OFFICE OF THE DIRECTOR OF POLICE
THE UNIVERSITY OF TEXAS SYSTEM
TRAINING BULLETIN 020

ENCOUNTERS WITH MENTALLY ILL
MARCH 12, 2018

I. Purpose

The purpose of this bulletin is to provide best practice-based guidance to University of Texas System Police (UTSP) officers when the officers encounter a person who exhibits the symptoms of mental illness or appears otherwise to be in crisis. This bulletin is intended to inform, guide, and encourage a positive and productive interaction when these encounters occur.

II. Discussion

Encounters between UTSP officers and those in crisis is a daily occurrence across the University of Texas System. Community expectations require that a law enforcement officer be sufficiently trained to recognize those in crisis or exhibiting the symptoms of a mental illness, be prepared to respond appropriately, apply de-escalation techniques when necessary and ensure the proper care is offered or provided. While most encounters will not involve persons who are physically violent toward the responding officers or others, when force must be used the requirements of ODOP/UTSP Policy 601, Use of Force, will apply.

The circumstances under which an officer may encounter a person who exhibits the symptoms of mental illness or is otherwise in acute crisis may include, but not be limited to:

- A request from a family member to assist with a relative suffering a psychiatric emergency
- A request from a friend, associate or co-worker to assist with a person suffering a psychiatric emergency
- A request from a person who recognizes that he/she is in crisis and needs assistance
- A request from a third party complainant or witness that a person's behavior is assaultive, threatening, delusional or self-destructive
- Responding to or observing a circumstance in which a person has suicidal ideations
- Responding to a public affray, family or dating violence or workplace violence/threatening behavior
- Investigation of a reported threat, implicit or explicit, made by one person and reported to law enforcement or another source of authority and then reported to law enforcement
- Investigation of reported drug use
- A request from a physician, mental health counselor or crisis intervention professional for assistance with a patient or client

III. Definitions

Mental Illness: Mental illnesses are health conditions involving changes in thinking, emotion or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities.

Delusion: False beliefs not based on factual information. A delusion implies belief in something that is contrary to fact or reality, resulting from deception, a misconception, or a mental disorder. A persistent belief maintained in spite of evidence to the contrary.

Hallucination: Distortions in the senses where the individual experiences auditory sounds and/or visual images that are actually not present.

Crisis: A person suffering from a temporary breakdown in coping skills that includes perception, decision-making, and problem solving abilities.

Developmental Disorder: comprise a group of psychiatric conditions originating in childhood that involve serious impairment in different cognitive and/or behavioral areas.

IV. Procedures

A. Recognizing Abnormal Behavior

Law enforcement officers in general, including UTSP officers, are not trained to diagnose mental illnesses or acute psychiatric crises that are manifested in the presence of officers. Such diagnoses are the provenance of mental health professionals. Officers are to recognize behaviors that are indicative of persons affected by mental illness or in crisis, with special emphasis on those that suggest potential violence and/or danger.

The following are generalized signs and symptoms of behavior that may suggest mental illness or crisis, although officers should also consider other potential causes such as reactions to alcohol or psychotropic drugs of abuse, dementia, traumatic brain injury, other head injuries or temporary emotional disturbances that are situational in nature, or medical conditions:

- Strong and unrelenting fear of persons, places, or things; extremely inappropriate behavior for a given context
- Frustration in new or unforeseen circumstances; inappropriate or aggressive behavior in dealing with the situation
- Abnormal memory loss regarding familiar facts
- 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")
- Hallucinations of any of the five senses (e.g., hearing voices commanding the person to act, feeling one's skin crawl, smelling strange odors); and/or
- The belief that one suffers from extraordinary physical maladies that are not possible, such as persons who are convinced that their heart has stopped beating for extended periods of time.

