



## Cover Memorandum

### Individuals with Behavioral Health Conditions, JHPD Directive #415

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#### **Purpose of the Directive**

The purpose of this Directive is to provide general guidance regarding interactions between Johns Hopkins Police Department (JHPD) members and individuals who are experiencing behavioral health conditions. Other relevant policies include JHPD Directive #416, *Behavioral Health Crisis Dispatch*; Directive #417, *Emergency Medical Examination and Assistance*; and Directive #418, *Behavioral Threat Assessment*. Working together, these policies seek to equip JHPD members with the tools to safely and appropriately interact with individuals experiencing behavioral health conditions; reduce the inappropriate involvement of these individuals in the criminal justice system; de-escalate crises to achieve peaceful resolutions and reduce unreasonable, unnecessary, or disproportional uses of force; promote collaboration with Johns Hopkins (JH) and community partners; and assist individuals with behavioral health conditions obtain support and resources.

#### **Summary of Directive Requirements**

This Directive explains that it is the policy of the JHPD to afford individuals who have or are experiencing behavioral health crises or conditions the same rights, dignity, and access to programs and services provided to all other persons without compromising the safety of the individuals, officers, or community. JHPD will work collaboratively with medical, behavioral health, and human service providers to help facilitate the delivery of services where requested, and when doing so may prevent or de-escalate a crisis and improve the quality of life for members of the JHU community.

The response to incidents involving people who are experiencing behavioral health conditions shall generally be led by members of the JH Behavioral Health Crisis Support Team (BHCST), which pairs behavioral health clinicians and unarmed public safety officers (PSOs) who are trained in crisis intervention. JHPD's involvement will be limited to those situations in which it is reasonable to conclude that the individual in question poses a threat of imminent physical harm to themselves or others.

The Directive includes definitions for various terms relating to behavioral health, the requirements set forth by the Americans with Disabilities Act (ADA), and steps for ensuring that members protect individuals' rights. Additionally, the Directive lists several common indicators of behavioral health conditions that members should recognize upon interacting with members of the public, including symptoms related to social withdrawal, depression, thought disorders, behavior, expression of feelings, and cognitive impairments. It also describes common situations in which persons with behavioral health conditions may be encountered, including wandering, causing disturbances, and exhibiting atypical or inappropriate behaviors. The Directive also provides members with general guidance on how to respond to individuals who have a behavioral health condition, such as speaking calmly and in a non-judgmental manner; repeating short, direct phrases; calling the person's caregiver, and being attentive to sensory

impairments. It also discusses actions that members should avoid, such as sudden movements; touching or crowding the person; or challenging hallucinatory or delusional statements.

Additionally, the Directive states that all JHPD members will receive documented entry-level training regarding interactions with persons suspected of suffering from behavioral health conditions that is appropriate for their assignment. Training shall be developed in collaboration with behavioral health professionals. The Directive also discusses ongoing and refresher training, as well as Crisis Intervention Training (CIT). Finally, the Directive provides a list of behavioral health resources offered at both JH and within the larger community.

### **Blueprint for the Policy Development Process**

The draft JHPD policies (hereinafter referred to as “directives”) shared for community feedback are based on examples of 21st century best practices in public safety policy, identified through extensive benchmarking of university and municipal law enforcement agencies across the nation. Taken together, they represent a comprehensively progressive approach to policing that prioritizes equity, transparency, accountability, and community-based public safety strategies.

The JHPD’s draft directives embody approaches that community advocates and leading experts have championed locally and in law enforcement reform efforts across the nation. The draft directives have also been developed based on input received through robust community engagement in prior phases of JHPD development, including suggestions received in the legislative process as well as last fall’s Memorandum of Understanding (MOU) public comment period and feedback opportunities.

In addition, the directives were drafted to exceed the minimum requirements of the Constitution and laws of the United States and the State of Maryland, to align with the Community Safety and Strengthening Act (CSSA) and to fulfill the requirements of the MOU between the Johns Hopkins University and the Baltimore Police Department. The Hopkins community and our neighbors throughout Baltimore can help improve and strengthen these directives further through their feedback and input.

