

Responding to Persons Experiencing a Mental Health Crisis

August 2018

The IACP Law Enforcement Policy Center creates four types of documents: Model Policies, Considerations Documents, Concepts & Issues Papers, and Need to Know one-page summaries. Typically, for each topic, either a Model Policy or a Considerations Document is created, supplemented with a Concepts & Issues Paper. This file contains the following documents:

- **Model Policy**: Provides police agencies with concrete guidance and directives by describing in sequential format the manner in which actions, tasks, and operations are to be performed.
- **Concepts & Issues Paper**: Designed to provide context and background information to support a Model Policy for a deeper understanding of the topic.
- **Need to Know...**: Synthesizes the key points of the topic into a brief, one-page overview. This document is developed by Policy Center staff following the final approval of the policy and paper.

Model Policy

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Responding to Persons Experiencing a Mental Health Crisis

I. PURPOSE

It is the purpose of this policy to provide guidance to law enforcement officers when responding to or encountering persons experiencing a mental health crisis. For the purposes of this document, the term person in crisis (PIC) will be used.

II. POLICY

Responding to situations involving individuals reasonably believed to be PIC necessitates an officer to make difficult judgments about the mental state and intent of the individual and necessitates the use of special skills, techniques, and abilities to effectively and appropriately resolve the situation, while minimizing violence. The goal is to de-escalate the situation safely for all individuals involved when reasonable and consistent with established safety priorities. Applicable law of the jurisdiction shall guide the detention of PIC.

It is the policy of this agency that officers be provided with training to determine whether a person's behavior is indicative of a mental health crisis and with guidance, techniques, response options, and resources so that the situation may be resolved in as constructive, safe, and humane a manner as possible.

III. DEFINITIONS

Mental Health Crisis: An event or experience in which an individual's normal coping mechanisms are overwhelmed, causing them to have an extreme emotional, physical, mental, and/or behavioral response. Symptoms may include emotional reactions such as fear, anger, or excessive giddiness; psychological impairments such as inability to focus, confusion, or 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 "freeze, fight, or flight" response. Any individual can experience a crisis reaction regardless of previous history of mental illness.

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 they display 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 their welfare with regard to basic provisions for clothing, food, shelter, or safety.

IV. PROCEDURES

A. Recognizing Atypical 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 potentially indicative of PIC, with special emphasis on those that suggest potential violence and/or danger. The following are generalized signs and symptoms of behavior that may suggest an individual is experiencing a mental health crisis, but each should be evaluated within the context of the entire situation. However, officers should not rule out other potential causes, such as effects of alcohol or psychoactive drugs, temporary emotional disturbances that are situational, or medical conditions.

1. Strong and unrelenting fear of persons, places, or things.
2. Extremely inappropriate behavior for a given context.
3. Frustration in new or unforeseen circumstances; inappropriate or aggressive behavior in dealing with the situation.
4. Memory loss related to such common facts as name or home address, although these may be signs of other physical ailments such as injury, dementia, or Alzheimer's disease.
5. Delusions, defined as 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").
6. Hallucinations of any of the five senses (e.g., hearing voices, feeling one's skin crawl, smelling strange odors, seeing things others cannot see).
7. The belief that one suffers from extraordinary physical ailments that are not possible, such as persons who are convinced that their heart has stopped beating for extended periods of time.
8. Obsession with recurrent and uncontrolled thoughts, ideas, and images.
9. Extreme confusion, fright, paranoia, or depression.
10. Feelings of invincibility.

B. Assessing Risk

1. Most PIC are not violent and some may present dangerous behavior only under certain circumstances or conditions. Officers may use several indicators to assess whether a PIC represents potential danger to themselves, the officer, or others. These include the following:
 - a. The availability of any weapons.
 - b. Threats of harm to self or others or statements by the person that suggest that they are 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 exhibits, particularly the amount of physical control, over emotions such as 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. Indications of substance use, as these may alter the individual's self-control and negatively influence an officer's capacity to effectively use de-escalation strategies.
 - f. The volatility of the environment. Agitators that may affect the person or create a particularly combustible environment or incite violence should be taken into account and mitigated. For example, the mere presence of a law enforcement vehicle, an officer in uniform, and/or a weapon may be seen as a threat to a PIC and has the potential to escalate a situation. Standard law enforcement tactics may need to be modified to accommodate the situation when responding to a PIC.
 - g. Aggressive behaviors such as advancing on or toward an officer, refusal to follow directions or commands combined with physical posturing, and verbal or nonverbal threats.
2. Failure to exhibit violent or dangerous behavior prior to the arrival of the officer does not guarantee that there is no danger.
 3. A PIC may rapidly change their 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 they will become violent or threatening, but officers should be prepared at all times for a rapid change in behavior.
 4. Context is crucial in the accurate assessment of behavior. Officers should take into account the totality of circumstances requiring their presence and overall need for intervention.

C. Response to PIC

If the officer determines that an individual is experiencing a mental health crisis and is a potential threat to themselves, the officer, or others, law enforcement intervention may be required, as prescribed by statute. All necessary measures should be employed to resolve any conflict safely using the appropriate intervention to resolve the issue. 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. Request assistance from individuals with specialized training in dealing with mental illness or crisis situations (e.g., Crisis Intervention Team (CIT) officers, community crisis mental health personnel, crisis negotiator, or police psychologist).
3. Contact and exchange information with a treating clinician or mental health resource for assistance, based on law and statute.¹
4. Take steps to calm the situation. Where possible, eliminate emergency lights and sirens, disperse crowds, lower radio volume, 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.

