



CITY OF PORTLAND, OREGON



Bureau of Police

Ted Wheeler, Mayor

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Mental Health Suite: Directives 850.20, Police Response to Mental Health Crisis; 850.21, Peace Officer Custody (Civil); 850.22, Police Response to Mental Health Director Holds and Elopement; and 850.25, Police Response to Mental Health Facilities Executive Summary

Introduction

At the conclusion of its 2011 investigation to determine whether Portland Police Bureau (PPB) members engage in a pattern or practice of using excessive force against people who have or are perceived to have a mental illness or are in mental health crisis, the Department of Justice (DOJ) identified the need for revisions to Directive 850.20, Police Response to Mental Health Crisis, in order to address the findings of its investigation. As a result, the Bureau, in conjunction with the DOJ, the Compliance Officer/Community Liaison (COCL) and their respective mental health experts, revised the directive and developed three related directives to provide improved guidance to members with regard to procedures for all aspects of member response to calls and interactions of this nature.

Review Timeline and Process

All DOJ-identified policies that have previously been approved by the DOJ are subject to additional review after the initial enactment. The DOJ first approved Directive 850.20, Police Response to Mental Health Crisis, which is colloquially referred to as the “trunk” directive of the mental health suite, in July 2016. The “branch” directives—850.21, Peace Officer Custody (Civil); 850.22, Police Response to Mental Health Director Holds and Elopement; and 850.25, Police Response to Mental Health Facilities received DOJ approval in October 2016.

Due to disparate review dates for each directive and the need to consult with DOJ and COCL stakeholders, the Bureau posted the directives for the first and second universal review and public comment periods at various points between August 2017 and June 2018.

Public Comments

Because there have not been significant shifts in the law or best practices pertaining to this subject matter since the initial approvals by the DOJ, the Policy Development Team, with the advice and consent of the DOJ and COCL, made only minor changes to the policies to account for adjustments in procedure (e.g., the transport of individuals in actual or perceived crisis to a secure evaluation facility) and to clarify intended practices (e.g., report writing requirements).

The Bureau received comments on the mental health suite from a handful of community and Bureau members, some in favor of the revised policies and others with specific recommended changes. The proposed revisions largely pertained to the definition of terms and the presence and appearance of PPB members at mental health facilities. Additionally, one commenter recommended that the Bureau establish a dedicated mental health unit within the Bureau.

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Definitions

A commenter expressed trepidation about a parenthetical example included in the definition of “mental health crisis” and voiced concern about the exclusion of some terms or phrases that had been included in previous versions of one of the directives. The examples included in the definition do not form a discrete list of criteria; rather, Bureau members are trained to observe the individual, taking into account several potential indicators of a mental health crisis, to inform their actions and behaviors when responding to a scene where an individual may be in crisis.

The directives review and revision process affords the Bureau the opportunity to address changes to law and best practice standards, clarify intended practices and procedures and reassess the need for or placement of certain language. The Bureau removed certain terms that generated confusion (i.e., non-engagement) and reorganized the directive to include in the procedure section descriptions of other concepts (e.g., delaying custody, disengagement). When trained on disengagement, members are instructed to assess the scene and individual and, based on the totality of the circumstances, make a determination to establish or maintain contact or not to engage at all. This is a tactic on which the Bureau continues to train, and members are encouraged to employ the approach when safe and appropriate to do so.

Presence and Appearance of PPB Members at Mental Health Facilities

The Bureau received feedback from a few community members calling for the Bureau to require PPB members to remove their firearms when entering or present in a mental health facility. The Bureau recognizes that both the presence and appearance of its members may have an unintended impact on an individual in mental health crisis; however, the safety of the public, mental health facility staff and Bureau members is the priority of the Bureau. To ensure the safety of all involved, the Bureau will continue its current practices in this regard.

Related to that issue, the Bureau also received a comment recommending that mental health facility staff, rather than Bureau members, oversee the handling of a subject when entering a facility. Again, acknowledging the potential effect that a Bureau member’s presence may have on a subject, the Bureau is not in a position to impose requirements on the staff of external facilities. As a result, the current practice shall also remain in place.

Dedicated Mental Health Unit

Recognizing the prevalence of incidents that have a mental health component, one commenter suggested that the Bureau consider establishing a dedicated mental health unit. The Bureau’s Behavioral Health Unit (BHU) is designed to provide comprehensive assistance to people in actual or perceived mental health crisis and to oversee the Bureau’s response to individuals in crisis. All PPB sworn members receive basic Crisis Intervention Training and periodic refresher training. Furthermore, BHU assists in the oversight of the Bureau’s Enhanced Crisis Intervention Team (ECIT), comprised of volunteer officers who complete additional training and provide a more specialized response to these incidents; Behavioral Health Response Teams (BHRT), which consist of a patrol officer and a licensed mental health professional who conduct proactive outreach to at risk individuals and connect them with community resources; and the Service Coordination Team, a program designed to provide treatment to frequent offenders to address drug and alcohol addiction, mental health treatment and criminality.

We thank every individual who took the time to provide feedback on this directive. All comments received during both review periods are attached at the end of this document. We have removed all personal information to protect the privacy of commenters.

The Bureau's Revised Policy

The updated policies include changes that resulted from recommendations made by the DOJ, as well as the public. Many of these changes reflect shifts in current practices and address the need for clarification with regard to reporting requirements.

The Bureau believes that the revised directive provides clearer guidance to its members; however, any suggestions to further improve this policy are welcome during its next review.

Directives 850.20, Police Response to Mental Health Crisis; 850.21, Peace Officer Custody (Civil); 850.22, Police Response to Mental Health Director Holds and Elopement; and 850.25, Police Response to Mental Health Facilities will go into effect on October 6, 2018.

Published 09/06/18

850.20 Police Response to Mental Health Crisis

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 Temporary Detention and Custody of Juveniles
- 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:

- De-escalation: A deliberate attempt to reduce the necessity or intensity of force to resolve confrontation.
- 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. Request AMR transport for the involved person to a mental health or medical facility for voluntary care. Members should inform AMR personnel of the situation so AMR can pass the information along to staff at the facility upon arrival. Members may meet up with AMR at the facility and may 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 arrange for AMR transport to a medical facility in accordance with Directive 850.21, Peace Officer Custody (Civil), or Directive 850.22, Police Response to Mental Health Directors Holds and Elopement.
 - 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.

History:

- Originating Directive Date: 09/06/01
- Last Revision Signed: 09/06/18
 - Effective Date: 10/06/18
- Next Review Date: 10/06/19

850.20 Police Response to Mental Health Crisis

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- DIR 850.30 [Temporary Detention and Custody of Juveniles, Custody](#)
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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.

~~1.2.1.3.~~ Mental Health Response Training:

~~1.2.1.1.3.1.~~ All new sworn members will receive Mental Health Response training.

~~1.2.2.1.3.2.~~ All existing sworn members will receive Mental Health Response refresher training during annual, in-service training.

~~1.2.3.1.3.3.~~ 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.

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- 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):
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 - 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~~Request AMR transport for the involved person to a mental health or medical facility for voluntary care. Members should inform AMR personnel of the situation so AMR can pass the information along to staff at the facility upon arrival. Members may meet up with AMR at the facility and may 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 arrange for AMR 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~~Directors Holds and Elopement.
 - 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.

850.21 Peace Officer Custody (Civil)

Refer:

- ORS § 426.005, Definitions for ORS § 426.005 to 426.390
- ORS § 426.228, Custody
- DIR 630.45 Emergency Medical Custody Transports
- DIR 630.50 Emergency Medical Aid
- DIR 850.20 Police Response to Mental Health Crisis
- DIR 850.22 Police Response to Mental Health Director's Holds and Elopement
- DIR 850.25 Police Response to Mental Health Facilities

Definitions:

- De-escalation: A deliberate attempt to reduce the necessity or intensity of force to resolve confrontation.
- 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.
- Peace Officer Custody: An exercise of civil authority when there is probable cause to believe a person is dangerous to self or to any other person and is in need of immediate care, custody, or treatment for mental illness.

Policy:

1. In the context of mental health crisis, the Portland Police Bureau recognizes the importance of civil rights and the need for individuals to have control over their person. The Police Bureau also recognizes there are times when, as a result of mental health crisis, a person may lack the capacity to make sound judgments about their personal situation. After considering the alternatives outlined in Directive 850.20, and after finding probable cause exists for a hold, members may take the individual into custody on a Peace Officer Hold. Members shall treat the individual with dignity and compassion at all times.
2. Members shall be guided by law regarding civil custody of persons in mental health crisis with the goal of assessing the need for custody. When the need arises, the act of custody shall be resolved in a safe, constructive, and humane manner as possible.
3. A member's ability to manage custody by this expectation is of critical importance to the involved person, the involved person's support system, community members, mental health providers, and the Police Bureau.

Procedure:

1. Peace Officer Custody:
 - 1.1. Members may take a person into peace officer custody if the member has probable cause to believe the person is dangerous to self or to any other person and is in need of immediate care, custody or treatment for mental illness.
 - 1.2. Before taking a person into peace officer custody for a mental health evaluation, members shall:
 - 1.2.1. 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. Tactics members should consider in devising a tactical plan include, but are not limited to, the following (“ROADMAP” is a mnemonic device that assists members in remembering tactics taught in training):
 - 1.2.1.1. **R** – Request specialized units,
 - 1.2.1.1.1. 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 needed, assistance may be requested through the Bureau of Emergency Communications (BOEC).
 - 1.2.1.1.2. Evaluate the need for possible consultation with a mental health provider (Refer to the Behavioral Health Unit’s Community Mental Health Resources Guide), and/or anyone else the member deems appropriate.
 - 1.2.1.2. **O** - Observe or use surveillance to monitor subject or situation,
 - 1.2.1.3. **A** – Area containment (perimeter, containment),
 - 1.2.1.4. **D** – Disengage with a plan to resolve later,
 - 1.2.1.4.1. Disengagement is a tactic to be considered to reduce undue safety risk to the member, the involved persons, or others. Members will 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 and notify the Multnomah County Crisis Line of the situation (e.g. name, date of birth, disposition).
 - 1.2.1.5. **M** – More resources/summon reinforcements,
 - 1.2.1.6. **A** – Arrest delayed (get a warrant, or try different time/place),
 - 1.2.1.7. **P** – Patience. Use time and communication to attempt to de-escalate the subject.
 - 1.3. After taking a person into peace officer custody for a mental health evaluation, members shall arrange transport by AMR of the individual to the appropriate secure evaluation facility or nearest designated hospital emergency department that conducts mental health evaluations. Refer to Directives 630.45, Emergency Medical Custody Transports, and 630.50, Emergency Medical Aid, for additional direction and procedures.
 - 1.4. Juveniles may be taken into civil custody for a mental health evaluation under the same legal standard as adults. Members shall notify the juvenile's legal guardian or the Department of Human Services prior to transport to a secure evaluation facility or

nearest designated hospital emergency department that conducts mental health evaluations.