Material that was considered in the drafting of the Directive and Procedure Manual, include:

**a. Publicly available policies from municipal police departments that have undergone substantial reform efforts**, including: the New Orleans Police Department; Seattle Police Department; Portland Police Department; Detroit Police Department; Ferguson Police Department; and Baltimore Police Department;

**b. National guidance on best practices and model policies from criminal justice reform efforts, social science research centers, and civil rights organizations**, including: the Leadership Conference on Civil and Human Rights; American Civil Liberties Union (ACLU), including the ACLU of Massachusetts’s “Racially Just Policing: Model Policies for Colleges and Universities”; the International Association of Chiefs of Police (IACP); the Police Executive Research Forum (PERF); U.S. Department of Justice Office of Community Oriented Policing Services (COPS Office); The Justice Collaboratory (The JC) at Yale University Law School; and The Center for Innovation in Community Safety (CICS) at Georgetown Law School.

**c. National and local higher education institutions that are based in comparable environments and make policies publicly available**, including: Carnegie Mellon University; Morgan State University;

Towson University; University of Chicago; University of Cincinnati; University of Maryland, Baltimore County; University of Pennsylvania; and Yale University.

To ensure that the proposed directives captured national best practices in community-focused public safety services, the development team collaborated with independent experts from two organizations: National Policing Institute (the Institute), a non-profit dedicated to advancing excellence in policing through research and innovation, and 21CP Solutions, an expert consulting team of former law enforcement personnel, academics, civil rights lawyers, and community leaders dedicated to advancing safe, fair, equitable, and inclusive public safety solutions. Each directive was reviewed by experts selected by both organizations, who provided feedback, suggestions, and edits that were fully incorporated into the current draft.

Finally, individuals and organizations representing the diversity of the Johns Hopkins University community provided feedback to ensure the policies and procedures reflect and respond to the values of our institution and to our community's public safety service needs.

Now they are available for your review. Johns Hopkins is committed to adopting, incorporating, or otherwise reflecting recommended changes and feedback in the final version of policies so long as feedback is aligned with our values and commitments, permissible within legal parameters, and supported by national best practices for community policing and public safety.



**POLICE DEPARTMENT**

**INDIVIDUALS WITH  
BEHAVIORAL HEALTH  
CONDITIONS**

**OPERATIONAL  
PROCEDURE #415**

Responsible Executive:  
Chief of Police  
Responsible Office:  
Vice President for Public Safety  
Approved by:  
Dr. Branville G. Bard, Jr.  
Issued: [full date]  
Revised: [full date]

**Table of Contents**

**POLICY STATEMENT .....1**

**WHO IS GOVERNED BY THIS POLICY.....1**

**PURPOSE .....2**

**DEFINITIONS.....2**

**POLICY.....3**

**CORE PRINCIPLES .....4**

**PROCEDURES.....5**

**POLICY ENFORCEMENT .....14**

**RELATED RESOURCES .....14**

**CONTACTS .....14**

**Policy Statement**

It is the policy of Johns Hopkins (JH) to afford individuals experiencing crises or behavioral health conditions the same rights, dignity, and access to programs and services provided to all other persons without compromising the safety of the individuals, officers or community. The Johns Hopkins Police Department (JHPD) will work collaboratively with medical, behavioral health and human service providers to help facilitate the delivery of services where requested, and when doing so may prevent or de-escalate a crisis and improve the quality of life for members of the Johns Hopkins campus community.

**Who is Governed by this Policy**

All personnel, including sworn, non-sworn and contractual or voluntary persons in service with the Johns Hopkins Police Department are governed by this Directive.

## Purpose

The purpose of this Directive is to provide general guidance regarding interactions between JHPD members and individuals who are experiencing crisis or a behavioral health condition. In addition, JHPD Directive #416, Behavioral Health Crisis Dispatch details the specific procedures for dispatch and response to incidents involving people who are in crisis or experiencing behavioral health condition. Other relevant resources include JHPD Directives #417, Emergency Medical Examination & Assistance and #418, Behavioral Threat Assessment.

Working together, these policies seek to equip JHPD members with the tools to safely and appropriately interact with individuals experiencing crises or behavioral conditions; reduce the inappropriate involvement of these individuals in the criminal justice system; de-escalate crises to achieve peaceful resolutions and reduce unreasonable, unnecessary or disproportional uses of force; promote collaboration with JHU and community partners; and assist individuals in crisis or with a behavioral health condition obtain support and resources.

