2-19 RESPONSE TO BEHAVIORAL HEALTH ISSUES

Related SOP(s), Form(s), Other Resource(s), and Rescinded Special Order(s):

A. Related SOP(s)

1-37 Crisis Intervention Division and Program (Formerly 2-13 and 2-19)
2-8 Use of On-Body Recording Devices (Formerly 1-39)
2-20 Hostage Situations, Barricaded Individual, and Tactical Threat Assessments
2-79 Law Enforcement Assisted Diversion (LEAD)
2-82 Restraints and Transportation of Individuals
2-85 Certificates for Evaluation

B. Form(s)

PD 1502 CIT Contact Sheet (In Mark43)

C. Other Resource(s)

Department Memorandum 21-87 Evaluation and Transportation of Individuals Experiencing Behavioral Health Crisis
Health Insurance Portability and Accountability Act (HIPAA) of 1996
NMSA 1978, § 43-1-10 Emergency Mental Health Evaluation and Care

D. Rescinded Special Order(s)

None

2-19-1 Purpose

The purpose of this policy is to provide specific guidance to Albuquerque Police Department (Department) sworn personnel and supervisors for responding to individuals experiencing a behavioral health issue or behavioral health crisis. This policy provides guidance, techniques, and resources that should be used so that contact with the affected individual may be resolved in a constructive and compassionate manner.

2-19-2 Policy

It is the policy of the Department to respond to incidents involving individuals experiencing behavioral health crises in ways that attempt to de-escalate the situation safely and to reduce or eliminate the need to use force.

N/A **2-19-3 Definitions**

A. Albuquerque Community Safety (ACS)

A cabinet-level department operating independently from and in collaboration with the Department and Albuquerque Fire and Rescue (AFR).

B. 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 shall 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.

C. 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).

D. Certificate for Evaluation (CforE)

A document completed by a qualified, 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, which may include grave passive neglect. All Certificates for Evaluation will be considered expired seventy-two (72) hours after they are issued unless explicitly stated otherwise.

E. Crisis Intervention Division (CID)

The CID is comprised of Crisis Intervention Unit (CIU) Detectives, Mobile Crisis Team (MCT) sworn personnel, crisis clinicians, and data analysts. The CID is responsible for the overall administration and goals of the Crisis Intervention Team (CIT) and the Enhanced Crisis Intervention Team (ECIT) programs. The CID is the Department's liaison to the Mental Health Response Advisory Committee (MHRAC).

F. Crisis Intervention Team (CIT) Program

The CIT Program is a community-based program designed to improve the way the Department and the community respond collaboratively to individuals experiencing behavioral health crises. The CIT Program is built on strong partnerships among the

Department, behavioral health provider agencies, community-based organizations, individuals, and families of individuals living with behavioral health issues or who are experiencing behavioral health crises.

G. Crisis Intervention Trained Officer (CITO)

A CITO is an officer who has successfully completed the forty (40) hour basic CIT training.

H. Crisis Intervention Unit Clinician (CIC)

A clinician who is a qualified mental health professional who provides evaluations, completes general psychological assessments, assists in crisis intervention, conducts dangerousness assessments, assists with safety planning, and makes referrals for individuals in the community living with behavioral health issues who interact with the Department personnel.

I. De-escalate

A concerted effort 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, body posture, personal space, eye contact, empathy, and compassion to promote officer and individual safety, consistent with SOP Response to Behavioral Health Issues.

1. Commands and orders (e.g., “stop” and/or “get on the ground”) are not de-escalation techniques.

J. Disengagement

A decision, approved by the sergeant and on-duty lieutenant, to discontinue contact 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 individual, sworn personnel, and the public. This determination is evaluated by the totality of the situation and the information available to sworn personnel and supervisors on the scene.

K. Enhanced Crisis Intervention Team (ECIT)

The ECIT is comprised of specifically trained, sworn personnel who function as specialists to respond to calls involving individuals affected by behavioral health disorders or experiencing behavioral health crises.

