

SEMI-ANNUAL OUTCOME ASSESSMENT REPORT

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For the City of Portland, Oregon



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Executive Summary

As part of the responsibilities of the COCL, we are required by Par. 173 of the Settlement Agreement to “lead semi-annual qualitative and quantitative outcome assessments to measure whether the City and PPB’s implementation of this Agreement has created: (1) capable systems and resources for responding to persons in mental health crisis; (2) competent accountability and oversight systems; (3) effective training for police officers that increase the knowledge, skills and abilities necessary for effective and successful delivery of service to persons in mental health crisis; (4) proper management of the use of force to meet constitutional standards; and (5) robust systems of community engagement.” The Settlement Agreement further states in Par. 174 that “[i]n conducting these outcome assessments, the COCL may use any relevant data collected and maintained by PPB, provided that it has determined, and the Parties agree, that this data is reasonably reliable and complete.”

In fulfillment of our responsibilities under Pars. 173 and 174, we submit this second semi-annual report regarding the City’s and PPB’s creation of such systems. This report will address each of the five (5) sections identified above, including an assessment of the completeness and reliability of data that PPB currently maintains. The COCL is currently working with the PPB in many areas related to the Settlement Agreement regarding proper data collection, compilation, and dissemination. Thus, this outcomes assessment report includes comments on the status of PPB’s progress in these areas and makes suggestions for future directions. This report also provides quantitative analyses of data we feel are reliable for baseline interpretation, when available. We emphasize that this is a “work in progress” in the sense that it will take time for PPB to achieve full compliance on the creation of reliable data-based systems for management and oversight relevant to this Settlement Agreement. This work is time consuming and resource intensive.

PPB is required to create the five core systems described above. The COCL is required to evaluate whether these systems have been created and are resulting in the desired outcomes. We view this as two separate but related processes. PPB must create the above systems to ensure transparent progress toward compliance with the terms of the Settlement Agreement and to provide the basis for measuring the effectiveness of these reforms. As such, these robust systems must contain sufficient data for COCL and the PPB to evaluate both process and impact. In addition to PPB data, the COCL has proposed additional data collection to best achieve the goals of the Settlement Agreement. These measurement tools are described herein. We will continue to work with PPB to ensure that measures employed are appropriate, reliable, and valid indicators of systematic change in desired outcomes. As part of this Executive Summary, we provide an overview of each assessment section and describe the progress to date.

As we address each core system, we emphasize that on the whole, it is too early to draw definitive conclusions about the outcomes of PPB’s reform efforts. Some systems described in this report are just starting while others may not be implemented in their complete form. Thus, most systems are not at the point where they generate reasonably reliable and complete data. Hence, we encourage the reader to be cautious in drawing strong conclusions at this point in time. In this Outcome Assessment, the COCL analyzes various data, but also comments on the progress made by PPB and the City in creating these systems. We also suggest directions for future improvement of these systems.

While this report largely overlaps the time period covered by our Compliance Assessment for Q3 and Q4 of 2015, occasionally we discuss developments which occurred in early 2016. For some analyses, we report data from before Q3 and Q4 of 2015. By providing a longer span of data, the City, PPB, and the community can better identify trends and be informed of recent developments that were not possible to report in our Compliance Assessment. For all sets of data, we provide the timeframe so that the reader is aware of the parameters of the analysis.

Capable Systems and Resources for Responding to Persons in Mental Health Crisis

In the first section, we assess whether PPB has created “capable systems and resources for responding to persons in mental health crisis.” We have reviewed data from five sources in this section: (1) Enhanced Crisis Intervention Team (ECIT) Template data, (2) Bureau of Emergency Communication (BOEC) ECIT Call Type data, (3) BOEC Suicide Attempt/Threat data, (4) Behavioral Health Response Team (BHRT) data, and (5) Service Coordination Team (SCT) data.

We have reviewed call data from the first three sources for the timeframe of August 1, 2015 to February 1, 2016 (six months). The data suggests that PPB mental health related interactions most frequently involved White males under the age of 50 years old. Additionally, between 15% and 25% of the mental health related interactions involve an arrest and in 50% to 60% of the interactions, the community member was transported to the hospital. The current data have some limitations that prevent us from fully assessing whether capable systems are in place or if successful and effective delivery of service to persons in mental health crisis is occurring. We provide an update on PPB’s progress toward addressing these data issues and implementing the Mental Health Mask, which is a data form that requires all officers to collect data on interactions involving persons in actual or perceived mental crisis.

We provide analysis of the BHRT and SCT data similar to our previous report, including demographics, factors related to program inclusion, and outcomes. For BHRT, a community member considered a risk to others or displaying escalating behavior accounted for nearly 70% of program clients. For over half of BHRT clients, they were connected with services or were provided assistance through the mental health or criminal justice systems. We also provide analysis of individuals who refuse BHRT services so that BHRT might tailor their approaches to engaging with them. For SCT, only 15.6% of clients completed the program from start to finish, though some individuals were able to finish the low barrier portion of the program before leaving. More than half of the clients were found to be non-compliant with the terms of SCT or engaged in criminal activity or violence, and were thus removed from the program. We found differences in housing status at entry and exit related to whether a client completed the SCT program as well as employment status at entry and exit. We cannot state a causal relationship between status of housing/employment and completing the SCT program, though the results should be useful for PPB.

Competent Accountability and Oversight Systems

For the “Competent Accountability and Oversight Systems” section, we detail PPB’s current utilization of the Employee Information System (EIS), describe our suggestions for expanding the use of EIS, and review the handling of complaints against police officers. At present, PPB’s use of EIS could be

expanded to allow for greater accountability and oversight of police actions. We have discussed with PPB the type of expansions that we believe would enhance management's oversight, while at the same time increase supervisory responsiveness to at-risk employees.

As currently used by PPB, the EIS, specifically the Performance Discussion Tracker (PDT), is a tool for supervisors to manage officers and review officers' past behavior. The EIS is also used for flagging potentially problematic behaviors by officers and providing instructive intervention when appropriate. However, for EIS flags PPB does not currently track the elements involved in the decision making process, leaving the decision to forward the flag for supervisory review to the subjective judgment of the EIS administrators. The rate at which flags are forwarded for supervisory review is, in our opinion, lower than optimal. We also encourage PPB to use EIS in a more predictive fashion, identifying a profile of officers who are most likely to be the subject of complaints and providing instructive intervention before such complaints occur.

PPB provided COCL with data related to the prevalence of supervisors utilizing EIS on a monthly basis to compare EIS activity between supervisors and units. However, the data were in MS Word format and thus did not allow for in-depth analysis. PPB provided data related to supervisory review of EIS for officer Semi-Annual Reviews (SA Par. 116(a)) and data related to officer transfers to a new supervisor (SA Par. 116(b)). For the most part, the data suggest that PPB is complying with the requirements of these subsections. However, we maintain that their current data analyses do not adequately address their responsibilities of identifying and comparing "patterns of activity" (SA Par. 116(c)) nor do they address the overall function of EIS to "identify at-risk employees, supervisors, and teams to address potentially problematic trends in a timely fashion" (SA Par. 116). Additional investment is needed in these areas to create "competent" systems of accountability and oversight.

We were also provided data for allegations of policy violation against PPB officers, including data on allegation types, specific policy violations, average length of time for investigating complaints, and outcomes for complaints. Nearly half of all allegations were related to allegations of procedure violations, though for allegations of specific directive violations, the most commonly cited directive was 310.40 (Courtesy). Nearly half of all investigations were completed between 30 and 60 days. Approximately 73% of allegations were not investigated as they were either declined by the Independent Police Review (IPR) or Internal Affairs (IA). This low rate of investigation is one of the primary concerns of DOJ and a focal point of the reform efforts regarding the independent review process.

Effective Training for Police Officers that Increases the Knowledge, Skills and Abilities Necessary for Effective and Successful Delivery of Service to Persons in Mental Health Crisis

In November of 2015, members of the COCL team observed the Enhanced Crisis Intervention Team (ECIT) training for officers. We found the overall training to be consistent with other CIT trainings held throughout the country, but we identified some issues in the evaluation of the training as it pertains to the Kirkpatrick Model of program evaluation currently used by PPB. The identified issues pertain largely to how officer learning is measured. In the absence of a strong measurement and evaluation system, neither the PPB nor COCL can determine whether an effective training program has been implemented.

In this section, we also recommend refresher training for Crisis Intervention (CI) skills. PPB currently incorporates elements of CI training during In-Service, but it is not the primary focus of the training. Our call for refresher training is based, in part, on two examples of problematic interactions with persons experiencing mental health crisis. While these two cases cannot be said to constitute a trend, they do represent instances where CI strategies, if employed, may have improved the outcome of mental health interactions. We also recommend refresher training because research has shown that skill sets in the police force decline with the passage of time.

Proper Management of the Use of Force to Meet Constitutional Standards

PPB is still in the process of creating a system for the “proper management of use of force to meet constitutional standards.” To this point, we highlight significant progress made by the PPB in utilizing a new force audit methodology. Rather than reporting force trends overall (though we do discuss PPB’s new quarterly force reporting format), we provide a focused examination of the audit methodology. Once the force audit system was in place and operational, the COCL was provided files for ten cases which allowed us to independently code and compare our results to those generated by the PPB. Overall, we were in agreement with PPB on coding, though we highlight select instances where we disagreed and in, some instances, where PPB’s coding seems to contradict the information found in the case file. These differences will be discussed with PPB before the methodology is finalized.

We also provide a case study related to the proper management of use of force. In the case study, the officer was deemed to be technically in policy with regard to the application of force. However, in the 940 command review process, multiple reviewers expressed concern regarding the officer’s decision making. We find this to be problematic as the ultimate finding did not reflect the reviewers’ collective wisdom that the elements of the force were unnecessary given the totality of the circumstances. Because the action was within policy, no formal action was taken to intervene with the officer.

In this section we also report instances of force against persons with perceived mental illness. The data provided by PPB includes force options found in the Force Data Collection Report (FDCR) (e.g. takedown, Taser, pointing of a firearm, etc.) as well as “non-FDCR reportable force” (e.g. force to overcome resistance to handcuffing, grappling/wrestling not resulting in a takedown, etc.). In approximately 91% of interactions where force was used against a person with mental illness, the interaction ended with the community member being taken into custody, taken to a medical facility, or being placed on a Police Officer Hold (POH). Further, in approximately 81% of the interactions, the community member was reported to have been actively resistant or assaultive. In the remaining 19% of interactions, the community member was reported to have been passively resistant or not resistant at all. The COCL will consult with PPB on how these results might be used to reduce the rate of force events involving persons with perceived mental illness, but regardless, we would suggest that PPB expand the data collected to include specific categories of non-FDCR reportable force.

Robust Systems of Community Engagement

With regard to “Robust Systems of Community Engagement,” we begin by discussing the various ways in which PPB proactively attempts to engage the community through social media, their website, and

community events. The PPB is active with the community in many ways. We also touch upon PPB's current system of reporting when an officer participates in a non-PPB sponsored event and our desire for an enhanced system for documenting such community interactions.

We go on to discuss the various methodologies implemented by COCL, COAB, and the City for measuring community sentiment toward the PPB and police-community relations. This includes focus groups, a community partner survey, and the results of the city-wide community survey. We report the results of the City's community survey developed in consultation with the COCL and COAB and administered by Davis, Hibbits, & Midghall, Inc. (DHM). Overall, the survey results indicate that a slight majority of Portland residents hold positive perceptions of the PPB, although more work is needed regarding the PPB's relationship with the community and raising public awareness of positive changes currently underway inside the PPB. The results of the citywide community survey, combined with other methodologies, should be utilized to shape the Community Engagement and Outreach (CEO) Plan, as well as contribute to PPB's overall systems of community engagement.

Finally, we discuss our recommendation that the City institute a citywide contact survey that allows for the documentation of community experiences with the PPB. In our last Outcomes report, we recommended two separate surveys – a mental health contact survey to capture the views of individuals with mental health issues during police contacts, and a community survey that captures the views of others who have contact with the PPB. Based on discussions with various individuals, we have decided to recommend that these two surveys be combined into a single contact survey designed to capture community member experiences in different types of encounters with PPB. The contact survey would provide a direct measure of how well PPB officers are engaging with various segments of the Portland community, including persons with mental health issues, as well as generate new information about the effectiveness of police training overall (par. 80) and mental health response training (e.g. par. 93). We also recommend that the City make a version of the survey available on line for caregivers and family members to provide feedback to PPB related to their experiences with PPB's mental health crisis response.

CAPABLE SYSTEMS AND RESOURCES FOR RESPONDING TO PERSONS IN MENTAL HEALTH CRISIS

ECIT Template Data

PPB implemented an ECIT Template form to capture data on interactions with community members experiencing a mental health crisis. When ECIT officers utilize crisis intervention skills during an interaction, they are required to complete the Template to document their interaction. We requested ECIT Template data from the PPB for the timeframe of August 1, 2015 to February 1, 2016. The types of information contained in the data set we received include variables related to the incident, the officer, presence of supervisors and mental health professionals on scene, and de-identified information about the community member. We received data on 348 unique cases where an ECIT officer utilized crisis intervention skills and completed the data form. Some cases found in the ECIT Template data were also present in the ECIT Type Code data or in the Suicide Attempt/Threat data that we also describe in this section. Thus there is some overlap between the three datasets.

In the third quarter of 2015, BHU recognized a decline in form completions and released a memo to ECIT officers reiterating the importance of consistent data collection. Our analysis of the data by month indicates lower numbers of completed forms for August, October, and November (44, 53, and 51, respectfully) compared to December and January (69 and 67, respectfully). The increase in the number of Templates completed during December and January may be due to several factors, including the expanded criteria for ECIT response, an increase in the number of ECIT officers following the November ECIT training, and/or the reminder from BHU. We will monitor the use of the newly implemented MH Mask data form (discussed below) to document fluctuations in reporting in the future.

In February of 2016, PPB began a pilot test of a new strategy for capturing data on mental health related encounters called the Mental Health mask in Central Precinct. Eventually, all officers will be required to utilize this form. Full implementation of the MH Mask will replace the ECIT Template. Thus, while we await the full implementation of the MH Mask, we report here data from the ECIT Template. The reader should interpret the results with caution given fluctuation in the number of reports noted above. However, we feel the data are useful for illustrating situations where an officer uses crisis intervention skills. The information described here will provide a background for our next Outcome Assessment where we provide data from the MH Mask.

From August 1, 2015 to January 31, 2016, there were 354 ECIT templates filled out for a total of 348 interactions, with 38.5 % in Central Precinct, 31.9% in East Precinct and 29.6% in North Precinct. In 57.8% of the interactions, the officer who completed the ECIT Template indicated that he/she was acting as the Primary Officer, in contrast to 39.7% of the interactions where the authoring officer reported acting in an assistance or consultation role. Supervisors were on scene for 34.8% of the interactions, while 21.1% of the time, a mental health professional also responded to the scene. In one case, telephone care was provided to the subject.

Based on the ECIT Template data, the community members that ECIT officers assisted were most frequently White males under the age of 30 (See Figure 1 for a demographic breakdown by sex, race/ethnicity and age).

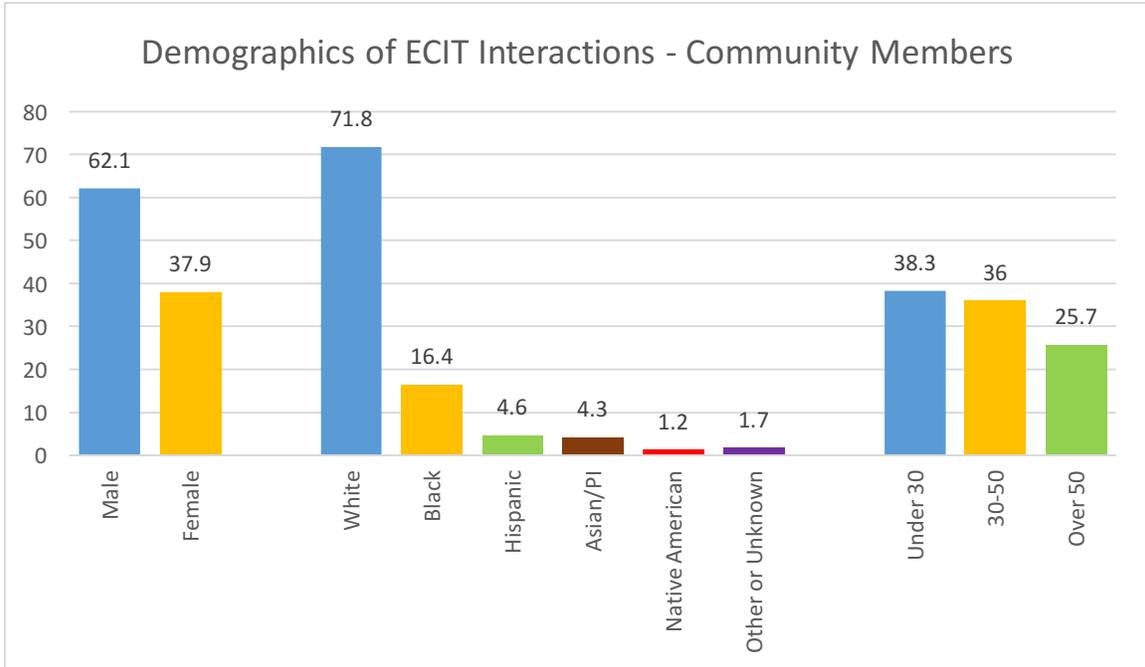


Figure 1 – Community Member Demographics (Percent of Interactions, N=348)

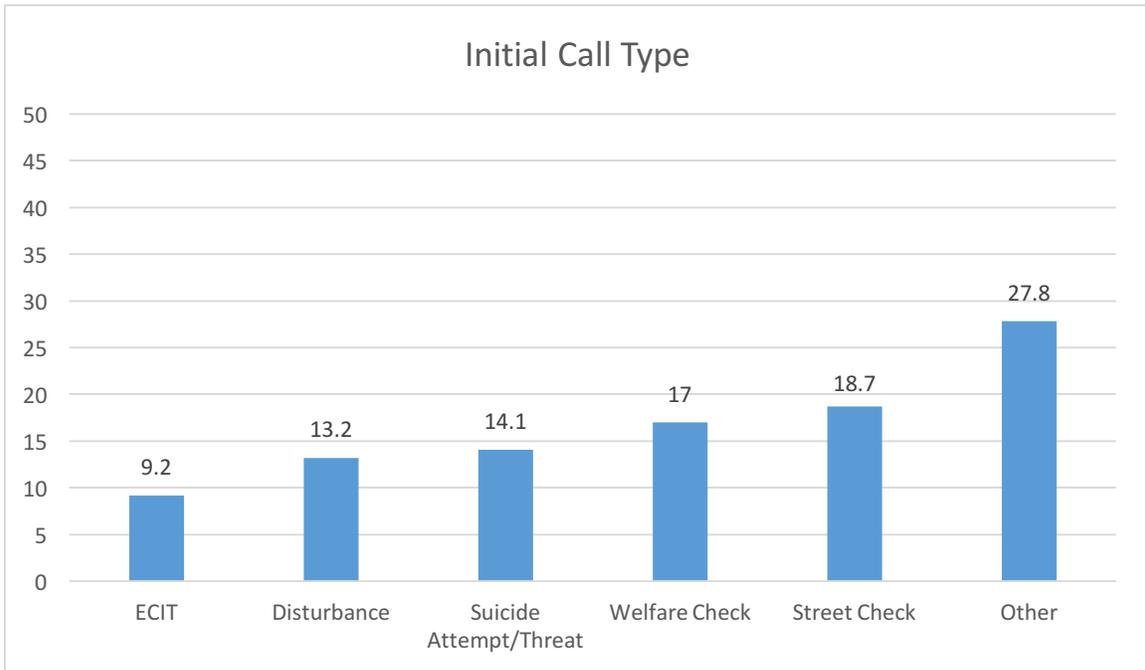


Figure 2 – Initial Call/Report Type of Interaction (Percent of Interactions, N=348)

We also looked at the initial Call Type, i.e., the initial reason an officer was dispatched to a scene. ECIT officers maintain their normal call duties until dispatched as ECIT. Therefore, it is wholly possible that during their normal duties, without being dispatched as ECIT, they will still utilize their CI training (Other than the Call Type “ECIT”, the data do not indicate whether the officer was dispatched to a scene as a result of their ECIT status). We collapsed the data to reflect the six most frequent call types reported in the ECIT Templates: ECIT, Disturbance, Suicide Attempt/Threat, Welfare Check, Street Check, and Other. For the 22 call types in the “Other” category, no individual call type comprised more than 5% of the total data, suggesting that ECIT officers are dealing a wide range of encounter types. Combined, the “Other” category represents 27.8% of Initial Call Types.

The Initial Report Type most often associated with an officer completing an ECIT Template was “Street Check” (18.7% of interactions). For example, if an officer stops to check on a person who is asleep on the sidewalk (whether it is officer initiated or as a result of a community member call), this would be considered a “Street Check.” Welfare checks made up the next highest percentage of interactions (17%), with Suicide Attempt/Threat, Disturbances, and ECIT as the next three highest (14.1%, 13.2%, and 9.2%, respectively).

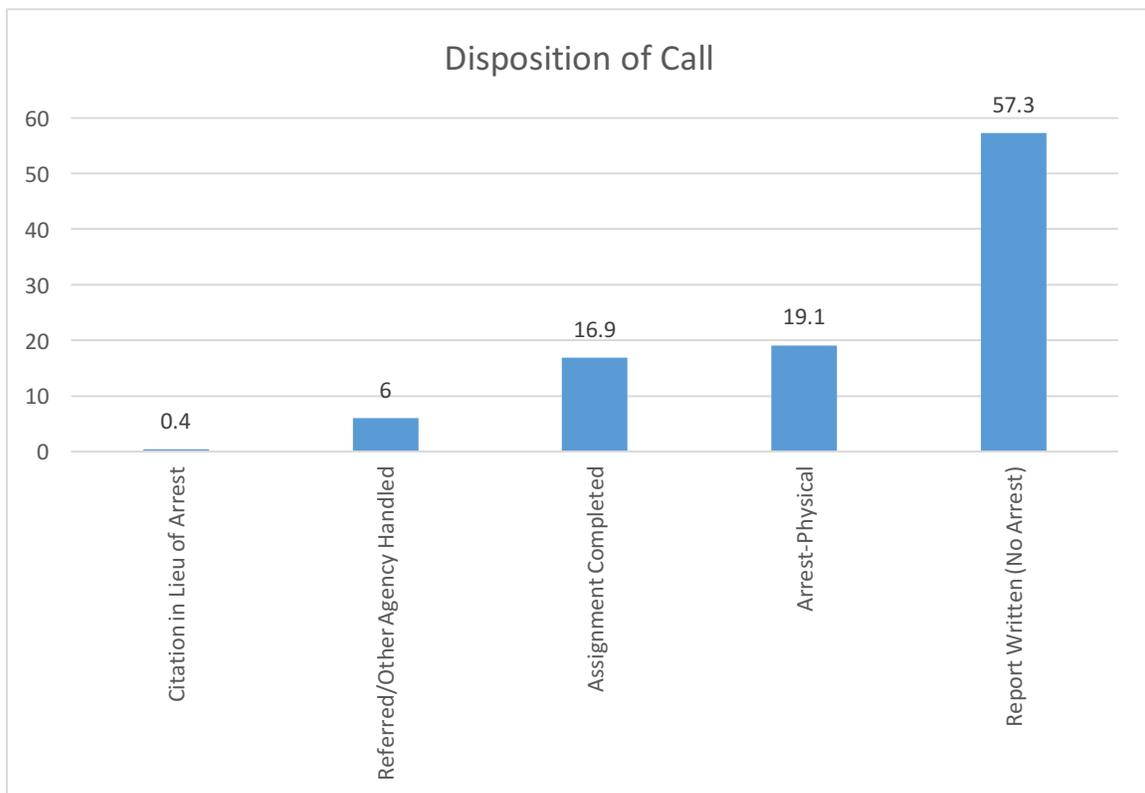


Figure 3 – Disposition of Call (Percent of Interactions, N=348)

We likewise looked at how the reported calls were resolved. Many calls do not involve criminal activity, and thus are disposed without an arrest. For over half of the calls (56.9%), the officer did not make an arrest or give a citation. In these cases, a report was created for the interaction, but no criminal sanctions occurred for the community member. In 19.5% of the interactions, the officer arrested the community member. In 16.7% of the interactions, the called was given the disposition code "Assignment Completed", indicating no report was created for the interaction and no arrests were made. Whether the community member was transported to the hospital was not included as a data point for ECIT Templates. In other datasets, we have seen this to be highly correlated with "Report Written (No Arrest)", though do not have the data to report hospital transports here.

We performed a crosstab analysis to determine the most common outcomes for the different Initial Call Types. For "Street Checks", 87.3% of the call type ended with the disposition "Report Written (No Arrest)" or "Assignment Completed". There were no people arrested when the Initial Call Type was a "Street Check". The call type "Welfare Check" followed a similar pattern as that of Street Check. Of the five major call types (excluding the category of "Other"), "Disturbance" and "ECIT" were most likely to lead to an arrest (both approximately 27% of the time), whereas a report was written (without an arrest) between 50% and 60% of the two call types.

In approximately 19% of the cases, the subject was armed with a weapon. For these, a knife was the most common weapon present (46.9% of cases where a weapon was present) while firearms were present in 19.6% of such cases. For cases involving a weapon, the reporting officer indicated force was used 6.1% of the time. If the subject did not have a weapon, force was used 1.4% of the time. Overall, force was used in 2.3% of all interactions. Subjects were also more likely to be arrested in situations where a weapon was present (31.8% of cases involving a weapon). By contrast, when a weapon was not present, the subject was arrested in 16.5% of cases.

