RICHMOND POLICE DEPARTMENT
GENERAL ORDER

Subject: **RECOGNIZING AND RESPONDING TO PERSONS IN CRISIS**	Chapter 6	Number 14	# Pages 8

References:	Related Orders:	Effective Date: 09/17/2026
CALEA: 1.1.3, 41.2.7a-e State Code: §16.1-40.1, 16.1-341(B), 16.1-340.3, 37.2-808, 37.2-809, 37.2-1104	01-13, 06-10, 06-17, 06-18, 07-20 & 07-34	Revised by: N/A Prv. Rev. Date: N/A

If any provision of this general order conflicts with any collective bargaining article, the collective bargaining agreement shall govern.

Chief of Police: Robert D. Edwards

I. PURPOSE

The purpose of this directive is to establish the policy and procedure for the recognition of and response to persons in crisis by members of the Richmond Police Department.

II. SUMMARY OF CHANGE

This is a new policy, incorporating some language from existing General Order 06-17, Persons in Mental Health Crisis, and additional new language on recognizing mental health conditions and individuals in crisis.

III. POLICY

It is the policy of the Richmond Police Department to provide guidance to its sworn personnel regarding the ways to approach and handle a situation involving a person in mental health crisis.

IV. ACCOUNTABILITY STATEMENT

All employees are expected to fully comply with the guidelines and timelines set forth in this general order. Responsibility rests with the division commander to ensure that any violations of policy are investigated and appropriate training, counseling, and disciplinary action is initiated.

This directive is for internal use only and does not enlarge an employee's civil liability in any way. It should not be construed as the creation of a higher standard of safety or care in an evidentiary sense, with respect to third party claims. Violation of this directive, if proven, can only form the basis of a complaint by this Department, and then only in a non-judicial administrative setting.

V. DEFINITIONS

A. DEVELOPMENTAL DISABILITIES – Long-term disabilities attributable to a physical impairment, mental impairment, or a combination of impairments that result in functional limitations in major life activities, such as understanding and expressing language, learning, ambulatory movement, self-direction, self-care, independent living, and economic self-sufficiency.

B. INTELLECTUAL DISABILITIES – A subset of developmental disabilities characterized by limited or diminished intellectual functioning and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions.

C. MENTAL HEALTH CONDITION – A diagnosable condition that can substantially impair a person's thinking, perception of reality, emotional process, judgment, behavior, or ability to cope with the daily stresses of life.

D. PERSON IN CRISIS – An individual who exhibits symptoms of known, suspected, or perceived behavioral and/or mental health conditions, including, but not limited to mental health conditions, intellectual or developmental disabilities, or co-occurring conditions, such as substance use disorders. Symptoms may include emotional reactions such as fear, anger, or excessive giddiness; psychological impairments such as inability to focus, confusion, or nightmares, and potentially even psychosis; physical reactions like vomiting/stomach issues, headaches, dizziness, excessive tiredness, or insomnia; and/or behavioral reactions including the trigger of a "freeze, fight, or flight" response. Any individual can experience a crisis reaction regardless of previous history or diagnosis.

E. SUBSTANCE USE DISORDERS – A condition that occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

VI. PROCEDURE

A. Recognizing Individuals in Crisis:

1. Department members are not trained to diagnose mental health conditions, developmental disabilities, or substance use disorders, but rather to recognize behaviors that may be indicative of an individual in crisis, with special emphasis on those that suggest potential violence or danger to oneself or to others. Department members will utilize their training and the following guidelines to assist in recognizing individuals in crisis and in need of intervention.