¹ Officers in the United States can provide the HIPAA exemption reference number (45 CFR 164.512(j)(1)(i)(A)) for the clinician's reference, if necessary. This exemption states that it is allowable for a covered entity to disclose protected health information to law enforcement if it "is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public."

5. Create increased distance, if possible, in order to provide the officer with additional time to assess the need for force options.
6. Utilize environmental controls, such as cover, concealment, and barriers to help manage the volatility of situations.
7. Move slowly and do not excite the individual. Provide reassurance that officers are there to help and that the individual will be provided with appropriate care.
8. Ask the individual's name or by what name they would prefer to be addressed and use that name when talking with the individual.
9. 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 individual's feelings and allow the individual to express feelings without judgment.
10. 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 individual.
11. Do not threaten the individual with arrest, or make other similar threats or demands, as this may create additional fright, stress, and potential aggression.
12. Avoid topics that may agitate the individual and guide the conversation toward subjects that help bring the situation to a successful conclusion. It is often helpful for officers to apologize for bringing up a subject or topic that triggers the PIC. This apology can often be a bridge to rapport building.
13. Attempt to be truthful with the individual. If the individual becomes aware of a deception, they 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.)" are recommended. Validating and/or participating in the individual's delusion and/or hallucination is not advised.

D. Taking Custody or Making Referrals to Mental Health Professionals

1. Based upon the overall circumstances of the situation, applicable law and statutes, and agency policy, an officer may take one of several courses of action when responding to a PIC.
 - a. Offer mental health referral information to the individual and/or family members.
 - b. Assist in accommodating a voluntary admission for the individual.
 - c. Take the individual into custody and provide transportation to a mental health facility for an involuntary psychiatric evaluation.
 - d. Make an arrest.
2. When circumstances indicate an individual meets the legal requirements for involuntary psychiatric evaluation and should be taken into custody and transported to a mental health facility, or when circumstances indicate that an arrest is necessary, the officer should, when possible, request the assistance of crisis intervention specialists to assist in the custody and admission process, as well as any interviews or interrogations.
3. Officers should be aware that the application or use of restraints may aggravate any aggression being displayed by a PIC.

4. In all situations involving a PIC, officers should
 - a. Continue to use de-escalation techniques and communication skills to avoid escalating the situation.
 - b. Remove any dangerous weapons from the area.
 - c. Where applicable, ensure that the process for petition for involuntary committal has been initiated by the appropriate personnel.

E. Documentation

Officers should

1. Document the incident, regardless of whether or not the individual is taken into custody. Where the individual is taken into custody or referred to other agencies, officers should detail the reasons why.
2. Ensure that the report is as specific 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.
3. In circumstances when an individual is transported to a mental health facility for a psychiatric evaluation, and agency policy permits, provide documentation to the examining clinicians detailing the circumstances and behavior leading to the transport.

Every effort has been made by the IACP Law Enforcement Policy Center staff and advisory board to ensure that this model policy 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. 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. Readers outside of the United States should note that, while this document promotes procedures reflective of a democratic society, its legal basis follows United States Supreme Court rulings and other federal laws and statutes. Law enforcement administrators should be cautioned that each law enforcement agency operates in a unique environment of court rulings, state laws, local ordinances, regulations, judicial and administrative decisions, and collective bargaining agreements that must be considered and should therefore consult their legal advisor before implementing any policy. This document is not intended to be a national standard.

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Concepts & Issues

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Responding to Persons Experiencing a Mental Health Crisis

I. INTRODUCTION

A. Purpose of Document

This paper was designed to accompany the *Model Policy on Responding to Persons Experiencing a Mental Health Crisis* developed by the IACP Law Enforcement Policy Center. This paper provides essential background material and supporting documentation to provide greater understanding of the developmental philosophy and implementation requirements for the model policy. This material will be of value to law enforcement executives in their efforts to tailor the model policy to the requirements and circumstances of their community and their law enforcement agency.

B. Background

Law enforcement agencies across the globe are increasingly required to respond to and intervene on behalf of persons experiencing a mental health crisis. For the purposes of this document, the term person in crisis (PIC) will be used to describe individuals who are affected by mental illness or are experiencing a mental health crisis. Many individuals affected by mental illness are currently housed in jails, prisons, and juvenile detention centers, rather than mental health treatment facilities. Individuals who are unable to obtain effective mental health treatment through the limited available resources are likely to behave in ways that bring them into contact with law enforcement. In far too many communities, the local detention center or jail is inappropriately utilized as the only location to which law enforcement can bring those who are behaving erratically due to a mental health crisis.

In addition, there is an increased likelihood that PIC will be arrested for low-level crimes such as, but not limited to, petty theft, aggressive panhandling, public urination, littering, and trespassing; offenses that often characterize the behavior of homeless people affected by untreated mental health disorders. Unless enhanced enforcement of these types of crimes is accompanied by increased access to treatment and support services, PIC who commit these “nuisance” offenses will likely become trapped in a repetitive cycle of arrest, short jail stays, and return to the streets without treatment, only to commit more minor illegal acts that result in their re-arrest.

