



CITY OF MADISON POLICE DEPARTMENT STANDARD OPERATING PROCEDURE



Mental Health Incidents/Crises

Eff. Date 06/08/2018

Purpose

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

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

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

MENTAL HEALTH LIAISON/OFFICER PROGRAM

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

Mental Health Officer (MHO)

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

Mental Health Liaison Officer (MHLO)

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

RESPONSE GUIDELINES

When Mental Health Issues are Suspected

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

Disposition Options

- Release with referral made to a mental health agency.
 - Place individual in the care of family or friends.
 - Convey voluntarily to Crisis or hospital for further evaluation.
 - Place in protective custody for the purpose of an evaluation for an Emergency Detention.
 - Arrest for a statute or city ordinance violation.
 - Protective custody to Detox if applicable.
- If the subject's behavior constitutes a criminal violation but criteria for an emergency detention is also present, officers should:
 - Consult with Journey Mental Health to determine the best short-term disposition/placement.
 - If the subject is placed under emergency detention, a probable cause affidavit should be completed for the appropriate criminal violations. Request that the destination facility where the subject is conveyed contact MPD when he/she is released to facilitate conveyance/booking.
 - If the underlying offense for which probable cause exists is a mandatory arrest under Wis. Stat. 968.075, the disposition of the subject must be an emergency detention, protective custody, or arrest (voluntary admissions are not an option).

If Harmful Acts are Committed or Threats Made (suicide attempts, overdose, non-suicidal self-injury, other overt acts or threats)

- Ascertain whether the subject has consumed alcohol and/or drugs. If alcohol is on board and the subject is medically cleared, or where medical clearance is unnecessary, transport to Detox under protective custody.
 - For suicidal subjects – make sure to request that Crisis is notified, both verbally and written in the narrative box on the Detox admission form and request a copy for your report. Notify Crisis by phone prior to clearing from the call when there are heightened concerns of imminent risk.
- Overdose Calls
 - Suicide attempts by overdose and accidental overdose are essentially medical emergencies. The role of law enforcement in most cases is very limited to a preliminary investigation to determine if a crime has been committed. Where no crime is committed, our primary role is to assure a safe environment for EMS and other responders. These situations can be divided into two categories, those where EMS transports the subject, and those where they do not.

EMS transports the subject

- An officer shall respond to the hospital if:
 - EMS requests assistance on the rig with a combative subject
 - Death appears imminent
 - The subject is not sufficiently coherent to provide an adequate statement
 - The call precipitates a criminal investigation that cannot be completed at the scene
- Reports in non-criminal overdose cases should reflect the limited role of law enforcement. The report should include the circumstances surrounding the overdose, that the subject was conveyed by EMS, and identification of the victim and witnesses. Extensive medical history information is not required. On some occasions, information received at the scene may be needed later by other officers to establish grounds for an Emergency Detention so these reports should not be held over.

EMS does not transport the subject

- When EMS does not transport, the call will likely become an Emergency Detention assessment, PC conveyance, or a death investigation and should be handled as such.
 - If family is willing to accept responsibility for the patient, and the officer believes that they are capable of preventing the subject from harming him/herself, the family may work directly with their health care providers to assure necessary treatment is provided
- In cases where officers respond to the hospital, consult with ER staff regarding medical admission.
 - If admitted medically, release to hospital and get doctor information for report.
 - If medically cleared, assess for Emergency Detention.

Note – Many suicide attempts by overdose are taken to hospitals and clinics with no police involvement. If family or medical personnel do not request the police, officers should not be dispatched in these cases. If this should occur, advise a supervisor or OIC.

Assessing for Emergency Detention

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

Emergency Detention (ED)

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

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

Final Dispositions

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

Voluntary Admission – Where ED Criteria is NOT Present

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

Voluntary Admission – Where ED Criteria is Present

Often times, even when the criteria for an ED are clearly present, a voluntary admission is still the preferred outcome because it is the least restrictive, and therefore, most likely to result in productive treatment. In these situations, officers shall stay with the subject until they are assured that the subject will follow through with an admission (e.g., signed papers, escorted through the doors of the psychiatric unit, or medical personnel has assumed responsibility for the person and their continued safety.) Officers may leave prior to admission under certain circumstances and only with the approval of a supervisor.

Supervisors should evaluate this early departure based on the following factors:

- Subject's demonstrated level of compliance and willingness to seek treatment
- Subject's history of in-patient psychiatric admission and compliance therewith
- Subject's demonstrated level of insight to their condition and the behavior that led to police involvement
- The level of dangerousness exhibited in that behavior and the presence of any criminal exposure
- The presence of family, friends or other supports at the Emergency Room
- The hospital social worker or charge nurse have been briefed on the situation
- Police call volume and the need for the allocation of police resources city-wide

Officers should request that hospital personnel re-contact their agency should the subject attempt to leave prior to being fully admitted so that an ED can be completed. Officers must complete a report before their shift ends and the original ED form must be left with the OIC.

Emergency Detention

When the basis for detention exists do the following:

- Contact Crisis on **all** emergency detentions.
- Crisis must approve all placements for Emergency Detention.
- Receive medical clearance prior to conveyance to authorized facility.
- Complete ED form and/or review form if filled out by mental health professional. The form **MUST** articulate dangerousness, threats, history, behavior, etc. and list names of witnesses. The form must also be faxed while officers and subject are still at the hospital, prior to the subject going to his/her final destination.
- Forms: 4 copies of ED form. 1 – Subject, 1 – Law Enforcement Agency, 1 – Crisis, 1 – Detention Facility. Fax original to probate court.
- Complete report as a priority and route it to PD Mental Health.

Reminders

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

Helpful Mental Health Definitions

DIRECTOR'S HOLD

- The Treatment Director of a mental health facility/unit may file a statement of ED and detain a patient who has already been admitted to the psychiatric facility/unit.

ORDER TO TREAT

- The court may order that medication may be administered to an individual regardless of his/her consent (involuntarily and/or forcibly).

NON-SUICIDAL SELF-INJURY (NSSI)

- DSM-V symptoms include:
 - Act or its consequence can cause significant distress to the individual's daily life.
 - The act is not taking place during psychotic episodes, delirium, substance intoxication, or substance withdrawal. It also cannot be explained by another medical condition.
 - The individual engages in self-injury expecting to:
 - Get relief from a negative emotion
 - Deal with a personal issue
 - Create a positive feeling
 - The self-injury is associated with one of the following:
 - The individual experienced negative feelings right before committing the act.
 - Right before self-injury, the individual was preoccupied with the planned act.
 - The individual thinks a lot about self-injury even if it does not take place
- NSSI may include, but not limited to, cutting, scratching, picking, burning, head banging, and toxic ingestion.

SETTLEMENT AGREEMENT

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

THREE-PARTY PETITION

- Three adults sign a sworn petition that is drafted by the County Corporation Counsel.

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

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

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

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

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

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

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

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

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

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