Police Liability for Suicide Risk Assessment

by Sgt. Russell M. Iger[1]

In June 2020, staff from United Services, Inc. came to the Coventry Police Department to discuss best practices in responding to a mental health crisis. They conducted a training on how to properly complete the Police Emergency Examination Request ("PEER")[2] form, and discussed the use of the Columbia Suicide Severity Rating Scale ("C-SSRS")[3] as an investigative tool in evaluating suicidality during welfare checks. The C-SSRS is a series of evidence-based questions used to identify the severity and immediacy of a person's risk of committing suicide, and to gauge the level of support that the person needs. Many, if not all, hospitals in Connecticut use C-SSRS to evaluate patients when they come in expressing suicidality, so an emergency room receiving a "PEER[4]-ed" patient is likely to admit or release them based on the Columbia Protocol. Dr. Kelly Posner Gerstenhaber, Founder and Director of The Columbia Lighthouse Project,[5] states "[i]t's about saving lives and directing limited resources to the people who actually need them." It is not always appropriate to request an emergency evaluation, and it is

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[2]Police Emergency Examination Request (CGS § 17a-503). There is a common perception among mental health professionals that police officers are uncomfortable with completing the PEER form due to liability issues. However, there is also a common practice among officers that any call involving a suicidal person, whether the intent to harm themselves is imminent or not, will result in a PEER evaluation if the criteria of the statute is met.

[3]The Columbia Suicide Severity Rating Scale, also known as the Columbia Protocol. The Connecticut Alliance to Benefit Law Enforcement (CABLE) first offered this training to officers during its 2017 Annual CIT Symposium.

[4]The name of the PEER form has recently been changed for Adult Mobile Crisis providers to a PREE form (Police Request for Emergency Evaluation) to reduce confusion pertaining to peer support efforts and documentation.

[5]The Columbia Lighthouse Project was formed to disseminate the Columbia Protocol (C-SSRS). In 2012, the Food and Drug Administration declared the Columbia Protocol the standard for measuring suicidal ideation and behavior.

not helpful for an individual who is not imminently suicidal, especially if the hospital is going to release them upon their arrival based on lack of imminent intent. The goal for officers should be to offer the individual in crisis the best outcome by directing them to the proper resources. This article aims to address the legal liability of officers in making suicide risk assessments, and how the C-SSRS acts as a tool to assist in this task.[6]

Discretionary Act Immunity

'Connecticut courts have long held that municipal employees are immune from liability for their official acts or omissions as long as they are done "in good faith, in the exercise of an honest judgment, and not in abuse of discretion, or maliciously or wantonly."'[7] The choice to complete a PEER is a discretionary act done by officers who must make a judgment based upon the information available to them at the time of the call.[8]

> Any police officer who has reasonable cause to believe that a person has psychiatric disabilities and is dangerous to himself or herself, or others or gravely disabled, **and in need of immediate care and treatment** (emphasis added), may

[6]*See* "About the Protocol," The Columbia Lighthouse Project, accessed on March 4, 2021, https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/, detailing that "[t]he Columbia Protocol questions use plain and direct language, which is most effective in eliciting honest and clear responses. For example, the questioner may ask: Have you wished you were dead or wished you could go to sleep and not wake up? Have you been thinking about how you might kill yourself? Have you taken any steps toward making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away, or writing a suicide note)?"

[7]*See* Lawrence K. Furbish, "Immunity for State and Local Police Under Current State Law," *OLR Research Report* (October 7, 2003) citing *Wadsworth v. Middletown*, 94 Conn. 435, 440 (Conn. 1920), "where the discretion has been exercised erroneously but in good faith through an error of judgment, the public official should not be required to pay damages for his acts."; *see also Wadsworth*, quoting the defendant's brief that "the exercise of this discretion does not justify their acting wantonly or maliciously, or with a clear abuse of discretion."

