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

Introduction

Directives 850.20, Police Response to Mental Health Crisis; 850.21, Peace Officer Custody (Civil); 850.22, Police Response to Mental Health Director Holds and Elopement; and 850.25, Police Response to Mental Health Facilities ("mental health series"), form the core of the Portland Police Bureau's practices around responding to calls that involve an individual experiencing a mental health crisis. The Bureau continues to work closely with the Department of Justice (DOJ) and the Compliance Officer/Community Liaison (COCL) to review all DOJ-identified policies, such as the mental health series, which must comport with the terms of the DOJ settlement agreement.

Review Timeline

The DOJ originally approved the mental health series in 2016, making this the third annual review of the directives, following an initial six-month review after first implementing the revised policies in 2016. The Bureau initiated this review in late 2019, one year after enacting the revised policy; however, several unforeseen circumstances delayed the timely completion of the review process.

Public Comments

The Bureau received limited feedback on the series during both universal review and public comment periods. The comments and recommendations primarily focused on policy definitions and reporting requirements.

Definitions

The Bureau received a recommendation that it revise the definition of "mental health crisis" to provide clearer and expanded guidance around factors and indicators that suggest that an individual may be experiencing a mental health crisis. The Bureau adopted the term and definition from the DOJ settlement agreement to ensure compliance and consistency with the agreement. While the Bureau endeavors to provide clear and tailored guidance through its policies, Bureau directives form one of several pillars that guide and inform members' practices. Policies serve as the foundation of training, but the Training Division also builds upon policy to provide pointed instruction to members. Although the mental health crisis definition includes a finite list of parenthetical examples, members receive ongoing robust training, in this regard, to enhance their understanding of a range of potential indicators.

The commenter also encouraged the Bureau to revise the definition of "de-escalation" to shift the emphasis from force. The Bureau, with the advice and approval of the DOJ and COCL, modified the de-escalation definition during its last review of Directive 1010.00, Use of Force. The addition of the word "prevent" captures the non-force related techniques (e.g., verbal skills and engagement, repositioning, etc.) that a member may employ to avoid using force. Overlapping policies, as well as Training Division instruction, provide additional context and supplemental guidance to members, particularly with regard to as expansive and integral of a concept as de-escalation.

Mental Health Indicator Documentation and General Reporting Requirements
A commenter inquired about the source of the mental health indicator question referenced in Directive 850.20, noting that the policy does not directly address where members document that information. Additionally, the commenter sought clarification regarding the report-writing requirement in Directive 850.22 for calls involving civil custody requests.

When a member complete a call, they are required to answer the mental health indicator question in the computer aided dispatch (CAD) system. Any additional reporting requirements are contingent upon the action the member took during the call. Members who take any police action (i.e., exercise or attempt to exercise police authority) are required to complete and submit a report to document the incident, pursuant to Directive 900.00, General Reporting Guidelines. The nature of the member's action determines the report type (e.g., general offense report, force report, etc.). Members receive detailed instruction on report-writing requirements in training.

<u>The Bureau's Revised Policies</u>
The Bureau made minor revisions to Directives 850.20, Police Response to Mental Health Crisis; 850.21, Peace Officer Custody (Civil); 850.22, Police Response to Mental Health Director Holds; and Elopement and 850.25, Police Response to Mental Health Facilities. The Policy Development Team worked closely with the Bureau's mental health experts, the DOJ, and the COCL to ensure the policies continue to align with best practice standards and provide clear guidance to members. The workgroup identified only a few areas across all four policies that necessitated changes, most significantly, revising the de-escalation definition for consistency with other directives and incorporating language to draw a clear distinction between a mental illness and other conditions or circumstances.

The Bureau welcomes further feedback on these policies during the next review period.

The directives go into effect on 12/18/20.

Published on 11/18/20.

850.20 Police Response to Mental Health Crisis

Refer*:*

- ORS § 161.375(4), Authority of Psychiatric Security Review Board to issue warrant of arrest
- ORS § 426.223, Authority of facility director or designee to require assistance of a peace officer to retake custody of committed person who has left a facility without lawful authority
- ORS § 426.005, Definitions for ORS § 426.005 to 426.390 – Persons with Mental Illness
- ORS § 426.228, Authority of peace officer to take a person into custody for mental health treatment
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- ORS § 430.735-765, Duty of government officials (incl. Peace Officers) to report abuse of persons with mental illness or developmental disabilities
- DIR 630.45, Emergency Medical Custody Transports
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- DIR 850.25, Police Response to Mental Health Facilities
- DIR 850.39, Missing, Runaway, Lost or Disoriented Persons
- DIR 850.10 Custody, Civil Holds
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- 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 resolve the confrontation.

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

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

- Mental Health Crisis: An incident in which someone with an actual or perceived mental illness experiences intense feelings of personal distress (e.g. anxiety, depression, anger, fear, panic, hopelessness), a thought disorder (e.g. visual or auditory hallucinations, delusions, sensory impairment or cognitive impairment), obvious changes in functioning (e.g. neglect of personal hygiene) and/or catastrophic life events (e.g. disruptions in personal relationships, support systems or living arrangements; loss of autonomy or parental rights; victimization or natural disasters), which may, but not necessarily, result in an upward trajectory of intensity culminating in thoughts or acts that are dangerous to self and/or others.

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

About Mental Health:

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

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

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

4. Mental illness is distinct from 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 with mental illness who present in crisis or with immediate needs. The Portland Police Bureau is committed to

serving individuals in mental health crisis in partnership with mental health providers, the justice system, emergency medical services, and community members. When appropriate, referral to community-based treatment services is a preferred alternative to arrest and incarceration of persons who are in mental health crisis.

2. The Portland Police Bureau recognizes that members will have contact with residents who experience mental illness but are not in crisis. Many members of the Portland Police Bureau will come to be familiar with individuals in the community who members know to have a mental illness. The Police Bureau provides training so that members may recognize signs and symptoms of mental illness in the absence of crisis, and expects members to engage these individuals with dignity and respect, using the skills they have learned in their crisis training. It is the Police Bureau's intention that members give special consideration to these situations, recognizing that using crisis intervention skills with all individuals experiencing mental illness will support the Bureau's goal of safely resolving situations, providing excellent service and building respectful relationships with mental health peers, family members, providers and other involved City of Portland residents.

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

Procedure:

1. Member Expectation and Training:
   - 1.1. When members recognize that a person whom they are contacting has signs and symptoms indicative of a mental illness, members are expected to use their training to attempt engagement without escalating the situation. When responding to incidents involving persons who are experiencing a mental health crisis, members are also expected to manage the scene and develop a reasonable disposition plan.
   - 1.2. All members on a call shall answer the mental health indicator question. Members shall document the incident on an appropriate police report, complete all reporting requirements for a mental health crisis response, and submit the information to a supervisor before the end of shift.