B. Assessing Risk

Most persons affected by mental illness or in crisis are not physically dangerous to others and some may only present dangerous behavior under certain circumstances or conditions. Officers may rely on several indicators to assess whether a person who reasonably appears to be suffering from mental illness or in crisis represents potential danger to himself or herself, the officer, or others. These include the following:

- The availability of any weapons.
- Statements by the person that suggest that he or she is prepared to commit a violent or dangerous act. Such comments may range from subtle innuendo to direct threats that, when taken in conjunction with other information, paint a more complete picture of the potential for violence.
- A personal history that reflects prior violence under similar or related circumstances. The person's history may already be known to the officer—or family, friends, or neighbors may be able to provide such information.
- The level and extent of self-awareness and control of their emotions exhibited by the person. Indicators that there is a lack of self-control may include extreme agitation, verbal and physical threats, destructive behavior, clutching oneself or other objects to maintain control.
- Triggers that may affect the person or escalate the situation.

Failure to exhibit violent or dangerous behavior prior to the arrival of the officer does not ensure that there is no risk of danger to the responding officer or persons in the area.

An individual affected by mental illness or emotional crisis may rapidly change his or her presentation from calm and command-responsive to physically active. This change in behavior may come from an external trigger (such as an officer stating "I have to handcuff you now") or from internal stimuli (delusions or hallucinations). A variation in the person's physical presentation does not necessarily mean he or she will become violent or threatening, but officers should be prepared at all times for a rapid change in behavior.

C. Response to Persons Affected by Mental Illness or in Crisis

If the officer determines that an individual is exhibiting symptoms of mental illness or in crisis and is a potential threat to himself or herself, the officer, or others, or may otherwise require law enforcement intervention as prescribed by statute, the following responses should be considered (this assumes that physical violence is neither occurring in the officer's presence nor is it being threatened):

- Request a backup officer; always do so in cases where the individual will be taken into custody.
- Take steps to calm the situation. Where possible, eliminate emergency lights and sirens, disperse crowds, and assume a quiet nonthreatening 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. Officers should operate with the understanding that time is an ally and not to unnecessarily rush or force the situation.
- Move slowly and do not excite the person. Provide reassurance that the police are there to help and that the person will be provided with appropriate care.
- Ask the individual his/her name and use it throughout your interaction.

- Communicate with the individual in an attempt to determine what is bothering him or her; if possible, speak slowly and use a low tone of voice; relate concern for the person's feelings and allow the person to express feelings without judgment.
- Where possible, gather information on the individual from acquaintances or family members and/or request professional assistance if available and appropriate to assist in communicating with and calming the person.
- Avoid topics that may agitate the person and guide the conversation toward subjects that help bring the individual back to reality.
- Always attempt to be truthful with the individual. If the person becomes aware of a deception, he or she may withdraw from the contact in distrust and may become hypersensitive or retaliate in anger; in the event an individual is experiencing delusions and/or hallucinations and asks the officer to validate these, statements such as "I am not seeing what you are seeing, but I believe that you are seeing (the hallucination, etc.)" is recommended; validating and/or participating in the individual's delusion and/or hallucination is not advised.
- Request assistance from individuals with specialized training in dealing with mental illness or crisis situations (e.g., Crisis Intervention Training (CIT) officers, community crisis mental health personnel, Crisis Negotiator).
- Supervisors should respond to any scene:
  - Where a weapon (including firearm, edged weapon, rocks, or other improvised weapon) is reported
  - Where there is a reasonable belief that there is potential for significant use of force.
  - Once on the scene and if circumstances permit, supervisors should attempt to "huddle" with officers before responding to develop a plan of action that focuses on de-escalation where possible. In the case of persons with mental illness, supervisors who are not specially trained should consult and coordinate with officers on the scene who are specially trained.

D. Taking into Custody, Transporting to Mental Health Facility or Hospital

Based on the totality of the circumstances and a reasonable belief that the individual may pose an imminent risk of harming self or others or if there is a deterioration in the quality of life to the extent that person cannot be left alone, officers may need to detain the person and transport him/her to the nearest appropriate mental health facility for an emergency mental health evaluation. Officers should do the following:

- When possible, summon mental health officers to assist in the custody and admission process.
- If an officer has made the determination that an individual meets the criteria for apprehension by a peace officer without warrant, they will complete a peace officer's notification of detention, HSC 573.001, HSC 573.002.
- Continue to use de-escalation techniques and communication skills to avoid provoking a volatile situation once a decision has been made to detain the individual.
- Remove any dangerous weapons from the immediate area and restrain the individual consistent with ODOP/UTSP Use of Force Policy and institution police department standard operating procedure. Officers should keep in mind that using restraints on persons affected by mental illness or in crisis may cause further deterioration in their mental state and an explanation to the persons as to why restraint is necessary may de-escalate a potentially volatile step.
- The method of restraint must permit the patient to sit in an upright position without undue difficulty of maintaining that posture while being transported.

