*Please Note: This is a working draft of Directive 0850.20. The PPB has not implemented any portion of this draft. Submit your comments using the "Provide Feedback Here" link located at the end of the directive.

A redline copy of the updated directive is included in this attachment.

0850.20 Police Response to Mental Health Crisis
Second Universal Review: 6/15/22 – 7/15/22

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 – Persons with Mental Illness
- 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 0630.45, Emergency Medical Custody Transports
- DIR 0640.35, Abuse of Elderly/Persons with Disabilities
- DIR 0720.00, Special Emergency Reaction Team (SERT) and Crisis Negotiation Team (CNT) Use
- DIR 0850.21, Peace Officer Custody (Civil)
- DIR 0850.22, Police Response to Mental Health Director Holds and Elopement
- DIR 0850.25, Police Response to Mental Health Facilities
- DIR 0850.30 Temporary Detention and Custody of Juveniles
- DIR 0850.39, Missing, Runaway, Lost or Disoriented Persons
- DIR 0900.00, 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 prevent or reduce the amount of force necessary to safely and effectively resolve confrontations.

- 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).

- Disengagement: The intentional decision, based on the totality of the circumstances, to discontinue contact with a person the member could lawfully take into custody.

- 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 persons who may have a mental illness.

- Feasible: When time and safety allow for a particular action.

- Mental Health Crisis: An incident in which *someone with an actual or perceived mental illness* experiences intense feelings of personal distress, a thought disorder, obvious changes in functioning, and/or catastrophic life events, 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.

- Police Action: Any circumstance, on or off duty, in which a sworn member exercises or attempts to exercise police authority. This includes, but is not limited to, stops, searches, arrests, and use of force.

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.

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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 an intoxicant or a substance-induced condition.

5. 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 people with mental illness who present in crisis or with immediate needs. The Bureau is committed to serving persons 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 Bureau recognizes that members will have contact with people who experience mental illness but are not in crisis. Many Bureau members will become familiar with persons in the community known to have a mental illness. The Bureau provides training so that members may recognize signs and symptoms of mental illness in the absence of crisis, and expects members to engage these persons with dignity and respect, using the skills they have learned in their crisis training. The Bureau expects that members give special consideration to these situations, recognizing that using crisis intervention skills with all persons 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 may 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 indicate a mental health crisis. The Bureau prioritizes using de-escalation skills to maximize the likelihood of a safe outcome for everyone.

Procedure:

1. Member Expectation and Training:

*Please Note: This is a working draft of Directive 0850.20. The PPB has not implemented any portion of this draft. Submit your comments using the "Provide Feedback Here" link located at the end of the directive.

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1.1. When members recognize signs and symptoms of a mental illness in someone they are contacting, they 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 shall receive Mental Health Response training.

1.3.2. All existing sworn members shall 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 persons experiencing mental illness with dignity and respect.

2. Police Action and Involvement.

2.1. When responding to incidents involving persons displaying signs and symptoms of mental health crisis, members shall consider the following actions to manage the incident for the safety of all at the scene:

2.1.1. Evaluate the incident and determine the need for police action 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 police action is needed, consider, when feasible, using 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. If the member decides police action is not needed, document the reason why in the CAD call or a police report.

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

3. Resources and Strategies for Mental Health Crisis Response.

3.1. When responding to and managing scenes involving persons in mental health crisis, members should consider making a plan and using the following resources and strategies:

3.1.1. Requesting specialized units such as Enhanced Crisis Intervention Team (ECIT) members or the Crisis Negotiation Team (CNT);

3.1.2. Consulting with a mental health provider;
3.1.3. Surveillance;
3.1.4. Area containment;
3.1.5. Requesting more resources/summoning reinforcements;
3.1.6. Delaying arrest (get a warrant, or try different time/place);
3.1.7. Using time, distance, and communication to attempt to de-escalate the person; and
3.1.8. Disengagement with a plan to resolve later.

4. Disengagement.
4.1. Members shall consider a disengagement plan when the benefits to be gained by police action are clearly outweighed by the risks associated with the call.

4.2. When determining whether to disengage, members shall:
4.2.1. Attempt to gather relevant information about the person in crisis from readily available sources, such as the Multnomah County Behavioral Health Call Center, and
4.2.2. Consult with a supervisor to determine whether to make contact at a different time or under different circumstances.

