Lexington Police Department	**Subject:** Responding to the Mentally Ill	**Policy Number:** 410
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By Order of: Mark J. Corr, Chief of Police

The Municipal Police Institute, Inc. (MPI) is a private, nonprofit charitable affiliate of the Massachusetts Chiefs of Police Association. MPI provides training and model policies and procedures for police agencies. This policy is an edited version of MPI Policy 1.16, "Handling the Mentally Ill."

GENERAL CONSIDERATIONS AND GUIDELINES

Reaction to the mentally ill covers a wide range of human responses. People afflicted with mental illness are ignored, laughed at, feared, pitied and often mistreated. Unlike the general public, however, a police officer cannot permit personal feelings to dictate his/her reaction to the mentally ill. His/her conduct must reflect a professional attitude and be guided by the fact that mental illness, standing alone, does not permit or require any particular police activity. Individual rights are not lost or diminished merely by virtue of a person's mental condition. These principles, as well as the following procedures, must guide an officer when his/her duties bring him/her in contact with a mentally ill person.

Every year police officers are severely hurt or even killed when responding to calls involving the mentally ill. It is extremely important that officers are professional and cognizant of officer safety when handling these calls for service.

It is the policy of the Lexington Police Department that:

- Officers shall accord all persons, including those with mental illness, all the individual rights to which they are entitled; and
- Officers shall attempt to protect mentally ill persons from harm and shall refer them to agencies or persons able to provide services where appropriate.

PROCEDURE

A. Definitions

1. **Bipolar**: Also known as "manic-depressive illness," the disorder causes extreme swings in a person's moods, emotions and behaviors. In the "manic" state, these strong moods may include intense elation or irritability. In the "depression" state, a deep sadness or hopelessness is prevalent. Both are manifested in the "mixed state."

2. **Schizophrenia**: A serious disorder, which affects how a person thinks, feels and acts. The illness is characterized by dramatic changes in behavior and thinking. Someone with schizophrenia may have difficulty distinguishing between what is real and what is imaginary; may be unresponsive or withdrawn; and may have difficulty expressing normal emotions in social situations. The person suffering from schizophrenia may also become or display symptoms of paranoia.

3. **Paranoid personality disorder:** is a psychiatric diagnosis characterized by paranoia and a pervasive, long-standing suspiciousness and generalized mistrust of others.

4. **Hallucinations**: Perceptual experiences that are not actually occurring, such as hearing voices telling one to harm oneself.

5. **Delusions**: Fixed false beliefs about the self, such as: "Everyone is out to get me."

6. **Mental Illness**: For purposes of admission to an inpatient facility under Section 12, "Mental Illness" means a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, and capacity to recognize reality or ability to meet the ordinary demands of life. Symptoms caused solely by alcohol or drug intake, organic brain damage or developmental disabilities do not constitute a serious mental illness.

7. "**Likelihood of Serious Harm:**" (1) a substantial risk of physical harm to the person himself as manifested by evidence of, threats of, or attempts at, suicide or serious bodily harm; (2) a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; or (3) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community.

8. **Pink Slip** or "**Section 12**": Refers to an involuntary commitment to an emergency mental health facility pursuant to M.G.L c. 123 s. 12.

B. Dispatching of Personnel

1. A minimum of two officers should be dispatched to incidents involving the mentally ill.

2. If a street supervisor is available [s]he will also be dispatched to the call.

3. Medical personnel will be dispatched to the location upon request of the officers on scene or if there is a belief of potential injuries.

C. Recognition and Handling [41.2.7 (a)]

1. It is helpful in handling a situation properly if an officer is able to recognize some of the characteristics of a person who is mentally ill.

2. Factors that may aid in determining if a person is disturbed are:

a. Severe changes in behavioral patterns and attitudes;
b. Unusual mannerisms and/or appearance;
c. Distorted memory or loss of memory;
d. Hallucinations or delusions;
e. Irrational explanation of events;
f. Hostility to and distrust of others;
g. Fear of others such as paranoia;
h. Marked increase or decrease in efficiency;
i. Lack of cooperation and tendency to argue;
j. One-sided conversations; and
k. Lack of insight regarding his/her mental illness.

3. These factors are not necessarily, and should not be treated as, conclusive. They are intended only as a framework for proper police response. It should be noted that a person exhibiting signs of an excessive intake of alcohol or drugs might also be mentally ill.

