CLINTON TOWNSHIP POLICE DEPARTMENT
POLICIES AND PROCEDURES

SUBJECT: EMOTIONALLY DISTURBED PERSONS	
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PURPOSE The purpose of this policy is to maintain guidance for department personnel in recognizing and dealing with persons with mental illness or emotional disturbances including participating in the *ARRIVE Together Program*.

POLICY It is the policy of the Clinton Township Police Department to treat emotionally disturbed persons and persons with mental illness with dignity and respect and divert them from the criminal justice system whenever possible.

It is further the policy of this department that the procedures necessary to involuntarily commit emotionally disturbed persons and persons with mental illness conform to N.J.S.A. 30:4-27-1 et seq. to provide for the public good while maintaining the rights and dignity of the persons being committed.

Although mental health professionals treat various mental disorders differently, for purposes of this order mental illness also includes anxiety, personality, mood, developmental, and emotional disorders, including disorder due to intoxication, when this agency's response is somewhat consistent.

It is also the policy of this agency to participate in the *ARRIVE Together Program* through Hunterdon Health Behavioral Health Services (HHBHS) to reduce the risk of violence when interacting with individuals experiencing a mental health crisis, and to protect and serve persons by providing a safer, more effective response to mental health emergencies.

PROCEDURES

I. DEFINITIONS

A. Alzheimer's disease is a progressive, degenerative disease of the brain in which brain cells die and are not replaced. It results in impaired memory, thinking and behavior. It is the most common form of dementia illness.

B. *ARRIVE Together Program* has been created to reduce the number of times police use force when responding to such calls for service.

1. ARRIVE is an acronym that stands for *Alternative Responses to Reduce Instances of Violence and Escalation*.

2. The *ARRIVE Together Program* shall perform follow-up tasks and proactively visit individuals in the community who would benefit from such an outreach program.

3. General program oversight and management including coordination between law enforcement and Hunterdon Health Behavioral Health Services (HHBHS), is a function of the Hunterdon County Prosecutor's Office.

4. Program types:

a. Close in Time Follow-up Program – CIT trained law enforcement officers and HHBHS specialist respond to emergency service calls and/or follow up visits that relate to behavioral health crisis in separate vehicles. This response may be simultaneous or there may be a short delay in the HHBHS response, but generally within 30 minutes of the law enforcement encounter. The HHBHS response may also require staging prior to arrival at the scene with law enforcement. HHBHS will provide social and health services as determined by the parties.

1) On-duty crisis intervention team (CIT) trained officers will be on duty during the program's shifts.

2) HHBHS will provide two experienced specialists to participate in the program. The participating specialists will perform crisis intervention and screening services consistent with their statutory and regulatory duties at each call for service.

3) CIT officers and program specialists will respond to all behavioral health crisis calls for service within Hunterdon County, including those originating from the public, those incoming from other law enforcement officers or agencies within the area, and those incoming from the HHBHS to law enforcement and/or Hunterdon County Communications.

b. Follow-up Program – law enforcement officers inform HHBHS specialists of individuals encountered by law enforcement who may benefit from the services of HHBHS within a designated timeframe following the law enforcement interaction as determined by the parties.

c. The Close in Time Follow-up Program will be available Monday through Friday from 1200 hours through 2000 hours. Shift times may be altered if, in consultation with DHS and HHBHS, the HCPO determines that a higher volume of calls for service consistently occur at different hours.

d. The Follow-up Program will be always available.

C. Autism/Autism Spectrum Disorder (ASD) is a biologically based disorder that affects the development and functioning of a person's verbal and non-verbal communication skills, social interactions, and patterns of behavior. Autism affects people of all races, ethnicities and socio-economic groups and is found throughout the world. Autism is four times more prevalent in boys than girls. Some signs and symptoms associated with ASD include, but are not limited to:

1. No babbling, pointing or meaningful gestures by 1 year of age.

2. No single words by age 16 months.

3. Loss of language or other skills at any age.

4. Little or no eye contact.

5. Lack of pretend, imitative, and functional play appropriate to developmental age.

6. Stereotypical and repetitive behavior.

7. Failure to develop peer relationships appropriate to developmental age.

8. Unusual or inappropriate fears.

D. Behavioral health crisis calls mean emergency calls for service received by Hunterdon County Communications (HCC) or by the HHBHS, which involve:

1. Behavioral/mental health; or

2. Confused/disoriented persons; or

3. Welfare checks; or

4. Suicide attempts; or

5. Any other behaviors that officers deem appropriate related to behavioral health identified during the investigation.

E. Dangerous to self means that by reason of mental illness the person has threatened to harm him/herself or has behaved in such a manner as to indicate that the person is unable to satisfy their need for nourishment, essential medical care, or shelter, so that it is probable that substantial bodily injury, serious physical debilitation, or death will result within the reasonably foreseeable future. However, no person shall be deemed to be unable to satisfy their need for nourishment, essential medical care, or shelter if they are able to satisfy such needs with the supervision and assistance of others who are willing and available (N.J.S.A. 30:4-27.2h).

