2-13 RESPONSE TO BEHAVIORAL HEALTH ISSUES

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2-13-01 Purpose

This policy will establish guidelines for when a person's behavior is indicative of a behavioral health disorder or behavioral health crisis. It will provide guidance, techniques, and resources so that the situation may be resolved in a constructive and compassionate manner.

2-13-02 Policy Statement

Behavioral health crisis situations require an officer to make difficult judgments about the mental state and intent of the individual. It also necessitates the use of special police skills, techniques, and abilities to effectively and appropriately resolve the situation. The ideal resolution for a crisis incident is that the subject is connected with resources that can provide long term stabilizing support

The goal shall be to de-escalate the situation safely with minimum force for all individuals involved when reasonable and practical, and consistent with established safety priorities. Officers are trusted to use their best judgment during behavioral crisis incidents, and the Department recognizes that individual officers will apply their unique set of education, training and experience when handling crisis intervention. Field Services Bureau officers are not mental health professionals, but will receive on-going training to equip them with information and techniques to better respond to individuals with behavioral health disorders. The Department also provides enhanced training to certain field service officers (ECIT) and maintains a permanent unit of officers and mental health professionals (CIU/COAST) to assist in responses, training, and follow-up with individuals in order to not only promote positive outcomes in the first contact, but to deter further problems between these individuals and the criminal justice system.

2-13-03 Definitions

A. Behavioral Health Crisis:
A crisis that is caused by, or results in, significant behavioral, emotional, or cognitive dysfunction. Often the severity of symptoms may appear to be disproportionate to the objective stressor.

Not all people living with behavioral health disorders are in crisis, nor are all crises experienced by people living with a behavioral health disorder are caused by that illness. Crisis intervention skills can be applied to people in a non-behavioral health related crisis, and officers are encouraged to use these skills broadly.

B. Behavioral Health Disorder:
A disorder that is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

C. Certificate Of Evaluation:
A document completed by a licensed physician, certified psychologist, or a qualified mental health professional licensed for independent practice who is affiliated with a community mental health center or core service agency, that certifies a person, as a result of a mental disorder, presents a likelihood of harm to him/herself or others and that immediate detention is necessary to prevent such harm.

D. Crisis: When an individual experiences an intense difficulty or danger.

E. Crisis Intervention Section (CIS):
Comprised of Crisis Intervention Unit Detectives (CIU), Crisis Outreach and Support Team (COAST), Mobile Crisis Teams (MCT), Enhanced Crisis Intervention Team (ECIT) Program, Crisis Clinicians, a licensed psychiatrist, and data analysts. The CIS is responsible for the overall administration and goals of the Crisis Intervention Team (CIT) program.

F. Crisis Intervention Trained Officer (CITO):
These are Field Services Bureau officers who have successfully completed the basic crisis intervention team training.

G. Crisis Intervention Team (CIT) Program:
A community based program that includes the department's crisis intervention section and the department's personnel who are involved with behavioral health interactions with the public.

H. Crisis Intervention Unit Clinicians:
The Crisis Intervention Clinician (CIC) provides evaluation, general psychological assessment, crisis intervention, dangerousness assessments, safety planning, and referrals for people in the community living with mental illness who come into contact with the Albuquerque Police Department.

I. Crisis Outreach And Support Team (COAST):
Composed of civilian employees supervised by a sworn supervisor (Sergeant), COAST enhances the CIT program by providing crisis intervention, linkage to services and community education in response to police referrals. COAST is assigned to the Criminal Investigations Bureau (CIB)-Crisis Intervention Section.

J. De-Escalate:
A deliberate attempt to use verbal methods to support an individual in calming down to resolve the situation.

K. Disengagement:
The intentional decision, based on the totality of circumstances to discontinue contact after initial attempts to engage with a person in crisis.

L. Enhanced CIT (ECIT):
Composed of specially trained volunteer Field Services Bureau patrol officers that function within their patrol teams as specialists in handling calls involving individuals experiencing a behavioral health disorders, and other calls of crisis not related to behavioral health issues.