## Definitions<sup>1</sup>

<b>Behavioral Health:</b>	A term of convenience that refers to both mental illnesses and mental health needs (e.g., trauma) and substance use...disorders and substance use needs and issues, as well as to the overlap of those behavioral health issues into primary health, cognitive disabilities, criminal justice, child welfare, schools, housing and employment, and to prevention, early intervention, treatment and recovery. Behavioral health also includes attention to personal behaviors and skills that impact general health and medical wellness as well as prevent or reduce the incidence and impact of chronic medical conditions and social determinants of health.
<b><u>Behavioral Health Condition:</u></b>	An umbrella term for substance use disorders and mental health conditions.
<b>Behavioral Health Crisis Support Team (BHCST):</b>	A joint JHU team that pairs mental health clinicians with campus public safety officers (PSOs) to respond to students, faculty, and staff who are experiencing a behavioral health crisis.
<b>Crisis:</b>	A perception or experience of an event/situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms.
<b>Crisis Intervention Team (CIT) Trained Officer:</b>	Campus officers who are specially trained to respond to students, faculty, and staff who are experiencing a crisis.

<sup>1</sup> Definitions related to mental or behavioral health in this Directive, including various conditions or crisis, are taken from U.S. Department of Justice's Bureau of Justice Assistance Style Guide for Using the Sequential Intercept Model: Behavioral Health and Intellectual and Developmental Disability Considerations, August 2021: available at: [https://www.informedpoliceresponses.com/files/ugd/e7007a\\_6febdbef767f4ff4b53d799dba64ce9c.pdf](https://www.informedpoliceresponses.com/files/ugd/e7007a_6febdbef767f4ff4b53d799dba64ce9c.pdf)[https://www.informedpoliceresponses.com/files/ugd/e7007a\\_6febdbef767f4ff4b53d799dba64ce9c.pdf](https://www.informedpoliceresponses.com/files/ugd/e7007a_6febdbef767f4ff4b53d799dba64ce9c.pdf)

<b>Developmental Disability:</b>	Physical and/or mental impairments that begin before age 22, are likely to continue indefinitely, and result in substantial functional limitations in at least three of the following: self-care (dressing, bathing, eating, and other daily tasks), walking/moving around, self-direction, independent living, economic self-sufficiency, and language. Self-direction is a conceptual skill that refers to the ability to analyze and make decisions for oneself.
<b>Intellectual Disability:</b>	A disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 22. An intellectual disability is a category of developmental disability.
<b>Member:</b>	All members of the JHPD, including employees, officers, and volunteers, unless the term is otherwise qualified (e.g., member of the public, member of the Baltimore Police Department, etc.).
<b>Mental Health Condition:</b>	A wide range of conditions that can affect mood, thinking, and/or behavior. This term is more inclusive than “mental illness.” Individuals living with a mental health condition may not necessarily be medically diagnosed with a mental illness.
<b>Mental Illness:</b>	Diagnosable medical conditions that involve changes in cognition, thinking, and/or behavior. Mental illness is associated with psychological distress and/or difficulties with functioning in daily activities. May also be referred to as a mental health disorder.
<b>Substance Use Disorder:</b>	<p>A medical illness caused by repeated use of a substance or substances. “According to the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5®), substance use disorders are characterized by clinically significant impairments in health, social function, and ... control over substance use and are diagnosed by assessing cognitive, behavioral, and psychological symptoms.” Substance use disorders range from mild to severe and from temporary to chronic. They typically develop gradually over time with repeated misuse, leading to changes in brain circuits governing incentive salience (the ability of substance-associated cues to trigger substance seeking), reward, stress, and executive functions such as decision-making and self-control.</p> <ul style="list-style-type: none"> <li>• <u>Note:</u> Severe substance use disorders are commonly called “addictions.”</li> </ul>

## Policy

The Johns Hopkins Police Department (JHPD) will afford individuals who are experiencing crises or behavioral health conditions, the same rights, dignity, and access to programs and services provided to all other persons without compromising the safety of the individuals, officers, or community. The JHPD response to incidents involving people who are experiencing crises or behavioral health conditions shall generally be led by members of the Johns Hopkins

University (JHU) joint Behavioral Health Crisis Support Team (BHCST), which pairs behavioral health clinicians and unarmed public safety officers (PSOs) who are trained in crisis intervention. JHPD's involvement will be limited to those situations in which it is reasonable to conclude that the individual in question poses a threat of imminent physical harm to themselves or others.