F. Dangerous to others or property means that by reason of mental illness there is a substantial likelihood that the person will inflict serious bodily harm upon another person or cause serious property damage within the reasonably foreseeable future. This determination shall consider a person's history, recent behavior and any recent act or threat (N.J.S.A. 30:4-27i).

G. De-escalation is calmly communicating with an agitated person to understand, manage and resolve his/her concerns. Ultimately, these actions should help reduce the person's agitation and potential for future aggression or violence.

H. Dementia is a generic term used for all memory impairing diseases.

I. Emergency medical services (EMS) means a member of a first aid squad, ambulance, rescue squad, or fire department, whether paid or volunteer.

J. Emotionally disturbed person is generic term used to describe a person with an emotional disturbance, behavioral disorder, diminished mental capacity, or mental illness. There is a wide range of specific conditions that differ from one another in their characteristics and treatment including, but not limited to:

1. Anxiety disorders.

2. Autism/Autism Spectrum Disorder.

3. Bipolar Disorder (sometimes called manic depression).

4. Behavioral disorders (including disorder due to substance abuse).

5. Diminished capacity.

6. Drug or alcohol induced diminished mental capacity.

7. Obsessive-compulsive disorder (OCD).

8. Psychotic disorders.

9. Mental illness.

K. Excited delirium is a medical disorder generally characterized by observable behaviors, including extreme mental and physiological excitement, intense agitation, hyperthermia often resulting in nudity, hostility, exceptional strength, endurance without apparent fatigue, and unusual calmness after restraint accompanied by a risk of sudden death.

L. HHBHS specialist means a mental health screener as defined by N.J.S.A. 30:4-27.2 or other qualified specialist, such as a crisis intervention specialist, therapist, social worker, psychiatrist, psychologist, nurse, or other professional possessing the relevant academic training or experience to do outreach for the purposes of clinical screening.

M. Incapacitated means, incapable, lack of normal intellectual power. Incapacitated also means the condition of a person:

1. As a result of the use of alcohol or drugs is unconscious or has his/her judgment so impaired that he/she is incapable of realizing and making a rational decision with respect to his/her need for treatment; or

2. In need of substantial medical attention; or

3. Likely to suffer substantial physical harm.

N. In need of involuntary commitment means that an adult who is mentally ill, whose mental illness causes the person to be dangerous to self or dangerous to others or property and who is unwilling to be admitted to a facility voluntarily for care, and who needs care at a short-term care facility or special psychiatric hospital because other services are not appropriate or available to meet the person's mental health care needs (N.J.S.A. 30:4-27.2m).

O. Intoxicated person means a person whose mental or physical functioning is substantially impaired because of the use of alcoholic beverages or drugs.

P. Mental illness means a current, substantial disturbance of thought, mood, perception, or orientation which significantly impairs judgment, capacity to control behavior or capacity to recognize reality, but does not include simple alcohol intoxication, transitory reaction to drug ingestion, organic brain syndrome or developmental disability unless it results in the severity of impairment described herein. The term mental illness is not limited to psychosis or active psychosis but shall include all conditions that result in the severity of impairment described within (N.J.S.A. 30:4-27.2r).

Q. Positional asphyxia happens when a person can't get enough air to breathe due to the positioning of his/her body. This happens when a person is placed in a position when his/her mouth and nose is blocked or when his/her chest/torso may be unable to fully expand resulting in suffocation.

R. Screening means the process by which it is ascertained that the patient being considered for commitment meets the standards for both mental illness and dangerous to self, others, or property and that all stabilization options have been explored or exhausted.

S. Screening outreach visit means an evaluation provided by a mental health screener wherever the person may be when clinically relevant information indicates the person may need involuntary commitment and is unable or unwilling to come to a screening service and the police are unable or unwilling to transport without an evaluation (N.J.S.A. 30:4-27.2aa).

T. Short-term custody for purposes of this policy, means except when delinquent conduct is alleged, a law enforcement officer may take any juvenile into short-term custody consistent with the provisions of this policy, not to exceed six hours, when there are reasonable grounds to believe that the health and safety of the juvenile is seriously in danger and that immediate custody is necessary for the juvenile's protection (N.J.S.A. 2A: 4A-32).

II. GENERAL PROVISIONS

A. Absent criminal behavior or danger to self or others, persons with mental illness and/or emotional disturbances require no special police response. Mentally ill and emotionally disturbed persons have a right to be left alone if they do not violate the law.

B. No person suspected of having mental illness or emotional disturbance is to be taken involuntarily into police custody unless such person has committed an offense that could result in their arrest or has demonstrated by acts observed by a police officer or other reliable persons, that he/she is dangerous to the lives or safety of others or himself/herself.

C. No one is to be treated as being mentally ill or emotionally disturbed unless a compelling necessity exists. Police officers shall exercise extreme care in determining that a person is mentally ill and in conforming to the procedures set out in this policy.