4.3. Members shall not disengage if an individual presents an immediate danger to a third party.

4.4. If a person presents an immediate danger to themselves, before disengaging members shall assess whether they could reasonably remain at the scene and use other tactics to diminish the risk of harm to the person without increasing the risk of harm to the member or third parties. A perception of risk is based on articulatable facts and not suspicion alone.
4.4.1. If a member decides to disengage, they shall:
4.4.1.1. Complete a general offense report;
4.4.1.2. Notify the Multnomah County Behavioral Health Call Center of the situation (e.g. name, date of birth, disposition); and
4.4.1.3. Develop a plan in accordance with Bureau training.

5. Non-Criminal Disposition:
5.1. 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:
5.1.1. Refer the involved person to a mental health provider; see the Behavioral Health Unit's Community Mental Health Resources, for referral information.
5.1.2. 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.

5.1.3. Take the involved person into custody and arrange for AMR transport to a medical facility in accordance with Directive 0850.21, Peace Officer Custody (Civil), or Directive 0850.22, Police Response to Mental Health Directors Holds and Elopement.

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

5.3. If a person with a mental illness or in mental health crisis is taken into custody, either civilly or criminally, members are required to document consideration and/or use the strategies outlined in section 3. of this directive.

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

6.1. When requested, ECIT members will respond to support the dispatched member on a mental health crisis call. The dispatched member shall maintain their status as the primary member on the call, unless the ECIT member volunteers to become the primary member.

6.1.1. The dispatched member shall be responsible for fulfilling all other requirements related to the call, such as investigation, collection of evidence, follow up, and the completion of appropriate reports.

6.1.2. The dispatched member shall include in their report the name of the ECIT member who provided support and a brief description of assistance they provided.

6.2. 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. Members should refer to Directive 0720.00, Special Emergency Reaction Team (SERT) and Crisis Negotiation Team (CNT) Use, for additional guidance.

6.3. ECIT members will notify their supervisor when leaving their assigned precinct.

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

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A redline copy of the updated directive is included in this attachment.

7. Supervisor Responsibilities:
   7.1. Supervisors shall manage the dispatch and use of ECIT members and coordinate with the Bureau of Emergency Communications (BOEC) as appropriate.

   7.2. Supervisors shall acknowledge or respond to all calls where a member is dispatched to a designated mental health facility, in accordance with Directive, 0850.25, Police Response to Mental Health Facilities.

   7.3. Supervisors shall ensure their members follow reporting requirements for mental health crisis response.

Provide Feedback Here.

0850.20 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 – Persons with Mental Illness
- 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 ~~6300~~0630.45, Emergency Medical Custody Transports
- DIR ~~6400~~0640.35, Abuse of Elderly/Persons with Disabilities
- DIR ~~850~~0720.00, Special Emergency Reaction Team (SERT) and Crisis Negotiation Team (CNT) Use
- DIR 0850.21, Peace Officer Custody (Civil)
- DIR 0850.22, Police Response to Mental Health Director Holds and Elopement
- DIR 0850.25, Police Response to Mental Health Facilities
- ~~DIR 850~~DIR 0850.30 Temporary Detention and Custody of Juveniles
- DIR 0850.39, Missing, Runaway, Lost or Disoriented Persons
- ~~DIR 850.10 Custody, Civil Holds~~
- ~~DIR 850.30 Temporary Detention and Custody of Juveniles~~
- ~~DIR 9000~~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 prevent or reduce the amount of force necessary to safely and effectively resolve ~~the confrontation~~confrontations.

- 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).

- Disengagement: The intentional decision, based on the totality of the circumstances, to discontinue contact with a person the member could lawfully take into custody.

- 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~~persons who may have a mental illness.

- Feasible: When time and safety allow for a particular action.

- 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.

- Police Action: Any circumstance, on or off duty, in which a sworn member exercises or attempts to exercise police authority. This includes, but is not limited to, stops, searches, arrests, and use of force.

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 an intoxicant or a substance-induced condition.

