City of Lyons Police Department
POLICE OPERATIONS MANUAL

Chapter 23 Mental Illness	Effective Date:	February 1, 2023	# of Pages:	9
	Revised Date:		Distribution:	
	SPECIAL INSTRUCTIONS:			

I. PURPOSE

The purpose of this policy is to establish guidelines and procedures for personnel of the Lyons Police Department in the recognition and safe handling of suspected mentally ill and/or intoxicated persons.

II. DEFINITIONS

A. DELIRIUM: Sudden severe confusion and disorientation due to rapid changes in brain function that occur with physical or mental illness. Diseases, injuries, or substances that cause brain inflammation, blood pressure changes, or oxygen deprivation can cause delirium, often accompanied by abnormal heart and organ function. Due to this being considered a serious medical emergency, persons in this state of mind shall be transported to the hospital by a medical unit for medical evaluation. Some common types of delirium include:

- **Hyperactive delirium** is characterized by extreme agitation, overheating, excessive tearing of the eyes, hostility, superhuman strength, aggression, acute paranoia, and endurance without apparent fatigue.
- **Hypoactive delirium** is characterized by excessive sleep, severe inattention and disorganization with daily tasks.
- **Delirium Tremens (DTs)** is due to alcohol withdrawal. Mortality for patients with DTs is 5% with medical management.
- **Sundowners** is related to dementia (most common in elderly individuals) and is characterized by sadness, agitation, fear, delusions and/or hallucinations and occurs around afternoon or evening. People who are “sundowning” are at an elevated risk of wandering, becoming combative, or self-harming. Caregivers often need ongoing education and support to deal with the syndrome.

B. PSYCHOSIS: One manifestation of mental illness that develops over time, characterized by an impaired grasp on reality, disorganized thinking and speech, difficulty conforming to social standards such as tactful communication, problems interpreting social cues, belief that others have mal-intent, rapid mood changes, and atypical motor symptoms

such as slowed motor response, tics, repetitive or purposeless movement, or freeze states. Delusions and hallucinations are two important signs of psychosis.

- **Delusions** are characterized by holding bizarre beliefs despite evidence that the belief is inaccurate or unreal. These beliefs are extremely difficult to dissuade and do not evolve over time. Challenging the belief strengthens the individual's perception of conspiracy and persecution, adding an element of paranoia. Challenging a delusion will not gain compliance.

- **Hallucinations** are sensory experiences not based in reality. Hallucinations are most often auditory. Auditory hallucinations are often in the form of voices saying hurtful, disparaging things or giving commands that are dangerous to self and/or others. Other types of hallucinations include visual, tactile (Example: Feeling bugs crawling on or under the skin), or scents/odors. Individuals with hallucinations may have 'insight,' meaning they are aware that the hallucination is not real. To explore an individual's level of insight, state that you are not hearing or seeing what they are. Ask if they often experience something that others cannot see or hear. Their answer will shed light on whether they have insight or an accompanying delusion (Example: If they report hearing voices but have insight, they will say they often hear voices but know they are not real. If they hear voices but are delusional, they may say the voices are transmitted through a chip in their brain).

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

III. RULES AND REGULATIONS

STANDARD OPERATING PROCEDURE EFFECTIVE: February 1, 2023

S.O.P. 23-1

Agency personnel will afford individuals who have mental illnesses the same rights, dignity and access to police and other government and community services that are provided to all citizens. It is the policy of the Lyons Police Department to manage suspected mentally ill, intoxicated, and/or homeless persons in a safe, effective, and efficient manner. Employing the services of the Lyons Police Department Mental Health Clinician ensures appropriate assessment and management of mental health crises, as well as appropriate follow-up care with the goal being to mitigate the factors that lead to unsupported mental health crises in the future.

A. RECOGNIZING AN INDIVIDUAL WITH A MENTAL ILLNESS

Indicators that a person may be suffering from mental illness include Verbal, Behavioral, and Environmental Cues. When making observations of the following cues, personnel should:

1. Note as many indicators as possible
2. Put the indicators into the context of the situation
3. Be mindful of environmental and cultural factors.

Verbal Cues

a. Expressing irrational thoughts
   1. Expressing a combination of unrelated or abstract topics (Tangential Thoughts).
   2. Expressing thoughts of greatness, e.g., person believes they are GOD (Grandiose Delusions).
   3. Expressing ideas of being harassed or threatened, e.g., CIA monitoring through TV set (Delusions of Persecution).
   4. Preoccupation with death, germs, guilt, etc. (Obsessions).

b. Unusual Speech Patterns
   1. Nonsensical speech or chatter (Disorganized speech or Word Salad)
   2. Word repetition – frequently stating the same or rhyming words or phrases.
   3. Pressured speech – expressing urgency in manner of speaking.
   4. Extremely slow speech.

c. Verbal hostility or excitement
   1. Talking excitedly or loudly.
   2. Argumentative, belligerent, unreasonably hostile.