We examined what Crisis Intervention tactics were employed during the interaction. The ECIT Template includes five tactics of Crisis Intervention: De-Escalation, Disengagement, Delaying Custody, Eloping, and Non-Engagement. Officers reported using at least one of the tactics in 54.9% of interactions. As shown in Figure 4, the most commonly used CI tactic was verbal De-Escalation (33.6% of all incidents), while Disengagement was the next most commonly used tactic (13.8% of all incidents). Eloping, Delaying Custody, and Non Engagement were all used in approximately 4% to 6% of incidents.

The ECIT Template data provides some useful insight to the types of calls ECIT officers are responding to and how they are resolving them. However, it is impossible to determine the consistency of Template completion, as it is up to the officers to determine if crisis intervention skills were used and take the steps to complete the form. As discussed below, PPB is addressing this issue with the Mental Health Mask data form, which should provide more valid and reliable data for determining the extent to which they have implemented capable systems for responding to mental health calls.

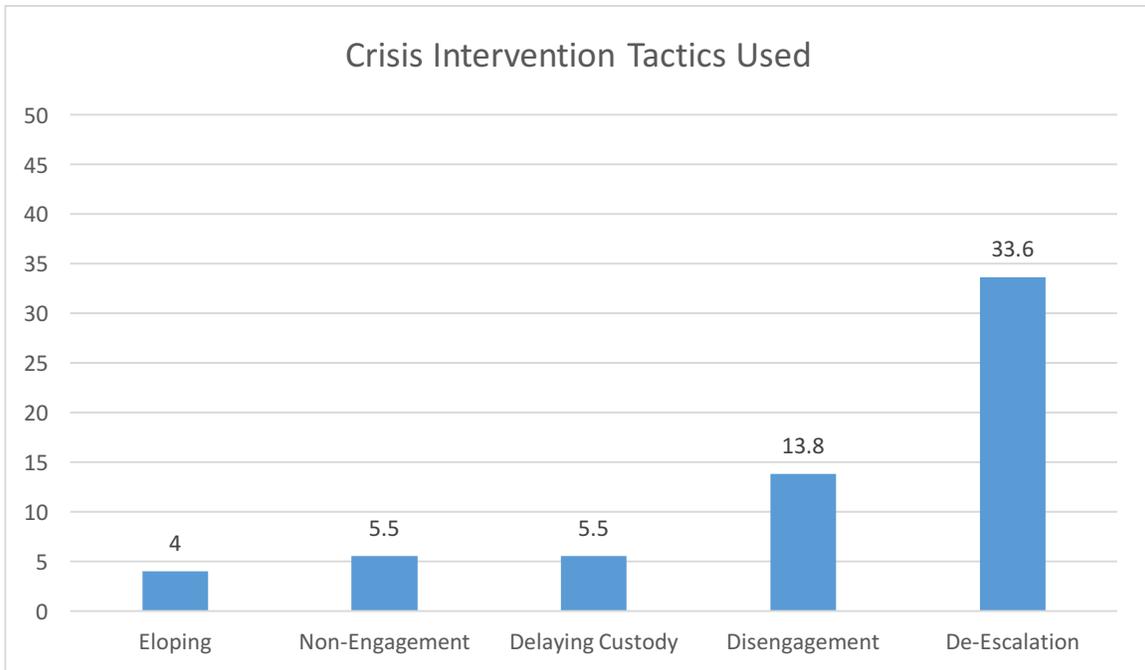


Figure 4 – Crisis Intervention Tactic Used (Percent in Interaction, N=348)

BOEC Dispatch Records

Another source of data for analyzing interactions with community members experiencing mental health crises is the Bureau of Emergency Communications (BOEC). Calls meeting the ECIT criteria will receive an ECIT Type Code from BOEC. A call receives an ECIT code if the call (a) involves a mental health component and (b) one of the following elements: the subject is violent, a weapon is involved, the subject is attempting suicide, the call is at a known residential mental health facility, or at the request of an officer or community member. We have reviewed data provided by BOEC for the time period of August 1, 2015 to February 1, 2016 and find that the data quality has improved from our last Outcome Assessment. In our previous report, the data were provided in format that made analysis difficult. As we noted, “one incident involving an ECIT Type Code could have multiple officers and multiple community members, each with a variety of study codes, dispositions, incident descriptions and other case specifics.” The data provided for the current report reduces the amount of entries by using the case number as the primary identifier rather than the officer (where there might be several officers per case) Thus, usability of the dataset is much improved.

To look at the incident level (i.e., looking only at the event as a whole rather than individual persons involved in the event), we took the case identifying key and filtered out all duplicates. This leaves only one case per event and thus allows us to report the incident level characteristics. Out of the 83 incidents, BOEC dispatches receiving an ECIT Type Code occurred most frequently in Central Precinct (47%), followed by East Precinct at (31.3%), and North Precinct at 21.7%. While all were coded as meeting criteria for the ECIT call type, only 65.1% had an ECIT Officer on the call. This percentage may have been affected by the November ECIT training. Before the November ECIT training, 61.4 of ECIT

Type Code events had an ECIT Officer respond. After the November ECIT training (during the months of December and January), the percent increased to 72%. Thus, after the increase in ECIT-trained officers, a higher percentage of ECIT Type Codes calls received an ECIT response. PPB should use these data to help estimate the number of ECIT officers needed to provide comprehensive ECIT coverage consistent with ECIT dispatch criteria.

We removed the duplicate filter so that we might be able to examine individual demographics related to ECIT events. Of the 164 BOEC ECIT Type Code data entries received, 93 (56.7%) included demographic information for the person coded as “Mental Health, Subject, Suspect, or Arrested Party”. The group’s demographics were similar to the group described in ECIT Template analysis reported above. The modal ECIT Type Code call involved a young, White, male. Males represented two-thirds of the sample, while females represented one-third. The “Under 30” age group and the “30 to 50” age group were nearly equally represented (37.6% and 38.7%, respectively), with community members over 50 making up a smaller percentage of the sample (23.7%). Whites represented 74.2% of the community members involved in ECIT incidents, while Blacks represented 20.4%. Figure 5 shows the demographic breakdown in graphical form.

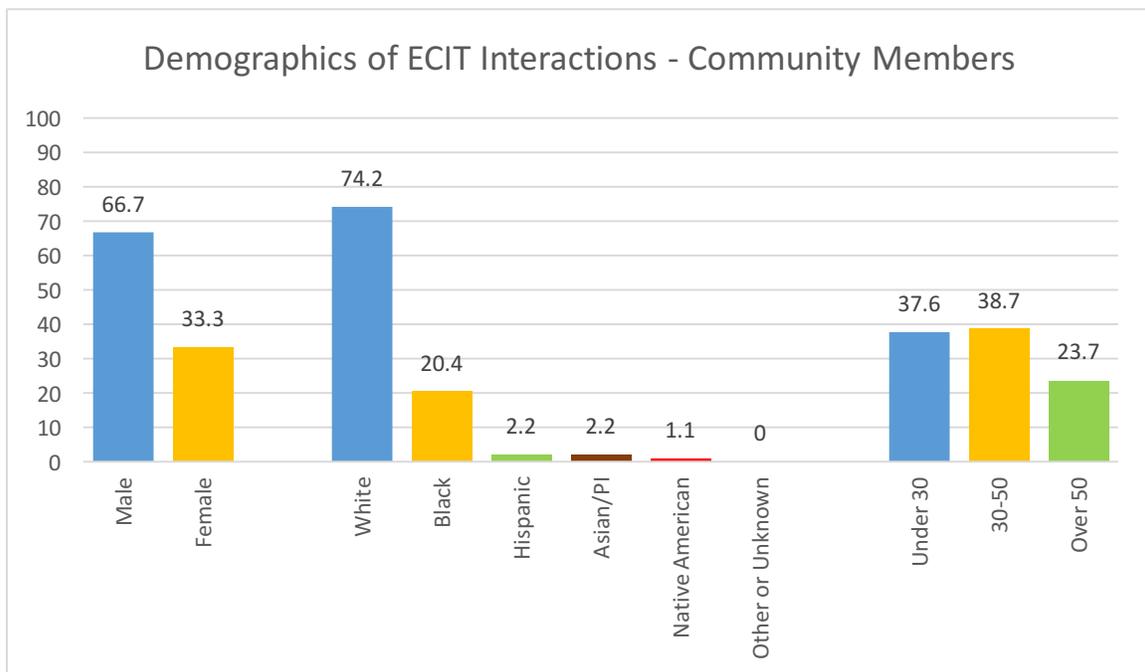


Figure 5 – Community Member Demographics (Percent of ECIT Type Code Interactions, N=93)

We also looked at the outcomes for the events related to the ECIT Type Code interactions. Following a similar pattern as the ECIT Template data, the most common disposition for ECIT Call Type events was an officer writing a report with no arrest (57.8%), followed by arrest (24.1%). All other dispositions had a lower frequency.

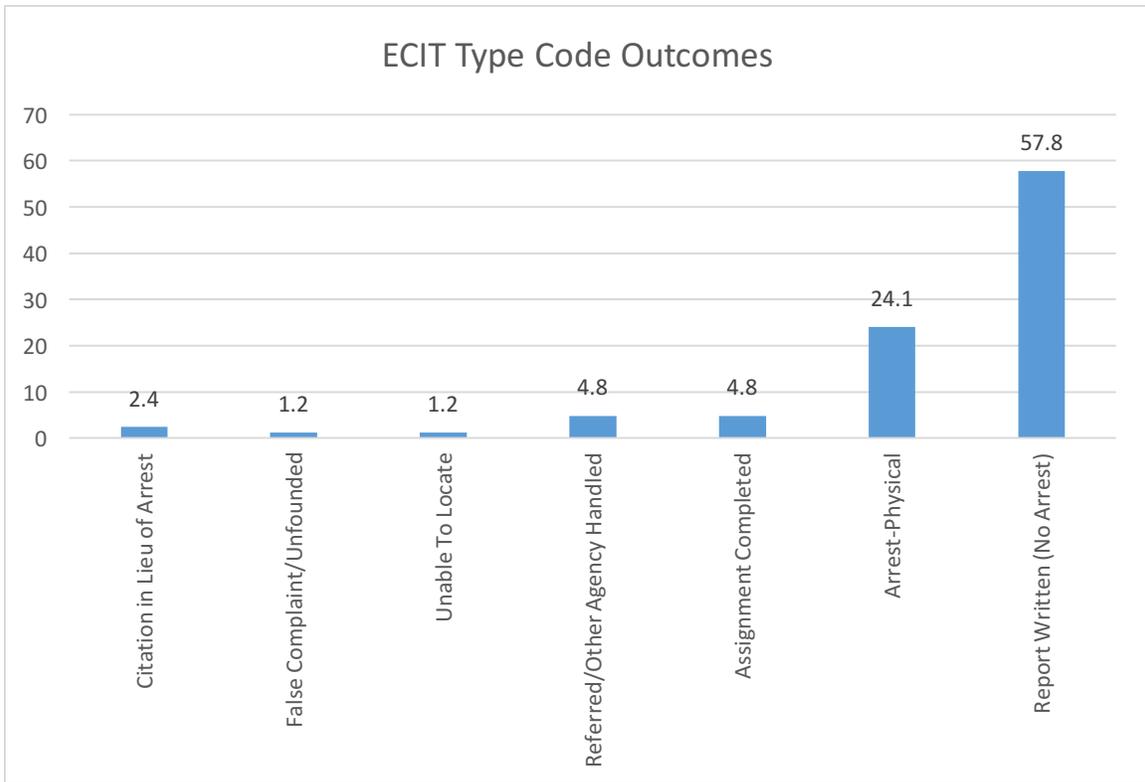


Figure 6 – ECIT Type Code Outcome (Percent of ECIT Type Code Interactions, N=83)

Separate from the disposition, we were provided data related to whether the community member was transported to the hospital. In the 83 events, 48 included a person being transported to the hospital (57.8%). Thirty transports (62.5% of transports) occurred when a report was written (no arrest), while ten transports (20.8% of transports) occurred when the disposition indicated an arrest was made. Of the 48 events that resulted in a person being transported to the hospital, 28 of them were involuntary (58.3%) while the remaining 20 (41.7%) were voluntary. In only two of the 83 total events was force used (2.4%).

The data provided by BOEC regarding ECIT dispatch is used for assessing whether the current capacity for ECIT response is adequate. This data suggests there is potential utility in increasing the number of ECIT officers to increase the capacity for response. However, given the recent expansion of ECIT criteria and some confusion regarding coding of call types (are suicide attempt calls now being coded as ECIT call types, are suicide attempts calls still included in the suicide threat/attempt call type data) the extent to which capacity should be expanded cannot be fully determined with the current data. We look forward to working with the PPB and BOEC to understand and resolve these coding issues. Once resolved, we will turn our attention to assessing system outcomes.

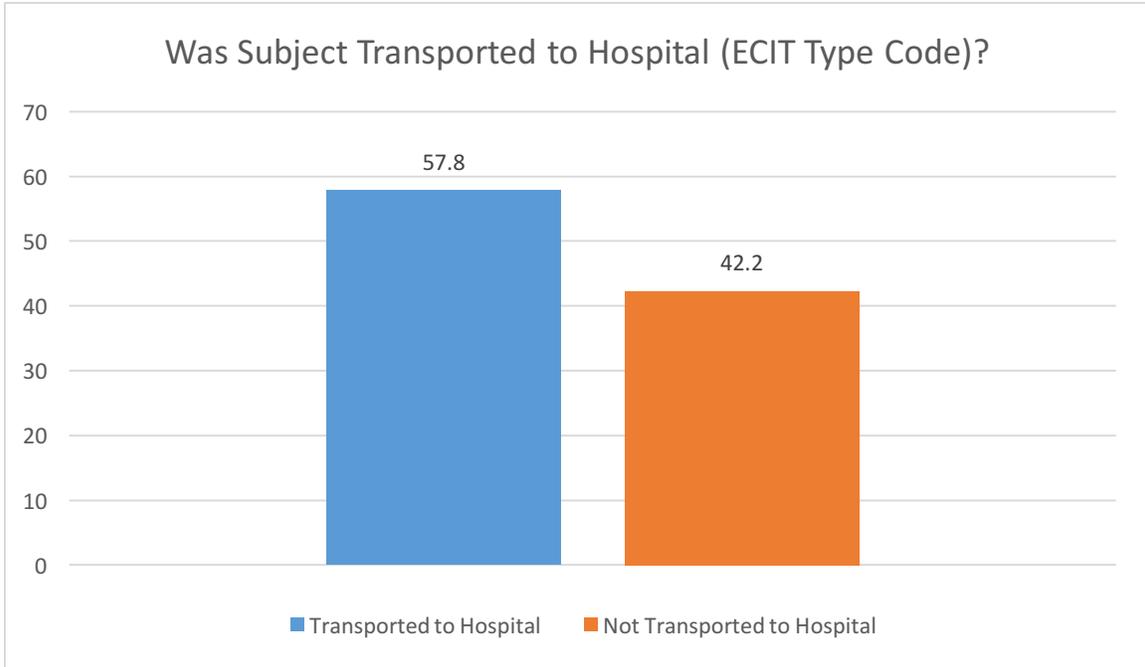


Figure 7 – Was Subject Transported to Hospital (Percent of ECIT Type Code Interactions, N=83)

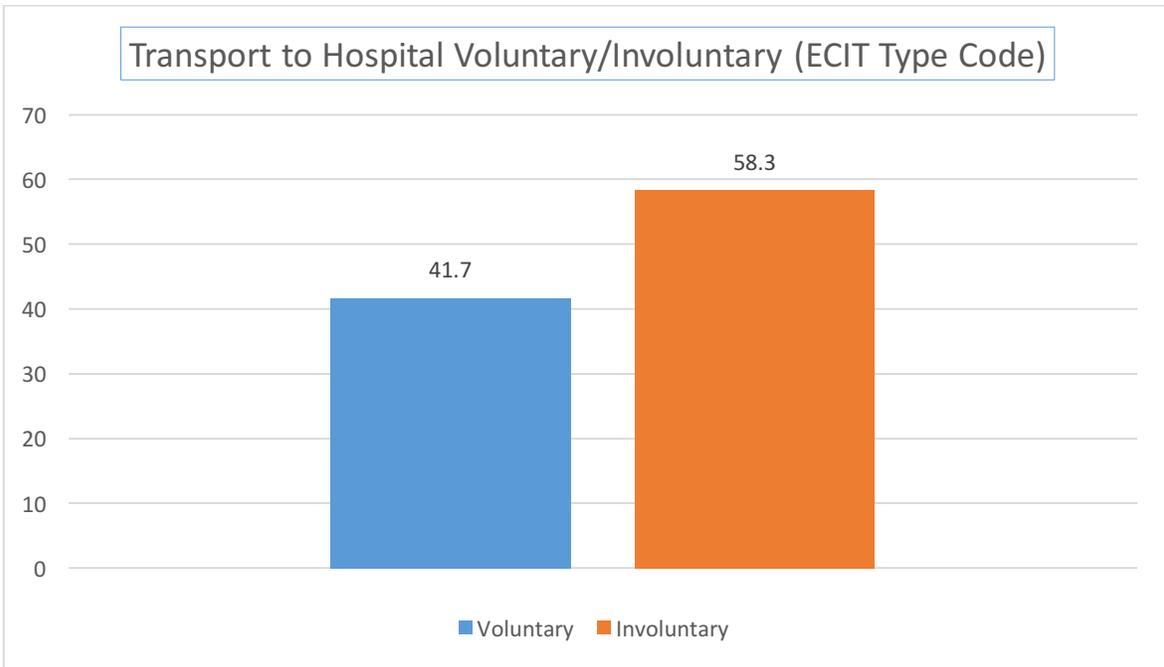


Figure 8 –Transport to Hospital Voluntary/Involuntary (Percent of Hospital Transports, N=48)

BOEC Suicide Attempt/Threat Data

We have received data from BOEC regarding calls involving a person who is attempting or threatening suicide. In early fall of 2015, PPB broadened the criteria for ECIT officer dispatch to include all Suicide Attempt calls. Before the expanded criteria for ECIT dispatch took effect, suicide only attempts/threats with a weapon present was part of the ECIT dispatch criteria. Given how the suicide data are currently coded, we are not able to distinguish calls identified as Suicide Attempts versus Suicide Threats (which does not meet the expanded ECIT criteria unless a weapon is present). We have, however, been provided with the criteria BOEC uses to distinguish a suicide threat from and attempt. A call is coded as a Suicide Threat when the caller expresses suicidal threats or feelings, but does not have a weapon or means to harm him/herself; does not need immediate medical attention and is not threatening to jump from a bridge or structure or threatening to jump in the path of a vehicle.

There were 252 unique incidents of threatened or attempted suicides between August 1, 2015 and February 1, 2016. At the incident level, BOEC dispatches related to attempted or threatened suicides occurred more frequently in Central Precinct (38.1%), followed by North Precinct (32.9%) and East Precinct (29.0%). ECIT Officers were on scene for 53.8% of the calls. PPB can utilize this information to estimate the number of ECIT Officers needed to provide comprehensive coverage.

For subject demographics, we examined cases where the community member's role related to some variation of the phrase Mental Health, Subject, Suspect, or Arrested Party. The sample was again consistent in terms of demographics with the other data sets related to mental health response. The typical BOEC call coded as attempt or threaten suicide involved a young/middle-aged White male. The sample was 56% male, 44% female. Three-quarters of the sample (75%) was White and 11.6% was Black. Hispanic and Asian community members each represented 5.4% of the sample. The 30 to 50 age group comprised the largest portion of the sample (44.8%), while person over the age of 50 comprised the smallest portion of the sample (16.2%). Figure 9 shows the demographic breakdown of the sample.

As with the previous analyses of ECIT Template and ECIT Type Code data, we examined the outcomes of calls involving a suicide attempt or threat. For suicide related calls, the most common result is that the officer writes a report and the person is not arrested (73% of the sample). Individuals were arrested in 18.3% of the sample, while the remaining dispositions occurred infrequently.

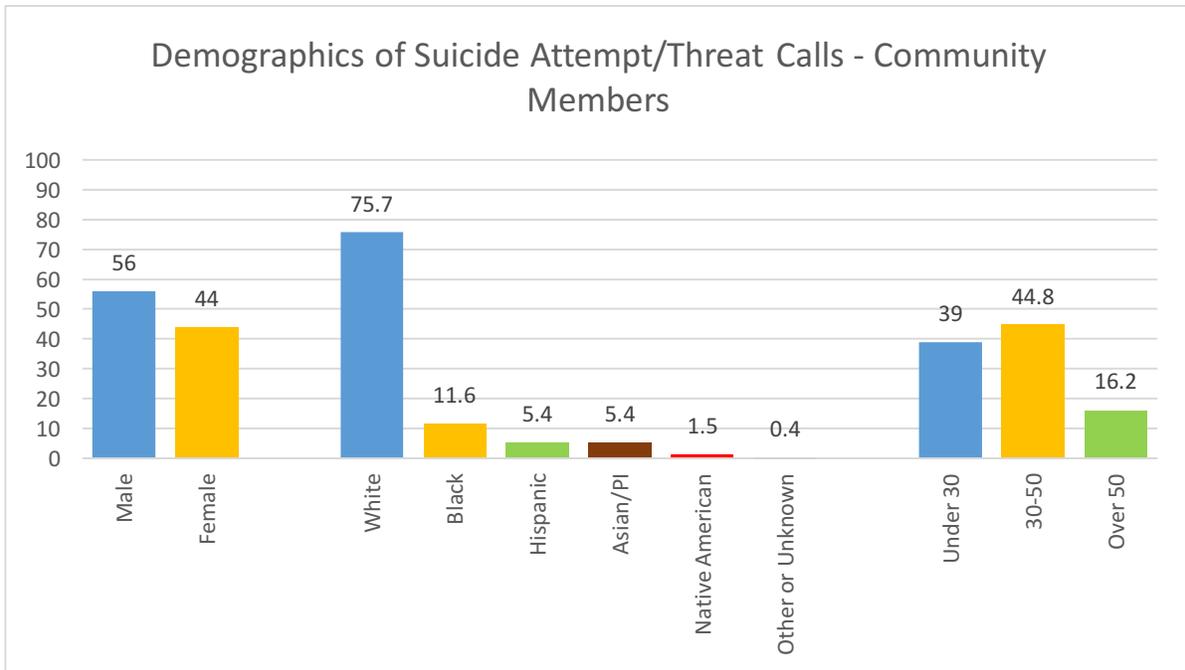


Figure 9 – Demographics of Suicide Attempt/Threat Calls (Percent of suicide related calls, N=259)

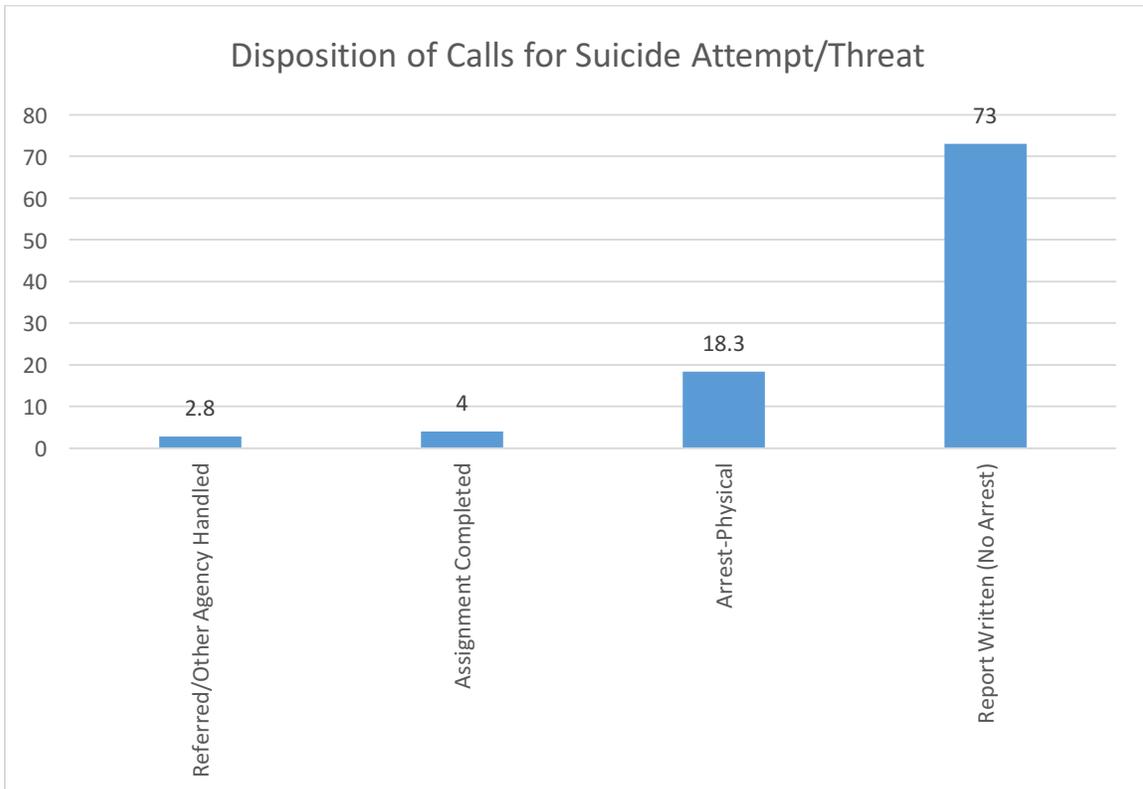


Figure 10 – Disposition of Call for Suicide Attempt/Threat (Percent of Suicide Related Calls, N=252)

We also looked at whether the community member was transported to the hospital as a result of the interaction. In 130 of the events (51.6%), the person was transported to the hospital. In 97 (74.6% of transports) of these cases, a report was written (no arrest) and in 21 (16.2% of transports) an arrest was made. For those who were transported to the hospital, 57.7% were transported voluntarily while 42.3% were transported involuntarily (police hold). Force was used in three (1.2%) of the 252 events involving a person attempting or threatening suicide.