L. Grave Passive Neglect

The failure to provide for basic personal or medical needs or for one's own safety to such an extent that it is more likely than not that serious bodily harm will result in the near future.

M. Mobile Crisis Team (MCT)

The MCT is a two (2) person unit comprised of one (1) licensed mental health professional and one (1) ECIT officer who jointly respond to calls with a behavioral health component. It provides immediate behavioral health services once the scene is secure. MCTs are trained to complement the ECIT and CIU.

N. Non-Engagement

Non-engagement is a decision approved by a sergeant and an on-duty lieutenant to avoid contacting an individual in a behavioral health crisis, who is not a threat to others, and with whom further interaction may result in an undue safety risk to the individual, sworn personnel, and the public. The notification for this decision is sent from the sergeant to the on-duty lieutenant and the determination is made by sworn personnel after evaluating the totality of the situation and the information available on the scene.

O. Qualified Mental Health Professional

A physician, a psychologist, 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 with behavioral health disorders.

6 2-19-4 Recognizing Behavioral Health Disorders

A. When responding to an incident, sworn personnel shall consider whether the individual with whom sworn personnel are interacting may be in a behavioral health crisis.

B. Only a trained mental health professional can diagnose behavioral health issues, psychiatric disorders, or illnesses. Department personnel, sworn personnel, and Emergency Communications Center (ECC) personnel cannot and shall not diagnose an individual’s mental health condition. However, they must apply their training to recognize behaviors and signs that indicate the individual may be affected by a behavioral health disorder or is in a behavioral health crisis and adapt police responses accordingly.

C. Department personnel, sworn personnel, and ECC 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.

D. An ECC employee shall 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, shall dispatch an ECIT officer or MCT, when appropriate and available.

E. If ECC employees receive a call indicating an individual may be in a behavioral health crisis, ECC employees shall determine whether it would be beneficial to transfer the call to the New Mexico Crisis and Access Line. If so, ECC shall call 1-855-NMCRISIS (855-622-7474) and collaborate with the Crisis Line personnel to take responsibility for the call if appropriate and available.

1. ECC personnel should also consider using Albuquerque Community Safety Department responders for non-violent behavioral health situations when available.

6 2-19-5 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. Sworn personnel should assess whether someone may be a danger to themselves, the officer, or others, by considering the following:

1. The individual's access to weapons;

2. The individual's statements, conduct, or inferences that suggest the individual shall commit a violent or dangerous act;

3. The individual's history, which may be known to the Department, the officer, family, friends, and neighbors. Indications that the individual lacks self-control, including a lack of physical and psychological control over rage, anger, fright, or agitation are important considerations. An individual's public social media accounts may also provide important information to assist in response;

4. Signs of lack of self-control, which may include extreme agitation, inability to sit still, 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 lacking self-control; and

5. The volatility of the environment. Agitators who may upset the individual, create a combustible environment, or incite violence should be carefully noted and controlled.

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

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 an individual’s demeanor or conduct do not mean they will become violent or threatening; however, sworn personnel should observe and be prepared at all times for a rapid change in behavior.

6 2-19-6 Response to Individuals Experiencing a Behavioral Health Crisis

A. When responding to an individual experiencing a behavioral health crisis, sworn personnel shall request the assistance of an ECIT officer or MCT, when available.

B. When feasible, on-scene sworn personnel shall attempt to de-escalate the situation until an officer with a higher level of training arrives to control the scene and direct operations, when needed. If a supervisor assumes responsibility for a scene, they must seek input from an ECIT, MCT, or CIU detective in situations where it is practical to do so.

1. When on scene, ECIT sworn personnel, MCT, or CIU detectives shall take the lead in interacting with individuals in a behavioral health crisis. If a supervisor has assumed responsibility for the scene, the supervisor shall seek input from ECIT, MCT or CIU on strategies for de-escalating, calming and resolving the crisis, when the situation allows such consultation safely. Supervisors are encouraged to become ECIT trained to better evaluate the ECIT sworn personnel they oversee or assist in situations where an ECIT officer is unavailable.

