)  
*They believe that there needs to be better access to mental health treatment and that outreach programs need to be better.*
14. What is your greatest obstacle in regards to your job?  
*1: Finding people in the system, they can flag them by address but not by name. The technicalities could use some work.  
2: The lack of agencies that will go out to the mentally ill.*
15. Do you think there is a better/different way to aid the mentally ill?  
*They believe that it should be less office-based. It is hard to expect those with mental illnesses to come in. It is less effective. They should meet people where they are at.*
16. What is your favorite thing to do at work? (Attend to a call; Paperwork; etc.)  
*1: The "code" or lights and siren calls.  
2: Talking to people who are actually in crisis, because it is rewarding.*
17. Do you think the BHU could be a model for other cities or states?  
*Yes, because the BHU attacks multiple issues because they have many types of teams, BHRT, ECIT, CIT, and SCT.*
18. What, in your opinion, is a potential solution to the crisis of the mentally ill?  
*1: Gaining more capacity, housing, outreach programs, and engagement from the community.  
2: The law needs to change, because the bar is set too high. The capacity also needs to increase, and there should be parole/probation for the mentally ill, possibly with incentives for housing and such.*

**#4:**

1. How do individuals get into the BHU?  
*Through officer referrals. They then follow up based on the referrals from other law enforcement, and evaluate whether the individuals needs help or not. They try to limit the number of community referrals.*
2. What types of trainings did you have to complete?  
*CIT, ECIT which are an additional 40 hours, ASIST (Suicide Prevention), Trauma Informed Care, Involuntary Commitment Investigation, and Threat Assessment Trainings.*
3. Are there specific requirements to be an officer with the BHU? (Schooling/Personal History)  
*For a general patrol officer, 2 years of college, or military service, or reserve officer experience.*
4. What types of aid are provided to individuals in the BHU?  
*For a BHRT officer, they do not provide care or mental health services; rather they connect them to the appropriate care. They advocate and take the time to engage and build trust with the individual.*
5. Is there an “expiration date” on how long someone can be in the BHU?  
*No, as long as the officer is doing a good job. The 72-hour rule is bad language because it is dependent on the person.*
6. Do you often see or come into contact with the same people?  
*Yes, quite frequently. The first attempt does not usually work.*
7. How do you feel Portland’s BHU program compares to other similar programs around the state?  
*The BHU is the most-layered program. Officers are more involved than most places. ECIT focuses on hotspot emergency with Project Respond. The BHRT are like detectives. There are 24 hour clinicians that can come to the individual.*
8. What made you want to work for the BHU?  
*It was the right time, a new unit, and a big problem. This individual has led units before, and they created the BHU as it went along. It was an attempt to impact the broken system. You cannot complain if you will not get in the game.*
9. What do you believe is the best aspect of the BHU?  
*That they have the time to be thoughtful and figure out what will work. They help those who cannot advocate for themselves.*
10. Which aspect(s) could use some work?  
*Resources. They need more people and time. They also need a way to effectively communicate with the community. They need to educate them on how difficult this is to do.*
11. What do you enjoy most about your job?  
*The talented people, working for a purpose, and doing good work. They cannot cure it but they can make the individuals life better.*
12. What is your hope for the BHU?  
*That the Threat Assessment Training will become mandatory. The community safety needs to be built up. They want to see the data to make sure it is effective. They want to continue to maintain and bring quality to the people.*
13. Do you feel that you have the appropriate tools to help those in need? (Knowledge/Skills)

*They know what needs to be done to advocate but the system they are working with is designed to help easy problems. It does not have the capacity to deal with the serious or violent.*

14. What is your greatest obstacle in regards to your job?

*Trying to get assistance for citizens who desperately need care. But the system cannot respond well to the serious or violent. It is not a system because it does not coordinate and communicate. It is a huge civil rights issue. The police do not make the laws, they just navigate them. Also, the private hospitals do not partner at all. They are independent, and do not coordinate.*

15. Do you think there is a better/different way to aid the mentally ill?

*We need to figure out how to provide more support in the community. We need to get away from the suicide necessity and provide good humane positive care. They need to bring families in. How do we partner effectively?*