3. Threatening harm to self and/or others.

Behavioral Cues

a. Physical appearance
   1. Inappropriate for the environment – e.g., shorts in winter, heavy coats in summer.
   2. Bizarre clothing or makeup, considering current trends.
   3. Emotional expression that conflicts with situation – e.g., laughing at an automobile accident (inappropriate affect).
   4. Nonverbal expressions of sadness or grief.
   5. Overreacting to situations in an overly angry or frightening way.

b. Bodily Movements
   1. Strange postures or mannerisms – e.g., continuously looking over shoulder as if being followed, holding unusual body positions for a long time.
   2. Lethargic, sluggish movements (Bradykinesia).
   3. Pacing, agitation.
   4. Repetitious, ritualistic movements.
   5. Tics and stereotyped involuntary movements

c. Behaviors related to experiential phenomena
   1. Seeing, smelling, or hearing things that are not able to be confirmed (Hallucinations).
   2. Confusion about or unawareness of surroundings (Disorientation).
   3. Causing injury to self – e.g., cutting self with sharp objects, cigarette burns on body, starving self.
   4. Neglect of basic personal needs – taking off clothes in the cold, unaware of hunger.
   5. Unawareness of social norms – lacking a sense of privacy or embarrassment.

d. Behaviors related to environment
   1. Strange trimmings, inappropriate use of household items, e.g., aluminum foil covering windows.
   2. Waste matter/trash.
   3. “Packratting” – accumulation of trash, e.g., hording string, newspapers, paper bags, clutter, etc.
   4. The presence of feces or urine on the floor or walls.
   5. Age-inappropriate objects.

B. INTERACTING WITH AN INDIVIDUAL WITH MENTAL ILLNESS

The following guidelines detail how to approach and interact with an individual who may have mental illness and who may be a crime victim, witness, or suspect. These guidelines shall be followed in all contacts, whether in the field or during more formal interviews and interrogations. Officers, while protecting their own safety, the safety of the person with mental illness, and others at the scene shall:

1. OFFICER BODY LANGUAGE
    a. Remember, the mentally ill individual is in crisis and is generally afraid. Use your words and body language to convey a sense of safety, respect, and human connection.
    b. Maintain appropriate distance between you and the person.
    c. Be aware that the uniform, firearm, handcuffs, etc., may frighten the person with mental illness, attempt to reassure him/her that no harm is intended;
    d. Remain calm and avoid overreacting. Model deep breathing, calm vocal tone, clear speech of moderate pace.
    e. Move slowly. It may even be appropriate to say what you are doing before you do it (i.e. "I am going to walk behind you and place my hand on your shoulder.").
    f. Continually assess the situation for an escalation of risk to all parties.
    g. Remove distractions, upsetting influence and disruptive people from the scene; Be aware of nonverbal cues that the person triggered by something/someone at the scene. Mitigate accordingly.
    h. Gather information from family and/or bystanders.

2. OFFICER VERBAL COMMUNICATION
    a. For disorganized communication, repeat the last or most important part of what the individual tells you. This conveys that you are listening, and it encourages them to stay on a train of thought.
    b. If a person is highly emotional but not physically aggressive, avoid commanding them to "calm down." Alternatives to "calm down."

        1. "Let's take a breath and take a moment. Now, tell me what's going on."
        2. "I really want to understand what you need to tell me. Can you slow down just a bit so I can understand?"

3. "I'm here to listen, so just focus on me and tell me what you want me to know."

c. Respond to apparent feelings, rather than content.

1. "You look/sound scared."

d. Try to help. People, generally, will respond to questions concerning their basic needs (e.g., safety, shelter, food).

1. "What would make you feel safer, etc.?"

e. Give clear/concise directions. The person is likely already confused and may have trouble making even the simplest decision. Ideally, only one person should attempt to communicate with the individual.

f. When giving a command, allow for extra time for processing and motor response. People with a mental illness may have delayed processing and voluntary motor responses. Do not assume that a slowed response to a verbal command is resistance.

g. Respond to delusions and hallucinations by addressing the person's feelings rather than what he or she is saying. Do not agree or disagree directly with a hallucination or delusion.

1. "That sounds frightening,"
2. I can see why you are angry."
3. "I don't see _____, but I believe you do. That must be frustrating."

3. BEHAVIORS TO AVOID
While each incident will be different when interacting with an individual who may have a mental illness, personnel should be aware their actions may have an adverse effect on the situation. **Actions that officers should generally avoid include:**

a. Moving suddenly, giving rapid orders or shouting;
b. Stare at the person; this may be interpreted as a threat;
c. Crowding the person or moving into his/her zone of comfort;
d. Give multiple choices – Giving multiple choices increases the person's confusion;
e. Whisper, joke, or laugh – this could increase the person's suspiciousness with potential for violence;

f. Expressing anger, impatience, or irritation;
g. Assuming that a person who does not respond cannot hear;
h. Using inflammatory language, such as ‘mental’ or ‘mental subject’;
i. Deceiving the individual, being dishonest increases fear and suspicion;
j. Minimize concerns (i.e., “Oh things can’t be that bad,” etc.);
k. Touch the person (unless essential for safety) – Although touching can be helpful to some individuals who are upset, for many, it may cause more fear and lead to violence.

