PBP FORM 290				
PITTSBURGH BUREAU OF POLICE *"...honor, integrity, courage, respect, and compassion."*		**SUBJECT:** **RESPONDING TO INCIDENTS INVOLVING PEOPLE WITH MENTAL ILLNESS**		**ORDER NUMBER:** **40-15**
		PLEAC STANDARD: **2.7.8**		**PAGE 1 OF 7**
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1.0 PURPOSE

1.1 It is the purpose of this policy to provide guidance to Bureau of Police officers when responding to incidents involving people with mental illness.

2.0 POLICY

2.1 Responding to individuals in law enforcement and related situations, who are known or show signs and/or symptoms of mental illness, carries the potential for violence and requires an officer to make difficult judgments about the mental state and intent of the individual. It requires the use of additional Crisis Intervention Team (C.I.T.) training to effectively and legally deal with the person so as to avoid unnecessary violence and potential civil litigation.

2.2 Given the sometimes unpredictable and violent behavior of people with mental illness, officers should never compromise or jeopardize their safety or the safety of others when dealing with individuals displaying signs and/or symptoms of mental illness.

2.3 In the context of enforcement and related activities, officers shall be guided by the law of the Commonwealth of Pennsylvania regarding the detention of people with mental illness.

2.4 Officers shall use this policy to assist them in defining whether a person's behavior is indicative of mental illness and dealing with people with mental illness in a constructive and professional manner.

3.0 DEFINITIONS

3.1 Mental Illness – A behavioral or psychological syndrome that is associated with distress or disability. An individual may suffer from mental illness if he/she displays an inability to think rationally, exercise adequate control over behavior or impulses, or take reasonable care of his/her welfare with regard to basic provisions for clothing, food, shelter or safety.

3.2 C.I.T. Related Calls – Any transport to a Central Recovery Center (CRC), Mobile Crisis Team response, officer referral or provision of information, or any arrest where psychiatric symptoms are displayed.

3.3 C.I.T. Trained Officer - An officer who has attended and completed the approved C.I.T. training in recognizing mental illness, developmental delays or disabilities, and drug and alcohol chemical dependency when handling such instances.

3.4 Resource Facility – Geographical service location chosen by responding police officer(s), Allegheny County Mental Health worker, or Mercy Behavioral Health or Resolve Crisis Network supervisor. These areas are also known as "drop-off centers" and may also include local hospitals such as Western Psychiatric Institute and Clinic (WPIC or "Western Psych") or any hospital with a psychiatric department.

3.5 Mental Health Delegate- The authority for Section 302 determinations rests with the County Mental health Administrator. The Administrator can delegate responsibility to individuals who acts on his or her behalf. The delegate assures fair, correct, and appropriate administration of the procedure for an involuntary admission. In regards to Section 302 (a), they assess reports in deciding to issue a warrant.

3.6 Voluntary Commitment (201) - Section 201 is that part of the Mental Health Procedures Act relating to voluntary consent for a psychiatric examination and treatment. Anyone 14 years of age or older can consent to inpatient treatment. Admission is based on the determination of a psychiatrist that this level of care is needed.

3.7 Involuntary Commitment (302) - Section 302 is the part of the Mental Health Procedures Act relating to a psychiatric examination and treatment without the consent of the individual. The behavior must have occurred in the past 30 days and must have been observed first-hand by a responsible petitioner.

3.8 Petitioner - An individual who files a petition must truthfully describe in writing the behavior that they witnessed in the past 30 days that supports their belief that an individual is clear and present danger to herself/himself or others. The petitioner may be asked to attend a hearing to testify about the information that they gave about the individual's behavior.

4.0 APPLICABLE STATUTES

4.1 Mental Health Procedures Act – Pennsylvania Statute Title 50, Chapter 15 of 1997.

4.2 Americans With Disabilities Act (ADA) - of 1990 and ADA Amendments Act of 2008.

5.0 PROCEDURES

5.1 Recognizing Abnormal Behavior

5.1.1 Mental illness is often difficult for even the trained professional to define in a given individual. Many signs and symptoms represent internal emotional states that are not readily observable from outward appearance but may become noticeable in conversation with the individual.

