



ALBUQUERQUE POLICE DEPARTMENT
PROCEDURAL ORDERS

SOP 2-19

Effective: 04/04/19 Review: 04/04/20 Replaces: 11/29/17

2-19 RESPONSE TO BEHAVIORAL HEALTH ISSUES

2-19-1 Purpose

The policy of the Albuquerque Police Department is to require officers to assess whether a person's behavior or actions indicate that the person may be affected by a behavioral health disorder or is in a behavioral health crisis. Further, this policy provides specific guidance to officers and supervisors for responding to individuals so affected. The policy provides guidance, techniques, and resources that may be used so that contact with the affected person may be resolved in a constructive and compassionate manner. For the roles, responsibilities, and program description of CIS, refer to SOP – Crisis Intervention Section and Program.

2-19-2 Policy

APD personnel working with persons in crisis will do so in a manner which meets a standard of excellence and awareness for our Department personnel, officers, and supervisors with respect to treatment and interaction of individuals with a behavioral health disorder, a developmental disability, or who are experiencing a behavioral health crisis. Individuals in behavioral health crisis will be treated with dignity; and given reasonable accommodations of their disabilities, and given appropriate access to law enforcement, government, and community services.

Officers are not mental health professionals, but they will receive on-going training to equip them with information and techniques to help them better respond to individuals with behavioral health disorders or who are in a behavioral health crisis. Officers will be trained in intervention and de-escalation techniques and will be familiar with available behavioral health resources to enhance both officer and public safety. This training does not restrict an officer's discretion to make an arrest when probable cause exists, however, officers are encouraged to jail divert individuals affected by a behavioral health disorder or in a behavioral health crisis. (See section 2-19-8, below).

Officers and communities must act in concert with behavioral health professionals to successfully resolve an incident involving individuals in behavioral health crises. An important role for law enforcement is to, when appropriate, help people and their families access behavioral health services, substance abuse programs, hospitals, clinics, and shelter facilities.

Incidents involving individuals in a behavioral health crisis require the use of special police skills and training, de-escalation techniques, and available resources to effectively and positively resolve the situation. The ideal resolution for a behavioral health crisis incident is that the individual is connected with resources that can provide behavioral health support and guidance after the crisis has been resolved.

The goal during an incident involving an individual in a behavioral health crisis is to de-escalate the situation safely with the least amount of force for all individuals involved, consistent with established safety priorities, and to ensure appropriate referrals are made for follow-up activities.



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2-19-3 Definitions

A. Behavioral Health Crisis

A behavioral health crisis is an incident in which an individual is experiencing intense feelings of personal distress (e.g., anxiety, depression, fear, anger, panic, hopelessness), obvious changes in functioning (e.g., neglect of personal hygiene, unusual behavior), or catastrophic life events (e.g., disruptions in personal relationships, support systems, or living arrangements; loss of autonomy or parental rights; victimization; or natural disasters), which may, but will not necessarily, result in an upward trajectory or intensity, culminating in thoughts or acts that are possibly dangerous to the individual in crisis, and/or others.

B. Behavioral Health Disorder

A behavioral health disorder is a disorder that is characterized by a disturbance in an individual's cognition, emotion regulation, or behavior. It reflects a dysfunction in the individual's psychological, biological, or developmental processes underlying mental functioning. This includes individuals with Intellectual and Developmental Disabilities (I/DD).

C. Certificate of Evaluation

A Certificate of Evaluation is a document, completed a qualified, licensed mental health professional which certifies that a person, as a result of a mental disorder, presents a likelihood of harming themselves or others and that immediate detention is necessary to prevent such harm or grave passive neglect.

D. Qualified Mental Health Professional

A qualified mental health professional is a licensed, independent social worker, a licensed professional clinical mental health counselor, a marriage and family therapist, a certified nurse practitioner, or a clinical nurse specialist with a specialty in mental health, who is qualified to work with persons having behavioral health crises or disorders.

