CRT 4.12.17

From: Yasmeen Krameddine <krameddi@ualberta.ca>
Sent: Thursday, February 18, 2016 12:42 PM
To: Gregory Gelembiuk
Cc: Peter Silverstone
Subject: Re: a question about police training

Gregory,

Thank you very much for your email and for your involvement in your community's police reform.
You ask very excellent questions and I am happy to answer them for you.

What differentiates the training you've developed from typical U.S. CIT training (CIT training that includes role playing)?

Typical Crisis Intervention Team (CIT)	Our program (ProTraining)
Training is a one-time 40-hour program that focuses on training officers about **signs and symptoms** of mental health. Each CIT program usually focuses on the same premise, however each CIT session can be different depending on which organization is offering it. E.g. the topics covered in the lectures can be different. But overall it focuses on 3 things: **1) Power Point lectures to increase knowledge about mental health** (e.g. Clinical Issues Related to Mental Illnesses Medications and Side Effects Alcohol and Drug Assessment Co-Occurring Disorders Developmental Disabilities Family/Consumer Perspective Suicide Prevention and Practicum Aspects Rights/Civil Commitment Mental Health Diversity Policies and Procedures Personality Disorders Post Traumatic Stress Disorders (PTSD) Legal Aspects of Officer Liability Community Resources	Depending on the level of training needed, our program offers 3 units, to be taken in sequential order. It is recommended that officers take unit 1 and 2. **Unit 1. On-line training stage** (90 minutes) using a very novel and interactive approach where learners interact through video based e-learning scenarios and assessment opportunities. There are 4 modules, each portraying a different mental illness. What is unique about our training is that we want to make it as interactive as possible, and we use first-person video where the learner, gets to choose what you want to do. Depending on what you choose, determines how the interaction turns out, so it incorporates gamification into the training. **Unit 2. 4-hour in-person session** designed to allow experiential practice of skills learned in the eLearning Unit 1 where you will be taught how to properly engage individuals with mental illness. **Unit 3. 40-hour intensive unit** is designed for police officers that have frequent interactions with those suffering from mental

2) Onsite visits and exposure **3) De-escalation training and techniques (4 hrs) and role-play training (4hrs)**	illness and crisis negotiators. This is a more advanced course focusing again, on behaviours. (Not all officers will need to take this. We recommend police and crisis teams as well as crisis negotiators).
Length: One – 40 hour training session – taken once All **information** components are taught in a class room using power point slides.	**Length:** **3 units** – based on training need with the option for a refresher every 3 years (online and in person) **Unit 1** – (**information** component) offers the ability to learn the basic behavioural/verbal skills needed in an interaction on your own time, and at your own pace (online). A print out of the specific techniques that should be used in every interaction can be printed out after completion of training. Although our training uses learning slides at some points, we have reinforced our learning by including video's and learner interaction – keeping in engaging and interactive. E.g. In our beginning scenario, learners get to see the worst-case scenario and what could happen if they incorrectly interact (seen from the eyes of the officer) through a 2-3 minute video. Allowing the officer to see how quickly something can go wrong. The officers will have the opportunity to interact with the mentally ill individual at the end of the eLearning session again, to see if they can end with a positive outcome. This final scenario is shown through the eyes of the individual in crisis. This scenario shows some video and allows the officer to choose what they want to do/say. There is a meter on the screen that shows if you have made a correct choice (The correct choice will show the meter on the screen to go down (de-escalation) or the incorrect choice will show the meter going up (escalation).

Refresher training: Most CIT organizations do not do refresher. Since CIT is 40 hours, it takes lots of time to just get all officers through it once, and putting them through a refresher can be very difficult.	**Refresher training:** Our online component makes widespread use easier and allows regular updates to training (including refreshers every 3 years) making it easier to distribute to all police members and associated civilians in a cost - effective manner. We offer refreshers to Unit 1 (online) & Unit 2 (hands-on).
Information is taught to increase knowledge about mental health (focusing on memorization of signs and symptoms of mental illness). Training is taught with the belief that changing attitudes creates a change in behaviour. This is not as true as it sounds (see below)	**Information** and practical experience is trained to improve behaviours of officers, and increase the recognition of behaviours in others. We do not want to train police officers to be psychiatrists. Police officers have to know so much information in their day-to-day, so we feel they only need to know the bare minimum of information that will improve their interactions that will keep both them and those they interact with safe. This is why our training does not focus on teaching all of the symptoms for each mental illness (like CIT does). We only focus on the behaviours that are seen most frequently in police and mental health interactions - and we teach a step by step "how-to" interact, when individuals display certain behaviours. **Thus training is taught with the belief that we must focus on behaviours to change behaviours.** E.g. - De-escalation, verbal and nonverbal communication strategies, empathy techniques to build rapport in mental health interactions, and what to do if someone is threatening, uncooperative or unresponsive. - Information on exact steps that need to be taken during and after an interaction (with practical implementation) - What would make the interaction worse and what would make it better.

	- Depending on the severity, where should the individual should be taken? - If this individual needs to go to the hospital, how do you fill in a mental health form so that this individual will be accepted into the hospital? All of the training units focus extensively on improving officer behaviour, and understanding and practicing how to interact with certain behaviours other exhibit.
Although training tends to focus on increasing knowledge (through lecture based training), there is evidence to show that **increasing knowledge and changing attitudes does not necessarily lead to a change in behaviours** (e.g. If someone knows smoking is bad for their health, they do not necessarily quit smoking) * see attached article (Krameddine & Silverstone, 2015) about attitudes and behaviours. The best way to change behaviours is to focus directly on changing behaviours, instead of training to improve attitudes and hoping that it leads to behavioural change.	
Training Creation: Members of each department usually create the training materials, some in collaboration with NAMI, some without collaboration and not based on evidence-based research.	**Training Creation:** Our training has been created with the help of an International Advisory Board of police officers, police educators, mental health professionals, academic researchers, adult educators, eLearning experts and individuals with lived experiences of mental illness from the UK, the Netherlands, Sweden, Australia, New Zealand, USA and Canada.
Evidence based evaluation: Although CIT has been around for many years (since 1988 in Memphis Tennessee), it only recently is becoming properly evaluated. In a recent (properly evaluated) evaluation by (Compton, 2014) it was found that CIT training does increase the use of de-escalation skill and referral decisions in interactions (which is great!) however, it does not show any differences between those officers who are trained and not trained in use of force, number of arrests and time per call. (I attached the Compton article.)	**Evidence based evaluation:** Our units are based on my PhD research where we trained over 650 Edmonton Police officers in mental health at the University of Alberta with a new program, similar to medical student simulations. We analyzed our program and we found evidence based success 6 months after training: 41% decrease in physical use-of-force 26% decrease in weapon force 19% increase in efficiency 41% increase in mental health awareness 23% increase in officer confidence

