GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF POLICE COMPLAINTS

PCB POLICY REPORT #24-1:
Improved Guidance on Involuntary Emergency Hospitalization Procedures

Summary:

Customarily, police officers are the first responders to calls for service for individuals experiencing a mental health crisis. Emergency hospitalization is a legal mechanism that officers can use to protect people in crisis from causing harm to themselves, officers, or others. However, given the potential violation of civil liberties that comes with emergency involuntary hospitalization, it is imperative that the Metropolitan Police Department (MPD) provide its members clear written guidance and training on the legal standard for involuntary hospitalization to avoid infringing on people's constitutional rights and protect against otherwise avoidable civil liability for the District, MPD, and its members.[1] [2] In recent years, the D.C. Office of Police Complaints (OPC) has received several complaints with allegations of unlawful involuntary hospitalization of people experiencing a mental health crisis by MPD officers. Accordingly, this report highlights the need for MPD to ensure that there are proper procedures and training in place, as well as oversight, to ensure that when officers detain individuals for involuntary hospitalization, they are balancing the goals of safety and treatment with respect for the constitutional rights of individuals with mental health conditions.

Background:

In the District, involuntary emergency hospitalization is the warrantless detainment of an individual believed to have a mental illness who, because of the mental illness, is likely to injure themselves or others if not immediately detained and transported for observation and diagnosis.[3] Therefore, MPD officers responding to a call for service for a person experiencing a mental health crisis are required to make two determinations: 1) whether they have reason to believe the

[1] The Police Complaints Board (PCB) is issuing this report pursuant to D.C. Code § 5-1104(d), which authorizes the Board to recommend to the District of Columbia Mayor, Council, MPD Police Chief, and the Director of District of Columbia Housing Authority reforms that have the potential to improve the complaint process or reduce the incidence of police misconduct.

[2] The PCB would like to recognize and thank legal intern José Salvador Icaza V for his contributions to this policy recommendation.

[3] Code of the District of Columbia § 21–521. Detention of persons believed to be mentally ill; transportation and application to hospital., available at https://code.dccouncil.gov/us/dc/council/code/sections/21-521#:~:text=An%20accredited%20officer%20or%20agent,because%20of%20the%20illness%2C%20is.

person has a mental illness, and 2) whether, as a result of the mental illness, the person is likely to injure himself or others if not immediately detained.[4] If officers authorized to make arrests reasonably believe a person meets these criteria, they "may, without a warrant, detain and take the person into custody, and transport them to a public or private hospital, or to the Department."[5] The officer must also complete an application to the DC Superior Court for emergency hospitalization, which usually consists of a Form FD-12,[6] citing the circumstances under which the person was taken into custody and the reason for detainment.[7]

Following an emergency hospitalization, a person may be involuntarily committed for a specified period of time pursuant to a court order.[8] Involuntary civil commitment may occur if the court or a jury finds that "the person is mentally ill and, because of that mental illness, is likely to injure himself or others if not committed."[9] While the officers are responsible for taking the person into custody and transporting them for admission to the hospital, the court, when making a determination on whether to continue holding the person, "shall consider the written reports of the […] officer […] who made the application under section 21-522."[10] This places an enormous responsibility on officers as they are expected to recognize symptoms of mental illness without formal medical training and then prognosticate whether someone might injure themselves or others as a result of that mental illness if not immediately detained. Without proper training and written guidance, it would be unreasonable to require officers to act as de facto mental health experts and make these crucial decisions that may strip people of their freedom by involuntarily hospitalizing them.

Current Laws, Policies, and Standards:

D.C. Official Code § 21–521

The law governing involuntary emergency hospitalization by law enforcement officers, D.C. Official Code § 21–521. Detention of persons believed to be mentally ill; transportation and application to hospital, instructs members, **"**…an officer authorized to make arrests in the District of Columbia…who has reason to believe that a person is mentally ill and, because of the illness, *is likely to injure himself or others if he is not immediately detained* may, without a warrant, take the person into custody, transport him to a public or private hospital, or to the Department, and make application for his admission thereto for purposes of emergency