E. Crisis Intervention Section (CIS)

The Crisis Intervention Section (CIS) is comprised of Crisis Intervention Unit detectives (CIU), Crisis Outreach and Support Team members (COAST), Mobile Crisis Teams (MCT), crisis clinicians, a licensed psychiatrist, and data analysts. The CIS is responsible for the overall administration and goals of the Crisis Intervention Team (CIT) and the Enhanced Crisis Intervention Team (ECIT) programs.

F. Crisis Intervention Trained Officer (CITO)



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Crisis Intervention Trained officers (CITO) are Field Services Bureau officers who successfully completed the 40-hour basic crisis intervention team training.

G. Crisis Intervention Team (CIT) Program

The Crisis Intervention Team (CIT) Program is a community-based program designed to improve the way law enforcement and the community respond to people experiencing behavioral health crises. The CIT Program is built on strong partnerships between law enforcement, behavioral health provider agencies, individuals, and families of those affected by mental illness.

H. Crisis Intervention Unit Clinicians (CIC)

Crisis Intervention Clinicians (CIC) are qualified mental health professionals who provide evaluations, general psychological assessments, crisis intervention, dangerousness assessments, safety planning, and referrals for individuals in the community living with behavioral health disorders who come into contact with the Department.

I. Crisis Outreach and Support Team (COAST)

The Crisis Outreach and Support Team (COAST) is staffed by civilian employees and supervised by a Department sergeant. COAST enhances the CIT program by providing crisis intervention, access to mental health services, and education, in and response to police referrals. COAST is assigned to the Compliance Bureau/Crisis Intervention Section.

J. De-escalate

To de-escalate is to attempt to calm a situation or to prevent a situation from escalating into a physical confrontation or injury, by using verbal and non-verbal techniques, including active listening skills, tone of voice, announcement of actions, body posture, personal space, eye contact, empathy, and compassion to promote safety for both officers and members of the public.

K. Disengagement

Disengagement is a decision, approved by the sergeant and on-duty lieutenant, to discontinue contact after attempts to engage with an individual in a behavioral health crisis after determining the individual is not a threat to others and that further interaction with the individual will result in an undue safety risk to the person, officers, and the public. This determination will be evaluated by the totality of the situation and the information available to officers and supervisors on the scene.

L. Enhanced Crisis Intervention Team (ECIT)



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The Enhanced Crisis Intervention Team (ECIT) is comprised of specially-trained uniformed officers who function as specialists to handle calls involving individuals affected by a behavioral health disorder or experiencing a behavioral health crisis.

M. Grave Passive Neglect

An individual's failure to provide for one's basic personal needs, medical needs, or to care for one's own safety to such an extent that it is likely to result in serious bodily harm in the immediate future.

N. Mobile Crisis Teams (MCT)

A Mobile Crisis Team (MCT) is a two-person unit comprised of mental health professionals who work with ECIT officers and are responsible for responding to priority calls with a behavioral health component. They provide immediate behavioral health services once the scene is secure. MCTs are trained to complement the ECIT and CIU.

O. Non-Engagement

Non-engagement is the decision, approved by a sergeant and the on-duty lieutenant, to avoid making contact with a person in a behavioral health crisis, who is not a threat to others, and that further interaction with the individual will result in an undue safety risk to the person, officers, and the public. This determination will be evaluated by the totality of the situation and the information available to officers and supervisors on the scene.

2-19-4 The Crisis Intervention Team (CIT) Program

Moved to CIT Program and Crisis Intervention Section Responsibilities (See SOP – Crisis Intervention Section and Program).

2-19-5 Recognizing Behavioral Health Disorders

- A. When responding to an incident, officers should consider whether the person may be in a behavioral health crisis.
- B. Only a trained mental health professional can diagnose behavioral health issues, mental disorders, or illness. Department personnel, officers, and Emergency Communications Center employees do not diagnose an individual's mental health condition. However, they must apply their training to recognize behaviors and signs that indicate the person may be affected by a behavioral health disorder or is in a behavioral health crisis and to adapt police responses accordingly.



