



ALBUQUERQUE POLICE DEPARTMENT
GENERAL ORDERS

SOP 2-19

Draft as of July 17, 2018 (Submitted by Crisis Intervention Section)

2-19 RESPONSE TO BEHAVIORAL HEALTH ISSUES

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2-19-1 Purpose

This policy establishes guidelines for assessing whether a person's behavior or actions indicates an individual may be affected by a behavioral health disorder, a behavioral health crisis, and for responding to that individual. It provides guidance, techniques, and resources so that contact with the person may be resolved in a constructive and compassionate manner.

2-19-2 Policy

The goal of this policy is to set a standard of excellence and awareness for our personnel, officers, and supervisors with respect to treatment and interaction of individuals with a behavioral health disorder, a developmental disability, or during a behavioral health crisis. Individuals in behavioral health crisis will be treated with dignity and will be given reasonable accommodations of their disabilities, and given appropriate access to law enforcement, government, and community services.

Officers are not mental health professionals, but they will receive on-going training to equip them with information and techniques to help them better respond to individuals with behavioral health disorders or in behavioral health crisis. Officers will be trained in intervention and de-escalation techniques and behavioral health resources to enhance both officer and public safety. This training does not restrict an officer's discretion to make an arrest when probable cause exists, however, officers are encouraged to jail divert individuals affected by a behavioral health disorder or in a behavioral health crisis. Ref. section (2-19-8)



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Officers and communities must act in concert with behavioral health professionals to successfully resolve an incident involving an individual in behavioral health crisis. An important role for law enforcement is to help people and their families access behavioral health services or substance abuse programs, hospitals, clinics, and shelter facilities.

Incidents involving individuals in a behavioral health crisis require the use of special police skills and training, de-escalation techniques, and resources to effectively and positively resolve the situation. The ideal resolution for a behavioral health crisis incident is that the subject is connected with resources that can provide long-term behavioral health support and guidance.

The goal during an incident involving an individual in a behavioral health crisis is to de-escalate the situation safely with the least amount of force for all individuals involved, consistent with established safety priorities.

2-19-3 Definitions

A. Behavioral Health Crisis

An incident in which someone is experiencing intense feelings of personal distress (e.g., anxiety, depression, fear, anger, panic, hopelessness), obvious changes in functioning (e.g., neglect of personal hygiene, unusual behavior), or catastrophic life events (e.g., disruptions in personal relationships, support systems, or living arrangements; loss of autonomy or parental rights; victimization; natural disasters), which may, but not necessarily, result in an upward trajectory or intensity culminating in thoughts or acts that are possibly dangerous to his or herself and/or others.

B. Behavioral Health Disorder

A disorder that is characterized by clinically-significant disturbance in an individual's cognition, emotion regulation, or behavior. It reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. This includes individuals with Intellectual and Developmental Disabilities (IDD).

C. Certificate of Evaluation

A document, completed by a licensed physician, certified psychologist, or a qualified, licensed mental health professional practicing independently who is affiliated with a community mental health center or core service agency, which certifies that a person, as a result of a mental disorder, presents a likelihood of harming themselves or others and that immediate detention is necessary to prevent such harm or grave passive neglect.

D. Crisis Intervention Section (CIS)



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Comprised of Crisis Intervention Unit detectives (CIU), Crisis Outreach and Support Team members (COAST), Mobile Crisis Teams (MCT), crisis clinicians, a licensed psychiatrist, and data analysts. The CIS is responsible for the overall administration and goals of the Crisis Intervention Team (CIT) and Enhanced Crisis Intervention Team (eCIT) programs.

E. Crisis Intervention Trained Officer (CITO)

Field Services Bureau officers who successfully completed the basic crisis intervention team training.

F. Crisis Intervention Team (CIT) Program

A community based program designed to improve the way law enforcement and the community respond to people experiencing behavioral health crises. The CIT Program is built on strong partnerships between law enforcement, behavioral health provider agencies, individuals, and families affected by mental illness.

G. Crisis Intervention Unit Clinicians (CIC)

Crisis Intervention Clinicians are qualified mental health professionals who provide evaluations, general psychological assessments, crisis intervention, dangerousness assessments, safety planning, and referrals for individuals in the community living with behavioral health disorders who come into contact with the Department.

H. Crisis Outreach and Support Team (COAST)

Civilian employees supervised by a Department Sergeant. COAST enhances the CIT program by providing crisis intervention, access to mental health services, and education in response to police referrals. COAST is assigned to the Compliance Bureau /Crisis Intervention Section.

I. De-escalate

An action to attempt to calm a situation or to prevent a situation from escalating into a physical confrontation or injury, by using verbal and non-verbal techniques, including active listening skills, tone of voice, announcement of actions, body posture, personal space, eye contact, empathy, and compassion to promote officer and individual safety.

J. Disengagement

An officer's decision, to discontinue contact after attempts to engage with an individual in behavioral health crisis.

K. Enhanced Crisis Intervention Team (eCIT)



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Specially-trained officers who function within their teams as specialists to handle calls involving individuals affected by a behavioral health disorder or experiencing a behavioral health crisis.

L. Grave Passive Neglect

Failure to provide for one's basic personal needs, medical needs, or for one's own safety to such an extent that it is likely to result in serious bodily harm in the near future.

M. Mental Health Response Advisory Committee (MHRAC)

Comprised of subject matter experts from within the community who assist the Department in identifying and developing mental health resources, solutions to behavioral health crises, and emergency intervention designed to improve outcomes for individuals living with a behavioral health disorder or who are in behavioral health crisis. The committee analyzes and recommends appropriate changes to Department policies, procedures, and training methods regarding Department interaction with individuals in a behavioral health crisis, affected by a behavioral health disorder, or individuals experiencing chronic homelessness.

N. Mobile Crisis Team (MCT)

A two person unit comprised of **Mental health professionals who work with** eCIT officers and are responsible for responding to priority calls with a behavioral health component. They provide immediate behavioral health services once the scene is secure. MCTs are trained to complement the eCIT and CIU.

O. Non-Engagement

A decision to avoid making contact with a person in a behavioral health crisis.

P. Qualified Mental Health Professional

A licensed, independent social worker, a licensed professional clinical mental health counselor, a marriage and family therapist, a certified nurse practitioner, or a clinical nurse specialist with a specialty in mental health, who are qualified to work with persons having behavioral health crisis or disorder.

2-19-4 **The Crisis Intervention Team (CIT) Program**

The CIT program consists of three core components and are defined below.

- Inclusive Collaboration
- Training
- Coordinated Responses



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A. Inclusive Collaboration

1. The Department's CIT program collaborates with community partners and the MHRAC to strengthen the Department's response to individuals with behavioral health disorders or in a behavioral health crisis. The program also seeks to avoid the stigma of behavioral health issues. The MHRAC and community collaboration will develop and maintain the CIT program.

Successful diversion requires accessible crisis services. True collaboration can occur only when law enforcement, behavioral health agencies, consumers/peers, families, and advocates have a clear understanding of and respect for each other's roles in the CIT program.

The program includes:

- Ongoing partnerships between law enforcement, advocacy groups, peers, and the behavior health community.
- MHRAC, community feedback, and participation in CIT program including training.
- Policy and procedure development, which is reviewed by the community and MHRAC.

B. Training

1. CIT training promotes community collaboration and community policing. The Crisis Intervention Section, primarily through the Coordinator, collaborates with MHRAC and other community partners to develop ongoing trainings tailored to the department personnel supporting the CIT program. Trainings will be conducted by a combination of CIU detectives, behavioral health professionals, community members, and individuals affected by behavioral health disorders where appropriate.

2. These trainings are developed and delivered using the ADDIE model cycle of five steps:

- Needs assessment/analysis (e.g. identify the type of personnel to be trained and desired outcomes);
- Design (e.g. lesson plans and assessment instruments);
- Development (e.g. preparation of presentations, PowerPoints, etc.);
- Implementation (e.g. train the trainer, begin trainings), and
- Review for effectiveness (e.g. through feedback, performance or assessment instruments, and analysis of post-training data).

3. Current training requirements for department personnel are:



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- a. In-service training for CITO's and Emergency Communications Center (ECC) employees at least every two years.
- b. Advanced in-service training for eCITs at least every two years, and
- c. Crisis Intervention Team certification for all field service officers.

4. Central to the success of CIT is not only the training of the law enforcement officer, but also the education of those agencies and individuals within the behavioral health community who will be involved in the process.

C. Coordinated Responses

1. Many Department personnel work together to effectively respond to situations involving behavioral health disorders or crisis and to support the CIT Program.

- a. Emergency Communications Center employee's intake calls and are trained to recognize indicators of behavioral health disorders or crisis and to dispatch a specialized response in the form of eCIT or MCT as available.
- b. CIT officers are field service officers who receive at least 40 hours of CIT training. The Department's goal is for every field service officer to achieve at least a CITO level of training. These officers are the primary call responders and may encounter individuals affected by behavioral health disorders or who are in behavioral health crisis unexpectedly through calls or other encounters. Their training equips them with tools for de-escalation, information about jail diversion, and other resources available through the CIT program to assist the individual and resolve the situation.
- c. ECIT officers are field service officers who receive enhanced training and ongoing training above the CITO training. These officers will be the primary responders when Emergency Communications Center employees identify a need for a specialized CIT response and will also respond to officers' request for specialized CIT back-up.
- d. Mobile Crisis Teams (MCT) are mental health professionals who respond to priority behavioral health crisis calls in collaboration with eCIT officers in one vehicle.
- e. CIT Area Command Sergeant coordinators are field services sergeants who volunteer to assist the CIT program and to provide guidance and leadership to CITO's and eCITs within their area command.
- f. The Crisis Intervention Section is the primary team within the Department for overseeing and coordinating the CIT program. It coordinates with community partners, receives and provides up-to-date



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training, and provides direct services to people in behavioral health crisis. CIS includes:

- Crisis Intervention Unit (CIU)
- Crisis Outreach and Support Team (COAST)
- CIT Program Coordinators
- Mobile Crisis Team (MCT)

2-19-5 Recognizing Behavioral Health Disorders

- A. When responding to an incident, officers should consider whether the person may be in behavioral health crisis.
- B. Only a trained mental health professional can diagnose behavioral health issues, mental disorders, or illness. Officers and Emergency Communications Center employees do not diagnose an individual's mental health condition. However, they apply their training to recognize behaviors and signs that indicate the person may be affected by a behavioral health disorder or is in behavioral health crisis and to adapt police responses accordingly.
- C. Officers and Emergency Communications Center employees should consider that someone may be in behavioral health crisis due to behavioral disorders or distress, impairment from alcohol or psychoactive drugs, or may have a hearing impairment, deafness, dementia, autism, or physical injury and tailor their response accordingly.
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 D. A telecommunication employee will apply their training and experience to identify calls that indicates the subject may be affected by a behavioral health disorder or a behavioral health crisis, and if so, will dispatch an eCIT officer or MCT, when appropriate and available.
- E. If Emergency Communications Center employees receive a call indicating the person may be in a behavioral health crisis, Emergency Communications Center employees will (when available) determine whether it would be beneficial to transfer the call to the New Mexico Crisis and Access Line. If so, Communications will call 1-(855)-NMCISIS (622-7474) and collaborate with the Crisis Line personnel to help respond to the call if appropriate and available.

