CITY OF PORTLAND, OREGON

Bureau of Police
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Executive Summary for Directives:
0850.20 Police Response to Mental Health Crisis
0850.21 Peace Officer Custody (Civil)
0850.22 Police Response to Mental Health Director Holds and Elopement
0850.25 Police Response to Mental Health Facilities

Introduction

The Portland Police Bureau began its review of its Mental Health directive series in late 2021. The Mental Health series includes Directives 0850.20, Police Response to Mental Health Crisis; 0850.21, Peace Officer Custody (Civil); 0850.22, Police Response to Mental Health Director Holds and Elopement; and 0850.25, Police Response to Mental Health Facilities. The Bureau posted these directives for First Universal Review in January 2022, and posted proposed revisions during Second Universal Review in June-July 2022.

The Bureau continues to work closely with the United States Department of Justice (DOJ) and the Compliance Officer/Community Liaison (COCL) to review all DOJ-identified policies, including the Mental Health series, for adherence to the DOJ settlement agreement. During this review, the Bureau primarily made minor changes and edits, with the most substantial changes made to the overarching directive in the series, 0850.20 Police Response to Mental Health Crisis.

Of note, the Bureau made several changes to the definitions section, removed the ROADMAP mnemonic device, and clarified the role of Enhanced Crisis Intervention Team (ECIT) officers.

Public Comments

The Bureau received limited feedback during both universal review and public comment periods. Several comments were the same as comments received in 2019 and addressed in the Executive Summary published in 2020.

The Bureau received feedback that the definition of "mental health crisis" was too broad, long, and confusing. Accordingly, the Bureau deleted the examples formerly found in parentheticals, removing language that some viewed as problematic, making the definition more succinct.

In the former version of the directive, the Bureau used the ROADMAP mnemonic device to help members recall resources and strategies for responding to persons in mental health crisis. The mnemonic device was not useful in practice, and the Bureau simplified the directive by editing unnecessary language and presenting the resources and strategies in a short list. One comment

suggested that, mnemonic or not, the list should be presented in an order with preferred responses at top. The Bureau does not list these resources and strategies in priority order, as different circumstances may call for different responses and resources.

The Bureau received feedback suggesting that references to the private ambulance company, AMR, be struck and replaced with the more general term ambulance. The Bureau adopted that suggestion in the revised directive.

The Bureau received a comment recommending the Bureau re-insert a definition for "disengagement" and the Bureau adopted that recommendation. The change is discussed more below.

The Revised Directives

The primary changes to Directive 0850.20 are found in the definitions section. The definition of "de-escalation" changed for consistency with how the Bureau defines the term in revised Directive 1010.00, Use of Force. The Bureau reintroduced a definition of "disengagement." The term is intentionally narrowly defined, as a term of art, clarifying expectations that may apply in some custody situations. The term is not used in the plain sense of the word (deciding to withdraw from an encounter), as that action is always an option if members have determined no police action is needed. The definition of "mental health crisis" was changed for the reasons stated above in the Public Comments section.

Throughout the directive, the Bureau replaced references to "individuals" with "persons" as a matter of writing style, consistency with the most recently revised Bureau directives, and accuracy.

The Bureau removed the ROADMAP mnemonic for the reasons stated above in the Public Comments section.

Perhaps most significantly, the Bureau clarified the section on ECIT member responsibilities. The additional language explains the supportive role that ECIT members fill, and clarifies reporting and administrative responsibilities for primary dispatched member on the call.

In the "About Mental Health" section, the Bureau deleted a sentence about mental health problems potentially escalating to mental health crisis. The sentence was inconsistent with the Bureau's definition of mental health crisis, which requires actual or perceived mental illness per the directive. While the sentence aimed to address mental health crisis in the broader sense, it created confusion given the narrower definition of mental health crisis found within the directive.

Finally, in Directive 0850.21, the Bureau deleted a sentence from Policy Paragraph 1 that referred to the term "Peace Officer Hold." The sentence was problematic because it used the term "Peace Officer Hold" where the term should be "Peace Officer Custody" and because it inaccurately suggested a procedural order of applying Directive 0850.20 first, and then accepting or rejecting strategies listed therein before applying Directive 0850.21. In actuality, Directive 0850.20 is an overarching directive for all of the concepts listed within the Mental Health series.

Conclusion

The Bureau made generally small changes to the Mental Health series of directives. The Policy Development Team worked closely with the Bureau's mental health experts, the DOJ, and the

COCL, to ensure the directives align with best practice standards and provide clear guidance to members.

The Bureau welcomes further feedback on these directives during their next review.

These directives go into effect on November 15, 2022, to allow for member training during the fall in-service. Published on September 19, 2022.

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 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 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, including but not limited to 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.

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 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:
   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, when feasible, 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 feasible, if the benefits to be gained by police action are clearly outweighed by the risks associated with the call.

   4.2. In determining whether to disengage, members shall, when feasible:
      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 shall be 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 shall consider the totality of the circumstances, including the behavior of the person and the governmental interests at stake. Non-criminal dispositions that may be appropriate at the scene include, but are not limited to, the following:

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 ambulance transport for the involved person to a mental health or medical facility for voluntary care. Members should inform ambulance personnel of the situation so they can pass the information along to staff at the facility upon arrival. Members may coordinate with medical providers and arrange to 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 ambulance 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 shall complete an appropriate police report.

5.3. If a person 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 shall 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 shall 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 shall 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.

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.

Established:	09/06/2001
Revision History:	2002, 2007, 2014, 2016, 2018, 2020, 2022
Effective:	November 15, 2022
Next Review:	November 15, 2023

0850.20 Police Response to Mental Health Crisis

Refer:

- ORS § 161.375(4), Authority of Psychiatric Security Review Board to issue warrant of arrest
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- 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~~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
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- 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~~, including but not limited to 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, when feasible, 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 feasible, if the benefits to be gained by police action are clearly outweighed by the risks associated with the call.

4.2. In determining whether to disengage, members ~~will make reasonable efforts~~shall, when feasible:

~~2.2.6.~~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

~~2.2.7.~~4.2.2. Consult with a supervisor to determine whether to make contact at a different time or under different circumstances.

4.3. ~~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~~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 shall be based on ~~mere~~ articulatable facts and not suspicion ~~will not constitute 'immediate danger.'~~ 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

~~2.3.1.1.~~ Develop a plan in accordance with Bureau training. ~~**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.~~

4.4.1.3.