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- C. Department personnel, officers, and Emergency Communications Center employees should consider that someone may be in behavioral health crisis due to behavioral disorders or distress, impairment from alcohol or psychoactive drugs, or may have a hearing impairment, deafness, dementia, autism, or physical injury, and tailor their response accordingly.
- 6-7** D. A telecommunication employee will apply their training and experience to identify calls that indicate the individual may be affected by a behavioral health disorder or a behavioral health crisis, and if so, will dispatch an ECIT officer or MCT, when appropriate and available.
- E. If Emergency Communications Center employees receive a call indicating the person may be in a behavioral health crisis, Emergency Communications Center employees will determine whether it would be beneficial to transfer the call to the New Mexico Crisis and Access Line. If so, Communications will call 1-(855)-NMCRISIS (622-7474) and collaborate with the Crisis Line personnel to help respond to the call if appropriate and available.

2-19-6 Assessing Risk

- A. Most people affected by a behavioral health disorder or who are in behavioral health crisis are not dangerous, although some may present dangerous behavior under certain circumstances or conditions. Officers should assess whether someone may be a danger to themselves, the officer, or others, by considering the following:
 - 1. The person's access to weapons.
 - 2. The person's statements, conduct, or inferences that suggest the person will commit a violent or dangerous act.
 - 3. The person's history. The person's history may be known to the Department, the officer, family, friends, and neighbors. Indications that the person lacks self-control, particularly lack of physical and psychological control over rage, anger, fright, or agitation are important considerations.
 - 4. Signs of lack of self-control. These can include extreme agitation, inability to sit still, or clear difficulty communicating effectively, and/or rambling incoherent thoughts and speech. Clutching oneself or other objects to maintain control, or moving very rapidly, may also suggest that the individual is losing control.
 - 5. The volatility of the environment. Agitators who may upset the person, create a combustible environment, or incite violence should be carefully noted and controlled.



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- B. Individuals affected by a behavioral health disorder or crisis may rapidly change their conduct or demeanor from calm and responsive to physically active and agitated or to non-responsive. This behavior change may result from an external trigger (such as an officer who states, "I have to handcuff you now,") or from internal stimuli (such as delusions or hallucinations). Changes in a person's demeanor or conduct do not mean they will become violent or threatening; however, officers should observe and be prepared at all times for a rapid change in behavior.

2-19-7 Response

- 7** A. In responding to an individual experiencing a behavioral health crisis, officers will attempt to de-escalate and calm the situation if feasible, until a supervisor, ECIT, or MCT arrives to control the scene and direct operations.
1. Once on scene, ECIT, MCT, or CIU will take the lead in interacting with individuals in a behavioral health crisis. If a supervisor has assumed responsibility for the scene, the supervisor will seek input from ECIT, MCT or CIU on strategies for de-escalating, calming and resolving the crisis, when safety allows such consultation.
 - 6** 2. The responding officer will request a backup officer whenever the individual will be taken into custody (either for booking or for emergency mental health evaluation). The officer should specifically request an ECIT officer as a backup, unless the requesting officer is an ECIT officer.
 3. Officers should take steps to calm the situation. Where possible, eliminate emergency lights and sirens, disperse crowds, and assume a quiet, non-threatening tone and manner when approaching or conversing with the individual. Where possible, avoid physical contact, and take time to assess the situation. Officers should operate with the understanding that, in most cases, time is an ally, and there is no need to rush or force the situation.
 4. Officers should move slowly in order to not excite or agitate the person. Provide reassurance that the police are there to help and that the person will be offered appropriate care, assistance, and resources.
 5. Officers should communicate clearly and calmly. If possible, speak slowly and use a low tone of voice. Express concern for the person's feelings, and allow the person to share feelings without expressing judgment.
 6. Where possible, officers should gather information from acquaintances or family members. Attempt to find out the nature of the crisis the individual is experiencing. Request professional assistance, if available and appropriate, to assist in communicating with and calming the person.