Once issues with coding distinctions are resolved (i.e. between suicide attempt/threats that do and do not fit the criteria for ECIT dispatch), these data will be useful for assessing the extent to which BOEC and PPB are getting ECIT officers to the right calls, and ultimately whether that improves call outcomes. At this time, however, the data does suggest some similarities across the three different data sets in terms of the demographics of subjects, call types, and resolutions. As the data improves, we will be in a position to better assess whether PPB has capable systems for mental health response in place.

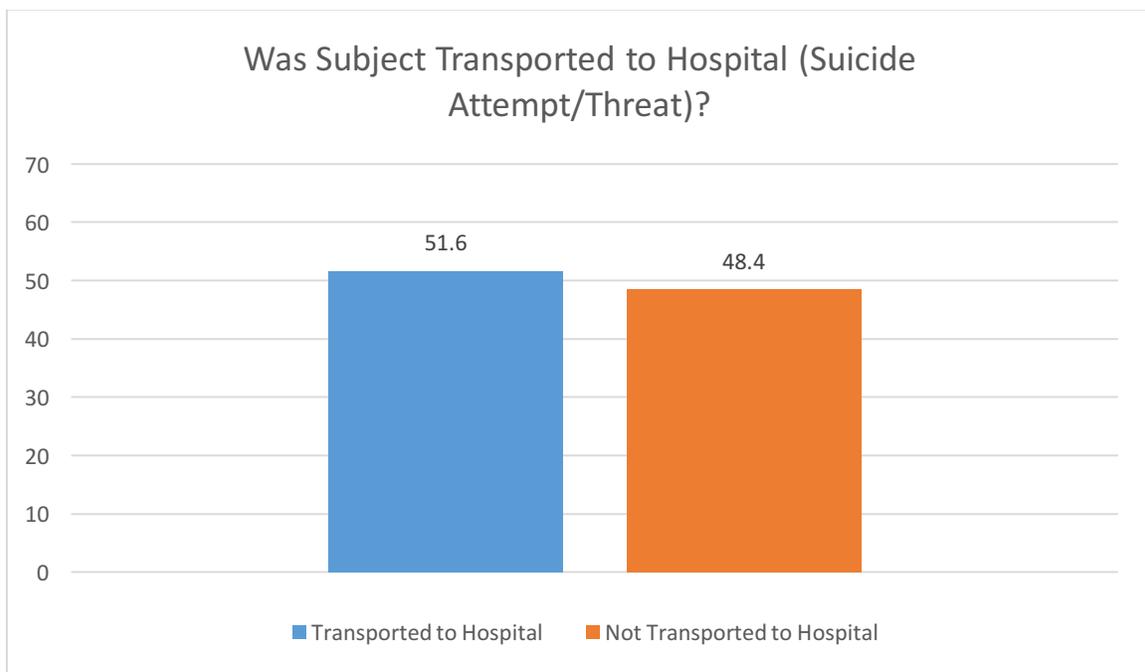


Figure 11 – Was Subject Transported to Hospital (Percent of Suicide Attempt/Threat Calls, N=252)

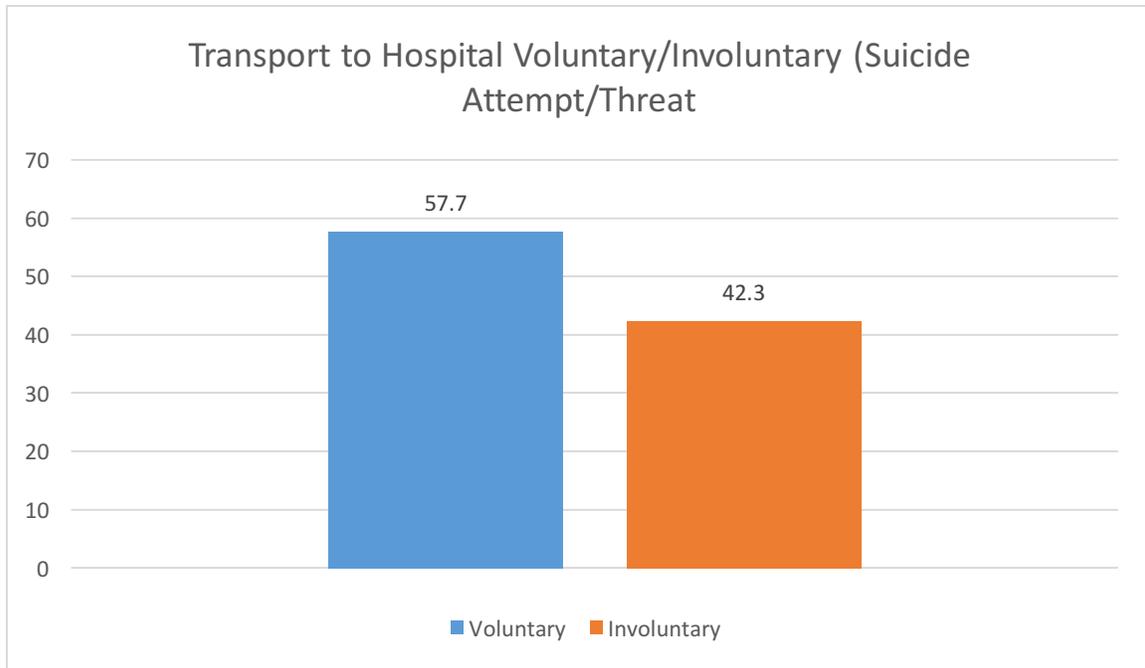


Figure 12 –Transport to Hospital Voluntary/Involuntary (Percent of Hospital Transports, N=130)

Behavioral Health Response Team (BHRT) Data

The Behavioral Health Response Team (BHRT) is a two-person team made up of one PPB officer and one mental health professional from Project Respond. The BHRT “proactively works with individuals who have multiple contacts with police to attempt to connect them with appropriate services in advance of a mental health crisis” (<https://www.portlandoregon.gov/police/article/458966>). There is a BHRT team in each precinct of Portland. BHRT members meet on a regular basis to consider referrals and identify individuals who might benefit most from BHRT intervention.

We received and analyzed data from the Behavioral Health Response Team. Our previous Outcome Assessment examined data for the time period of January 2012 to December 2014. For this report, we have received data for 552 BHRT clients between January of 2015 and January of 2016. Below, we provide data on the number of BHRT clients by month, examine community member demographics for BHRT clients, the initial reason they were assigned to the BHRT, and the final disposition from the BHRT.

The number of clients accepted by BHRT varies by month, with an average of approximately 42 clients accepted per month. Clients are listed on the BHRT roster for an average of 19.8 days before receiving a disposition, though the range of days found in the data is between 0 and 208. Individuals in the system more than 50 days without receiving a disposition were rare, representing only 7% of BHRT’s clients.

The typical BHRT client is a White male over 50 years old. Three quarters were male, three quarters were White, and 45.3% were over 50 years old.

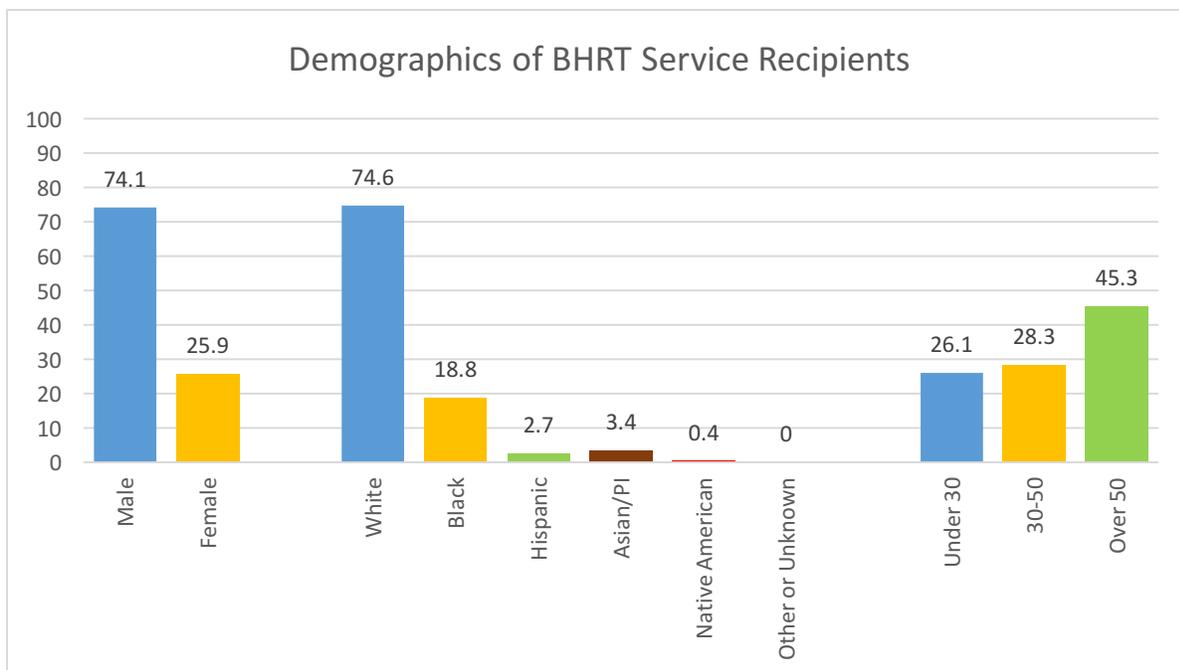


Figure 13 – Demographics of BHRT Service Recipients (Percent of BHRT clients, N=552)

We examined initial criteria for accepting clients for BHRT intervention. “Risk to others” was the most frequent criteria listed (36.4%) followed by “Escalating behavior” (32.1%). “Frequent contacts” with the police and “Risk to self” each were listed for approximately 15% of the sample, and there were two cases where another reason provided the impetus for BHRT intervention. These numbers vary from the breakdown found in our previous Outcome Assessment. In that report, frequent contact and escalating behavior were each listed for approximately 28% of clients and Risk to self was listed for 8.3%. Comparing these two time periods, frequent contacts has markedly decreased, while risk to self has markedly increased.

Finally, we examined the outcomes associated with BHRT intervention. There are seven primary outcome possibilities for BHRT clients: Civil Commitment, Connection with Coordinated Services, Entry into the Criminal Justice System, Client Refused Assistance, Unable to Locate, Concern Mitigated, and Systems Coordination. Per the codebook provided by PPB, Systems Coordination refers to cases where a community member is not assigned the BHRT, though some coordination through the BHU is conducted with either the mental health system or criminal justice system. Other outcomes are rare and may include things such as the person has moved to a different state or passed away.

The most common outcome for a BHRT recipient is being connected with coordinated services. This occurred in approximately 41% of cases, whereas in 21.9% of cases the concern that the community member might be a harm to themselves or others was mitigated through means other than mental health service or other resources. Outcomes related to “Systems Coordination and “Unable to Locate” both occurred in approximately 10% of the cases. Referred individuals less frequently were civilly committed (3.8%), entered into the criminal justice system (6.2%), and refused assistance (4.5%).

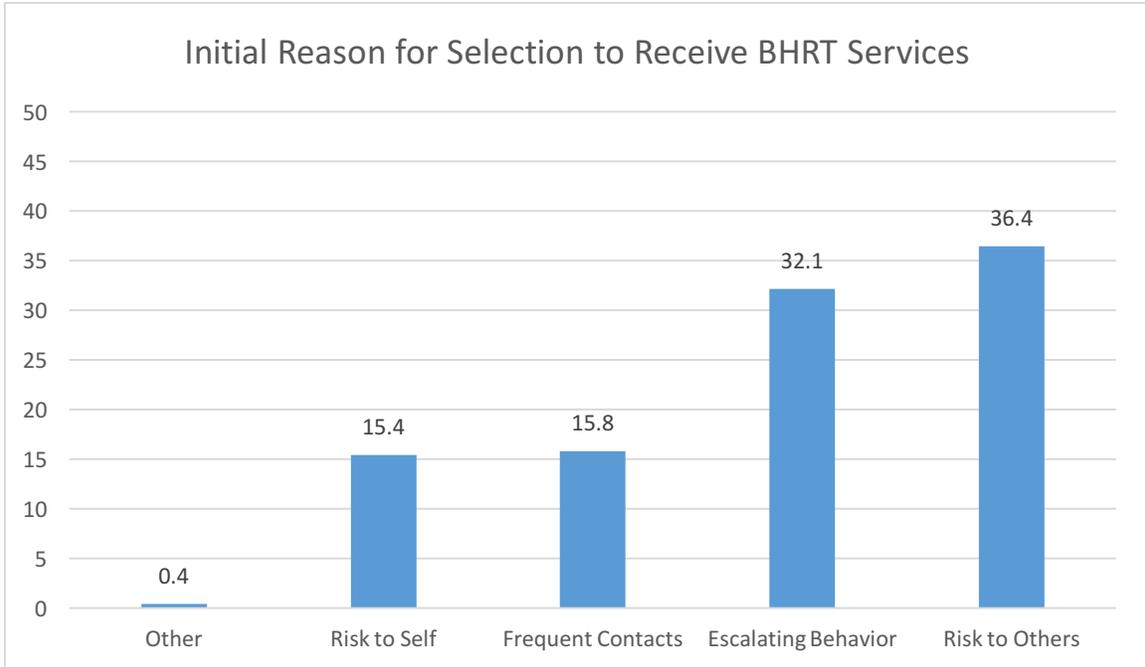


Figure 14 – Initial Reason for Selection to Receive BHRT Services (Percent of BHRT clients) (N=552)

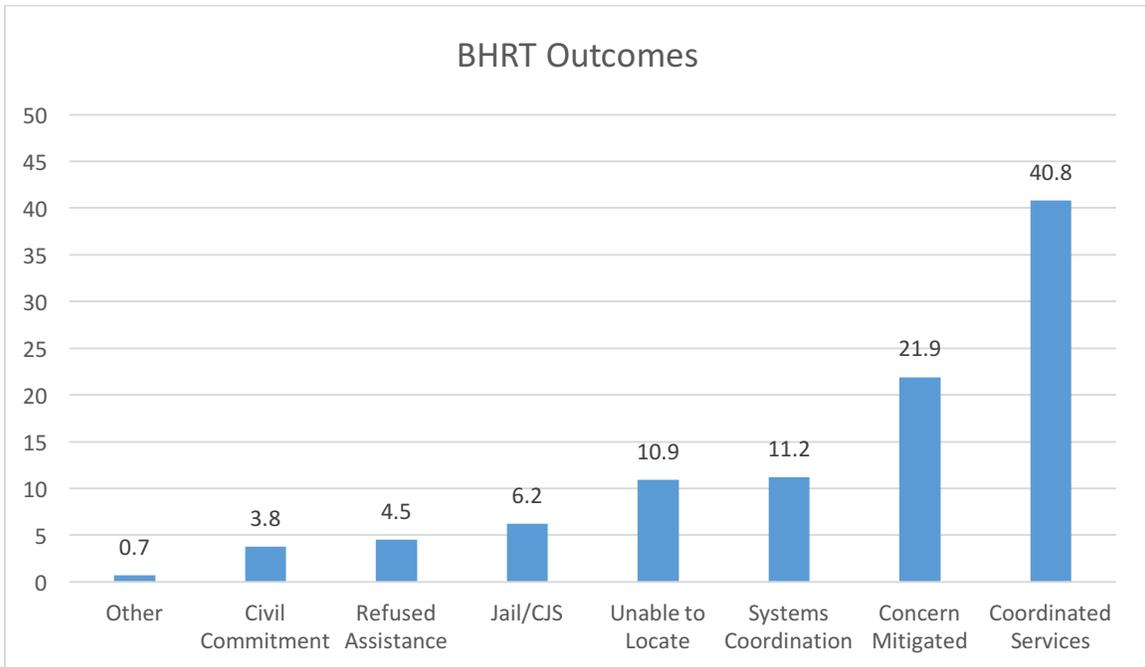


Figure 15 – BHRT Outcomes (Percent of BHRT clients, N=552)

We examine the profile of individuals who refused BHRT services so that tailored approaches might be taken to engage those individuals. We then looked for race, age, and gender groups who are overrepresented in the refusal category relative to their proportion in BHRT referrals. As shown in Table 1, our results indicate that White male community members under 30 years of age and between the ages of 30 to 50 refused services at higher rates relative to their proportion of BHRT referrals. This group may be particularly difficult to engage and may require the development of additional engagement strategies.

| | <u>Percent of BHRT Intake</u> | <u>Percent of “Refusal of Service” Outcome</u> |
|-----------------|-------------------------------|--|
| GENDER | | |
| Male | 74.1% | 84% |
| Female | 25.9% | 16% |
| RACE | | |
| White | 74.6% | 80% |
| Black | 18.8% | 20% |
| Hispanic | 2.7% | 0% |
| Asia | 3.4% | 0% |
| Native American | .4% | 0% |
| AGE | | |
| Under 30 | 26.1% | 32% |
| 30 to 50 | 45.3% | 52% |
| Over 50 | 28.3% | 12% |

Table 1 – Refusal of Service Demographics Compared to Overall Data Demographics (N=552)

Service Coordination Team (SCT) Data

The Service Coordination Team (SCT) provides housing, counseling, and other resource services to individuals with a high degree of addiction and/or criminality. The SCT data provided by PPB contains case information for 219 clients who are currently in the program or who exited the program between January of 2015 and early February of 2016. For this report, we examine the demographics of SCT Participants, the number of clients who joined/exited the program within the data timeframe, exit outcomes, and housing/employment changes related to program completion.

The SCT client is most frequently a White male community member between the ages of 30 and 50 years old. Males represented 73.5% of SCT clients in the data set, while females constituted 25.6%. White community members represented 63.9% of SCT clients, followed by Black community members (31.1%). All other racial categories made up less than 3% of clients. In terms of age, 62.1% of the sample was between the ages of 30 and 50 years old, while 21.5% were over 50 years of age and 16.4% were under 30 years of age.

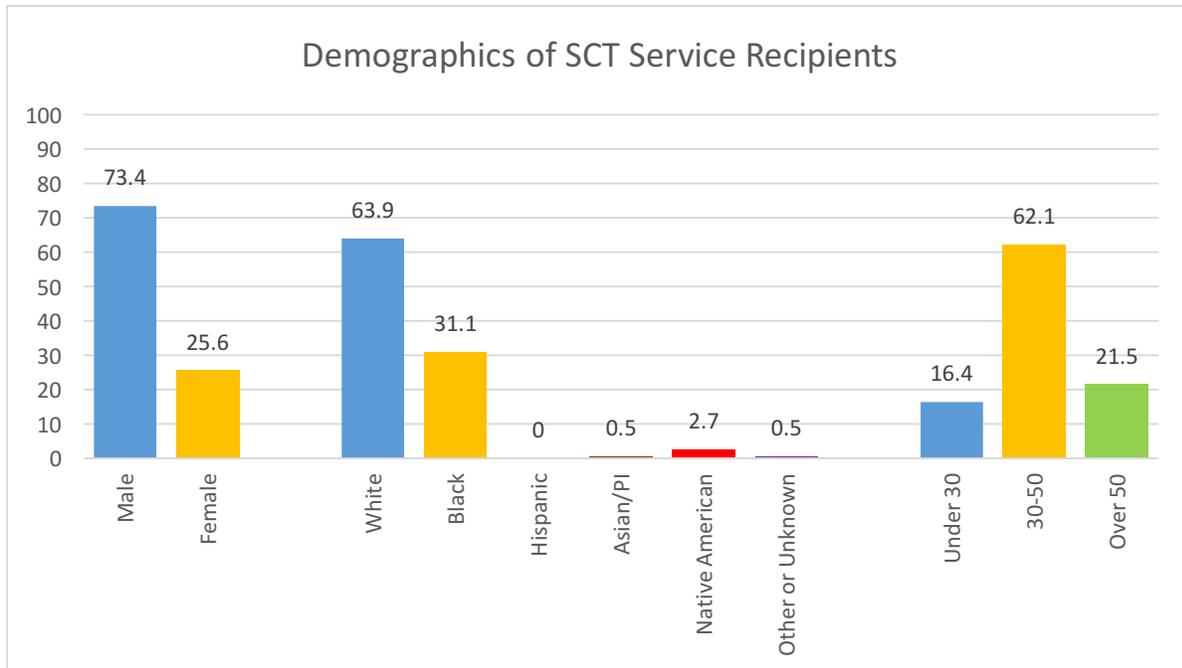


Figure 16 – Demographics of SCT Service Recipients (Percent of SCT service recipients, N=219)

Between January of 2015 and February of 2016, there were 171 new individuals enrolled in the SCT program. Also between those months, there were 180 clients who left the program. Of these, there were 133 total clients who both entered *and* exited the SCT program between January 2015 and February 2016. A total of 47 individuals who left the program had entered before January of 2015. There are a total of 39 clients who are still SCT clients. Of the 39 current clients, only one entered before 2015.

| YEAR ENTERED SCT | YEAR EXITED SCT | | |
|-------------------------|------------------------|-------------|-----------------------|
| | 2015 | 2016 | Current Client |
| 2013 | 2 | 0 | 0 |
| 2014 | 44 | 1 | 1 |
| 2015 | 119 | 13 | 33 |
| 2016 | - | 1 | 5 |

Table 2 – Year Entered by Year Exited SCT (N=219)

When looking at outcomes of upon SCT program exit, we removed the 39 clients who are currently still in the program. The data provided by PPB for this report includes more in-depth descriptions of outcomes than the data provided for our previous Outcome Assessment Report. We thank PPB for the expanded descriptions and believe they provide a more complete picture of the range of outcome achieved. For example, a client may have completed the low barrier housing portion of the program

before exiting the program (the low barrier housing portion is an early step of the SCT program). The client may have also exited for a number of reasons, such as another housing opportunity or they may have transferred to another program. We have broken the array of outcomes into the following categories: Completed Low Barrier Portion of Program, Completed Program, Non-Compliance with Program or Criminal Activity/Violence, Needs Could Not be Met, Unknown or the Client Disappeared, and Other.

Figure 17 below provides the breakdown of SCT outcomes. More than half of SCT clients (56.1%) were removed from the program as a result of non-compliance or criminal activity/violence. For clients who were removed for this reason, they were most always removed for non-compliance with the program rather than for criminal activity or violence. 15.6% of clients went on to successfully complete the program, while 7.2% completed the low barrier portion of the program before leaving. Therefore, 22.8% of clients completed some portion of the program. Of the 180 clients who exited the program between January 2015 and February 2016, there were only 3 (1.7%) whose needs could not be met.

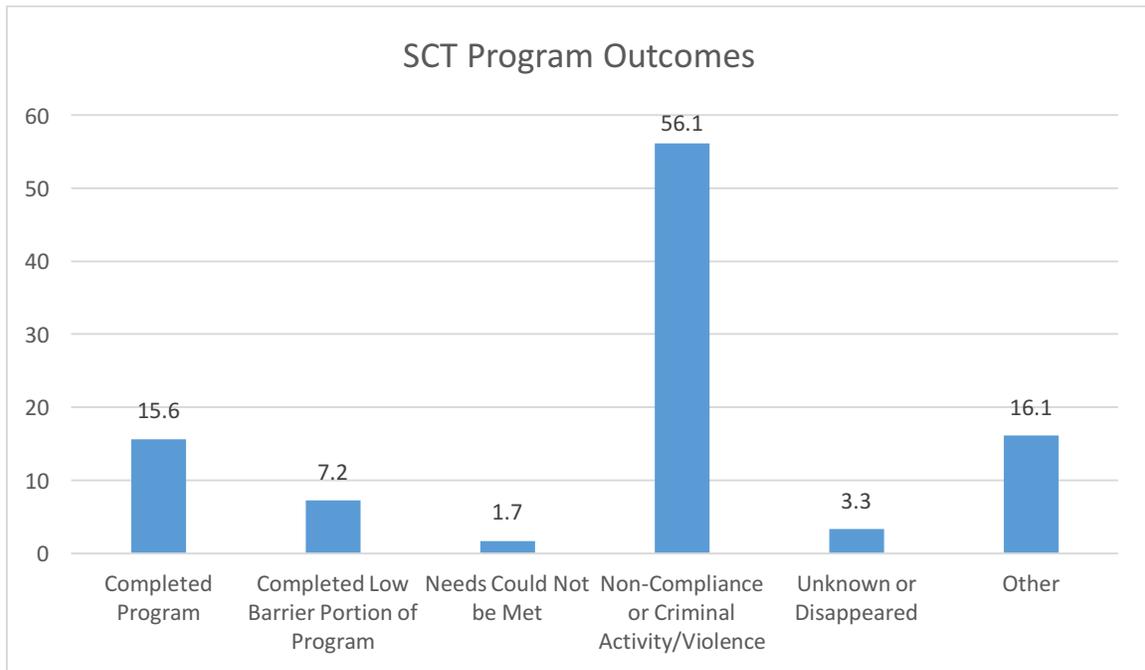


Figure 17 – SCT Program Outcomes (Percent of SCT Clients who have completed program, N=180)

Finally, we provide analyses regarding employment and housing status between the beginning and end of SCT participation. For these analyses, the percentages found within the tables are comparisons between those who completed the program and those who did not. The percentages for *all* individuals combined are found within the body of the text. While we cannot state a causal effect of SCT participation and changes in employment/housing, the trends should be monitored longitudinally by SCT to determine whether overall changes are consistent with the mission of SCT.