2-19-6 Assessing Risk

- A. Most people affected by a behavioral health disorder or who are in behavioral health crisis are not dangerous, although some may present dangerous behavior under certain circumstances or conditions. Officers should assess whether someone may be a danger to themselves, the officer, or others, by considering the following:



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1. The person's **access** to weapons.
 2. The person's statements, conduct, or inferences that suggest the person will commit a violent or dangerous act.
 3. The person's history. The person's history may be known to the Department, the officer, family, friends, and neighbor indications that the person lacks self-control, particularly lack of physical and psychological control over rage, anger, fright, or agitation.
 4. Signs of lack of self-control include extreme agitation, inability to sit still or communicate effectively, and rambling incoherent thoughts and speech. Clutching oneself or other objects to maintain control **or moving very rapidly**, may also suggest that the individual is losing control.
 5. The volatility of the environment. Agitators who may upset the person, create a combustible environment, or incite violence should be carefully noted and controlled.
- B. An individual affected by a behavioral health disorder or crisis may rapidly change their conduct or demeanor from calm and responsive commands to physically active and agitated or non-responsive. This behavior change may result from an external trigger (such as an officer who states, "I have to handcuff you now,") or from internal stimuli (such as delusions or hallucinations). Variations in a person's demeanor or conduct does not mean they will become violent or threatening. Officers should observe and be prepared at all times for a rapid change in behavior.

2-19-7 Response

- 7**
- A. In responding to an individual experiencing a behavioral health crisis, an officer will attempt to de-escalate and calm the situation if feasible, until a supervisor, eCIT, or MCT arrives to control the scene and direct operations.
1. eCIT, MCT, or CIU will take the lead in interacting with individuals in a behavioral health crisis. If a supervisor has assumed responsibility for the scene, the supervisor will seek input from eCIT, MCT or CIU on strategies for de-escalating, calming and resolving the crisis, when it is safe.
- 6**
2. The responding officer will request a backup officer whenever the individual will be taken into custody (either for booking or for emergency mental health evaluation). **The officer should specifically request an eCIT officer as backup, unless the officer is an eCIT officer.**
 3. Officers should take steps to calm the situation. Where possible, eliminate emergency lights and sirens, disperse crowds, and assume a quiet, non-threatening tone and manner when approaching or conversing with the



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individual. Where possible, avoid physical contact, and take time to assess the situation. Officers should operate with the understanding that time is an ally, and there is no need to rush or force the situation.

4. Officers should move slowly and do not excite or agitate the person. Provide reassurance that the police are there to help and that the person will be provided with appropriate care, assistance and resources.
5. Officers should communicate clearly and calmly. If possible, speak slowly and use a low tone of voice. Express concern for the person's feelings, and allow the person to share feelings without expressing judgment.
6. Where possible, officers should gather information from acquaintances or family members. Attempt to **find out the nature** of the crisis the individual is experiencing. Request professional assistance, if available and appropriate, to assist in communicating with and calming the person.
7. Officers should not threaten the individual with arrest or physical harm, as this may create additional fright, stress, and potential aggression.
8. Officers should avoid topics that seem to agitate the person, and guide the conversation away from areas that cause stress or agitation and towards topics that seem to ease the situation.
9. Officers should always be truthful. If the person senses deception, they may withdraw in distrust, become hypersensitive, or retaliate in anger. If an individual is experiencing delusions and/or hallucinations and asks the officer to validate them, statements such as, "I am not seeing what you are seeing, but I believe that you are seeing them," are recommended. Validating and/or participating in the individual's delusion or hallucination is not advised.
10. Officers should offer to connect individuals to mental health service agencies, or provide transportation to the hospital.

6 B. Officers will complete an original incident report where required (e.g. there are charges filed, a CIU referral, or transport to the hospital by ambulance or officer). Regardless of whether an incident report is required, officers will complete a CIT contact sheet for any dispatch in which the subject's behavior indicates a behavioral health disorder or behavioral health crisis.

1. To make a referral to the CIU, employees must forward their original incident report to APDCIT@cabq.gov for review and indicate that a CIU referral was made on the CIT contact sheet.

6 C. Non-engagement or Disengagement to Dispatched Calls for Service



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1. If a supervisor determines, after consulting with eCIT or a mental health professional, that a person exhibiting behavioral health disorder or behavioral health crisis is not a threat to others and that further interaction with the individual will result in an undue safety risk to the person, the public, or officers, they should disengage. A supervisor will notify a lieutenant of this decision and will coordinate with CIU to contact the person at a different time or under different circumstances. A police report and a CIT contact sheet will be generated documenting the following elements:
 - a. Details of the call;
 - b. Reasons for disengagement;
 - c. Actions taken to deescalate the situation;
 - d. Actions taken to promote safety;
 - e. Follow-up plans and referrals made; and
 - f. Flagged address for a safety bulletin.
2. The word "disengagement" will be placed in the incident summary line of the report and a CIT contact sheet.
3. If the subject is barricaded, the officers will follow the additional procedures set forth in the [Hostage, Suicidal/Barricaded Subject, and Tactical Threat Assessment SOP](#).
4. In limited circumstances, officers may be aware of the identity and behavior of an individual before making contact that indicates that the individual is not currently a threat to others, no alleged criminal activity, and that contact with law enforcement would not be helpful but only serve to escalate the situation. In these circumstances, a supervisor may approve non-engagement. The supervisor will report non-engagement decisions to a lieutenant. The non-engagement will be documented in the same manner as a disengagement with the word "non-engagement" placed in the incident summary line of the report and a CIT contact sheet.
5. Nothing in this section shall prohibit officers from utilizing discretion in on-site activity.

2-19-8 Diversion from Jail

Department personnel may divert individuals with behavioral health disorders or who are in behavioral health crisis from jail through the following measures:

- A. Individuals with behavioral health disorders or in behavioral health crisis may have encounters with law enforcement for misdemeanor, petty misdemeanor crimes, or non-violent felonies. When possible and allowed by SOP, those persons may be better served by jail diversion, which can include the following:
 1. Issuing a verbal warning;



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2. Issuing a citation;
 3. Giving a summons for misdemeanors or submitting a non-violent felony case to the District Attorney;
 4. Transporting the person to a mental health provider either voluntarily or involuntarily pursuant to NMSA 43-1-10; or
 5. Disengagement. A supervisor will notify a lieutenant of this decision.
- B. Jail diversion through issuance of citations, summons, or submission of a case is subject to an officer's discretion and is typically appropriate unless:
1. The individual, subject to lawful arrest, fails to identify themselves satisfactorily.
 2. The individual refuses to sign the citation.
 3. Arrest or taking the individual into custody is necessary to prevent imminent harm to others, or it is necessary to remove the individual from the scene of the offense **to ensure that no person is injured.**
 4. **The individual has no ties to the jurisdiction reasonably sufficient to ensure their appearance and there is substantial likelihood that violators would refuse to respond to the citation. The fact that the person appears to be homeless is not a sufficient basis for an arrest.**
 5. **If an individual is intoxicated to the point that they no longer have control of their faculties, the officer should arrange for transportation to an appropriate medical facility.**
 6. **If one or more of the above factors are present and the individual is displaying signs of a behavioral health crisis, the officer should transport to a mental health facility for an evaluation.**
- C. Jail Diversion Collaboration
1. CITO, eCIT, MCT, and CIS will work with behavioral health care providers within the community to deter the individual from future contact with the criminal justice system.
 - a. CIS will meet with personnel from the University of New Mexico, Presbyterian Kaseman Hospital, HealthCare for the Homeless, Hopeworks, New Mexico Solutions, and others as needed or requested to ensure familiarization with diversionary goals.
 - b. Officers will testify at civil commitment proceedings to promote mental health resolution rather than criminal sanctions.



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2. CITO, eCIT, and MCT will make referrals to CIS and use COAST and/or Crisis Intervention Unit Clinicians, to reduce the likelihood of future behavioral health crises and thus reduce the possibility of contact with the criminal justice system by evaluating the situation and connecting to appropriate services available to individuals living with behavioral health disorders.
3. On active CIU cases, CIU Detectives may coordinate with the Pre-Trial Services diversionary unit in the court system to address the needs of the individuals with behavioral health disorders who were booked into the detention facility.
4. The primary officer will retain case responsibility if a citation, summons, or case is submitted. CIU/COAST assists if the individual needs follow-up intervention. When sending a copy of the incident report to Court Services, officers will attach a note stating the individual may be a candidate for Mental Health Court.
- 6 5. If the individual is not appropriate for jail diversion, the officer should ensure that the individual is referred to the Psychiatric Services Unit within the detention center (PSU) by writing "PSU REFERRAL" at the top of the pre-booking slip.

7 2-19-9 Roles and Responsibilities

A. Crisis Intervention Section Lieutenant or Civilian Section Supervisor

The Lieutenant or Supervisor is responsible for the efficiency and effectiveness of the various units and for coordinating their functions and activities. The units include the Crisis Intervention Unit (CIU), Enhanced CIT Program (eCIT), Mobile Crisis Teams (MCT), Crisis Outreach and Support Team (COAST), Crisis Intervention Clinician(s), and psychiatrist, as well as the management of the department's Crisis Intervention Team program. The Lieutenant or Supervisor is responsible for overseeing every aspect of the CIT Program, including maintaining community partnerships, supervising CIT training, and evaluating the CIT program on an on-going basis.

B. The CIT Coordinator

The Coordinator is a CIU Detective appointed by the CIS Lieutenant who acts as a liaison with program stakeholders to ensure the success of the CIT program. The coordinator oversees the CIT program and serves as the Department's point of contact. The CIT Coordinator examines, reviews, and recommends actions to ensure that Department and community needs are met.

The Coordinator is responsible for the following activities:



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1. Develop curricula and training on CIT, de-escalation, behavioral health, crisis intervention, and other mental-health related topics. This includes developing an effective scenario-based training program.
2. Develop and maintain the CIT program through:
 - Networking;
 - Outreach;
 - Community ownership in the CIT program;
 - Promoting CIT;
 - Regularly attending the Mental Health Response Advisory Committee (MHRAC) meetings;
 - Meeting with Department leadership; and
 - Working with Emergency Communication Center (ECC) employees.
3. Maintain continuous relationships with:
 - Community partners;
 - Mental health providers; and
 - Mental health advocates.
4. Develop and revise CIT-related policies and procedures and review laws by:
 - Study of trends and data from the CIT Program;
 - Case law review;
 - Mental health codes study;
 - Civil commitment and transportation of individuals with behavioral health disorder or those in behavioral health crisis; and
 - Input into legislation development.
5. Provide guidance and review to CITO by:
 - Addressing issues raised by officers,
 - Interfacing with supervisors in problem-solving issues, and
 - Addressing community issues raised by officers.
6. Assist in developing CIT programs in other jurisdictions to ensure that agencies follow a uniform approach to CIT in accordance with the national model of police-based crisis intervention.