2. Member Responsibilities:

- 2.1. When a member takes a person into custody under the member's peace officer authority, the member will complete a Report of Peace Officer Custody of an Allegedly Mentally Ill Person (this is Form MHD [ORS § 426.228] of the Mental Health Division of the Oregon Health Authority). Members shall provide the report to AMR or, in those extraordinary circumstances when the officer provides transport, the treating physician at the secure evaluation facility.
- 2.2. When a member takes a person into custody under the direction of the Community Mental Health Program Director or designee, the member shall provide the custody report of the Community Mental Health Program Director or designee to AMR or, in those extraordinary circumstances when the officer provides transport, the treating physician at the secure evaluation facility.
- 2.3. The member will submit a copy of the Report of Peace Officer Custody of an Allegedly Mentally Ill Person, along with an original police report about the incident, to their supervisor before the end of shift.

3. Supervisor Responsibilities:

- 3.1. Supervisors shall ensure their members follow the reporting requirements for peace officer custody.

History:

- Originating Directive Effective: 05/02/17
- Last Revision Signed: 09/06/18
 - Effective Date: 10/06/18
- Next Review Date: 10/06/19

850.21 Peace Officer Custody (Civil)

Refer:

- ORS § 426.005, Definitions for ORS § 426.005 to 426.390
- ORS § 426.228, Custody
- DIR 630.45 Emergency Medical Custody Transports
- DIR 630.50 Emergency Medical Aid
- DIR 850.20 Police Response to Mental Health Crisis
- DIR 850.22 Police Response to Mental Health Director's Holds and Elopement
- DIR 850.25 Police Response to Mental Health Facilities
- ~~DIR 630.45 Emergency Medical Custody Transports~~
- ~~DIR 630.50 Emergency Medical Aid~~

Definitions:

- De-escalation: A deliberate attempt to reduce the necessity or intensity of force to resolve confrontation.
- 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.
- Peace Officer Custody: An exercise of civil authority when there is probable cause to believe a person is dangerous to self or to any other person and is in need of immediate care, custody, or treatment for mental illness. ~~ORS § 426.005 (1)(e); ORS § 426.228.~~

Policy:

1. In the context of mental health crisis, the Portland Police Bureau recognizes the importance of civil rights and the need for individuals to have control over their person. ~~However,~~ ~~the~~The Police Bureau also recognizes there are times when, as a result of mental health crisis, a person may lack the capacity to make sound judgments about their personal situation. After considering the alternatives outlined in Directive 850.20, and after finding probable cause exists for a hold, members ~~shall~~may take the individual into custody on a Peace Officer Hold. Members shall treat the individual with dignity and compassion at all times.
2. Members shall be guided by law regarding civil custody of persons in mental health crisis with the goal of assessing the need for custody. ~~If~~When the need arises, the act of custody shall be resolved in a safe, constructive, and humane manner as possible.
3. A member's ability to manage custody by this expectation is of critical importance to the involved person, the involved person's support system, community members, mental health providers, and the Police Bureau.

Procedure:

1. Peace Officer Custody:

1.1. Members may take a person into peace officer custody if the member has probable cause to believe the person is dangerous to self or to any other person and is in need of immediate care, custody or treatment for mental illness.

1.2. Before taking a person into peace officer custody for a mental health evaluation, members shall:

1.2.1. 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. Tactics members should consider in devising a tactical plan include, but are not limited to, the following (“ROADMAP” is a mnemonic device that assists members in remembering tactics taught in training):

1.2.1.1. **R** – Request specialized units,

1.2.1.1.1. 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 needed, assistance may be requested through the Bureau of Emergency Communications (BOEC).

1.2.1.1.2. Evaluate the need for possible consultation with a mental health provider (Refer to the Behavioral Health Unit’s Community Mental Health Resources Guide), and/or anyone else the member deems appropriate.

1.2.1.2. **O** - Observe or use ~~Surveillance~~surveillance to monitor subject or situation,

1.2.1.3. **A** – Area ~~Containment~~containment (perimeter, containment),

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

1.2.1.4.1. Disengagement is a tactic to be considered to reduce undue safety risk to the member, the involved persons, or others. Members will 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 and notify the Multnomah County ~~Call Center~~Crisis Line of the situation (e.g. name, date of birth, disposition).

1.2.1.5. **M** – More ~~Resources/Summon Reinforcements~~resources/summon reinforcements,

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

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

~~Transport or facilitate the transport~~

1.3. After taking a person into peace officer custody for a mental health evaluation, members shall arrange transport by AMR of the individual to the appropriate secure evaluation facility or nearest designated hospital emergency department that conducts mental health evaluations. Refer to Directives 630.45, Emergency Medical Custody Transports, and 630.50, Emergency Medical Aid, for additional ~~information~~direction and procedures.

1.4. Juveniles may be taken into civil custody for a mental health evaluation under the same legal standard as adults. Members ~~will~~shall notify the juvenile's legal guardian or the Department of Human Services prior to transport to a secure evaluation facility or nearest designated hospital emergency department that conducts mental health evaluations.

2. Member Responsibilities:

2.1. When a member takes a person into custody under the member's peace officer authority, the member will complete a Report of Peace Officer Custody of an Allegedly Mentally Ill Person (this is Form MHD [ORS § 426.228] of the Mental Health Division of the Oregon Health Authority). Members shall provide the report to AMR or, in those extraordinary circumstances when the officer provides transport, the treating physician at the ~~hospital or Unity Center~~secure evaluation facility.

2.2. When a member takes a person into custody under the direction of the Community Mental Health Program Director or designee, the member shall provide the custody report of the Community Mental Health Program Director or designee to AMR or, in those extraordinary circumstances when the officer provides transport, the treating physician at the ~~hospital or Unity Center~~secure evaluation facility.

2.3. The member will submit a copy of the Report of Peace Officer Custody of an Allegedly Mentally Ill Person, along with an original police report about the incident, to their supervisor before the end of shift.

3. Supervisor Responsibilities:

3.1. Supervisors ~~will~~shall ensure their members follow the reporting requirements for peace officer custody.

850.22 Police Response to Mental Health Director Holds and Elopement

Refer:

- ORS § 426.005, Definitions for ORS § 426.005 to 426.390
- ORS § 426.070, Initiation
- ORS § 426.223, Retaking persons in custody of or committed to Oregon Health Authority
- DIR 850.20 Police Response to Mental Health Crisis
- DIR 850.21 Peace Officer Custody (Civil)
- DIR 850.25 Police Response to Mental Health Facilities

Definitions:

- Community Mental Health Program Director: The director of an entity, including Multnomah County, which provides community mental health program services.
- 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).
- Elope: To abscond, depart, leave, or walk away.
- Unlawful Elopement: To elope in violation of a civil or criminal legal/commitment status.

Policy:

1. In the context of mental health services, mental health providers, not law enforcement, are responsible for the evaluation, diagnosis, and treatment of persons who are in mental health crisis. There are times, however, when mental health providers need police services.
2. Because mental health custody as initiated by mental health providers may be civil, which can include Director's Custody, Order of Civil Commitment, Psychiatric Security Review Board (PSRB) Commitment Orders, Revocation Orders in legal/commitment status, members shall be guided by law when responding to mental health provider service requests.
3. A member's ability to manage a person in custody in a safe, constructive, and humane manner is of critical importance to the involved person, the involved person's support system, community members, mental health providers, and the Police Bureau. Members shall treat the individual with dignity and compassion at all times.

Procedure:

1. Police Response to Civil Custody Requests:
 - 1.1. Community Mental Health Program Director's Custody:

- 1.1.1. Members shall take a person into custody when the Community Mental Health Program Director, or designee, notifies the member that the Director has probable cause to believe that the person is dangerous to self or to any other person.
- 1.1.2. When assisting a community mental health program director or designee as defined in ORS § 426.005 (1) (a) with taking a person into custody (Director's Custody), members shall:
 - 1.1.2.1. Determine if taking civil custody of the person named on the Director's Custody Report may be achieved in a safe manner. Delaying custody is a tactic that may be used if the member determines that taking the person into custody under present circumstances may result in an undue safety risk to members, the involved person, and/or others. If delaying custody, members shall notify a supervisor and then develop a plan to determine a safer time and method to take the person into civil custody. An appropriate police report shall be completed documenting the details of this decision.
 - 1.1.2.2. If a member takes a person into custody, the member shall arrange for AMR transport to the secure evaluation facility, unless extraordinary circumstances warrant police transport.
 - 1.1.2.3. When necessary, members shall complete an appropriate police report and mental health text template documenting the civil custody or Director's Hold.
- 1.2. Unlawful Elopement from a Mental Health Facility or Hospital:
 - 1.2.1. If a person is being held on a Notice of Mental Illness (NMI) and elopes without permission from a facility, they have unlawfully eloped and members may be contacted to bring that person back to the facility.
 - 1.2.2. If a person is on commitment status (e.g., Order of Commitment) and elopes without permission from a facility, they have unlawfully eloped and members may be contacted to bring that person back to the facility.
 - 1.2.3. In the above circumstances, members shall:
 - 1.2.3.1. Verify that the NMI or Order of Commitment exists. The facility should have a copy of the Order on location; otherwise, members may verify the NMI or Order with the Multnomah County Crisis Line.
 - 1.2.3.1.1. Criteria for court ordered civil commitments are dictated by individual state laws. If a patient has eloped from a mental health facility in another state, members shall assess the person and take action in accordance with Directive 850.20, Police Response to Mental Health Crisis and/or Directive 850.21, Peace Officer Custody (Civil). Members shall contact the reporting facility and notify them of the disposition.
 - 1.2.3.2. Determine if taking civil custody of the person named on the Order of Commitment may be achieved in a safe manner. Delaying custody is a tactic that may be used if the member determines that taking the person into custody under present circumstances may result in an undue safety risk to members, the involved person, and/or others. If delaying custody, members shall notify a supervisor and then develop a plan to determine a safer time and method to take the person into civil custody.