   - 1.3. Mental Health Response Training:
     - 1.3.1. All new sworn members will receive Mental Health Response training.
     - 1.3.2. All existing sworn members will receive Mental Health Response refresher training during annual, in-service training.
     - 1.3.3. The Bureau provides training so that members may recognize signs and symptoms of mental illness and develop skills to engage individuals experiencing mental illness with dignity and respect.
2. Responding to and managing scenes involving persons in mental health crisis:
   - 2.1. When responding to incidents involving persons displaying behavior indicative of mental health crisis members will consider the following actions to manage the incident for the safety of all at the scene:

2.1.1. Evaluate the nature of the incident and necessity for police intervention when feasible, based on information known to the member at the time (e.g. reports, known history, observed behavior, etc.).

2.1.2. If the member decides to intervene, consider, when feasible, the use of verbal and non-verbal communication skills to engage a person who may be agitated, upset or at risk of becoming emotionally unstable in order to calmly and safely resolve the situation.

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

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

2.1.3.1.1. Evaluate the need for assistance from individuals with additional training in working with mental health crisis situations (e.g. Enhanced Crisis Intervention Team (ECIT) members, Project Respond, Crisis Negotiation Team (CNT)). When a member determines that ECIT assistance is needed, they shall make the request through the Bureau of Emergency Communications (BOEC).

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

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

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

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

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

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

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

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

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

3. Disposition:
   3.1. In determining a non-criminal resolution for a person with a mental illness or in mental health crisis, members will consider the totality of the circumstances, including the behavior of the person and the governmental interests at stake. Following is a list of non-criminal dispositions that may be appropriate at the scene, among others:
      3.1.1. Refer the involved person to a mental health provider; see the Behavioral Health Unit's Community Mental Health Resources, for referral information.
      3.1.2. Request AMR transport for the involved person to a mental health or medical facility for voluntary care. Members should inform AMR personnel of the situation so AMR can pass the information along to staff at the facility upon arrival. Members may meet up with AMR at the facility and may escort the person into the waiting area, introduce them to facility staff, and share with staff a brief verbal report on the facts of the case. Members are not required to standby.
      3.1.3. Take the involved person into custody and arrange for AMR transport to a medical facility in accordance with Directive 850.21, Peace Officer Custody (Civil), or Directive 850.22, Police Response to Mental Health Directors Holds and Elopement.

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

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

4. Enhanced Crisis Intervention Team (ECIT) Member Responsibilities:
   4.1. ECIT members will respond as the primary member on a mental health crisis call when dispatched or at the request of any member.

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

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

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

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

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

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

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

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

#1

COMPLETE

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Q1 Please provide feedback for this directive

COMMENTS on Employment, Mental Health and Training Directives, January 2020

To Chief Resch, Capt. Parman, Lieutenant Morgan, PPB Policy Analysts, Compliance Officer/Community Liaison Team, Community Oversight Advisory Board staff, US Dept. of Justice, Citizen Review Committee and the Portland Police Bureau:

Below are our comments on the various Directives posted for review in January at). Portland Copwatch (PCW) continues to have concerns about the 15-day response period for these reviews, particularly since the Training Advisory Council (TAC), which only meets once every two months, met 7 days before the release of the Training Directive. They will miss the chance to comment on what we believe is the only Directive mentioning the TAC. With the exception of the "Extra Employment" Directive (210.80), all of these policies have been posted previously and we are repeating many of our past comments here.

Along those lines, we continue to urge the Bureau to add letters to each major section (Refer, Definitions, Policy, Procedure) and to number the definitions for easy reference.

----------MENTAL HEALTH DIRECTIVES----------

General comments we made in May 2018 when these Directives about Mental Health (850,20, 850.21, 850.22 and 850.25) were last posted include:

--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" (820.25). Incidentally, 850.25 still has a typo we pointed out saying "treat these individual" rather than "individuals."

--In the "Refer" section, all four Directives point to ORS 426.005, using the state's official title "Definitions for ORS 426.005 to 426.390," which is vague and confusing. We suggested using part of the Chapter 426 title and saying "Definitions for ORS 466.005 to 426.390 - Persons With Mental Illness."

--We also continue to believe the PPB should change its inadequate mnemonic for handling possible mental health crisis situations, "ROADMAP." 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." 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.

We think PD will be easy for officers to remember, even though we locals know our Department is the PPB. We noted in our last three sets of comments that officers can use all of these tactics (as well as non-engagement) on someone regardless of whether they are in mental health crisis as alternatives to using force.

--We still believe the Bureau should not refer to AMR, the private company which contracts for ambulance services in the County, but rather use a generic term about ambulances, especially if the Fire Bureau or other agency might transport the individuals. In the last iteration of the policies, references to the Unity Center were replaced by the generic term "secure evaluation facility."

--Also, PCW continues to urge the Bureau to define the term "de-escalation" to mean calming a situation down using verbal and physical tactics, not for lowering the amount of force already being used on a suspect (which is mitigation of force).

Here are our comments on the four individual Mental Health policies. (NOTE: separated individuallly for the PPB's feedback form purposes.)

DIRECTIVE 850.20 MENTAL HEALTH CRISIS RESPONSE

Many of these comments are from May 2018.

--Paragraph 1.2 requires officers to "answer the mental health indicator question," though it is not clear where that question is posed.

--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." In addition, 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. "

--Similarly, even though the Directive recognizes that "Mental health providers are responsible for the ...diagnosis of persons with mental illness" [Policy 1]), we continue to suggest better-defined decision-making guidance.

--->Section 3.1 tells officers to "consider the governmental interests at stake" (Section 3.1) with no examples.

---.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.

--->Section 4 guiding the work of the Enhanced Crisis Intervention Team (ECIT) similarly cut out specific examples of when ECIT officers might respond, including the concept that a community member can request an ECIT officer and references to violence, weapons, and attempted suicide. PCW also suggested adding a reference to Directive 850.20 (Police Response to Mental Health Facilities), though we also believe the Bureau's rules should require officers to check their weapons at such facilities.

--Other parts of the Directive that were previously cut have not been reinstated, including the definitions of de-escalation, 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.

--->The other above-listed words 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."

--We also wrote three times previously: "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.

--Policy 3 still talks about officers being "increasingly required to respond" to persons with mental illness. It seems that with a Sergeant assigned to emergency dispatch and other plans such as Portland Street Response underway, 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.

--Section 5.2 says Supervisors "will acknowledge or respond to" calls in designated mental health facilities. Given the high stakes raised by the deaths of Jose Mejia Poot in 2001 and Merle Hatch in 2013, we suggested Supervisory response go back to being mandatory-- especially because it is required in Directive 850.25 (Sections 1.1 and 1.3).

