Behavioral Crisis Response Policy Framework

For Oregon Law Enforcement Agencies

Oregon Mental Health Crisis Response Work Group

OREGON ASSOCIATION CHIEFS OF POLICE AND

OREGON STATE SHERIFFS' ASSOCIATION

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MENTAL HEALTH TASK FORCE – EXECUTIVE SUMMARY

A Right Response: Law Enforcement Encounters with People in a Mental Health Crisis

INTRODUCTION AND BACKGROUND

It does not require one to do much research on the internet to quickly realize that law enforcement encounters with persons in a mental health crisis or having a perceived behavioral problem can quickly escalate into a use of force incident. A two year compilation of police shootings by the Washington Post found that a quarter of police involved shootings involved a person in a reported mental health crisis (December 2016, Washington Post). Additional studies throughout the country clearly show that in many states, a high percentage of police shootings involved a mental health aspect, and in many of those cases, the subject with the mental health disorder was killed (see *References*).

The United States Department of Justice (USDOJ) notes the following in their *2016 Guide to Critical Issues in Policing*, "Persons who have a mental illness, are under the influence of drugs or alcohol, or have disorders such as autism can present police officers with difficult challenges. In some cases, a person may brandish a weapon or otherwise appear to pose a threat to the public, to the police, or to himself or herself. The threat may be a real one, or the situation may be less dangerous than it appears. These situations often are complicated when, because of their conditions, persons cannot understand an officer's questions or orders or cannot communicate effectively with the officer."

The United States Appellate Courts have continued to weigh in on law enforcement interactions involving police encounters with persons suffering from a mental health crisis or behavioral problems. These Court rulings have inevitably been driven from use of force encounters. The Courts unquestioningly are advising law enforcement to review and revise use of force policy specific to these types of encounters. The 4th, 5th, 9th, and 10th Circuit Courts have all made rulings in recent years finding that law enforcement essentially needs to slow down, take into consideration a person's mental state, and attempt to de-escalate situations before "forcing" an encounter. ***Sheehan v. City & Cnty. of San Francisco***, 743 F.3d 1211 (9th Cir. 2014); ***Deorle v. Rutherford,*** 272 F.3d 1272 (2001). The 9th Circuit Court has found that a Law Enforcement Officer may be held liable for "intentionally or recklessly provoke[ing] a violent confrontation" despite his otherwise defensive use of deadly force. ***Glenn v. Washington County***, 673 F3d 864 (9th Cir. 2011).

Law enforcement leaders in our state, as well as across the nation, have to navigate this difficult topic, make good sound policy and response decisions for their personnel, the communities they serve, and continue to engage their personnel and communities in conversations around police encounters involving persons in a mental health or behavioral crisis.

In October of 2015, a presentation to the joint memberships of the Oregon Association of Chiefs of Police (OACP) and the Oregon State Sheriffs' Association (OSSA) centered on case law specific to the 9th Circuit Court of Appeals and use of force in the State of Oregon. Upon conclusion of the training it was evident that several Oregon law enforcement leaders were unfamiliar with the latest case law regarding use of force encounters with persons in crisis. It was apparent that there likely was a disconnect between law enforcement use of force training at the agency level compared to what was being taught at the Oregon Public Safety Academy (Department of Public Safety Standards and Training). This disconnect was again in reference to case law specific to the 9th Circuit Court of Appeals.

Furthermore, two additional incidents had come to light that continued to push these issues to the forefront of law enforcement in the State of Oregon. A 2013 Federal lawsuit, *Harrigan v Marion County*, *Oregon*, had a nexus context of violating the plaintiffs rights specific to the American with Disabilities Act (ADA) and unlawful use of force based on the argument that the plaintiff's disability was not taken into consideration prior to the use of force. The second incident related to a City of Eugene, Oregon incident where a veteran with mental health issues was shot and killed by police (Babbs).

DEVELOPING THE TASK FORCE

Both OACP and OSSA agreed to form a Mental Health Task Force consisting of law enforcement, the Department of Public Safety Standards and Training (DPSST) (Oregon Public Safety Academy), local non-profits, mental health professionals, Oregon Health Authority (OHA), 9-1-1 Dispatch, Fire Services, and emergency medical technicians. The purpose of this task force was to provide recommendations around the following: (1) Policy Framework (best practices) regarding police encounters with persons experiencing a mental health crisis; (2) Training at the individual agency level and Department of Public Safety Standards and Training (DPSST), including terminology associated with police encounters of persons in a mental health crisis; (3) Review of DPSST's Mental Health and Disabilities training and identifying recommended components for inclusion in the training component of Crisis Intervention Team (CIT) programs throughout the state.

The first meeting of the Joint Oregon Association of Chiefs of Police and Oregon State Sheriff's Association Mental Health Task Force was in January of 2016. The meeting was led by joint chairs, Woodburn PD Chief Jim Ferraris and Marion County Undersheriff Troy Clausen Two sub-

committees, formed to oversee the overall joint process, were led by City of Eugene Police Chief Pete Kerns, City of Salem Police Chief Gerald Moore, Gilliam County Sheriff Gary Bettencourt and Linn County Sheriff Bruce Riley. Over the course of a year the Joint Task Force met four times and each sub-committee held meetings of their own. The Joint Task Force, its members, and recommendations came to an end in February of 2017. The body of their work is contained in this document. Many hours of conversations, case studies, and work went into producing this document and its recommendations. The Task Force met the goals that had been established around policy framework, training, and defining Crisis Intervention Team training (CIT) within the State of Oregon. Recommendations in each area are backed up with subsequent data, best practices from other states and nations, and from the Federal government.

