POLICE RESPONSE
TO EMOTIONALLY
DISTURBED PEOPLE
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Dimensions LLC
policing with perspective

Police Response to Emotionally Disturbed People

John Sofis Scheft, Esq.
Law Enforcement Dimensions, LLC
7 Central Street, Suite 100
Arlington, Massachusetts 02476
781-646-4377
ledimensions.com

Goodway Group of Massachusetts
16 A Street, Burlington, MA 01803

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Guideline development sponsored by
Massachusetts Interlocal Insurance Assoc.
3 Center Plaza - Suite 610
Boston, Massachusetts 02108
Telephone: (617) 426-7272

Technical research and writing by
John Sofis Scheft, Esq.
Law Enforcement Dimensions, LLC

POLICE INTERVENTION WITH EMOTIONALLY DISTURBED PERSONS (EDPs)

November 2, 2022

Section I. PERSPECTIVE & INTERVENTION

A. Purpose & Coverage

This policy provides guidelines for interacting with those who may be experiencing an emotional or mental health crisis.

Emotionally Disturbed Persons (EDPs) experience distress or mental health symptoms in a way that exceeds their ability to manage their behavior, emotions, or judgment.

- **Distress or mental illness can affect anyone.** It is not a result of weak character or lack of intelligence. Distress or mental illness may interfere with perception, judgment, behavior, and the ability to relate to others. Many individuals have episodic mental health crises, meaning they have good and bad days.

- **People with mental health needs are no more violent than the general population.** In fact, many are withdrawn and uncomfortable. If they become aggressive, it is usually because they feel frightened or confused. Maintaining safety may be challenging when a person has stopped taking prescribed medication or has a dual diagnosis — that is, a mental health disorder and a substance abuse problem.

This policy does not provide guidelines for the protective custody of people who are incapacitated by alcohol or drugs. See 111B, §§ 9 and 10 (protective custody for alcohol incapacitation). 111E, § 9A (protective custody for drug incapacitation).

However, it does cover the involuntary commitment of people who suffer from chronic alcohol or substance abuse. See Section III.

Multi-disciplinary intervention produces better outcomes. The members of this department understand that practical, ongoing collaboration with mental health providers and other community stakeholders has proven to produce better, more lasting outcomes in cases involving EDPs.

For this reason, the Chief designates a Mental Health Clinician, who:[i]

- Co-responds with officers in the field to calls for service involving EDPs;
- Provides officers, EDPs, and their families with assistance and referrals concerning mental health issues;
- Helps identify, develop, and support programs, services, resources, and training to enhance our department's response to EDPs.

All personnel must understand that the law and written guidelines can never provide all the answers — especially when it comes to EDPs. Officers, clinicians, and dispatchers are expected to make the best decision possible given the information they have. The department will support personnel whose decisions attempt to balance the need for public safety and the best interests of EDPs and their families.

Beyond following these written guidelines, personnel will be assessed on their intent as much as on the results of their intervention.

B. Initial Police Response

When coordinating the response to an incident that may involve an EDP, dispatch should provide critical information as it becomes available. This includes, but is not limited to:

- **History.** Whether there have been prior incidents or suicide threats/attempts.
- **Medication.** Whether the EDP took or failed to take medication.

[i] The preferred delivery system for departments is the Jail Diversion Program sponsored by the Department of Mental Health (DMH), which places Mental Health Clinicians with specific police departments in Massachusetts. There may be other models that departments utilize. The key is to provide police officers with assistance from a mental health clinician in real time.

- **Contacts.** Any contact information for a physician, mental health professional, or other legitimately involved party (e.g., family member, social worker, employer, etc.).

When encountering extreme behaviors on scene, officers should:

- **Consider the possibility of distress or a mental health episode.** Do not assume the EDP is dangerous or a criminal.[1] Typical indicators of a mental health episode include:
  - A plain, emotionless facial expression and body language.
  - Incoherent thoughts or speech.
  - Inability to focus or concentrate.
  - Bizarre appearance, movements, or behaviors.
  - Delusions of personal importance or identity; unrealistic over-confidence.
  - Hallucinations or perceptions unrelated to reality.
  - Agitation, often without clear reason.
  - Pronounced feelings of hopelessness, sadness, or guilt.
- **Consult individuals on scene who know the EDP.** They often provide the best information. For example, a parent, family member, friend or co-worker may know about the EDP's illness and behaviors, which may alert officers about ways to calm the situation instead of provoking a "fight-or-flight" response. Ask about medication. Many EDPs do not take prescribed medications because they dislike the side effects, deny their illness, or misuse them (hoping to lose weight or get high).
- **Consider passively monitoring the situation.** Sometimes presence alone may be the best police response, especially if a person on scene is having a positive impact on the EDP. Officers may monitor the situation and decide to take no action. If circumstances change, officers may intervene.

- **Interact calmly and compassionately.** Officers are advised to:

  - Introduce themselves *by name* and attempt to obtain the EDP's *name*. This greatly facilitates rapport and a calmer dialogue. [*Note:* It is not unprofessional to use first names. Use your judgment depending on the comfort level of the EDP.]

  - *Most important:* Understand that the failure to follow police directives during an episode may not be an act of deliberate defiance *and* may not present an officer safety issue.

  - Recognize that the EDP may be overwhelmed by sensations, thoughts, surroundings, internal sounds or voices. Try to limit the number of officers on scene and other distractors, such as flashing lights.

  - Reassure the EDP that you are there to help, not harm.

  - Be friendly and accepting, but remain firm and professional.

  - Speak simply and announce your actions before initiating them. Do not move suddenly or give rapid orders.

  - Avoid direct, continuous eye contact.

  - If possible, do not touch the EDP. Do not crowd his or her "comfort zone."

  - Ask the EDP for cooperation, and allow time to respond.

  - Remove upsetting influences and people from the scene.

  - Understand that you may not have a rational discussion, but try to keep the conversation concrete by redirecting the topic when needed.

  - Do not express impatience or irritation.

  - Acknowledge that the EDP's delusions are real to him or her. Do not argue. At the same time, do not mislead the EDP to think that you feel or think the same way.

- **Request assistance from the Mental Health Clinician or other medical or mental health personnel (if** needed).

- **Apply the least amount of force consistent with public, EDP and officer safety.**[2] Officers should factor into their tactical decision-making:

  - The display or use of a weapon or dangerous item.

  - An assault or aggressive behavior.

  - Self-injurious behavior that risks danger to the EDP or another.