2. When feasible, the responding officer shall request a backup officer whenever the individual shall be taken into custody (either for booking or for an emergency mental health evaluation) before attempting to take the individual into custody. When making the request, the officer should specify an ECIT officer as a backup, unless the requesting officer is an ECIT officer.

3. When feasible sworn personnel should take steps to calm a situation when dealing with an individual experiencing a behavioral health crisis; including eliminating emergency lights and sirens, and assuming a quiet, non-threatening tone and manner while approaching or conversing with the individual. When possible, avoid physical contact and take time to assess the situation. Sworn personnel should operate with the understanding that, in most cases, time and distance are allies, and there is no need to rush or force the situation.

4. When feasible, sworn personnel should move slowly in order to not excite or agitate the individual; provide reassurance that the police are on-scene to help; and offer appropriate care, assistance, and resources to the individual.

5. Sworn personnel shall communicate clearly and calmly. Sworn personnel should make every effort to speak slowly and use a low tone of voice. Sworn personnel should express concern for the individual’s feelings, and allow the individual to share feelings without expressing judgment.

6. When feasible, sworn personnel should gather information from acquaintances, family members, or in emergency situations, the individual's behavioral health provider, if known. Sworn personnel should attempt to understand the nature of the crisis the individual is experiencing and try to learn what has helped de-escalate the individual in similar situations in the past. Request the assistance of the MCT, if available to assist, when ECIT sworn personnel are unable to make progress in de-escalating the situation and the scene is safe for a clinician to engage with the individual.

7. Sworn personnel should not threaten the individual with arrest or physical harm, as this may create additional fear, stress, and potential aggression.

8. Sworn personnel should avoid topics that seem to agitate the individual, and guide the conversation away from topics that cause stress or agitation and towards topics that seem to ease the situation.

9. Sworn personnel should always be truthful. If the individual 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. Sworn personnel should offer to connect individuals to mental health service agencies or provide transportation to the hospital.

C. Sworn personnel shall complete a CIT Contact Sheet in the Department's records management system for any interaction with an individual who is experiencing a behavioral health crisis, regardless of the call type or reason for the interaction.

D. Sworn personnel shall complete a report noting the following actions or decisions when responding to a call involving an individual experiencing a behavioral health crisis when:

1. Charges were filed against an individual;

2. Sworn personnel have handcuffed or detained an individual for any reason, include the officer's justification for use of handcuffs or detention;

3. An officer employs the tactics of non-engagement or disengagement. Include the names of both the sergeant and lieutenant who authorized the tactic in the report;

4. Sworn personnel are detaining an individual for a mental health evaluation, and the individual's detention and transport are involuntary, consistent with this SOP and NMSA 1978, § 43-1-10, regardless of whether the individual is transported by ambulance or the officer;

5. An officer transports an individual for a mental health evaluation in their vehicle;

6. Sworn personnel make a referral to the Crisis Intervention Unit for possible follow up;

    a. To make a referral to the CIU, Department personnel must add the label "Crisis Intervention Unit" to their Mark 43 report and/or 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 include, but are not limited to, high risk individuals suspected of living with a mental illness, frequent callers, individuals who have certificates for evaluation that sworn personnel have attempted to serve but have been unable to contact, individuals who would benefit from being linked to services, or any case sworn personnel feel would benefit from the service of the Crisis Intervention Unit
        ii. Cases referred to the CIU where the goal is outreach and resource allocation, and do not have threats of dangerousness or violence, can be forwarded by the CIU to the Albuquerque Community Safety (ACS) department for possible follow up.
        iii. Cases are viewed by the CIU sergeant, who determines the need to assignment based on several factors, such as a person's dangerousness or the volume of calls for service generated. If a referral is made to CIU for follow up, the officer's reasoning for the referral should be clearly articulated in the narrative of the incident report.
        iv. Sworn CIU personnel, including MCT sworn personnel, do not generally file criminal charges against individuals. Case responsibility for criminal allegations shall remain with the incident's primary officer or the appropriate investigative unit. Referrals should not be made to CIU requesting criminal charges be filed against an individual;
        v. In cases where an individual experiencing a behavioral health crisis is actively threatening others and cannot be located or immediate follow up may be needed, Department personnel must contact CIU's on-call detective. CIU has both a detective and a supervisor on call at all times to assist in these situations;
        vi. In the event that Department personnel feel a safety bulletin should be issued for an individual, they must contact CIU's on-call detective to review the incident and issue the bulletin if necessary; and
        vii. The APDCIT@cabq.gov email address is not monitored twenty-four (24) hours a day. In situations where immediate response is required, contact the CIU on-call detective; and

