BURLINGTON POLICE DEPARTMENT
Antonio B. Pomerleau Building
1 North Avenue
Burlington, Vermont 05401

Michael E. Schirling
Chief of Police

Phone (802) 658-2704
Fax (802) 865-7579
TTY/TDD (802) 658-2700

DRAFT

Review of Mental Health Response Options
February 3, 2014

In the wake of ongoing dramatic increases in response to mental health calls in Burlington and individual tragedies that occurred in Chittenden County, we undertook a review of response options beginning in late-November of 2013. In December we began crafting alternative response methodologies using a "co-responder" model, enhancing what has been in place in the City since 2009 with our Street Outreach Interventionist program – an ongoing partnership with the HowardCenter. In January the City Council requested, via resolution, a report back on the review of policy, response options, and progress. What follows is a description of those efforts and our recommendation and actions.

In late November/early December of 2013, then Deputy Chief Andi Higbee was tasked with a review of key documents, reports, and programs. Many of these documents were already on file at the Department as they had been used as a basis for our current response methodologies and programs – such as the Outreach Interventionist Program, begun in 2009. However, this review was designed to look on the documents through the new lens provided by the call volume and events that had occurred in 2013 – culminating with the tragic death of a man with a history of mental illness in a violent encounter on November 6, 2013.

What follows is an executive level summary of our review of key reports and documents in this arena, a brief overview of some of our efforts, and recommendations for moving forward.

Documents Reviewed & Brief Synopses

DRAFT Report of the Attorney General Regarding Law Enforcement Mental Health Trainings (2014)

This report DRAFT was not released until after DC Higbee's initial review. Prior versions of this report create the basis upon which law enforcement training in Vermont on the topic of mental health is based. 100 percent of Burlington Police Officers have received training as recommended by prior iterations of this report. The current DRAFT (subject to revision in the days to come) outlines fourteen recommendations including:

- Develop local crisis intervention teams (CITs).
- Fund police social worker programs.
- Identify an entity to coordinate regional/local conversations between law enforcement, crisis workers, service providers, and peer-supports.

It should be noted that for many years both Chief Michael Schirling and Community Support Specialist Brooke Hadwen were involved in the Act 79/80 Working Group, as was retired Deputy Chief Walter Decker.

Building Safer Communities: Improving Police Response to Persons with Mental Illness – Recommendations from the IACP National Policy Summit (2010)

This report outlines broad national and statewide policy-level suggestions. Among the suggestions for street level law enforcement approaches are Crisis Intervention Teams and Co-Responder Teams.

Law Enforcement Response to People with Mental Illness: A Guide to Research-Informed Policy and Practice (2009)

Among the most informative of the literature, this document also emphasizes Crisis Intervention Teams and co-responder models, but also gives a template of "Ten Essential Elements" to success in mental health response development. They are (comments embedded in parentheses):

1. Collaborative planning and implementation (ongoing)
2. Program design (ongoing)
3. Specialized training (ongoing)
4. Call-taker and dispatcher protocols (in place and will be enhanced)
5. Stabilization, observation, and disposition (options for disposition, beyond incarceration, are very often limited in Vermont)
6. Transportation and custodial transfer (not legal in Vermont but currently advocated for by the Vermont Association of Chiefs of Police)
7. Information exchange and confidentiality (an ongoing challenge in some cases but information is shared readily from police to treatment providers)
8. Treatment, supports, and service (Often, community supports and services are overwhelmed by the numbers of people with illness and significant acuity cascading through the system as a result of less-than-robust back end placement options.)
9. Organizational support (The Department supports and creates alternative response methods and practices.)
10. Program evaluation and sustainability (Programs such as the Outreach Interventionist have been evaluated and found effective. Sustainability is achieved through multiple organizations contributing money for ongoing funding. More could be done in this area In addition the Service Executives Group has begun to assess how to interface respective agency data to allow for better trend analysis.).

