

Crisis Intervention Incidents

464.1 PURPOSE AND SCOPE

Best Practice

This policy provides guidelines for interacting with those who may be experiencing a mental health or emotional crisis. Interaction with such individuals has the potential for miscommunication and violence. It often requires an officer to make difficult judgments about a person's mental state and intent in order to effectively and legally interact with the individual.

464.1.1 DEFINITIONS

Best Practice MODIFIED

Definitions related to this policy include:

Person in crisis - A person whose level of distress or mental health symptoms have exceeded the person's internal ability to manage his/her behavior or emotions. A crisis can be precipitated by any number of things, including an increase in the symptoms of mental illness despite treatment compliance; non-compliance with treatment, including a failure to take prescribed medications appropriately; or any other circumstance or event that causes the person to engage in erratic, disruptive or dangerous behavior that may be accompanied by impaired judgment.

Mental Health Crisis - An event or experience in which an individual's normal coping mechanisms are overwhelmed, causing them to have an extreme emotional, physical, mental, and/or behavioral response. Symptoms may include emotional reactions such as fear, anger, or excessive giddiness; psychological impairments such as inability to focus, confusion, or nightmares, and potentially even psychosis; physical reactions like vomiting/stomach issues, headaches, dizziness, excessive tiredness, or insomnia; and/or behavioral reactions including the trigger of a "freeze, fight, or flight" response. Any individual can experience a crisis reaction regardless of a lack of previous history of mental illness.

Mental Illness - An impairment of an individual's normal cognitive, emotional, or behavioral functioning, caused by physiological or psychosocial factors. A person may be affected by mental illness if they display an inability to think rationally (e.g., delusions or hallucinations); exercise adequate control over behavior or impulses (e.g., aggressive, suicidal, homicidal, sexual); and/or take reasonable care of their welfare with regard to basic provisions for clothing, food, shelter, or safety.

464.2 POLICY

Best Practice MODIFIED

The Indio Police Department is committed to providing a consistently high level of service to all members of the community and recognizes that persons in crisis may benefit from intervention. The Department will collaborate, where feasible, with mental health professionals to develop an overall intervention strategy to guide its members' interactions with those experiencing a mental health crisis. This is to ensure equitable and safe treatment of all involved. It is the purpose of

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this policy to provide guidance to law enforcement officers when responding to or encountering persons experiencing a mental health crisis.

464.3 SIGNS

Best Practice **MODIFIED**

Only a trained mental health professional can diagnose mental health illness, and even they may sometimes find it difficult to make a diagnosis. Officers are not expected to diagnose mental or emotional conditions, but rather to recognize behaviors that are potentially indicative of a person in mental health crisis, with special emphasis on those that suggest potential violence and/or danger to self and others in addition to indicators indicating a person may be gravely disabled and unable to care for self and others. The following are generalized signs and symptoms of behavior that may suggest an individual is experiencing a mental health crisis, but each should be evaluated within the context of the entire situation. However, officers should not rule out other potential causes, such as effects of alcohol or psychoactive drugs, temporary emotional disturbances that are situational, or medical conditions. Members should be alert to any of the following possible signs of mental health issues or crises which include but are not limited to:

- (a) A known history of mental illness
- (b) Threats of or attempted suicide
- (c) Loss of memory
- (d) Incoherence, disorientation or slow response
- (e) Delusions, hallucinations, perceptions unrelated to reality or grandiose ideas
- (f) Depression, pronounced feelings of hopelessness or uselessness, extreme sadness or guilt
- (g) Social withdrawal
- (h) Manic or impulsive behavior, extreme agitation, lack of control
- (i) Lack of fear
- (j) Anxiety, aggression, rigidity, inflexibility or paranoia
- (k) Strong and unrelenting fear of persons, places, or things.
- (l) Extremely inappropriate behavior for a given context.
- (m) Frustration in new or unforeseen circumstances; inappropriate or aggressive behavior in dealing with the situation.
- (n) Memory loss related to such common facts as name or home address, although these may be signs of other physical ailments such as injury, dementia, or Alzheimer's disease.
- (o) Delusions, defined as the belief in thoughts or ideas that are false, such as delusions of grandeur ("I am Christ") or paranoid delusions ("Everyone is out to get me").
- (p) Hallucinations of any of the five senses (e.g., hearing voices, feeling one's skin crawl, smelling strange odors, seeing things others cannot see).