MCT and ECIT officers shall be identified by recommendation from training facilitators and or supervisors. These officers will have apparent and/or demonstrated skills and abilities in crisis de-escalation, attitude and maturity when interacting with individuals with behavioral health disorders/crisis

M. Grave Passive Neglect:
Failure to provide for one's basic personal needs, medical needs, or for one's own safety, to such an extent that it is likely to result in bodily harm or death or harm to another person.

N. Mental Health Response Advisory Committee (MHRAC):
This committee is comprised of subject matter experts from within the community that will assist the Department in identifying and developing solutions and interventions that are designed to lead to improved outcomes for individuals perceived to be or actually suffering from a behavioral health disorder and or crisis. This committee shall also analyze and recommend appropriate changes to policies, procedures, and training methods regarding police contact with individuals who are in crisis and or experiencing a behavioral health disorder.

Through community collaboration, the MHRAC will also be responsible for considering new and current response strategies for dealing with chronically homeless individuals. This includes seeking to enhance the coordination with local behavioral health providers/health systems for those experiencing homelessness and behavioral health disorders/crisis.

O. Mobile Crisis Team(S) (MCT):

Composed of ECIT officers, who respond to priority behavioral health crisis calls for service, including suicide threats. They are partnered with a mental health professional who can provide immediate behavioral health services once the scene is made safe. These teams are part of a tiered response and complement ECIT and CIU.

P. Non-Engagement:
The intentional decision, based on the totality of circumstances, not to make contact with a person in crisis.

Q. Qualified Mental Health Professional:
An independent social worker, a licensed professional clinical mental health counselor, a marriage and family therapist, a certified nurse practitioner or a clinical nurse specialist with a specialty in mental health, all of whom by training and experience are qualified to work with persons with a mental disorder.

2-13-04 CIT PROGRAM

A. APD's CIT Program is responsible for maintaining community collaboration with community partners and MHRAC to sustain the Department's response to individuals in behavioral health crisis and promote de-stigmatization of behavioral health issues. The CIT program consists of three core components:

- Community Partnership
- Operational Core
- Sustaining Elements

Central to the success of CIT is not only the training of the law enforcement officer, but also the education of those agencies and individuals within the behavioral health community who will be involved in the process. Successful diversion requires accessible crisis services. True collaboration can occur only when law enforcement, behavioral health agencies, consumers, and families and advocates have a clear understanding of and respect for each other's roles in a CIT program.

B. Community Partnership:
MHRAC and community collaboration will be the driving force for the development and maintenance of the CIT program. These ongoing elements will include:
- Partnerships with Law Enforcement, Advocacy, and Behavior Health Community
- Mental Health Response Advisory Committee (MHRAC)
- CIT Training
- Policies and Procedure development and review

C. Operational Core:

The operational core of the CIT program has multiple distinct components:
1. Dispatcher/Telecommunicators
2. Officers who have undergone basic CIT Training

3. Officer who are part of the Enhanced CIT
4. CIT Field Sergeant Coordinators
5. CIT Training
6. CIT Coordinators
7. Crisis Intervention Section

The Crisis Intervention Section is a key role in the CIT Program; CIS includes:

- Mobile Crisis Team (MCT)
- Crisis Intervention Unit (CIU)
- Crisis Outreach and Support Team (COAST)
- CIT Program Coordinators

CIT Training:

Although not the focus of the CIT program, the CIT training is a place where community collaboration and community policing efforts take place. The training program is an evolving program that is created and reviewed in five steps:

- Needs assessment/ analyze
- Design
- Development
- Implementation
- Review for effectiveness

D. Sustaining Elements are ongoing activities of the department that will ensure the CIT program maintains itself and grows and responds to the needs of the community.
   - Evaluation and Research
   - Maintenance of effort in-service training
   - Advanced in-service training
   - Recognition and honors

2-13-05 Recognizing Behavioral Health Disorders

A. Only a trained mental health professional can diagnose mental illness, and even they may sometimes find it difficult to make a diagnosis. Officers and Communications employees are not expected to diagnose mental or emotional conditions, but rather apply their training to recognize behaviors that are indicative of persons affected by a behavioral health disorder or in crisis.

