Lunenburg Police Department

Policy Number: 1.14	Subject: Responding to Persons Affected by Mental Health Issues or In Crisis
Issue Date: 11/03/2021 Revision Date(s): 1/20/2022 Effective Date: 11/03/2021	Massachusetts Police Accreditation Standards Referenced: 41.2.7(a); 41.2.7(b); 41.2.7(c); 41.2.7(d); 41.2.7(e); 70.1.8; 70.3.1; 70.4.1; 70.1.6 (b); 72.5.4
Issuing Authority: *Chief Thomas L. Gammel*	

I. INTRODUCTORY DISCUSSION

It is the purpose of this policy to provide guidance to agency personnel when responding to or encountering situations involving persons displaying behaviors consistent with mental health issues or crisis.

Responding to situations involving individuals who officers reasonably believe to be affected by mental health issues or in crisis carries potential for violence; requires an officer to make difficult judgments about the mental state and intent of the individual; and necessitates the use of special police skills, techniques, and abilities to effectively and appropriately resolve the situation, while avoiding unnecessary violence and potential civil liability. The goal shall be to de-escalate the situation safely for all individuals involved when reasonable, practical, and consistent with established safety priorities. Officers shall use this policy to assist them in determining whether a person's behavior is indicative of a mental health issue or crisis and to provide guidance, techniques, and resources so that the situation may be resolved in as constructive and humane a manner as possible. **[41.2.7(a)]**

II. POLICY

It is the policy of the Police Department to protect the constitutional and civil rights of all citizens. Allegations of discriminatory practices, real or perceived, are detrimental to the relationship between the police and the community they serve. This trust is essential to effective community based policing and building community and social values.

III. PROCEDURES

A. Definitions

1. *Mental Health Issue:* An impairment of an individual's normal cognitive, emotional, or behavioral functioning, caused by physiological or psychosocial factors. A person may be affected by mental health issues if he or she displays an inability to think rationally (e.g., delusions or hallucinations); exercise adequate control over behavior or impulses (e.g., aggressive, suicidal, homicidal, sexual); and/or take reasonable care of his or her welfare with regard to basic provisions for clothing, food, shelter, or safety.
2. *Crisis:* An individual's emotional, physical, mental, or behavioral response to an event or experience that results in trauma. A person may experience crisis during times of stress in response to real or perceived threats and/or loss of control and when normal coping mechanisms are ineffective. Symptoms may include emotional reactions such as fear, anger, or excessive giddiness; psychological impairments such as inability to focus, confusion, nightmares, and potentially even psychosis; physical reactions like vomiting/stomach issues, headaches, dizziness, excessive tiredness, or insomnia; and/or behavioral reactions including the trigger of a "fight or flight" response. Any individual can experience a crisis reaction regardless of previous history of mental health issues.

B. Recognizing Atypical Behavior

Only a trained mental health professional can diagnose mental health issues, and even they may sometimes find it difficult to make a diagnosis. Officers are not expected to diagnose mental or emotional conditions, but rather to recognize behaviors that are indicative of persons affected by mental health issues or in crisis, with special emphasis on those that suggest potential violence and/or danger. The following are generalized signs and symptoms of behavior that may suggest a mental health issue or crisis, although officers should not rule out other potential causes such as reactions to alcohol or psychoactive drugs of abuse, temporary emotional disturbances that are situational or medical conditions. [**41.2.7(a)**]

1. Strong and unrelenting fear of persons, places, or things. Extremely inappropriate behavior for a given context.
2. Frustration in new or unforeseen circumstances; inappropriate or aggressive behavior in dealing with the situation.
3. Abnormal memory loss related to such common facts as name or home address (although these may be signs of other physical ailments such as injury or Alzheimer's disease).
4. Delusions, the belief in thoughts or ideas that are false, such as delusions of grandeur ("I am Christ") or paranoid delusions ("Everyone is out to get me").
5. Hallucinations of any of the five senses (e.g., hearing voices commanding the person to act, feeling one's skin crawl, smelling strange odors); and/or

6. The belief that one suffers from extraordinary physical maladies that are not possible, such as persons who are convinced that their heart has stopped beating for extended periods of time.