  - The physical features of the location where they encounter the EDP. Specifically, officers may be able to establish a "buffer zone" or contain the EDP in an area where he or she does not present a risk of harm to others. Police/EDP dialogue at this point can be very helpful in de-escalating the situation.

6E, § 14 mandates that — prior to using any physical force — officers attempt de-escalation or determine that it is not feasible.[ii] 6E, § 1 defines de-escalation as proactive approaches designed to stabilize a law enforcement situation and gain a person's voluntary compliance or reduce the need to use force. Specific tactics include, but are not limited to:

- Verbal persuasion (see previous EDP indicators and communication approaches);

- Warnings;

- Slowing down the pace of an incident;

- Waiting out a person;

- Creating distance between the officer and the threat;

- Requesting additional resources to resolve the incident, including calling in medical or licensed mental health professionals.

[ii] Feasible means practical, probable, likely, achievable, attainable. Google search "definition of feasible." Sometimes — e.g., an EDP is actively assaulting a family member — de-escalation is not feasible and officers need to go "hands on" immediately.

C. Intervention Options

The primary goal is to resolve the situation safely for all involved individuals. This may be accomplished by:

- **Release to community.** Officers may allow the EDP to leave the scene alone or in the company of a caretaker or other reputable person.

- **Referral to mental health specialist.** Many non-dangerous calls involving an EDP are best handled by encouraging or arranging professional intervention at the scene, over the telephone, or at another location/facility.

- **Voluntary commitment.** Sometimes a family may be more inclined to push for treatment if they know it will persuade the police to avoid involuntary commitment. This approach also works with an EDP who is rational enough to acknowledge a need for treatment.

  - Under 123, § 10, voluntary commitment may be sought by: (1) a person who is at least 16 years old; (2) a parent or guardian on behalf of a person under 18; or (3) a court-appointed guardian on behalf of a person under his care (no age limitation).[3]

  - Officers may transport the EDP to a facility for this purpose. If, at any point, the EDP changes his mind regarding voluntary evaluation, officers may proceed with an application for involuntary civil commitment.

- **Transport for evaluation and involuntary commitment.** Officers may initiate a mental health evaluation, or they may be called on to detain an EDP on behalf of a qualified mental health clinician. See Section II.

- **Arrest for crime.** While officers are free to use their discretion and not pursue charges, they should arrest an EDP when appropriate. The SJC has ruled that determining criminal responsibility is the role of the trial court, and that officers in the field may arrest or apply for a criminal complaint solely based on probable cause to believe that the EDP committed the crime charged.[4] This policy encourages use of the court process, which is often an effective avenue for mental health services and has the added benefit of holding an EDP accountable for the failure to participate in an assigned program.

D. Documentation & Confidentiality

Officers must fully document incidents when they are dispatched to the scene, or detain an EDP, or refer an EDP for evaluation and/or treatment. Officers may document routine or social interaction with an EDP if necessary.

Officers and employees must keep information about EDPs confidential, except when revealing information in the course of their duties for an official and legally permissible police, medical, or mental health purpose.

E. Supervisors & Commanders

Supervisors and commanders should monitor police responses to incidents involving EDPs. These incidents can be challenging, and officers may need support and assistance. In particular, supervisors and commanders should, in appropriate cases:

- **Respond to the scene**.
- **Help formulate an effective response** — including everything from passive monitoring and disengagement; to community-based services; to detention and involuntary commitment; to protective custody; to arrest or a complaint application for criminal behavior.
- **Assist in securing appropriate resources**.
- **Closely monitor any use of force**, including restraints, and ensure that those subjected to the use of force are provided with timely access to medical care.
- **Ensure that all reports are complete**.
- **Debrief involved members**. Sometimes an after-action, operational debriefing is warranted, and/or a critical incident stress management debriefing.

Section II. CIVIL COMMITMENT PROCESS FOR MENTAL HEALTH

A. Eligibility & Categories

Involuntary commitment is based on a "likelihood of serious harm."[iii] 123, § 1 defines this as:

- **Danger to self.** The EDP presents a substantial risk of physical harm to himself (e.g., a suicidal threat or attempt); or
- **Danger to others.** The EDP presents a substantial risk of physical harm to other persons; or
- **Inability to protect self.** The EDP presents a *very* substantial risk of injury to himself based on evidence that the EDP's judgment "is so affected that he is unable to protect himself in the community."

There are four categories of involuntary commitment. Under 123, § 12(a), they are:[5]

- **Category 1 — Clinician issues commitment order based on examination of EDP.** Following a personal examination of an EDP, a qualified mental health clinician may sign a commitment order if he or she has reason to believe that the EDP poses a likelihood of serious harm.
- **Category 2 — Clinician issues commitment order in emergency, where EDP refuses examination.** Even if the EDP refuses examination, a qualified clinician may still issue a commitment order based on facts and circumstances that show that the EDP poses a likelihood of serious harm.
- **Category 3 — Officer restrains EDP in emergency.** In an emergency, officers may restrain an EDP who they believe poses a likelihood of serious harm, if no qualified clinician is available to sign a commitment order. This is always an option for officers in the field.
- **Category 4 — Judge issues warrant of apprehension.** At any time, *any person* may apply to a District or Juvenile Court for a commitment order and, after a hearing, the judge may issue a warrant for the apprehension for an EDP that poses a likelihood of serious harm.

[iii] Involuntary commitment under 123, § 12 is for a maximum of three days. To hold a person longer requires a separate legal proceeding under 123, §§ 7 and 8, or voluntary commitment under 123, § 10.

Note: A benefit of a Category 4 approach under 123, § 12 is that it gives officers the option of calling upon another party to initiate the involuntary civil commitment process by filing a petition in District or Juvenile Court.

B. Police Procedures for Involuntary Commitment

Categories 1, 2, and 4:

- **Since the commitment order is issued by a clinician and/or a judge, officers may enter private homes to carry out a detention for involuntary commitment.** Categories 1, 2, and 4 are, in effect, arrest warrants for mental health detention.[6]

- **Since EDPs constitute a diverse and, at times, unpredictable group of people, officers should obtain information from the court, clinician, and/or family.** When called on to execute a commitment order or warrant of apprehension, officers should always get some preliminary information from those familiar with the EDP. For example, is the EDP paranoid? Would it be better to have plainclothes personnel handle the situation? Should a family member be present during police entry?[7]

- **Transport EDP to appropriate local facility (Categories 1 and 2) or to the court that issued the warrant (Category 4).** Officers should either utilize their own cruiser or have an ambulance assigned for transport. Officers should follow in their cruiser or ride in the ambulance to the mental health facility to ensure that the EDP, who they took into custody, arrives safely.

