

SOUTH PORTLAND POLICE DEPARTMENT

STANDARD OPERATING PROCEDURES

Subject:	Mental Health Crisis Intervention / Protective Custody	Policy #:	4-40-C
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I. PURPOSE:

To establish guidelines for officers during interactions with persons suspected of being mentally ill and / or experiencing a mental health crisis, so as to assist the person and protect the general public.

II. POLICY:

It is the policy of the South Portland Police Department to attempt to assist persons who are known or suspected to be mentally ill, particularly persons who present a threat of imminent and substantial physical harm to themselves or to others. Responding to such situations 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. Due to the unpredictable nature of these types of contacts, all officers will be trained in crisis intervention techniques. Consistent with the priority of life considerations, officers will take steps, to the extent possible, to de-escalate the situation and safely resolve it for third persons, the involved officers, and the mentally ill person. A minimum of two officers shall be assigned to such calls, including one CIT officer, as available. The on-duty patrol supervisor should also be notified. Given this is a statutorily mandated policy, officers must abide by this SOP as it applies to all standards of the MCJA Board of Trustees.¹

III. DEFINITIONS:

- A. **Advanced Health Care Directive:** An individual instruction from, or power of attorney for health care by, an individual with capacity for use when the person appears to lack capacity.
- B. **Crisis Intervention Training (CIT):** Officers specially trained in the identification, handling, de-escalation and disposition of individuals exhibiting signs of a mental health crisis.
- C. **De-escalation:** The use of verbal or non-verbal actions and tactics, whenever feasible and possible, preceding a potential force encounter. This may include, but is not limited to the use of distance, cover, tactical repositioning, and communication in order to stabilize the situation, reduce the immediacy of the threat, and allow for more time and options for resolution.
- D. **Threat of Imminent and Substantial Physical Harm:** Any condition creating a reasonably foreseeable risk of harm to someone, taking into consideration the *immediacy*, *seriousness*, and *likelihood* of the potential harm, if not prevented. Threatened harm may include suicide or serious self-injury, violent behavior, or placing others in reasonable fear of serious physical harm; and / or reasonable certainty of severe impairment or injury because a person is unable to avoid harm or protect themselves from harm.
- E. **Involuntary Commitment:** A three step process by which a person (friend, relative, social worker, psychologist, medical doctor, law enforcement officer) applies for involuntary and temporary admission of a person to a mental hospital; a clinician evaluates the individual and, if the clinician certifies that the individual is mentally ill and “poses a likelihood of serious harm,” a judicial officer reviews and endorses the *Application for Emergency Involuntary Admission to a Mental Hospital Form* (“Blue Paper”).²
- F. **Least Restrictive Form of Transportation:** A vehicle and any restraining devices used during transportation that impose the least amount of restriction, taking into consideration the stigmatizing impact upon the individual being transported.

¹ 25 M.R.S.A., § 2803-B

² 34-B M.R.S.A. § 3863

- G. **Mentally Ill Person:**³ A person having a psychiatric or other disease that substantially impairs their mental health or creates a substantial risk of suicide. A mentally ill person includes those suffering from the effects of the use of drugs, narcotics, hallucinogens or intoxicants, including alcohol. A person with developmental disabilities or diagnosed as a sociopath is not, for those reasons alone, a mentally ill person.
- H. **Mental Health Crisis:** Behavior often due to a triggering event or experience where an individual’s normal coping mechanisms are overwhelmed, causing them to have an extreme emotional, physical, mental, and / or behavioral response and in which a reasonable person would perceive the individual as presenting a “threat of *imminent* and *substantial physical harm* to the person exhibiting the behavior or another person. Symptoms may include, but are not limited to loss of contact with reality, abnormal memory loss, inability to focus, delusions, confusion, hallucinations, anger, fear, extreme agitation, rigidity or inflexibility, severe depression, excessive giddiness, flight, fight or freeze responses, suicidal or homicidal statements or actions; or an inability care for oneself, control behavior, or avoid or protect oneself from impairment or injury.
- I. **Mobile Crisis Response:** A team providing mobile crisis services on a 24/7 basis. Services include triage for consumers, immediate responses to consumer needs when in crisis and assistance with a proper disposition of cases (e.g., hospitalization, placement in a “crisis bed,” in home supports, or referral for services). The system is accessed by calling 774-HELP, 888-568-1112 or 211.
- J. **Probable Cause:** The standard required to take a person into protective custody, based on the totality of the circumstances, which may include, but is not limited to: 1) personal observation; 2) reliable oral or written information from third parties (as long as the third party has reason to believe, based upon recent personal observations or conversations with the person, that the person may be mentally ill and that, due to that condition, the person presents a threat of imminent and substantial physical harm); and 3) any prior history of the person experiencing the mental health crisis.
- K. **Protective Custody:** Custody taken by an officer based either on probable cause that the person may be mentally ill and, due to that condition, “presents a threat of *imminent* and *substantial physical harm* to that person or to other persons;” or based on the officer’s knowledge that the person has an advance healthcare directive authorizing mental health treatment and the officer has probable cause to believe the person lacks capacity.⁴