4. Medications: Some medications commonly prescribed for mental illnesses are:

Trade Name	Generic	Trade Name	Generic
ATIVAN	LORAZEPAM	LITHOBID/ LITHIUM	LITHIUM CARBONATE
CALAN	VERAPAMIL	NEUROTIN	GABAPENTIN
CLOZARIL	CLOZAPINE	PROZAC	FLUOXETINE
DEPAKENE	VALPROIC ACID	RISPERDAL	RISPERIDONE
DEPAKOTE	DIVALPROEX	SEROQUEL	QUETIZPINE
GEODON	ZIPRASIDONE	TEGRETOL	CARBAMAZEPINE
HALDOL	HALOPERIDOL	TOPAMAX	TOPIRAMATE
KLONOPIN	CLONAZEPAM	WELLBUTRIN	BUPROPION

LAMICTAL	LAMOTRIGINE	ZYPREXA	OLANZAPINE

D. Common Mental Disorders

1. **Bipolar Disorder**: This is typically a lifelong illness that most often begins in the later teenage years or early adulthood. It commonly runs in families, but not always, and affects more than two million Americans. It is a treatable illness.

   a. Warning Signs: These signs, outlined in the chart below, are often painful, last a long time and are serious. They usually interfere with a person's ability to conduct a normal family, work and personal life.

Signs of Mania	**Signs of Depression**
Excitability or feeling "high"	Feeling sad, depressed or guilty
Increased talkativeness	Slowed or sluggish behavior
Fast speech	Hopelessness
Decreased need for sleep	Thoughts or plans of suicide
Excessive energy	Change in sleep, appetite, energy
Risky behaviors	Problems concentrating

   b. Some people will self-medicate with alcohol or illegal drugs.

2. **Schizophrenia**: Persons in a psychotic state may have high anxiety, faulty reality testing, poor judgment, or diminished impulse control.

   a. They may be at risk of harming themselves or others.
   b. Warning Signs include:

      i. Delusions (false or unreal beliefs);
      ii. Hallucinations (hearing, smelling, tasting or feeling something that is not really there);
      iii. Disorganized speech and/or speaking less;
      iv. Bizarre behavior;
      v. Blunted or dulled emotions;
      vi. Withdrawing emotionally from people;
      vii. A loss of interest in school or work;
      viii. Difficulty paying attention;
      ix. Lack of energy and motivation;
      x. Thoughts of death or suicide, or suicide attempts;
      xi. Outbursts of anger; and
      xii. Poor hygiene and grooming.

3. **Depression**: This is more than just feeling sad or a little "under the weather."

a. Depression is a mental illness that can seriously affect a person's feelings, thought patterns, behavior and quality of life.

b. Warning Signs include:

i. Ongoing sad, anxious or empty feelings;
ii. A loss of interest in activities that normally are pleasurable, including sex;
iii. Appetite and weight changes (either loss or gain);
iv. Sleep problems (insomnia, early morning wakening or oversleeping);
v. Irritability;
vi. A loss of energy and a sense of fatigue, or being "slowed down";
vii. Feelings of guilt, worthlessness and helplessness;
viii. Feelings of hopelessness and pessimism;
ix. Difficulty in concentrating, remembering and making decisions;
x. Thoughts of death or suicide, or suicide attempts; and
xi. Ongoing body aches and pains or problems with digestion that are not caused by physical disease.

E. Mental Health Resources Contact Information

1. Advocates Psychiatric Emergency Services
675 Main Street
Waltham, MA 02453
Main # 781-893-2003, 800-540-5806, **Fax** -781-647-0183.

2. Lexington Human Services Department: 781-861-0194;

3. Massachusetts Department of Mental Health: Phone: 617-626-8000, http://www.mass.gov; and

4. National Alliance on Mental Illness (NAMI): 1-800-950-NAMI (6264), http://www.nami.org/.

5. Central Middlesex Police Partnership: 339-223-1730

F. Dealing with the Mentally Ill in Administrative Settings

1. Non-sworn employees may interact with mentally ill persons in an administrative capacity, such as dispatching, records request, animal control issues, etc.

2. If an employee believes [s]he is interacting with a mentally ill person, [s]he should proceed patiently and act in a calm manner.

3. Although the person is mentally ill, his or her requests or inquiries should normally be treated as if the person making the request or inquiry were not mentally ill.
4. Understand that due to the person's illness, the person could make bizarre claims or requests.

5. At all times, employees should act with respect towards the mentally ill person. A person with mental illness may be both highly intelligent and acting irrationally.

6. If the person's behavior makes the employee feel unsafe, a police officer should be summoned. The police officer need not deal with the person directly, but be present during the interaction to react if the person becomes disruptive or violent.

7. If the person is disruptive, violent, or acts in such a manner as to cause the employee to believe that the person may be harmful to him/herself or others, a police officer should be summoned to address the situation in accordance with this policy.