These recommendations do not come lightly and are made with the intention of keeping Oregon at the forefront of our approach to this difficult topic. As mentioned above, the goal of this task force was to assist our law enforcement leaders navigate this difficult topic, make good sound policy and response decisions for their personnel and communities, and to continue to engage their communities in conversations around police encounters involving persons in a mental health or behavioral crisis.

We would like to sincerely thank the members of the Joint OACP/OSSA Mental Health Task Force. Their dedication to this profession and our communities' health was undeniable. Every person associated with this Task Force was set on helping to develop sound recommendations, practice, and training components. We could not have done this work without them. Furthermore, the assistance of the Department of Public Safety Standards and Training was invaluable, specifically, that of Director Eriks Gabliks and the support services provided by Executive Assistant Theresa Janda.

FINDINGS and RECOMMENDATIONS

POLICY FRAMEWORK

Sub-Committee Co-Chairs: Chief Jerry Moore, Salem Police Department
Sheriff Bruce Riley, Linn County Sheriff's Office

The goal of the Policy Framework subcommittee was to establish recommended parameters for which Oregon policing agencies could potentially adopt into their existing policies around encounters with persons in a mental health or behavioral crisis. The policy framework recommendations as outlined in the *"Law Enforcement Response to Individuals in Behavioral Crisis: A Framework Detailing Options/Recommendations to Law Enforcement Officers Responding to Calls Involving Individuals in Behavioral Crisis,"* are presented in the following fashion:

I.) Purpose of the Framework Recommendations: The intent of these recommendations are to provide all peace officers with resources to deal with subjects who are in behavioral crisis. This includes people exhibiting signs of mental illness, as well as people suffering from substances abuse and personal crisis.

Peace officers within the purview of the United States 9th Circuit Court of Appeals are instructed to consider the potential of a mental crisis that a person may be experiencing during all encounters. This includes the decision to use force if necessary during the contact. De-escalation of these incidents should always be the goal of Oregon peace officers. This expectation does not ask the peace officer to attempt to de-escalate when faced with an imminent safety risk that requires an immediate response.

II.) Definitions: Having a common understanding amongst Oregon law enforcement in policy/protocol terminology both in training and in practical practice brings a better opportunity for understanding how to de-escalate incidents involving law enforcement and persons experiencing a behavioral crisis.

III.) Response Alternatives: Recommendations for communities and law enforcement to have alternatives to arrest and jail. Many of these incidents can be resolved in a manner that does not require charging an individual in a mental health crisis with a crime. The ability to have community partnerships and resources cannot be overstated. Peace officers need viable alternatives to incarceration for many of these contacts. Furthermore, for individuals who are only a danger to themselves and no one else, what alternatives are available to peace officers when making decisions on the scene to not-engage, engage, or disengage with a person in crisis.

Many Oregon law enforcement agencies are developing internal "Response Considerations" for individuals who may be barricaded and suicidal based on case law around exigency. It is the recommendation of this Task Force that Oregon law enforcement agencies have an understanding of the risk associated with Not-Engaging, Engaging, or Disengagement during a behavioral crisis incident (see below in policy framework recommendations). These "Response Considerations" should be based on sound case law review, officer safety considerations, the sanctity of human life, and risk management.

Twenty-four/seven, 365-day Psychiatric Crisis Facilities that are available within Oregon have shown to be extremely successful in helping communities and local law enforcement when dealing with these difficult situations. In addition, the advent of Mobile Crisis Response Teams (police and mental health workers responding to in-progress calls together) has shown to be very effective in the communities they are operating. As an example, Marion County Mobile Crisis units responded to over 500 in progress active mental health calls in 2017 which resulted in only 19 custody arrests and only two (2) uses of force. The Task Force strongly advocates for additional Psychiatric Crisis Centers to be created within the State of Oregon, especially in rural areas where services are limited. The Oregon Health Authority, Oregon National Alliance on Mental Illness (NAMI), Greater Oregon Behavioral Health, Inc. (GOBHI), League of Oregon Cities, and the Association of Oregon Counties would be recommended partners to have at the table to discuss long term strategies for crisis services in Oregon communities. Furthermore, we strongly advocate for additional Mobile Crisis Teams within the state.

TRAINING

Sub-committee Co-Chairs: Chief Pete Kerns, Eugene Police Department

Sheriff Gary Bettencourt, Gilliam County Sheriff's Office

The goal of the training sub-committee was to establish recommendations to the Department of Public Safety Standards and Training on the amount of training hours for basic police recruits during the 16-week Basic Police Academy. The Training Sub-Committee would recommend to the work group that DPSST provide a structured twenty-five (25) hours of dedicated training hours around mental health issues, including response scenarios.

The Basic Police Mental Health Series would consist of: Introduction of the topic (8 hrs.); Scenarios (4 hrs); Legal Considerations (2 hrs.); De-escalation (3 hrs); Veteran Awareness (4 hrs); Scenarios (4 hrs). The National Alliance of Mental Illness's (NAMI) "In Our Own Voice" would also be an optional training for Basic Students while attending DPSST. This is a 2-hour

presentation from community members who suffer from a mental illness condition and are successfully dealing with the diagnosis.

The Training Sub-Committee indicated the proposed curriculum would allow students to be introduced to the concepts and issues they will face on a professional level and then progress through the series in the classroom and in live scenarios that will focus on de-escalation. In addition, information on substance abuse and trauma informed care will also be provided.

On a state-wide level, the Task Force has recommended to DPSST to add a requirement that of the 84 hours of required law enforcement maintenance training to be completed within a 3-year window, 3 hours of training specific to "dealing" with persons in crisis be mandatory for Oregon law enforcement officers. This will be a discussion between DPSST and the Oregon Association of Chiefs of Police and the Oregon State Sheriffs' Office to finalize.

