THE POLICIES AND PROCEDURES INCLUDED IN THIS MANUAL ARE NOT A CONTRACT OF EMPLOYMENT AND SHOULD NOT BE RELIED ON AS SUCH. THESE POLICIES AND PROCEDURES ARE SUBJECT TO AND MAY BE CHANGED AT ANY TIME BY THE DEPARTMENT OF PUBLIC SAFETY, MEDICAL UNIVERSITY OF SOUTH CAROLINA.

A. Purpose

It is the purpose of this policy and procedure to provide guidance to law enforcement officers when dealing with suspected mentally ill or intoxicated persons.

B. Policy

Dealing with individuals in enforcement and related contexts who are known or suspected to be mentally ill carries the potential for violence, requires an officer to make difficult judgments about the mental state and intent of the individual, and requires special police skills and abilities to effectively and legally deal with the person so as to avoid unnecessary violence and potential civil litigation. Given the unpredictable and sometimes violent nature of the mentally ill, officers should never compromise or jeopardize their safety or the safety of others when dealing with individuals displaying symptoms of mental illness. In the context of enforcement and related activities, officers shall be guided by this state’s law regarding the detention of the mentally ill. Officers shall use this policy to assist them in defining whether a person’s behavior is indicative of mental illness and dealing with the mentally ill in a constructive and humane manner.

C. Definitions

Mental Illness:

Any of various conditions characterized by impairment of an individual’s normal cognitive, emotional, or behavioral functioning, and caused by social, psychological, biochemical, genetic, or other factors, such as infection or head trauma.
A subject may suffer from mental illness if he/she displays an inability to think rationally, exercise adequate control over behavior or impulses (e.g. aggressive, suicidal, homicidal, sexual), and/or take reasonable care of his/her welfare with regard to basic provisions for clothing, food, shelter, or safety. (CALEA 41.2.7.a)

D. Procedure

1. Recognizing Abnormal Behavior (CALEA 41.2.7.a)

Mental illness is often difficult for even the trained professional to define in a given individual. Officers are not expected to make judgments of mental or emotional disturbance but rather to recognize behavior that is potentially destructive and/or dangerous to self or others. The following are generalized signs and symptoms of behavior that may suggest mental illness although officers should not rule out other potential causes such as reactions to narcotics or alcohol or temporary emotional disturbances that are situational motivated. Officers should evaluate the following and related symptomatic behavior in the total context of the situation when making judgments about an individual’s mental state and need for intervention absent the commission of a crime.

a. **Degree of Reactions.** Mentally ill persons may show signs of strong and unrelenting fear of persons, places, or things. The fear of people or crowds, for example, may make the individual extremely reclusive or aggressive without apparent provocation.

b. ** Appropriateness of Behavior.** An individual who demonstrates extremely inappropriate behavior for a given context may be emotionally ill. For example, a motorist who vents his/her frustration in a traffic jam by physically attacking another motorist may be emotionally unstable.

c. **Extreme Rigidity or Inflexibility.** Emotionally ill persons may be easily frustrated in new or unforeseen circumstances and may demonstrate inappropriate or aggressive behavior in dealing with the situation.

d. In addition to the above, a mentally ill person may exhibit one or more of the following characteristics:

1) Abnormal memory loss related to such common facts as name, home address, (although these may be signs of other physical ailments such as injury or Alzheimer’s disease);

2) Delusions, the belief in thoughts or ideas that are false, such as
delusions of grandeur (“I am Christ”) or paranoid delusions (“Everyone is out to get me”);

3) Hallucinations of any of the five senses (e.g. hearing voices commanding the person to act feeling one’s skin crawl, smelling strange odors, etc.);

4) The belief that one suffers from extraordinary physical maladies that are not possible, such as persons who are convinced that their heart has stopped beating for extended periods of time, and/or;

5) Extreme fright or depression.

2. Determining Danger

Not all mentally ill persons are dangerous while some may represent danger only under certain circumstances or conditions. Officers may use several indicators to determine whether an apparently mentally ill person represents an immediate or potential danger to himself, the officer, or others. These include the following:

a. The availability of any weapons to the suspect.

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

c. A personal history that reflects prior violence under similar or related circumstances. The person’s history may be known to the officer, or family, friends, or neighbors may be able to provide such information.

d. Failure to act prior to arrival of the officers does not guarantee that there is no danger, but it does in itself tend to diminish the potential for danger.

e. The amount of control that the person demonstrates is significant, particularly the amount of physical control over emotion of rage, anger, fright or agitation. Signs of a lack of control including extreme agitation, inability to sit still or communicate effectively, wide eyes, and rambling thoughts and speech. Clutching one’s self or other objects to maintain control, begging to be left alone, or offering frantic assurances that one is all right may also suggest that the individual is close to losing control.

f. The volatility of the environment is a particularly relevant factor that
officers must evaluate. Agitators that may affect the person or a particularly combustible environment that may incite violence should be taken into account.