C. Assessing Risk

1. Most persons affected by a mental health issue or in crisis are not dangerous and some may only present dangerous behavior under certain circumstances or conditions. Officers may use several indicators to assess whether a person who reasonably appears to be affected by a mental health issue or in crisis represents potential danger to themselves, the officer, or others. These include the following:
    a. The availability of any weapons.
    b. Statements by the person that suggest that he or she is prepared to commit a violent or dangerous act. Such comments may range from subtle innuendo to direct threats that, when taken in conjunction with other information, paint a more complete picture of the potential for violence.
    c. A personal history that reflects prior violence under similar or related circumstances. The person's history may already be known to the officer—or family, friends, or neighbors might provide such information.
    d. The amount of self-control that the people, particularly the amount of physical control over emotions of rage, anger, fright, or agitation. Signs of a lack of self-control include extreme agitation, inability to sit still or communicate effectively, wide eyes, and rambling thoughts and speech. Clutching oneself or other objects to maintain control, begging to be left alone, or offering frantic assurances that one is all right may also suggest that the individual is close to losing control.
    e. The volatility of the environment is a particularly relevant concern that officers must continually evaluate. Agitators that may affect the person or create a particularly combustible environment or incite violence should be taken into account and mitigated.

2. Failure to exhibit violent or dangerous behavior prior to the arrival of the officer does not guarantee that there is no danger, but it might diminish the potential for danger.
3. An individual affected by a mental health issue or crisis may rapidly change his or her presentation from calm and command-responsive to physically active. This change in behavior may come from an external trigger (such as an officer stating "I have to handcuff you now") or from internal stimuli (delusions or hallucinations). A variation in the person's physical presentation does not necessarily mean he or she will become violent or threatening, but officers should be prepared at all times for a rapid change in behavior.

D. Response to Persons Affected By Mental Health Issues or in Crisis

If the officer determines that an individual is exhibiting symptoms of a mental health issue or in crisis and is a potential threat to themselves, the officer, or others, or may otherwise require law enforcement intervention as prescribed by statute, the following responses shall be considered: [**41.2.7 (c)**]

1. Request a backup officer. Always do so in cases where the individual will be taken into custody.
2. Take steps to calm the situation. Where possible, eliminate emergency lights and sirens, disperse crowds, and assume a quiet nonthreatening manner when approaching or conversing with the individual. Where violence or destructive acts have not occurred, avoid physical contact, and take time to assess the situation. Officers should operate with the understanding that time is an ally and there is no need to rush or force the situation.
3. Move slowly and do not excite the person. Provide reassurance that the police are there to help and that the person will be provided with appropriate care.
4. Communicate with the individual in an attempt to determine what is bothering them. If possible, speak slowly and use a low tone of voice. Relate concern for the person's feelings and allow the person to express feelings without judgment. Where possible, gather information on the individual from acquaintances or family members and/or request professional assistance if available and appropriate to assist in communicating with and calming the person.
5. Do not threaten the individual with arrest, or make other similar threats or demands, as this may create additional fright, stress, and potential aggression.
6. Avoid topics that may agitate the person and guide the conversation toward subjects that help bring the individual back to reality.
7. Always attempt to be truthful with the individual. If the person becomes aware of a deception, he or she may withdraw from the contact in distrust and may become hypersensitive or retaliate in anger. In the event an individual is experiencing delusions and/or hallucinations and asks the officer to validate these, statements such as "I am not seeing what you are seeing, but I believe that you are seeing (the hallucination, etc.)" is recommended. Validating and/or participating in the individual's delusion and/or hallucination is not advised.
8. Request assistance from individuals with specialized training in dealing with mental health issues or crisis situations (e.g., Crisis Intervention Training (CIT) officers, community crisis mental health personnel, Crisis Negotiator). [**41.2.7(b)**]
9. Any officer having contact with such an individual shall keep such matter confidential except to the extent that revelation is necessary during the course of official proceedings, or for conformance with departmental procedures regarding reports.
10. Officers shall be required to file arrest/incident reports for such encounters. Officers should avoid attempting to diagnose the individual and should pay particular attention to describing all of the physical characteristics and behavioral cues exhibited by the individual.

E. CIT Officer Response Protocol [If Applicable]
   1. The Department is committed to providing a high level of service to persons experiencing mental health issues or in crisis. The Department has officers who have completed a forty-hour Crisis Intervention Team (CIT) Training. This training gives

the CIT Officers specialized training and knowledge in responding to calls involving those affected by mental health issues or in crisis.

2. A CIT Officer can respond to the scene of a mental health issue or crisis call by the following methods: **[41.2.7(b)]**
    a. The CIT Officer is dispatched as the primary or backup officer on a call for service.
    b. The CIT Officer has a self-initiated encounter with the person.
    c. The CIT Officer can make a request to the Officer-in-Charge to respond to a call due to the nature of the call or past experience with the involved person.
    d. A non-CIT trained officer can call for a CIT Officer to respond to a call at the discretion of the Officer-in-Charge.
    e. The Officer-in-Charge can send a CIT Officer to a call they believe would benefit from the presence of a CIT Officer.