## Core Principles

The Johns Hopkins Police Department prioritizes the behavioral health of all individuals, including those who are crime victims, witnesses, or suspects. This policy is guided by the following core principles:

- I. **Providing Assistance:** The JHPD has an important role in the JHU's crisis response system by effectively responding to and de-escalating incidents that pose an imminent danger to community safety and diverting individuals to resources that provide appropriate services. JHPD will maintain a collaborative relationship with JHU's Behavioral Health Crisis Support Team (BHCST) and other community resources as part of a comprehensive crisis response system that allows for the least police-involved response consistent with community safety.
- II. **Civil Rights:** All members who respond to persons with behavioral health conditions shall always respect their dignity and civil rights. Even in crisis, individuals retain their constitutional rights, including their rights to liberty and due process. JHPD members will follow all constitutional requirements, as well as those set forth by Maryland law, when making decisions regarding transporting individuals for Emergency Evaluations or civil commitment. JHPD members shall be trained to understand the value to society of persons living with disabilities; the need to avoid assumptions, stereotyping, or discrimination; and how to address bias that may be present when interacting with people who have behavioral health conditions.
- III. **Community and Officer Safety:** JHPD's goal is to help ensure the least police-involved response necessary for persons with behavioral health conditions that is consistent with the safety of the individual, the officers and members of the community. JHPD will ensure that members have the training and resources to appropriately respond to these situations, including de-escalating and promoting peaceful resolutions to incidents, and diverting individuals to community resources.
- IV. **De-Escalation:** All members shall use de-escalation techniques and tactics in accordance with JHPD Directive #401, De-Escalation, to attempt the peaceful resolution of an incident without resorting to the need for force. Although JHPD members are not expected to diagnose behavioral health conditions, they are expected to recognize behaviors that are indicative of persons experiencing a behavioral health condition or crisis.
- V. **Sanctity of Human Life:** All members shall make every effort to preserve human life in all situations.

## Procedures

### I. Americans with Disabilities Act

- A. The Americans with Disabilities Act (ADA) entitles people with or experiencing behavioral health conditions, impairments or disabilities to the same services and protections that public safety agencies provide to anyone else.
- B. People with or experiencing behavioral health conditions, impairments or disabilities may not be excluded from services or otherwise be provided with lesser services or protection than are provided to others. The ADA calls for public safety personnel to make reasonable adjustments and modifications in their policies, practices, or procedures on a case-by-case basis.
  - For example, if a person exhibits symptoms of a behavioral health condition, expresses that they have a behavioral health condition or requests accommodation for a behavioral health condition (such as access to medication), Johns Hopkins Public Safety (JHPS) personnel may need to modify routine practices and procedures, take more time, or show more sensitivity to extend the services or protections that would be extended to someone else in a similar circumstance.

### II. General

- A. While many people experiencing behavioral health conditions manage symptoms successfully with the use of medications or other therapies, others who do not have access to mental health services, fail to take their medications, or do not recognize that they are ill can experience psychiatric difficulties.
- B. When anyone experiencing a behavioral health condition comes into contact with JHPD for whatever reason or circumstance, personnel must be especially vigilant to ensure that the person's rights are not violated and that they understand what is occurring.
  - Some individuals may lack skills, abilities, or capacities necessary to comprehend or understand basic *Miranda* rights. Simply reading the rights to someone with these types of impairments and having the individual acknowledge that they understood may not be sufficient. Prior to taking action, officers, with assistance from a BHCST member, shall further explain the individual's rights in a manner that enables the individual to understand them.
- C. Members must ensure that people experiencing behavioral health conditions receive the necessary assistance to access services. This may require time and patience beyond what is normally provided.



