

**62.1 PURPOSE**

The purpose of this chapter is to provide guidance to the law enforcement officers of this Department when responding to and resolving situations that involve persons suspected of being mentally ill.

**62.2 POLICY**

It is the policy of the Hagerstown Police Department to recognize that in enforcement and related contexts, dealing with individuals who are known or suspected to be mentally ill, and who are potentially a danger to themselves or other, requires officers to make difficult judgments about the mental state and intent of the individual. Given the unpredictable and sometimes violent nature of the mentally ill, officers are never expected to 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 state law regarding the detention of the mentally ill. Officers shall use this policy to assist them in deciding whether a person's behavior is indicative of mental illness, and in determining appropriate assistance and referral options with the mentally ill in a constructive and humane manner.

**62.3 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.

**62.4 RECOGNIZING SYMPTOMS OF MENTAL ILLNESS AND ABNORMAL BEHAVIOR**

- .1 The information in this section is intended to assist officers with formulating appropriate strategies for gaining the individual's compliance, determining whether medical or other assistance is required, determining whether detention is appropriate or required, and, if the suspect is to be questioned or interrogate deciding whether the individual is competent to waive his constitutional rights and submit to questioning in a rational manner. Officers are not expected to make diagnosis of mental illness, rather they need to recognize behavior that is potentially destructive and/or dangerous to self or others.
- .2 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. Officers should not rule out other potential causes such as reactions to narcotics or alcohol, or temporary emotional disturbances that are situationally 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:
  - **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 provocation.
  - **Appropriateness of Behavior.** An individual who demonstrates extremely inappropriate behavior for a given content may be mentally ill. For example, a motorist who vents his frustration in a traffic jam by physically attacking a motorist may be emotionally unstable.
  - **Extreme rigidity of Inflexibility.** Emotionally ill persons may be easily frustrated at new or unforeseen circumstances and may demonstrate inappropriate or aggressive behavior when dealing with the situation.
  - **Abnormal mental loss.** This could include common facts such as name or home address. In some cases, however, such memory lose may be the product of other physical ailments. With older persons, in particular, one should not overlook the possibility of Alzheimer's disease.
  - **Delusions.** This includes 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"). Delusional persons may also have generalized fears or beliefs such as unrealistic fears that they are being constantly watched; that their conversations or even their thoughts are being overheard, recorded, or monitored; or, that they we being talked about, followed, or otherwise persecuted.

- **Hallucinations.** This may affect any of the five senses (e.g., hearing voices commanding the person to act, feeling one's skin to crawl, smelling strange odors, etc.). However, hallucinations may also be induced by drugs or alcohol.
- .3 Mental Illness can also be evident when individuals display sudden changes in lifestyle, which include but are not limited to an unwillingness to live up to commonly accepted roles and responsibilities, sudden and drastic mood swings, serious lack of judgment regarding money, job, family, and property; or marked and extreme departures in dress and sexual behavior. The mentally ill person may also be obsessed with recurrent and uncontrolled thoughts, ideas, or images, or may appear highly confused, frightened or depressed. Extreme fright or depression.

### 62.5 OTHER CAUSES OF ABNORMAL BEHAVIOR

Officers should not confuse mental illness with abnormal behavior that is the product of other physical disabilities. This includes mental retardation or other developmental disabilities that may include some of the characteristics of the mentally ill. There are important differences between individuals suffering from these other medical conditions and the mentally ill. These conditions include the following:

- **Mental retardation.** Mental retardation refers to subnormal intellectual capacity and deficiencies in a person's ability to deal effectively with social conventions and interaction. The mentally retarded may display behaviors that are rational but that are similar to younger persons who are not retarded. The mentally retarded individual does not demonstrate this type of behavioral fluctuation. The mentally retarded individual does not engage in violent behavior without the types of provocations that may initiate violence among the non-retarded person.
- **Cerebral palsy.** Persons suffering from cerebral palsy exhibit motor dysfunctions that may, at first glance, be confused with some characteristics of either the mentally retarded or the mentally ill. These include awkwardness in walking, involuntary and uncontrollable movements, or seizures and problems in speech and communication.
- **Autism.** The characteristics of an autistic person may also be confused with those of mental retardation and mental illness. The autistic often engage in compulsive behavior, or repetitive and peculiar body movements, and can become very distressed over minor changes to their environment. They may also display unusual reactions to objects or people they see around them; appear insensitive to pain; and may, be hyperactive, passive, or susceptible to tantrums. Such persons may also appear retarded in some areas, but highly capable or even gifted in others.

