*Please note: This is a working draft of Directive 850.20. This is proposed language and the Bureau has not implemented any changes to the current policy at this time.

850.20 Police Response to Mental Health Crisis
2nd Universal Review: 05/15/18-06/14/18 (Clean view)

Refer:

- ORS § 161.375(4), Authority of Psychiatric Security Review Board to issue warrant of arrest
- ORS § 426.223, Authority of facility director or designee to require assistance of a peace officer to retake custody of committed person who has left a facility without lawful authority
- ORS § 426.005, Definitions for ORS § 426.005 to 426.390
- ORS § 426.228, Authority of peace officer to take a person into custody for mental health treatment
- ORS § 426.233, Authority of community mental health program director or designee to place mental health hold and order transport to treatment
- ORS § 430.735-765, Duty of government officials (incl. Peace Officers) to report abuse of persons with mental illness or developmental disabilities
- DIR 630.45, Emergency Medical Custody Transports
- DIR 640.35, Abuse of Elderly/Persons with Disabilities
- DIR 850.25, Police Response to Mental Health Facilities
- DIR 850.39, Missing, Runaway, Lost or Disoriented Persons
- DIR 850.10 Custody, Civil Holds
- DIR 850.30 Juveniles, Custody
- DIR 900.00, General Reporting Guidelines
- Portland Police Bureau, Behavioral Health Unit's Community Mental Health Resources
- Report of Peace Officer Custody of a Person with Alleged Mentally Illness
- Report of Peace Officer Custody of a Person with Alleged Mentally Illness as Directed by a
- Community Mental Health Director
- Bureau of Emergency Communications Mental Health and Enhanced Crisis Intervention Team Dispatch Protocol

Definitions:

- Designated Residential Mental Health Facility: Secure and non-secure treatment facilities registered with Multnomah County Mental Health and Addiction Services to provide residential mental health treatment for adults in a home like environment supervised by twenty four (24) hour staff to provide stabilization, treatment, and community integration, which have been identified and flagged by the Portland Police Bureau's Behavioral Health Unit (BHU). ORS § 426.005 (1) (c) (d).

- Enhanced Crisis Intervention Team (ECIT): ECIT consists of sworn members who have volunteered and been selected to complete an additional forty (40) hours of mental health response training to serve as specialized responders to individuals who may have a mental illness.

- Mental Health Crisis: An incident in which someone with an actual or perceived mental illness experiences intense feelings of personal distress (e.g. anxiety, depression, anger, fear, panic, hopelessness), a thought disorder (e.g. visual or auditory hallucinations, delusions, sensory impairment or cognitive impairment), obvious changes in functioning (e.g. neglect of personal hygiene) and/or catastrophic life events (e.g. disruptions in personal relationships, support systems or living arrangements; loss of autonomy or parental rights; victimization or natural disasters), which

may, but not necessarily, result in an upward trajectory of intensity culminating in thoughts or acts that are dangerous to self and/or others.

- Mental Health Providers: Mental health providers are professionals who evaluate, diagnose, and treat mental health conditions. Providers have advanced education, training, and/or licensure. Common types of mental health providers include psychiatrist, psychologist, physician assistant, social worker, professional counselor, and qualified mental health professional. Providers may specialize in certain areas such as depression, substance abuse, or family therapy. Providers may work in different settings such as private practice, hospitals, or community agencies.

About Mental Health:

1. Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society.

2. Mental illnesses are health conditions that are characterized by alternations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alternations in thinking, mood, or behavior contribute to a host of problems-patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom.

3. Mental health problems refer to signs and symptoms of insufficient intensity or duration to meet the criteria for a mental illness diagnosis. Almost everyone has experienced mental health problems in which the distress one feels matches some of the signs and symptoms of mental illness. Mental health problems may warrant active efforts in health promotion, prevention, and treatment. Mental health problems may escalate to the level of mental health crisis if the situation and person's level of distress exceeds his or her abilities to cope.

4. Mental illness is distinct from intellectual or developmental disabilities.

Policy:

1. In the context of mental health services, mental health providers are responsible for the evaluation, diagnosis, and treatment of persons with mental illnesses and assessment and intervention with those who are in mental health crisis. However, the Portland Police Bureau recognizes that its members are often first responders to individuals with mental illness who present in crisis or with immediate needs. The Portland Police Bureau is committed to serving individuals in mental health crisis in partnership with mental health providers, the justice system, emergency medical services, and community members. When appropriate, referral to community-based treatment services is a preferred alternative to arrest and incarceration of persons who are in mental health crisis.