A more effective approach involves redirecting societal resources from containment to treatment of PIC whose behaviors are seen as atypical or aberrant. In a number of jurisdictions, law enforcement agencies have partnered with justice system, mental health, and other community agencies to develop more compassionate and cost-effective

approaches that emphasize providing community-based treatment instead of arrest and incarceration for both adult and juvenile PIC. Ideally, the only PIC who should come into contact with law enforcement are those who are victims of crimes, suspected of committing crimes, or who are a danger to themselves or others. Those who do not fall into the category of potentially dangerous behavior are more appropriately handled by mental health provider response and referral. Also, if mental health services and other social support systems are functioning optimally, a much smaller proportion of PIC will likely engage in criminal, threatening, or suicidal behavior that becomes the focus of a law enforcement response.

Officers should assess the behavior and intention of PIC, while performing enforcement and investigative functions. PIC and their families rely on first responders, particularly law enforcement officers, to behave in an effective manner, treating the PIC with compassion and respect. Law enforcement officers who face these complex situations must be as prepared as possible so that they can respond in ways that ensure their safety, the public's safety, and the safety of the PIC. It is critical for the officer responding to a mental health call to possess the proper knowledge and training to adequately assess the situation and engage community resources in the best interests of the PIC, the officer, and the community.

To this end, it is helpful for officers to understand the symptomatic behavior of PIC. In this way, officers are in a better position to formulate appropriate strategies for gaining the individual's compliance and determining whether medical or other assistance is required, whether detention is appropriate or required, and, whether a suspect is in a suitable state to be questioned. However, a law enforcement officer should not attempt to diagnose PIC. Mental illness is often difficult for even the trained professional to diagnose under controlled circumstances; for an officer who confronts such an individual in an enforcement setting with other aggravating factors in play, the task would be even more complex and uncontrolled. However, officers can and should be able to recognize behavior that is characteristic of mental illness and particularly that which is potentially destructive and/or dangerous.

II. POLICY RECOMMENDATIONS

A. Symptoms of Mental Illness

Mental health problems are health conditions involving changes in thinking, mood, and/or behavior and are associated with distress or impaired functioning. When these conditions are more severe, they are called mental illnesses. Mental illness is 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 or experiencing a mental health crisis if they display an inability to think rationally (e.g., delusions or hallucinations); to exercise adequate control over behavior or impulses (e.g., aggressive, suicidal, homicidal, sexual); and/or to take reasonable care of their welfare with regard to basic provisions for clothing, food, shelter, or safety. Some types of mental illness include anxiety disorders, attention-deficit/hyperactivity disorder, depressive and other mood disorders, eating disorders, and schizophrenia. The following are some of the more commonly encountered forms of mental illness.

Schizophrenia. Schizophrenia tends to appear earlier in men than in women, showing up in their late teens or early 20s, as compared to their 20s or early 30s in women. Schizophrenia often begins with an episode of psychotic symptoms like the individual hearing voices (i.e., hallucinations) or irrationally believing that others are trying to control or harm them (i.e., delusions). The delusions—thoughts that are fixed, bizarre, and have no basis in reality—may occur along with hallucinations and disorganized speech and behavior, leaving the individual frightened, anxious, and confused. A person with schizophrenia may exhibit grandiose delusions, such as “I am Christ,” or persecutory delusions such as “Everyone is out to get me.” Delusional persons may also have generalized fears or beliefs such as unrealistic fears that they are being constantly watched; that their conversations or even their thoughts are being overheard, recorded, or monitored; or, that they are being talked about, followed, or otherwise persecuted, harassed, or controlled.

Hallucinations are usually present with schizophrenia. Hearing or seeing things is most common, but hallucinations can involve any of the five senses. For example, the individual may hear voices commanding them to act in a particular way, may feel their skin “crawl,” smell strange odors, or see “devils” or “ghosts.” While hallucinations are usually symptomatic of schizophrenia, they may also be caused by controlled substances or alcohol.

Bipolar Disorder. Bipolar disorder, formerly called manic-depressive illness, is a type of mood disorder characterized by recurrent episodes of highs (mania) and lows (depression) in mood. These episodes involve extreme changes in mood, energy, and behavior. Manic symptoms include extreme irritable, euphoric, or elevated mood; an inflated sense of self-importance (grandiosity); increased high-risk behaviors; distractibility; increased energy; and a perceived decreased need for sleep. Depressive episodes of bipolar disorder involve a period of a pervasive sense of sadness and/or loss of interest or pleasure in most activities that interferes with the ability to work or function. This is a severe condition that can impact a person’s thoughts, sense of self-worth, sleep, appetite, energy, and concentration. It is frequently associated with thoughts of suicide. Individuals affected by bipolar disorder may demonstrate alternating cycles of a mood disturbance with repeated episodes of depression, mania, or a mixture of both.

Major Depressive Disorder. Like the periods of depression in bipolar disorder, major depressive disorder involves a pervasive sadness and/or loss of interest or pleasure in most activities. The disorder interferes with the ability to work, study, sleep, eat, and enjoy once pleasurable activities. The condition can impact a person’s thoughts, sense of self-worth, sleep, appetite, energy, and concentration. Suicidal thoughts may be prominent. The condition can occur as a single debilitating episode or as recurring episodes. It differs from bipolar disorder in that it is unipolar—the person suffers only from periods of depression.

