Watertown Police Department

RESPONSE TO MENTAL HEALTH & SUBSTANCE USE DISORDERS Chapter 41H

General Order Number: 17-002
Reference:
Accreditation Standards: 41.2.7
Mass. Gen. Law: Ch. 123 §12(e), Ch. 123 §18, Ch. 123 §35
Other:

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I. POLICY:

Reaction to those with mental illness or substance use disorder covers a wide range of human responses. People afflicted with these conditions are ignored, laughed at, feared, pitied and often mistreated. Unlike the general public, however, a police officer cannot permit personal feelings to dictate his/her reaction to these individuals. His/her conduct must reflect a professional and compassionate attitude and be guided by the fact that these conditions, standing alone, do not permit or require any particular police activity. Individual rights are not lost or diminished merely by virtue of a person's mental condition or addiction. Officers that encounter individuals vulnerable due to these conditions, will attempt to identify their needs and resources that may be of assistance. These principles, as well as the following procedures, must guide an officer when encountering an individual suffering from mental illness or substance use disorder.

II. DEFINITIONS:

A) **Jail Diversion Program (JDP):** Established to alleviate the growing number of Emotionally Disturbed Persons (EDP) in the criminal justice system. The program seeks to divert individuals with mental health needs to community based care.

B) **Psychiatric Emergency Services (PES):** Counseling and intervention services offered by Advocates staff on a 24-hour basis to support individuals suffering from a mental health or emotional crisis.

C) **Emotionally Disturbed Person (EDP):** An individual suffering from a mental health disorder, a physical disorder, addiction or emotional crisis that leads to inappropriate types of behavior or feelings under normal circumstances. Often Police Officers are alerted to these individuals when their condition poses a risk to their safety or the safety of others.

D) **Substance Use Disorder:** Refers to the over use of, or dependence on, a drug leading to effects that are detrimental to the individual's physical and/or mental health.

E) **Incapacitated:** shall mean the condition of a person who, by reason of the consumption of alcohol, a controlled substance or toxic vapor is: (1) unconscious; (2) in need of medical attention; (3) likely to suffer or cause physical harm or damage property; or (4) disorderly.

III. Procedures:

A. Recognition of Mental Illness: An officer must be able to recognize a mentally ill individual if he/she is to handle a situation properly.

1. Factors that may aid in determining if a person is mentally ill are listed below. These factors are not necessarily conclusive and are intended only as a framework for proper police response.

    a. severe changes in behavioral patterns and attitudes;
    b. unusual or bizarre mannerisms;
    c. loss of memory / disorientation
    d. hostility to and distrust of others;
    e. lack of cooperation and tendency to argue;
    f. known history of mental illness
    g. unresponsiveness to social cues
    h. distracted/inattentive behavior
    i. impaired judgment
    j. substance intoxication
    k. grandiosity- exaggerated self-appraisal
    l. rapid, hard to interrupt speech
    m. suicidal statements, hopelessness, or irrational guilt
    n. paranoia
    o. responding to voices/ one-sided conversations

B. Recognition of Substance Use Disorder: Signs and symptoms of substance use disorder in some cases, may be similar to those of mental illness.

1. Because of the vast array of drugs that impact the human body in various ways, symptoms of drug use are almost limitless. These are some of the more common we encounter.

    a. constricted or dilated pupils;
    b. lethargy or manic behavior and swings between the two;
    c. neglect of personal hygiene;
    d. insomnia;
    e. memory loss;
    f. diarrhea or constipation;
    g. significant weight loss or gain;
    h. swollen fingers;
    i. neglecting social ties;
    j. secrecy;
    k. withdrawal can trigger violence, trembling, seizures, hallucinations and sweats.

C. De-escalation: Whether the encounter be with a person suffering from mental illness or substance use disorder, the officer's first goal should be to render the scene safe. The most efficient way of achieving this is usually by trying to verbally calm the individual.

1. Handling the encounter requires patience and effective use of communication skills. Listening with empathy and trying to understand the individual's perspective is a key to de-escalating a crisis.

2. Productive tactics include: giving undivided attention, remaining nonjudgmental, allowing silence and using restatement to clarify messages.

3. Unproductive tactics include: confrontation, boxing a suspect in, arguing with them about their delusions, and making direct eye contact.