- 1.2.3.3. Transport the named person back to the facility unless the member determines the person meets the criteria in Directive 850.21, Peace Officer Custody (Civil).
 - 1.2.3.4. Complete the appropriate police report and mental health text template documenting the incident and submit the report to a supervisor before the end of shift.
- 1.3. Elopement from a Mental Health Facility:
- 1.3.1. If a person is not on commitment status (e.g., Order of Commitment) and elopes without permission from a facility, that person is free to leave.
 - 1.3.2. If a person wishes to voluntarily return to the facility, members may transport that person to the facility.
 - 1.3.3. Should members receive a call alleging the eloped person is deemed to be dangerous to self or others, members must assess the person in accordance with Directive 850.20, Police Response to Mental Health Crisis and/or Directive 850.21, Peace Officer Custody (Civil).
- 1.4. Member -Supervisor Coordinated Response Required:
- 1.4.1. Warrants of Detention/Trial Visitation: During pre-trial civil commitment processes, a person with an alleged mental illness may be released into the community and be monitored by a civil commitment investigator. A civil warrant of detention may also be issued by a judge to take a person with mental illness into custody. Because the statutory authority to serve a warrant of detention rests with the Multnomah County Sheriff's Office, members shall not become involved in these activities unless called to an incident to assist a civil commitment investigator or civil deputy in fulfilling the investigator's or deputy's mission.
2. Police Response to Criminal Custody Requests:
- 2.1. Psychiatric Security Review Board (PSRB) Revocation Orders:
 - 2.1.1. Under ORS § 161.375(4), the Psychiatric Security Review Board (PSRB) has the authority to take PSRB supervised persons into custody on Revocation Orders, which are comparable to arrest warrants and subject to the same rules.
 - 2.1.2. A member is notified of a PSRB Revocation Order through a PSRB Law Enforcement Data Systems (LEDS) message reading: "No Criminal Warrant, PSRB order for mandatory return to Oregon State Hospital." Members shall then:
 - 2.1.2.1. Take the person named in the Revocation Order into custody and notify a supervisor.
 - 2.1.2.2. Ensure the Oregon State Hospital Communications Center is notified; the phone number can be found in the PSRB LEDS message.
 - 2.1.2.3. Transport the person with one other member, to the Oregon State Hospital Communication Center and notify a supervisor of the transport.
 - 2.1.2.4. If additional verification of Revocation Order is needed, the PSRB Executive Director may be contacted. The phone number can be found in the PSRB LEDS message.

2.1.2.5. 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.

2.2. Unlawful Elopement from PSRB:

2.2.1. If a person is under the jurisdiction of the PSRB and elopes without permission from a facility, they have unlawfully eloped and members may be contacted to bring that person back to the facility. ORS § 161.336(4)(a). Under such circumstances, members shall:

2.2.1.1. Verify the person is under the jurisdiction of the PSRB. The facility should have a copy of the Order on location; otherwise members may verify the Order within LEDS.

2.2.1.2. Determine if taking custody of the person named on the PSRB Order may be achieved in a safe manner. Delaying custody is a tactic that may be used if the member determines that taking the person into custody under present circumstances may result in an undue safety risk to members, the involved person, and/or others. If delaying custody, members shall notify a supervisor and then develop a plan to determine a safer time and method to take the person into custody.

2.2.1.3. Transport the named person back to the facility unless the member determines the person meets the criteria in Directive 850.21, Peace Officer Custody (Civil).

2.2.1.4. Complete the appropriate police report and mental health text template documenting the incident and submit the report to a supervisor before the end of shift.

3. Police Response to Civil or Criminal Custody Requests: Escape from an Oregon State Hospital:

3.1. If the superintendent of an Oregon State Hospital issues an escape warrant for the apprehension and return of a person, members shall:

3.1.1. Verify the identity of the person in LEDS.

3.1.2. Take the named person into custody and notify a supervisor.

3.1.3. Ensure the Oregon State Hospital Communications Center is notified; the phone number can be found in the LEDS message.

3.1.4. Transport, with one other member, the person to the Oregon State Hospital Communications Center and notify a supervisor of the transport.

3.1.5. Document the incident on an appropriate police report and mental health text template and submit to a supervisor before the end of shift.

4. Supervisor Responsibilities:

4.1. Supervisors shall ensure their members follow reporting requirements for the civil or criminal custody.

History:

- Originating Directive Effective: 05/02/17
- Last Revision Signed: 09/06/18

- Effective Date: 10/06/18
- Next Review Date: 10/06/19

850.22 Police Response to Mental Health ~~Director's~~Director Holds and Elopement

Refer:

- ORS § 426.005, Definitions for ORS § 426.005 to 426.390
- ORS § 426.070, Initiation
- ORS § 426.223, Retaking persons in custody of or committed to Oregon Health Authority
- DIR 850.20 Police Response to Mental Health Crisis
- DIR 850.21 Peace Officer Custody (Civil)
- DIR 850.25 Police Response to Mental Health Facilities

Definitions:

- Community Mental Health Program Director: The director of an entity, including Multnomah County, which provides community mental health program services.
- 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) (e) (d).~~
- Elope: To abscond, depart, leave, or walk away.
- Unlawful Elopement: To elope in violation of a civil or criminal legal/commitment status.

Policy:

1. In the context of mental health services, mental health providers, not law enforcement, are responsible for the evaluation, diagnosis, and treatment of persons who are in mental health crisis. There are times, however, when mental health providers need police services.
2. Because mental health custody as initiated by mental health providers may be civil¹, ~~(e.g., which can include~~ Director's Custody, Order of Civil Commitment) ~~or criminal (e.g.,²~~ Psychiatric Security Review Board (PSRB) Commitment Orders, Revocation Orders) in legal/commitment status, members shall be guided by law when responding to mental health provider service requests, ~~resolving custody in as safe, constructive, and humane a manner as possible.~~
3. A member's ability to manage a person in custody in a safe, constructive, and humane manner is of critical importance to the involved person, the involved person's support system, community members, mental health providers, and the Police Bureau. Members shall treat the individual with dignity and compassion at all times.

Procedure:

1. Police Response to Civil Custody Requests:
 - 1.1. Community Mental Health Program Director's Custody:

- 1.1.1. Members shall take a person into custody when the Community Mental Health Program Director, or designee, notifies the member that the Director has probable cause to believe that the person is dangerous to self or to any other person.
- 1.1.2. When assisting a community mental health program director or designee as defined in ORS § 426.005 (1) (a) with taking a person into custody (Director's Custody), members shall:
 - 1.1.2.1. Determine if taking civil custody of the person named on the Director's Custody Report may be achieved in a safe manner. Delaying custody is a tactic that may be used if the member determines that taking the person into custody under present circumstances may result in an undue safety risk to members, the involved person, and/or others. If delaying custody, members shall notify a supervisor and then develop a plan to determine a safer time and method to take the person into civil custody. An appropriate police report shall be completed documenting the details of this decision.
 - 1.1.2.2. If a member takes a person into custody, the member shall ~~call~~arrange for AMR ~~to~~ transport to the ~~Unity Center or hospital~~secure evaluation facility, unless extraordinary circumstances warrant police transport.
 - 1.1.2.3. ~~Members~~When necessary, members shall complete an appropriate police report and mental health ~~mask-text template~~ documenting the civil custody or Director's Hold.

1.2. Unlawful Elopement from a Mental Health Facility or Hospital:

- 1.2.1. If a person is being held on a Notice of Mental Illness (NMI) and elopes without permission from a facility, they have unlawfully eloped and members may be contacted to bring that person back to the facility. ~~ORS § 426.070.~~
- 1.2.2. If a person is on commitment status (e.g., Order of Commitment) and elopes without permission from a facility, they have unlawfully eloped and members may be contacted to bring that person back to the facility. ~~ORS § 426.223.~~
- 1.2.3. In the above circumstances, members shall:
 - 1.2.3.1. Verify that the NMI or Order of Commitment exists. The facility should have a copy of the Order on location; otherwise, members may verify the NMI or Order with the Multnomah County ~~Call Center~~Crisis Line.
 - 1.2.3.1.1. Criteria for court-ordered civil commitments are dictated by individual state laws. If a patient has eloped from a mental health facility in another state, members ~~should~~shall assess the person and take action in accordance with Directive 850.20, Police Response to Mental Health Crisis and/or Directive 850.21, Peace Officer Custody (Civil). Members ~~should~~shall contact the reporting facility and notify them of the disposition.
 - 1.2.3.2. Determine if taking civil custody of the person named on the Order of Commitment may be achieved in a safe manner. Delaying custody is a tactic that may be used if the member determines that taking the person into custody under present circumstances may result in an undue safety risk to members, the involved person, and/or others. If delaying custody, members shall notify a supervisor and then develop a plan to determine a safer time and method to take the person into civil custody.

1.2.3.3. Transport the named person back to the facility unless the member determines the person meets the criteria in Directive 850.21, Peace Officer Custody (Civil).

1.2.3.4. Complete the appropriate police report and mental health ~~mask-text template~~ documenting the incident and submit the report to a supervisor before the end of shift.

1.3. Elopement from a Mental Health Facility:

1.3.1. If a person is not on commitment status (e.g., Order of Commitment) and elopes without permission from a facility, that person is free to leave.

1.3.2. If a person wishes to voluntarily return to the facility, members may transport that person to the facility.

1.3.3. Should members receive a call alleging the eloped person is deemed to be dangerous to self or others, members must assess the person in accordance with Directive 850.20, Police Response to Mental Health Crisis and/or Directive 850.21, Peace Officer Custody (Civil).

1.4. Member -Supervisor Coordinated Response Required:

1.4.1. Warrants of Detention/Trial Visitation: During pre-trial civil commitment processes, a person with an alleged mental illness may be released into the community and be monitored by a civil commitment investigator. A civil warrant of detention may also be issued by a judge to take a person with mental illness into custody. Because the statutory authority to serve a warrant of detention rests with the Multnomah County Sheriff's Office, members ~~should~~shall not become involved in these activities unless called to an incident to assist a civil commitment investigator or civil deputy in fulfilling the investigator's or deputy's mission.

2. Police Response to Criminal Custody Requests:

2.1. Psychiatric Security Review Board (PSRB) Revocation Orders:

2.1.1. Under ORS § 161.375(4), the Psychiatric Security Review Board (PSRB) has the authority to take PSRB supervised persons into custody on Revocation Orders, which are comparable to arrest warrants and subject to the same rules.

2.1.2. A member ~~shall typically be~~is notified of a PSRB Revocation Order through a PSRB Law Enforcement Data Systems (LEDS) message reading: "No Criminal Warrant, PSRB order for mandatory return to Oregon State Hospital." Members shall then:

2.1.2.1. Take the person named in the Revocation Order into custody and notify a supervisor.

2.1.2.2. Ensure the Oregon State Hospital Communications Center is notified; the phone number can be found in the PSRB LEDS message.

2.1.2.3. Transport the person with one other member, ~~the person~~ to the Oregon State Hospital Communication Center and notify a supervisor of the transport.

2.1.2.4. If additional verification of Revocation Order is needed, the PSRB Executive Director may be contacted. The phone number can be found in the PSRB LEDS message.