--We raised concerns that Section 3.1.2 does not require officers to stand by when a person checks into a mental health facility. Because the policies were all re-written to reflect that people are now transported by ambulance to these facilities, this is not as much of a concern.

CONCLUSION

In a previous analysis of Directive 1500.00, we raised our concern that the PPB's Advanced Academy has been cut from 14 weeks to 10 weeks to push new recruits out on the streets faster. We referred to a 2004 community policing City Council resolution (binding City Policy), which called for Advanced Academy to be expanded from 14 to 16 weeks. We asked the Bureau to reconsider and/or find a way to get the new recruits all the training they need and repeat that here.

We also continue to be concerned that the short time frame to review Directives-- especially ones as meaningful and complex as the ones under review here-- is not conducive to input from organizations which only meet once a month (or less frequently). Due to lack of time, the Portland Commission on Community Engaged Policing is frequently in the position of being unable to comment on Directives, even though their founding document encourages them to do so.

PCW also encourages the Bureau to post the comments that come in as they are received, rather than at the time the policies are being finalized, so community members can compare notes about and/or build off of ideas that are being floated.

Thank you for the opportunity to comment
Dan Handelman and other members of
Portland Copwatch

Q2 Contact Information (optional)

Name	**Portland Copwatch**
Email Address	**copwatch@portlandcopwatch.org**

#1

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Tuesday, April 14, 2020 4:15:34 PM
Last Modified:	Tuesday, April 14, 2020 4:16:10 PM
Time Spent:	00:00:36

Page 1

Q1 Please provide feedback for this directive

To Chief Resch, Capt. Parman, Lieutenant Morgan, PPB Policy Analysts, Compliance Officer/Community Liaison Team, Community Oversight Advisory Board staff, US Dept. of Justice, Citizen Review Committee and the Portland Police Bureau:

Below are our comments on the Mental Health Directives posted for review in March/April at). Although we made extensive comments on these in January, there were only minor changes proposed to two of them (850.20 and 850.21). Thus we are adding short commentary on those changes but otherwise simply reposting the earlier comments below.

We are choosing not to comment on two other Directives at this time, Personnel Rosters (220.10) and 860.30 Citations in Lie of Custody, because (a) they were not appropriately noticed via the Bureaus increasingly faulty email system (we found them at https://www.portlandoregon.gov/police/73677) and (b) the former is likely going to be rescinded and the latter is too complicated for the limited time we had to look at it.

We continue to urge the Bureau to add letters to each major section (Refer, Definitions, Policy, Procedure), to number the definitions for easy reference, and to allow more time for groups, including the Bureau's official advisory bodies, to comment.

----------MENTAL HEALTH DIRECTIVES----------

General comments we made in May 2018 and January 2020 when these Directives about Mental Health (850,20, 850.21, 850.22 and 850.25) were last posted include:

--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" (820.25). Incidentally, 850.25 ***still*** has a typo we pointed out saying "treat these individual" rather than "individuals."

--In the "Refer" section, all four Directives point to ORS 426.005, using the state's official title "Definitions for ORS 426.005 to 426.390," which is vague and confusing. We suggested using part of the Chapter 426 title and saying "Definitions for ORS 466.005 to 426.390 - Persons With Mental Illness."

--We also continue to believe the PPB should change its inadequate mnemonic for handling possible mental health crisis situations, "ROADMAP." 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." 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.

We think PD will be easy for officers to remember, even though we locals know our Department is the PPB. We noted in our previous sets of comments 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.

--We still believe the Bureau should not refer to AMR, the private company which contracts for ambulance services in the County, but rather use a generic term about ambulances, especially if the Fire Bureau or other agency might transport the individuals. In an older iteration of the policies, references to the Unity Center were replaced by the generic term "secure evaluation facility."

--Also, PCW continues to urge the Bureau to define the term "de-escalation" to mean calming a situation down using verbal and physical tactics, not for lowering the amount of force already being used on a suspect (which is mitigation of force).

Here are our comments on the four individual Mental Health policies.

DIRECTIVE 850.20 MENTAL HEALTH CRISIS RESPONSE

The few changes proposed to this Directive are (a) minor word changes in the Definition of "De-escalation," which still doesn't resolve the issue mentioned in the general comments about the difference between not escalating a situation by using force versus ending the use of force once it's been applied; (b) adding a new Section 4 in the "About Mental Health" area of the Directive to clarify that Mental Illness is not the same as being intoxicated; and (c) one word changed in Policy Section 2 which says officers may recognize "symptoms" of mental illness, rather than the original word "behaviors"-- we're not sure this is an improvement since officers are not doctors. That's all the proposed edits.

Here are comments we made in May 2018 and January 2020 to further improve the policy.

--Paragraph 1.2 requires officers to "answer the mental health indicator question," though it is not clear where that question is posed.

--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." In addition, 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. "

--Similarly, even though the Directive recognizes that "Mental health providers are responsible for the ...diagnosis of persons with mental illness" [Policy 1]), we continue to suggest better-defined decision-making guidance.

--->Section 3.1 tells officers to "consider the governmental interests at stake" (Section 3.1) with no examples.

--->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.

--->Section 4 guiding the work of the Enhanced Crisis Intervention Team (ECIT) similarly cut out specific examples of when ECIT officers might respond, including the concept that a community member can request an ECIT officer and references to violence, weapons, and attempted suicide. PCW also suggested adding a reference to Directive 850.20 (Police Response to Mental Health Facilities), though we also believe the Bureau's rules should require officers to check their weapons at such facilities.

--Other 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.

--->The other above-listed words 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."

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--Policy 3 still talks about officers being "increasingly required to respond" to persons with mental illness. It seems that with a Sergeant

assigned to emergency dispatch and other plans such as Portland Street Response underway, 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.

--Section 5.2 says Supervisors "will acknowledge or respond to" calls in designated mental health facilities. Given the high stakes raised by the deaths of Jose Mejia Poot in 2001 and Merle Hatch in 2013, we suggested Supervisory response go back to being mandatory--especially because it is required in Directive 850.25 (Sections 1.1 and 1.3).

CONCLUSION

The overall finding of the Department of Justice which has led to the now almost eight-year-old Settlement Agreement was that the Portland Police used too much force against people who are or appear to be in mental health crisis. While many of these policies could help reduce harm against this vulnerable portion of our population, the incidents of use of deadly force against people in mental health crisis continues unabated. The ideas of de-escalation and other tactics outlined in these policies should not be thrown out the window because an officer or officers default to pulling firearms, pile on an agitated person, or use 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.

Thank you for the opportunity to comment
dan handelman
Portland Copwatch

Q2 Contact Information (optional)

Name	**Portland Copwatch**
Email Address	**copawtch@portlandcopwatch.org**

850.21 Peace Officer Custody (Civil)

Refer:

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

Definitions:

- De-escalation: A deliberate attempt to reduce the necessity or intensity of force to resolve confrontation.