For the analysis of housing, the data provides a total of 16 different codes for the types of locations where the client may be living. We report here the most commonly indicated codes though would ask the SCT to explore whether these codes might be able to be grouped together. Ultimately, we are interested in examining whether improvements in housing status can be measured. For instance, if a client is living in a place not meant for habitation upon entry into SCT, we would be interested to know whether they exited SCT with a more habitable living environment. We do not believe this type of analysis currently occurs within SCT. We look forward to discussing such possibilities with SCT in the future.

The most commonly indicated housing code for people entering SCT is “place not meant for habitation,” which is indicated for 16.9% of SCT clients. 13.3% of clients entering SCT indicate they are staying or living in a family member or friend’s room, apartment, or house. For 12.8% of clients, they are in jail, prison, or a juvenile detention center upon entering SCT. 8.7% are living in a substance abuse treatment facility/detox center, while another 8.2% are living in transitional housing for homeless persons. Furthermore, about 7.8% are living in an emergency shelter and 6.4% reside in a hospital or other residential non-psychiatric medical facility. All other housing codes individually make up less than 5% of SCT clients, though combined are about one-fourth of responses.

However, the overall numbers mask differences between those who successfully completed the program and those who exited for other reasons. For those who completed the SCT program, approximately 25% were residing in a substance abuse treatment facility/detox center upon entry into the program, while another 21.4% were residing in transitional housing for homeless persons upon entry. Approximately 10% lived in a place not meant for habitation upon entry. The percentages for this subset of SCT clients are markedly different from SCT clients as a whole regarding housing upon entry. Thus, housing status prior to entering the SCT program may be related to the client’s potential for completing the program. Figure 18 shows the differences between the two groups.

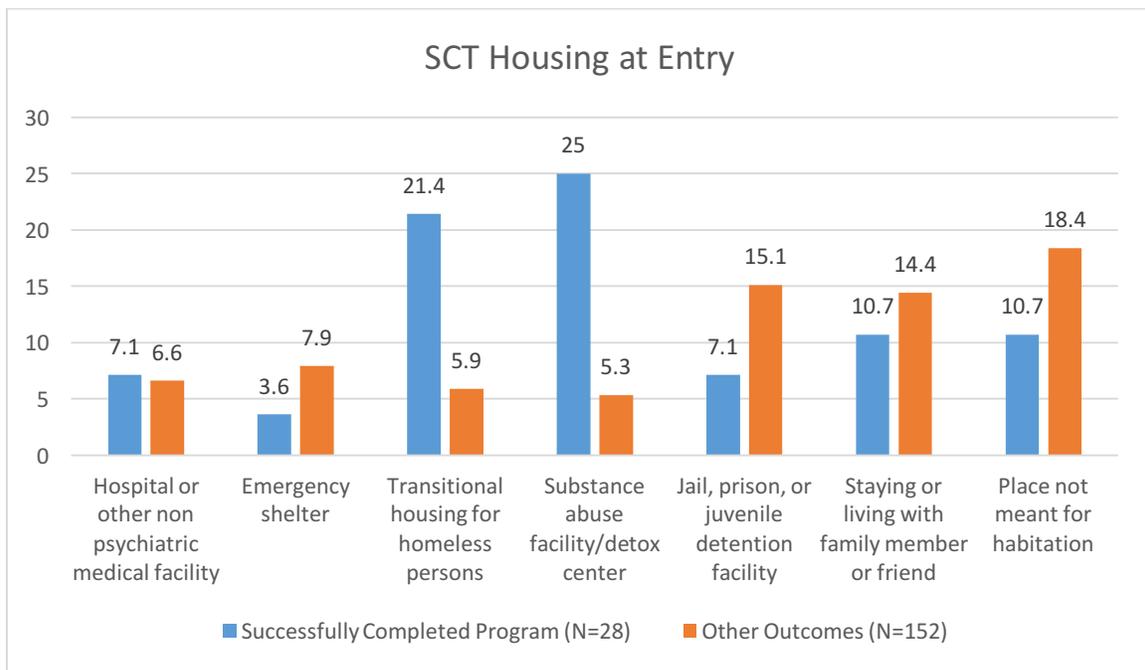


Figure 18 – SCT Housing at Entry (Percent of SCT clients not currently in program, Total N=180)

Upon exiting the SCT program, the most commonly indicated housing code was that the client did not know where they were going to live (40.1%). For 20.3% of exiting clients, there was no exit interview completed or the data were not collected. For 11.6% of SCT clients, they were staying or living with a family member or friend, whether permanently or temporarily. About 6.9% of SCT clients were renting housing upon exiting the SCT program. There are again differences in housing at exit between those who completed the SCT program and those who exited for other reasons. Nearly 40% of those who completed the SCT program indicated they were renting housing upon exiting the SCT program and an additional 31.2% indicated they were staying or living with a family member or friend, whether permanently or temporarily. Only 3.6% of clients who completed the program indicated they did not know where they were going to live, versus 44.7% of those who did not complete the program.

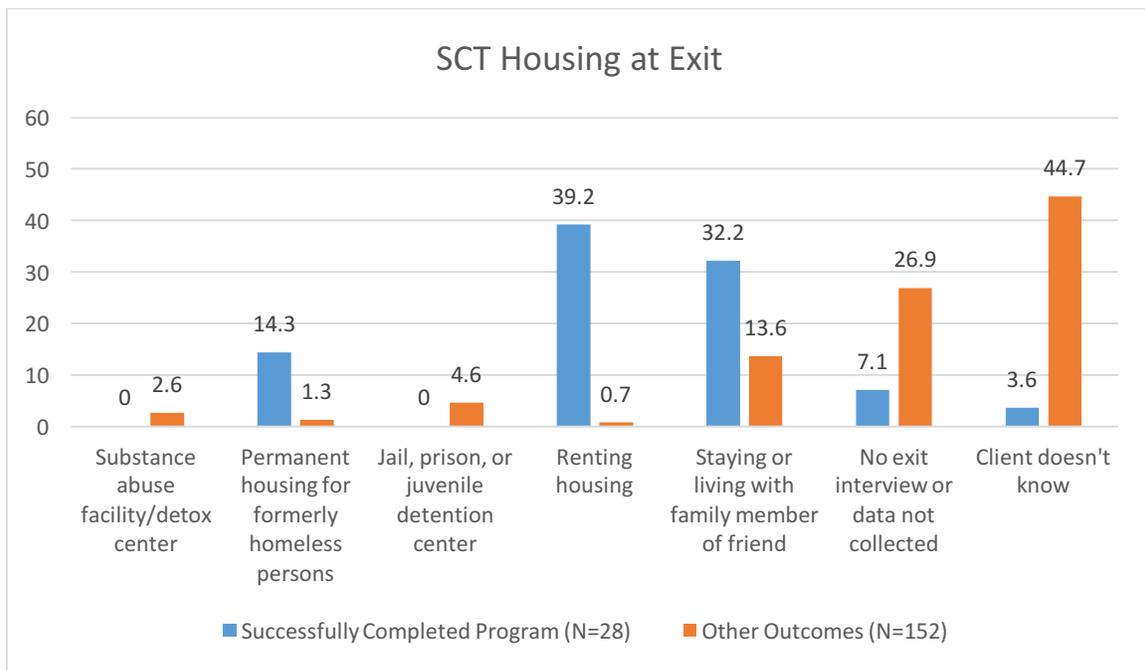


Figure 19 – SCT Housing at Exit (Percent of SCT clients no longer in the program, Total N=180)

We examined employment status before entering the SCT program and exiting the SCT program. Before entering the SCT program, approximately 90% of the clients were unemployed while 1.4% of clients indicated they had employment. The remaining 9.2% were on some type of Social Security, whether that be Social Security Disability (SSD/SSDI) or Supplemental Security Income (SSI). There were differences in employment at entry between those who successfully completed the program and those who did not. For those who completed the SCT program, 10.7% were employed versus 0% of those who did not complete the program.

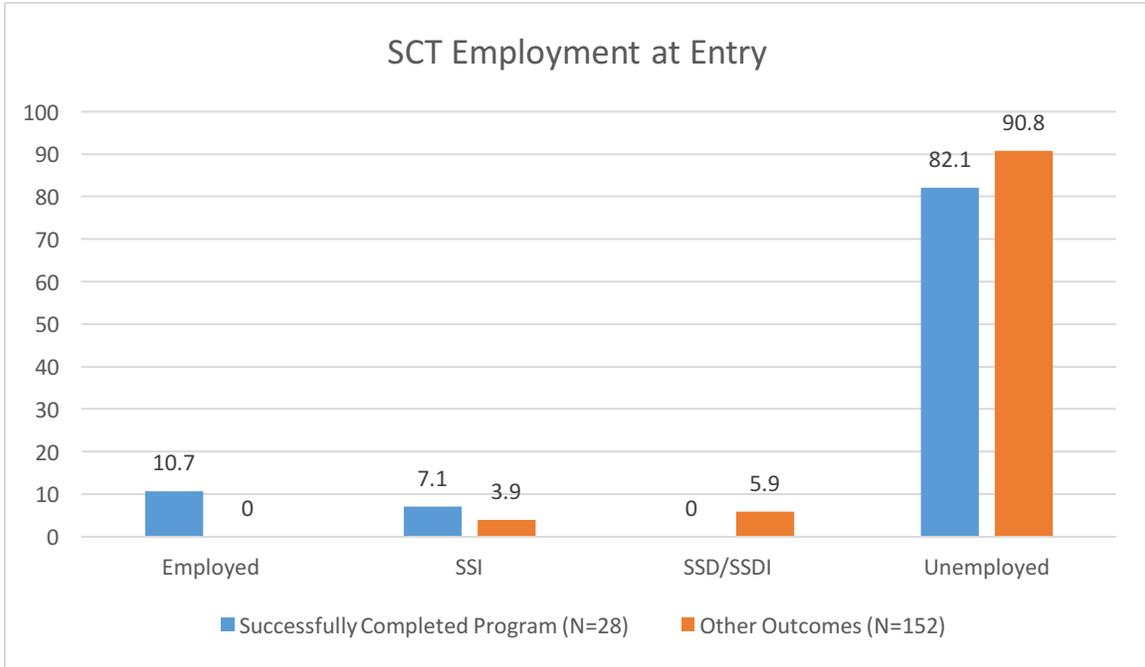


Figure 20 – SCT Employment at Entry (Percent of SCT clients no longer in the program, Total N=180)

Upon exiting SCT, we see an increase in the percentage of clients who were employed, with 17% of all clients indicating they were employed. The remaining 9.6% of clients were on some type of Social Security. For employment upon exit, there were differences between those who successfully completed the SCT Program and those with other outcomes. For those who completed the SCT Program, upon exiting 88.5% were employed while only one person was unemployed at exit (3.8%). There were 2 people (7.7%) on some type of Social Security.

While it is not possible to determine an overall causal relationship between SCT participation and employment, the change is significant. For example, of the 30 total people employed at SCT exit (regardless of whether they completed the program), 27 of them were unemployed at entry. As seen in the charts, there is a significant change in employment status for those who completed the program. As with housing upon entry and exit, we believe it to be worthwhile to measure change scores between entry and exit as they relate to SCT goals. We look forward to working with PPB and SCT to determine how this might be calculated.

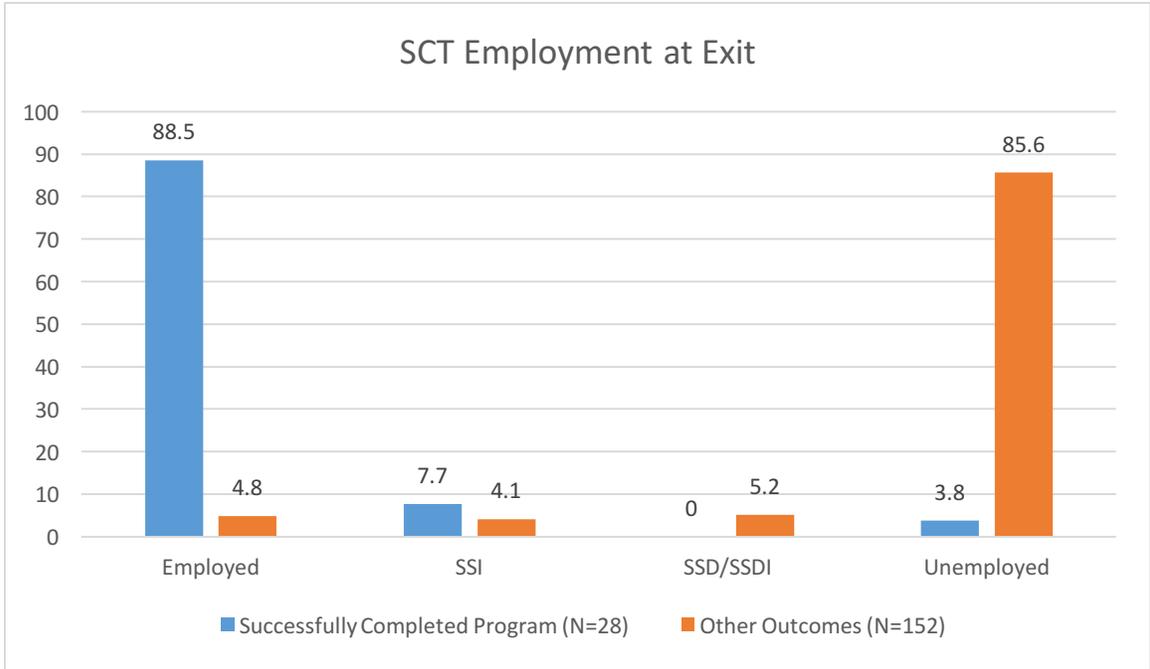


Figure 21 – SCT Employment at Exit (Percent of SCT Clients who have completed program, Total N=180)

COMPETENT ACCOUNTABILITY AND OVERSIGHT SYSTEMS

In our first Outcomes Assessment Report, we expressed our desire for a single database that would aid PPB in their accountability and oversight requirements. As stated in that report, the number of PPB's current data systems make "meaningful data analysis a tedious and potentially impossible endeavor" across systems. Because many of the systems within PPB do not communicate with each other, the task of extracting and combining data elements is extremely time consuming and labor intensive. Therefore, we continue to maintain that PPB's ability to perform analytic tasks related to accountability and oversight is restricted without a single, relational database. We will continue to discuss with the City and PPB the cost-benefit ratio of creating a new system or finding other ways to accomplish these tasks.

PPB Employee Information System (EIS)

Portland Police Bureau has expanded the use of its Employee Information System (EIS) within the Bureau and has trained supervisors in the use of EIS. The PPB has included thresholds beyond what is required by the Settlement Agreement (Pars. 118 and 119). There are eight (8) thresholds which trigger an EIS review: 3 traumatic incidents in 30 days, 2 commendations in 6 months, any allegation of criminal misconduct, 2 complaints in the same category in 6 months (e.g. discourtesy), 3 complaints in any category in 6 months, 3 use of force incidents in 30 days, use of force in 20% of an officer's arrests ("force ratio") in the past 6 months, and using force 3 times more often than officers in the same detail. PPB has also begun to analyze the extent to which supervisors are utilizing the EIS, making entries into officers' Performance Discussion Tracker, and whether such entries are positive, neutral, or negative. We believe these initial steps by PPB are strong and that they should continue. However, we feel additional steps are required to meet the letter and intent of the Settlement Agreement.

We have discussed with PPB the potential for their current Employee Information System to track threshold breaks and the potential for other data housed within PPB to be used as a tool for preventing future problematic behavior. We have provided PPB a Technical Assistance Statement detailing our observations and impressions (see Appendix A). Our focal points for this section of the Outcome Assessment relate to the tracking of EIS flags for accountability purposes, the ability of current EIS tabs to accurately define who would benefit from supervisory intervention, and the use of EIS to identify a profile of officers who may benefit from additional instruction or training.

When an EIS flag is generated as a result of a threshold break, PPB reviews and evaluates the following factors:

- Events which triggered the alert
- Arrests
- CAD records
- Commendations
- Complaints
- Employee Leave
- Extra Employment
- Investigative Cases
- Leave Summary

- Overtime
- Street Checks
- Traffic Citations Given
- Traumatic Incidents
- Use of Force History
- Work Hour Summary
- Performance Discussion Tracker

These tabs are reviewed by the EIS Administrator to determine whether to send an alert to the RU Manager based on the “administrator’s best judgement about whether the employee could stand to gain something from a review and intervention at the RU level” (EIS SOP provided by PPB). However, “best judgement” is a subjective term, which does not allow for quantitative analysis to evaluate reliability or validity. We have recommended to PPB that, at a minimum, the above considerations must be quantified and tracked for reasons of transparency and consistency.

We have been informed by the EIS administrators that the EIS, as currently designed, cannot automatically pull data into a database, but instead is a warehouse for information – a pointer system. Therefore, PPB cannot at this time provide a relational database to show that the decision to send a EIS flag on for supervisory review, as well as the disposition of that review, are done in a consistent manner. As a result, COCL has prepared an Excel spreadsheet for PPB to utilize when a threshold is broken. This spreadsheet documents the reviews and findings found at each step of the EIS flag process. The spreadsheet allows for the systematic documentation of the process, thus increasing transparency and assuring consistency. The spreadsheet contains approximately 60 variables that are currently a part of the review process for EIS flags detailed above. We are currently discussing with PPB how such tracking of EIS flags, utilizing the proposed spreadsheet (or a comparable tracking tool), will occur in the future.

We have also expressed reservations about PPB’s current process for forwarding EIS threshold breaks on for supervisory review. The PPB’s 2015 Q3 Update for Pars. 118-119 indicates that approximately 5% of the force alerts were sent out for Supervisory review. PPB has indicated that alerts that are not sent out for review generally fall into five categories: duplicate, transfer, singular use of force, data error, and other. For duplications and data error, we understand why these alerts may not be sent out for review. However, we are not convinced why declinations as a result of transfers, singular use of force, and “other” are not better served by a supervisor review. PPB’s own explanation for the EIS Alert Process states that an officer’s “shift lieutenant and/or sergeant are most likely to be the supervisors with the most day to day contact with the employee under the review” (EIS Explanation for DOJ and COCL provided by PPB). Given this reality, the COCL maintains that, in many cases, supervisors are in a much better position to assess the officer than are the EIS administrators.

We further do not believe that the current review captures enough information or combines information in a manner that will result in effective intervention. The theory behind EIS is to cast a wide enough net to identify potentially problematic officers. (EIS should also be able to identify problematic behaviors across officers if the data are properly compiled). The tabs found on the EIS may provide some insight as to whether an officer might be at risk, though information related to work history alone is insufficient to make such determinations. Personal information such as unusual work habits, stress outside of work or other factors should be considered. These factors are more likely to be known to the

officer's supervisor than the EIS administrators. We acknowledge that some factors should not be entered into EIS, but should be used for supervision and coaching.

According to the EIS SOP provided by PPB, the decision to forward EIS flags to supervisors is based on "whether the employee could stand to gain something from a review and intervention" (EIS SOP provided by PPB). We disagree with this position. The decision to *decline* sending an alert to the RU should be the exception to the rule. Rather than the criteria being that "the employee could stand to gain something", we maintain that reviews should be declined only in situations where the employee stands to gain *absolutely nothing*. We feel this flipping of standards will result in an increase in the number of alert reviews as well as an increase in the quality of reviews.

Finally, we do not feel that PPB's current EIS can "effectively identify at-risk employees, supervisors, and teams." This would require a systematic analysis of an organized, relational database. Granted, predicting (with precision) who will and who will not engage in problem behaviors in the near future is very difficult, but the EIS system should be able to identify individuals and groups that are at risk and display patterns that deviate from others within the PPB. Also, further analysis may allow the PPB to construct a profile of a hypothetical officer who is most likely to get in trouble and who is most likely to benefit from additional training and instruction before a problematic occurrence is possible. Also, a profile of problematic behavior patterns is possible. For these reasons, we recommended that PPB seek assistance from researchers who are currently working on this issue. Recently, the Data Science for Social Good project (housed within the University of Chicago) partnered with the Charlotte-Mecklenburg Police Department to work on EIS related data collection, with initial positive results (see <http://dssg.uchicago.edu/2015/10/27/reducing-adverse-police-interactions/>).

Another way of describing the problem with the current EIS approach is as follows: First, PPB is looking at whether an officer has exceeded any one of the 8 threshold indicators that would trigger a review. An officer may not exceed the threshold on any one indicator (especially since the thresholds are set very high), but yet shows a pattern of above-average activity on multiple indicators. This could be indicative of a problem, but would not be detected under the current system. Second, when a review is triggered, the EIS administrator looks at the 16 possible activities that could be causing the trigger. Whether the administrator is looking at one or two of these activities routinely (and ignoring the others), whether he/she combines them, weighs them differently, or uses some other mental assessment is completely unknown. Here again, the variables, if recorded, could be combined in a more scientific (and less subjective) manner to look for patterns. Maybe, for example, more overtime and fewer arrests combine to trigger a threshold, or maybe extra employment, higher levels of street checks, and a traumatic incident must all be present to trigger a review (cumulative or interactive effect). These questions are answerable, but not with the current system.

For now, PPB has implemented a methodology that simply assesses the degree to which supervisors are utilizing EIS to review their employees in accordance Par. 116 and related subsections. We have received the datasets related to their analysis so that we may report them here.

Subsection (a) of Par. 116 states that PPB will require commanders and supervisors to review EIS records of employees under their supervision and document the review in EIS. PPB has incorporated the review of EIS records into officers' Semi-Annual Reviews. Thus, PPB knows when a review must occur and can identify whether or not such a review occurred. PPB has provided us the data for Q4 related to this subsection. Overall, PPB saw an 85.1% compliance rating during the fourth quarter, a reported increase

from the third quarter of 2015 when PPB stated it had a 77.6% compliance rating. Looking at the data, we do not see any obvious patterns or problems with any specific divisions, precincts, or shifts. The Youth Services Division had two people who should have been reviewed and neither were, though it is difficult to determine a pattern based on a cross-section of time and with only two cases. After consulting with DOJ, PPB recently began collecting data related to Par. 116(a) on a regular basis, but at this point, the dataset is not large enough for trend analysis. We encourage PPB to continue collecting these data so that trends might be observed in supervisory compliance with the requirement to review EIS records of employees.

Subsection (b) of Par. 116 states that commanders and supervisors must review EIS records for officers new to their command and document the review in EIS. PPB has added the qualifier that such reviews must be within 30 days of a transfer. The data provided by PPB includes 48 cases where an officer was required to be reviewed as the result of a transfer. In 46 of the cases, a review was not completed on time. In 22 of the 48 cases an email was sent after 21 days to remind the responsible supervisor that a review was required. The use of such reminder emails by PPB is a potentially effective way to increase compliance with this subsection. On average, the number of days taken to review an employee was 13.75 days. In 23 of the 48 cases (47.9%), the review was done in 10 days or less.

Subsection (c) of Par. 116 states that EIS staff will perform data analysis of units and supervisors to identify and compare patterns of activity. PPB provided the data to the COCL in a Word format that did not allow for analysis. We are in the process of discussing with PPB expanding their interpretation of Par. 116(c) that is tied in with our discussion of expanding EIS overall (see above). We will report on developments related to this in future reports. Our concerns about the current system of subjective analysis are noted above.

Complaint Database

We requested and were provided data for community complaints made to either IPR or PPB. The data provided by PPB includes any community complaint initiated between August 1, 2015 and February 1, 2016. We were provided a total of 170 cases, of which 145 had received a finding. As of the March 1, 2016, there were a total of 25 cases awaiting a finding. For the 170 cases, there were a total of 409 allegations made, resulting in an average of 2.41 allegations per complaint. Of the 170 complaints, 66 complaints (38.8%) had only one allegation, 77 complaints (45.3%) had two or three total allegations, and 27 allegations (15.9%) had four or more total allegations. Of the 170 cases, 83.5% were initiated through the Independent Police Review (IPR), with 15.3% being initiated through Internal Affairs (IA). There were two complaints (1.2%) where it was not immediately clear whether they were initiated through IPR or IA.

There were six allegation types found in the data: Conduct, Control, Courtesy, Disparate Treatment, Force, and Procedure. We were provided definitions by IPR for each of the allegation types:

- Force: An allegation of use of excessive or inappropriate force. Force (as defined by PPB) is physical coercion used to affect, direct, or influence an individual, as well as the pointing of a firearm and use of maximum restraint. Control holds and un-resisted handcuffing do not constitute force unless physical or mechanical intervention is applied against physical resistance.

- Control Techniques: An allegation that a “control technique” was used unreasonably or inappropriately.
- Conduct: An allegation that tends to bring reproach or discredit upon the Police Bureau or the City. It involves behavior by a member that is unprofessional, unjustified, beyond the scope of their authority, or unsatisfactory work performance. Typically, this would include violation of the Bureau’s Standard of Conduct, Conform to Laws, Unsatisfactory Performance, Truthfulness, etc.
- Disparate Treatment: Allegations of specific action or statement that indicate inappropriate treatment of an individual that is different from another because of race, sex, age, national origin, or physical disability. Covered by Directive 344.05 (Biased Based Policing) and HR Rule 2.2.
- Courtesy: Allegations relating to attitude and rude or discourteous conduct other than disparate treatment.
- Procedure: Allegation that an administrative or procedural requirement was not met. This would normally include areas such as failing to write a report or inappropriate handling of a community member’s property.

As shown in Figure 22 below, nearly half of allegations (49.6%) related to Procedure. Conduct type allegations made up approximately one-fifth of allegations (20.3%), while complaints related to Courtesy accounted for 16.6% of allegations. Allegations of Force were approximately 10% of all allegations against PPB, while Disparate Treatment and Control were less prevalent (2.7% and .7%, respectively).

