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POLICE INTERVENTION WITH EMOTIONALLY DISTURBED PERSONS (EDPs)

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Section I. PERSPECTIVE & INTERVENTION

This policy provides guidelines for interacting with those who may be experiencing an emotional or mental health crisis.

Emotionally Disturbed Persons (EDPs) experience distress or mental health symptoms in a way that exceeds their ability to manage their behavior, emotions or judgment.

- **Distress or mental illness can affect anyone.** It is not a result of weak character or lack of intelligence. Distress or mental illness may interfere with perception, judgment, behavior, and the ability to relate to others. Many individuals have episodic mental health crises, meaning they have good and bad days.

- **People with mental health needs are no more violent than the general population.** In fact, many are withdrawn and uncomfortable. If they become aggressive, it is usually because they feel frightened, confused, or hopeless. Maintaining safety may be challenging when a person has stopped taking prescribed medication or has a dual diagnosis — that is, a mental health disorder and a substance abuse problem.

Multi-disciplinary intervention produces better outcomes. The Chief of this Police Department understands that practical, ongoing collaboration with mental health providers and other community stakeholders has been proven to produce better, more lasting outcomes in cases involving EDPs. For this reason, the Chief will designate a **Coordinator of Mental Health Services**, who is responsible for the ongoing development of programs, services, resources and training to enhance the department's and community's response to EDPs.

Initial Police Response

When coordinating the response to an incident that may involve distress or mental illness, dispatch should provide critical information as it becomes available. This includes, but is not limited to:

- **History.** Whether there have been prior incidents or suicide threats/attempts.
- **Medication.** Whether the EDP took or failed to take medication.
- **Contacts.** Any contact information for a physician, mental health professional, or other legitimately involved party (e.g., family member, social worker, employer, etc.).

When encountering extreme behaviors on scene, officers should:

- **Consider the possibility of distress or a mental health episode.** Do not assume the EDP is dangerous or a criminal.[1] Typical indicators of a mental episode include:
  - A plain, emotionless facial expression and body language.
  - Incoherent thoughts or speech.
  - Inability to focus or concentrate.
  - Bizarre appearance, movements, or behaviors.
  - Delusions of personal importance or identity; unrealistic over-confidence.
  - Hallucinations or perceptions unrelated to reality.
  - Agitation, often without clear reason.
  - Pronounced feelings of hopelessness, sadness, or guilt.
- **Consult individuals on scene who know the EDP.** They often provide the best information. For example, a parent, family member, friend or co-worker may know about the EDP's illness and behaviors, which may alert officers about ways to calm the situation instead of provoking a "fight-or-flight" response. Ask about medication. Many EDPs do not take prescribed medications because they dislike the side effects, deny their illness, or misuse them (hoping to lose weight or get high).

- **Consider passively monitoring the situation.** Sometimes presence alone may be the best police response, especially if a person on scene is having a positive impact on the EDP. Officers may monitor the situation and decide to take no action. If circumstances change, officers may intervene.

- **Interact calmly and compassionately.** Officers are advised to:

  - Introduce themselves *by name* and attempt to obtain the EDP's *name*. This greatly facilitates rapport and a calmer dialogue. [*Note:* It is not unprofessional to use first names. Use your judgment depending on the comfort level of the EDP.]

  - *Most important:* Understand that the failure to follow police directives during an acute episode may not be an act of deliberate defiance *and* may not present an officer safety issue.

  - Recognize that the EDP may be overwhelmed by sensations, thoughts, surroundings, internal sounds or voices. Try to limit the number of officers on scene and other distractors, such as flashing lights.

  - Reassure the EDP that you are there to help, not harm.

  - Be friendly and accepting, but remain firm and professional.

  - Speak simply and announce your actions before initiating them. Do not move suddenly or give rapid orders.

  - Avoid direct, continuous eye contact.

  - If possible, do not touch the EDP. Do not crowd his or her "comfort zone."

  - Ask the EDP for cooperation, and allow time to respond.

  - Remove upsetting influences and people from the scene.

  - Understand that you may not have a rational discussion, but try to keep the conversation concrete by redirecting the topic when needed.

  - Do not express impatience or irritation.

  - Acknowledge that the EDP's delusions are real to him or her. Do not argue or mislead the EDP to think that you feel or think the same way.

- **Request additional resources and a supervisor** (if needed).

- **Apply the least amount of force consistent with public, EDP and officer safety.**[2] Officers should factor into their tactical decision-making:

  - The display or use of a weapon or dangerous item.