7. Any other reason exists to document the encounter as directed elsewhere in Department Standard Operating Procedures (SOP) or at the direction of a supervisor.

N/A F. Interviews and Interrogations

Absent exigent circumstances, prior to sworn personnel conducting an interview or interrogation of an individual suspected of being affected by a behavioral health disorder or experiencing a behavioral health crisis and suspected of committing a felony-level crime, sworn personnel should immediately contact the District Attorney's Office to consult regarding whether the individual should be interviewed or interrogated.

6 G. Non-engagement or Disengagement Incident

1. If a responding sergeant and on-duty lieutenant determine, after consulting with an ECIT officer or a mental health professional, that an individual experiencing 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 individual, the public, or sworn personnel, all responding sworn personnel should disengage.

   a. A sergeant shall respond to the scene for any non-engagement or disengagement incident.
   b. A lieutenant is not required to respond to the scene and may approve a non-engagement or disengagement over the telephone with the responding sergeant. The lieutenant may also respond in person.

2. After a non-engagement or disengagement incident, a sergeant shall email a completed Uniform Incident Report and a CIT Contact Sheet to APDCIT@cabq.gov, 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; and
   f. If required, a hazard on the address through the ECC .

3. If the individual is barricaded, the sworn personnel shall follow the additional procedures set forth in SOP Hostage Situations, Barricaded Individuals, and Tactical Threat Assessment.

4. In limited circumstances, sworn personnel 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, responding sworn personnel should notify a supervisor who may approve non-engagement. The supervisor shall report non-engagement decisions to a lieutenant. Non-engagement decisions shall be documented in the same manner as disengagement with the word “non-

engagement" placed in the offense/incident summary line of the report and a CIT Contact Sheet.

5. After an approved disengagement or non-engagement has been implemented, if the individual makes additional calls to the ECC during the responding officer's same shift, sergeants and lieutenants shall coordinate with ECC supervisors to dispatch sworn personnel to the additional calls for service. Except for new allegations of criminal activity or a clear and convincing willingness on the part of the individual to cooperate with responding sworn personnel, sworn personnel shall not be dispatched to most of the additional calls for service.

6. Nothing in this section shall prohibit sworn personnel from using discretion in on-site activity.

2-19-7 Diversion from Jail

N/A

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

1. 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, sworn personnel should use jail diversion instead of making an arrest. This process applies only to non-violent misdemeanor and non-violent felony cases where there is not an obligation to protect a victim. When possible and allowed by SOP, those individuals may be better served by jail diversion; in those circumstances, sworn personnel should consider the following:

   a. Issuing a verbal warning;
   b. Issuing a citation;
   c. Giving a summons for misdemeanors or submitting a non-violent felony case to the District Attorney;
   d. Transporting the individual to a mental health provider either voluntarily or involuntarily pursuant to NMSA 1978, § 43-1-10; or
   e. Disengagement: A supervisor shall notify the on-duty lieutenant of the situation and obtain their authorization for disengagement.

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2. 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.