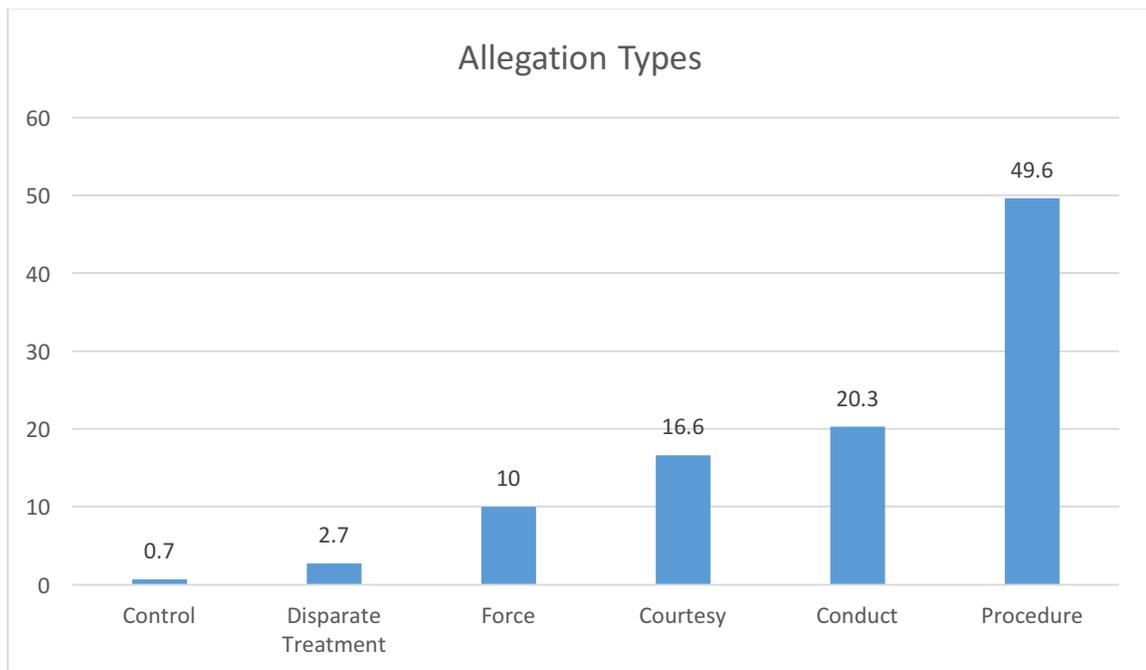


Figure 22 –Allegation Types (Percent of Allegations) (N=409)

Within these allegations, we also examined allegations of specific policy violation as displayed in the next figure. For instance, an allegation of Procedure violation may contain violation of Directives 312.00 (Request for Assistance), 315.30 (Satisfactory Performance), 640.50 (Traffic Crash Investigations), or 311.30 (Off-Duty Responsibilities). Similarly, an allegation of Courtesy may contain violation of Directive 310.40 (Courtesy), but also Directives 312.00 (Request for Assistance) and 310.00 (Conduct, Professional). We examined all allegations for the data set, finding that allegations related to Directive 310.40 (Courtesy) were most often made (16.1% of allegations). Allegations of violation of Directives 315.30 (Satisfactory Performance), 312.00 (Request for Assistance), and 1010.00 (Use of Force) all constituted more than 10% of allegations. Allegations of violation related to Directives 310.00 (Conduct, Professional) and 315.00 (Laws, Rules, and Orders) each made up approximately 5% of all allegations. There are a total of 38 other specific Directives for which allegations of violation occurred. While the combined effect of these other allegations made up approximately 35% of all allegations, individually, none of the 38 made up more than 3% of the data set.

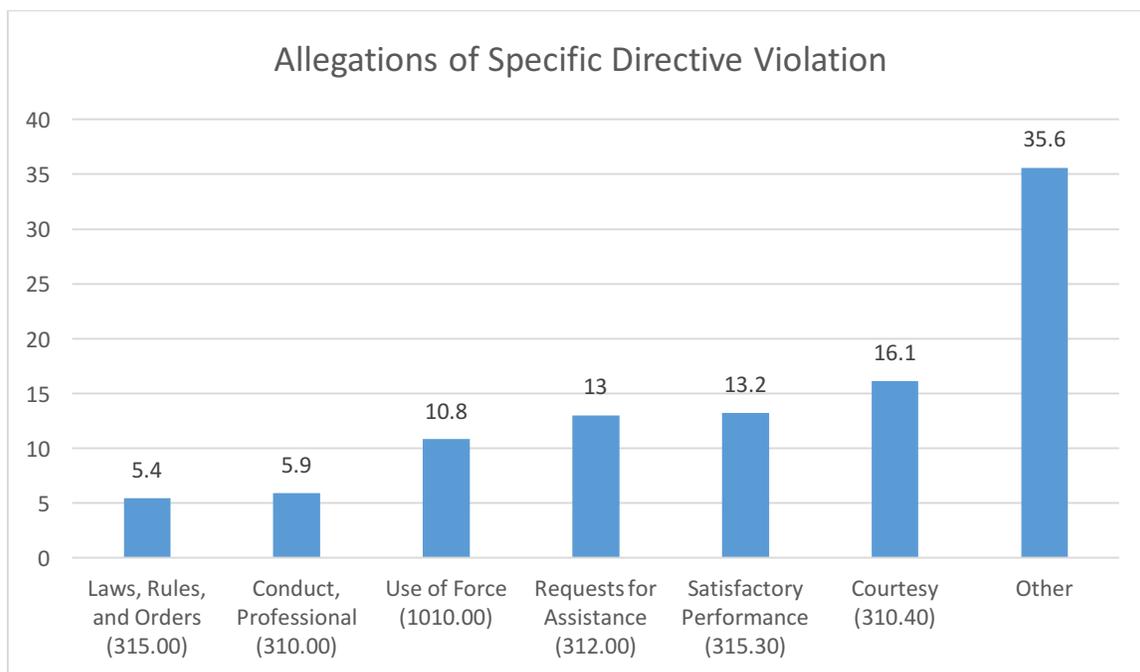


Figure 23 – Allegations of Specific Directive Violations (Percent of Allegations) (N=409)

We requested the Department of Public Safety and Services Training (DPSST) number for each complaint in order to determine the “number of officers who are subjects of repeated complaints” (SA, Par. 173(e)(iv)). The DPSST for the officers were not provided within the dataset; however, PPB provided a separate response for this specific request. PPB response indicates that for complaints “that are closed and have allegations”, there were 135 officers who received only one complaint, there were 13 officers who received two complaints, and there were two officers who received three complaints. There were also 31 complaints where the officer was unidentified in the complaint. None of the officers had more

than one sustained finding. This special analysis is helpful but in the future, we ask that the DPSST be included as a variable in the larger database so that we might be able to determine whether repeated complaints against a particular officer where the same complaint type or same policy violation.

The time needed to conduct a complaint investigation and provide findings varies considerable, ranging from 3 days to 148 days. On average, there were 50.11 days between a complaint being filed and a disposition being provided. We collapsed the time for complaint investigation into four categories. As seen in Figure 24 below, nearly half (47.4%) of all complaint investigations took between 31 and 60 days. A little bit more than one-quarter of complaint investigations (28.1%) took a month or less to complete. Investigations taking more than 60 days were less common.

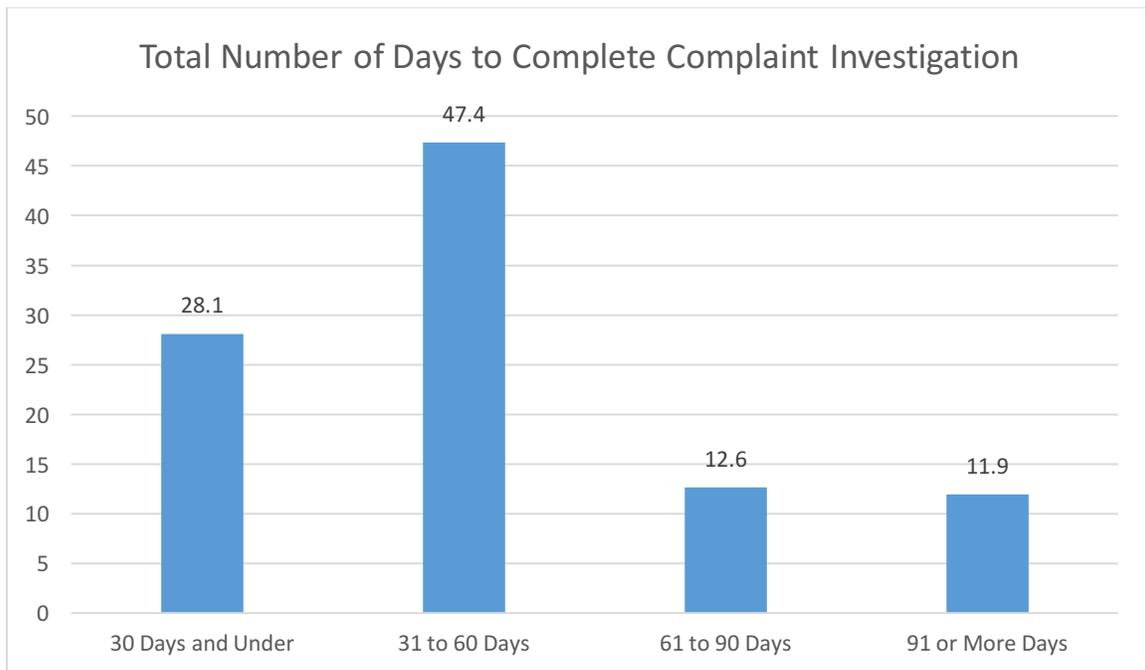


Figure 24 – Total number of days to complete complaint investigation (Percent of completed investigations) (N=145)

We examined the commonality of different types of findings for 291 allegations related to the 145 complaints which had a finding. For the overall findings chart below, we collapsed findings into 9 categories for each allegation: Exonerate, Internal Affairs (IA) Decline, Independent Police Review (IPR) Decline, Mediation, Not Sustained, Service Improvement Opportunity (SIO), Suspended, Sustained, and Unfounded. For all allegations, the most common finding was IPR Decline, which accounted for two-thirds of the allegation findings (67.4%). The next most common finding was a Service Improvement Opportunity (12.7%). IA Decline and Not Sustained were each approximately 5% of allegation findings, while the allegation was Sustained 3.1% of the time. All other finding categories were less than 2% of the dataset.

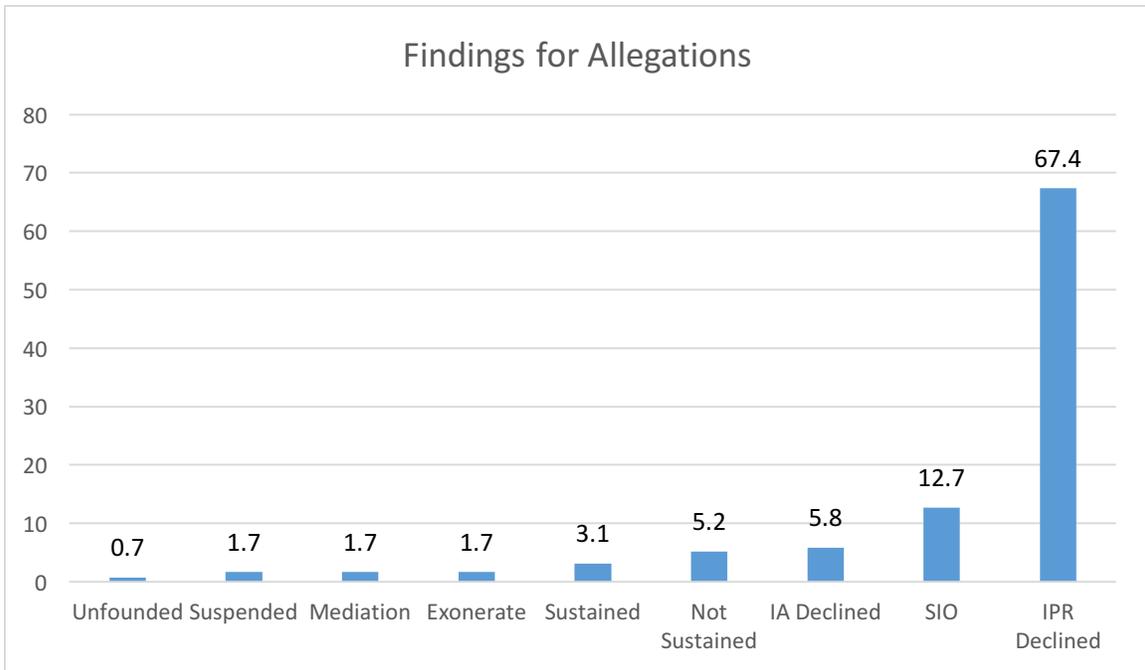


Figure 25 – Findings for Allegations (Percent of Findings) (N=291)

As part of the dataset, there was one case related to a lawsuit being filed against the Portland Police Bureau. The lawsuit is still pending and therefore no information is available other than that PPB is listed as a defendant and the nature of the suit involves an alleged unlawful search of a backpack and bodily injury during the arrest. We will report further on this case as it progresses. We also requested from PPB any other lawsuits have been filed against PPB which may not have been related to a complaint and we are awaiting that response.

Overall, we believe PPB’s current systems for oversight and accountability are adequate in some areas and require expansion in others. The data provided for administrative complaints appears to be adequate for PPB and IPR to identify implications for improved service. The high degree of complaints related to procedure, conduct, and courtesy should be incorporated into PPB’s plan for training, as should allegations of specific policy violations. While complaints appear to be generally resolved in a timely fashion, PPB and IPR should examine the proportion of cases which are declined to determine whether declinations are related to the merit of the case or resources to investigate complaints.

We do not believe PPB’s current utilization of EIS is adequate for oversight and accountability. We will continue to discuss with PPB how EIS might be expanded to better evaluate officers when they have created a threshold flag. Further, we will continue to discuss with PPB how data might be used to predict a profile of potentially problematic officers and identify problematic behavior patterns. The expansion of EIS is likely to be an iterative process and we will continue to provide updates as progress is made.

**EFFECTIVE TRAINING FOR POLICE OFFICERS THAT INCREASES THE KNOWLEDGE, SKILLS, AND ABILITIES
NECESSARY FOR EFFECTIVE AND SUCCESSFUL DELIVERY OF SERVICE
TO PERSONS IN MENTAL HEALTH CRISIS**

ECIT Training

Between November 17 and November 20, 2015, members of the COCL team observed ECIT training provided to members of the Portland Police Bureau. The ECIT training was a four day training. Each day had approximately 9 hours of curriculum, including classroom material, consumer and family panels, site visits, scenarios, and discussion groups. This training was also observed by a representative from DOJ and a representative from the COAB, as well as members of the BHUAC. We have provided PPB an overall assessment of our observations during a phone conference that was joined by DOJ. We have also provided PPB a Technical Assistance Statement detailing our observations and impressions. Rather than repeating this statement in its entirety here, we have attached it as Appendix B. Our focal points for this section of the Outcome Assessment relate to the materials provided to the ECIT officers, the officers' evaluation of the ECIT class topics covered in training, and PPB's evaluation of learning and attitude change as a result of attending the ECIT training. We address each topic in turn.

A member of the COCL team observed each day of the training. We have reviewed the PowerPoint slides, lesson plans, and other materials related to the ECIT training. On the whole, we found the material presented to the students to be consistent with other CIT trainings held throughout the country with regards to content and quality of information.

As part of the Kirkpatrick Model of program evaluation (currently utilized by PPB in their evaluation of training), officers were asked to complete evaluation forms measuring their perceptions of training topics and presentations. PPB is currently coding and analyzing the results from the student feedback surveys and will report the results in the 2015 ECIT Training Report, slated for release in July of 2016. We have requested the raw data from the student surveys, however PPB is not comfortable sharing the raw data at this time.

PPB breaks up their class evaluation into two surveys – one for Days 1 and 2 and one for Days 3 and 4. The two forms utilized by PPB to evaluate student perceptions appear comprehensive, though we have a few recommendations which may improve the data collection process. For instance, on the Day 1/2 evaluation form, there is an open-ended question stating “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”. This question appears limiting to us, as improvements can be made regardless of whether the officer felt the session was a good use of their time. An alternative form might be, “Were there any sessions that you feel could have been improved in any way, and if so, how?” This question opens the door for a wider range of comments.

We also find a statement in the instructions problematic in that it could bias officers' responses. The respondents to the evaluation are informed that the PPB is “currently working on a system to protect the confidentiality of these records. They currently could be subject to public records requests”. This statement (apparently alluding to the Settlement Agreement) will likely bias responses to the survey if officers feel their answers can be linked to them or feel that because of the Agreement, they should give

a favorable evaluation of the training. The statement implies that officers need to “watch out” because their answers might be leaked to the public. This type of statement is unnecessary and should not be included on any training evaluation surveys. When COCL receives any training data, we expect it to be de-identified.

Another step in the Kirkpatrick Model is to evaluate student learning and attitude change as a result of the training. We consulted with the PPB training evaluation staff prior to the training and encouraged them to include some measures of knowledge and attitudes about individuals with mental illnesses as a pre- and post-test. As a result, PPB created a knowledge measure tailored to the content of the training which appears to be well constructed. We also suggested several brief attitude measures that have been used in prior evaluations of CIT training. Only a few attitude items were included rather than the scales that were suggested. We were not provided with the final evaluation measures until after the training and thus we were unable to provide further consultation. We have concerns that the attitude measures used may not adequately capture the impact of training. We will be consulting with PPB before the next ECIT training to discuss with them the inclusion of the attitude scales.

By design, PPB is not able to identify individual officer’s performance scores related to these trainings. We consider this problematic for ensuring officers are mastering important course content. Individual skill assessment would ensure officers left the course with the requisite knowledge and interpersonal competencies to function as ECIT officers. We will be consulting with PPB before the next ECIT training to discuss this as well.

In addition to the learning and attitude change evaluations performed by PPB during the ECIT training, PPB conducted a follow-up survey in March of 2016. This survey was designed to gain feedback from the officers who attended the ECIT training to see how they viewed the training in hindsight, how they have applied their training on the job, and what future training needs the officers recognize. We will review results of this survey and discuss with PPB prior to the next ECIT training.

PPBs Model of Mental Health Crisis Response

PPB’s Mental Health Crisis Response Model varies from the Memphis Crisis Intervention Team (CIT) model in several ways. Because all officers receive 40 hours of Crisis Intervention Training based on the Memphis curriculum, the volunteer specialist Enhanced Crisis Intervention Team (ECIT) officers are not dispatched to all pre-identified mental health calls as is done with Memphis CIT officers. Rather ECIT officers are reserved for a subset of higher risk mental health crisis calls. Additionally, once on scene, the ECIT officer may take on different roles depending his/her assessment of the scene. PPB is in the process of collecting data to determine the effectiveness of their variation on the Memphis Model. We encourage PPB to continue their data collection efforts and look forward to consulting with them on this process.

Given that the current strategy does not dispatch an ECIT officer to all calls with a mental health component or even all mental health crisis calls, we recommend that non-ECIT officers get refresher CI-training. PPB currently incorporates some aspects of crisis intervention training as part of their annual In-Service training (see Paragraph 98 of the Settlement Agreement), though this not the primary training objective. An officer’s last exposure to CI-training could have been more than five years ago. Over time,

skills may diminish or drift, which could lead to a higher likelihood of use of force in mental health crisis calls.

As part of the refresher CI-training, we recommend PPB incorporate aspects of two incidents as examples where officers might have acted differently to potentially avoid a force incident. These events are isolated incidents and, as such, are not presented here as evidence of PPB's overall mental health response. Quantitative analysis of overall mental health response is presented above and our analysis of the cases below should not be considered indicative of a larger trend. Rather we present them as examples that can be learned from and perhaps used as "teachable moments" for refresher CI-training..

The first incident involved a potential attempted suicide, where the subject was suspected of having taken a dangerous quantity of pills. Officers located the subject in a park and approached her. One officer, in an interview with an Internal Affairs detective stated (emphasis added), "...and so I'm kind of talking to her in a calm and quiet voice, **and I grab a hold of her arm**. I don't – I don't anchor her arm down, but I keep hold of her, and she's kind of dancing around and trying to struggle with me a little bit, trying to get away, but I'm – I'm maintaining control of her enough to where I can stay with her until [Partner Officer] gets out of the car." After placing the subject in handcuffs, the subject kicked her leg towards one of the officers in an attempt to knock her purse out of the officer's hands while the officer was searching it. This resulted in the officers using force against the subject.

This incident could be used as an example to discuss the potential that grabbing a person who is in crisis may have for escalating the situation. Coupled with this, officers might engage in conversation weighing the need to get the community member to the hospital versus avoiding escalation of the situation. Instructors could ask officers what might have been done differently to effect custody without escalation. By encouraging the consideration of alternative strategies, officers could weigh the pros and cons of different approaches for when they are placed in a similar situation.

The second incident involved a community member in the midst of a mental health crisis inside a public building. While approaching the subject, the officers began putting on gloves and walking towards him. At one point, one of the officers grabbed a hold of the subject's wrist. This caused the subject to attempt to pull his wrist away from the officer, who did not let go. The subject then, while having his left arm being held by the officer, swung at the officer, resulting in the officers utilizing force. As a result of this incident the community member was charged with Criminal Trespassing, Assaulting a Police Officer, Criminal Mischief, and Resisting Arrest. A video of this incident has been posted on YouTube and the COCL has reviewed PPB documentation of this incident. We have identified a number of training implications in this incident, both for refresher CI-training as well as for supervisor training. We present each of these implications in turn as we go through the incident.

Although the subject was agitated and ranting, there was not an apparent immediate safety concern and the situation did not appear to escalate until the officers closed in and grabbed his wrist. Refresher CI-training could reinforce CI concepts such as using time as a tool, maintaining a comfortable (yet safe) distance, and verbal de-escalation tactics. The officers might also discuss the pros and cons of different approaches discussed in the previous example. While it is impossible to know, CI concepts and an alternative approach might have allowed the officers to gain compliance without the use of force and the need for additional charges. This may have taken more time, and thus extended the disruption of the public venue, but also avoided the need to use force and the additional charges. We acknowledge the need to have the subject removed from the public venue in order to conduct business. We are not

implying here that the subject should not have been removed. We instead are recommending that this incident be used as a training tool to discuss potential alternative strategies when removing a community member from a public venue without the need for force.

There are also issues related to accountability found within this incident, which provide training opportunities for supervisors and individuals in the 940 Review chain of command. We found that in the 940 review process, not one of the reviewers used the term “mental health crisis” nor was this term found in the authoring Sergeant’s description of the event. This may imply that supervisors need refresher training on identifying the signs and symptoms of mental health crisis. Upon review of the video, it was clear to us that this was a mental health crisis because of such signs and symptoms. The community member exhibited escalation, pressured and tangential speech delusion, and broken thought processes. However, terms used in the official reports were “aggressive”, “agitated”, “violent” and similar phrases. Additionally, it appears that officers on the scene recognized the mental health component of the incident, as when Project Respond was requested and when communicating with BOEC, and officer commented he thought the subject was “off his meds.”

Finally, the Force Data Collection Report (FDCR) indicates, under the Mental Health Indicators, that it was “Unknown” whether there was mental illness, that the officer did not have prior knowledge of the community member’s mental health history, and that there was a mental health professional at the scene. With regards to the first two statements, the authoring officer of the FDCR had indicated in previous statements that the community member “had some mental health issues” and that the community member was “very agitated today”, indicating a previous knowledge of the subject and possible awareness that the community member may have been off his medication. We have talked with other members of PPB who have also stated the subject and his mental health history is well known. Why “Unknown” was checked as it related to mental illness, and why the officer denied having prior knowledge of the mental health history is unclear to us, when there is evidence to the contrary for both checkboxes. We recommend refresher training on how these checkboxes should be filled out and what the criteria are for responding in the affirmative. There also appears to be an issue with item validity regarding whether a mental health professional was on the scene. While Project Respond arrived “just before” the community member was being transported to jail, they did not interact with the community member. No consultation occurred between Project Respond and the officers before the interaction nor did Project Respond contribute after the arrest. We recommend some distinction be made between whether a mental health professional was “on-scene” and whether some type of interaction occurred between the mental health professional and the officer/the person experiencing mental health crisis. Thus, for all these checkboxes, we recommend refresher training on how the Mental Health Indicators should be filled out in order to address issues of consistency and accuracy.

We reiterate that two interactions do not make a pattern and should not be considered as representative of all PPB interactions with persons experiencing mental health crisis. However, both interactions provide opportunity for refresher training in skills, approaches, and tactics that may prevent future force events. We understand the PPB’s current In-Service training is partially dictated by State mandated training requirements, and must include other elements of PPB operations as well as the Settlement Agreement. While we encourage refresher training for all officers in crisis intervention during In-Service as required by the Agreement, we suggest PPB go beyond this while being sensitive to the time concerns of In-Service. This may include video training, Tips and Techniques and supervisory support for CI-approaches. The two above interactions should be used as informative tools for the

refresher training. The second incident also calls attention to the need for complete and accurate force reporting (FDCR) in order for PPB to generate a reliable and valid system of measurement. The COCL will continue to review cases to determine if other examples exist that might be used for training purposes and will address implications for training in future reports upon further review.

PROPER MANAGEMENT OF THE USE OF FORCE TO MEET CONSTITUTIONAL STANDARDS

PPB Quarterly Use of Force Reports

In October of 2015, the COCL team reviewed a draft of the Q2 Quarterly Use of Force Summary Reports prepared by PPB. Upon review, the COCL identified several areas where we felt the PPB's reporting of force had improved as well as areas where the reports could be enhanced. The strength of PPB's new way of reporting including an upfront summary of the total number of force reports and cases involving force, breakdowns by Precinct/Division, Type of Force, and other elements of the force incident. PPB also provided a set of definitions for each type of force. Furthermore, several graphs were included, showing trends over the quarter by Precinct/Division, race/ethnicity of the subject, and type of force. PPB also incorporated the demographic summary, providing both numeric counts and percentages.