  - An assault or aggressive behavior.

  - Self-injurious behavior that risks danger to the EDP or another.

  - The physical features of the location where they encounter the EDP. Specifically, officers may be able to establish a "buffer zone" or contain the EDP in an area where he or she does not present a risk of harm to others. Police/EDP dialogue at this point can be very helpful in de-escalating the situation.

The primary goal is to de-escalate the situation safely for all involved individuals. This may be accomplished by:

- **Release to community.** Officers may allow the EDP to leave the scene alone or in the company of a caretaker or other reputable person.

- **Referral to mental health specialist.** Many non-dangerous calls involving an EDP are best handled by encouraging or arranging professional intervention.

- **Voluntary commitment.** Sometimes a family may be more inclined to push for treatment if they know it will persuade the police to avoid involuntary commitment. This approach also works with an EDP who is rational enough to acknowledge a need for treatment.

  - Under 123, § 10, voluntary commitment may be sought by: (1) a person who is at least 16 years old; (2) a parent or guardian on behalf of a person under 18; or (3) a court-appointed guardian on behalf of a person under his care (no age limitation).[3]

  - Officers may transport the EDP to a facility for this purpose. If, at any point, the EDP changes his mind regarding voluntary evaluation, officers may proceed with an application for involuntary civil commitment.

- **Detention for evaluation and involuntary commitment.** Officers may initiate a mental health evaluation, or they may be called on to detain an EDP on behalf of a qualified mental health clinician.[4]

- **Arrest for crime.** While officers are free to use their discretion and not pursue charges, they should arrest an EDP when appropriate. *Note:* The Attorney General has ruled that determining criminal responsibility is the role of the trial court, and that officers in the field may arrest or apply for a criminal complaint on the basis of probable cause to believe that the EDP committed the crime charged.[5]

Officers are expected to fully document incidents when they were dispatched to the scene, or detained an EDP, or referred an EDP for evaluation and/or treatment. Routine or social interaction with an EDP need not be documented.

Officers and employees must keep information about EDPs confidential, except when revealing information in the course of their duties for an official and legally permissible police, medical or mental health purpose.

Supervisors & Commanders

Supervisors and commanders should monitor police responses to incidents involving EDPs. These incidents can be challenging, and officers may need support and assistance. In particular, supervisors and commanders should, in appropriate cases:

- **Respond to the scene**.

- **Help formulate an effective response** — including everything from passive monitoring and disengagement; to community-based services; to detention and involuntary commitment.

- **Assist in securing appropriate resources**.

- **Closely monitor any use of force**, including restraints, and ensure that those subjected to the use of force are provided with timely access to medical care.

- **Ensure that all reports are complete**.

- **Debrief involved members**. Sometimes an after-action, operational debriefing is warranted, and/or a critical incident stress management debriefing.

Section II. CIVIL COMMITMENT PROCESS

Involuntary commitment[i] is permissible based on a "likelihood of serious harm." G.L. c. 123, § 1 defines this as:

- **Danger to self.** The EDP presents a substantial risk of physical harm to himself (e.g., a suicidal threat or attempt); or
- **Danger to others.** The EDP presents a substantial risk of physical harm to other persons; or
- **Inability to protect self.** The EDP presents a *very* substantial risk of injury to himself based on evidence that the EDP's judgment "is so affected that he is unable to protect himself in the community."

There are four categories of involuntary commitment. Under G.L. c. 123, § 12(a)[6], they are:

- **Category 1 — Clinician issues commitment order based on examination of EDP.** Following a personal examination of an EDP, a qualified mental health clinician may sign a commitment order if he or she has reason to believe that the EDP poses a likelihood of serious harm.
- **Category 2 — Clinician issues commitment order in emergency, where EDP refuses examination.** Even if the EDP refuses examination, a qualified clinician may still issue a commitment order based on facts and circumstances that show that the EDP poses a likelihood of serious harm.
- **Category 3 — Officer restrains EDP in emergency.** In an emergency, officers may restrain an EDP who they believe poses a likelihood of serious harm, if no qualified clinician is available to sign a commitment order.
- **Category 4 — Judge issues Warrant of Apprehension.** At any time, *any person* may apply to a District or Juvenile Court for a commitment order and, after a hearing, the judge may issue a warrant for the apprehension of an EDP that poses a likelihood of serious harm.

[i] Involuntary commitment under 123, § 12 is for a maximum of three days. To hold a person longer requires a separate legal proceeding under 123, §§ 7 and 8, or voluntary commitment under 123, § 10.