4. It is not necessarily true that these individuals will be armed or resort to violence. However, this possibility should not be ruled out and because of the potential dangers, the officer should take all precautions to protect everyone involved. However, it is more likely the person is at risk for harming him/herself.

5. It is not unusual for such persons to employ abusive language against others. An officer must ignore verbal abuse when handling such a situation.

D. Relationship Between Mental Illness and Substance Use Disorder: Officers must understand that individuals often suffer from both mental illness and substance use disorder. Depending on the individual's circumstances, one ailment might lead to the other. Determining which is the underlying cause of an individual's condition may be difficult, even for medical professionals. Whenever possible, Officers must attempt to develop an understanding for the causal factors leading to an individual's crisis. This practice will more likely enable an Officer to understand an individual's behavior and how to provide assistance.

1. An officer should ask questions of persons available to learn as much as possible about the individual. It is especially important to learn whether any person, agency or institution presently has lawful guardianship of the individual, and whether the individual has a history of criminal, violent or self-destructive behavior. Also, ask whether the person has any current treatment providers, prescribed medications, compliance with medications, substance abuse issues, history of self-injurious or suicidal behavior.

E. Special populations: Officers must be aware of the fact that they will inevitably encounter individuals suffering from the following;

1. Homelessness: May contribute to mental health disorders for some individuals and underlying mental health disorders may make some individuals more prone to homelessness. The JDP clinician may be able to provide assistance and the Watertown Services Resource Specialist should be referred to (617-744-9585).

2. Domestic Violence: May contribute to mental health disorders for some individuals and underlying mental health disorders may make some individuals more prone to being involved with domestic violence. The JDP clinician should be contacted and a referral should be made to the Domestic Violence Detective.

3. Hoarders**:** If the JDP clinician is on duty, contact them as soon as possible to assist. The officer should complete the HOMES checklist and Clutter Rating Inventory (found in Digital Headquarters) and forward to the Watertown Board of Health.

4. Veterans**:** May be more likely to suffer from posttraumatic stress. If a veteran in crisis is encountered, contact the JDP clinician. If the individual in crisis has a history of military service, a referral can be made to the Watertown Veteran's Services Officer (617-972-6416).

F. Additional Resources: Officers should consider what services or support is available to help an individual work through their crisis. Some of the more commonly needed services include the following (see attached appendix for contact information);

1. The Jail Diversion Program (JDP) clinician can be contacted for assistance. Psychiatric Emergency Services (PES) personnel are available to respond on a 24 hour basis and can be reached immediately through dispatch. The JDP clinician can provide assistance in the form of immediate counseling to de-escalate a crisis, follow up services such as home visits and authorizing involuntary emergency hospitalizations.

2. Food pantry services are available at the Watertown Food Pantry (St. John's Methodist Church) and St. Vincent de Paul's Food Pantry at St. Patrick's Church.

3. Area shelters include the Bristol Lodge Men's Shelter and Women's Shelter, both in Waltham.

4. The Massachusetts Department of Veteran's Services is available to assist veterans in crisis. Peer Specialists are available on a 24 hour basis to assist veterans who have been charged with a criminal offense as a first time offender. In the event of such an incident, the Peer Specialist should be contacted prior to arraignment. The Peer Specialist will respond to the District Court to determine if the arrestee is available for a jail diversion program supervised by the Department of Veteran's Services.

5. Springwell Protective Services is available to assist with follow up services for elders in crisis. This organization compiles up to date information on professional care services to include legal consultation, home care and counseling.

6. Free Community Narcan Program: Individuals and families in Watertown that are struggling with opioid addiction may obtain Narcan at no cost. Vouchers for a Narcan kit may be obtained through the Community and Staff Development Division, the town's Social Service Resource Specialist or the Watertown Fire Department.

7. Right Turn is a drug addiction treatment center located at 440 Arsenal St. Watertown. Right Turn provides intervention services, outpatient treatment, inpatient treatment and medically assisted treatment.

8. Square Medical Group is located at 124 Watertown St. Watertown. This medical facility addresses behavior health and substance abuse. Medically assisted treatment and primary care physicians are available.