B. Officers and Communications employees 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.

C. If Communications receives a call that indicates the subject may be affected by behavioral health issues, Communications will dispatch an ECIT officer or MCT as available.

2-13-06 Assessing Risk

A. Most people affected by a behavioral health disorder or in crisis are not dangerous and some may only present dangerous behavior under certain circumstances or conditions. Officers may use several indicators to assess whether a person who reasonably appears to be affected by a behavioral health disorder or in crisis represents potential danger to himself or herself, the officer, or others. These include the following:

1. The availability of any weapons.
2. 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.
3. 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.
4. The amount of self-control that the person displays; particularly the amount of physical and psychological 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.
5. 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.

B. 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.

C. 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 (e.g., delusions or hallucinations). A variation in the person's physical presentation does not necessarily mean he or she will become violent or threatening, but officers should be prepared at all times for a rapid change in behavior.

D. Non-engagement or Disengagement:

If the supervisor or officer determines that contact or continued contact with the person will result in an undue safety risk to the person, the public, and/or officers, they should employ the tactic or non-engagement or disengagement as applicable. Officers will notify a supervisor and then determine whether to develop a plan to make contact at a different time or under different circumstances. A police report and/or CIT contact sheet will be generated documenting the following: details of the call; reasons for non-engagement or disengagement; actions taken to de-escalate the situation; actions taken to promote safety; follow up plans and referrals made, and whether the address is flagged for a safety bulletin. The words "disengagement" will be placed in the incident summary line of the report or CIT contact sheet.

2-13-07 Response

A. The following responses should be considered to promote de-escalation and a safe resolution of the situation:

1. When available, APD will ensure that ECIT, MCT or CIU will take the lead, once on scene and when appropriate, in interacting with individuals in crisis. If a supervisor has assumed responsibility for the scene, the supervisor will seek input of the ECIT, MCT or CIU on strategies for resolving the crisis when it is practical to do so. [DOJ 128]

2. Request a backup officer. Always do so in cases where the individual will be taken into custody. If the responding officer is a CITO, the officer should specifically request an ECIT officer or MCT as backup.

3. Take steps to calm the situation. Where possible, eliminate emergency lights and sirens, disperse crowds, and assume a quiet non-threatening 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.

4. 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.

5. 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.

6. Do not threaten the individual with arrest, or make other similar threats or demands, as this may create additional fright, stress, and potential aggression.

7. Avoid topics that may agitate the person and guide the conversation toward subjects that help bring the individual back to reality.

8. 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.

9. Officers should attempt to connect individuals to appropriate services, which could include transportation to the hospital.

10. Where required, officers will complete an original incident report. Of no incident report is required, officers will complete a CIT contact sheet for any dispatch in which the subject's behavior is indicative of behavioral health disorder or crisis. For these calls, the officer will forward a copy of the incident report or contact sheet to CIT data analysts.

2-13-08 Diversion from Jail or the Criminal Justice System

CITO, ECIT, MCT and CIS will promote diversion of individuals with behavior health disorders or in crisis from the criminal justice system through the following measures:

A. At times individuals who live with a mental illness may have run-ins with law enforcement for misdemeanor and/or petty misdemeanor crimes, including non-violent felonies. When possible those subjects may be better served by:
   1. Issuance of a citation;
   2. Summons for misdemeanors or submitting felony case to the district attorney; or
   3. Transport to a mental health provider. This may be in addition to or in lieu of charges, based on the officer's discretion.

B. The primary officer will retain case responsibility if a citation, summons, or case is submitted. CIU/COAST can assist if the individual needs follow-up intervention to deter future police contacts.

C. When sending a copy of the incident report to Court Services, officers will attach a note stating the subject may be a candidate for Mental Health Court.