5.1.2 Officers are expected to recognize behavior that is potentially destructive and/or dangerous to self or others.

5.1.2.1 When possible, a C.I.T officer should handle a call involving an emotionally disturbed person.

5.2 The following 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 situation motivated.

5.2.1 Degree of Reactions – Mentally ill persons may show signs of strong and unrelenting fear of people, places or things. The fear of people or crowds, for example, may make the individual extremely reclusive or aggressive without apparent provocation.

5.2.2 Extreme Rigidity or Inflexibility – Emotionally ill persons may be easily frustrated in new or unforeseen circumstances and may demonstrate inappropriate or aggressive behavior in dealing with the situation.

5.2.3 In addition to the above, a mentally ill person may exhibit one or more of the following characteristics:

5.2.3.1 Abnormal memory loss related to such common facts as name, home address, (although these may be signs of other physical ailments such as injury or Alzheimer's disease)
5.2.3.2 Delusions, 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.")
5.2.3.3 Manic behavior – accelerated thinking and speaking or hyperactivity with no apparent need for sleep and sometimes accompanied by delusions of grandeur.
5.2.3.4 Hallucinations of any of the five senses (e.g., hearing voices commanding the person to act, feeling one's skin crawl, smelling strange odors, etc.)
5.2.3.5 Excited Delirium – associated with mental illness and/or drug use. Common symptoms include fear, high body temperature, repetitious and incoherent speech, paranoia, profuse sweating, nudity, irrational shouting, bizarre statements and behavior.
5.2.3.6 Depression – deep feelings of sadness, hopelessness or uselessness.
5.2.3.7 Anxiety – intense and seemingly unfounded feelings of fear or panic. The person may have trembling hands, sweaty palms, dry mouth, or may be 'frozen' with fear.

5.2.4 Officers should evaluate the symptomatic behavior under the total context of the situation when making judgments about an individual's mental state and the need for intervention absent the commission of a violent crime.

5.2.4.1 At this point, an officer might need to assess the feasibility and if transport to a community mental health/crisis facility would be appropriate under the circumstances.

5.3 Determining Danger – Not all people with mental illness are dangerous, although some may represent danger only under certain circumstances or conditions. Officers may use several indicators to determine whether an apparent person with mental illness represents an immediate or potential danger to himself, the officer or others. These include the following:

5.3.1 The availability of any weapons to the suspect.

5.3.2 Statements by the person that suggest to the officer that the individual is prepared to commit a violent or dangerous act. Such comments may range from subtle innuendoes to direct threats that, when taken in conjunction with other information, provide a more complete picture of the potential for violence.

5.3.3 A personal history that reflects prior violence under similar or related circumstances. The responding officer may be familiar with the person or can learn about the person's history by gathering information from family members or others present.

5.3.4 The amount of control that the person demonstrates is significant, particularly the amount of physical control over emotions of rage, anger, fright, or agitation.

5.3.4.1 Signs of a lack of control include extreme agitation, inability to sit still or communicate effectively, wide eyes and rambling thoughts and speech.

5.3.4.2 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 that the individual is close to losing control.

5.3.5 The volatility of the environment is a particularly relevant factor that officers must evaluate. Agitators which may affect the person or a particularly combustible environment that may incite violence should be taken into account.

6.0 RESPONDING TO PEOPLE WITH MENTAL ILLNESS

6.1 If the officer determines that an individual may be mentally ill and a potential threat to himself, the officer, or others, or may otherwise require law enforcement intervention for humanitarian reasons as prescribed by statute, the following responses may be taken:

6.1.1 Request a backup officer, and always do so in cases where the individual will be taken into custody.

6.1.2 Request emergency medical services when treatment of an injury is urgent. Look for and follow procedures indicated on medical alert bracelets or necklaces.