G. Taking A Mentally Ill Person into Custody:

1. A mentally ill person may be taken into custody if:

    a. [S]he has committed a crime.
    b. [S]he poses a **substantial risk of physical harm** to other persons by exhibiting homicidal or other violent behavior, or poses a substantial risk of physical impairment or injury to

him/herself (for example, by threats or attempts at suicide), or [s]he is exhibiting gross impairment of judgment, and is unable to protect him/herself in the community.

c. [S]he has escaped or eluded the custody of those lawfully required to care for him/her.

d. When an officer possesses a commitment order pursuant to M.G.L. Ch. 123 § 12(e), commonly referred to as a "pink paper" or "Section 12". Such order will be issued allowing emergency restraint and hospitalization of persons posing a risk of serious harm by reason of mental illness.

e. Officers may *not* make a forcible entry into a person's dwelling to execute an involuntary civil commitment order (M.G.L. Ch. 123 §12) unless they have a:

(1) Warrant of Apprehension, **or**

(2) a civil commitment order per G.L. c. 123 § 12

(3) **and** *exigent circumstances*

2. In an emergency situation, if a physician or qualified psychologist is not available, **a police officer**, who believes that failure to hospitalize a person would create an **immediate likelihood of serious harm** by reason of mental illness, **may restrain** such person and apply for the psychological evaluation and potential hospitalization of such person for a three-day period at a public facility or a private facility authorized for such purpose by the Massachusetts Department of Mental Health.

3. Although "any person," including a police officer, may petition the district court to commit a mentally ill person to a facility if failure to confine that person would cause a likelihood of serious harm, generally, a police officer should be the last person to initiate such proceedings. It is preferred that a physician or mental health worker initiate or assist with this process. Commitment proceedings under section 12(e) of Chapter 123 should be initiated by a police officer only if all of the following procedures have been observed:

a. determination has been made that there are no outstanding commitment orders pertaining to the individual; and

b. every effort has been made to enlist an appropriate physician, psychiatrist, psychologist, social worker or family member to initiate the commitment proceedings; and

c. the officer has received approval from the Shift Commander.

4. If a patient or resident of a facility of the Massachusetts Department of Mental Health is absent without authorization, the superintendent of the facility is required to notify the state and local police, the local district attorney and the next of kin of such patient or resident. Such persons who are absent for less than six months may be returned by the police.

5. Whenever police take a mentally ill person into custody PES should be notified. Police officers are immune from civil suits for damages for restraining, transporting, applying for the admission of or admitting any person to a facility if the officer acts pursuant to the provisions of Chapter 123.

6. At all times, an officer should attempt to gain voluntary cooperation from the individual.

7. Any officer having contact with a mentally ill person shall keep such matter confidential except to the extent that revelation is necessary for conformance with departmental procedures regarding reports or is necessary during the course of official proceedings.

8. Whenever a mentally ill or intellectually challenged person is suspected of a crime and is taken into custody for questioning, police officers must be particularly careful in advising the subject of his Miranda rights and eliciting any decision as to whether he will exercise or waive those rights. Before interrogating a suspect who has a known or apparent mental condition or disability,

police should make every effort to determine the nature and severity of that condition or disability, the extent to which it impairs the subject's capacity to understand basic rights and legal concepts such as those contained in the Miranda warnings and whether there is an appropriate "interested adult," such as a legal guardian or legal custodian of the subject, who could act on behalf of the subject and assist the subject in understanding his Miranda rights and in deciding whether or not to waive any of those rights in a knowing, intelligent and voluntary manner.

9. If a mentally ill or intellectually challenged person is reported lost or missing, police should consult the departmental policy and procedure on ***Missing Persons Chapter 41M.***

10. An officer who receives a complaint from a family member of an allegedly mentally ill person who is not an immediate threat or is not likely to cause harm to themselves or others, should advise such family member to consult a physician or mental health professional. The officer should also notify the PES clinician by documenting the contact in an incident report and forwarding a copy to the PES clinician's inbox, located outside of the OIC's office.

11. Once an officer arrests a mentally ill person who is unable to be safely contained at the holding facility, the person should be brought to a proper mental health facility for evaluation.

    If the person is able to be safely contained, but is threatening self-harm or presenting with concerning psychiatric symptoms, contact the JDP clinician, or in their absence PES for consultation or to request evaluation at the station.

    Occasionally, the facility to which an officer transports a mentally ill person will either refuse to admit them entirely or will direct the officer to another mental health facility. Officers should contact the Officer in Charge for specific instructions in such cases.