IV. PROCEDURES:

A. **Recognizing Unusual Behavior / Mentally Ill Person:**

1. Mental illness is often difficult for even the trained professional to define in a given individual. Officers are not expected to diagnose a mental condition or disturbance, but should attempt to recognize behavior that is potentially destructive, dangerous and / or indicative of a person experiencing a mental health crisis.
2. Officers must recognize that a person may exhibit unusual behavior because of a mental or physical disease or condition, but should not exclude other potential causes. Officers should assess and evaluate the behavior and make a determination as to whether the person is experiencing a mental health crisis. The behavior may or may not be criminal, and may or may not pose a risk of imminent and substantial physical harm to that person or to others. The following behavior(s) should be evaluated in total context of the situation and the need for intervention:
 - a. Loss of contact with reality;
 - b. Disconnected thought patterns, abnormal memory loss (e.g., name, address, phone, date of birth);
 - c. Constant movement or pacing;
 - d. Delusions or hallucinations;
 - e. Extreme agitation, mood changes or reactivity, rigidity or inflexibility;
 - f. Extreme fright, anxiety, depression, or feelings of hopelessness and helplessness;
 - g. Suicidal or homicidal statements or actions, possibly based upon life changing triggering event(s);
 - h. Disoriented as to time and place;

³ 34-B, M.R.S.A. §3801(5)

⁴ 34-B, M.R.S.A. §3862

- i. Inappropriately frustrated or aggressive;
 - j. Inability to care for oneself, control behavior, or avoid or protect oneself or another from impairment or injury (e.g., person who has not slept, eaten or taken prescribed medications for extended period, found wandering, leaving items on stove, etc.);
 - k. Substance abuse
3. Officers should be cognizant of the rights of people with disabilities under the Americans with Disabilities Act (ADA) and other applicable Federal and State laws.

B. Interacting with the Mentally Ill:

1. When dispatched to a possible mental health call, officers should assess the situation to determine whether or not a crime has been committed and / or whether the person requires police intervention to aid in a medical or psychological evaluation or treatment. A CIT trained officer should be assigned or requested to assist at the scene of all such calls.
2. Officers are encouraged to consider appropriate referrals or other alternatives to arrest when investigating violations of a minor nature committed by a person with mental illness.
3. Officers must evaluate and document the mental state of any person suspected or accused of a criminal act when conducting interviews or interrogations. While it is not the officer's responsibility to determine competency as it relates to future decisions of the Court, it is a responsibility to ensure the person undergoing questioning is capable of understanding the nature of the questioning and the potential consequences of any statements given to allow future consideration during any legal process.
4. Officers should be aware of the following guidelines when interacting with a person suspected to be mentally ill or experiencing a mental health crisis, whether on the street or during more formal interview or interrogations:
 - a. Unless otherwise directed by a supervisor, make it a priority to utilize the time necessary to assess the situation and attempt de-escalation techniques. The goal of these tactics is to slow down the situation, allowing access to additional resources that may mitigate the intensity of the encounter, help gain voluntary compliance, or otherwise allow for control of the situation and the safety of those involved without the need to use force, or with the use of a lower level of force.
 - b. Whenever possible, take steps to calm the situation and not incite the person. Attempt to eliminate emergency lights and sirens, disperse any crowds, and assume a non-threatening manner. Move slowly and avoid physical contact, as possible, to avoid triggering a negative / hostile reaction.
 - c. Request a backup officer, especially in cases when the individual may be taken into custody.
 - d. Communicate with the individual. Attempt to find out what is bothering the person. Allow the person to vent / talk, and provide reassurance that the police are there to help. Attempt to avoid topics that may agitate the person and always attempt to be truthful.
 - e. When possible, gather information not only from the individual, but from available family members and / or acquaintances.
 - f. Constantly assess any threats, behavior and individual actions based upon the totality of the circumstances. The assessment and response to any such threats, behavior and individual actions must be consistent with SOP #1-1-A, USE OF FORCE & CONTROL.
 - g. Request assistance from the *Mobile Crisis Response Team*, the department's Behavioral Health Liaison, and / or other department or community mental health resource to assist in communicating with and calming the person, as deemed necessary and appropriate.
 - h. If there are any doubts about how a particular incident or subject should be dealt with, officer(s) should request that a supervisor come to the scene to provide guidance or make a final determination.