Category 3

- **Since street officers make the decision to take the EDP into custody, they must have probable cause[8] that the EDP poses a "likelihood of serious harm."**[9]

- **When entering a home to take an EDP into custody under Category 3:**

  - ***If possible, obtain a commitment order from a clinician.*** If there is time to consult with a clinician who can issue an order, this is preferred. The situation then becomes a Category 2 entry.

  - ***If exigent circumstances make consulting with a clinician impractical, seek consent to enter and, if that fails, force entry.*** If possible, seek supervisory approval prior to a forced entry.[10]

- **Transport EDP to appropriate local facility and file application for commitment.** A Category 3 detention is not an involuntary commitment. It simply permits officers to transport the EDP for evaluation. The reviewing clinician at the health care facility decides whether to issue a commitment order or arrange another intervention (including discharge of the EDP).

C. Transport & Restraint

Officers are authorized to transport and restrain patients.[iv] 123, § 21 allows officers to:

- **Transport both voluntary and involuntary patients.**

- **Use restraints on an adult for up to 2 hours prior to examination, and on a minor for up to one hour.** Take reasonable precautions, including the use of handcuffs, but avoid other restraints unless clearly necessary.

Prior to transport, officers shall:

- **Search the EDP for weapons and contraband** (including any containers or items possessed by the EDP unless turned over to a third party with the permission of the responding officer).

- **Decide whether to transport the EDP in a police cruiser or by ambulance.** Safety may necessitate that an officer ride in an ambulance with the EDP. Officers should consider the perspective of EMS personnel in making this decision.

- **Attempt to learn if the EDP owns or has potential access to any firearm or other deadly weapon.** Officers should evaluate how, in compliance with search and seizure law, they may seize any firearms or other dangerous weapons. Officers should document the results of this inquiry and, if necessary, seek assistance from the police licensing authority or other personnel.[11]

- **Notify, or have dispatch notify, the receiving facility** of the estimated time of arrival, the EDP's level of cooperation, and whether any special care or restraints are needed.

[iv] 123, § 22 states that officers are "immune from civil suits . . . for restraining, transporting, . . . or admitting any person to a facility." To operate under the protective blanket of § 22, officers should properly document their actions in dealing with the EDP.

Upon arrival at the health care facility, officers shall:

- **Escort the individual into a waiting or treatment area designated by facility staff.**

- **Inform a staff member about the facts and circumstances that resulted in the EDP being transported to the facility.**

- **In the case of an involuntary admission, provide the staff member with a written application for commitment** (if requested). Keep a copy to attach to the incident report. See Attachment A for the form.

While at the health care facility, officers may:

- **Assist staff with the EDP's admission and security —** including transferring the EDP from police restraints to facility restraints; providing information about the EDP's behavior and background; and, if necessary, watching the EDP until facility personnel can exercise adequate control.

- **Be present for safety purposes during an EDP's interaction with staff, including a psychotherapist.** While a patient may request a private consultation, officers are not required to leave a hospital room so that the patient can speak to a psychotherapist alone. Patient confidentiality does not require that psychotherapists put their safety at risk. Officers are authorized to be present to protect a clinician during confidential interactions, and they must document any incriminating statements they hear from the EDP (although these statements may be held inadmissible in later court proceedings).[12]

D. Arrest & the Civil Commitment Process

Civil commitment is preferred over arrest for EDPs who commit minor crimes. If an EDP is being taken into custody for civil commitment *and* suspected of a minor offense, officers are advised to file an application for a criminal complaint.

If an EDP has already been arrested, the OIC may, under 123, § 18(b), release the EDP to pursue voluntary mental health treatment. The decision to release belongs solely to the OIC. The OIC should inform the bail commissioner and, if necessary, adjust the arraignment date to accommodate treatment. The OIC may arrange for an officer, family member, or caseworker to transport the EDP to a treatment facility.

When an EDP, who may qualify for civil commitment, has committed a serious crime that would normally result in arrest, officers should:

- **Arrest the EDP if there is probable cause to do so**.

- **Notify a supervisor about the facts supporting the arrest *and* involuntary commitment.** Later, these facts should be documented in the incident report.

The OIC or supervisor may direct that the EDP be:

- **Transported to court for evaluation and arraignment**; or

- **Evaluated by a mental health professional at the police lockup** under 123, § 18(a) and, if necessary, ordered by the District Court to be transferred to a mental health facility for involuntary commitment pending an appearance in court.[13]

The OIC may consult with the bail commissioner and consider the seriousness of the offense, the treatment options available, and other relevant factors in deciding the best way to hold the EDP for court.

Section III. CIVIL COMMITMENT PROCESS FOR SERIOUS ALCOHOL OR DRUG DEPENDENCY

Petition must initially be filed in District or Juvenile Court. Under 123, § 35, a police officer, physician, spouse, blood relative, guardian, or court official may file a written petition in District or Juvenile Court concerning a person who is a chronic alcoholic or substance abuser (including inhalants) to the degree that it substantially affects his or her health or social or economic functioning.[v]

Note: Similar to the warrant of apprehension under 123, § 12, a benefit of § 35 is that it gives officers the choice of taking matters into their own hands or calling upon another party to initiate the process.

Upon receiving the written petition, the judge may:

- **Schedule a hearing and issue a summons for the appearance of the subject**; or

- **Issue a warrant of apprehension for the subject**.[vi]

Upon receiving a warrant of apprehension, officers shall:

- **Execute the warrant within 5 consecutive days after the date it was issued.** The 5-day period does not include days when the court is closed.

- **Execute the warrant only if the subject may be immediately presented to a judge.** This requirement means that a § 35 warrant should only be executed when court is in session. Police officers must not take a subject into custody on a § 35 after hours unless they have a separate legal basis — e.g., arrest for a crime, protective custody for alcohol or drugs, etc.

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[v] The § 35 is significantly different from protective custody for alcohol (111B, § 8) or for drugs (111E, § 9A). Protective custody applies to anyone who is, in the moment, incapacitated by alcohol or drugs. Incapacitation means that the subject is disorderly, unconscious, in need of medical attention, or presents a risk of injury or property damage. In contrast, § 35 applies to chronic alcohol or drug abusers who need longer term in-patient treatment.

[vi] The court may issue a warrant based on reasonable grounds to believe the subject will not appear, and that delay will present an immediate danger to the physical well-being of this person.

