CITY OF PORTLAND, OREGON

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

Introduction

The Policy Development Team began the review process for its mental health directive suite in December 2023. The suite includes Directives 0850.20, Police Response to Mental Health Crisis; 0850.21, Peace Officer Custody (Civil); 0850.22, Police Response to Mental Health Director Holds and Elopement; and 0850.25, Police Response to Mental Health Facilities. The team posted the directives for First Universal Review in January 2024 and posted proposed revisions during Second Universal Review in March 2024.

The Bureau also coordinated its review with the Department of Justice (DOJ) and the court-appointed Independent Monitoring Team (Monitor) to ensure directive compliance with the DOJ settlement agreement. The Bureau received little public feedback during the universal review periods and no recommendations for substantive changes from the Monitor and DOJ, thereby resulting in few changes to the directives.

Public Comments

The Bureau received several repeat comments from previous reviews. The Bureau aims to address all actionable comments and recommendations and has previously provided responses to the repeated comments in the related executive summaries; therefore, it will not speak to those comments in this summary. Otherwise, the Bureau received few recommendations for significant changes during the universal review periods, with most commenters merely suggesting that the Bureau clarify existing terms, practices and requirements.

A commenter asked for a clearer definition of de-escalation, referencing the Bureau's use of "Reactive De-escalation" and "Proactive De-escalation" in Directive 1010.00, Use of Force. Although the term is not defined in the DOJ settlement agreement, the Bureau closely worked with the DOJ in recent years to develop the definition, which remains the same across all directives in which the Bureau uses the term for consistency. The addition of "reactive" and "proactive" in Directive 1010.00 provides additional context and clarity on its meaning in application, however, the Bureau does not see the need to alter the definition itself.

The Bureau received a recommendation that the directive specify how or where members answer the mental health indicator question. Members currently answer the mental health indicator question in the Computer Aided Dispatch (CAD), however, the directive does not specifically this medium to allow for

flexibility if the medium changes. Technology and system changes impact this function, so naming the specific medium would require a directive revision if the medium changes.

One commenter asked for examples of when members call Enhanced Crisis Intervention Team (ECIT) officers. The Bureau of Emergency Communications (BOEC) dispatches ECIT officers when there is a mental health component to the call and the responding officer or a community member requests an ECIT officer, the person is violent or has a weapon, the person is threatening or attempting suicide, their behavior is increasing the risk of harm to themselves or others, or the call is at a designated residential mental health facility.

The same commenter also suggested that the Bureau allows for community requests for an ECIT officer. As noted above, this is an existing practice.

Finally, a commenter suggested that a supervisor be required to respond on scene to all mental health crisis calls. Staffing levels directly impact how the Bureau responds to calls for service. Given this limitation, it is not feasible to require supervisors to respond to all calls of this nature; however, nothing in the policies prohibits such action.

The Bureau's Revised Policies

The Bureau made very minor changes to ensure consistency across all four of the mental health-related directives. Most revisions consisted of aligning guidance for transporting people, updating some descriptive language in the policy sections, and updating the name of the Multnomah County Behavioral Health Call Center.

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

The directives go into effect on April 17, 2025. Published on March 18, 2025.

0850.20 Police Response to Mental Health Crisis

Refer*:*

- ORS § 161.375(4), Authority of Psychiatric Security Review Board to issue warrant of arrest
- ORS § 426.223, Authority of facility director or designee to require assistance of a peace officer to retake custody of committed person who has left a facility without lawful authority
- ORS § 426.005, Definitions for ORS § 426.005 to 426.390 – Persons with Mental Illness
- ORS § 426.228, Authority of peace officer to take a person into custody for mental health treatment
- ORS § 426.233, Authority of community mental health program director or designee to place mental health hold and order transport to treatment
- ORS § 430.735-765, Duty of government officials (incl. Peace Officers) to report abuse of persons with mental illness or developmental disabilities
- DIR 0630.45, Emergency Medical Custody Transports
- DIR 0640.35, Abuse of Elderly/Persons with Disabilities
- DIR 0720.00, Special Emergency Reaction Team (SERT) and Crisis Negotiation Team (CNT) Use
- DIR 0850.21, Peace Officer Custody (Civil)
- DIR 0850.22, Police Response to Mental Health Director Holds and Elopement
- DIR 0850.25, Police Response to Mental Health Facilities
- DIR 0850.30 Temporary Detention and Custody of Juveniles
- DIR 0850.39, Missing, Runaway, Lost or Disoriented Persons
- DIR 0900.00, General Reporting Guidelines
- Portland Police Bureau, Behavioral Health Unit's Mental Health Resources Guide (Intranet)
- Report of Peace Officer Custody of a Person with Alleged Mentally Illness (precinct form)
- Report of Peace Officer Custody of a Person with Alleged Mentally Illness as Directed by a Community Mental Health Director (precinct form)
- Bureau of Emergency Communication's (BOEC's) Enhanced Crisis Intervention Team (ECIT) Dispatch Protocol

Definitions:

- De-escalation: A deliberate attempt to prevent or reduce the amount of force necessary to safely and effectively resolve confrontations.

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

- Disengagement: The intentional decision, based on the totality of the circumstances, to discontinue contact with a person the member could lawfully take into custody.
- Enhanced Crisis Intervention Team (ECIT): ECIT consists of sworn members who have volunteered and been selected to complete an additional forty (40) hours of mental health

response training to serve as specialized responders to persons who may have a mental illness.