### 62.6 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 a mentally ill person represents an immediate or potential danger to himself, the officer or others. These include the following:

- The availability of any weapons to the suspect.
- 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.
- 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.
- Failure to act prior to arrival of the officer does not guarantee that there is no danger, but it does in itself tend to diminish the potential for danger.
- The amount of control that the person demonstrates is significant particularly the amount of physical control over emotions of rage, anger, fright, or agitation. Signs of a lack of control include 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.
- 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.

**62.7 POLICE RESPONSE TO THE MENTALLY ILL**

- .1 For the officer who must deal with a person acting in a bizarre or abnormal manner, the immediate issue is one of determining the intent and capabilities of the individual and taking those steps to ensure the safety of the officer and others.
- .2 Officers must always be aware of the unpredictable nature of many mentally ill persons.
- .3 The more information obtained on the individual, the better the officer will be in making responsive decisions. Sources of information may include dispatchers, concerned citizens, court documents, family members, or other individuals. Important information includes the person's present or past use of prescription drugs. Many persons who suffer from mental illness fail to use medication that has been prescribed for their diagnosed mental illness. In addition, many mentally ill persons attempt to alleviate their anxieties and related mental disturbances through self-medication with drugs, alcohol, or a combination of these substances. The use of these drugs can exacerbate existing mental problems.
- .4 Unless a crime of violence has been committed and/or a dangerous weapon is involved, officers should normally respond to the incident or approach a known mentally ill subject in a low-profile manner. If used, emergency lights and siren should be turned off as soon as possible upon arrival.
- .5 Where there is reason to believe that the subject is in a crisis situation, such as threatening suicide or involved in a hostage and/or barricade, a supervisor shall be notified to respond to the scene. The supervisor shall notify the SRT Commander or assistant team leader who shall assess the need for SRT and Hostage Negotiators.
- .6 At the scene, take time, if possible, to survey the situation. Before approaching the suspected mentally ill person, try to bring the immediate situation under control. Control (preferable disperse) crowds, bystanders, or family members who create disruption.
- .7 Once the immediate surroundings are under control, attention should be directed toward determining whether the individual represents a danger to himself or others. The following are examples of characteristics indicative of such danger:
  - Threatening statements made by the subject where the capacity or capability to commit violence exists. Such statements may range from subtle innuendoes to direct threats.
  - Personal history.
  - Observed actions, both on the scene and prior to the officer's arrival.
  - The amount of control that an individual demonstrates.
  - Volatility of the environment.
- .8 When making contact with a suspected mentally ill person, officers should attempt the following:
  - Move slowly toward the and assume a physically defensive posture in relationship to the individual.
  - Attempting to build rapport by speaking in a calm, relaxed, non-judgmental manner.
  - When speaking with the individual, the officer should exhibit a take-charge attitude but without becoming overbearing, condescending, or intimidating.
  - Demonstrate empathy for the individual's problems, no matter how trivial or bizarre they may appear.
  - Avoiding issues and topics that may serve to agitate the individual.
  - Guide the conversation toward subjects that help bring the subject back to reality.
  - Reassure the individual that the officers are there to help and that an appropriate resolution of the problem can be reached.
  - Allow the person to ventilate in order to determine what is bothering him.
  - Be truthful. If the person becomes aware that officers are deceiving him, he may withdraw from contact in distrust and may become hypersensitive or retaliate in anger.

