PORTLAND POLICE BUREAU
TRAINING DIVISION

EVALUATION REPORT

2018 ENHANCED CRISIS INTERVENTION TRAINING

Training usefulness, on-the-job applications, and reinforcing of training objectives

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Introduction:

The Portland Police Bureau (PPB) developed its Enhanced Crisis Intervention Team (ECIT) training in 2013 in response to the ever-changing landscape of law enforcement and the increased number of interactions with individuals who are in behavioral health crises. The training – which includes elements such as crisis communication skills, mental illness indicators, interactions with consumers and family members, and scenario exercises – builds upon the skills taught in officers' basic police academy courses, but with increased emphasis on the assessment of an event involving an individual in a behavioral health crisis and connections to community resources meant to divert such individuals from jail to the appropriate care.

ECIT officers are trained to perform many tasks, including identifying risk factors and providing strategy considerations to the members on scene, providing specific resource information to link community and family members to the mental health system, and making referrals to the Behavioral Health Unit, which coordinates the PPB response to individuals in behavioral health crises.

The training was initially developed with two desired results:

1) To have police and community member interactions that result in the safest possible outcome for the police and community members (specifically community members experiencing a behavioral health crisis) and,
2) To be a partner with the mental health system in public safety issues related to behavioral health crises.

To accomplish these goals, the PPB Training Division relies upon feedback from multiple sources, including mental health partners and the Behavioral Health Advisory Committee, as well as the PPB's mental health specialist, to build a training that would equip officers with the skills necessary to navigate an incident involving a community member in crisis, and bring that incident to the safest possible resolution.

While designing this program, the Training Division began an evaluation of the training to track attainment of the above-mentioned goals. The evaluation tracks how students respond to the initial training event, learning that occurs as a result of the training, application of the skills on the job, and how well the organization is meeting its ECIT training goals. The evaluation assesses all four levels of the Kirkpatrick model.[1] This report provides an examination of the data and feedback collected pertaining to the 2018 ECIT training and provides an update on program outcome results.[2]

Overview:

To begin, it is helpful to provide an overview of ECIT in Portland and the core concepts integral to the success of the program. Since 2013, PPB has trained 155 officers in enhanced crisis intervention techniques, with 101 actively situated in patrol positions in 2018. A total of 3,427 ECIT calls were dispatched in 2018.

ECIT Dispatch Criteria:

The Bureau of Emergency Communications (BOEC) dispatches ECIT officers to a call with a mental health nexus under seven circumstances:

1) Upon the request of a citizen
2) Upon the request of the responding member
3) The subject is violent
4) The subject has a weapon
5) The subject is threatening or attempting suicide
6) The crisis call is at a designated residential mental health facility, or

[1] The Kirkpatrick Model, created by Dr. Donald Kirkpatrick, was developed in 1954 and has become a distinguished standard for training evaluation. More information about the Kirkpatrick Model and related books can be obtained at http://www.kirkpatrickpartners.com/.

[2] Data and feedback was collected throughout the ECIT training process, including survey data of the training participants from the initial training event and a subsequent follow-up survey. Additional feedback was obtained from program coordinators and instructors, the Behavioral Health Unit, the Bureau of Emergency Communications, the Enhanced Crisis Intervention Team Advisory Council, and the Behavioral Health Unit Advisory Committee Recommendations.

7) The call involves a subject in a mental health crisis whose behavior appears to be escalating the risk of harm to self or others.

The 7th criterion were expanded on April 1, 2018. In addition, BOEC trained its staff to more accurately differentiate between ECIT and non-ECIT calls. Futhermore, PPB instituted a procedure to assist BOEC dispatchers in capturing and recording more ECIT calls. When an ECIT-trained officer responds to a call and uses their ECIT skills, they now notify BOEC that they are acting as an ECIT officer.

ECIT Training Key Components

De-escalation:

De-escalation techniques can be a successful intervention tool in situations involving community members in a behavioral health crisis. Techniques such as using verbal communication designed to calm an agitated subject, decreasing exposure to a potential threat using distance, cover, or concealment, and avoiding physical confrontation unless immediately necessary help reduce the volatility of a scene. De-escalation techniques are numerous in nature and difficult to define, however, members are trained to take proactive steps which establish control of the scene in an attempt to minimize the need for the use of force.

ECIT Roles:

ECIT officers are trained to assess the mental status of individuals and identify potential risk factors associated with certain behaviors. Additionally, these officers are trained to evaluate various situational risk factors, and to utilize resources and techniques to resolve the call in the safest way possible. Officers are trained to use the acronym "AAA" – Assess, Advise, Apply – to observe the scene and prioritize certain actions when arriving to a call as an ECIT officer. In the "Apply" phase of this process, officers may choose to fill one of three specific roles (depending on the severity of the call and the number of officers on scene). These roles can be summarized as follows:

Primary

The individual responsible for a majority of the communication with the subject can be described as the Primary Communicator. This individual is in charge of communicating with the subject and using "time as a tactic" to allow the individual time to de-escalate and engage in problem solving.

Coach

The Communication Coach supports the Primary by providing suggestions to the Primary on topics that may help de-escalate the subject, or actions the primary can take that may help resolve the situation as safely as possible. The Coach also assists the on-scene sergeant in strategizing the best methods to utilize based on the circumstances of the incident. The Coach often receives the information relayed from the Intelligence Gatherer (see below), and helps pass along pertinent information to other members of the team throughout the incident.

Intelligence

During an incident, there may be specific knowledge about the subject or the situation that can be gleaned through various methods (e.g. contacting family members, completing a records search, etc.). If possible, the Intelligence Gatherer can be specifically focused on gathering this information and relaying pertinent factors to the Coach in order to be used by the Primary Communicator.

Taken together, this "Communication Team" may effectively coordinate available resources to bring the incident to a safe resolution. Not all of these roles will be filled on every ECIT call, as there may be a limited number of officers on scene, the incident may not necessitate all of the roles be filled, or one officer may fill more than one role as required. Nevertheless, ECIT officers are trained on this Communication Team concept in order to accommodate the specific needs of subject(s), family member(s), and care provider(s).

Training Event and Student Learning:

The 40-hour ECIT training event consisted of four 10-hour days of training comprised of in-class lectures, site visits, and role-playing scenarios.[3] Students completed an evaluation survey at the end of each day and a learning assessment on the final day of classes, to gauge student reactions to the training event, as well as their retention of critical information. Overall, feedback from the evaluations was largely positive, with students finding a majority of the classes to be a worthwhile use of training time. Students were asked to assess the value of each course across each day of the training, via a 6-point Likert scale ranging from "Strongly Disagree" to "Strongly Agree." Many students were additionally asked the level to which each course expanded upon their previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.

On days three and four of the training additional survey items were included to assess the level of student retention and confidence in performing various crisis response tasks, as well as gauge their before-and-after knowledge of core competencies in the ECIT curriculum. These items assist in evaluating the students' comprehension of the key ECIT learning objectives, as well as gauge their confidence in performing those critical behaviors on the job.

Each survey contained additional qualitative survey items such as, "If any of the sessions were not a good use of your training time, please provide us further information as to why so we can make program improvements," and "Please feel free to provide any additional comments for improving this training here." These questions allowed students to provide feedback outside of the structured quantitative survey items and provide an opportunity to evaluate training components that could be improved in the future.

Quantitative Assessment

On quantitative items, students responded most favorably to the *Mental Illness, Risk Assessment, and System Coordination* class, taught by a guest-instructor. Sixteen of seventeen respondents (94.1 percent) strongly agreed that the course was a good use of training time, with several students making positive remarks about the class in the qualitative section of the survey. High levels of agreement were also seen on the *Crisis Response for ECIT* session (13/17 strongly agree, 76.5 percent), *Psychosis and Communication* (13/17 strongly agree, 76.5 percent), and the *Crisis Communication Skill Exercises* (13/17 strongly agree, 76.5 percent).

Qualitative Assessment

Several responses to qualitative survey items pertained to redundancy in material and certain classes being too similar to the CIT training officers received in their basic academy courses. This was seen across multiple days, with one student commenting that the training held across days one and two was not challenging enough. Another student expressed a desire for additional focus on the Bureau's expectations of ECIT officers. When taken together with findings from the follow-up survey provided to the students four months post-training[4], this may indicate a need for additional clarification on the role of ECIT officers to students during the training, as well as clarification to non-ECIT officers on the role ECIT officers should occupy when arriving on scene.

Multiple students responded favorably in the qualitative section to the role-playing scenarios, commenting that they were useful, realistic, and relevant to their jobs. When asked about the *Consumer Panel Discussion*, students commented that they appreciated listening to different perspectives and learning about the peer support program. Several students commented that they found the panel valuable, but believed it would have been better with a more structured format. The call for more structure was seen across three classes

[3] Referred to as the "40-hour ECIT training" throughout this report, to differentiate it from the Crisis Intervention training officers completed in Basic and Advanced Academies.

[4] See page 8 for follow-up results.

during the training: the *Consumer Panel Discussion*, the *NAMI overview*, and the *Family Member Panel*. Upon discussion with ECIT program coordinators, it appears the students may not be prepared for the format of these classes, causing lower levels of satisfaction than other classes. Coordinators believe this can be remedied with an introduction emphasizing the learning objectives for those specific classes.

Main Findings

Crisis Response for ECIT

The material provided in the *ECIT Overview* and *Crisis Response for ECIT* sections is key to officers' understanding of their role during incidents involving a behavioral health crisis. Officers are provided with material on responding to crisis calls in both their basic crisis intervention courses (taken during their basic and advanced academies), as well as the 40-hour ECIT course. In prior courses some students alluded to the material in this section being repetitive to that which they learned during CIT courses in basic academies. As mentioned above, in the 2018 course there were several comments of this nature in the qualitative surveys. ECIT coordinators (BHU command staff and PPB's mental health specialist) believe this makes sense, as younger cohorts of officers are going through the 40-hour training sooner following their basic academies. Taken together, this indicates the emphasis placed on crisis intervention techniques in recent trainings has resonated well with students, and the ECIT 40-hour training may be able to emphasize additional topics that go beyond the basic academy courses.

Consumer Panel Discussion

ECIT program coordinators include Consumer Panel Discussions due to positive feedback from previous trainings. During the Consumer Panel Discussion officers hear the stories of individuals living with mental illness and learning how the actions of officers can impact them during the course of an event. Several students commented the panel could benefit from a more organized structure. Through conversations with ECIT program managers, it appears there may be a benefit in placing the session later in the schedule of courses, and priming officers beforehand on the intended purpose of the class. The act of priming benefits both the students and the panel by communicating the intended learning objectives at the start of the conversation. ECIT program coordinators believe this priming conversation may be of benefit in several of the ECIT courses where the format differs from the traditional classroom-lecture style.

Mental Illness/Risk Assessment/Systems Coordination

This class received highly positive reviews from students and instructors alike, with verbal and survey feedback both noting that the instructor's perspective was invaluable to their understanding of mental illness. The ECIT program coordinators also considered the presentation to be a highly beneficial aspect of the training. The coordinators plan to include this instructor in future training sessions.

Family Member Panel

Similar to the *Consumer Panel Discussion*, this course had a positive impact emphasizing the lived experiences of people with mental illness, but could be enhanced via a focused introduction on the learning objectives and intended purpose of the course. Several students appreciated the different viewpoints of parents and the importance of using family members as a resource to create a response plan. Similar to the *Consumer Panel Discussion,* moving this class later in the week may also be of benefit, as several comments reflected a desire for more ECIT-response focused material earlier in the training. Taken together with the observations of program coordinators, it would appear that restructuring the order of classes and adding a purposeful introduction which communicates the intended learning objectives may be of benefit to the students.

Mental Health Facilities Response

The directive guiding this class (850.25) was being rewritten at the time of this ECIT training. Coordinators plan on providing an update and addressing changes to the directive.

Site Visits

Post-training officer feedback showed that the officers have continued to refer and transport individuals to mental health facilities since the ECIT training.[5] In the qualitative responses, one student commented that they would like an additional hour for site visits, but would like the visits to be broken up over multiple days of the training. ECIT program coordinators believe these visits may also benefit from the focused introduction discussed for the *Consumer Panel Discussion* and *Family Member Panel*.

ECIT Scenarios

The scenarios received largely positive feedback from students and instructors, with comments on the material being realistic and relevant to their jobs. Two students asked for the inclusion of juvenile scenarios, including elements of parental involvement and access to resources. One student suggested having a scenario that utilizes a loud hail component for giving commands.

On-the-Job Application: Post-Training Officer Feedback

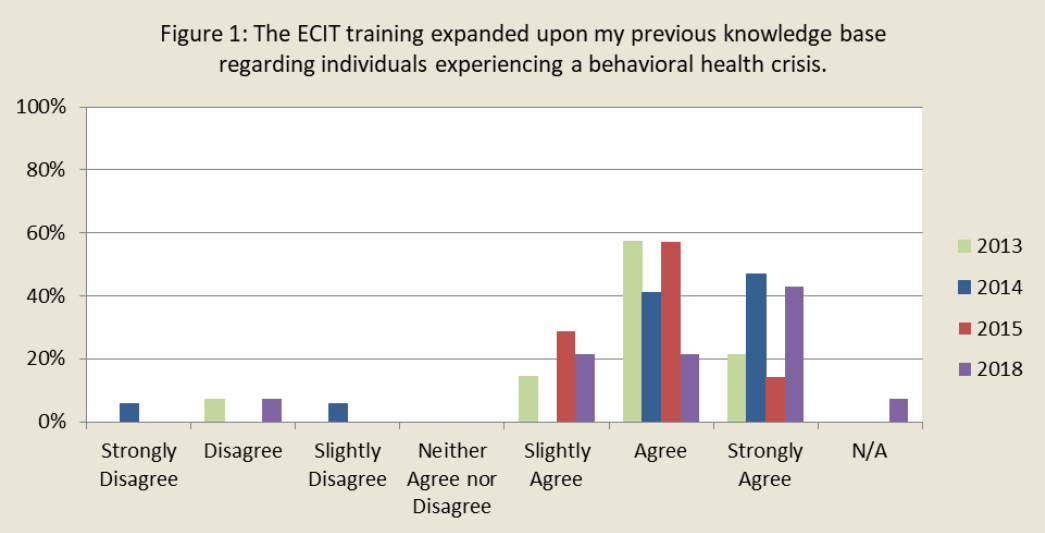
The 2018 ECIT Training cohort was given a follow-up survey four months post-training to assess the level to which aspects of the training were the most useful to them on the job, challenges they faced applying ECIT skills on the job, and confidence regarding their ability to engage with individuals during behavioral crisis incidents. The survey consisted of fourteen close-ended (quantitative) survey items, and three open-ended (qualitative) questions. The survey was delivered in an online format, via an email distributed by the Acting ECIT Lieutenant. A subsequent email was sent out two weeks after the initial email, allowing members who had not yet responded an opportunity to complete the survey. Ultimately, the survey was delivered to all 17 officers who attended the August 2018 training, with 14 officers responding. The survey was nearly identical to the follow-up surveys delivered to previous training cohorts, to allow for cross-comparison of results between the cohorts[6] (survey items were only altered to reflect the updated classes/visits that occurred in the 2018 training, e.g. site visits that the students attended).

[5] See page 11 for more information.

[6] Questions 8, 9, 12, and 13 were only presented to students in 2015 and 2018. All other questions were included on surveys in 2013, 2014, 2015, and 2018.

Section One: Usefulness of the Enhanced Crisis Intervention Team Training

1. *The ECIT training expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis.*



- Among the 2018 cohort, 64.3 percent of the officers that responded they agreed or strongly agreed that the training expanded upon their previous knowledge base regarding individuals experiencing a behavioral health crisis.
    - Out of fourteen respondents, six strongly agreed, three agreed, three slightly agreed, one disagreed, and one responded "not applicable".

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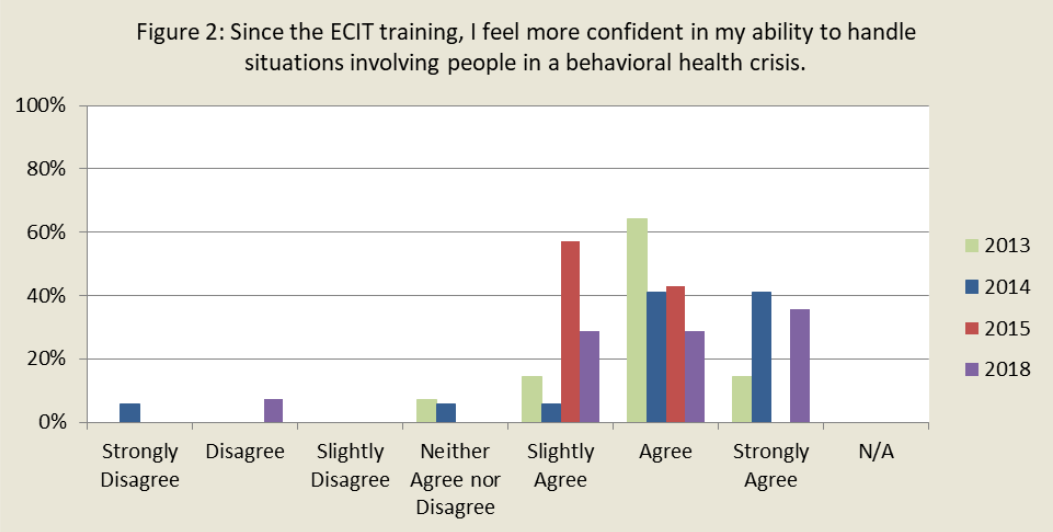
2. *Since the ECIT training, I feel more confident in my ability to handle situations involving people in a behavioral health crisis.*



- Among the 2018 cohort, 64.3 percent of the officers responded they agreed or strongly agreed that they feel more confident in their ability to handle situations involving people in a behavioral health crisis.
    - Out of fourteen respondents, five strongly agreed, four agreed, four slightly agreed, and one disagreed.

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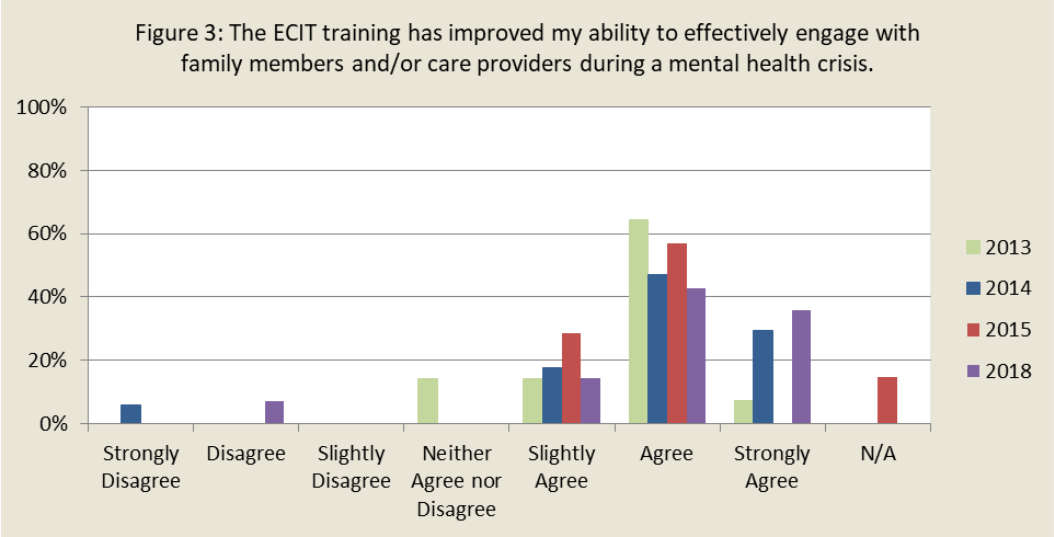
3. *The ECIT training has improved my ability to effectively engage with family members and/or care providers during a mental health crisis.*



- Among the 2018 cohort, 78.6 percent of the officers responded they agreed or strongly agreed that the ECIT training improved their ability to effectively engage with family members or care providers during a mental health crisis.
    - Out of fourteen respondents, five strongly agreed, six agreed, two slightly agreed, and one disagreed.