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7. Officers should not threaten the individual with arrest or physical harm, as this may create additional fright, stress, and potential aggression.
8. Officers should avoid topics that seem to agitate the person, and guide the conversation away from areas that cause stress or agitation and towards topics that seem to ease the situation.
9. Officers should always be truthful. If the person senses deception, they may withdraw in distrust, become hypersensitive, or retaliate in anger. If an individual is experiencing delusions and/or hallucinations and asks the officer to validate them, statements such as, "I am not seeing what you are seeing, but I believe that you are seeing them," are recommended. Validating and/or participating in the individual's delusion or hallucination is not advised.
10. Officers should offer to connect individuals to mental health service agencies or provide transportation to the hospital.

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- B. Officers will complete a CIT contact sheet in TraCS for any interaction with an individual who is experiencing a behavioral health crisis, regardless of the call type or reason for the interaction.
- C. Officers will complete an original incident report noting the following actions or decisions when responding to a behavioral health call:
 1. Charges were filed against an individual.
 2. If officers have handcuffed an individual for any reason, to include the officer's justification for detention.
 3. If an officer employs the tactics of non-engagement or disengagement.
 - a. This report will include the names of both the sergeant and lieutenant who authorized the tactic.
 4. If officers are detaining an individual for a mental health evaluation, and the individual's detention and transport are involuntary, (consistent with SOP 2-19-11 and NMSA 1978, Section 43-1-10) regardless of whether the individual is transported by ambulance or the officer.
 5. If an officer transports an individual for a mental health evaluation in their vehicle.
 6. If officers make a referral to the Crisis Intervention Unit for possible follow up.



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N/A

- a. To make a referral to the CIU, employees must forward their original incident report to APDCIT@cabq.gov for review and indicate that a CIU referral was made on the CIT contact sheet.
 - i. Cases that should be referred to CIU/COAST include, but are not limited to, high risk individuals suspected of living with a mental illness, frequent callers, persons who have certificates of evaluation that officers have attempted to serve but have been unable to contact, individuals who would benefit from being linked to services, or any case officers feel would benefit from the service of the Crisis Intervention Unit/COAST.
7. Any other reason to document the encounter as directed elsewhere in APD SOP or at the direction of a supervisor.

6 D. Non-engagement or Disengagement to Dispatched Calls for Service

1. If a sergeant and lieutenant determine, after consulting with an ECIT officer or a mental health professional, that a person exhibiting a behavioral health disorder or behavioral health crisis is not a threat to others and that further interaction with the individual will result in an undue safety risk to the person, the public, or officers, they should disengage. The sergeant will coordinate with CIU to contact the person at a different time or under different circumstances. A police report and a CIT contact sheet will be generated documenting the following elements:
 - a. Details of the call
 - b. Reasons for disengagement
 - c. Actions taken to de-escalate the situation
 - d. Actions taken to promote safety
 - e. Follow-up plans and referrals made
 - f. Flagged address for a safety bulletin
2. The word “disengagement” will be placed in the incident summary line of the report and noted on the CIT contact sheet.
3. If the individual is barricaded, the officers will follow the additional procedures set forth in SOP – Hostage, Suicidal/Barricaded Individual, and Tactical Threat Assessment.
4. In limited circumstances, officers may be aware of the identity and behavior of an individual before making contact. This information may indicate that the individual is not currently a threat to others, there is no alleged criminal activity, and that contact with law enforcement would not be helpful but only serve to escalate the situation. In these circumstances, a supervisor may approve non-engagement. The supervisor will report non-engagement decisions to a lieutenant. The non-engagement will be documented in the same manner as a disengagement with the word “non-engagement” placed in the incident summary line of the report and a CIT contact sheet.



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5. Nothing in this section shall prohibit officers from utilizing discretion in on-site activity.

