Temple University Department of Public Safety

POLICIES AND PROCEDURES

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PURPOSE

The purpose of this policy is to establish clear procedures and responsibilities for all members of the Temple University Department of Public Safety (TUDPS) in supporting the wellness of the campus community and responding effectively and compassionately to individuals experiencing a mental health or emotional crisis. The policy is designed to promote early identification of individuals in distress, guide appropriate referrals to campus resources, and ensure safe and lawful intervention when necessary, with specific protocols based on whether personnel are sworn or non-sworn.

POLICY

It is the policy of the Temple University Department of Public Safety (TUDPS) to promote a safe and supportive campus environment by assisting individuals experiencing a mental health crisis or emotional disturbance with compassion, professionalism, and respect for individual dignity. All TUDPS personnel, sworn and non-sworn, are expected to take an active role in promoting wellness, recognizing signs of crisis, and responding appropriately within the scope of their training and authority.

DEFINITIONS

CARE Team: The Temple University CARE Team (Crisis, Assessment, Response, Education) is a multidisciplinary group from key student support offices (e.g., Tuttleman Counseling, Disability Resources, TUDPS). The team reviews student-related concerns, determines appropriate interventions,

and assigns follow-up responsibilities. The CARE Team is not an emergency response service, urgent threats should be directed to emergency services. Referrals are managed by the Case Management Staff in the Dean of Students Office. Contact: 215-204-7188 or careteam@temple.edu.

Clinician: A licensed mental health professional authorized to conduct assessments and provide crisis intervention.

Co-Responder Team: A sworn TUDPS officer and a licensed or credentialed mental health clinician responding jointly.

Crisis Response Center (CRC): A 24-hour psychiatric emergency service, most commonly accessed through Temple University Hospital Episcopal Campus. The CRC provides evaluation, treatment, and referrals for individuals experiencing behavioral health crises. Other crisis response centers may be utilized as necessary based on circumstances and availability; Contact: 215-707-2577.

Mental Health Crisis: An event or experience in which an individual's normal coping mechanisms are overwhelmed, causing them to have an extreme emotional, physical, mental, and/or behavioral response. 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 of mental illness.

Mental Illness: An impairment of normal cognitive, emotional, or behavioral functioning, caused by physiological or psychosocial factors. A person may be affected by mental illness if they display an inability to think rationally (e.g., delusions or hallucinations); exercise adequate control over behavior or impulses (e.g., aggressive, suicidal, homicidal, sexual); and/or take reasonable care of their welfare with regard to basic provisions for clothing, food, shelter, or safety.

Mental Health Delegate: An individual appointed by the City of Philadelphia Department of Behavioral Health and Intellectual Disability Services (DBHIDS) who reviews applications for emergency involuntary psychiatric evaluation.

PROCEDURES

I. Recognizing Abnormal Behavior (CALEA 41.2.7 a)

A. Mental illness is often difficult for even the trained professional to recognize in a given individual. Employees of TUDPS are not expected to make judgments of mental or emotional disturbance, but rather to recognize exhibited behavior that is potentially destructive and/or dangerous to themselves or others.

B. The following are generalized signs and symptoms of behavior that may suggest mental illness, although TUDPS employees should not rule out other potential causes, such as medical conditions, reactions to narcotics or alcohol, or temporary emotional crises that are situationally motivated. TUDPS employees should evaluate 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.

1. Loss of memory and confusion.

a) Abnormal memory loss related to such common facts as name, home address, (although these may be signs of other physical ailments such as injury, a reaction to diabetes, or Alzheimer's disease).

2. Delusions.

a) Delusions, the belief in thoughts or ideas that are false, such as delusions of grandeur or paranoid delusions;

3. Hallucinations of any of the five (5) senses (e.g. hearing voices commanding the person to act, feeling one's skin crawl, smelling strange odors, etc.);

a) Note that olfactory, visual, and tactile hallucinations are not common among people with mental illness and may indicate substance use or a medical condition.

4. Depression, deep feelings of sadness, hopelessness, or uselessness.

5. Manic behavior accelerated thinking and speaking or other forms of hyperactivity.

II. Wellness and Prevention Resources

A. TUDPS is committed to supporting the mental health and emotional well-being of its students, faculty, and staff. While the TUDPS plays a key role in crisis response, prevention, and early intervention are equally vital to community safety and individual success. TUDPS personnel should be familiar with the following wellness-related resources and procedures for referring individuals in distress.