6.1.3 If the person is acting erratically, but not threatening any other person or him or herself, allow time for the person to calm down.

6.1.4 Take steps to de-escalate the situation. Where possible, eliminate emergency lights and sirens, remove distractions, upsetting influences and disruptive people, and assume a quiet non-threatening manner when approaching or conversing with the individual. Where violence or destructive acts have not occurred, avoid physical contact, and take time to assess the situation.

6.1.5 Move slowly and do not excite the disturbed person. Announce actions before initiating them. Avoid crowding the person unnecessarily.

6.1.6 Speak simply and briefly. Do not give rapid orders. Do not shout. Do not try to force discussion.

6.1.7 Communicate with the individual in an attempt to determine what is bothering them. Where possible, continue to gather information on the subject from family members, others present and/or request professional assistance if available and appropriate to assist in communicating with and calming the person.

6.1.8 Do not threaten the individual with arrest or in any other way; as this will create additional fear, stress, and potential aggression.

6.1.9 Avoid topics that may agitate the person and guide the conversation toward subjects that help bring the individual back to reality.

6.1.10 Always attempt to be truthful with a mentally ill individual. If the subject becomes aware of deception, he/she may withdraw from the contact in distrust.

6.1.11 Request the response of an available C.I.T. officer through communications if one is available. If there is no C.I.T. officer on-duty within the Zone of occurrence, then dispatch shall attempt to locate one from another Zone.

6.2 Determine, when warranted, whether the person may meet the criteria for emergency evaluation.

7.0 VOLUNTARY EXAMINATION

7.1 Persons that may be subject to **VOLUNTARY** examinations under the Mental Health Procedures Act:

7.1.1 Any person 14 years of age or over who believes that he/she is in need of treatment and substantially understands the nature of voluntary treatment.

7.1.2 A Juvenile from the age of 14-18, a child may sign themselves in, but may also be signed in by a parent, etc.

7.2 General Procedure for **VOLUNTARY** examination:

7.2.1 The officer will transport the person to an approved facility.

7.2.2 The person may be searched and handcuffed prior to transport in accordance with applicable PBP procedural policy.

8.0 INVOLUNTARY EXAMINATION

8.1 When a person is severely mentally disabled and in need of immediate treatment, he/she made be made subject to **INVOLUNTARY** emergency examination and treatment.

8.1.1 A person is severely mentally disabled when, as a result of mental illness, their capacity to exercise self control, judgment and discretion in the conduct of their affairs and social relations or to care for their own personal needs are so lessened that they pose a clear and present danger of harm to others or to themselves.

8.1.2 A parent, guardian, or person in *loco parentis,* may subject a child under the age of 18 to an involuntary examination/inpatient admission. (from the age of 14-18, a child may sign themselves in, but may also be signed in by a parent, etc.)

8.2 Determination of clear and present danger

8.2.1 Clear and present danger to others shall be shown by establishing that within the past 30 days the person had inflicted or attempted to inflict serious bodily harm on another and that there is a reasonable probability that such conduct will be repeated

8.2.2 Clear and present danger to himself or herself shall be shown by establishing that within the past 30 days:

8.2.2.1 The person has acted in such a manner as to evidence that he/she would be unable, without care, supervision and the continued assistance of others, to satisfy his/her need for nourishment, personal or medical care, shelter, or self- protection and safety, and that there is a reasonable probability that death, serious bodily injury, or serious physical debilitation would ensue within 30 days unless adequate treatment were afforded; or

8.2.2.2 The person has attempted suicide and that there is the reasonable probability of suicide unless adequate treatment is afforded. For the purposes of this subsection, a clear and present danger may be

demonstrated by the proof that the person has made threats to commit suicide and has committed acts which are in furtherance of the threat to commit suicide; or

8.2.2.3 The person has substantially mutilated him/herself or attempted to mutilate him/herself substantially and that there is the reasonable probability of mutilation unless adequate treatment is afforded. For the purposes of this subsection, a clear and present danger shall be established by proof that the person has made threats to commit mutilation and has committed acts, which are in furtherance of the threat to commit mutilation.

