BURLINGTON POLICE DEPARTMENT
DEPARTMENT DIRECTIVE
DD13.3 –Interacting with Persons with Diminished Capacities

I. General Policy & Discussion: Every community can expect its law enforcement officers to encounter persons of diminished capacities stemming from a host of underlying issues. This group of individuals presents field officers with different and often complex issues. These types of persons, whether from intoxication, suicidal potential, medical complications, intellectual limitations, or mental illness, present field officers with a wide range of behaviors. Persons with diminished capacities may display conduct that is bizarre, irrational, unpredictable and threatening. They may appear to not receive or comprehend commands or other forms of communication in the manner that the officer would expect. They often do not respond to authoritative persons or the display of force. It is the primary task of officers confronting these situations to resolve the encounter in the safest manner. It is preferred to bring these types of persons to professional resources, when necessary. It is not the role of officers to diagnose the root cause for the person's behavior. Every officer can expect to encounter persons with diminished capacity. Proper tactical and intervention techniques can assist in resolving encounters and hasten the intervention by professional resources.

The guidelines below are designed to provide a response framework for situations where there is a known person with apparent or actual diminished capacity who is presenting a risk to themselves or others. It is understood that while this policy provides guidance for dealing with difficult situations, events often unfold quickly and in unpredictable ways. Additionally, this policy is designed to augment, not supplant, the Crisis Negotiation Directive/policy.

II. Definitions:

A. Persons of diminished capacity: This refers to a segment of the community officers will be expected to deal with including all persons encountered in the field who exhibit unusual behaviors commonly referred to as irrational, bizarre, unpredictable or weird. These outward observable symptoms could be the result of intoxication, drug use, suicidal indications, mental illness or medical complications.

B. Mental Illness: This policy does not require officers to make a diagnosis of whether the subject is mentally ill or what form of mental illness the subject may have but rather to use reasonable judgment to recognize behavior which is outside the norm in which a person poses a danger to themselves or others.

C. "A Person With a Mental Illness" used in this context means a person with substantially impaired capacity to use self-control, judgment, or discretion in the conduct of the person's affairs and social relations, associated with maladaptive behavior or recognized emotional symptoms where impaired capacity, maladaptive behavior, or emotional symptoms can be related to physiological, psychological or social factors.

D. Professional resources: These sources are those available to the police such as mental health professionals, emergency medical facilities, and detoxification centers.

E. A Dangerous Person With a Mental Illness: meaning the person is one who presents a substantial risk of serious harm to self or another person or persons within the near future as manifested by evidence of recent acts or threats of violence or by placing others in reasonable fear of such harm.

III. Procedures: The ultimate mission of law enforcement when encountering a person of diminished capacity exhibiting behavior that is in need of intervention is to control the encounter and then determine the best course of action for the subject person. This field response can be segmented into four components: Containment, Coordination, Communication and Time.

A. Containment: Before any reasonable control and defusing techniques can be used, the subject must be contained:

1. Where possible, Two (2) officers shall be dispatched to an incident involving a person of diminished capacity. Should an officer find him/herself in a situation with such a person, the officer shall request a back up before attempting to intercede.
2. To the extent it can be done safely, responding officers should consider avoiding the use of emergency lights and siren when coming into close proximity of the location such that the subject will hear or see the emergency equipment in operation. Experience has demonstrated that this may agitate the response by the subject of the call or encounter.
3. The officers should devise a plan that separates the subject from other civilians. This containment should respect the comfort zone of the subject in order to reduce any unnecessary agitation. Officers should continuously evaluate this comfort zone and not compress it, unless necessary.
4. It is important for officers to ensure that on-lookers and family members are not in a position to become involved either verbally or physically in the control methods. In rare instances the Crisis Negotiation Team Supervisor may determine that contact with family would be advantageous and may recommend it to the Officer in Charge.
5. Effective containment reduces the elements of agitation, such as large groupings of persons/officers emergency vehicle equipment, loud police radio transmissions, and multiple persons directing communications to the subject. Containment is meant to reduce outside influences and sources of agitation.
6. Officers should be aware that sudden movements could increase the subject's agitation.
7. Officers should utilize all available tactics to de-escalate the situation where possible, however if an officer is faced with a dynamic and violent situation that poses a threat to the officer or other persons present, then officers should utilize tactics outlined in the Response to Resistance policy to control the subject.

B. Coordination: This is essential for control of the encounter and is the foundation for the development of an effective plan and use of personnel and resources:

1. One officer at the scene shall be designated or assume the position of being the lead officer. This may not necessarily be the most senior person on the scene.
2. A perimeter should be considered as necessary to ensure that outside persons and/or family members don't become involved.
3. Officers should limit observable indications of force, including firearms, to the extent reasonably possible.
4. The lead officer should designate an officer to gather intelligence regarding the subject being encountered. This type of information can come from persons at the scene, neighbors and/or family or law enforcement records systems. This information can

become important in determining the further tactical approaches to the subject and the most appropriate form of referral.