D. When the individual's criminal behavior appears to stem from a behavioral health disorder and they would be better served in a treatment location than a criminal justice setting, officers should seek professional behavioral health intervention in lieu of criminal charges.
   1. CITO, ECIT, MCT and CIS will network with behavioral health care providers within the community to deter future events that may lead to an individual being introduced to the criminal justice system.
      a. Frequent meetings are to be conducted with mental health care administrators to insure familiarization with diversionary goals.
      b. Officers/Detectives will provide testimony in civil commitment proceeding to promote mental health resolution versus criminal sanction.
   2. CITO, ECIT, MCT and CIU Detectives will utilize COAST and/or Crisis Intervention Unit Clinicians where appropriate to deter future crisis and thus reduce the possibility of an individual's contact with the criminal justice system.
   3. CIU Detectives will coordinate with the Pre-Trial Services diversionary component within the court system to address the needs of the individuals with behavioral health disorders who have been booked into the detention facility.

E. These outcomes will be tracked and monitored by the CIT Coordinator.

2-13-09 Crisis Intervention Section/Crisis Outreach and Support Team

A. Crisis Intervention Section Lieutenant or Civilian Section Supervisor:

Responsible for the efficiency and effectiveness of the various units and for coordinating their functions and activities. The units include the Crisis Intervention Unit (CIU), Enhanced CIT Program, Mobile Crisis Teams, Crisis Outreach and Support Team (COAST), Crisis Intervention Clinician(s), and psychiatrist and the management of the Department's Crisis Intervention Team program.

B. The CIT Coordinator:

The coordinator is a CIU detective appointed by the CIS Lieutenant who will act as a liaison with program stakeholders in order to ensure the success of the CIT program. The coordinator maintains continuity in the CIT program and serves as a point of contact for the agency. The CIT Coordinator will serve many roles with an emphasis on examining, reviewing, and making recommendations to ensure Department and community needs are met. The coordinators will consist of:

The Coordinator will be responsible for:

1. Taking primary responsibility for curriculum development and training on CIT, de-escalation, behavioral health, and other related topics. This duty includes developing effective scenario-based training through the use of actual incidents.
2. Developing and maintaining the CIT Program through:
    - Networking
    - Outreach
    - Increase community ownership in the CIT program
    - Promotion of CIT
    - Attend the Mental Health Response Advisory Committee (MHRAC)
    - Meet with Department leadership
    - Work with 911 and call takers
3. Maintaining continuous relationship with:
    - Community Partners
    - Mental Health Agencies
    - Advocates
4. Monitoring law and issues related to crisis services
    - Review case law
    - Review mental health codes
    - Commitment and transportation laws
    - Provide input in legislation
    - Review and develop CIT policy and procedures
5. Providing guidance and review to CIT field officers
    - Address issues raised by officers
    - Interface with FSB supervisors in problem-solving issues
    - Address community issues raised by CIT field officers
6. Assisting in developing CIT training models in other jurisdictions to ensure that local agencies follow uniform approach to CIT in accordance with the national model of police-based crisis intervention

C. Crisis Intervention Section Sergeant. The Sergeant will:

1. Oversee the Crisis Intervention Unit as well as the COAST Unit.
2. Be responsible for consultation and liaison between CIT and mental health care providers, and working with the Crisis Outreach Psychiatrist, clinicians and other clinical personnel.
3. Ensure that information from Offense/Incident reports and/or CIT Contact Sheet from CIT calls are entered into a case management system, and that necessary information about elevated risk subjects are appropriately disseminated to Field Services personnel through Power DMS or Email.

4. Serve as liaison between the CIT Area Command Sergeant Coordinator(s).

D. CIT Area Command Sergeant Coordinator

Field service sergeants may volunteer to serve as CIT Area Command Sergeant Coordinators. The CIS Lieutenant will designate a CIT Area Command Sergeant Coordinator for each area command, with the approval of that sergeant's chain of command. These coordinators will participate in efforts of assisting, implementing and sustaining CIT as a community program. Coordinators should help promote constitutional, effective poling and minimization of force against individuals in crisis due to a mental illness or diagnosed behavioral disorder.