D. Entry-level officers shall receive documented training in the police academy or with this department prior to assuming operational duties.

E. Documented refresher training in this policy shall be conducted at least once every three years.

III. RECOGNIZING SIGNS OF MENTAL ILLNESS / EMOTIONAL DISTURBANCE

A. Officers could encounter a person with an emotional disturbance or mental illness at any time. Common situations in which such individuals may be encountered include, but are not limited to, the following:

1. Wandering: individuals with emotional disturbances or mental illness may be found wandering aimlessly or engaged in repetitive or bizarre behaviors in a public place.

2. Seizures: emotionally disturbed, mentally ill, or incapacitated persons are more subject to seizures and may be found in medical emergency situations.

3. Disturbances: disturbances may develop when caregivers are unable to maintain control over emotionally disturbed or mentally ill persons engaging in self-destructive behaviors.

4. Strange and bizarre behaviors: repetitive and seemingly nonsensical motions and actions in public places, inappropriate laughing or crying, and personal endangerment.

5. Offensive or suspicious persons: Socially inappropriate or unacceptable acts such as ignorance of personal space, annoyance of others, inappropriate touching of oneself or others, are sometimes associated with emotionally disturbed or mentally ill persons who are not conscious of acceptable social behaviors.

B. Symptoms vary and each person with mental illness is different, but all people with mental illness or emotional disturbances have some of the thoughts, feelings, or behavioral characteristics listed below. While a single symptom or isolated event is not necessarily a sign of mental illness or emotional disturbances, multiple or severe symptoms may indicate a need for a mental health evaluation. These symptoms should not be construed as an all-inclusive list.

1. Changes in thinking or perceiving, such as:

    a. Hallucinations.

    b. Delusions.

    c. Excessive fears or suspiciousness.

    d. Inability to concentrate.

    e. Expressing a combination of unrelated or abstract topics.

    f. Expressing thoughts of greatness (e.g., believes they are God).

    g. Expressing ideas of being harassed or threatened (e.g., CIA is monitoring their thoughts through TV set).

    h. Preoccupation with death, germs, guilt, etc.

2. Changes in mood:

    a. Sadness coming out of nowhere, unrelated to events or circumstances.

    b. Extreme excitement or euphoria.

    c. Pessimism, perceiving the world as gray and lifeless.

    d. Expressions of hopelessness.

    e. Loss of interest in once pleasurable activities.

    f. Thinking or talking about suicide.

3. Changes in behavior:

    a. Sitting and doing nothing.

    b. Friendlessness, abnormal self-involvement.

    c. Dropping out of activities, decline in academic or athletic performance.

    d. Hostility, from one formerly pleasant and friendly.

    e. Indifference, even in highly important situations.

f. Seeing or hearing things that cannot be confirmed.

g. Confusion about or unawareness of surroundings.

h. Lack of emotional response.

i. Causing injury to self, others, or damage to property.

j. Inappropriate emotional reactions, such as:

1) Overreacting to situations in an overly angry or frightening way.

2) Reacting with opposite of expected emotion (e.g., laughing at a vehicle crash).

k. Inability to express joy.

l. Inability to concentrate or cope with minor problems.

m. Irrational statements.

n. Peculiar use of words or language structure.

o. Excessive fears or suspiciousness.

p. Unexplained involvement in vehicle collisions.

q. Drug or alcohol abuse.

r. Forgetfulness and loss of valuable possessions.

s. Attempts to escape through geographic change, frequent moves, or hitchhiking trips.

t. Bizarre behavior (skipping, staring, strange posturing).

u. Unusual sensitivity to noises, light, clothing.

4. Physical changes:

a. Hyperactivity or inactivity or alternations of these.

b. Deterioration in hygiene or personal care.

c. Unexplained weight gain or loss.

d. Sleeping too much or being unable to sleep.

5. Physical appearance:

a. Wearing clothing inappropriate to environment (e.g., shorts in winter, heavy clothing in summer).

b. Wearing bizarre clothing or cosmetics (considering current trends).

6. Body movements:

a. Strange postures or mannerisms.

b. Lethargic, sluggish movements.

c. Repetitious, ritualistic movements.

7. Unusual speech patterns:

a. Nonsensical speech or chatter.

b. Word repetition (frequently stating the same or rhyming words or phrases).

c. Pressured speech (expressing an urgency in manner of speaking).

d. Extremely slow speech.

8. Verbal hostility or excitement:

a. Talking excitedly or loudly.

b. Argumentative, belligerent or unreasonably hostile.

c. Threatening harm to self, others, or property.

9. Environmental Indicators:

a. Decorations (e.g., strange trimmings, inappropriate use of household items such as aluminum foil covering windows).

b. Waste matter and trash.

c. Accumulation of trash such as newspapers, paper bags, egg cartons, etc. (e.g., Hoarding Syndrome).

d. Presence of feces and/or urine on the floor or walls.