Post-traumatic Stress Disorder (PTSD). Post-traumatic Stress Disorder affects about 7.7 million adult Americans.¹ PTSD occurs after an individual experiences an event such as military combat, a sexual or physical assault, automobile accidents, or a natural disaster. First responders can be traumatized by exposure to calls such as collecting human remains or through repeated exposure to details of child abuse. With PTSD, individuals struggle with re-experiencing the original trauma either through nightmares or disturbing, intrusive thoughts throughout the day that may make them feel detached, numb, irritable, or aggressive. Attempts to avoid thinking about the trauma may be present including amnesia for all or part of the event. Persistent negative thoughts or feelings (e.g., survival guilt) may continue beyond the trauma. Ordinary events may serve as reminders of the trauma and may cause flashbacks, hyperarousal, or panic. Some people recover a few months after the event, while others experience lasting or chronic PTSD.

Personality Disorders. Personality disorders are conditions marked by enduring maladaptive personality traits and characteristics. No psychotic symptoms (i.e., hallucinations and delusions) are present. Two of these conditions are frequently encountered by law enforcement: Borderline Personality Disorder and Antisocial Personality Disorder. However, while Antisocial Personality Disorder usually does not present in a way that rises to the level of distress or emotional crisis that is the topic of this paper.

Borderline Personality Disorder. Borderline Personality Disorder causes uncertainty about the person’s identity or view of themselves. As a result, interests and values can change rapidly, and behavior may be fickle and unstable. Individuals affected by the disorder tend to view things in terms of extremes, such as either all good or all bad. Their views of other people can change quickly. A person who is looked up to one day may be looked down on the next. These suddenly shifting feelings often lead to intense and unstable relationships, extreme fear of being abandoned, intolerance for being alone, recurring feelings of emptiness and boredom, and frequent displays of inappropriate anger and impulsiveness, such as with substance abuse or sexual relationships. Recurring suicidal behaviors or threats or self-harming behavior, such as cutting, frequently occur.

¹ National Institutes of Health, “Post-Traumatic Stress Disorder,” fact sheet, http://report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?c_sid=58&key=P#P.

B. Other Causes of Atypical Behavior

Officers should not confuse mental illness with seemingly atypical behavior that is the product of other types of disabilities. This includes intellectual disability or other developmental disabilities (I/DDs) that may manifest similarly to mental illness. There are important differences between individuals affected by I/DDs and those affected by mental illness. To officers, it is often not possible to differentiate I/DDs from mental illness, especially from a brief interaction with a person with a suspected disability. Instead of trying to diagnose individuals, officers should focus instead on addressing immediate safety concerns and then addressing the person's need. For example, someone with a disability may need to feel safe, extra time to calm down, medical assistance, transportation assistance, and/or access to mental health services.²

Developmental disabilities (DD) refers to long-term disabilities attributable to a physical, mental, or combination of impairments that result in functional limitations in major life activities, such as understanding and expressing language, learning, moving, self-direction, self-care, independent living, and economic self-sufficiency. The disability must have originated before the age of 22 and is likely to continue throughout the individual's life. "Developmental disability" is an umbrella term that encompasses intellectual disability, but also covers some physical disabilities. Some DDs might consist only of physical or sensory impairments, such as blindness from birth. Other DDs involve both physical impairments and diminished intellectual functioning stemming from genetic or other causes, such as Down syndrome.

Examples of DDs include the following:

- *Intellectual Disability (ID)*. Intellectual disability is characterized by limited or diminished intellectual functioning and difficulty with adaptive behaviors, such as managing money, schedules and routines, or social interactions. Unlike ID, individuals affected by mental illness may not be impaired intellectually. ID is a type of DD, with onset during an individual's early years of development and continues across the lifespan, whereas mental illness may develop during any period of an individual's life and can be cyclical, episodic, short-term, or long-term. People affected by mental illness may benefit from various therapies and/or psychotropic medications. However, people with an ID may benefit from different forms of therapy, such as behavioral therapy, but generally will not benefit from the use of psychotropic medications unless they are also affected by mental illness. Individuals who have both an ID and are affected by mental illness are referred to as having a "dual diagnosis."
- *Cerebral Palsy*. Cerebral palsy is a type of DD. Persons with cerebral palsy often have limitations in motor and speech functions, which may impact their ability to move and communicate. People with cerebral palsy might or might not also have a co-occurring intellectual disability, so officers should not assume the person automatically has ID. People with cerebral palsy may use mobility devices, such as wheelchairs, scooters, walking sticks, walkers, and/or canes, and may also use communication devices, such as iPads, type-to-text technologies, and picture boards. Some people with cerebral palsy may be mistakenly perceived as drunk or otherwise under the influence of drugs, due to slurred speech and involuntary motor movements.
- *Autism Spectrum Disorders*. Autism is a type of DD that affects language, communication, social skills, sensory systems, and behavior. Due to differences in sensory perception and processing, people with autism may be easily distressed by changes in their environment or routine; may experience pain at lesser or greater intensity; and may react unpredictably to touch or other forms of stimuli, such as flashing lights or sirens. People with autism may engage in repetitive behavior

² For more information on responding to individuals with I/DDs, see the IACP *Model Policy and Concepts & Issues Paper on Interactions with Individuals with Intellectual and Developmental Disabilities* available at http://www.theiacp.org/model-policy/model_policy/developmentally-disabled/.

and may also exhibit atypical body movements, such as hand flapping or rocking. These behaviors may be mistakenly perceived as the product of being under the influence of drugs.