- Do not threaten with arrest or other enforcement action as this will only add to the subject's fright and stress and may potentially spark aggression.
- Consider the assistance of a professional, if available and appropriate to communicate with and/or calm the person.

### 62.8 TAKING CUSTODY

- .1 Persons suspected of mental illness may be taken into custody pursuant to a lawful arrest, a Petition for Emergency Evaluation, or both. Once a decision has been made to take a suspected mentally ill person into custody, it should be done as soon as possible to avoid prolonging a potentially violent situation. Department policy pertaining to the use of force, restraints, and prisoner transportation shall be followed (refer to HPD Rules and Regulations Chapters 12, 24, and 27).
- .2 If an officer anticipates a violent or potentially violent person will be taken into custody, the officer shall attempt to have less lethal weapons present before custody is attempted. Such weapons will be deployed according to training and Department policy and procedures.
- .3 Petition for Emergency Evaluation (form CC/DC 13)
  - .1 The Health General Article, §10-620 to 10-626, provides the circumstances under which an individual suspected of mental illness is to be taken into custody pursuant to a Petition for Emergency Evaluation (CC-DC 13).
  - .2 If the petition presented to HPD for service has been endorsed by the court within the last 5 days, or if it is accompanied by the certification page (CC-DC 14) signed by one of the qualified persons listed on the form, HPD officers shall take the person into custody.
  - .3 If the officer is the petitioner, he/she shall complete the petition and the Certification by Peace Officer section of the CC-DC 14. This may be done after the officer has taken the person into custody, but as soon after arrival at the Hospital as possible. It must be completed before the person can be examined.
  - .4 Once a person is in custody pursuant to a Petition for Emergency Evaluation, the officer(s) shall transport the person to the Meritus Medical Center for evaluation. The person and the Petition shall be presented to the appropriate medical personnel.
  - .5 After an officer takes the emergency evaluatee to WCH, the officer need not stay unless, because the emergency evaluatee is violent, a physician asks the officer's supervisor to have the officer stay. The officer shall stay until the supervisor responds to the request for assistance. If the emergency evaluatee is violent, the supervisor shall allow the officer to stay. If a physician asks that an officer stay, a physician shall examine the emergency evaluatee as promptly as possible.
  - .6 The serving officer will complete an investigative report anytime a Petition for Emergency Evaluation is served, regardless of origin.
- .4 Arrest
  - .1 Should an officer determine that a person known or suspected to be mentally ill has committed a violation of law, the officer will take the same appropriate action (e.g. arrest, apply for charging document, issue citations, advise warrants) as with persons not known or suspected to be mentally ill.
  - .2 If an arrested person meets the conditions for an Emergency Petition, the person will be handled as described in the above procedures for Petition for Emergency Evaluation. If the person is to be admitted, an officer or officers will remain with the person until the person is turned over to the facility or appropriate transport personnel. The arresting officer will ensure that the facility is notified of the charges against the person and requested notification of the release date prior to the persons release. Upon notification from the facility that the person is to be released, the patrol supervisor will arrange for transportation back to HPD, or warrant service by another agency if feasible.

.5 Detention

If a person known or suspected to be mentally ill is arrested, the arresting officer shall follow the procedures in section 27.4 of the HPD Rules and Regulations Manual.

## 62.9 INTERVIEWS AND INTERROGATIONS

.1 If the officer ascertained that a crime or other incident has occurred and an investigation is necessary, he or she should first consult with the other officers initially responding and the supervisor. If mental health issues have been identified in relation to a witness, victim or suspect these must be documented in the resulting reports. Investigative techniques may deviate from standard procedures in light of the needs of the subject, but also in light of prosecutorial needs.