C. Often the symptoms are cyclic, varying in severity from time-to-time. The duration of an episode also varies. Some people are affected for a few weeks or months while for others the condition may last many years or for a lifetime. There is no reliable way to predict what the course of the condition may be. Symptoms may change from year-to-year. Also, one person's symptoms may be very different from those of another although the diagnosis may be the same.

D. In many cases of apparent mental illness, other diseases or maladies are found to be the cause including, but not limited to, Alzheimer's, epilepsy, Parkinson's, diabetes, etc. Be alert for and note behaviors to relay to mental/behavioral health professionals for their diagnosis. A thorough examination by a health professional should be the first step when mental illness is suspected.

E. People with Alzheimer's disease share several behavioral patterns and symptoms, which include:

1. Blank facial expression.

2. Unsteady walk/loss of balance.

3. Age (common age of onset 65+).

4. Repeats questions.

5. Inappropriate clothing for season.

6. Safe Return Program identification.

7. Inability to grasp and remember the current situation.

8. Difficulty in judging the passage of time.

9. Agitation, withdrawal, or anger.

10. Inability to sort out the obvious.

11. Confusion.

12. Communication problems.

13. Delusions and hallucinations.

14. Inability to follow directions.

IV. ENCOUNTERS WITH EMOTIONALLY DISTURBED PERSONS

A. Upon receiving a call involving a behavioral health crisis, during *ARRIVE Together* hours, Hunterdon County Communications will dispatch a CIT officer to the scene and the HHBHS specialist to stage in the area.

1. UNDER NO CIRCUMSTANCES should a response to such a call be delayed or otherwise held to await the *ARRIVE Together* Team.

2. Officers shall continue to respond to such calls in accordance with this policy and this agency's policy concerning *Vehicle Operation and Call Response*.

3. In the event of an emergency response, non-CIT officers shall take the appropriate action as needed and turn the incident over to a CIT officer when appropriate or reasonable.

4. If a CIT officer is not available communications personnel shall check the availability of a CIT officer in a neighboring jurisdiction for mutual aid.

5. Mutual aid CIT officers are not responsible for the transport of subjects who are going to HHBHS. Transportation remains the responsibility of this agency.

6. Communications personnel shall provide the CIT officer with the HHBHS specialist's mobile contact information so he/she can speak directly to them when possible.

7. Upon arrival on scene, CIT officers shall identify themselves as law enforcement officers and ensure the scene is safe. Once CIT officers deem the scene is safe, they will contact the HHBHS specialist directly or advise communications via the police radio that it is safe for the HHBHS specialist to respond to the scene.

8. The CIT officer will collect data relevant to the *ARRIVE Together* Program and remain at the scene, to ensure the scene remains safe, while the HHBHS specialist provides services.

9. If the HHBHS specialist is continuing to render follow-up services and does not have any safety concerns, they may release the CIT officer from the scene.

10. If the HHBHS specialist is unable to respond to a behavioral health crisis call, and the CIT officer does not believe outreach services are needed at that time but does believe that the subject could benefit from mental health services or follow-up, the officer shall complete the Hunterdon County *ARRIVE Together Referral Form* and fax it to HHBHS in a timely manner, not to exceed the end of the officer's shift.

11. If there is not a CIT officer available to respond to a behavioral health crisis call, a non-CIT officer can respond in accordance with this policy and this agency's policy concerning *Vehicle Operation and Call Response*.

12. The non-CIT officer may request outreach services from HHBHS in accordance with this policy.

13. If the non-CIT officer does not believe outreach services are needed at that time but does believe that the subject could benefit from mental health services or follow-up, the officer shall complete the *Hunterdon County Behavioral Health Referral Form* and send fax it to HHBHS in a timely manner, not to exceed the end of the officer's shift.

B. When encountering a person with suspected mental illness or emotional disturbance, officers shall use de-escalation tactics to the extent possible. Examples include, but are not limited to:

1. Approach the person with extreme caution. Be alert and maintain a calm and casual demeanor.

2. If possible, identify a friend or relative that can aid in dealing with the person or who may be able to explain the behavior.

3. Speak to the person by name, if known. Your tone of voice should be soothing, but firm and businesslike.

4. Avoid exciting the person. Do not say or do anything that may threaten or intimidate the person.

5. Ask questions slowly, one at a time, and be patient in waiting for a response. Be prepared that the person may not understand questions and/or instructions or be able to answer in an understandable manner.

6. Avoid arguing with or scolding the person. Do not allow anyone else to do so.

7. Avoid deceiving the person (although sometimes it may be necessary)

8. Ignore verbal abuse directed at you or others.

9. Make use of friends or relatives who know how to talk to, and deal with, the person unless there is friction between them.

10. Whenever possible, try and stall until a backup arrives at the scene.

11. Show kindness and understanding. Maintain professionalism.

12. Be aware that the person may respond the way he/she thinks you want him/her to.

13. If the person exhibits dangerous or violent behavior or has a history of dangerous or violent behavior, consider the use of force or the use of tactical resources when warranted.