As you will read below, Burlington has already embraced most of these essential elements.

DRAFT

Improving Responses to People with Mental Illness: The Essential Elements of a Specialized Law Enforcement-Based Program – Bureau of Justice Assistance & Council of State Governments (2008)

This report outlines a host of experiences nationwide that directly mirror the Vermont experience. They include but are not limited to: mental health calls increasing and taking long periods of time; special skills and experience necessary to intervene in mental health crises; and repeat contact with the same individuals. Outcomes are often dependent on the availability of community mental health resources; and occasionally involve volatile situations, risking the safety of all involved. Specialized response strategies are the best practice.

Crisis Intervention Teams Overview – Portland, ME Police Department
Crisis Intervention Teams Overview – Houston, TX Police Department

Both of these briefs outline the training provided during a 35 to 40 hour Crisis Intervention Team Training based on the "Memphis Model."

Report of Lou Reiter, Contract Investigator for the City of Winooski regarding the incident of April 25, 2013

This report outlines the events and policy implications regarding the discharge of a firearm at a mentally ill man in Winooski in April of 2013. We did not find any specific recommendations in that report – beyond those outlined in other documents that were reviewed - that were applicable.

<u>Efforts in Progress</u>

Below are just a few of the programs, initiatives, and partnerships that are in place in the realm of mental health response.

I. Street Outreach Team – Partnership

For the past 12 years, the Department has partnered with the HowardCenter and funding sources including Fletcher Allen Healthcare, the Church Street Marketplace, the United Way of Chittenden County, the Department of Mental Health, and others, to deliver what began as one outreach worker in the downtown and has expanded to four. This team works daily to manage a variety of behaviors and unmet needs that have historically devolved into crime and disorder in the central core of the City.

II. Street Outreach Interventionist

Since 2009, we have deployed a street outreach interventionist, who works from the Department, in direct partnership with the HowardCenter, to provide a host of services to many in our community suffering from mental illness, substance abuse challenges, and other unmet social service needs. Since 2009, the Interventionist has worked from the police department on an evening shift helping to manage high service users in the community and prevent issues from rising to the level of a crisis that requires response by law enforcement, incarceration, visits to the emergency department, or hospitalization. In 2011 we received an International Association of Chiefs of Police Award for this initiative.

III. Service Executives Meetings

DRAFT

Convened in 2012 by BPD, this monthly meeting brings together executives from direct services agencies including but not limited to: Spectrum, HowardCenter, Department of Mental Health, Department of Corrections, Agency of Human Services, United Way, Fletcher Allen Hospital, Pathways to Housing, the Vermont Health Department, CVOEO, the Community Health Center, and others. This group meets to discuss emerging and unmet needs within the community, and project planning.

IV. Training

All officers (100%) have received training in compliance with the statewide effort to train law enforcement officers in mental health response via Act 80. Beyond that, the Department trains on an ongoing basis on topics related to mental health and response to persons with diminished capacity. In addition to core trainings directly on this topic, woven into our integrated scenario based trainings are scenarios related to mental health crisis.

V. Crisis Negotiation Team

For approximately the last 17 years the Department has trained and maintained a Crisis Negotiation Team. This team consists of specially trained crisis/hostage negotiators who respond to events in which a subject is threatening to harm themselves or others, often is armed or is atop a building or bridge. In instances where it is known that a subject is armed, in a dangerous place, and has been recognized as an imminent threat to themselves or others, this team is called upon to try to resolve the situation.

VI. CARES Program

In 2012 we began a multi-faceted program to provide tools and support to all staff in the area of mental health. CARES is a program in which an in-house licensed clinician works to provide a number of things including, but not limited to:

- Support for staff after stressful events
- Ongoing resiliency training for staff and supervisors
- Training for staff on responding to and dealing with mental illness
- Support for survivors of critical incidents

DRAFT

<u>Suggestions for policy and response options</u>

Re-design the Street Outreach Interventionist Operation Methodology to more closely mirror a "co-responder" model

In early January of 2014 we began a pre-pilot test of changes to the response protocol for the Street Outreach Interventionist. Attached/embedded below is a memo that outlines that test, which will continue through approximately early March. If successful, a second Interventionist may be hired to provide additional direct first response options, using funding from the Vermont Department of Mental Health. See attached/embedded memo for full details.