The CIT Area Command Sergeant Coordinators will:

1. Assist the CIT Coordinator in developing and maintaining the CIT Program
   - Networking & Outreach
   - Promotion of CIT
   - Assist in training
   - Shall recommend officers for ECIT with apparent or demonstrated skills and abilities in CIT policing (DOJ)
   - Attend the Mental Health Response Advisory Committee (MHRAC) on a rotating basis
   - Participate monthly in the CIT Knowledge Network (ECHO Collaboration)
   - Assist in reviewing and developing CIT policy and procedures
2. Provide guidance and leadership to CIT field officers
   - Address issues raised by officers
   - Address community issues raised by CIT field officers
   - Conduct training assessments as needed

E. CIU Detectives will investigate:

1. Risk to Others: If a person's behavior is putting someone else's safety at risk. This is often associated with verbal threats to harm or kill someone else, disorderly conduct, assault, or other person crimes involving weapons.

2. Escalating Behavior: The person is not currently posing a risk to anyone else's safety, but is displaying behavior that is increasingly causing alarm to others through physical actions, threats, or property damage. If not addressed, the behavior will likely result in risk to self or others.

3. CIU detectives will be on an on-call basis 24 hours a day to assist officers with behavioral health issues they encounter. CIU detectives shall limit their case intake to referrals from department officers only (not from dispatch or

the public), unless exigent circumstances exist. The officer makes the referral by forwarding their incident report to the CIS. Officers making the referral should note at least one of the following circumstances and include as much information as possible in their incident report regarding:

a. Availability of weapons to the individual
b. Substantiated statements to commit, or the actual commitment of a violent or dangerous act
c. Personal history, known or provided, that reflects prior violence under similar circumstances; or
d. Any corroborating information that would lead a CIU detective to believe the individual is a risk to others or displays escalating behavior.

4. The detective's primary objective in all assigned cases will be to evaluate the risk the individual poses to themselves or others and to resolve the crisis causing police interaction by linking the individual with appropriate services. In doing so, the detective will meet with the individual and consult with CIS clinicians regarding best options.

5. CIU detectives will network and collaborate with numerous community health providers which include, but are not limited to the Mental Health Response Advisory Committee, Bernalillo Forensic Intervention Consortium (BFIC), National Alliance for Mental Illness (NAMI).

F. COAST Specialists will to support the CIT Program as described below

1. The Crisis Outreach and Support Team (COAST) will be utilized by officers to provide further crisis intervention, referrals to services, and education for non-violent individuals who are experiencing homelessness.
2. When an officer has determined the scene is safe and there is a need for COAST on scene, they will contact radio and request a COAST unit. One indication for COAST involvement may be frequent dispatched calls with respect to the same individual.
3. COAST specialists will take referred cases involving assisting people who are a risk to self.
4. COAST specialists will take other cases assigned to them by the CIU Sergeant.
5. COAST's primary objective in all cases will be to resolve the crisis causing police interaction by linking the individual with appropriate services. In doing so, the COAST specialist will contact the individual and follow up with phone or in person visits to ensure connection with appropriate prevention services and treatment options.
6. COAST specialist will network and collaborate with numerous community mental health providers to ensure the appropriate intervention response.

These providers include, but are not limited to the MHRAC, Bernalillo Forensic Intervention Consortium (BFIC), National Alliance for Mental Illness (NAMI).

7. Other referrals COAST may receive are a command or city leadership request for COAST to conduct follow up due to the additional time and resources required beyond patrol response.
8. Be responsible for homeless resource outreach.

The following activities are not part of the activities of COAST Specialists:

1. Providing long term or intensive case management or counseling services.
2. Providing victim's assistance in domestic violence cases.
3. Providing victim's advocacy services for victims of crimes.
4. Providing long-term follow up throughout the judicial process.
5. Providing comprehensive explanations or case management or follow up with victims/witnesses regarding the procedures involved in the prosecution of their cases.
6. Providing personal/family counseling services for department employees.
7. Transporting violent or potentially violent individuals in their vehicles.