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[4] *Id*.
[5] *Id*.
[6] MPD Executive Order 23-014: Revised FD-12 Form and Procedures – Attachment A, Sample FD-12 Form, available at https://go.mpdconline.com/GO/EO_23_014.pdf.
[7] *Id*.
[8] Code of the District of Columbia
§ 21–523. Court order requirement for hospital detention beyond 48 hours; maximum period for observation., available at https://code.dccouncil.gov/us/dc/council/code/sections/21-523.
[9] Code of the District of Columbia
§ 21–526. Extension of maximum periods of time., available at https://code.dccouncil.gov/us/dc/council/code/sections/21-526.
[10] Code of the District of Columbia
§ 21–524. Determination and order of court. (b), available at https://code.dccouncil.gov/us/dc/council/code/sections/21-524.

observation and diagnosis. The application shall reveal the circumstances under which the person was taken into custody and the reasons therefor."[11]

MPD General Order 308.04

MPD has regulations and training in place to provide guidance to its officers on interacting with community members experiencing mental health conditions.[12] For example, in December 2023, MPD announced that the Integrating Communications Assessment and Tactics (ICAT) training would be included in its professional development training, beginning in 2024.[13] This 16-hour course developed by the Police Executive Research Forum (PERF) aims to enhance officer and public safety by providing officers with more tools for handling crises, particularly those that involve subjects experiencing mental health crises.[14] ICAT supplements the Mental Health First Aid (MHFA) training, which every MPD officer has completed since 2022 if not already certified as a Crisis Intervention Officer (CIO). However, a review of MPD's policies conducted by OPC revealed that MPD's written policy, General Order 308.04, Interacting with Mental Health Consumers, may be confusing to members because it does not contain the same language or standard for emergency hospitalization as stated in the DC Code and the Form FD-12 application for emergency hospitalization. The general order is also vague in that it does not provide guidance to officers on how to determine whether someone may be suffering from a mental illness or poses a danger or risk of injury to oneself or others.

FD-12 Form

The FD-12 form is the application that an MPD member, or another authorized agent, must complete in order to involuntarily hospitalize an individual in the District. The form is titled, "Superior Court of the District of Columbia APPLICATION FOR EMERGENCY OBSERVATION AND DIAGNOSIS BY A PHYSICIAN OR PSYCHOLOGIST OF THE PERSON, OFFICER OR AGENT OF D.C. DEPARTMENT OF BEHAVIORAL HEALTH, OR AN OFFICER TO MAKE ARRESTS."[15] The FD-12 form asks officers to attest, "That I am an officer authorized to make arrests in the District of Columbia; and having reason to believe that "Name of person to be hospitalized" has a mental illness and, because of such illness, is likely to injure self and/or others if not immediately detained…" The form also asks officers to do the following: "(1) State circumstances under which person was taken into custody; (2) State facts which lead you to believe person has a mental illness; (3) State facts which lead you to believe person is likely to injure self and/or others as a result of mental illness."[16] While the officers are primarily responsible for detaining and transporting the person for admission to the hospital, the

[11] Code of the District of Columbia § 21–521. Detention of persons believed to be mentally ill; transportation and application to hospital., available at https://code.dccouncil.gov/us/dc/council/code/sections/21-521#:~:text=An%20accredited%20officer%20or%20agent,because%20of%20the%20illness%2C%20is.
[12] MPD General Order 308.04, Interacting with Mental Health Consumers (February 9, 2015), available at https://go.mpdconline.com/GO/GO_308_04.pdf.
[13] See https://mpdc.dc.gov/release/metropolitan-police-department-announces-new-training-aimed-calming-potentially-dangerous-0.
[14] See https://www.policeforum.org/trainingguide.
[15] MPD Executive Order 23-014: Revised FD-12 Form and Procedures – Attachment A, Sample FD-12 Form, available at https://go.mpdconline.com/GO/EO_23_014.pdf.
[16] *Id.*

FD-12 form requires officers to provide details on the person's condition and propensity to injure themselves or others. As previously mentioned, the court will consider the officer's written report when making a determination on whether to continue holding the person.[17] Thus, it is imperative that MPD provide detailed written guidance and comprehensive training to officers to ensure they are competent in filling out the FD-12 and their assessment is accurate, informed, and meets the legal threshold for involuntary hospitalization.

