Sheridan Police Department
Policies and Procedures
28.9
Chapter 28 – Call Response
Section 9 – Mental Illness

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Signature:

The need to diagnose or treat persons with a mental illness is not the responsibility of police officers; however, the need to assess the mental state and intention of individuals is a routine requirement of police officers performing enforcement and investigative functions. Mental illness may play a role in the lives of people that police come in contact with and so officers should have a basic understanding of mental illness and consider the effects of mental illness in the situation at hand. Dealing with individuals in enforcement situations who are known or suspected to be mentally ill carries the potential for violence, requires an officer to make difficult judgments about the mental state of the individual, and requires special police skills to effectively and legally deal with the person to avoid unnecessary violence and violations of civil rights.

28.9.1 Recognition of Mental Illness

A. Mental illness is quite often difficult to define in a given individual. Officers are not expected to make judgments of mental or emotional disturbance but rather to recognize behavior that is potentially destructive and/or dangerous to self or others. The following guidelines are generalized signs and symptoms of behavior that may suggest mental illness, although officers should not rule out other potential causes, such as reactions to narcotics or alcohol or temporary emotional disturbances that are situationally motivated.

B. There are three types of indicators that a person may be suffering from mental illness.
    1. Verbal Cues -- these may include:
        a. Illogical thoughts
            i. Expressing a combination of unrelated or abstract topics.
            ii. Expressing thoughts of greatness (i.e. - person believes he or she is God).
            iii. Expressing ideas of being harassed or threatened (i.e. - CIA monitoring thoughts through television set).
            iv. Preoccupation with death, germs, guilt, etc.
        b. Unusual speech patterns
            i. Nonsensical speech or chatter.
            ii. Word repetition -- frequently stating the same or rhyming words or phrases.
            iii. Pressured speech -- expressing urgency in manner of speaking.
            iv. Extremely slow speech.
        c. Verbal hostility or excitement
            i. Talking excitedly or loudly.
            ii. Argumentative, belligerent, unreasonably hostile.

iii. Threatening harm to self or others.

2. Behavioral Cues -- these may include:
    a. Physical appearance:
        i. Inappropriate to environment (i.e. - shorts in winter, heavy coats in summer.
        ii. Bizarre clothing or makeup, taking into account current trends.
    b. Bodily movements:
        i. Strange postures or mannerisms.
        ii. Lethargic, sluggish movements.
        iii. Repetitious, ritualistic movements.
    c. Seeing or hearing things that aren't able to be confirmed.
    d. Confusion about or unawareness of surroundings.
    e. Lack of emotional response.
    f. Causing injury to self.
    g. Nonverbal expressions of sadness or grief.
    h. Inappropriate emotional reactions:
        i. Overreacting to situations in an overly angry or frightening way.
        ii. Reacting with opposite of expected emotion (i.e. - laughing at auto crash).
3. Environmental Cues -- Surroundings are inappropriate, such as:
    a. Strange trimmings, inappropriate use of household items (i.e. - aluminum foil covering windows).
    b. Waste matter/trash:
        i. Accumulation of trash (i.e. - hoarding string, newspapers, paper bags, clutter, etc.).
        ii. Presence of feces or urine on the floor or walls.
    c. Childish objects.

C. When making observations, personnel should note as many cues as possible, put the cues into the context of the situation, and be mindful of environmental and cultural factors.

D. Physical causes of abnormal behavior may include some of the characteristic behavior of the mentally ill but should not be confused with mental illness. There are important differences between individuals suffering from medical conditions and the mentally ill. These include the following:
    1. Intellectual disability refers to subnormal intellectual capacity and deficiencies in a person's ability to deal effectively with social conventions and interaction. The intellectually disabled may display behaviors that are rational but that are similar to younger persons who are not intellectually disabled. By contrast, the mentally ill may not be impaired intellectually and may act in many instances as rational, functional members of society. Their behavior generally fluctuates between the normal and the irrational. The intellectually disabled individual does not demonstrate this type of behavioral fluctuation. Intellectual disability is evident during a person's early years and is a permanent condition for life, whereas mental illness may develop during any period of an individual's life. The intellectually disabled individual does not engage in violent behavior without the types of provocations that may initiate violence among the non-intellectually disabled person.

2. Persons suffering from cerebral palsy exhibit motor dysfunctions that may be confused with some characteristics of either the intellectually disabled or the mentally ill. These include awkwardness in walking, involuntary and uncontrollable movements, or seizures and problems in speech and communication.
3. Autistic persons often engage in compulsive behavior or repetitive and peculiar body movements. They can become very distressed over minor changes in their environment. They may also display unusual reactions to objects or people they see around them; appear insensitive to pain and may be hyperactive, passive, or susceptible to tantrums. Such persons may also appear intellectually disabled in some areas, but highly capable or gifted in others.