[8]"The hallmark of a discretionary act is that it requires the exercise of judgment." *Bonington v. Westport*, 297 Conn. 297, 306 (2010) as cited by Elliot Spector, Esq., "Governmental Immunity: Understanding Liability for Failure to Protect," *A CIRMA Law Enforcement Advisory Committee White Paper* (April 2018) p. 2.

take such person into custody and take or cause such person to be taken to a general hospital for emergency examination under this section.[9]

Qualified immunity for involuntary hospitalization based on C.G.S. § 17a-503(a) "hinges on whether it was objectively reasonable for the Defendant to believe at the time of Plaintiff's hospitalization that Plaintiff suffered from a psychiatric disability and was a danger to himself or society."[10] Hospitals typically do not admit suicidal patients who do not display imminent intent to harm themselves, and officers are often surprised to find that a person they have sent to the emergency room on a PEER is released within hours. Despite this involuntarily seizure, the officer who completed the PEER will likely have no liability if he or she reasonably believed that the subject of the PEER suffered from a psychiatric disability and was a danger to himself or others. Alternatively, an officer who does not complete a PEER based upon the lack of evidence of a person's imminent suicidality, and chooses to refer that person to other services, friends or family instead, will also be acting within their legal discretion. "If a harm is not so likely to happen that it gives rise to a clear duty to correct the dangerous condition creating the risk of harm immediately upon discovering it, the harm is not imminent."[11] This is where the use of the C-SSRS can act as due diligence in making such assessments.[12]

[9]Connecticut General Statutes §17a-503, Police Emergency Examination Request.

[10]*Perrelli v. Taylor*, No. 301 CV 1464, 2003 U.S. Dist. LEXIS 25602, 2003 WL 23648096 (D. Conn. Sept. 5, 2003). Departments will need to monitor changes to qualified immunity on the state and Federal levels as legislation seeking to modify or eliminate it continues to progress. *See* An Act Concerning Police Accountability, Pub. Act No. 20-1, 2020 Connecticut.

[11]*Haynes v. City of Middletown*, 314 Conn. 303, 318 (2014); *see also* Spector, *supra* note 8.

[12]The Columbia Protocol allows officers to use a proven method to evaluate suicidality. Alternatively, *see Kerman v. City of New York*, 374 F.3d 93, 111 (2d Cir. 2004) for an example of where officers fail to make efforts to evaluate suicidality (finding that it "was sufficiently clear in light of preexisting law that [the plaintiff] had a right not to be detained or involuntarily hospitalized by an officer who… did not know, and who patently ignored opportunities to determine, …whether he was dangerous to himself or others").

Identifiable Person-Imminent Harm Exception

This exception to discretionary act immunity occurs where there is an assessment of immediate or imminent harm to an identifiable person.[13] The imminent harm exception refers to when an officer's failure to act would likely subject an identifiable person to imminent harm. Circumstances must make it apparent to the officer that the harm will occur within a discrete place and time period, not some unspecified time in the future,[14] in order for the potential of liability to exist. The officer must also be aware that their act or omission could subject the person to imminent harm.[15] An officer using the C-SSRS asks the person- "have you taken any steps toward making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away, or writing a suicide note)?" These questions are designed to elicit honest and clear responses and allow the officer to assess the severity and immediacy of the risk, in essence, acting as due diligence in determining whether or not imminent harm exists.

Fourth Amendment "Reasonableness"

Even when an officer determines that there is cause to complete a PEER, there will be circumstances that will not warrant a forcible detention for evaluation or non-consensual entry into a home. Officers find that even with a criminal arrest warrant for an individual, it is not always reasonable to enter that person's home by force to take

[13]"The identifiable person-imminent harm exception has three requirements: 1. An imminent harm; 2. An identifiable victim; and 3. A public official to whom it is apparent that his or her conduct is likely to subject that victim to that harm." *Haynes* at 312-313; *see also Brooks v. Powers*, 165 Conn. App. 44 (2016) explaining the exception as "[w]hen circumstances make it apparent to the public officer that his or her failure to act would likely subject an identifiable person to imminent harm."

[14]"Imminent does not simply mean a foreseeable event at some unspecified point in the not too distant future. Rather, we have required plaintiffs to identify a discrete place and time period at which the harm will occur." *Haynes* at 318.

[15]*See Doe v. Petersen*, 272 Conn. 607, 618 (2006), specifying that it must not only be apparent to the officer that an identifiable person is subject to imminent harm, but also that the officer's act or omission will likely subject that person to imminent harm; *see also* Adam Wolkoff, "Town's Liability for Police Officer's Negligence," *OLR Research Report* (March 2, 2006) citing *Shore v. Stonington*, 187 Conn. 147 (1982) where the court held that "a plaintiff, whose decedent was killed by a drunk driver, could not sue the town or its police for negligence even though a town police officer had pulled over, but failed to arrest, the drunk driver before the fatal accident."