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

- Mental Health Crisis: An incident in which *someone with an actual or perceived mental illness* experiences intense feelings of personal distress, a thought disorder, obvious changes in functioning, and/or catastrophic life events, which may, but not necessarily, result in an upward trajectory of intensity culminating in thoughts or acts that are dangerous to self and/or others.

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

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

About Mental Health:

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

2. Mental illnesses are health conditions that are characterized by alternations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alternations in thinking, mood, or behavior contribute to a host of problems, including but not limited to distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom.

3. Mental health problems refer to signs and symptoms of insufficient intensity or duration to meet the criteria for a mental illness diagnosis. Almost everyone has experienced mental health problems in which the distress one feels matches some of the signs and symptoms of mental illness. Mental health problems may warrant active efforts in health promotion, prevention, and treatment.

4. Mental illness is distinct from an intoxicant or a substance-induced condition.

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

Policy:

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

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

3. Members may respond to and intervene on behalf of persons who are in mental health crisis. While members are not expected to make mental health diagnoses, they are expected to recognize signs and symptoms that may suggest a mental illness as well as behaviors that indicate a mental health crisis. The Bureau prioritizes using de-escalation skills to maximize the likelihood of a safe outcome for everyone.

Procedure:

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

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

   1.3. Mental Health Response Training:
      1.3.1. All new sworn members shall receive Mental Health Response training.
      1.3.2. All existing sworn members shall receive Mental Health Response refresher training during annual, in-service training.

1.3.3. The Bureau provides training so that members may recognize signs and symptoms of mental illness and develop skills to engage persons experiencing mental illness with dignity and respect.

2. Police Action and Involvement.
   2.1. When responding to incidents involving persons displaying signs and symptoms of mental health crisis, members shall consider the following actions to manage the incident for the safety of all at the scene:
      2.1.1. Evaluate the incident and determine the need for police action based on information known to the member at the time (e.g. reports, known history, observed behavior, etc.).
      2.1.2. If the member decides police action is needed, consider, when feasible, using verbal and non-verbal communication skills to engage a person who may be agitated, upset, or at risk of becoming emotionally unstable in order to calmly and safely resolve the situation.
      2.1.3. If the member decides police action is not needed, document the reason why in the CAD call or a police report.
      2.1.4. If custody is necessary, develop and communicate a tactical plan, when feasible, to participating members, to take advantage of the most effective options that may safely resolve the incident.

3. Resources and Strategies for Mental Health Crisis Response.
   3.1. When responding to and managing scenes involving persons in mental health crisis, members should consider making a plan and using the following resources and strategies:
      3.1.1. Requesting specialized units such as Enhanced Crisis Intervention Team (ECIT) members or the Crisis Negotiation Team (CNT);
      3.1.2. Consulting with a mental health provider;
      3.1.3. Surveillance;
      3.1.4. Area containment;
      3.1.5. Requesting more resources/summoning reinforcements;
      3.1.6. Delaying arrest (get a warrant, or try different time/place);
      3.1.7. Using time, distance, and communication to attempt to de-escalate the person; and
      3.1.8. Disengagement with a plan to resolve later.

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

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

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

4.4. If a person presents an immediate danger to themselves, before disengaging members shall assess whether they could reasonably remain at the scene and use other tactics to diminish the risk of harm to the person without increasing the risk of harm to the member or third parties. A perception of risk shall be based on articulatable facts and not suspicion alone.

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

4.4.1.1. Complete a general offense report;

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

4.4.1.3. Develop a plan in accordance with Bureau training.

5. Non-Criminal Disposition:

5.1. In determining a non-criminal resolution for a person with a mental illness or in mental health crisis, members shall consider the totality of the circumstances, including the behavior of the person and the governmental interests at stake. Non-criminal dispositions that may be appropriate at the scene include, but are not limited to, the following:

5.1.1. Refer the involved person to a mental health provider; contact the Multnomah County Behavioral Health Call Center for assistance.

5.1.2. Request ambulance transport for the involved person to a mental health or medical facility for voluntary care. Members should inform ambulance personnel of the situation so they can pass the information along to staff at the facility upon arrival. Members may coordinate with medical providers and arrange to escort the person into the waiting area, introduce them to facility staff, and share with staff a brief verbal report on the facts of the case. Members are not required to standby.

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

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

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

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

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

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

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

6.2. ECIT officers may serve as a resource to the Crisis Negotiation Team (CNT). Additionally, ECIT officers may facilitate an efficient transition when CNT arrives on scene. However, ECIT shall not be used in place of CNT. Members should refer to Directive 0720.00, Special Emergency Reaction Team (SERT) and Crisis Negotiation Team (CNT) Use, for additional guidance.

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

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

7. Supervisor Responsibilities:

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

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

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

- **Effective: 4/17/2025**
- **Next Review: 4/17/2027**

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      2.1.3. If the member decides police action is not needed, document the reason why in the CAD call or a police report.
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      3.1.6. Delaying arrest (get a warrant, or try different time/place);
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4. Disengagement.
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   4.2. In determining whether to disengage, members shall, when feasible:
      4.2.1. Attempt to gather relevant information about the person in crisis from readily available sources, such as the Multnomah County Behavioral Health Call Center, and

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

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4.4.1.1. Complete a general offense report;

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

4.4.1.3. Develop a plan in accordance with Bureau training.

5. Non-Criminal Disposition:

5.1. In determining a non-criminal resolution for a person with a mental illness or in mental health crisis, members shall consider the totality of the circumstances, including the behavior of the person and the governmental interests at stake. Non-criminal dispositions that may be appropriate at the scene include, but are not limited to, the following:

5.1.1. Refer the involved person to a mental health provider; ~~see~~contact the Multnomah County Behavioral Health ~~Unit's Community Mental Health Resources,~~Call Center for ~~referral information~~assistance.