Police Procedures for Involuntary Commitment

Categories 1, 2, and 4:

- **Since the commitment order is issued by a clinician and/or a judge, officers may enter private homes to carry out a detention for involuntary commitment.** Categories 1, 2, and 4 are, in effect, arrest warrants for mental health detention.[7]

- **Since EDPs constitute a diverse and, at times, unpredictable group of people, officers should obtain information from the court, clinician, and/or family.** When called on to execute a commitment order or warrant of apprehension, officers should always get some preliminary information from those familiar with the EDP. For example, is the EDP paranoid? Would it be better to have plainclothes personnel handle the situation? Should a family member be present during police entry?[8]

- **Transport EDP to appropriate local facility (Categories 1 and 2) or to the court that issued the warrant (Category 4).** Officers should either utilize their own cruiser or have an ambulance assigned for transport. Officers should follow in their cruiser or ride in the ambulance to the mental health facility to ensure that the EDP, who they took into custody, arrives safely.

Category 3

- **Since street officers make the decision to take the EDP into custody, they must have probable cause[9] that the EDP poses a "likelihood of serious harm."**[10]

- **When entering a home to take an EDP into custody under Category 3:**

  - ***If possible, obtain a commitment order from a clinician.*** If there is time to consult with a clinician who can issue an order, this is preferred. The situation then becomes a Category 2 entry.

  - ***If exigent circumstances make consulting with a clinician impractical, seek consent to enter and, if that fails, force entry.*** If possible, seek supervisory approval prior to forceful entry.[11]

- **Transport EDP to appropriate local facility and file application for commitment.** A Category 3 detention is not an involuntary commitment. It simply permits officers to transport the EDP for evaluation. The clinician decides whether to issue a commitment order or arrange another intervention (including discharge of the EDP).

Transport & Restraint

Officers are authorized to transport and restrain patients.[ii] G.L. c. 123, § 21 specifically allows officers to:

- **Transport both voluntary and involuntary patients.**

- **Use restraints on an adult for up to 2 hours prior to examination, and on a minor for up to one hour.** Take reasonable precautions, including the use of handcuffs, but avoid other unnecessary restraints.

Prior to transport, officers or dispatch shall notify the receiving facility of the estimated time of arrival, the EDP's level of cooperation, and whether any special medical care or restraints are needed.

Prior to transport, officers shall:

- **Search the EDP for weapons and contraband** (including any containers or items possessed by the EDP unless turned over to a third party).

- **Decide whether to transport the EDP in a police cruiser or by ambulance.** If safety requires that an officer ride in an ambulance with the EDP, then supervisor approval is required before transport begins.

- **Attempt to learn if the EDP owns or has potential access to any firearm or other deadly weapon.** Officers should evaluate how, in compliance with search and seizure law, they may seize any firearms or other dangerous weapons. Officers should document the results of this inquiry and, if necessary, follow up with police personnel. Officers may need a warrant before entering a residence or other place to search, unless they have exigent circumstances or consent.[12]

Upon arrival at the facility, officers will:

- **Escort the individual into a treatment area designated by a facility staff member.**

- **Inform the staff member about the facts and circumstances that resulted in the EDP being transported to the facility.**

[ii] G.L. c. 123, § 22 states that officers are "immune from civil suits . . . for restraining, transporting, . . . or admitting any person to a facility." To operate under the protective blanket of § 22, officers should properly document their actions in dealing with an EDP.

- **In the case of an involuntary admission, provide the staff member with a written application for a commitment order** (if requested). See *Attachment A*. Keep a copy to attach to the incident report.

Officers should not normally assist facility staff with the admission process. However, if the EDP is transported and delivered while restrained, officers may assist with transferring the EDP to facility restraints and will be available to assist during the admission process (if requested).

Under normal circumstances, officers will not apply facility-ordered restraints.

Arrest & the Civil Commitment Process

Civil commitments should be preferred over arrest for EDPs who are suspected of minor crimes or creating other public safety issues. If an EDP is being taken into custody for civil commitment *and* suspected of a minor offense, officers are advised to file an application for a criminal complaint.

When an EDP, who may qualify for civil commitment, has committed a serious criminal offense that would normally result in arrest, officers should:

- **Arrest the EDP if there is probable cause to do so**.

- **Notify a supervisor about the facts supporting the arrest *and* involuntary commitment.** Later, these facts should be documented in the incident report.