.2 Victims/Witnesses with special mental health needs. The mentally ill/mentally deficient are frequently victims or witnesses of crimes and incidents. Recognizing the condition and reacting appropriately may be the key to an effective investigation. Investigating officers should be aware of the following when a victim/witness with special mental health needs is to be interviewed:

- If the victim/witness appears to the officer to require treatment or counseling prior to an effective questioning, ensure this is obtained as soon as possible and before any questioning. Refer to the section below on referrals. HPD Victim/Witness advocates may be helpful in coordinating treatment or counseling.
- If it appears the victim/witness requires special techniques of a more experienced investigator, questioning should be conducted by experienced personnel.
- Establish the victim/witness understands the investigative procedure. Initial questioning should ask simple questions about the day of the week, the date, knowledge of well known current events – these questions may help determine the strength of the subject’s memory and perception.
- Establish whether or not the victim/witness has a history of problems with perception of time and distance (very common in the mentally deficient due to retardation or age)? If so, take special note of the answers and compare distances and time frames to points of reference known to the victim/witness instead of units of measure or days of the week.
- When possible, tape record the statement of the victim/witness. A variety of issues may prevent the victim/witness from testifying effectively, such as lapse of memory, change in mental condition, change in relationship with the suspect, etc.

.3 Suspects with special mental health needs. The mentally ill/mentally deficient suspect presents additional issues, as these issues will play into issues of proof for the State, may play into an insanity defense, and certainly will affect the leniency or “treatment” meted out by a sentencing court. Identifying malingering or “faking it” is less important than establishing the degree of mental illness or mental deficiency. Issues regarding the defendant’s ability to control his behavior and understanding right and wrong frequently will be analyzed in light of his or her initial statement (perhaps the only opportunity to get a statement). Most crucial will become a determination of whether or not the suspect gave his or her statement knowingly and voluntarily. Documentation is crucial.

- Tape recording or video recording of the defendant is crucial.
- Photograph the suspect.
- In an important case, consult with the prosecution staff early; if possible while the initial interview is underway.
- If the suspect brings up the issue of his or her “condition”, follow up with additional questions as this is a tell tale sign that the Defendant is exaggerating his or her condition.
- When possible, develop probable cause and search the suspect’s person or property documenting specifically the medicines found, and any writings of the suspect, as these are very helpful in identifying a potential mental condition.

**62.10 MAKING REFERRALS**

- .1 When the criteria for taking the person into custody does not exist, officers can make mental health referrals and provide some basic guidance for the individual. Officers may also provide the person's friends, family, or other support systems in the community with information on mental health facilities. A list of referral sources may be found at the end of this chapter.
- .2 Officers may, based on the nature of the situation, request assistance by either direct intervention by a mental health professional, either at the scene, by telephone, or by transporting the subject to a centralized location where professional treatment can be obtained. Refusal to submit to voluntary examinations or professional assistance can be expected in many instances. If appropriate, officers may explain that without professional assistance, the person's action may eventually result in his/her being arrested or subject to involuntary examination in a mental health facility where legal grounds exist. Many mentally ill persons, recognizing that they are not fully in control of their actions and/or thoughts and aware of stories of confinement related by other mentally ill acquaintances, fear mental health professionals and examinations. Officers can dispel some of that fear by explaining that an examination does not mean incarceration or confinement in a mental health facility but may provide them with much-needed assistance and possibly allow them to avoid future confrontations with others, including the police.
- .3 In cases where the individual is extremely agitated, it is generally inadvisable to leave the person unattended as the person may resort to the same behavior that was the basis for police intervention in the first place. In such cases, officers may, with supervisory permission, provide transportation for a willing individual to a facility that can provide shelter, counseling, or related mental health services, or to the home of a friend, family member, or acquaintance who may be willing to provide assistance.