2.1.2.5. Document the incident on an appropriate police report ~~and~~, complete all reporting requirements for a mental health ~~mask~~crisis response, and submit the information to a supervisor before the end of shift.

2.2. Unlawful Elopement from PSRB:

2.2.1. If a person is under the jurisdiction of the PSRB and elopes without permission from a facility, they have unlawfully eloped and members may be contacted to bring that person back to the facility. ORS § 161.336(4)(a). Under such circumstances, members shall:

2.2.1.1. Verify the person is under the jurisdiction of the PSRB. The facility should have a copy of the Order on location; otherwise members may verify the Order within LEDS.

2.2.1.2. Determine if taking custody of the person named on the PSRB Order may be achieved in a safe manner. Delaying custody is a tactic that may be used if the member determines that taking the person into custody under present circumstances may result in an undue safety risk to members, the involved person, and/or others. If delaying custody, members shall notify a supervisor and then develop a plan to determine a safer time and method to take the person into custody.

2.2.1.3. Transport the named person back to the facility unless the member determines the person meets the criteria in Directive 850.21, Peace Officer Custody (Civil).

2.2.1.4. Complete the appropriate police report and mental health ~~mask~~text template documenting the incident and submit the report to a supervisor before the end of shift.

3. Police Response to Civil or Criminal Custody Requests: Escape from an Oregon State Hospital:

3.1. If the superintendent of an Oregon ~~state hospital~~State Hospital issues an escape warrant for the apprehension and return of a person, members shall:

3.1.1. Verify the identity of the person in LEDS.

3.1.2. Take the named person into custody and notify a supervisor.

3.1.3. Ensure the Oregon State Hospital Communications Center is notified; the phone number can be found in the LEDS message.

3.1.4. Transport, with one other member, the person to the Oregon State Hospital Communications Center and notify a supervisor of the transport.

3.1.5. Document the incident on an appropriate police report and mental health ~~mask~~text template and submit to a supervisor before the end of shift.

4. Supervisor Responsibilities:

4.1. Supervisors shall ensure their members follow reporting requirements for the civil or criminal custody.

850.25 Police Response to Mental Health Facilities

Refer:

- ORS § 426.005, Definitions for ORS § 426.005 to 426.390
- DIR 850.20 Police Response to Mental Health Crisis
- DIR 850.21 Peace Officer Custody (Civil)
- DIR 850.22 Police Response to Mental Health Director Holds and Elopement

Definitions:

- **Mental Health Facility:** Includes secured residential treatment facility, residential treatment facility/home, adult foster home/care facility, supported housing, or hospitals/clinics that provide supervision and housing for people diagnosed with a mental illness.
- **Designated Residential Mental Health Facility:** Secure and non-secure treatment facilities designated by the Multnomah County Mental Health and Addiction Services and/or the State of Oregon 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).

Policy:

1. It is the responsibility of mental health facilities to have the proper resources to manage people in mental health crisis and to transport persons under their supervision to other care facilities. Mental health facilities should direct routine and urgent calls to their facility administrator or the Multnomah County Crisis Line. It is the expectation that mental health facilities will not request police assistance with behavior management, such as gaining physical control of a person who is aggressive, resistive, or refuses to go with facility-arranged transportation. Members should not become involved in these behavior management matters. Members shall respond to: 1) assaults in progress and/or other serious events in which immediate intervention is required to stop or mitigate injury to a person; 2) investigate crimes and take action as appropriate; and 3) requests for mental health custody in accordance with Directive 850.22, Police Response to Mental Health Directors Holds and Elopement. Members shall treat these individual with dignity and compassion at all times.

Procedure:

1. Member-Supervisor Coordinated Response Required:
 - 1.1. Response to emergencies (Priority 1-3) at designated secure residential mental health treatment facilities shall include a supervisor and a minimum of four (4) officers, one of which is an Enhanced Crisis Intervention Team (ECIT) Officer, if available. ECIT officers shall advise Sergeants on the mental health aspects of the call, when feasible. Unless extreme exigent circumstances exist, members may not enter a designated secure mental health facility without notifying their supervisor of the request and coordinating a response.
 - 1.2. Lower priority calls at designated secure residential mental health treatment facilities shall be dispatched to the district officer and require supervisor notification. A supervisor may request assistance of an ECIT officer if necessary.

- 1.3. Response to emergencies (Priority 1-3) at designated non-secure residential mental health treatment facilities shall include a supervisor and a minimum of two (2) officers, one of which is an ECIT officer, if available. ECIT officers shall advise Sergeants on the mental health aspects of the call when feasible. Unless extreme exigent circumstances exist, members may not enter a non-secure mental health facility or residential mental health facility without notifying their supervisor of the request and coordinating a response.
- 1.4. In addition to ROADMAP, as listed in Directive 850.20, Police Response to Mental Health Crisis, the following are other tactical options for members and their supervisors to consider before entry into a designated residential mental health facility:
 - 1.4.1. Evaluate the nature of the situation and necessity for police intervention.
 - 1.4.2. When time allows, have responding members stage and wait for the arrival of all necessary personnel and resources.
 - 1.4.3. Request a staff member meet police outside the facility to provide information on: 1) the facility layout; 2) the locations of the person who requires police response, other patients, visitors, and staff; and 3) any other information about the incident and persons involved that would aid police in planning their response.
 - 1.4.4. If police intervention is warranted, evaluate contact options, including by phone, in person, or other means. If in person, evaluate the need to utilize additional cover members. Develop a tactical plan, taking advantage of the most effective control options that may safely resolve the incident.
2. Behavioral Health Unit (BHU) Responsibilities:
 - 2.1. The Behavioral Health Unit shall:
 - 2.1.1. Post designated secure residential mental health treatment facility floor plans on the Bureau's Intranet.
 - 2.1.2. Regularly review the designated Multnomah County and/or State of Oregon mental health facility lists to ensure the accuracy of mental health facility hazard flags.
 - 2.1.3. Follow up on concerns regarding police response to designated residential mental health facilities. As appropriate, the Behavioral Health Unit shall meet with facility management representatives to review the representatives' expectations of police assistance in emergencies and facility emergency policies for addressing concerning incidents.

History:

- Originating Directive Date: 06/07/06
- Last Revision Signed: 09/06/18
 - Effective Date: 10/06/18
- Next Review Date: 10/06/19

850.25 Police Response to Mental Health Facilities

Refer:

- ORS § 426.005, Definitions for ORS § 426.005 to 426.390
- DIR 850.20 Police Response to Mental Health Crisis
- DIR 850.21 Peace Officer Custody (Civil)
- DIR 850.22 Police Response to Mental Health ~~Director's~~Director Holds and Elopement

Definitions:

- Mental Health Facility: Includes secured residential treatment facility, residential treatment facility/home, adult foster home/care facility, supported housing, or hospitals/clinics that provide supervision and housing for people diagnosed with a mental illness.
- Designated Residential Mental Health Facility: Secure and non-secure treatment facilities registered with designated by the Multnomah County Mental Health and Addiction Services and/or the State of Oregon 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).~~

Policy:

1. It is the responsibility of mental health facilities to have the proper resources to manage people in mental health crisis and to transport persons under their supervision to other care facilities. Mental health facilities should direct routine and urgent calls to their facility administrator or the Multnomah County ~~Call Center Crisis Line~~. It is the expectation that mental health facilities will not request police assistance with behavior management, such as gaining physical control of a person who is aggressive, resistive, or refuses to go with facility-arranged transportation. Members should not become involved in these behavior management matters. ~~But, members~~ Members shall respond to: 1) assaults in progress and/or other serious events in which immediate intervention is required to stop or mitigate injury to a person; 2) investigate crimes and take action as appropriate; and 3) requests for mental health custody in accordance with Directive 850.22, Police Response to Mental Health ~~Director's~~Directors Holds and Elopement. Members shall treat ~~the~~these individual with dignity and compassion at all times.

Procedure:

1. Member-Supervisor Coordinated Response Required:
 - 1.1. Response to emergencies (Priority 1-3) at designated secure residential mental health treatment facilities shall include a supervisor and a minimum of four (4) officers, one of which is an Enhanced Crisis Intervention Team (ECIT) Officer, if available. ECIT officers shall advise Sergeants on the mental health aspects of the call, when feasible. Unless extreme exigent circumstances exist, members may not enter a designated secure mental health facility ~~or designated non-secure residential mental health facility~~ without notifying their supervisor of the request and coordinating a response.

- 1.2. Lower priority calls at designated secure residential mental health treatment facilities shall be dispatched to the district officer and require supervisor notification. A supervisor may request assistance of an ECIT officer asif necessary.
- 1.3. Response to emergencies (Priority 1-3) at designated non-secure residential mental health treatment facilities shall include a supervisor and a minimum of two (2) officers, one of which is an ECIT officer, if available. ECIT officers shall advise Sergeants on the mental health aspects of the call when feasible. Unless extreme exigent circumstances exist, members may not enter a non-secure mental health facility or residential mental health facility without notifying their supervisor of the request and coordinating a response.
- 1.4. In addition to ROADMAP, as listed in Directive 850.20, Police Response to Mental Health Crisis, the following are other tactical options for members and their supervisors to consider before entry into a designated residential mental health facility:
 - 1.4.1. Evaluate the nature of the situation and necessity for police intervention.
 - 1.4.2. When time allows, have responding members stage and wait for the arrival of all necessary personnel and resources.
 - 1.4.3. Request a staff member meet police outside the facility to provide information on: 1) the facility layout; 2) the locations of the person who requires police response, other patients, visitors, and staff; and 3) any other information about the incident and persons involved that would aid police in planning their response.
 - 1.4.4. If police intervention is warranted, evaluate contact options, including by phone, in person, or other means. If in person, evaluate the need to utilize additional cover members. Develop a tactical plan, taking advantage of the most effective control options that may safely resolve the incident.

2. Behavioral Health Unit (BHU) Responsibilities:

2.1. The Behavioral Health Unit shall:

- 2.1.1. Post designated secure residential mental health treatment facility floor plans on the Bureau's Intranet.
- 2.1.2. Regularly review the designated Multnomah County ~~designated residential~~ and/or State of Oregon mental health ~~facilities list~~ facility lists to ensure the accuracy of mental health facility hazard flags.
- 2.1.3. Follow up on concerns regarding police response to designated residential mental health facilities. As appropriate, the Behavioral Health Unit shall meet with facility management representatives to review the representatives' expectations of police assistance in emergencies and facility emergency policies for addressing concerning incidents ~~with combative or uncooperative patients~~.