	Improved empathy, communication and de-escalation in officers after training. (Krameddine, 2013)
Continued evaluation: Does not exist to my knowledge, however, external groups may evaluate.	**Continued evaluation:** We offer evaluation of our program before and after organizations participate in any level of our course.
Role play component: From my research, the role-play in <u>most</u> CIT programs consists of 2-5 minutes of role-play per person (over a 4 hour period) E.g. There are 20-40 members in CIT for the week. For the 4 hour session, all members are watching one individual that is in the middle of the room, role-playing with an veteran officer for 2-5 minutes. After, all other members give feedback to this individual. It takes time for members to go through the role-play, thus in the 4 hour time it takes all members to go through the role-play training, each will only be role-playing (usually with a veteran officer) for 2-5 minutes. I am not sure if this is true for your organization, but this is the case for most others.	**Role play component:** **Our unit 2** is our role-play training. Officers will go through 4 scenarios (10 minutes of role-play in each) – allowing 40 minutes of role-play in 4 hours. (All 4 scenarios are taking place at the same time and they switch from one to the other). - After they complete their scenario they will be given 3 questions to think about. These questions focus on the 3 main learning points of every scenario (on top of how to talk to them, they learn these points). - No other officers are "watching" them role-play (alleviating stress, and producing realistic responses, and a realistic atmosphere.) **E.g.** In our scenario training, groups of 2 go through a minimum of 10 minutes of scenario role-play every hour, interacting with an actor portraying mental illness. After the role play is over, there is a debrief and feedback portion of the scenario where officers are given feedback from the Supervising facilitator, a mental health facilitator and the actors in the scenario. We focus on behaviour by: - Actors modifying their responses depending on how the officer treats them. E.g. If an actor feels they are not being treated with respect they will not give the officer any information. However, if the officer is sincere then the actor will tell the officer everything they need to know.

	There are some scenarios that end in the actor pulling out a knife (if they are treated poorly) – but the exact same scenario can end with the actor going willingly with the officer and allowing them to be handcuffed, if they are treated with the respect that they need. - Our actors are trained to give feedback to officers (in the debrief) in terms of how the officer made them feel when they acted certain ways: **Example of Actor feedback:** When you stood over me it made me feel very afraid of you. Perhaps next time, if you come down to my level and spoke to me, I would have answered all of your questions because you would have been less of a threat. Or: When you asked me "how long have you been drunk?" – I got very offended by the word "drunk". Perhaps next time you can ask "When did you start drinking" etc.
Role-play: usually veteran officers are acting – this can be difficult, as sometimes officers do not take the training seriously.	**Role-play:** done with trained actors, usually ones that have mental illness themselves, so they can speak towards how individuals with mental illness feel when officers interact with them.
Onsite mental health exposure	We do not have onsite visits however we have actors that are living with mental illness themselves as well as mental health professionals in every scenario facilitating the interaction.

In your publications, I see that your training is designed to alter officer behavior, not just attitudes or knowledge. How exactly is this done, in a way that might differ from standard U.S. CIT training?

Yes, this is true. As mentioned above the focus on behaviours is done in all Units of our training.

E.g. You enter a scene where an aggressive individual is believing that someone is watching him and going to kill him. He acts aggressive towards you.
Our approach: focus on his behaviours: he is acting in a way that shows he is afraid. Therefore what can I do to:

- make him feel less afraid?
- let him know I am here to help?
- let him know I care about his safety?

Once you de-escalate this individual, then you can focus on next steps:

- What to write on the mental health form, if you do end up taking them to the hospital
- Techniques you can use to approach the scene in a calm manner
- Words to speak and to avoid when speaking to someone who is afraid

CIT approach:
This person is having hallucinations & delusions and is suffering from schizophrenia. I know that since he has schizophrenia he needs to be taken to the hospital so my main goal is to get him to come with me to the hospital.

We do not talk about labeling a specific mental illness, we speak of behaviours others are exhibiting.

I'm wondering if there's something that's available (and ideally evidence-based) that might be more effective than the training approach currently being used with Madison police officers.

It sounds like the Madison police officers are doing constant training, which is a very good thing. Evidence suggests that training must happen every 3 years at minimum, so the more training the better - ideally with a focus on behaviours and not on memorization of signs and symptoms.

In regards to evidence based practices, currently we are evaluating our Unit 1 – online training (since it is very new), however as mentioned it has been created with international advisory board input of experts around the world. The benefit of our Unit 1 - online, interactive training is that it can be taken any time, in any place, as long as a computer is available. The easy access is valuable in the sense that no one has to wait to take training. As well it can be taken at low cost - $20 - $34.95 (depending how many units are purchased).

Our Unit 2 – hands on scenario learning using professional actors is evidence based and we travel to all parts of Canada and USA, implementing our training in police organizations. We are traveling to Chicago on August 22 & 23, 2016 to deliver our Unit 2.

With everything being said, I would strongly recommend our Unit 1-3 training programs. I have been working passionately on this project for 5 years and have

complete confidence in it. I know they can improve the relationship and interactions between police and those they interact with.

After informing you of how our program differs from CIT, I am wondering how we can best help you achieve your goals with the Madison Police?
What are your next steps, and how can we help you get there?

I am able to give you access to our Unit 1 - online training, if you wanted to experience it.
I look forward to your response, and hope I have answered your questions.