Adopt a Burlington-specific version of the VT League of Cities and Towns Model Policy: Dealing with Persons of Diminished Capacity (2012)

Portions of this model policy have been used as a template for a number of Department policies and our operations fully comply with the key elements of this model policy. However, it had not

been adopted as a stand-alone policy for reference. Attached is a revision to a Burlington Police policy that incorporates the key elements of this model.

Explore Crisis Intervention Team training if/when the State adopts the recommendations of the 2014 Act 79 DRAFT Report

While our Crisis Negotiation Team is well trained, their training does not exactly match the curriculum of the "Memphis Model." BPD has limited training resources and budget. We fully support the recommendation of the Act 79 Committee to deploy this training on a statewide basis. As an important note we feel compelled to emphasize that this training should not be relied upon as a mechanism to continue to rely so heavily on law enforcement to be the defacto first responders to mental health crisis. Even with CIT training, police officers are not operating at a clinician-level.

Continue to advocate for statewide compliance and enforcement for patients mandated to take medication as a result of criminal pre-trial conditions of release or orders of non-hospitalization

Common themes emerge when talking with families impacted by mental illness as well as in stories from Vermont and elsewhere in which tragedy is an ultimate result. One of the most common themes involves a person with mental illness who receives some treatment or intervention and for which the prescribed/mandated follow-up plan is for them to continue taking medication to avoid in-patient hospitalization or incarceration. Despite clinicians recommendations, patients often experience little or no consequence, or in a timely manner, when they stop taking their medications as directed. Put simply, this needs to change to provide one more very predictable intervention in an effort to avoid future tragedies.

The suggestions and revisions outlined here are one small piece of a very large and complex puzzle. Reform in our statewide mental health system is a top priority; not just in Burlington, but throughout Vermont. The organizations currently advocating for systemic change include the Vermont Coalition of Mayors, the Vermont Association of Chiefs of Police, hospitals, and others. Without systemic changes to the systems that support those who suffer from mental illness and without a robust set of options ranging from solid first response alternatives that often do not involve law enforcement to secure placements for those is serious crisis, the best efforts of those working in our mental health system at every level will not be enough to avert repeat tragedies.

<u>Review of this report</u>

Prior to discussing this document with the Burlington Police Commission, the Department asked for review by two area subject matter experts familiar with the Vermont landscape and the Department's operations. It was reviewed by Bob Bick, Director of Mental Health and Substance abuse Services for the HowardCenter and Dr. Tom Simpatico, Director of Public Psychiatry at the University of Vermont and Chief Medical Officer at the Vermont Department of Health Access. We also sought feedback on this report as well as the draft policy from Barbara Brunette of Burlington. Her feedback led directly to the incorporation of the final recommendation, above.

DRAFT

BURLINGTON POLICE DEPARTMENT
Antonio B. Pomerleau Building
1 North Avenue
Burlington, Vermont 05401

Michael E. Schirling
Chief of Police

Phone (802) 658-2704
Fax (802) 865-7579
TTY/TDD (802) 658-2700

DRAFT

To: **All Personnel**
From: **Michael E. Schirling, Chief of Police**
CC: **Bob Bick, Matt Young, Justin Verette – HowardCenter**
All Street Outreach Staff
Mayor Miro Weinberger; Police Commission
Re: **Pre-Pilot Test of Crisis Response Using Street Outreach Interventionist**
Date: **January 14, 2014**
Memo #: **2014-02**

As all are aware, there has been staggering increase in the number of calls for service stemming from mental illness over the past 5 years. That increase has been accelerating, despite the best efforts of those working locally in our Street Outreach Program, the HowardCenter Crisis Teams, and others around the State.