B. Campus Mental Health Resources (For Students)

1. The following services are available to students and may be appropriate for referral in non-emergency situations:

a) Tuttleman Counseling Services (TCS)

(1) Offers individual and group therapy, psychiatric services, crisis

support, and referrals.

(2) Contact: 215-204-7276

(3) After hours, police officers should call TCS's after hours line: (855)-845-5961. (NOTE: This phone number must not be given to students.)

b) CARE Team (Crisis, Assessment, Response, and Education)

(1) A behavioral intervention team that addresses student-related concerns and coordinates follow-up through the Dean of Students Office.

(2) Contact: 215-204-7188 | careteam@temple.edu

c) Disability Resources and Services (DRS)

(1) Supports students with psychological, emotional, or cognitive disabilities through accommodations and resources.

(2) Contact: 215-204-1280

d) Crisis Response Center (CRC)

(1) A 24-hour psychiatric emergency facility, most commonly accessed through Temple University Hospital – Episcopal Campus. The CRC provides evaluation, treatment, and referrals for individuals experiencing behavioral health crises. Other approved crisis centers may be used based on location or availability.

(2) Contact: 215-707-2577

C. National & Local Mental Health Resources

1. Philadelphia Suicide and Crisis Response Line

a) Contact: 215-685-6440

2. National Suicide & Crisis Lifeline

a) Dial: 988

D. All TUDPS employees should be aware of these wellness resources and be prepared to offer them to students as a supportive measure. These referrals are intended to promote early intervention and are not intended for crisis-level or emergency situations.

III. Crisis Response Principles for All Personnel

A. This section applies when a situation has escalated beyond wellness concerns into a mental health or behavioral crisis, where a person is potentially a danger to themselves, others, or is unable to function safely without intervention. In these situations, immediate and coordinated action is necessary to protect the individual and the community.

B. A crisis may involve:

1. Threats or attempts of self-harm or suicide;

2. Aggressive or erratic behavior;

3. Severe confusion or disorientation;

4. Psychosis, hallucinations, or delusional behavior;

5. Inability to care for basic needs due to mental health deterioration

C. All TUDPS personnel, sworn and non-sworn, are expected to respond based on their training and authority. Responses should prioritize safety, de-escalation, and access to appropriate care.

D. Guiding Principles

1. Mental illness is not a crime. Individuals should not be arrested or detained solely based on symptoms of mental illness unless required by law or safety considerations.

2. Behavior, not diagnosis, drives response. Whether a person has a known mental health condition is less important than whether their behavior indicates a crisis or threat.

3. Time and space are tools. Do not rush interactions with someone in crisis. Create physical and emotional distance when safe to do so.

4. De-escalation is a priority. Use a calm tone, non-threatening body language, and simple language to help reduce agitation.

5. Safety is mutual. Officer, staff, and subject safety must all be considered when determining the appropriate response.

E. Response Protocol – Non-Sworn Personnel (Civilian Staff) **(CALEA 41.2.7 c)**

1. Non-sworn members of TUDPS, including civilian security officers, communications staff, and other support personnel, often serve as the first point of contact when individuals are in distress. Their observations, judgment, and timely communication are critical to ensuring a safe and coordinated response to mental health emergencies.

2. When faced with behavior that raises concern for personal safety or the well-being of others, non-sworn personnel should prioritize maintaining a safe distance and avoiding direct engagement with the individual. If there is a potential threat, others in the immediate area should be moved away when feasible.

3. Sworn police response must be requested immediately by dialing 911 or by contacting the TUDPS Communications Center at 215-204-1234. Non-sworn personnel should provide clear information, including location, observed behavior, a physical description of the individual, and any relevant context.

4. Non-sworn staff should not attempt to physically restrain, escort, or control an

individual in crisis. Their role is to observe from a safe position, maintain scene awareness, and assist sworn officers with accurate information once they arrive.

5. If the individual is calm and there is no immediate threat, staff may speak in a steady, respectful tone to offer reassurance. Physical contact should be avoided, and personnel should not attempt to resolve or de-escalate the situation beyond their comfort or training.

6. After the incident, employees shall notify their supervisor and may be asked to document the event at the discretion of the supervisor.