G. Interactions/interviews with the Mentally Ill in the Field **[41.2.7(c)]**

1. If an officer believes [s]he is faced with a situation involving a mentally ill person, [s]he should not proceed in haste unless circumstances require otherwise.

   a. An officer should be deliberate and take the time required for an overall look at the situation.
   b. An officer should ask questions of persons available to learn as much as possible about the individual. It is especially important to learn whether any person, agency or institution presently has lawful custody of the individual, and whether the individual has a history of criminal, violent or self-destructive behavior.
   c. An officer should obtain information regarding current or previous Doctor's care.
   d. It is not necessarily true that mentally ill persons will be armed or resort to violence. However, this possibility should not be ruled out and because of the potential dangers, the officer should take all precautions to protect everyone involved.

2. It is not unusual for such persons to employ abusive language against others. An officer must ignore verbal abuse when handling such a situation.

3. Avoid excitement. Crowds may excite or frighten the mentally ill person. Groups of people should not be permitted to form or should be dispersed as quickly as possible.

4. Reassurance is essential. An officer should attempt to keep the person calm and quiet. [S]he should attempt to show that [s]he is a friend and that [s]he will protect and help. It is best to avoid lies and not to resort to trickery.
5. An officer should at all times act with respect towards the mentally ill person. Do not "talk down to" such person or treat such a person as "child-like." A person with mental illness may be both highly intelligent and acting irrationally. Mental illness, because of human attitudes, carries with it a serious stigma. An officer's response should not increase the likelihood that a disturbed person will be subjected to offensive or improper treatment.

H. Involuntary Examinations (Section 12) **[1.1.3]**

The authority for an application for Involuntary Examination is described in M.G.L. c. 123 s. 12.

- Medical Personnel: Any physician, qualified psychiatric nurse, mental health clinical specialist, or qualified psychologist, after examining a person and having reason to believe that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness, may restrain the person and apply for hospitalization for a three (3) day period.[i]
- Police Officers: In an emergency situation, if a physician or qualified psychologist is not available, a police officer who *reasonably believes* under the circumstances that failure to hospitalize a person would create a likelihood of serious harm by reason of mental illness may restrain such person and apply for the hospitalization of such person for a three (3) day period at a public facility or a private facility authorized for such purpose by the Massachusetts Department of Mental Health.[ii]
- Any Person (including a police officer) may petition a district court to commit a mentally ill person to a facility for a three (3) day period if failure to confine that person would cause a likelihood of serious harm.[iii]

I. Taking a Mentally Ill Person into Custody

1. A mentally ill person may be taken into custody if:

   a. [S]He has committed a crime.
   b. The officer has a reasonable belief, under the circumstances, that [s]he poses a substantial danger of physical harm to himself/herself or other persons
   c. [S]He has escaped or eluded the custody of those lawfully required to care for him/her.

2. At all times, an officer should attempt to gain voluntary cooperation from the individual.

3. If an officer believes an emergency commitment is required under M.G.L. c. 123 s 12, the following guidelines should be followed: **[41.2.7 (b)]**

   a. The Commanding Officer shall be consulted about the facts of the situation.
   b. The current Psychiatric Emergency Service provider will be contacted by phone. (Currently we use Advocates Psychiatric Emergency Services 800-540-5806.)
   c. The circumstances will be conveyed to the on call clinician regarding the request for a section 12 committal.
   d. If it is agreed that a section 12 is warranted it shall be completed by the on call clinician and faxed to the Police Station, as soon practicable.
   e. Once it has been confirmed that a section 12 has been issued a private ambulance should be contacted for transportation to the psychiatric facility listed on the section 12.
   f. Officers will stay with the mentally ill subject until custody has been transferred to ambulance personnel.
   g. If the subject has a Doctor that they have been currently dealing with and contact is easily accessible, this is also an option for obtaining the Section 12.
   h. If the Section 12 procedure is initiated through the Lexington Police Department then the issuing officer shall document it in an incident report.

   Note: Although the law clearly permits a police officer the ability to sign a section 12 Pink slip the best practice is to initiate the process through the current Psychiatric Service provider. In an emergency situation, Commanding Officers may authorize an issuance of a section 12 by a Lexington Police Officer.

4. Officers may affect a warrantless entry into the home of a subject for whom a section 12 application for temporary hospitalization (pink slip) has been issued, provided:[iv]

   a. They have actual knowledge of the issuance of the pink slip.
   b. The entry is of the residence of the subject of the pink slip.
   c. The pink paper was issued by a qualified physician, psychologist, or psychiatric nurse in an emergency situation and where the subject refused to consent to an examination.
   d. The warrantless entry is made within a reasonable amount of time after the pink slip has been issued.

   *** NOTE**: Each situation is fact specific; the special needs and interests of the subject whom the pink paper is directed towards will be examined thoroughly prior to entry into any home. If all the above criteria are met, **and** reasonable exigent circumstances are present, entry may be

gained. If exigency does not exist and consent is not granted a warrant must be obtained prior to any entry of a residence to execute a pink slip.