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

Date	Individual	Comment
1 st Universal Review		
9/9/17		<p>COMMENTS ON MENTAL HEALTH CRISIS RESPONSE DIRECTIVE, SEPTEMBER 2017</p> <p>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:</p> <p>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.</p> <p>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</p>

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 and 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

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

		<p>feedback on its policies, practices, training, and culture.</p> <p>Thank you as always for the opportunity to comment</p> <p>*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.</p>
9/3/17		<p>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!</p>
8/17/17		<p>This document looks ready.</p>
8/16/17		<p>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.</p>

#1

COMPLETE

Collector: Web Link 1 (Web Link) 2nd Universal Review /1 /18 6/1 /18
Started: Tuesday, May 15, 2018 9:11:44 AM
Last Modified: Tuesday, May 15, 2018 9:15:44 AM
Time Spent: 00:03:59
IP Address: 65.100.48.249

Page 1

Q1 Please provide feedback for this directive

Changes made to format and edited document. See below for changes: Note: It would be nice if we could upload the document to provide feedback vs. copy paste....Just a thought for future options.

*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 § 426.005, Definitions for ORS § 426.005 to 426.390
- 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 § 426.228, 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 center
- 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 and/or Civil Holds
- DIR 850.30, Juveniles and/or 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 mental health 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

Directive 850.20 Feedback

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 Portland 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 Portland 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. Peace Officers 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 Peace Officers recognize that a person whom they are contacting has signs and symptoms indicative of a mental illness, Peace Officers 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, Peace Officers are also expected to manage the scene and develop a

Directive 850.20 Feedback

reasonable disposition plan.

1.2. All Peace Officers on a call shall answer the mental health indicator question. Peace Officers 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 Peace Officers will receive Mental Health Response training.

1.3.2. All existing sworn Peace Officers 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 Peace Officers 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,

2.1.3.5 Disengagement is a tactic to be considered to reduce undue safety risk to the Peace Officer, the involved persons, or others. Prior to disengagement, Peace Officers 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 Peace Officers 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. Peace Officers 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 Peace Officers 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 Peace Officer 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. Peace Officers 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. Peace Officers are not required to standby

Directive 850.20 Feedback

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 members may serve as a resource to the Crisis Negotiation Team (CNT). Additionally, ECIT members 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.
-

Q2 Contact Information (optional)

Respondent skipped this question

#2

COMPLETE

Collector: Web Link 1 (Web Link) 2nd Universal Review /1 /18 6/1 /18
Started: Monday, May 28, 2018 1:24:53 PM
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Page 1

Q1 Please provide feedback for this directive

Dear Portland Police Bureau,

Thank you for encouraging citizens to submit ideas for improving directive 850.20 (Police Response to Mental Health Crisis), and for being concerned with improving Portland Police interaction for people suffering with mental illness. I've included efficient, implementable initiatives that would help accomplish these goals.

Establish a 'Mental Health' Police Unit

With Portland PD receiving an abundance of mental health crisis related calls, having a ECIT or CNT on-call poses a challenge to an officer responding to a call where seconds matter. Designating a particular 'Mental Health Unit' would consist of not only a trained officer in mental health crisis situations, but include a ECIT or CNT. This would reduce precious response time, give the officers professional assistance and show initiative on mental health protection while protecting Police Officers as well as Citizens.

Expand Mental Health Crisis Training (Expanding on the R and O of "ROADMAP")

Understanding a mental health crisis is just one part of the challenge. Having mental health crisis professionals assisting in training is well served in expanding on existing training as well as teaching new tools available to Police Officers during a mental health crisis situation.

Moving forward with these realistic approaches while increasing and expanding training for 2.1.3.1 and 2.1.3.2 (evaluation and request) would help reduce altercations and incidents during mental health crisis situations, as well as help police officers better understand mental health crisis situations, ensuring better protection of police officers themselves. 'The Mental Health Unit' would help reduce critical response time from a mental health professional. It also shows great initiative from The Portland Police Bureau taking mental illness seriously and helps instill confidence within the public while creating what could very well be an adaptable national model. Enacting these life saving policies and procedures would not only help save lives, show initiative but can all be done without increasing cost and adding budgetary constraints.

Police Stations that take a pragmatic approach and use professional mental health assistance when responding to mental health crisis calls will not only help protect the citizens they are serving, but also protect the officers themselves.

I hope you seriously consider these measures.

Thank you for your concern,

#3

COMPLETE

Collector: Web Link 1 (Web Link) 2nd Universal Review /1 /18 6/1 /18
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Page 1

Q1 Please provide feedback for this directive

Under the "ROADMAP" section it indicates that in the case of disengagement, a GO must be completed, notification completed and plan made. It does not say to document the plan or the notification.

Q2 Contact Information (optional)

Respondent skipped this question

#4

COMPLETE

Collector:	Web Link 1 (Web Link)	2nd Universal Review	/1 /18	6/1 /18
Started:	Friday, June 08, 2018 1:57:10 PM			
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Page 1

Q1 Please provide feedback for this directive

COMMENTS ON MENTAL HEALTH DIRECTIVES MAY/JUNE 2018

To Chief Outlaw, 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:

Below are our comments on the set of Mental Health-related Directives, which were posted May 15 at . Since these are all on the same subject, we have some general comments to make up front. Three of the Directives (850.21, 850.22 and 850.25) were last posted in November 2017, at which time it appears from the PPB's paperwork that Portland Copwatch (PCW) made the only comments on these policies. Three other people or entities commented on 850.20-- Mental Health Crisis Response-- when it was posted in August/September 2017. In our comments last year we thanked the Bureau for requiring officers to "treat the individual with dignity and compassion at all times" in the Policy section of the three "branch" Directives (there is slightly different wording in 850.20). For some reason in 850.25 the language is being proposed to say "these individual [sic]." If it is changed to "these individuals" (plural) that change should apply to all three branch Directives.

Also, all four Directives point to ORS 426.005 in the "Refer" section, but use the state's official title "Definitions for ORS 426.005 to 426.390," which is vague and confusing. This is a problem the legislature created, but we suggest the PPB make it clearer by using part of the title of Chapter 426, "Persons With Mental Illness."

The PPB's mnemonic for handling possible mental health crisis situations, ROADMAP, is inadequate. We pointed out in our last comments that "Patience" should not be the last item on the list. It's also hard to fathom that most officers will see the first of the two "A"s and think "Oh, that means Area Containment." We suggest changing that part of the acronym to a "C" and then re-vamping the mnemonic as "PD-MACRO." That way the order of items will be:

- Patience
- Disengagement
- More Resources
- Arrest Delayed
- Containment
- Request Specialized Units
- Observe or use surveillance.

Yes, many people from out of town call the PPB the "PPD" by accident, but since most law enforcement units are called "PD"s, our idea may be more useful than "ROADMAP." We noted in our 2015 and 2017 comments that all of these tactics (and non-engagement) can be used on someone regardless of whether they are in mental health crisis as alternatives to officers using force. Also, PCW continues to urge the Bureau to define 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.

Generally speaking, the PPB made very few (although some important) changes based on PCW's previous comments. However, in one

Directive 850.20 Feedback

case something we complimented the Bureau for adding is now on the chopping block as a proposed cut.

It is notable that these Directives all came with "redline" versions showing the proposed changes, and that this is the first set of multiple changes in which the community will have 30 days to comment rather than the previous 15 day window. We still urge the Bureau to indicate potential changes and give at least a 30 day period during the "First Universal Reviews" but this is a step in the right direction.

PCW repeats its ongoing suggestions that the Bureau add letters to section headings (Definitions, Policy, Procedure) to avoid having multiple sections with the same numbers, and go back to its earlier practice of enumerating the Definitions. Our comments below refer to the Procedure sections unless otherwise noted.

DIRECTIVE 850.20 MENTAL HEALTH CRISIS RESPONSE

One major change in this Directive is the addition of new paragraph 1.2, which requires officers to "answer the mental health indicator question," though it is not clear where that question is posed. It requires paperwork to be turned in before the end of a shift, which PCW supports.

In our 2015 and 2017 comments, we were concerned that the definition of mental health crisis was so broad it could have included just about anyone. The current version still 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." We have repeatedly suggested being more precise about how the PPB includes the concept of "neglect of personal hygiene" in its list of symptoms. We stated:

"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 Section in a previous version 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 not reinserted. For some reason, after we complimented the Bureau for including such guidelines for calls to the Enhanced Crisis Intervention Team (ECIT) in Section 4, the new draft proposes cutting those guidelines back out. It is likely the intention is to expand the kinds of incidents to which ECIT members respond, but specific examples should remain in the policy. One net result is the PPB has removed the concept that a community member can request an ECIT officer (existing 4.1.1). PCW also suggested adding a reference to Directive 850.20 (Police Response to Mental Health Facilities) to existing Section 4.1.6 listing calls to mental health facilities as one ECIT criterion.* The cuts also remove references to violence, weapons, and attempted suicide.

The definitions of important terms have not been reinstated despite our suggestion: de-escalation, disengagement, delayed custody, and non-engagement. We noted that non-engagement is no longer an option given in the Directive, except for the clause in Section 2.1.2 which begins "If the member decides to intervene...", implying that deciding not to intervene is always an option.

The other words all appear in some form in the ROADMAP mnemonic Section of the policy (2.1.3), which as noted above should be changed to "PD-MACRO."

We also wrote in 2015 and 2017: "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)." We added that our allies in the mental health community have noted that some people might respond better to a uniformed officer than to a mental health professional, but the Directive should offer options to consider for de-escalating, such as putting on PPB polo shirts or other less intimidating gear.

Directive 850.20 Feedback

We continue to appreciate the acknowledgment that law enforcement should not evaluate, diagnose and treat mental health ailments, Policy 3 still talks about officers being "increasingly required to respond" to persons with mental illness. As we wrote earlier, "since Policy 1 describes the PPB seeking to be part of a holistic system an[d] 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." If the Directive is not changed and such 9-1-1 calls decrease or remain constant, the statement will no longer be accurate.

Section 5.2 says Supervisors "will acknowledge or respond to" calls in designated mental health facilities. Given the high stakes raised by the deaths of Jose Mejia Poot in 2001 and Merle Hatch in 2013, we suggested Supervisory response go back to being mandatory-- especially because it is required 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.

*-and police should be required to check their firearms at such facilities unless a person somehow has obtained a gun inside a secure, locked building.

CONCLUSION

As noted in our comments on the other Directive posted in May, we believe regardless of the (estimated) start-up of the Portland Committee for Community Engaged Policing in September, the PPB should be proactive in seeking out comments on its policies, particularly from affected community members and their advocates. We also continue to have concerns that organizations like PCCEP and other advisory groups will not have enough time to meet the Bureau's strict 15 and 30 day timelines on comments for this process. Even though there are relatively few changes in these four Directives, and we were working with previously generated comments, it still took a considerable amount of time for PCW to create this document. We once again urge the Bureau to reconsider its timelines.