Standard for Involuntary Hospitalization:

DC Code § 21–521. Detention of persons believed to be mentally ill; transportation and application to hospital.	**MPD General Order 308.04**	**Form FD-12**
"[…] an officer authorized to make arrests in the District of Columbia […] who has reason to believe that *a person is mentally ill* and, ***because of the illness***, ***is likely to injure himself or others if he is not immediately detained*** may, without a warrant, take the person into custody, transport him to a public or private hospital, or to the Department, and make application for his admission thereto for purposes of emergency observation and diagnosis..."[18]	"…a member who reasonably believes that an adult individual *is mentally ill* and ***poses a danger or threat of danger to himself or herself or others***, shall transport the individual without delay to the Comprehensive Psychiatric Emergency Program (CPEP)…"[19] "The information entered on the Form FD-12 shall describe the specific behaviors or statements of the mental health consumer which led the member initiating the emergency hospitalization to believe that *the person was in* ***imminent*** *danger of harming himself or herself or others*."[20]	"I, _____, state that I am an officer authorized to make arrests in the District of Columbia; and having reason to believe that, (Name, address and age of person to be hospitalized), *has a mental illness* and, ***because of such illness***, ***is likely to injure self and/or others if not immediately detained***, hereby make application under the provisions of Title 21§ 521 D.C. Code for the admission of said person to the above-named hospital for emergency observation and diagnosis…"[21]

[17] Code of the District of Columbia § 21–524. Determination and order of court.(b), available at https://code.dccouncil.gov/us/dc/council/code/sections/21-524.

[18] Code of the District of Columbia § 21–521. Detention of persons believed to be mentally ill; transportation and application to hospital., available at https://code.dccouncil.gov/us/dc/council/code/sections/21-521#:~:text=An%20accredited%20officer%20or%20agent,because%20of%20the%20illness%2C%20is.

[19] General Order 308.04(V)(C)(2).

[20] General Order 308.04(V)(C)(5)(c)(1).

[21] MPD Executive Order 23-014: Revised FD-12 Form and Procedures – Attachment A, Sample FD-12 Form, available at https://go.mpdconline.com/GO/EO_23_014.pdf.

While the language distinction in the table above is nuanced, it seems General Order 308.04 has a different threshold for emergency hospitalization than the DC Code and the FD-12 form. In order to detain and take into custody an individual under General Order 308.04, the individual need only be mentally ill and pose a danger or threat of danger to himself or others. This differs from the DC Code and FD-12 application in a number of ways. First, under General Order 308.04, there need be no *likelihood* that the person poses any kind of threat of danger or injury. Second, General Order 308.04 does not posit that there must be a need for *immediate* detention to prevent some risk of injury or harm. Third, General Order 308.04 does not require that the person may *injure* themselves or others, but merely pose a danger or threat of danger. General Order 308.04 does not differentiate injury from danger. Fourth, and perhaps most importantly, General Order 308.04 does not prescribe a causal nexus between the mental illness and the likelihood of injury/danger. Moreover, General Order 308.04 later notes, "If the adult does not voluntarily agree to go to CPEP," the member shall complete the FD-12 and "describe the specific behaviors or statements of the mental health consumer which led the member initiating the emergency hospitalization to believe that the person was in *imminent* danger of harming himself or herself or others."[22] Imminence is not the legal threshold listed in the DC Code nor on the FD-12 form; but rather, as mentioned above, the law is concerned with the person being likely to injure oneself or others. Likely[23] and imminent[24] carry different definitions, respectively. As involuntary hospitalization entails a loss of liberty, it is critical that General Order 308.04 exactly match the language of the DC Code and the FD-12 form to better assist officers in understanding the threshold for involuntary hospitalization.

Limited written guidance currently exists for members on *how* to identify a member of the community as having a mental illness nor do the general orders indicate how officers should respond *after* an officer has identified a member of the community as having a mental illness. The FD-12 form asks officers to do the following: "(1) State circumstances under which person was taken into custody; (2) State facts which lead you to believe person is mentally ill; (3) State facts which lead you to believe person is likely to injure self and/or others as a result of mental illness."[25] Even if officers are receiving training on the matter, lack of accurate written guidance with respect to officers' recognition of community members experiencing a mental health crisis can result in officers involuntarily hospitalizing individuals who may not meet the threshold of being likely to injure themselves or others if not immediately detained. This can gravely affront the liberty interests of individuals detained for emergency hospitalization. Lack of instruction on how to interact with people in crisis may also escalate interactions unnecessarily, increasing risk of injury to the officer, the subject, and others.