5.1.2. Request ambulance transport for the involved person to a mental health or medical facility for voluntary care. Members should inform ambulance personnel of the situation so they can pass the information along to staff at the facility upon arrival. Members may coordinate with medical providers and arrange to escort the person into the waiting area, introduce them to facility staff, and share with staff a brief verbal report on the facts of the case. Members are not required to standby.

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

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

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

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

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

6.2. ECIT officers may serve as a resource to the Crisis Negotiation Team (CNT). Additionally, ECIT officers may facilitate an efficient transition when CNT arrives on scene. However, ECIT shall not be used in place of CNT. Members should refer to Directive 0720.00, Special Emergency Reaction Team (SERT) and Crisis Negotiation Team (CNT) Use, for additional guidance.

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

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

7. Supervisor Responsibilities:

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

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

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

0850.21 Peace Officer Custody (Civil)

Refer:

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

Definitions:

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

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

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

- Mental Health Crisis: An incident in which *someone with an actual or perceived mental illness* experiences intense feelings of personal distress, a thought disorder, obvious changes in functioning, and/or catastrophic life events, which may, but not necessarily, result in an upward trajectory of intensity culminating in thoughts or acts that are dangerous to self and/or others.

- Peace Officer Custody: An exercise of civil authority when there is probable cause to believe a person is dangerous to self or to any other person and is in need of immediate care, custody, or treatment for mental illness. ORS § 426.005 (1) (e); ORS § 426.228.

Policy:

1. In the context of mental health crisis, the Bureau recognizes the importance of civil rights and the need for individuals to have control over their person. However, the Bureau also recognizes there are times when, as a result of mental health crisis, a person may lack the capacity to make sound judgments about their personal situation.

2. Members shall be guided by law regarding civil custody of persons in mental health crisis with the goal of assessing the need for custody. If the need arises, the act of custody shall be resolved in as safe, constructive, and humane of a manner as possible.

3. A member's ability to manage custody by this expectation is of critical importance to the involved person, the involved person's support system, community members, mental health providers, and the Bureau.

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

Procedure:

1. Peace Officer Custody:

1.1. Members may take a person into Peace Officer Custody if the member has probable cause to believe the person is dangerous to self or to any other person and needs immediate care, custody or treatment for mental illness.

1.2. Before taking a person into Peace Officer Custody for a mental health evaluation, members shall:

1.2.1. Develop and communicate a tactical plan, when feasible, to participating members, to take advantage of the most effective options that may safely resolve the incident.

1.2.1.1. When making a tactical plan, members should consider the following resources and strategies:

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

1.2.1.1.2. Consulting with a mental health provider;

1.2.1.1.3. Surveillance;

1.2.1.1.4. Area Containment;

1.2.1.1.5. Requesting more resources/summoning reinforcements;

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

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

1.2.1.1.8. Disengagement with a plan to resolve later.

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

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

2. Member Responsibilities:

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

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

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

3. Supervisor Responsibilities:

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

- **Effective: 4/17/2025**
- **Next Review: 4/17/2027**

0850.21 Peace Officer Custody (Civil)

Refer:

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

Definitions:

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

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

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

- Mental Health Crisis: An incident in which *someone with an actual or perceived mental illness* experiences intense feelings of personal distress, a thought disorder, obvious changes in functioning, and/or catastrophic life events, which may, but not necessarily, result in an upward trajectory of intensity culminating in thoughts or acts that are dangerous to self and/or others.

- Peace Officer Custody: An exercise of civil authority when there is probable cause to believe a person is dangerous to self or to any other person and is in need of immediate care, custody, or treatment for mental illness. ORS § 426.005 (1) (e); ORS § 426.228.

Policy:

1. In the context of mental health crisis, the Bureau recognizes the importance of civil rights and the need for individuals to have control over their person. However, the Bureau also recognizes there are times when, as a result of mental health crisis, a person may lack the capacity to make sound judgments about their personal situation.

2. Members shall be guided by law regarding civil custody of persons in mental health crisis with the goal of assessing the need for custody. If the need arises, the act of custody shall be resolved in as safe, constructive, and humane of a manner as possible.

3. A member's ability to manage custody by this expectation is of critical importance to the involved person, the involved person's support system, community members, mental health providers, and the Bureau.

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

Procedure:

1. Peace Officer Custody:

1.1. Members may take a person into Peace Officer Custody if the member has probable cause to believe the person is dangerous to self or to any other person and needs immediate care, custody or treatment for mental illness.

1.2. Before taking a person into Peace Officer Custody for a mental health evaluation, members shall:

1.2.1. Develop and communicate a tactical plan, when feasible, to participating members, to take advantage of the most effective options that may safely resolve the incident.