F. Taking Custody **[41.2.7(c)]**

1. A person affected by a mental health issue or in crisis may be taken into custody if:
    a. The individual has committed a crime;
    b. They pose a substantial danger of physical harm to other persons by exhibition of homicidal or other violent behavior, or the individual poses a substantial risk of physical harm or injury to themselves (for example, by threats or attempts at suicide), or the individual is unable to protect themselves in the community. Threats or attempts at suicide should never be treated lightly; or
    c. The individual has escaped or eluded the custody of those lawfully required to care for them.

2. Whenever police take a person affected by a mental health issue or in crisis into custody, the appropriate mental health officials shall be contacted. They shall be informed of the individual's condition and their instructions sought on how to properly handle and, if necessary, restrain the individual, and to what facility they should be taken. If a mentally ill person has attempted to harm themselves, threatened suicide, expressed that they have thoughts of harming themselves the officer shall notify the Officer-in-Charge, who shall ensure that the person is evaluated by an appropriate mental health official, and if the person is a detainee, the officer shall enter the individual into CJIS as a Q5 suicide risk. **[41.2.7(b)]**
3. At all times an officer should attempt to gain voluntary cooperation from the individual. Officers shall be bound by use of force requirements consistent with the department policy ***1.01 Use of Force***.
4. Whenever such an individual is a suspect in a criminal offense and is taken into custody for questioning, police officers must be particularly careful in advising the subject of his/her *Miranda* rights and eliciting any decision as to whether the individual will exercise or waive those rights. Before interrogating a suspect who has a known or apparent mental condition or disability, police should make every effort to determine the following: **[41.2.7(c)]**
    a. The nature and severity of that condition or disability;

b. The extent to which it impairs the subject's capacity to understand basic rights and legal concepts (such as those contained in the *Miranda* warnings); and

c. Whether there is an appropriate "interested adult," such as a legal guardian or legal custodian of the subject, who could act on behalf of the subject and assist the individual in understanding his/her *Miranda* rights and in deciding whether or not to waive any of those rights in a knowing, intelligent and voluntary manner.

5. If such an individual is reported lost or missing, police shall consult the departmental policy and procedures on ***Missing Persons***.
6. An officer, who receives a complaint from a family member of such an individual who is not an immediate threat or is not likely to cause harm to themselves or others, should advise such family member to consult a physician, mental health professional, or a local mental health agency for advice.
7. When an officer takes custody of such an individual who is likely to cause serious harm to themselves or others, they shall only release the person to a proper mental health facility. Occasionally, the facility to which an officer transports a mentally ill person will either refuse to admit the individual entirely or will direct the officer to another mental health facility. The officer shall contact the Officer-in-Charge for specific instructions in such cases. **[72.5.4]**
8. Any detainee charged with a criminal offense being held by this department may apply for voluntary emergency admission to a mental health facility in accordance with G.L. c. 123, § 18(b). See departmental policies entitled ***3.03 Detainee Processing*** and ***3.04 Detaining Prisoners***.

G. Involuntary Emergency Hospitalization [**41.2.7 (b)**]

1. Section 12 Admissions

a. The authority for an application for Temporary Involuntary Hospitalization is described in G.L. c. 123, § 12.

b. In an emergency situation, if a physician or qualified psychologist is not available, a police officer who *reasonably believes* under the circumstances that failure to hospitalize a person would create a ***likelihood of serious harm*** by reason of mental illness may restrain such person and apply for the hospitalization of such person for a three (3) day period at a public facility or a private facility authorized for such purpose by the Massachusetts Department of Mental Health.[1] A ***likelihood of serious harm*** means that the person:

i. Presents a substantial risk of physical harm to themselves; or

ii. Presents a substantial risk of physical harm to others; or

iii. Presents a *very* substantial risk of injury to themselves based on evidence that the person's judgment "is so affected that the individual is unable to protect themselves in the community."

[1] G.L. c. 123, § 12(a); Ahern v. O'Donnell, 109 F.3d 809 (1st Cir. 1997).

c. A police officer may also convince a person who they believe needs such services to agree to a voluntary admission for a mental health evaluation.

d. Commitment proceedings under section 12(a) of Chapter 123 should be initiated by a police officer only if all of the following procedures have been observed:

i. Determination has been made that there are no outstanding commitment orders pertaining to the individual;

ii. Every reasonable effort has been made to enlist an appropriate physician, psychiatrist, psychologist, social worker or family member to initiate the commitment proceedings; and

iii. The officer has received approval from the Officer-in-Charge.

e. Officers may effect a warrantless entry into the home of a subject for whom a section 12 application for temporary hospitalization has been issued, provided:[2]

i. They have actual knowledge of the issuance of the application;

ii. The entry is of the residence of the subject of the application;

iii. The application was issued by a qualified physician, psychologist, or psychiatric nurse in an emergency situation where the subject refused to consent to an examination; and

iv. The warrantless entry is made within a reasonable amount of time after the application has been issued.