- **Enter a home pursuant to the warrant based on a reasonable suspicion that the subject is inside.** Officers should knock and announce their presence. Ideally, an occupant will admit officers but, after consulting with a supervisor, officers may force entry if necessary.[14]

- **Transport the subject to the appropriate court.** *Note:* Read the warrant. The court that issued the warrant may authorize its return to another court. For example, if a mother from Chelsea petitions the court for a § 35 against her son, who lives in Worcester, the Chelsea court may issue a warrant of apprehension returnable to the Worcester court, who will conduct the evaluation and hearing.

- **Document, in an incident report, how the warrant was executed and the suspect brought to court.**

After a hearing, the court may order up to 90 days of inpatient care.[15]

[1] It is estimated that 40% of emotionally disturbed persons are, at some point in their lives, arrested by police. Swanson, *Police Administration* (Prentice Hall, N.J.; 6th Ed.) at page 595.

[2] *San Francisco v. Sheehan,* 135 S.Ct. 1765 (2015) [Supreme Court strongly suggests that Title II of the Americans with Disabilities Act (ADA) mandates that police officers consider the mental health condition of the EDP when deciding the level of force that makes sense to employ to resolve the situation]. The amount of force used in carrying out the detention may be a source of liability, even when the detention itself is justified. *Samuelson v. City of New Ulm* 455 F.3d 871 (8th Cir. 2006).

[3] The drawback of this strategy is the relative ease with which a patient may be released. First, the facility may discharge a patient on its own. However, if the patient is a child, the facility must provide a parent or guardian with 14 days notice. Second, an adult patient may choose to leave, or a parent or guardian may withdraw his child. As a safeguard, facility staff may insist on 3 days written notice and restrict departure to normal business hours. In extreme cases, a patient may be held beyond the 3 day period if the facility files a petition for longer term, involuntary commitment.

[4] *Comm. v. Newton N.,* 478 Mass. 747 (2018) Also see *Comm. v. Lawson,* 475 Mass. 806 (2016) (a defendant's mental status must be addressed post-arraignment as part of the court process; it is not grounds to dismiss an otherwise valid arrest based on probable cause).

[5] *Ahern v. O'Donnell,* 109 F.3d 809 (1997) specifically uses the term "category" in describing the different methods for initiating the mental health commitment process under 123, § 12(a).

[6] Both the commitment order and warrant of apprehension constitute a type of special process which authorizes officers to enter private dwellings. *McCabe v. Lifeline Ambulance & City of Lynn,* 77 F.3d 540 (1996).

[7] Considering potential difficulties *before* the police enter and detain the EDP may avoid a tragic result. *McCabe v. Lifeline Ambulance & City of Lynn, supra.* (64 year old Holocaust survivor died at her home during a traumatic effort by police to execute a commitment order).

[8] *Ahern v. O'Donnell,* 109 F.3d 809 (1997) (probable cause required for police mental health detention under 123, § 12). *Fisher v. Harden,* 398 F.3d 837 (6th Cir. 2005) (same).

[9] *Ahern v. O'Donnell, supra.* (messages left by EDP revealed a deeply disturbed and depressed individual). Also see *Palter v. City of Garden Grove,* 2007 U.S. App. Lexis 13848 (9th Cir.) (officer had probable cause to believe, at the time he detained a man for psychiatric evaluation, that the man was suicidal; the EDP had talked about killing himself, had access to a gun, was about to be served with divorce papers, had pain medication, was under a therapist's care, and was possibly on his way to leave a "goodbye" note at his daughter's house). Compare *Meyer v. Board of County Commissioners,* 482 F.3d 1232 (10th Cir. 2007) (boyfriend was a town employee and personal friend of several deputies; there was evidence that the deputies lied to get his girlfriend involuntarily committed in retaliation for her reporting his domestic violence).

[10] *McCabe v. Lifeline Ambulance & City of Lynn, supra*. ("The potential consequences attending a delayed commitment — both to the mentally ill subject and others — may be extremely serious, sometimes including death or bodily injury"). Compare *Comm. v. Allen,* 54 Mass. App. Ct. 719 (2002) (police sergeant had insufficient evidence that a disabled person he knew was in need of immediate assistance; therefore, his warrantless entry into the apartment was invalid).

[11] *Comm. v. Adams,* 482 Mass. 514 (2019) established that the Licensing Authority (LA) may suspend or revoke a firearms license on the basis that the holder is no longer "suitable." This means that the holder poses a credible risk of danger to self or others. If the LA has evidence supporting this concern, the LA may provide notice to the "unsuitable" individual seeking immediate surrender of his or her license, firearms, and ammunition. 140, § 131(f). The fact that the license holder plans to appeal is irrelevant. These items must be surrendered to police "without delay." Failure to do so is a crime under 269, § 10(i) with a penalty of HC NMT 2½ years; or Fine NMT $1,000.

[12] *Comm. v. Waweru,* 480 Mass. 173 (2018).

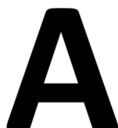
[13] Under 123, § 18(a), the EDP may be held initially for a maximum of 30 days.

[14] *Hill v. Walsh*, 884 F.3d 16 (2018): 28 year old Matthew Hill, who struggled with opioid addiction, was taken to the hospital. The next day, his sister filed a § 35 petition to have him committed. The court issued a warrant of apprehension with his parents' home address. Officers arrived and thought they saw someone. They reasonably believed it was Matthew and properly entered.

[15] A 123, § 35 commitment must be based on clear and convincing evidence that: (1) the person is unable to protect himself in the community from physical harm; and (2) there is a substantial risk that, without treatment, harm will happen reasonably quickly (days or weeks rather than months). *In the Matter of G.P.*, 473 Mass. 112 (2015). *In the Matter of N.F.,* 93 Mass. App. Ct. 1115 (2018) (texts showed mother's son was a heroin addict and suicidal).

The subject must be housed separately from convicted criminals, and the facility superintendent must evaluate whether the subject should be released on days 30, 45, 60, and 75. The subject may be released early by the superintendent, who may also authorize the subject's transfer to a different facility for continuing treatment.

Attachment



COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
APPLICATION FOR AN AUTHORIZATION OF TEMPORARY INVOLUNTARY HOSPITALIZATION
M.G.L. Chapter 123, Sections 12 (a) and 12 (b)

Application Pursuant to 12 (a)

1). Application to (Facility name): ____
2). I hereby apply for admission of (name of individual): ________________________________

Address:________________________City/Town________________________State____________

Social Security Number: _________________ Date of Birth: ____________ Sex: M ☐ F ☐

to the facility named above pursuant to M.G.L. c. 123, s. 12 (a). I hereby authorize transport and the use of restraint i of the person named above but only if necessary for the safety of the person being transported or of others who are likely to come into contact with him or her. M.G.L. Chapter 123, s. 21.