1.2.1.1. When making a tactical plan, members should consider the following resources and strategies:

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

1.2.1.1.2. Consulting with a mental health provider;

1.2.1.1.3. Surveillance;

1.2.1.1.4. Area Containment;

1.2.1.1.5. Requesting more resources/summoning reinforcements;

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

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

1.2.1.1.8. Disengagement with a plan to resolve later.

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

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

2. Member Responsibilities:

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

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

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

3. Supervisor Responsibilities:

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

0850.22 Police Response to Mental Health Director Holds and Elopement

Refer:
- ORS § 426.005, Definitions for ORS § 426.005 to 426.390 – Persons with Mental Illness
- ORS § 426.070, Initiation
- ORS § 426.223, Retaking persons in custody of or committed to Oregon Health Authority
- DIR 0850.20 Police Response to Mental Health Crisis
- DIR 0850.21 Peace Officer Custody (Civil)
- DIR 0850.25 Police Response to Mental Health Facilities

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

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

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

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

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

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

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

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

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

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

1.1.2. When assisting a Community Mental Health Program Director or designee as defined in ORS § 426.005 (1) (a) with taking a person into custody (Director's Custody), members shall determine if taking civil custody of the person named on the Director's Custody Report may be achieved in a safe manner.

1.1.2.1. If members disengage, they shall notify a supervisor and then develop a plan to determine a safer time and method to take the person into civil custody. All appropriate police reports shall be completed documenting the details of this decision.

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

1.1.2.3. When necessary, members shall complete an appropriate police report and mental health mask documenting the civil custody or Director's Hold

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

1.2.1. If a person is being held on a Notice of Mental Illness (NMI) and elopes without permission from a facility, they have unlawfully eloped and members may be contacted to bring that person back to the facility.

1.2.2. If a person is on commitment status (e.g., Order of Commitment) and elopes without permission from a facility, they have unlawfully eloped and members may be contacted to bring that person back to the facility.

1.2.3. In the above circumstances, members shall:

1.2.3.1. Verify that the NMI or Order of Commitment exists. The facility should have a copy of the Order on location; otherwise, members may verify the NMI or Order with the Multnomah County Behavioral Health Call Center.

1.2.3.1.1. Criteria for court-ordered civil commitments are dictated by individual state laws. If a patient has eloped from a mental health facility in another state, members shall assess the person and act in accordance with Directive 0850.20, Police Response to Mental Health Crisis and/or Directive 0850.21, Peace Officer Custody (Civil). Members shall contact the reporting facility and notify them of the disposition.

1.2.3.2. Determine if taking civil custody of the person named on the Order of Commitment may be achieved in a safe manner. If members disengage, they shall notify a supervisor and then develop a plan to determine a safer time and method to take the person into civil custody.

1.2.3.3. Transport the named person back to the facility unless the member determines the person meets the criteria in Directive 0850.21, Peace Officer Custody (Civil), in which case, Members shall:

1.2.3.3.1. Request ambulance transport for the involved person to a mental health or medical facility for voluntary care, and adhere to Directive 850.20, or

1.2.3.3.2. Take the involved person into custody and arrange for ambulance transport to a medical facility in accordance with Directive 0850.21,

Peace Officer Custody (Civil), or Directive 0850.22, Police Response to Mental Health Directors Holds and Elopement.

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

1.3. Elopement from a Mental Health Facility:

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

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

1.3.3. Should members receive a call alleging the eloped person is deemed to be dangerous to self or others, members must assess the person in accordance with Directive 0850.20, Police Response to Mental Health Crisis and/or Directive 0850.21, Peace Officer Custody (Civil).

1.4. Member-Supervisor Coordinated Response Required:

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

2. Police Response to Criminal Custody Requests:

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

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

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

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

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

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

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

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

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

2.2. Unlawful Elopement from PSRB:

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

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

2.2.1.2. Determine if taking custody of the person named on the PSRB Order may be achieved in a safe manner. If members disengage, they shall notify a supervisor and then develop a plan to determine a safer time and method to take the person into custody.

2.2.1.3. Transport the named person back to the facility unless the member determines the person meets the criteria in Directive 0850.21, Peace Officer Custody (Civil).

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

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

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

3.1.1. Verify the identity of the person in LEDS.

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

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

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

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

4. Supervisor Responsibilities:

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

- **Effective: 4/17/2025**
- **Next Review: 4/17/2027**

0850.22 Police Response to Mental Health Director Holds and Elopement

Refer:
- ORS § 426.005, Definitions for ORS § 426.005 to 426.390 – Persons with Mental Illness
- ORS § 426.070, Initiation
- ORS § 426.223, Retaking persons in custody of or committed to Oregon Health Authority
- DIR 0850.20 Police Response to Mental Health Crisis
- DIR 0850.21 Peace Officer Custody (Civil)
- DIR 0850.25 Police Response to Mental Health Facilities

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

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

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

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

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

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

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

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

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

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

1.1.2. When assisting a Community Mental Health Program Director or designee as defined in ORS § 426.005 (1) (a) with taking a person into custody (Director's Custody), members shall determine if taking civil custody of the person named on the Director's Custody Report may be achieved in a safe manner.

1.1.2.1. If members disengage, they shall notify a supervisor and then develop a plan to determine a safer time and method to take the person into civil custody. All appropriate police reports shall be completed documenting the details of this decision.

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

1.1.2.3. When necessary, members shall complete an appropriate police report and mental health mask documenting the civil custody or Director's Hold~~.~~

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

1.2.1. If a person is being held on a Notice of Mental Illness (NMI) and elopes without permission from a facility, they have unlawfully eloped and members may be contacted to bring that person back to the facility.