2-19-8 Diversion from Jail

Department personnel may divert individuals with behavioral health disorders or who are in behavioral health crisis from jail through the following measures:

- A. When an individual's criminal behavior appears to stem from a behavioral health disorder and he or she would be better served in a treatment location rather than in a criminal justice setting, officers should seek such interventions in lieu of criminal charges. This process applies only to misdemeanor and non-violent felony cases. When possible and allowed by SOP, those persons may be better served by jail diversion, which can include the following:
 1. Issuing a verbal warning.
 2. Issuing a citation.
 3. Giving a summons for misdemeanors or submitting a non-violent felony case to the District Attorney.
 4. Transporting the person to a mental health provider either voluntarily or involuntarily pursuant to NMSA 43-1-10.
 5. Disengagement. A supervisor will notify a lieutenant of this decision.
 6. If an individual is intoxicated to the point that they no longer have control of their faculties, the officer should request an evaluation by emergency medical services.
- B. Jail diversion through the issuance of citations, summons, or submission of a case to the District Attorney is subject to an officer's discretion and is typically appropriate unless:
 1. The individual, subject to lawful arrest, fails to identify themselves satisfactorily.
 2. The individual refuses to sign the citation.
 3. Arrest or taking the individual into custody is necessary to prevent imminent harm to others, or it is necessary to remove the individual from the scene of the offense to ensure that no person is injured.
 4. The individual has no ties to the jurisdiction reasonably sufficient to ensure their appearance and there is a substantial likelihood that violators would refuse to respond to the citation. The fact that the person appears to be experiencing homelessness is not a sufficient basis for an arrest.



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C. Jail Diversion Collaboration

1. CITO, ECIT, MCT, and CIS will work with behavioral health care providers within the community to deter the individual from future contact with the criminal justice system.
 - a. CIS will meet with personnel from the University of New Mexico, Presbyterian Kaseman Hospital, HealthCare for the Homeless, Hopeworks, New Mexico Solutions, and others as needed or requested to ensure familiarization with diversionary goals.
 - b. Officers will testify at civil commitment proceedings to promote mental health resolution rather than criminal sanctions.
2. CITO, ECIT, and MCT will make referrals to CIS and use COAST and/or Crisis Intervention Unit Clinicians, to reduce the likelihood of future behavioral health crises and thus reduce the possibility of contact with the criminal justice system by evaluating the situation and connecting to appropriate services available to individuals living with behavioral health disorders.
3. On active CIU cases, CIU Detectives may coordinate with the Pre-Trial Services diversionary unit in the court system to address the needs of the individuals with behavioral health disorders who were booked into the detention facility.
4. The primary officer will retain case responsibility if a citation, summons, or case is submitted. CIU/COAST assists if the individual needs follow-up intervention. When sending a copy of the incident report to Court Services, officers will attach a note stating the individual may be a candidate for Mental Health Court.
- 6-7 5. If the individual is not appropriate for jail diversion, the officer should ensure that the individual is referred to the Psychiatric Services Unit within the detention center (PSU) by writing "PSU REFERRAL" at the top of the pre-booking slip and checking the Psychiatric Services Unit Referral box on the pre-booking worksheet in TraCS.
- 7 6. Officers shall document on the CIT contact sheet for the call by typing "jail diversion" in the narrative, or, once available, selecting the jail diversion box on the Contact Sheet and choosing the jail diversion option used.

2-19-9 Mobile Crisis Teams

A. Mobile Crisis Teams (MCT)

1. The Mobile Crisis Team (MCT) will serve on teams that are composed of one ECIT Officer, from APD or BCSO, and one independently licensed Clinician through St. Martins Hopeworks.
2. Mobile Crisis Teams (MCT) are responsible for:



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- a. Primarily responding to priority one calls with a behavioral health component, city, and county wide. May need to respond to some priority two calls with a behavioral health component.
- b. May be utilized as a resource and for consultation for the Field Service Bureau.
- c. Assessing individuals for risk to self or others, especially if a person affected by a behavioral health disorder or in behavioral health crisis puts someone else's (including community members or the officer's) safety at risk.
- d. Assessing escalating behavior or erratic conduct. A person may not currently pose a risk to themselves or anyone else's safety; however, they may be displaying behavior that causes increasing alarm to others through physical actions, threats, or property damage. The behavior may result in increased risk to self or others, including officers.
- e. The APD assigned MCT reports to the CIS. The MCT's primary objectives in all interventions are to evaluate the risk the individual poses to themselves or others and to de-escalate and calm the situation in an effort to safely resolve the crisis. When responding to any call for service, the law enforcement officers will always proceed first and make sure the scene is safe enough to have an MCT Clinician interact with the identified person in need. MCT is a specialized response unit and it is discouraged from separating the clinician from the officer.