Sincerely,

Yasmeen Krameddine

Fyfe's Principles in relation to Normal Accident Theory

The rules formulated by James Fyfe for how police should deal with resistant emotionally disturbed persons (including those who might be armed) fit well with recommendations from normal accident theory (a theory - with considerable empirical support - of factors underlying risk of disasters).

Under normal accident theory, the risk of accidents is tied to 1. the interactive complexity of a system (more parts or more people interacting = higher risk) and 2. the degree of coupling in the system (tight coupling, with little capacity to accommodate things going wrong = higher risk). Normal accident theory was first applied to officer involved shootings by David Klinger (2005) and recently more formally by Bryan Vila et al.

Fyfe's rules:

1. Officers should keep a safe distance away from EDPs (emotionally disturbed persons) and otherwise avoid putting themselves in harm's way when handling EDPs.

[more distance = looser coupling. Better able to accommodate errors/unexpected actions]

2. Officers should avoid unnecessary and provocative displays or threats of force.

3. An officer should try to avoid confronting an EDP while alone and should always make sure that back-up assistance is called so that the EDP can be contained at the same time that bystanders are cleared away.

[clearing bystanders reduces complexity of the system, though backup officers increase complexity]

4. One officer (the talker) should be designated to talk to the EDP, and everybody else on the scene should "shut up and listen."

[reduction in complexity]

5. Officers should make sure that the talker is in charge of the scene and that nobody takes unplanned action unless life is in immediate danger.

[reduction in complexity. retain the benefit of backup officers while ameliorating the additional risk created by having more officers present]

6. Officers should make sure that the talker does not threaten the EDP, but instead makes it plain that the police want to help him or her and that the way to accomplish this is for the EDP to put down any weapons and to come with the police for help.

7. Officers should take as much time as necessary to talk EDPs into custody, even if this runs into hours or days.

[allowing as much time as needed = more slack/less pressure/looser coupling]

NYPD policy appears to largely be based on Fyfe's rules, with some additional elements. One key addition - the officer in charge is required to "Establish firearms control.
a. Direct members concerned not to use their firearms or use any other deadly physical force unless their lives or the life of another is in imminent danger."

Policing the Emotionally Disturbed

James J. Fyfe, PhD

J Am Acad Psychiatry Law 28:345–7, 2000

In New York City from 1971 to 1975, only 1.6 percent of all police firearms discharges involved the class of people police have since come to call emotionally disturbed persons (EDPs). Still, because police were comparatively unrestrained in those years, the number of such incidents was quite large: 46, or better than 9 per year.[1] In the years since then, police shootings have declined dramatically; fatal shootings by New York police have decreased from 93 in 1971 to 11 in 1999. There, as in most big cities, police apparently have become much more sophisticated in helping officers to avoid shootings of all kinds, including those involving EDPs.

If the lawyers who call me, in my capacity as a police practices expert, to request a consultation in their cases are any indication, however, the decrease in EDP shootings may not hold true in many smaller and midsized U.S. police jurisdictions. With great regularity, I hear variants of the same story: my client's decedent, the lawyer will tell me, was a troubled young man who had just undergone a great emotional shock. He ran out onto the street with a knife, shouting and frightening people, but never really attacked anyone. The police were called; they saw him, drew their guns, and closed in on him, warning him to drop his knife. He backed up until he was against a wall, then tried to run. Because the police had cut off all his escape routes, he was then running in a police officer's direction with a knife in his hand; consequently, the police shot and killed him to defend their colleague. With only minor differences, I have worked on such cases in suburban, rural, and small city police agencies from Texas, Florida, and New Mexico to Maine and Michigan; from California and Oregon to New Jersey and New York. They are terrible tragedies that victimize police officers as well as EDPs and their families, that strain the relationship between police and community, and that have cost police chiefs and elected officials their careers. Certainly, unlike the not-too-distant past, they no longer go unnoticed or written off as unavoidable "nut-with-a-knife" cases.

The major reason that the big cities have become more sophisticated than smaller jurisdictions in resolving EDP situations is a simple matter of numbers and exposure. The New York City Police Department (NYPD) responds to about 18,000 EDP calls every year, and even the small number that have gone wrong and resulted in tragedy have been enough to embarrass the organization and prompt it to action designed to help officers avoid hurting others and being hurt themselves. The 1985 Bronx police shooting of Elinor Bumpurs, a mentally disturbed 67-year-old, 270-pound grandmother who attacked police with a knife, for example, led to a reexamination and overhaul of the NYPD's policies related to EDPs, which has no doubt saved other lives. Not so in smaller jurisdictions, where volatile street people and deranged seniors are not a part of the routine of policing. Instead, they often come as a surprise to young officers who have been given no relevant training or, even worse, have participated in training likely to lead to overly aggressive police responses.

Consider officers untrained for their work with EDPs. They have been trained to get rational offenders to submit to their authority by approaching them forcefully and making it plain that resistance is only likely to make things worse. This intimidating approach almost always succeeds in gaining criminal

Dr. Fyfe is Professor, Department of Criminal Justice, Temple University, Philadelphia. Address correspondence to: James Fyfe, PhD, Temple University Dept. of Criminal Justice, 512 Gladfelter Hall, Philadelphia, PA 19122. E-mail: jamesjfyfe@aol.com

suspects' compliance. The survival instinct rules among all rational people, and most offenders are in the crime business because they are interested in making themselves comfortable with as little effort as possible. Not so with EDPs; the police are called to handle them precisely because, for reasons that might not affect more stable individuals, they have become frightened and potentially dangerous to themselves and others. In such cases, the forceful police approaches that work so well with rational offenders—threats, intimidation, closing in on personal space—are liable to force unnecessary confrontations and to put officers into perilous circumstances from which they can extricate themselves only by resorting to the most extreme types of force, that is, by shooting. Almost universally, police recognize and act upon this distinction between rational offenders and EDPs in situations in which barricaded subjects and hostage takers are concerned, and they react accordingly. Too often, however, this distinction is overlooked in street-level encounters, and tragedy ensues.