- Mental Health Crisis: An incident in which someone with an actual or perceived mental illness experiences intense feelings of personal distress (e.g. anxiety, depression, anger, fear, panic, hopelessness), a thought disorder (e.g. visual or auditory hallucinations, delusions, sensory impairment or cognitive impairment), obvious changes in functioning (e.g. neglect of personal hygiene) and/or catastrophic life events (e.g. disruptions in personal relationships, support systems or living arrangements; loss of autonomy or parental rights; victimization or natural disasters), which may, but not necessarily, result in an upward trajectory of intensity culminating in thoughts or acts that are dangerous to self and/or others.

- Peace Officer Custody: An exercise of civil authority when there is probable cause to believe a person is dangerous to self or to any other person and is in need of immediate care, custody, or treatment for mental illness. 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.

Procedure:

1. Peace Officer Custody:

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

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

1.2.1. Develop and communicate a tactical plan to participating members, so as to take advantage of the most effective options that may safely resolve the incident. Tactics members should consider in devising a tactical plan include, but are not limited to, the following ("ROADMAP" is a mnemonic device that assists members in remembering tactics taught in training):

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

1.2.1.1.1. Evaluate the need for assistance from individuals with additional training in working with mental health crisis situations (e.g. Enhanced Crisis Intervention Team (ECIT) members, Project Respond, Crisis Negotiation Team (CNT)). When needed, assistance may be requested through the Bureau of Emergency Communications (BOEC).

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

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

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

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

1.2.1.4.1. Disengagement is a tactic to be considered to reduce undue safety risk to the member, the involved persons, or others. Members will consult with a supervisor to determine whether to make contact at a different time or under different circumstances. The tactic requires members to complete a general offense report and notify the Multnomah County Call Center of the situation (e.g. name, date of birth, disposition).

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

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

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

1.2.2. Transport or facilitate the transport of the individual to the appropriate secure evaluation facility or nearest designated hospital emergency department that conducts mental health evaluations. Refer to Directives 630.45 Emergency Medical Custody Transports and 630.50 Emergency Medical Aid for additional information.

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

2. Member Responsibilities:

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

the treating physician at the hospital or Unity Center.

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

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

3. Supervisor Responsibilities:
   3.1. Supervisors will ensure their members follow the reporting requirements for peace officer custody.

850.21 Peace Officer Custody (Civil)

Refer:

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

Definitions:

- De-escalation: A deliberate attempt to reduce the necessity or intensity of force to resolve confrontation.

- Mental Health Crisis: An incident in which someone with an actual or perceived mental illness experiences intense feelings of personal distress (e.g. anxiety, depression, anger, fear, panic, hopelessness), a thought disorder (e.g. visual or auditory hallucinations, delusions, sensory impairment or cognitive impairment), obvious changes in functioning (e.g. neglect of personal hygiene) and/or catastrophic life events (e.g. disruptions in personal relationships, support systems or living arrangements; loss of autonomy or parental rights; victimization or natural disasters), which may, but not necessarily, result in an upward trajectory of intensity culminating in thoughts or acts that are dangerous to self and/or others.

- Peace Officer Custody: An exercise of civil authority when there is probable cause to believe a person is dangerous to self or to any other person and is in need of immediate care, custody, or treatment for mental illness. 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 ~~a~~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.

Procedure:

1. Peace Officer Custody:

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

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

1.2.1. Develop and communicate a tactical plan to participating members, so as to take advantage of the most effective options that may safely resolve the incident. Tactics members should consider in devising a tactical plan include, but are not limited to, the following ("ROADMAP" is a mnemonic device that assists members in remembering tactics taught in training):

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

1.2.1.1.1. Evaluate the need for assistance from individuals with additional training in working with mental health crisis situations (e.g. Enhanced Crisis Intervention Team (ECIT) members, Project Respond, Crisis Negotiation Team (CNT)). When needed, assistance may be requested through the Bureau of Emergency Communications (BOEC).

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

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

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

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

1.2.1.4.1. Disengagement is a tactic to be considered to reduce undue safety risk to the member, the involved persons, or others. Members will consult with a supervisor to determine whether to make contact at a different time or under different circumstances. The tactic requires members to complete a general offense report and notify the Multnomah County Call Center of the situation (e.g. name, date of birth, disposition).

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

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

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

1.2.2. Transport or facilitate the transport of the individual to the appropriate secure evaluation facility or nearest designated hospital emergency department that conducts mental health evaluations. Refer to Directives 630.45 Emergency Medical Custody Transports and 630.50 Emergency Medical Aid for additional information.

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

2. Member Responsibilities:

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

the treating physician at the hospital or Unity Center.

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

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

3. Supervisor Responsibilities:
   3.1. Supervisors will ensure their members follow the reporting requirements for peace officer custody.

#1

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Thursday, January 16, 2020 11:12:15 AM
Last Modified:	Thursday, January 16, 2020 11:13:45 AM
Time Spent:	00:01:29

Page 1

Q1 Please provide feedback for this directive

I like how this directive states "Members shall treat the individual with dignity and compassion at all times." But it has no follow through as far as how members are trained and how they are held accountable to make sure this was done. The training for these members needs to be more clearly defined along with accountability.

Q2 Contact Information (optional)

Name	**Daniel Franco-Nunez**
Email Address	**daniel.franco-nunez@portlandoregon.gov**
Phone Number	**5034213192**

#2

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, January 16, 2020 1:41:24 PM
Last Modified: Thursday, January 16, 2020 1:43:15 PM
Time Spent: 00:01:51

Page 1

Q1 Please provide feedback for this directive

There are have been a number of cases where officers have placed subjects on POH who are not mentally ill but rather intoxicated. With the closing of Detox I believe this may occur more as officers try to find solutions. The policy may want to explicitly speak to this issue.

Q2 Contact Information (optional)

Name	**Niiya**

#3

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Thursday, January 30, 2020 2:08:07 PM
Last Modified:	Thursday, January 30, 2020 2:08:53 PM
Time Spent:	00:00:46

Page 1

Q1 Please provide feedback for this directive

COMMENTS on Employment, Mental Health and Training Directives, January 2020

To Chief Resch, Capt. Parman, Lieutenant Morgan, PPB Policy Analysts, Compliance Officer/Community Liaison Team, Community Oversight Advisory Board staff, US Dept. of Justice, Citizen Review Committee and the Portland Police Bureau:

Below are our comments on the various Directives posted for review in January at). Portland Copwatch (PCW) continues to have concerns about the 15-day response period for these reviews, particularly since the Training Advisory Council (TAC), which only meets once every two months, met 7 days before the release of the Training Directive. They will miss the chance to comment on what we believe is the only Directive mentioning the TAC. With the exception of the "Extra Employment" Directive (210.80), all of these policies have been posted previously and we are repeating many of our past comments here.