7. Additional Expectations for Security Officers

a) Security officers are non-sworn personnel who may serve in public-facing or patrol roles on campus. While they do not have enforcement authority and may not take individuals into custody, they may be responsible for maintaining order and safety in the area of a crisis.

b) When confronted with a mental health crisis, security officers shall:

(1) Request TUDPS police response by contacting TUDPS Communications/Dispatch via their department-issued radio (if applicable), by calling 215-204-1234, or by dialing 911;

(2) Limit access to the scene;

(3) Keep bystanders at a safe distance;

(4) Maintain open access routes for responding police or EMS personnel; and

(5) Remain on scene, when safe to do so, and be prepared to update responding officers on the individual's location, behavior, and any changes or concerns observed before their arrival.

c) Security personnel shall not physically restrain or detain any individual in crisis. Any containment of the scene must be passive and limited to creating space and preserving safety until sworn officers arrive.

F. Crisis Response Guidelines for Sworn Personnel **(CALEA 41.2.7 c)**

1. Sworn officers of TUDPS are responsible for assessing and managing situations involving individuals experiencing a mental health crisis. Officers must apply sound judgment, prioritize safety for all parties, and determine the most effective course of action based on observed behavior, known context, and statutory authority.

2. Request adequate back up, including a CIT trained officer, if not personally CIT Trained, and a Co-Responder (Clinician) unit, if available.

3. When conditions permit, officers should approach in a calm and non-threatening manner. Emergency lights and sirens should be discontinued whenever possible, and efforts should be made to reduce other stressors and to help de-escalate the

situation.

4. Officers should make every effort to communicate clearly and respectfully, using simple language and a steady tone.

    a) Commands should be direct but not confrontational.

    b) When safe, officers should allow space and time for the individual to respond.

IV. Behavioral Health Co-Responder Program

A. The Temple University Department of Public Safety (TUDPS) utilizes a Behavioral Health Co-Responder Program to enhance its response to individuals experiencing a mental health or emotional crisis when clinically informed intervention may reduce the need for arrest, use of force, or involuntary commitment.

B. The Co-Responder Program pairs a sworn TUDPS police officer with a licensed or credentialed mental health clinician operating under the clinical supervision of Tuttleman Counseling Services. This model is intended to provide a health-centered, trauma-informed response while maintaining officer and public safety.

C. The use of a co-responder does not replace sworn officer authority or responsibility for scene safety. Rather, it supplements traditional law enforcement response with clinical expertise when appropriate.

D. Guiding Principles

1. When utilizing the Co-Responder Program, personnel shall adhere to the following principles:

    a) Mental illness alone is not criminal behavior.

    b) The least intrusive, most clinically appropriate response should be used whenever feasible and safe.

    c) Time, distance, and communication are primary de-escalation tools.

    d) Scene safety remains the responsibility of sworn officers at all times.

E. Dispatch and Call Triage

1. Communications personnel shall screen calls for behavioral health indicators, including but not limited to suicidal ideation, psychosis, severe emotional distress, or erratic behavior.

2. Calls involving behavioral health concerns without weapons, active violence, or imminent threats should be routed to the Co-Responder Unit when available. The availability of a co-responder does not delay sworn police response when

immediate safety concerns exist.

F. Response Protocol

1. When deployed:

a) The sworn officer and clinician should respond jointly when practical.

b) The clinician shall not be uniformed and shall wear department-approved protective vests clearly identifying their role.

c) The sworn officer shall ensure the scene is stable and secure prior to permitting clinician engagement.

d) The clinician may lead engagement and assessment only after the scene has been stabilized.

2. Additional patrol resources shall be requested if safety conditions change.

G. Roles and Responsibilities

1. Sworn Officers shall:

a) Maintain responsibility for scene safety and enforcement decisions.

b) Utilize de-escalation techniques consistent with this policy.

c) Request CIT-trained officers or additional support when appropriate.

d) Retain final authority regarding arrest, custody, and transport decisions.

2. Clinicians shall:

a) Conduct behavioral health assessments and crisis intervention.

b) Assist with de-escalation and communication.

c) Recommend disposition options and follow-up care.

d) Serve as petitioner for involuntary commitment when legally appropriate and clinically indicated.

e) If the officer and clinician disagree on disposition, the on-duty supervisor shall determine the appropriate course of action and document the decision.

H. Documentation

1. Sworn officers shall document all substantive contacts involving the Co-Responder Program in an incident report and mark “Co-Responder” in the categories options to note this was a call handled by the Behavioral Health

Co-Responder team.

2. Clinicians shall complete clinical documentation in accordance with professional standards and applicable privacy laws. Information sharing shall be limited to what is necessary for safety and service delivery and shall comply with HIPAA, FERPA, and applicable law. Clinicians shall not have access to departmental records management systems or CJIS.