Public Safety agencies across the state of Oregon should also strongly consider implementing the following training strategies for skills based scenario training as well as common approaches to problem solving for their personnel in the field. Both the Boyd Model, commonly referred to as the OODA loop (The OODA loop is an important concept in litigation, business, law enforcement, and military strategy. According to the Boyd Model, decision-making occurs in a recurring cycle of observe-orient-decide-act) and the National Decision Model, a risk assessment framework, or decision making process, that is used by police forces across the country. It provides five different stages that officers can follow when making any type of decision. Both models are referenced below.

CRISIS INTERVENTION TEAMS/TRAINING:

Sub-committee Co-Chairs: Kevin Rau and Linda Maddy, DPSST

Carol Speed, Greater Oregon Behavioral Health, Inc

The Mental Health Task Force in support of DPSST and the newly formed Crisis Intervention Team Center of Excellence (CITCOE) recommends the following for Oregon law enforcement:

Support of the core elements training curriculum designed by CITCOE and adapted from the "Memphis Model" and Crisis Intervention Team (CIT) training throughout the country. CITCOE and the Task Force both agree that developing a core curriculum for Oregon law enforcement agencies who wish to provide the 40 hour CIT intensive training class only strengthens our understanding, approach, and response to persons in a mental health or behavioral crisis incident. What the Task Force and CITCOE hope to prevent are Oregon law enforcement

agencies providing training either locally or regionally and calling it CIT training when the class is less than 40 hours.

CITCOE presented their 40-hour curriculum to the Task Force. We strongly recommend that Oregon law enforcement leaders and both OACP and OSSA support a mandatory definition that Crisis Intervention Team training in Oregon should include the curriculum elements defined by CITCOE.

As an alternative to the 40 hour CIT training classes, Oregon law enforcement agencies could provide training such as Mental Health First Aid for Public Safety (MHFAPS) created by the National Council for Behavioral Health. MHFAPS is an eight-hour codified, evidence based best practice, training curriculum specifically modified to address the law enforcement population and provide a general awareness of mental health issues. It offers information and skills to support someone in a mental health crisis or who is developing a mental health problem. It should be noted that MHFAPS is not a replacement for the "gold standard" of a 40 hour CIT training class and should not be referenced as CIT training.

CITCOE also wanted local law enforcement leaders to under that DPSST does not conduct Crisis Intervention Team training. Rather, DPSST provides training on mental illness and communication as well as response considerations when an officer encounters a person experiencing a mental health crisis. The Basic Police curriculum does not contain all the key components of a CIT curriculum as many of these are driven by community partnerships with mental health provides which vary county by county. Because each Basic Police class is comprised of officers from urban, rural and frontier areas (each having their own resources and challenges), it is problematic to try to include those components in the Basic Police Academy context.

Additional Recommended Readings:

Included in this report are recommended readings and articles for law enforcement leaders and agencies to consider as they look to implement policies and practices regarding law enforcement contacts with people in a mental health or behavioral crisis. The Task Force would strongly recommend reading the Police Executive Research Forums (PERF) work on *Use of Force: Taking Policing to a Higher Standard* and the Bureau of Justice Affairs, *Police-Mental Health Collaboration programs checklists.*

Launching the Data-Driven Justice Initiative: Disrupting the Cycle of Incarceration:

Every year, more than 11 million people move through America's 3,100 local jails, many on low-level, non-violent misdemeanors, costing local governments approximately $22 billion a year. In local jails, 64 percent of people suffer from mental illness, 68 percent have a substance abuse disorder, and 44 percent suffer from chronic health problems. Communities across the country have recognized that a relatively small number of these highly-vulnerable people cycle repeatedly not just through local jails, but also hospital emergency rooms, shelters, and other public systems, receiving fragmented and uncoordinated care at great cost to American taxpayers, with poor outcomes. (White House Briefing Room, 30 June, 2016: https://obamawhitehouse.archives.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle). (DOJ and National Association of Counties).

Stepping Up Initiative:

The National Association of Counties (NACo), the Council of State Governments (CSG) Justice Center, and the American Psychiatric Association (APA) Foundation have come together to lead a national initiative to help advance counties' efforts to reduce the number of adults with mental illnesses and co-occurring substance use disorders in jails. With support from the U.S. Justice Department's Bureau of Justice Assistance and other sponsors, the initiative will build on the many innovative and proven practices being implemented across the country.

Stepping Up urges county leaders to pass a resolution and convene teams of agency decision makers and diverse stakeholders to develop a six-step action plan to reduce the number of people with mental illnesses in jails (http://www.naco.org/resources/programs-and-services/stepping-initiative).

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Guide to Critical Issues in Policing, (2016, Jan. 29) *Community Relations Services Toolkit for Policing* United States Department of Justice. https://www.justice.gov/crs/file/836416/download

Examples and Resources to Support Criminal Justice Entities in Compliance with Title II of the Americans with Disabilities Act (2017, Jan.) United States Department of Justice, Civil Rights Division. https://www.ada.gov/cjta.html

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Additional Resources/References:

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Public Safety Mental Health Task Force

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Law Enforcement Response to Individuals in Behavioral Crisis:

A Policy Framework Detailing Options Available to Law Enforcement Officers Responding to Calls Involving Individuals in Behavioral Crisis

Executive Summary

Law enforcement responses to calls involving people suffering from a behavioral health crisis has become an issue that has captured the attention of the public, policy makers, mental health advocates and community leaders who are all seeking more effective outcomes from these encounters. In response, law enforcement officials are looking to specialized approaches to these calls in order to improve these interactions and to reduce the number of individuals suffering from mental illnesses entering the criminal justice system. These approaches show great promise as they are designed to provide training and resources to improve law enforcement officers' ability to safely intervene and connect individuals with needed mental health services and divert them from the criminal justice system where appropriate.
Law enforcement officers' contacts with people suffering from mental illness present several challenges as these encounters:

- Generally take longer to resolve than other calls for service,
- Law enforcement officers do not feel adequately trained to effectively respond to mental health crises calls,
- May depend on the availability of community health resources for successful outcomes,
- Typically involve repeat contacts with the same individuals who have unresolved and frequently untreated mental health needs,
- Involve a relatively minor or "nuisance" offense,
- Calls can be unpredictable and dangerous, potentially posing greater risk to the safety of all involved.