Thank you for the opportunity to comment

Q2 Contact Information (optional)

Name

Email Address

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Page 1

Q1 Please provide feedback for this directive

Mental Health and Drug Abuse

We have over 800 people living under the care of non-profits and another 680 or so (possibly to be nearly 900 if the proposed shelter is approved) living in shelters in our neighborhood, Old Town Chinatown. Approximately 2/3rd of the people living North of Burnside are either in shelters or in care. A reasonable estimate is 35% have a disability. Another estimate is more than a 1/3 of those with a disability report a mental illness and another 1/3 substance abuse. Latest figures reported for the unsheltered (2017 Point in Time) suggest that 45% or 747 adults report a serious mental illness. Some might say we who live here are living in a homeless ghetto. We who are not sheltered or on the street are outnumbered. With the addition of a 200-bed low barrier shelter, the number of folks here in the North Gate area of the New Chinatown Japantown historic district rises to 657 sheltered/special needs folks to 333+renters/condo owners. Of the 657 it would not be a stretch to estimated over 300 of them has a mental or substance abuse problem. It could be close to 1 to 1 ration of renters to mentally ill. I hope I exaggerate. Now, despite the best of intentions to meet this problem with the Behavioral Health Unit and partners in the mental health and drug abuse field, the bottom line is that we 300 plus renters and condo owners don't feel very safe at all. One murder in the lobby of Pacific Towers, a knifing across the street, and a murder around the corner over the last six months coupled with high rates of assault and drug offenses and a case could be made that we have good reason to not feel safe as we are not. Meanwhile, when City staff to include ONI and police officers come to speak to us residents we get sheets of papers and phone numbers to call when in fact there are few resources to assign to us. The City has not made the investment to support concentrating homeless folks into one small area of the City, and a historic district at that. Many of us have stopped calling. This is so for both reporting those on the street having an episode and in danger as well as reporting drug selling/using activity on our corners. Most of us in the neighborhood believe strongly that mentally ill folks do not commit crimes in any greater number than the general public and may along with drug users be more likely to be assaulted. We understand that the overwhelming number of housing units in our neighborhood are shelters and for special needs. What is not easy to understand is that if you create a ghetto, the City has an obligation to keep those in the ghetto safe, including the homeless and those who rent and own homes. We need more conversations between our protectors and our residents who are not under care and I am not talking one-way informational conversations and where there are no staff members from the Mayor's Office in attendance. They need to be educated as well. I have lived in the Pacific Tower Apartments on the second floor overlooking NW Flanders and NW 4th Avenue since September 2012. I also work out of my apartment so I am here all day and night. I am 71 years old and have lived in San Francisco, Washington, D.C. and New York City (during the late 70's when NYC was out of control both crime and money-wise). I publish (blog) and produce videos (Youtube) as pdxdowntowner.com.

Q2 Contact Information (optional)

Name

Email Address

Phone Number

#2

COMPLETE

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Page 1

Q1 Please provide feedback for this directive

COMMENTS ON MENTAL HEALTH AND OTHER DIRECTIVES NOVEMBER/DECEMBER 2017

To Chief Outlaw, 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:

First of all, we welcome Chief Outlaw to this process of public review of Bureau policies. The process, which was developed as part of the US Department of Justice Settlement Agreement, is a good example of something both Portland Copwatch and the Bureau might deem "community policing," though shortcomings still exist. In August, we noted that Portland Copwatch (PCW) has commented on over 100 Directives over the last four years, some of them 3 or 4 times, in hopes of creating a more professional, accountable and transparent Bureau, while helping de-emphasize violence and conflict.

While it has been a relief to have two months off since the last set of Directives were posted for comment, we're now faced once again with the Bureau creating overlapping deadlines for sets of policies released in mid-November (addressed in this email) and early December (comments to follow). For the November set of Directives, which were posted at <http://www.portlandoregon.gov/police/59757>, we have put in most of our comments below these introductory thoughts. We note, however, that the Bureau has not taken up our reasonable suggestion to post its current list of intended changes, or even areas requiring attention, when posting Directives for review. Rather, the community is given 30 days to comment on existing Directives with no clue as to what is under scrutiny, but only 15 days to comment once the Bureau releases proposed revisions. The comment period should be at least 30 days on both ends, as we've noted many times, so that organizations including official city advisory boards have time to meet and compile recommendations.

We are not making comments on Directives 414.00 (Pregnancy), 212.20 (Milk Expression) or 410.00 (Injuries/Illness), the latter of which is up for its first review.

We note here that all three Mental Health Directives under review were revised in early 2017 even though they were last posted for input in April 2015, with some of the changes coming after the opening of the Unity Center earlier this year. We very much appreciate that the Policy Section of all three Directives now includes the sentence "Members shall treat the individual with dignity and compassion at all times."

PCW has continually suggested-- to no avail-- that the Bureau add letters to section headings (Definitions, Policy, Procedure) to avoid having multiple sections with the same numbers. We also strongly suggest PPB go back to its earlier practice of enumerating the Definitions, to make referencing them easier. Our comments below refer to the Procedure section unless otherwise noted.

DIRECTIVE 850.21 PEACE OFFICER CUSTODY (CIVIL)

This Directive underwent some major revisions.

--Policy Section 1, which we complimented last time for honoring people's civil rights and their ability to control their own lives, has

Directive 850.21 Feedback

added a few sentences-- beginning with a qualifying "however." The new sentences declare that when a person lacks capacity to make "sound judgments about their personal situation" and with probable cause an officer "shall" take the person into custody. The sentence saying "after considering alternatives outlined in 850.20" should begin "In such circumstances" to be clear that officers should only be directed to use holds in the described situation. PCW also suggests removing the word "shall" which means a mandatory hold, especially since later in the Directive, disengagement is described as a valid tactic, but also because officers may not be objectively assessing a person's mental health status. While arguably anyone in this country who challenges a police officer's authority could be seen as having mental health issues, since the officers are likely to respond unkindly, such assertion of rights should never be construed by police as an inability to "make sound judgments."

--On the topic of disengagement, "delayed custody" was removed from the definitions section, and old Section 1.3.1 which was cut entirely. Presumably Section 1.2.1.4, the "D" in the "ROADMAP" mnemonic, which suggests officers "Disengage with a plan to resolve later" replaces that term.

--It is unfortunate that the clunky "ROADMAP" lettering has "Patience" as the last tactic to be considered rather than the first.

--Old Section 1.2 which told officers to consider the "totality of the circumstances, including.... the governmental interests at stake" when making a non-criminal detention was cut and not replaced.

--Old Sections 1.3.3.1-1.3.3.2, which said officers who do not get a person to voluntarily enter a mental health facility can drop them back at a "safe location" (undefined) were cut. It is not clear if this is because police are no longer transporting persons in crisis to mental health facilities since the Unity Center opened.

--That said, Section 2.2 refers to "AMR" rather than using a generic term for Emergency Medical Services or ambulance services. Should AMR, a private company, not win the County contract for transportation-- and/or if the Portland Fire Bureau makes transports-- the Directive will have to be rewritten.

CONCLUSION

In our last two sets of comments, we noted that the Portland Committee on Community Engaged Policing (or whatever the replacement for the Community Oversight Advisory Board will be called) will, by City Ordinance, be integrated into the Directives review process. Since the person who will help design the recruitment process does not have to turn in a resume until January 5, we continue to ask that the Bureau recognize PCW's concerns about the process and substance of these policies.

Thank you for the opportunity to comment

Q2 Contact Information (optional)

Name

Email Address

#1

COMPLETE

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2nd Universal Review /1 /18 6/1 /18

Page 1

Q1 Please provide feedback for this directive

COMMENTS ON MENTAL HEALTH DIRECTIVES MAY/JUNE 2018

To Chief Outlaw, 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:

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Also, all four Directives point to ORS 426.005 in the "Refer" section, but use the state's official title "Definitions for ORS 426.005 to 426.390," which is vague and confusing. This is a problem the legislature created, but we suggest the PPB make it clearer by using part of the title of Chapter 426, "Persons With Mental Illness."

The PPB's mnemonic for handling possible mental health crisis situations, ROADMAP, is inadequate. We pointed out in our last comments that "Patience" should not be the last item on the list. It's also hard to fathom that most officers will see the first of the two "A"s and think "Oh, that means Area Containment." We suggest changing that part of the acronym to a "C" and then re-vamping the mnemonic as "PD-MACRO." That way the order of items will be:

- Patience
- Disengagement
- More Resources
- Arrest Delayed
- Containment
- Request Specialized Units
- Observe or use surveillance.

Yes, many people from out of town call the PPB the "PPD" by accident, but since most law enforcement units are called "PD"s, our idea may be more useful than "ROADMAP." We noted in our 2015 and 2017 comments that all of these tactics (and non-engagement) can be used on someone regardless of whether they are in mental health crisis as alternatives to officers using force. Also, PCW continues to urge the Bureau to define 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.

Generally speaking, the PPB made very few (although some important) changes based on PCW's previous comments. However, in one case something we complimented the Bureau for adding is now on the chopping block as a proposed cut.

Directive 850.21 Feedback

It is notable that these Directives all came with "redline" versions showing the proposed changes, and that this is the first set of multiple changes in which the community will have 30 days to comment rather than the previous 15 day window. We still urge the Bureau to indicate potential changes and give at least a 30 day period during the "First Universal Reviews" but this is a step in the right direction.

PCW repeats its ongoing suggestions that the Bureau add letters to section headings (Definitions, Policy, Procedure) to avoid having multiple sections with the same numbers, and go back to its earlier practice of enumerating the Definitions. Our comments below refer to the Procedure sections unless otherwise noted.

DIRECTIVE 850.21 PEACE OFFICER CUSTODY (CIVIL)

The biggest changes to this Directive were made in response to PCW's previous comments. In Policy Section 1, the qualifier about whether or not people should be able to control their own lives-- that is, starting the second sentence of the paragraph with the word "however," is being removed. Then the Bureau is changing the requirement for officers to take someone into custody ("shall") to an option ("may"). PCW appreciates these changes.

--As with other Directives, terms including "delayed custody" were previously removed from the Definitions section. We noted that the "D" in the "ROADMAP" (or PD-MACRO), which suggests officers "Disengage with a plan to resolve later," replaces "delayed custody." Perhaps "Arrest Delayed" is also part of that option, though often taking a person into custody in mental health crisis is not for arrest purposes.

--Old Section 1.2 was still not reinserted, telling officers to consider the "totality of the circumstances, including... the governmental interests at stake" when making a non-criminal detention.