~~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~~shall 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~~ include, but are not limited to, the following:

~~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~~ambulance transport for the involved person to a mental health or medical facility for voluntary care. Members should inform ~~AMR~~ambulance personnel of the situation so ~~AMR~~they can pass the information along to staff at the facility upon arrival. Members may ~~meet up~~coordinate with ~~AMR at the facility~~medical providers and ~~may~~arrange to 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~~ambulance transport to a medical facility in accordance with Directive ~~8500~~0850.21, Peace Officer Custody (Civil), or Directive ~~8500~~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~~shall complete an appropriate police report.

~~3.3.~~5.3. ~~If an individual~~If a person 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~~shall 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~~shall 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~~shall 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, ~~8500~~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

COMPLETE

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

Page 1

Q1

Please provide feedback for this directive

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

COMPLETE

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

Page 1

Q1

Please provide feedback for this directive

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)

#1

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Tuesday, June 14, 2022 3:24:51 PM
Last Modified:	Tuesday, June 14, 2022 3:25:04 PM
Time Spent:	00:00:12

Page 1

Q1

Please provide feedback for this directive

test

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: Friday, July 15, 2022 8:20:40 AM
Last Modified: Friday, July 15, 2022 8:24:07 AM
Time Spent: 00:03:26

Page 1

Q1

Please provide feedback for this directive

The directive includes several changes where the verb ‘will’ is swapped out for ‘shall.’ The word ‘shall’ is intended to communicate a stronger requirement, but it’s probably not going to make a difference to most readers. It’s also not a change that matches good governance practices; the U.S. federal government suggests avoiding using “shall” in legislative, policy, and legal writing, because it’s been so corrupted by misuse. Instead, using the word “must” is recommended to communicate a specific duty or requirement. https://www.plainlanguage.gov/guidelines/conversational/shall-and-must/

Why does this directive avoid discussing how calls are coded for mental health crises? Robert Delgado was clearly experiencing a mental health crisis last year before Zachary DeLong killed him, but the call was not coded as such.

Q2

Respondent skipped this question

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

#3

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Friday, July 15, 2022 3:21:35 PM
Last Modified:	Friday, July 15, 2022 3:22:39 PM
Time Spent:	00:01:04

Page 1

Q1

Please provide feedback for this directive

COMMENTS on Vehicle Pursuit, Mental Health and Procedural Justice Directives, July 2022

COMMENTS ON VEHICLE PURSUIT, MENTAL HEALTH AND PROCEDURAL JUSTICE DIRECTIVES, JULY 2022

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

Below are our comments on the Directives posted for review on in July . With the exception of the Vehicle Interventions and Pursuits policy, which was last posted in 2018, these are all "Second Universal Reviews" which we commented on earlier this year.

We have asked that the Bureau release, during the First Universal Review, a list of known issues that are going to be addressed in the revisions. This would both alert community members to the appropriate parts of the Directives and make it so that Portland Copwatch can't claim victory when the Bureau was already planning to make changes we suggest. So it's a win-win.

While some of our previous suggestions have been incorporated, they were not necessarily made in ways that improve the policies, and are few in number.

It would greatly help the navigation of the hundreds of policies if the Bureau would give different labels to all of the sections of the Directives, such as the Definitions, Policy and Procedure sections so there are not multiple sections numbered "1." Our comments here refer to the Procedure section unless otherwise noted.

_____MENTAL HEALTH DIRECTIVES (last commented on January 2022)_____

We begin again with general comments we made about the Directives about Mental Health (850.20, 850.21, 850.22 and 850.25), repeated or updated from previous comments:

--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).

--Prioritize Responses: It looks as if the Bureau has given up on its mnemonic for officers on responses to mental health crisis, formerly "ROADMAP." The list of possible responses is no longer summarized this way, but has been changed without adequate consideration of what should be the priorities among what has gone from seven to eight items listed. The items are:

#1- Request Specialty Units (formerly #1, Portland Copwatch suggested as #6 of 7).
#2- Consult a Mental Health Provider (new item)
#3- Observation / surveillance (formerly #2, PCW suggested #7 of 7)
#4- Area containment (formerly #3, PCW suggested #5 of 7)
#5- Request resources (formerly #5, PCW suggested #3 of 7)
#6- Delay arrest (formerly #7, PCW suggested as #4 of 7)
#7- Patience / de-escalation (formerly #7, PCW suggested as #1 of 7)
#8- Disengagement (formerly #4, PCW suggested as #2 of 7).

Technically how the revised list is written, the acronym would be "RCARDUD" which is not easy to recall. But clever ways to

remember things isn't as important as the underlying policy, which in this case seems to continue pushing de-escalation and disengagement toward the bottom of the list rather than the top. We urge the PPB to publish the list in a way that makes officers think first about calming things down before calling in backup.

To be clear, after reviewing the full list, PCW now suggests this order: Patience/de-escalation, Disengagement, Consult a Mental Health Provider, Request Resources, Delay Arrest, Observation/surveillance, Area containment, Request Specialty Units.

--Prevent Revisions, Be Clear, Use Generic Terms: PCW continues to suggest that the PPB not refer to AMR, the private company which contracts for ambulance services in the County, in its policies. Using a generic term about ambulances would be better, especially if the Fire Bureau or other agency might transport the individuals, or if AMR changes its name. As previously noted, the Bureau has already changed references to the Unity Center with the generic term "secure evaluation facility."

--De-escalation Double Definition: Despite some progress in another Directive, the PPB continues to define "de-escalation" as both trying to avoid the use of force (agreed) _and_ lowering the amount of force already being used on a suspect (which is mitigation of force, called "Reactive De-escalation" in the proposed revised 1010.00).

--Definition Returns: The PPB has put the Definition for "disengagement" back into Directives 850.20 and 850.21; PCW appreciates this responsiveness to our suggestion.

Here are comments on the four individual policies, also updated from previous input.

DIRECTIVE 850.20 MENTAL HEALTH CRISIS RESPONSE

--Mostly Positive Change: The Definition of Mental Health Crisis is being edited to remove some of the problematic language PCW previously identified, such as focusing on a person's "neglect of personal hygiene." It may still be too broad, continuing to list "intense feelings of personal distress, a thought disorder, obvious changes in functioning, and/or catastrophic life events." Related to this are these other issues:

---> 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.

---> What Governmental Interests?: Section 5.1 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 6 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.

--Explain "Mental Health Indicator Question": Paragraph 1.2 still requires officers to "answer the mental health indicator question," though it is not clear what that question looks like or where it is posed.