OPC Case Examples:

[22] General Order 308.04(V)(C)(5)(c)(1).
[23] Merriam-Webster defines "likely" as, "having a high probability of occurring or being true: very probable." Available at https://www.merriam-webster.com/dictionary/likely.
[24] Merriam-Webster defines "imminent" as, "Ready to take place: happening soon," and notes, "often used of something bad or dangerous seen as menacingly near." Available at https://www.merriam-webster.com/dictionary/imminent.
[25] MPD Executive Order 23-014: Revised FD-12 Form and Procedures – Attachment A, Sample FD-12 Form, available at https://go.mpdconline.com/GO/EO_23_014.pdf.

Over the past decade, OPC has received several complaints with allegations of unlawful involuntary detainment for emergency hospitalization. Interviews with the subject officers responsible for the detainment in these cases revealed that the officers either did not understand the standard for involuntary hospitalization or did not present sufficient or appropriate evidence to the hospital. The following cases highlight the need for proper written guidance and training for MPD officers on how to recognize mental illness and threat of injury, and whether detention for involuntary hospitalization is appropriate.

Case Example 1:
In September 2016, officers responded to a call for service from the complainant's daughter, who told the officers her mother was experiencing a manic episode and was not taking her medication correctly. Upon arrival, the officers observed the complainant having dinner with a guest with a partially consumed glass of wine at the table. The complainant's daughter showed the officers a video of her mother drinking a full glass of wine before the officers arrived; however, the officers did not observe the complainant drink any alcohol in their presence. When the complainant attempted to enter her vehicle to drive her guest home, the officers handcuffed her and transported her to the hospital involuntarily.

Both officers described the complainant's behavior as calm, and the complainant expressly stated to the officers that she did not want to harm herself or others. One officer did not think she was intoxicated, and the other officer was unable to determine whether she was intoxicated. One of the subject officers told OPC that the officers completed an FD-12 form to hospitalize the complainant because she was not taking her medicine, she was mixing her medication with alcohol, and she was a danger to herself and her guest when she tried to drive. The other officer initially did not agree with involuntarily hospitalizing the complainant, but changed his mind when she tried to drive. Other than the statement of the complainant's daughter, neither subject officer was able to articulate what specific behaviors or statements led them to believe the complainant was mentally ill and that because of her mental illness she would be likely to injure herself or others if not immediately detained. The hospital rejected the FD-12 form submitted by the officers because there was not enough evidence to involuntarily hospitalize the complainant. The officers did not witness any erratic behavior to suggest the complainant met the standard for involuntary hospitalization and there was no threat of immediate injury to anyone. The act of driving a vehicle after being diagnosed with a mental illness and after consuming a glass of wine does not equate to a likelihood of injury, nor is it evidence of one's intent to injure themselves or another.[26]

Case Example 2:
In October 2017, officers responded to the complainant's apartment after her mother called and said the complainant had made suicidal threats. Officers and EMS responded, and the complainant denied having suicidal ideations. EMS checked her vitals and determined the complainant had to go to the hospital due to high blood pressure and the complainant voluntarily got into the ambulance. However, she jumped out of the back of the ambulance during the ride and ran down the street until she was apprehended by several officers. The subject officer was not at the complainant's home, and only responded to the scene on the street after she jumped out

[26] OPC Case No. 17-0029.

of the ambulance. Once they arrived at the hospital, the subject officer filled out the FD-12 form to involuntarily hospitalize the complainant for psychiatric evaluation.

The subject officer said he interviewed the other officers on scene about the complainant's mental health and that was how he learned the information he used to complete the FD-12. OPC reviewed the FD-12, in which the officer wrote that the complainant was going to jump out of her apartment window to kill herself as an example of why he believed she was mentally ill. The officer said the statement about the complainant threatening to jump out of her apartment window was learned from interviewing officers. However, body-worn camera (BWC) footage revealed that the officers who responded to the complainant's *ground floor unit* did not have any conversation about her jumping out of a window. The subject officer admitted he did not observe any mental health symptoms by the complainant or recall any conversations amongst officers discussing the complainant's mental health.

Based upon the statements and evidence, OPC had serious concerns about the inaccurate fact regarding the complainant threatening to jump out of her apartment window being used as evidence of mental illness on the FD-12. OPC found that the subject officer showed little concern regarding an important legal document that takes away a person's liberty and involuntarily confines them to a hospital.[27]

Case Example 3:
In May 2022, officers responded after the complainant called 911 because her teenage daughter was punching holes in the wall and throwing things around the house. The subject officer learned that the complainant and her daughter were both mental health consumers who had gotten into an altercation. The BWC footage showed that the teenager was able to clearly articulate that she kicked a hole in the wall because her mother made her upset by putting her hands on her. The teenager also claimed the complainant contributed to the holes in the wall. The complainant wanted her teenager to be involuntarily hospitalized, but was in a state of psychosis during the incident and was not a credible witness. The subject officer admitted to OPC that he did not witness any violent behavior from the teenager. He observed the teenager sitting on the floor crying with her dog in her arms.