Along those lines, we continue to urge the Bureau to add letters to each major section (Refer, Definitions, Policy, Procedure) and to number the definitions for easy reference.

----------MENTAL HEALTH DIRECTIVES----------

General comments we made in May 2018 when these Directives about Mental Health (850,20, 850.21, 850.22 and 850.25) were last posted include:

--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" (820.25). Incidentally, 850.25 still has a typo we pointed out saying "treat these individual" rather than "individuals."

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--We also continue to believe the PPB should change its inadequate mnemonic for handling possible mental health crisis situations, "ROADMAP." 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." We suggested changing the mnemonic to "PD-MACRO," with the items listed as:
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__Containment
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We think PD will be easy for officers to remember, even though we locals know our Department is the PPB. We noted in our last three sets of comments that officers can use all of these tactics (as well as non-engagement) on someone regardless of whether they are in mental health crisis as alternatives to using force.

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--Also, PCW continues to urge the Bureau to define the term "de-escalation" to mean calming a situation down using verbal and physical tactics, not for lowering the amount of force already being used on a suspect (which is mitigation of force).

Here are our comments on the four individual mental health policies.(NOTE: separated individuallly for the PPB's feedback form purposes.)

DIRECTIVE 850.21 PEACE OFFICER CUSTODY (CIVIL)

We made these comments in May 2018.

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

--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.

--Policy Section 2 reads "When the need arises, the act of custody shall be resolved in a safe, constructive and humane manner as possible"; we noted that the word "a" is likely supposed to be the word "as."

CONCLUSION

In a previous analysis of Directive 1500.00, we raised our concern that the PPB's Advanced Academy has been cut from 14 weeks to 10 weeks to push new recruits out on the streets faster. We referred to a 2004 community policing City Council resolution (binding City Policy), which called for Advanced Academy to be expanded from 14 to 16 weeks. We asked the Bureau to reconsider and/or find a way to get the new recruits all the training they need and repeat that here.

We also continue to be concerned that the short time frame to review Directives-- especially ones as meaningful and complex as the ones under review here-- is not conducive to input from organizations which only meet once a month (or less frequently). Due to lack of time, the Portland Commission on Community Engaged Policing is frequently in the position of being unable to comment on Directives, even though their founding document encourages them to do so.

PCW also encourages the Bureau to post the comments that come in as they are received, rather than at the time the policies are being finalized, so community members can compare notes about and/or build off of ideas that are being floated.

Thank you for the opportunity to comment
Dan Handelman and other members of
Portland Copwatch

Q2 Contact Information (optional)

Name	**Portland Copwatch**
Email Address	**copwatch@portlandcopwatch.org**

#1

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Tuesday, April 14, 2020 4:17:18 PM
Last Modified:	Tuesday, April 14, 2020 4:18:09 PM
Time Spent:	00:00:51

Page 1

Q1 Please provide feedback for this directive

To Chief Resch, Capt. Parman, Lieutenant Morgan, PPB Policy Analysts, Compliance Officer/Community Liaison Team, Community Oversight Advisory Board staff, US Dept. of Justice, Citizen Review Committee and the Portland Police Bureau:

Below are our comments on the Mental Health Directives posted for review in March/April at). Although we made extensive comments on these in January, there were only minor changes proposed to two of them (850.20 and 850.21). Thus we are adding short commentary on those changes but otherwise simply reposting the earlier comments below.

We are choosing not to comment on two other Directives at this time, Personnel Rosters (220.10) and 860.30 Citations in Lie of Custody, because (a) they were not appropriately noticed via the Bureaus increasingly faulty email system (we found them at https://www.portlandoregon.gov/police/73677) and (b) the former is likely going to be rescinded and the latter is too complicated for the limited time we had to look at it.

We continue to urge the Bureau to add letters to each major section (Refer, Definitions, Policy, Procedure), to number the definitions for easy reference, and to allow more time for groups, including the Bureau's official advisory bodies, to comment.

----------MENTAL HEALTH DIRECTIVES----------

General comments we made in May 2018 and January 2020 when these Directives about Mental Health (850,20, 850.21, 850.22 and 850.25) were last posted include:

--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" (820.25). Incidentally, 850.25 ***still*** has a typo we pointed out saying "treat these individual" rather than "individuals."

--In the "Refer" section, all four Directives point to ORS 426.005, using the state's official title "Definitions for ORS 426.005 to 426.390," which is vague and confusing. We suggested using part of the Chapter 426 title and saying "Definitions for ORS 466.005 to 426.390 - Persons With Mental Illness."

--We also continue to believe the PPB should change its inadequate mnemonic for handling possible mental health crisis situations, "ROADMAP." 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." 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.

We think PD will be easy for officers to remember, even though we locals know our Department is the PPB. We noted in our previous sets of comments 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.

--We still believe the Bureau should not refer to AMR, the private company which contracts for ambulance services in the County, but rather use a generic term about ambulances, especially if the Fire Bureau or other agency might transport the individuals. In an older iteration of the policies, references to the Unity Center were replaced by the generic term "secure evaluation facility."

--Also, PCW continues to urge the Bureau to define the term "de-escalation" to mean calming a situation down using verbal and physical tactics, not for lowering the amount of force already being used on a suspect (which is mitigation of force).

Here are our comments on the four individual Mental Health policies.

DIRECTIVE 850.21 PEACE OFFICER CUSTODY (CIVIL)

There is only one change proposed to this Directive, based on a comment that Portland Copwatch made previously. It fixes Policy Section 2 where there was a grammatical issue describing how to resolve custody in "as safe, constructive and humane of a manner as possible." Thank you for fixing this.

We made these other comments in May 2018 and January 2020.

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

--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.

CONCLUSION

The overall finding of the Department of Justice which has led to the now almost eight-year-old Settlement Agreement was that the Portland Police used too much force against people who are or appear to be in mental health crisis. While many of these policies could help reduce harm against this vulnerable portion of our population, the incidents of use of deadly force against people in mental health crisis continues unabated. The ideas of de-escalation and other tactics outlined in these policies should not be thrown out the window because an officer or officers default to pulling firearms, pile on an agitated person, or use 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.

Thank you for the opportunity to comment
dan handelman
Portland Copwatch

Q2 Contact Information (optional)

Name	**Portland Copwatch**
Email Address	**copwatch@portlandcopwatch.org**

850.22 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 850.20 Police Response to Mental Health Crisis
- DIR 850.21 Peace Officer Custody (Civil)
- DIR 850.25 Police Response to Mental Health Facilities

Definitions:

- Community Mental Health Program Director: The director of an entity, including Multnomah County, which provides community mental health program services.

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

- Elope: To abscond, depart, leave, or walk away.