3. Jail diversion through the issuance of a citation or summons, or submission of a case to the District Attorney, is subject to an officer's discretion and is typically appropriate unless:

   a. Jail diversion is not appropriate for violent felonies. When sworn personnel have established probable cause exists to believe an individual has committed a violent felony, an arrest shall be made;
   b. The individual, subject to lawful arrest, fails to identify themselves satisfactorily;

c. The individual refuses to sign the citation;
d. 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 individual is injured; or
e. 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 an individual appears to be experiencing homelessness is not a sufficient basis for an arrest.

4. Jail Diversion Collaboration

   a. CITO, ECIT, MCT, and CID personnel shall work with behavioral health care providers within the community to deter the individual from future contact with the criminal justice system.
      i. CID shall meet with personnel from the University of New Mexico Hospital (UNM), Presbyterian Kaseman Hospital, Albuquerque Health Care for the Homeless, HopeWorks, New Mexico Solutions, and others as needed or requested to ensure familiarization with diversionary goals.

5. When requested sworn personnel shall testify at civil commitment proceedings to promote mental health resolution rather than criminal sanctions.

   a. CITO, ECIT, and MCT shall make referrals to CID and use CIU Clinicians and/or ACS 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.

6. 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.

7. The primary officer shall retain case responsibility if a citation or summons is issued or a case is submitted to the District Attorney. CIU, and ACS assist if the individual needs follow-up intervention. When charges have been filed and a specialty court could benefit the individual, sworn personnel are encouraged to send a copy of the report to Court Services. Sworn personnel should indicate that the individual may be a candidate for a specialty court, such as mental health court, veteran's court, or drug court in the report.

8. When the Law Enforcement Assisted Diversion (LEAD) Program is appropriate, sworn personnel are encouraged to divert individuals to LEAD.

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9. If the individual is not appropriate for jail diversion, the officer should be sure to refer the individual to Psychiatric Services Unit (PSU) within the detention center by clicking the Psychiatric Services Unit Referral box on the pre-booking worksheet in TraCS.

7

10. Sworn personnel shall document the use of jail diversion on the CIT Contact Sheet for the call by selecting the jail diversion box on the contact sheet and choosing the jail diversion method used.

2-19-8 Mobile Crisis Teams

N/A

A. Mobile Crisis Teams (MCT)

1. When responding to an incident involving a person experiencing a behavioral health crisis, the Mobile Crisis Teams' goal is to employ de-escalation techniques and safety assessments to defuse the crisis and maintain the individual in the community whenever possible, to reduce the risk of arrests as a result of mental illness, to limit emergency room visits, to eliminate costly ambulance transports, and to eliminate any excessive usage of resources.

2. The MCTs are composed of one ECIT Officer from either the Department or the Bernalillo County Sheriff's Office, and one independently licensed clinician. This team is governed by this policy and guided by a contract between the City of Albuquerque and the County of Bernalillo.

3. Mobile Crisis Teams (MCT) Responsibilities:

   a. Respond to high priority calls with a behavioral health component, city-wide, and county-wide when available;
   b. Serve as a resource for consultation by the Field Services Bureau (FSB);
   c. When responding to calls for service assessing individuals for risk to self or others, taking appropriate actions if an individual affected by a behavioral health disorder or in a behavioral health crisis puts another's safety at risk;
   d. When responding to calls for service assessing individuals for escalating behavior or erratic conduct. An individual 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 sworn personnel; and
   e. Ensure law enforcement sworn personnel always proceed first and make sure the scene is safe for an MCT clinician to interact with the identified individual in need. MCT is a specialized response unit and it is discouraged from separating the clinician from the officer.
      i. The Department ECIT officer assigned to MCT reports to the CID.