We provided recommendations for PPB to consider before they released their final version of the Q2 Quarterly Use of Force Summary Report. These recommendations related to clarifying differences between "Total Force Incidents", "Cases Involving Force", "FDCR Reports Written", "Type of Force Used", "Total Subjects Involved in PPB Use of Force Incidents", and "Total Individual Applications". We recommended PPB chose the most appropriate/informative of these to use throughout the report. We also recommended PPB provide definitions and clarity for terms that may not be readily understood by members of the community. We provided PPB an example of a table which could be used to compare raw numbers and percentages for race and gender categories across force types. Finally, we provided PPB recommendations related to the presentation of individual force types.

Overall, we are satisfied that PPB took our suggestions into consideration and we believe the final Q2 report, and subsequent Q3 and Q4 reports, constitute a dramatic improvement in PPB's reporting format. We believe the report to be substantially more informative than previous reports. We also note that PPB has included some aspects of the report which went above and beyond our suggestions. For example, the "heat map" for Precinct and Shift found within the new reports are something we believe to be a useful tool for analyzing trends in use of force. We encourage the PPB to use this mapping information and other analytic tools to help inform training, supervision, and other PPB functions relevant to the Settlement Agreement.

Apart from these improvements, we still believe some aspects of the report could benefit from revision. For instance, some tables might still be confusing to the general public, and we believe that percentages in some charts will be more informative than absolute numbers. The report is of considerable length and there are some areas of redundancy. We would support presenting the data in a more parsimonious manner so long as the quality of information is not affected. These are relative small issues when compared to the overall improvements in the report.

We recommended to the PPB that community input should be gathered regarding the scope and content of the force reports. We also encourage the COAB to review the reports, notice the improvements, and provide any additional suggestions to improve the content and readability of the reports.

Force Audit Methodology

In 2015, the PPB, in consultation with the COCL, began the planning and implementation of a methodology for auditing use of force reports and command reviews, pertaining to Pars. 74, 75, and 77 of the Settlement Agreement. In January of 2016, PPB used the methodology to review all use of force reports and command reviews that occurred within that month. This provided a dataset of 43 cases, each with over 300 variables which required coding. This was a substantial undertaking for the PPB. For this Outcome Assessment, we asked PPB to provide the entire dataset as well as reports and documents for 10 cases so that we might be able to independently assess the data. We reviewed and coded the documents for the ten cases, identifying discrepancies as we went along.

For this Outcome Assessment, we do not report analysis of the outcomes, as there are issues that still need to be discussed and resolved with PPB prior to such analyses. Rather, we assess the adequacy of PPB's data collection efforts related to force auditing, issues we have found during our independent coding, and proposals for future sampling plans. When any new system is created, we expect a learning curve to a certain degree. We provide differences between PPB's coding and our own independent coding as an indication of progress towards an agreed upon coding scheme. As this is an ongoing process, we will be consulting with PPB in the near future to discuss any discrepancies identified, methods for resolving such discrepancies, and an appropriate sampling methodology for future audits. However, we believe PPB has taken a major step towards proper management of use of force with the implementation of this auditing system.

PPB provided COCL with the force auditing dataset which includes all the variables agreed upon in our previous meetings with them. In our last Outcome Assessment we reported one small section of the auditing process. The entire process breaks down all parts of Pars. 74, 75, and 77 (and subsections) of the Settlement Agreement and translates them into tangible measures. PPB has included each one of these measures in an online survey tool. When a force event occurs, PPB is able to read the relevant documents, go through the survey and answer related questions. The online survey tool is an efficient and effective tool to collect and store data related to the audit. The online methodology returns the data in a format that can be analyzed in Excel or a statistical package such as SPSS. After reviewing the dataset, we are confident that PPB is collecting each of the variables we have agreed upon and through the online tool, has done it in a consistent and reliable manner.

When looking at the coding done by the Inspector's team within the Professional Standards Division (PSD), our independent coding reached the same results for the large majority of variables. For areas where we disagree with the PPB coding, the issue that arose most often pertained to the use of the codes "Yes", "No", and "N/A". For instance, one of the variables in the dataset asked whether the subject's mental health issues influenced the officer's decision making. In one case, no mental health issues were identified but PPB coded the variable as "No". Since there were no mental health issues identified, this should be "N/A". By coding it "No", it is not possible to determine whether the officer filed a deficient report or whether the influence of mental health issues were not applicable to the interaction. Thus, we will recommend better differentiation between when something is not applicable and when something is not properly filled in.

There are other areas of the audit which may need to be revised to assess other issues with PPB report writing. For instance, we have found instances of Force Data Collection Reports (FDCR) which indicate the FDCR was written at the exact time as the force event. In one case, the FDCR indicates it was

written five minutes before the force event actually occurred. Officers are required to complete a FDCR prior to going off shift (Directive 910.00, Section 1.1.1; Directive 1010.00, Section 9.1) and PPB needs a records system that allow it to determine whether reports are written in a timely fashion. However, reports are incapable of demonstrating this adherence when the FDCR shows that the report was written at the same time as the event. This limits PPB's ability to assess how much time passes between force events and when officers prepare the FDCR. The audit must be able to identify this as a deficiency in report writing and address it with the Training Division so that PPB can demonstrate that reports are written in a timely fashion.

We also found one instance where, during the 940 After Action Review, the Sgt. indicated that de-escalation was used during the encounter since the officer "gave [suspect] a lawful order to stop his aggressive assault on [victim] in an attempt to de-escalate him and use less force than the maximum allowed by law". We believe this is a broad interpretation of the term "de-escalation". While there is no universally accepted definition of "de-escalation," giving a lawful order to stop aggressive behavior is not generally considered de-escalation. The CIT Center at the University of Memphis provides specific skills related to de-escalation, including "voice tone, 'I' statements, reflection, summary, and basic courtesy." Providing a lawful order does not appear to fall in line with the skills normally associated with de-escalation. We will discuss with PPB how de-escalation is defined by the Training Division so that the audit may better address accuracies for 940 reviews. We also note here that in this event, conventional definitions of de-escalation would most likely not have been an option due to the aggressive actions of the suspect and the need for the officer to get the community member in custody. Although perhaps not an option for this incident, the indication that giving a lawful order constitutes de-escalation is not consistent with conventional thought on the topic.

We also found inaccuracies in some areas of coding that are potentially problematic. In one instance, the Chief's Office review indicated his Office was requesting additional investigation, though the dataset indicated no additional request was made. In another instance, the dataset indicated that the Chief's Office had found the force to be out of policy. A review of the documentation does not show the Chief's Office making such a finding for that case. We do not know whether these two occurrences were the result of coder error or were the result of downloading and merging data files. The data we were provided came in 11 separate Excel sheets (due to the high number of variables) which we then combined into a single SPSS file. There are common identifiers across the 11 sheets which we used to ensure cases matched across sheets. We are fairly certain that using the identifiers to combine the sheets resulted in a true single dataset, so we will need to discuss with PPB why the variables in question were found to be inaccurate. On the whole, however, our preliminary conclusion, based on an analysis of the sample data, is that the audit database being created by the Inspector's office appears to be reliable, with consistent codes being applied.

We have spoken to PPB about the audit process, issues that have come up, and whether the audit is feasible for every force event which occurs. The largest concern related to the force audits is the amount of time taken to complete them. After having completed some of these audits ourselves, we are well aware of the number of hours required to complete a single audit. For the coding, we only looked at the primary officer and the primary community member involved with the force event. In some cases, there are multiple officers and multiple community members, compounding the number of hours required. However, performing the audit on every single force event is not necessary to achieve

the ultimate goal of improving report writing, command reviews, and training. Thus, a sampling plan must be agreed upon between COCL and PPB for future use of force events.

A brief articulation of auditing and sampling theory is needed here to set the stage. Audits serve multiple purposes, but are generally used to identify problems, correct problems, and prevent future problems. The force event audits also serve these goals, with the added element of building public trust in the process of internal police accountability. Essentially, the force event audits is two-fold: initially, the audits should be used to accurately identify the nature and extent of problems with force reporting in the PPB, and report this information to the PPB administration and to the public in the interest of transparency and trust building. Subsequently, the audits can, and should be used as a means for deterrence, or perhaps more accurately, encouragement of proper documentation. These two separate purposes affect the number of cases that should be sampled in order to achieve their required goals.

For the first part, we believe the audits should focus not only on force events in general, but on specific types of force events at the supervisor, shift, and precinct level. This will uncover the full scope of any deficiencies in force reporting and supervisory review. Using sample size calculators to determine a representative sample size (including aspects of confidence intervals and margins of error), we estimate that PPB would need to audit nearly 75% of force events to provide a representative sample of force cases. While this would require a large degree of effort on the front end, the outcome would be beneficial. By providing a statistically reliable sample, the community can be sure that PPB is comprehensively incorporating the requirements of the Agreement. We also believe that the information gleaned from PPB's analysis would provide them with ability to identify areas of deficient report writing so that officers and supervisors could be better trained. By informing the administration of the types of errors and issues that are found in FDCR and 940 reporting, the PPB can make significant progress toward the goal of meeting the information requirements of the Agreement, as well as enhancing the accountability of the entire police force.

Once PPB and COCL are satisfied that the information required by the Agreement is consistently present in a reliable sample of cases, we view the purpose of the audit as changing to one of prevention or deterrence for the long haul. This auditing goal requires a smaller sample size because representativeness is not the main objective. Here, the theory (based on scientific principles of deterrence) is that officers and supervisors will be more inclined to accurately and completely report/review force incidents when they expect that their reports will be audited, and expect consequences for noncompliance with Bureau policy. Only a percentage of force reports need to be audited to maintain a deterrent effect, so long as the selection process is random, and so long as there are known and visible consequences for noncompliance. Therefore, while the sample size should be large enough that officers and supervisors feel their work has a good chance of being reviewed by the Inspector and other administrators, it would not have to be so large to conform to the requirements of confidence intervals and margin of errors. We will work with the PPB to establish a sampling plan that is reasonable in light of limited resources. First, the new force auditing system should be in the field long enough to remove any "bugs" and identify patterns of problematic reporting. Then, the sample size can be reduced to perform this deterrent function.

We wish to note here that the auditing system requires much more, when all is said and done, than accurately gathering data about compliance and noncompliance with force reporting requirements. The real question, once the system is up and running with integrity, is how the PPB handles and responds to

the information it receives about problems with force reporting and review process. If officers are making errors, what should be done about it? If first-line supervisors are making errors on the 940s, what should be done about it? If command-level personnel are making errors, what should be done about it? The question is not only what should be done about it, but what is being done about it? These are fundamental questions that the COCL will address in future reports. Clearly, PPB will need to establish systems of response that involve corrective action, and then monitor to ensure that changes have occurred.

Case Study – Force Event Command Review

While PPB is still in the process of setting up the force audit system, we present one case that may provide PPB insight into where force reporting may be improved. In our presentation of this case, we have removed any identifying information. The case involves officers chasing a suspect and ultimately engaging in a physical struggle with the suspect. The use of force at issue involves an officer holding a flashlight in his hand while punching the suspect in the head. We believe a review of the 940 process and PPB systems of accountability related to this case may assist in better refinement of the overall process.

The involved officer in this use of force case was holding onto the subjects arm while retaining his flashlight in one hand (this event occurred at night and the officer had his flashlight out while chasing the suspect). The officer stated that he did not wish to set his flashlight down for fear that it might be lost in the brush where the force event occurred. When utilizing his hand strike to the suspect, the officer retained his flashlight in the striking hand. The 940 related to this case indicates that no part of the flashlight struck the suspect during the force event.

In the 940, one command-level reviewer states that while the use of force did not technically violate policy, the reviewer stressed the word “technically”. The reviewer went on to say that the reasons for not setting the flashlight down were “weak”. Furthermore, another command-level reviewer states that the officer’s “concern about misplacing his flashlight in the brush should not have been a factor in his decision to keep it in his hand while punching [the suspect]” and that a solid object in an officer’s hand has the potential for additional force in the hand strike. However, even though multiple reviewers in the 940 chain of command determined that the officer had no or minimally valid reason for retaining his flashlight, the officer did not violate Directive 1010.00.

This case was also subject to the administrative complaint process. In a memo from Internal Affairs to the Professional Standards Division, the author states “[The involved officer] reasoned that he did not want to set his flashlight down for fear of losing it in the brushes. This is not a valid reason in itself for using a higher level of force, but [the suspect’s] alleged crimes, [the suspect’s] flight, and [the suspect’s] violent resistance still make [the involved officer’s] use of force a reasonable decision”. Thus in the administrative investigation, the officer was not found to have violated policy.

In this case, individuals in various stages of the system believed the officer should not have retained his flashlight. However, based on the wording of Directive 1010.00, the officer was found to have not violated policy. While PPB may revise the use of force policy (1010.00) to cover this situation, it would be impossible to write a completely comprehensive force policy to cover every possible situation. In the

event of similar cases in the future, we believe PPB might use Directive 315.30 (Satisfactory Performance) to ensure that force is properly managed. This policy requires “sound tactics and good decision-making during a confrontation” (2.1) and is evaluated based on “whether the member pursued the Bureau’s goal of resolving a confrontation safely and effectively...and whether there is valid reasoning in the member’s confrontation management decision-making” (2.6). As various reviewers in the above case found that the officer did not have a valid reason to retain the flashlight, we feel there should have been a determination as to whether Directive 315.30 was violated.

We do not have information on the prevalence of such types of incidents, and one case certainly does not display a trend. We therefore do not imply that most force cases are dealt with in the same way. However, in order to bolster their overall systems of force management and accountability, and to send a clearer message about the acceptability of certain behaviors, we believe it may be beneficial to consider potential violations of Directive 315.30 for all 940 After Actions.

Officers’ use of “sound tactics and good decision-making during a confrontation” should be a priority for the Portland Police Bureau. Thus, in any interaction where there is a use of force or any interaction which leads to a community member complaint, there should be an appraisal of the requirements of Directive 315.30. Procedural justice, which is highly valued by the community, is not about policy violations or law violations, but about fairness, dignity, and respect. We are not arguing that the Directive should be used for disciplinary reasons (e.g. suspension or dismissal). Rather, when officers do not use good “confrontation management decision-making” and when such poor judgment is repeated, they should be referred for Service Improvement Opportunities or supplemental training. This use of Directive 315.30 for targeted intervention could reduce the likelihood of bad decisions in the future and may ultimately reduce the likelihood of policy violations or excessive force. This would also hold officers accountable for their overall responsibility of acting professionally and following the spirit of the force directive in addition to the letter.

We also identify potential issues with EIS documentation found in the above case. The involved officer was briefed on his decision to retain the flashlight during the physical strikes. However, in the 940 reviews, there was no recommendation that this discussion be entered into the EIS Performance Discussion Tracker (PDT) until the final command-level reviewer. The first-line supervisor who compiled the 940 is the one who would have briefed the officer and therefore would be responsible for entering a comment into the PDT (Directive 345.00 – Employee Information System, Section 4.2). Had the recommendation to enter the discussion into the PDT not been noted in the 940, it is unclear to us whether this would have occurred. Furthermore, one reviewer notes inconsistencies in the reporting of the suspect’s injuries found within officers’ reports. The ability of PPB to have reliable information of injuries is necessary to their systems of accountability; however, no recommendation for PDT entry was made, even by the reviewer who noted the inconsistencies. Multiple layers of review is helpful for catching errors made at lower levels (and we see evidence of such success here), but some reporting problems slip through the entire system (also noted here). With any new system, we can expect oversights or mistakes. We believe that as the auditing system becomes more efficient, and reviewers become more familiar with the requirements, PPB should be able to detect and ultimately correct, most of the force reporting issues.

We do not raise these issues to chastise PPB but rather to assist them in their auditing of force events to increase overall accountability for reporting and shaping behavior. PPB must seek to determine

whether violations of any policy occurred during a use of force event. PPB must also ensure that the PDT is utilized consistently for the benefit of the entire agency. From the issues raised with this case, PPB can evaluate whether changes to the review process are needed to improve force reviews and, ultimately, generate a higher level of public trust.

Force Used Against People with Actual or Perceived Mental Illness

We received and reviewed data related to the use of force against people with actual or perceived mental illness. Our previous Outcome Assessment examined force against this population to an extent, though we focused only on Force Data Collection Report (FDCR) reportable force. Our earlier analysis did not capture non-FDCR force against people with actual or perceived mental illness. In accordance with Directive 940.00 (After Action Reports), Section 4.2, the Professional Standards Division (PSD) will “be notified immediately of any use of force against a person with actual or perceived mental illness”. This includes FDCR reportable force (e.g. Control Holds Causing Injury, Takedown, Impact Weapon, Baton Use, Pepper Spray, ECW, Beanbags, Pointing of a Firearm, K9 Bites, and Hobble) as well as non-FDCR reportable force. Examples of non-FDCR reportable force includes instances where the officer uses force to overcome resistance to handcuffing, grappling/wrestling where the officer does not take the community member to the ground, and control holds that do not result in injury but where the community member provides physical resistance and the officer applies physical or mechanical intervention.

The dataset provided to us covers the timeframe of August 1, 2015 to February 1, 2016 and includes a total of 168 cases where force was used against a person with actual or perceived mental illness. Of the 168 cases, 51 (30.4%) were FDCR reportable force events, with the remaining 117 (69.4%) not categorized as FDCR reportable force events. We were not provided descriptions of the force types which are not categorized as FDCR reportable force events. Therefore, we are unable to report the prevalence of non-FDCR categories of force.

We begin by reporting incident characteristics associated with force interactions that involved a person with actual or perceived mental illness. We were provided data related to whether the community member was armed with a weapon, the level of resistance offered by the community member, the disposition of the interaction, and officer attempts at disengagement. These requested incident level variables were in response to Par. 173(a)(i). Variables related to the reason for the interaction and the type of weapon the community member was armed with (if applicable) were not included for this dataset. We request that PPB include such variables for future reports.

For all of the cases (FDCR and non-FDCR reportable force), the community member was taken into custody in 33% of the interactions. In 37.5% of the interaction, the community member was taken to a medical facility and in another 20.2% of cases the community member was placed on a Police Officers Hold (POH). In four cases (2.4%) the interaction ended with disengagement. For the 51 FDCR reportable force events, the interaction resulted in the community member being taken into custody 41.1% of the time. In 39.2% of the FDCR reportable cases, the community member was taken to a medical facility, while in 7.8% of the cases, the person was placed on a Police Officer Hold. For all other dispositions, each occurred in a single instance. There were 117 instances of non-FDCR force, wherein 27.4% of the community members were taken into custody, 36.8% were taken to a medical facility, and 25.6% were

placed on a POH. Disengagement was used in the three of the cases (2.6%) and in five cases (4.3%), the community member was taken to a detox facility.

In 13.7% of all incidents, the community member was reported to be armed with a weapon, though the dataset does not indicate whether the weapon was a knife, a gun, or some other type of weapon. For only FDCR reportable events, the community members was reported to be armed in approximately one fourth of the events. For non-FDCR reportable events, the community member was reported to be armed in 8.5% of the events.

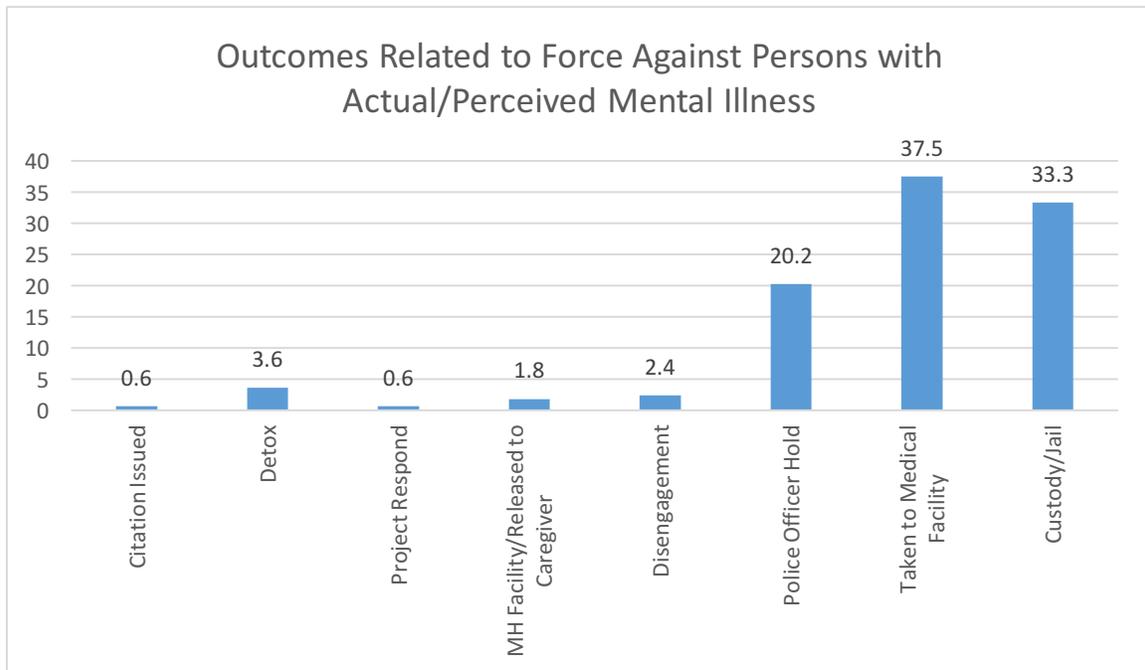


Figure 26 –Outcomes Related to Force Against Persons with Actual/Perceived Mental Illness (Percent of all force events) (N=168)

PPB also provided the level of resistance offered by the community member. In 58.9% of all cases, the data indicated the community member was being actively resistant. Active resistance is defined (in PPB’s audit methodology for force events) as the subject “tensing up, wiggling around, fleeing or attempting to flee, or thrashing”. In 22.0% of all force events, the community member was described as displaying assaultive resistance, defined as “punching, kicking, spitting, or biting”. In 4.8% of all force events, the community was described as displaying passive resistance, defined as the subject “going limp or becoming dead weight”. In 14.3% of all force events, the community member was not reported to have been resistant. All but one of the cases involving no resistance were non-FDCR reportable force. In the one case where FDCR reportable force was used on a person not resisting, the community member was armed with a weapon and the force used was pointing a firearm.

For FDCR reportable force, the community member was reported actively resistant in 60.8% of interactions and assaultive resistant in 37.3% of interactions. There were no FDCR reportable force

events where the community member was reported as being passively resistant. For non-FDCR reportable force, the community member was reported actively resistant in 58.1% of interactions, assaultive resistant in 15.4% of interactions, and passively resistant in 6.8% of interactions. In 19.7% of the interactions, the community member was not reported to have been resistant.

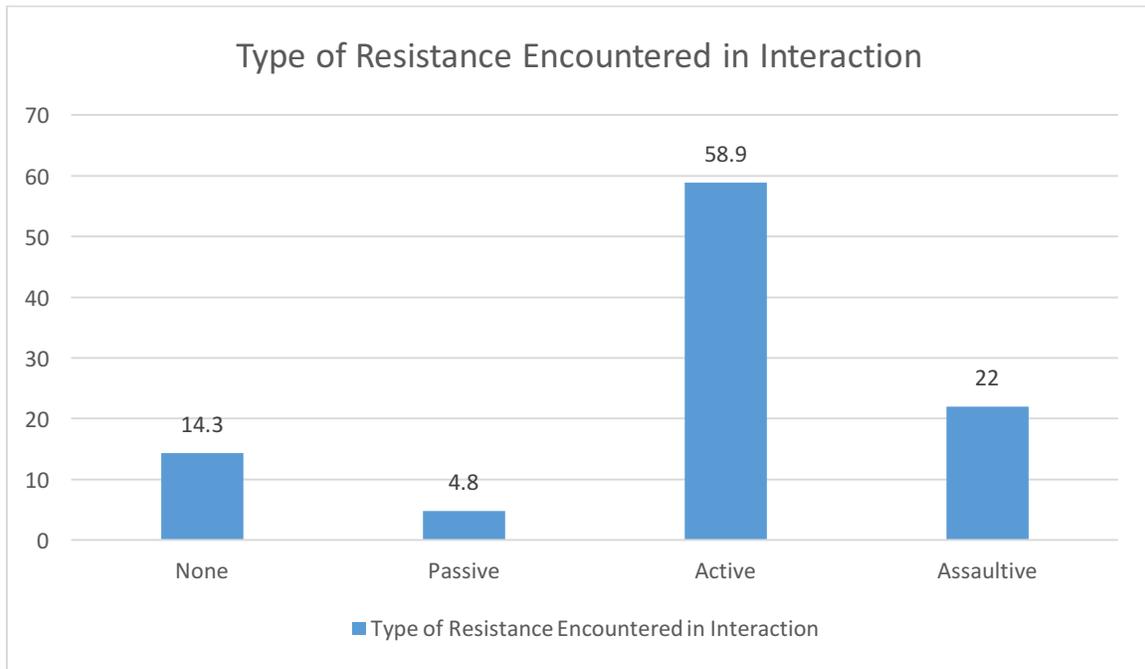


Figure 27 –Type of Resistance Encountered in Interaction (Percent of all force events) (N=168)

For specific force used during interactions involving persons with actual or perceived mental illness, we only have data on FDCR reportable force. For FDCR reportable force, Takedown was the force application used most frequently. In 26.2% of force applications against persons with actual or perceived mental illness, a Takedown was used. Furthermore, in 77.3% of force events in which a Takedown occurred, the Takedown was the only force used against the community member. For the 51 FDCR reportable cases we received related to a person with mental illness, no other individual force option was used in more than 5% of the cases. For the reporting timeframe, K9 Bites and Hobble were not used at all on a person with actual or perceived mental illness.