C. Crisis Intervention Section Sergeants

The Sergeants are responsible for:

1. Overseeing the CIU, COAST, and MCT.



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2. Consulting and liaising between CIT and mental health care providers, working with the CIU Psychiatrist, clinicians, and other clinical personnel.
3. Ensuring that information from offense and incident reports and/or CIT contact sheets from CIT calls is entered into a case management system, and that necessary information about elevated-risk subjects is shared with Field Services personnel through PowerDMS or email.
4. Serving as liaison with the CIT Area Command Sergeant Coordinator(s)/Lieutenant.

D. CIT Area Command Sergeant/Lieutenant Coordinator

Sergeants/Lieutenants may volunteer to serve as the CIT Area Command Sergeant/Lieutenant Coordinators. The CIS Lieutenant designates a CIT Area Command Sergeant/Lieutenant Coordinator for each area command, with the approval of that sergeant's/Lieutenant's chain of command. These coordinators will participate in efforts of assisting, implementing, and sustaining CIT as a community program. Coordinators should promote constitutional, effective policing using the least restrictive means in interacting with individuals in a behavioral health crisis or affected by a behavioral health disorder.

The CIT Area Command Sergeant/Lieutenant Coordinators are responsible for the following activities:

1. Assist the CIT Coordinator to develop and maintain the CIT program through:
 - Networking and outreach;
 - Promoting CIT;
 - Training;
 - Recommending officers for eCIT who possess demonstrated skills and abilities in CIT policing;
 - Attending Mental Health Response Advisory Committee (MHRAC) on a rotating basis;
 - Participating in monthly CIT ECHO (Extensions for Community Healthcare Outcomes) meetings
 - Reviewing and developing CIT-related policies and procedures.
2. Provide guidance and leadership to CITOs and eCITs by:
 - Addressing issues raised by officers;
 - Addressing community issues raised by CIT field officers, and;

E. CIU Detectives



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1. CIU Detectives are responsible for:

- a. Assessing individuals for risk to others.
- b. Assessing escalating behavior or erratic conduct. A person may not currently pose a risk to anyone else's safety, but they are displaying behavior that causes increasing alarm to others through physical actions, threats, or property damage. The behavior may result in increased risk to self or others, including officers.

2. CIU detectives are on call on a rotating basis 24 hours a day to assist officers who interact and need assistance and intervention with individuals with behavioral health disorder or who are in behavioral health crisis.

3. CIU meet and work with community health providers including, the Mental Health Response Advisory Committee, and the National Alliance for Mental Illness (NAMI) for continued community collaboration.

F. The Crisis Outreach and Support Team (COAST) Specialists support the CIS as described below.

1. COAST assists officers by providing additional crisis intervention skills, referrals to services, and education and outreach for non-violent individuals who are experiencing behavioral health crisis and/or homelessness. COAST specialists assist individuals who are a risk to themselves.
2. When an officer has determined the scene is safe and there is a need for COAST on scene, the officer will contact radio and request a COAST unit. A history of frequent dispatched calls for same individual is indicative of the need for a COAST unit.
3. COAST specialists are assigned other cases by the CIU Sergeant.
4. Command leadership may also request COAST to follow up interactions with individuals with behavioral health issues to reduce the additional time and resources required for continued officer response.
5. COAST's primary objective is to safely resolve the behavioral health crisis causing police interaction by referring the individual with behavioral health disorder or in behavioral health crisis to professional mental health services. The COAST specialist will contact the individual and follows up to ensure the person's participation in appropriate prevention services and treatment options.
6. COAST specialists meet and confer with community mental health providers to ensure the appropriate intervention response.
7. COAST Specialists do not provide:



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- Long-term or intensive case management or counseling services;
- Victim's assistance in domestic violence cases;
- Victim's advocacy services for victims of crimes;
- Long-term follow up throughout the judicial process;
- Comprehensive explanations, case management, or follow up with victims or witnesses regarding the procedures involved in the prosecution of their cases;
- Personal or family counseling services for department employees;
- Transportation of violent or potentially violent individuals in their vehicles.

G. CIU Psychiatrist

The CIU psychiatrist is available to assist with all aspects of the CIU program. The Psychiatrist helps with training, clinical guidance, consults on cases, and conducts as needed home visits with detectives and clinicians. The Psychiatrist partners with the community, as well as represents and promotes the program. In addition, the Psychiatrist oversees the two CIU clinicians, and is the director of Behavioral Sciences.

H. Crisis Intervention Unit Clinician

Crisis Intervention Unit Clinicians serve on CIU teams with CIU detectives. The Clinician provides evaluation, assessment, crisis intervention, safety risk assessments, safety planning, and referrals for people in the community living with a behavioral health disorder who come into contact with the Department. The Clinician performs community education services and a variety of related tasks that promote and enhance the City's community policing efforts.

I. Crisis Intervention Data Analysts

The Data Analysts and a civilian statistician will collect and distribute data used for management purposes only and do not include personal identifying information of individuals. Data Analysts create presentations, make recommendations, and analyze data to help successfully guide the department's response to behavioral health issues.

J. Mobile Crisis Team (MCT)

1. The Mobile Crisis Team (MCT) will serve on teams that are composed of one eCIT Officer, from APD or BCSO, and one independently licensed Clinician through St. Martin's Hopewoods.



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2. Mobile Crisis Teams (MCT) are responsible for:

- a. Primarily responds to priority one calls with a behavioral health component city and county wide. May need to respond to some priority two calls with a behavioral health component.
- b. May be utilized as a resource and for consultation for the Field Service Bureau.
- c. Assessing individuals for risk to self or others, especially if a person affected by a behavioral health disorder or in behavioral health crisis puts someone else's (including community members or the officer's) safety at risk.
- d. Assessing escalating behavior or erratic conduct. A person may not currently pose a risk to themselves or anyone else's safety, but they are displaying behavior that causes increasing alarm to others through physical actions, threats, or property damage. The behavior may result in increased risk to self or others, including officers.

The APD assigned MCT will report to the CIS. The MCT's primary objective in all interventions is to evaluate the risk the individual poses to them self or others and to de-escalate and calm the situation in an effort to safely resolve the crisis. When responding to any call for service the law enforcement officers will always proceed first and make sure the scene is safe enough to have a MCT Clinician interact with the identified person in need. MCT is a specialized response unit and it is discouraged from separating the clinician from the officer.

3. Mobile Crisis Team (MCT) Call Signs

The call signs will be MCT1 through MCT5 for both city and county teams.

4. Dispatch and calls

- a. MCT should be utilized for behavioral health related calls. If other criminal allegations arise from a call other officers should be dispatched.
- b. All MCT responses will begin from either a call from dispatch, from officers on scene, or self-initiated where it has been determined that the individual in question is experiencing a mental health crisis or a mental health problem.
- c. Dispatch is to utilize training and SOP to contact the mobile crisis unit upon a receiving a mental health call. Officers will use their best judgement to determine if and when an MCT is needed on scene in order de-escalate the individual and to provide acute crisis services.
- d. MCT units will arrive on scene in the officer's vehicle. If another officer is already on scene, the on-scene officer(s) will render the scene safe before any MCT clinician comes into contact the individual in question. Under no circumstance shall any MCT clinician engage an individual before the scene has been rendered safe.



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- e. Once the scene has been cleared for safety, MCT clinician will be cleared to engage the individuals in order to gain an understanding of the issue and work to provide acute crisis services and provide referrals if necessary.
- f. MCT clinician and officers shall work together to be swift and responsive to all calls for which they have been dispatched to provide services.
- g. If MCT is involved in a use of show of force the appropriate area command supervisor will be responsible for determining what level of force was used and the initial investigation.

5. Services

- a. MCT clinician shall provide services beginning with de-escalation and primary assessment. Such assessment may vary depending on the situation. Such assessments may include a crisis assessment, mental status exams and general mental health assessments to determine mental health diagnosis.
- b. Once individuals have been assessed, MCT clinician shall conduct face to face crisis intervention services. Services may also include but are not limited to crisis planning, referrals for other services, and recommendations for higher levels of care which may or may not include certificates for evaluation.
- c. MCT clinician shall work to provide referral services to individuals in crisis. Referrals should be provided in a way that will allow for MCT clinician to follow up to determine if individuals have obtained those services.
- d. MCT clinician shall provide follow up services for individuals previously encountered during a crisis.
- e. All services shall be documented in the agency's Electronic Health Record and on other forms as directed and provided by St. Martin's Hope Works Behavioral Health leadership team.

6. Referrals

- a. MCT shall make needed referrals for services. MCT shall refer for the following services: Housing, Psychiatric, Therapy, Substance use, Employment, Comprehensive Community Support Services, Outreach, Emergency services etc.
- b. MCT clinician shall work with the St. Martin's Hope Works clinician to coordinate appropriate referrals and follow-ups.
- c. In the event an individual needs a higher level of care, MCT clinician may complete certificates for evaluation. MCT clinician shall consider utilizing detox services in the event individuals are presenting as intoxicated.

If MCT feels further follow up is required, they shall submit a referral to the Crisis Intervention Section.

2-19-10 People with Developmental Disabilities



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Persons with developmental disabilities have a mental or physical impairment that creates difficulties in certain areas of life, especially language, mobility, learning, self-help, and independent living. These individuals are often limited in their ability to effectively communicate, interact with others, and make reasoned decisions on their own. Difficult interactions may result in counterproductive police actions if officers do not recognize and deal with behaviors and reactions of these individuals.

A. Common Traits

There are many forms of developmental disability. Many individuals have additional related, but distinct disorders, such as Autism Spectrum Disorder, Down Syndrome, Fetal Alcohol Spectrum Disorder, Fragile X Syndrome, and Rett Syndrome. Although officers are not in a position to diagnose persons with such disabilities, officers will be alert to symptoms suggestive of such disorders. These include, the following symptoms in various combinations and degrees of severity:

- Difficulty communicating and expressing oneself;
- Communication by pointing or gestures rather than words;
- Repetition of phrases or words;
- Repetitive body movements which may cause harm to themselves; movements may include, swaying, spinning, clapping hands, flailing arms, snapping fingers, biting wrists, or banging the head;
- Little or no eye contact;
- Uneven gross or fine motor skills;
- Unresponsiveness to verbal commands; appearance of being deaf;
- Aversion to touch, loud noise, bright lights, and commotion;
- No fear of danger;
- Oversensitivity or lack of sensitivity to pain; and/or
- Self-injurious behavior.

B. Common Encounters

Officers may encounter persons who have developmental disabilities in a variety of situations. Due to the nature of developmental disabilities, the following are some of the most common encountered:

- Wandering;
- Seizures;
- Disturbances;
- Welfare check;
- Interfering with another person's rights.

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C. Handling and Deescalating Encounters



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Like anyone else, persons with developmental disabilities can become upset, engage in tantrums or self-destructive behavior, or even sometimes become aggressive. Fear, frustration, and minor changes in their daily routines and surroundings may trigger erratic behavior among some people. Officers should take measures to prevent these reactions by de-escalating situations and attempting to safely calm the situation. These measures include the following:

- Speak calmly.
- Do not shout
- Do not unnecessarily touch the person
- Avoid commotion.
- Keep animals away.
- Ask for personal identification.
- Call the contact person, caregiver, or guardian.
- Be patient and prepare for a potentially long encounter.
- Repeat short, direct phrases in a calm voice.
- Be attentive to sensory impairments.
- Maintain a safe distance. Provide the person with a zone of comfort that will also serve as a buffer for officer safety.
- Avoid topics that cause agitation or distress.