them into custody.[16] This is even more so a fact in the case of an emergency evaluation. During a recent training that aimed to bring together police officers and mental health crisis professionals,[17] some experts expressed their concerns about working with officers. They indicated that most clinicians are unauthorized to complete PEER evaluations and rely on officers to do so. They stated that sometimes when they give officers their professional assessment that an evaluation needs to take place, the officer will not complete one. What the mental health crisis professionals may not be taking into consideration is that the officer is assessing more than just the mental state of the person. They are also assessing the person's Fourth Amendment right to be free from unreasonable seizures. It may not be the best choice to PEER someone if you will have to make a non-consensual entry into their home, or use force to effect the evaluation.[18]

More frequently, officers are taking the time to de-escalate situations involving people who are experiencing a mental health crisis. The best outcomes may be achieved by simply slowing things down to make a proper assessment. Furthermore, there is no specific legislative authority under Connecticut law that allows officers to use force in order to effect an evaluation.[19] Therefore, the assessment of the mental state of an

[16]Reasonableness is the standard for a Fourth Amendment seizure. *See* U.S. Const. am. IV., stating that "[t]he right of the people to be secure… against unreasonable searches and seizures, shall not be violated."

[17]CIT Special Topics, Connecticut Alliance to Benefit Law Enforcement, (November 19. 2020).

[18]*See* "How to Avoid Legal Missteps on Suicidal-subject Calls," Force Sciences Institute, *Police One* online, February 19, 2019, https://www.policeone.com/legal/articles/482818006-how-to-avoid-legal-missteps-on-suicidal-subject-calls/, stating "[w]hen you're confronting a suicidal subject who isn't committing a serious crime and isn't an active threat to anyone other than themselves, the best response may be not to engage and to withdraw from the situation. This may seem like a sin of omission, but it is often the most legally appropriate as well as the safest response." This reasoning becomes critical when officers force entry in an attempt to save someone, or when specialized police units like a SWAT team are deployed. *See Id.* stating that "[w]e see situations where officers have forced entry to save a person from killing himself – and end up killing him themselves."

[19]See *Hull v. Town of Newtown*, Supreme Court of Connecticut (SC 19656, Decided: December 26, 2017) distinguishing what custody means under a civil law PEER evaluation (CGS §17a-503) versus a criminal arrest. A PEER evaluation is not an arrest and does not authorize the use of force to take someone into custody as a criminal arrest does; *see also* Connecticut General Statute §53a-22, specifying when an officer is justified in using physical force. A PEER evaluation is not included. Despite the lack of explicit legislative authority to use force to effect an emergency evaluation, annual

individual is only one factor that contributes to the reasonableness of that seizure when there is a determination that a PEER evaluation is authorized. Increasingly, officers are benefiting from working in conjunction with mental health professionals to achieve the best outcomes for individuals in crisis. Cooperation with mobile crisis providers, such as Community Health Resources ("CHR") and United Services, and other mental health agencies will help officers refer these individuals to the proper resources. However, mental health crisis professionals will need to be available on a 24/7 basis for this to be effective.[20]

Grounds for a Civil Rights Lawsuit under USC Title 42, §1983

Other areas of potential liability for officers arise under the doctrines of Special Relationship or State-Created Danger.[21] A special relationship exists when officers detain or take a person into custody. If you fail to put a seatbelt on a detainee in the back of your cruiser and injuries are suffered during transport, you may face liability under this doctrine. A special relationship can also be created by a promise to protect by an

use of force assessments typically show that a great number of the incidents involving the use of force by officers occur during mental health related calls for service. An injury to a person being taken into custody for the purpose of a PEER evaluation could put an officer at risk of liability. However, some level of restraint may be reasonable to effect the evaluation. *See* Directive 4.7.8, Coventry Police Department, which states that in the course of a PEER evaluation, "person may be restrained but only to the extent necessary to protect the person, officer and/or the public, using only that amount of force necessary to affect the restraint."

[20]Due to the fact that a mental health crisis can occur at unpredictable times, the typical availability of clinicians who respond to calls for service in the field (Monday through Friday, 09:00-19:00) is ineffective for law enforcement purposes. Further state funding of United Services, CHR, and other DMHAS-funded mobile crisis teams would enhance this ability.