- D. People experiencing a behavioral health condition may also be suspects or arrestees and require detention, transport, and processing.
- All individuals taken into custody must be searched, restrained, and transported in accordance with JHPD Directive #412, Custody, Transport & Processing.
  - Members must familiarize themselves with the proper methods of transport, arrest, and detention to ensure officer safety while providing all reasonable support to an arrestee with a behavioral health condition or crisis. See JHPD Directives #424, Arrests & Alternatives to Arrest, and #412, Custody, Transport & Processing.
- E. Members should be mindful that responses of people with certain behavioral health conditions, besides substance abuse disorders, may resemble those of people who are under the influence of or experiencing the effects of using substances such as alcohol or drugs. Individuals who may appear as though they are on a substance or intoxicated may instead be struggling with symptoms that are consistent with a behavioral health condition.
- F. Pursuant to its Student Amnesty for Alcohol & Drug Emergencies policy, JHU will not impose disciplinary action of record for a violation of student alcohol or drug possession or consumption against individual students or Recognized Student Groups/Organizations when they report to or seek assistance from on-duty medical staff or law enforcement for a medical emergency or condition. The procedure for initiating the amnesty protocol can be found on the JHU website: <https://studentaffairs.jhu.edu/policies-guidelines/amnesty/>.

### III. **Common Symptoms of Behavioral Health Conditions** (CALEA 41.2.7.a)

- A. Behavioral health conditions are often difficult for even trained professionals to identify in individuals. Officers are not expected to diagnose or make judgments about an individual's behavioral health condition. However, they must be alert to symptoms and signs common to such conditions and recognize behavior that is potentially dangerous to self or others.
- B. Symptoms of behavioral health conditions may vary from person to person. Commonly, persons with a variety of behavioral health conditions have thoughts, feelings, or behavioral characteristics which, at varying times, result in an inability to cope with the ordinary demands of life. Many of these symptoms represent internal, emotional states that are not readily observable from a distance but are noticeable in conversation with the individual.
- C. Often, symptoms of behavioral health conditions are cyclic, varying in severity from time to time. Duration of an episode can also vary, from weeks to months for some, and across many years or a lifetime for others. Many people have periods of lucidity, coupled with periods where they are more symptomatic.

- D.** Observing these symptoms or behaviors in someone does not automatically mean that they have a behavioral health condition but may instead indicate that they might be experiencing some trauma, crisis, are overly stressed or tired, are intoxicated, or are displaying symptoms or behaviors caused by an undetected illness or malady.
- E.** Symptoms of behavioral health conditions may include, but are not limited to:
- F. Social Withdrawal**
- Sitting and doing nothing
  - Withdrawal from family, friends; abnormal self-centeredness
  - Dropping out of activities such as occupations or hobbies
  - Decline in academic or athletic performance
  - Others saying the person is not “themselves”
- G. Depression**
- Loss of interest in once-pleasurable activities
  - Expression of hopelessness, helplessness, inadequacy
  - Changes in appetite; weight loss or gain
  - Behaviors unrelated to events or circumstances
  - Excessive fatigue and sleepiness, or an inability to sleep
  - Pessimism; perceiving the world as “dead”
  - Thinking or talking about suicide
- H. Thought Disorders**
- Inability to concentrate or cope with minor problems
  - Irrational statements: Poor reasoning, memory, and judgment. Expressing a combination of unrelated or abstract topics. Expressing thought of grandiosity, e.g., a person believes they are God. Expressing ideas of being harassed or threatened, e.g., CIA monitoring thoughts through TV set.
  - Peculiar use of words or language structure: Nonsensical speech or chatter. Word repetition – frequently stating the same or rhyming words or phrases. Extremely slow speech. Pressured speech – expressing an urgency in manner of speaking.
  - Excessive fears or suspiciousness: Preoccupation with death, germs, guilt, etc.
  - Delusions: Beliefs that are held with strong conviction despite strong evidence to the contrary (e.g., believing they are God, believing the CIA is after them, believing they have been abducted by aliens).
  - Hallucinations: False or distorted sensory experiences; when someone sees, hears, tastes, feels or smells things that are not outside of their mind (e.g., seeing people who don't exist, hearing voices others don't hear, feeling bugs crawling on their skin when there are no bugs).