1.2.2. If a person is on commitment status (e.g., Order of Commitment) and elopes without permission from a facility, they have unlawfully eloped and members may be contacted to bring that person back to the facility.

1.2.3. In the above circumstances, members shall:

1.2.3.1. Verify that the NMI or Order of Commitment exists. The facility should have a copy of the Order on location; otherwise, members may verify the NMI or Order with the Multnomah County ~~Crisis Line~~Behavioral Health Call Center.

1.2.3.1.1. Criteria for court-ordered civil commitments are dictated by individual state laws. If a patient has eloped from a mental health facility in another state, members shall assess the person and act in accordance with Directive 0850.20, Police Response to Mental Health Crisis and/or Directive 0850.21, Peace Officer Custody (Civil). Members shall contact the reporting facility and notify them of the disposition.

1.2.3.2. Determine if taking civil custody of the person named on the Order of Commitment may be achieved in a safe manner. If members disengage, they shall notify a supervisor and then develop a plan to determine a safer time and method to take the person into civil custody.

1.2.3.3. Transport the named person back to the facility unless the member determines the person meets the criteria in Directive 0850.21, Peace Officer Custody (Civil~~).~~), in which case, Members shall:

1.2.3.3.1. Request ambulance transport for the involved person to a mental health or medical facility for voluntary care, and adhere to Directive 850.20, or

1.2.3.3.2. Take the involved person into custody and arrange for ambulance transport to a medical facility in accordance with Directive 0850.21,

Peace Officer Custody (Civil), or Directive 0850.22, Police Response to Mental Health Directors Holds and Elopement.

~~1.2.3.3.~~1.2.3.4. Complete the appropriate police report and mental health mask documenting the incident and submit the report to a supervisor before the end of shift.

1.3. Elopement from a Mental Health Facility:

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

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

1.3.3. Should members receive a call alleging the eloped person is deemed to be dangerous to self or others, members must assess the person in accordance with Directive 0850.20, Police Response to Mental Health Crisis and/or Directive 0850.21, Peace Officer Custody (Civil).

1.4. Member-Supervisor Coordinated Response Required:

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

2. Police Response to Criminal Custody Requests:

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

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

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

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

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

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

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

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

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

2.2. Unlawful Elopement from PSRB:

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

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

2.2.1.2. Determine if taking custody of the person named on the PSRB Order may be achieved in a safe manner. If members disengage, they shall notify a supervisor and then develop a plan to determine a safer time and method to take the person into custody.

2.2.1.3. Transport the named person back to the facility unless the member determines the person meets the criteria in Directive 0850.21, Peace Officer Custody (Civil).

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

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

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

3.1.1. Verify the identity of the person in LEDS.

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

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

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

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

4. Supervisor Responsibilities:

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

0850.25 Police Response to Mental Health Facilities

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

Definitions:
- Mental Health Facility: Includes secured residential treatment facility, residential treatment facility/home, adult foster home/care facility, supported housing, or hospitals/clinics that provide supervision and housing for people diagnosed with a mental illness.

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

Policy:
1. It is the responsibility of mental health facilities to have the proper resources to manage people in mental health crisis and to transport persons under their supervision to other care facilities. Mental health facilities should direct routine and urgent calls to their facility administrator or the Multnomah County Behavioral Health Call Center. It is the expectation that mental health facilities will not request police assistance with behavior management, such as gaining physical control of a person who is aggressive, resistive, or refuses to go with facility-arranged transportation. Members should not become involved in these behavior management matters. However, members shall respond to: 1) assaults in progress and/or other serious events in which immediate intervention is required to stop or mitigate injury to a person; 2) investigate crimes and take action as appropriate; and 3) requests for mental health custody in accordance with Directive 0850.22, Police Response to Mental Health Directors Holds and Elopement.

2. Members shall treat these persons with dignity, respect, and compassion at all times.

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

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

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

1.4. In addition to the strategies and resources listed in Directive 0850.20, Police Response to Mental Health Crisis, the following are other strategies for members and their supervisors to consider before entry into a designated residential mental health facility:

1.4.1. Evaluate the situation and necessity for police intervention.

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

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

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

2. Behavioral Health Unit (BHU) Responsibilities:

2.1. The BHU shall:

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

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

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

- **Effective: 4/17/2025**
- **Next Review: 4/17/2027**

0850.25 Police Response to Mental Health Facilities

Refer:

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

Definitions:

- Mental Health Facility: Includes secured residential treatment facility, residential treatment facility/home, adult foster home/care facility, supported housing, or hospitals/clinics that provide supervision and housing for people diagnosed with a mental illness.

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

Policy:

1. It is the responsibility of mental health facilities to have the proper resources to manage people in mental health crisis and to transport persons under their supervision to other care facilities. Mental health facilities should direct routine and urgent calls to their facility administrator or the Multnomah County Behavioral Health Call Center. It is the expectation that mental health facilities will not request police assistance with behavior management, such as gaining physical control of a person who is aggressive, resistive, or refuses to go with facility-arranged transportation. Members should not become involved in these behavior management matters. However, members shall respond to: 1) assaults in progress and/or other serious events in which immediate intervention is required to stop or mitigate injury to a person; 2) investigate crimes and take action as appropriate; and 3) requests for mental health custody in accordance with Directive 0850.22, Police Response to Mental Health Directors Holds and Elopement.