D. Officers should constantly assess the situation to determine if police involvement is appropriate. If there is an absence of criminal activity and there are no immediate safety concerns, officers should consider alternative responses.

28.9.2 Interacting With People Who Are Mentally Ill

A. When interacting with a mentally ill person, personnel should:
1. Continually assess the situation for danger;
2. Maintain adequate space between the officer and subject;
3. Remain calm;
4. Give firm clear directions. If possible, only one officer should talk to the subject;
5. Respond to apparent feelings, rather than content;
6. Respond to delusions and hallucinations by talking about the person's feelings rather than what he or she is saying; and
7. Be helpful or offer assistance to make the person feel safer/calmer, etc.

B. When interacting with a mentally ill person, personnel should not:
1. Join into the behavior related to the person's mental illness (i.e. - agreeing with delusions or hallucinations);
2. Stare at the subject. This action may be interpreted as a threat;
3. Confuse the subject. One (1) officer should interact with the subject;
4. Give multiple choices. Giving multiple choices increases the subject's confusion;
5. Whisper, laugh or joke about the situation, this will increase the subject's suspiciousness increasing the potential for violence;
6. Deceive the subject, being dishonest increases fear and suspicion; or
7. Make unnecessary contact. Although touching can be helpful to some people who are upset, for the disturbed mentally ill person, it may cause more fear in the person and lead to violence.

C. Officers may use several indicators to determine whether an apparently mentally ill person represents an immediate or potential danger to himself or herself, the officer, or others. These include the following:
1. The availability of any weapons to the suspect.
2. Statements by the person that suggest to the officer the individual is prepared to commit a violent or dangerous act. Such comments may range from subtle innuendos 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 disturbed person's history may be known to the officer, family, friends, or neighbors who may be able to provide helpful information.
4. Failure of the disturbed individual to act prior to arrival of the officer does not guarantee that there is no danger, but it does in itself tend to diminish the potential for danger.
5. The amount of control the person demonstrates is significant, particularly the amount of physical control over emotions of rage, anger, fright, or agitation. Signs of a lack of control include extreme agitation, inability to sit still or communicate effectively, wide eyes, and rambling thoughts and speech. Clutching one's self or other objects to maintain control, begging to be left alone, or offering frantic assurances that one is all right may also suggest the individual is close to losing control.
6. The volatility of the environment is a particularly relevant factor that officers must evaluate. Agitators that may affect the person or a particular combustible environment that may incite violence should be taken into account.

28.9.3 Emergency Detention

A. A person in need of mental health services may gain access to such services by voluntary admission or involuntary commitment. An officer who encounters an individual in need of treatment for mental illness shall encourage the individual to seek voluntary admission to a treatment facility. If the individual agrees to do so, officers shall assist with transportation or other help as needed.

B. If the person refuses to seek voluntary examination, and does not meet the criteria for involuntary admission, the officer should refer the person to mental health services.

C. A law enforcement officer may detain a person that the officer has reasonable cause to believe is mentally ill and:
    1. Evidences a substantial probability of physical harm to himself or herself or others; or
    2. Evidences behavior he or she is unable to satisfy basic needs for nourishment, essential medical care, shelter or safety.

D. Once a decision has been made to take an individual into custody, it should be done as soon as possible to avoid prolonging a potentially volatile situation. Remove any dangerous weapons from the immediate area, restrain and search the individual in accordance with procedures set forth in section 10.1.42. Using restraints on mentally ill persons can aggravate their aggression. Officers should be aware of this fact, but should take those measures necessary to ensure the safety of those present.

E. A person taken into custody under Wyoming Statute 25-10-109 (Emergency Detention) shall be transported to the emergency room at Sheridan Memorial Hospital Emergency Room.

F. Personnel will evaluate the condition of the subject prior to determining the best method of transportation. Combative subjects may be transported in patrol vehicles. Cooperative subjects, or subjects with severe physical disabilities, may be transported by ambulance.

G. The detaining officer will relate relevant information concerning the individual to the hospital's emergency room physician, or other appropriate attending medical personnel.

H. The law enforcement officer who detained the person shall immediately notify the person responsible for the care and custody of the detained person, if known, of the time and place of detention.

I. The law enforcement officer or examiner who initially detained the person shall make a written statement of the facts of the emergency detention. A copy of the statement shall be given to the examiner.

J. At the time of emergency detention the person shall be informed orally and in writing of the right to contact his or her family and an attorney, of the right to appointed counsel if he or she is indigent, of his or her right to remain silent and that statements may be used as a basis for involuntary hospitalization.

K. The detaining officer should stay with the person until the screening and evaluation are concluded or the screener advises the officer there is no longer a need for the officer's presence and accepts responsibility for the person.