2. The Portland Police Bureau recognizes that members will have contact with residents who experience mental illness but are not in crisis. Many members of the Portland Police Bureau will come to be familiar with individuals in the community who members know to have a mental illness. The Police Bureau provides training so that members may recognize signs and behaviors of mental illness in the absence of crisis, and expects members to engage these individuals with dignity and respect, using the skills they have learned in their crisis training. It is the Police Bureau's

intention that members give special consideration to these situations, recognizing that using crisis intervention skills with all individuals experiencing mental illness will support the Bureau's goal of safely resolving situations, providing excellent service and building respectful relationships with mental health peers, family members, providers and other involved City of Portland residents.

3. Members are increasingly required to respond to and intervene on behalf of persons who are in mental health crisis. While members are not expected to make mental health diagnoses, they are expected to recognize signs and symptoms that may suggest a mental illness as well as behaviors that are indicative of mental health crisis. The goal is to use de-escalation skills to maximize the likelihood of a safe outcome for members, individuals, and the community.

Procedure:

1. Member Expectation and Training:
   1.1. When members recognize that a person whom they are contacting has signs and symptoms indicative of a mental illness, members are expected to use their training to attempt engagement without escalating the situation. When responding to incidents involving persons who are experiencing a mental health crisis, members are also expected to manage the scene and develop a reasonable disposition plan.

   1.2. All members on a call shall answer the mental health indicator question. Members shall document the incident on an appropriate police report, complete all reporting requirements for a mental health crisis response, and submit the information to a supervisor before the end of shift.

   1.3. Mental Health Response Training:
      1.3.1. All new sworn members will receive Mental Health Response training.
      1.3.2. All existing sworn members will receive Mental Health Response refresher training during annual, in-service training.
      1.3.3. The Bureau provides training so that members may recognize signs and symptoms of mental illness and develop skills to engage individuals experiencing mental illness with dignity and respect.
2. Responding to and managing scenes involving persons in mental health crisis:
   2.1. When responding to incidents involving persons displaying behavior indicative of mental health crisis members will consider the following actions to manage the incident for the safety of all at the scene:
      2.1.1. Evaluate the nature of the incident and necessity for police intervention when feasible, based on information known to the member at the time (e.g. reports, known history, observed behavior, etc.).
      2.1.2. If the member decides to intervene, consider, when feasible, the use of verbal and non-verbal communication skills to engage a person who may be agitated, upset or at risk of becoming emotionally unstable in order to calmly and safely resolve the situation.
      2.1.3. Tactics members should consider in devising a response plan include, but are not limited to, the following ("ROADMAP" is a mnemonic device that assists members in remembering tactics taught in training):
         2.1.3.1. **R –** Request specialized units,
            2.1.3.1.1. Evaluate the need for assistance from individuals with additional training in working with mental health crisis situations (e.g. Enhanced Crisis Intervention

Team (ECIT) members, Project Respond, Crisis Negotiation Team (CNT)). When a member determines that ECIT assistance is needed, they shall make the request through the Bureau of Emergency Communications (BOEC).

2.1.3.1.2. Evaluate the need for possible consultation with a mental health provider (e.g. see the Behavioral Health Unit's Community Mental Health Resources such as the Multnomah County Call Center, the involved person's mental health providers), and/or anyone else the member deems appropriate.

2.1.3.2. **O -** Observe or use Surveillance to monitor subject or situation,

2.1.3.3. **A –** Area Containment (perimeter, containment),

2.1.3.4. **D –** Disengage with a plan to resolve later,

2.1.3.4.1. Disengagement is a tactic to be considered to reduce undue safety risk to the member, the involved persons, or others. Prior to disengagement, members will make reasonable efforts to gather relevant information about the person in crisis from readily available sources, such as the Multnomah County Call Center, and consult with a supervisor to determine whether to make contact at a different time or under different circumstances. The tactic requires members to complete a general offense report, notify the Multnomah County Call Center of the situation (e.g. name, date of birth, disposition), and develop a plan in accordance with Bureau training. Members shall not disengage where an individual presents an immediate danger to a third party. Where an individual presents an immediate danger to her/himself, prior to disengagement members shall assess whether they could reasonably remain at the scene and use other tactics to diminish the risk of harm to the individual without increasing the risk of harm to the member or third parties. A perception of risk based on mere suspicion will not constitute 'immediate danger.'