After the fact, police have recently been prone to write off such tragedies as "suicide by cop," a classification that, in my experience, is far more often a *post hoc* justification for sloppy police work than a valid explanation of why and how somebody died. The term "suicide by cop" should describe only situations in which even officers who adhere closely to the industry standard for dealing with EDPs are given no choice but to kill them. Unfortunately, it has become a catchy descriptor for a far larger number of cases in which officers put themselves unnecessarily into harm's way and must then shoot their way out of it.

Worse yet are some of the EDP shootings by usually young and impressionable officers who have been trained to believe that every street encounter leaves them at the mercy of homicidal maniacs and that they must therefore be constantly alert and ready to shoot at an instant's notice. A longtime leader in the business of providing training to officers whose agencies are not sufficiently large or expert to develop their own is the Calibre Press, whose widely distributed videotape, "Surviving Edged Weapons,"[2] is illustrative. It begins with a dramatization of cavemen killing each other with "edged weapons" and proceeds through explanations and demonstrations of how psychopaths armed with swords and multiple knives can easily ambush and kill police officers, moving to a dissertation on an alleged "knife culture" that is purportedly populated by persons of Hispanic distraction. According to former San Diego Police Chief Robert Burgreen, the tape led two of his officers to engage in inappropriate shootings.[3] Burgreen is not alone in his suspicion that there may be a link between training of this nature and officers' propensity to shoot; within weeks after viewing this videotape, two officers in another police department with which I consulted shot and killed EDPs who were carrying edged weapons. One was a butter knife, held by a man who had been sitting at his table eating breakfast when police came into his house to investigate an hours-old domestic complaint. The other was a pen knife, carried by a young man whose girlfriend had broken off with him and who was shot and killed in his front yard in front of his whole family. Both had made the fatal mistake of coming within a 21-foot "zone of safety" prescribed by the Calibre Press video.

There is a message here: some police training on this subject may actually be worse than none. Any police organization or government officials or medical professionals concerned with seeing that police do their work with the least violence necessary should not content themselves with knowing that officers are being trained to interact with EDPs; they must carefully examine such training to assure that it is not sending the wrong message.

Training designed to help officers deal with EDPs should teach that there is a difference between rational offenders and EDPs and that they will be held accountable for treating these situations with the same concern for life that was demonstrated by the Los Angeles Police Department in the nationally televised low speed chase involving O. J. Simpson, a revolver, and a white Bronco. In that case, the police did all they could to avoid forcing a confrontation, even tying up one of the busiest metropolitan areas in the world during the evening rush hour. This approach worked; Simpson was taken into custody, and nobody was hurt. It also stands in sharp contrast to the testimony of the Illinois police trainer who said, after one of his officers had shot and killed a female EDP, that he would cut off negotiations after a half-hour because nothing in the world was worth more than a half-hour of police time.*

The dangers and unpredictability of police encounters with EDPs are significant, but they can be

* Readers interested in the citation for this testimony may contact Professor Fyfe directly.

reduced greatly by adherence to a few simple principles:

1. Officers should keep a safe distance away from EDPs and otherwise avoid putting themselves in harm's way when handling EDPs.
2. Officers should avoid unnecessary and provocative displays or threats of force.
3. An officer should try to avoid confronting an EDP while alone and should always make sure that back-up assistance is called so that the EDP can be contained at the same time that bystanders are cleared away.
4. One officer (the talker) should be designated to talk to the EDP, and everybody else on the scene should "shut up and listen."
5. Officers should make sure that the talker is in charge of the scene and that nobody takes unplanned action unless life is in immediate danger.
6. Officers should make sure that the talker does not threaten the EDP, but instead makes it plain that the police want to help him or her and that the way to accomplish this is for the EDP to put down any weapons and to come with the police for help.
7. Officers should take as much time as necessary to talk EDPs into custody, even if this runs into hours or days.

These principles, which can be taught and absorbed in no more than a couple of days, considerably increase the chances of resolving EDP confrontations without bloodshed; they simply equate to good, street-level police work. Learning these techniques does not guarantee success, but if the police do all of these things and still have to shoot an EDP, the fault does not lie with the police. As doctors know, operations can be successful even though patients die; both the police and doctors can do no better than to act in the ways most likely to succeed, knowing all the while that they cannot absolutely control their clients' fates.

Because the techniques and strategies for resolving EDP situations are relatively simple, all police patrol officers, who are almost invariably the first police responders to such situations, should be trained in them and held accountable for following them. This approach would minimize the need for special units charged with particular responsibility for dealing with EDPs, reducing division within policing, and following the principle, well-known in both policing and medicine, that no specialty should be created unless its members can perform their task significantly better than can generalists. In policing as in medicine, the key to assuring that most cases conclude happily is to enhance the diagnostic and early treatment skills of the general practitioner, the profession's first contact with the great majority of people in need of help.

References

1. Fyfe JJ: Shots fired: an analysis of New York City police firearms discharges. Unpublished doctoral dissertation, State University of New York at Albany, 1978, p 679
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PATROL GUIDE

Section: Tactical Operations		Procedure No: 221-13	
MENTALLY ILL OR EMOTIONALLY DISTURBED PERSONS			
DATE ISSUED: 06/01/16	DATE EFFECTIVE: 06/01/16	REVISION NUMBER:	PAGE: 1 of 5

PURPOSE To safeguard a mentally ill or emotionally disturbed person who does not voluntarily seek medical assistance.

SCOPE The primary duty of all members of the service is to preserve human life. The safety of ALL persons involved is paramount in cases involving emotionally disturbed persons. If such person is dangerous to himself or others, necessary force may be used to prevent serious physical injury or death. Physical force will be used ONLY to the extent necessary to restrain the subject until delivered to a hospital or detention facility. Deadly physical force will be used ONLY as a last resort to protect the life of the uniformed member of the service assigned or any other person present. If the emotionally disturbed person is armed or violent, no attempt will be made to take the EDP into custody without the specific direction of a supervisor unless there is an immediate threat of physical harm to the EDP or others are present. If an EDP is not immediately dangerous, the person should be contained until assistance arrives. If the EDP is unarmed, not violent and willing to leave voluntarily, a uniformed member of the service may take such person into custody. When there is time to negotiate, all the time necessary to ensure the safety of all individuals will be used.