There were 11 instances where more than one force option was used on the community member, constituting 6.5% of the cases. In eight cases, two force options were used, while in two cases, three force options were used. In one case, there were a total of five FDCR reportable force options used on the community member. In that case the community member was armed with a weapon and was engaging in assaultive resistance.

ROBUST SYSTEMS OF COMMUNITY ENGAGEMENT

Current PPB Community Engagement Outreach Efforts

The opening paragraph to Section IX of the Settlement Agreement identifies the “significant community and City interest in improving PPB’s community relationships.” In this section we discuss ways that the PPB has engaged with the Portland community, as well as various methods being implemented or planned, to gauge the nature, extent, and quality of community engagement.

Upon review of materials and discussions with members of the Portland Police Bureau as well as members of the Portland community, the PPB should be recognized for a number of ways they have engaged in public outreach. PPB has utilized social media in various ways, maintaining a Twitter account, Facebook account, YouTube account, PPB website, and an email notification system (FlashAlert) to keep the community apprised of crime alerts, community events, and public relations materials. This type of social media engagement is substantially more than what we have observed in other police agencies. PPB also engages in types of community interaction which include awarding scholarships, supporting wrestling tournaments, collecting items for food and clothing relief, and various programs for Portland youth. Furthermore, PPB provides other opportunities for citizens to engage the police (such as advisory groups) and to learn about PPB operations (such as Police Cadets and the Police Reserve Unit). The COCL believes that if members of the community are not already familiar with the current avenues of community engagement provided by PPB, they should be encouraged to look at the PPB’s website for a list of PPB’s efforts (<http://www.portlandoregon.gov/police/30379>).

The above examples of PPB engaging with the community are related to PPB-sponsored groups, activities, and events. PPB also provided us with a list of community partners with whom they interact. We discuss the make-up of this community partner list in our analysis related to a “partnership methodology” below. PPB’s list of community groups, advisory committees, business and neighborhood associations, and other partners may well demonstrate the extent to which PPB is engaged with the community in non-PPB sponsored programs and activities. We discussed with PPB the importance of better defining the types of interactions officers have with the community for non-PPB sponsored events. For now, PPB has a system wherein an officer can indicate that he/she attended a community meeting or took time out to play basketball with neighborhood youth. These types of community interactions can be important for breaking down the “us vs. them” mentality. However, our understanding is that the system for officers to report informal community engagements is inconsistently used and therefore, any data would most likely be incomplete or unreliable. We do not wish to remove the spontaneity of such activities or create a deterrent for community engagement by creating “another form to fill out.” We look forward to discussing with PPB the feasibility of better documenting informal community interactions, perhaps through problem solving projects.

For more formal community engagement related to community groups, advisory committees, business and neighborhood associations, and other partners, we will discuss with PPB the potential for providing further details related to the community engagement. These may include documenting the Precinct involved, the demographics of the involved community, and the nature of the relationship, among other details.

Focus Group Formation

The COCL and COAB, with the support of the City, is in the final stages of planning focus groups scheduled to occur in the 2nd or 3rd quarter of 2016. The populations being recruited for focus groups include: police officers (ECIT and Non-ECIT), youth, LGBT community members, houseless community members, and three different groups of community members living with mental illness. The COAB asked that members of these communities be involved in the focus groups as they have been understudied regarding their interactions with the police. In the focus groups for police officers attention will be given to their perceptions on crisis intervention, ECIT Training (for ECIT Officers) and issues related to community engagement.

Funding for the focus groups intended to work with the communities listed above was obtained from the City of Portland and preparation for hosting the groups is in the planning stage. The specific methodology is still being planned with input from the COCL and COAB. The focus group questions include questions regarding respondents' perceptions of the police, their perceptions of police interactions with persons in mental health crisis, their perceptions of police interactions with members of their specific in-group. In addition, participants will be encouraged to suggest potential training of for Portland Police Bureau officers. COAB input, particularly from the Mental Health subcommittee, will be sought in the development of focus group questions,. At this time, we are determining when this work can be scheduled with the subcommittee. An update on the focus group progress will be included in our next Outcomes Assessment report.

Partnership Survey

We previously recommended the City engage in a Partnership Survey to solicit the perceptions of various businesses, groups, neighborhood associations, and other entities regarding their relationship with the Portland Police Bureau. Upon discussion with PPB and the City, concern was expressed that the Portland State University methodology used in 2013 did not capture the perceptions of all community partners or drill down sufficiently on specific community engagement issues. In that survey, the City and PPB received a majority of responses from neighborhood and business associations, two groups who already provide regular feedback to PPB. In 2016, information is being sought from groups whose voices are not regularly heard in the dialogue about police-community relations.

The City, PPB, and COCL met with Davis, Hibbits, & Midghall Inc. Research (DHM) to discuss a new methodology designed to yield more diverse input and viewpoints about PPB partnerships and engagement. This new strategy requires a mixed methods approach, including both a survey component and more in-depth interviews. The cost for the new methodology exceeds the amount of money budgeted for FY2015-2016. Thus, the Community Partner survey has been delayed until FY2016-2017, when funds can be appropriated.

With the remaining FY2015-2016 funds originally budgeted for the Partner Survey, the City plans to focus on community engagement with the Latino community. PPB acknowledges that the current relationship with the Latino community must be strengthened. The methodology for outreach into the Latino community is in the initial planning stage while PPB and the City consult with community leaders

in Latino neighborhoods. We feel that PPB's desire to strengthen its relationship with the Latino community is a positive step towards developing a comprehensive community engagement plan.

We support the City's efforts to increase the relationship with the Latino community, and we urge the City to provide sufficient funds for FY2015-2016 to examine police-community partnerships using the mixed methodology described above. Also, we encourage the City and COAB to seek additional input from the African American community and mental health providers as part of the focus group methodology described above.

In preparation for the future development of a PPB Community Partner methodology, we asked the Portland Police Bureau to provide us with a list of community partners with which they are currently affiliated. PPB provided us with a data set recognizing 351 community partners, which they had grouped into 18 different partner types. The three most common types of community partners are Neighborhood Associations (28.5% of PPB community partners), Crime Prevention or Public Safety groups (14.2% of PPB community partners), and Business Associations (13.4% of PPB community partners). These three partnership types account for 56.1% of PPB partnerships. Of the remaining 15 partnership types, no single type accounted for more than 7% of PPB partnerships, which suggests that PPB engages with a large and diverse set of community and organizational partners.

PPB and the City have indicated they routinely receive feedback from Neighborhood Associations and Business Associations. This suggests that the PPB should consider focusing its Partnership efforts on other types of partners. For example, PPB reports a total of 18 separate partners related to mental health and developmental disability advocacy groups. With the primary focus of the Settlement Agreement on persons experiencing (or believed to be experiencing) a mental health crisis, these are essential partners with whom to improve relationships and with whom to collaborate in pursuit of the broader goals of the Settlement Agreement.

Upon securing funds for the Community Partner methodology, we suggest the City coordinate with the COCL to identify the scope and content of the research and to refine the methodology. A more focused approach with limited resources would be beneficial.

Community Survey

In September of 2015, DHM submitted their report titled "Portland Police Community Relations Survey Research Report". This report was prepared in partial fulfillment of Par. 146(a) of the Settlement Agreement ("...the City, in consultation with COAB, will conduct a reliable, comprehensive, and representative survey of members of the Portland community..."). The survey items were created from a collaboration of COCL, COAB, the City of Portland, and DHM.

The survey was distributed to a random sample of Portland residential mailing addresses. To capture traditionally underrepresented populations, we instructed DHM to oversample areas of the city with higher percentages of African-American and Hispanic populations. Overall the final sample was fairly representative of Portland's actual demographics, although Hispanics were slightly underrepresented.

For all respondents, results were weighted to better reflect the true demographic proportions of the population. The overall sample size for the survey was 1,248 residents, constituting a response rate of

23% based on a total of 5,363 surveys being sent out. Using a sample size of 1,248, a margin of error for each question was calculated to be between $\pm 1.7\%$ and $\pm 2.8\%$. This means that for each question, the true responses may be a larger or smaller percentage than reported, though still within the 1.7% to 2.8% range.

While we report some of the results of the survey here, we urge the reader to refer to the full report provided by DHM for specific findings. This report has been posted to the COCL-COAB website (cocl-coab.org). For this Outcomes Assessment, we provide an overview of the Summary & Observations section found in the DHM report, as well as select findings which we feel are especially related to the Settlement Agreement.

The DHM report identifies nine (9) overall summary findings:

- The Portland respondents looked favorably upon the Portland Police Bureau when it comes to fighting crime
- Close to six in ten respondents reported they would be comfortable calling the police for assistance for family members with a mental health crisis (58%). Six in ten of those who do so are satisfied with their experience (60%)
- Respondents displayed concern about how the police performed in developing relationships with the community and specific groups within the community
- Respondents were largely unaware of improvements being made by the Portland Police Bureau
- Members of marginalized populations often had more negative perceptions of Portland police
- Hispanic respondents expressed specific concerns about police performance rather than one consistent viewpoint
- The African American respondents, in contrast, expressed consistently negative views about the Portland Police
- People who have ever received treatment for mental health problems, or have family members who have done so, were more negative about Portland Police
- Neighborhood matters: Respondents had different opinions about and experiences with the police based on where they lived

Overall, the respondents felt that Portland Police Bureau has legitimacy and is worthy of the community's cooperation. Examples of statements that garnered the most agreement were: "If I saw a crime happening in my neighborhood I would call the Portland Police to report it" (89%) and "I would work with the Portland Police to identify a person who committed a crime in my neighborhood" (88%). Approximately 59% of respondents agreed with the statement "The Portland Police are trustworthy" and approximately 56% of respondents agreed with the statement "When a Portland police officer makes a request, you should do what he/she says even if you disagree with it". These are indications that a slight majority of Portland residents trust the PPB to act as a legitimate government authority, although a substantial portion have concerns about the police.

Statements related to respondents' perceptions of the PPB interacting with the community did not attain the same levels of support. Less than 37% of respondents agreed with statements that Portland police treated people respectfully, regardless of their gender or sexual orientation, race, and mental

health status. Only 32% indicated that the relationship between the police and Portland community members was very good and 33% felt the PPB was well managed by professional leaders.

These results varied based on demographics, with White and Asian/Pacific Islander groups, older community members, and respondents living in SW or NW Portland having more positive perceptions of the police. These same demographic groups gave the PPB higher ratings on overall performance and officers' use of appropriate force (believing that officers did not use more force than necessary).

Respondents, on the whole, did not rate the PPB's job performance very high. For instance, less than 42% of respondents felt the PPB is doing a good or very good job of responding to mental health issues in Portland, building trust with the community, working with the community to solve neighborhood problems, being open and honest with the public, listening to community concerns, and being accepting/supportive of citizens who want to file a complaint against a police officer. However, approximately 55% felt the PPB was doing a very good/good job of fighting crime.

As indicated in the DHM summary of findings, many Portland community members were largely unaware of PPB's efforts to improve services in Portland. Less than 40% of respondents indicated they knew whether PPB was training officers to use force only when absolutely necessary, to help people when they are having a mental crisis, or to work with people from diverse racial and ethnic backgrounds. Approximately 23% of respondents indicated they were aware of efforts by PPB to hire more people of color and women as police officers. Further, less than 20% of respondents indicated they were aware of efforts by PPB to hold officers accountable who have violated Bureau policies as well as thoroughly investigating complaints against officers. On the whole, most respondents indicated they simply did not know whether or not PPB is doing any of these activities, with more than 50% of respondents for each statement indicating they "Don't Know". Regardless of whether respondents were aware of changes within the PPB, less than 40% were confident that any changes would have a lasting and positive effect on police-community relations.

Finally, for questions related to PPB's relationship with individuals living with mental illness, perceptions of respondents were mixed. For instance, 44% of all respondents perceived Portland police officers as using more physical force than necessary when dealing with people experiencing a mental health crisis. Approximately 1/3 of respondents (33%) disagreed with the statement that the Portland Police treat people respectfully regardless of their mental health status. Respondents were somewhat neutral of the police's response to mental health issues in the community, with 29% indicating they were doing a poor/very poor job, 31% indicating they were doing a good/very good job, and 40% indicating they were doing a fair job. In addition, approximately 61% indicated they disagreed with the statement that PPB may stereotype them because they have a mental health condition (though it is unclear what percent of respondents actually did have a mental health condition). Many respondents (39%) indicated they were aware of PPB efforts to train officers to help people when they are having a mental health crisis. Finally, respondents indicated they would be fairly comfortable (58%) calling the police for assistance if a family member was experiencing a mental health crisis. For respondents who indicated they had called for help for someone experiencing a mental health crisis, approximately 64% indicated they were satisfied/very satisfied with the help they received.

As we noted in our previous reporting, the relationship between community members and police on a personal level is one avenue for improvements in community engagement. One way to measure the personal relationship between community and police is to ask whether the community members know

the name of the police officer that works in their neighborhood. For Portland community members, only 7% knew the first or last name of the police officer who patrols their neighborhood. The low percentage of community members who know their neighborhood officers by name suggests the need for improvement in community engagement efforts.

Overall, the results of the survey indicate that the general Portland community perceives PPB to be doing well in some areas and is in need of improvement in others. The Portland community also appears to be, on the whole, unaware of changes that might be occurring within the PPB to improve services and reform the organization. These community survey findings should be viewed as a starting point for the PPB. These baseline results should be examined for their implications towards training, accountability, and dissemination of information regarding the PPB's efforts.

Many efforts have been made in Portland to gather information that will be used to help develop the community engagement plan (CEO Plan) as required by the Agreement. These efforts include, but are not limited to: public input at COAB meetings, the community survey, the PPB organizational survey (reported in our previous Outcome Assessment), the presentation to the COAB of prior and current outreach efforts by the PPB, and an initial request by the COAB Community Engagement and Outreach Plan Subcommittee (CEOPS) for more information from the Community Police Relations Committee (CPRC). In accordance with Par. 146 of the Settlement Agreement, more activity is required before the CEO Plan is drafted by the PPB. There is not currently a specific date for completion of the first draft of the CEO Plan, but the PPB and COAB are working diligently to gather information needed to inform the development of the Portland Police Bureau's Community Engagement Plan.

Contact Survey

One of the best ways to determine whether police engagement with community members has improved is to ask the recipients of police services. In October of 2015, we recommended that the City work with the COCL to implement a mental health contact survey and a community contact survey. After several meetings, we concluded that the best and most efficient course of action would be to combine these efforts into a single contact survey. This survey would seek feedback from all individuals who have had a recent contact with a PPB officer, including persons who have had contact due to a possible mental health crisis. The contact survey would provide a direct measure of how well PPB officers are engaging with various segments of the Portland community, as well as generate new information about the effectiveness of police training overall (par. 80) and mental health response training (e.g. par. 93).

The COCL team has considerable experience with this type of survey in more than 50 American cities and will continue to work with the City and PPB to develop the methods and logistics of data collection. The survey will measure procedural justice and related variables (voice, respect, neutrality, trust, empathy, competence, and social etiquette), use of force, resistance, and overall satisfaction with the encounter. We recommend that an independent third party manage the contact survey and the results. The PPB will need to collect phone numbers and email addresses on police reports to improve survey efficiency, reduce costs and increase response rates. We also recommend that PPB make a version of the survey available on line for caregivers and family members to provide feedback to PPB related to their experiences with PPB's mental health crisis response.

LIST OF ABBREVIATIONS

AAR: After Action Report (also referred to as 940)

AMR/EMS: American Medical Response/Emergency Medical Service

AS: Accountability Subcommittee (COAB)

BHRT: Behavioral Health Response Team

BHU: Behavioral Health Unit

BHUAC: Behavioral Health Unit Advisory Committee

BOEC: Bureau of Emergency Communications

CCO: Coordinated Care Organization

CEOPS: Community Engagement and Outreach Subcommittee (COAB)

CI Training: Crisis Intervention Training

CIT: Crisis Intervention Team

COAB: Community Oversight and Advisory Board

COCL: Compliance Officer and Community Liaison

CPRC: Community Police Relations Committee

CRO: Communication Restriction Order

DHM: Davis, Hibbitts, & Midghall, Inc. Research

DOJ: Department of Justice

DSUFCS: Data Systems, Use of Force, and Compliance Subcommittee (COAB)

ECIT: Enhanced Crisis Intervention Team

ECW: Electronic Control Weapons

EIS: Employee Information System

FDCR: Force Data Collection Report

HRC: Human Rights Commission

IA: Internal Affairs

IPR: Independent Police Review

LMS: Learning Management System

MHCRS: Mental Health Crisis Response Subcommittee (COAB)

PES: Psychiatric Emergency Services

POH: Police Officer Hold

PPB: Portland Police Bureau

PSD: Professional Standards Division

RU: Responsibility Unit

SCT: Service Coordination Team

SOP: Standard Operating Procedure

TA Statement: Technical Assistance Statement

TAC: Training Advisory Council

APPENDIX A – TECHNICAL ASSISTANCE STATEMENT (EIS)

We issue this Technical Assistance Statement to the City and PPB regarding the requirements set forth in Section VII of the Settlement Agreement, Employee Information System (herein referred to as EIS). This Technical Assistance Statement allows us to document our assessment of the current state of EIS and relevant consultation by the COCL to the Portland Police Bureau (PPB) and City. Such Technical Assistance Statements provide a more in-depth analysis of particular topics than what can be found in other COCL reports. Section VII of the Settlement Agreement reads as such:

116. PPB has an existing Employee Information System (“EIS”) to identify employees and design assistance strategies to address specific issues affecting the employee. See PPB Manual 345.00. PPB agrees to enhance its EIS to more effectively identify at-risk employees, supervisors and teams to address potentially problematic trends in a timely fashion. Accordingly, within 90 days of the Effective Date, PPB shall:

a. Require that commanders and supervisors conduct prompt reviews of EIS records of employees under their supervision and document the review has occurred in the EIS performance tracker;

b. Require that commanders and supervisors promptly conduct reviews of EIS for officers new to their command and document the review has occurred in the EIS performance tracker; and

c. Require that EIS staff regularly conduct data analysis of units and supervisors to identify and compare patterns of activity.

117. PPB agrees to collect data necessary to conduct these analyses at supervisor- and team-levels.

118. PPB shall continue to use existing thresholds, and specifically continue to include the following thresholds to trigger case management reviews:

a. Any officer who has used force in 20% of his or her arrests in the past six months; and

b. Any officer who has used force three times more than the average number of uses of force compared with other officers on the same shift.

119. Within 90 days of the Effective Date, PPB shall add one additional threshold to trigger case management review of any officer who has three uses of force in a one-month period.

120. Within 90 days of the Effective Date, PPB shall identify and train a second EIS administrator. This individual may be assigned to other tasks within the Professional Standards Division or as otherwise needed.

We provided our initial evaluation of these provisions in our 2nd Quarterly Report. This Technical Assistance Statement provides a focused evaluation of verbiage found in Paragraphs 116 and 116(c). While we retain the authority to further comment on other components of Section VII in later reports and TA Statements, this document looks at the following two components:

- *“PPB agrees to enhance its EIS to more effectively identify at-risk employees, supervisors and teams to address potentially problematic trends in a timely fashion.”*
- *“Require that EIS staff regularly conduct data analysis of units and supervisors to identify and compare patterns of activity.”*

We begin this TA Statement with an overview of EI Systems (also referred to as Early Intervention Systems in the literature) in order to provide background for readers unfamiliar with EI Systems. EI Systems within police agencies are designed to utilize data and trends to identify officers who may be at risk of violating policy or engaging in problematic interactions with the public, including use of force or excessive force. Such systems are intended to be a proactive tool to help officers at risk to avoid future problems that could jeopardize their careers. EI systems typically involve four components or processes: (1) the creation of one or more performance indicators which suggest that officers may be at-risk of additional problems (e.g. number of citizen complaints, use of force reports, civil actions, violations of policy, vehicle pursuits, etc.); (2) the application of thresholds to identify officers who are extreme on these performance indicators; (3) interventions with these officers to prevent or correct the problem (e.g. coaching, counseling, retraining); and (4) post-intervention monitoring to ensure that the risk or problem behaviors have declined (Walker & Milligan, 2005; Worden, et al, 2013).

Research has pointed to several issues that must be addressed in order for EI Systems to be successful. Officers must not view EI Systems as punitive. Rather, officers must be informed that EI systems are designed to help officers avoid problems down the road (i.e. save careers) and are meant to serve as training and coaching tools. If officers feel stigmatized by being labeled “at-risk” or a “problem officers,” morale may decline and possibly productivity. Hence, supervisors should pay strict attention to whether EIS feedback is having positive or adverse effects on officers. Also, EIS administrators and supervisors must understand, and the system must be designed to recognize, that officers who produce more citations and arrests typically receive more complaints because of their higher productivity levels. Further, research informs us that officers assigned to high-crime neighborhoods or special units are at greater risk of citizen complaints and force encounters than other officers. Thus, if EI systems are not implemented thoughtfully, there is a danger of labeling productive officers as problem officers.

Research does not give enough guidance about the specific factors that cause some officers to generate more force complaints or other problematic behavior patterns than other officers. Thoughtful consideration is necessary when selecting threshold criteria (Lersch, et al, 2006). However, aside from threshold criteria, there is no substitute for good supervision. Supervisors should get to know their employees and work with them to resolve issues and concerns at work. EI Systems should help to flag these employees, but in the end, the interventions by supervisors are what deserve the most attention and training. Each employee’s problems are unique and deserve a tailored response. Although policy violations or EIS flags must be documented, face-to-face interventions beyond written comments are essential for good supervision. Thus, while supervisors should be required to use EI Systems, they should not become reliant on them as substitutes for communicating in person with their employees.

This short review of EI Systems does not touch upon each issue related to such systems, but it does provide the context necessary for this TA Statement. We now move to discussing each of the two components of the Settlement Agreement noted earlier.

Par. 116: PPB agrees to enhance its EIS to more effectively identify at-risk employees, supervisors and teams to address potentially problematic trends in a timely fashion.

For this section of the TA Statement, we describe PPB's progress to date and items we feel continue to need improvement. To be clear, the PPB has expanded the use of EIS within the Bureau and has trained supervisors in the use of EIS. The PPB has included thresholds beyond what is required by the Settlement Agreement. There are eight (8) thresholds which trigger an EIS review: 3 traumatic incidents in 30 days, 2 commendations in 6 months, any allegation of criminal misconduct, 2 complaints in the same category in 6 months (e.g. discourtesy), 3 complaints in any category in 6 months, 3 use of force incidents in 30 days, use of force in 20% of his/her arrests ("force ratio") in the past 6 months, and using force 3 times more than officers working the same shift.

PPB has also expressed a desire to examine the content of discussion tracker comments for tone analysis (positive/neutral/negative). This is related to the notion that EIS should be used as a tool for positive feedback for officers. PPB has reported that there is a ratio of approximately 9 positive comments in the Performance Discussion Tracker to every 1 negative comment. We feel this ratio is in line with the intent of the Agreement. However, whether the absolute volume of constructive criticism per officer is sufficient to encourage officers to take corrective action regarding risky behaviors is uncertain and would require a more in-depth analysis.

More importantly, while we believe PPB has made significant initial efforts in enhancing EIS, we do not believe them to be in substantial compliance with the requirement to enhance EIS to a point where they might be able to "more effectively identify at-risk employees, supervisors and teams to address potentially problematic trends in a timely fashion". One step which would bring PPB closer to substantial compliance is improving the protocols for reviewing an EIS threshold break and distributing it for supervisor review.

The PPB's 2015 Q3 Update for Pars. 118-119 states that approximately 5% of the force alerts created were sent out for review. Both DOJ and COCL have expressed concern regarding the low percentage of RU Manager and Supervisor review for EIS alerts. As a response to our concerns, PPB drafted an "EIS Alert Process Explanation," detailing the how alerts are reviewed and sent on for RU Manager and Supervisor review. We have incorporated the information contained within this EIS Alert into this assessment.

As stated in our summary of EI Systems, there is no substitute for supervisory review. As indicated in PPB's EIS Alert Process Explanation, an officer's "shift lieutenant and/or sergeant are most likely to be the supervisors with the most day to day contact with the employee under review". Certainly, the EIS Administrators should review each flag to make sure that duplicates are not sent out and the system remains credible. The question remains why more flagged cases are not forwarded for review by supervisors after staff within the Professional Standards Division has completed its work. We are not suggesting that EIS Administrators are not diligent in their reviews. Our interviews with the EIS

Administrators indicate they are thoughtful, conscientious individuals. Our issue is with the process and the fact that the officer's supervisors are more familiar with the officer and are in a better position to assess the officer than are the EIS Administrators.

PPB indicates that EIS alerts that are not sent for an RU review generally fall into five categories: duplicate, transfer, singular use of force, data error, and other. We understand why duplications and data error are not sent for review, assuming no other issues are identified. However, we would need to be convinced as to why declinations as a result of transfers, singular use of force, and "other" are not better served by a supervisor review. Singular use of force may reveal the same implications as multiple uses of force within a certain timeframe. A threshold break as the result of a transfer may indicate different cultures within units. Or, in the instance of a promotion, the flag may indicate more field activity than desired for a supervisor. PPB's definition of "other" is vague ("none of the above criteria applied" – PPB Q3 Status Report). In September of 2015, 20% of all declinations were in this "other" category. Unless the "other" reasons are similar to those of duplication or data error, we urge PPB to send them for supervisory review.