The subject officer stated his justification for facilitating the involuntary psychiatric hold was because the complainant called 911 and stated the teenager was tearing up the house and acting violently. Another subject officer, the CIO who filled out the FD-12 paperwork told OPC during his interview that the FD12 paperwork stated, "When you start kicking holes in walls and punching things, it's only a matter of time before it stops being walls and it start being someone else. And when you're kicking and punching walls, you can hurt yourself doing that as well." The subject officer asked the CIO if he had enough to complete the FD12 and the CIO responded by shrugging his shoulders, as if implying he was unsure. Nevertheless, the CIO filled out the paperwork and the officers transported the teenager to the hospital. The CIO admitted to OPC that the FD12 paperwork was completed as a preventative measure so the teenager would not pose a threat to herself or others in the future.

[27] OPC Case No. 18-0101.

OPC contacted the Community Response Team (CRT) to get their professional opinion on whether kicking holes in the wall and having a mental illness met the burden of proof for an involuntary hospitalization. The CRT stated that the officers did not meet the burden of proof. According to the CRT, the teenager would have had to verbally say and/or show that she was going to harm herself and/or others. Based on the BWC footage for this incident, there was no evidence to support either.

In this case, OPC did not find that the subject officers met the burden of proof for an involuntary psychiatric hold. The complainant, who called the police, was not a reliable witness as she was suffering from psychosis at the time. The BWC footage showed that the teenager was able to clearly articulate that she kicked a hole in the wall because her mother made her upset by putting her hands on her. Since the burden of proof for involuntary hospitalization requires officers to believe that the subject is mentally ill and, because of such illness, is likely to injure self and/or others if not immediately detained, it was not met in this case. In this instance, the behavior identified was consistent with a teenager with behavioral problems rather than one attempting to cause harm to herself or others. This case elucidates the need for training to ensure that officers understand the burden of proof for involuntary emergency hospitalization.[28]

Nationwide Policies:

Many police departments throughout the U.S. provide guidance for officers on recognizing mental health crises and how to determine whether to involuntarily transport people to hospitals for psychiatric care. Police departments in other jurisdictions also provide training to their members on lawful detainment for emergency hospitalization with the goal of balancing the safety interests of patients, officers, and others with the patient's constitutional right to be free from involuntary hospitalization.

Example 1: Chicago Police Department Special Order S04-20, Recognizing and Responding to Individuals in Crisis.[29]

Special Order S04-20 exemplifies how written guidance can assist officers responding to people in crisis. Special Order S04-20 defines mental illness, intellectual, and development disabilities; provides detailed lists of verbal, behavioral, and environmental clues to help officers recognize whether an individual is in need of mental health treatment; outlines procedures for *interacting* with persons requiring involuntary admission to a hospital; and, directs officers to a slew of other separate directives, including "People with Disabilities,"[30] a standalone directive on "Persons Subject to Involuntary or Voluntary Admission Non-Arrestees,"[31] and, an Illinois State Police form on "Person Determined to Pose a Clear and Present Danger."[32] Chicago's Special Order

[28] OPC Case No. 22-0429.
[29] Chicago Police Department Special Order S04-20, Recognizing and Responding to Individuals in Crisis *Draft* (September 30, 2020), available at https://home.chicagopolice.org/wp-content/uploads/2020/11/S04-20-Recognizing-and-Responding-to-Individuals-in-Crisis-DRAFT.pdf.
[30] See https://home.chicagopolice.org/wp-content/uploads/S02-01-01_People-with-Disabilities_Current_24JUN16.pdf.
[31] See https://home.chicagopolice.org/draft_policy/persons-subject-to-involuntary-or-voluntary-admission-non-arrestees-policy-draft/.
[32]See https://www.ispfsb.com/Public/Firearms/ClearAndPresentDanger.pdf.

S04-20 includes clear, yet simple instructions for officers on recognizing signs of mental illness and determining whether a person poses a danger such that they need to be involuntarily hospitalized.