--Section 2.1 and 2.2 still refers to "AMR" rather than using a generic term for Emergency Medical Services or ambulance services as we suggested, since AMR is a private company which could be replaced by the Fire Bureau or another transportation entity. In contrast, the Bureau is wisely proposing to change references to the Unity Center in the same sections with the generic term "secure evaluation facility."

--Curiously, for the sentence in Policy Section 2 "If the need arises, the act of custody shall be resolved in a safe, constructive and humane manner as possible," the PPB is proposing to change the word "If" to "When." Perhaps it means, "_Cases where police choose to take a person into custody_ shall be resolved in _as_ safe...."

CONCLUSION

As noted in our comments on the other Directive posted in May, we believe regardless of the (estimated) start-up of the Portland Committee for Community Engaged Policing in September, the PPB should be proactive in seeking out comments on its policies, particularly from affected community members and their advocates. We also continue to have concerns that organizations like PCCEP and other advisory groups will not have enough time to meet the Bureau's strict 15 and 30 day timelines on comments for this process. Even though there are relatively few changes in these four Directives, and we were working with previously generated comments, it still took a considerable amount of time for PCW to create this document. We once again urge the Bureau to reconsider its timelines.

Thank you for the opportunity to comment

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Page 1

Q1 Please provide feedback for this directive

COMMENTS ON MENTAL HEALTH AND OTHER DIRECTIVES NOVEMBER/DECEMBER 2017

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DIRECTIVE 850.22 POLICE RESPONSE TO MENTAL HEALTH DIRECTOR'S HOLDS AND ELOPEMENT

--The name of this Directive was changed from "Police Response to Requests for Mental Health Custody."

Directive 850.22 Feedback

--As with 850.21 (Civil Holds), the definition of "delayed custody" was cut. However, it is still used in Sections 1.2.1 and 1.2.3.2.

--Oddly, the Section (1.1.2.1) that required officers to verify the person ordering a hold has the proper authority was cut. It seems this could present serious legal issues for the City and the Bureau.

--The requirement that a police report be filed by the end of shift was cut from 1.1.2.3 (previously 1.1.2.6), though such a deadline is included in 1.2.3.4 and 2.2.1.4 on elopement, and 2.1.2.5 on revocation orders.

--Section 1.2 now includes references to "Notice of Mental Illness" (NMI), which does not appear to be a term used in the statute cited (ORS 426.070), and sounds a little like a "scarlet letter." If the term is a legal term, clearly the Bureau would have to go to the legislature to change it. Either way, we hope a less broad term will be substituted.

--In our previous comments we noted that the Directive states a person voluntarily at a medical facility who elopes is "free to leave" (1.3.1), something we suggested be reflected in other policies to ensure community members know when they are being detained or not.

--Previous sections 1.1.2.3-1.1.2.5, which had to do with officers' interactions with medical facilities, were cut, again presumably due to the opening of the Unity Center. However since officers sometimes do enter the Unity Center and other hospitals with persons in crisis, some direction should be retained. Also, language we commented on previously discouraging officers from "controlling" people inside facilities unless there are crimes like assault involved was cut (old Section 1.4.2); this issue is addressed in 850.25 (Police Response to Mental Health Facilities). Though that Directive is referenced in the "Refer" section, maybe an explicit statement should be added saying "for information on interactions at mental health facilities, see Directive 850.25."

CONCLUSION

In our last two sets of comments, we noted that the Portland Committee on Community Engaged Policing (or whatever the replacement for the Community Oversight Advisory Board will be called) will, by City Ordinance, be integrated into the Directives review process. Since the person who will help design the recruitment process does not have to turn in a resume until January 5, we continue to ask that the Bureau recognize PCW's concerns about the process and substance of these policies.

Thank you for the opportunity to comment

Q2 Contact Information (optional)

Name

Email Address

#1

COMPLETE

Collector: Web Link 1 (Web Link) 2nd Universal Review /1 /18 6/1 /18
Started: Tuesday, May 15, 2018 11:00:41 AM
Last Modified: Tuesday, May 15, 2018 11:06:09 AM
Time Spent: 00:05:28
IP Address: 74.120.152.118

Page 1

Q1 Please provide feedback for this directive

Policy 2 is missing a comma immediately after "Order of Civil Commitment".

It may be more appropriate for Procedure 1.1.2.2 to direct a member to contact BOEC to arrange for transport, rather than calling AMR directly, if this reflects the actual practice.

Procedure 1.2.3.1.1 needs to have the "a" in the first sentence removed.

Procedure 3.1 needs to have "state" and "hospital" capitalized when referring to OSH.

Procedure 3 and 3.1 refer to "an" Oregon State Hospital. Oregon State Hospital is one legal entity with two campuses. The references should either be to "Oregon State Hospital" or "a campus of Oregon State Hospital."

Q2 Contact Information (optional)

Respondent skipped this question

#2

COMPLETE

Collector:	Web Link 1 (Web Link)	2nd Universal Review	/1 /18	6/1 /18
Started:	Friday, June 08, 2018 2:02:09 PM			
Last Modified:	Friday, June 08, 2018 2:03:28 PM			
Time Spent:	00:01:18			
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Page 1

Q1 Please provide feedback for this directive

COMMENTS ON MENTAL HEALTH DIRECTIVES MAY/JUNE 2018

To Chief Outlaw, 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:

Below are our comments on the set of Mental Health-related Directives, which were posted May 15 at . Since these are all on the same subject, we have some general comments to make up front. Three of the Directives (850.21, 850.22 and 850.25) were last posted in November 2017, at which time it appears from the PPB's paperwork that Portland Copwatch (PCW) made the only comments on these policies. Three other people or entities commented on 850.20-- Mental Health Crisis Response-- when it was posted in August/September 2017. In our comments last year we thanked the Bureau for requiring officers to "treat the individual with dignity and compassion at all times" in the Policy section of the three "branch" Directives (there is slightly different wording in 850.20). For some reason in 850.25 the language is being proposed to say "these individual [sic]." If it is changed to "these individuals" (plural) that change should apply to all three branch Directives.

Also, all four Directives point to ORS 426.005 in the "Refer" section, but use the state's official title "Definitions for ORS 426.005 to 426.390," which is vague and confusing. This is a problem the legislature created, but we suggest the PPB make it clearer by using part of the title of Chapter 426, "Persons With Mental Illness."

The PPB's mnemonic for handling possible mental health crisis situations, ROADMAP, is inadequate. We pointed out in our last comments that "Patience" should not be the last item on the list. It's also hard to fathom that most officers will see the first of the two "A"s and think "Oh, that means Area Containment." We suggest changing that part of the acronym to a "C" and then re-vamping the mnemonic as "PD-MACRO." That way the order of items will be:

- Patience
- Disengagement
- More Resources
- Arrest Delayed
- Containment
- Request Specialized Units
- Observe or use surveillance.

Yes, many people from out of town call the PPB the "PPD" by accident, but since most law enforcement units are called "PD"s, our idea may be more useful than "ROADMAP." We noted in our 2015 and 2017 comments that all of these tactics (and non-engagement) can be used on someone regardless of whether they are in mental health crisis as alternatives to officers using force. Also, PCW continues to urge the Bureau to define 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.

Generally speaking, the PPB made very few (although some important) changes based on PCW's previous comments. However, in one

Directive 850.22 Feedback

case something we complimented the Bureau for adding is now on the chopping block as a proposed cut.

It is notable that these Directives all came with "redline" versions showing the proposed changes, and that this is the first set of multiple changes in which the community will have 30 days to comment rather than the previous 15 day window. We still urge the Bureau to indicate potential changes and give at least a 30 day period during the "First Universal Reviews" but this is a step in the right direction.

PCW repeats its ongoing suggestions that the Bureau add letters to section headings (Definitions, Policy, Procedure) to avoid having multiple sections with the same numbers, and go back to its earlier practice of enumerating the Definitions. Our comments below refer to the Procedure sections unless otherwise noted.

DIRECTIVE 850.22 POLICE RESPONSE TO MENTAL HEALTH DIRECTOR'S HOLDS AND ELOPEMENT

In this Directive, three instances of the term "should" are being replaced with the word "shall," which will be a positive change. Two changes are in Section 1.2.3.1 (assessing a person from another state and contacting the reporting facility) and the third is in 1.4.1 (police can only serve warrants when helping the County Sheriff).

--As with 850.21 (Civil Holds), the definition of "delayed custody" was cut. However, it is still used in Sections 1.2.1 and 1.2.3.2.

--And old Section that required officers to verify the person ordering a hold has the proper authority was not reinstated even though PCW pointed out this could present serious legal issues for the City and the Bureau.

--The requirement that a police report be filed by the end of shift has still not been put back into Section 1.1.2.3, though such a deadline is included in 1.2.3.4 and 2.2.1.4 on elopement, and 2.1.2.5 on revocation orders.

--We expressed concern that Section 1.2 includes references to "Notice of Mental Illness" (NMI), which does not appear in the statute cited (ORS 426.070), and sounds like a "scarlet letter." If NMI is a legal term, the Bureau would have to go to the legislature to change it. Regardless, a less broad term should be substituted.

--In our previous comments we noted and we say again here, that the Directive states a person voluntarily at a medical facility who elopes is "free to leave" (1.3.1)-- an idea the PPB should include in other policies to ensure community members know when they are being detained or not.

--We continue to believe an explicit statement should be added to this Directive saying "for information on interactions at mental health facilities, see Directive 850.25."

--References to the mental health mask in 1.1.2.3, 1.2.3.4 and 3.1.5 remain even though the PPB stopped using the mask many months ago. This term was changed to "all reporting requirements" in 2.1.2.5 and "mental health text template" in 2.2.1.4. We are reluctant to suggest using the term "Mental Health Template" throughout since the Mental Health Mask was created and replaced within a two year period, but at the least the list of what forms are required should be kept in an easier-to-change document that is cross-referenced here. That document should also be available to the public for transparency's sake.

--In a related issue, Section 1.1.2.3 instructs officers to fill out reports "when necessary" but doesn't define what that means.

--Policy Section 2 removes the word "criminal" before listing examples including orders from the Psychiatric Security Review Board; perhaps this is because the question of a person's mental health is not a criminal question. This is an example of how the Bureau can explain its proposed changes to inform the community why they are being made.

--For some reason, the PPB is proposing to insert the word "a" so that 1.2.3.1.1 will read "criteria for court a ordered civil commitments are dictated by individual state laws."

CONCLUSION

Directive 850.22 Feedback

As noted in our comments on the other Directive posted in May, we believe regardless of the (estimated) start-up of the Portland Committee for Community Engaged Policing in September, the PPB should be proactive in seeking out comments on its policies, particularly from affected community members and their advocates. We also continue to have concerns that organizations like PCCEP and other advisory groups will not have enough time to meet the Bureau's strict 15 and 30 day timelines on comments for this process. Even though there are relatively few changes in these four Directives, and we were working with previously generated comments, it still took a considerable amount of time for PCW to create this document. We once again urge the Bureau to reconsider its timelines.