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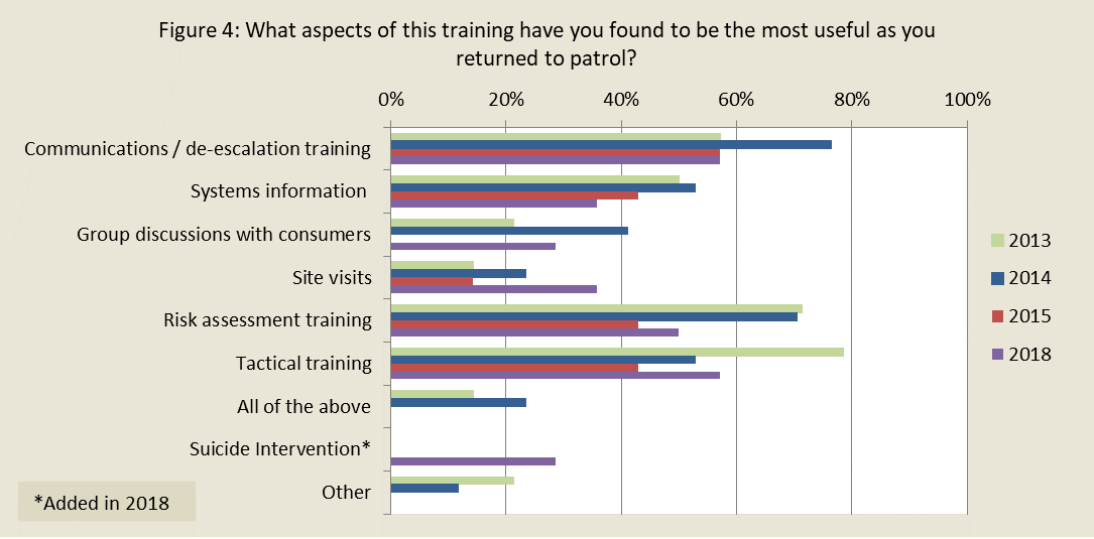
4. *What aspects of this training have you found to be the most useful as you returned to patrol? (Choose all that apply)*



Officers were able to choose from a list of training aspects for this item, selecting an unlimited number and/or entering their own responses in a free-write field. The categories listed were: communications/de-escalation training, systems information, group discussions with consumers, site visits, risk assessment training, tactical training, suicide intervention, all of the above, and other.

- Among the 2018 cohort, respondents favored communications/de-escalation training and tactical training as the most useful aspects, with eight individuals (57.1 percent) selecting each of those options. The risk assessment training was also valued by respondents, with seven individuals (50%) selecting it

as useful. Five individuals (35.7 percent) each selected the site visits and the systems information as the most useful aspect. Four individuals (28.6 percent) each chose the group discussions with consumers and the suicide intervention aspects. There were no write-in responses for other training aspects.

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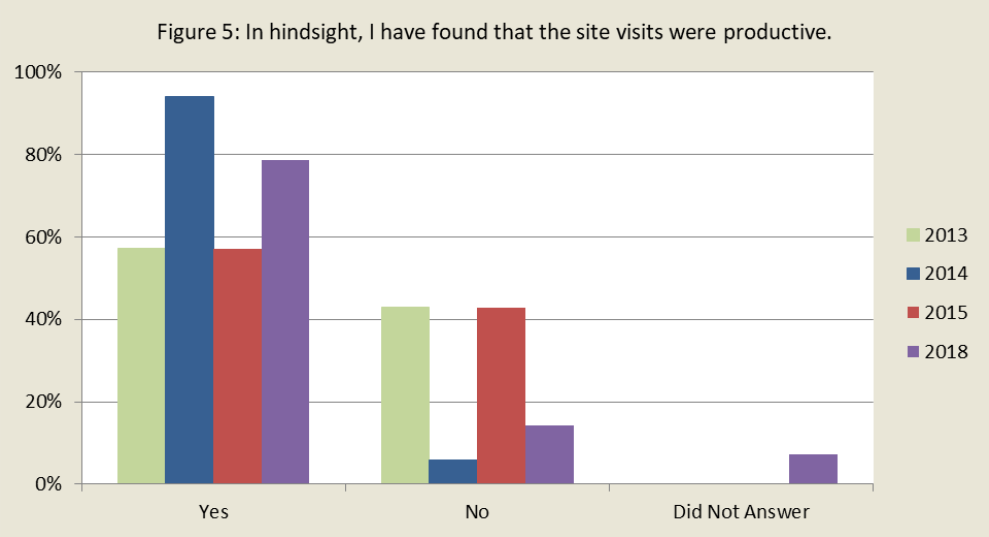
5. *In hindsight, I have found that the site visits were productive.*



- Among the 2018 cohort, eleven individuals (78.6 percent) responded that they found the site visits productive. Two individuals (14.3 percent) responded that they did not find the site visits productive. One individual (7.1 percent) did not respond to the item.

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6. *Please mark which site visits you attended during the ECIT training, which ones you have taken someone to since the training, which ones you have referred someone to since the training, and which ones you thought were helpful to learn about.*

Figure 6:	Attended this site visit	Brought someone to site	Referred someone to site	Helpful to learn about
Unity Center	4	4	3	3
Arbor Place	3	0	0	3
Golden West	3	2	0	1
North Star (NAMI)	3	0	0	3

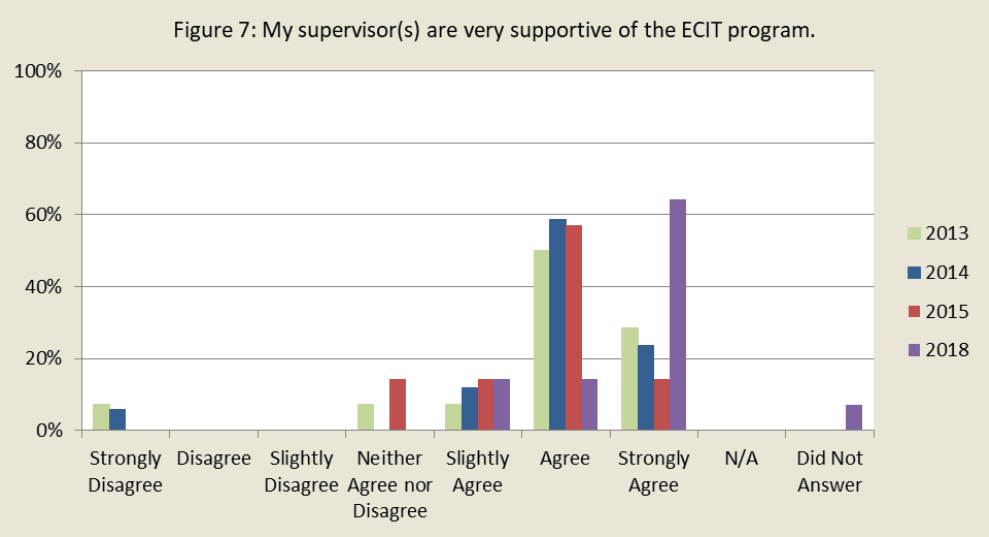
Students were asked which of the site visits they attended or had utilized via drop-off or referral since the training, and which sites they found helpful to learn about. Students were able to mark any selections via check mark, making their selections not mutually exclusive. Some indicated they had brought someone to a site without marking that they had attended the site visit. Because of the anonymity of the survey, it cannot be determined which officers who utilized various sites attended those site visits during the training.

The responses to the site visit item were as follows:

- Since the 2018 training, four officers brought at least one person to the Unity Center, three referred someone to the site, and three found it helpful to learn about.
- Two officers responded that they had brought at least one person to Golden West since the training, and one individual marked that it was helpful to learn about.
- Three individuals responded that they found Arbor Place helpful to learn about. Three individuals also responded that they found North Star (NAMI) helpful to learn about.
- Nine individuals responded to this section of the survey. One individual wrote that they would have liked to have seen all the sites.

Section Two: Supervisor and Peer Support

7. *My supervisor(s) are very supportive of the ECIT program.*



- Among the 2018 cohort, 78.6 percent of the officers that responded agreed or strongly agreed that their supervisors are very supportive of the ECIT program
    - Nine of the officers strongly agreed, two agreed, two slightly agreed, and one did not answer.

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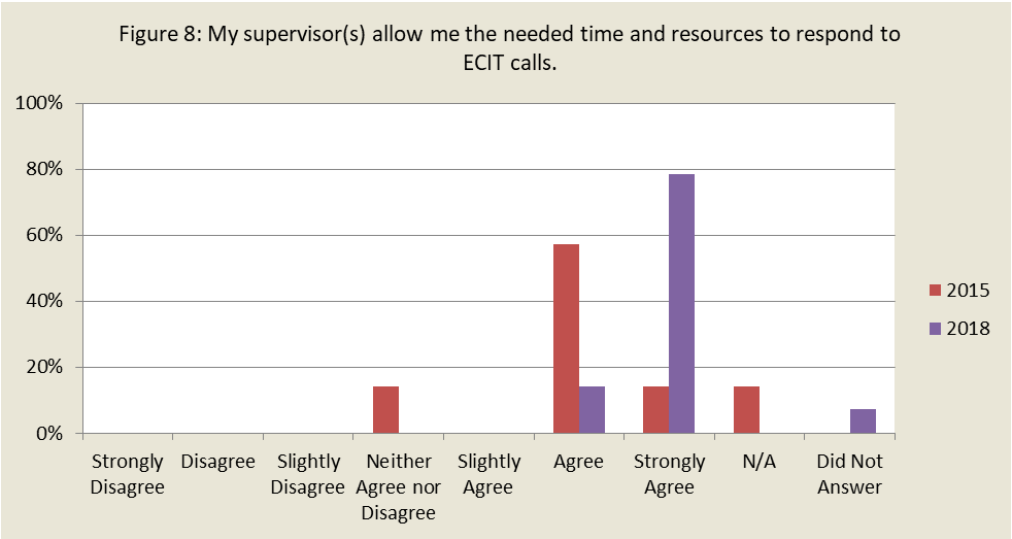
8. *My supervisor(s) allow me the needed time and resources to respond to ECIT calls.*



- Among the 2018 cohort, 92.9 percent of the officers that responded agreed or strongly agreed that their supervisor(s) allow them the needed time and resources to implement the ECIT training.
    - Eleven of the officers strongly agreed, two agreed, and one did not answer.

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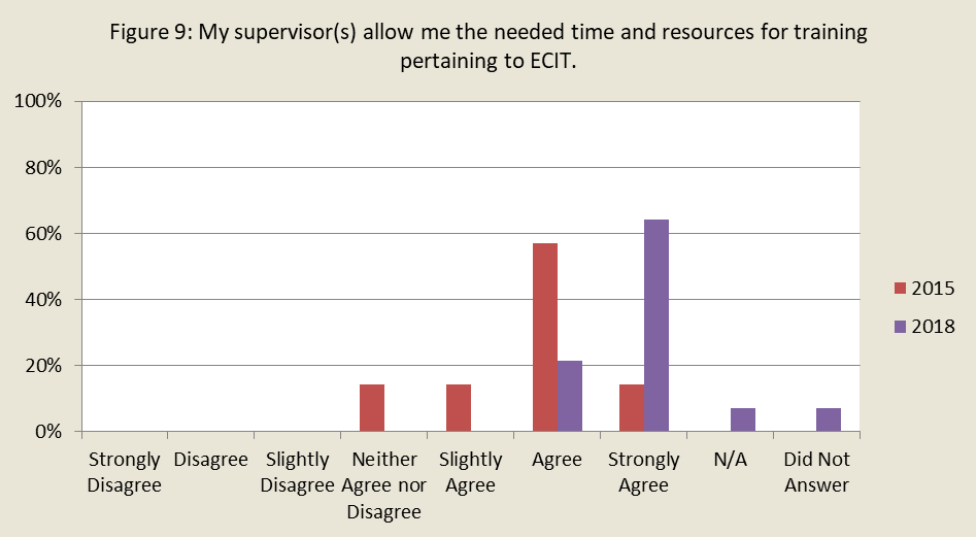
9. *My supervisor(s) allow me the needed time and resources for training pertaining to ECIT.*



- Among the 2018 cohort, 85.7 percent of the officers that responded agreed or strongly agreed that their supervisor(s) allow them the needed time and resources for training pertaining to ECIT.
    - Nine of the officers strongly agreed, three agreed, one responded 'N/A', and one did not answer.

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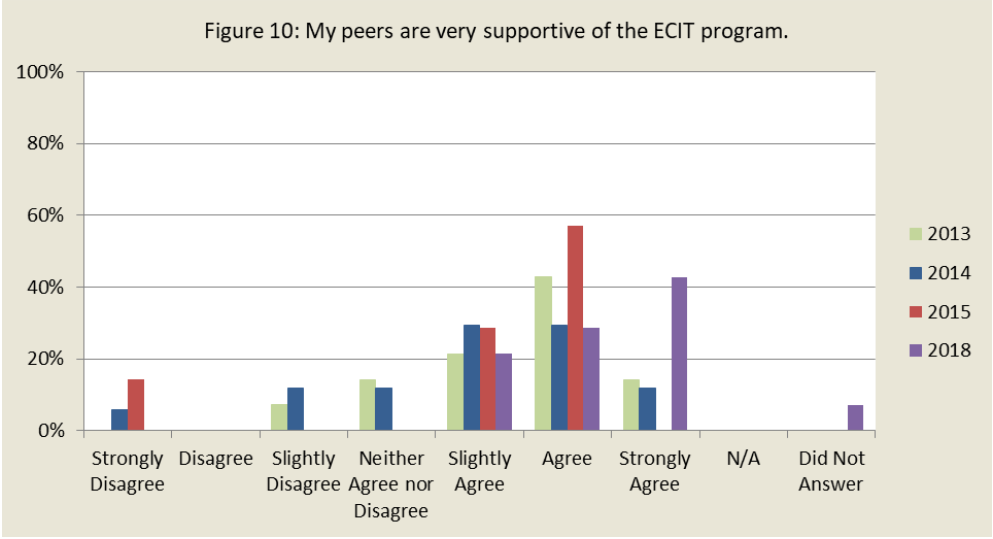
10. *My peers are very supportive of the ECIT program.*



- Among the 2018 cohort, 71.4 percent of the officers that responded agreed or strongly agreed that their peers are very supportive of the ECIT program.
    - Six of the officers strongly agreed, four agreed, three slightly agreed, and one did not answer.

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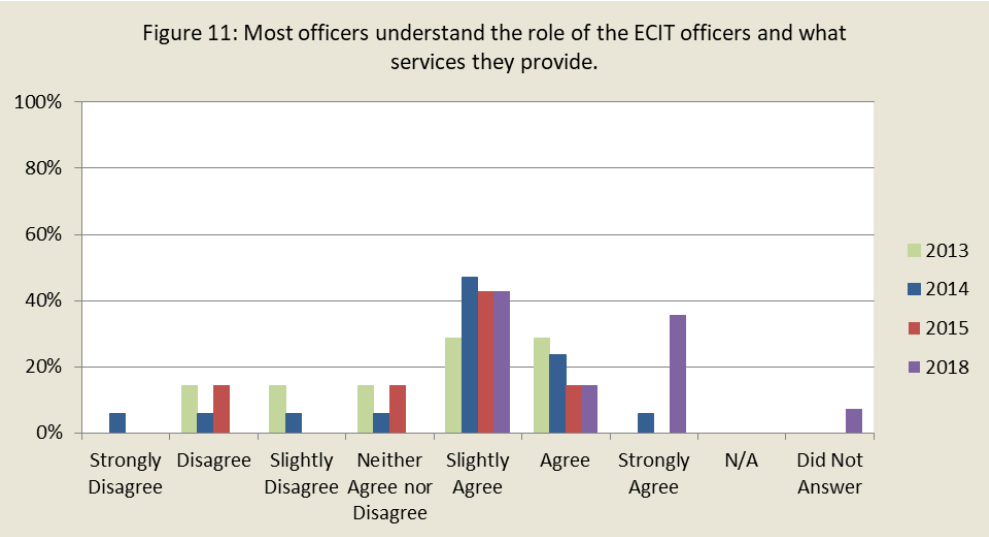
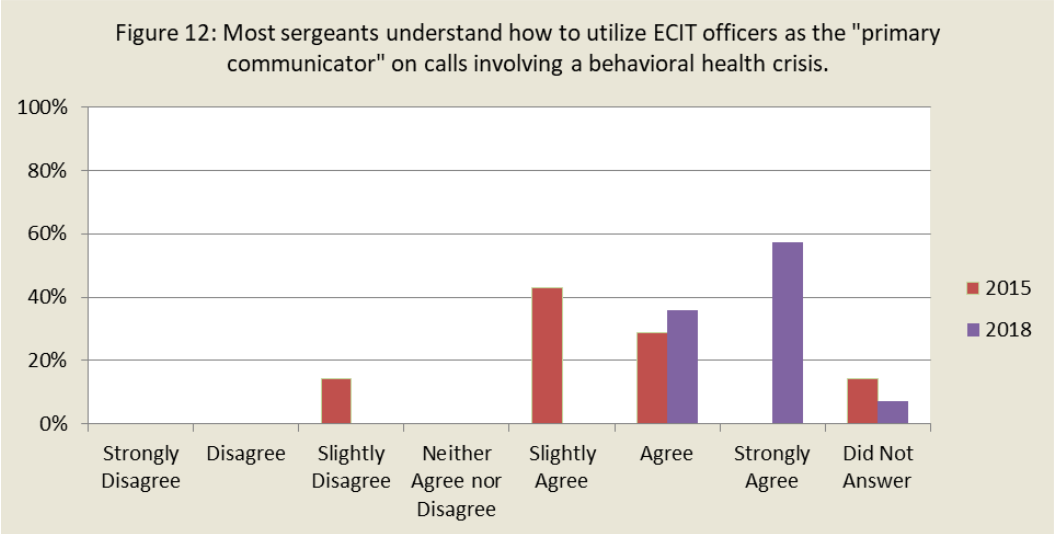
11. *Most officers understand the role of the ECIT officers and what services they provide.*



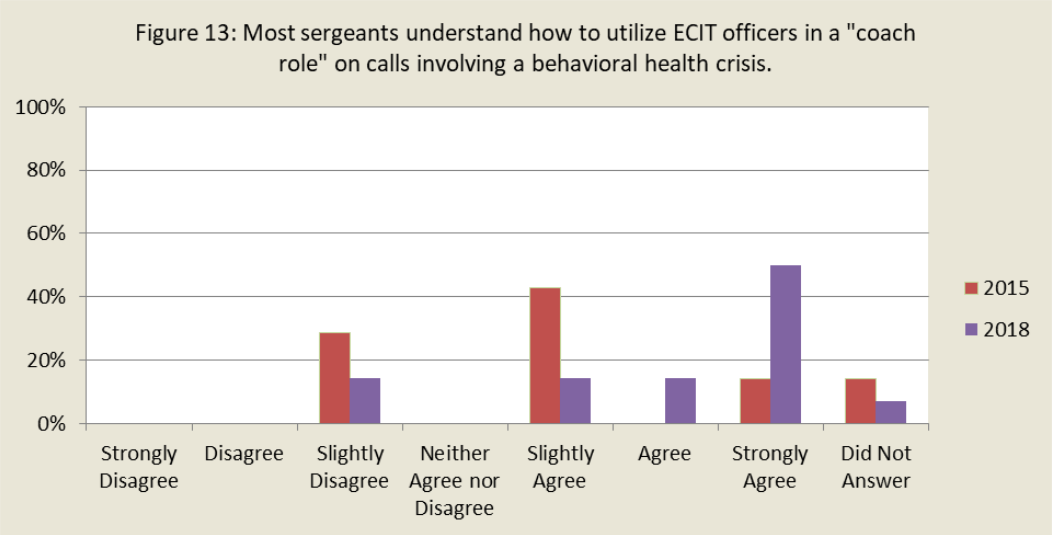
- Among the 2018 cohort, 50 percent of the officers that responded agreed or strongly agreed that most officers understand the role of the ECIT officers and what services they provide.
    - Five of the officers strongly agreed, two agreed, six slightly agreed, and one did not answer.

12. *Most sergeants understand how to utilize ECIT officers as the "primary communicator" on calls involving a behavioral health crisis.*



- Among the 2018 cohort, 92.9 percent of the officers that responded agreed or strongly agreed that most sergeants understand how to utilize ECIT officers as the "primary communicator" on calls involving a behavioral health crisis.
    - Eight of the officers strongly agreed, five agreed, and one did not answer.