- Unlawful Elopement: To elope in violation of a civil or criminal legal/commitment status.

Policy:

1. In the context of mental health services, mental health providers, not law enforcement, are responsible for the evaluation, diagnosis, and treatment of persons who are in mental health crisis. There are times, however, when mental health providers need police services.

2. Because mental health custody as initiated by mental health providers may be civil which can include Director's Custody, Order of Civil Commitment, Psychiatric Security Review Board (PSRB) Commitment Orders, Revocation Orders in legal/commitment status, members shall be guided by law when responding to mental health provider service requests.

3. A member's ability to manage a person in custody in a safe, constructive, and humane manner is of critical importance to the involved person, the involved person's support system, community members, mental health providers, and the Police Bureau. Members shall treat the individual with dignity and compassion at all times.

Procedure:

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

1.1.1. Members shall take a person into custody when the Community Mental Health Program Director, or designee, notifies the member that the Director has probable cause to believe that the person is dangerous to self or to any other person.

1.1.2. When assisting a community mental health program director or designee as defined in ORS § 426.005 (1) (a) with taking a person into custody (Director's Custody), members shall:

1.1.2.1. Determine if taking civil custody of the person named on the Director's Custody Report may be achieved in a safe manner. Delaying custody is a tactic that may be used if the member determines that taking the person into custody under present circumstances may result in an undue safety risk to members, the involved person, and/or others. If delaying custody, members shall notify a supervisor and then develop a plan to determine a safer time and method to take the person into civil custody. An appropriate police report shall be completed documenting the details of this decision.

1.1.2.2. If a member takes a person into custody, the member shall arrange for AMR transport to the secure evaluation facility, unless extraordinary circumstances warrant police transport.

1.1.2.3. When necessary, members shall complete an appropriate police report and mental health 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 in accordance with Directive 850.20, Police Response to Mental Health Crisis and/or Directive 850.21, Peace Officer Custody (Civil). Members shall contact the reporting facility and notify them of the disposition.

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

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

1.2.3.4. Complete the appropriate police report and mental health 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 850.20, Police Response to Mental Health Crisis and/or Directive 850.21, Peace Officer Custody (Civil).

1.4. Member-Supervisor Coordinated Response Required:

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

2. Police Response to Criminal Custody Requests:

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

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

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

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

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

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

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

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

2.2. Unlawful Elopement from PSRB:

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

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

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

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

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

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

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

3.1.1. Verify the identity of the person in LEDS.

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

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

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

3.1.5. Document the incident on an appropriate police report and mental health 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.

850.22 Police Response to Mental Health Director Holds and Elopement

Refer:

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1.2.3.1.1. Criteria for court-ordered civil commitments are dictated by individual state laws. If a patient has eloped from a mental health facility in another state, members shall assess the person and take action in accordance with Directive 850.20, Police Response to Mental Health Crisis and/or Directive 850.21, Peace Officer Custody (Civil). Members shall contact the reporting facility and notify them of the disposition.

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

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

1.2.3.4. Complete the appropriate police report and mental health 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 850.20, Police Response to Mental Health Crisis and/or Directive 850.21, Peace Officer Custody (Civil).

1.4. Member-Supervisor Coordinated Response Required:

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

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

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

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

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

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

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

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

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#1

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Thursday, January 30, 2020 2:09:34 PM
Last Modified:	Thursday, January 30, 2020 2:10:07 PM
Time Spent:	00:00:33

Page 1

Q1 Please provide feedback for this directive

COMMENTS on Employment, Mental Health and Training Directives, January 2020

To Chief Resch, Capt. Parman, Lieutenant Morgan, PPB Policy Analysts, Compliance Officer/Community Liaison Team, Community Oversight Advisory Board staff, US Dept. of Justice, Citizen Review Committee and the Portland Police Bureau:

Below are our comments on the various Directives posted for review in January at). Portland Copwatch (PCW) continues to have concerns about the 15-day response period for these reviews, particularly since the Training Advisory Council (TAC), which only meets once every two months, met 7 days before the release of the Training Directive. They will miss the chance to comment on what we believe is the only Directive mentioning the TAC. With the exception of the "Extra Employment" Directive (210.80), all of these policies have been posted previously and we are repeating many of our past comments here.

Along those lines, we continue to urge the Bureau to add letters to each major section (Refer, Definitions, Policy, Procedure) and to number the definitions for easy reference.

----------MENTAL HEALTH DIRECTIVES----------

General comments we made in May 2018 when these Directives about Mental Health (850,20, 850.21, 850.22 and 850.25) were last posted include:

--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" (820.25). Incidentally, 850.25 still has a typo we pointed out saying "treat these individual" rather than "individuals."

--In the "Refer" section, all four Directives point to ORS 426.005, using the state's official title "Definitions for ORS 426.005 to 426.390," which is vague and confusing. We suggested using part of the Chapter 426 title and saying "Definitions for ORS 466.005 to 426.390 - Persons With Mental Illness."

--We also continue to believe the PPB should change its inadequate mnemonic for handling possible mental health crisis situations, "ROADMAP." 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." We suggested changing the mnemonic to "PD-MACRO," with the items listed as:
__Patience
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We think PD will be easy for officers to remember, even though we locals know our Department is the PPB. We noted in our last three sets of comments that officers can use all of these tactics (as well as non-engagement) on someone regardless of whether they are in mental health crisis as alternatives to using force.

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--Also, PCW continues to urge the Bureau to define the term "de-escalation" to mean calming a situation down using verbal and physical tactics, not for lowering the amount of force already being used on a suspect (which is mitigation of force).

Here are our comments on the four individual mental health policies.(NOTE: separated individuallly for the PPB's feedback form purposes.)

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

We made these comments in May 2018, plus we identified one typo that the Bureau fixed.

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

--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.

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

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

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

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

--The "mental health text template" referred to in 2.2.1.4 should be available to the public for transparency's sake.

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

CONCLUSION

In a previous analysis of Directive 1500.00, we raised our concern that the PPB's Advanced Academy has been cut from 14 weeks to 10 weeks to push new recruits out on the streets faster. We referred to a 2004 community policing City Council resolution (binding City Policy), which called for Advanced Academy to be expanded from 14 to 16 weeks. We asked the Bureau to reconsider and/or find a way to get the new recruits all the training they need and repeat that here.

We also continue to be concerned that the short time frame to review Directives-- especially ones as meaningful and complex as the ones under review here-- is not conducive to input from organizations which only meet once a month (or less frequently). Due to lack of time, the Portland Commission on Community Engaged Policing is frequently in the position of being unable to comment on Directives, even though their founding document encourages them to do so.

PCW also encourages the Bureau to post the comments that come in as they are received, rather than at the time the policies are being finalized, so community members can compare notes about and/or build off of ideas that are being floated.