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D. Taking Persons into Custody

Taking custody of a person with developmental disability should be avoided whenever possible as it will invariably initiate a severe anxiety response and escalate the situation. Therefore, in minor offense situations, officers will explain the circumstances to the complainant and request that alternative means be taken to remedy the situation. This normally will involve disengagement or release of the person to family or an authorized caregiver. In more serious offense situations or where alternatives to arrest are not reasonable, officers will observe the following guidelines:

1. Contact a supervisor for advice.
2. Summon the person's family or caregiver to have them accompany the person and to assist in the calming and intervention process. If a caregiver is not readily available, summon a mental health crisis intervention worker, MCT or eCIT if available.
3. Employ calming and reassuring nonjudgmental language and use de-escalation protocols provided in this policy.
4. Do not incarcerate the person in a lockup or other holding cell if possible. Do not incarcerate the person with others since they are vulnerable and at risk of harm

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5. If possible and until alternative arrangements can be made, put the person in a quiet room with subdued lighting with a caregiver or other responsible individual or another officer who is experienced in dealing with such persons.

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E. Interviews and Interrogations

If possible and until alternative arrangements can be made, make every effort to reduce the level of anxiety for the person by changing the environment and by asking a caregiver or another person to be present to assure the person's safety

Officers conducting an interview or interrogation of a person suspected of being developmentally disabled and suspected of committing a felony-level crime should immediately consult with a mental health professional. They should also contact the Bernalillo County District Attorney's Office to determine whether the person is competent to understand his or her rights to remain silent and to have an attorney present.

2-19-11 Procedures for Emergency Mental Health Evaluation

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- A. In accordance with NMSA 43-1-10, an officer may detain a person for emergency evaluation and care at a hospital, mental health facility, or an evaluation facility in the absence of a valid court order only if:
 1. The person is otherwise subject to arrest.
 2. The officer has reasonable grounds to believe the person has just attempted suicide.
 3. The officer, based on personal observation and investigation, has reasonable grounds to believe the person, as a result of a mental disorder, presents a serious threat of harming themselves or others and immediate themselves **through** grave passive neglect.
 4. Immediately upon arrival at the evaluation facility, the officer will be interviewed by the admitting physician.
 5. A licensed physician, certified psychologist, or a qualified mental health professional licensed for independent practice who is affiliated with a community mental health center or core service agency has certified that the person, as a result of a mental disorder, presents a likelihood of committing serious harm to themselves herself or others, and that immediate detention is necessary. Certification will constitute authority for the officer to transport the individual.
 6. If an individual meets the criteria for an emergency mental evaluation, the officer will put the individual in protective custody and arrange transportation to



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a mental health facility. If possible, the officer will ascertain the individual's health care provider information and assist in transportation of the individual to the appropriate facility. UNM Mental Health Center at 2600 Marble and Kaseman Presbyterian Hospital at 8300 Constitution have acute care units for evaluating and treating people with behavioral health disorders. Area facilities that may evaluate individuals include:

University of New Mexico Hospital –Psychiatric Center	
2600 Marble Ave. NE, Albuquerque, NM, 87106	(505) 272-2800
University of New Mexico Hospital - Sandoval Regional Medical Center	
3001 Broadmoor Blvd. NE, Rio Rancho, NM, 87144	(505) 994-7000

Presbyterian Hospital – Downtown	
1100 Central Ave. SE, Albuquerque, NM, 87106	(505) 841-1234
Presbyterian Hospital –Kaseman	
8300 Constitution Ave. NE, Albuquerque, NM, 87110	(505) 291-2000
Presbyterian Hospital – Rust	
2400 Unser Blvd. SE, Rio Rancho, NM, 87124	(505) 253-7878

Lovelace – Downtown	
601 Dr. Martin Luther King Jr. Ave. NE, Abq, NM, 87102	(505) 727-8000
Lovelace - Westside	
10501 Golf Course Rd. NW, Albuquerque, NM, 87114	(505) 727-2000
Lovelace – Women's Hospital	
4701 Montgomery Blvd. NE, Albuquerque, NM, 87109	(505) 727-7800
Veterans Administration Hospital	
1501 San Pedro Dr. SE, Albuquerque, NM, 87108	(505) 265-1711

7. When an individual is taken to a mental health facility, the officer will ensure that the mental health staff has a detailed and accurate account of the incident surrounding the protective custody. The officer will complete and sign an application for emergency hospitalization. If the individual is a juvenile, the officer will ensure that a parent or guardian is notified.
8. If an individual is identified as dangerous to themselves or others, the officer will guard the individual to protect the individual and others until the medical facility assumes responsibility for the individual.
9. Whenever an individual is transported to a mental health facility, on either a voluntary or involuntary basis, for evaluation or custody, Certificates of Evaluation, grave passive neglect, crisis, or arrest, an offense or incident report will be prepared by the officer or the mental health care professional.



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10. Officers who are provided with a Certificate of Evaluation concerning an individual will attempt to verify the authenticity of the certificate by directly talking to the source in person or by calling the facility or doctor who issued the certificate. Real Time Crime Center (RTCC) shall also be utilized to gather additional information.
11. In the event an officer determines that a person has a behavioral health disorder or is in behavioral health crisis but is not dangerous, the officer may request the assistance from a Mobile Crisis Team, the person's mental health provider or COAST if the individual would likely benefit from further crisis intervention, linkage to services, and/or education regarding services in the community.
12. When officers take a prisoner to the Metropolitan Detention Center and have knowledge of a prisoner who has some kind of behavioral health disorder, they will notify the Metropolitan Detention Center (MDC) medic who can then notify the Psychological Service Unit (PSU).

2-19-12 Training

The CIT Program Coordinator ensures that the following training is developed and provided for officers.

A. Cadets

All cadets receive state-mandated behavioral health training and additional training as developed by the CIT program while at the APD Academy. Upon completion of the field training program, the field training staff ensures that all graduates receive an additional 40-hour basic crisis intervention training designed for field service officers.

B. Field Service Officers

All field service officers receive 40-hour basic crisis intervention training designed for field officers. Upon completion of this course, officers are crisis intervention trained officers (CITO). Field service officers receive a two-hour in-service training every 2 years covering behavioral health-related topics.

C. eCIT Officers

eCITs receive all field service officers' training. eCIT Officers also receive advanced training in behavior health issues developed by the CIT program. In addition, ECIT officers receive 8 hours of in-service crisis intervention training every 2 years.

D. Emergency Communications Center Employees



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Emergency Communications Center employees receive 20 hours of behavioral health training, to focus on telephone suicide intervention, crisis management, de-escalation. Communication employees will receive training on appropriate interactions with individuals with behavioral health issues, roles of different CIT program members, and procedures for calls regarding behavioral health issues, including appropriate team/officer dispatch requirements in response to calls. Emergency Communications Center employees will receive a 2-hour in-service training every 2 years covering behavioral health-related topics.

E. CIU/COAST/MCT

CIU/COAST/MCT participates in the same training as eCIT officers. The CIT Program Coordinator will develop additional training for these team members.

2-19-13 Partnering with MHRAC

- A. The Mental Health Response Advisory Committee (MHRAC) was established to partner with the Department to improve outcomes for interactions between police officers and individuals with behavioral health disorders or who are in behavioral health crisis.
- B. Members of the Department, including command staff, eCIT officers, CIU and COAST members, and employee or Department-contracted and mental health professionals will serve on the MHRAC. The CIU lieutenant is responsible for recruiting Department members on MHRAC. MHRAC and the lieutenant will work together to recruit members from other community organizations, such as the City Department of Family & Community Services, UNM Psychiatric Department, mental health professionals, advocacy groups for consumers of mental health services, mental health service providers, homeless service providers, and similar groups. MHRAC will appoint members to serve.
- C. Department personnel will cooperate and support MHRAC's operations.
 1. The Deputy Chief of the Compliance Bureau will designate Department personnel to regularly attend MHRAC meetings, to facilitate communication and to provide support needed for MHRAC's functions.
 2. Other department personnel will attend MHRAC meetings as requested by MHRAC to provide more information regarding the department's policies, procedures, training, and performance.
 3. The CIU Lieutenant, in conjunction with the data analysts, will produce regular reports for MHRAC concerning the activities of CIU and COAST, and provide data regarding interactions between officers and individuals believed to be affected by behavioral health disorder or who are crisis. The CIU Lieutenant and data analysts will work with MHRAC chairs and subcommittee chairs at and



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between MHRAC meetings to gather requested data for MHRAC's review and analysis.

4. Other department personnel will provide data to MHRAC that is subject to public disclosure, upon MHRAC's request. If there are any concerns about the propriety of releasing certain information, the personnel will work with the department's legal advisor and the MHRAC chair(s) to handle the data request appropriately.
- D. The Deputy Chief of the Compliance Bureau will work with all divisions and units across the Department to ensure that MHRAC's recommendations are evaluated by department personnel and incorporated into procedures. The recommendations apply to a broad range of activities such as:
 1. Policies and procedures regarding contact with individuals who have behavior health disorders.
 2. Protocols regarding suicidal and barricaded, suicidal subjects.
 3. Training, particularly scenario-based training, regarding contact with individuals who have behavior health disorders.
 4. Recruitment of eCIT officers, CIU, MCT, and COAST personnel.
 5. Protocols for providers and officers about releasing and exchanging information about individuals with known behavioral health disorders.
 6. Development of resources and networks to facilitate better communication and relationships among community members in order to treat behavioral health concerns through connection with community services rather than through the criminal justice system.
- E. The crisis intervention data analysts will track data and prepare analysis to assist in evaluation and improvement of the CIT Program.
 1. The data analysts will prepare an annual report analyzing Department interactions with individuals affected by a behavioral health disorder or crisis including the following factors:
 - a. Date
 - b. Duty shift
 - c. Area command
 - d. Individual's demographic information
 - e. Whether and how the individual was armed
 - f. Individual's veteran status
 - g. Whether a supervisor responded to the scene
 - h. Whether an ECIT or MCT responded to the scene



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- i. Injuries
 - j. Techniques used
 - k. Disposition of the encounter
2. The data analysts will prepare an annual report analyzing the CIS's crisis prevention services including the following factors:
 - a. Number of CIU or COAST cases
 - b. Number of people connected with services
 - c. Date of incident/follow ups
 - d. Duty shift of incident/follow ups
 - e. Area Command of incident/follow ups
 - f. Individual's demographic information
 - g. Individual's veteran status
 - h. Injuries
 - i. Techniques used
 - j. Disposition of the encounter
3. The data analysts will prepare additional reports as needed by chain of command or MHRAC.
4. MHRAC, the CIT coordinator and Lieutenant/civilian supervisor will use the reports to assess the effectiveness of the CIT program, including but not limited to assessing overall staffing levels, geographic and shift deployment of resources, training needs, and evaluation of specific personnel or techniques.



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2-19 RESPONSE TO BEHAVIORAL HEALTH ISSUES

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2-19-1 Purpose

This policy establishes guidelines for assessing whether a person's behavior or actions indicates an individual may be affected by a behavioral health disorder, a behavioral health crisis, and for responding to that individual. It provides guidance, techniques, and resources so that contact with the person may be resolved in a constructive and compassionate manner.