13. *Most sergeants understand how to utilize ECIT officers in a "coach role" on calls involving a behavioral health crisis.*



- Among the 2018 cohort, 64.3 percent of the officers that responded agreed or strongly agreed that most sergeants understand how to utilize ECIT officers in a "coach role" on calls involving a behavioral health crisis.
    - Seven of the officers strongly agreed, two agreed, two slightly agreed, two slightly disagreed, and one did not answer.

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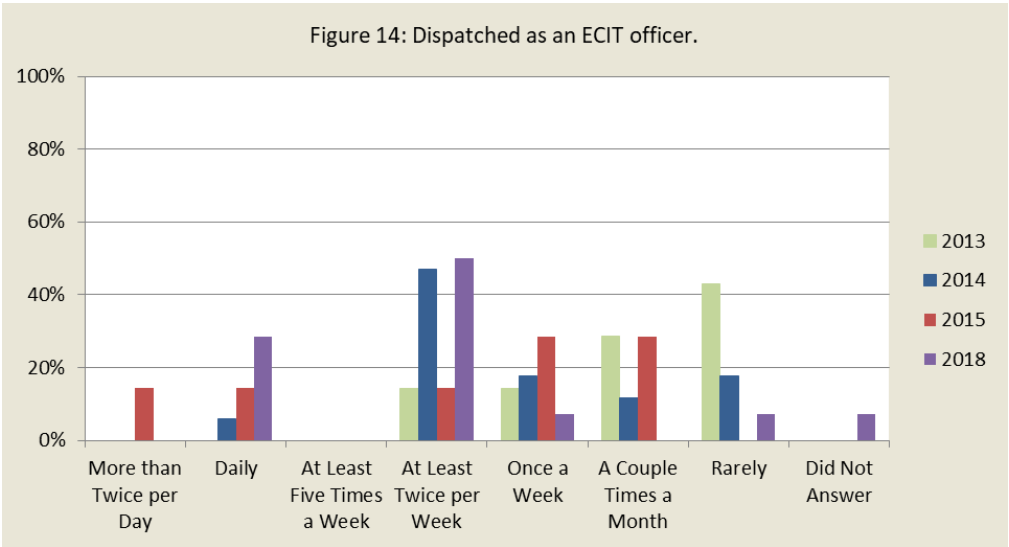
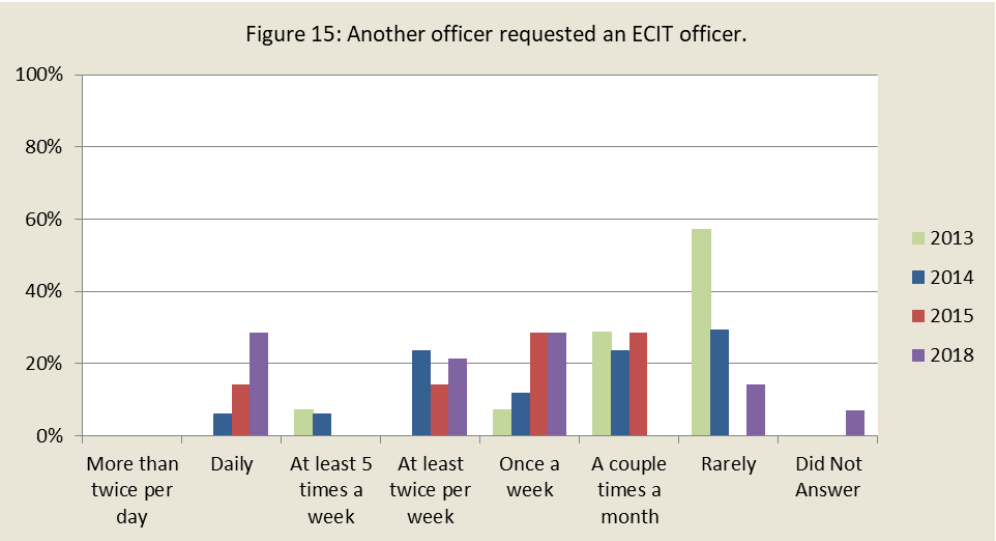
14. *Approximately how often are you responding to calls as an ECIT officer under the following circumstances?*
    a. *Dispatched as an ECIT officer*



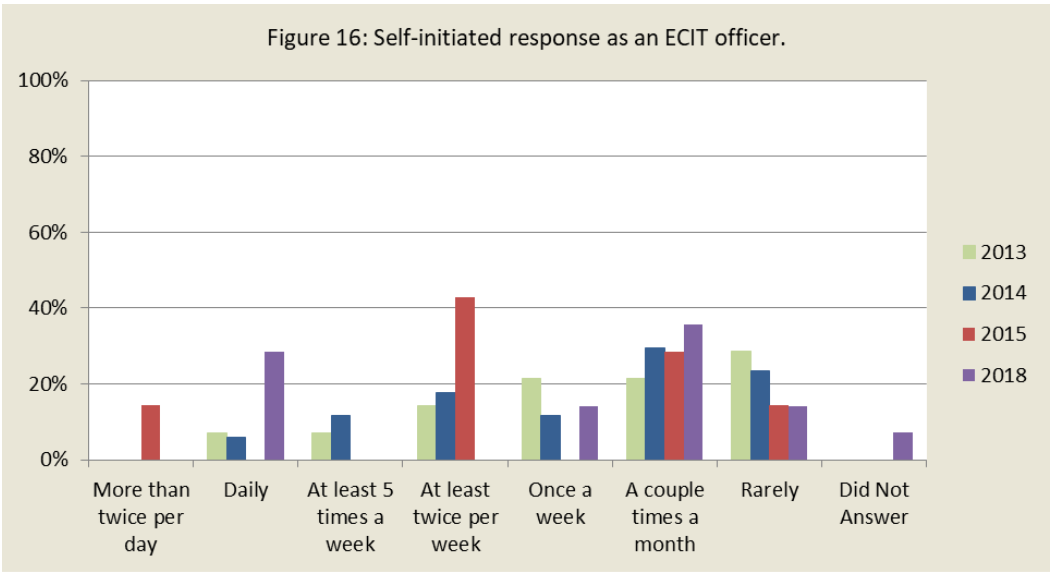
- Among the 2018 cohort, 85.7 percent of the officers that responded reported being dispatched as an ECIT officer at least once per week.
    - Four officers reported being dispatched daily, seven officers reported being dispatched at least twice per week, one officer reported being dispatched at least once a week, one officer reported being dispatched rarely, and one did not answer.

b. Another officer requested an ECIT officer



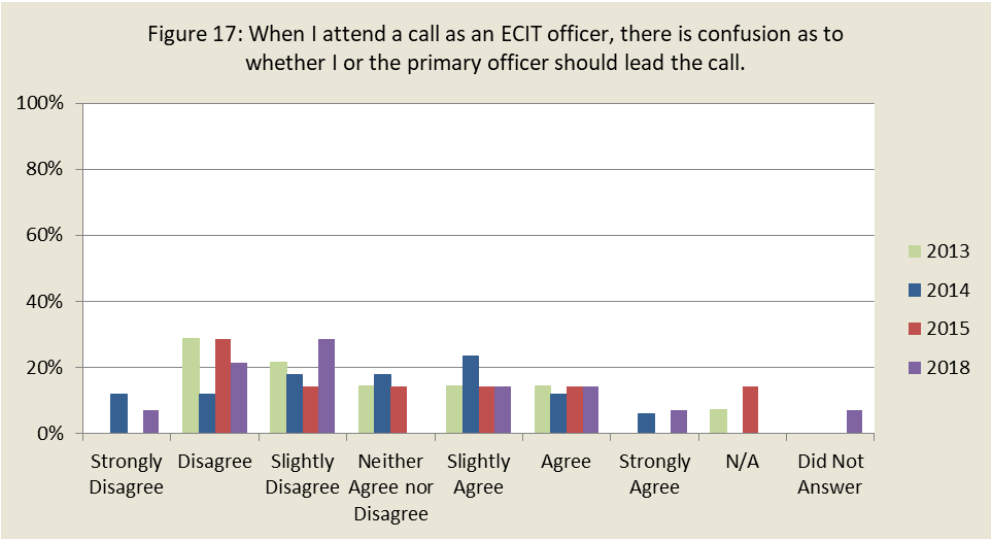
- Among the 2018 cohort, 78.6 percent of the officers that responded reported being requested as an ECIT officer at least once per week.
    - Four officers reported being requested daily, three officers reported being requested at least twice per week, four officers reported being requested once a week, two officers reported being requested rarely, and once did not answer.

c. Self-initiated response as an ECIT officer



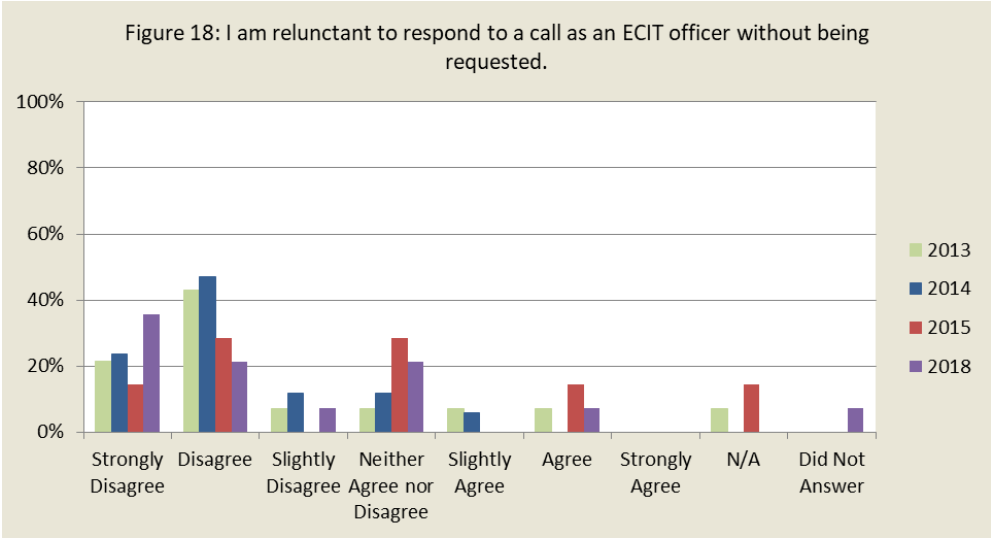
- Among the 2018 cohort, 42.9 percent of the officers reported that they self-initiated responding as an ECIT officer at least once per week.
    - Four officers reported responding daily, two officers reported responding once a week, five officers reported responding daily, and one did not answer.

15. *When I attend a call as an ECIT officer, there is confusion as to whether I or the primary officer should lead the call.*



- Among the 2018 cohort, 21.4 percent of the officers who responded reported that there is confusion regarding who should lead a call when responding as an ECIT officer.
    - One officer responded strongly agree, two responded agree, two responded slightly agree, four responded slightly disagree, three responded disagree, one responded strongly disagree, and one did not answer.

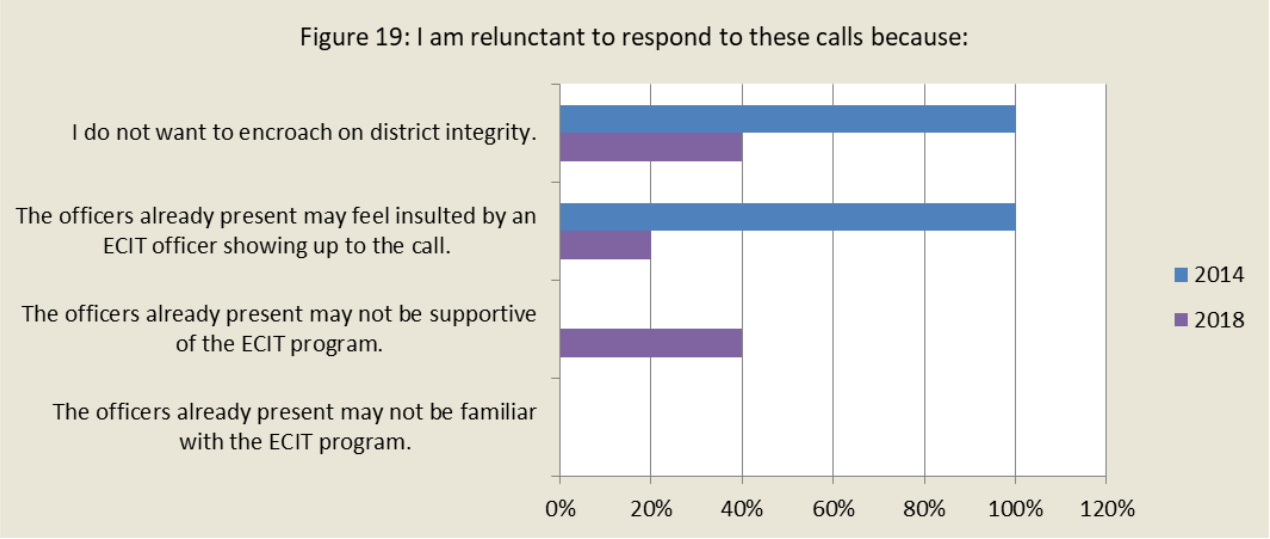
16. *I am reluctant to respond to a call as an ECIT officer without being requested.*



- Among the 2018 cohort, 7.1 percent of the officers who responded reported that they are reluctant to respond to a call as an ECIT officer without being requested.
    - One officer responded agree, three responded neither agree nor disagree, one responded slightly disagree, three responded disagree, five responded strongly disagree, and one did not answer.

For those who responded in agreement to the above question, the following additional question was provided:

17. I am reluctant to respond to these calls because (Select all that apply):



- Among the 2018 cohort, five officers responded to this item. Two officers responded that they are reluctant because they do not want to encroach on district integrity, one responded that the officers already present may feel insulted by an ECIT officer showing up to the call, and two responded that the officers already present may not be familiar with the ECIT program.

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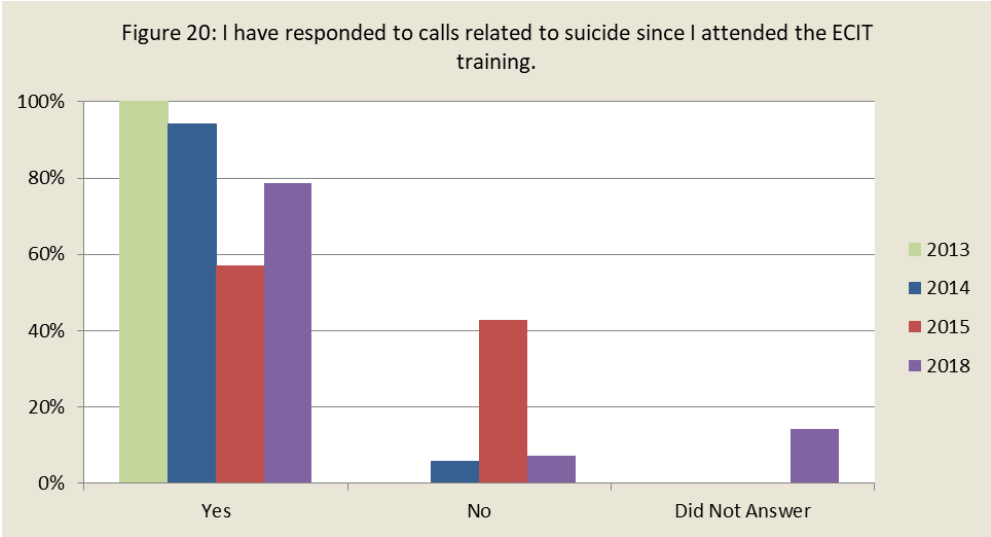
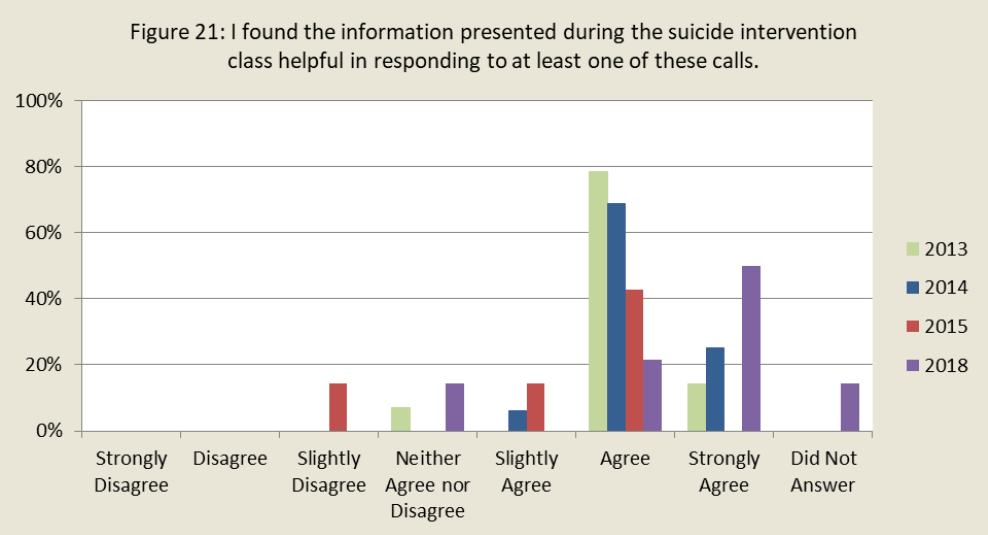
18. I have responded to calls related to suicide since I attended the ECIT training.



- Among the 2018 cohort, 78.6 percent (11) of the officers reported they had responded to calls related to suicide since attending the ECIT training. One officer (7.1 percent) indicated they had not responded to calls related to suicide, and two officers (14.3 percent) did not answer the item.

For those who indicated that they had responded to suicide calls since the ECIT training, the following two additional questions were provided:

19. *I found the information presented during the suicide intervention glass helpful in responding to at least one of these calls.*



- Among the 2018 cohort, 71.4 percent of the officers who responded agreed or strongly agreed that they found the information presented during the suicide intervention class helpful in responding to at least one of these calls.
    - Seven officers strongly agreed, three officers agree, two officers neither agreed nor disagreed, and two officers did not answer.

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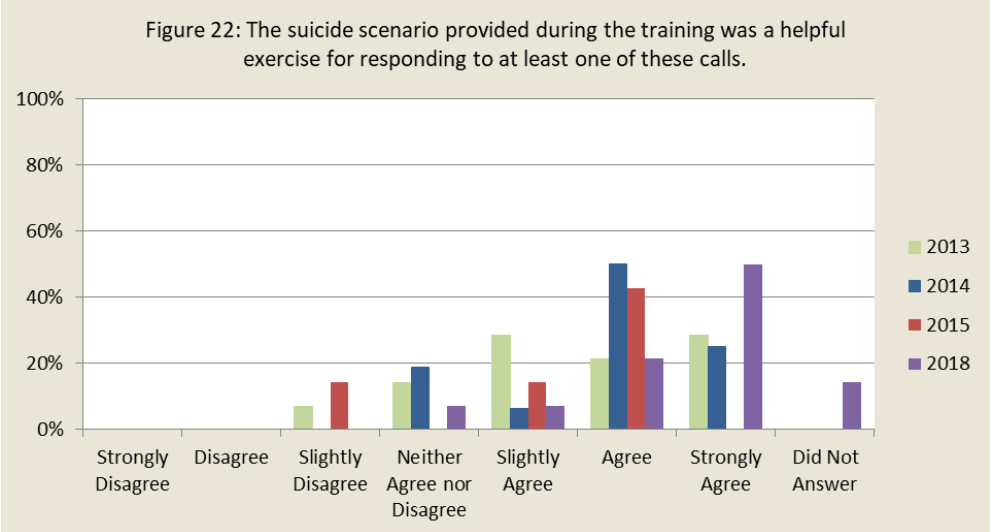
20. *The suicide scenario provided during the training was a helpful exercise for responding to at least one of these calls.*



- Among the 2018 cohort, 71.4 percent agreed or strongly agreed that the suicide scenario was a helpful exercise for responding to at least one suicide call.
    - Seven officers strongly agreed, three agreed, one slightly agreed, one neither agreed nor disagreed, and two did not answer.

