DUBLIN POLICE DEPARTMENT

STANDARD OPERATING PROCEDURE

SECTION: P-017 DE-ESCALATION / MENTALLY ILL

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# I. PURPOSE

# It is the purpose of this policy to establish guidelines for de-escalation. De-escalation is the result of a combination of communication, empathy, instinct, and sound officer(s) safety tactics. Its goal is to help the officer(s) achieve a good outcome where neither the officer(s) nor the subject is injured.

**II. POLICY**

# The overall goal of this policy is to promote thoughtful resolutions to situations and to reduce the likelihood of harm to all persons involved. De-escalation is reviewed and evaluated under the totality of the circumstances present at the time of the incident.

# III. DE-ESCALATION

# De-escalation may take the form of scene management, team tactics, and/or individual engagement. Even when individual engagement is not feasible, de-escalation techniques including scene management and team tactics such as time, distance, and shielding, should still be used unless doing so would create undue risk of harm to any person due to the exigency/threat of a situation.

# De-escalation tactics and techniques are actions used by the officer(s), when safe and feasible without compromising law enforcement priorities, that seek to minimize the likelihood of the need to use force during an incident and increase the likelihood of voluntary compliance.

# When safe and feasible under the totality of the circumstances, the officer(s) shall attempt to slow down or stabilize the situation so that more time, options, and resources are available for incident resolution.

# When Safe, Feasible, and Without Compromising Law Enforcement Priorities, Officer(s) Shall Use De-Escalation Tactics in Order to Reduce the Need for Force.

# Given an encounter with a non-compliant, non-violent subject, the officer(s) will employ de-escalation techniques to stabilize the situation.

1. Officer(s) shall conduct a threat assessment so as not to precipitate an unnecessary, unreasonable, or disproportionate use of force by placing themselves or others in undue jeopardy.

# Team approaches to de-escalation are encouraged and should consider officer(s) training and skill level, number of officers, and whether any officer(s) has successfully established rapport with the subject. Where officers use a team approach to de-escalation, each individual officer’s obligation to de-escalate will be satisfied as long as the officer’s actions complement the overall approach.

1. Selection of de-escalation options should be guided by the totality of the circumstances with the goal of attaining voluntary compliance; considerations include:
2. **Communication**

Using communication intended to gain voluntary compliance, such as:

* Verbal persuasion
* Advisements and warnings are given in a calm and explanatory manner.

**Exception**: **Warnings given as a threat of force are not considered part of de-escalation.**

* Clear instructions
* Using verbal techniques, such as Listening and Explaining with Equity and Dignity (LEED) to calm an agitated subject and promote rational decision-making
* Avoiding language, such as taunting or insults, that could escalate the incident

Considering whether any lack of compliance is a deliberate attempt to resist rather than an inability to comply based on factors including, but not limited to:

* Medical conditions
* Mental impairment
* Developmental disabilities
* Physical limitation
* Language barrier
* Drug interaction
* Behavioral crisis
* Fear or anxiety
1. **Time**

Attempt to slow down or stabilize the situation so that more time, options, and resources are available for incident resolution.

* + Scene stabilization assists in transitioning incidents from dynamic to static by limiting access to unsecured areas, limiting mobility, and preventing the introduction of non-involved community members
	+ Avoiding or minimizing physical confrontation, unless necessary (for example, to protect someone, or stop dangerous behavior)
	+ Calling extra resources or officers to assist, such as Crisis Intervention Team (CIT) or Less-Lethal Certified officers
1. **Distance**

Maximizing tactical advantage by increasing distance to allow for greater reaction time.

1. **Shielding**

Utilizing cover and concealment for tactical advantage, such as:

* + Placing barriers between an uncooperative subject and officers
	+ Using natural barriers in the immediate environment

**IV. MENTALLY IMPAIRED INDIVIDUALS**

Should the officer reasonably believe that an individual may be mentally ill and a potential threat to himself, the officer, or others, or may otherwise require law enforcement intervention for humanitarian reasons as prescribed by statute, the following responses may be taken.