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4. Dispatch and Calls

   a. MCT personnel should only be used for calls involving individuals experiencing behavioral health crisis. When criminal allegations arise from a call originally identified as a behavioral health-related call, the MCT shall contact the ECC and request the dispatch of sworn personnel, who shall assume case

responsibility. Examples of MCT-appropriate call types include, but are not limited to:

i. Suicidal individuals who have either attempted or are threatening self-harm;
ii. Welfare checks where there is a behavioral health component or history, including grave passive neglect;
iii. Any call where a behavioral health issue is a driving factor in an individual's behavior;
iv. Any call involving an individual on the CIU's caseload either currently or in the past; and
v. Personnel may always phone MCT in situations where a clinician's assessment may be helpful for advice and possible response.

b. All MCT personnel responses shall begin from either a call from dispatch, a request from sworn personnel or a supervisor on scene, or MCT initiated interactions where it has been determined that the individual in question is experiencing a behavioral health crisis.
c. When requesting an MCT response:
   i. ECC personnel are to use training and this SOP to contact the MCT upon receiving a behavioral health call.
   ii. Sworn personnel shall 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 personnel may be requested for response at any point during a behavioral health call at the request of sworn personnel or a supervisor already on scene. Individuals in crisis should be contacted by a minimum of two (2) sworn personnel, one of which could be the MCT officer. The MCT officer and clinician must not be left alone on crisis calls until the individual is transported, when needed, or the scene is cleared.
e. MCT personnel shall arrive on the scene in the officer's vehicle. If another officer is already on scene, the officer shall ensure the scene is safe before any MCT clinician interacts with the individual in question. Under no circumstance shall any MCT clinician engage or be asked to engage with an individual before the scene is safe.
f. Once the scene is safe, the MCT clinician shall engage the individual in order to gain an understanding of the issue and work to provide acute crisis services and provide referrals if necessary.
g. The MCT clinician and sworn personnel shall work together to provide swift and responsive service for all calls for which they have been dispatched to provide the services deemed necessary and appropriate.
h. If MCT personnel are involved in a use of force, the appropriate area command supervisor shall 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). This also includes missed applications of force.
i. The MCT clinician shall often be the highest behavioral health authority on the scene. Sworn personnel and supervisors shall consider their advice and recommendations in determining how a situation should be resolved.

5. Referrals

   a. In the event an individual needs a higher level of care, the MCT clinician may complete a certificate for evaluation. The MCT clinician shall consider using detoxification services in the event individuals are presenting as intoxicated.
   b. If the MCT clinician believes further follow up is required, they shall submit a referral to the CIU.

2-19-9 People with Developmental Disabilities

N/A

A. Individuals 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.

1. Common Traits

   a. There are many forms of developmental disability. Many individuals have additional related, but distinct, disorders, such as Autism Spectrum Disorder, Down's Syndrome, Fetal Alcohol Spectrum Disorders, Fragile X Syndrome, and Rett Syndrome. Although sworn personnel are not in a position to diagnose individuals with such disabilities, sworn personnel shall be alert to symptoms suggestive of such disorders. These include the following symptoms in various combinations and degrees of severity:
      i. Difficulty communicating and expressing oneself;
      ii. Communication by pointing or gestures rather than words;
      iii. Repetition of phrases or words;
      iv. 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;
      v. Little or no eye contact;
      vi. Uneven gross or fine motor skills;
      vii. Unresponsiveness to verbal commands or the appearance of being deaf;
      viii. Aversion to touch, loud noise, bright lights, and commotion;
      ix. No fear of danger;
      x. Oversensitivity or lack of sensitivity to pain;
      xi. Self-injurious behavior;
      xii. Talking to themselves; and
      xiii. Chewing on things that are not edible.

2. Common Encounters

   a. Sworn personnel may encounter individuals who have developmental disabilities in a variety of situations. Due to the nature of developmental disabilities, the following are some of the most commonly encountered:
      i. Wandering;

ii. Seizures;
iii. Disturbances;
iv. Welfare checks; and
v. Encroachment on another individual's personal space.