**62.11 REPORTING INCIDENTS**

- .1 If an incident involving a person suspected of being mentally ill results in an arrest, emergency evaluation, an/or other report being filed, the report needs to be as explicit as possible concerning the circumstances of the incident and the observed behavior. 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.
- .2 Some other information that should be documented include:
  - Officer's initial observations and the steps taken immediately after getting the situation assessed and under control.
  - Appearance and demeanor.
  - History known to you, or given to you by subject or others.
  - Doctor's name, if any.
  - Drugs, prescribed and unprescribed.
  - Steps taken to make the situation safe and obtain immediate treatment.
  - Statements of subject.
- .3 **LEGAL CAUTIONS:** Mental health records are highly sensitive. Do not ask for such records from any source. If obtained unintentionally, immediately give it to a supervisor. The supervisor give the records to the Support Services Administrator who shall contact the city attorney for further guidance.

**62.12 TRAINING**

- .1 All sworn personnel, Records Unit Personnel (due to their responsibilities as city switchboard operators, and community service officer shall receive entry-level training regarding interaction with persons suspected of suffering from mental illness. Additionally, these personnel shall receive refresher training every three years. Entry level and refresher training shall be coordinated by the Training Coordinator who shall also document same.
- .2 Every three years, all sworn personnel shall receive training regarding interaction with persons believed to have autism or Down Syndrome.

**62.13 DEALING WITH PERSONS BELIEVED TO HAVE AUTISM**

- .1 Autism is defined as a neurodevelopmental disability. Autism and its related disorders affect the normal development of the brain in the areas of social interaction, communication, repetitive behaviors and difficulty adjusting to change.
- .2 Autism is NOT a mental or psychological disorder.
- .3 People with developmental disabilities are seven times more likely to come in contact with police than a member of the general public
- .4 Recognition: While law enforcement officers are not expected to diagnose Autism, they may observe some common signs in a field situation.

Social Interaction:

- Avoids eye contact.
- Prefers to be alone.
- Does not notice other people.
- Does not respond to name (may appear deaf, cover their ears and look away).
- Lacks empathy.
- Is unable to see another person's perspective.
- Has unrealistic fears (bugs, dogs, dentist, etc.).
- Has difficulty making transitions.

Communication:

- Is non-verbal (about 50%), or have limited speech.
- Has limited vocabulary.
- Has problem with speech volume (loud whisper, and/or monotone sounding, like a computer talking).
- Talks to themselves or no one in particular.
- Uses echolalic speech (echoes, or repeats everything you say).
- Does not point to objects or use gestures.
- Does not respond to other people's words or gestures.
- Laughs, giggles or other inappropriate response to questions (May say "No" or "Why" to everything).
- Unable to process nonverbal cues like facial expressions or body language.

Behavior:

- Has unusual repetitive behaviors such as rocking back and forth, spinning, hand flapping, finger flicking or twirling an object.
- Has tantrums (i.e., screaming, hitting, biting, hair pulling) if anything disrupts the daily routine or the obsessive behaviors.
- Has an obsessive need for order and routine.
- Has unusual reactions to pain; either unresponsive or over reacting.

- Has unusual responses to light, sound or other sensory input.
- Seeks sensory stimulation, including heavy pressure.
- Has no fear or sense of danger.
- Avoids touch.
- Displays unusual gait. May appear clumsy, walk pigeon-toed, use double footing on stairs or run with a “duck-waddle” motion.
- Has attraction to water, lights, reflections and shiny objects.

Identification:

People with autism may wear a medical alert bracelet, a shoe tag or carry an autism information card with their name, address, phone number and contact numbers for parents/caregivers and doctors. If a vehicle is involved, look for an autism alert decal, puzzle ribbon, or bumper sticker. There may be an Autism Emergency Contact Form in the glove compartment. A high functioning person with autism may verbally tell you that he/she has autism and carry an information card.

Sensory Overload: A person with autism may react differently to what we perceive as normal levels of light, sound, touch, odor and taste (the five senses). A person with autism may run from or toward lights, sirens, two-way radios, canine partners, aromas, or a light touch on his/her body. They cannot handle stimuli from more than one sense at a time. Sensory overload results in the person starting a self-stimulating, or “*stimming*” behavior. He/she will be so fixated on what he/she is doing that you cannot get his/her attention. If the person is also hypersensitive to touch, he/she may suddenly pull away, run or scream when touched. ***Be very aware of and manage the sensory environment during any situation with a person possibly having autism.*** Assess the scene for sensory influences. If safe to do so, turn off sirens and flashing lights, remove canine partners, and move the person to a quiet area. The key here is that “Calm creates calm”. If the behavior escalates, use geographic containment and maintain a safe distance until behavior improves. Be patient. Give the person space and time to calm down. Speak in simple “bullet point” language and reassure the person that he/she is OK.