The OIC or supervisor may direct that the EDP be:

- **Transported to court for evaluation and arraignment**; or

- **Allowed to enter a mental health facility voluntarily subject to a later appearance in court**; or

- **Evaluated by a mental health professional at the police lockup** and, if necessary, transferred to a mental health facility for involuntary commitment pending an appearance in court.[13]

The OIC or supervisor may consult with the bail commissioner and consider the seriousness of the offense, the treatment options available, and other relevant factors in making this decision.

[1] It is estimated that 40% of emotionally disturbed persons are, at some point in their lives, arrested by police. Swanson, *Police Administration* (Prentice Hall, N.J.; 6th Ed.) at page 595.

[2] *San Francisco v. Sheehan,* 135 S.Ct. 1765 (2015) [Supreme Court strongly suggests that Title II of the Americans with Disabilities Act (ADA) mandates that police officers consider the mental health condition of the EDP when deciding the level of force that makes sense to employ to resolve the situation]. The amount of force used in carrying out the detention may be a source of liability, even when the detention itself is justified. *Samuelson v. City of New Ulm* 455 F.3d 871 (8th Cir. 2006).

[3] The drawback of this strategy is the relative ease with which a patient may be released. First, the facility may discharge a patient on its own. However, if the patient is a child, the facility must provide a parent or guardian with 14 days notice. Second, an adult patient may choose to leave, or a parent or guardian may withdraw his child. As a safeguard, facility staff may insist on 3 days written notice and restrict departure to normal business hours. In extreme cases, a patient may be held beyond the 3 day period if the facility files a petition for longer term, involuntary commitment.

[4] See later discussion in Part II concerning civil commitment under 123, § 12.

[5] Op.Atty.Gen., July 1966 at 36.

[6] *Ahern v. O'Donnell,* 109 F.3d 809 (1997) specifically uses the term "category" in describing the different methods for initiating the mental health commitment process under 123, § 12(a).

[7] Both the commitment order and warrant of apprehension constitute a type of special process which authorizes officers to enter private dwellings. *McCabe v. Lifeline Ambulance & City of Lynn,* 77 F.3d 540 (1996).

[8] Considering potential difficulties *before* the police enter and detain the EDP may avert a tragic result. *McCabe v. Lifeline Ambulance & City of Lynn, supra.* (64 year old Holocaust survivor died at her home during a traumatic effort by police to execute a commitment order).

[9] *Ahern v. O'Donnell,* 109 F.3d 809 (1997) (probable cause required for police mental health detention under 123, § 12). *Fisher v. Harden,* 398 F.3d 837 (6th Cir. 2005) (same).

[10] *Ahern v. O'Donnell,* 109 F.3d 809 (1997) (messages left by EDP revealed a deeply disturbed and depressed individual). Also see *Palter v. City of Garden Grove,* 2007 U.S. App. Lexis 13848 (9th Cir.) (officer had probable cause to believe, at the time he detained a man for psychiatric evaluation, that the man was suicidal; the EDP had talked about killing himself, had access to a gun, was about to be served with divorce papers, had pain medication, was under a therapist's care, and was possibly on his way to leave a "goodbye" note at his daughter's house). Compare *Meyer v. Board of County Commissioners,* 482 F.3d 1232 (10th Cir. 2007) (boyfriend was a town employee and personal friend of several deputies; there was evidence that the deputies lied to get his girlfriend involuntarily committed in retaliation for her reporting his domestic violence).

[11] *McCabe v. Lifeline Ambulance & City of Lynn, supra*. ("The potential consequences attending a delayed commitment — both to the mentally ill subject and others — may be extremely serious, sometimes including death or bodily injury"). Compare *Comm. v. Allen,* 54 Mass. App. Ct. 719 (2002) (police sergeant had insufficient evidence that a disabled person he knew was in need of immediate assistance; therefore, his warrantless entry into the apartment was invalid).

[12] Confiscating a license holder's guns is legally more complicated. See, e.g., *Pasqualone v. Gately,* 422 Mass. 398 (1996) (prior to confiscation of weapons, license holder typically must receive written notice and a right of appeal unless there is exigent circumstances). *Mazurczuk v. Chief of Police of Chelmsford,* 2014 WL 6994664 (Appeals Court) (police chief acted within his authority when he revoked the plaintiff's LTC due to his confrontations with neighbors, lack of control, and refusal to cooperate with police).

[13] 123, § 18.