Thank you for the opportunity to comment
Dan Handelman and other members of
Portland Copwatch

Q2 Contact Information (optional)

Name	**Portland Copwatch**
Email Address	**copwatch@portlandcopwatch.org**

#1

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Tuesday, April 14, 2020 4:19:15 PM
Last Modified:	Tuesday, April 14, 2020 4:19:54 PM
Time Spent:	00:00:38

Page 1

Q1 Please provide feedback for this directive

To Chief Resch, Capt. Parman, Lieutenant Morgan, PPB Policy Analysts, Compliance Officer/Community Liaison Team, Community Oversight Advisory Board staff, US Dept. of Justice, Citizen Review Committee and the Portland Police Bureau:

Below are our comments on the Mental Health Directives posted for review in March/April at). Although we made extensive comments on these in January, there were only minor changes proposed to two of them (850.20 and 850.21). Thus we are adding short commentary on those changes but otherwise simply reposting the earlier comments below.

We are choosing not to comment on two other Directives at this time, Personnel Rosters (220.10) and 860.30 Citations in Lie of Custody, because (a) they were not appropriately noticed via the Bureaus increasingly faulty email system (we found them at https://www.portlandoregon.gov/police/73677) and (b) the former is likely going to be rescinded and the latter is too complicated for the limited time we had to look at it.

We continue to urge the Bureau to add letters to each major section (Refer, Definitions, Policy, Procedure), to number the definitions for easy reference, and to allow more time for groups, including the Bureau's official advisory bodies, to comment.

----------MENTAL HEALTH DIRECTIVES----------

General comments we made in May 2018 and January 2020 when these Directives about Mental Health (850,20, 850.21, 850.22 and 850.25) were last posted include:

--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" (820.25). Incidentally, 850.25 ***still*** has a typo we pointed out saying "treat these individual" rather than "individuals."

--In the "Refer" section, all four Directives point to ORS 426.005, using the state's official title "Definitions for ORS 426.005 to 426.390," which is vague and confusing. We suggested using part of the Chapter 426 title and saying "Definitions for ORS 466.005 to 426.390 - Persons With Mental Illness."

--We also continue to believe the PPB should change its inadequate mnemonic for handling possible mental health crisis situations, "ROADMAP." 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." 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.

We think PD will be easy for officers to remember, even though we locals know our Department is the PPB. We noted in our previous sets of comments 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.

--We still believe the Bureau should not refer to AMR, the private company which contracts for ambulance services in the County, but rather use a generic term about ambulances, especially if the Fire Bureau or other agency might transport the individuals. In an older iteration of the policies, references to the Unity Center were replaced by the generic term "secure evaluation facility."

--Also, PCW continues to urge the Bureau to define the term "de-escalation" to mean calming a situation down using verbal and physical tactics, not for lowering the amount of force already being used on a suspect (which is mitigation of force).

Here are our comments on the four individual Mental Health policies.

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

We made these comments in May 2018 and January 2020.

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

--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.

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

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

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

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

--The "mental health text template" referred to in 2.2.1.4 should be available to the public for transparency's sake.

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

CONCLUSION

The overall finding of the Department of Justice which has led to the now almost eight-year-old Settlement Agreement was that the Portland Police used too much force against people who are or appear to be in mental health crisis. While many of these policies could help reduce harm against this vulnerable portion of our population, the incidents of use of deadly force against people in mental health crisis continues unabated. The ideas of de-escalation and other tactics outlined in these policies should not be thrown out the window because an officer or officers default to pulling firearms, pile on an agitated person, or use 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.

Thank you for the opportunity to comment
dan handelman
Portland Copwatch

Q2 Contact Information (optional)

Name	**Portland Copwatch**
Email Address	**copwatch@portlandcopwatch.org**

850.25 Police Response to Mental Health Facilities

Refer:

- ORS § 426.005, Definitions for ORS § 426.005 to 426.390
- DIR 850.20 Police Response to Mental Health Crisis – Persons with Mental Illness
- DIR 850.21 Peace Officer Custody (Civil)
- DIR 850.22 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 Health and Addiction Services and/or the State of Oregon to provide residential mental health treatment for adults in a home-like environment supervised by twenty four (24) hour staff to provide stabilization, treatment, and community integration, which have been identified and flagged by the Portland Police Bureau's Behavioral Health Unit (BHU).

Policy:

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

Procedure:

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

   1.2. Lower priority calls at designated secure residential mental health treatment facilities shall be dispatched to the district officer and require supervisor notification. A supervisor may request assistance of an ECIT officer if necessary.

1.3. Response to emergencies (Priority 1-3) at designated non-secure residential mental health treatment facilities shall include a supervisor and a minimum of two (2) officers, one of which is an ECIT officer, if available. ECIT officers shall advise Sergeants on the mental health aspects of the call when feasible. Unless extreme exigent circumstances exist, members may not enter a non-secure mental health facility or residential mental health facility without notifying their supervisor of the request and coordinating a response.

1.4. In addition to ROADMAP, as listed in Directive 850.20, Police Response to Mental Health Crisis, the following are other tactical options for members and their supervisors to consider before entry into a designated residential mental health facility:

1.4.1. Evaluate the nature of the situation and necessity for police intervention.

1.4.2. When time allows, have responding members stage and wait for the arrival of all necessary personnel and resources.

1.4.3. Request a staff member meet police outside the facility to provide information on: 1) the facility layout; 2) the locations of the person who requires police response, other patients, visitors, and staff; and 3) any other information about the incident and persons involved that would aid police in planning their response.

1.4.4. If police intervention is warranted, evaluate contact options, including by phone, in person, or other means. If in person, evaluate the need to utilize additional cover members. Develop a tactical plan, taking advantage of the most effective control options that may safely resolve the incident.

2. Behavioral Health Unit (BHU) Responsibilities:

2.1. The Behavioral Health Unit shall:

2.1.1. Post designated secure residential mental health treatment facility floor plans on the Bureau's Intranet.

2.1.2. Regularly review the designated Multnomah County and/or State of Oregon mental health facility lists to ensure the accuracy of mental health facility hazard flags.

2.1.3. Follow up on concerns regarding police response to designated residential mental health facilities. As appropriate, the Behavioral Health Unit shall meet with facility management representatives to review the representatives' expectations of police assistance in emergencies and facility emergency policies for addressing concerning incidents.

850.25 Police Response to Mental Health Facilities

Refer:

- ORS § 426.005, Definitions for ORS § 426.005 to 426.390
- DIR 850.20 Police Response to Mental Health Crisis – Persons with Mental Illness
- DIR 850.21 Peace Officer Custody (Civil)
- DIR 850.22 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.