I. Supervision and Quality Assurance

1. The Behavioral Health Co-Responder program is a joint program between TUDPS and the Tuttleman Counseling Center and therefore, both organizations will work in partnership in the supervision of personnel and the overall quality of the program.

2. TUDPS police officers shall complete a report on all substantive contacts between a co-responder and the public. Officers shall check the "counselor" box in ARMS (Automated Record Management System)

3. TUDPS supervisors shall review the co-responder team's deployments for policy compliance, safety outcomes, and service effectiveness. Aggregate data will be used for program evaluation.

4. Training conducted by the TUDPS will be monitored and administered by the Director of Tactical and Professional Development Unit

5. Clinical work including counseling for follow up care, disposition and associated reporting by the Clinician shall be reviewed and supervised by the staff of the Tuttleman Counseling Center.

6. Clinical training, including any training required to maintain licensure, will be monitored and overseen by the staff of the Tuttleman Counseling Center.

J. Confidentiality and Information Sharing

1. Information sharing shall be limited to what is necessary for safety and service delivery, consistent with HIPAA, FERPA, and applicable law. Clinicians will not be permitted access to departmental records management systems nor Criminal Justice Information Services (CJIS).

K. Program Evaluation

1. The Behavioral Health Co-Responder Unit will be evaluated annually in June, including metrics such as repeat calls, arrests avoided, use-of-force incidents, and linkage to care. This report will be completed by the Deputy Director of Organizational Affairs in consultation and collaboration with personnel from the Tuttleman Counseling Center.

V. Dispositions

A. The appropriate course of action shall be determined based on the individual's behavior, level of cooperation, and legal criteria. The following options may apply:

1. No Immediate Action Required

a) If the individual is calm, not a threat to themselves or others, and no criminal conduct has occurred, officers may:

(1) Provide verbal support and reassurance,

(2) Offer mental health resource information (see Section II of this policy),

2. Voluntary Transport to Treatment (201)

a) If the individual is cooperative and agrees to receive care, officers may assist in arranging or providing transport to a local treatment facility (see Section IV of this policy for additional guidance).

3. Involuntary Commitment (302)

a) If the individual meets criteria under the Mental Health Procedures Act, officers shall take the individual into custody and transport them to an approved mental health facility (see section V of this policy for additional guidance).

b) EMS may be requested if medical transport is more appropriate.

4. Criminal Arrest

a) If a criminal offense has occurred:

(1) Officers may take the individual into custody in accordance with department policy,

(2) If the individual also meets criteria for 302 commitment, officers must ensure appropriate mental health evaluation after processing,

(3) Arrest and commitment can occur in sequence when required by law and safety (see section VI of this policy for additional guidance).

B. All decisions must be based on observed behavior and articulated facts. Officers should select the least restrictive lawful option that ensures safety and connects the individual with appropriate care. Every incident must be clearly documented, including behavior observed, actions taken, and the justification for the chosen disposition.

VI. Procedures For Voluntary Examination And Treatment (201)

A. Adults

1. Officers responding to calls for service involving a mental health emergency will provide assistance to individuals seeking voluntary services under the Mental Health Procedures Act to the fullest extent possible. If the individual does not exhibit any signs or behaviors which would constitute involuntary emergency examination and treatment (302) and they wish to voluntarily commit themselves for mental health treatment (201), the officer will transport or arrange for the transport of the individual to a local medical or mental health facility.

B. Children

1. A minor age 14 or older may consent to inpatient mental health treatment. Once a minor gives consent to inpatient care, a parent or guardian cannot override that consent.

2. Further, on the recommendation of a physician who has examined the minor, the parent may consent to voluntary inpatient mental health treatment for the minor without the minor's consent.

    a) It is important to note that the minor cannot refuse treatment and said treatment is still considered voluntary as the parent is deemed to be acting for the child.

3. Officers will transport or arrange for the transport of the minor to an appropriate facility for treatment.

    a) Officers may also seek guidance from the Office of Children and Youth Services by contacting 800-416-4511 during normal business hours or 610-892-8400 after normal business hours, holidays, and weekends.