Our interviews with PPB personnel and review of PPB documents have raised concerns with PPB's approach to managing EIS alerts. Namely, we are concerned that when there is an EIS flag, PPB primarily evaluates the events that triggered the alert rather than examining all potentially contributing factors. For instance, if an officer uses force three times in a one month period, the review of the EIS flag focuses on whether each of those force events was within policy and whether the number of events may be reasonable, rather than whether breaking the threshold may be a signal that work or personal problems may exist

This is not the rationale behind EI Systems. The point of EI Systems is to cast a wider net than necessary, allowing police agencies to focus their attention on a profile of officers who are potentially problematic. Supervisors for these officers should then evaluate them not only on their professional conduct but on a personal level as well. This includes personal information known to the supervisor (e.g. unusual work habits, stress outside of work due to marital, alcohol or financial problems), personality characteristics, and other potentially contributing factors. For individual cases, evaluation would benefit from reaching beyond the elements housed within the EIS.

We know that EI Systems will be ineffective if they rely entirely on a sterilized equation (with only a few risk factors) attempting to accurately pinpoint who will offend and who will not. However, PPB has the opportunity to enhance their EIS to a point where it can, quantitatively, identify a profile of a hypothetical person who is most likely to get in trouble, thereby yielding preventative information for all supervisors. Along these lines, we recommend that PPB seek assistance from researchers who are currently working on this issue to refine the data analytics necessary for prediction (e.g. University of Chicago). We acknowledge that this field is in its infancy, but cutting edge work could place the PPB on the forefront of policing.

On the qualitative level, another justification for increasing the number of alerts that receive supervisory review is the potential adverse effects of use of force events on officers. PPB correctly acknowledges that lethal force events are critical incidents which may affect an officer psychologically. However, even the pointing of a firearm or a physical confrontation can be critical incidents and have negative effects on an officer. Multiple uses of force in a short window of time may also indicate a cause for concern for the officer's psychological well-being. For instance, if an officer is required to use

force against a community member, the situation may result in the officer being “on-edge”. Regardless of whether the officer is within policy to use force, being in a state of heightened anxiety may have future negative consequences. This is something which may not be apparent to the EIS administrators as they review force events individually, but may be known to the officer’s supervisor.

We are recommending that PPB revise their review protocols to increase the number of supervisory reviews for an EIS flag and that such reviews go beyond the elements of the flag. We recommend that PPB create a new standard for sending EIS flags for review. In the EIS SOP provided by PPB, the “decision to send an alert to the RU should be based on the administrator’s best judgement about whether the employee could stand to gain something from a review and intervention at the RU level.” We feel PPB has it backwards in their tone and standpoint. The decision to *decline* sending an alert to the RU should be the exception to the rule, not the norm. Rather than the criteria being that “the employee could stand to gain something”, reviews should be declined only in situations where the employee stands to gain *absolutely nothing*. We feel this flipping of standards will result in an increase in the number of alert reviews as well as an increase in the quality of reviews.

We are also recommending that PPB begin tracking EIS flags in a database so that each decision point in the process can be evaluated. Currently, PPB does not have such a database. This database should indicate the reason for the flag, the decision to send the flag for supervisory review, what occurred during the review process, and what the disposition of the review was (among other data points). We will be working with PPB in the very near future about the creation of such a database. This database would inform a flow diagram that displays the disposition of cases that flow through the EI system. Such information would help to educate the Bureau and the community.

Par. 116(c): Require that EIS staff regularly conduct data analysis of units and supervisors to identify and compare patterns of activity.

Our technical assistance for this subsection of Par. 116 relates to our interpretation of the phrase “identify and compare patterns of activity”. PPB has indicated to us they believe their responsibilities under this subsection relate to patterns of activity of EIS utilization. Thus, their analysis has included how often a supervisor uses EIS, how many people the supervisor has looked up, what has been entered into those officers’ PDT, and whether the supervisor input is determined to be positive, negative, or neutral. We agree with PPB that this type of analysis is important and we urge PPB to continue these analyses.

We do not agree with PPB that these analyses alone satisfy the letter and intent of the Settlement Agreement, nor are these analyses alone consistent with the intent of EI Systems. We provide our rationale step-by-step so that PPB may better understand our interpretation. We anticipate a clarifying discussion between PPB, DOJ, and COCL in the future.

Subsections (a) through (c) of Par. 116 are housed within the overarching objective of Par. 116. Specifically, “PPB agrees to enhance its EIS to more effectively identify at-risk employees, supervisors and teams to address potentially problematic trends in a timely fashion. *Accordingly*, within 90 days of the Effective Date, PPB shall...” (Emphasis added). Through the use of the term “*accordingly*”, the

Settlement Agreement implies that each subsection is designed to achieve the goal of “effectively identify[ing] at-risk employees, supervisors and teams to address potentially problematic trends”.

As it relates to “at-risk employees”, subsections (a) and (b) requires supervisors to examine EIS records of “employees under their supervision” and “officers new to their command”. Under these two subsections, supervisors can compare employees on the individual level. An officer under the command of a supervisor can be compared against all other officers under the same command. This is the first level of review designed to “address potentially problematic trends” and requires careful analysis on the part of the supervisor.

PPB has made the argument that subsections (a) and (b) only require commanders and supervisors to “review EIS records” and “document the review has occurred in the EIS performance tracker”. This literal interpretation does not include a sense of purpose. The purpose of subsections (a) and (b) is found in the overarching objective – “identify at-risk employees”. Inherent in PPB’s ability to do this is the requirement of comparison. Simply reviewing EIS and documenting the review does not achieve this.

Par. 116 (c) expands the identification of potentially problematic trends to a second tier – that of the unit and supervisor. This requires a higher level of review, thus the responsibility is assigned to EIS staff. This 2nd level of review compares units and supervisors against other units and supervisors within the PPB. Thus both levels of review are achieving the same overarching objective of Par. 116.

Having explained the rationale behind our interpretation of Par. 116 and its subsections, we may now return to the issue at hand: the phrase “compare patterns of activity”. We contend that the comparison mentioned in subsection (c) relates to the second tier of comparison discussed above. Examining how often supervisors access EIS (while important) does not achieve this. We therefore recommend PPB begin conducting “data analysis of units and supervisors to identify and compare patterns of activity” as they relate to issues of force, accountability, and other matters which led to this Settlement Agreement.

We also contend that PPB’s interpretation of “patterns of activity” cannot feasibly be applied to “units”. PPB can, and has, examined supervisor patterns of EIS utilization. Supervisors are individuals who are tasked with utilizing EIS. Units are collective bodies and as a collective body cannot access or use EIS. To date, we do not have any information indicating PPB has monitored EIS data for problematic behavior at the unit or team level. Such analysis would help to identify a rogue unit or team whose members may all have performance indicators that are in line with fellow members, but signal problems when compared to other units. This is an important issue, since there is reason to believe that special units (in other cities) have a history of problematic behavior that is due in part to their difficult assignment and perhaps to reduced accountability. Also, across districts and shifts, there may be differences in officer-level conduct that can be attributed to differences in styles of supervision and leadership.

Summary

Our interpretation of the Settlement Agreement is consistent with the principles of EI Systems as they were initially conceived. Our recommendations for PPB to enhance their EIS are derived from a

vision of a comprehensive review from a number of different entities. As a general practice, supervisors are required to review employees under their direction. A qualitative comparison of each employee to all others under their review allows supervisors to identify which employees might benefit most from additional guidance. In addition to this, EIS flags would be forwarded to each supervisor so that there is another layer of identifying potentially problematic officers. In addition, EIS administrators, with the help of researchers, can develop a profile of at-risk officers, allowing for easier identification in the future and preventive education for supervisors. Apart from individual employees, EIS staff is required to compare supervisors and units to identify higher level differences which may contribute to problematic behavior. Through the combination of these reviews, a wide net is cast to reduce the likelihood of problematic behavior.

In conversations with us, PPB has expressed reservations that EIS can predict who will be a problematic officer and who will not be. At the individual level, we agree this is a problem for quantitative research, and the accuracy of prediction is increased by looking at a wide range of variables. Cutting edge research is working on that issue now and we encourage the PPB to be part of this new effort. In the meantime, supervisors have a wealth of qualitative information at their fingertips that can be used to make such idiosyncratic predictions.

In the absence of individual-level prediction, we maintain that EI Systems in general and PPB's EIS are capable of identifying a profile of individuals who are more likely to engage in problematic behaviors (Research has already documented enormous differences between officers in rates of citizen complaints, etc.). By creating a sketch of the at-risk officer, the PPB can educate supervisors and create generic strategies for identifying and intervening through coaching, education, and training. The function of EI Systems is not to prevent every incident of misconduct, but to reduce the likelihood of such events overall and our recommendations to PPB in this TA Statement are designed to achieve such reduction.

Finally, we note that a critical component of EIS is intervention with employees. While taking action with employees is not central to the language of the Settlement Agreement, there is no need for EIS if it cannot be helpful with intervention. Providing guidance to employees is essential for preventing risky behavior. The intervention dispositions should be well documented in a database and flow diagram, as noted above (e.g. counseling, training, employee assistance program, other interventions, or no intervention). . Researchers and practitioners have failed to take this component seriously when it is the most important to success. This is a topic for future discussion.

A solid EIS program that is scientifically rigorous and employs sound management principles should communicate to the public that the police are accountable and able to police themselves internally. By monitoring police discretion on the streets, the Bureau can reduce inappropriate behaviors, increase procedural fairness, reduce complaints, and encourage a guardian mentality during police-community encounters. The PPB has made good progress by developing and implementing its Employee Information System, and we look forward to the continued evolution of this initiative.

References

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Walker, S. & Milligan, S. (2005). *Supervision and Intervention with Early Intervention Systems: A Guide for Law Enforcement Chief Executives*. Washington, DC: Police Executive Research Forum.

APPENDIX B – TECHNICAL ASSISTANCE STATEMENT (ECIT TRAINING)

We issue this Technical Assistance Statement to the City and PPB regarding their requirements set forth in Section VI of the Settlement Agreement (Crisis Intervention), specifically Par. 102 regarding CI-Team member training (herein referred to as ECIT training). This Technical Assistance Statement allows us to document our assessment of the current state of ECIT training for the benefit of the City, PPB, and the community. Such Technical Assistance Statements allow us to go into greater detail than is possible in our quarterly reports and semi-annual assessments. Section VI, Par. 102 of the Settlement Agreement reads as such:

102. PPB shall specially train each C-I Team member before such member may be utilized for C-I Team operations. PPB, with the advice of the ABHU Advisory Committee, shall develop such training for C-I Team members consistent with the Memphis Model.¹

Between November 17 and November 20, 2015, members of the COCL team observed the entire 40 hour ECIT training provided to members of the Portland Police Bureau over a four day period. Each day involved approximately 9 hours of curriculum comprised of classroom lecture, group table top exercises, consumer and family panels, site visits, role play scenarios, and discussion groups. Members of the COCL were joined in our observation by a representative from the DOJ and a representative from the COAB.

Overall, we find the majority of content delivered during the training was relevant, well organized, and delivered effectively. The curriculum covered a range of topics, most of which was very similar to the Memphis Model of CIT training, with some advanced and additional content accounting for the slightly different role played by ECIT officers and the prior CI-training they had already completed. For the benefit of the reader, we are attaching the training schedule for the week which contains the date, time, topic, instructor, and location for each class. As the schedule suggests, training content was delivered by PPB personnel and a variety of content experts from stakeholder agencies and the community.

Before providing comments on specific segments of the training, we offer some general overall observations and feedback:

1. While handouts were distributed to officers for material presented on Thursday and Friday, to our knowledge, officers were not provided with handouts for ALL of the lecture presentations included in the training or any type of binder of course materials. Additionally, very little notetaking was observed during these segments of the training. Given the amount of detailed information covered during the training, hard copies of the materials (e.g. PowerPoint handouts) would help to reinforce the information, facilitate notetaking, and improve retention. **Thus, we recommend that in future trainings, officers**

¹ Since the authoring of the Settlement Agreement, the names of groups have been changed. C-I Team is now referred to as ECIT. ABHU is now referred to as BHU. The updated names will be utilized in this TA Statement.

be provided with a training binder that includes all training materials, resource information and notes pages.

2. Many CIT programs include a graduation ceremony at the end of the CIT training week, often with the agency Chief or Police Commissioner awarding completion certificates and CIT pins/patches. This underscores the importance of the role the newly trained officers play in the department's mission to provide effective, safe and respectful responses to persons experiencing mental health crises. It is a symbolic and important gesture. **We recommend that PPB include a graduation ceremony in future ECIT trainings.** We recognize that it is a very packed 40 hour week. However, several training days ended 30 minutes early. Thus, there is likely room in the schedule for an hour at the end of the training for this ceremony.
3. We are concerned that the PPB did not plan for the full and complete observation of the ECIT training by members of the COCL, DOJ, and COAB. For instance, the COAB representative that observed training was informed that she would not be able to attend the site visit that the COCL and DOJ were able to attend. We remind the PPB that the COAB has the authority to independently assess the implementation of the Settlement Agreement. **We therefore recommend PPB allow COAB members the same opportunity to observe the full and complete training that was afforded to COCL and DOJ.**

Comments on specific days/sessions

Day 1 included introductory material, an overview of mental health diagnoses, the peer recovery movement, trauma informed care, resource information and family and consumer panels. Classroom lectures were provided by content experts from several service agencies. The panels of persons with lived experience of mental illness and family members are a staple of Crisis Intervention Team training that provides opportunities for officers to interact with members of these groups in a non-crisis situation and develop a better understanding of their experiences and concerns. Research suggests that the contact provided in such panels is the most effective approach to reducing stigma and increasing empathy, and hence, these panels are considered among the most important components of CIT training.

We observed a somewhat unfortunate exchange during the family panel when an officer challenged a family member's concerns of disparate racial treatment. In another instance, an officer suggested that consumers and family members must know what to tell a BOEC operator for a better police response. While these types of discussions are important to have, the purpose of the panels is not for officers to debate the experiences of the panel members. Rather, it is for them to gain a better understanding and appreciation for the experiences of the panel members. **In future ECIT trainings, instructors and panel facilitators should review the purpose of the panels and some ground rules with the class prior to panels.**

We also noted that, because the family member panel was right before the lunch break, officers seemed anxious to leave and may not have asked as many questions as they might of if the session was scheduled at a different time. **Another option would be to bring in lunch the day of the consumer and**

family panels and ask panel members to join the officers for lunch discussions. Again, we recognize this would require funds and that officers may not want to “work” through lunch. However it is an option to explore.

Day 2 included content on risk assessment, suicide, psychosis, mental status indicators and mental health facility response. Content was delivered by PPB BHU staff and content experts from Cascadia Behavioral Health. Additionally, officers went on site visits to mental health service provider agencies.

In general, the content of training was relevant and well delivered. For the site visits, officers went in groups to one of the following: a walk in/drop off \ center, residential treatment facilities, Project Respond, NorthStar Clubhouse and the Multnomah County Crisis Line. We feel each of these sites provide a wealth of information for ECIT officers. Upon returning from their site visit, each group of officers gave oral reports on a set of assigned questions. This occurred late in the long training day and we noted a lack of engagement during the reporting back period. **We recommend that if time allows, the groups should report back on their experiences the following morning when everyone is fresher. An alternative approach to exposing officers to more than one site would be to make visiting one or more sites in their assigned precinct (pre-arranged by BHU staff) an assignment for officers to complete within the six months following ECIT training completion.** We are aware that this has occurred organically in at least one case, with officers developing a relationship with NorthStar following their ECIT training.

Day 3 included content on crisis response, crisis communication skills, tools and techniques, information on Lines for Life and group exercises related to crisis communication skills. All of the class room lecture, except for the Lines for Life presentation, was provided by PPB Sgt. Troy King. The material was excellent, well organized and Sgt. King kept the group effectively engaged. Trainees were provided with handouts of PowerPoint slides and a few took notes. The communication skills exercises were well designed and facilitated and the officers were very engaged. No concerns were noted on the day’s content or delivery.

Day 4 included content on patrol and behavioral crisis tactics, a table top exercise and role play scenarios in the scenario village. While the lesson plan content on patrol tactics included extremely important content, the presentation of the material could have been better structured. Officers were provided with a handout, but the instructor was working from a different handout and directing the group to page numbers that did not correspond with their material. Use of PowerPoint slides with the material outlined would have helped orient the audience. This was very important material that included the ECIT role and responsibilities, use of force, disengagement, and ROADMAP concepts. Many topics were not fully explained; rather, the instructor indicated that he assumed most officers knew the material rather than reviewing it. **We recommend more structured and thorough coverage of this content in future ECIT trainings.**

Officers were very engaged in the Lukas Glen table top exercise and the scenarios were well designed and facilitated. We were particularly impressed by the role play scenarios, which included a variety of settings and situations related to mental health crisis. Trainees took these very seriously and even those not directly engaged in the scenario actively participated by writing questions and suggestions on index cards (this was an excellent approach to increase engagement). The extended time allotted to the scenarios allowed officers to experience the discomfort of being “in the muck” and

working through the situation. This appeared to be an extremely valuable aspect of the scenarios-as officers practiced using time to reach a desired outcome. This is a key crisis intervention skill that is important to practice. The debrief of each scenario from both the clinical and policing perspective provided officers with very useful feedback. We have only two recommendations related to these scenarios. First, the actors involved in the scenarios were all Caucasian. We recognize many of the skills needed to effectively respond to a mental health crisis are the same regardless of the race of the person in crisis. However, there are differences in culture and context that may impact how a crisis encounter unfolds. **Thus, we recommend PPB work to incorporate scenarios that capture the culture and contexts relevant to diverse communities and that may also trigger implicit bias. We cannot point to a specific model for doing this—however, we recommend seeking input from the BHUAC, the COAB, and other community groups.**

Finally, while all participants were very engaged during the scenarios, many officers did not get the opportunity to directly participate due to only one scenario being run at a time. We do **not** recommend that scenarios be shortened to allow more officers to participate, as the opportunity to spend time "in the muck" is a strength of the scenarios as implemented. **Rather, we recommend breaking the officers into groups and running several scenarios at once to provide additional opportunities for officers to practice skills.** We recognize this would require additional training and clinical staff.

Evaluation

We have several concerns about the approach to evaluation of the training.

1. Officers were asked to complete two training evaluation forms, one that covered days one and two and one that covered days three and four. These forms asked officers to rate the usefulness of the training content and the extent to which they perceived the training to have enhanced their knowledge and skills. Our primary concerns about the evaluation forms is related to the introductory instructions. The forms indicated that completing the form is voluntary, that officers could choose to skip any question, and that officers' responses could be subject to public records requests. Given that the purpose of asking officers to complete the forms was to evaluate a training that they completed as part of their job, not research for generalizable knowledge, these statements are completely unnecessary and could actually bias officer responses. Introducing the idea that someone outside the PPB might look at their answers implied that certain answers would be unacceptable or that somehow their identity might be revealed. Neither expectation should be created. **We recommend these statements be removed from future training evaluation forms.**
2. Dr. Watson consulted with PPB training evaluation staff prior to the training and encouraged them to include measures of knowledge and attitudes about individuals with mental illnesses as a pre and post-test as one approach to assessing training impact. PPB created a knowledge measure tailored to the content of the training. That test appears to be well constructed. Dr. Watson suggested several brief attitude measures that have been validated and used in prior evaluations of CIT trainings. Instead of selecting one of the validated measures, PPB apparently selected three individual items from the measures. How the specific items were selected is

unclear. We were not provided with the selected evaluation measures until after the training thus, we were not able to provide further consultation on final versions and have concerns that the attitude measure may not capture the impact of the training on officer attitudes as well as a validated measure would. **We would recommend inclusion of one of the validated scales or at minimum rationale for the items selected for inclusion.**

3. Based on the copy of the knowledge and attitude measures provided to COCL, it does not appear that PPB can identify individual officer scores. This is appropriate for the pre-test and attitudes measures, but **we recommend that PPB develop a graded course exam to ensure officer mastery important course content. Likewise, skills assessment would ensure officers left the course with the requisite competencies to function as ECIT officers.**
4. We have been informed that trainees will be asked to complete a follow-up survey in March. Dr. Watson offered to provide feedback on the planned survey, but has not been provided with a copy. **We strongly encourage PPB to take advantage of COCL consultation prior to implementing these evaluation measures so that concerns can be addressed early on.** We look forward to the ECIT training evaluation report as well as to implementation of the later stages of the Kilpatrick model that examine the impact of training on 3) behavior and 4) results.

Final Comments

Although the contents of this Technical Assistance Statement only contains items which we feel need to be improved upon by the PPB, overall the ECIT training was well executed and generally consistent with the Memphis Model training. When a rigorous evaluation plan has been implemented, we will know more about whether this curriculum is reaching most of the officers who participate in the training and where the curriculum needs to be strengthened to improve the social competencies of the students. Our role as COCL is to ensure that all facets of the ECIT training are in line with the Settlement Agreement and with our understanding of theoretically sound, evidence-based pedagogy. The issues contained within this TA Statement need to be addressed by the PPB. However, we feel all other aspects of the ECIT training were done very professionally and PPB should be commended. We look forward to working with PPB on the issues contained in this TA Statement in the future.

2015 ENHANCED CRISIS INTERVENTION TEAM TRAINING

****DRAFT** November 17-20, 2015 40 Hours ** DRAFT****

| TUES/Nov 17 | HRS | Connector To Resources | INSTRUCTORS | LOCATION |
|--------------------|------------|--|--------------------------------------|-------------------------|
| 0700-0730 | 0.5 | Course overview/ECIT program intro | OFC B-Dehnert/Dr. Liesbeth Gerritsen | 14912 NE Airport Way |
| 0730-0800 | 0.5 | History of Mental Health Treatment | Kay Peterson, Cascadia | PPB TF Room 1927 |
| 0800-0900 | 1 | Overview of Mental Health Diagnoses | Kay Peterson, Cascadia | PPB TF Room 1927 |
| 0900-0930 | 0.5 | Peer Recovery Movement | Ann Kasper, Peer Support Specialist | PPB TF Room 1927 |
| 0930-1030 | 1 | Consumer Panel Discussion | Ann Kasper, Peer Support Specialist | PPB TF Room 1927 |
| 1030-1100 | 0.5 | NAMI Overview | Patricia Tenyck, NAMI | PPB TF Room 1927 |
| 1100-1130 | 0.5 | EASA Overview | Leticia Sainz, EASA | PPB TF Room 1927 |
| 1130-1230 | 1 | Family Member Panel Discussion | Shannon Pullen, BHUAC | PPB TF Room 1927 |
| 1230-1330 | 1 | LUNCH | | |
| 1330-1530 | 2 | Trauma Informed Care | Brian Jacoby, Cascadia | PPB TF Room 1927 |
| 1530-1630 | 1 | CJS Mental Health resources | Katie Burgard, MCDL MH | PPB TF Room 1927 |
| 1630-1700 | 0.5 | Community Mental Health Resources | Meghan Chaloupka, CCC | PPB TF Room 1927 |
| WED/Nov 18 | | Assess Risk Level | | |
| 0700-0800 | 1 | Mental Health Risk Assessment | Brian Jacoby, Cascadia | PPB TF Room 1927 |
| 0800-0900 | 1 | Psychosis and Communication | Kay Peterson, Cascadia | PPB TF Room 1927 |
| 0900-1000 | 1 | Mental status indicators | Kay Peterson, Cascadia | PPB TF Room 1927 |
| 1000-1130 | 1.5 | Suicide Intervention | Dinah Brooks, Casadia | PPB TF Room 1927 |
| 1130-1200 | 0.5 | Mult Co Threat Advisory Team | SGT Bob McCormick, BHU | PPB TF Room 1927 |
| 1200-1300 | 1 | LUNCH | | |
| 1300-1500 | 2 | Site Visits* | small group assignments (6) | |
| 1500-1600 | 1 | Site visit backbriefs* | small group assignments (6) | PPB TF Room 1927 |
| 1600-1700 | 1 | Mental Health Facilities Response | OFC Bruner-Dehnert, BHU | PPB TF Room 1927 |
| THUR/Nov 19 | | Crisis Response Resource | | |
| 0700-0900 | 2 | Anatomy of a Successful Crisis Call | SGT Troy King, PPB CNT | PPB TF Room 1927 |
| 0900-1100 | 2 | Crisis Communication Skills | SGT Troy King, PPB CNT | PPB TF Room 1927 |
| 1100-1200 | 1 | LUNCH | | |
| 1200-1300 | 1 | Lines for Life resource | Lines for Life | |
| 1200-1600 | 3 | Crisis Communication Skills Exercises | Morgan Leets, Lines for Life | PPB TF Room 1927 |
| 1600-1700 | 1 | Tools & Techniques for Crisis Calls | SGT Troy King, PPB CNT | PPB TF Room 1927 |
| FRI/Nov 20 | | Patrol Tactics | | |
| 0700-0800 | 1 | Behavioral Crisis Calls Tactical Options | OFC Harris & OFC Foxworth, TRG | PPB TF Room 1927 |
| 0800-0900 | 1 | Lukas Glenn Table top Exercise | OFC Harris & OFC Foxworth, TRG | PPB TF Room 1927 |
| 0900-1130 | 2.5 | Scenarios | OFC Harris & OFC Foxworth, TRG | PPB TF Scenario Village |
| 1130-1230 | 1 | LUNCH | | |
| 1230-1630 | 4 | Scenarios | OFC Harris & OFC Foxworth, TRG | PPB TF Scenario Village |
| 1630-1700 | 0.5 | Course completion & evaluation | LT Hager / Command Staff | PPB TF Room 1927 |

***Site Visits**

Multco Crisis Line
 Project Respond West Office
 Cascadia SRTF Arbor Place
 Northstar
 Golden West
 Urgent Walk In Clinic