--Define Other Alternative Strategies: Although the definition of "disengagement" came back (see general comments), other parts of the Directive that were previously cut have not been reinstated, including an option for non-engagement. That option implies police decide never to make contact in the first place, while disengagement is about "discontinuing" contact. There is still a clause in

Section 2.1.2 which begins "If the member decides police action is needed...", implying that deciding not to intervene is still an option.

--Mere Presence Can Escalate: This is our seventh 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.

--Require Supervisor Response: Section 7.2 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).

--Another Positive Change: Policy 3 formerly talked about officers being "increasingly required to respond" to persons with mental illness. The revised version says officers "may respond to and intervene on behalf of persons who are in mental health crisis." Thank you.

CONCLUSION

Chief Lovell made a comment at a meeting recently about how public comments have been incorporated to improve PPB policies. While it is nice to be acknowledged, the reality is that the Bureau has either ignored or mis-applied the vast majority of comments Portland Copwatch has made over the years. We continue to believe that direct dialogue about the changes during public meetings would lead to an improved process, improved outcomes, and improved trust. The PPB could better understand community members' concerns and explain its rationale for why things are written in a certain way. Given the requirement for advisory bodies such as the Citizen Review Committee, Portland Committee on Community Engaged Policing and Training Advisory Council to make policy recommendations, holding these meetings in conjunction with those groups would make sense. Extending the deadlines to comment would also allow those groups, which only meet once every month or two, time to formulate meaningful feedback.

Finally, we once again call attention to the fact that a higher percentage of people in mental health crisis have been shot/shot at/killed by Portland Police officers since the implementation of the US Department of Justice Settlement Agreement. So while the policies focusing on this vulnerable part of the population are improving, they are still not fixing an underlying issue where force is relied on too heavily.

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

Q2

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

Name	**Portland Copwatch**

#4

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Friday, July 15, 2022 6:36:06 PM
Last Modified: Friday, July 15, 2022 6:37:37 PM
Time Spent: 00:01:30

Page 1

Q1

Please provide feedback for this directive

Fire everyone on the department and outsource policing in Portland to Multnomah County. You fascists are destroying our city, and no performative feedback will change that.

Q2

Respondent skipped this question

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

0850.21 Peace Officer Custody (Civil)

Refer:

- ORS § 426.005, Definitions for ORS § 426.005 to 426.390 – Persons with Mental Illness
- DIR 0630.45 Emergency Medical Custody Transports
- DIR 0630.50 Emergency Medical Aid
- DIR 0850.20 Police Response to Mental Health Crisis
- DIR 0850.22 Police Response to Mental Health Director's Holds and Elopement
- DIR 0850.25 Police Response to Mental Health Facilities
- DIR 0850.30 Temporary Detention and Custody of Juveniles

Definitions:

- De-escalation: A deliberate attempt to reduce the necessity or intensity of force to safely and effectively resolve confrontations.

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

- 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.

- 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 Bureau recognizes the importance of civil rights and the need for individuals to have control over their person. However, the 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.

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 the need arises, the act of custody shall be resolved in as safe, constructive, and humane of a 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 Bureau.

4. Members shall treat the individual with dignity and compassion at all times.

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 needs 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, when feasible, to participating members, to take advantage of the most effective options that may safely resolve the incident.
         1.2.1.1. When making a tactical plan, members should consider the following resources and strategies:
            1.2.1.1.1. Requesting specialized units such as Enhanced Crisis Intervention Team (ECIT) members or the Crisis Negotiation Team (CNT);
            1.2.1.1.2. Consulting with a mental health provider;
            1.2.1.1.3. Surveillance;
            1.2.1.1.4. Area Containment;
            1.2.1.1.5. Requesting more resources/summoning reinforcements;
            1.2.1.1.6. Delaying arrest (get a warrant, or try different time/place);
            1.2.1.1.7. Using time, distance, and communication to attempt to de-escalate the person; and
            1.2.1.1.8. Disengagement with a plan to resolve later.

   1.3. When taking a person into Peace Officer Custody, members shall transport or facilitate the transport of the person to the appropriate secure evaluation facility or nearest designated hospital emergency department that conducts mental health evaluations. Refer to Directives 0630.45 Emergency Medical Custody Transports and 0630.50 Emergency Medical Aid for additional information.

   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 before 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 shall 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 ambulance personnel or, in those extraordinary circumstances when the officer provides transport, the treating physician at the hospital or Unity Center.

   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 ambulance personnel or, in those extraordinary circumstances when the officer provides transport, the treating physician at the hospital or Unity Center.

2.3. The member shall submit a copy of the Report of Peace Officer Custody of an Allegedly Mentally Ill Person, along with all required police reports 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.

Established: 05/02/2017

Revised: 2018, 2020, 2022

Effective: 11/15/2022

Next Review: 11/15/2023

0850.21 Peace Officer Custody (Civil)

Refer:

- ORS § 426.005, Definitions for ORS § 426.005 to 426.390 – Persons with Mental Illness
- DIR ~~630~~0630.45 Emergency Medical Custody Transports
- DIR ~~630~~0630.50 Emergency Medical Aid
- DIR ~~850~~0850.20 Police Response to Mental Health Crisis
- DIR ~~850~~0850.22 Police Response to Mental Health Director's Holds and Elopement
- DIR ~~850~~0850.25 Police Response to Mental Health Facilities
- DIR 0850.30 Temporary Detention and Custody of Juveniles

Definitions:

- De-escalation: A deliberate attempt to reduce the necessity or intensity of force to safely and effectively resolve ~~confrontation~~confrontations.

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

- 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.

- 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 ~~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 850.20, and after finding probable cause exists for a hold, members shall 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 the need arises, the act of custody shall be resolved in as safe, constructive, and humane of a 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.

4. Members shall treat the individual with dignity and compassion at all times.

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~~needs 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, when feasible, to participating members, ~~so as~~ to take advantage of the most effective options that may safely resolve the incident. ~~Tactics~~
         1.2.1.1. When making a tactical plan, 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):~~resources and strategies:
      ~~1.2.1.2. **R** – Request~~Requesting specialized units~~,~~
         ~~1.2.1.2.1.~~1.2.1.1.1. ~~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 needed, assistance may be requested through the Bureau of Emergency Communications (BOEC).);~~
         ~~1.2.1.2.2.~~1.2.1.1.2. ~~Evaluate the need for possible consultation~~Consulting 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.;~~
         ~~1.2.1.2.3.~~1.2.1.1.3. ~~**O** – Observe or use~~ Surveillance ~~to monitor subject or situation,;~~
         ~~1.2.1.2.4.~~1.2.1.1.4. ~~**A** –~~ Area Containment ~~(perimeter, containment),;~~
         1.2.1.1.5. ~~**D** – Disengage with a plan to resolve later,~~ Requesting more resources/summoning reinforcements;
   Delaying arrest
         ~~1.2.1.2.5. 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 of the situation (e.g. name, date of birth, disposition).~~
      ~~1.2.1.3. **M** – More Resources/Summon Reinforcements,~~
         ~~1.2.1.3.1.~~1.2.1.1.6. ~~**A** – Arrest Delayed~~ (get a warrant, or try different time/place~~),~~);
         ~~1.2.1.3.2.~~1.2.1.1.7. ~~**P** – Patience. Use~~Using time, distance, and communication to attempt to de-escalate the ~~subject.~~person; and
         1.2.1.1.8. Disengagement with a plan to resolve later.