DEFINITIONS EMOTIONALLY DISTURBED PERSON (EDP) - A person who appears to be mentally ill or temporarily deranged and is conducting himself in a manner which a police officer reasonably believes is likely to result in serious injury to himself or others.

ZONE OF SAFETY - The distance to be maintained between the EDP and the responding member(s) of the service. This distance should be greater than the effective range of the weapon (other than a firearm), and it may vary with each situation (e.g., type of weapon possessed, condition of EDP, surrounding area, etc.). A minimum distance of twenty feet is recommended. An attempt will be made to maintain the "zone of safety" if the EDP does not remain stationary.

PROCEDURE When a uniformed member of the service reasonably believes that a person who is apparently mentally ill or emotionally disturbed, must be taken into protective custody because the person is conducting himself in a manner likely to result in a serious injury to himself or others:

UNIFORMED MEMBER OF THE SERVICE

1. Upon arrival at scene, assess situation as to threat of immediate serious physical injury to EDP, other persons present, or members of the service. Take cover, utilize protective shield if available and request additional personnel, if necessary.
   a. If emotionally disturbed person's actions constitute immediate threat of serious physical injury or death to himself or others:
      (1) Take reasonable measures to terminate or prevent such behavior. Deadly physical force will be used only as a last resort to protect the life of persons or officers present.

NOTE *Damaging of property would not necessarily constitute an immediate threat of serious physical injury or death.*

UNIFORMED MEMBER OF THE SERVICE (continued)

b. If EDP is unarmed, not violent and is willing to leave voluntarily:
   (1) EDP may be taken into custody without the specific direction of a supervisor.

c. In all other cases, if EDP's actions do not constitute an immediate threat of serious physical injury or death to himself or others:
   (1) Attempt to isolate and contain the EDP while maintaining a zone of safety until arrival of patrol supervisor and Emergency Service Unit personnel.
   (2) Do not attempt to take EDP into custody without the specific direction of a supervisor.

2. Request ambulance, if one has not already been dispatched.
   a. Ascertain if patrol supervisor is responding, and, if not, request response.

NOTE *Communications Section will automatically direct the patrol supervisor and Emergency Service Unit to respond to scene in such cases. Patrol supervisors' vehicles are equipped with non-lethal devices to assist in the containment and control of EDP's, and will be used at the supervisor's direction, if necessary.*

3. Establish police lines.
4. Take EDP into custody if EDP is unarmed, not violent and willing to leave voluntarily.

PATROL SUPERVISOR

5. Verify that Emergency Service Unit is responding, if required.
   a. Cancel response of Emergency Service Unit if services not required.
6. Direct uniformed members of the service to take EDP into custody if unarmed, not violent, and willing to leave voluntarily.

NOTE *When aided is safeguarded and restrained comply with steps 25 to 32 inclusive.*

WHEN AIDED IS ISOLATED/CONTAINED BUT WILL NOT LEAVE VOLUNTARILY:

PATROL SUPERVISOR

7. Establish firearms control.
   a. Direct members concerned not to use their firearms or use any other deadly physical force unless their lives or the life of another is in imminent danger.
8. Deploy protective devices (shields, etc.).
   a. Employ non-lethal devices to ensure the safety of all present (see *"ADDITIONAL DATA"* statement).
9. Comply with provisions of *P.G. 221-14, "Hostage/Barricaded Person(s),"* where appropriate.
10. Establish police lines if not already done.

PATROL SUPERVISOR (continued)

11. Request response of hostage negotiation team and coordinator through Communications Section.
12. Notify desk officer that hostage negotiation team and coordinator have been notified and request response of precinct commander/duty captain.
13. Request Emergency Service Unit on scene to have supervisor respond.
14. If necessary, request assistance of:
    a. Interpreter, if language barrier
    b. Subject's family or friends
    c. Local clergyman
    d. Prominent local citizen
    e. Any public or private agency deemed appropriate for possible assistance.

NOTE *The highest ranking uniformed police supervisor at the scene is in command and will coordinate police operations. If the mentally ill or EDP is contained and is believed to be armed or violent but due to containment poses no immediate threat of danger to any person, no additional action will be taken without the authorization of the commanding officer or duty captain at the scene.*

EMERGENCY SERVICE UNIT SUPERVISOR

15. Report to and confer with ranking patrol supervisor on scene.
    a. If there is no patrol supervisor present, request response forthwith, and perform duties of patrol supervisor pending his/her arrival.

NOTE *The presence of a supervisor from any other police agency does not preclude the required response of the patrol supervisor.*

16. Evaluate the need and ensure that sufficient Emergency Service Unit personnel and equipment are present at the scene to deal with the situation.
17. Verify that hostage negotiation team and coordinator are responding, when necessary.
18. Devise plans and tactics to deal with the situation, after conferral with ranking patrol supervisor on scene.

DESK OFFICER

19. Verify that precinct commander/duty captain has been notified and is responding.
20. Notify Operations Unit and patrol borough command of facts.

COMMANDING OFFICER/ DUTY CAPTAIN

21. Assume command, including firearms control.
22. Confer with ranking Emergency Service Unit supervisor on scene and develop plans and tactics to be utilized.
23. Direct whatever further action is necessary, including use of negotiators.
24. Direct use of alternate means of restraint, if appropriate, according to circumstances.

WHEN PERSON HAS BEEN RESTRAINED:

UNIFORMED MEMBER OF THE SERVICE

25. Remove property that is dangerous to life or will aid escape.
26. Have person removed to hospital in ambulance.
    a. Restraining equipment including handcuffs may be used if patient is violent, resists, or upon direction of a physician examiner.
    b. If unable to transport with reasonable restraint, ambulance attendant or doctor will request special ambulance.
    c. When possible, a female patient being transported should be accompanied by another female or by an adult member of her immediate family.
27. Ride in body of ambulance with patient.
    a. At least two uniformed members of the service will safeguard if more than one patient is being transported.