8.3 General Procedures for **INVOLUNTARY** Examination

8.3.1 The officer shall transport the person to the approved facility serving the location chosen by responding police officer(s), Allegheny County Mental Health worker, or Mercy Behavioral Health, or Resolve Crisis Network supervisor where the person was taken into custody.

8.3.2 The officer shall adhere to PBP Policy #12-06, "Use of Force", when necessary to affect custody and ensure the safety of the person, the public, and the officer.

8.3.3 All persons in the custody of the PBP for involuntary examination shall be handcuffed and searched prior to transport in any vehicle.

8.3.4 All necessary police reports and forms shall be completed detailing all facts pertaining to taking the person into custody. The following information, at a minimum, shall be documented on a PBP Form #3.0, "Investigative Report":

8.3.4.1 The circumstances in which the person was encountered.
8.3.4.2 Personal observations by the officer that constituted reasonable grounds for the involuntary examination. Do not make conclusions about the observed behavior, for example: "He is off his meds", without supporting information.
8.3.4.3 Statements made by the person that may be pertinent to this mental state.
8.3.4.4 Use of force required, if applicable.
8.3.4.5 Use of restraints.
8.3.4.6 Any known medical or mental conditions and any medications found during the incident. Confidential information shared with the officer by mental health professionals should not be documented in police reports.
8.3.4.7 Officers should ensure that witness statements, spontaneous utterances, 911 tapes (if needed) and physical evidence / weapons are collected and documented.

8.3.5 Measures that can be taken to ensure the security of any personal property that may be exposed to damage or theft during the person's absence:

8.3.5.1 Secure the house, apartment, and personal property.
8.3.5.2 Check for hazards (gas stove, heaters, water conditions).
8.3.5.3 Notify appropriate agency if animals will be left unattended.
8.3.5.4 Notify appropriate agency as to dependants whose care may suffer in the person's absence.
8.3.5.5 Documentation of the actions taken and notice to shift supervisor of the situation.

9.0 WARRANTS FOR INVOLUNTARY EMERGENCY EXAMINATION

9.1 Upon presentation of a warrant for involuntary emergency examination issued by the county administrator, a PBP officer will make all reasonable efforts to serve the warrant.

9.1.1 The warrant must be physically in-hand, or its existence confirmed by another officer who has the warrant physically in-hand prior to it being acted upon. Copies or faxes are acceptable.

9.1.2 The officer will verify or will have verified by an officer with the warrant in-hand, that the warrant is properly signed by the county administrator (or his or her designee) prior to it being acted upon.

9.2 Absent a warrant, and upon personal observation of the conduct of a person constituting reasonable grounds to believe that he or she is severely mentally disabled and in need of immediate treatment, a PBP officer may take such person to an approved facility for an emergency examination.

9.2.1 The officer will complete all paperwork required for the person's admission to the treatment facility, including a statement as to why he has reasonable grounds to believe that the person needs an emergency examination.

9.2.2 The officer will provide the intake staff and medical professionals at the treatment facility with any known medical history, dependent and family contact information.

9.2.3 If the officer is the petitioner and the patient is retained by the facility, the officer must attend the 303 hearing at the mental health facility where the patient was admitted. Hearsay will not be admitted, therefore the petitioner (the officer) must be present to substantiate throughout the entirety of the case.

9.2.4 As specified in the Mental Health procedures, PA Statue Title 50, Chapter 15, the mental health or medical professional has final authority to uphold, overturn, or reduce a 302 involuntary commitment to a 201 voluntary commitment.