2.1.3.5. **M** – More Resources/Summon Reinforcements,

2.1.3.6. **A –** Arrest Delayed (get a warrant, or try different time/place),

2.1.3.7. **P –** Patience. Use time and communication to attempt to de-escalate the subject.

2.1.4. If custody is necessary, develop and communicate a tactical plan to participating members, so as to take advantage of the most effective options that may safely resolve the incident.

3. Disposition:

3.1. In determining a non-criminal resolution for a person with a mental illness or in mental health crisis, members will consider the totality of the circumstances, including the behavior of the person and the governmental interests at stake. Following is a list of non-criminal dispositions that may be appropriate at the scene, among others:

3.1.1. Refer the involved person to a mental health provider; see the Behavioral Health Unit's Community Mental Health Resources, for referral information.

3.1.2. Transport the involved person to a mental health or medical facility for voluntary care. Members should escort the person into the waiting area, introduce them to facility staff, and share with staff a brief verbal report on the facts of the case. Members are not required to standby.

3.1.3. Take the involved person into custody and transport to a medical facility in accordance with Directive 850.21, Peace Officer Custody (Civil), or Directive 850.22, Police Response to Requests for Mental Health Custody.

3.2. Regardless of which disposition above is used, members are required to complete an appropriate police report.

3.3. If an individual is taken into custody, either civilly or criminally, members are required to document consideration and/or use of ROADMAP tactics.

4. Enhanced Crisis Intervention Team (ECIT) Member Responsibilities:

4.1. ECIT members will respond as the primary member on a mental health crisis call when dispatched or at the request of any member.

4.2. ECIT members may also volunteer to become the primary member on any call.

4.3. ECIT officers may serve as a resource to the Crisis Negotiation Team (CNT). Additionally, ECIT officers may facilitate an efficient transition when CNT arrives on scene. However, ECIT will not be used in place of CNT.

4.4. ECIT members will notify his/her supervisor when leaving their assigned precinct.

4.5. ECIT members who participate in a mental health crisis call by using their crisis intervention skills shall complete any required report.

5. Supervisor Responsibilities:

5.1. Supervisors will manage the dispatch and use of ECIT members and coordinate with the Bureau of Emergency Communications (BOEC) as appropriate.

5.2. Supervisors will acknowledge or respond to all calls where a member is dispatched to a designated mental health facility, in accordance with Directive, 850.25, Police Response to Mental Health Facilities.

5.3. Supervisors will ensure their members follow reporting requirements for mental health crisis response.

Provide feedback here

850.20 Police Response to Mental Health Crisis
2nd Universal Review: 05/15/18-06/14/18 (redline markup)

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         2.1.3.4. **D –** Disengage with a plan to resolve later,
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3.2. Regardless of which disposition above is used, members are required to complete an appropriate police report.

3.3. If an individual is taken into custody, either civilly or criminally, members are required to document consideration and/or use of ROADMAP tactics.

4. Enhanced Crisis Intervention Team (ECIT) Member Responsibilities:

4.1. ECIT members will respond as the primary member on a mental health crisis call~~, involving the following:~~ when dispatched or at the request of any member.

~~4.1.1. Upon request of a citizen,~~

~~4.1.2. Upon request of the responding member,~~

~~4.1.3. The subject is violent,~~

~~4.1.4. The subject has a weapon,~~

~~4.1.5. The subject is threatening or attempting suicide, or~~

~~4.1.6. The call is at a residential mental health facility.~~

4.2. ECIT members may also volunteer to become the primary member on any call.

4.3. ECIT officers may serve as a resource to the Crisis Negotiation Team (CNT). Additionally, ECIT officers may facilitate an efficient transition when CNT arrives on scene. However, ECIT will not be used in place of CNT.

4.4. ECIT members will notify his/her supervisor when leaving their assigned precinct.

4.5. ECIT members who participate in a mental health crisis call by using their crisis intervention skills shall complete any required report.

5. Supervisor Responsibilities:

5.1. Supervisors will manage the dispatch and use of ECIT members and coordinate with the Bureau of Emergency Communications (BOEC) as appropriate.

5.2. Supervisors will acknowledge or respond to all calls where a member is dispatched to a designated mental health facility, in accordance with Directive, 850.25, Police Response to Mental Health Facilities.