Based on my examination[1], it is my opinion that the person requires hospitalization at the above named facility so as to avoid the likelihood of serious harm by reason of mental illness. Evidence supporting my opinion includes:

A). Mental Illness: For purposes of admission to an inpatient facility under Section 12, "Mental Illness" means a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life. Symptoms caused solely by alcohol or drug intake, organic brain damage or mental retardation do not constitute a serious mental illness. Specify evidence including behavior and symptoms:

____
____
____

B). Likelihood of Serious Harm (check all categories that apply):

_____ (1) Substantial risk of physical harm to the person himself/herself as manifested by evidence of threats of, or attempts at suicide or serious bodily harm; and/or

_____ (2) Substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; and/or

_____ (3) Very substantial risk of physical impairment or injury to the person himself/herself as manifested by evidence that such person's judgment is so affected that he/she is unable to protect himself/herself in the community and the reasonable provision of his/her protection is not available in the community.

Specify evidence including behavior and symptoms:____
____
____
____

3). Applicant Certification (check all applicable boxes)

a. I am a: ☐Licensed Physician or Nurse Practitioner (GL. Ch 112 §80i) ☐Qualified (i.e. Licensed) Psychologist
☐Qualified (i.e. Licensed and Certified) Psychiatric Nurse Mental Health Clinical Specialist
☐Police Officer ☐ Licensed Independent Clinical Social Worker (LICSW)

b. . I have ☐ I have not ☐ personally examined this person. If not, why?
____
____

d. ☐I have consulted with either the receiving facility or emergency screening program.
☐I have not so consulted because____
____

Applicant's name (not patient):
(print)____Phone:______________________________
Address:___________________________________City/Town______________________State____

Applicant's signature:____________________________ Date: _______________ Time:_________

NOTE: Parts 1) through 3), above, must be completed to apply for involuntary hospitalization.

[1] If an examination is not possible because of the emergency nature of the case and because of the refusal of the person to consent to such examination, the physician, qualified psychologist, qualified psychiatric nurse mental health clinical specialist or licensed independent clinical social worker on the basis of the facts and circumstances may determine that hospitalization is necessary and may apply therefore. G.L. c.123 s.12(a)

COMMONWEALTH OF MASSACHUSETTS **DEPARTMENT OF MENTAL HEALTH**

Authorization Pursuant to Section 12 (b)

Designated Physician* Authorization :

(NOTE: Boxes A. through G., below, must be checked to authorize a Section 12(b) involuntary admission to a facility.)

A. ☐ I am a designated physician* of the aforementioned facility with authority to authorize admissions under Section 12 (b).

B. ☐ I have personally examined this person

☐ within 2 hours of his/her arrival at the facility

☐ more than 2 hours after his/her arrival at the facility due to the fact that I was engaged in an emergency situation.** The emergency situation was: ________________________________

____

____and I examined the patient at ________ am/pm.

C. ☐ This person does not require emergency or inpatient medical or surgical care.

D. ☐ I have offered this person an application for Care and Treatment on a Conditional Voluntary Basis and the person:

(one of the two boxes below must be checked to proceed with a Section 12(b) authorization)

☐ refused to sign, or

☐ the application was rejected (the reasons why the application was rejected must be stated on the application and the rejected application shall become part of this person's medical record at the facility).

Note: *104 CMR 27.07 (1) requires that the patient be offered an opportunity to change to conditional voluntary status again within three days of admission.*

E. ☐ I concur with the applicant's recommendation and have completed a psychiatric examination to support this conclusion. Alternatively, I am the applicant, I have personally examined this person, and have completed sections **1)**, **2), 2A)** and **2B)** on the opposite side of this form.

F. ☐ In my opinion, at the present time there is no less restrictive placement that is appropriate for this person to which he or she is willing to go.

G. ☐ I authorize this person's admission.

H. ☐ I reject this application for admission for the following reasons:______________________

____

____

____

____

Designated Physician's Name (print):

____Phone:___________________________

Address: ____

____

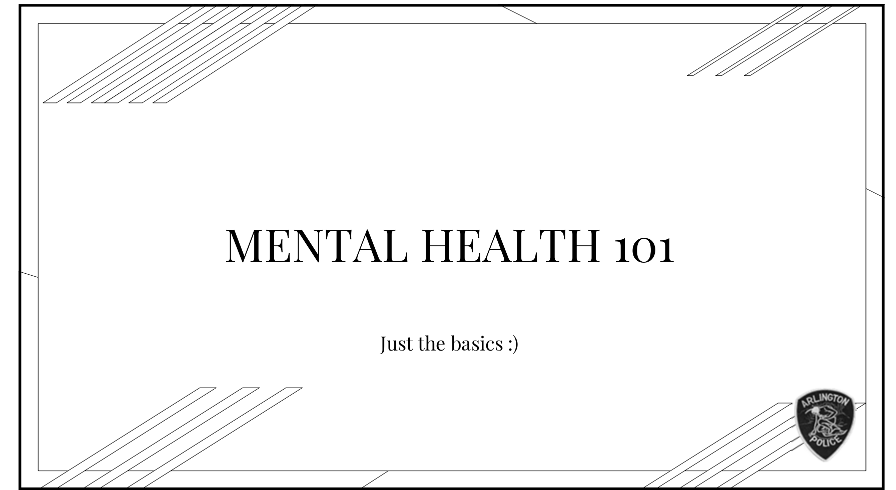
____

Designated Physician's Signature:____

Date: ___________________________________ Time: ______________________________

* A physician who meets the criteria in 104 CMR 33.03

** See 104 CMR 27.07 (2)



MENTAL HEALTH 101

Just the basics :)

1

ANXIETY DISORDERS

- Generalized Anxiety Disorder
- Panic Disorder
- Obsessive-Compulsive Disorder (OCD)
- Post-Traumatic Stress Disorder (PTSD)
- Social Anxiety Disorder
- Separation Anxiety
- Selective Mutism
- Phobias

MEDICATIONS:

- Benzodiazepines most commonly used to treat anxiety disorders are clonazepam (Rivotril), alprazolam (Xanax) and lorazepam (Ativan)
- SSRIs and SNRIs are often the first-line treatment for anxiety
  - Common SSRI brands are Celexa, Lexapro, Luvox, Paxil, and Zoloft, and common SNRI brands are Pristiq, Cymbalta, and Effexor XR