3. Dealing with the Mentally Ill (CALEA 41.27.c)

The following will apply to any and all situations which involve contact with a mentally ill or suspected mentally ill individual by an officer whether on the street or during an interview and interrogation. Should the officer determine that an individual may be mentally ill and a potential threat to himself, the officer, or others, or may otherwise require law enforcement intervention for humanitarian reasons as prescribed by statute, the following responses may be taken:

a. Request a backup officer, and always do so in cases where the individual will be taken into custody.

b. Take steps to calm the situation. When possible, eliminate emergency lights, and sirens, disperse crowds, and assume a quiet non-threatening manner when approaching or conversing with the individual. Where violence or destructive acts have not occurred, avoid physical contact, and take time to assess the situation.

c. Communicate with the individual in an attempt to determine what is bothering him. Relate your concern for his/her feelings and allow him to ventilate his/her feelings. Where possible, gather information on the subject from acquaintances or family members and/or request professional assistance if available and appropriate to assist in communication with and calming the person.

d. Do not threaten the individual with arrest or in any manner as this will create additional fright, stress, and potential aggression.

e. Avoid topics that may agitate the person and guide the conversation towards subjects that help bring the individual back to reality.

f. Always attempt to be truthful with a mentally ill individual. If the subject becomes aware of a deception, he may withdraw from the contact in distrust and may become hypersensitive or retaliate in anger.

g. Non-sworn personnel coming in contact with a person that is mentally ill or suspected to be mentally ill will contact dispatch and request a sworn officer for assistance. In the interim time period from notification and arrival of a sworn officer, non-sworn personnel will follow the above procedures until the sworn officer assume control of the scene.
h. Should the contact occur at the front desk, the duress alarm located under the counter will be activated. Front desk personnel will follow the above procedures until a sworn officer arrives.

4. Taking Custody or making Referrals  (CALEA 41.2.7.b)

Based on the overall circumstances and the officer’s judgment of the potential for violence, the officer may provide the individual and family members with referrals on available community mental health resources, (Attachment “A”), or take custody of the individual in order to seek an involuntary emergency evaluation.

a. Make mental health referrals when, in the best judgment of the officer, the circumstances do not indicate that the individual must be taken into custody for his/her own protection or the protection of others or for other reasons as specified by state law.

b. Summon an immediate Supervisor or the senior officer on shift prior to taking into custody a potentially dangerous individual who may be mentally ill or an individual who meets other legal requirements for involuntary admission for mental examination. When possible, summon crisis intervention specialists to assist in the custody and admission procedures.

c. Once a decision has been made to take an individual into custody, do it as soon as possible to avoid prolonging a potentially volatile situation. Remove any dangerous weapons from the immediate area, and restrain the individual. Using restraints on mentally ill persons can aggravate their aggression. Officers should be aware of this fact, but should take those measures necessary to protect their safety.

d. An Incident Report will be completed whether or not the individual is taken into custody. Ensure that the report is as explicit as possible concerning the circumstances of the incident and the type of behavior that was observed. Terms such as “out of control” or “psychologically disturbed” should be replaced with descriptions of the specific behaviors involved. The reasons why the subject was taken into custody or referred to other agencies should be reported in detail.

E. Response to the Psychiatric Hospital (CALEA 41.2.7.c, 91.2.3.a)

1. The most likely source of contact with mentally-ill personnel by this Department will be the Psychiatric Hospital. When our assistance is requested at this area,
take the following action:

a. The Dispatcher will immediately notify Public Safety and the Medical Center Supervisor. At least two (2) officers, designated by Supervisors, will be dispatched. Additional officers may be dispatched if needed.

b. Supervisors and officers will immediately respond to the gun security lockers located at the security desk. Before proceeding to the ward, all firearms will be secured in the security lockers. At no time will firearms be taken into any psychiatric ward. Secure the firearm, and take the key with you. When you retrieve your firearm, put the key back in the key cabinet. Officers are authorized to carry both their OC spray and their straight batons into any psychiatric ward. Use of the officer’s OC spray and/or their straight batons will be in accordance with the Department’s Use of Force Policy and Procedure #56.

c. Upon arrival at the ward, the Senior Public Safety officer will immediately coordinate with the medical staff and receive a full briefing on the situation. The Senior Public Safety Officer will make recommendations to the medical staff and initiate action appropriate to the situation, as time permits, in accordance with guidance and direction of the Senior Medical Staff on scene. Should the pin shield be deployed, only qualified personnel will participate and the Senior Public Safety Officer will serve as the team leader for the duration of the deployment. Officer’s response will be in accordance with the Department’s Policy and Procedures, and consistent with the Department’s training and officers skill levels.

d. **Do not use excessive force.** Use only that amount of force necessary to control or restrain the patient, as directed by the team leader. In many cases, a show of force is enough to resolve the problem without resorting to other actions. The most desirable course of action, if force is necessary, is to have enough officers to overpower the individual, so that fighting or wrestling is not required.

e. Except as a last resort, handcuffs will not be used to restrain a patient in the psychiatric ward. Only hospital-approved restraints will be used.

f. Remain in the ward until released by team leader.

g. If an officer is injured in any manner, obtain medical assistance and accomplish appropriate reports.