21. *Please provide feedback regarding any obstacles you are facing with the ECIT program in the field and any suggestions you have for making the process of responding to calls related to mental health crisis more efficient.*

In 2018, three of the fourteen officers wrote responses to this item. One officer responded they have difficulty when members assume ECIT officers become primary on a call, and they face a lack of understanding regarding the coaching role. Another officer indicated they are regularly dispatched as ECIT for a precinct other than their own, but are often called off prior to arriving. They indicated ECIT is being used as a "check the box" option, only to be called off while en route. Lastly, one officer indicated they feel ECIT officers should have incentive pay.

Summary and Discussion

Usefulness of the Enhanced Crisis Intervention Training

A majority of the respondents indicated that the 2018 ECIT training expanded upon their previous knowledge regarding behavioral health crises, and increased their confidence in handling situations involving a behavioral health crisis. The levels of agreement were slightly lower than what was seen in prior cohorts. When taken together with some of the qualitative feedback received, it would appear that some of the material presented in the 2018 40-hour training was duplicative of that which officers received in their basic and advanced academy courses, leading to lower levels of agreement on some survey items (see Figures 1 and 2).

All of the main categories of the training were reported as being useful for officers on patrol, including the group discussions with consumers. In prior trainings, this was a session officers felt was less useful. This indicates that the 2018 discussions (with the new cohort of officers) improved over prior years. The training sessions on communications/de-escalation training, risk assessment, and tactical training received the highest levels of agreement on areas officers found useful, consistent with prior training years.

Some additional questions were asked to obtain more specific feedback regarding the utilization of site visits and suicide components of the training. A majority of the respondents reported finding the site visit

s helpful and indicated that they had utilized at least one of the facilities since the training (either by referral or bringing someone to the facility).

A majority of the officers reported having responded to calls related to suicide since the training, with high levels of agreement seen on items pertaining to the helpfulness of the classroom session as well as the suicide intervention scenario. Higher levels of agreement were seen among the 2018 students than previous cohorts, suggesting the small changes made by instructors to those sessions were well received by students.

Supervisor and Peer Support

Among the 2018 cohort, responding officers reported receiving sufficient support from their supervisors when responding to calls as ECIT, an improvement over previous years. A large majority of students reported receiving the needed time and resources to respond to ECIT calls, with slightly lower levels of agreement seen on items pertaining to supervisor support of the ECIT program and the allowance of time to train for ECIT. All three items received greater levels of agreement than previous cohorts, an indication that efforts to increase supervisor support for the program are having a positive impact.

A majority of officers agreed that their peers are supportive of the ECIT program, also an

improvement over previous years.[7] Lower levels of agreement were seen regarding officers understanding the role of ECIT officers and the services they provide. Additionally, more variability was seen on responses pertaining to confusion when an ECIT officer attends a call, as to whether the ECIT officer or other officer should lead the call. Taken together, these results indicate a potential need for clarification on ECIT officers' purpose to non-ECIT officers. Agreement on these items was still an improvement over previous years, indicating recent efforts to clarify the role of ECIT officers are having a positive impact. The continuing efforts of ECIT coordinators in this area may provide additional clarification.

Call Load and BOEC

A large majority of officers reported being dispatched as an ECIT officer at least once per week. The reported frequency was similar for attending a call when requested by another officer, but lower for self-initiated responses. More officers reported being dispatched daily or at least twice per week than previous cohorts, which coincides with the increase in ECIT calls in 2018. These results, taken together with the likelihood that more ECIT officers will be promoting in coming years, indicate the need for additional officers to be trained as ECIT to ensure an adequate number in patrol positions.

On-the-Job Application: BHU Feedback

PPB utilizes multiple strategies to positively impact interactions with people in mental health crises. The BHU's mission includes partnering with representatives of the mental health system to coordinate care to resources when available and appropriate. Tracking these approaches, including how ECIT resources are utilized, is key to ensuring the program is meeting its intended goals.

Some progress measurements can be obtained by reviewing data collected throughout the contact-process, including call data, the utilization of health facilities and community based mental health services (such as Project Respond), the use of techniques such as disengagement and de-escalation, and monitoring the usage of the BHU's Electronic Referral System.

Mental Health Template

PPB introduced a new method to collect data regarding mental health calls on April 25, 2017, in an effort to improve data accuracy and capture additional information on the specific aspects of calls involving mental health crises. The new mental health template records information regarding: whether an ECIT officer was on scene, whether a mental health professional was on scene, any weapons present, any injuries sustained, and transportation outcomes for the subject. Taken together, this data helps inform the PPB on its strategies in mental health crisis response, and is useful for training and program development as well as resource allocation.

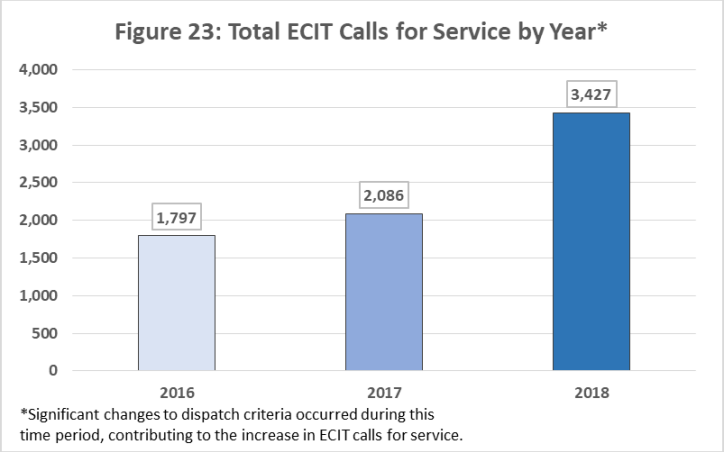
Data from the mental health templates was analyzed to assess how officers are addressing behavioral health crises on ECIT calls, and to inform the Training Division on how the fundamentals of ECIT training are being applied in such incidents.

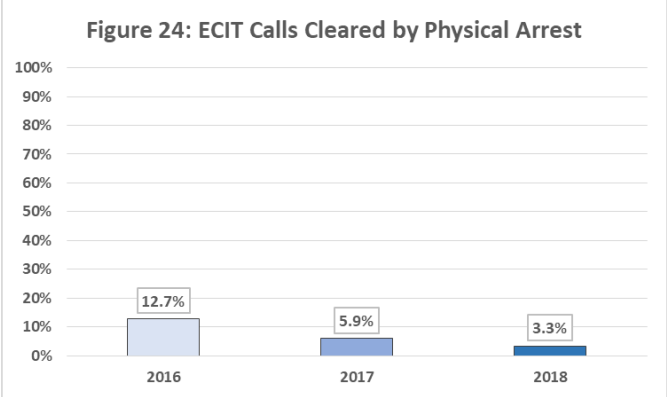
[7] These results were also supported by student evaluations for the 2018 ECIT In-service.

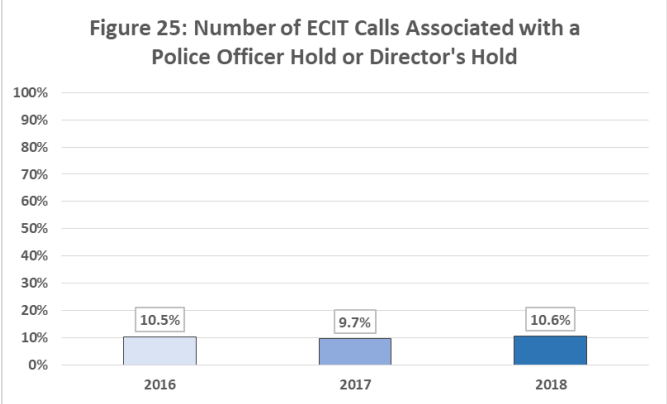
Dispatch Data

On April 1st, 2018, the Bureau of Emergency Communications (BOEC) trained its staff to appropriately identify ECIT calls, and expanded ECIT dispatch criteria to include calls with a subject in a mental health crisis whose behavior is escalating to the point of risking harm to self or others. This change, which included providing BOEC dispatchers with appropriate training on the protocol, potentially contributed to a 64 percent increase in total ECIT calls for service from 2017 to 2018 (see Figure 23).

Officers aim to resolve calls involving behavioral health crises in the manner safest for the subject, the officers, and the community. This requires evaluating the totality of the circumstances at the scene, including the behavior of the person and the governmental interests at stake. Whenever possible and appropriate, this may mean transporting the individual to a hospital or mental health facility equipped to provide the subject with necessary resources. In some situations, physical arrest is necessary, due to the nature of crimes committed or the existence of a warrant. Officers are trained, and guided by directives[8], to evaluate the need for assistance and manage a scene in the manner that will lead to the safest possible result for all parties.







In 2018, 112 of the 3,427 ECIT calls (3.3 percent) were cleared by the physical arrest of a subject. 363 calls (10.6 percent) were associated with a police officer hold or director's hold. The 3.3 percent arrest rate reflects a decrease from 2016 and 2017, while the rate of police officer/director's holds has remained steady (see Figures 24 and 25).

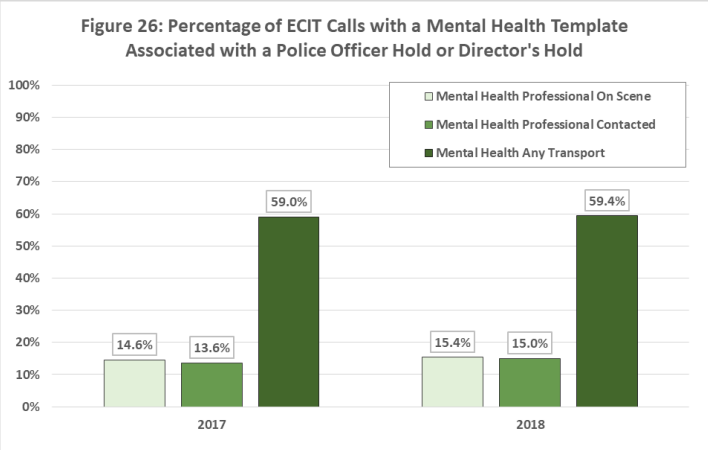
Utilization of Mental Health Resources:

The new mental health template provides more accurate data collection on the use of mental health resources on ECIT calls (see Figure 26). Approximately 59.4 percent of ECIT calls with a mental health template resulted in a transport on a police officer hold or director's hold in 2018. Additionally, 15 percent of those calls included either contacting a mental health professional or having one on scene.

For the most part, PPB finds that officers are correctly utilizing mental health resources, including Project Respond and the Unity Center. Officers continue to face challenges with resources being understaffed and capacity issues at facilities during both crisis and non-crisis situations. Co-morbidity issues also continue to present challenges, with crisis symptoms sometimes co-

[8] See Directive 850.20 – Police Response to Mental Health Crisis for additional information.

occurring with individuals being under the influence of drugs or alcohol.

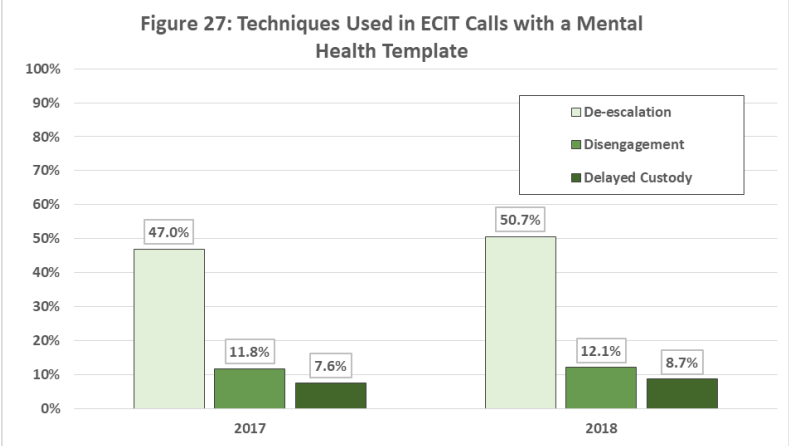


Disengagement and De-escalation:

The utilization of techniques related to disengagement and increasing the likelihood of de-escalation is also a central component of the ECIT program. The effectiveness of these techniques varies widely on individual factors, situational factors, and the intersection of these various characteristics. One of the goals of the ECIT program is to resolve calls involving a behavioral health crisis with as little reliance on force as practical. One of the strategies to support this is providing officers additional training in communication and other skills that may promote de-escalation in crisis situations.

Like the utilization of health services, effectively utilizing disengagement techniques and skills that promote de-escalation can vary greatly among individuals and circumstances. Therefore, the BHU utilizes multiple methods to capture how often ECIT officers employ these techniques.

Information on the use of de-escalation and disengagement was collected from mental health templates completed by officers on ECIT calls. This is a more reliable method of data collection over previous years, streamlining the more manual process utilized in previous years. Overall, PPB officers utilize de-escalation tactics effectively (now defined more specifically in Directive 1010.00).[9] Disengagement with a plan has been the focus of several trainings, including the 2018 Spring In-Service as well as the 2019 PPB Sergeant's Academy. Specifically, the Sergeant's Academy emphasized the role of sergeants who have been recently promoted and are also ECIT trained, including the process for correctly documenting a disengagement with a plan and notification to the Multnomah County Crisis Line (MCCL).



Utilization of the BHU Electronic Referral System

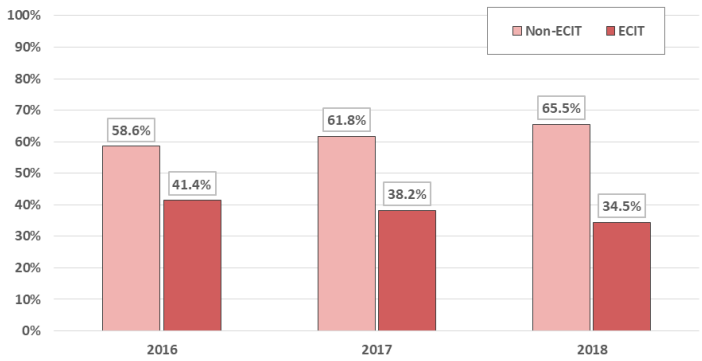
The BHU's Electronic Referral System (BERS) allows any member of the police bureau to make mental health referrals to the Behavioral Health Unit. The BERS captures pertinent information collected from police officers, citizens, and care providers. These referrals are prioritized and followed up by the Behavioral Health Response Teams (BHRTs). Although BERS is only a small component of the ECIT training, the utilization of the BERS is considered a critical component of achieving organizational goals associated with the ECIT program. BERS underwent an update in May of 2017, leading to improved data collection and allowing the BHU to better utilize the information.

[9] Directive 1010.1.1.1 states "De-escalation techniques include, but are not limited to: 1) using verbal techniques to calm an agitated subject and promote rational decision making; 2) allowing the subject appropriate time to respond to direction; 3) communicating with the subject from a safe position using verbal persuasion, advisements, or warnings; 4) decreasing exposure to a potential threat by using distance, cover, or concealment; 5) placing barriers between an uncooperative subject and an officer; 6) ensuring there are an appropriate number of members on scene; 7) containing a threat; 8) moving to a safer position; and 9) avoiding physical confrontation, unless immediately necessary."

It is now in its fifth year of operation, receiving approximately 1,000 referrals per year.

The BHU has implemented feedback loops wherein a BHU sergeant provides an explanation to officers who make referrals on whether their cases receive follow-up by a BHRT. The BHU analyst has created processes to examine referrals to ensure they include relevant cases, and that subjects are being properly referred to appropriate resources properly. Levels of referrals made by ECIT officers versus non-ECIT officers have remained relatively steady, with 34.5 percent (397 of 1,151) of 2018 referrals coming from ECIT officers (see Figure 28).

Figure 28: BERS Referrals by Officer Type



Reinforcers

An important part of the training evaluation process is considering how the organization reinforces key objectives. The Behavioral Health Unit and the Chief's Office continue to reinforce the utilization of health facilities and community based mental health services, techniques related to disengagement with a plan, de-escalation, and BERS.

To create a feedback loop with officers, BHU sergeants respond to every BERS referral with information on follow-up plans and feedback on their referral. Additionally, the BHU coordinates with MCCL on follow-ups to ensure all parties are aware of plan details. The BHU emphasizes "data-driven decision-making" as a tool for reinforcing program goals, and meeting the needs of both officers and community members.

The BHU continues to release their quarterly newsletter, highlighting cases of de-escalation, disengagement, and suicide intervention. The newsletters feature success stories from clients who participated in BHU and ECIT programs, as well as incidents where officers utilized their skills to resolve calls without the use of force.

The BHU conducts outreach to mental health and other facilities related to improving effective interactions among all parties involved in a police response to a facility. Information from these visits that could assist officers during their police response is shared with officers during rollcalls as needed and quarterly internal ECIT Advisory Committee meetings

Organizational Level Outcomes

This section of the evaluation process examines if related organizational goals are being met and the alignment between Enhanced Crisis Intervention Team (ECIT) outcomes and program and organizational goals.

Within the context of the broader organizational mission, the goals specific to the ECIT program are:

1) To have police and community member interactions involving a behavioral health crisis result in the safest possible outcome for the police and community members.
2) To be a partner with the mental health system in public safety issues related to behavioral health crises.

Use of Force

To assess the first goal, the Portland Police Bureau examines all uses of force and injuries occurring during ECIT calls. Of the 3,427 ECIT calls that occurred in 2018, force was used in 46 cases (1.34 percent). Of those 46 cases, 35 (83.3 percent) were Category IV cases, indicating that the lowest levels of force were used and no injuries occurred to the officer(s) or subject(s).

On August 19th, 2017, PPB implemented the newest version of Directive 1010.00, Use of Force. The updated 1010.00 policy expanded the types of actions that require officers to complete a use of force template. These expanded types of force – including Control Against Resistance, Resisted

Handcuffing, and Controlled Takedowns – were previously documented in officers' reports, but were not included in data collected on the use of force by PPB officers.

Collecting data on these additional force types naturally resulted in an increase to many figures the PPB has used to track force across previous quarters, making it difficult to compare counts of force prior to August 2017 with counts which came after. With the new force types came a new method of force categorization, wherein force types are categorized based on the likelihood of resulting in injury.[10] Under this method, cases where lower level force types are utilized and no injury results to the officer or subject are investigated as Category IV.[11]

Force categories can be influenced by a host of other factors, including the discretion of the investigating supervisor, however cases investigated at Category IV inherently involve lower levels of force, and no resulting injury (cases with injuries would automatically be investigated at Category 3 or above). For the purposes of ECIT evaluation, the prevalence of Category IV cases indicates that, in incidents where circumstances require a member to use force, officers are utilizing the lowest methods available, and are doing so in a manner that does not injure the subject or themselves. This is in alignment with the first goal listed above ("…interactions involving a behavioral health crisis result in the safest possible outcome for the police and community members").

In the remaining 11 cases, the primary uses of force were resisted handcuffing and control against resistance. Officers used conducted electronic weapons (CEWs) in six cases, less lethal munitions in five cases, and pointed their firearm in three cases. More than one officer used force in seven cases. One case involved a juvenile subject. Subjects sustained minor injuries (abrasions or bruises) in three cases, and officers sustained minor injuries (lacerations or pain and swelling) in two cases.

Force Categorization: Force types under the new 1010.00 policy

*New force types shown in red

Category 2-3	Category 4
(Control) Holds with Injury	Baton (Nonstrike)
Takedown	Controlled Takedown
Strikes/kicks	Resisted Handcuffing
Impact Weapons	Pointing of a Firearm
Less Lethal	Hobble Restraint
Aerosol Restraint	Firearm discharge to end the suffering of a wounded animal
CEW	Box-in
K9 Bite	Control Against Resistance
P.I.T.	
Firearm discharge to stop an aggressive animal	
Vehicle Ram	

Partnerships:

Assessing the second goal (to be a partner with the mental health system in public safety issues related to behavioral health crises) is more complex and is therefore being conducted in stages. In early 2018, the Behavioral Health Unit and Training Division, in partnership with Portland State University, completed a study assessing the interaction between law enforcement and the mental health field. Initially, an environmental scan of the topic area was conducted through literature research and interviews with those working in the mental health field and/or law enforcement, with the rest of the study focused on the partnerships between the Portland Police Bureau and the local mental health facilities.

Overall, the study found many positive indications of substantial effort being made among both law enforcement and the mental health field to develop

[10] Injury as defined in ORS 161.015 – "Physical injury" means impairment of physical condition or substantial pain."