5. The lead officer or the Officer in Charge is responsible for determining what resources should be requested including crisis clinicians, additional police personnel, specialized weapons, professional resources and staged medical personnel.
6. When warranted, the lead person or Officer in Charge will designate the location for a command post and staging area. This should be out of sight of the location of the subject encounter.

C. Communication with the person of diminished capacity should be planned and controlled:

1. Prior to engaging the subject in communication, the initial responder should await the arrival of a cover officer. When dealing with subjects armed with edged weapons officers should, where possible, maintain a zone of safety that allows for reaction should the subject decide to attack.
2. One officer should be designated as the command voice and other officers shall refrain from becoming involved.
3. Verbal communication should be non-threatening. Whenever possible, use open-ended questions designed to facilitate the subject's participation. If the subject does not respond, use other communication techniques. It may be necessary to change the person designated as the command voice and determine whether that might be beneficial.
4. Officers should use calming, truthful, communicative attempts to the extent reasonably possible, reassuring the subject that the police are there to help them.
5. Officers must continuously analyze what affect, if any, their efforts are having on the subject to attempt to identify areas that appear to agitate the subject that should then be avoided.
6. Normally, family members should not be used in an attempt to establish communications. This frequently exacerbates the situation.

D. Time is the concept of elongating the encounter, rather than hastening it:

1. History has shown that the longer the encounter is allowed to occur, the better the chance for a successful and safe resolution. Time encourages the ability to communicate and create a relationship between the subject.
2. Increasing the time of the encounter and using defusing techniques allows the subject to reflect upon his/her predicament.
3. Creating time also allows for the field units to be supported by the deployment of additional police personnel, specialized equipment and medical support personnel.

E. Intervention procedures: The primary purpose for police response to an incident involving a person of diminished capacities is to control the situation and ensure that the person receives the most appropriate form of professional resources.

1. In determining the most appropriate form of professional resource and referral officers should consider the information provided by professional resources persons and family members.
2. It is important for the officers on the scene to determine what, if any, on-going threat potential the subject poses to him or herself, family, community and the officers. This threat potential

may necessitate an involuntary commitment procedure rather than simply hand off the subject to the family for a voluntary commitment. All pertinent information should be gathered and relayed to medical personnel as available.

3. See 18 V.S.A. 7505 (2010) for commitment procedures.

IV. Operating Guidelines – Street Outreach Interventionist

Outreach Interventionists (social workers/clinicians) employed by the HowardCenter and embedded within the Department will be available to respond to and assist with calls for service involving mental health, substance abuse, or other unmet social service needs. The primary goal is, as much as possible, to deliver a clinician to non-violent events.

While an Outreach Interventionist is on duty (scheduled generally during peak call volume times) they may be called upon on a case-by-case basis using the following general methodology:

Incidents or individuals where there is a known threat or danger - Any call in which there is an articulable and imminent threat to a person's or the community's safety or significant destruction of property. These calls will be handled by a police officer and the Outreach Interventionist will be notified to respond and assist as they are able/as safety allows at the discretion of the responding officer(s) and the officer in charge with feedback from the interventionist.

Incidents or individuals where there is NO known threat or danger and no reasonable inference that one may occur – Any call in which there is not an immediate and articulable threat to safety or property. For these calls, if an Outreach Interventionist is available, they may be dispatched as the primary resource. Communications staff, an officer, the Interventionist or the Officer in Charge, may all choose to also detail an officer to assist. However, absent exigency, the preference for first contact is the Outreach Interventionist.

It is acknowledged that for most calls we are operating with incomplete and sometimes inaccurate information. If at any time, circumstances or information change and the best judgment of the interventionist and the responding officer(s)/officer in charge is that the response methodology should be altered – they have the latitude to make alterations to the guidelines above.

The Outreach Interventionist MAY offer to take on the primary responsibility, responding with or in lieu of an officer for any call they hear over the radio that appears to be primarily related to a mental health problem. The Officer in Charge shall have final authority of the assignment of any call.

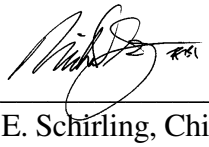
Communications staff should ask common sense questions to ascertain which category a call falls into – such as what the subjects intentions are, whether they are armed or have access to weapons, weather any threats have been made directly or indirectly. It is understood that the response times to some calls handled by an interventionist may be notably longer than it would take an officer to respond. That is by design. Putting the correct resource at the scene despite response delays is done based on the best information available at the time (not hindsight) in hopes of achieving better outcomes.

Outreach interventionists are assigned radio numbers and carry department issued radios during each shift for use, at a minimum, for emergencies.

Records of incidents - Each call, regardless of who is responding, shall be entered into the Department's records management system and each call that relates to mental health shall have the appropriate box checked for tracking. Outreach interventionists will make applicable notes about their response – NOT containing any clinical, diagnostic, or medical information – to help inform future responses and other interventionists.

Clinical oversight of the interventionists rests with the HowardCenter. Day to day general oversight of responses rests with Burlington Police supervisors.

Reviewed and adopted by the Burlington Police Commission on March 25, 2014. Updated June 24, 2014.



Michael E. Schirling, Chief of Police

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