Thank you for the opportunity to comment

Q2 Contact Information (optional)

Name

Email Address

#1

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Wednesday, November 15, 2017 3:14:09 PM
Last Modified: Wednesday, November 15, 2017 3:18:07 PM
Time Spent: 00:03:58

11st Universal Review 11/1 18

Page 1

Q1 Please provide feedback for this directive

We need a provision that states that officers are encouraged not to enter the secured area of the facility. Facility staff should bring the person of interest out into the lobby area of the facility. (I say this because everyone has an opinion after the fact and one of the constant comments we hear is the following: "Why did the police have to go into the facility" The staff are perfectly capable of handling the situation" "If given an opportunity and time the staff could have dealt with the issue" "The cops have no business taking weapons into a secure facility"

For these reasons we need to draft something that specifically speaks to these concerns.

Q2 Contact Information (optional)

Respondent skipped this question

#2

COMPLETE

Collector: Web Link 1 (Web Link) 11st Universal Review 11/1 /8
Started: Thursday, December 14, 2017 3:45:57 PM
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Page 1

Q1 Please provide feedback for this directive

COMMENTS ON MENTAL HEALTH AND OTHER DIRECTIVES NOVEMBER/DECEMBER 2017

To Chief Outlaw, 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:

First of all, we welcome Chief Outlaw to this process of public review of Bureau policies. The process, which was developed as part of the US Department of Justice Settlement Agreement, is a good example of something both Portland Copwatch and the Bureau might deem "community policing," though shortcomings still exist. In August, we noted that Portland Copwatch (PCW) has commented on over 100 Directives over the last four years, some of them 3 or 4 times, in hopes of creating a more professional, accountable and transparent Bureau, while helping de-emphasize violence and conflict.

While it has been a relief to have two months off since the last set of Directives were posted for comment, we're now faced once again with the Bureau creating overlapping deadlines for sets of policies released in mid-November (addressed in this email) and early December (comments to follow). For the November set of Directives, which were posted at <http://www.portlandoregon.gov/police/59757>, we have put in most of our comments below these introductory thoughts. We note, however, that the Bureau has not taken up our reasonable suggestion to post its current list of intended changes, or even areas requiring attention, when posting Directives for review. Rather, the community is given 30 days to comment on existing Directives with no clue as to what is under scrutiny, but only 15 days to comment once the Bureau releases proposed revisions. The comment period should be at least 30 days on both ends, as we've noted many times, so that organizations including official city advisory boards have time to meet and compile recommendations.

We are not making comments on Directives 414.00 (Pregnancy), 212.20 (Milk Expression) or 410.00 (Injuries/Illness), the latter of which is up for its first review.

We note here that all three Mental Health Directives under review were revised in early 2017 even though they were last posted for input in April 2015, with some of the changes coming after the opening of the Unity Center earlier this year. We very much appreciate that the Policy Section of all three Directives now includes the sentence "Members shall treat the individual with dignity and compassion at all times."

PCW has continually suggested-- to no avail-- that the Bureau add letters to section headings (Definitions, Policy, Procedure) to avoid having multiple sections with the same numbers. We also strongly suggest PPB go back to its earlier practice of enumerating the Definitions, to make referencing them easier. Our comments below refer to the Procedure section unless otherwise noted.

DIRECTIVE 850.25 POLICE RESPONSE TO MENTAL HEALTH FACILITIES

Our comment from April 2015 on this policy still stands: "This Directive still does not discuss the issue of officers bringing firearms and other weapons into hospitals and other facilities, as the introduction of such weapons could escalate the situation." We remind the

Directive 850.25 Feedback

Bureau that Jose Mejia Poot was shot inside a mental health facility in 2001 when he was armed with nothing but the aluminum push-rod from a door. We have also read that despite hospital protocols, Portland Police do not check their firearms into lockers when entering the Unity Center.

--While Sections 1.1 and 1.3 still require the presence of Enhanced Crisis Intervention Team officers in emergency situations, Section 1.2 continues to downplay the role of these specially trained officers, saying a supervisor "may" call ECIT.

--It is possible we overlooked Policy Section 1, which limits officer response to facilities to "assaults in progress, investigat[ing] crimes, and requests for mental health custody" when we noted the 2009 version had such limitations but we didn't see them in the last version.

--We also earlier noted that while Section 1.4.4 directs officers to decide whether to contact the person in crisis by phone or in person (or, now, by "other means"), the suggestion for officers to use the phone to determine the "severity of the threat" was removed from the pre-2015 Section 1.4.1 on tactical options.

--Sections 1.4.5 to 1.4.8, which outline specific options such as calling for ECIT, Crisis Negotiators, or mental health providers were all cut. These are replaced by parts of the ROADMAP mnemonic, referred to as being in Directive 850.20. However, since the entire ROADMAP is spelled out in 850.21 we wonder why it isn't at least summarized here.

--PCW appreciates that the term "dealing with combative or uncooperative persons" was changed to "addressing incidents with" such persons, a less pejorative term (Section 2.1.3).

CONCLUSION

In our last two sets of comments, we noted that the Portland Committee on Community Engaged Policing (or whatever the replacement for the Community Oversight Advisory Board will be called) will, by City Ordinance, be integrated into the Directives review process. Since the person who will help design the recruitment process does not have to turn in a resume until January 5, we continue to ask that the Bureau recognize PCW's concerns about the process and substance of these policies.

Thank you for the opportunity to comment

Q2 Contact Information (optional)

Name

Email Address

#3

COMPLETE

Collector: Web Link 1 (Web Link) 11st Universal Review 11/1/18
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Page 1

Q1 Please provide feedback for this directive

Directive 850.21 Peace Officer Custody (Civil);
Directive 850.22 Police Response to Mental Health Director's Holds and Elopment; and
Directive 850.25 Police Response to Mental Health Facilities

First, the National Lawyers Guild does not believe that police officers should be responding to mental health crises. Portland should look to other examples, like CAHOOTS in Eugene, to develop its own community-based mobile mental health crisis response team. Given the size of our city and the available resources (i.e. people willing to volunteer time and expertise to help run such a program), we believe this is a viable option for the Portland Community.

Second, there is no mention of lethal arms or firearms in 850.20, 850.21, 850.22, or 850.25. We do not believe officers responding to mental health crises should be armed with lethal force. Armed officers have the potential to escalate the "upward trajectory of intensity culminating in thoughts or acts that are dangerous to self and/or others" in action or in perceived action. This potential to immediately escalate a situation places the individual experiencing a crisis, the responding officer, and the surrounding community at great risk.

Third, while 850.20 highlights the composition of the Enhanced Crisis Intervention Team (ECIT), the general training process, and its role in responding to mental health crises, it does not detail how members are selected and trained. It does not provide information about the structure or content of the training, standards for quantitative and qualitative measurement of the training materials, or how its members are assessed in their knowledge of the material. Moreover, 40 hours seems minimal when compared to the amount of educational and professional training career mental health experts go through. The public (especially individuals suffering from mental illness and trained mental health professionals) should be able to provide insight into what the ECIT team and its training look like.

Fourth, we acknowledge that the city is investigating ways to effectively measure its success in responding to mental health crises. We would like to push that an accountability and effectiveness measure be outlined in the directives once the city determines what those will look like.

Fifth, we endorse Portland Copwatch's comments regarding these directives. Additionally, we would like to add a few minor comments.

Section 1 of "Policy" under Directive 850.21

Change "After considering" to "After exhausting." This change would reiterate the fact that there are numerous steps and actions to de-escalate which should be taken prior to custody. This word change gives teeth to those prior measures.

There is a significant amount of discretion given to officers when deciding whether to place somebody in a Peace Officer Hold. For public transparency, perhaps the directive could suggest a non-exhaustive list of examples where Probable Cause is given.

Former Section 1.1.2.1 under Directive 850.22

We would like to especially reiterate Copwatch's note that officer verification of the proper authority should be required when a hold order is given.

#1

COMPLETE

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2nd Universal Review /1 /18 6/1 /18

Page 1

Q1 Please provide feedback for this directive

As someone who works with secure residential treatment facility, we do not have away To transport Someone Who is in crisis. While we do not want officers to help manage Our behavioral interventions, We do rely on Ambulance transport 2 hospital. We find that it is the ambulance who calls the police, not the center. What is the remedy for that?

Q2 Contact Information (optional)

Name

Email Address

Phone Number

#2

COMPLETE

Collector: Web Link 1 (Web Link)
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2nd Universal Review /1 /18 6/1 /18

Page 1

Q1 Please provide feedback for this directive

COMMENTS ON MENTAL HEALTH DIRECTIVES MAY/JUNE 2018

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- Disengagement
- More Resources
- Arrest Delayed
- Containment
- Request Specialized Units
- Observe or use surveillance.

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Directive 850.25 Feedback

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--Sections 1.1 and 1.3 still require the presence of Enhanced Crisis Intervention Team officers in emergency situations, but Section 1.2 continues to downplay the role of these specially trained officers, saying a supervisor "may" call ECIT. The only change made to this section despite our comment is that the supervisor may call ECIT "if necessary" rather than "as necessary."

--We also earlier noted that while Section 1.4.4 directs officers to decide whether to contact the person in crisis by phone, in person or by "other means," the suggestion for officers to use the phone to determine the "severity of the threat" was removed from the pre-2015 Section 1.4.1 on tactical options.

--Section 1.4 includes references to parts of the ROADMAP mnemonic in Directive 850.20. However, since the entire acronym is spelled out in 850.21 we wonder why it isn't at least summarized here... and as noted elsewhere it should be changed to PD-MACRO.

--The part of Section 2.1.3 which was changed previously to talk about "addressing incidents with combative or uncooperative persons" is now proposed to say "addressing concerning incidents." While it is best not to stigmatize some people based on behavior, pulling out specific examples makes this concept too vague. We suggest saying "addressing concerning incidents such as persons who are combative."

CONCLUSION

As noted in our comments on the other Directive posted in May, we believe regardless of the (estimated) start-up of the Portland Committee for Community Engaged Policing in September, the PPB should be proactive in seeking out comments on its policies, particularly from affected community members and their advocates. We also continue to have concerns that organizations like PCCEP and other advisory groups will not have enough time to meet the Bureau's strict 15 and 30 day timelines on comments for this process. Even though there are relatively few changes in these four Directives, and we were working with previously generated comments, it still took a considerable amount of time for PCW to create this document. We once again urge the Bureau to reconsider its timelines.

Thank you for the opportunity to comment