[21]"The Fifth and Fourteenth Amendment due process clauses provide grounds for a civil rights lawsuit under either of two separate doctrines: (1) the "special relationship" doctrine- when the state assumes control over an individual; or (2) the "state-created danger" doctrine- where state action creates or exposes an individual to a danger which he or she would not otherwise have faced." *See* Rutledge, Devallis. "Liability for Failure to Protect," *Police Mag* online, June 1, 2010, https://www.policemag.com/340328/liability-for-failure-to-protect.

officer.[22] The sources of liability for state-created danger are best served by examples from case law:

- When the passenger of a vehicle was left to walk home alone in a high crime area after the driver was arrested for DWI and the vehicle towed, the officers put her at greater risk of being assaulted than she had faced prior to police intervention, and were found liable when she was raped while walking home. *Wood v. Ostrander*, 879 F. 2d 583 (1989).
- When officers allowed a husband to walk home while they further detained his drunken wife they were found liable, when she was injured walking home without assistance and fell down an embankment suffering severe brain damage, based on the theory that their decision to release her to walk home alone and unsteady due to her inebriation increased the level of danger that she would fall and injure herself. *Kniepp v. Tedder*, 95 F.3d 1199 (1996).
- Officers were called to a bar to eject a patron causing a disturbance. He was prevented from getting into his truck or reentering the bar. The temperature outside was 11 degrees with a wind-chill of minus 25, and he wore only jeans and a T-shirt. He froze to death two blocks away. The court held that the police had "placed him in a more dangerous position than the one in which they found him…" *Munger v. Glasgow*, 227 F.3d 1082 (2000).[23]

Although these examples do not specifically deal with suicidality, they show where officers can find themselves in trouble if they do not perform their duties properly. It is important for officers to ensure the safety of those with whom they interact, and strive to achieve the best outcomes for them by referring them to the appropriate services for their situation. That is why it is imperative for officers to investigate each

[22]*See* "How to Avoid Legal Missteps on Suicidal-subject Calls," *supra* note 18, describing how an officer's promise to address a situation can lead to liability if action is not taken after someone relies upon that promise.

[23]*See* Rutledge, *supra* note 21, detailing the State-Created Danger doctrine.

situation they encounter involving a person suffering from a mental health crisis based on the information they have on scene and to make a reasonable decision.

Using C-SSRs to Conduct an Investigation in Good Faith, and Honest Judgment

Officers responding to a report that a neighbor or family member may be suicidal should take it seriously, but conduct their own investigation to confirm or deny the information.[24] They may find that the reporter has misinterpreted or exaggerated a person's behavior, and that there is actually no intent to attempt suicide. It may be appropriate to leave the person with friends and family and refer them to mental health services through a Mobile Crisis provider if there is no imminent intent to harm themselves. A voluntary self-referral is another option where a person has friends or family to ensure that they will receive the care. Involuntary evaluation or PEER may be the only choice where the officer assesses that imminent harm will occur. Under the foregoing situations, use of the C-SSRS to evaluate these circumstances can be very effective.[25]

Unfortunately, in some cases, arrest of a person who is suffering from a mental health crisis may be necessary based upon their criminal acts. If this occurs and the person is taken into custody, officers must ensure that staff are aware of the person's suicidal intent and that they receive a mental health evaluation without delay.[26] This is

[24]*See* 2012 (3) AELE Mo. L. J. 101, 105-6, Civil Liability Law Section – March 2012, discussing various alternatives for responding to a suicidal subject.

[25]Responses are rated on a scale of low risk, moderate risk, and high risk based on the recency of suicidal ideation and behaviors. A high risk assessment would trigger a PEER evaluation where a low or moderate assessment may indicate that other resources are more effective in assisting the individual in crisis. *See* "Triage and Risk Identification," The Columbia Lighthouse Project, accessed on March 10, 2021, https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/risk-identification/. Officers should base their decision on the totality of the circumstances in conjunction with the C-SSRS answers. For example, are lethal means present on scene such as a firearm or medications that can be used to overdose, is a family member or friend unavailable or too far away, or has a message been sent to others communicating the wish to harm themselves? A combination of these factors could alter the level of risk present. If a person is sent for an evaluation, family members should be encouraged to follow up with the hospital to ensure that the seriousness of the situation is addressed.

[26]"Understanding Key Factors for Police De-Escalation of Potential Suicides," Force Sciences Institute, *Police One* online, June 29, 2018, https://www.police1.com/de-

necessary to avoid "special relationship" liability, and ensure that the person gets the mental health care they need. Sadly, some police responses to suicide risk will result in the officer finding that the person has died by suicide. The officer's primary job then is to protect the scene until investigators arrive, and also to provide resources to survivors if present. Having a tool such as the C-SSRS to assist the officer in determining the next steps to take when responding to a person who is having a mental health crisis can be an indispensable tool to help make these crucial decisions.