5. 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~~people with mental illness who present in crisis or with immediate needs. The ~~Portland Police~~ Bureau is committed to serving ~~individuals~~persons 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~~people who experience mental illness but are not in crisis. Many Bureau members ~~of the Portland Police Bureau~~ will ~~come to be~~become familiar with ~~individuals~~persons in the community ~~who members know~~known to have a mental illness. The ~~Police~~ Bureau provides training so that members may recognize signs and symptoms of mental illness in the absence of crisis, and expects members to engage these ~~individuals~~persons with dignity and respect, using the skills they have learned in their crisis training. ~~It is the Police Bureau's intention~~ The Bureau expects that members give special consideration to these situations, recognizing that using crisis intervention skills with all ~~individuals~~persons 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~~may 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~~ indicate a mental health crisis. The ~~goal is to use~~Bureau prioritizes using de-escalation skills to maximize the likelihood of a safe outcome for ~~members, individuals, and the community~~everyone.

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~~ in someone they are contacting, they 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~~shall receive Mental Health Response training.

1.3.2. All existing sworn members ~~will~~shall 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~~persons experiencing mental illness with dignity and respect.

~~2. Responding to and managing scenes involving persons in mental health crisis:~~

2. Police Action and Involvement.

2.1. When responding to incidents involving persons displaying ~~behavior indicative~~signs and symptoms of mental health crisis, members ~~will~~shall 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~~determine the need for police ~~intervention when feasible,~~action 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,~~ police action is needed, consider, when feasible, ~~the use of~~using 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~~If the member decides police action is not needed, document the reason why in the CAD call or a police report.

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

3. Resources and Strategies for Mental Health Crisis Response.

~~2.2.~~3.1. When responding to and managing scenes involving persons in mental health crisis, members should consider ~~in devising a response plan include, but are not limited to,~~making a plan and using the following ~~("ROADMAP" is a mnemonic device that assists members in remembering tactics taught in training):~~resources and strategies:

~~2.2.1.1. **R** – Request~~Requesting specialized units~~,~~

~~2.2.2.~~3.1.1. ~~Evaluate the need for assistance from individuals with additional training in working with mental health crisis situations (e.g.~~ such as Enhanced Crisis Intervention Team (ECIT) members~~, Project Respond,~~ or the 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).);~~

~~2.2.2.1.1. 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.~~

3.1.2. ~~O - Observe or use~~ Consulting with a mental health provider;

~~2.2.3.~~3.1.3. Surveillance ~~to monitor subject or situation,~~;

~~2.2.4.~~3.1.4. ~~A –~~ Area ~~Containment (perimeter,~~ containment~~),~~;

3.1.5. ~~D – Disengage~~ Requesting more resources/summoning reinforcements;

3.1.6. Delaying arrest (get a warrant, or try different time/place);

3.1.7. Using time, distance, and communication to attempt to de-escalate the person; and

~~2.2.5.~~3.1.8. Disengagement with a plan to resolve later~~,~~.

4. Disengagement ~~is~~.

4.1. Members shall consider a ~~tactic to be considered to reduce undue safety risk to the member, the involved persons, or others. Prior to~~ disengagement plan when the benefits to be gained by police action are clearly outweighed by the risks associated with the call.

4.2. When determining whether to disengage, members ~~will make reasonable efforts~~shall:

4.2.1. Attempt to gather relevant information about the person in crisis from readily available sources, such as the Multnomah County Behavioral Health Call Center, and ~~consult~~

4.2.2. 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.~~

4.3. Members shall not disengage ~~where~~if an individual presents an immediate danger to a third party. ~~Where an individual~~

~~2.3.~~4.4. If a person presents an immediate danger to ~~her/himself, prior to disengagement~~themselves, before disengaging members shall assess whether they could reasonably remain at the scene and use other tactics to diminish the risk of harm to the ~~individual~~person without increasing the risk of harm to the member or third parties. A perception of risk is based on ~~mere~~ articulatable facts and not suspicion ~~will not constitute 'immediate danger.'~~ alone.

~~2.3.1.1. M – More Resources/Summon Reinforcements,~~

~~2.3.1.2. A – Arrest Delayed (get a warrant, or try different time/place),~~

~~2.3.1.3. P – Patience. Use time and communication to attempt to de-escalate the subject.~~

~~2.3.2. 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.~~

4.4.1. If a member decides to disengage, they shall:

4.4.1.1. Complete a general offense report;

4.4.1.2. Notify the Multnomah County Behavioral Health Call Center of the situation (e.g. name, date of birth, disposition); and

4.4.1.3. Develop a plan in accordance with Bureau training.

~~3.~~5. Non-Criminal Disposition:

~~3.1.~~5.1. 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.~~5.1.1. 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.~~5.1.2. 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.~~5.1.3. Take the involved person into custody and arrange for AMR transport to a medical facility in accordance with Directive ~~850~~0850.21, Peace Officer Custody (Civil), or Directive ~~850~~0850.22, Police Response to Mental Health Directors Holds and Elopement.