C. If it is necessary to restrain or take the person into custody, do so carefully. Use physical restraint sparingly as it may cause more aggressive behavior. Keep sidearms and other weapons out of the person's reach. Contact EMS for restraints and/or transportation.

1. Avoid chokeholds and be alert to the potential for positional asphyxia.

2. Any use of force other than constructive authority and/or physical contact to control an emotionally disturbed person must be reported on a use of force report.

D. Not all mentally ill or emotionally disturbed persons are dangerous, while some may represent danger only under certain circumstances or conditions. An emotionally disturbed or mentally ill person may not understand or immediately respond to police commands. Officers may use several indicators to determine whether an apparently emotionally disturbed/mentally ill person represents an immediate or potential danger to themselves, others, or property. These include the following:

1. The availability of any weapons.

2. Statements by the person that suggest to the officer that the person is prepared to commit a violent or dangerous act. Such comments may range from subtle innuendos to direct threat that, when taken in conjunction with other information that is present, a more complete picture of the potential for violence.

3. A personal history that reflects prior violence under similar or related circumstances. The emotionally disturbed person's history may be known to the officer, family, friends, or neighbors who may be able to provide helpful information.

4. Failure of the emotionally disturbed individual to act prior to arrival of the officer does not guarantee that there is no danger, but it does tend to diminish the potential for danger.

5. The amount of control the person demonstrates is significant, particularly the level of physical control over emotions of rage, anger, frights, or agitation. Signs of lack of control include extreme agitation, inability to sit still or communicate effectively, wide eyes, and rambling thoughts and speech. Clutching oneself or other objects to maintain control, begging to be left alone, or offering frantic assurances that he/she is okay may also suggest the individual is close to losing control.

6. The volatility of the environment is a particularly relevant factor that officers must evaluate. Agitators that may affect the person or a particular combustible environment that may incite violence should be considered.

E. When encountering a person suspected of having Alzheimer's disease or dementia:

1. Approach that person from the front and establish and maintain eye contact.

2. Introduce yourself as a police officer and explain that you have come to help. You may need to reintroduce yourself several times.

3. Remove the person from crowds and other noisy environments. Turn off flashing lights and lower the volume on the radio.

4. Establish one-on-one conversation. Talk in a low-pitched, reassuring tone, looking into the victim's eyes. Speak slowly and clearly, using short, simple sentences with familiar words. Repeat yourself. Accompany your words with gestures when this can aid in communication but avoid sudden movements.

5. Explain your actions before proceeding. If the person is agitated or panicked, gently pat them, or hold their hand, but avoid physical contact that could seem restraining.

6. Give simple, step-by-step instructions and, whenever possible, a single instruction. Avoid multiple, complex, or wordy instructions. Also, substitute nonverbal communication by sitting down if you want that person to sit down.

7. Ask one question at a time. 'Yes' and 'No' questions are better than questions that require the person to think or recall a sequence of events.

8. Do not leave the person alone. He/she could wander away.

9. Find emergency shelter for the person with the help of a local *Alzheimer's Association* chapter (Greater New Jersey Chapter 24-hour hotline 800-272-3900) if no other caregivers can be found.

F. In accordance with N.J.S.A. 26: 2B-16, a person who appears intoxicated, but not incapacitated, in a public place and appears to need help:

1. If a person who has been drinking is neither intoxicated nor incapacitated, such person should be left alone unless criminal activity is observed or suspected.

2. With the person's consent, he/she may be transported or sent:

a. Home or normal place of abode if within Clinton Township.

b. To a licensed intoxication treatment facility using an ambulance.

c. To a medical facility using EMS.

3. Without the intoxicated person's consent, no law enforcement action should be taken unless it appears the person is incapacitated due to alcohol or drugs.

G. A person who is so intoxicated that he/she appears to be incapacitated by alcohol and/or drugs and obviously cannot consent or decide for him/herself if he/she needs treatment should be taken into protective custody and transported to an emergency medical facility.

1. Any person who is unconscious or injured should be taken directly and immediately to an emergency medical facility.

2. An intoxicated person arrested for a violation of a municipal ordinance or disorderly persons offense may be taken directly to an intoxication treatment center or emergency medical facility to be treated before processing on the criminal offense.

H. If it is necessary to restrain or take the person into custody, do so carefully. Use physical restraint sparingly as it may cause more aggressive behavior. Keep sidearms and other weapons out of the person's reach. Contact EMS for restraints and/or transportation, if necessary.

I. Any use of force other than constructive authority and/or physical contact to control an emotionally disturbed/mentally ill person must be reported on a use of force report, see this department's policy on *Use of Force*.

J. Avoid chokeholds and be continually aware of the potential for positional asphyxia. Chokeholds and vascular restraints are prohibited unless deadly force is justified.

K. In addition to the requirements set forth in this agency's policy on *Interview and Interrogation* and depending on the circumstances, personnel need to establish that any confession made by someone with mental illness is knowingly and intelligently given, see *State v. Flower* 224 NJ Super (App. Div. 1988). Officers in such situations should consult with the tour commander who then may contact the Hunterdon County Prosecutor for guidance, if needed.