NOTE

If an ambulance is NOT available and the situation warrants, transport the EDP to the hospital by RMP if able to do so with reasonable restraint, at the direction of a supervisor. UNDER NO CIRCUMSTANCES WILL AN EDP BE TRANSPORTED TO A POLICE FACILITY.

28. Inform examining physician, upon arrival at hospital, of use of non-lethal restraining devices, if applicable.
29. Safeguard patient at hospital until examined by psychiatrist.
    a. When entering psychiatric ward of hospital, unload revolver at Firearm Safety Station, if available (see *P.G. 216-07, "Firearms Safety Stations at Psychiatric Wards and Admitting Areas"*).
30. Inform psychiatrist of circumstances which brought patient into police custody:
    a. Inform relieving uniformed member of circumstances if safeguarding extends beyond expiration of tour.
    b. Relieving uniformed member will inform psychiatrist of details.
31. Enter details in **ACTIVITY LOG (PD112-145)** and prepare **AIDED REPORT WORKSHEET (PD304-152b)**.
    a. Indicate on **AIDED REPORT WORKSHEET**, name of psychiatrist.
32. Deliver **AIDED REPORT WORKSHEET** to desk officer.

ADDITIONAL DATA

Refer persons who voluntarily seek psychiatric treatment to proper facility.

Prior to interviewing a patient confined to a facility of the NYC Health and Hospitals Corporation, a uniformed member of the service must obtain permission from the hospital administrator who will ascertain if the patient is mentally competent to give a statement.

Upon receipt of a request from a qualified psychiatrist, or from a director of a general hospital or his/her designee, uniformed members of the service shall take into custody and transport an apparently mentally ill or emotionally disturbed person from a facility licensed or operated by the NYS Office of Mental Health which does not have an inpatient psychiatric service, or from a general hospital which does not have an inpatient psychiatric service, to a hospital approved under Section 9.39 of the Mental Hygiene Law.

ADDITIONAL DATA (continued)

Uniformed members of the service will also comply with the above procedure upon direction of the Commissioner of Mental Health, Mental Retardation and Alcoholism Services or his/her designee.

USE OF NON-LETHAL DEVICES TO ASSIST IN RESTRAINING EMOTIONALLY DISTURBED PERSONS

Authorized uniformed members of the service may use a conducted energy weapon (CEW) to assist in restraining emotionally disturbed persons, if necessary.

Authorized uniformed members of the service will be guided by Patrol Guide 221-08, 'Use of Conducted Electrical Weapons (CEW),' when a CEW has been utilized.

***THREAT, RESISTANCE OR INJURY (T.R.I.) INCIDENT WORKSHEET (PD370-154)** will be prepared whenever a less lethal device is used by a uniformed member of the service in the performance of duty.*

RELATED PROCEDURES

Unusual Occurrence Reports (P.G. 212-09)
Hostage/Barricaded Person(s) (P.G. 221-14)
Unlawful Evictions (P.G. 214-12)
Aided Cases General Procedure (P.G. 216-01)
Mental Health Removal Orders (P.G. 216-06)
Use of Conducted Electrical Weapons (CEW) (P.G. 221-08)

FORMS AND REPORTS

ACTIVITY LOG (PD112-145)
AIDED REPORT WORKSHEET (PD304-152b)
THREAT, RESISTANCE OR INJURY (T.R.I.) INCIDENT WORKSHEET (PD370-154)
UNUSUAL OCCURRENCE REPORT (PD370-152)

RESPONDING TO PERSONS AFFECTED BY MENTAL ILLNESS OR IN CRISIS

Model Policy

Effective Date	*Number*
January 2014	

Subject
Responding to Persons Affected by Mental Illness or in Crisis

Reference	*Special Instructions*

Distribution	*Reevaluation Date*	*No. Pages*
		4

I. PURPOSE

It is the purpose of this policy to provide guidance to law enforcement officers when responding to or encountering situations involving persons displaying behaviors consistent with mental illness or crisis.

II. POLICY

Responding to situations involving individuals who officers reasonably believe to be affected by mental illness 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. In the context of enforcement and related activities, officers shall be guided by this state's law regarding the detention of persons affected by mental illness or in crises. Officers shall use this policy to assist them in determining whether a person's behavior is indicative of mental illness 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.

III. DEFINITIONS

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

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 illness.

IV. PROCEDURES

A. Recognizing Abnormal Behavior

Only a trained mental health professional can diagnose mental illness, 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 illness 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 mental illness 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.

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.

B. Assessing Risk

1. Most persons affected by mental illness 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 mental illness or in crisis represents potential danger to himself or herself, 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 person, 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 mental illness or emotional 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.

C. Response to Persons Affected by Mental Illness or in Crisis

If the officer determines that an individual is exhibiting symptoms of mental illness or in crisis and is a potential threat to himself or herself, the officer, or others, or may otherwise require law enforcement intervention as prescribed by statute, the following responses should be considered:

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 him or her. 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 illness or crisis situations (e.g., Crisis Intervention Training (CIT) officers, community crisis mental health personnel, Crisis Negotiator).

D. Taking Custody or Making Referrals to Mental Health Professionals
1. Based on the totality of the circumstances and a reasonable belief of the potential for violence, the officer may provide the individual and/or family members with referral information on available community mental health resources, or take custody of the individual in order to seek an involuntary emergency evaluation. Officers should do the following:
2. Offer mental health referral information to the individual and or/family members when the circumstances indicate that the individual should not be taken into custody.
3. Summon an immediate supervisor or the officer-in-charge prior to taking custody of a potentially dangerous individual who may be affected by mental illness or in crisis or an individual who meets other legal requirements for involuntary admission for mental examination. When possible, summon crisis intervention specialists to assist in the custody and admission process.
4. Continue to use de-escalation techniques and communication skills to avoid provoking a volatile situation once a decision has been made to take the individual into custody. Remove any dangerous weapons from the immediate area, and restrain the individual if necessary. Using restraints on persons affected by mental illness or in crisis can aggravate any aggression, so other measures of de-escalation and commands should be utilized if possible. Officers should be aware of this fact, but should take those measures necessary to protect their safety.
5. Document the incident, regardless of whether or not the individual is taken into custody. Ensure that the report is as detailed and explicit as possible concerning the circumstances of the incident and the type of behavior that was observed. Terms such as "out of control" or "mentally disturbed" should be replaced with descriptions of the specific behaviors, statements, and actions exhibited by the person. The reasons why the subject was taken into custody or referred to other agencies should also be reported in detail.