~~3.2.~~5.2. Regardless of which disposition above is used, members are required to complete an appropriate police report.

~~3.3.~~5.3. ~~If an individual~~If a person with a mental illness or in mental health crisis is taken into custody, either civilly or criminally, members are required to document consideration and/or use ~~of ROADMAP tactics~~the strategies outlined in section 3. of this directive.

~~4.~~6. Enhanced Crisis Intervention Team (ECIT) Member Responsibilities:

~~4.1.~~When requested, ECIT members will respond ~~as~~to support the ~~primary~~dispatched member on a mental health crisis call ~~when~~. The dispatched ~~or at the request of any member~~.

~~4.2.~~6.1. shall maintain their status as the primary member on the call, unless the ECIT ~~members may also volunteer~~member volunteers to become the primary member ~~on any call~~.

6.1.1. The dispatched member shall be responsible for fulfilling all other requirements related to the call, such as investigation, collection of evidence, follow up, and the completion of appropriate reports.

6.1.2. The dispatched member shall include in their report the name of the ECIT member who provided support and a brief description of assistance they provided.

~~4.3.~~6.2. 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. Members should refer to Directive 0720.00, Special Emergency Reaction Team (SERT) and Crisis Negotiation Team (CNT) Use, for additional guidance.

~~4.4.~~6.3. ECIT members will notify ~~his/her~~their supervisor when leaving their assigned precinct.

~~4.5.~~6.4. ECIT members who participate in a mental health crisis call by using their crisis intervention skills shall complete any required report.

~~5.~~7. Supervisor Responsibilities:

~~5.1.~~7.1. Supervisors ~~will~~shall manage the dispatch and use of ECIT members and coordinate with the Bureau of Emergency Communications (BOEC) as appropriate.

~~5.2.~~7.2. Supervisors ~~will~~shall acknowledge or respond to all calls where a member is dispatched to a designated mental health facility, in accordance with Directive, ~~850~~0850.25, Police Response to Mental Health Facilities.

~~5.3.~~7.3. Supervisors ~~will~~shall ensure their members follow reporting requirements for mental health crisis response.

#1

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Monday, January 03, 2022 1:23:12 PM
Last Modified: Monday, January 03, 2022 1:23:46 PM
Time Spent: 00:00:34

Page 1

Q1

Please provide feedback for this directive

Stop murdering them.

Q2

Respondent skipped this question

Contact Information (optional - your name will be visible on PPB's website)

#2

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Sunday, January 16, 2022 4:48:58 PM
Last Modified: Sunday, January 16, 2022 4:49:30 PM
Time Spent: 00:00:31

Page 1

Q1

Please provide feedback for this directive

COMMENTS ON MENTAL HEALTH, CUSTODY, IMMIGRATION AND OTHER DIRECTIVES, JANUARY 2022

To Chief Lovell, Capt. Parman, Lieutenant Morgan, PPB Policy Analysts, Compliance Officer/Community Liaison Team, Portland Committee on Community Engaged Policing, US Dept. of Justice, Citizen Review Committee and the Portland Police Bureau:

Below are Portland Copwatch's comments on the 13 of the 15 Directives posted for review in January . The "First Universal Review" is particularly challenging, not only because of the very short (15 day) timeline, but because it is difficult to know if the Bureau intends to make any changes to the policies. Because the public is presented with the policies as they currently exist, it is extremely challenging to determine if any changes were made between the last Second Universal Review and the present time. We strongly suggest that the Bureau include both (a) a statement of intent if there is a particular reason a Directive has been chosen and (b) a link to an existing implementation memo which might include a final redline of the previous iteration and the Bureau's reflections on public comments.

The wide variety of topics in this set of Directives is offset for us by the fact that we've made comments on all of them, except for 850.30 on Juveniles, previously. We've tried to indicate where the Bureau has made its (rare) changes reflective of our input. Otherwise, many of these comments are repeats of ones we made between January 2015 and January 2021.