A Connecticut Model for the Use of C-SSRS for Suicide Risk Assessment

In February 2021, the Connecticut Department of Mental Health and Addiction Services ("DMHAS") facilitated a meeting with their colleagues in New Hampshire[27] to answer a question that had been proposed on the national Zero Suicide approach[28] list serve for health and behavioral healthcare: "does anyone have experience with using evidence based screening tools that law enforcement and other first responders can use to screen for suicide risk in individuals they come into contact with during crisis calls?" The resulting meeting brought together a group of professionals dedicated to developing a coordinated effort between law enforcement and mental health advocates. The model that DMHAS introduced was Connecticut's own use of the C-SSRS by law enforcement as facilitated by Connecticut Alliance to Benefit Law Enforcement ("CABLE") and other agencies that provide mobile crisis services, such as United Services.[29] These New

escalation/articles/understanding-key-factors-for-police-de-escalation-of-potential-suicides-saawi7CIqti6Tk7K/.

[27] New Hampshire representatives of the National Alliance on Mental Illness (NAMI) and a local New Hampshire law enforcement leader, in conjunction with members of CHR and DHMAS Connecticut. I was asked to present on the liability issues associated with use of the C-SSRS for suicide assessment, after the Connecticut participants referred the group to my lecture on this topic that was first given at the 2019 Annual CIT Symposium sponsored by CABLE on October 29, 2019.

[28] *See* https://zerosuicide.edc.org/, for further information about this approach.

[29] Training is not required and no mental health experience is necessary to use the Columbia Protocol. However it can be helpful and online or in person training is available. United Services has offered training and CABLE has presented on its use as well. An officer trained in the Columbia Protocol could also effectively train other officers. *See* "Free Training for Communities and Healthcare," The Columbia Lighthouse Project, accessed on March 10, 2021, https://cssrs.columbia.edu/training/training-options/. NAMI New Hampshire indicated that they

Hampshire-based advocates were moving forward with a plan to introduce the use of the C-SSRS for suicide risk assessment from the ground up incorporating NAMI-NH and law enforcement to implement it properly for their community.

After the meeting, DMHAS staff and I discussed producing a tear-off, adhesive C-SSRS questionnaire sheet as a tool that Connecticut officers, as well as mobile crisis service providers, can use while responding to calls. The C-SSRS sheet can then be attached to the PEER form so that hospital staff can see exactly how officers evaluated suicidality on scene, using the same standards they use. The C-SSRS sheets can also act as added evidence of an officer's efforts to properly evaluate a suicidal person. This new C-SSRS tool is currently in production, and the Coventry Police Department will be among the first to implement this welcome tool.[30]

One thing is clear, efforts to standardize and make suicide assessment more effective in Connecticut are moving forward. Departments that embrace the use of the C-SSRS will have added protection against liability for the discretionary acts of their officers in this area. Much like the introduction of de-escalation techniques into the realm of police response, the C-SSRS acts as a tool for officers to solve the problems they encounter and bring the proper resources to their communities that help save lives. They also help to ensure that those suffering from a mental health crisis are not just getting transported to the hospital and subsequently discharged without having their underlying issues addressed. Officers that use suicide assessment protocols to evaluate individuals in crisis will find that they have better outcomes and reduced liability for their exercise of discretion.

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would be doing the training for officers there. In Connecticut, departments have several options. Teaching the Columbia Protocol at the recruit level, on FTO, or during recertification may be the most effective ways to implement its use.

[30]The C-SSRS sheets will be available soon, and it and other free resources may be found here: www.preventsuicidect.org/materials. Officers who begin to use C-SSRS now can reference responses to the questions directly on the PEER form to assist hospital staff in their evaluation. A copy of the C-SSRS for law enforcement to use in the field is attached to this article.

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screening Version – Since Last Contact for Law Enforcement

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Since Last Contact	
Ask questions that are bold and underlined	YES	NO
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		
6) *Have you done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

Recommended Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral and Crisis Numbers
Item 2 Behavioral Health Referral and Crisis Numbers
Item 3 Consider Further Mental Health Evaluation
Item 4 Urgent Mental Health Evaluation with Escort
Item 5 Urgent Mental Health Evaluation with Escort
Item 6 Urgent Mental Health Evaluation with Escort

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