C. Persons in Crisis

Without regard to whether a person is affected by mental illness, they may react in inappropriate ways or display bizarre behavior if experiencing a mental health crisis. “Mental health crisis,” for purposes of this discussion, relates to an event or experience in which an individual’s normal coping mechanisms have become overwhelmed, causing them to have an extreme emotional, physical, mental or behavioral response. A person may experience a mental health crisis during times of stress and in response to real or perceived threats and/or loss of control. Symptoms may include emotional reactions such as fear, anger, or excessive giddiness; psychological impairments such as an inability to focus, confusion, nightmares, and potentially even psychosis; physical reactions like vomiting or stomach issues, headaches, dizziness, excessive tiredness, or insomnia; and/or behavioral reactions, including the trigger of a “freeze, fight, or flight” response. Any individual can experience a crisis reaction regardless of previous history of mental illness.

D. Law Enforcement Response to PIC

The dynamics and circumstances of response to a call involving a PIC will be determined to some degree by the manner in which the contact is initiated. Family members of a PIC are frequently the initiators of law enforcement contact, often when the affected person has created a family disturbance. Such family disturbances can be the source of complex and challenging dilemmas for officers. Family members usually call asking for assistance in the hopes of gaining access to treatment for their family member. These situations can have a high potential for noncompliance and resistance from the PIC to law enforcement, which may lead to misunderstandings and dissatisfaction, particularly when the situation results in a use of force and/or an arrest. A PIC may also seek out assistance from law enforcement themselves, particularly when there is a degree of familiarity between the officer and person based on prior contacts.

Possible points of contact between law enforcement and a PIC are on city streets and in other public places. Members of the public may contact law enforcement if they witness a PIC behaving in a way that is perceived as bizarre or disruptive. While the intention may be to act as a Good Samaritan, some members of the public may simply be uncomfortable in the presence of a PIC, which leads them to call for assistance from law enforcement.

In both enforcement and investigative capacities, officers often encounter PIC among the homeless population inhabiting public places on a full-time or part-time basis. A large proportion of these individuals are affected by mental illness.³ Other homeless persons may have milder forms of mental illness that often allow them to move between living on the street and the homes of relatives and friends, shelters, care homes, or other living arrangements. Among these are also persons who are affected by a combination of mental illness, alcoholism, drug abuse, head injury, and degenerative or incapacitating diseases.

E. Assessing Risk

Due to the unpredictable nature of some PIC, officers must be particularly conscious of their own safety and that of bystanders when dealing with individuals in crisis. Promotion of a more thoughtful approach to calls involving PIC does not reduce the emphasis on officer safety. Assessment of the individual and the situation must be ongoing throughout the contact, beginning with the receipt of basic information about the individual and continuing until the contact is over. The more the officer can obtain health-related information about the individual (e.g., do they have a diagnosed condition, are they taking medication, is there an established relationship with a mental health provider), the better prepared the officer is to make responsive decisions. If the initial contact is made through a dispatched call

³ National Alliance on Mental Illness, “Mental Health by the Numbers,” <https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers>.

for service, some basic information can be obtained from communications personnel. The same type of information should be obtained if possible from other sources, whether that is a concerned citizen, another officer, the court, jail personnel, or family member.

When situationally appropriate and time allows, responding officers should seek helpful information, as available. Such information can include, but is not limited to, the characteristics and specific behavior of the PIC, relationship of the complainant to the PIC (if any), whether a crime is involved, the availability of weapons to the PIC, prior law enforcement contact with the PIC, and the nature of any previous mental health dispositions.

Once equipped with this type of information, the responding officer can better determine an appropriate response. Unless a crime of violence has been committed and/or a dangerous weapon is involved, officers should normally respond to the incident or approach a PIC in a low-profile manner while still remaining tactically sound. Emergency lights and sirens should be used only when urgent response is critical, and these devices should be turned off as soon as possible upon arrival. Emergency equipment can have a disturbing and altogether negative impact on a PIC and may potentially heighten the person's anxiety, further hindering the officers' efforts to calm the situation. When circumstances allow, contacts with PIC should be slowed down. Officers should try to establish themselves as helpers, rather than enforcers; the uniform, duty weapon, and badge imply that a uniformed officer is capable of using force and is authorized to engage in enforcement activities, so it need not be emphasized. When it is situationally appropriate, officers should try to understand the person's issues and concerns, and focus on developing rapport, before attempting to gain compliance. By reassuring the PIC that they are there to help keep them safe, officers will help to foster a relationship that can increase their ability to use influence rather than force to gain compliance.

Where there is reason to believe that the individual is in a crisis situation, such as threatening suicide or involved in a hostage and/or barricade situation, officers should request any specialized crisis intervention assistance available while taking initial steps necessary to moderate or defuse the situation. This may include summoning officers with special training in crisis negotiations, such as Crisis Intervention Team (CIT) trained officers, or crisis negotiators.

At the scene of an incident involving a PIC, officers should first take time, if possible, to assess the situation and gather necessary information, avoiding hasty and potentially counterproductive decisions and actions. Such calls usually have a better outcome if time is used to an officer's advantage. While circumstances may preclude such inquiries, where time permits, family members or friends of the individual can often lend some insight into the person's background and specifics about their behavior. Friends or acquaintances may be able to provide some information regarding the person's present behavior. Pinpointing the cause of the behavior, as perceived by the individual, can provide officers with a basis for discussion and possible moderation of the person's distress and behavior. It can also help the officer decide if the problem is the result of a disability.