5.3. Supervisors will ensure their members follow reporting requirements for mental health crisis response.

Directive 850.20 – Website comments 8/16/17-9/14/17

Date	Individual	Comment
1st Universal Review		
9/9/17		COMMENTS ON MENTAL HEALTH CRISIS RESPONSE DIRECTIVE, SEPTEMBER 2017 To Acting Chief Uehara, Capt. Bell, Lieutenant Morgan, PPB Policy Analysts, Compliance Officer/Community Liaison Team, Community Oversight Advisory Board staff, US Dept. of Justice, Citizen Review Committee and the Portland Police Bureau: The posting of Directive 850.20 on Mental Health Crisis Response brings to light reasons the Bureau's Directives review system has made some advances but still has far to go. This policy, which is crucial to the US Department of Justice (DOJ) Agreement with the City, was last posted for review in January and April, 2015, at which time Portland Copwatch (PCW) made extensive remarks. The policy was quietly adopted with the approval of the DOJ in May, 2016, long before the Bureau began posting the near-final copies with "redlines" and cover memos explaining the changes made. Examining the current active version of the Directive which has been posted for review at <http://www.portlandoregon.gov/police/59757>, PCW noticed numerous changes made between 2014 and 2015, not the least of which was renaming the core training on mental health. What used to be called (and still is, to most of us following the Portland Police) "Crisis Intervention Training" was renamed "Mental Health Response Training" in this Directive. Perhaps this was because Portland's model doesn't exactly mirror Memphis' Crisis Intervention Team model, or it was to better differentiate the basic 40 hour training from the Enhanced Crisis Intervention Team's extra 40 hours. Regardless, the fact that a group like PCW, which follows Portland Police issues closely, wasn't aware of this change until we closely examined the new policy indicates that the Bureau has serious issues communicating information to the community. We will not take time here to comment on the various policies which have been posted in their final forms (especially since the Bureau claims they do not want to receive such commentary) but may do so in the coming weeks. These include the Crowd Control policy that was posted on August 2, and Vehicle Interventions and Pursuits posted August 27. Today, September 8, the Bureau posted for Second review the Bias Based Policing Directive. Upon visiting the PPB website, we found that seven other Directives were posted for review (three First Reviews and four Second Reviews) on September 1, while your notification system only sent out a message with a link to the current version of Directive 1010.10. We wrote back asking why that happened and received no reply. The Bureau should send out a new notice and re-set the clock on those

		seven Directives since the public wasn't properly notified. We still believe having links to specific policies under consideration cross-listed on the main Directives page, the First and Second Review pages, and the Pending Enactment page, would help those who are trying to keep up with the process. The Mental Health Directive is a First review document, meaning there is no indication of what the Bureau is considering changing, and, as noted above, there is no "redline" version showing what was changed from the April 2015 draft to the May 2016 enacted version. We appreciate having 30 days to comment on this Directive but also continue to believe having 30 days after the proposed changes are released would give more time to respond to the Bureau's draft. As always, we ask that the Bureau add letters to section headings (Definitions, Policy, Procedure) so that there are not multiple sections with the same numbers, and to put numbers on the Definitions. Our comments below refer to the Procedure section unless otherwise noted. DIRECTIVE 850.20 MENTAL HEALTH CRISIS RESPONSE In our 2015 comments, we were concerned that the definition of mental health crisis was so broad it could have included just about anyone. The current version discusses mental health, mental illnesses and mental health "problems," defining Mental Health Crisis to include "intense feelings of personal distress, a thought disorder, obvious changes in functioning, and/or catastrophic life events." While the characterization of "unusual behavior" was deleted, the idea of "neglect of personal hygiene" was not. It is true that taken in as part of the longer list of factors, this could indicate mental health problems, but the list should note that just that one "symptom" by itself does not indicate an issue. Otherwise this could lead to officers assuming anyone who doesn't self-groom whether by choice or lack of access to facilities is by definition in mental health crisis. As a means to overcome assumptions made based on this definition (and recognizing, as the Directive does, that "Mental health providers are responsible for the ...diagnosis of persons with mental illness" [Policy 1]), we suggested better-defined decision making guidance than telling officers to "consider the governmental interests at stake" (Section 3.1). No such definition was added. A previous Section, for instance, that outlined why police might need to be called to the scene of mental health crises, which raised the issue of whether the person is armed, was removed in the 2015 draft and the current enacted version. Such guidelines, though, are included for