Law enforcement officers have discretion as to how they address minor offenses or calls where no crime has been committed but citizens want them to "do something" about the unusual behavior or mere presence of a person who appears to be in a behavioral or mental health crisis. These encounters provide law enforcement officers with the opportunity to connect individuals with appropriate behavioral health supports and services with the hope that future law enforcement encounters are prevented. The following is a recommended policy framework from the work of Oregon's law enforcement Mental Health Task Force:

Policy Framework Recommendations

Purpose of Policy

The intent of this policy is to provide all peace officers with resources to deal with subjects who are in behavioral crisis. This includes people exhibiting signs of mental illness, as well as people suffering from substance abuse and personal crises.

For the purposes of this policy, a behavioral health crisis is defined ***as an episode of mental and/or emotional distress in a person that is creating significant or repeated disturbance and is considered disruptive by the community, friends, family or the person themselves.***

The [Insert Agency] recognizes the need to bring community resources together for the purpose of safety and to assist and resolve behavioral crisis issues. The [Agency] further recognizes that many people suffer crises and that only a small percentage has committed crimes or qualifies for an involuntary evaluation. Persons suffering crises will be treated with dignity and will be given access to the same law enforcement, government and community service provided to all members of the public.

Peace officers are instructed to consider the crises that subjects may be experiencing during all encounters. Peace officers should recognize that subjects may require law enforcement assistance and access to community mental health and substance abuse resources. The ideal resolution for a crisis incident is that the subject is connected with resources that can provide long-term stabilizing support.

Peace officers are trusted to use their best judgment during behavioral crisis incidents, and the [Agency] recognizes that individual peace officers will apply their unique set of education, training and experience when handling crisis intervention. The [Agency] acknowledges that peace officers are not mental health professionals. Peace officers are not expected to diagnose a subject with a mental illness, nor are they expected to counsel a distraught subject into composure. When peace officers need to engage with a subject in behavioral crisis, the [Agency's] expectation is that they will attempt to de-escalate the situation, when feasible and reasonable.

The purpose of de-escalation is to provide the opportunity to refer the subject to the appropriate services. This expectation does not restrict a peace officer's discretion to make an arrest when probable cause exists, nor are peace officers expected to attempt de-

escalation when faced with an imminent safety risk that requires immediate response. A peace officer's use of de-escalation as a reasonable alternative will be judged by the standard of objective reasonableness, from the perspective of a reasonable peace officer's perceptions at the time of the incident.

Definitions

Basic Needs: Oregon appellate courts have held that the 'basic needs' commitment standard focuses on the capacity of the individual to survive, either through own resources or with help of family or friends; to obtain some commodity (food or water) or service (medical care) without which the individual cannot sustain life. The essential question is whether the individual is able to access the resources necessary for continued survival. Danger must be imminent, not speculative. There must be a likelihood that a person probably would not survive in the near future because the person is unable to provide for basic personal needs and is not receiving care necessary for health and safety.

Crisis: "Crisis" means either an actual or perceived urgent or emergent situation that occurs when an individual's stability or functioning is disrupted and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental or physical health or to prevent referral to a significantly higher level of care. OAR 309-019-0105 (29)

Crisis Intervention Training (CIT) program: A model for community policing training that brings together law enforcement, behavioral health providers, hospital emergency departments and individuals with mental illness and their families to improve responses to people in crisis. CIT programs enhance communication, identify mental health resources for assisting people in crisis and ensure that officers get the training and support that they need.

De-escalate/De-escalation: Taking action or using specific strategies or techniques during a potential force or actual use of force event with the goal to stabilize the situation and reduce the immediacy of the threat. De-escalation may include the use of any types of communication or other techniques that may reasonably allow for more time, options, and resources that will be beneficial in resolving the situation or at a minimum reduce the amount of force necessary to resolve the situation. Additionally, strategies that may apply a de minimis or lesser amount of force as a means of decreasing a higher likelihood of a higher level force being used, thus potentially reducing the likelihood of greater injury to any actors related to the use of force event, may also be considered a form of de-escalation.

Delaying Custody: A tactic that can be used if the member determines immediately taking the person into custody may result in an undue safety risk to the individual, peace officers or members of the community.

Disengagement: The intentional decision, based on the totality of the circumstances, to discontinue contact after initial attempts with a person in crisis.

Emotionally disturbed person: A person with emotional, mental or erratic behavior that affects their decision-making process that may include hurting themselves or others.

Engagement: Encounter between a law enforcement officer and an individual experiencing a state of crisis.

Mental Illness: An impairment of an individual's normal cognitive, emotional, or behavioral functioning, caused by physiological or psychosocial factors. A person may be affected by mental illness if he or she displays an inability to think rationally (e.g., delusions or hallucinations); exercise adequate control over behavior or impulses (e.g., aggressive, suicidal, homicidal, sexual); and/or take reasonable care of his or her welfare with regard to basic provisions for clothing, food, shelter, or safety.