1. Do not interpret lack of eye contact or strange actions as indications of deceit.

2. Use simple and straightforward language. He/she may have limited vocabulary or speech impairment.

3. Recognize that the individual might be easily manipulated and highly suggestible.

L. Miranda warnings may need to be explained, rather than just read, to the individual in language that is understandable to him or her. When reading the Miranda warnings to someone with mental impairment, or to others who may have difficulty understanding, use simple words and modify the warnings to help the individual understand. It's important to determine whether the individual genuinely understands the principles, protections, and concepts within the warnings. With the permission of the individual, officers can seek a person familiar with the individual to assist as a representative for the individual.

V. EXCITED DELIRIUM

A. Excited delirium often includes descriptions by complainants of wild, uncontrollable physical action, and hostility that comes on rapidly. While officers cannot diagnose excited delirium, specific signs and characteristic symptoms may be evidence including, but not limited to:

1. Constant or near constant physical activity.

2. Irresponsiveness to police presence.

3. Nakedness/inadequate clothing that may indicate self-cooling attempts.

4. Elevated body temperature/hot to touch.

5. Rapid breathing.

6. Profuse sweating.

7. Extreme aggression or violence.

8. Making unintelligible, animal-like noises.

9. Insensitivity to or extreme tolerance of pain.

10. Excessive strength (out of proportion to the person’s physique).

11. Lack of fatigue despite heavy exertion.

12. Screaming and incoherent talk.

13. Paranoid or panicked demeanor.

14. Attraction to bright lights/loud sounds/ glass or shiny objects.

B. Physical control must be applied quickly to minimize the intensity and duration of resistance and struggle, which often are direct contributors to sudden death.

C. When responding to a call involving possible excited delirium, officers should:

1. If possible, eliminate unnecessary emergency lights and sirens.

2. If possible, ensure that an adequate number of backup officers have been dispatched to effectuate rapid control of the subject.

3. Ensure that EMS is on the scene or en route (note: if possible, EMS should be on site when subject control is initiated).

D. When the subject is responsive to verbal commands, one officer should approach the subject and employ verbal techniques to help reduce his/her agitation before resorting to the use of force. The officer should:

1. Not rush toward, become confrontational, verbally challenge, or attempt to intimidate the subject, as he/she may not comprehend or respond positively to these actions and may become even more agitated or combative; and

2. Ask the subject to sit down, which may have a calming effect; and

3. Be prepared to repeat instructions or questions.

E. When there is no apparent threat of immediate injury to the subject or others, the officer should not attempt to take physical control of the subject. This would likely precipitate a struggle and exacerbate the subject's physical and emotional distress. The officer should wait for backup and EMS assistance before attempting to control the subject.

F. Reasonable steps should be taken to avoid injury, such as moving the subject from asphalt to a grassy area to reduce abrasions and contusions, if feasible.

G. If the subject poses a threat of death or serious bodily injury to the officer, others, or to him or herself, apart from the dangers inherent in excited delirium alone, intervention should be taken using that level of force reasonably necessary to control the individual.

H. Normally, mechanical force options are ineffective due to the subject's elevated threshold of pain. Officers may consider a physical takedown using multiple officers if an adequate number of officers are available.

I. Officers should not attempt to control continued resistance or exertion by pinning the subject to the ground or against a solid object, using their body weight. When restrained, officers should position the subject in a manner that will assist breathing, such as placement on his or her side, and avoid pressure to the chest, neck, or head (positional asphyxia).

J. Officers should check the subject's pulse and respiration on a continuous basis until transferred to EMS personnel. Officers shall ensure the airway is unrestricted and be prepared to administer CPR or an automated external defibrillator (AED) if the subject becomes unconscious.

K. Whenever required, an officer should accompany the subject to the hospital for security purposes and to assist as necessary.

VI. VOLUNTARY REFERRAL

A. The preferred method of obtaining mental health evaluation and assistance is getting the person to accept a voluntary referral.

B. In most situations, no extraordinary steps are required other than to be patient, calm and attempt to convince the person to seek professional assistance. Officers should tactfully inform the person that Hunterdon Medical Center is equipped to handle their problems and that transportation can be arranged to the hospital.

C. Prior to transport and whenever possible, advise communication personnel to notify the emergency room advising them that an emotionally disturbed person is in route.

1. If the person refuses to cooperate and responsible adult members of the person's family or the person's guardian are known, the officer may want to contact them and suggest that they try to influence the person to seek care.

2. Unless the person is considered a threat to himself or herself or the officer or if the person has a history of violence, one officer can arrange transportation to the hospital. Additionally:

a. The officer should conduct a protective frisk to check for weapons or implements that could cause harm.

b. Ask a family member to accompany the person to the hospital in their personally owned vehicle.

c. Ordinarily, EMS personnel will determine whether it is necessary for an officer to accompany or follow the ambulance to the hospital.

d. If officers conduct the transportation in a police vehicle, two officers should be present in the vehicle, or one officer can transport with a second officer closely following.