   1.3. When taking a person into Peace Officer Custody, members shall transport or facilitate the transport of the ~~individual~~person to the appropriate secure evaluation facility or nearest designated hospital emergency department that conducts mental health evaluations. Refer to Directives ~~6300~~0630.45

Emergency Medical Custody Transports and ~~6300~~0630.50 Emergency Medical Aid for additional information.

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~~before 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~~shall 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~~ambulance personnel or, in those extraordinary circumstances when the officer provides transport, the treating physician at the hospital or Unity Center.

   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~~ambulance personnel or, in those extraordinary circumstances when the officer provides transport, the treating physician at the hospital or Unity Center.

   2.3. The member ~~will~~shall submit a copy of the Report of Peace Officer Custody of an Allegedly Mentally Ill Person, along with ~~an original~~all required police ~~report~~reports 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.

#1

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Sunday, January 16, 2022 2:55:28 PM
Last Modified:	Sunday, January 16, 2022 2:56:02 PM
Time Spent:	00:00:34

Page 1

Q1

Please provide feedback for this directive

- 2.1 and 1.2.2 both seem to apply to similar or the same situations, but define expected behavior differently; one suggests members transport people in custody themselves, another directs members to use AMR.

- 1.2 is potentially awkward in that it says members must take action per 1.2.2 before taking subjects into custody, but completion of 1.2.2 implies the subject is in some sort of custody.

- Section 2 makes explicit reference to AMR, but that is subject to change; maybe it should refer to a Multnomah County licensed ambulance provider?

Q2

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

Name	**Nathan Castle**

#2

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Sunday, January 16, 2022 4:48:12 PM
Last Modified:	Sunday, January 16, 2022 4:48:41 PM
Time Spent:	00:00:28

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 850.21 PEACE OFFICER CUSTODY (CIVIL)

--Memorize in Priority Order: As noted in our introduction to these Directives, "ROADMAP" should be changed PD-MACRO (Section 1.2.1).

--Make Officers Think Through Custodies: A previous clause telling officers to consider the "totality of the circumstances, including.... the governmental interests at stake" when making a non-criminal detention still has not been reinserted. Examples of such interests should also be included.

--Use Appropriate Language Even When the State Does Not: Section 2.1 refers to ORS 426.228, whose title includes the phrase "An Allegedly Mentally Ill Person." Enlightened language use refers to persons with mental illness rather than making the adjective part of who they are; we don't say "a Cancerous person." So even if quoting the state statute, the PPB should either correct the language in brackets or explain the appropriate use in a separate sentence.

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**

#1

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Friday, July 15, 2022 8:26:40 AM
Last Modified:	Friday, July 15, 2022 8:27:26 AM
Time Spent:	00:00:46

Page 1

Q1

Please provide feedback for this directive

The directive includes several changes where the verb ‘will’ is swapped out for ‘shall.’ The word ‘shall’ is intended to communicate a stronger requirement, but it’s probably not going to make a difference to most readers. It’s also not a change that matches good governance practices; the U.S. federal government suggests avoiding using “shall” in legislative, policy, and legal writing, because it’s been so corrupted by misuse. Instead, using the word “must” is recommended to communicate a specific duty or requirement. https://www.plainlanguage.gov/guidelines/conversational/shall-and-must/

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:	Friday, July 15, 2022 3:22:55 PM
Last Modified:	Friday, July 15, 2022 3:23:34 PM
Time Spent:	00:00:39

Page 1

Q1

Please provide feedback for this directive

COMMENTS on Vehicle Pursuit, Mental Health and Procedural Justice Directives, July 2022

COMMENTS ON VEHICLE PURSUIT, MENTAL HEALTH AND PROCEDURAL JUSTICE DIRECTIVES, JULY 2022

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

Below are our comments on the Directives posted for review on in July . With the exception of the Vehicle Interventions and Pursuits policy, which was last posted in 2018, these are all "Second Universal Reviews" which we commented on earlier this year.

We have asked that the Bureau release, during the First Universal Review, a list of known issues that are going to be addressed in the revisions. This would both alert community members to the appropriate parts of the Directives and make it so that Portland Copwatch can't claim victory when the Bureau was already planning to make changes we suggest. So it's a win-win.

While some of our previous suggestions have been incorporated, they were not necessarily made in ways that improve the policies, and are few in number.

It would greatly help the navigation of the hundreds of policies if the Bureau would give different labels to all of the sections of the Directives, such as the Definitions, Policy and Procedure sections so there are not multiple sections numbered "1." Our comments here refer to the Procedure section unless otherwise noted.

_____MENTAL HEALTH DIRECTIVES (last commented on January 2022)_____

We begin again with general comments we made about the Directives about Mental Health (850.20, 850.21, 850.22 and 850.25), repeated or updated from previous comments:

--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).

--Prioritize Responses: It looks as if the Bureau has given up on its mnemonic for officers on responses to mental health crisis, formerly "ROADMAP." The list of possible responses is no longer summarized this way, but has been changed without adequate consideration of what should be the priorities among what has gone from seven to eight items listed. The items are:

#1- Request Specialty Units (formerly #1, Portland Copwatch suggested as #6 of 7).
#2- Consult a Mental Health Provider (new item)
#3- Observation / surveillance (formerly #2, PCW suggested #7 of 7)
#4- Area containment (formerly #3, PCW suggested #5 of 7)
#5- Request resources (formerly #5, PCW suggested #3 of 7)
#6- Delay arrest (formerly #7, PCW suggested as #4 of 7)
#7- Patience / de-escalation (formerly #7, PCW suggested as #1 of 7)
#8- Disengagement (formerly #4, PCW suggested as #2 of 7).

