Crisis Intervention Incidents

463.1 PURPOSE AND SCOPE

This policy provides guidelines for interacting with those who may be experiencing a mental health or emotional crisis. Interaction with such individuals has the potential for miscommunication and violence. It often requires an officer to make difficult judgments about a person's mental state and intent in order to effectively and legally interact with the individual.

463.1.1 DEFINITIONS

Crisis – A personal experience of intensified psychological, emotional, and/or mental disease that can be precipitated by situational stress, trauma, non-compliance with treatment, failure to appropriately take prescribed medications, loss and/or acute episode of a pre-existing mental illness.

Crisis Intervention Training (CIT) – A training program established to enhance the skills of Department members responding to incidents involving persons in crisis.

CIT Program Coordinator – A Vancouver Police Command Staff member designated by the Chief of Police to supervise the general oversight of the Crisis Intervention Training (CIT) Program.

463.2 POLICY

The Vancouver Police Department is committed to providing a consistently high level of service to all members of the community and recognizes that persons in crisis may benefit from intervention. The Department will collaborate, where feasible, with mental health professionals to develop an overall intervention strategy to guide its members' interactions with those experiencing a mental health crisis. This is to ensure equitable and safe treatment of all involved.

463.3 RECOGNIZING A PERSON IN CRISIS

Dealing with people who are known or suspected to have a mental health issue or be in crisis carries the potential for violence. Officers should exercise special skills and abilities to effectively manage the person in crisis. Officers are not expected to make a judgment of the mental or emotional disturbance but rather recognize behavior that is potentially destructive and/or dangerous to self or others.

There are many behaviors associated with people suffering from mental illness. In RCW 71.05.020, a mental disorder is described as: "Any organic, mental, or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions."

Behavior of a mentally ill person may include one or more of the following:

- A known history of mental health issues
- Threats of, or attempted suicide
- Depression, pronounced feelings of hopelessness, extreme sadness or guilt
- Social withdrawal

- Manic or impulsive behavior, extreme agitation, lack of control
- Rapid mood swings
- Lack of fear
- Unreasonable fears
- Neglect personal hygiene
- Anxiety, aggression, rigidity, paranoia
- Incoherent or disorganized speech
- Delusional
- Talking or laughing to one's self
- Hearing commands from the television or radio
- Rapid speech
- Staring blankly or not moving for long periods of time
- Loss of memory or confusion
- Hearing, smelling or seeing things that are not there

Not all mentally ill persons are dangerous while some may represent danger only under certain circumstances or conditions. Officers may use several indicators to determine whether an apparently mentally ill person represents an immediate or potential danger to himself or others. These include the following:

- Availability of weapons
- Threatening statements by the person
- Past history of violence
- The amount of control the person exhibits over their emotions

Members should be aware that this list is not exhaustive. These behaviors may be changed or intensified by the use of alcohol, illicit drugs, foreign / mind altering substances or the failure to take prescribed medications.

463.4 DE-ESCALATION

For the purposes of this section violence de-escalation means tactics, action, and communication methods used by officers to achieve the following objectives:

1. Manage pace of an interaction;
2. Increase the distance between the officer and person involved;
3. Create shielding to protect the officer and others from an imminent threat; and

4. Engage in communication to gain cooperation to increase options for resolving the incident and reduce the likelihood of injury to all parties involved.

Once it is determined that a situation is a mental health crisis and immediate safety concerns have been addressed, responding members should be aware of the following considerations and should generally:

- Evaluate safety conditions.
- Introduce themselves and attempt to obtain the person's name.
- Be patient, polite, calm, courteous and avoid overreacting.
- Speak and move slowly and in a non-threatening manner.
- Moderate the level of direct eye contact.
- Remove distractions or disruptive people from the area.
- Utilize active listening skills (e.g., summarize the person's verbal communication to build rapport).
- Provide for sufficient avenues of withdrawal or escape should the situation become volatile.
- Use cover and distance to create time to start a dialogue.

Responding officers generally should not:

- Use stances or tactics that can be interpreted as aggressive.
- Allow others to interrupt or engage the person.
- Corner a person who is not believed to be armed, violent or suicidal.
- Argue, speak with a raised voice or use threats to obtain compliance.
- Rush the situation exclusively for the sake of time.