[11] See Force Categorization Table for all force types and their respective categories.

more effective partnerships. The study also found many opportunities for strengthening these partnerships, such as having better alignment between law enforcement and mental health facility policy and procedures, more education regarding Portland Police Bureau's BHU and ECIT services, more safety planning and resources for some mental health facilities, and more availability and cohesive mental health resources.

A brief overview of the findings pertaining to enhancing these partnerships are provided below.[12] Given the siloed nature of the local mental health system, these findings are not generalizable to all facilities. Many differences were found between facilities, however, there were some common themes as well. In addition, numerous findings pertaining to either the partnerships between law enforcement and the mental health field or the interaction between law enforcement and those in crisis were collected during the study. The findings below and those in the full report focus on those identified as most critical to successful interactions during calls for service at facilities.

Policy and Procedures

The study found that there are some discrepancies between the current guidelines for law enforcement and many mental health facilities. For instance, some mental health workers are instructed to contact the police, per their policy, while police may have a conflicting policy regarding their response procedures. These situations tend to pertain to lower level safety or disturbance calls, and lead to frustration among both law enforcement and mental health workers. The mental health facility employees are sometimes left in situations where there is not an alternative resource to assist them in managing the situation and law enforcement officers are in an awkward situation of having to explain current PPB policy and/or procedures. Working out these discrepancies during a crisis causes strain for both the mental health and law enforcement workers. In some cases, these circumstances also lead to an increase in problematic behavior from the client when they see that law enforcement will disengage from the situation.

Information on Current Law Enforcement Procedure for Mental Health Direct Care Workers

The study found good familiarity with the BHU and ECIT at the program manager and above levels, but not at the direct care worker levels in the mental health field. In the survey, approximately 49 percent of the mental health workers reported they were "not at all familiar" or only "a little familiar" with the Portland Police Bureau's ECIT program. Approximately 21 percent reported being "very familiar" with the ECIT program. Those who were unaware and had the opportunity to learn more about these services during the study expressed much gratitude for the information, as well as the importance of it for their work.

Safety Resources and Planning Needed for Many Mental Health Facilities

Many facilities appeared to have limited resources, planning, and training pertaining to managing safety situations. Most facilities, even secured ones, do not have security personnel on staff and many do not have an alternative resource to call in cases of managing lower level behavioral issues. Many of the mental health direct care workers in the study expressed an interest in having more resources as well as learning about the procedures other facilities provide. It was brought up during the study that law enforcement could be a valuable partner in facility safety planning and procedures.

Availability of Mental Health Resources

Many challenges regarding the availability and allocation of mental health resources arose during the study from both mental health and law enforcement participants. Some of the main themes related to facilities not being set up to effectively manage higher risk clientele, limited mental health resources during the late afternoon, and night shifts, and the limited amount of outreach, transitional, and follow-up services.

[12] See Appendix B: 2017 Mental Health Facility Outcome Study for full text

Information on the Mental Health System's Limitations

Throughout the study it was clear that the local mental health system is siloed, varied, and complex in many aspects. Although this has some benefits, it creates challenges for both law enforcement and mental health workers. One aspect of this are the challenges for officers to know what to expect when assisting at facilities given the vast array of facility policy and procedures in the area. Another aspect is for officers to understand the challenges for the mental health workers during interactions. Officers having a better understanding of these challenges was brought up as something that would be helpful for enhancing collaboration and response to facility calls.

Conclusion

The Portland Police Bureau has developed a well-rounded Enhanced Crisis Intervention Training program that thoughtfully incorporates curriculum and scenarios relevant to the work ECIT officers perform on the street.

The 2018 ECIT 40-hour training remained largely consistent with the training delivered in previous years, with only small alterations to the schedule and presenters. The ECIT program coordinators and mental health professional were pleased with the 2018 training, with only a small number of practical changes in mind for future years. These revolve largely around scheduling and priming, with the intent to provide officers with the most well-rounded and focused training possible.

The ECIT evaluation results indicate that the 2018 training improved officers' abilities to interact with individuals experiencing behavioral health crises, with officers appreciating the communication and de-escalation training provided. Additionally, officers appreciated the tactical skills and risk assessment portions of the training, with the instructors of these sessions receiving positive remarks.

Areas where the training may benefit from small alterations include the panel sessions, where the format differs from a majority of the sessions provided throughout the training. In future trainings, ECIT coordinators plan to provide focused introductions to the panel and site visit sessions, which communicate the learning objectives and goals of each course, so that officers may be primed regarding the intent of each session from the outset.

Additionally, some feedback provided indicated that the material provided in the 2018 course was redundant to that which officers had learned in their Basic and Advanced Academies. This makes sense, given the increased emphasis placed on crisis intervention strategies in the introductory academies, both at PPB and DPSST. ECIT coordinators believe this to be a positive finding, indicating that officers are retaining that which they learned in earlier academies, and the 40-hour ECIT training can elaborate on those topics in a more challenging manner. Additionally, much of the material is intended to be a review of that which officers previous learned. Coordinators intend to communicate this in future ECIT trainings.

Taken together, the evaluation findings largely indicate that the ECIT program is accomplishing its intended goals, with some additional work to be done with regards to ECIT use at mental health facilities.[13] The results of the 40-hour training support the value of the program, and signify that officers are gaining knowledge and skills from the training experience that are beneficial to them on the job, and assist when they are responding to calls involving individuals in behavioral health crises.

[13] See Appendix B: Mental Health Facility Outcome Study

Appendix A: 2018 ECIT Training Student Survey and Learning Assessment Results

The following are the class sessions provided to students during the 2018 ECIT training, as well as the corresponding student survey results. The 2018 ECIT training had a class size of 17 students.

DAY ONE OF ECIT TRAINING

ECIT Course Overview

In this session, the Behavioral Health Unit's crisis intervention training coordinator and the Training Division's non-sworn mental health professional provided an overview of the training week and the ECIT officer's role within the Behavioral Health Unit and the Bureau. This included an overview of the Crisis Response Model, the ECIT officer's role on an ECIT call, and dispatch protocols pertaining to ECIT calls.

Student Survey Results

Table 1: **ECIT Training:** ECIT Overview *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [ECIT Overview] session was a good use of my training time.	0%	0%	0%	5.9% (1)	47.1% (8)	47.1% (8)	0%

Crisis Response for ECIT

This class emphasizes the role of ECIT officers in coordinating available resources during calls involving people in mental health crises, as well as being able to fill any of the critical roles necessary during such an incident. Specific emphasis was placed on crisis communication and de-escalation techniques. Students are instructed on the Scaled Crisis Response Model, which illustrates how each incident requires unique resources in order to be resolved effectively. Concepts include the communication team pyramid, the "Golden Bridge Technique" for negotiation, and the "Assess, Advise, Apply" (AAA) acronym.

Student Survey Results

Table 2: **ECIT Training:** Crisis Response for ECIT *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [Crisis Response for ECIT] session was a good use of my training time.	0%	0%	0%	5.9% (1)	17.7% (3)	76.5% (13)	0%

Peer Recovery Movement

In this session, a peer support specialist introduced officers to the peer recovery movement and how peers and Peer Specialists can be a resource to the police.

Student Survey Results

Table 3: **ECIT Training:** Peer Recovery Movement *Shown as: Percentage of Total (Number of Respondents)* *n = 27*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [Peer Recovery Movement] session was a good use of my training time.	5.9% (1)	0%	0%	35.3% (6)	17.7% (3)	41.2% (7)	0%
The [Peer Recovery Movement] session expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.	0%	11.8% (2)	5.9% (1)	5.9% (1)	41.2% (7)	35.3% (6)	0%

Consumer Panel Discussion

The training participants were provided with an opportunity to interact with a panel consisting of people with lived experience regarding mental health concerns. These facilitated discussions provided an opportunity for people all parties to share their perspectives and gain additional insights into the complex dynamics of responding to people and their families during a mental health crisis. The people with lived experience shared personal stories to highlight various aspects of the crisis experience. The panel consisted of four people with lived experience, with each member sharing different experiences related to various mental health diagnoses. A peer representative introduced each panel member and facilitated the discussion.

The students were also assessed for their ability to work with people in a mental health crisis in the Patrol Procedures scenarios on Day 4.

Student Survey Results

Table 4: **ECIT Training:** Consumer Panel Discussion *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [Consumer Panel Discussion] session was a good use of my training time.	5.9% (1)	0%	0%	35.3% (6)	17.7% (3)	41.2% (7)	0%
The [Consumer Panel Discussion] session expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.	5.9% (1)	0%	5.9% (1)	47.1% (8)	17.7% (3)	23.5% (4)	0%
This section of the training gave me a greater understanding of how mental health issues can be overcome.	5.9% (1)	0%	5.9% (1)	41.2% (7)	17.7% (3)	29.5% (5)	0%

Mental Illness/Risk Assessment/Systems Coordination

This class was instructed by a forensic neuropsychiatrist from outside of the Bureau, who presented on categories of mental health diagnoses, considerations for risk assessments when determining behavior that presents a danger to the self or others, and the complex systems of care involved in involuntary commitments and the Psychiatric Security Review Board. Emphasis was placed on communication tactics to use with individuals in various states of psychoses, and ways to determine if an individual is in or out of touch with reality. This class presented topics that were previously present in the *Overview of Mental Health Diagnoses* and *Mental Status Indicators* courses which occurred in prior ECIT 40-hour courses.

Student Survey Results

Table 5: **ECIT Training:** Mental Illness/Risk Assessment/System Coordination *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [MI/Risk Assessment/Systems Coordination] session was a good use of my training time.	0%	0%	0%	5.9% (1)	0%	94.1% (16)	0%
The [MI/Risk Assessment/Systems Coordination] session expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.	0%	0%	0%	5.9% (1)	17.7% (3)	76.5% (13)	0%

Psychosis and Communication

This class was presented by a psychiatric mental health nurse practitioner from Cascadia Behavioral Healthcare Services and the Training Division's non-sworn mental health professional. This class reviews and builds upon the training officers received in the Advanced Academy.

It was designed to improve ECIT officers' abilities to communicate with people experiencing psychosis, as well as increase the officers' awareness of the daily functioning challenges faced by people experiencing psychosis. This class was developed as a result of the instructor and program coordinator observations during the 2014 ECIT training evaluation process, which suggested students would likely benefit from additional training time on communicating with a person with a psychotic disorder.

Communication skills pertaining to psychotic disorders are more difficult to master, partially due to the overall infrequency of occurrence, which lessens opportunities for gaining experience.

Student Survey Results

Table 6: **ECIT Training:** Psychosis and Communication *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [Psychosis and Communication] session was a good use of my training time.	0%	0%	0%	5.9% (1)	17.7% (3)	76.5% (13)	0%
The [Psychosis and Communication] session expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.	0%	0%	5.9% (1)	5.9% (1)	11.8% (2)	76.5% (13)	0%

DAY TWO OF ECIT TRAINING

Multnomah County Threat Advisory Team

This class was presented by the Behavioral Health Unit's Multnomah County Threat Advisory Team sergeant. It provided an introduction to the purpose and primary functions of the Threat Advisory Team.

Police will often be the first ones to receive information on potential indicators of targeted violence. ECIT officers need to know what resources are available for following-up on potential cases of targeted violence in order to assist in disrupting the pathway to violence.

Student Survey Results

Table 7: **ECIT Training:** Multnomah County Threat Advisory Team *Shown as: Percentage of Total (Number of Respondents)* *n = 19*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [Multnomah County Threat Advisory Team] session was a good use of my training time.	0%	5.3% (1)	0%	5.3% (1)	31.6% (6)	57.9% (11)	0%
The [Multnomah County Threat Advisory Team] session expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.	5.3% (1)	0%	0%	11.8% (2)	41.2% (7)	41.2% (7)	0%

Trauma Informed Care

This course was added after the 2014 ECIT training as a result of feedback from the Behavioral Health Advisory Committee. The class highlighted that a high percentage of people involved in the criminal justice system have experience serious trauma throughout their lifetime.

The effects of trauma can challenge a person's capacity for recovery and pose significant barriers to accessing services, often resulting in increased contact with law enforcement and creating a vicious cycle. Trauma-informed criminal justice responses can help avoid re-traumatizing individuals and increase the ability of officers to effectively communicate with a person in crisis. ECIT officers need to be familiar with the impact of trauma on people and understand that behaviors and emotions are not always directed at officers but are a result of past experiences.

A trauma-informed response is not excusing, permitting, or justifying unacceptable behavior but developing supportive accountability and responsibility. ECIT officers learned to develop ways to minimize potential re-traumatization, as well as self-reflect on personal reactions during crisis events. The class was instructed by a licensed professional counselor at Cascadia Behavioral Healthcare.

Student Survey Results

Table 8: **ECIT Training:** Trauma Informed Care *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [Trauma Informed Care] session was a good use of my training time.	0%	5.9% (1)	0%	11.8% (2)	47.1% (8)	35.3% (6)	0%
The [Trauma Informed Care] session expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.	5.9% (1)	5.9% (1)	0%	17.7% (3)	41.2% (7)	29.4% (5)	0%

NAMI Overview

This training session was presented by the Executive Director of NAMI. It introduced officers to the services that NAMI provides to consumers and their family members, as well as how NAMI can be a resource to the police.

Student Survey Results

Table 9: **ECIT Training:** NAMI Overview *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [NAMI] session was a good use of my training time.	0%	5.9% (1)	5.9% (1)	11.8% (2)	47.1% (8)	29.4% (5)	0%
The [NAMI] session expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.	5.9% (1)	0%	5.9% (1)	17.7% (3)	41.2% (7)	29.4% (5)	0%

Family Member Panel Discussion

The training participants were provided with an opportunity to interact with a panel consisting of family members of people with lived experience.

These facilitated discussions provided an opportunity for all parties to share their perspectives and gain additional insights into the complex dynamics of responding to people and their families during a mental health crisis.

The family members shared personal stories to highlight various aspects of the crisis experience. The panel consisted of three family members, with each member sharing different experiences related to various mental health diagnoses. Two members of the Behavioral Health Advisory Committee introduced each panel member and facilitated the discussion.

Student Survey Results

Table 10: **ECIT Training:** Family Member Panel *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [Family Member Panel] session was a good use of my training time.	0%	11.8% (2)	0%	17.7% (3)	41.2% (7)	29.4% (5)	0%
The [Family Member Panel] session expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.	5.9% (1)	11.8% (2)	5.9% (1)	17.7% (3)	23.5% (4)	35.3% (6)	0%
The Family Member Panel Discussion gave me a greater understanding of the challenges families have when a member has a mental illness.	5.9% (1)	5.9% (1)	5.9% (1)	23.5% (4)	17.7% (3)	41.2% (7)	0%

Mental Health Template Training

This training session provided students with an opportunity to learn about the new Mental Health Template, presented by the primary Behavioral Health Unit analyst. This section focused on the process by which to fill out the mental health template, including the revisions that took place in January 2018. Instructors discussed the importance of data in accomplishing PPB goals and better understanding the outcomes of calls involving mental illness.

Student Survey Results

Table 11: **ECIT Training:** Mental Health Template *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [Mental Health Template] session was a good use of my training time.	0%	5.9% (1)	0%	5.9% (1)	47.1% (8)	41.2% (7)	0%

Mental Health Facilities Response

ECIT officers are dispatched to crisis calls in designated residential mental health facilities. These calls frequently do not involve a criminal custody but rather involve a request by staff to restore order in the facility or transport based on a director's custody "hold". Police response to mental health facilities are multifaceted and sometimes involve competing interests. ECIT officers consider the requests of the mental health facility staff and balance this with officer safety concerns and PPB response directives.

This class was instructed by the Behavioral Health Unit's crisis intervention training coordinator and provided the students with information pertaining to responding to various mental health facilities. The students were encouraged to familiarize themselves with the various mental health facilities within their precincts.

Student Survey Results

Table 12: **ECIT Training:** Mental Health Facilities Response *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [Mental Health Facilities Response] session was a good use of my training time.	0%	0%	0%	11.8% (2)	29.4% (5)	58.8% (10)	0%
The [Mental Health Facilities Response] session expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.	5.9% (1)	0%	0%	23.5% (4)	58.8% (10)	11.8% (2)	0%

Site Visits

ECIT officers have an integral part in building relationships between the Portland Police Bureau and the mental health community. Site visits to mental health service facilities assist in breaking down communication barriers between police officers, providers, and members of the mental health community. In this class, ECIT officers learned about various mental health facilities and crisis service providers in order to better assist patrol officers when responding to persons in crisis.

After the classroom component, the students visited various mental health facilities as well as crisis service providers. The class was divided up into groups for the visits, which included a residential facility, a community-based crisis resource, or an advocacy/peer support side. This training session was facilitated by the Behavioral Health Unit's crisis intervention training coordinator.

Student Survey Results

There was no survey item which pertained to this course on the 2018 evaluations surveys.

DAY THREE OF ECIT TRAINING

Crisis Response for ECIT

This session was a continuation of the *Crisis Response for ECIT* class that took place on Day 1. This day placed more of an emphasis on crisis communication skills, preparing students for additional communication classes later in the day, as well as the Scenario exercises on Day 4. The Portland Police Bureau's full-time Crisis Negotiation Team sergeant instructed the classroom portion of this session.

Student Survey Results

Table 13: **ECIT Training:** Crisis Response for ECIT *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [Crisis Response for ECIT] session was a good use of my training time.	0%	0%	0%	5.9% (1)	35.3% (6)	58.8% (10)	0%
The [Crisis Response for ECIT] session expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.	0%	0%	0%	5.9% (1)	35.3% (6)	58.8% (10)	0%

Communication Team Kit (COMTEK)

In an effort to more effectively resolve critical incidents through the use of communication and coordination, the PPB Crisis Negotiation Team (CNT) designed a pocket-sized piece of equipment intended to mitigate the risk of communication errors during critical incidents in which the mode of communication is a telephone. The kit consists of a small set of amplified speakers, a 10 foot speaker extension cord, a digital voice recorder, an ear bud pickup microphone, and a set of earbuds or headphones. The equipment allows multiple officers to listen to real-time telephone conversations during negotiations. The kits were designed in 2015 and were first issued to ECIT members in July of 2017.

Student Survey Results

Table 14: **ECIT Training:** Communication Team Kit (COMTEK) *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [COMTEK] session was a good use of my training time.	0%	0%	0%	0%	29.4% (5)	70.6% (12)	0%

Community Resource Forum

This session was instructed by a licensed professional counselor from Central City Concern. It focused on identifying community services for people with mental illness and their families. It also highlighted interactions with community providers in order to more effectively respond to people in a mental health crisis, while ensuring they are connected to the appropriate services. This presentation included providing participants with community resource cards that patrol officers can leave with consumers or family members, as well as instruction on how to access a comprehensive guide of local mental health resources.

Student Survey Results

Table 15: **ECIT Training:** Community Resource Forum *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [Community Resource Forum] session was a good use of my training time.	0%	0%	3.7% (1)	11.8% (2)	58.9% (10)	23.5% (4)	0%
The [Community Resource Forum] session expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.	0%	0%	3.7% (1)	11.8% (2)	47.1% (8)	35.3% (6)	0%

Suicide Intervention

ECIT officers assist on calls involving people in mental health crises and threatening suicide. In this course, the Training Division's non-sworn mental health professional and a Qualified Mental Health Professional presented Dr. Thomas Joiner's theory of "why people die by suicide" so that students become more adept at recognizing a suicidal mindset.

Active listening communication techniques, time, and patience are emphasized as strategies that may help de-escalate people in crisis and help them access their ability to problem solve. Redirecting the person in crisis to proper resources is also emphasized.

Student Survey Results

Table 16: **ECIT Training:** Suicide Intervention *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [Suicide Intervention] session was a good use of my training time.	0%	0%	0%	11.8% (2)	35.3% (6)	52.9% (9)	0%
The [Suicide Intervention] session expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.	0%	0%	0%	11.8% (2)	47.1% (8)	41.2% (7)	0%

Crisis Communication Skills Exercises

This class is designed for officers to review techniques and practice their communication skills. Emphasis was placed on the use of communication teams, the overall role of ECIT officers to assess, advise, and assist, and specific tools to consider such as transitioning communication from BOEC call-takers to officers on scene. One hour of instruction is reinforced by six practical exercises which incorporate pieces of the presentation as well as previous instruction from the ECIT course.