C. Community Referrals / Protective Custody / Emergency Hospitalization:

1. Based on the overall circumstances, officers must assess each situation and use their training, experience discretion and priority of life considerations to best resolve the call, taking steps to maximize the safety of the public, the officer(s), and the persons involved. Dispositions include but are not limited to voluntary transports to a hospital or mental health provider; contacting the *Mobile Crisis Response Team* or (774-

HELP), the department's Behavioral Health Liaison, and / or other department or community mental health resource(s); leaving the person alone or in the care of friends, relatives or service providers; providing the individual and / or family members with referrals to available community mental health resources; or taking the person into protective custody based upon probable cause.

2. If an officer has reasonable grounds to believe, based upon probable cause, that a person may be mentally ill and that due to that condition the person presents a threat of imminent and substantial physical harm to that person or to others, or if an officer knows that a person has an advance healthcare directive authorizing mental health treatment and the officer has reasonable grounds to believe, based upon probable cause, that the person lacks capacity,⁵ the officer may, as circumstances reasonably dictate, take that person into protective custody⁶ and present that person to a duly licensed physician, a licensed clinical psychologist, a physician's assistant, a nurse practitioner or a certified psychiatric clinical nurse specialist, without undue delay.
3. In general, if attempts at de-escalation have failed and control and safety of the scene are absent, once a decision has been made to take an individual into custody, it should be done as soon as possible to avoid prolonging a potentially volatile situation. Per Maine law, persons taken into protective custody will be transported to the hospital by the least restrictive form of transportation possible. As such, and consistent with SOP #7-71, PRISONER HANDLING & TRANSPORTATION, officers may use discretion in the use of handcuffs or other restraints on calm, cooperative individuals who do not pose a threat to the officer, themselves or others.
4. Based upon the exigency of the circumstances, and consistent with the priority of life concept, an officer may have the authority to make a warrantless entry into a premise and search for the person if the person presents a threat of imminent and substantial physical harm to the life or safety of members of the public, a third person, police officers, and lastly, the person in a mental health crisis. Although potentially authorized, officers should seek supervisory direction and both must consider if the need to take the person into custody at that moment outweighs the challenges and risks associated with making such an entry. Options to making entry include attempting to establish telephone contact, monitoring / surveilling the location from a discreet location or stand-off distance, notification or referral of the person / situation to the *Mobile Crisis Response Team (774-HELP)*, the department's Behavioral Health Liaison, or other department or community mental health resource, family, or other appropriate crisis or caseworkers, and / or standing down.
5. For this department, the default hospital for mental health crisis evaluations will be the Maine Medical Center Emergency Room, with Mercy Hospital as a secondary location if requested by the person or otherwise deemed to be appropriate. In any case, the officer should request that dispatch advise the destination hospital of the officer's anticipated arrival. In all such transports, the officer will communicate directly with hospital staff, providing them with a CIT Report, and completing other requested documentation. Under no circumstances will an officer simply provide transport and drop off any person at a hospital without making contact with hospital staff.
6. If the person in protective custody is also under arrest for a violation of law or has committed a criminal act, the person may be retained in custody until the person is detained or released in accordance with the law and other procedures. In such cases, the officer, in conjunction with the on-duty Shift Commander and duly licensed practitioner, will determine the most appropriate condition to satisfy the protection of the public and the treatment of the person. Options would include a Bail Commissioner being called to set bail; issuance of a USAC, or P.R. bail and release (Class D and E crimes); or, in circumstances in which the Shift Commander determines that the seriousness of the circumstances warrant it (e.g., felony violent crime against a person), this department shall post and maintain an officer as a guard until the person is arraigned.
7. If after being evaluated, the practitioner determines that the person does not warrant an involuntary commitment, the officer shall release the person from protective custody. Consistent with state law, if contacted and with the person's permission, the officer will return the person to where the person was taken