Non engagement: The intentional decision, based on the totality of the circumstances, not to make contact with a person in crisis.

Peace Officer Custody: A peace officer may take into custody a person who the officer has probable cause to believe is dangerous to self or to any other person and is in need of immediate care, custody or treatment for mental illness.

Mental Health Program Director Custody: A peace officer shall take a person into custody when the community mental health program director, pursuant to ORS 426.233, notifies the peace officer that the director has probable cause to believe that the person is imminently dangerous to self or to any other person.

Response Alternatives

In determining the appropriate resolution for a person in crisis, members will consider the totality of the circumstances, including the behavior of the person with a suspected mental illness or developmental disability and the governmental interests at stake. Following is a list of dispositions that may be appropriate at the scene, among others:

- Take the person into custody and to jail for a criminal offense that supports custodial arrest and presentation to a magistrate for charging.

- Refer the person to a mental health agency, crisis hotline, or other related service agency.

- Consult with a mental health or medical professional prior to taking action.

- Transport the person to a behavioral health or medical facility for voluntary care. Assisted persons should not be dangerous and should be able to manage their behavior. Peace officers should escort persons into the waiting area and introduce the person to facility staff. Peace officers are not required to standby. Peace officers will complete a report to document the incident and transport.

- Take the person into custody on a peace officer hold, an exercise of civil authority, when there is probable cause to believe the person is a danger to self or to any other person, or is unable to provide for basic personal needs and is not receiving the care necessary for health and safety, and is in need of immediate care, custody, or treatment for mental illness. Peace officers will transport him or her to the appropriate secure evaluation unit or to the nearest designated hospital for mental health evaluation.

- Consider non-engagement or disengagement if the peace officer determines that contact or continued contact with the person will result in an undue safety risk to the person, the public, and/or members.

- Delaying custody if the peace officer determines that taking the person into custody under present circumstances may result in an undue safety risk to the person, the public, and/or peace officers.

MENTAL HEALTH TASK FORCE – SUMMARY OF TRAINING RECOMMENDATIONS

BASIC TRAINING

The Task Force recommended the following changes to the Basic Police Academy which were proposed and approved by the Board on Public Safety Standards and Training:

- Improved sequencing of 25 dedicated training hours; delivered in 2-4 hour sessions throughout the 16-week academy program.
- Addition of a 2-hour course on legal considerations related to interactions between law enforcement officers and persons with mental illness.
- Addition of 4 hours of scenario-based training focused on de-escalating a person in crisis.
- New content related to addiction and expanded discussion on co-occurring disorders.
- Information on trauma-informed care integrated into the curriculum.
- Addition of NAMI's "In Our Own Voice" program as an optional training for students to interact with individuals living with mental illness.

Basic Police Mental Health Series

NOTE: Specific curriculum information is located in *Appendix A* of this document.

IN-SERVICE TRAINING

The Task Force recommended the following changes to Oregon Administrative Rule related to the maintenance training standards for certified law enforcement officers:

OAR 259-008-0065

Rule Caption
Adds 3 hours of Mental Health/Crisis Intervention related training to law enforcement certification maintenance training.

Rule Summary
This proposed rule change applies to currently employed and certified law enforcement officers which includes police officers, corrections officers, parole and probation officers and OLCC regulatory specialists.

On July 27, 2017, the Board on Public Safety Standards and Training adopted a recommendation that designates three hours of the maintenance training requirements to mental health/crisis intervention related training. Implementation of the change to the law enforcement officer maintenance training requirements will be modeled after the current maintenance training standards.

- The three hours of mental health or crisis intervention related training will be a part of the three year maintenance cycle and not above and beyond the 84 hours required.
- The title of the training category allows for a broad range of topics within mental health or crisis intervention.
- The employing agency will maintain discretion on selection of training topics, how training is delivered, and if the training takes place as a lump sum total at one time or in smaller time allotments.

The proposed rule change includes a phasing in period that will transition the training from recommended training to required training by January 1, 2020.

CRISIS INTERVENTION TEAM (CIT) TRAINING

The Task Force recommended that Oregon law enforcement leaders, as well as the Oregon Association of Chiefs of Police and the Oregon State Sheriff's Association, support a mandatory definition that Crisis Intervention Team (CIT) training in Oregon should include the curriculum elements defined by Oregon's CIT Center of Excellence (CITCOE).

NOTE: Specific curriculum information is located in *Appendix B* of this document.