7

3. Handling and De-escalating Encounters

a. Like anyone else, individuals with developmental disabilities may 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 individuals with developmental disabilities. Sworn personnel should take measures to prevent these reactions by de-escalating situations and attempting to calm the situation safely. These measures include the following:
i. Speak calmly;
ii. Do not shout;
iii. Do not unnecessarily touch the individual;
iv. Avoid commotion;
v. Keep animals away;
vi. Ask for personal identification;
vii. Call the contact individual, caregiver, or guardian;
viii. Be patient and prepare for a potentially long encounter;
ix. Repeat short, direct phrases in a calm voice;
x. Be attentive to sensory impairments and remove distractions when possible;
xi. Maintain a safe distance. Provide the individual with a zone of comfort that shall also serve as a buffer for officer safety; and
xii. Avoid topics that cause agitation or distress.

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4. Taking Individuals with a Developmental Disability Into Custody

a. Whenever possible, taking custody of an individual with a developmental disability should be avoided as it shall likely initiate a severe anxiety response and escalate the situation. Therefore, in minor offense situations, sworn personnel shall explain the circumstances to the complainant and use jail diversion whenever possible. This normally shall involve disengagement or release of the individual to family or an authorized caregiver. In incidents where a violent felony is alleged or where alternatives to arrest are not reasonable, sworn personnel shall observe the following guidelines:
i. Contact a supervisor for advice;
ii. Request the individual's family or caregiver to accompany the individual and to assist in the calming and intervention process. If a caregiver is not readily available, call MCT or an ECIT officer, if available;
iii. Employ calming and reassuring, nonjudgmental language and use de-escalation techniques as outlined in the response section in this policy; and
iv. Do not incarcerate the individual in a holding cell if possible. Do not incarcerate the individual with others since they are vulnerable and at risk of harm.

b. If possible, and until alternative arrangements can be made, put the individual in a quiet room with subdued lighting with a caregiver or other responsible individual or another officer who is experienced in dealing with such individuals.

5. Interviews and Interrogations

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

2-19-10 Procedures for Emergency Mental Health Evaluation

7 A. In accordance with NMSA 1978, § 43-1-10, an officer may detain an individual 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 individual is otherwise subject to arrest;

2. The officer has reasonable grounds to believe the individual has just attempted suicide;

3. The officer, based on personal observation and investigation, has reasonable grounds to believe the individual, 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; or

4. 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 individual, 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 shall constitute authority for the officer to transport the individual.

7 B. If an individual meets the criteria for an emergency mental health evaluation, the officer shall attempt to transport the individual to a mental health facility. If possible, the officer shall ascertain the individual's health care provider information and assist in the transportation of the individual to the appropriate facilities:

1. UNM Psychiatric Center (2600 Marble Ave NE);

2. Any Presbyterian emergency department, including Presbyterian Kaseman Hospital (8300 Constitution Ave NE), Presbyterian Rust Medical Center (2400 Unser Blvd SE), or Presbyterian Hospital (1100 Central Ave SE);

3. Any Lovelace emergency department, including Lovelace Medical Center (601 Dr. Martin Luther King Jr. Ave NE), Lovelace Westside Hospital (10501 Golf Course Rd NW), or Lovelace Women's Hospital (4701 Montgomery Blvd NE); and

4. Raymond G. Murphy Department of Veterans Affairs Medical Center (1501 San Pedro Dr. SE, for qualifying former and current Armed Services members).

   a. All facilities listed immediately above have care units for evaluating and treating individuals experiencing behavioral health emergencies. A complete list of area facilities that may evaluate individuals is available through ECC.

6 C. Prior to transporting an individual for an involuntary mental health evaluation, including transportation of the individual by emergency medical services (EMS) personnel, sworn personnel shall conduct an inventory search of the individual to protect and safeguard the individual's property, to provide for the safety of the officer and others, and to protect the Department against claims or lawsuits for loss or destruction of private property. Department personnel shall notify the transported individual of the aforementioned intent of this search.

N/A 1. Sworn personnel shall ensure the individual's property is accounted for, consistent with the SOP Collection, Submission, and Disposition of Evidence and Property (refer to SOP Collection, Submission, and Disposition of Evidence and Property for sanction classifications and additional duties).

   a. In most cases, an individual's personal property will be accepted by hospital intake staff upon arrival at the evaluating facility, to be returned to the transported individual upon discharge. In situations where property is not accepted by hospital intake staff, officers shall ensure that the property is submitted into the evidence system under the heading of safekeeping.