⁵ 18-A, M.R.S.A., §5-801 and 5-802

⁶ 34-B M.R.S.A., §3862, *Protective Custody*.

into custody or to the person's residence, if in or around South Portland. It should be noted that whenever an officer delivers a person in protective custody to the hospital for involuntary commitment, and the hospital does not admit but releases the person, the hospital is required to notify this department.⁷ This information will be promptly relayed to the Shift Commander, who will include the information on the shift / pass on report, and ensure that the incident's CAD call is updated to reflect that status.

8. If after being evaluated, the practitioner opts to involuntarily commit the person, the officers may be asked to assist with the involuntary commitment ("blue paper") process. Once the evaluation is completed, the appropriate section on the "Blue Paper" is then completed by the authorized practitioner. The "Blue Paper" is then signed by a judge or a complaint justice. Copies are given to the evaluator, the judge, the officer, and to the location where the person will be transported. Law enforcement agencies are eligible for the reimbursement costs for this involuntary commitment process.⁸

E. Reporting / Follow-up:

1. Upon clearing any call resulting in protective custody, involving a mental health crisis, and / or a mentally ill person, and / or otherwise caused or involving mental illness, the primary officer or supervisor shall request dispatch to tag the disposition of the call as mental health related.
2. An incident report, including a narrative, shall be completed whenever an officer responds to a call involving a person in mental health crisis, whether or not the person is formally arrested, taken into protective custody, voluntarily transported to the hospital or the call is otherwise informally resolved. In all cases where a person is taken into custody (protective custody or arrest), the officer's report shall provide sufficient detail to establish probable cause.
3. A Crisis Intervention (CIT) Report shall be completed as follows:
 - a. Whenever a person experiencing a mental health crisis is *involuntarily* taken into protective custody;
 - b. Whenever a mentally ill person, or a person experiencing a mental health crisis, is transported to a hospital, *voluntarily* or *involuntarily*;
 - c. Whenever a person in mental health crisis is arrested;
 - d. Whenever a person is suspected to have *intentionally overdosed* on any drug, or to have *overdosed*, intentionally or accidentally, on any *illicit* drug;
 - e. By any officer requesting crisis or behavioral health follow-up on a specific incident or person.
4. Whenever a person is transported to the hospital, whether voluntarily or involuntarily, the officer completing the CIT Report shall:
 - a. verbally tell the triage nurse that the person is in protective custody for purposes of a mental health evaluation;
 - b. accompany the patient to the Acute Psychiatry ward, and present the psychiatric staff with the completed CIT Report, again advising that the person is in protective custody for purposes of a mental health evaluation;
 - c. if the person is taken to a different area of the ED (e.g., for medical reasons), the officer will still hand deliver the CIT Report to staff in Acute Psychiatry, advising them that a person in protective custody for purposes of a mental health evaluation was presented to the ED, but not yet brought back to them.
5. Based on the circumstances, or as otherwise deemed necessary and appropriate by the officer or a supervisor, the officer may also provide the hospital with copies of any related narrative reports and / or supporting documents (e.g., witness statements, prior calls for service, etc.). In addition to the facts and circumstances of the incident, and those establishing probable cause for protective custody, officers' reports should document what hospital staff (e.g., Triage Nurse, Acute Psych social worker, etc.) were advised that the person was in custody for purposes of a mental health evaluation, and who was provided with a copy of the CIT Report.

⁷ 34-B, M.R.S.A., §3863(6-A)

⁸ 34-B, M.R.S.A., §3863

6. The original CIT Reports should be forwarded to the designated Public Safety Administrative Assistant for scanning. The Behavioral Health Liaison will review the CIT reports and may assign CIT follow-up, as deemed necessary and appropriate.

F. Training:

1. All department personnel should strive to maintain proficiency interacting with people in a mental health crisis.
2. All recruit officers receive “Mental Health First Aid” training at the Maine Criminal Justice Academy and will be trained on this SOP during the Field Training Program.
3. All department personnel will receive CIT training as early in their career as possible, followed by relevant annual refresher training.

By Order Of:

Timothy B. Sheehan
Chief of Police