16. What is your favorite thing to do at work? (Attend to a call; Paperwork; etc.)

*Figure stuff out, and solve problems. Getting confirmation that they have helped. They like working with a dedicated team.*

17. Do you think the BHU could be a model for other cities or states?

*Yes. It can be scaled up or down. It has real potential. You could plug it into what works for a specific city. It is viable, but not the only way.*

18. What, in your opinion, is a potential solution to the crisis of the mentally ill?

*The system needs to figure out a better way to help those people within civil rights. What can they do? How can they help the really challenging problems and get to them where they are at? How do we set up care systems to help them? It should be really hard to cut off care. There should be some kind of incentive program. The VA is not allowed to say no, and neither is the police, so no one else should be able to.*

**#5:**

1. How do individuals get into the BHU?  
*Through police officer referral, unless it is from important personnel. They do listen to their community partners as well depending upon the threat level.*
2. What types of trainings did you have to complete?  
*CIT, ECIT, ASIST (Suicide Prevention), Informed Trauma, and Threat Assessment.*
3. Are there specific requirements to be an officer with the BHU? (Schooling/Personal History)  
*There can be no use of force, depending on how it looks. They need qualifications as an officer, participation in ECIT, and they need to show persistence through training.*
4. What types of aid are provided to individuals in the BHU?  
*They coordinate with the individuals to connect or reconnect them to services. They want to stay away from being case workers. They want to connect them to resources.*
5. Is there an “expiration date” on how long someone can be in the BHU?  
*No. They do have weekly meetings to discuss why this is happening and how they can better connect people to the proper sources. There are no resources for long term care.*
6. Do you often see or come into contact with the same people?  
*Yes, they check in based on the level of danger the individuals present.*
7. How do you feel Portland’s BHU program compares to other similar programs around the state?  
*It works best for the City of Portland. Rather than one car waiting for a call, BHRT officers provide follow up. What are the needs not just in the moment but continuously? They get them connected so that they reduce contact with the police.*
8. What made you want to work for the BHU?  
*It was in place, and it is the future. It is innovative. They needed to adapt and educate themselves.*
9. What do you believe is the best aspect of the BHU?  
*The team, from the supervisors on down. Cooperation and respect makes this job easy. They are a cohesive team so work gets done efficiently and with great quality.*
10. Which aspect(s) could use some work?  
*They need more people. They are at capacity. If they could even add one more car in the central precinct it could improve the quality.*
11. What do you enjoy most about your job?  
*Making life easier for the street cops. It is not about how many arrests they make anymore. They can be flexible because of good leadership.*
12. What is your hope for the BHU?  
*Each community needs to assess their own needs. The DOJ is attempting to use a cookie cutter type of model. Every place is different. They need to start with an outline and be more flexible. They need to look at the goals of a community and answer the needs.*
13. Do you feel that you have the appropriate tools to help those in need? (Knowledge/Skills)  
*Yes. In the beginning there was zero training. The Bureau invested in the unit and sent them to trainings. They have a great commitment to the unit.*
14. What is your greatest obstacle in regards to your job?  
*HIPAA laws. Everyone interprets it differently. It does protect people but it is the way it is applied.*

15. Do you think there is a better/different way to aid the mentally ill?  
*They need to spend the money for community outreach, and they need to spend the money to be flexible. If they have a place for people to go, eventually they will spend less money overall. They need to I.D. the problem and fix it.*
16. What is your favorite thing to do at work? (Attend to a call; Paperwork; etc.)  
*Being a part of something new. They were part of the team that started this from the ground level.*
17. Do you think the BHU could be a model for other cities or states?  
*Yes, it is a good model, but you have to be flexible when re-applying it to other communities. There are different views.*
18. What, in your opinion, is a potential solution to the crisis of the mentally ill?  
*There has to be a plan, but a universal one. Everyone has to be involved. They need to follow through. They cannot just quit. There needs to be flexibility. They need to be able to tweak it. Do not throw the plan away. They need to stop and assess it and tweak it while still sticking to it.*

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