Also important is information on the person's present or past use of psychiatric medication. Many persons who are affected by mental illness fail to use medication that has been prescribed for their diagnosed mental illnesses. This is common, for example, among persons affected by schizophrenia and bipolar disorder. Many people affected by schizophrenia receive treatment on an outpatient basis and gain a degree of self-control and remission of symptoms as long as that treatment is continued. However, without medical supervision, many are incapable or unwilling to maintain the prescribed treatment regimen on their own, either due to a lack of insight into their illness, an inability to afford or access medication, or a substantial discomfort from the medication's side effects. As such, they often revert to their previous pattern of symptomatic behavior.

In addition, some persons affected by mental illness attempt to alleviate their anxieties and related mental illness symptoms through self-medication with alcohol, controlled substances, or a combination of these. The use of these drugs tends to exacerbate existing mental conditions, compounds the difficulty in diagnosing and treating these individuals, and causes additional difficulty for officers in their attempts to gain control of the individual's behavior.

Before approaching the PIC, officers should attempt to control the immediate surroundings and establish a perimeter. PICs are generally adversely influenced by distractions including noise and crowds. Crowds of curious bystanders generally, and antagonistic or rowdy persons, in particular, can excite and unduly agitate a PIC,

particularly those who are threatening suicide or violence. Therefore, where such crowds or bystanders are on hand they should be controlled and preferably removed so officers may better communicate with the PIC. Family members who create disruption or who contribute to the confusion of the PICs are no exception. However, witnesses and those who can provide information or assistance that is helpful in resolving the situation should be asked to remain nearby.

Once the immediate surroundings are under control, attention should be directed toward determining whether the individual represents a danger to himself, herself, or others. The presence of a dangerous weapon is an obvious indication that violence is possible, but there are other behavioral characteristics that an officer can use to help determine whether the PIC is prone to dangerous conduct toward self or others.

Statements of the PIC. Any threatening statements made by the PIC should be given serious consideration and should not be dismissed simply as the ramblings of a confused or troubled individual. This is particularly the case where the capacity or capability to engage in dangerous conduct exists. Such statements may range from subtle innuendo to direct threats. Comments that suggest intent to commit a dangerous act do not have to be taken at face value. When taken in conjunction with other information, such threats can paint a more complete picture of the potential for violence. In as much as a direct threat is not required to conclude a person is dangerous to themselves or others, the officer should assess in totality whether the PIC poses a serious threat of substantial harm to themselves or others.

Personal History. It is not uncommon for law enforcement officers to have some familiarity with a PIC based on prior contacts. Under such circumstances, officers are in a better situation to assess the individual's propensity for violence as well as the predictability of the individual's behavior. Where the PIC is unknown to the officers, friends, family, or others may be able to provide some insight into the individual's behavior and capacity for dangerous behavior. With or without such information, officers should be cautioned that PIC may be unpredictable. Even the familiar and often compliant PIC can sometimes react in a dangerous manner without perceived provocation.

Observed Actions. The PIC's actions while officers are on the scene, as well as those that were observed prior to the officers' arrival, are relevant to a determination of the individual's propensity for violence. Acts or threats of violence should be taken seriously. Failure to act in a dangerous manner prior to an officer's arrival does not guarantee that there is no danger, but it does tend to diminish the potential.

Officers should make mental notes of the precise actions and behaviors taken by the individual so that these can be entered into their report. Descriptions of the exact actions of a PIC are particularly important when justification is required for arrest or evaluation and possible commitment to a mental health facility. Use of generalized terms such as "bizarre" or "crazy" to describe the nature of an individual's actions are not sufficient and should be substantiated with concrete illustrations of actual behavior. Verbatim quotes are very helpful when providing a description of the PIC's comments, either when taking an individual into custody for a mental health evaluation or during an arrest that may lead to later questions regarding the arrestee's mental state at the time of the crime.

Degree of Control. The amount of control that an individual demonstrates is significant, particularly the amount of physical control over emotions of rage, anger, fright, or agitation. Signs of a lack of control include extreme agitation, inability to sit still or communicate effectively, wide eyes, and rambling thoughts and speech. In addition, 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. It may also be pertinent to note whether the PIC is actively losing control during the contact as this could be a sign of acute mental illness and/or a decompensation of the PIC's ability to remain oriented to place and time.

Volatility of the Environment. The general environment surrounding the event should also be taken into consideration. This potentially covers a broad range of issues in addition to those involving crowds, noise, and confusion already mentioned. For example, if a criminal offense is involved and an arrest is required, attempts to restrain the individual can be the source of agitation and confrontation between the officers and the PIC if not handled wisely and skillfully. In open public spaces where attention is being drawn, the individual may be more easily distracted and/or agitated as opposed to isolated or private settings.

F. Approaching and Interacting with PIC

When officers are preparing to approach a PIC, they should take several factors into consideration. First, officers should always be aware of their personal safety when interacting with a PIC. A backup officer should be summoned to provide assistance. This is particularly necessary prior to efforts to take the person into custody. Officers should also recognize that they are not in a position personally to solve the problems of a PIC. However, it is entirely possible that this same person will again come into contact with law enforcement in a similar or related context, so officers should remember that their actions may have a long-term impact on the perceptions of that person toward law enforcement. A negatively remembered contact will also invariably create difficulty for the same or other officers in future interactions with that individual. In a worst-case scenario, failure to interact responsibly and fairly with the individual may lay the groundwork for a later, more serious confrontation with law enforcement and the community involving potential physical injury or loss of life.