Since 2010 our collaborative Project between the Burlington Police Department and the HowardCenter delivering a Street Outreach Interventionist during the evening hours to some in need of social services has proven successful.

More elusive has been both the resources and the ability to embrace a philosophical shift away from using police officers as the primary responders to all crises.

As a result of the increase in call volume, coupled with recent events, the HowardCenter has received word that they will be able to utilize funds from the Department of Mental Health (Act 79) to create a pilot project to add another responder to the options available for issues that present immediately as those stemming from mental illness.

As we work together to draft a full job description and to hire this new staff person who will work from BPD at least initially, we are going to use existing resources to conduct a "pre-pilot project." It will work as follows.

Beginning January 15, 2014 while an Outreach Interventionist is on duty (generally from 1:30 pm to 9:30 pm Tuesday through Saturday) we will begin testing alterations to mental health calls using our Street Outreach Interventionists (currently Justin Verette & Stephanie Tanner) in a greater direct response role than he has had to date. Additionally, our Community Support Specialist (Brooke Hadwen) MAY be available during hours prior to 1:30 pm to act as the Outreach Interventionist on a case by base basis and as time permits. Calls during this pre-pilot phase will fall into two categories. It is anticipated that three categories will exist after the pre-pilot phase.

- **Category 1** - Any call in which there is an articulable and imminent threat to a person'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.

- **Category 2** – Any call in which there is not immediate and articulable threat to safety or property. For these calls, if an Outreach Interventionist is available, they will 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.

Communications staff should ask a robust set of basic questions to ascertain which category a call falls into. 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, will hopefully lead to better outcomes.

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.

Each call, regardless of who is responding, shall be entered in Valcour and each call that relates to mental health shall have the appropriate box checked for tracking.

The on-duty Outreach Interventionist may carry a BPD radio and shall also carry a cell phone.

During this pre-pilot, the Outreach Interventionists will, among other things, be collecting clinical information and data that will help guide the final project design. All staff are encouraged to make observations and suggestions to help guide the final project design as the job description is finalized and additional staff are sought. Any new positions will be HowardCenter staff in addition to those already in place.

Day to day supervision of the Interventionist as they respond to calls shall be provided by the Officer in Charge. However, all clinical supervision of treatment, treatment plans, and healthcare information shall be done by the HowardCenter.

DRAFT

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 special needs persons 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 of 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 special needs persons 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 these types of special needs persons. 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. "Mentally Ill Person" 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. Mentally Ill Dangerous Person: 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.

DRAFT

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 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 to the extent reasonably possible. If firearms are drawn, they should be maintained in the low ready position and not displayed by officers who are attempting to establish communications with the subject. Contact officers should make all reasonable attempts to avoid displaying lethal force options at all, while attempting to establish communications with the subject.

DRAFT

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 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.

DRAFT

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.

Reviewed and adopted by the Burlington Police Commission on January 28, 2014.

_____ _____

Michael E. Schirling, Chief of Police Effective Date

DRAFT

BURLINGTON POLICE DEPARTMENT
Antonio B. Pomerleau Building
1 North Avenue
Burlington, Vermont 05401

Jerome F. O'Neill, Chair
Board of Police Commissioners

Telephone (802) 658-2704
Fax (802) 865-7579
TTY/TDD (802) 658-2700

MEETING OF THE BOARD OF POLICE COMMISSIONERS
TUESDAY, FEBRUARY 18, 2014, 6:00 P.M.
BURLINGTON POLICE DEPARTMENT, COMMUNITY ROOM, 1 NORTH AVENUE

****

AGENDA

1. Public Forum
2. Chief's Report
3. Review Drafts of Mental Health Response Options Review and Interacting with Persons with Diminished Capacities policies
4. Review of Any Incoming Correspondence *{as needed}*
5. Commissioners' Updates/Comments
6. Review Updated Directives *{as needed}*
7. Consent Agenda – Minutes of 1/28/2014
8. Next Meeting's Agenda Items and Date
9. Executive Session *(anticipated)*
10. Adjournment

