Behavioral Health Awareness Initiative

City of Mission
Mission Police Department

The City of Mission through the Mission Police Department is implementing a new and innovative program titled, the Behavioral Health Awareness Initiative. The initiative is directed to assist citizens of Mission who have a loved one living in their home who suffers from behavioral health-related issues. The program is designed to gather important information on your loved one's current behavioral health condition in an effort to provide advanced information on his/her condition to police officers responding to your home.

The information gathered is vital in assuring that the responding Mission Police Officer(s) have the most accurate information in order to access and coordinate appropriate behavioral health services in the area. Attached you will find a questionnaire with the information we ask you to provide about your loved one. Please contact Mrs. Diana Macias, our Crime Victims Liaison, at the Mission Police Department for assistance in completing the questionnaire. She can also be reached at (956) 584-5052.

Your loved one's information will be securely maintained at the Mission Police Department's Communications Center. Our Telecommunication Officers can relay your loved one's information quickly and efficiently to officers responding to your address.

The City of Mission, through our police department, is dedicated to the delivery of quality police services. Our Behavioral Health Awareness Initiative is yet another way we remain committed to addressing the growing needs of our community.

Behavioral Health Awareness Initiative

City of Mission

Mission Police Department

The objective of the Behavioral Health Initiative is to promote sensitivity with encounters within our communities through awareness of residents with behavioral health issues.

The following questionnaire should assist you in determining possible behavioral health issues:

1. Are you or anyone in your family currently being treated for a mental health illness such as: depression, anxiety, schizophrenia, alcohol/drug abuse?
    - If yes, please list their gender, DOB, and diagnosis.

2. Is this person currently under the care of a doctor?
    - What is the name of the doctor?

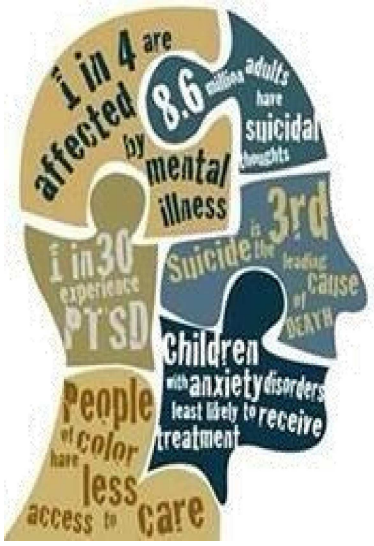
3. Is this person currently prescribed medication for their mental illness?
    - Are they compliant with their medication?

4. Does this person have a history of aggressive behavior such as hitting, kicking, etc.?
    - When was the last incident that happened?

5. Has this person ever been in a psychiatric inpatient hospital?
    - If yes, when?

6. Has this person ever threatened to commit suicide?
    - If yes, when and what did they say they were going to do?

7. Has this person ever attempted suicide?
    - If yes, when and what did they do?



Behavioral Health Awareness Initiative

City of Mission
Mission Police Department

MENTAL HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.

PERSONAL INFORMATION

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Address:	**City, State, Zip**		**Phone Number:**
Height:	**Weight:**		**Eye Color:**

PARENT / LEGAL GUARDIAN INFORMATION

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Address:	**City, State, Zip**		**Phone Number:**

BEHAVIORAL HEALTH QUESTIONS

1. Are you or anyone in your family currently being treated for mental health illness such as: depression, anxiety, schizophrenia, alcohol/drug abuse? If yes, please list their gender, DOB, and diagnosis below.

History		
Gender	**Date of Birth**	**Diagnosis**

2. Is this person(s) currently under the care of a doctor? What is the name of the doctor?

Doctor's Information		
Name:	**Address:**	**Phone Number:**
Name:	**Address:**	**Phone Number:**
Name:	**Address:**	**Phone Number:**

3. Is this person currently prescribed medication for their mental illness? ☐ Yes ☐ No
   Are they compliant with their medication? ☐ Yes ☐ No

List your prescribed drugs and over-the-counter drugs		
Name the Drug	***Strength***	***Frequency Taken***

4. Does this person have a history of aggressive behavior such as hitting, kicking, etc?

Aggressive Behavior		
Type of Behavior (Hitting, Kicking, Etc):	***Last Episode***	***Outcome (hospitalized, ER, Etc.)***

5. Has this person ever been in a psychiatric inpatient hospital? ☐ Yes ☐ No
If yes, please list information below:

Hospitalizations		
Name of Facility:	***Date Hospitalized:***	***Reason:***

6. Has this person ever threatened to commit suicide? ☐ Yes ☐ No
If yes, please list details below:

Suicide Threats	
Date of Threat:	***Threat:***

7. Has this person ever attempted suicide: ☐ Yes ☐ No
If yes, please list details below:

Suicide Attempts	
Date of Attempt:	***Attempt:***

8. Additional comments or concerns:

I certify that the information I have provided is true and correct to the best of my knowledge. I understand that the information provided is confidential and will only be used to aid responding officers when dispatched to our address.

Signature _____ Date _____

Parent/Legal Guardian Signature _____ Date _____