463.5 RECOGNIZING EXCITED DELIRIUM

While the subject's behavior may be of law enforcement concern and the person must be controlled for the safety of themselves and those around them (a primary law enforcement duty), he/she must also be evaluated by medical professionals as soon as practical. Generally, this requires recognizing Excited Delirium. This is much different than the often slowed, dulled, and inappropriate behavior of simple alcohol intoxication.

Subjects can demonstrate some or all of the indicators below in law enforcement settings:

- Extremely aggressive or violent behavior
- Constant or near constant physical activity
- Does not respond to police presence
- Attracted to glass and reflection

- Attracted to bright lights and loud sounds
- Naked or inadequately clothed
- Attempted “self-cooling” or hot to the touch
- Rapid breathing
- Profuse sweating
- Making unintelligible animal-like noises
- Impervious to pain
- Excessive strength
- Does not tire despite heavy exertion

When you recognize a subject is suffering from Excited Delirium, call for backup. These subjects are difficult to control and can demonstrate paranoia, violence, and feats of great strength.

Excited Delirium subjects are at a high risk for sudden death, so emergency medical staff should also be dispatched, as soon as practicable, staged in the area and ready to respond once the subject is under police control.

If an officer or emergency medical staff believes the subject is suffering from Excited Delirium, the subject should, when practical, be transported by ambulance to a hospital for treatment. If a subject is not transported to a hospital, the officer or supervisor making that decision must articulate the reason why.

463.6 COORDINATION WITH MENTAL HEALTH PROFESSIONALS

The Chief of Police should designate a CIT Program Coordinator to collaborate with mental health professionals to develop an education and response protocol. The CIT Program Coordinator will work with CRESA to maintain a current list of resources to be accessed by VPD employees upon request.

463.7 FIRST RESPONDER SAFETY MEASURES

Safety is a priority for first responders. It is important to recognize that individuals under the influence of alcohol, drugs or both may exhibit symptoms that are similar to those of a person in a mental health crisis. These individuals may still present a serious threat to officers; such a threat should be addressed with reasonable tactics. Nothing in this policy shall be construed to limit an officer’s authority to use reasonable force when interacting with a person in crisis.

Additionally, employees are reminded that persons suffering from or displaying behaviors associated with a mental health crisis may not be involved in criminal acts. Erratic or unusual behavior by itself is not considered a crime. Employees should be aware that persons exhibiting mental health crisis behavior may benefit from treatment as opposed to incarceration: However, nothing in this section should be construed as preventing an

officer from making a good faith arrest in accordance with probable cause, if criminal activity has occurred.

An officer responding to a call involving a person in crisis should:

(a) Promptly assess the situation along with the reported information and determine whether a mental health crisis may be a factor.

(b) Request available backup officers, and if it is reasonably believed that the person is in a crisis situation, use conflict resolution and de-escalation techniques to stabilize the incident as appropriate.

(c) If feasible, and without compromising safety, turn off flashing lights, bright lights or sirens.

(d) Attempt to determine if weapons are present or available.

(e) Consider any past history of violence and threatening statements made by the subject.

(f) Take into account the person's mental and emotional state, and potential inability to understand commands or to appreciate the consequences of his/her action or inaction as perceived by the officer.

(g) Secure the scene and clear the immediate area as necessary.

(h) Move slowly and provide reassurance that you are there to help and provide care.

(i) Allow them to vent their frustrations safely.

(j) Do not threaten the person with arrest.

(k) Avoid topics that may agitate the person, and guide the conversation toward the subject that help bring them back to calm.

(l) Always attempt to be truthful.

(m) Employ tactics to preserve the safety of all participants by removing any dangerous weapons or items from the immediate area.

(n) Determine the nature of any crime.

(o) Request a supervisor as warranted.

(p) Evaluate any available information that might assist in determining cause or motivation for the person's actions or stated intentions.

(q) If circumstances reasonably permit, consider and employ alternatives to force.

463.8 INCIDENT ORIENTATION

When responding to an incident that may involve mental illness or a mental health crisis, the officer should request that dispatch provide critical information as it becomes available. This includes:

(a) Whether the person relies on drugs or medication, or may have failed to take his/her medication.

(b) Whether there have been prior incidents, suicide threats/attempts, and whether there has been previous police response.