H. Taking a Person with Substance Use Disorder into Custody:

1. A person with substance use disorder may be taken into custody if:

    a. [S]he has committed a crime;
    b. When an officer possesses a commitment order pursuant to M.G.L. Ch. 123§ 35, commonly referred to as a warrant of apprehension. Such order will be issued allowing an arrest of an individual who is an alcoholic or substance abuser.

       A police officer, physician, spouse, blood relative, guardian or court official may apply for the warrant. A warrant of apprehension may only be served when the individual can be brought <u>immediately before the court</u>. A warrant of apprehension will remain in effect for no more than five business days.

I. Protective Custody: Individuals that are incapacitated due to ingestion of alcohol or other drugs may be taken into protective custody. The intent of MGL Chapter 111B Section 8 (alcohol intoxication) and MGL Chapter 111E Section 9A (drug intoxication) is to protect the incapacitated individual without criminal consequences.

1. Protective Custody due to alcohol (MGL Chapter 111B Section 8);

    a. Any person who is <u>incapacitated</u> (due to alcohol consumption) may be assisted by a police officer with or without his/her consent to his residence, to a facility or to a police station. It is

preferred that the individual's residence be the first option (only if a responsible party is available to provide care).

b. A person transported to the police department will be offered the opportunity to make a phone call and submit to a breathalyzer test. A test resulting in .10 percent BAC or greater will presume intoxication. The person will be held no more than 12 hours in a holding cell. The Officer in Charge will be responsible for notifying the nearest treatment facility that an individual has been taken into protective custody.

c. A test resulting in .05 percent BAC or less will presume a lack of intoxication. The person will be released forthwith. A test result greater than .05 percent and less than .10 percent will require tests of coordination and speech to determine intoxication.

d. Officers will submit detailed reports documenting the condition of the individual taken into protective custody, any field sobriety tests or other observations indicating incapacitation and the circumstances indicating the person was unable to care for him/herself.

2. Protective Custody due to drug use (MGL Chapter 111E Section 9A);

a. Any person who is incapacitated (due to drug or toxic vapor consumption) may be taken into custody by a police officer without his/her consent for the purpose of immediately transporting the person to a medical facility.

b. Most commonly, officers might be required to act upon Chapter 111E when at the scene of an overdose, at which the patient has been revived but then refused transport to a medical facility for further evaluation.

c. Transportation will be via Watertown Fire/Rescue or Armstrong Ambulance, accompanied by a police officer onboard.

d. Officers will submit detailed reports documenting the condition of the individual taken into protective custody, any field sobriety tests or other observations indicating incapacitation and the circumstances indicating the person was unable to care for him/herself.

J. Detainment for Criminal Offense: The following procedures should be followed when a person is in Police Lock-Up prior to arraignment, but is in need of in-patient psychiatric hospitalization due to unsafe behaviors.

1. There should be a probable cause determination as required by *Jenkins.*

2. The detainee should receive an in-cell assessment by the JDP clinician or in their absence a clinician from PES.

3. If the clinician recommends inpatient psychiatric evaluation, the clinician will contact the on-call clinician for the Department of Mental Health who will respond directly to the station and evaluate the prisoner. They will locate an appropriate locked in-patient placement and have an in-patient bed held for the detainee. A recommendation for hospitalization of the detainee should be prepared with the findings.

4. Once an in-patient bed has been located, the judicial response system on-call judge should be contacted by the DMH clinician in coordination with the police. The police should be prepared to provide the judge with the following information:

i. the charges
ii. the condition of the detainee, including the findings from the clinician
iii. a listing of any default warrants (if any) outstanding
iv. any other pertinent information

5. The on-call judge after conferring with the police and with the evaluating clinician, may issue an order committing the detainee to a specified, locked in-patient facility pursuant to G.L c. 123 § 18, until court is in session.

6. On the designated court day, the detainee will be transported to court.

IV. Reporting:

The documentation of contacts with persons who appear to be suffering from mental illness, substance use disorder and homelessness can be a key to ensure they receive proper assistance. If an Officer encounters an individual who is clearly in crisis as a result of a mental illness, addiction or homelessness, the incident will be documented in the form of an "OF", an "AR" or an "FI" report. The Officer in Charge will print a copy of this report and forward it to the Jail Diversion Clinician to ensure that proper follow up may be conducted.

V. Training:

All personnel (including civilians who deal directly with the public) will receive training on these procedures during their orientation as well as a refresher at least every three years.