VII. INVOLUNTARY COMMITMENT

A. Because involuntary commitment entails certain deprivations of liberty, it is necessary that State law balance the basic value of liberty with the need for safety and treatment, a balance that is difficult to affect because of the limited ability to predict behavior.

B. These procedures are consistent with rules promulgated by the New Jersey Department of Human Services, Division of Mental Health and Services Screening Outreach, specifically N.J.A.C. 10:31-8.1 through N.J.A.C. 10:31-8.3.

C. Unless committed under a valid court order, there are four situations in which a mentally ill or emotionally disturbed person may be taken into custody.

1. If he/she committed a crime for which, under normal circumstances, he/she would be arrested; or

2. When from acts observed by the officer or other reliable persons, the officer believes the person is a danger to others or property; or

3. From acts observed by the officer or other reliable persons, the officer believes the person poses a substantial risk of physical impairment or injury to himself/herself as manifested by evidence that his/her judgment is so affected that he/she is unable to protect himself/herself in the community and that reasonable provision for his/her protection is not available in the community; or

4. When from acts observed by the officer or other reliable persons, the person demonstrates a substantial risk of physical harm to himself as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm.

D. If it has been determined that the person fits into one of the above situations and must be taken into custody, seek to convince the person to come voluntarily and peacefully. If these measures fail or are impracticable, the person shall be restrained with handcuffs, but only with as much force as necessary to accomplish this task.

E. Unless otherwise directed by the HHBHS specialist and determining that a person needs involuntary commitment or further evaluation, contact county dispatch to notify the appropriate health care facility:

PRIMARY

Hunterdon Health Behavioral Health Services
2100 Wescott Drive
Flemington, N.J. 08822
CRISIS HOTLINE: (908) 788-6400

SECONDARY

Saint Luke's Hospital
85 Roseberry Street
Phillipsburg, NJ 08865
EMERGENCY ROOM: (866) 785-8537

Robert Wood Johnson University Hospital Somerset
110 Rehill Avenue
Somerville, NJ 08876
HOTLINE: (908) 526-4100

F. This notification shall include information related to the person's:

1. Name, if known.

2. Age, if known.

3. Physical condition (obvious injuries or illnesses).

4. Whether ambulatory.

5. A summary of the observations leading to the need for involuntary commitment.

6. Criminal charges, if applicable.

G. Depending on the circumstances, the officer on scene may request a screening outreach visit, if available.

H. In situations when there is overt and extreme danger or believed to be such, communication personnel shall contact one of the facilities and request screening outreach as soon as practicable.

1. Officers should attempt to stabilize the situation to the extent of their training and experience, when possible.

a. Certain situations may require prompt intervention prior to the arrival of screening personnel. (Examples: person threatening to jump from a bridge, building or other structure, person threatening him/herself with a firearm or other weapon.)

b. Screening personnel should verbally engage the subject only with the approval of this department's officers.

c. Officers shall not permit screening personnel to place themselves in harm's way to engage a subject.

I. Often a screening outreach visit by a screener may occur without this department's prior knowledge. A physician or a family member may have arranged these visits. If the screener determines that police intervention is necessary due to the potential for danger or to escort the subject to a medical facility, he/she will contact this department for assistance.

J. If a screening outreach visit is unavailable or impracticable, officers shall arrange for transportation to the designated facility as the situation dictates.

1. Ordinarily, EMS should conduct transportation in accordance with N.J.A.C. 8:40-4.10.

a. If the person is an involuntary transport, the officer can ride in the ambulance to the facility.

b. Keep sidearms and other weapons out of reach to the extent possible.

c. If the person is violent or has a history of violence, a second officer may ride behind the ambulance to be able to render immediate aid.

2. Generally, physical behavioral restraints are not authorized unless:

a. A physician or court has authorized the placement of the restraints or

b. The patient is in the custody of a law enforcement officer; or

c. The medical condition of the patient mandates transportation to, and treatment at, a healthcare facility, and the patient manifests such a degree of behavior that he or she:

1) Poses serious physical danger to himself or herself or to others; or

2) Causes serious disruption to ongoing medical treatment, which is necessary to sustain his or her life or to prevent disability.

3. No subject shall be kept in physical behavioral restraints for a period greater than one hour unless:

   a. A physician or court has authorized the use of the restraints for longer than one hour; or

   b. A law enforcement officer accompanies the patient in the rear of the ambulance.

4. No physical behavioral restraint shall be of a type, or used in a manner, that causes undue physical discomfort, harm, or pain to a subject. Hard restraints, such as handcuffs, are specifically prohibited unless the officer who applied the hard restraints/handcuffs accompanies the subject.

5. A subject placed in any type of restraint shall be closely monitored to ensure that his/her airway is not compromised in any way. In no circumstance shall a patient be placed in a prone (face down) position on a stretcher while in restraints.

6. Officers shall assist with screening center security until the subject is released to the custody of the on-site security personnel. If the subject is under arrest, officers will stand by until a commitment can be obtained.