9.2.5 If a medical professional reduces to a 302 involuntary commitment to a 201, the officer will document the name of the doctor or medical professional on PBP Form #3.0, "Investigative Report," or PBP Form #8.11, "Supplemental Report".

10.0 REPORTING OF C.I.T. RELATED CALLS

10.1 C.I.T. related calls include any transport to a CRC, Mobile Crisis Team response, Officer referral or provision of information, or any arrest where psychiatric symptoms are displayed.

10.2 When any Pittsburgh Police Officer clears a C.I.T. related call, the officer must tell the dispatcher that the disposition code is C.I.T. and request a CCR #.

10.3 Members shall complete a PBP Form #20.20, "C.I.T. Report," located in the Police Officers Toolkit, for all C.I.T. related calls. Officers shall complete the "Comments/Continuation" portion of the form detailing the origination and circumstances of the call.

10.3.1 The completed C.I.T Report should be faxed immediately and the original should be forwarded via interdepartmental mail to the C.I.T. Coordinator.

10.3.2 The C.I.T. Coordinator will maintain a file of all C.I.T. Reports.

11.0 MAKING REFERRALS TO AVAILABLE MENTAL HEALTH RESOURCES

11.1 When the responding officer's assessment of all of the circumstances lead him or her to believe that the person does not meet the criteria for emergency examination, the officer will make/offer referrals to the available mental health resources for the person and/or family members.

11.2 PBP Form #20.20, "C.I.T. Report" may be used as a Referral Form if an officer feels a situation involves a mental health issue that should be followed up by Mental Health Professionals.

11.2.1 In these situations, the reporting officer shall complete the C.I.T. Report, including the "Comments/Continuation" portion of the form detailing the origination and circumstances of the call, and will check the "Other" box, noting that it is a referral.

11.2.2 The completed C.I.T. Report should be faxed immediately to the C.I.T. Coordinator.

11.2.3 The original should be forwarded via interdepartmental mail to the C.I.T. Coordinator. The C.I.T. Coordinator may follow up with the appropriate agency on a case by case basis.

11.3 The officer(s) may suggest to the individual that there are resources in our community available to work through their situation such as Western Psychiatric, Mercy Behavioral Health, and ReSolve Crisis Network.

11.3.1 If the individual agrees to go to one of these facilities with the officer to seek treatment, standard operating procedures for the transportation of these persons shall apply for the safety of the officer.

11.3.2 Upon arrival at the "drop-off" facility," the officer will then complete a PBP Form #20.20, "C.I.T. Form" which is to be left at the facility.

11.3.2.1 These forms are provided at each C.I.T. facility or they can be found in the "Police Officers Toolkit."

11.3.2.2 The form should be completed and a copy left at the Central Recovery Center (CRC) when an individual is transported to the CRC.

11.3.2.3 The original C.I.T. Report should be forwarded via interdepartmental mail to the C.I.T. Coordinator after it is scanned with other reports generated for the incident.

11.3.2.4 The C.I.T. Coordinator will maintain a file of all C.I.T. Reports.

12.0 TRAINING

12.1 All employees will participate in Mental Health training and updates as directed by the Pittsburgh Bureau of Police Training Academy or The Municipal Police Officers' Education & Training Commission (MPOETC).

12.2 Pittsburgh Bureau of Police Recruits shall be certified in Mental Health Crisis Intervention Training (CIT).

12.2.1 All recruits will receive 40 hours of certifying instruction on Mental Health Crisis Intervention by a certified instructor.

12.2.2 All recruits must successfully complete the C.I.T. course prior to graduating from the Pittsburgh Bureau of Police Academy.

12.3 If applicable, training on mental health statutes or Department policy changes must be provided within 90 days or as required by statute.

12.4 Training shall be provided annually, to include training provided through the course of legal mandate and/or MPOETC regulation, if available, to all personnel of the Bureau of Police to ensure that compliance is maintained in accordance with all provisions of Section 4.0 of this General Order.

Approved By:

Scott Schubert
Chief of Police