Student Survey Results

Table 16: **ECIT Training:** Crisis Communication Skills Exercises *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [Crisis Communication Skills Exercises] session was a good use of my training time.	0%	0%	0%	0%	23.5% (4)	76.5% (13)	0%
The [Crisis Communication Skills Exercises] session expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.	0%	0%	0%	5.9% (1)	23.5% (4)	70.6% (12)	0%

Table 17: **Crisis Response Resources** *Shown as: Percentage of Total (Number of Respondents)* *n - 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The Crisis Response sections expanded upon my previous knowledge base regarding responding to calls involving a behavioral health crisis.	0%	0%	0%	5.9% (1)	41.2% (7)	52.9% (9)	0%
I have a better understanding of how to create a face-saving resolution during a behavioral health crisis situation.	0%	0%	0%	11.8% (2)	35.3% (6)	52.9% (9)	0%
Assisting the on scene police officers while maintaining a broad view of a situation is a role I can envision doing.	0%	0%	0%	0%	29.4% (5)	70.6% (12)	0%
I can envision assisting in the role of a coach during a behavioral health crisis call.	0%	0%	0%	0%	35.3% (6)	64.7% (11)	0%
I found the training helpful for framing my role as an ECIT officer.	0%	0%	0%	0%	41.2% (7)	58.8% (10)	0%

DAY FOUR OF ECIT TRAINING

Behavioral Crisis Calls Tactical Options

Day 4 of the ECIT training provided students with a full day of ECIT Patrol Tactics training. The day began with a classroom lecture led by a Patrol Tactics lead instructor. The class provided training on how tactics used in routine patrol calls and higher intensity critical incidents can help lead to de-escalation of people in a mental health crisis. The class also reinforced decision-making processes regarding individuals in mental health crises who have been involved in some form of criminal activity.

The main tactics discussed were:

1) Disengagement or a delay of custody
2) Area containment

3) Utilizing surveillance to aid in determining risk and gaining intelligence
4) Using time when advantageous
5) Utilizing reinforcements and specialized units
6) Identifying and fulfilling a person's need when possible (e.g. hunger, thirst, etc.)

The training day includes three main sections: a classroom portion on tactical options for responding to calls involving a mental health crisis, a case study table top exercise, and six interactive scenarios. During the scenario portion of the class, students applied and demonstrated skills using the tactics discussed in the class. These scenarios provided opportunities for students to practice applying their skills in a safe training environment and discussing their decision-making process.

For the 2018 training, the Training Division made additional staff and training facilitators available to allow students to run through more scenarios in an ECIT role (as opposed to observing). Students still observed some scenarios, however the addition of more staff and an added mental health facilitator meant that more students were able to participate in key roles in the various scenarios.

Student Survey Results

Table 18: **ECIT Training:** Behavioral Crisis Calls Tactical Options *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [Behavioral Crisis Calls Tactical Options] session was a good use of my training time.	0%	0%	0%	5.9% (1)	35.3% (6)	52.9% (9)	5.9% (1)
The [Behavioral Crisis Calls Tactical Options] session expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.	0%	0%	0%	11.8% (2)	41.2% (7)	41.2% (7)	5.9% (1)

Lukus Glenn Table Top Exercise

At the beginning of the week, the class was provided with a copy of an actual 9th Circuit Court case[14] ruling from an incident involving deadly force and a person in mental health crisis. The students were broken up into small groups and given discussion questions. The questions were designed to apply the information presented in the class to the 9th Circuit ruling. Examples of the questions included:

- Could the communication have been better between Lukus Glenn and the officers? If so, how?
- Could the communication have been better between the officers? If so, how?
- Should police try to anticipate the reaction of a subject, and why?
- What are the advantages and disadvantages of having a rigid "line in the sand?"
- What tactics were discussed in the class that might have been tried in this incident, understanding that these tactics may not have affected the outcome in any way?
- According to the 9th Circuit Court, what is the standard that police will be judged by when dealing with people in crisis.

The lead instructors and the Training Division's non-sworn mental health specialist observed the students for their understanding of how the various tactical options discussed in class can be applied to calls involving people in mental health crises, analysis of priorities when dealing with both criminal activity and mental health crises, and legal considerations. The students applied the class material to the case, as evidenced by a lengthy and robust discussion in the small groups. The full class then reconvened and shared their findings with

[14] Glenn v. Washington County. United States court of Appeals, Ninth Circuit. 27 Dec. 2011

everyone through a teach-back assessment. All of the groups' findings were written on the board for comparison and discussion.

Student Survey Results

Table 18: **ECIT Training:** Lukus Glenn Table Top Exercise *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [Lukus Glenn Table Top Exercise] session was a good use of my training time.	0%	0%	0%	5.9% (1)	35.3% (6)	52.9% (9)	5.9% (1)
The [Lukus Glenn Table Top Exercise] session expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.	0%	5.9% (1)	0%	5.9% (1)	41.2% (7)	41.2% (7)	5.9% (1)

ECIT Scenarios

The ECIT scenarios serve as skill application learning assessments for many of the classes presented in the first three days of the training. The following provides a brief description of each of the scenarios. It is important to note that each student did not perform in each scenario.

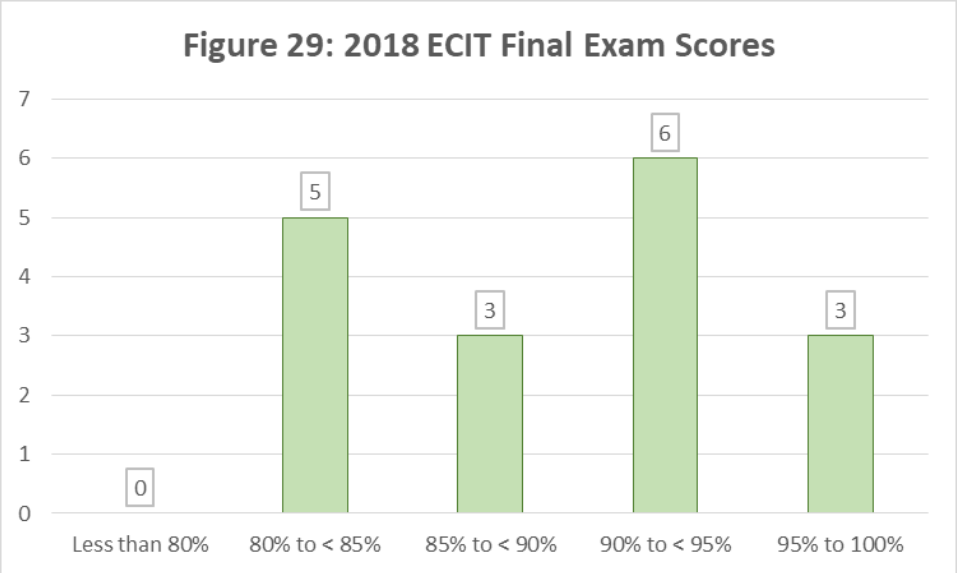
Table 19: **ECIT Training:** Lukus Glenn Table Top Exercise *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The [Lukus Glenn Table Top Exercise] session was a good use of my training time.	0%	0%	0%	5.9% (1)	35.3% (6)	52.9% (9)	5.9% (1)
The [Lukus Glenn Table Top Exercise] session expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis or resources related to behavioral health.	0%	5.9% (1)	0%	5.9% (1)	41.2% (7)	41.2% (7)	5.9% (1)

Table 20: **ECIT Training:** ECIT Scenarios *Shown as: Percentage of Total (Number of Respondents)* *n = 17*	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**	**Missing**
The facts of the scenarios were plausible.	0%	0%	5.9% (1)	0%	58.8% (10)	29.4% (5)	5.9% (1)
I found the scenarios appropriately challenging.	0%	0%	0%	5.9% (1)	58.8% (10)	29.4% (5)	5.9% (1)
I learned a lot from watching others go through the scenarios and debriefs.	0%	5.9% (1)	0%	11.8% (2)	41.2% (7)	41.2% (6)	5.9% (1)
A critical scenario was missed and should be included in future trainings.	23.5% (4)	17.7% (3)	11.8% (2)	17.7% (3)	17.7% (3)	5.9% (1)	5.9% (1)

Table 21: **Please estimate your level of knowledge, understanding, or skill level before and after the ECIT training in the following areas.**		**None**		**Very Low (1)**		**(2)**		**Moderate (3)**		**(4)**		**High (5)**		**Very High (6)**		**Missing**
Understanding of how I can assist on calls as an ECIT officer.	Before the Training	0	0.00%	1	5.88%	2	11.76%	6	35.29%	4	23.53%	3	17.65%	1	5.88%	0
	After the Training	0	0.00%	0	0.00%	0	0.00%	0	0.00%	2	11.76%	5	29.41%	9	52.94%	1
Understanding the need for intelligence gathering.	Before the Training	0	0.00%	0	0.00%	3	17.65%	0	0.00%	2	11.76%	8	47.06%	4	23.53%	0
	After the Training	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	6	35.29%	10	58.82%	1
Understanding of how to assist the on scene police officers with maintaining a broad view of a situation.	Before the Training	0	0.00%	0	0.00%	2	11.76%	4	23.53%	3	17.65%	5	29.41%	3	17.65%	0
	After the Training	0	0.00%	0	0.00%	0	0.00%	1	5.88%	0	0.00%	7	41.18%	9	52.94%	0
Understanding of how to set up a communication team that includes a communicator, coach, and intelligence gatherer.	Before the Training	0	0.00%	2	11.76%	1	5.88%	6	35.29%	5	29.41%	1	5.88%	2	11.76%	0
	After the Training	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	4	23.53%	13	76.47%	0
Confidence in de-escalating people who are in a behavioral health crisis.	Before the Training	0	0.00%	0	0.00%	0	0.00%	1	5.88%	6	35.29%	6	35.29%	3	17.65%	1
	After the Training	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	8	47.06%	9	52.94%	0
Confidence in effectively assessing situations involving people in a behavioral health crisis.	Before the Training	0	0.00%	0	0.00%	0	0.00%	1	5.88%	6	35.29%	7	41.18%	3	17.65%	0
	After the Training	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	5.88%	7	41.18%	8	47.06%	1
Confidence in talking with someone with a serious mental illness (e.g. Schizophrenia, Bipolar) about their health symptoms.	Before the Training	0	0.00%	0	0.00%	0	0.00%	2	11.76%	2	11.76%	10	58.82%	3	17.65%	0
	After the Training	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	5.88%	9	52.94%	7	41.18%	0
Confidence effectively communicating with someone with a serious mental illness (e.g. Schizophrenia, Bipolar) in general.	Before the Training	0	0.00%	0	0.00%	0	0.00%	1	5.88%	4	23.53%	9	52.94%	3	17.65%	0
	After the Training	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	5.88%	8	47.06%	8	47.06%	0
Confidence in empathizing with someone with a serious mental illness (e.g. Schizophrenia, Bipolar).	Before the Training	0	0.00%	0	0.00%	0	0.00%	1	5.88%	3	17.65%	7	41.18%	6	35.29%	0
	After the Training	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	5.88%	8	47.06%	8	47.06%	0
Confidence in assisting in the role of a coach during a behavioral health crisis call.	Before the Training	0	0.00%	1	5.88%	2	11.76%	4	23.53%	2	11.76%	4	23.53%	4	23.53%	0
	After the Training	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	10	58.82%	7	41.18%	0

2018 ECIT Final Exam[15]

Students were given a final exam on the last day of training, covering topics they had learned throughout the previous four days. The test items are listed below, with the correct answers highlighted. The student score breakdown can be seen in Figure 29.



1. According to Directive 850.20, an ECIT officer will respond as the primary member on a mental health crisis call involving the following six criteria:
    1. Upon the request of a citizen
    2. Upon the request of a the responding member
    3. The subject has a weapon
    4. The subject is threatening or attempting suicide
    5. The call is at a designated mental health facility

Select the sixth criteria from the list below:

A. The subject is on parole/probation
B. The subject has a history of mental illness
C. The subject is violent
D. The subject is under the influence of drugs/alcohol

2. Acceptable facilities for police transport for persons under 18 years of age: *(select all that apply)*
    a. Hospital Emergency Room
    b. Randall Children's Hospital
    c. Unity Center
    d. Urgent Walk-In Clinic

[15] In the 2018 ECIT Training, students completed one final exam at the end of the fourth day of training. This differed slightly from prior 40-hour ECIT trainings, due to the Training Division evaluation capacity at the time. Full evaluation and assessment will resume in future ECIT trainings, as staffing capacity allows.

3. What are the signs and symptoms of psychosis? *(select one)*
    a. Delusions, hallucinations, and disorganization
    b. Flashbacks, hypervigilance, nightmares
    c. Rapid speech, racing thoughts, excessive energy
    d. Suicidal thoughts, lethargy, hopelessness

4. Which of the following responsibilities are filled by the Coach? *(select all that apply)*
    a. Relaying intelligence to the primary communicator
    b. Broadcasting important information
    c. Providing cover
    d. Giving ideas/support to the primary communicator

5. NAMI can be a resource to the community in the following ways: *(select all that apply)*
    a. Providing education and support to families with mental health
    b. Developing outreach strategies to raise awareness of mental health issues
    c. Assisting families to influence county level systems of care on mental health issues
    d. Assisting state and local law enforcement in locating and prosecuting mentally ill suspects

6. A "peer" is defined as any individual who has similar life experience, either as a current or former recipient of addictions or mental health services, or as a family member of an individual who is a current or former recipient of addictions or mental health services. The state of Oregon recognizes and trains peers to perform duties in the professional positions of Peer Support Specialists. Services they can provide may include: *(select all that apply)*
    a. Understanding the stigma from self and others
    b. Understanding the impacts of shame and trauma
    c. Providing legal advice in court proceedings
    d. Providing peer-run support groups

7. According to a theory developed by Thomas Joiner, which three elements are commonly seen in suicidal persons? *(select one)*
    a. Emotional dysregulation, failed connection, acquired capacity
    b. Hopelessness, failed connection, acquired capacity
    c. Mental illness, perceived burden, failed connection
    d. Perceived burden, failed connection, acquired capacity

8. With respect to suicide safety planning, which of the following can lead to a more effective plan? *(select all that apply)*
    a. Rehearse the safety plan
    b. Involve others in the safety plan
    c. Ask the person for their ideas
    d. Write down the plan and put it in a prominent place

9. The person responsible for deciding whether someone goes to a hearing to determine hospitalization due to mental illness: *(select one)*
    a. The Deputy Mental Health DA
    b. Pre-commitment Investigator
    c. Emergency Department MD
    d. County Mental Health Director

10. The COMTEK can be used in which of the following situations: *(select one)*
    a. Officers are in telephone contact with a barricaded person in mental health crisis threatening suicide by firearm
    b. Officers are talking with a person on his cell phone who is threatening to commit suicide by jumping off a parking structure
    c. Officers have been conferenced into a 911 call made by a kidnapped domestic violence victim who is being held against her will by the offender
    d. All of the above

11. When the COMTEK digital recorder is used to make a recording, the recording should be: *(select one)*
    a. Erased at the conclusion of the incident in accordance with PPB policy and procedure
    b. Put into evidence in accordance with PPB policy and procedure
    c. Put on a thumb drive and sent to detectives in accordance with PPB policy and procedure
    d. Kept on the digital recorder until it needs to be erased to make more room in memory

12. For the COMTEK to operate you must: *(select one)*
    a. Adjust and test the speaker volume before making a call
    b. Turn on the digital recorder and speakers and hit the "record" button
    c. Turn on the digital recorder and speakers only, as it activates automatically
    d. Turn on the speakers and hit the "record" button

13. _____ is described as developing problems due to exposure to other's trauma, and happens to some people who care for those who have experienced extremely or traumatically stressful events. *(select one)*
    a. Complex trauma
    b. Direct trauma
    c. Systemic trauma
    d. Vicarious trauma

14. _____ are the most basic and long-lasting cause of health risk behaviors, mental illness, social malfunction, disease, disability, death, and healthcare costs. *(select one)*
    a. Adverse childhood experiences
    b. Mental health crises
    c. Stress events
    d. Systemic trauma

15. Listening for what the subject may view as a positive outcome and altering the scene to match the primary communicator's message can be most accurately referred to as which of the following: *(select one)*
    a. Active listening strategies
    b. Defining the event
    c. Reframing the event
    d. The Golden Bridge Technique

16. Identify the three elements of a communication team: *(select one)*
    a. Arrest element, communication element, primary officer
    b. Contact element, communication element, command element

c. First communicator, second communicator, supervisor
d. Primary communicator, communication coach, intelligence element

17. What is the preferred order of priorities for ECIT officer when using their ECIT skills on a call? *(select one)*
    a. Arrive, Advise, Arrest
    b. Arrive, Assess, Adjust
    c. Assess, Advise, Apply
    d. Apply, Assess, Advise

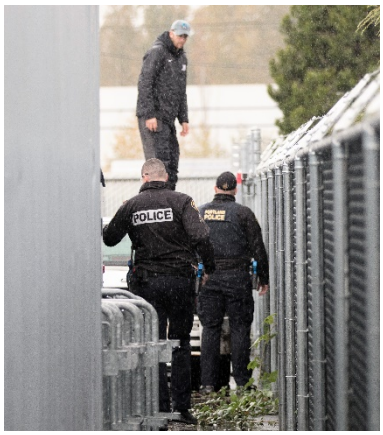
18. A subject in crisis calls 911. The call-taker learns the name of the officer who will be talking with the subject, provides an introduction of the officer on the phone, provides a summary of the subject's perspective on the phone for both the officer and subject to hear, and then mutes the call taker's microphone but remains on the line. Which statements are true of this process? *(select all that apply)*
    a. This call can continue to be monitored by the call-taker
    b. This is referred to as a conference call
    c. This is referred to as a transferred call
    d. This process is not possible with BOEC
    e. This process maximizes verbal containment and transference of influence

INTRODUCTION

The Portland Police Bureau created the Enhanced Crisis Intervention Team (ECIT) training in 2013 to train a select group of volunteer officers to assist with specific calls involving a behavioral health crisis. This included calls with a mental health component and at least one of the following: a violent subject; a subject with a weapon; the call location is at a designated residential mental health facility; the call involves someone who is threatening suicide by jumping; or an ECIT officer is requested by an officer or citizen. On July 27, 2016, the directive was updated to include all calls where a subject is threatening or attempting suicide, in addition to the previous criteria. The ECIT team is a component of the Portland Police Bureau's Behavioral Health Unit (BHU), which was established in 2013 to manage and coordinate the increasing demands related to police contacts involving behavioral health crises.[1] A description of the Portland Police Bureau's complete mental health response model is provided in Appendix A.

The ECIT officers have three primary roles when responding to behavioral health crisis calls:

1. Identify risk factors and provide additional crisis intervention strategy considerations to the primary officer and/or supervisor on scene.
2. Provide specific mental health system and community resource knowledge to officers, supervisors, providers and family members involved in crisis calls.
3. Make referrals to the Portland Police Bureau's Behavioral Health Unit and community providers to help solve both immediate and recurring issues.



Officers practicing de-escalation skills in scenario training

The ECIT Evaluation Process

The Training Division and Behavioral Health Unit utilize multiple research methodologies within the Kirkpatrick Model of training evaluation for evaluating the effectiveness and impact of this training. For the ECIT training, the evaluation process includes examining the quality of the training event, student learning, the relevancy of the material, on-the-job barriers, on-the-job outcomes, and organizational level goals.

The organizational level goals pertaining to this program are:

- To have police and community member interactions involving a behavioral health crisis result in the safest possible outcome for the police and community member.

[1] More information about the Behavioral Health Unit can be obtained at http://www.portlandoregon.gov/police/62135.

- To be a partner with the local mental health system in public safety issues related to behavioral health crises.

This particular report focuses on the portion of the ECIT evaluation process assessing the partnership between the mental health system and the Portland Police Bureau, examining what is working well and what challenges still exist. It assesses how much alignment there is with the program goals, mental health and law enforcement management, mental health management and mental health direct care workers, and law enforcement management and patrol (Figure 1). This part of the program had not yet been formally assessed and is a critical indicator for the program's success and sustainability over time. How much alignment there is in these areas impacts how successful the interactions will be between law enforcement and mental health personnel during calls for service, and ultimately the quality of service provided to those with mental health issues.