APPENDIX A

STATE OF OREGON

DEPARTMENT OF PUBLIC SAFETY STANDARDS AND TRAINING

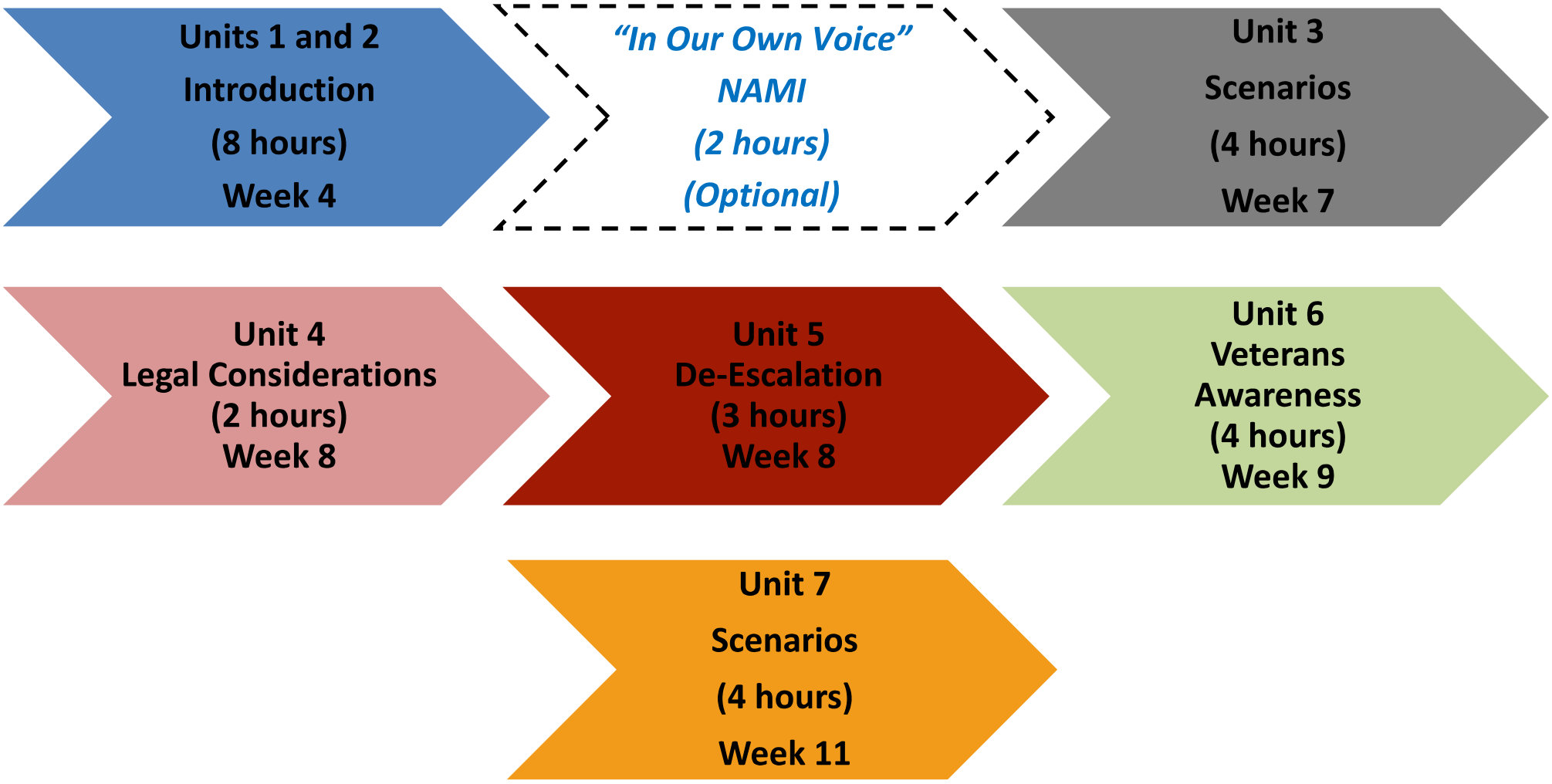
Basic Police Mental Health

2017 CURRICULUM OVERVIEW

PROGRAM CHANGES – "AT A GLANCE"

- Improved sequencing of 25 dedicated training hours; delivered in 2-4 hour sessions throughout the academy
- Addition of 2-hour course on legal considerations related to interactions between law enforcement officers and persons with mental illness
- Addition of 4 hours of scenario-based training focused on de-escalating a person in crisis
- New content related to addiction and expanded discussion on co-occurring disorders
- Information on trauma-informed care integrated into curriculum
- Addition of NAMI's "In Our Own Voice" program as an optional training for students; provides an opportunity to interact with individuals living with mental illness

Basic Police Mental Health Series



Acknowledgments

This 25 hour Basic Police Mental Health curriculum was developed for basic police officers by mental health and law enforcement professionals. This effort is a direct result of work done by the Mental Health Workgroup lead by the Oregon State Sheriff's Association and the Oregon Association Chiefs of Police. Numerous individuals provided valuable contributions to this successful curriculum revision, and the agencies they represent reflect the demographic diversity of Oregon's communities.

Mental Health Work Group Leadership

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Oregon State Sheriff's Association

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Oregon Chapter

Basic Police Mental Health Units 1 & 2
Introduction

TIME: 8 hours

LEARNING GOAL:

This course is designed to develop a new police officer's understanding of behaviors commonly associated with mental illness, addiction, trauma and developmental disabilities.

LEARNING OUTCOMES:

Following instruction, students will be able to:
• Recognize how stigma impacts mental illness and addiction.
• Describe behaviors commonly associated with mental illness, addictions, trauma and developmental disabilities.
• Identify potential barriers to communication with a person experiencing a mental health crisis.

UNITS 1 AND 2 OUTLINE:

I. Mental Health – General
   a. Stigma
   b. Current Statistics
   c. Overview of Statutory references

II. Observable Behaviors
   a. Recognizing behaviors associated with mental illness
   b. Behaviors in a crisis
   c. Overview of major mental illnesses
      i. Schizophrenia and psychotic disorders
      ii. Depression
      iii. Bipolar Disorder
      iv. Anxiety Disorders

III. Trauma
   a. Common reactions to crisis or trauma

IV. Substance Abuse
   a. Behaviors associated with addiction
   b. Co-occurring Disorders

V. Suicide
   a. Identifying persons at risk

b. Intervention

VI. Disabilities

a. Intellectual Disability

b. Autism

c. Dementia

Basic Police Mental Health Unit 3
Scenarios

TIME: 4 hours

LEARNING GOAL:

This course is designed to provide a new police officer an opportunity to apply their knowledge of mental illness, addictions, trauma and developmental disabilities in a scenario.