Portland Copwatch (PCW) has chosen again not to comment on 660.32 Informant Processing because of the distasteful nature of such government-sponsored subterfuge, and 630.50 on Medical Aid, to which no changes have been made despite its previous posting in 2016.

We continue to ask that the Bureau add numbers or letters to the Definitions, Policy and Procedure sections to make them easier to reference. Our comments below refer to the Procedure section unless otherwise noted.

_____MENTAL HEALTH DIRECTIVES (last commented on April, 2020)_____

We begin with general comments we made when these Directives about Mental Health (850.20, 850.21, 850.22 and 850.25) were previously posted, updated here:

--Consistent Humanity Reminders: All four policies should reflect Policy Section 2 of 850.20 and Policy Section 1 of 850.25, which call on officers to treat people in mental health crisis "with dignity," "respect" (850.20) and "compassion" (850.25)-- "at all times" (also 820.25).

--References Mostly Fixed: We previously noted that all four Directives list "Definitions for ORS 426.005 to 426.390" in the Refer section and suggested the summary title "Persons With Mental Illness" be added. This was done in 850.20, 850.21 and 850.22. The summary title appears to be in the wrong place in 850.25.

--Memorize in Priority Order: We continue to believe the PPB should change its inadequate "ROADMAP" mnemonic for handling possible mental health crisis situations. The concept of "Patience" should not be the last item on the list. There are also two letter "A"s, with one standing for "Area Containment" and one for "Arrest Delayed," which can cause confusion. We suggested changing the mnemonic to "PD-MACRO," with the items listed as:
__Patience
__Disengagement
__More Resources
__Arrest Delayed
__Containment
__Request Specialized Units

__Observe or use surveillance.

"PD" should be easy for officers to remember, even though locals know our Department is the PPB. We note here again that officers can use all of these tactics (as well as non-engagement) on someone regardless of whether that person is in mental health crisis as alternatives to using force.

--Be Generic to Avoid Problems: For a few reasons, the Bureau should not refer to AMR, the private company which contracts for ambulance services in the County, in its policies. We suggest using a generic term about ambulances, especially if the Fire Bureau or other agency might transport the individuals, or if AMR ever changes its name. The Bureau has already shown a willingness to do so when references to the Unity Center were replaced by the generic term "secure evaluation facility."

--De-escalation Not About Stopping Using High Force Levels: 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 (which is mitigation of force).

Here are comments on the four individual policies drawn from earlier input.

DIRECTIVE 850.20 MENTAL HEALTH CRISIS RESPONSE

--What's a Mental Health Indicator Question: Paragraph 1.2 requires officers to "answer the mental health indicator question," though it is not clear where that question is posed.

--Don't Over-Diagnose Mental Health Issues: The Definition of Mental Health Crisis is still too broad, saying it includes "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. "

--Officers are Not Clinically Trained: Even though the Directive recognizes that "Mental health providers are responsible for the ...diagnosis of persons with mental illness" [Policy 1]), the Directive should include better-defined decision-making guidance; for example:

--->What Governmental Interests?: Section 3.1 tells officers to "consider the governmental interests at stake" with no examples.

--->Why are Officers Called?: An earlier version of the Directive outlined why police might need to be called to the scene of mental health crises, including the question of whether the person is armed.

--->Explain Why ECIT is Called: Section 4 guiding the work of the Enhanced Crisis Intervention Team (ECIT) no longer contains specific examples of when ECIT officers might respond, including the concept that a community member can request an ECIT officer. There also used to be references to violence, weapons, and attempted suicide. PCW also continues to suggest adding a reference to Directive 850.25 (Police Response to Mental Health Facilities), though we also believe the Bureau's rules should require officers to check their weapons at such facilities.

--Define Alternative Strategies: Parts of the Directive that were previously cut have not been reinstated, including the definitions of disengagement, delayed custody, and non-engagement. We note again 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.

--->Disengagement, delayed custody, and non-engagement all appear in some form in the ROADMAP mnemonic Section of the policy (2.1.3), which as noted in our general comments should be changed to "PD-MACRO."

--Mere Presence Can Escalate: This is our sixth time writing: "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.