L. If a subject is also to be charged criminally, information must be noted on the involuntary detention paperwork. The attending physician and hospital security personnel must also be verbally advised that other charges are pending.

M. If a commitment is denied by the screening physician, the officer shall notify the person responsible for the care and custody of the detained person, if known, of the results of the evaluation, if possible and/or proceed with any criminal charges, which may have occurred due to the person's conduct.

28.9.4 Welfare Check Requests of Mental Health Patients in Crisis (PIC)

A. Family members, medical professionals, other law enforcement agencies, or concerned citizens will call the police department requesting the check of a person's welfare they suspect is a person in crisis (PIC) related to mental health struggles, and not related to any violations of law.

B. Assessment. Prior to making contact with a person in crisis from a requested welfare check, the communications technician and assigned officer should first ascertain from the reporting person, and other appropriate sources of information as much of the following information as possible:

1. Has the reporting person went to check on their welfare- if not, why?
2. Is the PIC seeing or under the care of a mental health professional, or physician (who)?
3. Is the PIC's location known?
4. What concerning behaviors has the PIC demonstrated?
5. What specific threats has the PIC made, when were the threats made, and to whom?
6. Is there a history of threats of self-harm, and have they been acted on in the past?
7. Is the PIC alone? Who else is with the PIC?
8. Is the PIC currently under the influence of alcohol or a controlled substance?
9. Does the PIC have any firearms, or access to firearms?
10. Does the PIC have any known agitators (law-enforcement, doctors, etc….)?
11. Is there a history of violence as demonstrated in SPD involvements and PIC's criminal history?
12. Has the PIC requested help, if so what specific help have they asked for?
13. Has the PIC indicated they do not want help- specifically will law enforcement agitate the issue further?
14. Any other relevant information.

C. Response. Once officers have made an initial assessment of the (PIC) officers will use this policy to determine a response. It is recognized that each situation is unique and officers shall

use alternative responses when necessary to prevent injury and protect life. Context is crucial in the accurate assessment of behavior. Officers should take into account the totality of circumstances requiring their presence and overall need for intervention. The following are guidelines to help officers determine a response based on the initial assessment. Responses may change depending on information learned.

1. LEVEL 1. PIC's behaviors are odd or concerning to the reporting person. PIC is acting in a manner not consistent with social norms. Reporting person may be concerned because of past incidents with the PIC. No criminal acts reported. PIC is not attending scheduled meetings for care. No threats of violence to self or others have been recently communicated by the PIC.
    a. LEVEL 1 RESPONSE: Officers will not respond to these. Officers will provide the reporting person with information about community mental health resources. If the PIC, or reporting person is only seeking transportation for the PIC to a local medical facility an ambulance can be dispatched, or taxi information will be provided.
2. LEVEL 2. PIC has made recent statements or actions that indicate they desire to harm themselves or others. PIC has requested help. PIC is alone, or with others that are in no apparent danger and free to leave.
    a. LEVEL 2 RESPONSE:
        i. Officers will first attempt phone contact with the PIC and confirm the situation, and if practical plan with the PIC to come visit with them.
        ii. Officers will attempt to meet with the PIC. If there are valid concerns, they will transport the PIC to the Emergency Room by cooperation, or Title-25 (see 28.9.3).
        iii. If there are no grounds for an immediate hospitalization officers will provide the PIC with the SPD mental health resource brochure.
        iv. Officers will contact the RP and update them on the case resolution.
3. LEVEL 3: PIC has made recent statements or actions that indicate they desire to harm themselves or others. PIC has indicated they do not want help- specifically that law-enforcement may trigger them towards violence. PIC is alone, or with others that are in no apparent danger and free to leave.
    a. LEVEL 3 RESPONSE:
        i. Officers will first attempt phone contact with the PIC. If the PIC is agreeable to meet with the officer and seek assistance, the response will become a level 2.
        ii. If phone contact can't be made, or if after phone contact the PIC is not agreeable to meet with law enforcement, officers will not force contact.
        iii. Officers will attempt to encourage others, for their safety, in contact with the PIC to leave while the PIC is contemplating self-harm.
        iv. Officers should notify neighbors of any potentially harmful situations when necessary.
        v. Officers will check back with the PIC in 24 hrs. over the phone to inquire as to their current welfare. If the situation has downgraded to a safe situation the officer should try to arrange a time to meet with the PIC and provide them with a SPD mental health resource brochure.

vi. Officers will update the reporting person with the case resolution.

4. LEVEL 4: PIC has made recent statements or actions that indicate they desire to harm themselves or others. PIC has indicated they do not want help. Indications of violence towards self or others appear imminent and there are innocent involvements that are not free to leave the situation.
    a. LEVEL 4 RESPONSE: Refer to policies 21.7 (Hostage and Barricade Situations), and 21.8 (Active Shooter).