h. **Intermediate Weapons: (CALEA 1.3.4)** The use of intermediate weapons is authorized in accordance with the Department’s “Use of Force” policy.
F. Transporting Mentally Ill patients (CALEA 41.2.7.c, 91.2.3.d)

1. Upon receipt of a request from a staff member to transport a patient to the VA, or IOP, the dispatcher must ask if the patient is mentally ill and committed. Supervisor discretion and approval is required for voluntary (self-referral) psychiatric patients needing transportation to a mental health facility. The following additional questions must be asked and actions taken by the responding officer(s)
   a. Is the patient violent?
   b. Does the patient have weapons on their person or in their personal effects?
   c. Dispatch two (2) officers to transport
   d. Emergency Admission Certification (signed & notarized) paperwork for involuntarily committed patients pursuant to S.C. State Code of Laws, Section 44-17-410, and/or Probate Court order, etc. must be verified as complete before taking custody of the patient and conducting the transport to IOP, VA or any other authorized mental health treatment facility.
   e. Pat the patient down for weapons.
   f. Transport all personal effects in the trunk or back of vehicle, out of reach of patient.
   g. Upon arrival at destination, advise the receiving agency of any pat down results or presence of any devices in personal effect which could be used as a weapon.

2. All mentally ill self-committed patients must be transported in the same manner as a standard 10-59. Meducare will generally transport self-committed patients.

NOTE: ON OCCASION A MEDUCARE AMBULANCE MAY BE THE PREFERRED OR THE DIRECT MODE OF TRANSPORTATION FOR THE FOLLOWING CATEGORIES OF PATIENTS:

1. COMMITTED PATIENTS
2. VOLUNTARY / SELF REFERRAL PATIENTS
3. INTOXICATED PATIENTS
4. PATIENTS HELD FOR PSYCHOLOGICAL EVALUATION
5. OTHER HIGHT RISK PATIENTS
NO OFFICER WILL WEAR A FIREARM IN THE PATIENT TREATMENT AREA OF ANY MEDUCARE AMBULANCE!


IF IT IS DECIDED THAT DUE TO THE COMBATIVE NATURE OF THE PATIENT THAT AN OFFICER IS TO RIDE IN THE PATIENT TREATMENT AREA, THEN A SECOND OFFICER IN A PATROL CAR IS TO ACCOMPANY THE AMBULANCE WITH THE FIRST OFFICER’S SIDEARM SECURED WITHIN THE PATROL CAR.

G. Handling Intoxicated Complainants

1. When an officer comes in contact with a complainant in such an intoxicated condition (mere drinking is not sufficient) that any information from him is doubtful or unfounded, and in the total absence of witnesses and/or physical evidence, the officer shall proceed as follows:

   a. Accomplish an Incident Report (PSD-17), noting the condition of the complainant.

   b. Advise the complainant that a supplemental report will be taken by the police, if the complainant calls when he is sober.

   c. If the complainant is arrested, his complaint will be noted in the narrative section of the Incident Report.

   d. Exceptions:

      1) There is visible, or suspected, injury to the complainant or another.

      2) The offense was witnessed by a sober person.

      3) It is obvious that a crime has occurred.

   e. If there is continued harassment (numerous unfounded calls by the complainant) refer to Criminal Code to prefer charges and/or have him admitted for psychiatric evaluation, depending on the circumstances.

   f. Police action, involving mentally-ill, incompetent, or intoxicated

POLICY AND PROCEDURE # 59 Handling Mentally-Ill

8
persons/complaints requiring medical assistance, will be handled as follows:

1) These people will be examined by a physician before any other action is taken.

2) Officers are instructed to use only that force necessary for the protection of the public and the officer, and to enforce the removal and protection of the demented/incompetent/intoxicated person.

3) The investigating officer, using an Incident Report form, should describe the complete investigation and any police action.

h. Training (41.2.7.d and .e)

1. All certified law enforcement officers receive initial training in handling mentally ill individuals as part of their Law Enforcement Basic Training at the South Carolina Criminal Justice Academy (SCCJA). This training is documented in the individual’s and Department’s training records. (41.2.7.d)

2. All non-sworn personnel receive initial training in handling mentally ill individuals as part of their New Employee Orientation, conducted by the Department. This training is documented in the individual’s and Department’s training records. (41.2.7.d)

3. All Department personnel will receive refresher training in handling mentally ill individuals at least every three years, conducted by the Department. This training is documented in the individual’s and Department’s training records. (41.2.7.e).

i. Behavioral Intervention Team (CALEA 91.1.7)

1. The Patrol Commander will be the Public Safety representative for the Behavioral Support and Intervention Team.

2. He will be responsible for providing to the Behavioral Support and Intervention Team information that has been relayed to this department concerning negative conduct by students.

3. The Patrol Commander will report any information considered a threat to the campus safety to the Director.

Attachment #A Mental Health Service Providers
MENTAL HEALTH SERVICE PROVIDERS

MUSC B Institute of Psychiatry
(Inpatient and outpatient services) 843-792-9888

Charleston Mental Health 843-727-2118
After hours 843-727-2000
Mobile Crisis 843-414-2350

Dorchester Mental Health 843-873-5063

Probate Court 843-958-5030