Note If any of the above criteria are not met, and unless exigent circumstances are present, a warrant shall be obtained prior to any entry of a residence.

f. Whenever practical, prior to transporting, the emergency mental health facility that police plan to take the person to should be contacted. This may be done by the police, a dispatcher, emergency medical personnel, or staff from the facility from which the mentally ill person is being transported. The facility should be informed of the circumstances and any known clinical history, determine if it is the proper facility, and be given notice of any restraints to be used and whether such restraint is necessary.[3] **[70.1.6(b)]**

2. Section 18 Admissions

a. If a detainee retained in custody on pending charges and that detainee is believed to be in immediate need of hospitalization for mental health issues, a commitment should be sought under the provisions of G.L. c. 123, § 18(a).

b. The services of a qualified physician or psychologist must be obtained through the Emergency Services Provider. That physician or psychologist will examine and evaluate the detainee in person. If the examining physician or psychologist determines that the detainee is in need of hospitalization, that physician or psychologist must report his/her findings directly to a justice of the district court. If the justice concurs with the physician's or psychologist's

[2] McCabe v. Life-Line Ambulance Service, Inc., 77 F.3d 540 (1st Cir. 1996).
[3] G.L. c. 123, § 12(a).

evaluative findings, that justice can issue an order committing the detainee to a Department of Mental Health Facility for examination and evaluation for a period of up to 30 days.

c. The use of a section 18, rather than a section 12, is a benefit in that the Department of Mental Health Facility may not release the detainee without first notifying the court.

3. Transport **[70.3.1]**
   a. Normally, a person who is to be transported to a hospital or facility under this section will be transported by ambulance.
   b. A police officer may transport such person in a police transportation vehicle equipped with a protective barrier if, in the opinion of a police officer, the person poses a threat due to violence, resisting, or other factors. Authorization from a supervisor should be sought prior to transport. **[70.4.1]**
   c. See departmental policy entitled ***3.04 Detaining Prisoners*** for procedures regarding the security and control of detainees transported to medical care facilities of hospitals for treatment, examination, or admission.
4. If an officer makes application to a hospital or facility and is refused, or if the officer transports a person with a commitment paper signed by a physician, and that person is refused admission, the officer should ask to see the administrative officer on duty to have them evaluate the patient. If refusal to accept the mentally ill person continues, the officer shall not abandon the individual, but shall take measures in the best interests of that person and, if necessary, take the mentally ill person to the police station. Notification of such action shall immediately be given to the Officer-in-Charge, who can notify the Department of Mental Health and the officer shall document his/her actions in such cases.
5. Police officers are immune from civil suits for damages for restraining, transporting, applying for the admission of or admitting any person to a facility. Immunity applies to officers acting pursuant to the provisions of G.L. Chapter 123.[4]

H. Escapes from Mental Health Facilities

1. In accordance with G.L. c. 123, § 30, if a patient or resident of a facility of the Massachusetts Department of Mental Health is absent without authorization, the superintendent of the facility is required to notify the state and local police, the local district attorney and the next of kin of such patient or resident. Such persons who are absent for less than six (6) months without authorization consistent with the provisions of M.G.L. Ch. 123, the regulations of the Department of Mental Health, or the rules of said facility, may be returned by the police. However, this six-month limitation does not apply to persons who have been found not guilty of a criminal charge by reason of insanity or to persons who have been found incompetent to stand trial on a criminal charge.
2. Taking a subject into custody for return to a mental health facility shall not be considered an arrest. The subject may be turned over directly to employees of the facility.

[4] G.L. c. 123, § 22.

I. Training [**41.2.7(d)**; **41.2.7(e)**]

1. All entry-level sworn personnel and civilian employees who deal directly with the public such as dispatchers, records personnel, detention attendants, parking enforcement personnel, etc., will receive documented training upon hire, regarding the interaction of agency employees with persons suspected of suffering from mental health issues.
2. Additionally, a documented refresher of this training will be conducted no less than every 2 years by all sworn personnel and civilian employees who deal directly with the public such as dispatchers, records personnel, detention attendants, parking enforcement personnel, etc.