2. The following are generalized signs and symptoms of behavior that may suggest an individual is experiencing a mental health crisis, but each should be evaluated within the context of the entire situation. Department members should not rule out other potential causes, such as alcohol or drugs, temporary emotional crises that are situational, or medical conditions. Department members should be aware that one or more verbal, behavioral, or environmental cues could suggest the individual is in need of mental health treatment. These include, but are not limited to the following:

a) Verbal Cues:

i. Statements of harm to self or to others;

ii. Statements of false, fixed beliefs (delusions), e.g., "I am Christ";

iii. Statements of false sensory perceptions (hallucinations), e.g., hearing voices that are not audible to anyone else; seeing a TV or newspaper talking directly to him or her; feeling bugs crawl all over skin; seeing things others cannot see, e.g., believing a satellite or streetlight is watching him or her;

iv. Disorganized or slurred speech, e.g., using incoherent words, phrases, or sounds; rapidly shifting from topic to topic with no connection between thoughts.

b) Behavioral Cues:

i. Causing injury to self, e.g., cutting, cigarette burns, banging head against the wall;

ii. No longer performing major life activities, e.g., eating, sleeping, poor personal hygiene;

iii. Unusual demeanor, e.g., underdressing/overdressing for weather conditions;

iv. Unusual body movements. e.g., pacing, muscular rigidity, repetitive actions;

v. Confusion and lack of awareness of surroundings, e.g., wandering in and out of traffic, unable to identify self or location;

vi. Reacting to intrusive, distressing thoughts, e.g., flashbacks or commands to harm self or another;

vii. Extreme emotional responses, e.g., lack of emotion or excessive emotion;

viii. Unresponsiveness to verbal commands;

ix. Difficulty with motor skills or loss of coordination, e.g., stumbling, swaying, or dropping things;

x. Strong and unrelenting fear of persons, places, or things;

xi. Frustration in new or unforeseen circumstances; inappropriate or aggressive behavior in response to the situation;

xii. Obsession with recurrent and uncontrolled thoughts, ideas, and images;

xiii. Extreme confusion, fright, paranoia, or depression.

c) Environmental Cues:

i. Written suicide notes or letters;

ii. Excessive hoarding, e.g., garbage, newspapers, animals;

iii. Presence of urine or feces on the floor or on walls.

NOTE: Department members should be aware of individuals unable to take reasonable care of their welfare with regard to basic provisions for clothing,

food, shelter, or safety and make the necessary referrals or take the appropriate actions as outlined in General Order 06-17, Persons in Mental Health Crisis, General Order 07-34, Elder Abuse, Neglect, or Exploitation, and/or General Order 07-20, Child Abuse, Neglect, or Abandonment.

[CALEA 41.2.7a]

B. Response to Persons in Crisis:

If the officer determines that an individual is experiencing a crisis and is a potential threat to themselves, the officer, or others, law enforcement intervention may be required, as prescribed by statute. See General Order 06-17. All necessary measures should be employed to resolve any conflict safely using the appropriate intervention to resolve the issue. The following responses should be considered:

1. Request a backup officer if one has not already been dispatched. Always do so in cases where the individual will be taken into custody.

2. Request assistance from individuals with specialized training in dealing with mental illness or crisis situations (e.g., Crisis Intervention Trained (CIT) officers, Community Response Team (CRT), Richmond Behavioral Health Authority (RBHA)).

3. Take steps to calm the situation. Where possible, eliminate emergency lights and sirens, disperse crowds, lower radio volume, and assume a quiet non-threatening manner when approaching or conversing with the individual. Where violence or destructive acts have not occurred, avoid physical contact, and take time to assess the situation. Officers should operate with the understanding that time is an ally and there is no need to rush or force the situation.

4. Create increased distance, if possible, in order to provide the officer with additional time to assess the need for force options.

5. Utilize environmental controls, such as cover, concealment, and barriers to help manage the volatility of the situation.

6. Move slowly and do not excite the individual. Provide reassurance that officers are there to help and that the individual will be provided with appropriate care.

7. Ask the individual's name or by what name they would prefer to be addressed and use that name when talking with the individual.

8. Communicate with the individual in an attempt to determine what is bothering them. If possible, speak slowly and use a low tone of voice. Relate concern for the individual's feelings and allow the individual to express feelings without judgment.