J. Transporting Mentally Ill Persons to Treatment

1. Normally, a person who is to be transported to a hospital for a mental health evaluation pursuant to M.G.L. c. 123 s. 12 will be transported by private ambulance.

2. The Lexington Fire Department, if authorized by the Fire Chief, may also transport mentally ill patients in an ambulance.

3. A Lexington Police Officer may transport such person in a police cruiser equipped with a protective barrier if, in the opinion of a police officer, the person poses a threat due to violence, resisting, or other factors. The Commanding Officer or Patrol Supervisor must be consulted for authorization prior to transport. Alternatively, officers may escort or accompany Fire Department personnel in a Town ambulance.

K. Escapes from Mental Health Facilities (Chapter 13 Section 30)

1. If a patient or resident of a facility of the Massachusetts Department of Mental Health is absent without authorization, the superintendent of the facility is required to notify the state and local police, the local district attorney and the next of kin of such patient or resident.[v]

2. Such persons who are absent for less than six months may be returned by the police.

3. Persons who have been found not guilty of a criminal charge by reason of insanity or persons who have been found incompetent to stand trial on a criminal charge and have escaped from a mental health facility may be returned directly to the facility they escaped from, regardless of the length of absence.[vi]

4. Taking a subject into custody for return to a mental health facility shall not be considered an arrest. The subject may be turned over directly to employees of the facility.

L. Indemnification

Police officers are immune from civil suits for damages for restraining, transporting, applying for the admission of or admitting any person to a facility if the officer acts pursuant to the provisions of Chapter 123.[vii]

M. Interrogating Mentally Ill Suspects **[41.2.7(c)]**

1. Whenever a mentally ill or mentally deficient person is a suspect and is taken into custody for questioning, police officers must be particularly careful in advising the subject of his/her Miranda rights and eliciting any decision as to whether [s]he will exercise or waive those rights. It may not be obvious that the person does not understand his/her rights. The Department policy **41K - *Interrogating Detainees and Arrestees*** should be consulted.

2. In addition, it may be very useful to incorporate the procedures established for interrogating juveniles when an officer seeks to interrogate a suspect who is mentally ill or mentally deficient. Those procedures are set out in the Department policy **44B - *Handling Youthful Offenders***.

3. Before interrogating a suspect who has a known or apparent mental condition or disability, police should make every effort to determine the nature and severity of that condition or disability; the extent to which it impairs the subject's capacity to understand basic rights and legal concepts, such as those contained in the Miranda warnings; and whether there is an appropriate "interested adult," such as a legal guardian or legal custodian of the subject, who could act on behalf of the subject and assist the subject in understanding his/her Miranda rights and in deciding whether or not to waive any of those rights in a knowing, intelligent and voluntary manner.

4. CONFIDENTIALITY: Any officer having contact with a mentally ill person shall keep such matter confidential except to the extent that revelation is necessary for conformance with Department procedures regarding reports or is necessary during the course of official proceedings.

N. Lost or Missing

1. If a mentally ill or deficient person is reported lost or missing, police should follow protocols described in the Department policy **42J - *Missing Persons***.

2. Officers may additionally refer the family of the missing person to the National Alliance for the Mentally Ill (NAMI)/Homeless or Missing Persons Service which operates an emergency hotline to assist all families and friends who have a missing relative or friend. The Information Helpline telephone number is **1-800-950-NAMI (6264),** and the web site is http://www.nami.org/.

3. COMPLAINTS WITH NO IMMEDIATE THREAT: An officer who receives a complaint from a family member of an allegedly mentally ill person who is not an immediate threat or is not likely to cause harm to himself or others, should advise such family member to consult a

physician or mental health professional and provide the name and number of our Family Services Detective for additional assistance.

O. Training

1. Department personnel (sworn and non-sworn) shall be trained in this policy upon initial employment during their Field Training Program. **[41.2.7(d)]**

2. The Captain of Administration shall through the Commanding Officers and Patrol Supervisors ensure that all employees undergo refresher training at least once every three years. **[41.2.7(e)]**

P. Public Log.

1. Public record laws specifically **prohibit** the publishing of mental health calls in a public log.

2. Any journal note, that clearly involves a mental health problem, should be identified in the comment line **and** excluded from the public log by marking the journal note not for public.

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[i] M.G.L. c. 123, §12 (a).
[ii] M.G.L. c. 123, §12(a); *Ahern v. O'Donnell*, 109 F.3d 809 (1st Cir. 1997).
[iii] M.G.L. c. 123, §12(e).
[iv] McCabe v. Life-Line Ambulance Service, Inc., 77 F.3d 540 (1st Cir. 1996).
[v] M.G.L. c. 123, §30.
[vi] M.G.L. c. 123, §30.
[vii] M.G.L. c. 123, s. 22