LEARNING OUTCOMES:

Following instruction, students will be able to:
• Identify that a person is likely experiencing a mental health crisis.
• Develop an appropriate intervention strategy based on observed behaviors related to a mental health crisis.

UNIT 3 OUTLINE:

I. Scenarios
   a. Review Units 1 and 2
   b. Recognizing behaviors associated with:
      i. Mental illness
      ii. Substance Abuse
      iii. Crisis/Trauma
      iv. Disabilities

Basic Police Mental Health Unit 4
Legal Considerations

TIME: 2 Hours

LEARNING GOAL:

This course is designed to develop a new officer's understanding of state and federal statutes and case law related to interactions between law enforcement officers and people with mental illness.

LEARNING OUTCOMES:

Following instruction, students will be able to:
• Describe an officer's authority under ORS 426.228
• Articulate significant case law principles impacting interactions between law enforcement and mentally ill persons
• Describe the significance of the Americans with Disabilities Act, as it relates to law enforcement interactions with mentally ill persons
• Identify those circumstances where possession of firearms by a mentally ill person is prohibited by law and/or by court order

UNIT 4 OUTLINE:

I. Custody of persons in need of emergency care and treatment – ORS 426.228
   A. Discretionary peace officer custody
   B. Mandatory peace officer custody – "Director's hold"

II. Selected cases - Use of force and persons with mental illness
   A. Deorle v. Rutherford
   B. Hayes v. San Diego
   C. Glenn v. Washington County
   D. Sheehan v. City and County of San Francisco

III. Discussion: The Americans with Disabilities Act
   A. Basic protections
   B. Rights related to contact with peace officers

IV. Firearms prohibitions
   A. ORS 166.250 – Unlawful possession of a firearm
   B. ORS 426.130 – Civil Commitment
   C. ORS 426.133 – Assisted Outpatient Treatment

Basic Police Mental Health Unit 5
Crisis De-escalation

TIME: 3 hours

LEARNING GOAL:

This course is designed to develop a new police officer's understanding of crisis and de-escalation techniques.

LEARNING OUTCOMES:

Following instruction, students will be able to:
• Describe the Crisis Cycle
• Identify behaviors associated with a person in crisis
• Identify potential barriers to communication with a person experiencing a mental health crisis.
• Demonstrate de-escalation skills.

UNIT 6 OUTLINE:

I. Review of Units 1-5
II. Overview of crisis
    a. Crisis Cycle
        i. Normal Baseline
        ii. Stimulation
        iii. Escalation
        iv. Crisis
        v. De-escalation
    b. Observable behaviors commonly associated with a mental health crisis
III. De-escalation
    a. Non-verbal de-escalation techniques
        i. Breathing
        ii. Body language
    b. Verbal de-escalation techniques
        i. Active Listening
        ii. Grounding

Basic Police Mental Health Unit 6
Veterans Awareness

TIME: 4 hours

LEARNING GOAL:

This course is designed to develop a new police officer's ability to recognize that a person in crisis may be a Veteran and to apply Veteran specific strategies and resources.

LEARNING OUTCOMES:

Following instruction, students will be able to:
• Describe Post Traumatic Stress Disorder and Traumatic Brain Injury.
• Describe Readjustment challenges a Veteran may experience when re-entering civilian life.
• Identify strategies to consider when interacting with Veterans.
• Identify general Veteran specific resources.

UNIT 5 OUTLINE:

I. Review Units 1 – 3
II. Military 101
   d. Overview of active duty, National Guard and Reserve
   e. Females
   f. Contractors
III. Deployment
   a. Global War on Terrorism
   b. Combat Stressors
IV. Post-Traumatic Stress Disorder
   a. Diagnostic Overview
   b. Symptoms
V. Traumatic Brain Injury
   a. Diagnostic Overview
   b. Symptoms
VI. Strategies
   a. Awareness – identifiers
   b. Strategies for working with Veterans
   c. Grounding
   d. Resources

Basic Police Mental Health Unit 7
Scenarios

TIME: 4 hours

LEARNING GOAL:

This course is designed to provide a new police officer the opportunity to apply de-escalation techniques and strategies in a scenario

LEARNING OUTCOMES:

Following instruction, students will be able to:
• Identify that a person is likely experiencing a mental health crisis.
• Demonstrate an appropriate strategy based on observed behaviors related to a mental health crisis.
• Demonstrate the ability to adapt an approach appropriately for a dynamic interaction with a person in mental health crisis.

UNIT 7 OUTLINE:

I. Scenarios
   a. Review of Units 1-5
   b. Applying knowledge to identify behaviors in a mental health crisis
   c. Applying strategies to de-escalate a person experiencing a mental health crisis

Basic Police Curriculum Change

The Training Division requests the approval of the Police Policy Committee to make the following adaptations to the Basic Police curriculum to accommodate the proposed 2017 Mental Health curriculum:

Replace the scenario block "Unattended Death Scenarios" with "Mental Health Scenarios"

Rationale:

DPSST's Tactical Section completed a review and proposed reorganization of scenario training blocks within the basic academy.

Several mental health related scenarios were dispersed throughout general scenario blocks such as Solo Officer Response and Patrol Week. The group identified that scenarios related to unattended death investigations could be dispersed into these general blocks instead, therefore affording dedicated time and consistency for scenarios related to mental health response.