**I. Expression of Feelings**

- Hostility from one formerly passive and compliant. Argumentative, belligerent, unreasonably hostile.
- Threatening harm to self or others
- Overreacting to situations in an overly angry or frightening way
- Indifference, even in highly important situations. Lack of emotional responses.
- Inability to cry, or excessive crying
- Inability to express joy
- Inappropriate laughter, reacting with opposite of expected emotion
- Nonverbal expressions of sadness or grief

**J. Behavior**

- Hyperactivity, inactivity, or altering between the two. Talking excitedly or loudly. Manic behavior, accelerated thinking, and speaking.
- Deterioration in personal hygiene and appearance. Bizarre clothing or makeup, inappropriate to environment – e.g., shorts in the winter, heavy coats in the summer.
- Involvement in automobile accidents.
- Drug or alcohol abuse.
- Forgetfulness and loss of valuable possessions.
- Attempts to escape through geographic change, frequent moves.
- Bizarre behavior – staring, strange postures or mannerisms, lethargic, sluggish movements, repetitious or ritualistic movements.
- Decorations- inappropriate use of household items; e.g., aluminum foil covering windows.
- “Pack ratting” waste matter/trash – accumulation of trash, hoarding.
- Unusual sensitivity to noises, light, colors, clothing.
- Changes in sleeping and eating habits.

**K. Cognitive Impairments**

- Disorientation in time, place, or person. Confusion, incoherence, and extreme paranoia.
- Inability to find their way in familiar settings.
- Inability to solve familiar problems.
- Impaired memory for recent events.
- Inability to wash and feed oneself; urinary or fecal incontinence. The presence of feces or urine on the floors or walls.

**IV. Common Encounters**

Officers should be prepared to encounter a person with a mental health challenge at any time. Common situations in which such individuals may be encountered include, but are not limited to, the following:

- A. **Wandering:** Individuals with behavioral health conditions or who are in crisis may be found wandering aimlessly or engaged in repetitive or atypical behaviors in public places, including on campus grounds and walkways and lobby areas.
- B. **Seizures:** Persons with developmental disabilities or other behavioral health conditions are more often subject to seizures and may be found in medical emergency situations.
- C. **Disturbances:** Disturbances may develop when caregivers are unable to maintain control over a person in crisis or experiencing a behavioral health condition and engaged in self-destructive behaviors.
- D. **Strange, atypical, and unusual behaviors:** Repetitive and seemingly nonsensical motions and actions in public places, inappropriate laughing or crying, and personal endangerment. For example, some individuals engage in “stimming,” which describes repetitive movements which tend to self-soothe individuals experiencing a crisis or behavioral health condition.
- E. **Offensive or socially inappropriate behaviors:** Socially inappropriate or unacceptable acts such as ignorance of personal space, self-neglect of hygiene, annoyance of others, inappropriate touching of oneself or others, are sometimes associated with an individual that has a behavior health condition who is not conscious of acceptable social behaviors.

V. **General Response** (CALEA 41.2.7.c)

Although the response to individuals experiencing behavioral health conditions generally should be led by members of the Johns Hopkins University (JHU) joint Behavioral Health Crisis Support Team (BHCST), JHPD officers may nonetheless need to interact with such individuals in a variety of contexts. This section provides guidance on how to approach and interact with people who may have a behavioral health condition or be in crisis, including those who may be crime victims, witnesses, or suspects. These guidelines should be followed in all contacts, whether on the street or during more formal interviews and interrogations. The specific procedures for responding to a call for service involving a person experiencing a crisis or behavioral health condition are detailed in JHPD Directive #416, Behavioral Health Crisis Dispatch.

- A. Persons with behavioral health conditions may be easily upset and may engage in difficult behaviors such as tantrums or other self-destructive behaviors. Changes in daily routines or other stressors may trigger these behaviors.
- B. Frequently, a family member, friend, pet, or emotional support animal is of great value in calming an individual exhibiting unusual behavior as a result of behavioral health crisis. Similarly, a member of the joint BHCST may have unique knowledge or rapport with the individual and could be of assistance in de-

escalating, calming, or uniting the individual with persons who could provide assistance.