2. Members shall treat these persons with dignity, respect, and compassion at all times.

Procedure:

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

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

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

1.4. In addition to the strategies and resources listed in Directive 0850.20, Police Response to Mental Health Crisis, the following are other strategies for members and their supervisors to consider before entry into a designated residential mental health facility:

1.4.1. Evaluate the situation and necessity for police intervention.

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

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

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

2. Behavioral Health Unit (BHU) Responsibilities:

2.1. The BHU shall:

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

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

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

#1

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Q1

Please provide feedback for this directive

COMMENTS ON EMPLOYEE AND MENTAL HEALTH DIRECTIVES JANUARY 2024

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

Below are Portland Copwatch's comments on the Directives posted for review in January (https://www.portland.gov/police/directives-overview). Many of our comments are repeated from earlier rounds of review, both because the Bureau hasn't responded to our requests and, as acknowledged in the posting, the Employee Information System Directive wasn't actually updated after its last review.

We continue to urge the Bureau to add letters to section headings (Definitions, Policy, Procedure) so that there are not multiple sections with the same numbers, and to number the individual Definitions. Our comments below refer to the Procedure Section unless otherwise noted.

_____MENTAL HEALTH DIRECTIVES (last comments July 2022)_____

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

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

--Prioritize Responses: It looks as if the Bureau has given up on its mnemonic for officers on responses to mental health crisis, formerly "ROADMAP." The list of possible responses is no longer summarized this way, and there are now eight items instead of seven. We suggest reordering the list in order of priority. While losing the easy way to remember the list, the greater problem is that the policy seems to continue pushing de-escalation and disengagement toward the bottom of the list rather than the top. We urge the PPB to publish the list in a way that makes officers think first about calming things down before calling in backup.

The items in 850.20 Section 3 and 850.21 Section 1.2 are:

#1- Request Specialty Units (formerly #1).
#2- Consult a Mental Health Provider (new item from 2022)
#3- Observation / "surveillance"* (formerly #2)
#4- Area containment (formerly #3)
#5- Request resources (formerly #5)
#6- Delay arrest (formerly #6)
#7- Patience / de-escalation (formerly #7)
#8- Disengagement (formerly #4).

Portland Copwatch suggests this order:

#1- Patience/de-escalation
#2- Disengagement
#3- Consult a Mental Health Provider
#4- Request Resources

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#8- Request Specialty Units.

--Make De-escalation Definition Clearer: The PPB defines "de-escalation" as trying to avoid the use of force, which is acceptable. However, it also uses the same term to refer to lowering the amount of force already being used on a suspect, which is mitigation of force, and is called "Reactive De-escalation" in Directive 1010.00 (Section 1.2). The first type is called "Proactive De-escalation" in 1010. If the Bureau refuses to use a term like "mitigation of force" at least use these other terms consistently.

--Credit is Due: PCW appreciates that the Bureau appears to have adopted our suggestion to stop referring to AMR, the private company which contracts for ambulance services in the County and is in hot water for poor performance, instead referring more generally to "ambulance personnel" (850.21 Sections 2.1 & 2.2) and "ambulance transport" (850.22 Section 1.1.2.2). Thank you.

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*-- Footnote for Mental Health intro: "surveillance" implies stealthy review of a person, possibly over a long period of time. "Observation" seems a better term.

DIRECTIVE 850.20 MENTAL HEALTH CRISIS RESPONSE

--Be Less Vague: The Definition of Mental Health Crisis is still too broad, continuing to list "intense feelings of personal distress, a thought disorder, obvious changes in functioning, and/or catastrophic life events." Almost anyone could be considered in crisis by this definition. Related to this issue:

---> Officers are Not Clinicians: In line with the Directive's recognition that "Mental health providers are responsible for the ...diagnosis of persons with mental illness" [Policy 1]), the Directive should include better-defined decision-making guidance for police.

---> Do You See Anything that Interests You?: Section 5.1 tells officers to "consider the governmental interests at stake," but gives no examples.

---> Include Examples (850.20): 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.

---> Spell Out Reasons for Calling Enhanced Specialists: Section 6 guiding the work of the Enhanced Crisis Intervention Team (ECIT) used to contain specific examples of when ECIT officers might respond, including the concept that a community member can request an ECIT officer. There also once were references to violence, weapons, and attempted suicide. PCW continues to suggest putting these examples back in, and adding a reference to Directive 850.25 (Police Response to Mental Health Facilities), though we also believe the Bureau's rules should require officers to check their weapons at such facilities.

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

--Not Engaging as an Option: The previously included option for non-engagement-- where police never make contact with the community member at all-- should be put back into the Directive. Disengagement, which is in the Directive, is about "discontinuing" contact. Section 2.1.2 has a clause which begins "If the member decides police action is needed...", which implies that deciding not to intervene is still an option.

--Acknowledge Police Presence Can Be a Trigger: This is our eighth time writing: "The Directive still does not call attention to the fact that the mere presence of a uniformed officer can cause trauma/stress for persons with mental health issues (and other members of the general public who are fearful of police due to past experience or witnessing of police violence)." We again note our allies in the mental health community acknowledge that some people might respond better to a uniformed officer than to a mental health professional. That being the case, the Directive should offer options to consider for de-escalating, such as putting on PPB polo shirts or other less intimidating gear.

--Some Situations Scream "Supervisor!": Section 7.2 says Supervisors "will acknowledge or respond to" calls in designated mental health facilities. Given the high stakes raised by the officer-caused deaths at such facilities of Jose Mejia Poot in 2001 and Merle Hatch in 2013, we continue to suggest that Supervisory response go back to being mandatory-- especially because it is required in Directive 850.25 (Sections 1.1 and 1.3).