C. PROCEDURES FOR ACCESSING COMMUNITY MENTAL HEALTH RESOURCES

Once sufficient information has been collected about the nature of the situation, and the situation has been stabilized, the officer has several options to consider when selecting an appropriate disposition.

1. If there is evidence of a medical problem or injury, appropriate Emergency Medical Services shall be requested to assess the individual, prior to release referral, and/or transporting.

2. If there is no evident medical problem or injury, a criminal offense has not been committed, and there is probable cause to believe the individual may be in crisis and/or experiencing behavioral health issues such as mental health, substance use, homelessness, etc., the officer shall contact the Mental Health Clinician, or in the absence of said clinician, the Georgia Crisis Access Line (GCAL) (800-715-4225) for crisis response services. If it is afterhours (4:30 pm to 7:29 AM Monday through Friday & all-day Saturday and Sunday), the officer shall contact the Mental Health Clinician ONLY when there is probable cause to believe that an individual may be experiencing a mental health crisis. If it is suspected that the individual is experiencing non-crisis behavioral health issues such as mental health, substance use, homelessness, domestic violence, etc., the officer will provide the individual with the Mental Health Clinician’s business card and program information and submit a referral form to the Mental Health Clinician within 24 hours of identifying the need. The Mental Health Clinician will follow up with the individual within 48 hours of receiving the referral.

   a. The Mental Health Clinician (MHC) is responsible for providing immediate intervention, coordinating 1013 referrals, and supporting officers in handling mental health issues. The MHC should respond within an hour of being notified. INFORM YOUR DIRECT SUPERVISOR THAT YOU ARE CONTACTING THE MHC, THEN CALL THE DIRECT CELL NUMBER FOR THE MHC. LEAVE A MESSAGE OR TEXT IF YOU GET NO ANSWER. IF AFTER AN HOUR THE MHC HAS NOT RESPONDED, CALL GCAL/BENCHMARK AT 800-715-4225.

b. Benchmark Human Services are designed to provide immediate intervention and should respond within an hour of being notified. Benchmark Human Services has the capability to make 1013 referrals upon their evaluation of the subject by a licensed clinician. If a 1013 referral is made and the form is completed by the licensed clinician, Benchmark Human Services are capable of transporting the individual, provided he or she goes voluntarily and is not a risk of harming themselves or others, then an Officer on scene shall transport the individual to the nearest emergency receiving facility.

4. Based upon and having in possession a valid court order of physician certificate “Emergency Admission Certificate and Report of Peace Officer,” also known as a “form 1013,” take the individual into custody and deliver the person named on the certificate to the nearest available emergency receiving facility. Any peace officer taking into custody and delivering for examination a person, as authorized by OCGA 37-3-41, shall complete the written report, located on the reverse side of the form 1013, detailing the circumstances under which such person was taken into custody. The report and either the physician’s certificate or court order authorizing such taking into custody shall be made a part of the patient’s clinical record as per Georgia Code Section 37-3-41.

5. Any Peace Officer may take any person to a physician or directly to an emergency receiving facility for an examination, if the person is committing a penal offense and the Officer has probable cause for believing that the individual is mentally ill and in need of involuntary treatment. The Officer need not formally tender charges against the individual prior to taking them in for an examination (OCGA 37-3-42(a)). Whenever a person is taken into custody for the purpose of transport to a physician or an emergency receiving facility for an examination, the Officer must complete the Report of Peace Officer located on the reverse side of the form 1013, to include whether or not the person is under criminal charges (OCGA 37-3-95)), along with a Departmental Incident Report detailing the circumstances under which such a person was taken into custody (OCGA 37-3-41; 37-3-42)). A copy of the 1013 form shall be attached to the incident report. Per OCGA 37-3-101, it shall be the responsibility of the governing authority of the county of the patient’s residence to arrange transportation from one facility to another facility.

6. If the individual commits a crime which requires them to be charged and booked into the Toombs County Jail, the Officer shall notify the MHC for review and linkage to identified services/resources.

7. The MHC shall be involved in any and all cases involving mental illness, psychological distress, substance use, and/or homelessness in one of the following ways:

a. The MHC card is provided to the individual or responsible party at the scene with a brief explanation of services.
b. The MHC is notified by referral to follow up on a case.
c. The MHC will follow up on all cases involving Persons In Need of Services (PINS), mental illness, substance use, homelessness, etc. on the jail roster.
d. Officers on the scene shall contact the on-call MHC for either a phone consultation or request for field support. With support from the MHC, every effort will be made to determine the severity of the behavior, the potential for change in the behavior, and the potential for danger presented by the individual to themselves, the Officers, and/or others.

D. TRAINING

1. Entry-Level
   The department shall provide entry level personnel with training in department policies regarding response and interaction to persons suspected of suffering from mental illness.

2. Refresher
   The department will provide training to personnel as outlined in General Order In-Service Training in policies and current law regarding response and interaction with persons with mental illness. This training shall be conducted during in-service training.