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- (q) The belief that one suffers from extraordinary physical ailments that are not possible, such as persons who are convinced that their heart has stopped beating for extended periods of time.
- (r) Obsession with recurrent and uncontrolled thoughts, ideas, and images.
- (s) Extreme confusion, fright, paranoia, or depression.
- (t) Feelings of invincibility.

Members should be aware that this list is not exhaustive. The presence or absence of any of these should not be treated as proof of the presence or absence of a mental health issue or crisis.

464.4 COORDINATION WITH MENTAL HEALTH PROFESSIONALS

Best Practice

The Chief of Police should designate an appropriate Division Chief to collaborate with mental health professionals to develop an education and response protocol. It should include a list of community resources, to guide department interaction with those who may be suffering from mental illness or who appear to be in a mental health crisis.

464.5 FIRST RESPONDERS

Best Practice

Safety is a priority for first responders. It is important to recognize that individuals under the influence of alcohol, drugs or both may exhibit symptoms that are similar to those of a person in a mental health crisis. These individuals may still present a serious threat to officers; such a threat should be addressed with reasonable tactics. Nothing in this policy shall be construed to limit an officer's authority to use reasonable force when interacting with a person in crisis.

Officers are reminded that mental health issues, mental health crises and unusual behavior alone are not criminal offenses. Individuals may benefit from treatment as opposed to incarceration.

An officer responding to a call involving a person in crisis should:

- (a) Promptly assess the situation independent of reported information and make a preliminary determination regarding whether a mental health crisis may be a factor.
- (b) Request available backup officers and specialized resources as deemed necessary and, if it is reasonably believed that the person is in a crisis situation, use conflict resolution and de-escalation techniques to stabilize the incident as appropriate.
- (c) If feasible, and without compromising safety, turn off flashing lights, bright lights or sirens.
- (d) Attempt to determine if weapons are present or available.
 1. Prior to making contact, and whenever possible and reasonable, conduct a search of the Department of Justice Automated Firearms System via the California Law Enforcement Telecommunications System (CLETS) to determine whether the person is the registered owner of a firearm (Penal Code § 11106.4).

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- (e) Take into account the person's mental and emotional state and potential inability to understand commands or to appreciate the consequences of his/her action or inaction, as perceived by the officer.
- (f) Secure the scene and clear the immediate area as necessary.
- (g) Employ tactics to preserve the safety of all participants.
- (h) Determine the nature of any crime.
- (i) Request a supervisor, as warranted.
- (j) Evaluate any available information that might assist in determining cause or motivation for the person's actions or stated intentions.
- (k) If circumstances reasonably permit, consider and employ alternatives to force.

464.6 DE-ESCALATION

Best Practice

Officers should consider that taking no action or passively monitoring the situation may be the most reasonable response to a mental health crisis.

Once it is determined that a situation is a mental health crisis and immediate safety concerns have been addressed, responding members should be aware of the following considerations and should generally:

- Evaluate safety conditions.
- Introduce themselves and attempt to obtain the person's name.
- Be patient, polite, calm, courteous and avoid overreacting.
- Speak and move slowly and in a non-threatening manner.
- Moderate the level of direct eye contact.
- Remove distractions or disruptive people from the area.
- Demonstrate active listening skills (e.g., summarize the person's verbal communication).
- Provide for sufficient avenues of retreat or escape should the situation become volatile.

Responding officers generally should not:

- Use stances or tactics that can be interpreted as aggressive.
- Allow others to interrupt or engage the person.
- Corner a person who is not believed to be armed, violent or suicidal.
- Argue, speak with a raised voice or use threats to obtain compliance.

464.7 INCIDENT ORIENTATION

Best Practice

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When responding to an incident that may involve mental illness or a mental health crisis, the officer should request that the dispatcher provide critical information as it becomes available. This includes:

- (a) Whether the person relies on drugs or medication, or may have failed to take his/her medication.
- (b) Whether there have been prior incidents, suicide threats/attempts, and whether there has been previous police response.
- (c) Contact information for a treating physician or mental health professional.

Additional resources and a supervisor should be requested as warranted.