- .5 Potential Autism-Related 911 Calls: Most autism-related calls for assistance will involve a person that is either exhibiting self-stimulating or aggressive behavior toward others, or has run or wandered away. Self-stimulating behaviors may escalate into Serious Injurious Behaviors (SIBs) due to things in the environment.

**Examples of Self-Stimulating or Aggressive Behavior calls:**

- Parent/caregiver actions are misunderstood. A parent refuses to buy his autistic son a toy at the mall and the child has a “melt down” by lying on his back on the floor, kicking and crying. The parent picks the child up and carries him out of the store still kicking and crying and bystanders call the police.
- The person is “acting weird” in a place where he/she is unknown. You receive a call from a store clerk because a man is opening food/drink packages, eating without paying and acting suspicious. When you arrive, he ignores your orders to put the packages down—gets belligerent and says that “these are MY chips” and seems aggressive and defensive.
- People with autism like to pick up random items and put them back down, or rearrange store displays. You receive a call from a music store because a teenager is randomly picking up CDs and putting them back into the display in different places—looking around the store, but never making eye contact with the employees.
- A high functioning person with autism may follow a customer around a store, even watching them from around corners of the displays trying to be helpful.

**Response:** Your best response is to stay calm and focussed. Use simple language and speak slowly. Be very patient—a person with autism has trouble sending and receiving messages. They will respond inconsistently depending on emotional state, familiarity with the people involved in the situation and the sensory environment.

**Running or Wandering Away Behavior:**

- May wander or run into traffic
- May look in windows or attempt to enter nearby homes
- May wander into wooded areas, onto train tracks and onto elevated places such as rooftops and towers.
- May hide in alleys or under things such as a mattress or box
- May be found wearing a tee shirt and shorts in freezing rain or snow and not be cold
- May be found running naked in the neighborhood
- Keep in mind that a person with autism does not know that he/she is lost and probably will not ask for help. Also be aware that a person with autism may not respond to you calling his/her name and may hide from a stranger.

**Response:** The best response for these calls is ***to call for backup*** while getting as much information as possible from the person making the call. Quite often this will be the parent or caregiver. Many parents/caregivers have their child's information in a local 911 Call Center database and/or an Autism Emergency Contact Form with a photo and detailed information about their child's characteristics, favorite places, and likes/dislikes including how to approach and de-escalate behaviors.

Check nearby water sources (pools, lakes, rivers and fountains). Drowning is a leading cause of death for people with autism.

***Check with the Emergency Communications Center to see if the person is a Project Lifesaver participant.*** If the person is a Project Lifesaver participant, he/she will have an electronic tracking device which will greatly enhance first responders' location and rescue efforts. This information will likely be gathered by the ECC call taker, however the responding officer should verify it. If the person is a Project Lifesaver participant, the ECC will begin the notification procedures for an Electronic Search Specialist (ESS) who will assist in the search using the electronic tracking equipment.

Check nearby water sources (pools, lakes, rivers and fountains). Drowning is a leading cause of death for people with autism.

- .6 During a field encounter, a person with autism may:
- Inappropriately approach, invade your personal space or stand too far away
  - Be nonverbal (around 50%)
  - Attempt to re-enter a dangerous environment (burning house, run into traffic, etc.). [They are a "bolt risk".]
  - Be upset about minor changes in daily routine
  - Have a problem recognizing police uniforms or vehicle
  - Not understand command presence, body language or nonverbal communication (eye rolling, shrugs, hand signals, etc.)
- .7 Safety and Communication Tips:
- Approach in a quiet, non-threatening manner.
  - Make sure person is unarmed and keep a safe distance.
  - Model calming body language (slow breathing and keeping hands down low).
  - Avoid rapid movements like pointing or waving.
  - Use low gestures and keep your hands down around waist level.
  - Talk calmly—talking louder does not help understanding.