C. While protecting their own safety, the safety of the person with behavioral health conditions or in crisis, and others at the scene, officer(s) should maintain a safe distance and:

- **Speak calmly:** Loud, stern tones will likely have either no effect or a negative effect on the individual. Let the individual know your concerns and ask if they are feeling distressed. Attempt to identify the problem.
- **Be accepting and non-judgmental:** Help the individual determine what the problem might be without minimizing their feelings or judging them for feeling distressed. Acknowledge your recognition that they are hurting or experiencing distress.
- **Use non-threatening body language:** Keep your hands by your sides if possible.
- **Eliminate commotion:** Eliminate, to the degree possible, loud sounds, bright lights, sirens, and crowds, moving the individual to a calm environment if possible.
- **Look for personal identification:** Medical tags or cards often indicate behavioral health conditions and will supply a contact name and telephone number.
- **Call the caregiver:** The caregiver is often the best resource for specific advice on calming the person and ensuring officer safety until the contact person arrives.
- **Prepare for a lengthy interaction:** Individuals with behavioral health conditions or in crisis should not be rushed unless there is an emergency.
- **Repeat short, direct phrases:** Too much talking can distract the person and confuse the situation.
- **Be attentive to sensory impairments:** Many individuals with behavioral health conditions or in crisis have sensory impairments that make it difficult to process information. Officers should use soft gestures and simple, direct language. Officers should refrain from touching the person unless absolutely necessary, making quick movements and automatically interpreting odd behavior as belligerent.
- **Be aware of different forms of communication:** Individuals with behavioral health conditions or in crisis often demonstrate limited speaking capabilities and use signals or gestures instead of words.

D. Officers should generally avoid actions that include, but are not limited to:

- Moving suddenly, giving rapid orders or shouting

- Forcing discussions
  - Maintaining direct, continuous eye contact
  - Touching the person, unless essential for safety
  - Resting their hands on their guns or other weapons on their duty belts, which may be perceived as threatening in some cases
  - Crowding the person or moving into the person's comfort zone
  - Expressing anger, impatience, or irritation
  - Assuming that a person who does not respond cannot hear
  - Using inflammatory language, such as "mental" or "mental subject"
  - Offering the person multiple choices that can add to the subject's confusion
  - Challenging delusional or hallucinatory statements
  - Misleading the person to believe that officers on the scene think, believe, or feel the way the person does
- E.** If the officer believes that the individual may be considering suicide, the officer may directly ask if the person is thinking about killing themselves. The officer may attempt to discern the individual's plan for carrying out the suicide, including the planned means for doing so, whether the person has access to those means, when and where they intend to carry out the plan, and whether they have attempted suicide in the past.
- The more specific and lethal the plan, the more recent a previous attempt, and the greater ability to carry out the plan, the higher the risk for suicidal behavior. See JHPD Directives #416, Behavioral Health Crisis Dispatch, and #417, Emergency Medical Examination and Assistance, for procedures to follow when an individual threatens to harm themselves.
- F.** Once sufficient information has been collected about the nature of the situation, and the situation has been stabilized, there is a range of options officers should consider when selecting an appropriate disposition. These options are detailed in JHPD Directives #416, Behavioral Health Crisis Dispatch; and #417, Emergency Medical Examination and Assistance; and #418, Behavioral Threat Assessment.
- G.** Officers shall not arrest an individual for behavioral manifestations of behavioral health conditions or crisis that are not criminal in nature. Even when a crime is committed, officers must consider the appropriate enforcement method, pursuant to JHPD Directive 424, Arrests & Alternatives to Arrest.
- Officers are reminded that arrest may be appropriate if a felony has been committed or a person has an outstanding criminal arrest warrant.

- However, for minor violations of the law, officers may refer persons to one of the behavioral health resources in lieu of arrest/engagement of the criminal justice system. See Section VIII of this Directive, Behavioral Health Resources, for a list of such resources.

**H.** An individual's immediate medical needs shall take precedent over arrest processing when a crime has been committed. When circumstances permit, officers should consider alternatives to arrest, such as issuance of a criminal written warning, citation, or completion of an Application for Statement of Charges and Criminal Summons.