CONCLUSION

PCW appreciates the opportunity to comment on Bureau policies, the occasional responses to our comments in the form of changes being made and the new process of flagging anticipated changes. However, we also believe the Bureau should engage in more dialogue to foster faster and more substantive changes. By hearing more directly from impacted community members, the PPB can narrow the gap and lower the distrust felt from those who are supposed to be protected and served.

Thank you
--dan handelman and other members of
--Portland Copwatch

Q2

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

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Thank you
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--Portland Copwatch

Q2

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#1

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Q1

Please provide feedback for this directive

COMMENTS ON MENTAL HEALTH AND JUVENILE DIRECTIVES APRIL 2024

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

Below are Portland Copwatch's comments on the Directives posted for review in April (https://www.portland.gov/police/directives-overview). Once again many of our comments on the Mental Health Directives are repeated from earlier rounds of review as they seem to mostly go unheeded. On the other hand, the comments we made in January, 2022 about the Juvenile Detention Directive were almost all addressed,* to the point where we did not send in follow up comments in July 2022. There are still a few issues which we've raised below.

It's also helpful to see the community comments in the Second Universal Reviews, though much of the time PCW's are the only comments. The Compliance Officer's report on Q3 2023 indicated that the Behavioral Health Unit's Advisory Committee asked the PPB to add specific options such as calling 988 or for Portland Street Response, and those recommendations should also be listed as part of the feedback received.

We would like to see the Bureau add letters to section headings (Refer, Definitions, Policy, Procedure) so that there are not multiple sections with the same numbers, and to number the individual Definitions. Our comments below refer to the Procedure Section unless otherwise noted.

* Footnote, introduction: We put the wrong number on 850.30 in our 2022 comments, sorry for the error.

_____MENTAL HEALTH DIRECTIVES (previous comments January 2024)_____

General Comments: These comments apply to all four Directives around Mental Health (850.20, 850.21, 850.22 and 850.25), repeated or updated from previous comments:

--Consistency Appreciated, One More For the Win: Following our comments, the Bureau is proposing to align all four policies by calling on officers to treat people in mental health crisis "with dignity, respect and compassion." Now all but 850.20 call for such treatment "at all times."

--Revisit Priorities: As noted previously, there is no longer a quick guide for officers to remember possible responses to mental health crises. We noted the current list begins with calling in specialty units, an item we suggested putting at the bottom of the list. However, it did not occur to us that calling in members of the Enhanced Crisis Intervention Team might be part of this tactic. Just to be clear that they're not looking for the Special Emergency "Reaction" Team or generic crisis negotiators, we've split this up below.

The items in 850.20 Section 3 and 850.21 Section 1.2 are:

#1- Request Specialty Units
#2- Consult a Mental Health Provider
#3- Observation / "surveillance"*
#4- Area containment
#5- Request resources
#6- Delay arrest
#7- Patience / de-escalation

#8- Disengagement.

Portland Copwatch suggests this order:

#1- Patience/de-escalation
#2- Disengagement
#3- Request Enhanced Crisis Intervention Team officers
#4- Consult a Mental Health Provider
#5- Request Resources
#6- Delay Arrest
#7- Observation
#8- Area containment
#9- Request Other Specialty Units.

--Consistently Define De-Escalation: The Compliance Officer/Community Liaison has mentioned repeatedly that officers seem unclear on what constitutes de-escalation. PCW believes this is because while the PPB correctly defines "de-escalation" as trying to avoid the use of force, it also uses the same term to refer to lowering the amount of force already being used on a suspect. The latter concept is really mitigation of force, and is called "Reactive De-escalation" in Directive 1010.00 (Section 1.2), while the first type is called "Proactive De-escalation." If the Bureau chooses not to use a term like "mitigation of force" at least use these other terms consistently.

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

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DIRECTIVE 850.21 PEACE OFFICER CUSTODY (CIVIL)

--List Reasons for Mental Health Calls (850.21): A previous clause telling officers to consider the "totality of the circumstances, including.... the governmental interests at stake" when making a non-criminal detention still has not been reinserted. Examples of such interests should also be included.

--Don't Repeat Offensive Legal Language (850.21): Section 2.1 refers to ORS 426.228, whose title includes the phrase "An Allegedly Mentally Ill Person." PCW suggests that the Bureau make it clear they are not the ones who are using the problematic phrasing of "mentally ill person" rather than "person with mental illness." PPB should use a bracketed comment to explain the language is from the State, by offering alternative language or simply saying "[sic]."

CONCLUSION

As always, PCW is appreciative of the opportunity to comment. We're far more appreciative of when there is an actual dialogue about the substance of policies and why the police might be reluctant to adopt seemingly common-sense proposals which will help engender trust in the community and potentially make life better for everyone. We have seen Policy Director Ashley Lancaster make presentations to the Training Advisory Council (in 2022) and the Portland Committee on Community Engaged Policing (March 2024) and hope there will be more opportunity for community engagement about these policies.

Thank you

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

Q2

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

Name	**Portland Copwatch**

#1

COMPLETE

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Q1

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COMMENTS ON EMPLOYEE AND MENTAL HEALTH DIRECTIVES JANUARY 2024

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DIRECTIVE 850.22 POLICE RESPONSE TO MENTAL HEALTH DIRECTOR HOLDS AND ELOPEMENT

--Trouble Waiting to Happen: 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.