Technically how the revised list is written, the acronym would be "RCARDUD" which is not easy to recall. But clever ways to

remember things isn't as important as the underlying policy, which in this case seems to continue pushing de-escalation and disengagement toward the bottom of the list rather than the top. We urge the PPB to publish the list in a way that makes officers think first about calming things down before calling in backup.

To be clear, after reviewing the full list, PCW now suggests this order: Patience/de-escalation, Disengagement, Consult a Mental Health Provider, Request Resources, Delay Arrest, Observation/surveillance, Area containment, Request Specialty Units.

--Prevent Revisions, Be Clear, Use Generic Terms: PCW continues to suggest that the PPB not refer to AMR, the private company which contracts for ambulance services in the County, in its policies. Using a generic term about ambulances would be better, especially if the Fire Bureau or other agency might transport the individuals, or if AMR changes its name. As previously noted, the Bureau has already changed references to the Unity Center with the generic term "secure evaluation facility."

--De-escalation Double Definition: Despite some progress in another Directive, the PPB continues to define "de-escalation" as both trying to avoid the use of force (agreed) _and_ lowering the amount of force already being used on a suspect (which is mitigation of force, called "Reactive De-escalation" in the proposed revised 1010.00).

--Definition Returns: The PPB has put the Definition for "disengagement" back into Directives 850.20 and 850.21; PCW appreciates this responsiveness to our suggestion.

Here are comments on the four individual policies, also updated from previous input.

DIRECTIVE 850.21 PEACE OFFICER CUSTODY (CIVIL)

--Give Examples of What's at Stake: A previous clause telling officers to consider the "totality of the circumstances, including.... the governmental interests at stake" when making a non-criminal detention still has not been reinserted. Examples of such interests should also be included.

--Don't Let State Language Go Without Commentary: Section 2.1 refers to ORS 426.228, whose title includes the phrase "An Allegedly Mentally Ill Person." PCW suggests that the Bureau make it clear they are not using the problematic phrasing of "mentally ill person" rather than "person with mental illness." PPB should use a bracketed comment to explain the language is from the State, by offering alternative language or simply saying "[sic]."

CONCLUSION

Chief Lovell made a comment at a meeting recently about how public comments have been incorporated to improve PPB policies. While it is nice to be acknowledged, the reality is that the Bureau has either ignored or mis-applied the vast majority of comments Portland Copwatch has made over the years. We continue to believe that direct dialogue about the changes during public meetings would lead to an improved process, improved outcomes, and improved trust. The PPB could better understand community members' concerns and explain its rationale for why things are written in a certain way. Given the requirement for advisory bodies such as the Citizen Review Committee, Portland Committee on Community Engaged Policing and Training Advisory Council to make policy recommendations, holding these meetings in conjunction with those groups would make sense. Extending the deadlines to comment would also allow those groups, which only meet once every month or two, time to formulate meaningful feedback.

Finally, we once again call attention to the fact that a higher percentage of people in mental health crisis have been shot/shot at/killed by Portland Police officers since the implementation of the US Department of Justice Settlement Agreement. So while the policies focusing on this vulnerable part of the population are improving, they are still not fixing an underlying issue where force is relied on too heavily.

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

Q2

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

Name	**Portland Copwatch**

0850.22 Police Response to Mental Health Director Holds and Elopement

Refer:

- ORS § 426.005, Definitions for ORS § 426.005 to 426.390 – Persons with Mental Illness
- ORS § 426.070, Initiation
- ORS § 426.223, Retaking persons in custody of or committed to Oregon Health Authority
- DIR 0850.20 Police Response to Mental Health Crisis
- DIR 0850.21 Peace Officer Custody (Civil)
- DIR 0850.25 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 Behavioral Health Division 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 Bureau's Behavioral Health Unit (BHU).

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

- 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 Bureau. Members shall treat the person 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 determine if taking civil custody of the person named on the Director's Custody Report may be achieved in a safe manner.

1.1.2.1. If members disengage, they shall notify a supervisor and then develop a plan to determine a safer time and method to take the person into civil custody. All appropriate police reports 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 ambulance 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 mask 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 act in accordance with Directive 0850.20, Police Response to Mental Health Crisis and/or Directive 0850.21, 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. If members disengage, they 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 0850.21, Peace Officer Custody (Civil).

1.2.3.4. Complete the appropriate police report and mental health mask 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 0850.20, Police Response to Mental Health Crisis and/or Directive 0850.21, 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."

2.1.3. Members who encounter a person who is subject to a PSRB Revocation Order shall:

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

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

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

2.1.3.4. 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.

2.1.4. If a member needs additional verification of a PSRB Revocation Order, the member may contact the PSRB Executive Director. The phone number can be found in the PSRB LEDS message.

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. If members disengage, they 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 0850.21, 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 mask 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.

Established: 05/02/2017

Revised: 2017, 2018, 2020, 2022

Effective: 11/15/2022

Next Review: 11/15/2023

0850.22 Police Response to Mental Health Director Holds and Elopement

Refer:

- ORS § 426.005, Definitions for ORS § 426.005 to 426.390 – Persons with Mental Illness
- ORS § 426.070, Initiation
- ORS § 426.223, Retaking persons in custody of or committed to Oregon Health Authority
- DIR ~~850~~0850.20 Police Response to Mental Health Crisis
- DIR ~~850~~0850.21 Peace Officer Custody (Civil)
- DIR ~~850~~0850.25 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~~Behavioral Health ~~and Addiction Services~~Division 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).

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

- 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~~person 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. 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~~

1.1.2.1. If members disengage, they shall notify a supervisor and then develop a plan to determine a safer time and method to take the person into civil custody. ~~An~~All appropriate police ~~report~~reports 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~~ambulance 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 mask 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~~act in accordance with Directive ~~850~~0850.20, Police Response to Mental Health Crisis and/or Directive ~~850~~0850.21, 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~~If members

disengage, they 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 ~~8500~~0850.21, Peace Officer Custody (Civil).

1.2.3.4. Complete the appropriate police report and mental health mask 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 ~~8500~~0850.20, Police Response to Mental Health Crisis and/or Directive ~~8500~~0850.21, 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."

2.1.3. Members who encounter a person who is subject to a PSRB Revocation Order shall ~~then~~:

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

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

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

~~2.1.4.1.1.1.~~ ~~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.~~

~~2.1.4.1.~~2.1.3.4. 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.

2.1.4. If a member needs additional verification of a PSRB Revocation Order, the member may contact the PSRB Executive Director. The phone number can be found in the PSRB LEDS message.

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~~ If members disengage, they 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 ~~8500~~0850.21, 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 mask 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.