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#1

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Wednesday, January 15, 2020 5:30:23 PM
Last Modified: Wednesday, January 15, 2020 5:41:50 PM
Time Spent: 00:11:26

Page 1

Q1 Please provide feedback for this directive

I see a potential conflict or wording that is a little confusing under "Policy, 1.". The policy states " 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".

I interpret this to mean that at some point the person may become aggressive, or resistive, and that the staff should be able to handle it.

The same section states that police "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;:"

I believe this language is a little confusing because a person who is aggressive or resistive, is likely to cause injury to a person. There is no wording that distinguishes the level of assault or injury that necessitates a police response.

Q2 Contact Information (optional)

Respondent skipped this question

#2

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, January 16, 2020 10:58:03 AM
Last Modified: Thursday, January 16, 2020 11:01:56 AM
Time Spent: 00:03:52

Page 1

Q1 Please provide feedback for this directive

There should be a formation of a group of hospital administrators and police to create a better policy. This directive says tha medical locations "shall" this and "do" that. but when it comes to the cops side of the responsability it says "when able" "when time allows" "reasonable". It sounds like the PPB is being easy on itself and holding up the medical side of the policy to higher standards. This policy needs to be developed or at least edited in collaboration with are medical administrators to provide a more accurate roadmap of the best course of action for the patient. Not what's most expedient for the PPB. Otherwise its just lip service and will be meaningless to community and executed half heartedly by officers.

Q2 Contact Information (optional)

Name	**Daniel Franco-Nunez**
Email Address	**daniel.franco-nunez@portlandoregon.gov**
Phone Number	**5034213192**

#3

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Thursday, January 16, 2020 12:54:10 PM
Last Modified: Thursday, January 16, 2020 12:54:46 PM
Time Spent: 00:00:36

Page 1

Q1 Please provide feedback for this directive

Is this a completely new directive?

What's been altered, if not new?

Q2 Contact Information (optional)

Name	**Maxine Bernstein**
Email Address	**mbernstein@oregonian.com**
Phone Number	**971-263-5103**

#4

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Thursday, January 30, 2020 2:10:50 PM
Last Modified:	Thursday, January 30, 2020 2:11:30 PM
Time Spent:	00:00:39

Page 1

Q1 Please provide feedback for this directive

COMMENTS on Employment, Mental Health and Training Directives, January 2020

To Chief Resch, Capt. Parman, Lieutenant Morgan, PPB Policy Analysts, Compliance Officer/Community Liaison Team, Community Oversight Advisory Board staff, US Dept. of Justice, Citizen Review Committee and the Portland Police Bureau:

Below are our comments on the various Directives posted for review in January at). Portland Copwatch (PCW) continues to have concerns about the 15-day response period for these reviews, particularly since the Training Advisory Council (TAC), which only meets once every two months, met 7 days before the release of the Training Directive. They will miss the chance to comment on what we believe is the only Directive mentioning the TAC. With the exception of the "Extra Employment" Directive (210.80), all of these policies have been posted previously and we are repeating many of our past comments here.

Along those lines, we continue to urge the Bureau to add letters to each major section (Refer, Definitions, Policy, Procedure) and to number the definitions for easy reference.

----------MENTAL HEALTH DIRECTIVES----------

General comments we made in May 2018 when these Directives about Mental Health (850,20, 850.21, 850.22 and 850.25) were last posted include:

--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" (820.25). Incidentally, 850.25 still has a typo we pointed out saying "treat these individual" rather than "individuals."

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--We also continue to believe the PPB should change its inadequate mnemonic for handling possible mental health crisis situations, "ROADMAP." 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." 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.

We think PD will be easy for officers to remember, even though we locals know our Department is the PPB. We noted in our last three sets of comments that officers can use all of these tactics (as well as non-engagement) on someone regardless of whether they are in mental health crisis as alternatives to using force.

--We still believe the Bureau should not refer to AMR, the private company which contracts for ambulance services in the County, but rather use a generic term about ambulances, especially if the Fire Bureau or other agency might transport the individuals. In the last iteration of the policies, references to the Unity Center were replaced by the generic term "secure evaluation facility."

--Also, PCW continues to urge the Bureau to define the term "de-escalation" to mean calming a situation down using verbal and physical tactics, not for lowering the amount of force already being used on a suspect (which is mitigation of force).

Here are our comments on the four individual mental health policies.(NOTE: separated individuallly for the PPB's feedback form purposes.)

DIRECTIVE 850.25 POLICE RESPONSE TO MENTAL HEALTH FACILITIES

We made most of these comments in May 2018.

--Our comment from April 2015 and November 2017 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.

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

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

--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.

--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 combative."

CONCLUSION

In a previous analysis of Directive 1500.00, we raised our concern that the PPB's Advanced Academy has been cut from 14 weeks to 10 weeks to push new recruits out on the streets faster. We referred to a 2004 community policing City Council resolution (binding City Policy), which called for Advanced Academy to be expanded from 14 to 16 weeks. We asked the Bureau to reconsider and/or find a way to get the new recruits all the training they need and repeat that here.

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Dan Handelman and other members of
Portland Copwatch

Q2 Contact Information (optional)

Name	**Portland Copwatch**
Email Address	**copwatch@portlandcopwatch.org**

#1

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Sunday, March 22, 2020 1:15:26 PM
Last Modified:	Sunday, March 22, 2020 1:26:45 PM
Time Spent:	00:11:18

Page 1

Q1 Please provide feedback for this directive

As an ECIT officer and supervisor I have experienced multiple calls into secured facilities. Oftentimes: 1) due to BOEC's policies regarding the prioritization of calls, the call does not warrant such a large response, 2) the large response serves to disrupt other clients/patients who live in the home, 3) can escalate the subject of the call, and 4) the medical providers within the facility do not want that many officers inside. I would recommend a supervisor be notified of the nature of the call and choose the number of officers (including ECIT) which is most prudent for the situation.

Other than that suggestion, I believe this policy is well written and carried out well by the members of the Portland Police Bureau.

Q2 Contact Information (optional)

Name	**Sergeant J. Sutton**
Email Address	**jasmine.sutton@portlandoregon.gov**

#2

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Tuesday, April 14, 2020 4:20:49 PM
Last Modified:	Tuesday, April 14, 2020 4:21:30 PM
Time Spent:	00:00:40

Page 1

Q1 Please provide feedback for this directive

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

--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.

--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 combative."

CONCLUSION

The overall finding of the Department of Justice which has led to the now almost eight-year-old Settlement Agreement was that the Portland Police used too much force against people who are or appear to be in mental health crisis. While many of these policies could help reduce harm against this vulnerable portion of our population, the incidents of use of deadly force against people in mental health crisis continues unabated. The ideas of de-escalation and other tactics outlined in these policies should not be thrown out the window because an officer or officers default to pulling firearms, pile on an agitated person, or use 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.

Thank you for the opportunity to comment
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