9. Where possible, gather information on the individual from acquaintances or family members and/or request professional assistance, if available and appropriate, to assist in communicating with and calming the individual.

10. Do not threaten the individual with arrest, or make other similar threats or demands, as this may create additional fright, stress, and potential aggression.

11. Avoid topics that may agitate the individual and guide the conversation toward subjects that help bring the situation to a successful conclusion. It is often helpful for officers to apologize for bringing up a subject or topic that triggers the person in crisis. This apology can often be a bridge to rapport building.

12. Be truthful with the individual. If the individual becomes aware of a deception, they may withdraw from the contact in distrust and may become hypersensitive or retaliate in anger. In the event an individual is experiencing delusions and/or hallucinations and asks the officer to validate these, statements such as "I am not seeing what you are seeing, but I believe that you are seeing (the hallucination, etc.)" are recommended. Validating and/or participating in the individual's delusion and/or hallucination is not advised.

C. Taking Custody or Making Referrals to Mental Health Professionals:

1. Based upon the overall circumstances of the situation, an officer may take one of several courses of action when responding to a person in crisis.

   a) Offer mental health referral information to the individual and/or family members.

   b) Assist in accommodating a voluntary admission for the individual.

   c) Take the individual into custody and provide transportation to a mental health facility for an involuntary psychiatric evaluation. (Refer to General Order 06-17)

   NOTE: If the officer takes the person into custody based on their observations or other information (paperless ECO), they should contact the Community Service Board (CSB) as soon as practical by calling (804) 819-4100. They should then follow the instructions of the CSB evaluator.

   d) Make an arrest, if applicable.

2. A person subject to involuntary admission treatment is in protective custody and not under custodial arrest. When necessary to prevent a person subject to involuntary admission from escape, harming themselves or others, or to facilitate the safe transportation of the person, members will adhere to the use of restraining devices consistent with the General Order 06-10, Restraint and Transportation of Custodial Arrestees. Whenever feasible, Department members will explain to the person who is the subject to involuntary admission what the restraining device is and why it is being used.

NOTE: Department members may utilize discretion when using restraining devices on individuals in crisis who are unarmed, not violent, and willing to comply.

3. Department members will remove property that is dangerous to life or will facilitate the escape of a person subject to involuntary admission prior to transport.

D. Interview and Interrogation of Persons with Mental Health Conditions:

[CALEA 41.2.7c]

1. Interviews and interrogations of persons believed to suffer from mental health conditions, developmental disabilities, or substance use disorders that are suspected of committing a criminal offense will be conducted in the same manner as for all other suspects. A person who is determined to have one of the above conditions may still knowingly and voluntarily give a reliable statement.

2. To assist in the prosecution of such an individual, the officer/detective conducting the interview or interrogation shall pay specific attention to and take note of whether the subject answers basic questions appropriately, remains alert at the time that questioning takes place**,** and/or demonstrates any indication of confusion.

3. If an officer/detective believes that the subject's mental state outweighs the seriousness of any applicable criminal charges, involuntary commitment may be sought according to the aforementioned procedure(s).

E. Documentation:

1. Document the incident, regardless of whether the individual is taken into custody. Where the individual is taken into custody or referred to other agencies, officers should detail the reasons why.

   a) Officers will compile an IBR in instances when a person is taken into custody on an ECO or TDO. If an incident begins as an ECO, the initial officer will generate the report. If a TDO is subsequently issued, a supplement to the report will be submitted with the additional details.

2. Ensure that the report is as specific and explicit as possible concerning the circumstances of the incident and the type of behavior that was observed. Terms such as "out of control" or "mentally disturbed" should be replaced with descriptions of the specific behaviors, statements, and actions exhibited by the person.

3. If the individual is not taken into custody, the officers shall complete a Field Interview Report (i.e. Mental Subject, Non-Custody) explaining the situation and provide details that may help with future interactions with the individual.