## **VI. Interview & Interrogation** (CALEA 41.2.7.c)

- A.** Officers attempting to interview an individual with a behavioral health condition or in crisis should consult with the appropriate State's Attorney's prosecutors with jurisdiction, as well as a behavioral health professional, to determine if the person understands the *Miranda* rights. See JHPD Directive #416, Behavioral Health Crisis Dispatch
- B.** When interviewing individuals with a behavioral health condition or impairment, officer(s) should:
- Not interpret lack of eye contact or "strange" actions as indications of deceit
  - Use simple and straightforward language
  - Refrain from suggesting answers, attempting to complete the person's thoughts, or posing hypothetical conclusions
  - Recognize that the individual might be easily manipulated and highly suggestible

## **VII. Training** (CALEA 41.2.7.d, e)

- A.** All JHPD members will receive documented entry-level training regarding interactions with persons suspected of suffering from a behavioral health condition that is appropriate for their assignment. Training shall be developed by the Public Safety Training Section in collaboration with behavioral health professionals.
- B.** JHPD shall provide all entry-level personnel with training on responding to persons with behavioral health conditions or in crisis. Newly hired personnel will receive training during the following times:
- Sworn officers – during the Police Academy and Field Training Program
  - Non-sworn officers – during New Hire Orientation

- C. JHPD shall provide refresher training on an annual basis. Annual refresher training may include, but not be limited to:
- Roll call training
  - Online exercises
  - In-service or professional development programs such as Mental Health First Aid, Crisis Intervention Training (CIT), etc.
  - At minimum, policy reviews will be assigned and completed using PowerDMS.
- D. All officers will receive specialized Crisis Intervention Team (CIT) training and be certified to address situations involving the mentally ill, incapacitated persons, persons in crisis, and their families.
- CIT certified officers are a resource when responding to individuals who exhibit behavioral indicators of mental illness, developmental disabilities, or display behaviors indicative of someone experiencing emotional trauma or incapacitation due to alcohol, drugs, or other substances.
  - Only CIT-certified officers should respond to calls for services involving individuals experiencing a mental health crisis. Responding officers should identify themselves as CIT-certified upon their arrival to the scene.

### **VIII. Behavioral Health Resources (CALEA 41.2.7.b)**

- A. Resources offered through JHU include:
- Student Health and Well-Being Mental Health Services (Homewood and East Baltimore campuses)
  - Student Outreach Services (SOS) (Homewood Campus)
  - Student Disability Services (SDS)
- B. Several providers in the larger community are also available to assist officers and telecommunicators. These include, but are not limited to:
- National Alliance on Mental Illness (NAMI) Metro Baltimore - (410) 435-2600
  - Baltimore Crisis Response, (410) 433-5175
  - National Alliance on Mental Illness (NAMI) Maryland, 1-877-878-2371
  - Maryland Behavioral Health Helpline, 211, press 1
  - National Alliance on Mental Illness District of Columbia (NAMI DC), (202) 546-0646
  - Washington DC Access HelpLine, 1-888-793-4357
  - National Alliance on Mental Illness (NAMI), 1-800-273-8255



- Maryland Mental Health Association
- Maryland Psychological Association
- Maryland Youth Crisis Hotline
- Mental Health Association of Maryland
- National Suicide Prevention Hotline: 988

## Policy Enforcement

<b>Enforcement</b>	Police Department managers and supervisors are responsible for enforcing this Policy.
<b>Reporting Violations</b>	Suspected violations of this Policy should be reported to the Public Safety Accountability Unit, (PSAU).

## Related Resources

<b>University Policies and Documents</b>
Operational Procedure #412, Custody, Transport & Processing. Operational Procedure #416, Behavioral Health Crisis Dispatch Operational Procedure #417, Emergency Medical Examination and Assistance Operational Procedure #418, Behavioral Threat Assessment Operational Procedure #424, Arrests & Alternatives to Arrest  JHU Campus Safety and Security General Orders C.10, Behavioral Health Crisis Support <a href="#">JHU Student Amnesty for Alcohol &amp; Drug Emergencies Policy</a> , <a href="#">JHU Behavioral Health Crisis Support Team</a>
<b>External Documentation</b>
The Arc of the United States, <a href="https://thearc.org/">https://thearc.org/</a> . American Psychiatric Association, <a href="https://www.psychiatry.org">https://www.psychiatry.org</a> .
<b>Police Department Forms and Systems</b>
<a href="https://powerdms.com/ui/login">https://powerdms.com/ui/login</a>

## Contacts

Subject Matter	Office Name	Telephone Number	E-mail/Web Address
Policy Clarification and Interpretation			