When approaching a PIC, officers should attempt to slow things down and build rapport by speaking in a calm and relaxed manner. It is important for officers to be prepared for physical contact, but critical that they do not come off as aggressive in their posture or stance as this could escalate the PIC's emotional state or level of agitation. Officers should avoid closely approaching the PIC until a degree of rapport has been developed, if this is at all possible. When speaking with the individual, officers should attempt to exhibit a caring attitude without becoming authoritarian, overbearing, condescending, or intimidating. While the PIC might not be in command of their behavior at all times, they do not necessarily lack intellectual abilities or insight, and may be provoked by demeaning, condescending, arrogant, or contemptuous attitudes of others. Officers should attempt to constructively help the person in a calm, non-judgmental manner and should maintain command presence by demonstrating some understanding and empathy for the individual's problems or concerns, while avoiding a tough or threatening manner.

Officers should engage in active listening (e.g., reflection of feelings, restating, paraphrasing, and supportive statements) by asking the person to express their concerns. This verbal tactic is a control strategy that helps de-escalate or defuse an agitated, fearful, or angry individual. The officer can enhance the person's willingness to engage by frequent communication of the officer's understanding of the person's concerns. In addition, avoiding issues and topics that may agitate the individual is recommended along with efforts to guide the conversation toward subjects that help bring the individual back to reality. Officers should reassure the individual that they are there to help and that an appropriate resolution of the problem can be reached. All attempts should be used to reassuringly communicate with the person first by allowing them to vent in order to determine the possible source of agitation or conflict. Efforts should be made to relate the officer's concern for the individual's feelings and an appreciation for the problems and concerns that the individual describes, no matter how trivial or bizarre they may appear. The emphasis here is to develop a rapport with the individual that will provide reassurance that the officer is not there simply in an authoritarian role but to assist them. In attempts to assist, however, officers should always strive to be truthful with a PIC. If the person becomes aware that officers are being deceitful, they may withdraw from contact in distrust and may become hypersensitive or retaliate in anger.

The individual should not be threatened with arrest or other enforcement action, as this will only add to their fright and stress and may potentially spark aggression. However, should arrest or detention be necessary, the officer should inform the person of what is about to occur, ask for their cooperation, and proceed with taking them into custody.

G. Taking Custody of PIC or Making Referrals to Mental Health Professionals

Based on the overall circumstances of the situation, applicable state law, and agency policy, an officer may take one of several courses of action when interacting with a PIC. The options for assisting such individuals generally fall into four response categories:

Counsel and/or Refer. When a criminal or other offense is not involved and there are not sufficient grounds for taking the person into custody for their own protection, the protection of others, or for other reasons (e.g., grave disability) as specified by law, it is often best to make mental health referrals and provide some basic guidance for the individual. For the PIC who resides in a public place, referrals to community mental health facilities may go unheeded. Individuals in this situation might be unable to recognize their mental health conditions and have even less ability or interest in acting upon referral recommendations. If the agency keeps track of calls involving PIC or works with liaisons in the mental health community, notifications should be made to these individuals. Some PIC go through periods of relative lucidity during which they may be able to recognize their needs and act upon an officer's suggestions, particularly if the location and telephone number of local mental health facilities has been provided to them in writing.

In cases where PIC have friends, family, and other support systems in the community, information on mental health facilities may also be provided directly to these individuals. With this information, they may be in a better position to seek assistance for their friend, acquaintance, or relative who is affected by mental illness. In cases where the individual is extremely agitated, it is generally inadvisable to leave them unattended. In many such cases, when left alone in a highly emotional state, the PIC may resort to the same behavior that was the basis for law enforcement intervention in the first place. In such cases, officers may, if permitted by agency policy, provide transportation for the individual to a group home, respite care, or other facility that can provide shelter, counseling, or related mental health services or, to the home of a friend, family member, or acquaintance who may be willing to provide assistance.

Professional Assistance. Because it is not possible for officers to diagnose mental illness or understand the degree to which some persons may need professional care in order to avoid violence to themselves or others, use of a trained mental health professional is often a preferred option. Some agencies are fortunate to have a mental health professional, such as a counselor or crisis intervention specialist, on staff who may be employed in this capacity. Agencies may also have contract community mental health providers who can assist. In any of these cases, officers may, based on the nature of the situation, request assistance by either direct intervention at the scene of the incident, by telephone consultation with a mental health professional, or by transporting the individual to a centralized location where assessment and other treatment can be obtained.

Refusal to submit to voluntary examinations or professional assistance can be expected in many instances, since PIC may lack an understanding that they are ill. However, it is entirely acceptable for officers to explain that such refusal may leave the officer with no other option than to seek alternative remedies, such as arrest where justified or detention for an involuntary examination in a mental health facility where legal grounds exist. Some PIC, recognizing that they are not fully in control of their actions and/or thoughts, and who may be aware of stories of confinement related by other mentally ill acquaintances, fear mental health professionals and examinations. Officers can dispel some of that fear by explaining that an examination does not mean incarceration or confinement in a mental health facility—but it may provide them with much-needed assistance and possibly allow them to avoid future confrontations with others, including law enforcement. Officers need to be mindful that they are assisting a vulnerable population, and act in accordance with that responsibility.