#1

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Sunday, January 16, 2022 2:36:18 PM
Last Modified: Sunday, January 16, 2022 2:36:47 PM
Time Spent: 00:00:29

Page 1

Q1

Please provide feedback for this directive

- 1.1.2.2 Explicitly mentions AMR. Consider making this less specific to mention the county's contracted ambulance service provider, or whatever definition makes sense. AMR is currently contracted, but that is subject to change in the future; as recently as 2013 there has been chatter about having PF&R take over ambulance services.

- 1.1.2.3 - what is a mental health mask?

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 4:47:25 PM
Last Modified:	Sunday, January 16, 2022 4:47:55 PM
Time Spent:	00:00:30

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 850.22 POLICE RESPONSE TO MENTAL HEALTH DIRECTOR HOLDS AND ELOPEMENT

--Delayed Definition: As with Directive 850.21 (Civil Holds), the definition of "delayed custody" was cut. However, it is still used here in Sections 1.1.2.1 and 1.2.3.2.

--Cover Your Actions: A Section from a previous version requiring 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.

--Set Firm Deadline: 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.

--Use Appropriate Language: We continue to express 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." A less broad term should be substituted. If NMI is a legal term, the Bureau should propose that the legislature change it.

--Free to Go in Other Circumstances: The Directive states a person voluntarily at a medical facility who elopes is "free to leave" (1.3.1)-- an idea we keep suggesting the PPB should include in other policies to ensure community members know when they are being detained or not.

--Add Direct Reference: 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."

--Share Template Publicly: A blank copy of the "mental health text template" referred to in 2.2.1.4 should be available to the public for transparency's sake.

--When Are Reports Required?: Section 1.1.2.3 instructs officers to fill out reports "when necessary" but doesn't define what that means.

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

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Monday, January 17, 2022 6:10:00 PM
Last Modified:	Monday, January 17, 2022 6:13:19 PM
Time Spent:	00:03:19

Page 1

Q1

Please provide feedback for this directive

3.1.1. can you define LEDS in definitions or spell it out?
1.1.2.3 What is a mental health mask? Never heard of it.
When police officer transports, is the person handcuffed?

Q2

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

Name	**Tia Palafox**

#1

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Friday, July 15, 2022 3:23:47 PM
Last Modified:	Friday, July 15, 2022 3:24:17 PM
Time Spent:	00:00:29

Page 1

Q1

Please provide feedback for this directive

COMMENTS on Vehicle Pursuit, Mental Health and Procedural Justice Directives, July 2022

COMMENTS ON VEHICLE PURSUIT, MENTAL HEALTH AND PROCEDURAL JUSTICE DIRECTIVES, JULY 2022

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

Below are our comments on the Directives posted for review on in July . With the exception of the Vehicle Interventions and Pursuits policy, which was last posted in 2018, these are all "Second Universal Reviews" which we commented on earlier this year.

We have asked that the Bureau release, during the First Universal Review, a list of known issues that are going to be addressed in the revisions. This would both alert community members to the appropriate parts of the Directives and make it so that Portland Copwatch can't claim victory when the Bureau was already planning to make changes we suggest. So it's a win-win.

While some of our previous suggestions have been incorporated, they were not necessarily made in ways that improve the policies, and are few in number.

It would greatly help the navigation of the hundreds of policies if the Bureau would give different labels to all of the sections of the Directives, such as the Definitions, Policy and Procedure sections so there are not multiple sections numbered "1." Our comments here refer to the Procedure section unless otherwise noted.

_____MENTAL HEALTH DIRECTIVES (last commented on January 2022)_____

We begin again with general comments we made about the Directives about Mental Health (850.20, 850.21, 850.22 and 850.25), repeated or updated from previous comments:

--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).

--Prioritize Responses: It looks as if the Bureau has given up on its mnemonic for officers on responses to mental health crisis, formerly "ROADMAP." The list of possible responses is no longer summarized this way, but has been changed without adequate consideration of what should be the priorities among what has gone from seven to eight items listed. The items are:

#1- Request Specialty Units (formerly #1, Portland Copwatch suggested as #6 of 7).
#2- Consult a Mental Health Provider (new item)
#3- Observation / surveillance (formerly #2, PCW suggested #7 of 7)
#4- Area containment (formerly #3, PCW suggested #5 of 7)
#5- Request resources (formerly #5, PCW suggested #3 of 7)
#6- Delay arrest (formerly #7, PCW suggested as #4 of 7)
#7- Patience / de-escalation (formerly #7, PCW suggested as #1 of 7)
#8- Disengagement (formerly #4, PCW suggested as #2 of 7).

Technically how the revised list is written, the acronym would be "RCARDUD" which is not easy to recall. But clever ways to

remember things isn't as important as the underlying policy, which in this case seems to continue pushing de-escalation and disengagement toward the bottom of the list rather than the top. We urge the PPB to publish the list in a way that makes officers think first about calming things down before calling in backup.

To be clear, after reviewing the full list, PCW now suggests this order: Patience/de-escalation, Disengagement, Consult a Mental Health Provider, Request Resources, Delay Arrest, Observation/surveillance, Area containment, Request Specialty Units.

--Prevent Revisions, Be Clear, Use Generic Terms: PCW continues to suggest that the PPB not refer to AMR, the private company which contracts for ambulance services in the County, in its policies. Using a generic term about ambulances would be better, especially if the Fire Bureau or other agency might transport the individuals, or if AMR changes its name. As previously noted, the Bureau has already changed references to the Unity Center with the generic term "secure evaluation facility."

--De-escalation Double Definition: Despite some progress in another Directive, the PPB continues to define "de-escalation" as both trying to avoid the use of force (agreed) _and_ lowering the amount of force already being used on a suspect (which is mitigation of force, called "Reactive De-escalation" in the proposed revised 1010.00).

--Definition Returns: The PPB has put the Definition for "disengagement" back into Directives 850.20 and 850.21; PCW appreciates this responsiveness to our suggestion.

Here are comments on the four individual policies, also updated from previous input.

DIRECTIVE 850.22 POLICE RESPONSE TO MENTAL HEALTH DIRECTOR HOLDS AND ELOPEMENT

--Mostly Good Change: The term "Delayed custody" has been replaced with "disengaging" in Section 1.1.2.1 and 1.2.3.2. This is a positive development, but would be made stronger by adding the Definition for disengagement back into the Directive.

--The PPB Has Enough Problems Already: A Section from a previous version requiring 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.

--Inconsistent Reporting Deadline: 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.

--Language from Elsewhere: We continue to express 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 negative labeling process. A more precise term should be substituted. If NMI is a legal term, the Bureau should make that clear in the Directive and propose that the legislature change it.