		Enhanced Crisis Intervention Team (ECIT) calls as we address in the next paragraph. Language in the previous draft saying "ECIT members may assist in incidents" was replaced with the appropriate stronger "ECIT members will respond as the primary member on a mental health crisis call" (Section 4.1). This section is specific as to the governmental interests that prompt ECIT involvement: request of a citizen or responding officer, a subject who is threatening suicide, violent and/or has a weapon, or if the call is at a residential mental health facility. There should be a reference in that last subsection (4.1.6) to Directive 850.25 on Police Response to Mental Health Facilities (and, as we've said numerous times, there should be guidelines in THAT Directive for officers not to enter those facilities with lethal weapons unless the suspect somehow has access to a gun). The Bureau took our advice and expanded the Definition of the ECIT, which used to say ECIT members are volunteer officers who take ECIT training, now explaining that those officers have 40 extra hours of mental health response training. However, for some reason the definitions of these important terms have been removed: de-escalation, disengagement, delayed custody, and non-engagement. In fact, non-engagement is no longer an option given in the Directive.* The other words all appear in some form in the new ROADMAP mnemonic Section of the policy (2.1.3). The D stands for Disengagement. The second A stands for "Arrest Delayed" (aka delayed custody). The "P" stands for "Patience" which mentions using time and communication to de-escalate. As we have noted elsewhere, we think the Bureau should only use the term "de-escalation" to mean calming a situation down using verbal and physical tactics, not for lowering the amount of force already being used on a suspect. We noted in our 2015 comments that these tactics (including non-engagement) can be used on someone regardless of whether they are in mental health crisis as alternatives to officers using force. We also wrote in 2015, and it is still true: "The Directive still does not call attention to the fact that the mere presence of a uniformed officer can cause trauma/stress for persons with mental health issues (and other members of the general public who are fearful of police due to past experience or witnessing of police violence)." Allies in the mental health community have noted that there are some people who might respond better to a uniformed officer than to a mental health professional showing up on scene, but the Directive should at least raise this issue and offer options to consider for de-escalating, such as putting on PPB polo shirts or other less

		intimidating gear. While we continue to appreciate the acknowledgment that law enforcement should not evaluate, diagnose and treat mental health ailments (as noted above, in Policy 1), it is too bad that there are still remnants of blaming the lack of adequate services for how often police interact with (and thus exert violence on and/or kill) people in crisis. Policy 3 still talks about officers being "increasingly required to respond" to persons with mental illness. Since Policy 1 describes the PPB seeking to be part of a holistic system an preferring referrals to community-based treatments, language laying blame elsewhere should all be removed. De-escalation, recognizing behaviors and avoiding excessive force should be mandatory regardless of what's going on with other agencies. Besides which, if the Directive is not changed for several years and such calls decrease, the statement will no longer be accurate. The Bureau partially responded to our concern that Supervisors, who previously were required to respond to calls in designated mental health facilities, were only asked to "acknowledge" such calls in the 2015 draft. The current version (Section 5.2) says Supervisors "will acknowledge or respond to" such calls. Given the high stakes raised by the deaths of Jose Mejia Poot and Merle Hatch, we suggest the response go back to being mandatory-- especially because it is mandatory in Directive 850.25 (Sections 1.1 and 1.3). We are still concerned that Section 3.1.2 does not require officers to stand by when a person checks into a mental health facility. Persons in trauma may feel confused and abandoned if left alone. Unless the PPB or the facility assigns an advocate to the person upon their being dropped off, the officer should stay with the subject. CONCLUSION At its August 24 hearing, the City formalized the guidelines for the new body replacing the Community Oversight Advisory Board, which will require the Bureau to integrate the new Committee into its Directives review process. We look forward to seeing this concept implemented, including but not limited to: public discussions about the policies and their implications, recommendations from the Committee being responded to by the PPB within a required 60 day time frame, and the community having a chance to hear about the Directives in a public setting and give direct feedback. In many ways, the Bureau doesn't need to create a plan for community engagement, they just need to take positive steps to actively listen to community

		feedback on its policies, practices, training, and culture. Thank you as always for the opportunity to comment Dan Handelman and other members of Portland Copwatch *There is, however, a clause in Section 2.1.2 which begins "If the member decides to intervene...", implying but not explicitly saying that deciding not to intervene is always an option.
9/3/17		I am impressed with the detail and approach that PPB handles mental illness. This is a difficult policy with multiple variations to situations, however the policy is well written. Nicely done!
8/17/17		This document looks ready.
8/16/17		Officers training in accordance with this directive will be most valuable in a community like ours where law violation is becoming a smaller proportion of an officer's duties. I have only praise for those who designed this directive and those who will abide by them and those citizens whose circumstances will require them.