VII. Procedures For Involuntary Examination And Treatment (302) (PLEAC 2.7.8 a)

A. Mental Health Procedures Act

1. A person is severely mentally disabled when, as a result of mental illness, their capacity to exercise self-control, judgment, and discretion in the conduct of their affairs and social relations, or to care for their own personal needs, is so lessened that they pose a clear and present danger of harm to others or themselves. The following acts determine whether a person is a clear and present danger to others or themselves.

    a) To others – Is shown when within the past 30 days, the individual has inflicted, attempted to inflict, or made a credible threat to inflict serious bodily harm on another and that there is a reasonable probability that such

conduct will be repeated.

b) To self – Is shown when within the past 30 days:

(1) The individual acted in such a manner that they would be unable, without care, supervision and the continued assistance of others, to satisfy their need for nourishment, personal or medical care, shelter, or self-protection and safety, and that there is reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30-days unless adequate treatment was afforded.

(2) The individual has attempted suicide and there is reasonable probability of suicide unless adequate treatment is afforded. This include threats to commit suicide along with the commission of acts that are in the furtherance of the threat to commit suicide.

(3) The individual has substantially mutilated themselves, or attempted to mutilate themselves substantially, and that there is a reasonable probability of mutilation unless adequate treatment is afforded. This includes threats to mutilate themselves along with the commission of acts that are in the furtherance of the threat to mutilate themselves.

B. Emergency examination by a police officer

1. Police Officers, upon personal observation of the conduct of an individual constituting treatment, and when no other family or authorized person is able to make the application, will take custody of the individual and transport, or arrange for their transportation, to an approved facility for an emergency examination.

a) When necessary, EMS can be contacted to transport the individual.

2. Upon arrival at the approved facility, the custodial officer will complete the Application for Involuntary Emergency Examination and Treatment, herein referred to as 302 paperwork, and forward to the county administrator or examining physician for review.

C. Involuntary emergency mental health examination by petitioner

1. A petitioner is a person with firsthand knowledge of the individual's behavior. They must be willing to sign the necessary petition to commit the individual for evaluation. The petitioner must also attest to the dangerous behavior observed and

attend any necessary hearings related to the petition.

2. Officers will provide the necessary assistance to family members or anyone with standing who has observed the conduct necessary for an "application for examination" to process an application for examination.

VIII. Involuntary Commitment of Persons in Police Custody

A. When a person is placed under arrest for a criminal offense and also meets the criteria for involuntary mental health commitment under Section 302 of the Mental Health Procedures Act, officers must determine the appropriate order of action based on the severity of the individual's condition and the safety of all involved.

B. If Processing Can Be Completed Safely

1. If the individual is able to safely undergo arrest processing, the following steps apply:

a) The arresting officer shall notify a supervisor that the individual also meets the threshold for a 302.

b) The individual shall be transported to the Philadelphia Police Department or the appropriate Law Enforcement Agency for processing.

c) A Temple University police officer shall personally observe the individual for the duration of the processing procedure, regardless of location, and shall not leave the individual unaccompanied at any time. Continuous observation is required to ensure the individual's safety, emotional stability, and access to emergency care if needed.

d) Upon completion of processing, the individual shall be transported without delay to the appropriate mental health facility for the involuntary commitment.

2. If the Individual Cannot Be Safely Processed

a) If the individual's behavior presents a risk so significant that they cannot be safely processed (e.g., active psychosis, extreme agitation, violent self-harm behavior), the officer shall:

(1) Document the observed behavior that prevented standard arrest processing,

(2) Transport the individual directly to an approved mental health facility for emergency psychiatric evaluation under a 302,

(3) Notify a supervisor and ensure the 302 documentation is

completed and submitted at the time of hospital intake.

b) In these cases, criminal charges may be pursued through alternative means, including a criminal summons or arrest warrant, in accordance with the Pennsylvania Rules of Criminal Procedure and department guidelines.

c) Officers may coordinate with the receiving hospital and follow up to serve the warrant, if applicable, following the individual's release from inpatient treatment.

IX. Training

A. All sworn personnel are required to successfully complete an initial mental health training program in order to recognize and respond to suspected mentally ill persons. **(CALEA 41.2.7 d) (PLEAC 2.7.8 b)**

B. All sworn personnel must undergo annual update training in the area of mental illness, which will include training provided through the course of legal mandate and/or MPOETC regulation, if available. **(CALEA 41.2.7 e) (PLEAC 2.7.8 c)**

C. If applicable mental health statutes or department policy changes occur during the accreditation period, training must be provided within ninety (90) days or as required by statute. **(PLEAC 2.7.8 d)**

D. Clinicians shall receive:

1. Orientation to police operations, officer safety, and TUDPS procedures.

2. Clinicians shall receive "Power in Peers" certification as a peer support mentor.

3. Initial and yearly policy review by TUDPS.