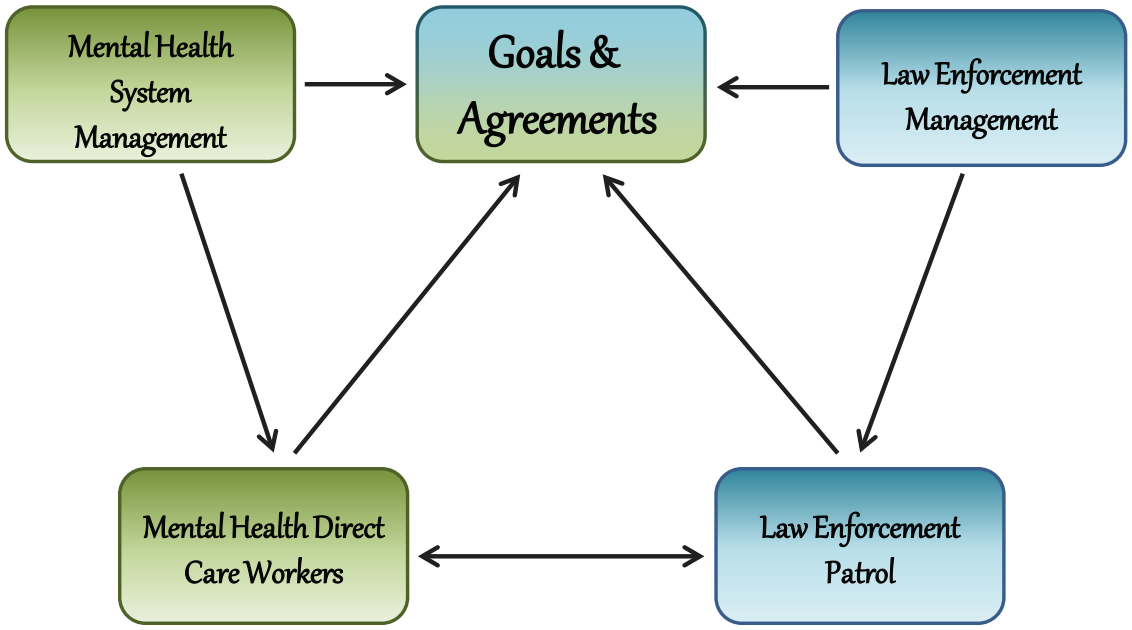


Figure 1. Partnership Alignment

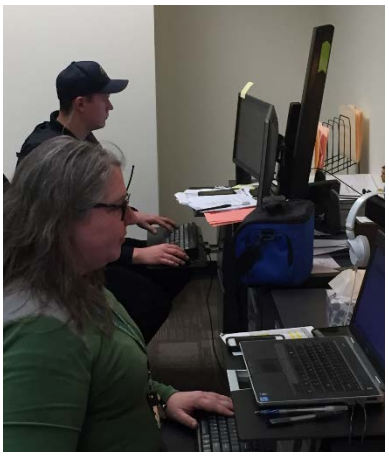
This portion of the evaluation was conducted in partnership with Dr. Yves Labissiere, from Portland State University. It included a series of interviews with employees from the mental health system and the Portland Police Bureau (at the managerial and direct provider/officer levels), literature reviews, focus groups with employees from both fields, and a survey to employees at a select group of local mental health facilities. Initially, this study focused on conducting a very broad environmental scan of the intersection between law enforcement and mental health. In the latter stages of this study, it focused more specifically on this intersection within the context of calls for service to mental health facilities. This was due in part to the amount of different mental health system components being too numerous for one study and the earlier parts of the study finding the partnership with mental health facilities being an area in more immediate need of attention.

The findings were numerous and more than could be discussed comprehensibly in one report. This report focuses on those identified as most critical to successful interactions between mental health facilities and law enforcement during facility calls for service. Throughout the study, these areas were repeatedly brought up by both mental health direct care workers and police patrol as areas most helpful to address for enhancing collaboration during crisis calls. Other findings will continue to be tracked and utilized during the full Enhanced Crisis Intervention Team training evaluation and the training needs assessment process. They will also be available for any additional work done in follow-up to this study, for addressing system issues pertaining to the intersection of law enforcement and mental health during calls for service.

MAIN FINDINGS ON CURRENT COLLABORATION

Overall, those that worked more closely with the Portland Police Bureau (PPB) were extremely supportive of the skills and partnership provided by both individual PPB members and the Behavioral Health Unit's (BHU) programs. One example that was repeatedly mentioned was the Behavioral Health Unit's Coordination Team meeting which started approximately five years ago in order to address some of the most difficult cases intersecting both the mental health and law enforcement fields. During interviews and focus groups this collaboration was often cited as one of the examples of "what is working". This meeting includes professionals from both the mental health and law enforcement fields. These professionals meet to resolve the most complex cases intersecting with multiple systems. Having this space has allowed for better communication and collaboration pertaining to addressing individual cases and getting people with multiple system challenges the assistance they need.

The value of the collaboration with officers during calls involving a mental health crisis was also clear. One example of this type of partnership is between the Portland Police Bureau and Project Respond, where officers and mental health providers often attend calls involving a mental health component together. Being able to collaborate with an officer during these calls often provides an increase in safety, access to situations such as police calls involving a person in crisis (which have historically been off-limits to non-police personnel), ability to provide service on higher risk calls, and greater priority when working with other agencies, than mental health providers are able to achieve on their own. The Portland Police Bureau officer's skills[2] in building rapport and abilities to creatively problem solve with those with mental illness, also enable some with mental illness to be connected with services or receive help they would not otherwise receive[3]. In turn, collaborating with Project Respond often brings additional mental health expertise for officers to rely on, knowledge about clients can help with planning successful approaches to a call, and building rapport with people who are uncomfortable talking with a police officer.



Project Respond Clinicians and Officers work together in the BHU

Although the importance of collaboration between these two systems was clear, as was the substantial progress towards greater collaboration being made over the last few years, several areas

[2] It was specifically noted on multiple occasions that overall the Portland Police Bureau officers have substantially higher skillsets in working with those with mental illness compared to emergency medical personnel and some other law enforcement agencies.

[3] While some people with mental illness are fearful of law enforcement due to various reasons, others are more comfortable talking with a law enforcement officer than a mental health worker. Both law enforcement and the mental health system play a critical role in assisting those with mental illness.

for strengthening collaboration were also noted. In particular, there appears to often be a disconnect between the policies and procedures for law enforcement and mental health, a need for more information on current law enforcement procedures for mental health direct care workers, more safety resources needed for many mental health facilities[4], more availability of resources, and information on the mental health system's limitations. While the impact of these challenges are frequently manifesting in confusion and conflicts for officers and mental health care workers in the field, often during calls for service, it was apparent that the cause was more attributable to system level challenges, rather than individual level.

Law Enforcement and Mental Health Facility Policy and Procedures

During this study, it was evident there are some discrepancies between the guidelines for law enforcement and many mental health facilities.

One of the largest sources of frustration during calls for service pertained to lower level safety calls for police assistance. These are often calls where a client is exhibiting some aggressive or unusual behaviors in a facility, but the behaviors do not rise to the level of requiring police action. In many of the facilities, mental health workers have been instructed by their state and local guidelines to call the police during these situations. Over the past few years, the Portland Police Bureau has increased its expectations of members to develop and use skills and abilities (such as de-escalation) that allow them to regularly resolve confrontations while minimizing the use of force in cases of perceived behavioral or mental health crisis. Current policy instructs Portland Police Officers to avoid or minimize the use of force in cases of perceived behavioral or mental health crisis and direct such individuals to appropriate mental health services[5]. Therefore, difficulties naturally arise when the mental health worker and the law enforcement officer come to the scene with these conflicting role expectations. Another call type frequently mentioned with some similar challenges pertained to client elopement from facilities.

Some facilities have alternative resources and procedures for lower level situations that do not rise to the level of law enforcement interaction, but many do not. When the latter occurs, the mental health worker is sometimes left in a difficult situation with no alternative and the officer is left in the uncomfortable situation of having to explain current policy. In some cases, the mental health workers reported, these situations actually lead to an increase in problematic behavior from the client when they see that law enforcement will walk away from the situation. It was also evident that finding out about this discrepancy in policy and procedure during a crisis often led to more disarray than necessary. Again, this finding reflects a systems issue in this case, not an individual issue. This misalignment in policy causes strain for both law enforcement officers and mental health workers.

[4] The safety resources among mental health facilities varied greatly. However, many are lacking the resources to manage lower level safety issues.
[5] See Portland Police Bureau Directive 1010.00 for further information.

Information on Current Law Enforcement Procedures for Mental Health Direct Care Workers

Although not true across all participants, it was apparent during this study that many mental health workers were largely unaware of the Portland Police Bureau's specialized mental health response programs, mental health related training for law enforcement, and current law enforcement policy and procedures when responding to a call involving mental health. This information gap was most prevalent among direct care workers, compared to the managerial level participants, who were significantly more aware of Portland Police Bureau's mental health response programs due to their close collaboration with the BHU. However, some direct care workers were familiar with the ECIT program and made specific compliments to the high skills of ECIT officers. In the survey results approximately half of the respondents reported they were at least somewhat familiar with the ECIT program (21 percent reporting they were "very familiar"), approximately 27 percent reported they were only "a little familiar", and 21 percent marked that they were "not at all familiar".

Many participants expressed interest in having a greater understanding of current policy and mental health training for law enforcement and believed it would be beneficial when working collaboratively with law enforcement. As mentioned above, many appear to be becoming aware of portions of the policy and procedures during an interaction, which frequently causes disruption. Becoming more aware of the substantial training and program efforts may help foster a greater sense of trust and collaboration with law enforcement as well.

Officers practice building rapport and managing situations involving a mental health crisis in scenario training

Safety Resources and Planning Needed for Many Mental Health Facilities

Many facilities appeared to have limited resources, planning, and training pertaining to managing safety situations. Most facilities, even secured ones, do not have security personnel on staff and many do not have an alternative resource to call in cases of managing behavioral issues that have not risen to the level of needing police interventions. Many mental health direct care workers in the study expressed a desire to have more of these resources available to them and took great interest in hearing about the resources and procedures one's facility provides to its employees. It was frequently mentioned that there is no one else to call other than law enforcement. Having more in-house resources would likely reduce police contact at facilities and increase desired outcomes for these lower level situations. Depending on the facility needs, it was also brought up that law enforcement may be a valuable partner in safety planning and procedures.

Availability of Mental Health Resources

The challenges regarding the availability and allocation of mental health resources were frequently mentioned from both mental health and law enforcement participants. Two main themes pertained

to facilities not being set up to effectively manage higher risk clientele and there being limited mental health resources during the late afternoon and night shifts.

The more respondents talked about the need for more resources, the more clear it became that they were making more than a numerical argument. Yes, more beds are needed. However, participants wanted to convey a more nuanced point about resources, specifically, that attention needed to be paid to allocations and deployment of the resources. For example, while a facility may have the resources and be equipped to handle a good number of less acute patients, they may have little to no support or resources for higher risk clientele. This reinforced another refrain from the focus group and interviews: the more acute are not well served.

Another example had to do with the way resources were deployed: Respondents mentioned mental health resources were more limited during the late afternoon and night shifts. In this example, when resources are available determine the likelihood the resources would meet a given need. A major takeaway from the reflection on resources is that it is not simply a matter of more but to also have a more nuanced and dynamic assessment of resource needs as they emerge and for the system to be flexible enough to direct resources in more tailored and directed fashion.

In terms of reducing the amount of law enforcement contact to manage mental health crises (both within and outside of facilities) and mental health acuity in general, many shared the need for more outreach, transitional, and follow-up services. Many explained how there are too many revolving doors in the mental health system that reduce the chances of individual's mental health improving or stabilizing. For example, it was expressed repeatedly that more mental health services needed to be provided outside of facilities for those that are more acute or have difficulties following up with their care protocols. Another theme in this area was the difficulty getting some people into services. Both police officers and mental health care workers had many experiences attempting to get people to the appropriate services, but ran into barriers with either entry into services or keeping them there. These barriers appear to often be tied to insurance, bed availability, facility funding criteria, and proficiency level in mental health care.

Information on the Mental Health System's Limitations

It was apparent throughout the study the local mental health system is very siloed, varied, and complex in many aspects. This has some benefits as it allows programs the flexibility to specialize in various areas, as well as some challenges in collaboration with more varied practices and procedures. There are some similarities between the mental health and law enforcement culture, but there are also many differences. Having a greater understanding of the local mental health system and its limitations was mentioned several times as something thought to be beneficial for enhancing collaboration. Given the study findings as a whole, this may be particularly important for those in law enforcement (sworn and non-sworn) who are working most closely in managing, coordinating, and evaluating the Behavioral Health Unit's programs, conducting facility outreach, advising on mental health response policy, and designing and instructing on mental health response training.

MAIN FINDING SUMMARY AND FOLLOW-UP NEEDS

Overall, the findings support substantial improvements have been made in the collaboration between the Portland Police Bureau and the local mental health system. It was clear this success was achieved by the dedication and passion of both those in law enforcement and those in the local mental health field. The findings were supportive of the Enhanced Crisis Intervention Team and other Behavioral Health Unit programs. They also highlighted the critical need for these programs and further work to be done to enhance these collaborative efforts.

The findings demonstrate some areas in need of attention in order for the program to fully reach its program goal of having an effective partnership with the mental health system and for the program to be sustainable over time. From the evaluation perspective, this is not viewed as a program failure but rather a natural evolution and growth of a developing program. Successful complex programs often go through several iterations of assessing what is working and where additional focus is needed for program development in order to achieve the program goals.

The most pressing area brought to surface pertained to addressing the discrepancies between the guidelines, policy, and procedures for law enforcement and many mental health facilities. This appears to be causing substantial confusion and frustration for both law enforcement officers and mental health care workers; it puts both parties in a difficult position during a stressful situation. Developing strong alignment in these areas is critical for enabling collaboration and program stability over time. It would appear that resolving these discrepancies successfully would require the input of both managers and direct workers in law enforcement and the mental health field. Ideally, the mental health and law enforcement field could collaborate in reviewing and resolving system level challenges that impact their combined efforts, starting with the discrepancies in policy and procedure. This was another concern repeatedly brought up during this study; there was collaboration formed around training and case work, but not for doing more in-depth evaluation and problem solving at a systems level. System level challenges frequently rise to attention during these other efforts; however, they are put aside in order to remain focused on the task at hand. There was also hopelessness around these situations, related to the system issues being so vast and difficult they were somewhat insurmountable. Due to this and some of the factors below, an approach which focuses only on one or two areas at a time would likely be more productive.

Additional Findings for Consideration in Follow-up Planning

These additional findings may be important to consider during any follow-up planning processes, such as developing alignment between law enforcement and mental health system policy and procedures.

The Mental Health System is Siloed

One recurring theme across the interviews and focus groups was that the mental health system and services are very fragmented and siloed. Often this was due to law mandates, various funding streams, privacy and protection of individual rights, and maintaining public trust. While there were some clear benefits of having a siloed system such as the ability to collect and protect various data and more independence in program design; it also brings additional challenges to examining system issues and related intervention strategies. For example, there appeared to be substantial differences among facilities in regards to procedures and resources for addressing safety issues and/or what types of resources would be most beneficial. This was found to be true between and within mental health organizations (some organizations, such as Cascadia Behavioral Healthcare, have several individual facilities). In addition, the sharing of information between agencies can be very limited or delayed. This has very important, protective benefits of individuals' personal information, however; it can also delay or prevent important information from being shared in a crisis situation.

Not only is much of the mental health system siloed, there are numerous components. In the Portland area there are over fifty mental health facilities. This can make the coordination of outreach or distribution of information more challenging. Therefore, for some system challenges, it may be beneficial to collaborate with a set amount of facilities at a time, to make the process manageable.

Trauma and Crisis Oriented Environments

Both the mental health and law enforcement systems serve a disproportionate amount of people struggling with trauma and/or the most stressful times of their lives. Employees are often exposed to a lot of crises and secondary trauma. Many of these positions require a keen focus on resolving short-term immediate problems and finding quick solutions under varied unexpected circumstances.

During this study, several examples arose where crisis exacerbates crisis or has become a part of the cultural identity of the organization. An issue may be well known for long periods of time, however, it will not be dealt with until it reaches a level of crisis. When it reaches the level of crisis, it is then managed in a crisis mode, often missing critical components for a sound long-term solution and leading towards another crisis down the road. It repeatedly came up that not enough time and resources were devoted to evaluation and planning processes. It also appeared that what evaluation and planning processes existed frequently were not thorough and did not include enough input from the people most involved in carrying out the work, leading to unnecessary difficulties.

Many participants expressed how the evaluation process itself provided them a valuable opportunity to reflect on their practice and process various aspects of the collaboration between mental health and law enforcement. On several occasions people made their own new realizations of what would aid in the collaboration, connected with information that was previously unknown to them, and gained ideas from listening to others speak on the topic.

These findings reiterate the likely importance of taking a staged approach to resolving system issues (focusing on only one or two issues at a time) and the need for thoughtful evaluation and planning processes that are inclusive of those conducting the work. If done well, these processes save an organization time, money, liability, and employee burnout.

Consistency in Mental Health and Law Enforcement Staff

The large amount of employee turnover in mental health facilities was a repeated theme in the study. On the law enforcement side, there is high stability of sworn staff within an organization; however, there can be frequent changes in roles and assignments. Staff turnover was mentioned as a contributing factor that interrupts successful collaboration between mental health and law enforcement. Having individual familiarity with one another was a critical factor to successful partnerships. Staffing turnover puts employees in a position of constantly establishing relationships; it was also reported to negatively impact knowledge and skill level (such as familiarity with the ECIT program and how best to manage crisis situations).

The survey findings reiterated these differences in years of experience. Those with fewer years of experience working with people with mental illness were less confident in recognizing safety threats, less familiar with the ECIT program, and felt less sufficiently trained and adequately prepared in de-escalating or managing a crisis situation. Mental health employees with less experience were much more likely to be working afternoon and evening shifts which was reported during the interviews and focus groups to have less support and resource availability.

Interestingly, employees with fewer years of experience reported greater satisfaction with the local mental health system and their experiences with law enforcement. This study did not include exploration into the reason for these findings. It may be a reflection of improvements in both systems and not having the burden of past experiences, or it could be due to age or having less exposure to some of the challenges in the field.

Efforts that reduce turnover caused by burn out or other preventable causes will assist goals surrounding successful mental health and law enforcement collaborations. Regardless of whether or not greater retention in employees can be achieved, understanding this factor is important to developing effective partnership strategies. For instance, if the environment is known to have high turnover, more extensive and ongoing resources may need to be provided in any training and relationship building efforts in order to achieve the desired outcomes.

APPENDIX A: THE PORTLAND POLICE BUREAU'S MENTAL HEALTH RESPONSE MODEL

The City of Portland's mental health response model starts at the moment a person calls 911. The Bureau of Emergency Communications (BOEC) dispatchers are triaging mental health calls to determine if police response is necessary or if the person can be referred to another resource. BOEC transfers appropriate calls to the Multnomah County Crisis Line to assist the person instead of dispatching an officer to the location.

All of Portland Police Bureau (PPB) Patrol officers have crisis intervention training and basic knowledge in responding to mental health related calls. All patrol officers have access to the following resources on any call:

- 24 hours a day and 7 days a week access to Project Respond
- The ability to have Enhanced Crisis Intervention Team Officers respond to calls
- Access to the Multnomah County Crisis Line
- The ability to make a Behavioral Health Unit referral for follow-up
- The ability to consult with the Crisis Negotiation Team
- Mental Health Resource Guide for distribution

The Portland Police Bureau's Enhanced Crisis Intervention Team (ECIT) officers provide additional skills and resources to assist on behavioral health calls. The volunteer ECIT officers have an additional 40 hours of Crisis Intervention Training. They have expanded resource knowledge, coupled with the ability to assess risk and additional communication skills training.

Post call, the Behavioral Health Response Teams (BHRT) are partner cars with police and Project Respond clinicians that provide follow up to connect people to community resources. BHRTs follow up on referrals from patrol officers that are determined to be high risk to others or who experience a high frequency of police contact resulting from mental illness.

The Service Coordination Team (SCT) provides treatment and supportive housing services to the City's most frequent drug and property crime offenders, addressing their drug and alcohol addictions, mental health issues and criminality.

