V. POLICE ENCOUNTERS WITH INDIVIDUALS WITH MENTAL ILLNESS OR SUICIDAL IDEATION

Our review included six instances in which members of the PPB encountered individuals with mental illness or persons actively pursuing suicide. In some of those cases the subjects' mental illness or suicidal ideation was known to the officers beforehand, sometimes it was not. In every case, however, that illness added a heightened level of unpredictability and associated risk to the encounter. What each actor brings to an encounter between a police officer and a person suffering mental illness will differ. On the side of the police officer, there will be wide variations in age, experience, maturity, culture, training, attitudes toward those with mental illness, and opportunities to exercise skills developed in training. On the side of the individual confronted, there too will be the same wide variations in background, including attitudes or assumptions about the police, and varying capacities to understand and assimilate instructions and to bring themselves into self-control. These are not easy cases from any perspective.

Many law enforcement agencies — including Portland — have the capacity to provide a specialist response to incidents involving individuals with mental illness. In the PPB, this specialist response is provided by Crisis Intervention Team (CIT) officers. CIT officers receive specialized training in dealing with individuals with mental illness or suicidal ideation, and learn to slow down and de-escalate incidents, negotiate with subjects, and respond more flexibly. According to the PPB's CIT Coordinator, 193 PPB officers have received CIT training since it was introduced in 1995, and approximately 25 percent of patrol officers are currently CIT-trained.

Portland's CIT model was patterned after the one used by the Memphis Police Department, which is often-cited as an example of best practice in the area.[219] In November 2000, *The Journal of the American Academy of Psychiatry and the Law*

[219] Memphis is a city of approximately 630,000 residents, and its police department employees some 900 uniform patrol officers. Of that, the Department of Justice reported that 213 have received critical incident training. *Bureau of Justice Assistance Bulletin from the Field Practitioner Perspectives,* July 2000.

published a study of Memphis's CIT model.[220] As in Portland, the Memphis CIT training takes 40 hours and "focused on scenarios developed from actual incidents. These scenarios allowed for the illustration of crisis de-escalation principles and included intensive feedback from fellow officers and mental health professionals."[221] Four distinct benefits flowed from implementation of a CIT model in Memphis where, because over 25 percent of all uniformed patrol officers had been trained, there were CIT-trained officers available on every shift in every precinct:[222]

1. *Timely response.* In 100 randomly selected cases, a Memphis CIT officer arrived in fewer than ten minutes, "with the great majority of those calls responded to in under five minutes."
2. *Decreased need for SERT or SWAT teams.* De-escalation training in Memphis decreased the need for such teams. The more instances in which CIT was used, the fewer instances when Memphis's SWAT team was called out.
3. *Decreased Officer Injuries.* In Memphis, officer injuries in encounters with persons with mental illness dropped by more than half following implementation of CIT and, based on anecdotal evidence, so did injuries to the involved individuals with mental illness.
4. *Reduced Criminalization of Mental Illness Events.* The arrest rate of persons with mental illness dropped after introduction of CIT to approximately two percent as contrasted to a national average of 20 percent. "The Memphis CIT officers have increased their department's involvement in mental illness events and referrals to the health care system. This increase has happened while they have maintained an extremely low rate of

[220] Dupont, R. and Cochran, S., "Police Response to Mental Health Emergencies — Barriers to Change," *J Am Acad Psychiatry Law* 28:338-44, 2000.

[221] *Id.* at 339.

[222] *Id.* at 340.

arrest for those with mental illness, while at the same time significantly reducing their own injury rate."[223]

It is not possible to determine from the small sample of relevant cases we reviewed whether Portland's version of the Memphis CIT program has achieved similar results.[224] Nor can we say whether the subjects in the relevant cases we reviewed would have been responsive to even letter-perfect application of CIT techniques. However, our review did identify some CIT-related areas of concern to which the PPB should pay close attention:

A. Use of de-escalation techniques

We were concerned by what appeared to have been missed opportunities to attempt de-escalation in two cases involving subjects with mental illness. Although this is a small number, these cases represent one third of the officer-involved shootings and in-custody death incidents we reviewed involving persons with mental illness and suicidal ideation. Moreover, de-escalation is an elementary technique for dealing with aggressive subjects suffering from mental illness, and any failures to attempt the technique should be considered as significant omissions.

B. Failure to deploy CIT officers

We were also concerned that CIT officers did not appear to have been deployed in one of the two incidents where the PPB had a prior indication that such a deployment

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[223] It should also be noted that a police response team is not the only model currently being employed in the United States. Another model involves the police department's hiring of mental health professionals who are not sworn officers to provide "on-site and telephone consultations to officers in the field." Borum, R., Improving High Risk Encounters Between People with Mental Illness and the Police," *J Am Acad Psychiatry Law* 28:332-37, *at 334*, 2000. A third model involves "partnerships or cooperative agreements . . . between police and mobile mental health crisis teams that exist as part of the local community mental health services system and operate independently of the police department." *Ibid.*

[224] Aside from the difficulties of drawing firm conclusions on the basis of a small sample of cases, our ability to comment on CIT issues is constrained by the scant documentation of CIT considerations in the files we reviewed.

would be appropriate. Moreover, we noted that in one case a CIT officer apparently did not attempt any specialist CIT techniques, despite being present at the scene of an incident involving an individual with mental illness.

The deployment omission we identified may indicate that the CIT arrangements in place during our review period were insufficient to ensure the consistent application of CIT skills to incidents involving subjects with mental illness. In order to realize the benefits of its CIT program, the PPB must work to ensure that its deployment of CIT officers is sufficient to create a CIT response whenever the need arises, that CIT-type incidents are assigned to CIT officers whenever feasible, and that CIT officers are diligent in following their training when they attend such incidents.

Although we lack sufficient information to make overall judgments in respect to these issues in relation to the period covered by our review, we were concerned by a relatively current indication that the PPB does not provide as comprehensive a CIT service as it might: According to the May/June 2003 edition of the PPB's CIT newsletter, CIT officers were available to deal with just one third of the CIT-related calls the Bureau received during the first three months of 2003. This figure suggests that there is room for improvement in the Bureau's deployment practices. The PPB's goal should be to deploy a CIT officer to every call where such an officer's presence could be beneficial.

Recommendation 7.22: The PPB should ensure that CIT officers consistently exercise their specialist skills when dealing with CIT-related incidents.

Recommendation 7.23: We encourage the Bureau to examine its current practices in order to identify means of improving deployment rates of, and better capitalizing on the skills possessed by, its pool of CIT officers.

Recommendation 7.20: The PPB should provide all operational personnel with a radio earpiece.

Recommendation 7.21: The PPB should establish a helicopter unit.

Recommendation 7.22: The PPB should ensure that CIT officers consistently exercise their specialist skills when dealing with CIT-related incidents.

Recommendation 7.23: The PPB should examine its current CIT deployment practices in order to identify means of maximizing the rate at which appropriately skilled officers attend CIT-related incidents.

Recommendation 7.24: The PPB should ensure that officers consistently follow the Bureau's training and policy in relation to sudden death syndrome and associated prisoner restraint issues.