Every effort has been made by the IACP National Law Enforcement Policy Center staff and advisory board to ensure that this document incorporates the most current information and contemporary professional judgment on this issue. However, law enforcement administrators should be cautioned that no "model" policy can meet all the needs of any given law enforcement agency. Each law enforcement agency operates in a unique environment of federal court rulings, state laws, local ordinances, regulations, judicial and administrative decisions and collective bargaining agreements that must be considered. In addition, the formulation of specific agency policies must take into account local political and community perspectives and customs, prerogatives and demands; often divergent law enforcement strategies and philosophies; and the impact of varied agency resource capabilities among other factors.

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IACP National Law Enforcement Policy Center Staff: Philip Lynn, Manager; Sara Dziejma, Project Specialist; and Vincent Talucci, Executive Director, International Association of Chiefs of Police.

Mental Health Incidents/Crises

Eff. Date 12/22/2016

Purpose

The Madison Police Department (MPD) recognizes that police are not qualified to solve the underlying problems of people who exhibit abnormal behavior due to a mental illness, however, officers can learn to recognize when mental illness may be a contributing factor. The officer's course of action at this first encounter can both calm the existing situation and increase the chance that if subsequent treatment is needed for the individual, it will be more effective. Responses to situations which involve abnormal behavior should reflect sensitivity to the needs of the people involved, concern for officer safety and safety of others at the scene and concern for alleviating the situation in a reasonable manner. The goal in all crises stemming from mental illness is to utilize the least restrictive measures to secure the welfare of all those concerned, connect individuals with mental illness to needed services and divert them from the criminal justice system whenever possible.

Procedure

All officers are trained to recognize behavior that may be attributable to mental illness and to respond to mental health related incidents in such a manner as to de-escalate crisis situations whenever possible. Situations involving individuals believed to be affected by mental illness or in crisis are often unpredictable and volatile. As such, these incidents require officers to make difficult judgments about the mental state and intent of the individual, and necessitate an understanding of the unique circumstances and approach required to resolve these crises safely.

Mental health providers have the primary responsibility to diagnose and treat individuals with mental illness. Due to limited services and the nature of mental illness, officers are increasingly required to respond to situations and crises stemming from mental illness. As a result, the MPD is committed to partnering with mental health providers, community service providers, and those in the justice system, to develop more compassionate and cost-effective approaches that emphasize providing community-based treatment instead of arrest and incarceration of individuals affected by a mental illness.

MENTAL HEALTH LIAISON/OFFICER PROGRAM

The MPD has a longstanding commitment to partnering with mental health providers in order to improve services to those with mental illness. The Mental Health Liaison/Officer Program serves to further supplement our overall response with a specialized approach and provides added support to first-responding officers before, during, and after any mental health crisis occurs.

Mental Health Officer (MHO)

In order to more consistently and comprehensively address mental health issues in our community and mitigate the increasing demands on patrol resources to provide services to people with mental illness, the MHOs will work with the formal and informal supports, Mental Health Liaison Officers, and the individuals affected by mental illness. MHOs will work to address both district-specific and city-wide systems issues related to mental health and individuals within their district areas of responsibility who are generating or are likely to generate police calls for service. While not call-driven or expected to field any and all mental health related calls, when possible the MHOs will respond into the field to address mental health related calls, particularly Emergency Detentions.

Mental Health Liaison Officer (MHLO)

Above and beyond their regular patrol responsibilities, MHLOs work collaboratively with mental health providers, advocates, consumers, and the MHOs to provide individual response plans and follow-up, address system issues/concerns, share information internally and externally as appropriate, and if possible respond to mental health calls for service when they arise.

RESPONSE GUIDELINES

When Mental Health Issues are Suspected

- Observe signs of abnormal behavior and circumstances under which observed (e.g., mental illness, alcohol).
- Attempt to obtain information regarding mental illness diagnosis, medical history, and medications.
- If danger to self or others, assess for Emergency Detention.
- Consult with Journey Mental Health (hereafter referred to as Crisis) for background information and general advice.
- Assess need for further police assistance.
- Route report to Mental Health Officer and Liaisons.

Disposition Options

- Release with referral made to a mental health agency.
- Place individual in the care of family or friends.
- Convey voluntarily to Crisis or hospital for further evaluation.
- Arrest for a statute or city ordinance violation.
- Protective custody to Detox if applicable.

If Harmful Acts are Committed or Threats Made (suicide attempts, overdose, cutting, other overt acts or threats)

- Ascertain whether the subject has consumed alcohol and/or drugs. If alcohol is on board and the subject is medically cleared, or where medical clearance is unnecessary, transport to Detox under protective custody.
  - For suicidal subjects – make sure to request that Crisis is notified, both verbally and in writing, on the Detox admission form and request a copy for your report. Detox staff will coordinate risk assessment by Crisis as needed for suicidal subject when detoxification is completed.
- If transported to hospital by EMS, consult with ER staff regarding medical admission.
  - If admitted medically, release to hospital and get doctor information for report.
  - If medically cleared or not transported to hospital by EMS, assess for Emergency Detention.

Assessing for Emergency Detention

- Consult with Crisis or other mental health practitioners as applicable. (If person is insured, Crisis will generally refer to provider, however, Crisis should still be involved.)
- Gather information regarding person's mental health history and/or support systems utilized in the past.
- When interviewing the subject don't hesitate to ask specific questions about their intent to harm himself or herself (i.e., "Do you want to hurt yourself?" "Did you really want to end your life?")
- If you have any concerns regarding the subject's welfare and they refuse to accept police assistance, you may place them under protective custody and convey them to Crisis or hospital for evaluation.