2

MOOD DISORDERS

- Depression
- Persistent Depressive Disorder
  - Also known as "Dysthymic Disorder"
- Bipolar Disorder

MEDICATIONS:

- Lithium
- Gabapentin (Neurotin)
- DIvalproex (Depakote)
- Olanzapine (Zyprexa)
- Quetiapine (Seroquel)
- Risperidone (Risperdal)
- Ariprazole (Abilify)
- Ziprasidone (Geodon)
- Clozapine (Clozaril)
- Prozac (Fluoxetine)
- Zoloft (Sertaline)
- Lexapro (Escitalopram)
- Wellbutrin (Bupropion)

3

PSYCHOTIC DISORDERS

- Schizophrenia
- Schizoaffective Disorder
- Schizotypal (Personality) Disorder
- Schizophreniform Disorder
- Delusional Disorder
- Brief Psychotic Disorder
- Substance/Medication-Induced Psychotic Disorder

MEDICATIONS:

- Haldol (Haloperidol)
- Loxitane (Loxapine)
- Thorazine (Chlorpromazine)

★ ***A-Typical***

- Abilify (Aripiprazole)
- Clozaril (Clozapine)
- Geodon (Ziprasideone)
- Risperdal (Risperidone)
- Seroquel (Quetiapine)
- Zyprexa (Olanzapine)

4

EATING DISORDERS

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Pica Eating Disorder
- Rumination Disorder
- Avoidant/Restrictive Food Intake Disorder

5

PERSONALITY DISORDERS

- Borderline Personality Disorder
- Narcissistic Personality Disorder
- Antisocial Personality Disorder
- Dissociative Identity Disorder
- Histrionic Personality Disorder
- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder
- General Personality Disorder
- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Dissociative Identity Disorder

MEDICATIONS:

- **Antidepressants**
  - useful if you have a depressed mood, anger, impulsivity, irritability or hopelessness, which may be associated with personality disorders
- **Mood stabilizers**
  - mood stabilizers can help mood swings or reduce irritability, impulsivity and aggression

6

Emotional & Behavioral Disorders

- Conduct Disorder
- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Impulse Control Disorder

Medications:

- Dextroamphetamine (Dexedrine)
- Methylphenidate (Ritalin)
- Atomoxetine (Strattera)
- Amphetamine/dextroamphetamine (Adderall)

7

Other Common Diagnosis:

- Dementia:
  a. Alzheimer's disease
  b. Parkinson's disease
  c. Huntington's disease
- Autism
- ADHD
- Substance-Related and Addictive Disorder

8

Resources:

- Crisis Text Line
  - Text “Home” to 741-741
- 988
- SAMHSA (Substance Abuse & Mental Health Services Administration)
- National Suicide Prevention
  - 800-273-8255 (talk)
- DMH
  - Emergency/Crisis Line - Available 24 Hours (877) 382-1609

MENTAL HEALTH
IS
HEALTH

9

De-Escalation:

- Be Empathic and Nonjudgmental
  - Do not judge or be dismissive of the feelings of the person in distress
  - Employ Empathy and Compassion
- Respect Personal Space
- Use Nonthreatening Nonverbals
- Keep Your Emotional Brain in Check
- Focus on Feelings
- Ignore Challenging Questions
- Set Limits
- Remain Cool, Calm, Collected
  - Manage Non-Verbal Messages
- Know what you don't know
- Look beyond the behavior to the emotional source of the crisis
- Don't Take It Personally
- Listen
- Apologize
- Don't Make Promises You Can't Keep.

The Art of
Verbal De-escalation

D — DECIDE
Decide if a patient is appropriate for verbal de-escalation
Clues include a patient which is responsive,
Engaged in conversation,
Not an active threat to safety

E — ENSURE SAFETY
Ensure adequate backup
Clear area of potential weapons (loose objects, supplies).
Respect personal space
(two arms length between you and patient)

F — FORM RELATIONSHIP
Introduce yourself by name and title
Ask what they like to be called
Ask "Will you allow us to help?"
Use short sentences, simple vocabulary

U — UTILIZE INTERESTS
Identify patient's wants and feelings
Agree as much as possible, either in truth, principle, odds, or to disagree
Reinforce that you will let no harm come to patient

S — SET LIMITS
Speak matter of factly about consequences for bad behavior
Offer choices for behavior, even it's between oral and IV meds
Use repetition as needed until you are heard by patient

E — ENFORCE/EVALUATE
If aggression escalates and violence seems imminent, withdraw and mobilize help
Once situation defused, by either verbal de-escalation or medication, debrief staff and/or patient

10

Arlington, Massachusetts Police Department

Proactive and Proud

Session One: Jail Diversion Program

1

AGENDA

- About Arlington
  - About the JDP
  - Funding & Grants
  - Education & Partnerships
- Policy & Procedures
  - Stats & Data
- HIPAA
  - Emergency
- Networking
- Section 12 vs. Section 35 (MA)
  - Rule of Court §4:74-7 and N.J.S.A. §30:4-27.2
- Other initiatives (mental health)
- Q&A

2

A bit about Arlington:

- Population: 44,731
- Area 5.5 sq/mi
- 6 miles Northwest of Boston
- Borders: Cambridge, Somerville, Medford, Belmont, Lexington, Winchester
- Median Age: 41.7
- Total households: 19,652

3

A quick look into ADP co-response

4

APD Jail Diversion Program Basics

- 40 hours per week
  - Funded through DMH grant
- Embedded into PD *full time* as the clinician (or clinical responder)
  - Co-respond with police to a 911 call related to mental health
- Goals:
  - De-escalate in the moment
  - Access to treatment options
    - Other than the hospital
  - Collaborate with officers
  - Divert from legal system

When: Began November 2010

- *Rebecca Wolfe started this JDP with the Arlington Police in 2010*

Why:

- Long wait times for clinical response
- Lack of resources & options in the moment of crisis

What:

- Collaborative co-response approach that creates alternative to arrest, booking and jail

How:

- Intervention
- Follow- up
- Training/ Education
- Community Partnerships

5

Arlington Jail Diversion Organizational Structure

Edinburg Center

Patti Mcguire
Chief Executive Officer

Vicki Fredrickson
Vice President of Mental Health

Lili Schwan Rosenwald, LICSW
Edinburg Service Director

Arlington Police Department

Chief Julie Flaherty

Captain Richard Flynn

Sergeant James Kiernan

Christina Valeri, LMHC
Jail Diversion Clinician

6

Jail Diversion Program Funding

Mass Police Agencies Receive Grants for Jail Diversion Programs

- The program strives to provide treatment instead of incarceration for those experiencing behavioral health crisis
- Fitchburg, Worcester & Marlboro are among 13 police departments that will receive a total of $1.9 million in grants
  - Implement crisis intervention team trainings & JDP
  - DMH will continue with grants and expand JDP to other agencies
  - Distributed over three years
    - Fitchburg ($39,000), Worcester ($45,00) & Marlboro ($45,000)
  - More than 40 local police dept. Have DMH jail diversion programs
- “Intervention training for our local police departments will help individuals with mental health issues find appropriate care,” Gov. Charlie Baker said in the announcement. “We are proud these grants will offer the assistance, skills and resources for local law enforcement to identify those in need of mental health or substance abuse care and seek out appropriate treatment services.”