--Ongoing Suggestion on Community Relations: As PCW noted previously, the Directive states a person voluntarily at a medical facility who elopes is "free to leave" (1.3.1). The PPB should include the concept of being "free to leave" in other policies to ensure community members know whether or not they are being detained.

--Add Reference for Clarity: 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." Directives 850.20 and 850.21 are referenced several times in this policy.

--Share Information Publicly: A blank copy of the "mental health text template" referred to in 2.2.1.4 should be made available to the public for transparency's sake.

--When Are Reports Required?: Section 1.1.2.3 instructs officers to fill out reports "when necessary" but doesn't define what that means.

CONCLUSION

Chief Lovell made a comment at a meeting recently about how public comments have been incorporated to improve PPB policies. While it is nice to be acknowledged, the reality is that the Bureau has either ignored or mis-applied the vast majority of comments Portland Copwatch has made over the years. We continue to believe that direct dialogue about the changes during public meetings would lead to an improved process, improved outcomes, and improved trust. The PPB could better understand community members' concerns and explain its rationale for why things are written in a certain way. Given the requirement for advisory bodies such as the Citizen Review Committee, Portland Committee on Community Engaged Policing and Training Advisory Council to make policy recommendations, holding these meetings in conjunction with those groups would make sense. Extending the deadlines to comment would also allow those groups, which only meet once every month or two, time to formulate meaningful feedback.

Finally, we once again call attention to the fact that a higher percentage of people in mental health crisis have been shot/shot at/killed by Portland Police officers since the implementation of the US Department of Justice Settlement Agreement. So while the policies focusing on this vulnerable part of the population are improving, they are still not fixing an underlying issue where force is relied on too heavily.

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

Q2

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

Name	**Portland Copwatch**

0850.25 Police Response to Mental Health Facilities

Refer:
- ORS § 426.005, Definitions for ORS § 426.005 to 426.390
- DIR 0850.20 Police Response to Mental Health Crisis – Persons with Mental Illness
- DIR 0850.21 Peace Officer Custody (Civil)
- DIR 0850.22 Police Response to Mental Health Directors 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 Behavioral Health Division 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 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 Behavioral Health Call Center. 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. However, 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 0850.22, Police Response to Mental Health Directors Holds and Elopement.

2. Members shall treat these persons 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 the strategies and resources listed in Directive 0850.20, Police Response to Mental Health Crisis, the following are other strategies for members and their supervisors to consider before entry into a designated residential mental health facility:

1.4.1. Evaluate 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 BHU 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 BHU shall meet with facility management representatives to review the representatives' expectations of police assistance in emergencies and facility emergency policies for addressing concerning incidents.

Established: 06/07/2006

Revised: 2014, 2016, 2018, 2020, 2022

Effective: 11/15/2022

Next Review: 11/15/2023

0850.25 Police Response to Mental Health Facilities

Refer:

- ORS § 426.005, Definitions for ORS § 426.005 to 426.390
- DIR ~~850~~0850.20 Police Response to Mental Health Crisis – Persons with Mental Illness
- DIR ~~850~~0850.21 Peace Officer Custody (Civil)
- DIR ~~850~~0850.22 Police Response to Mental Health Directors 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~~Behavioral Health ~~and Addiction Services~~Division 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.~~Behavioral Health Call Center. 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. However, 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~~0850.22, Police Response to Mental Health Directors Holds and Elopement.

2. Members shall treat these ~~individuals~~persons 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~~the strategies and resources listed in Directive ~~850~~0850.20, Police Response to Mental Health Crisis, the following are other ~~tactical options~~strategies 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~~BHU 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~~BHU shall meet with facility management representatives to review the representatives' expectations of police assistance in emergencies and facility emergency policies for addressing concerning incidents.

#1

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Sunday, January 16, 2022 1:47:54 PM
Last Modified: Sunday, January 16, 2022 1:49:01 PM
Time Spent: 00:01:07

Page 1

Q1

Please provide feedback for this directive

The policy section states expectations for mental health care homes. This is fine, but PPB directives don't seem like the right place to have that kind of policy. The City should consider updating city code to define standards for mental health care facilities, including guidelines for security personnel. I don't see any reason why a mental health care facility wouldn't rely on PPB for type 1-3 calls, and there is no mechanism to penalize institutions that are negligent in behavior management. Perhaps PPB should charge a fee for response to designated mental health facilities, similar to how fees are assessed for false alarms.

Q2

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

Name **Nathan Castle**

#2

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Sunday, January 16, 2022 4:46:28 PM
Last Modified:	Sunday, January 16, 2022 4:47:06 PM
Time Spent:	00:00:37

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 850.25 POLICE RESPONSE TO MENTAL HEALTH FACILITIES

--Appreciated Change (850.25): After we pointed it out multiple times, the Bureau finally fixed a typo that said "treat these individual" rather than "individuals." Thanks.

--Don't Bring a Gun to a Pillow Fight: Our analysis from earlier comments 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." 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 understand that despite hospital protocols, Portland Police do not check their firearms into lockers when entering the Unity Center.

--Require ECIT Response in "Lower Priority Calls": Sections 1.1 and 1.3 still require the presence of Enhanced Crisis Intervention Team officers in emergency situations, but Section 1.2 on "lower priority calls" continues to downplay the role of these specially trained officers, saying a supervisor "may" call ECIT.

--Be Clear About Contact with People: 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 a pre-2015 Section on tactical options. We added that contacting a person in crisis should not include the alleged look in the eye that Officer Kelly Van Blokland gave to Samuel Rice through a hotel's bathroom window before shooting Rice in the head with an assault rifle in 2018.

--Spell Out Options, Memorize in Priority Order: 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.

--What is "Concerning"?: Section 2.1.3 suggests officers should work with facilities about "addressing concerning incidents." While it is best not to stigmatize some people based on behavior, specific examples might be helpful to narrow down what is meant by "concerning." PCW's suggestion: "addressing concerning incidents such as persons who are physically combative."

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

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Monday, January 17, 2022 5:27:26 PM
Last Modified: Monday, January 17, 2022 5:29:27 PM
Time Spent: 00:02:01

Page 1

Q1

Please provide feedback for this directive

I appreciate the planning used & the emphasis on respecting people with a mental illness or in a mental health crisis.