- Talk in direct, short phrases; i.e., Stand up now, Go to the car, etc.
  - Allow for delayed responses to questions or commands. Allow 10-15 seconds at a minimum.
  - Avoid literal expressions including “That’s the way the cookie crumbles”, Are you waiving your rights? etc.
  - Consider using a communication board that displays Yes/No, alphabet, simple phrases, or pictures. Some can communicate using a computer.
  - Avoid positional asphyxia—turn person on side often if restrained
  - Person may have seizures if senses are overloaded.
- .8 De-escalating Behavior:
- Emergency situations require an immediate response. If you determine that the person is unarmed and not in immediate danger, allow time, space and management of the environment to help let the person de-escalate without your intervention.
  - Do not interpret the person’s failure to respond to your orders or questions as a lack of cooperation or a reason for increased force.
  - Ask a parent/caregiver how to communicate with the person.
  - If the person is fixated on an inanimate object—let him/her hold the object if officer safety is not compromised
  - Avoid stopping repetitive behavior unless individual or officer safety is an issue.
- .9 Restraining a Person with Autism:
- Avoid positional asphyxia. People with autism may have under-developed trunk muscles and may be unable to support their airway.
  - After takedown, turn the person on his/her side often
  - Monitor the person’s condition frequently
  - Up to 40% have some sort of seizure disorder. Asthma and heart conditions are also common.
  - The person may not recognize the futility of resistance and continue to struggle. Use communication, de-escalation and calming response techniques.
  - Avoid standing too near or behind the person as he/she may suddenly lurch backward.
- .10 Custody and Arrest Considerations:
- Document autism in your initial report
  - Consider a medical evaluation at the hospital, particularly if force is used to gain compliance.
  - Alert detention facility and suggest a segregation placement
  - Contact parents or caregivers for information regarding care of and communication with, the person.
- .11 Interviewing a Person with Autism: Remember that autism has a social interaction deficit, which means that many of the things individuals with autism do appear to be rude or disrespectful. Keep these techniques in mind:
- Speak in a calm voice using simple and direct questions.
  - Use casual conversation to assess the person’s ability to communicate before an interview
  - Allow for delayed responses to questions, directions and commands
  - Understand the need to repeat and rephrase questions
  - Make sure your words and his/her words mean the same thing to both of you
  - Explain that you might have to ask questions more than one time
  - Let the person know it is OK to say “No” to your questions
  - Avoid asking “What time did it happen”? Instead, learn the person’s schedule and determine events from that context
  - Do not interpret limited eye contact as deceit or disrespect. It is very hard for an autistic person to concentrate and understand what someone is saying when they are looking directly at the person. One autistic young man said “I keep telling you. I’m looking at you. I’m looking at you. I don’t understand a word you are saying, but I’m looking at you. It is your choice. You can have me look at you or you can have me understand what you’re saying, but I can’t do both”.