3. Mobile Crisis Teams (MCT) Call Signs

The call signs for mobile crisis team will be MCT and a numerical digit.

4. Dispatch and calls

- a. MCT should be utilized for behavioral health-related calls. If other criminal allegations arise from a call, other officers should be dispatched.
- b. All MCT responses will begin from either a call from dispatch, from officers on scene, or MCT initiated interactions where it has been determined that the individual in question is experiencing a mental health crisis or a mental health problem.
- c. Dispatch is to utilize training and SOP to contact the mobile crisis unit upon receiving a mental health call. Officers will use their best judgment to determine if and when an MCT is needed on the scene in order to de-escalate the individual and to provide acute crisis services.
- d. MCT units will arrive on the scene in the officer's vehicle. If another officer is already on scene, the on-scene officer(s) will render the scene safe before any MCT clinician comes into contact with the individual in question. Under no



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circumstance shall any MCT clinician engage an individual before the scene has been rendered safe.

- e. Once the scene has been cleared for safety, the MCT clinician will be cleared to engage the individuals in order to gain an understanding of the issue and work to provide acute crisis services and provide referrals if necessary.
- f. The MCT clinician and officers shall work together to provide swift and responsive services for all calls for which they have been dispatched to provide the services deemed necessary and appropriate.
- g. If MCT is involved in use or show of force, the appropriate area command supervisor will be responsible for determining what level of force was used, and when appropriate based on the use of force policies, for conducting the initial investigation. (See SOP – Use of Force policies).

5. Services

- a. The MCT clinician shall provide services beginning with de-escalation and primary assessment. Such assessment may vary, depending on the situation. Such assessments may include a crisis assessment, mental status exams, and general mental health assessments to determine mental health diagnosis.
- b. Once individuals have been assessed, the MCT clinician shall conduct face-to-face crisis intervention services. Services may also include, but are not limited to, crisis planning, referrals for other services, and recommendations for higher levels of care, which may or may not include certificates for evaluation.
- c. The MCT clinician shall work to provide referral services to individuals in crisis. Referrals should be provided in a way that will allow for the MCT clinician to follow up to determine if individuals have obtained those services.
- d. The MCT clinician shall provide follow-up services for individuals previously encountered during a crisis.
- e. All services shall be documented in the agency's Electronic Health Record System and on other forms as directed and provided by St. Martin's Hopeworks Behavioral Health leadership team.

6. Referrals

- a. The MCT shall make needed referrals for services. MCT may refer for the following services, including and not limited to: housing, psychiatric, therapy, substance use, employment, comprehensive community support services, outreach, and emergency services.
- b. The MCT clinician shall work with the St. Martin's Hopeworks clinician to coordinate appropriate referrals and follow-ups.



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- c. In the event an individual needs a higher level of care, the MCT clinician may complete certificates for evaluation. The MCT clinician shall consider utilizing detox services in the event individuals are presenting as intoxicated.
- d. If the MCT believes further follow up is required, they shall submit a referral to the Crisis Intervention Section.

2-19-10 People with Developmental Disabilities

Persons with developmental disabilities may have a mental or physical impairment that creates difficulties in certain areas of life, especially language, mobility, learning, self-help, and independent living. These individuals are often limited in their ability to effectively communicate, interact with others, and make reasoned decisions on their own. Difficult interactions may result in counterproductive police actions if officers do not accurately recognize and effectively deal with behaviors and reactions of these individuals.