7

Federal Grant

- Middlesex Sheriff’s office was awarded $244,373 in a grant to assist individuals with mental health and co-occurring disorders
- Justice and Mental Health Collaboration Program (JMHCP)
  - cross-system collaboration for individuals with mental illnesses or co-occurring mental health and substance abuse disorders who come into contact with the justice system
- *“The primary underlying drivers of incarceration for those in Middlesex County – as they are nationwide – are mental health and substance use disorders,”* said Sheriff Koutoujian. *“This grant will help us work with community and academic collaborators to craft, implement and manage an initiative creating greater continuity of care for those leaving our custody. This will include individually-tailored re-entry plans, evidence-based interventions and other services supported by a navigator.”*

- In calendar year 2017, 48 percent of all individuals entering the Middlesex Jail & House of Correction reported a history of mental illness, while 41 percent required medical detox

8

Elliot Human Services Grant C.A.R.E Initiative

- $100,000 grant awarded to expand the Middlesex District Attorney's Office's Project C.A.R.E initiative
  - designed to close service gaps by formalizing communication and care coordination practices between first responders, police departments, fire departments and community-based behavioral health providers after a child has experienced an opioid-related trauma
    - Immediate follow up post overdose
      - Contact a clinical supervisor
        - Create individualized plan with family members
          - Stabilization & Prevention
    - SMART Choices Program encourages youth to make healthy decisions

9

- They offers an array of innovative services which promote personal growth and independence, foster hope and enhance the quality of life of people with mental health conditions, co-occurring substance use conditions and/or developmental disabilities or brain injuries
- Spring 2021 was selected by the Cummings foundation for a $100,000 grant for a 4 year span
  - Nationwide program for non-profit human service providers
    - Located in Bedford, they were one of 140 local non-profits to win a grant
  - "This four-year grant will help us deliver essential support to hundreds of families each year by providing crisis counseling, referral to services and victim assistance," said Patti Maguire, Edinburg president and CEO. "It will truly transform lives."

10

Jail Diversion Program

- Jail Diversion is a collaborative approach between police officers and mental health professionals that focuses on creating alternatives to arrest and jail detention for individuals who come in contact with the police and could benefit from mental health and substance abuse services or other social services
- The Jail Diversion Clinician is based at the police department and is an integral part of the police organization
  - The Clinician accompanies patrol officers in the community, providing a joint response to calls for service
  - The Clinician follows-up with individuals during non-emergency times to provide support and stability to people whose situation would typically result in another emergency.
- The Clinician also responds to calls involving domestic issues such as reports of domestic violence and child abuse and neglect
- Clinicians assist in the stabilization of the scene utilizing de-escalation techniques and providing victim assistance
  - While the officers focus on maintaining a safe, secure scene, clinicians focus on assessing the needs of the individual family members
- The Edinburg Center provides services to the communities of Waltham and Arlington

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Intervention:

If a crime was committed:	If a crime was not committed:
⇩	⇩
The clinician and the police officer will work collaboratively and assess if the individual is appropriate to divert from arrest and go into immediate treatment	The clinician will work with the individual to identify services needed and arrange for continued follow up

Follow-up:

In the case of jail diversion, the clinician will arrange treatment for the individual; hospital or community-based setting	The clinician will follow up and provide ongoing support, review treatment referrals, connect the individual to the appropriate community resources and offer additional services

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Training/Education:

Multi-modality training initiatives designed to assist officers with:

- Recognizing the signs and symptoms of mental illness
- How to apply specialized de-escalation techniques
- Context-specific crisis management and intervention techniques
- Youth & brain development
- Trauma informed care
- Suicide risk and prevention
- Common psychiatric medications and usage
- MGL Chapter 123, Section 12, Section 18a, Section 35
- Narcan deployment and distribution training
- Signs & symptoms of overdose
- Mental Health First Aid (MHFA) for all officers

13

Community Partnerships:

- JDC attends community meetings and serve on inter-agency committees
- JDC interacts with numerous community organizations on a regular basis:
  - The Arlington Health and Human Services Department
  - Arlington Council on Aging
  - Arlington Youth Counseling Center
  - Arlington Youth Health and Safety Coalition
  - Arlington Public School Nursing and Guidance Departments
    - Youth population: attends Arlington Public School Health Initiative meetings, collaboration with Arlington School Resource/Truancy Officers
  - Arlington Fire Department
  - The Department of Children and Families
  - Arlington Housing Authority
  - Advocates Psychiatric Emergency Services
  - Cambridge Court Clinicians
  - Somerville Homeless Coalition
- Closely works with the town's veterans' agent, Elder Abuse Prevention Task Force, and is part of the Arlington Hoarding Task Force

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Success & Outcomes:

- APD has experienced a dramatic shift in response to calls involving persons with mental illness and substance abuse
  - Less repeat interactions
- Having our own in-house clinician has enabled us to connect people with treatment and services
  - Avoid unnecessary/costly trips to emergency departments
  - Has shortened the length of time officers spend at calls for service
  - Residents are able to have their needs addressed in a more timely manner
- *Since inception:*
  - There has been a significant increase for individuals who were eligible for pre-arrest jail diversion were diverted into either community or hospital-based treatment

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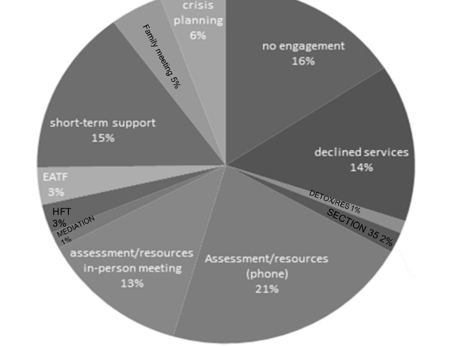
OUTREACH & CO-RESPONSE DATA & OUTCOMES:



16

DMH Data:

- Submitted monthly to data analysis from 54 police departments across MA
- Ability to track:
  - demographics, outcomes, what agency was present and intervened, what the reason for intervention was, mental health diagnosis, substance abuse diagnosis and past treatment, diversion, hospitalization

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18

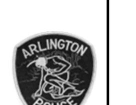
Arlington, Massachusetts Police Department

Proactive and Proud

Session Two: Community Partnerships

19

- Confidentiality & HIPAA
- Community Partnerships
  - *Group Homes*
  - *Hoarding Response Team*
  - *Elder Abuse*
  - *Arlington Human Services Network*
- Universal Releases
- Referrals
  - *DCF*
  - *DMH*
  - *Hospitals*
  - *Other clinical services*



20

Confidentiality, Law Enforcement, and Emergency Situations

Federal Confidentiality Law: HIPAA - HIPAA applies to physicians and other individual and institutional health care providers (e.g., dentists, psychologists, hospitals, clinics, pharmacies, etc.). It limits the circumstances under which these providers can disclose "*protected health information*" or "*PHI*." PHI is essentially any individually identifiable health information that relates to a patient's physical or mental health condition or treatment

***Imminent Danger* -** Health care providers may share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public – consistent with applicable law (such as state statutes, regulations, or case law) and the provider's standards of ethical conduct. See 45 CFR 164.512(j)

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Mental Health Professional's Duty to Warn

- Most states have laws that either require or permit mental health professionals to disclose information about patients who may become violent
- Those laws are receiving increased attention following recent mass shootings, such as those in Aurora, Colo., and Newtown, Conn
- A New York law enacted Jan. 15, 2013, moves that state's law from a permissive to a mandatory duty for mental health professionals to report when they believe patients may pose a danger to themselves or others but protects therapists from both civil and criminal liability for failure to report if they act "in good faith."

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Hoarding Response Team

- created in response to increased reports of hoarding in June of 2011
- first responder training
  - Working with BOH, COA, Fire/EMT, Housing
- reduction of homelessness
- creation of assessment tool

Elder Abuse Task Force

- locally works closely with council on aging & Minuteman protective services
- continued education for first responders on dementia/mental health needs, complies with all of the legal reporting/care management guidelines (neglect, abuse, exploitation)

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Arlington Human Services Network

- Started in Spring of 2018
- Collaboration of:
  - Board of health
  - Health & Human Services
  - Council on Aging
  - Housing Authority
  - Education
  - Arlington Police Department
  - Domestic Violence
  - Outreach
  - AYCC
  - Hospitals
- Identification of at risk individuals/families

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Arlington, Massachusetts Police Department

Proactive and Proud

Session 3: Officer Wellness and Trainings

25

Trainings

- How best to work with JDC
  - *Communication*
- How to get buy in
  - *Communication*
- Types of training
  - Mental Health First Aid
  - Update education through online & in-person sites

26

Critical Incident Stress Management

Debrief & Discuss through peer support

27

Challenges:

- Mental Health
- Compassion
- Attunement

VS.

- "Soft on crime"
  - Keeping community safe

★ Resolution:
  - Education, outreach & training

- Mental health has no "scheduled time"
  - Balance & need for clinician
    - What to do when not here
  - Tracking for when clinician is most utilized for co-response

28

29

Section 35

- police officer, physician, spouse, blood relative, guardian, or court official
- petition the court for commitment of individual suffering from alcohol/substance abuse to the point they are a danger to themselves/others.
- 30-90 days
- review at day 30,45,60,75
- Insurance is not necessary

Section 12

- physician, qualified psychologist, qualified psychiatric nurse mental health clinical specialist or licensed independent clinical social worker or a police officer
- believes that failure to hospitalize a person would create a likelihood of serious harm by reason of mental illness
    - may restrain such person and apply for the hospitalization of such person for a up to a 3 day period at a public facility or a private facility authorized for such purpose by the department

★ Belief that the person may cause harm to themselves or others

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Arlington, Massachusetts Police Department

Proactive and Proud

Session four: Judicial and Corrections

31

Finding the Right Pieces in an Effort to Solve the Puzzle

32

District Attorney Ryan

- Meeting with Arlington Youth Health and Safety Coalition
  - Group that is committed to preventing & reducing substance misuse among Arlington youth
- Launched several initiatives to combat the opioid epidemic
  - Donated over 4,000 doses of Narcan to police, fire departments, school health care workers and first responders
  - District Attorney Ryan also spoke to members about Project CARE and the SMART Choices Program, initiatives directed at Middlesex County's youth
  - Project CARE provides trauma services to children who experience opioid-related trauma and the SMART Choices Program encourages youth to make healthy decisions
- Narcan training (free) - Tewksbury MA

33

Mental Health Court

- Mental health court sessions include a court-imposed condition of probation for defendants who have serious mental illness or co-occurring mental health or substance use disorders
- The sessions provide an alternative to incarceration through case management, and by linking to community-based services with probation

- The Recovery with Justice Program (RWJ) is a specialized court session that helps defendants maintain stability, achieve recovery and avoid incarceration by providing intensive social services and mental health treatment

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Questions?

Contact:

Christina Valeri, LMHC

781-316-3947

cvaleri@town.arlington.ma.us

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Law Enforcement Dimensions & John Sofis Scheft, Esq.
present

Sir Robert Peel's 9 Principles of Policing

The essence of policing with perspective — originally developed in 1830.

1. **The basic mission for which the police exist is to prevent crime and disorder.**
2. **The ability of the police to perform their duties is dependent upon public approval of police actions.**
3. **Police must secure the willing co-operation of the public in voluntary observance of the law to be able to secure and maintain the respect of the public.**
4. **The degree of cooperation of the public that can be secured diminishes proportionately to the necessity of the use of physical force.**
5. **Police seek and preserve public favor not by catering to the public opinion but by constantly demonstrating absolute impartial service to the law.**
6. **Police use physical force to the extent necessary to secure observance of the law or to restore order only when the exercise of persuasion, advice and warning is found to be insufficient.**
7. **Police, at all times, should maintain a relationship with the public that gives reality to the historic tradition that the police are the public and the public are the police; the police being only members of the public who are paid to give full-time attention to duties which are incumbent on every citizen in the interests of community welfare and existence.**
8. **Police should always direct their action strictly towards their functions and never appear to usurp the powers of the judiciary.**
9. **The test of police efficiency is the absence of crime and disorder, not the visible evidence of police action in dealing with it.**