Q2

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

Name	**Tia Palafox**

#1

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Friday, July 15, 2022 3:24:33 PM
Last Modified:	Friday, July 15, 2022 3:25:09 PM
Time Spent:	00:00:36

Page 1

Q1

Please provide feedback for this directive

COMMENTS on Vehicle Pursuit, Mental Health and Procedural Justice Directives, July 2022

COMMENTS ON VEHICLE PURSUIT, MENTAL HEALTH AND PROCEDURAL JUSTICE DIRECTIVES, JULY 2022

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

Below are our comments on the Directives posted for review on in July . With the exception of the Vehicle Interventions and Pursuits policy, which was last posted in 2018, these are all "Second Universal Reviews" which we commented on earlier this year.

We have asked that the Bureau release, during the First Universal Review, a list of known issues that are going to be addressed in the revisions. This would both alert community members to the appropriate parts of the Directives and make it so that Portland Copwatch can't claim victory when the Bureau was already planning to make changes we suggest. So it's a win-win.

While some of our previous suggestions have been incorporated, they were not necessarily made in ways that improve the policies, and are few in number.

It would greatly help the navigation of the hundreds of policies if the Bureau would give different labels to all of the sections of the Directives, such as the Definitions, Policy and Procedure sections so there are not multiple sections numbered "1." Our comments here refer to the Procedure section unless otherwise noted.

_____MENTAL HEALTH DIRECTIVES (last commented on January 2022)_____

We begin again with general comments we made about the Directives about Mental Health (850.20, 850.21, 850.22 and 850.25), repeated or updated from previous comments:

--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).

--Prioritize Responses: It looks as if the Bureau has given up on its mnemonic for officers on responses to mental health crisis, formerly "ROADMAP." The list of possible responses is no longer summarized this way, but has been changed without adequate consideration of what should be the priorities among what has gone from seven to eight items listed. The items are:

#1- Request Specialty Units (formerly #1, Portland Copwatch suggested as #6 of 7).
#2- Consult a Mental Health Provider (new item)
#3- Observation / surveillance (formerly #2, PCW suggested #7 of 7)
#4- Area containment (formerly #3, PCW suggested #5 of 7)
#5- Request resources (formerly #5, PCW suggested #3 of 7)
#6- Delay arrest (formerly #7, PCW suggested as #4 of 7)
#7- Patience / de-escalation (formerly #7, PCW suggested as #1 of 7)
#8- Disengagement (formerly #4, PCW suggested as #2 of 7).

Technically how the revised list is written, the acronym would be "RCARDUD" which is not easy to recall. But clever ways to

remember things isn't as important as the underlying policy, which in this case seems to continue pushing de-escalation and disengagement toward the bottom of the list rather than the top. We urge the PPB to publish the list in a way that makes officers think first about calming things down before calling in backup.

To be clear, after reviewing the full list, PCW now suggests this order: Patience/de-escalation, Disengagement, Consult a Mental Health Provider, Request Resources, Delay Arrest, Observation/surveillance, Area containment, Request Specialty Units.

--Prevent Revisions, Be Clear, Use Generic Terms: PCW continues to suggest that the PPB not refer to AMR, the private company which contracts for ambulance services in the County, in its policies. Using a generic term about ambulances would be better, especially if the Fire Bureau or other agency might transport the individuals, or if AMR changes its name. As previously noted, the Bureau has already changed references to the Unity Center with the generic term "secure evaluation facility."

--De-escalation Double Definition: Despite some progress in another Directive, the PPB continues to define "de-escalation" as both trying to avoid the use of force (agreed) _and_ lowering the amount of force already being used on a suspect (which is mitigation of force, called "Reactive De-escalation" in the proposed revised 1010.00).

--Definition Returns: The PPB has put the Definition for "disengagement" back into Directives 850.20 and 850.21; PCW appreciates this responsiveness to our suggestion.

Here are comments on the four individual policies, also updated from previous input.

DIRECTIVE 850.25 POLICE RESPONSE TO MENTAL HEALTH FACILITIES

--Reference Fixed: We previously noted the summary title for "Definitions for ORS 426.005 to 426.390" in the Refer section was in the wrong place; thank you for fixing this error.

--People in Mental Health Hospitals Aren't Armed: Our analysis from earlier comments 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." 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 understand that despite hospital protocols, Portland Police do not check their firearms into lockers when entering the Unity Center.

--Encourage More ECIT Response to "Lower Priority Calls": Sections 1.1 and 1.3 still require the presence of Enhanced Crisis Intervention Team officers in emergency situations, but Section 1.2 on "lower priority calls" continues to downplay the role of these specially trained officers, saying a supervisor "may" call ECIT. The special expertise should be emphasized.

--Contact Decisions Should Consider De-Escalation: Section 1.4.4 directs officers to decide whether to contact the person in crisis by phone, in person or by "other means." A previous suggestion that officers use the phone to determine the "severity of the threat" was removed from a pre-2015 Section on tactical options. Whatever choice is made should be geared to de-escalate the situation. Contacting a person in crisis should not include the alleged look in the eye that Officer Kelly Van Blokland gave to Samuel Rice through a hotel's bathroom window before shooting Rice in the head with an assault rifle in 2018.

--Spell Out Options: While the reference to the old "ROADMAP" mnemonic for tactics was removed in this Directive, the options which are now listed in 850.20 and 850.21 should be listed here, at least briefly, for clarity.

--What is "Concerning"?: Section 2.1.3 suggests officers should work with facilities about "addressing concerning incidents." While it is best not to stigmatize some people based on behavior, specific examples might be helpful to narrow down what is meant by "concerning." PCW's suggestion: "addressing concerning incidents such as persons who are physically combative."

CONCLUSION

Chief Lovell made a comment at a meeting recently about how public comments have been incorporated to improve PPB policies. While it is nice to be acknowledged, the reality is that the Bureau has either ignored or mis-applied the vast majority of comments Portland Copwatch has made over the years. We continue to believe that direct dialogue about the changes during public meetings would lead to an improved process, improved outcomes, and improved trust. The PPB could better understand community members' concerns and explain its rationale for why things are written in a certain way. Given the requirement for advisory bodies such as the Citizen Review Committee, Portland Committee on Community Engaged Policing and Training Advisory Council to make policy recommendations, holding these meetings in conjunction with those groups would make sense. Extending the deadlines to comment would also allow those groups, which only meet once every month or two, time to formulate meaningful feedback.

Finally, we once again call attention to the fact that a higher percentage of people in mental health crisis have been shot/shot at/killed by Portland Police officers since the implementation of the US Department of Justice Settlement Agreement. So while the policies focusing on this vulnerable part of the population are improving, they are still not fixing an underlying issue where force is relied on too heavily.

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

Q2

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

Name	**Portland Copwatch**