6 2. Narcotics, for personal use, discovered as a result of an inventory search prior to transport for a mental health evaluation shall not be used for criminal prosecution. The narcotic shall be submitted into evidence for destruction. If large amounts of narcotics are found, such as an amount of narcotics consistent with trafficking, during an inventory search of this type, sworn personnel are to contact the on-call Assistant District Attorney for direction.

N/A D. If an individual meets the criteria for a transport under NMSA § 43-01-10 (including under order of a Certificate for Evaluation), that transport shall be considered involuntary, regardless of the individual's level of cooperation, and the individual shall be considered a threat of serious harm to themselves and/or others. As such, the transporting officer shall restrain the individual in handcuff restraining at the

individual's low back during transport to reduce the risk of harm to the individual's self and/or others (refer to SOP Restraints and Transportation of Individuals for sanction classifications and additional duties).

7 E. When an individual is taken to a mental health facility, the officer shall ensure that the mental health staff has a detailed and accurate account of the incident surrounding the protective custody. The officer shall complete and sign an application for emergency hospitalization. If the individual is a juvenile, the officer shall also ensure that a parent or guardian is notified.

6 F. If an individual is identified as dangerous to themselves or others, the officer shall guard the individual to protect the individual and others until the medical facility assumes responsibility for the individual. All Individuals identified as dangerous shall remain in restraints until hospital staff advises the officer that handcuffs can be safely removed. Sworn personnel should always consider recommendations made by hospital staff regarding restraint as the individual is checked into a facility.

6 G. Whenever an individual is transported to a mental health facility, by an officer for any reason, a report shall be prepared by the primary officer documenting the transport, in addition to the required CIT Contact Sheet.

H. In the event an officer determines that an individual has a behavioral health disorder or is in behavioral health crisis but is not dangerous, the ECIT officer may request the assistance from an MCT, the individual's mental health provider, or CIU personnel if the individual would likely benefit from further crisis intervention, linkage to services, and/or education regarding services in the community.

7 2-19-11 Transportation of Individuals Experiencing a Behavioral Health Crisis

A. If an individual experiencing a mental health crisis experiences a medical emergency and has a previous medical condition making transport by police car infeasible, or at the individual's request, sworn personnel shall request rescue to the scene to facilitate transport to a hospital for evaluation.

B. In situations where an officer believes that a person would be more likely to comply and/or would be more comfortable due to a physical condition or disability, sworn personnel should request rescue to the scene to facilitate transport to a hospital for evaluation.

C. In situations where a person is transported involuntarily, as outlined in Section 2-19-10, but is taken by ambulance, an officer will follow the ambulance to the hospital in order to provide hospital intake personnel a description of the person's behaviors that led to their transport to a hospital for evaluation.

1. If the officer following the transport is not the officer mandating the transport, the initial mandating officer shall brief the non-mandating officer on the circumstances mandating the transport.

2-19-12 Confidentiality, Communication, and Behavioral Health Emergencies

A. Communication from Entities Covered Under the Health Insurance Portability and Accountability Act (HIPAA) to Law Enforcement

1. Pursuant to HIPAA, an entity that is covered under HIPAA may disclose what would normally be protected health information to law enforcement when law enforcement would reasonably be able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public.

2. CID personnel may also communicate with the University of New Mexico Health Sciences Center due to a memorandum of understanding between the two parties. Communication generally is initiated by a licensed mental health professional working in CID.

B. Communication from Law Enforcement to Entities Covered Under HIPAA

1. Generally, sworn personnel are not subject to restrictions on communication under HIPAA.

a. Sworn personnel may communicate information gathered during an investigation to hospital intake personnel, including the perceived dangerousness of a person and the circumstances that contributed to sworn personnel voluntarily or involuntarily transporting a person to a hospital for evaluation.