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	City of Charleston Police Department Policy and Procedure Manual		EFFECTIVE DATE: **02/01/08**
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BY THE AUTHORITY OF THE CHIEF OF POLICE: Luther Reynolds			

32.1 MENTAL ILLNESS/DEVELOPMENTAL DISABILITIES POLICY (CALEA 41.2.7)

Emotionally Disturbed, mentally ill, and developmentally disabled can pose a significant challenge to police officers. Persons in these conditions can behave in an erratic and unpredictable manner and can often pose a serious officer safety hazard. The Charleston Police Department will strive to deal with these types of persons in a compassionate yet safe manner to protect the individual, the public, family members and officers. When dealing with mentally ill person's officers should:

1. Maintain officer safety at all times;
2. Protect the public and family members from harm from the person;
3. Protect the person from harm, which he/she or others may cause;
4. Attempt to stabilize the situation by calming the person, having one officer issue one clear simple instruction at a time, removing the person from the situation, and/or restraining the person as needed; and
5. Aid in acquiring proper medical attention for the person if needed.

The purpose of this policy is to define and establish guidelines regarding the interaction of agency personnel with persons suspected of suffering from the symptoms of mental illness or developmental disabilities requiring assistance. Definitions that will pertain to this policy are as follows:

Developmental Disability: A severe, chronic disability caused by one or more physical or mental impairments that may place substantial limitations on major life activities of understanding and expressing language, learning, mobility, self-direction, self-care, capacity for independent living, and ability to hold a job and support oneself. Developmental disabilities such as autism, Tourette's syndrome and non-developmental disorders, such as Asperger's Syndrome are NOT mental illnesses and should not be confused with mental illness.

Emergency Protective Custody (EPC): The process of a law enforcement officer taking a person into custody for protection when a likelihood of serious harm to the person or others exists.

Emotionally Disturbed Person (EDP): A person who is in an irrational emotional state. The condition may be associated with situational, medical or substance related causes. There may, or may not be, an underlying mental illness related to the emotional state.

Emotionally Ill: Interchangeable with "mentally ill" for the purpose of this policy, frequently a temporary or situational condition.

Involuntary Commitment: The process of detaining a person who is endangering him/herself or others for medical treatment. Only a medical doctor can determine if commitment is necessary.

Likelihood of Serious Harm: Due to mental or emotional illness or excessive alcohol or drug use there is:

1. A substantial risk of physical harm to the person him/herself as manifested by evidence of threats of or attempts at suicide or serious bodily harm;
2. A substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior and serious bodily harm to them; and/or
3. A substantial risk of physical impairment or injury to the person themselves as manifested by evidence that such person's judgment is so affected that he/she is unable to protect him/herself in the community and that reasonable provision for their protection is not available in the community.

Mental Illness: Any of various conditions characterized by impairment of an individual's normal cognitive, emotional, or behavioral functioning, and caused by social, psychological, biochemical, genetic, or other factors, such as infection or head trauma.

Mentally Ill: A person suffering from mental illness. For the purposes of this policy the term "mentally ill" will also refer to Emotionally Disturbed Persons and those suffering from chemical abuse or influence.

Order of Detention: An order issued by a Probate Court judge requiring detainment of a person for mental health evaluation. The order is based on the affidavit of someone who feels commitment is required. This is handled by the Charleston Sheriff's Office.

Voluntary Commitment: The process when a person voluntarily enters a mental health treatment center on his/her own accord.

32.2 RECOGNIZING THE DEVELOPMENTALLY DISABLED OR PERSONS SUFFERING FROM MENTAL ILLNESS (CALEA 41.2.7 a)

Officers should be aware that the following appearance and behavior symptoms in varying combinations and degrees of severity may be clues that the person encountered may be developmentally disabled. While the items below are provided as possible clues, this should not be considered an all-inclusive list.

1. Difficulty communicating and expressing thoughts;
2. Pointing and gesturing rather than speaking;
3. Repetitive, even self-harmful body movements such as swaying, spinning, clapping hands, snapping fingers, flailing arms, biting wrists or head-banging;
4. Failure to make or maintain eye contact;
5. Showing distress, laughter, or tears for no apparent reason;
6. Uneven gross or fine motor skill;
7. Non-responsive to verbal instructions; appears deaf, but hearing is normal;
8. Avoids or appears fearful of touching, loud noises, bright lights, and commotion;
9. No fear of danger;
10. Over or under-sensitive to pain;
11. Self-destructive or self-harming behavior;
12. Hyper-sensitivity to lights, sounds, physical contact;

13. Associated Physical Impairments.

Signs and symptoms of mental illness are, but not limited to, the following:

1. Delusions;
2. Hallucinations;
3. Disorganized speech;
4. Grossly disorganized behavior;
5. No emotion;
6. Anxiety.

32.3 DETERMINING DANGER (CALEA 41.2.7 a)

Not all mentally, emotionally ill, or developmentally disabled persons are dangerous while some may represent danger only under certain circumstances or conditions. The following indicators may indicate that the individual with symptoms of a mental illness represents an immediate or potential danger to him/herself or others:

1. Availability of weapons to the subject;
2. Statements by the subject that suggest that the person is prepared to commit a violent or dangerous act. Such comments may range from subtle innuendoes to direct threats that, when taken in conjunction with other information, paint a more complete picture of the potential for violence;
3. A personal history that reflects prior violence under similar or related circumstances;
4. Lack of control of emotions such as anger or fear. Signs of lack of control include extreme agitation, wide eyes, and rambling thoughts or speech. Clutching oneself or other objects to maintain control, begging to be left alone, or offering frantic assurances that one is all right may also suggest that the individual is close to losing control;
5. The volatility of the environment is a particularly relevant factor that officers must evaluate. Agitators that may affect the person or a particularly combustible environment that may incite violence should be taken into account; and/or;
6. A current state of intoxication from alcohol or other drugs.