G. Crisis Intervention Unit Clinician

Provides evaluation, assessment, crisis intervention, dangerousness assessments, safety planning, and referrals for people in the community living with mental illness who come into contact with APD; performs community education services and a variety of related tasks that promote and enhance the City's community policing efforts.

H. Crisis Intervention Data Analysts:

Responsible for the collection and distribution of data that is used for management purposes only and shall not include personal identifying information of individuals. Create presentations, recommendations, and analyze data to help successfully guide the department's response to behavioral health issues. Will collaborate with MHRAC. The analysts will be comprised of:

- Civilian statistician
- Civilian analyst

2-13-10 Developmentally Disabled Individuals

Persons afflicted with developmental disabilities have a mental or physical impairment that creates difficulties is certain areas of life, especially language, mobility, learning, self-help, and independent living. These individuals are often limited in their ability to effectively communicate, interact with others, and make reasoned decisions on their own. Often they are not able to control their behavior, which can make interactions

with such persons difficult in enforcement and other encounters and may result in inappropriate or counterproductive police actions if officers are not prepared to recognize and deal with symptomatic behaviors and reactions of such persons.

A. Common Symptoms

There are numerous forms of developmental disabilities. Many of the persons who have such disabilities have other related but distinct disorders as well (such as Autism Spectrum Disorder, Fragile X Syndrome, and Rett Syndrome). Although officers are not in a position to diagnose persons with such disabilities, officers shall be alert to the symptoms that are suggestive of such disorders. These include but are not limited to the following symptoms in various combinations and degrees of severity:

- Difficulty communicating and expressing oneself
- Communication by pointing or gestures rather than words
- Repetition of phrases or words
- Repetitive body movements—may be harmful to themselves (movements may include, but are not limited to, swaying, spinning, clapping hands, flailing arms, snapping fingers, biting wrists, or banging the head)
- Little or no eye contact
- Tendency to show distress, laugh, or cry for no apparent reason
- Uneven gross or fine motor skills
- Unresponsiveness to verbal commands; appearance of being deaf even though hearing is normal
- Aversion to touch, loud noise, bright lights, and commotion
- No real fear of danger
- Oversensitivity or undersensitivity to pain
- Self-injurious behavior
- Potential injurious behavior to others

B. Common Encounters

Officers may encounter persons who have developmental disabilities in a variety of situations commonly involving persons without such disabilities. However, due to the nature of developmental disabilities, the following are some of the most common situations in which such persons may be encountered:

1. Wandering
2. Seizures
3. Disturbance(s) (an interference with another's rights)

C. Handling and Deescalating Encounters

Some persons with developmental disabilities can be easily upset and may engage in

tantrums or self-destructive behavior or may become aggressive. Fear, frustration, and minor changes in their daily routines and surroundings may trigger such behavior. Therefore, officers should take measures to prevent such reactions and deescalate situations involving such persons in the course of taking enforcement and related actions. These include the following:

- Speak calmly
- Keep the commotion down
- Keep animals away
- Look for personal identification.
- Call the contact person or caregiver
- Prepare for a potentially long encounter
- Repeat short, direct phrases in a calm voice
- Be attentive to sensory impairments.
- Maintain a safe distance. Provide the person with a zone of comfort that will also serve as a buffer for officer safety.

D. Taking Persons into Custody

Taking custody of a developmentally disabled person should be avoided whenever possible as it will invariably initiate a severe anxiety response and escalate the situation. Therefore, in minor offense situations, officers shall explain the circumstances to the complainant and request that alternative means be taken to remedy the situation. This normally will involve release of the person to an authorized caregiver. In more serious offense situations or where alternatives to arrest are not reasonable, officers shall observe the following guidelines:

1. Contact a supervisor for advice.
2. Summon the person's caregiver to accompany the person and to assist in the calming and intervention process. If a caregiver is not readily available, summon a mental health crisis intervention worker if available.
3. Employ calming and reassuring language and de-escalation protocols provided in this policy.
4. Do not incarcerate the person in a lockup or other holding cell if possible. Do not incarcerate the person with others.
5. Until alternative arrangements can be made, put the person in a quiet room with subdued lighting with a caregiver or other responsible individual or another officer who has experience in dealing with such persons.