APPENDIX B: SURVEY RESULTS

The survey was distributed to seven local mental health facilities. Six of the facilities were selected based on having more frequent police calls for service. One of the selected organizations also chose to include one of their additional facilities. Only a small selection of agencies were selected for the survey due to the siloed nature of the mental health system and in order to make any needed follow-up work manageable. The idea being to start with a few facilities and gradually expand to others, until the Police Bureau and Mental Health partner goals have been met. Therefore, some of the below findings may not be generalizable to all facilities. For instance, some of the facilities included in the selection were known to have more emergency/safety resources and procedures for their staff compared to what appears to be more common (based on the interviews and focus group findings).

The surveys were collected between January 2 and 22, 2018. Twenty of the surveys were fully completed and thirteen of the surveys were partially completed to a reasonable amount. Four surveys were excluded from the analysis due to early survey termination from the respondent.

What type of mental health facility do you work at?	
Secure Residential Treatment	78.8%
Non-secure Residential Treatment	3.0%
Secure Supportive Housing Residence	9.1%
Non-secure Supportive Housing Residence	9.1%
Other	0.0%
n = 33	0 missing

How many years have you worked with people with mental illness?	
0-3 years	33.3%
4-7 years	33.3%
8-11 years	15.2%
12-15 years	3.0%
16-19 years	15.2%
n = 33	0 missing

Which shift do you work?	
Day	33.3%
Afternoon	12.1%
Evening	21.2%
It varies frequently	33.3%
n = 33	0 missing

Yes or No Questions n = 33			
	Yes	**No**	**Missing**
Do you regularly work with people experiencing mental illness in your main role at your facility?	97.0%	3.0%	0
Do you have security personnel at your facility?	100.0%	0.0%	0

How familiar are you with the Portland Police Bureau's Enhanced Crisis Intervention Team (ECIT)?	
Not at all familiar	21.2%
A little familiar	27.3%
Somewhat familiar	15.2%
Familiar	15.2%
Very familiar	21.2%
n = 33	0 missing

Contact with the Police n = 33			
	Yes	**No**	**Missing**
During the past 12 months, have you personally had contact with a Portland Police Officer at your facility?	87.9%	12.1%	0

Please rate your most recent experience with Portland Police at your facility. n = 33								
	No, not at all	Yes, to a small extent		Yes, moderately		Yes, to a large extent	N/A	Missing
Did the officer(s) respond in a timely manner?	3.7%	18.5%	14.8%	14.8%	29.6%	14.8%	3.7%	6
Were the officer(s) professional?	7.4%	18.5%	7.4%	22.2%	11.1%	33.3%	0.0%	6
Were you comfortable asking the officer(s) questions?	14.8%	7.4%	14.8%	14.8%	18.5%	29.6%	0.0%	6
Did the officer listen to your input?	22.2%	3.7%	14.8%	14.8%	14.8%	29.6%	0.0%	6
Did the officer attempt to understand your point of view?	22.2%	7.4%	22.2%	14.8%	7.4%	25.9%	0.0%	6

How would you describe the outcome of the call? n = 33											
Worst possible outcome										Best possible outcome	
0	1	2	3	4	5	6	7	8	9	10	Missing
0.0%	0.0%	0.0%	0.0%	3.8%	7.7%	19.2%	15.4%	26.9%	11.5%	15.4%	7

In your experience at your facility, how well do you feel Portland Police Officers use de-escalation techniques to resolve potentially dangerous situations? n = 33											
Not well at all										Extremely Well	
0	1	2	3	4	5	6	7	8	9	10	Missing
0.0%	0.0%	13.6%	4.5%	9.1%	9.1%	22.7%	4.5%	9.1%	22.7%	4.5%	11

How well do you believe mental health and law enforcement professionals collaborate with one another?

Twenty-one individuals provided open-ended responses. Seven of them indicated that mental health and law enforcement professionals collaborate well with one another, eight said it was okay or it depends, and six of them said that there was little to no collaboration, or that the collaboration was poor. Of the things that seemed to be working well, some respondents commented on the positives

of working with ECIT officers or others that appeared to have related training experiences, the dynamics improving over time, how law enforcement helps them secure their safety, and law enforcement helping to bring peaceful resolution. Some respondents included difficulties when officers do not take the desired action, are less empathic either to the client or mental health worker, do not understand the mental health workers' needs, and that they only meet during times of a crisis. Some also expressed they thought the success of the collaboration depended on the officer and/or mental health worker involved.

From your perspective, what barriers make it difficult to collaborate with a police officer during a mental health crisis at your facility?

Twenty individuals provided open-ended responses. Eight respondents indicated difficulties when the officer seems disinterested, less empathic or patient, not familiar enough with certain mental health diagnoses (such as schizophrenia), or do not remain calm. Six indicated there is sometimes role confusion and/or a lack of understanding of the facility's limitations in regards to security. Four individuals mentioned another barrier is that police officers are sometimes unwilling to assist for fear of negative repercussions or backlash. Other factors mentioned were when the officer doesn't know the background of the individual they are working with, when safety is not a priority, and there are time limitations for more communication.

From your perspective, what types of support do you find most helpful from police officers?

Twenty individuals provided open-ended responses, many of which listed multiple types of support that they find, or would find, helpful from police officers. Eleven individuals mentioned listening to the mental health professionals, asking questions, being flexible to different strategies for varied situations, and/or working collaboratively. Seven individuals mentioned security, or the ability to prevent or resolve any violent situations. Five individuals said that the presence of a police officer can sometimes be helpful in and of itself; however, one person said that the presence of a police officer can actually make the situation worse. One said when the officer has some background on the person they are dealing with. One person simply said crisis intervention. One person said that police support was not helpful.

In general, how well do you believe the Portland Police Bureau does in handling situations involving individuals with mental illness? n = 33											
Not well at all										**Extremely Well**	
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Missing**
0.0%	0.0%	4.2%	8.3%	4.2%	4.2%	20.8%	16.7%	25.0%	16.7%	0.0%	9

Time at Facility n = 33			
	Yes	No	Missing
Have you worked in this facility for 5 years or longer?	20.8%	79.2%	9

If the respondents responded yes, to working in their facility for five years or longer, these two additional items were included: 1) Compared to five years ago, my satisfaction with my interactions with the Portland Police Bureau has…., and 2) Compared to five years ago, my satisfaction with the Portland Police Bureau managing situations involving a person in crisis has… (both on a 7-point scale ranging from substantially decreased to substantially increased).

Only five respondents indicated they had worked at their facility for five years or longer, therefore the results are difficult to determine much meaning. However, for satisfaction with interactions, two marked slightly decreased, two said the same, and one said moderately increased satisfaction. For satisfaction with crisis management, one said slightly decreased, two marked the same, and two indicated a slightly increase in satisfaction.

What training have you received to handle crisis incidents with a safety challenge/component and where have you received this training? Please list or provide examples.

Seventeen individuals provided open-ended responses. Fifteen of them said that they received training from their organization. One individual mentioned receiving training through years of experience doing social work. One said that the received training through their master's program. Other individuals mentioned receiving training through their previous employers. Specific examples of the type of training received include:

- Verbal de-escalation techniques
- Pro-ACT
- Manual restraint
- Identifying and handling dangerous situations

Training on Calling Law Enforcement n = 33			
	Yes	No	Missing
Have you been trained at your facility on when to call law enforcement?	95.0%	5.0%	13

What is your understanding of when to call the police?

Nineteen individuals provided open-ended responses. All of them said that they call the police when the person in crisis poses a safety threat to themselves or others. Three of them also mentioned that they call the police when directed to.

Alternatives to Law Enforcement n = 33			
	Yes	No	Missing
Do you have someone other than law enforcement to call when you need help managing a crisis situation?	100.0%	0.0%	13

If yes, please describe what additional resources you have:

Eighteen individuals provided open-ended responses, many of which listed more than one resource. Thirteen individuals mentioned having an administrator, supervisor, or nurse on call. Eight said that they utilize Project Respond. Four mentioned using a crisis line, one specifically mentioning the Multnomah county crisis line. Two mentioned AMR.

Training and Preparedness: n = 33							
	No, not at all	Yes, to a small extent		Yes, moderately		Yes, to a great extent	Missing
Do you feel sufficiently trained to de-escalate a crisis situation with a mental health component?	0.0%	5.0%	0.0%	25.0%	25.0%	45.0%	13
Do you feel adequately prepared to deal with a person in a mental health crisis?	0.0%	10.0%	0.0%	15.0%	30.0%	45.0%	13

Describing Level of Confidence: n = 33							
	Not at all Confident	Moderately Unconfident	Slightly Unconfident	Slightly Confident	Moderately Confidant	Extremely Confidant	Missing
How confident are you in your ability to collaborate with a police officer on a crisis call?	0.0%	5.0%	10.0%	10.0%	35.0%	40.0%	13
How confident are you in your ability to recognize a safety threat at an early stage?	0.0%	0.0%	5.0%	10.0%	25.0%	60.0%	13

What is your general level of satisfaction with the following:							
n = 33							
	Very Dissatisfied	Generally Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Generally Satisfied	Very Satisfied	Missing
Current mental health system locally	5.3%	26.3%	21.1%	21.1%	26.3%	0.0%	14
Law enforcement in Portland	5.3%	15.8%	15.8%	31.6%	31.6%	0.0%	14
Your facility's capacity in dealing with persons with a mental illness in crisis	5.0%	0.0%	5.0%	10.0%	55.0%	25.0%	13

What is your gender?	
Female	45.0%
Male	40.0%
Transgender	0.0%
Gender variant - non conforming	0.0%
Prefer not to answer	15.0%
n = 33	13 missing

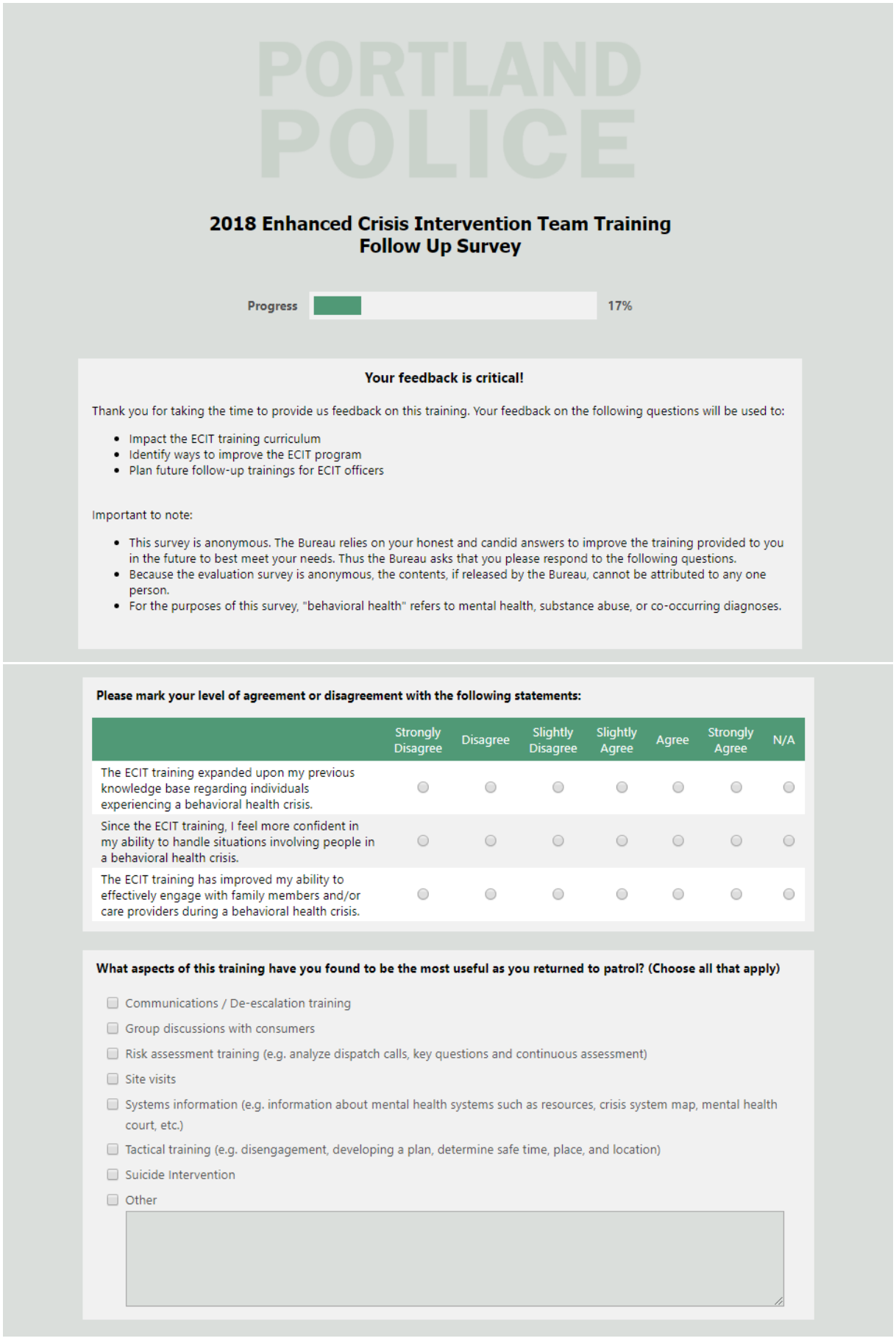
How would you describe your ethnicity?	
No, not of Hispanic, Latino, or Spanish origin	78.9%
Yes, Mexican, Mexican American, Chicano	5.3%
Yes, Puerto Rican	0.0%
Yes, Cuban	0.0%
Yes, another Hispanic, Latino, or Spanish origin	0.0%
Unavailable / Unknown	0.0%
Prefer not to answer	15.8%
n = 33	14 missing

How would you describe your race?

Sixteen individuals provided an open-ended response. Nine of them said either white or Caucasian. One said Mexican-Caucasian mix. Three said African American or Black. One said Native American, but one of the people who said white also mentioned being Cherokee. One said human, and one person said they wouldn't describe their race.

What is your highest level of education?	
8th grade completion	0.0%
High School Diploma / GED	10.0%
Associate Degree	15.0%
Bachelor's Degree	45.0%
Master's Degree	20.0%
Ph.D.	0.0%
Other	10.0%
n = 33	14 missing

Appendix C: Post-Training ECIT Officer Survey Questions



PORTLAND POLICE

2018 Enhanced Crisis Intervention Team Training Follow Up Survey

Progress 17%

Your feedback is critical!

Thank you for taking the time to provide us feedback on this training. Your feedback on the following questions will be used to:

- Impact the ECIT training curriculum
- Identify ways to improve the ECIT program
- Plan future follow-up trainings for ECIT officers

Important to note:

- This survey is anonymous. The Bureau relies on your honest and candid answers to improve the training provided to you in the future to best meet your needs. Thus the Bureau asks that you please respond to the following questions.
- Because the evaluation survey is anonymous, the contents, if released by the Bureau, cannot be attributed to any one person.
- For the purposes of this survey, "behavioral health" refers to mental health, substance abuse, or co-occurring diagnoses.

Please mark your level of agreement or disagreement with the following statements:

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	N/A
The ECIT training expanded upon my previous knowledge base regarding individuals experiencing a behavioral health crisis.	○	○	○	○	○	○	○
Since the ECIT training, I feel more confident in my ability to handle situations involving people in a behavioral health crisis.	○	○	○	○	○	○	○
The ECIT training has improved my ability to effectively engage with family members and/or care providers during a behavioral health crisis.	○	○	○	○	○	○	○

What aspects of this training have you found to be the most useful as you returned to patrol? (Choose all that apply)

- ☐ Communications / De-escalation training
- ☐ Group discussions with consumers
- ☐ Risk assessment training (e.g. analyze dispatch calls, key questions and continuous assessment)
- ☐ Site visits
- ☐ Systems information (e.g. information about mental health systems such as resources, crisis system map, mental health court, etc.)
- ☐ Tactical training (e.g. disengagement, developing a plan, determine safe time, place, and location)
- ☐ Suicide Intervention
- ☐ Other

Site Visits

In hindsight, I have found that the site visits were productive.

- ○ No
- ○ Yes

Please mark:

- **which site visits you attended during the ECIT training,**
- **which ones you have taken someone to since the training,**
- **which ones you have referred someone to since the training, and**
- **which ones you thought were helpful to learn about.**

	Attended this site visit	Brought someone to site	Referred someone to site	Helpful to learn about
Unity	☐	☐	☐	☐
Arbor Place	☐	☐	☐	☐
Golden West	☐	☐	☐	☐
North Star (NAMI)	☐	☐	☐	☐

If you did not find the site visits helpful, or you have experienced obstacles in utilizing these site visits as a resource, please provide more information here:

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	N/A
My supervisor(s) are very supportive of the ECIT program.	○	○	○	○	○	○	○
My supervisor(s) allow me the needed time and resources to respond to ECIT calls.	○	○	○	○	○	○	○
My supervisor(s) allow me the needed time and resources for training pertaining to ECIT.	○	○	○	○	○	○	○
My peers are very supportive of the ECIT program.	○	○	○	○	○	○	○
Most officers understand the role of the ECIT officers and what services they provide.	○	○	○	○	○	○	○
Most sergeants understand how to utilize ECIT officers as the "primary communicator" on calls involving a behavioral health crisis.	○	○	○	○	○	○	○
Most sergeants understand how to utilize ECIT officers in a "coach role" on calls involving a behavioral health crisis.	○	○	○	○	○	○	○

Approximately how often are you responding to calls as an ECIT officer under the following circumstances?

	More than twice per day	Daily	At least 5 times a week	At least twice per week	Once a week	A couple times a month	Rarely
Dispatched as an ECIT officer	○	○	○	○	○	○	○
Another officer requested an ECIT officer	○	○	○	○	○	○	○
Self-initiated response as an ECIT officer	○	○	○	○	○	○	○

	Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree	N/A
When I attend a call as an ECIT officer, there is confusion as to whether I or the primary officer should lead the call.	○	○	○	○	○	○	○	○
I am reluctant to respond to a call as an ECIT officer without being requested.	○	○	○	○	○	○	○	○

If you agree with the above statement, please mark all that apply.

I am reluctant to respond to these calls because:

- ☐ The officers already present may not be familiar with the ECIT program.
- ☐ The officers already present may not be supportive of the ECIT program.
- ☐ The officers already present may feel insulted by an ECIT officer showing up to the call.
- ☐ I do not want to encroach on district integrity.

Calls Related to Suicide

I have responded to calls related to suicide since I attended the ECIT training.

- ○ No
- ○ Yes

	Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree	N/A
I found the information presented during the suicide intervention class helpful in responding to at least one of these calls.	○	○	○	○	○	○	○	○
The suicide scenario provided during the training was a helpful exercise for responding to at least one of these calls.	○	○	○	○	○	○	○	○

Please provide feedback regarding any obstacles you are facing with the ECIT program in the field, and any suggestions you have for making the process of responding to calls related to behavioral health crises more efficient.

How often do you think ECIT officers should be offered follow-up trainings? Please feel free to include how many days of training you would recommend.

What topics would you like to see in future trainings for ECIT officers?

Appendix D: PPB Mental Health Template Form

MENTAL HEALTH TEMPLATE

Make sure to add Person or Unidentified Entity to the Event first

Name of the Subject (select from the drop-down):

Was the Subject a U.S. military veteran?

Was there an ECIT officer onscene acting in their capacity as an ECIT officer?

Was there a supervisor onscene?

Technique(s) used (mark all that apply):

- ☐ De-escalation
- ☐ Disengagement with a plan
- ☐ Delayed Custody
- ☐ Not Applicable; circumstances did not warrant any of the above

Was force used on the Subject?

Did a Mental Health Professional (like Project Respond) respond to the scene?

Did a Mental Health Professional contact the Subject at the scene?

Was the subject armed with a weapon?

If YES, type of weapon? (mark all that apply):

- ☐ Firearm
- ☐ Knife
- ☐ Other

If Other, specify:

Was anyone injured during this incident?

If YES, who? (mark all that apply)

- ☐ Officer
- ☐ Subject
- ☐ Other

Was the Subject transported to another location?

If YES, by whom?

To which facility?

If Other, specify:

If hospital, select a reason:

Was there a subsequent transport to jail?

Was the Subject placed on a mental health hold?

If YES, type of hold?

MAKE SURE YOU'VE ADDED THE MENTAL HEALTH TRACKING CODE (T99999) TO YOUR G.O.

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