Emergency Detention (ED)

S.S.51.15(1) – Basis For Detention: A law enforcement officer is authorized to take into custody a subject whom the officer has **cause to believe** is mentally ill, or drug dependent, or developmentally disabled, **and** that person evidences any of the following:

- A substantial probability of physical harm to self or others as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm.
- A substantial probability of physical impairment or injury to self or others due to impaired judgment as manifested by evidence of a recent act or omission.
- SS 51.15(1)(4) and 51.15 (1)(5) discuss lack of self-care issues and refusal to take medication as possible criteria as well.

Final Dispositions

Voluntary admission is generally the preferred option for individuals who are cooperative and need further mental health treatment.

Voluntary Admission – Where ED Criteria is NOT Present

This option is best used when the subject is cooperative and would benefit from further mental health treatment, yet any threats to their welfare do not rise to the level of an ED. In these situations, officers conveying individual to ER may detach from the call once the subject is in the care of hospital ER staff, even if not yet fully admitted. If the individual is brought to ER by someone else (EMS, family member) then officers do not need to accompany them to ER.

Voluntary Admission – Where ED Criteria is Present

Oftentimes, even when the criteria for an ED are clearly present, a voluntary admission is still the preferred outcome because it is the least restrictive, and therefore, most likely to result in productive treatment. In these situations, it is recommended that the officer stay with the subject until they are assured that the subject will follow through with an admission (e.g., signed papers, escorted through the doors of the psychiatric unit, or medical personnel has assumed responsibility for the person and their continued safety.) Officers should request that hospital personnel re-contact their agency should the subject attempt to leave prior to being fully admitted so that an ED can be completed.

Emergency Detention

When the basis for detention exists do the following:

- Contact Crisis on **all** emergency detentions.
- Crisis must approve all placements for Emergency Detention.
- Receive medical clearance prior to conveyance to authorized facility.
- Complete ED form and/or review form if filled out by mental health professional. The form MUST articulate dangerousness, threats, history, behavior, etc. and list names of witnesses.
- Forms: 4 copies of ED form. 1 – Subject, 1 – Law Enforcement Agency, 1 – Crisis, 1 – Detention Facility. Original to probate court – Courthouse Rm 1005, fax 283-4915.
- Complete report as a priority and route it to Mental Health Officer and Liaisons.

Reminders

- It is best to make phone contact with Crisis at the time of the incident, as well as route the report to the MHLOs for your agency.
- Officers may base an emergency detention on statements made by any reliable source, i.e., any mental health professional, or any direct witnesses to the subject's behavior such as family, friends, etc. **Officers do not have to witness dangerous behavior themselves and may rely solely on the opinion of mental health professionals recommending an ED.**
- If you are experiencing problems or have concerns while at the ER, contact the "point person" there who should be up to date on cases and able to communicate with involved parties. These "point persons" are: The Care Team Leader at UW, and the Charge Nurse at St. Mary's or Meriter.
- If other questions or concerns arise, contact your supervisor.
- Officers are not liable for any actions taken in good faith. The good faith of the actor shall be presumed in any civil action.

Helpful Mental Health Definitions

SETTLEMENT AGREEMENT

- A negotiated contract for treatment signed by the individual, his/her attorney, and the County Corporation Counsel, and approved by the court.
- Waives the court hearings for a specified period of time, up to 90 days.
- Cannot be extended at end of time period, if individual is compliant with treatment.
- Can be rescinded by County Corporation Counsel if the individual fails to comply with the treatment conditions.

ORDER TO TREAT

- The court may order that medication may be administered to an individual regardless of his/her consent (involuntarily and/or forcibly).
- This can be, but is not always, a part of a Chapter 51 commitment.

THIRD PARTY PETITION

- Three adults sign a sworn petition that is drafted by the County Corporation Counsel.
- At least one of the 3 petitioners (signers) must have personal knowledge of the individual's dangerous behavior. Petitioners who have not directly observed the individual's dangerous behavior must provide a basis for their belief that the allegations are true.
- Petition must allege that the individual is mentally ill, developmentally disabled, or drug dependent, and dangerous to self or others, and a proper subject for treatment.
- The County Corporation Counsel files the petition with the court. After review, the judge may order detention of the individual by law enforcement to a mental health detention facility, or may just set the case for a probable cause hearing without ordering detention.
- This process may take several days or more, so it should not be used for emergency situations.

DIRECTOR'S HOLD

- The Treatment Director of a mental health facility/unit may file a statement of ED and detain a patient who has already been admitted to the psychiatric facility/unit.
- A Treatment Director ED usually occurs when an individual is voluntarily admitted to a facility/unit, and later refuses treatment and/or requests discharge.

DEALING WITH DEMENTIA PATIENTS (DP) AT ASSISTED LIVING FACILITIES (ALF)

Madison Police Department (MPD) recognizes that combativeness may be a symptom of dementia for some patients and that this behavior is difficult to manage.

MPD will assist with stabilizing a dangerous scene if a DP is combative and is not calming down with staff intervention.

- It is not recommended to transport DP in the back of a squad car. If the DP cannot be calmed, call MFD to transport them to the hospital.
- Once the DP is calmed down, if ALF staff believes the person needs to be evaluated at a hospital, they should arrange a private ambulance.

Once the scene is stabilized, officers are advised to talk with staff about the care plan in place for when this person is combative.

- Does the DP give any signs prior to becoming combative so staff can divert them?
- What calms the DP down?
- Can the DP be safely removed from other patients during the outburst?
- Regarding medications, what is the policy for the DP refusing medications?
- What is the DP's legal status (guardian or activated Power of Attorney for Health?)
- Is this still an appropriate placement for this person?

Criminal charges or citations are not appropriate for combative DP as they are unable to learn/remember to act differently. Instead the facility needs to manage their behavior and work with MPD to keep them and everyone else safe.

WI Department of Human Services, ADRC, and WI Alzheimer's and Dementia Alliance can all be resources for ALFs and families of DPs.

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