1. Request a backup officer, and always do so in cases where the individual will be taken into custody.

2. Take steps to calm the situation. Where possible, eliminate emergency lights and sirens, disperse crowds, and assume a quiet non-threatening manner when approaching or conversing with the individual. Where violence or destructive acts have not occurred, avoid physical contact, and take time to assess the situation.

3. Move slowly and do not excite the disturbed person. Provide reassurance that the police are there to help and that he will be provided with appropriate care.

4. Communicate with the individual in an attempt to determine what is bothering him. Relate your concern for his feelings and allow him to vent his feelings. Where possible, gather information on the subject from acquaintances or family members and/or request professional assistance if available and appropriate to assist in communicating with and calming the person.

5. Do not threaten the individual with arrest or in any other manner as this will create additional fright, stress, and potential aggression.

6. Avoid topics that may agitate the person and guide the conversation toward subjects that help bring the individual back to reality.

7. Always attempt to be truthful with a mentally ill individual. If the subject becomes aware of a deception, he may withdraw from the contact in distrust and may become hypersensitive or retaliate in anger.

**V. INVOLUNTARY TREATMENT and EMERGENCY ADMISSIONS**

Contact Community Mental Health (478-272-1190) during business hours, or the Georgia Crisis and Access Line to request assistance from a Crisis Intervention Team. (800-715-4225)

*Involuntary treatment requires a Physician's Certificate (1013 form) or a Court Order (O.C.G.A. 37-3-41) or,*

If assistance is not available from Community Mental Health or the Crisis Line, the following options are also available to officers:

*Emergency admission of persons arrested for penal offenses; report by an officer; entry of report into clinical record (O.C.G.A 37-3-42)

(a)(1) A peace officer may take any person to a physician within the county or an adjoining county for emergency examination by the physician, as provided in Code Section 37-3-41, or directly to an emergency receiving facility if (1)* ***the person is committing a penal offense****, and (2)* ***the peace officer has probable cause for believing that the person is a mentally ill person requiring involuntary treatment.*** *The peace* ***officer need not formally tender charges*** *against the individual prior to taking the individual to a physician or an emergency receiving facility under this Code section. The peace officer shall execute a written report detailing the circumstances under which the person was taken into custody, and this report shall be made a part of the patient's clinical record.*

*(b) A peace officer may take any person to an emergency receiving facility if: (1) the peace officer has probable cause to believe that the person is a mentally ill person requiring involuntary treatment; and (2) the peace officer has consulted either in-person or via telephone or telehealth with a physician, as provided in Code Section 37-3-41, and the physician authorizes the peace officer to transport the individual for an evaluation. To authorize transport for evaluation, the physician shall determine, based on facts available regarding the person's condition, including the report of the peace officer and the physician's communications with the person or witnesses, that there is probable cause to believe that the person needs an examination to determine if the person requires involuntary treatment, The peace officer shall execute a written report detailing the circumstances under which the person detained, and this report shall be made a part of the patient's clinical record.*

***NOTE: In the absence of the aforementioned, officers have no authority to take an individual into custody solely for suspicion of mental illness. (See Boatright v. State)***

***NOTE:***

In ruling on the constitutionality of hogtie restraints, the United States Court of Appeals for the 10" Circuit asserted:

*The conduct at issue involves the tying of the decedent's arms behind his back, binding his ankles together, securing his ankles to his wrists, and then placing him face down on the ground. We note that while sister circuits may characterize the hog-tie restraint somewhat differently; we understand such to involve the binding of the ankles to the wrists, behind the back, with 12 inches or less of separation. We have not heretofore ruled on the validity of this type of restraint. We do not reach the question of whether all hog tie restraints constitute a constitutional violation per se but hold that* ***officers may not apply this technique when an individual's diminished capacity is apparent. The diminished capacity might result from severe intoxication, the influence of controlled substances, a discernible mental condition, or any other condition apparent to the officers at the time****, which would make the application of a hogtie restraint likely to result in any significant risk to the individual's health or well-being. In such situations, an individual's condition mandates the use of less restrictive means for physical restraint.*