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2-19-2 Policy

The goal of this policy is to set a standard of excellence and awareness for our officers and supervisors with respect to treatment and interaction of individuals with a behavioral health disorder, a developmental disability, or during a behavioral health crisis. Individuals in behavioral health crisis will be treated with dignity and will be given reasonable accommodations of their disabilities, and given appropriate access to law enforcement, government, and community services.

Field Services Bureau officers are not mental health professionals, but they will receive on-going training to equip them with information and techniques to help them better respond to individuals with behavioral health disorders or in behavioral health crisis. Officers will be trained in intervention and de-escalation techniques and behavioral health resources to enhance both officer and public safety. This training does not restrict an officer's discretion to make an arrest when probable cause exists, however, officers are encouraged to jail divert individuals affected by a behavioral health disorder or in a behavioral health crisis. Ref. section (2-19-8)

Officers and communities must act in concert with behavioral health professionals to successfully resolve an incident involving an individual in behavioral health crisis. An important role for law enforcement is to help people and their families access behavioral health services or substance abuse programs, hospitals, clinics, and shelter care facilities.

Incidents involving individuals in a behavioral health crisis require the use of special police skills and training, de-escalation techniques, and resources to effectively and positively resolve the situation. The ideal resolution for a mental health crisis incident is that the subject is connected with resources that can provide long-term mental health support and guidance.

The goal during an incident involving an individual in a behavioral health crisis is to de-escalate the situation safely with the least amount of force for all individuals involved, consistent with established safety priorities.



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2-19-3 Definitions

A. Behavioral Health Crisis

An incident in which someone is experiencing intense feelings of personal distress (e.g., anxiety, depression, fear, anger, panic, hopelessness), obvious changes in functioning (e.g., neglect of personal hygiene, unusual behavior), or catastrophic life events (e.g., disruptions in personal relationships, support systems, or living arrangements; loss of autonomy or parental rights; victimization; natural disasters), which may, but not necessarily, result in an upward trajectory or intensity culminating in thoughts or acts that are possibly dangerous to his or herself and/or others.

B. Behavioral Health Disorder

A disorder that is characterized by clinically-significant disturbance in an individual's cognition, emotion regulation, or behavior. It reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. This includes individuals with Intellectual and Developmental Disabilities (I/DD).

C. Certificate of Evaluation

A document, completed by a licensed physician, certified psychologist, or a qualified, licensed mental health professional practicing independently who is affiliated with a community mental health center or core service agency, which certifies that a person, as a result of a mental disorder, presents a likelihood of harming him/herself or others and that immediate detention is necessary to prevent such harm.

D. Crisis Intervention Section (CIS)

Comprised of Crisis Intervention Unit detectives (CIU), Crisis Outreach and Support Team members (COAST), Mobile Crisis Teams (MCT), Enhanced Crisis Intervention Team members (ECIT), crisis clinicians, a licensed psychiatrist, and data analysts. The CIS is responsible for the overall administration and goals of the Crisis Intervention Team (CIT) program.

E. Crisis Intervention Trained Officer (CITO)

Field Services Bureau officers who successfully completed the basic crisis intervention team training.



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F. Crisis Intervention Team (CIT) Program

A community-based program that includes members of the Department's crisis intervention section (including crisis intervention unit clinicians) and Department personnel who are not clinicians but who are trained in handling and de-escalating interactions between law enforcement and members of the public affected by behavioral health disorders or behavioral health crises.

G. Crisis Intervention Unit Clinicians (CIC)

Crisis Intervention Clinicians are qualified mental health professionals who provide evaluations, general psychological assessments, crisis intervention, dangerousness assessments, safety planning, and referrals for individuals in the community living with behavioral health disorders who come into contact with the Department.

H. Crisis Outreach and Support Team (COAST)

Civilian employees supervised by a Department Sergeant. COAST enhances the CIT program by providing crisis intervention, access to mental health services, and education in response to police referrals. COAST is assigned to the Criminal Investigations Bureau (CIB)/Crisis Intervention Section.

I. De-escalate

An officer's actions to attempt to calm a situation or to prevent a situation from escalating into a physical confrontation or injury, by using verbal and non-verbal techniques, including active listening skills, tone of voice, announcement of actions, body posture, personal space, eye contact, and empathy and compassion to promote officer and individual safety.

J. Disengagement

An officer's decision, to discontinue contact after attempts to engage with an individual in behavioral health crisis.

K. Enhanced Crisis Intervention Team (ECIT)

Specially-trained Field Services Bureau officers who function within their patrol teams as specialists to handle calls involving individuals affected by a behavioral health disorder or experiencing a behavioral health crisis.

Mobile Crisis Teams (MCT) and ECIT officers are selected for special mental health crisis intervention training with demonstrated skills and abilities in crisis de-escalation.



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L. Grave Passive Neglect

Failure to provide for one's basic personal needs, medical needs, or for one's own safety to such an extent that it is likely to result in serious bodily harm in the near future.

M. Mental Health Response Advisory Committee (MHRAC)

Comprised of subject matter experts from within the community who assist the Department in identifying and developing mental health resources, solutions to behavioral health crises, and emergency intervention designed to improve outcomes for individuals living with a behavioral health disorder or who are in behavioral health crisis. The committee analyzes and recommends appropriate changes to Department policies, procedures, and training methods regarding Department interaction with individuals in a behavioral health crisis, affected by a behavioral health disorder, or individuals experiencing chronic homelessness.

N. Mobile Crisis Team (MCT)

Mental health professionals who work with ECIT officers who are responsible for responding to priority behavioral health crisis calls and intervene. They provide immediate behavioral health services once the scene is secure. MCTs are trained to complement the ECIT and CIU.

O. Non-Engagement

An officer's decision to avoid making contact with a person in a behavioral health crisis,

P. Qualified Mental Health Professional

A licensed, independent social worker, a licensed professional clinical mental health counselor, a marriage and family therapist, a certified nurse practitioner, or a clinical nurse specialist with a specialty in mental health, who are qualified to work with persons having behavioral health crisis or disorder.



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2-19-4 The Crisis Intervention Team (CIT) Program

The CIT program consists of three core components and are defined below:

- Community Partnership
- Core Elements
- Sustaining Elements

A. Community Partnership

1. The Department's CIT program collaborates with community partners and the MHRAC to strengthen the Department's response to individuals with behavioral health disorders or in a behavioral health crisis. The program also seeks to avoid the stigma of behavioral health issues. The MHRAC and community collaboration will develop and maintain the CIT program. The program includes:
 - Ongoing partnerships between law enforcement, advocacy groups, and the behavior health community;
 - MHRAC and community feedback and participation in CIT program training;
 - Policy and procedure development and review by the community and MHRAC.
2. Central to the success of CIT is not only the training of the law enforcement officer, but also the education of those agencies and individuals within the behavioral health community who will be involved in the process. Successful diversion requires accessible crisis services. True collaboration can occur only when law enforcement, behavioral health agencies, consumers, and families and advocates have a clear understanding of and respect for each other's roles in the CIT program.

B. Core Elements

The Core Elements of the CIT program are the personnel and training that compose the resources used by the Department in responding to behavioral health issues.

1. Many Department personnel work together to effectively respond to situations involving behavioral health disorders or crisis and to support the CIT Program:
 - a. Emergency Communications Center employee's intake calls and are trained to recognize indicators of behavioral health disorders or crisis and to dispatch a specialized response in the form of ECIT or MCT as available.



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- b. CIT officers are field service officers who receive at least 40 hours of CIT training. The Department's goal is for every field service officer to achieve at least a CITO level of training. These officers are the primary call responders and may encounter individuals affected by behavioral health disorders or who are in behavioral health crisis unexpectedly through calls or other encounters. Their training equips them with tools for de-escalation, information about jail diversion, and other resources available through the CIT program to assist the individual and resolve the situation.
- c. ECIT officers are field service officers who receive enhanced training and ongoing training above the CITO training. These officers will be the primary responders when Emergency Communications Center employees identify a need for a specialized CIT response and will also respond to officers' request for specialized CIT back-up.
- d. Mobile Crisis Teams (MCT) are mental health professionals who respond to priority behavioral health crisis calls in collaboration with ECIT officers.
- e. CIT Area Command Sergeant coordinators are field services sergeants who volunteer to assist the CIT program and to provide guidance and leadership to CITO and ECITs within their area command.
- f. The Crisis Intervention Section is the primary team within the Department for overseeing and coordinating the CIT program. It coordinates with community partners, receives and provides up-to-date training, and provides direct services to people in behavioral health crisis. CIS includes:
 - Crisis Intervention Unit (CIU);
 - Crisis Outreach and Support Team (COAST), and;
 - CIT Program Coordinators.

2. CIT Training

- a. CIT training promotes community collaboration and community policing. The Crisis Intervention Section, primarily through the Coordinator, collaborates with MHRAC and other community partners to develop ongoing trainings tailored to the department personnel supporting the CIT program. Trainings will be conducted by a combination of CIT detectives, mental health professionals, community members, and individuals affected by behavioral health disorders where appropriate.
- b. These trainings are developed and delivered using the ADDIE model cycle of five steps:
 - Needs assessment/analysis (e.g. identify the type of personnel to be trained and desired outcomes);
 - Design (e.g. lesson plans and assessment instruments);
 - Development (e.g. preparation of presentations, PowerPoints, etc.);
 - Implementation (e.g. train the trainer, begin trainings), and
 - Review for effectiveness (e.g. through feedback, performance on assessment instruments, and analysis of post-training data).



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- c. Current training requirements for department personnel are described [below](#).
Ref (2-19-12)
- C. Sustaining elements are activities directed at program growth and response for the needs of the community. They include:
 - 1. Evaluation and research by CIS members in current practices and approaches to behavioral health disorders and behavioral health crises;
 - 2. In-service training for CITO's and Emergency Communications Center employees at least every two years;
 - 3. Advanced in-service training for ECITs at least every two years, and;
 - 4. Recognition and honors for officers who excel and/or have positive outcomes in interactions with individuals exhibiting behavioral health disorder or crisis.

2-19-5 Recognizing Behavioral Health Disorders

- A. When responding to an incident, officers should consider whether the person may be in behavioral health crisis.
- B. Only a trained mental health professional can diagnose behavioral health issues, mental disorders, or illness. Officers and Emergency Communications Center employees do not diagnose an individual's mental health condition. However, they apply their training to recognize behaviors and conduct that indicate the person may be affected by a behavioral health disorder or is in behavioral health crisis and to adapt police responses accordingly.
- C. Officers and Emergency Communications Center employees should consider that someone may be in behavioral health crisis due to behavioral disorders or distress, impairment from alcohol or psychoactive drugs, or may have a hearing impairment, deafness, dementia, autism, or physical injury and tailor their response accordingly.
- D. A telecommunication employee will apply his/her training and experience to identify calls that indicates the subject may be affected by a behavioral health disorder or a behavioral health crisis, and if so, will dispatch an ECIT officer or MCT, when appropriate and available.
- E. If Emergency Communications Center employees receive a call indicating the person may be in a behavioral health crisis, Emergency Communications Center employees will (when available) determine whether it would be beneficial to transfer the call to the New Mexico Crisis and Access Line. If so, Communications will call 1-(855)-NMCISIS (622-7474) and collaborate with the Crisis Line personnel to help respond to the call if appropriate and available.