(c) Contact information for a treating physician or mental health professional.

Officers should speak directly to the reporting party, if feasible, by phone or in person in order to gather relevant information about the subject in crisis.

Additional resources and a supervisor should be requested as warranted.

463.9 SUPERVISOR RESPONSIBILITIES

When a supervisor responds to the scene of any interaction with a person in crisis, the responding supervisor should:

(a) Attempt to secure appropriate and sufficient resources.

(b) Closely monitor any use of force, including the use of restraints, and ensure that those subjected to the use of force are provided with timely access to medical care.

(c) Consider strategic disengagement. Absent an imminent threat to the public and, as circumstances dictate, may include removing or reducing law enforcement resources or engaging in passive monitoring.

(d) Ensure that all reports are completed and that incident documentation uses appropriate terminology and language.

(e) Evaluate whether a critical incident stress management debriefing for involved members is warranted.

463.10 INCIDENT REPORTING

Members engaging in any oral or written communication associated with a mental health crisis should be mindful of the sensitive nature of such communications and should exercise appropriate discretion when referring to or describing persons and circumstances.

Members having contact with a person in crisis should keep related information confidential, except to the extent that revealing information is necessary to conform to Department reporting procedures or other official mental health or medical proceedings. (Refer to **Policy 418 - Emergent Detentions**)

463.10.1 DETENTIONS

Individuals who are detained for a mental health evaluation and not being arrested should be processed in accordance with **Policy 418 - Emergent Detentions**.

463.11 MEDICAL RESPONSE FOR ARRESTEE

During booking, each prisoner will be observed closely for apparent medical problems or injuries, and questioned concerning current illness, injury, medication and treatment. The prisoner's responses, or lack thereof, and the booking officer’s observations will be recorded in the arrest report.

During booking, each prisoner will be observed and any visible body deformities, trauma markings, bruises, lesions, jaundice, or obvious physical limitations will be documented in the case report.

If a prisoner appears mentally ill and either incapacitated or a danger to self or others, a Mental Health Professional will be consulted to determine if the prisoner should be transferred to an approved hospital or if s/he can be detained in the Clark County Jail. Any prisoner appearing to be under the influence of drugs shall be questioned as to what type of drug they have ingested and their condition shall be monitored closely. If necessary, the prisoner shall be transported to an approved hospital or Medical Center for examination by a qualified medical professional prior to being booked and placed in detention.

If the suspect is refused by Clark County Jail due to their mental illness related behavior, the suspect should be taken to an approved hospital.

If a prisoner is taken to a hospital for any reason, the officer should fill out a pre-book and notify the next shift supervisor of the suspect's location and need of transport to jail when released. Officers should indicate that charges will be pressed when stabilized and who to call for transport to jail for booking.

463.12 CIVILIAN INTERACTION WITH PEOPLE IN CRISIS

Civilian members may be required to interact with persons in crisis in an administrative capacity, such as a front counter contact or records request.

(a) Members should treat all individuals equally and with dignity and respect.

(b) If a member believes that he/she is interacting with a person in crisis, he/she should proceed patiently and in a calm manner.

(c) Members should be aware and understand that the person may make unusual or bizarre claims or requests.

If a person's behavior makes the member feel unsafe, if the person is or becomes disruptive or violent, or if the person acts in such a manner as to cause the member to believe that the person may be harmful to him/herself or others, an officer should be promptly summoned to provide assistance.

463.13 CRISIS INTERVENTION TEAM PROGRAM COORDINATOR

The Vancouver Police Department will maintain a CIT Program Coordinator. The coordinator acts as a liaison to mental health professionals and the community organizations that provide services for people with mental illness or developmental disabilities. The coordinator will also provide oversight to the CIT program.

463.14 TRAINING

As required by Washington law and certified by the Criminal Justice Training Commission, the Vancouver Police Department will follow the Crisis Intervention Team Model established by Memphis Police Department. To become certified, an officer must complete a 40-hour training course. Ongoing training of two hours per year is required to maintain certification. Areas that may be covered in training are causes of mental health crisis, symptoms and treatments for persons

in a mental health crisis; communication and de-escalation techniques for dealing with these situations, and the available resources and civil processes for persons with mental illness.