Involuntary Examination. Some laws provide the legal criteria and limitations for involuntary commitment of individuals for mental health examinations. While laws and statutes vary, they generally provide for a brief involuntary examination when the person is a danger to self or others, is gravely disabled by mental impairment, and/or is so impaired as to not understand the need for mental health treatment. Officers must refer to specific jurisdictional statutes for details in regarding these provisions and should be aware of the rights of those who are detained for mental health examinations and any special requirements expected of the officer in such situations. If the criteria for involuntary mental health examination has been satisfied, and a misdemeanor or other less serious violations have also been committed, officers may, depending upon agency policy, choose the course of involuntary commitment in lieu of or in addition to lodging criminal charges and may ask for notification from the facility at the time of discharge from the commitment, if permitted by law in the jurisdiction.

The issue of involuntary examination may be problematic for officers and others involved. Many mental health institutions have limited resources including bed space, which can sometimes result in the PIC being treated for a short period of time and then released back into the community, where law enforcement may make contact with that person again. This cycle can be frustrating for officers.

At the same time, failure to take action when there are sufficient grounds to believe that a PIC may be a danger to themselves or others can have serious consequences. In such situations, officers may place themselves and/or their agency in jeopardy of civil liability should a serious incident develop as the result of their inaction. Jurisdictions that have developed a coordinated law enforcement-mental health partnership to respond to PIC are in a far better position to respond to these and other related issues.

Arrest. As noted in the foregoing, arrest may be used solely or in combination with involuntary commitment. However, when a felony or other serious offense is involved, officers should normally make the arrest and rely on supervisory and other command-level personnel to determine whether an involuntary mental health examination is warranted.

Before taking a person into custody under arrest or for involuntary mental examination, officers should consider summoning a supervisor. Taking custody of a PIC can be a difficult undertaking. Once a decision has been made to take a PIC into custody, it should be done as soon as possible to avoid prolonging a potentially violent situation. Officers should immediately remove any objects that can be used as a dangerous weapon and restrain the person if necessary. While the use of restraints can, with some individuals, aggravate their aggression, officers should take these and related security measures necessary to protect the PIC's safety and the safety of others with whom the PIC will come in contact.

In cases where the arrest of a PIC is warranted, the officers should effectively communicate to the PIC in an attempt to reduce any additional stress.

III. CONCLUSION

All law enforcement officers should be familiar with the potential signs and symptoms of a PIC. However, it must be stressed that officers are not required to diagnose mental illness; instead, they should be able to recognize that an individual is in crisis and respond in an informed manner. The procedures suggested herein should be utilized when responding to a call involving a PIC, in an effort to provide appropriate care for the individual and ensure safety for all involved parties.

Each incident involving a PIC is different and therefore requires officers to have proper understanding and training to successfully assess the needs of the PIC and determine the best course of action. This often includes the use of tactics designed to slow down the encounter and provide an opportunity for officers to communicate with the PIC. Ideally, officers should aim to provide PIC with the resources they need, to include referrals to appropriate services or medical and/or psychiatric treatment, where necessary. However, in some instances, arrest and/or involuntary mental examination is the best resolution.

Increasingly, there are calls from the public for law enforcement to be well-trained in working with non- traditional populations, to include PIC. While the work of law enforcement officers is inherently unpredictable, training and education in responding to PIC provides officers with the tools to offer optimal assistance. Such a response works to improve trust and continue to bridge the gap between community and law enforcement.

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Need to Know ...

Updated: August 2018

Responding to Persons Experiencing a Mental Health Crisis

Law enforcement officers should be provided with guidance and training to effectively assess and respond to situations involving individuals experiencing a mental health crisis, with the goal of de-escalating the situation safely for all individuals involved whenever possible.

- A **mental health crisis** is defined as an event or experience in which an individual's normal coping mechanisms are overwhelmed, causing them to have an extreme emotional, physical, mental, and/or behavioral response. Individuals experiencing a mental health crisis may or may not be affected by mental illness.
- Law enforcement officers should be familiar with signs and symptoms of mental illness or a person in crisis (PIC) but are not required to make a **medical diagnosis**.
- Law enforcement agencies should partner with local mental health and other community agencies to develop a **holistic, community-based approach** to responding to these individuals.
- Officers responding to PICs should attempt to gather as much **information** as possible on the person through personal observation, as well as information from friends, family, and treating clinicians, where available. This information can then be utilized to assess the individual's potential danger to themselves, the officers, or others.
- The **safety** of all individuals involved should be the primary consideration when law enforcement responds to PICs.
- A backup officer should always be requested, as well as assistance from **individuals with specialized training in dealing with PICs**.
- Whenever possible, officers should take steps to **calm the situation**. This may include eliminating emergency lights and sirens, assuming a nonthreatening manner, and moving slowly.
- Officers should be prepared to provide the PIC and, where available, their family with information on **available resources**, such as mental health referral information.
- In some situations, **involuntary psychiatric commitment** may be necessary. Officers should be familiar with the associated legal requirements and potential transportation and custody concerns.
- All interactions with PICs should be **documented** in detail, using specific descriptions of the individual's behaviors, statements, and actions.



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