A. Common Traits

1. There are many forms of developmental disability. Many individuals have additional related, but distinct, disorders, such as Autism Spectrum Disorder, Down Syndrome, Fetal Alcohol Spectrum Disorder, Fragile X Syndrome, and Rett Syndrome. Although officers are not in a position to diagnose persons with such disabilities, officers will be alert to symptoms suggestive of such disorders. These include the following symptoms in various combinations and degrees of severity:
 - a. Difficulty communicating and expressing oneself.
 - b. Communication by pointing or gestures rather than words.
 - c. Repetition of phrases or words.
 - d. Repetitive body movements which may cause harm to themselves; movements may include, swaying, spinning, clapping hands, flailing arms, snapping fingers, biting wrists, or banging the head.
 - e. Little or no eye contact.
 - f. Uneven gross or fine motor skills.
 - g. Unresponsiveness to verbal commands; the appearance of being deaf.
 - h. Aversion to touch, loud noise, bright lights, and commotion.
 - i. No fear of danger.
 - j. Oversensitivity or lack of sensitivity to pain.
 - k. Self-injurious behavior.
 - l. Talking to themselves.
 - m. Chewing on things that are not edible.

B. Common Encounters



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1. Officers may encounter persons who have developmental disabilities in a variety of situations. Due to the nature of developmental disabilities, the following are some of the most common encountered:
 - a. Wandering
 - b. Seizures
 - c. Disturbances
 - d. Welfare check
 - e. Interfering with another person's rights

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C. Handling and De-escalating Encounters

1. Like anyone else, persons with developmental disabilities can become upset, engage in tantrums or self-destructive behavior, or even sometimes become aggressive. Fear, frustration, and minor changes in their daily routines and surroundings may trigger erratic behavior among some people. Officers should take measures to prevent these reactions by de-escalating situations and attempting to safely calm the situation. These measures include the following:
 - a. Speak calmly.
 - b. Do not shout.
 - c. Do not unnecessarily touch the person.
 - d. Avoid commotion.
 - e. Keep animals away.
 - f. Ask for personal identification.
 - g. Call the contact person, caregiver, or guardian.
 - h. Be patient and prepare for a potentially long encounter.
 - i. Repeat short, direct phrases in a calm voice.
 - j. Be attentive to sensory impairments.
 - k. Maintain a safe distance. Provide the person with a zone of comfort that will also serve as a buffer for officer safety.
 - l. Avoid topics that cause agitation or distress.

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D. Taking Persons into Custody

1. Taking custody of a person with a developmental disability should be avoided whenever possible, as it will invariably initiate a severe anxiety response and escalate the situation. Therefore, in minor offense situations, officers will explain the circumstances to the complainant and request that alternative means be taken to remedy the situation. This normally will involve disengagement or release of the person to family or an authorized caregiver. In more serious offense situations or



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where alternatives to arrest are not reasonable, officers will observe the following guidelines:

2. Contact a supervisor for advice.
3. Summon the person's family or caregiver to have them accompany the person and to assist in the calming and intervention process. If a caregiver is not readily available, summon a mental health crisis intervention worker, ECIT officer if available.
4. Employ calming and reassuring nonjudgmental language and use de-escalation protocols provided in this policy.
5. Do not incarcerate the person in a lockup or other holding cell if possible. Do not incarcerate the person with others since they are vulnerable and at risk of harm.
6. If possible, and until alternative arrangements can be made, put the person in a quiet room with subdued lighting with a caregiver or other responsible individual or another officer who is experienced in dealing with such persons.

E. Interviews and Interrogations

1. If possible, and until alternative arrangements can be made, make every effort to reduce the level of anxiety for the person by changing the environment and by asking a caregiver or another person to be present to assure the person's safety.
2. If feasible, prior to officers conducting an interview or interrogation of a person suspected of being developmentally disabled and suspected of committing a felony-level crime, the officers should immediately contact the Bernalillo County District Attorney's Office to consult regarding whether the person should be interviewed or interrogated.

2-19-11 Procedures for Emergency Mental Health Evaluation

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- A. In accordance with NMSA 43-1-10, an officer may detain a person for emergency evaluation and care at a hospital, mental health facility, or an evaluation facility in the absence of a valid court order only if:
1. The person is otherwise subject to arrest.
 2. The officer has reasonable grounds to believe the person has just attempted suicide.