**62.14 DEALING WITH PERSONS BELIEVE TO HAVE DOWN SYNDROME**

- .1 Down syndrome is a genetic condition that occurs in one in every 691 births. It is the most frequently occurring chromosomal condition and is found in people of all races and economic levels.
- .2 A few of the common physical traits of Down syndrome are low muscle tone, small stature, an upward slant to the eyes, and a single deep crease across the center of the palm. Every person with Down syndrome is a unique individual and may possess these characteristics to different degrees or not at all.
- .3 People with Down syndrome have an increased risk for certain medical conditions such as congenital heart defects, respiratory and hearing problems, Alzheimer's disease, childhood leukemia, and thyroid conditions. Although many of these conditions are now treatable, officers should be aware of them, and should consider a medical evaluation at the hospital, particularly if force is used to gain compliance.
- .4 People with Down syndrome experience cognitive delays, but the effect is usually mild to moderate and is not indicative of the many strengths and talents that each individual possesses. Children with Down syndrome learn to sit, walk, talk, play, and do most other activities, only somewhat later than their peers without Down syndrome.
- .5 Common Behavior Concerns
  - Wandering/running off.
  - Stubborn/oppositional behavior. At times the oppositional behavior may be the individual's way of communicating frustration or lack of understanding due to their communication/language problems. Children with Down syndrome become very good at distracting parents or teachers when they are challenged with a difficult task.
  - Attention problems: Individuals with Down syndrome can have ADHD but they should be evaluated for attention span and impulsivity based on developmental age and not strictly chronological age. The use of parent and teacher rating scales such as the Vanderbilt and the Connors Parent and Teacher Rating Scales can be helpful in diagnosis. Anxiety disorders, language processing problems and hearing loss can also present as problems with attention.
  - Obsessive/compulsive behaviors: These can be as simple as always wanting the same chair at the table to repetitive behaviors such as dangling beads or belts when not engaged directly in an activity. This type of behavior is seen more commonly in younger children with Down syndrome and while the number of compulsive behaviors is no different than those in typical children at the same mental age, the frequency and intensity of the behavior is often more in children with Down syndrome. Increased level of restlessness and worry may lead the child or adult to behave in a very rigid manner.
  - Autism Spectrum Disorder: Autism is seen in approximately 5-7% of people with Down syndrome.
- .6 Interventions strategies: While Down Syndrome is not the same condition as autism, the officers should employ the same intervention strategies identified in the previous section regarding persons believed to have autism.

## RESOURCES FOR DEALING WITH PERSONS WITH SUSPECTED MENTAL ILLNESSES

(Updated Dec. 2012)

Agency	Location	Phone Number	Services Available
Behavioral Health Services	11116 Medical Campus Road, Suite 2989	301-766-7600	Offers individual and group outpatient counselling to couples and individuals.
Brook Lane Health Services	13218 Brook Lane Dr.	301-733-0330	Private, not-for-profit psychiatric facility providing outpatient treatment and short-term hospitalization for all ages; for children and adolescents - Laurel Hall School, partial hospital program, and residential care
CASA, Inc.	116 W. Baltimore St.	301-739-4990  301-739-8975 hotline available 24 hours	Sexual Assault abuse and Domestic Violence related services, including legal advocacy. Hotline: 301-739-8975
Catholic Charities Villa Maria	229 N. Potomac St.	301-733-5858	Offers counselling and psychiatric services to individuals and families in need, regardless of faith or belief. It serves people with Medicaid, Pharmacy Assistance, and Maryland Children's Health Program (MCHP).
Health Department of Washington County	1302 Pennsylvania Ave.	Addictions & Mental Health: 240-313-3310	Offers services for those of all ages with all types of health issues.
Hospice of Washington County	747 Northern Ave.	301-791-6360	Provides community education and comprehensive care for the terminally ill person and his/her family as they face medical, emotional, social, and spiritual needs. Support is provided before and after the death of a loved one. Crisis counselling is available to all residents of Washington County. Sessions pertaining to assisting children can be arranged and can be held during the school day, with parent's permission.
Mental Health Center	1180 Professional Court	301-791-3045	Offers a comprehensive and coordinated menu of outpatient treatment and rehabilitation services to children, adolescents, adults, and their families
QCI Behavioral Health	201 North Burhans Blvd.	301-791-2660	Provides mental health outpatient and mobile treatment services to children, adolescents and adults. Only those with medical assistance or the ability to self-pay are served.

<b>Agency</b>	<b>Location</b>	<b>Phone Number</b>	<b>Services Available</b>
Washington County Mental Health Authority	339 East Antietam Street, Suite 5	301-739-2490	Provides information and referrals to persons with mental illness who are looking for assistance.