Attachment

A

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
APPLICATION FOR AN AUTHORIZATION OF TEMPORARY INVOLUNTARY HOSPITALIZATION
M.G.L. Chapter 123, Sections 12 (a) and 12 (b)

Application Pursuant to 12 (a)

1). Application to (Facility name): _____
2). I hereby apply for admission of (name of individual): _____

Address:_____City/Town_____State_____

Social Security Number: _____ Date of Birth: _____ Sex: M ☐ F ☐

to the facility named above pursuant to M.G.L. c. 123, s. 12 (a). I hereby authorize transport and the use of restraint of the person named above but only if necessary for the safety of the person being transported or of others who are likely to come into contact with him or her. M.G.L. Chapter 123, s. 21.

Based on my examination[1], it is my opinion that the person requires hospitalization at the above named facility so as to avoid the likelihood of serious harm by reason of mental illness. Evidence supporting my opinion includes:

A). **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, 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 intellectual disability do not constitute a serious mental illness. Specify evidence including behavior and symptoms:

_____
_____

B). **Likelihood of Serious Harm** (check all categories that apply):

_____ (1) Substantial risk of physical harm to the person himself/herself as manifested by evidence of threats of, or attempts at suicide or serious bodily harm; and/or

_____ (2) 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; and/or

_____ (3) Very substantial risk of physical impairment or injury to the person himself/herself as manifested by evidence that such person's judgment is so affected that he/she is unable to protect himself/herself in the community and the reasonable provision of his/her protection is not available in the community.

Specify evidence including behavior and symptoms:_____
_____
_____

3). Applicant Certification (check all applicable boxes)

a. I am a: ☐Licensed Physician or Nurse Practitioner (GL. Ch 112 §80i) ☐Qualified (i.e. Licensed) Psychologist
☐Qualified (i.e. Licensed and Certified) Psychiatric Nurse Mental Health Clinical Specialist
☐Police Officer ☐ Licensed Independent Clinical Social Worker (LICSW)

b. I have ☐ I have not ☐ personally examined this person. If not, why? _____
_____

c. ☐I have consulted with either the receiving facility or emergency screening program.

d. ☐I have not so consulted because_____
_____

Applicant's name (not patient):
(print)_____Phone:_____
Address:_____City/Town_____State____

Applicant's signature:_____ Date: _____ Time:_____

NOTE: Parts 1) through 3), above, must be completed to apply for involuntary hospitalization.

Form AA-5 *See Reverse for Section 12(b)* ***Effective – September 25, 2013***

[1] If an examination is not possible because of the emergency nature of the case and because of the refusal of the person to consent to such examination, the physician, qualified psychologist, qualified psychiatric nurse mental health clinical specialist or licensed independent clinical social worker on the basis of the facts and circumstances may determine that hospitalization is necessary and may apply therefore. G.L. c.123 s.12(a)

Authorization Pursuant to Section 12 (b)

Designated Physician***** Authorization :

(NOTE: Boxes A. through G., below, must be checked to authorize a Section 12(b) involuntary admission to a facility.)

A. ☐ I am a designated physician***** of the aforementioned facility with authority to authorize admissions under Section 12 (b).

B. ☐ I have personally examined this person
- ☐ within 2 hours of his/her arrival at the facility
- ☐ more than 2 hours after his/her arrival at the facility due to the fact that I was engaged in an emergency situation.** The emergency situation was: _____

_____

_____

_____ and I examined the patient at _____ am/pm.

C. ☐ This person does not require emergency or inpatient medical or surgical care.

D. ☐ I have offered this person an application for Care and Treatment on a Conditional Voluntary Basis and the person:
(one of the two boxes below must be checked to proceed with a Section 12(b) authorization)
- ☐ refused to sign, or
- ☐ the application was rejected (the reasons why the application was rejected must be stated on the application and the rejected application shall become part of this person's medical record at the facility).

***Note**: 104 CMR 27.07 (1) requires that the patient be offered an opportunity to change to conditional voluntary status again within three days of admission.*

E. ☐ I concur with the applicant's recommendation and have completed a psychiatric examination to support this conclusion. Alternatively, I am the applicant, I have personally examined this person, and have completed sections **1)**, **2), 2A)** and **2B)** on the opposite side of this form.

F. ☐ In my opinion, at the present time there is no less restrictive placement that is appropriate for this person to which he or she is willing to go.

G. ☐ I authorize this person's admission.

H. ☐ I reject this application for admission for the following reasons:_____

_____

_____

_____

_____

Designated Physician's Name (print):

_____Phone:_____

Address: _____

_____

_____

Designated Physician's Signature:_____

Date: _____ Time: _____

* A physician who meets the criteria in 104 CMR 33.03

** See 104 CMR 27.07 (2)