32.4 DEALING WITH PERSONS SHOWING SYMPTOMS OF A MENTAL ILLNESS/DEVELOPMENTAL DISABILITY (CALEA 41.2.7 A)

Should an officer determine that an individual is mentally or emotionally ill and a potential threat to him/her or others, or may otherwise require police intervention for humanitarian purposes, the following responses should be taken:

1. If not already present or in route, a backup officer must be requested; if available, a Crisis Intervention Team (CIT) Member should be started en route to the call.
2. Take steps to calm the situation. Where possible eliminate lights and sirens, disperse crowds, and assume a quiet and non-threatening manner when approaching or conversing with the person. Be aware that occasionally, an individual may experience paranoid delusions about uniformed authority figures such as police officers;
3. Issue only one simple command/request at a time. Be aware that officers may be competing with an individual's internal voices (auditory hallucinations);
4. Move slowly and do not excite the person. Provide reassurance that the police are there to help and that appropriate care will be provided. Speak in a respectful manner;
5. Communicate with the person to determine what is bothering him/her. Relate concern for his/her feelings and allow him/her to vent feelings. Where possible gather information about the person from acquaintances and/or

family members, as they can often relay information that will aide in de-escalation and help avoid triggers for unwanted behavior.

6. Request professional assistance such as Mobile Crisis, if needed;
7. Do not threaten the person with arrest or in any other manner as this may cause additional fright, stress and potential aggression;
8. Avoid topics that may agitate the person and guide the conversation toward subjects that help bring the person back to reality. However, do not attempt to argue the individual out of his/her delusion as this attempt will not be successful;
9. Always attempt to be truthful with a mentally ill person. If the subject becomes aware of deception he/she may withdraw from the contact in distrust and may become hypersensitive or retaliate in anger; and
10. Care should be taken when dealing with mentally ill persons during interviews and in-custody interviews. Symptomatic mentally ill persons should never be left alone and if there is any indication of unpredictable or violent behavior two (2) officers should be with the person at all times. The person should be restrained as necessary and searched for weapons.

32.5 TAKING CUSTODY OF & TRANSPORTING MENTALLY ILL PERSONS (CALEA 70.3.1)

The authority of an officer to take an individual into custody because the individual is a threat to himself or others is inherent to the role of the police officer. Officers may take symptomatic mentally ill persons or persons suffering from excessive alcohol or drug use into custody to prevent harm to the individual and/or others.

Many mentally ill and developmentally disabled persons live autonomous independent lives. The fact that a mentally ill or developmentally disabled person does not have a caregiver with them or has become involved in a situation that precipitated the officer's presence does not necessary require the officer to take custody of the individual. The decision to arrest or take into emergency protective custody is specific to the situation.

1. Emergency Protective Custody: Officers may take a person into Emergency Protective Custody when the officer believes the person is dangerous to him/herself and/or others and there is a likelihood of serious harm presented by the person to him/herself or others;
2. Reasons for taking a person into Emergency Protective Custody include, but are not limited to:
    a. Statements by the subject indicating suicidal intentions or death threats;
    b. Past history of threats to self or others;
    c. Observations indicating suicidal or homicidal intentions such as suicide note, 911 calls, and comments to officers or others;
    d. Evidence of excessive alcohol or drug use; and/or
    e. Valid statements of concern by family members.
3. Officers must fully document their reasons for believing that Emergency Protective Custody is necessary;
4. Emergency Protective Custody During Business Hours: The subject should be taken to the closest hospital emergency room or to the local mental health center for an evaluation;
5. Emergency Protective Custody After Business Hours: The subject should be taken to the closest hospital emergency room for an evaluation;
6. Emergency Protective Custody Transport: Charleston County EMS is available to transport the subject. However, when circumstances dictate, an officer may transport the subject. One or more officers may be needed to travel to the Emergency Room and/or ride in the ambulance if the subject is combative or uncooperative. The transporting

officers should consult with a supervisor to determine if two (2) transport officers are needed based on the person's behavior and history. If the person is, or has, demonstrated unpredictable and potentially dangerous behavior two transport officers and appropriate restraining devices should be used.

32.6 COMMUNITY RESOURCES (CALEA 41.2.7 b)

The Medical University of South Carolina is the primary mental health care provider and facility for Charleston County. Phone numbers for the various mental health centers in the area are:

1. MUSC's IOP: (843) 792-9888

The Charleston/Dorchester Mental Health Center (CDMHC) is the primary provider of mental health outpatient services in the two counties. Phone numbers for the various mental health centers in the area are:

1. Children/Adolescents/Families Services: (843) 740-6136
2. Children/Adolescents/Families-New Endeavors: (843) 745-5493
3. Charleston Adult Services: (843) 852-4100
4. Tri-county Crisis Stabilization Center: (843) 958-3530
5. Charleston County Probate Court-Commitment Division: (843) 958-5180
6. South Carolina Department of Mental Health: (803) 898-8581
7. Charleston County Mobile Crisis: (843) 414-2350

Additional resources and procedures for access can be found at:

1. http://www.scdmh.org/

32.7 TRAINING (CALEA 41.2.7 d, e)

All personnel will receive training regarding the mentally ill, Emotionally Disturbed Persons, and developmentally disabled as part of their initial training. Training will include recognition of persons suffering from mental illness, guidelines for dealing with these persons, procedures for Emergency Protective Custody, procedures for executing the commitment process, community mental health resources, and best methods of de-escalation.

All personnel will receive refresher training annually regarding dealing with mentally ill persons.