- Consistent with HSC 573.005, Officers may have an ambulance transport the individual to the hospital, if a memorandum of understanding has been completed between the institution police department and the appropriate ambulance service.
- Document the incident or encounter appropriately, regardless of whether or not the individual is taken into custody. Ensure that the report is as detailed as possible concerning the circumstances of the incident or the encounter and the type of behavior that was observed. Terms such as "out of control" or "mentally disturbed" should be replaced with descriptions of the specific behaviors, statements, and actions exhibited by the person. The reasons why the subject was taken into custody or referred to other agencies should also be reported in detail.
- Provide the individual and/or family members with referral information on available community mental health resources.

V. Training

In the current Basic Peace Officer Academy, cadets receive the state mandated 16 hours of Crisis Intervention Training. In 2017, the Sandra Bland Act, passed during the 85th legislative session, increased that state mandate to 40 hours of Crisis Intervention Training that will be required to be taught to police cadets. The 85th legislative session also mandated that a course be developed that focuses on, de-escalation tactics for the everyday civilian interactions.

After officers graduate from the academy, historically there has been no mandate that officers receive any further training on de-escalation or interacting with persons in crisis. Texas Commission on Law Enforcement has several elective courses that vary in length available for instruction. ODOP supports each institution police department to provide in-depth training to a subset of officers and field supervisors (preferably those who have indicated an interest in this area), with the goal of having MHO-trained personnel on duty and available to respond at all times. Each institution police department may choose to provide further CIT and MHO training to *all* of their personnel.

In both recruit and in-service programs, agencies should provide use-of-force training that utilizes realistic and challenging scenarios that officers are likely to encounter in the field. Strategies for dealing with people experiencing mental health crises should be woven into the tactical training that all officers receive, with a strong emphasis on communications, de-escalation techniques, maintaining cover and distance, and allowing for the time needed to resolve the incident safely for everyone.

Scenarios should be based on real-life situations and utilize encounters that officers in the agency have recently faced. Scenarios should go beyond the traditional "shoot-don't shoot" decision-making, and instead provide for a variety of possible outcomes, including some in which communication, de-escalation, and use of less-lethal options are most appropriate. Scenario-based training focused on decision-making should be integrated with officers' regular requalification on their firearms and less-lethal equipment.

While conducting in-service training the institution police departments should provide in-service training on critical decision-making, de-escalation, and use of force to teams of officers at the same time. When officers work together on a daily basis train together, coordination and consistency in tactics increase, and the likelihood of undesirable outcomes during critical incidents decreases. Much like active-shooter situations, where working as a team is more

effective than responding as individuals, mental health encounters are resolved more effectively when officers coordinate their communications, positioning, and tactics.

Recognizing that this approach may increase costs and disrupt scheduling, agencies should consider alternative arrangements to traditional, day-long in-service training classes—for example, by bringing in a team of officers for a few hours of training several times a year. If training as teams is not feasible, agencies should at least ensure standardization in their policies and training so that all officers are receiving the same information.

Where resources exist, institution police departments should partner with their mental health providers in the community and organizations such as the National Alliance on Mental Illness (NAMI) to create outreach and education programs for the families of persons with mental illness, assist with training, policy development, and responding to critical incidents.

VI. Risks to Law Enforcement

This policy does not replace or serve as a substitute for ODOP/UTSP Policy 601, "Use of Force." Due to the very nature of interacting with persons who have a mental illness or may be suffering from a crisis, their behavior may be erratic, unpredictable, and possibly violent requiring the use of some level of appropriate force.

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