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2-19-6 Assessing Risk

- A. Most people affected by a behavioral health disorder or who are in behavioral health crisis are not dangerous, although some may present dangerous behavior under certain circumstances or conditions. Officers should assess whether someone may be a danger to himself or herself, the officer, or others, by considering the following:
1. The person's access to weapons.
 2. The person's statements, conduct, or inferences that suggest the person will commit a violent or dangerous act.
 3. The person's history. The person's history may be known to the Department, the officer, family, friends, and neighbor indications that the person lacks self-control, particularly lack of physical and psychological control over rage, anger, fright, or agitation. Signs of lack of self-control include extreme agitation, inability to sit still or communicate effectively, wide eyes, and rambling incoherent thoughts and speech. Clutching oneself or other objects to maintain control or moving very rapidly, may also suggest that the individual is losing control.
 4. The volatility of the environment. Agitators who may upset the person, create a combustible environment, or incite violence should be carefully noted and controlled.
- B. An individual affected by a behavioral health disorder or crisis may rapidly change his or her conduct or demeanor from calm and responsive to commands to physically active and agitated or non-responsive. This behavior change may result from an external trigger (such as an officer who states, "I have to handcuff you now,") or from internal stimuli (such as delusions or hallucinations). Variations in a person's demeanor or conduct do not mean he or she will become violent or threatening. Officers should observe and be prepared at all times for a rapid change in behavior.



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2-19-7 Response

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A. In responding to an individual experiencing a behavioral health crisis, an officer will attempt to de-escalate and calm the situation if feasible, until a supervisor or ECIT or MCT arrives to control the scene and direct operations.

1. ECIT, MCT, or CIU will take the lead in interacting with individuals in a behavioral health crisis. If a supervisor has assumed responsibility for the scene, the supervisor will seek input from ECIT, MCT or CIU on strategies for de-escalating, calming and resolving the crisis, when it is safe.

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2. The responding officer will request a backup officer whenever the individual will be taken into custody (either for booking or for emergency mental health evaluation). The officer should specifically request an ECIT officer or MCT as backup, unless the officer is an ECIT officer.
3. Officers should take steps to calm the situation. Where possible, eliminate emergency lights and sirens, disperse crowds, and assume a quiet non-threatening tone and manner when approaching or conversing with the individual. Where possible, avoid physical contact, and take time to assess the situation. Officers should operate with the understanding that time is an ally, and there is no need to rush or force the situation.
4. Officers should move slowly and do not excite or agitate the person. Provide reassurance that the police are there to help and that the person will be provided with appropriate care, assistance and resources.
5. Officers should communicate clearly and calmly. If possible, speak slowly and use a low tone of voice. Express concern for the person's feelings, and allow the person to share feelings without expressing judgment.
6. Where possible, officers should gather information from acquaintances or family members. Attempt to find out the nature of the crisis the individual is experiencing. Request professional assistance, if available and appropriate, to assist in communicating with and calming the person.
7. Officers should not threaten the individual with arrest or physical harm, as this may create additional fright, stress, and potential aggression.
8. Officers should avoid topics that seem to agitate the person, and guide the conversation away from areas that cause stress or agitation and towards topics that seem to ease the situation.



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9. Officers should always be truthful. If the person senses deception, he or she may withdraw in distrust, become hypersensitive, or retaliate in anger. If an individual is experiencing delusions and/or hallucinations and asks the officer to validate them, statements such as, "I am not seeing what you are seeing, but I believe that you are seeing them," are recommended. Validating and/or participating in the individual's delusion or hallucination is not advised.

10. Officers should offer to connect individuals to mental health service agencies, or provide transportation to the hospital.

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B. Officers will complete an original incident report where required (e.g. there are charges filed, a CIU referral, or transport to the hospital). Regardless of whether an incident report is required, officers will complete a CIT contact sheet for any dispatch in which the subject's behavior indicates a behavioral health disorder or behavioral health crisis.

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C. Non-engagement or Disengagement to Dispatched Calls for Service

1. If a supervisor determines, after consulting with ECIT or a mental health professional, that a person exhibiting behavioral health disorder or behavioral health crisis is not a threat to others and that further interaction with the individual will result in an undue safety risk to the person, the public, or officers, they should disengage. A supervisor will notify a lieutenant of this decision and will coordinate with CIU to contact the person at a different time or under different circumstances. A police report and/or CIT contact sheet will be generated documenting the following elements:

- a. Details of the call;
- b. Reasons for disengagement;
- c. Actions taken to deescalate the situation;
- d. Actions taken to promote safety;
- e. Follow-up plans and referrals made; and
- f. Flagged address for a safety bulletin.

2. The word "disengagement" will be placed in the incident summary line of the report or CIT contact sheet.

3. If the subject is barricaded, the officers will follow the additional procedures set forth in the [Hostage, Suicidal/Barricaded Subject, and Tactical Threat Assessment SOP](#).



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4. In limited circumstances, officers may be aware of the identity and behavior of an individual before making contact that indicates that the individual is not currently a threat to others, and that contact with law enforcement would not be helpful but only serve to escalate the situation. In these circumstances, a supervisor may approve non-engagement. The supervisor will report non-engagement decisions to a lieutenant. The non-engagement will be documented in the same manner as a disengagement with the word "non-engagement" placed in the incident summary line of the report or CIT contact sheet.
5. Nothing in this section shall prohibit officers from utilizing discretion in on-site activity.

2-19-8 Diversion from Jail

Department personnel will divert individuals with behavioral health disorders or who are in behavioral health crisis from jail through the following measures:

- A. Individuals with behavioral health disorders or in behavioral health crisis may have encounters with law enforcement for misdemeanor and/or petty misdemeanor crimes, or for non-violent felonies. When possible, those persons may be better served by jail diversion, which can include the following:
 1. Issuing a verbal warning;
 2. Issuing a citation;
 3. Giving a summons for misdemeanors or submitting a non-violent felony case to the District Attorney;
 4. Transporting the person to a mental health provider either voluntarily or involuntarily pursuant to NMSA 43-1-10; or
 5. Disengagement.
- B. Jail diversion through issuance of citations or summons/submission of a case is subject to an officer's discretion and is typically appropriate unless:
 1. The individual, subject to lawful arrest, fails to identify himself or herself satisfactorily.
 2. The individual refuses to sign the citation.
 3. Arrest or taking the individual into custody is necessary to prevent imminent harm to others, or it is necessary to remove the individual from the scene of the offense.



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4. The individual has no ties to the jurisdiction reasonably sufficient to ensure their appearance and there is substantial likelihood that violators would refuse to respond to the citation. The fact that the person appears to be homeless is not a sufficient basis for an arrest.
 5. The individual is intoxicated to the point that they no longer have control of their faculties.
- C. When the individual's criminal behavior appears to stem from a behavioral health disorder and he or she would be better served in a treatment location than in a criminal justice setting, officers should seek such interventions in lieu of criminal charges.
1. CITO, ECIT, MCT, and CIS will work with behavioral health care providers within the community to deter the individual from future contact with the criminal justice system.
 - a. CIS will hold quarterly meetings with University of New Mexico. In addition, CIS will hold meetings with personnel from Presbyterian Kaseman Hospital, HealthCare for the Homeless, St. Martin's Hospitality Center, New Mexico Solutions and others as needed or requested to ensure familiarization with diversionary goals.
 - b. Officers will testify at civil commitment proceedings to promote mental health resolution rather than criminal sanctions.
 2. CITO, ECIT, MCT, and CIU Detectives will make referrals to CIS and use COAST and/or Crisis Intervention Unit Clinicians, to reduce the likelihood of future behavioral health crises and thus reduce the possibility of contact with the criminal justice system by evaluating the situation and connecting to appropriate services available to individuals living with behavioral health disorders.
 3. On active CIU cases, CIU Detectives may coordinate with the Pre-Trial Services diversionary unit in the court system to address the needs of the individuals with behavioral health disorders who were booked into the detention facility.
 4. The primary officer will retain case responsibility if a citation, summons, or case is submitted. CIU/COAST assists if the individual needs follow-up intervention. When sending a copy of the incident report to Court Services, officers will attach a note stating the individual may be a candidate for Mental Health Court.
 6. If the individual is not appropriate for jail diversion, the officer should ensure that the individual is referred to the Psychiatric Services Unit within the detention center (PSU) by writing "PSU REFERRAL" at the top of the pre-booking slip.
 7. The officer will note any jail diversion techniques used on the incident report, or if no incident report is required, on a CIT contact sheet before submission to the CIT data analysts.



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7 2-19-9 Roles and Responsibilities

A. Crisis Intervention Section Lieutenant or Civilian Section Supervisor

The Lieutenant or Supervisor is responsible for the efficiency and effectiveness of the various units and for coordinating their functions and activities. The units include the Crisis Intervention Unit (CIU), Enhanced CIT Program, Mobile Crisis Teams, Crisis Outreach and Support Team (COAST), Crisis Intervention Clinician(s), and psychiatrist, as well as the management of the department's Crisis Intervention Team program. The Lieutenant or Supervisor is responsible for overseeing every aspect of the CIT Program, including maintaining community partnerships, supervising CIT training, and evaluating the CIT program on an on-going basis.

B. The CIT Coordinator

The Coordinator is a CIU Detective appointed by the CIS Lieutenant who acts as a liaison with program stakeholders to ensure the success of the CIT program. The coordinator oversees the CIT program and serves as the Department's point of contact. The CIT Coordinator examines, reviews, and recommends actions to ensure that Department and community needs are met.

The Coordinator is responsible for the following activities:

1. Develop curricula and training on CIT, de-escalation, behavioral health, crisis intervention, and other mental-health related topics. This includes developing an effective scenario-based training program.
2. Develop and maintain the CIT program through:
 - Networking;
 - Outreach;
 - Community ownership in the CIT program;
 - Promoting CIT;
 - Regularly attending the Mental Health Response Advisory Committee (MHRAC) meetings;
 - Meeting with Department leadership; and
 - Working with 911 dispatchers.
3. Maintain continuous relationships with:
 - Community partners;
 - Mental health providers; and
 - Mental health advocates.
4. Develop and revise CIT-related policies and procedures and laws by:



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- Study of trends and data from the CIT Program;
- Case law review;
- Mental health codes study;
- Civil commitment and transportation of individuals with behavioral health disorder or those in behavioral health crisis; and
- Input into legislation development.

5. Provide guidance and review to CIT field officers by:

- Addressing issues raised by officers,
- Interfacing with FSB supervisors in problem-solving issues, and
- Addressing community issues raised by CIT field officers.

6. Assist in developing CIT training models in other nearby jurisdictions to ensure that local agencies follow a uniform approach to CIT in accordance with the national model of police-based crisis intervention.

C. Crisis Intervention Section Sergeant

The Sergeant is responsible for:

1. Overseeing the CIU and the COAST Unit.
2. Consulting and liaising between CIT and mental health care providers, working with the Crisis Outreach Psychiatrist, clinicians, and other clinical personnel.
3. Ensuring that information from offense and incident reports and/or CIT contact sheets from CIT calls is entered into a case management system, and that necessary information about elevated-risk subjects is shared with Field Services personnel through PowerDMS or email.
4. Serving as liaison with the CIT Area Command Sergeant Coordinator(s).