This material is available in alternative formats for persons with disabilities. To request an accommodation, please call: (802) 540-2107 (voice) or e-mail: kcaron@bpdvt.org

The latest approved Police Commission Meeting Minutes and Upcoming Meeting Agendas are posted on our website: www.bpdvt.org

BOARD OF POLICE COMMISSIONERS
MINUTES OF MEETING

A meeting of the Board of Police Commissioners was held in the Burlington Police Department Community Room on **Tuesday, February 18, 2014**. Chair O'Neill called the meeting to order at 6:05 p.m.

The following Commissioners were present: Jerry O'Neill, Chair, Bill Bryant, Vice-Chair, Sarah Kenney, Paul Hochanadel and Phil LaVigne. Also present were Chief Michael Schirling and Kimberly Caron, Police Commission Clerk.

Public Forum: Barbara Brunette was present, but did not address the Commission until after the Mental Health discussion.

Chief's Report:
~A Draft of the budget for FY15 has been submitted to the City Council and will be before voters on 3/5/2014.
~Staffing –2 officers are finishing Field Training. We have 7 new hires at the Police Academy. Dispatch is currently at 11 and in the hiring process for the 12th.
~The Rape Aggression Defense (R.A.D) Program started tonight, February 25th, 2014.
~The Community Impact Team letter specific to landlords was put in the mail this week as an insert to the annual rental property registration mailing through the Code Enforcement Office.

City Council – Request for Review of Mental Health Resolution:
~Chief Schirling explained the processes, which have already begun to take place concerning updates to the policy regarding Mental Health response calls. This included:

- Redesigning the Street Outreach team to resemble the co-responder model; which started on January 14, 2014.
- Adoption of the new Department Directive DD13-03: Dealing With Persons With Diminished Capacities. This Directive doesn't contain substantial new material, but instead gathers current practices as well as policy from other Directives pertaining to Persons With Diminished Capacities and compiles it into one specific document.
- Continuing to advocate for a State-wide Crisis Impact Training based on the Memphis Model of training.
- Developing a Multi-Agency letter to Vermont Legislature on Mental Health activity throughout the State.

~Discussion followed. Barbara Brunette addressed the Commission regarding her concern with the lack of non-lethal weapons that officers carry. Chief Schirling explained some of the less-lethal weapons officers have available and their uses.
~Commissioner Kenney suggested changing the language throughout the DD13.03 Directive to reflect a consistent explanation of Persons With Diminished Capacities. Discussion followed and language changes were made. Commissioner LaVigne moved to approve the Directive, Vice Chair Bryant seconded, all in favor so passed.
~The final version of the City Council's Request for Review of Mental Health Resolution, with the Mental Health Response Option Review will be placed on the next Police Commission Agenda, along with the Police Commission letter addressed to the City Council, where the Final Document will be discussed and approved to submit to the City Council.

Commissioners' Updates/Comments:
~Commissioner Kenney commented on Corporal Bonnie Beck's outstanding discussion with a local Kindergarten Class.
~Commissioner LaVigne requested to keep pressure on the drug activity.

Consent Agenda – Minutes of the 1/28/2014 Meeting: Commissioner LaVigne moved to approve the 1/28/2014 minutes, Commissioner Kenney seconded, all in favor so passed.

Next Meeting's Agenda Items and Date: The next regular meeting is set for Tuesday, March 25, 2014 at 6:00 p.m.

Executive Session: There was nothing to discuss in an Executive Session.

Adjournment: Commissioner LaVigne moved to adjourn the meeting, Commissioner Kenney seconded, all in favor so passed at 7:31 p.m.

Respectfully Submitted,

Kimberly Caron, Clerk of Police Commission

3/26/2014
Date