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3. The officer, based on personal observation and investigation, has reasonable grounds to believe the person, as a result of a mental disorder, presents a serious threat of harming themselves or others, including through grave passive neglect, and that immediate detention is necessary to prevent such harm.
4. Immediately upon arrival at the evaluation facility, the officer will be interviewed by the admitting physician.
5. A licensed physician, certified psychologist, or a qualified mental health professional licensed for independent practice who is affiliated with a community mental health center or core service agency has certified that the person, as a result of a mental disorder, presents a likelihood of committing serious harm to themselves or others, and that immediate detention is necessary. Certification will constitute authority for the officer to transport the individual.
7. If an individual meets the criteria for an emergency mental evaluation, the officer will put the individual in protective custody and arrange transportation to a mental health facility. If possible, the officer will ascertain the individual's health care provider information and assist in the transportation of the individual to the appropriate facility. UNM Mental Health Center (2600 Marble) and Kaseman Presbyterian Hospital (8300 Constitution) have acute care units for evaluating and treating people with behavioral health disorders. Area facilities that may evaluate individuals include:

University of New Mexico Hospital – Psychiatric Center	
2600 Marble Ave. NE, Albuquerque, NM, 87106	(505) 272-2800
University of New Mexico Hospital - Sandoval Regional Medical Center	
3001 Broadmoor Blvd. NE, Rio Rancho, NM, 87144	(505) 994-7000
Presbyterian Hospital – Downtown	
1100 Central Ave. SE, Albuquerque, NM, 87106	(505) 841-1234
Presbyterian Hospital – Kaseman	
8300 Constitution Ave. NE, Albuquerque, NM, 87110	(505) 291-2000
Presbyterian Hospital – Rust	
2400 Unser Blvd. SE, Rio Rancho, NM, 87124	(505) 253-7878
Lovelace – Downtown	
601 Dr. Martin Luther King Jr. Ave. NE, Abq, NM, 87102	(505) 727-8000
Lovelace – Westside	
10501 Golf Course Rd. NW, Albuquerque, NM, 87114	(505) 727-2000
Lovelace – Women’s Hospital	
4701 Montgomery Blvd. NE, Albuquerque, NM, 87109	(505) 727-7800



ALBUQUERQUE POLICE DEPARTMENT
PROCEDURAL ORDERS

SOP 2-19

Effective: 04/04/19 Review: 04/04/20 Replaces: 11/29/17

Veterans Administration Hospital

[1501 San Pedro Dr. SE, Albuquerque, NM, 87108](https://www.va.gov/locations/1501-san-pedro-dr-se-albuquerque-nm-87108)

(505) 265-1711

7. When an individual is taken to a mental health facility, the officer will ensure that the mental health staff has a detailed and accurate account of the incident surrounding the protective custody. The officer will complete and sign an application for emergency hospitalization. If the individual is a juvenile, the officer will ensure that a parent or guardian is notified.
- 6** 8. If an individual is identified as dangerous to themselves or others, the officer will guard the individual to protect the individual and others until the medical facility assumes responsibility for the individual.
9. Whenever an individual is transported to a mental health facility, by an officer, on either a voluntary or involuntary basis, for evaluation or custody, by order of a certificate of evaluation, grave passive neglect, or any other crisis, or arrest, an offense or incident report will be prepared by the primary officer or the mental health care professional.
- 7** 10. Officers who are provided with a Certificate of Evaluation concerning an individual will attempt to verify the authenticity of the certificate by directly talking to the source in person or by calling the facility or doctor who issued the certificate. Real Time Crime Center (RTCC) shall also be utilized to gather additional information.
11. In the event an officer determines that a person has a behavioral health disorder or is in behavioral health crisis but is not dangerous, the officer may request the assistance from a Mobile Crisis Team, the person's mental health provider, COAST, or CIU personnel if the individual would likely benefit from further crisis intervention, linkage to services, and/or education regarding services in the community.
12. When officers take a prisoner to the Metropolitan Detention Center and have knowledge of a prisoner who has some kind of behavioral health disorder, they will notify the Metropolitan Detention Center (MDC) medic who may then notify the Psychological Service Unit (PSU).