D. CIT Area Command Sergeant Coordinator

Sergeants may volunteer to serve as the CIT Area Command Sergeant Coordinators. The CIS Lieutenant designates a CIT Area Command Sergeant Coordinator for each area command, with the approval of that sergeant's chain of command. These coordinators will participate in efforts of assisting, implementing, and sustaining CIT as a community program. Coordinators should promote constitutional, effective policing using the least restrictive means in interacting with individuals in a behavioral health crisis or affected by a behavioral health disorder.

The CIT Area Command Sergeant Coordinators are responsible for the following activities:



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1. Assist the CIT Coordinator to develop and maintain the CIT program through:

- Networking and outreach;
- Promoting CIT;
- Training;
- Recommending officers for ECIT who possess demonstrated skills and abilities in CIT policing;
- Attending Mental Health Response Advisory Committee (MHRAC) on a rotating basis;
- Participating in monthly CIT Knowledge Network meetings (ECHO Collaboration), and;
- Reviewing and developing CIT-related policies and procedures.

2. Provide guidance and leadership to CITO's and ECIT's by:

- Addressing issues raised by officers;
- Addressing community issues raised by CIT field officers, and;
- Conducting training assessments.

E. CIU Detectives and CIU Teams

1. CIU Detectives and Teams are responsible for:

- a. Assessing individuals for risk to others, especially if a person affected by a behavioral health disorder or in behavioral health crisis puts someone else's (including community members or the officer's) safety at risk.
- b. Assessing escalating behavior or erratic conduct. A person may not currently pose a risk to anyone else's safety, but he or she is displaying behavior that causes increasing alarm to others through physical actions, threats, or property damage. The behavior may result in increased risk to self or others, including officers.

2. CIU detectives are on call on a rotating basis 24 hours a day to assist officers who interact and need assistance and intervention with individuals with behavioral health disorder or who are in behavioral health crisis.

3. CIU detectives will serve on teams that are composed of two CIU detectives and one Crisis Intervention Unit Clinician. The teams are responsible to follow up on CIU cases assigned to the team by their sergeant. CIU will only accept case intake referrals from department officers and shall not take calls from dispatch or the public, unless exceptional circumstances exist, as determined by the CIS sergeant. The officers making referrals will forward their incident reports to the CIS. Officers making the referral should include as much relevant information as possible in their incident report. In addition, to meet criteria for CIU team



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assignment, the officer should note the presence of at least one of the following circumstances indicating a potential for violent or escalating behavior:

- Availability of weapons to the individual;
- Substantiated statements by the individual of threat to commit, or the actual commitment of, a violent or dangerous act;
- Personal history, known or provided, that reflects prior acts of violence under similar circumstances; or
- Corroborating information to believe the individual is a risk to self, others, or officers, or displays escalating erratic behavior.

4. The CIU Team's primary objective in all interventions is to evaluate the risk the individual poses and to de-escalate and calm the situation in an effort to safely resolve the crisis.

5. CIU teams meet and work with community health providers including, the Mental Health Response Advisory Committee, Bernalillo Forensic Intervention Consortium (BFIC), and the National Alliance for Mental Illness (NAMI).

F. The Crisis Outreach and Support Team (COAST) Specialists support the CIT program as described below.

1. COAST assists officers by providing additional crisis intervention skills, referrals to services, and education and outreach for non-violent individuals who are experiencing homelessness. COAST specialists assist individuals who are a risk to themselves.

2. When an officer has determined, the scene is safe and there is a need for COAST on scene, the officer will contact radio and request a COAST unit. A history of frequent dispatched calls for same individual is indicative of the need for a COAST unit.

3. COAST specialists are assigned other cases by the CIU Sergeant.

4. Command leadership may also request COAST to follow up interactions with individuals with behavioral health issues to reduce the additional time and resources required for continued officer response.

5. COAST's primary objective is to safely resolve the behavioral health crisis causing police interaction by referring the individual with behavioral health disorder or in behavioral health crisis, to professional mental health services. The COAST specialist will contact the individual and follows up to ensure the person's participation in appropriate prevention services and treatment options.

6. COAST specialists meet and confer with community mental health providers to ensure the appropriate intervention response. These providers include the



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MHRAC, Bernalillo Forensic Intervention Consortium (BFIC), and the National Alliance for Mental Illness (NAMI).

7. COAST Specialists do not provide:

- Long-term or intensive case management or counseling services;
- Victim's assistance in domestic violence cases;
- Victim's advocacy services for victims of crimes;
- Long-term follow up throughout the judicial process;
- Comprehensive explanations, case management, or follow up with victims or witnesses regarding the procedures involved in the prosecution of their cases;
- Personal or family counseling services for department employees;
- Transportation of violent or potentially violent individuals in their vehicles.

G. Crisis Intervention Unit Clinician

Crisis Intervention Unit Clinicians serve on CIU teams with CIU detectives. The Clinician provides evaluation, assessment, crisis intervention, safety risk assessments, safety planning, and referrals for people in the community living with mental illness who come into contact with the Department. The Clinician performs community education services and a variety of related tasks that promote and enhance the City's community policing efforts.

H. Crisis Intervention Data Analysts

The Data Analysts and a civilian statistician will collect and distribute data used for management purposes only and do not include personal identifying information of individuals. Data Analysts create presentations, make recommendations, and analyze data to help successfully guide the department's response to behavioral health issues.



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2-19-10 People with Developmental Disabilities

Persons with developmental disabilities have a mental or physical impairment that creates difficulties in certain areas of life, especially language, mobility, learning, self-help, and independent living. These individuals are often limited in their ability to effectively communicate, interact with others, and make reasoned decisions on their own. Difficult interactions may result in counterproductive police actions if officers do not recognize and deal with behaviors and reactions of these individuals.

A. Common Traits

There are many forms of developmental disability. Many individuals have additional related, but distinct disorders, such as Autism Spectrum Disorder, Down Syndrome, Fetal Alcohol Spectrum Disorder, Fragile X Syndrome, and Rett Syndrome. Although officers are not in a position to diagnose persons with such disabilities, officers will be alert to symptoms suggestive of such disorders. These include, the following symptoms in various combinations and degrees of severity:

- Difficulty communicating and expressing oneself;
- Communication by pointing or gestures rather than words;
- Repetition of phrases or words;
- Repetitive body movements which may cause harm to themselves; movements may include, swaying, spinning, clapping hands, flailing arms, snapping fingers, biting wrists, or banging the head;
- Little or no eye contact;
- Uneven gross or fine motor skills;
- Unresponsiveness to verbal commands; appearance of being deaf;
- Aversion to touch, loud noise, bright lights, and commotion;
- No fear of danger;
- Oversensitivity or lack of sensitivity to pain; and/or
- Self-injurious behavior;

B. Common Encounters

Officers may encounter persons who have developmental disabilities in a variety of situations. Due to the nature of developmental disabilities, the following are some of the most common encountered:

- Wandering;
- Seizures;
- Disturbances;
- Welfare check;
- Interfering with another person's rights.

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C. Handling and Deescalating Encounters



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Like anyone else, persons with developmental disabilities can become upset, engage in tantrums or self-destructive behavior, or even sometimes become aggressive. Fear, frustration, and minor changes in their daily routines and surroundings may trigger erratic behavior among some people. Officers should take measures to prevent these reactions by de-escalating situations and attempting to safely calm the situation. These measures include the following:

- Speak calmly.
- Do not shout
- Do not unnecessarily touch the person
- Avoid commotion.
- Keep animals away.
- Ask for personal identification.
- Call the contact person or caregiver.
- Be patient and prepare for a potentially long encounter.
- Repeat short, direct phrases in a calm voice.
- Be attentive to sensory impairments.
- Maintain a safe distance. Provide the person with a zone of comfort that will also serve as a buffer for officer safety.
- Avoid topics that cause agitation or distress.

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D. Taking Persons into Custody

Taking custody of a person with developmental disability should be avoided whenever possible as it will invariably initiate a severe anxiety response and escalate the situation. Therefore, in minor offense situations, officers will explain the circumstances to the complainant and request that alternative means be taken to remedy the situation. This normally will involve disengagement or release of the person to family or an authorized caregiver. In more serious offense situations or where alternatives to arrest are not reasonable, officers will observe the following guidelines:

1. Contact a supervisor for advice.
2. Summon the person's family or caregiver to have him/her accompany the person and to assist in the calming and intervention process. If a caregiver is not readily available, summon a mental health crisis intervention worker, MCT or ECIT if available.
3. Employ calming and reassuring nonjudgmental language and use de-escalation protocols provided in this policy.
4. Do not incarcerate the person in a lockup or other holding cell if possible. Do not incarcerate the person with others since they are vulnerable and at risk of harm.



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5. If possible and until alternative arrangements can be made, put the person in a quiet room with subdued lighting with a caregiver or other responsible individual or another officer who is experienced in dealing with such persons.

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E. Interviews and Interrogations

Officers conducting an interview or interrogation of a person suspected of being developmentally disabled and suspected of committing a felony-level crime should immediately consult with a mental health professional. They should also contact the Bernalillo County District Attorney's Office to determine whether the person is competent to understand his or her rights to remain silent and to have an attorney present.

2-19-11 Procedures for Emergency Mental Health Evaluation

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- A. In accordance with NMSA 43-1-10, an officer may detain a person for emergency evaluation and care at a hospital, mental health facility, or an evaluation facility in the absence of a valid court order only if:

1. The person is otherwise subject to arrest.
2. The officer has reasonable grounds to believe the person has just attempted suicide.
3. The officer, based on personal observation and investigation, has reasonable grounds to believe the person, as a result of a mental disorder, presents a serious threat of harming himself or herself or others and immediate detention is necessary to prevent such harm. This includes possible harm to himself or herself through grave passive neglect.
4. Immediately upon arrival at the evaluation facility, the officer will be interviewed by the admitting physician.
5. A licensed physician, certified psychologist, or a qualified mental health professional licensed for independent practice who is affiliated with a community mental health center or core service agency has certified that the person, as a result of a mental disorder, presents a likelihood of committing serious harm to himself or herself or others, and that immediate detention is necessary. Certification will constitute authority for the officer to transport the individual.
6. If an individual meets the criteria for an emergency mental evaluation, the officer will put the individual in protective custody and arrange transportation to a mental health facility. If possible, the officer will ascertain the individual's health care provider information and assist in transportation of the individual to the appropriate facility. UNM Mental Health Center at 2600 Marble and Kaseman Presbyterian Hospital at 8300 Constitution have acute care units for evaluating



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and treating people with mental disorders. Area facilities that may evaluate individuals include:

University of New Mexico Hospital –Psychiatric Center	
2600 Marble Ave. NE, Albuquerque, NM, 87106	(505) 272-2800
University of New Mexico Hospital - Sandoval Regional Medical Center	
3001 Broadmoor Blvd. NE, Rio Rancho, NM, 87144	(505) 994-7000
Presbyterian Hospital – Downtown	
1100 Central Ave. SE, Albuquerque, NM, 87106	(505) 841-1234
Presbyterian Hospital –Kaseman	
8300 Constitution Ave. NE, Albuquerque, NM, 87110	(505) 291-2000
Presbyterian Hospital – Rust	
2400 Unser Blvd. SE, Rio Rancho, NM, 87124	(505) 253-7878

Lovelace – Downtown	
601 Dr. Martin Luther King Jr. Ave. NE, Abq, NM, 87102	(505) 727-8000
Lovelace - Westside	
10501 Golf Course Rd. NW, Albuquerque, NM, 87114	(505) 727-2000
Lovelace – Women’s Hospital	
4701 Montgomery Blvd. NE, Albuquerque, NM, 87109	(505) 727-7800
Veterans Administration Hospital	
1501 San Pedro Dr. SE, Albuquerque, NM, 87108	(505) 265-1711

7. When an individual is taken to a mental health facility, the officer will ensure that the mental health staff has a detailed and accurate account of the incident surrounding the protective custody. The officer will complete and sign an application for emergency hospitalization. If the individual is a juvenile, the officer will ensure that a parent or guardian is notified.
8. If an individual is identified as dangerous to himself or herself or others, the officer will guard the individual to protect the individual and others until the medical facility assumes responsibility for the individual.
9. If an individual is physically injured or has a pre-existing medical condition requiring attention, physical medical care needs take priority. The individual will be transported by a medically trained provider, EMS to a hospital emergency room. The hospital will assume responsibility for any mental health care intervention. The officer will complete the application for emergency hospitalization.
10. Whenever an individual is transported to a mental health facility, on either a voluntary or involuntary basis, for evaluation or custody, Certificates of



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Evaluation, grave passive neglect, crisis, or arrest, an offense or incident report will be prepared by the officer or the mental health care professional. The officer will forward a copy of the report to the CIT data analysts.