464.8 SUPERVISOR RESPONSIBILITIES

Best Practice

A supervisor should respond to the scene of any interaction with a person in crisis. Responding supervisors should:

- (a) Attempt to secure appropriate and sufficient resources.
- (b) Closely monitor any use of force, including the use of restraints, and ensure that those subjected to the use of force are provided with timely access to medical care (see the Handcuffing and Restraints Policy).
- (c) Consider strategic disengagement. Absent an imminent threat to the public and, as circumstances dictate, this may include removing or reducing law enforcement resources or engaging in passive monitoring.
- (d) Ensure that all reports are completed and that incident documentation uses appropriate terminology and language.
- (e) Conduct an after-action tactical and operational debriefing, and prepare an after-action evaluation of the incident to be forwarded to the Division Chief.

Evaluate whether a critical incident stress management debriefing for involved members is warranted.

464.9 INCIDENT REPORTING

Best Practice **MODIFIED**

Members engaging in any oral or written communication associated with a mental health crisis should be mindful of the sensitive nature of such communications and should exercise appropriate discretion when referring to or describing persons and circumstances.

Members having contact with a person in crisis should keep related information confidential, except to the extent that revealing information is necessary to conform to department reporting procedures or other official mental health or medical proceedings. If an individual is determined to be in mental health crisis and detained for a mental health evaluation, the incident shall be documented in a written report. When documenting such detentions, officers should do the following;

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- (a) Officers should ensure that the report is as specific and explicit as possible concerning the circumstances of the incident and the type of behavior that was observed.
- (b) In circumstances when an individual is transported to a mental health facility for a psychiatric evaluation, officers shall complete a 5150 WIC form and attach a copy to the police report.

464.9.1 DIVERSION

Best Practice

Individuals who are not being arrested should be processed in accordance with the Mental Illness Commitments Policy.

464.10 NON-SWORN INTERACTION WITH PEOPLE IN CRISIS

Best Practice

Non-sworn members may be required to interact with persons in crisis in an administrative capacity, such as dispatching, records request, and animal control issues.

- (a) Members should treat all individuals equally and with dignity and respect.
- (b) If a member believes that he/she is interacting with a person in crisis, he/she should proceed patiently and in a calm manner.
- (c) Members should be aware and understand that the person may make unusual or bizarre claims or requests.

If a person's behavior makes the member feel unsafe, if the person is or becomes disruptive or violent, or if the person acts in such a manner as to cause the member to believe that the person may be harmful to him/herself or others, an officer should be promptly summoned to provide assistance.

464.11 EVALUATION

Best Practice

The Division Chief designated to coordinate the crisis intervention strategy for this department should ensure that a thorough review and analysis of the department response to these incidents is conducted annually. The report will not include identifying information pertaining to any involved individuals, officers or incidents and will be submitted to the Chief of Police through the chain of command.

464.12 TRAINING

Best Practice MODIFIED

In coordination with the mental health community and appropriate stakeholders, the police training cadre & police training specialist will develop and provide comprehensive education and training to all department members to enable them to effectively interact with persons in mental health crisis.

This department will endeavor to provide Peace Officer Standards and Training (POST)-approved advanced officer training on interaction with persons with mental disabilities, welfare checks and

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crisis intervention (Penal Code § 11106.4; Penal Code § 13515.25; Penal Code § 13515.27; Penal Code § 13515.30).

The following POST training (<https://catalog.post.ca.gov>) is for officers that should be provided by the police training cadre & police training specialist but, is not limited to;

- **CRISIS INTERVENTION BEHAVIORAL HEALTH TRAINING SB 11-** Provides the student with the minimum topics mandated in section 13515.27(a) of the California Penal Code and meets the Perishable Skills Program for Tactical Communication. The training increases officer safety prior to, during and post contact.
- **LEGISLATIVE UPDATE** - Designed to update agency executives and officers to current case law trends, what they mean for agencies and how to practically satisfy new case law requirements. Some of these trends include de-escalation techniques and mental health considerations.
- **CRISIS INTERVENTION BEHAVIORAL HEALTH TRAINING FTO** - The course meets minimum 8 hours for Field Training Officer per SB 29. It will provide the trainee with the minimum topics mandated by 13515.28(a)(1) of the California Penal Code. Field training officers are required to have 8 hours of crisis intervention behavioral health training.
- **CRISIS INTERVENTION TRAINING** - (CIT) is a training program designed to help law enforcement officers manage potential crisis situations with individuals with mental illness within the community. The course focuses on specific mental illnesses, de-escalation skills, community resources, in addition to other various mental health related issues. CIT is a partnership between the Sheriff's Department and Riverside University Health System, Behavioral Health.