--Remove Outdated Present-Tense Commentary: Policy 3 still talks about officers being "increasingly required to respond" to persons with mental illness. Now that the PPB has a Sergeant assigned to emergency dispatch and alternative responders such as Portland Street Response are in place, this phrase only serves to perpetuate finger-pointing about lack of services. Perhaps it should say officers are "at varying times called to respond," so that as the frequency goes down, the Directive is accurate.

--Require Supervisor Response: 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 continue to suggest that Supervisory response go back to being mandatory-- especially because it is required in Directive 850.25 (Sections 1.1 and 1.3).

CONCLUSION

We recognize that the Directives development process has evolved since it began, particularly with the addition of redline versions and public comments posted in the Second Universal Review. There is still more to be gained by adding the information suggested in our introduction and holding public meetings to exchange ideas about suggested changes. Several advisory bodies including the Citizen Review Committee, Portland Committee on Community Engaged Policing and Training Advisory Council all have a stake in various Directives, but the first two only meet once a month and the latter only meets every two months, so they can't easily meet the Bureau's deadlines for input.

Many of these policies could help reduce harm against vulnerable parts of our population. However, the incidents of use of deadly force against people in mental health crisis continues unabated, with at least three of eight people shot by the PPB in crisis in 2021. Notably, the last time the Bureau was involved in this many deadly force incidents was 2005. Yet after nine years of oversight by the US Department of Justice, it seems the ideas of de-escalation and other tactics outlined in these policies are thrown out the window because an officer or officers default to pulling firearms, pile on an agitated person, or using so-called "less lethal" weapons. The number one priority should always be respecting the dignity and humanity of the civilian and making sure everyone gets to go home safe at night-- whether or not a suspected mental health issue is at play.

We appreciate being invited to provide input into the Bureau's policies. Our goal at Portland Copwatch is that so long as there is a Police Bureau, its should be free of corruption, brutality and racism. We hope that our suggestions will help lead to such a culture.

--dan handelman (and other members of)
--Portland Copwatch

Q2

Contact Information (optional - your name will be visible on PPB's website)

Name	**Portland Copwatch**

#3

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Collector: Web Link 1 (Web Link)
Started: Sunday, January 16, 2022 8:23:29 PM
Last Modified: Sunday, January 16, 2022 8:31:20 PM
Time Spent: 00:07:50

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Q1

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2.1.3.1.1. - Is the Project Respond (Cascadia - mobile crisis unit) still working together with PPB in a mental health crisis call or is it Portland Street Response?

2.1.3.1.2. Members may possibly consult with the involved person's mental health providers - How would a n officer get the person's provider's information? Would they ask for the info & get permission? It would be helpful to know if there are "rules" around this.

Q2

Contact Information (optional - your name will be visible on PPB's website)

Name **Tia Palafox**

#4

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Collector: Web Link 1 (Web Link)
Started: Monday, January 17, 2022 3:39:35 PM
Last Modified: Monday, January 17, 2022 3:41:40 PM
Time Spent: 00:02:04

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Q1

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Permissive language should be avoided and language more consistent with required conduct should be inserted in its place (i.e., “must” instead of “expected”). De-escalation and disengagement should be required whenever appropriate. And it is appropriate far more often than not.

Also, since the directive mentions substance induced conditions as outside the realm of mental illness - an assertion subject to argument based upon individual cases- it should include with clarity that those suspected of substance induced psychiatric symptoms will be managed consistent with the directive. It is often that those exhibiting substance induced symptoms do have diagnosable conditions for which they need immediate psychiatric treatment. Sometimes it’s a substance use disorder (SUD), and sometimes it’s a SUD co-occurring with another diagnosis such as bipolar disorder, schizophrenia, or post-traumatic stress disorder. Those with intellectual and developmental disability should also benefit from de-escalation and disengagement when appropriate. Essentially, the directive should make clear that anyone exhibiting potential psychiatric symptoms -regardless of etiology- is to be managed in accordance with the directive.

Also, since cited in the directive as a reference, the Behavioral Health Unit Resources should be updated. This resource appears to have been last updated in 2017 and does not take the pandemic into account. Nor does it focus on crises. Though slightly outside the scope of commenting on this directive, PPB officers should be given resources specific to use in crises that are reasonably high yield in value. If Portland has any.

Q2

Respondent skipped this question

Contact Information (optional - your name will be visible on PPB's website)