E. Interviews and Interrogations

Officers conducting interviews or interrogations of a person who is, or who is suspected of being developmentally disabled should consult with a mental health professional and the Bernalillo County District Attorney's Office to determine whether

the person is competent to understand his or her rights to remain silent and to have an attorney present.

2-13-11 Procedures for Emergency Mental Health Evaluation

[7]

A. In accordance with NMSA 43-1-10, an officer may detain a person for an emergency evaluation and care at a hospital, mental health facility, or an evaluation facility in the absence of a valid court order only if:

1. The person is otherwise subject to arrest.
2. The officer has reasonable grounds to believe the person has just attempted suicide.
3. The officer, based on personal observation and investigation, has reasonable grounds to believe the person, as a result of a mental disorder, presents a serious threat of harming him/herself or others and immediate detention is necessary to prevent such harm.
4. Immediately upon arrival at the evaluation facility, the officer shall be interviewed by the admitting physician.
5. A licensed physician, certified psychologist, or a qualified mental health professional licensed for independent practice who is affiliated with a community mental health center or core service agency has certified that the person, as a result of a mental disorder, presents a likelihood to commit serious harm to him/herself or others, and that immediate detention is necessary. Such certification shall constitute authority for the officer to transport the individual.

B. If an individual meets the criteria for an emergency mental evaluation, the officer will arrange transportation to a facility. If possible, the officer will, ascertain the individual's health care provider information and transport the individual to the appropriate facility. Area facilities include:

1. University of New Mexico Mental Health - 2600 Marble Ave. NE
2. Presbyterian Hospital - 1100 Central Ave. SE
3. Presbyterian-Kaseman Hospital - 8300 Constitution Ave NE
4. Lovelace Downtown - 601 Dr. Martin Luther King, Jr. Dr. NE
5. Women's Hospital - 4701 Montgomery Blvd. NE
6. Lovelace Westside - 10501 Golf Course Rd. NW
7. Veterans Hospital - 1501 San Pedro SE
8. Presbyterian Rust Medical Center – 2400 Unser Blvd. SE (Rio Rancho)
9. University of New Mexico Sandoval Regional Medical Center – 3001 Broadmoor Boulevard NE (Rio Rancho)

C. When an individual is taken to a mental health facility the officer shall ensure that the mental health staff has a detailed and accurate account of the incident

surrounding the protective custody. The officer will complete and sign an application for emergency hospitalization. If the individual is a juvenile, the officer will ensure that a guardian is present at the facility.

[6] D. If an individual is identified as dangerous to him/herself or others, the officer will guard the individual until the medical facility assumes responsibility for the subject.

[7] E. If an individual is physically injured or has a pre-existing medical condition requiring attention, physical medical care needs will take priority. The individual will be transported to a hospital emergency room. The hospital will assume responsibility for any mental health care intervention. The officer should still complete the application for emergency hospitalization.

F. Whenever an individual is transported to a mental health facility, this includes but is not limited to voluntary, involuntary, Certificates of Evaluation, grave passive neglect, is in crisis, or when the individual is under arrest, an Offense/Incident report shall be initiated. The officer will forward a copy of the report to the CIT data analysts.

[7] G. Officers who are provided with a Certificate of Evaluation concerning an individual, will attempt to verify the authenticity of the certificate by directly talking to the source in person or by calling the facility or doctor who issued the certificate. This includes ascertaining if the individual is known to have weapons or has exhibited unsafe behavior in the past. Real Time Crime Center (RTCC) shall also be utilized to gather additional information.

H. In the event an officer determines that a person is suffering from a behavioral health disorder or is in crisis, but is not dangerous, the officer may request the assistance from COAST if the individual would likely benefit from further crisis intervention, linkage to services and/or education regarding services in the community.