7. A thorough search should be made for weapons or contraband that could be used to injure officers involved or for any attempt to commit suicide, see this agency's policy on *Search Procedures*.

VIII. INVOLUNTARY COMMITMENT OF JUVENILES

A. When officers have reasonable cause to believe that a juvenile needs involuntary commitment, but the juvenile has not committed a crime or offense, contact Hunterdon Behavioral Health. Whenever possible, parental consent should be obtained, and the parents (guardians) should be present during the screening interview. If not:

   1. Contact the New Jersey Department of Children & Families (1-877-652-2873) or the Division of Child Protection & Permanency (1-800-392-2735) as they may already be involved if abuse and neglect exist; or

   2. Take the juvenile into short-term custody under N.J.S.A. 2A: 4A-31 et seq.

B. If a juvenile had committed a crime or offense, he/she shall be taken into custody for delinquency. Contact Hunterdon Behavioral Health or transport him/her there.

C. Notify a detective of the screening and/or involuntary commitment, so that the necessary follow up contacts are initiated.

IX. INCIDENTS INVOLVING ARRESTS

A. If the person is an arrestee:

1. If the arrestee is going to be incarcerated, ensure that the arrestee is screened for suicide potential.

2. The duty OIC shall order close observation of the arrestee while in custody.

B. When the mental status of an arrestee requires evaluation by a screener, the OIC or his/her designee shall cause notification to Hunterdon Behavioral Health.

1. Arrestees cannot refuse transportation.

2. If EMS personnel advise the officer that the arrestee has a serious medical condition and needs to be first transported to the closest medical center, officers can have the arrestee transported to the closest medical facility for such emergency medical treatment.

3. Officers can transport the subject to Hunterdon Behavioral Health for evaluation (see subsection VII.J of this policy for transportation procedures); or

4. Officers may request that a screener respond to this agency for an outreach screening.

a. If the screener determines that the subject does not meet the criteria for involuntary commitment, personnel shall continue with the arrest process.

b. If the subject is determined to meet criteria for involuntary commitment, the OIC shall cause transportation to the facility designated by the screener.

c. If the subject remains in custody, this agency is responsible for the person.

d. If the subject is released ROR from police custody and turned over to hospital security, then the screening center becomes responsible for the person.

C. In very rare cases, an arrestee might require commitment to a State of New Jersey psychiatric facility (i.e., Ancora Psychiatric Hospital, Greystone Psychiatric Hospital, Trenton Psychiatric Hospital, Ann Klein Forensic Center). Three qualifiers must be present (again, very rare):

1. Subject has pending criminal charges requiring bail or custodial confinement; **and**

2. Subject is being involuntarily committed for a mental health condition / emotional disturbance; **and**

3. Subject is being involuntarily committed to either Ancora Psychiatric Hospital, Greystone Psychiatric Hospital, Trenton Psychiatric Hospital, or Ann Klein Forensic Center.

4. In such instances, officers shall complete a *Uniform Detainer Form*. The detainer shall be forwarded to the psychiatric facility. Copies of the *Uniform Detainer Form* must be retained by this department, filed with all police reports, and filed with any criminal complaints that are forwarded to the courts.

   a. Under the provisions of N.J.S.A. 30:4-27.22c, law enforcement may be required to take custody of a person being released from involuntary commitment by the psychiatric facility and who was being held on bail or remand resulting from criminal charges.

   b. Normally, contact the Hunterdon County Sheriff's Office for transportation assistance.

X. REPORTING REQUIREMENTS

A. For the protection of all concerned parties, all incidents involving emotionally disturbed persons must be thoroughly documented in an *Investigation report*. The investigation report shall include the following information:

1. Name, address, telephone number, DOB, and SS# of subject (if known).

2. Description of circumstances that required police involvement.

3. Was law enforcement force used against the subject for any reason?

4. If custody of a subject is required for mental health screening, designate if the subject was:

   a. Dangerous to others or to property.

   b. Dangerous to self.

5. Name of transporting EMS, if applicable.

6. Name of mental health screening personnel contacted.

7. Name of mental health facility to where transported.

8. Whether medical attention prior to mental health screening was required.

9. Include results of screening (if applicable):

   a. Involuntary Commitment – Location and was it based on a commitment order from an HHBHS specialist

   b. Released – Voluntary Referral.

10. Include information on all criminal charges, if applicable.

11. If excited delirium is suspected, the following information must be included in the report:

    a. Conditions at the incident scene.

    b. Description of the subject's behavior and its duration.

    c. Description of what the subject said during the encounter.

    d. Type and duration of resistance.

    e. Identity of all officers at the scene.

    f. Actions taken to control the subject.

    g. Restraints used on the subject and the length of time applied.

    h. Location of the restraints on the subject.

    i. Means of transport.

    j. Behavior of the subject during transport.

    k. Means of resuscitation, if applicable.

    l. Information from relatives and friends of the subject that can provide insight to the potential causation of the incident.