--End of Shift or Not End of Shift?: 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 2.1.3.4 on revocation orders.

--It Doesn't Matter Who Started It (850.22): We continue to express concern that Section 1.2 includes references to "Notice of Mental Illness" (NMI), a term which does not appear in the statute cited (ORS 426.070), and sounds like a negative labeling process. A more precise and less pejorative term should be substituted. We noticed this term is suggested by the Oregon Health Authority. Again, the Bureau should make that clear in the Directive where the term came from and/or get the other agencies using this term to fix it.

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

--Cross-Reference The "Mental Health Suite": We continue to believe an explicit statement should be added to this Directive saying "for information on interactions at mental health facilities, see Directive 850.25." Directives 850.20 and 850.21 are referenced several times in 850.22.

--Show Us Your Work: A blank copy of the "mental health text template" referred to in 2.2.1.4 should be made available to the public for transparency's sake.

--Cops Don't Necessarily Know: Section 1.1.2.3 instructs officers to fill out reports "when necessary" but should define what that means.

CONCLUSION

PCW appreciates the opportunity to comment on Bureau policies, the occasional responses to our comments in the form of changes being made and the new process of flagging anticipated changes. However, we also believe the Bureau should engage in more dialogue to foster faster and more substantive changes. By hearing more directly from impacted community members, the PPB can narrow the gap and lower the distrust felt from those who are supposed to be protected and served.

Thank you
--dan handelman and other members of
--Portland Copwatch

Q2

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

Name	**Portland Copwatch**

#1

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Tuesday, January 30, 2024 3:43:23 PM
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Q1

Please provide feedback for this directive

COMMENTS ON EMPLOYEE AND MENTAL HEALTH DIRECTIVES JANUARY 2024

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

Below are Portland Copwatch's comments on the Directives posted for review in January (https://www.portland.gov/police/directives-overview). Many of our comments are repeated from earlier rounds of review, both because the Bureau hasn't responded to our requests and, as acknowledged in the posting, the Employee Information System Directive wasn't actually updated after its last review.

We continue to urge the Bureau to add letters to section headings (Definitions, Policy, Procedure) so that there are not multiple sections with the same numbers, and to number the individual Definitions. Our comments below refer to the Procedure Section unless otherwise noted.

_____MENTAL HEALTH DIRECTIVES (last comments July 2022)_____

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

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

--Prioritize Responses: It looks as if the Bureau has given up on its mnemonic for officers on responses to mental health crisis, formerly "ROADMAP." The list of possible responses is no longer summarized this way, and there are now eight items instead of seven. We suggest reordering the list in order of priority. While losing the easy way to remember the list, the greater problem is that the policy seems to continue pushing de-escalation and disengagement toward the bottom of the list rather than the top. We urge the PPB to publish the list in a way that makes officers think first about calming things down before calling in backup.

The items in 850.20 Section 3 and 850.21 Section 1.2 are:

#1- Request Specialty Units (formerly #1).
#2- Consult a Mental Health Provider (new item from 2022)
#3- Observation / "surveillance"* (formerly #2)
#4- Area containment (formerly #3)
#5- Request resources (formerly #5)
#6- Delay arrest (formerly #6)
#7- Patience / de-escalation (formerly #7)
#8- Disengagement (formerly #4).

Portland Copwatch suggests this order:

#1- Patience/de-escalation
#2- Disengagement
#3- Consult a Mental Health Provider

#4- Request Resources
#5- Delay Arrest
#6- Observation
#7- Area containment
#8- Request Specialty Units.

--Make De-escalation Definition Clearer: The PPB defines "de-escalation" as trying to avoid the use of force, which is acceptable. However, it also uses the same term to refer to lowering the amount of force already being used on a suspect, which is mitigation of force, and is called "Reactive De-escalation" in Directive 1010.00 (Section 1.2). The first type is called "Proactive De-escalation" in 1010. If the Bureau refuses to use a term like "mitigation of force" at least use these other terms consistently.

--Credit is Due: PCW appreciates that the Bureau appears to have adopted our suggestion to stop referring to AMR, the private company which contracts for ambulance services in the County and is in hot water for poor performance, instead referring more generally to "ambulance personnel" (850.21 Sections 2.1 & 2.2) and "ambulance transport" (850.22 Section 1.1.2.2). Thank you.

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

*-- Footnote for Mental Health intro: "surveillance" implies stealthy review of a person, possibly over a long period of time. "Observation" seems a better term.

DIRECTIVE 850.25 POLICE RESPONSE TO MENTAL HEALTH FACILITIES

--Nobody in a Hospital Has a Gun: Our analysis from earlier comments on this policy continues to stand: "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.

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

--De-Escalate When Contacting Person in Crisis: Section 1.4.4 directs officers to decide whether to contact the person in crisis by phone, in person or by "other means." Whatever choice is made should be geared to de-escalate the situation. Contacting a person in crisis should not include looking a person in the eye and then shooting them in the head, as Officer Kelly Van Blokland said he did before killing Samuel Rice through a hotel's bathroom window in 2018.

--List Options Again: The reference to the old "ROADMAP" mnemonic for tactics was removed in this Directive, but similar options are now listed in Directives 850.20 (Section 3.1) and 850.21 (Section 1.2). The Bureau should also list those options here, at least briefly, for clarity.

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

CONCLUSION