11. Officers who are provided with a Certificate of Evaluation concerning an individual will attempt to verify the authenticity of the certificate by directly talking to the source in person or by calling the facility or doctor who issued the certificate. Verification includes ascertaining if the individual is known to have weapons or has exhibited unsafe behavior in the past. Real Time Crime Center (RTCC) shall also be utilized to gather additional information.
12. In the event an officer determines that a person has a behavioral health disorder or is in behavioral health crisis but is not dangerous, the officer may request the assistance from a Mobile Crisis Team, the person's mental health provider or COAST if the individual would likely benefit from further crisis intervention, linkage to services, and/or education regarding services in the community.
13. When officers take a prisoner to the Metropolitan Detention Center and have knowledge of a prisoner who has some kind of behavioral health disorder, they will notify the Metropolitan Detention Center (MDC) medic who can then notify the Psychological Service Unit (PSU). The officer will forward a copy of the offense or incident report to the CIT Area Sergeant Coordinator.



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2-19-12 Training

The CIT Program Coordinator ensures that the following training is developed and provided for officers.

A. Cadets

All cadets receive state-mandated behavioral health training and additional training as developed by the CIT program while at the APD Academy. Upon completion of the field training program, the field training staff ensures that all graduates receive an additional 40-hour basic crisis intervention training designed for field service officers.

B. Field Service Officers

All field service officers receive 40-hour basic crisis intervention training designed for field officers. Upon completion of this course, officers are crisis intervention trained officers (CITO). Field service officers receive a two-hour in-service training every 2 years covering behavioral health-related topics.

C. ECIT Officers

ECITs receive all field service officers' training. ECIT Officers also receive advanced training in behavior health issues developed by the CIT program. In addition, ECIT officers receive 8 hours of in-service crisis intervention training every 2 years.

D. Emergency Communications Center Employees

Emergency Communications Center employees receive 20 hours of behavioral health training, to focus on telephone suicide intervention, crisis management, de-escalation. Communication employees will receive training on appropriate interactions with individuals with behavioral health issues, roles of different CIT program members, and procedures for calls regarding behavioral health issues, including appropriate team/officer dispatch requirements in response to calls. Emergency Communications Center employees will receive a 2-hour in-service training every 2 years covering behavioral health-related topics.

E. CIU/COAST

CIU/COAST participates in the same training as ECIT officers. The CIT Program Coordinator will develop additional training for these team members.



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Effective: 11/29/17 Review Due: 11/29/18 Replaces: 11/01/16

2-19-13 Partnering with MHRAC

- A. The Mental Health Response Advisory Committee (MHRAC) was established to partner with the Department to improve outcomes for interactions between police officers and individuals with behavioral health disorders or who are in behavioral health crisis.
- B. Members of the Department, including command staff, ECIT officers, CIU and COAST members, and employee or Department-contracted and mental health professionals will serve on the MHRAC. The CIU lieutenant is responsible for recruiting Department members on MHRAC. MHRAC and the lieutenant will work together to recruit members from other community organizations, such as the City Department of Family & Community Services, UNM Psychiatric Department, mental health professionals, advocacy groups for consumers of mental health services, mental health service providers, homeless service providers, and similar groups. MHRAC will appoint members to serve.
- C. Department personnel will cooperate and support MHRAC's operations.
 - 1. The Deputy Chief of the Investigative Bureau will designate Department personnel to regularly attend MHRAC meetings, to facilitate communication and to provide support needed for MHRAC's functions.
 - 2. Other department personnel will attend MHRAC meetings as requested by MHRAC to provide more information regarding the department's policies, procedures, training, and performance.
 - 3. The CIU lieutenant, in conjunction with the data analysts, will produce regular reports for MHRAC concerning the activities of CIU and COAST, and provide data regarding interactions between officers and individuals believed to be affected by behavioral health disorder or who are crisis. The CIU lieutenant and data analysts will work with MHRAC chairs and subcommittee chairs at and between MHRAC meetings to gather requested data for MHRAC's review and analysis.
 - 4. Other department personnel will provide data to MHRAC that is subject to public disclosure, upon MHRAC's request. If there are any concerns about the propriety of releasing certain information, the personnel will work with the department's legal advisor and the MHRAC chair(s) to handle the data request appropriately.



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- D. The Deputy Chief of the Investigative Bureau will work with all divisions and units across the Department to ensure that MHRAC's recommendations are evaluated by department personnel and incorporated into procedures. The recommendations apply to a broad range of activities such as:
1. Policies and procedures regarding contact with individuals who have behavior health disorders.
 2. Protocols regarding suicidal and barricaded, suicidal subjects.
 3. Training, particularly scenario-based training, regarding contact with individuals who have behavior health disorders.
 4. Recruitment of ECIT officers, CIU, and COAST personnel.
 5. Protocols for providers and officers about releasing and exchanging information about individuals with known behavioral health disorders.
 6. Development of resources and networks to facilitate better communication and relationships among community members in order to treat behavioral health concerns through connection with community services rather than through the criminal justice system.
- E. The crisis intervention data analysts will track data and prepare analysis to assist in evaluation and improvement of the CIT Program.
1. The data analysts will prepare an annual report analyzing Department interactions with individuals affected by a behavioral health disorder or crisis including the following factors:
 - a. Date
 - b. Duty shift
 - c. Area command
 - d. Individual's demographic information
 - e. Whether and how the individual was armed
 - f. Individual's veteran status
 - g. Whether a supervisor responded to the scene
 - h. Whether an ECIT or MCT responded to the scene
 - i. Injuries
 - j. Techniques used
 - k. Disposition of the encounter



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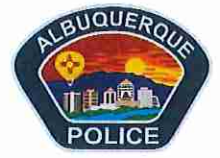
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2. The data analysts will prepare an annual report analyzing CIU's crisis prevention services including the following factors:
 - a. Number of CIU or COAST cases
 - b. Number of people connected with services
 - c. Date of incident/follow ups
 - d. Duty shift of incident/follow ups
 - e. Area Command of incident/follow ups
 - f. Individual's demographic information
 - g. Individual's veteran status
 - h. Injuries
 - i. Techniques used
 - j. Disposition of the encounter
3. The data analysts will prepare additional reports as needed by chain of command or MHRAC.
4. MHRAC, the CIT coordinator and Lieutenant/civilian supervisor will use the reports to assess the effectiveness of the CIT program, including but not limited to assessing overall staffing levels, geographic and shift deployment of resources, training needs, and evaluation of specific personnel or techniques.

Policy Development Form

Office of Policy Analysis



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SOP: 2-19

Date Completed: 7/17/2018

In order to gain a clear understanding of the reason for the policy change, please answer the questions below with as much detail as possible as this information will be shared with internal and external stakeholders interested in participating in APD's policy development process.

Explain the rationale or purpose for the new policy or amended policy? Example: Best practices, case law, liability, conflicts with other policies or regulations, CASA related.

This policy has been updated to reflect the day to day operations on the department, literature review of best practice, recommendations from the Mental Health Response Advisory Committee (MHRAC), and recommendation from the Crisis Intervention Section (CIS).

What is the policy intended to accomplish? Explain the general intent with respect to the specific topic of the policy.

This policy is designed to give personnel a guideline when interacting with someone in or suspected to be in a behavioral health crisis during the course of their job. This policy also outlines the department's operations in behavioral health training, coordinated responses, collaboration, and programs as it relates to behavioral health in our community.

How will the policy be measured to determine its effectiveness? (Example: Will data be collected, if so, in what format and who will maintain the information?)

This policy is wide reaching and the measurements for effectiveness will be accomplished in multiple ways. To measure effective responses to individuals experiencing crisis with minimal or no force the CIS Data Analyst will collect use of force data and data related to contacts with suspected or known individuals living with a mental illness through CADs, uniformed police reports, CIT contact sheets, and other sources deemed appropriate by the department to look for trends and outcomes. The data related to interactions is used to show effectiveness of the policy as it relates to response, training, and specialized units.

The jail diversion efforts will be measured by data collected from CADs, uniformed police reports, CIT contact sheets, and other sources deemed appropriate by the department to insure individuals living with a behavioral health disorder are

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linked to the appropriate services to address their crisis and reduce recidivism in the criminal justice system.

Anecdotal evidence from community feedback will be collect from meeting minutes at the Mental Health Response Advisory Committee to demonstrate the effectiveness of the overall policy.

From time to time the department's response to behavioral health crisis may be studied and analyzed by outside organizations. These findings will be used to judge effectiveness of the items in this policy.

All measures collect will be maintained by the Crisis Intervention Section.

Please list any references used to draft the policy such as policies from other agencies, case law, directives from the CASA, research papers, etc.

Diagnostic and statistical manual of mental disorders: DSM-V-TR. (2013). American Psychiatric Association.

Rosenbaum, N., Tinney, D. M., & Tohen, M. (2017). Collaboration to Reduce Tragedy and Improve Outcomes: Law Enforcement, Psychiatry, and People Living With Mental Illness. *American Journal of Psychiatry*, 174(6), 513-517. doi:10.1176/appi.ajp.2017.16080985

"Crisis Intervention Teams." *National Alliance on Mental Illness*. N.p., n.d. Web.
<<http://www2.nami.org/template.cfm?section=CIT2>>.

Watson, A. C., & Fulambarker, A. J. (2012). The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners. *Best Practices in Mental Health*, 8(2), 71.

University of Wisconsin-Milwaukee. (n.d.). Retrieved from <https://uwm.edu/lgbtrc/support/gender-pronouns/>

Mental Health Response Advisory Committee Policy Review Subcommittee and General Membership.

Please submit this form to OPA@cabq.gov

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