Example 2: Cleveland Division of Police General Police Order 5.11.03, Crisis Intervention Team Response.[33]

Cleveland's General Order 5.11.03 provides officers with the exact language of the law governing emergency hospitalization; lists specific examples of de-escalation techniques with examples of language to use when communicating with individuals in crisis; and offers detailed information on the application for emergency hospitalization. General Order 5.11.03 also instructs officers to use tactful language to talk the individual in crisis and any present family members by informing them of the steps being taken,[34] explain why the person might be handcuffed,[35] and convey to them "the officer's name and rank; the custody-taking is not a criminal arrest; and, the individual is being taken for examination by mental health professionals at a specified mental health facility identified by name."[36] Cleveland's general order is a singular reference that provides comprehensive direction to officers on how to provide trauma-informed service to individuals being detained for emergency hospitalization and their families.

Example 3: Baltimore Police Policy 713, Petitions for Emergency Evaluation & Voluntary Admission.[37]

Baltimore's Policy 713 starts off by citing the law and instructing officers, "Even in Crisis, individuals with Behavioral Health Disabilities retain their constitutional rights, including their rights to liberty and due process. Consistent with these rights and Maryland law, a member may only detain and/or transport an individual for emergency evaluation or civil commitment if they present a danger to the life and safety of themselves or others."[38] Policy 713 also provides key definitions such as behavioral health disability, crisis, mental disorder, and mental illness. Instructions are listed out in Policy 713 to aid officers in completing a Petition for Emergency Evaluation. Policy 713 also includes references to other relevant policies such as 712 – Crisis Intervention Program,[39] and 715 – Behavioral Health Crisis Dispatch.[40] Policy 713 is another

[33] Cleveland Division of Police General Order 5.11.03, Crisis Intervention Team Response (July 11, 2023), available at https://www.clevelandohio.gov/sites/clevelandohio/files/Public%20Safety/Police/5.11.03%20Crisis%20Intervention%20Team%20Response.pdf.
[34] Cleveland General Order 5.11.03(VIII)(C).
[35] Cleveland General Order 5.11.03(VII)(A)(3).
[36] Cleveland General Order 5.11.03(X)(C)(2).
[37] Baltimore Police Policy 713, Petitions for Emergency Evaluation & Voluntary Admission (June 29, 2021), available at https://public.powerdms.com/BALTIMOREMD/documents/51022.
[38] *Id*, citing (MD Health Gen. § 10 602 a).
[39] See https://public.powerdms.com/BALTIMOREMD/documents/355280/712%20DRAFT%20Crisis%20Intervention%20Program#:~:text=The%20CRT's%20goal%20is%20to,BPD%20personnel%2C%20and%20the%20community.
[40] See https://public.powerdms.com/BALTIMOREMD/documents/430636/715%20DRAFT%20Behavioral%20Health%20Crisis%20Dispatch.

example of a straightforward, instructive guide to help officers determine when and how to lawfully detain a person for emergency hospitalization.

Recommendations:

To help ensure its members understand and meet the proper threshold for involuntary emergency hospitalization, the Police Complaints Board recommends that:[41]

1. MPD should update General Order 308.04 to include detailed guidance for members on recognizing signs of mental health crises, interacting with mental health consumers, when and how to lawfully detain someone for emergency hospitalization, and the liberty interests of those involuntary hospitalized. The updated version should include the exact language from D.C. Code Title 21, Chapter 5, Subchapter III. Emergency Hospitalization., and the FD-12 form, and should provide relevant definitions. Officers will then be able to reference a single document for procedural instruction. This will alleviate confusion and allow for more seamless interactions between officers, community members experiencing mental health crises, and their families.

2. MPD should provide updated training for all members to ensure they are familiar with the changes made to General Order 308.04. This can be accomplished through roll call training and by updating MPD's training for new recruits. MPD can also include a training module or add to an existing module on mental health at its annual professional development training.

[41] OPC and the PCB provided a draft version of this recommendation to MPD for review and comment. MPD expressed to OPC a willingness to update General Order 308.04 and provide training to its members. However, MPD pontificated that OPC's interpretation of the language of the DC Code and General Order differs from guidance MPD has received from the Department of Behavioral Health (DBH), Office of the Attorney General (OAG), and the courts. The PCB believes that such external guidance should be added to MPD's written policies and procedures to alleviate confusion and better inform MPD members.