I. When an officer has knowledge of a prisoner who has some kind of behavioral health disorder, they will notify the Metropolitan Detention Center (MDC) medic who can then notify Psychological Service Unit (PSU). The Office will forward a copy of the Offense/Incident report to the CIT Area Sergeant Coordinator.

2-13-12 Training

The CIT Program Coordinator will ensure that the following training is developed and provided for officers:

A. Cadets. All cadets will receive state mandated behavioral health training and additional training as developed by the CIT Program while at the APD Academy. Upon completion of the field training program, the APD field training staff will ensure that all graduates receive an additional 40-hour basic crisis intervention training designed for field service officers.
B. Field service officers. All field service officers will received 40-hour basic crisis intervention training designed for field officers. Upon completion of this course, officers will be crisis intervention trained officers (CITO). Field service officers will receive a two hour in-service training every two years covering behavioral health-related topics.
C. ECIT Officers. Field service officers who wish to be specialized responders for behavioral health issues will receive all of the training for field service officers. ECIT will receive advanced training in behavior health issues developed by the CIT Program. ECIT officers will additionally receive eight hours of in-service crisis intervention training every two years.
D. Communications employees. Communication employees will receive 20 hours of behavioral health training, to focus on telephonic suicide intervention, crisis management and de-escalation, interactions with individuals with behavioral health issues, roles of different CIT program members, and procedures for calls regarding behavioral health issues, including appropriate team/officer dispatch requirements in response to calls. Communications employees will receive a two hour in-service training every two years covering behavioral health-related topics.
E. CIU/COAST will participate in the same training as ECIT officers. The CIT Program Coordinator may develop additional training for these team members.

2-13-13 Partnering with MHRAC

A. The Mental Health Response Advisory Committee (MHRAC) was established to partner with the department to improve outcomes for interactions between the police and individuals who have behavioral health disorders or who are in crisis.
B. Members of the Department, including command staff, ECIT officers, CIU and COAST members, and employee or department-contracted or mental health professionals, will serve on MHRAC. The lieutenant of CIU will be responsible for recruiting department members as needed. MHRAC and the lieutenant will work together to recruit members from the community other organizations, such the City Department of Family & Community Services, UNM Psychiatric Department, mental health professionals, advocacy groups for consumers of mental health services, mental health service providers, homeless service providers, and similar groups. Members are approved and appointed by MHRAC pursuant to its rules.
C. Department personnel will cooperate and support MHRAC's operations.

1. The Deputy Chief Investigative Bureau will designate personnel above and beyond department members of MHRAC to regularly attend MHRAC meetings to facilitate communication and support needed for MHRAC's functions.
2. Other department personnel will attend MHRAC meetings as requested by MHRAC to provide more information regarding the department's policies, procedures, training, and performance.
3. The CIU lieutenant will produce regular reports to MHRAC regarding the activities of CIU and COAST and data regarding interactions between officers and individuals believed to be affected by behavioral health disorder or crisis.
4. Other department personnel will provide data that it subject to public disclosure to MHRAC upon request of MHRAC. If there are any concerns about the propriety of releasing certain information, the personnel will work with the department legal advisor and the MHRAC chair(s) to handle the data request appropriately.

D. The Deputy Chief Investigative Bureau will work with different divisions and units across the department to ensure that MHRAC's recommendations are evaluated by department personnel and incorporated as much as possible given the department's resources and objectives. These recommendations may apply to a broad range of activities such as:
   1. Policies and procedures regarding contact with individuals with behavior health disorders;
   2. Training regarding contact with individuals with behavior health disorders, particularly scenario-based training;
   3. Recruitment of ECIT officers, CIU, and COAST personnel;
   4. Protocols for the release and exchange of information about individuals with known behavioral health disorders between providers and officers; and
   5. Community resources and networks to facilitate better communication and relationships to treat behavioral health issues as a community and through connection with services rather than through the criminal justice system.