Synopsis:

TRAINING COURSE	ORIGINAL HOURS	PROPOSED HOURS	CHANGES
Unattended Death Scenarios	4	0	-4 *
Mental Health Scenarios	4	8	+4

* Specific scenarios retained and redistributed within other training blocks

APPENDIX B

Oregon CIT Core Elements

This training Curriculum is adapted from the "Memphis Model" and Crisis Intervention Team (CIT) Trainings throughout the country. A CIT program is multifaceted. The training component addressed in this document is only one part of a complete CIT program. Presentation samples were provided by CIT programs in Columbia, Deschutes, Douglas, and Umatilla Counties in Oregon as well as the nationally awarded Memphis, Tennessee and Charlottesville, Virginia CIT programs.

The training emphasizes a better understanding of mental illnesses, including substance use disorders and how it affects a person's life. The course increases communication skills, using both practical experience and role-playing. Class participants are introduced to local mental health professionals, consumers and family members both in the classroom and in the field during site visits.

This 40 hour intensive training program provides a common base of knowledge about mental illness and gives the participants a basic foundation from which to build. The course is intended to provide officers and first responders with the skills to:

- Recognize signs and symptoms of mental illness and co-occurring disorders
- Recognize a mental health crisis situation
- Verbally de-escalate mental illness crisis – when safe and appropriate
- Know local resources on where to take consumers in crisis
- Learn about jail diversion options
- Know what the appropriate steps to follow up are, such as contacting case managers and providing families with community resources.
- Learn how to problem-solve with the treatment system

The curriculum outlined below allows flexibility for each community to develop aspects, needs and resources unique to their community.

Creating a CIT program and making it available to agency members can be challenging. The course information provided in this document is based on the training element of the "Memphis Model" and is what is commonly recognized as CIT training. All agencies should be providing some level of training to their staff on information, tactics and techniques for safely and effectively responding to incidents involving those experiencing a mental health crisis but not all agencies can effectively make CIT training available to their staff.

Suggested CIT Core elements of the Memphis Model include:

Mental health – 13 hours

a) Severe, persistent Mental illness
b) Child and youth, adolescence
c) Special focus issues – including suicide and PTSD
d) Substance use disorder
e) Assessment and commitment
f) Crisis cycle
g) Stress first aid
h) Cognitive Disorders

Community Support – 6 hours

a) Cultural Awareness & diversity
b) Veteran's Perspective
c) Community Resources
d) Advocacy/Perspective

De-Escalation – 9 hours

a) Verbal de-escalation
b) Law Enforcement tactics
c) Scenario Discussion
d) Scenarios and role plays

Site Visits – depending on local resources, 2 – 6 hours

a) Psychiatric hospital
b) Veteran's centers
c) Day treatment programs
d) Homeless programs
e) Outpatient treatment
f) Foster home/treatment homes

Law Enforcement – 4 hours

a) Policy and procedures
b) Liability
c) Officer Wellness
d) Mental health courts/jail diversion programs

Research and Systems –

a) CIT overview
b) Evaluation of the training
c) Administrative tasks

Core CIT Curriculum Classes (Total Hours = 40)				
Recommended Courses (32 – 34 hours)	Minimum Hours	Maximum Hours	Example 1	Example 2
Age related disorders	1		1	1
Cognitive Disorders	1		1	1
Community Resources	1		1	1
De-Escalation Role Plays	4		3	3
De-Escalation Strategies and Techniques	4		4	4
Graduation & CIT Evaluation	1		2	1
Lived Experience Panel (s)	2		2	3
Medication	1		2	1
Officer Wellness	1		2	1
Overview of CIT	1		1	1
Overview of Civil Involuntary Detention Laws and Liability	1		2	1
Overview of Mental Health Disorders	1		3	2
Site Visits	2		2	2
Substance use/Co-Occurring Disorders	1		2	1
Suicide Intervention	1		2	1
Veterans' issues and PTSD	1		2	2
Youth Intervention	1		2	1
The Minimum number of recommended class hours is 32. (6 additional hours from the above list are necessary to reach the 32 hour minimum)				27
The Maximum number of recommended class hours is 34 (no more than 8 additional hours from the above list are allowed to reach the 34 hour maximum)			34	

Elective Courses (6-8 Hours)	Minimum Hours	Maximum hours	Example 1	Example 2
Autism Spectrum Disorder	1			
Bipolar Disorder	1			
CIT from the Officer (s) Point of View	1			
Eating Disorder	1			
Excited Delirium	1		1	1
Guardianship and Power of Attorney	1			
Homelessness	1			
Inpatient Hospital Assessment Process	1			1
Jail Diversion	1			
Law Enforcement Suicide	1			
Mental Health First Aid for Law Enforcement	6	8		7
Mood Disorder	1			
Networking Lunch (local sponsorship required)	1		2	2
Personality Disorders	1			
Psychosis Simulator	1		1	
Reducing Stigma	1			
Specialty Courts	1		1	1
Suicidal vs. non-Suicidal Self-Harm	1			
Suicide by Cop	1			1
Supervision of CIT Officers/report writing/ data				
Synthetic Drugs	1			
Trauma Informed Care	1		1	
Veteran's Perspective	1			
Select at least 4 classes from the list to equal up to 8 hours				
The Minimum number of elective class hours is 6	6		6	13
The Maximum number of elective class hours is 8		8		
Total hours			40	40

**Achievement of the minimum/maximum recommended hours may be acquired throughout the training over several presentations. EX: De-escalation techniques may be included in the Autism Spectrum Disorder for specific ways to help de-escalate an individual with Autism.*

Training can be provided on any of the topics listed above but in and of itself cannot be considered CIT. Some training is better than no training at all, however. In addition to specific topic based training from those listed, there are also structured programs available which can provide a basic awareness of mental illness. As an example, "Mental Health First Aid", which is a curriculum developed by the National Council for Behavioral Health, has been used to effectively train criminal justice professionals to recognize behavior commonly associated with mental illness.