Appendix

AVAILABLE SERVICES

1. Advocates Psychiatric Emergency Services (781-893-2003)
2. Watertown Food Pantry St. John's Church 80 Mt. Auburn St. (617-972-6429)
3. St. Patrick's – St. Vincent de Paul's Food Pantry 26R Chestnut St. (617-926-7121)
4. Bristol Lodge Men's Shelter 27 Lexington St. Waltham (781-893-0108)
5. Bristol Lodge Women's Shelter 205 Bacon St. Waltham (781-894-1225 or 781-893-0108)
6. Veteran's Affairs Peer Specialist (857-259-2127) (Carolyn.jette@massmail.state.ma.us)
7. Springwell Protective Services (617-926-4100)
8. Salvation Army (Cambridge Corps Community Center) 402 Massachusetts Ave. (617-547-3400)

HOMES® Multi-disciplinary Hoarding Risk Assessment

❑ Health

❑Cannot use bathtub/shower ❑Cannot prepare food ❑Presence of spoiled food ❑Presence of insects/rodents
❑Cannot access toilet ❑Cannot sleep in bed ❑Presence of feces/Urine (human or animal)
❑Presence of mold or chronic dampness ❑Garbage/Trash Overflow ❑Cannot use stove/fridge/sink
❑Cannot locate medications or equipment
Notes:_____

❑ Obstacles

❑Cannot move freely/safely in home ❑Unstable piles/avalanche risk
❑Inability for EMT to enter/gain access ❑Egresses, exits or vents blocked or unusable
Notes:_____

❑ Mental health (Note that this is not a clinical diagnosis; use only to identify risk factors)

❑Does not seem to understand seriousness of problem ❑Defensive or angry ❑Unaware, not alert, or confused
❑Does not seem to accept likely consequence of problem ❑Anxious or apprehensive
Notes:_____

❑ Endangerment (evaluate threat based on other sections with attention to specific populations listed below)

❑Threat to health or safety of child/minor ❑Threat to health or safety of person with disability
❑Threat to health or safety of older adult ❑Threat to health or safety of animal
Notes:_____

❑ Structure & Safety

❑Unstable floorboards/stairs/porch ❑Leaking roof ❑Electrical wires/cords exposed ❑No running water/plumbing problems
❑Flammable items beside heat source ❑Caving walls ❑No heat/electricity ❑Blocked/unsafe electric heater or vents
❑Storage of hazardous materials/weapons
Notes:_____

HOMES® Multi-disciplinary Hoarding Risk Assessment (page 2)

Household Composition

# of Adults _____ _____ # of Children _____ # and kinds of Pets _____
Ages of adults: _____ Ages of children: _____ Person who smokes in home ❑ Yes ❑ No
Person(s) with physical disability_____ Language(s) spoken in home_____

Assessment Notes:_____
_____

Risk Measurements
❑ Imminent Harm to self, family, animals, public:_____
❑ Threat of Eviction: _____ ❑ Threat of Condemnation:_____

Capacity Measurements
Instructions: Place a check mark by the items that represent the strengths and capacity to address the hoarding problem
❑ Awareness of clutter
❑ Willingness to acknowledge clutter and risks to health, safety and ability to remain in home/impact on daily life
❑ Physical ability to clear clutter
❑ Psychological ability to tolerate intervention
❑ Willingness to accept intervention assistance
Capacity Notes:_____
_____

Post-Assessment Plan/Referral_____

Date: _____ Client Name: _____ Assessor: _____

HOMES® Multi-disciplinary Hoarding Risk Assessment

Instructions for Use

- **HOMES** Multi-disciplinary Hoarding Risk Assessment provides a structural measure through which the level of risk in a hoarded environment can be conceptualized.

- It is intended as an *initial* and *brief* assessment to aid in determining the nature and parameters of the hoarding problem and organizing a plan from which further action may be taken-- including immediate intervention, additional assessment or referral.

- **HOMES** can be used in a variety of ways, depending on needs and resources. It is recommended that a visual scan of the environment in combination with a conversation with the person(s) in the home be used to determine the effect of clutter/hoarding on **H**ealth, **O**bstacles, **M**ental Health, **E**ndangerment and **S**tructure in the setting.

- The Family Composition, Imminent Risk, Capacity, Notes and Post-Assessment sections are intended for additional information about the hoarded environment, the occupants and their capacity/strength to address the problem.