F. Training:

1. Training on how to handle individuals who may be experiencing a mental health crisis is conducted in conjunction with the local CSB. Department members shall receive documented entry-level training in recognizing and handling persons suffering from mental illnesses and in mental health crisis.

[CALEA 41.2.7d]

2. Members shall receive documented Mental Health refresher training courses annually.

[CALEA 41.2.7e]

VII. PROGRAMS AND RESOURCES

A. When a criminal or other offense is not involved, and there are not sufficient grounds for taking the individual in crisis into custody for their own protection or the protection of others, Department members will seek alternative options and divert individuals with mental health and substance use disorders away from the criminal justice and emergency medical systems. These options include, but are not limited to, the following:

[CALEA 41.2.7b]

1. "988" Hotline – 988, The 988 Lifeline Chat service is available 24/7. In 2020, Congress designated the new 988 dialing code to be operated through the existing National Suicide Prevention Lifeline.

2. RBHA Crisis Hotline – 804-819-4100, RBHA is licensed by the Virginia Department of Behavioral Health and Developmental Services and is the statutorily established public entity responsible for providing mental health, intellectual disabilities, and substance abuse and prevention services to the citizens of the City of Richmond. Services are provided directly by RBHA staff and through contracts with private providers in the community.

3. REACH – 833-968-1800, is a program to support individuals with developmental disabilities who are at risk of crisis due to challenging behavioral health needs which are negatively affecting their quality of life. REACH offers 24/7 crisis intervention and stabilization services (community-based and in the Crisis Therapeutic Home), as well as providing crisis prevention, training and support services for families and caregivers to reduce the likelihood of future crises.

4. Crisis Response and Stabilization Team (CReST) – 833-968-1800, 107 S. 5th St Richmond VA. CReST is a resource for children ages 5 - 18 or adults ages 18 & older who are in crisis and is a short-term intervention designed to prevent the need for more intensive care (i.e. hospitalization). There is no insurance requirement and no out-of-pocket expense.

5. Crisis Receiving Center (CRC) – 804-819-4141. 1700 Front St, Richmond VA. Also known as a 23-Hour Center, it provides ongoing assessment, crisis intervention, and clinical determination of the level of care for individuals experiencing a behavioral health crisis. Services are offered for up to 23 hours in a non-hospital, community-based crisis stabilization setting.

6. Tucker Assessment Center (TAC) – 804-483-1331, 7101 Jahnke Road, 0900-1700, Monday through Friday. TAC is designed for voluntary and non-emergent patients aged 11 and up in need of a behavioral health evaluation and offers assessment for in-patient, out-patient, and/or community providers.

7. Children's Crisis Stabilization Unit (CSU) – 804-874-9119, available through St. Joseph's Villa at 7000 Brook Road, Richmond VA. Designed to serve children and adolescents ages 5-17 who are experiencing a behavioral health crisis and require short-term, out-of-home placement.

8. Youth Crisis Receiving Center – 804-553-3201, 7000 Brook Road, Richmond VA. Offers rapid assessments and crisis stabilization services, and makes essential connections to community-based providers for follow-up care upon discharge. All individuals are discharged from the CRC within 23 hours of admission. Prior to discharge, staff, families, and youth jointly determine the next appropriate level of care.

[CALEA 1.1.3]

B. Community Response Team (CRT or Co-Responder Team):

1. The Marcus Alert's Community Response Team (CRT or Co-Responder Team) is a specialized program designed to address mental health crises in a collaborative way. The Teams pair an RBHA Clinician and a Richmond Police Officer to respond to calls involving individuals in crisis with an aim to deescalate situations, provide alternatives to an arrest or ECO/TDO, potentially expedite the TDO process, if applicable, and to assist and connect people with resources they need.

2. Officers may request assistance from the CRT by contacting the Department of Emergency Communications, Preparedness and Response (DECPR).

VIII. FORMS

A. IBR