# Narragansett Police Department

40 Caswell Street, Narragansett, RI 02882

| ORIGNAL ISSUES | LAST REVISED | NEXT REVIEW |
|---|---|---|
| March 16, 2008 | February 7, 2023 | February 7, 2026 |

| Policy 320.14 | Mental Health Response |
|---|---|

## 01. Purpose

Police officers are routinely the first responders to people with mental health disorders (MHD), intellectual and developmental disabilities (IDD) or emotionally disturbed persons (EDP). This policy establishes procedures under which the Crisis Intervention Team (CIT) shall operate to ensure a coordinated response in providing services to persons in crisis.

## 02. Policy

It is the policy of the Narragansett Police Department to ensure a consistently high level of service is provided to people experiencing behavioral health issues and crisis. This service will be provided while ensuring the same rights, dignity, and access to police and other government and community services as are provided to all citizens. We will provide this service relying upon the services of a Crisis Intervention Team (CIT).

## 03. Definitions

Crisis Incident: Any call in which an individual would benefit from the specialized training and knowledge of the CIT member. Crisis incidents include but are not limited to calls involving; persons known to have mental illness who are experiencing a crisis; persons displaying behavior indicative of mental illness; attempted or threatened suicides; calls involving gravely disabled individuals or calls in which individuals may be experiencing emotional trauma.

Mental Health Disorder (MHD): A mental disorder in which the capacity of a person to exercise self-control or judgment in the conduct of his/her affairs and social relations, or to care for his/her own personal needs, is significantly impaired.

Intellectual and Developmental Disability (IDD): A disorder that negatively affects a person's physical, intellectual or emotional development; including the ability to learn, reason, problem solve and everyday social and life skills.

Emotionally Disturbed Person (EDP): A person with emotional, mental, behavioral or erratic behavior that affects their decision-making process and may include hurting themselves or others.

Mental Health Professional: A psychiatrist, psychologist, social worker, Qualified Mental Health Professional (QMHP), and such other persons, including psychiatric nurse clinicians.

Mental Health Liaison (MHL): A QMHP who has been authorized to participate in a department specialized CIT program. The department MHL is documented in section L subsection 1 of this policy.

Crisis Intervention Team (CIT): A partnership between the police, mental health professionals and the community that seeks to achieve the common goals of safety, understanding and service to persons in crisis, people with mental illnesses and their families.

CIT Officer: A police officer trained and certified in first response crisis intervention.

## 04. Procedure

A. Dispatch Responsibilities

1. Dispatch is the primary source for identifying CIT calls. However, officers investigating an incident may classify it as a CIT situation.

2. Types of calls that may require a CIT officer response include, but are not limited to:
   a. Mental health disorders
   b. Traumatic incidents
   c. Sudden deaths
   d. Attempted suicides
   e. Medical assist/wellbeing checks
   f. Breach of peace/ disorderly conduct and
   g. Trespassing/refusing to leave property

3. Gathering information is critical in assessing situations involving people who have mental illnesses and is particularly critical at the onset. Dispatchers should assess the urgency of the situation and collect other relevant information such as:
   a. The nature of the behavior
   b. Events that may have precipitated the person's behavior
   c. The presence of weapons
   d. Medications
   e. Alcohol and/or drug use
   f. Intentions of harming self/others
   g. Presence of friends and/or family

4. Dispatch shall alert the OIC to the dispatch of a CIT call for service.

5. Dispatch shall coordinate with the OIC and attempt to dispatch a CIT officer to CIT calls as the primary responder along with the area officer. If a CIT officer is

not available at the time of dispatch, then they will respond as a secondary unit when they become available, if needed.

6. Dispatchers will relay relevant background information from IMC and cross agency checks to the responding officers, especially safety considerations.

7. When notified that a person with a mental illness has fled from a local hospital or mental health facility, dispatchers will gather and relay as much information as possible such as whether the patient was transported by police or rescue, if a doctor or QMHP is ordering the patient's return and whether the patient had been evaluated already.

8. Dispatchers will indicate in the IMC Central Index all locations and people where there is a reasonable concern for future officer safety, i.e., suicidal, weapons, previous violence.

9. Dispatchers will assign an offense report to any call involving the transportation of a person for a voluntary or an involuntary emergency mental health evaluation, or as requested by an officer.

10. At the direction of the OIC or the CIT officer on scene dispatch shall alert the Mental Health Liaison (MHL). Every effort shall be made to provide the MHL with as much information as possible such as the subject's name, address and activities.

B. First Responders (CIT and Non-CIT)

1. CIT Officers will notify their OIC's at roll call that they are CIT Certified in order for this to be noted in the shift lineup.

2. All officers, both CIT and Non-CIT, will rely on their training and experience in recognizing signs and symptoms of mental and intellectual disorders. Officers will make a risk assessment of harm. An officer's primary responsibility is to mediate, deescalate and defuse a crisis situation and then determine or coordinate appropriate treatment options.

3. Officers should consider underlying conditions that prompted that call (i.e., problems with medication, anxiety, inadequate supervision, etc.).

4. Officers should gather additional information from family members, friends, or neighbors to determine relevant history, risk of violence, and treatment providers to assess the situation and forward to emergency room clinicians.

5. If a CIT officer was not initially dispatched to a call non-CIT officer(s) on scene may call upon members of the department's CIT and/or the MHL for additional assistance.

6. Actions Officers should take that may help defuse crisis situations include the following.
    a. Remain calm; speak simply, move slowly, and announce actions before initiating them (**safety permitting**)
    b. Remove distractions and/or upsetting influences
    c. Understand a rational discussion may not take place; do not confirm delusions
    d. Recognize that the person may be overwhelmed by sensations, thoughts, frightening beliefs, sounds, "voices", or the environment
    e. Be aware that uniformed officer(s) may frighten the person with mental illness-reassure him/her that no harm is intended
    f. Determine any current medication or treatment providers

7. Officers should avoid:
    a. Forcing discussion
    b. Direct, continuous eye contact
    c. Touching the person (**unless essential to safety**)
    d. Moving suddenly, giving rapid orders, or shouting
    **e.** Approaching with emergency lights and siren activated. **Unless safety and/or urgency makes it unavoidable**

**NOTE**: Officer safety remains a priority. Contact and cover tactics should be employed and officer safety tactics shall not be sacrificed. The suggestions above are meant to be used to increase safety and deescalate the situation.

C. Determine Appropriate Disposition

1. Officers should consider the extent mental illness factored into an incident before deciding an appropriate response.

2. Arrest discretion. Officers may elect discretion for misdemeanor incidents with a complainant's consent where a person is apparently mentally ill.

3. Officers will consider the following range of response options:
    a. Request Narragansett Fire Department rescue to aid persons in need of medical attention.
    b. Refer to local mental health service provider
    c. Assistance from family, caregiver, or friend
    d. Assist in arranging a voluntary admission

        1) Any individual may apply for voluntary admission to an approved public treatment facility for treatment of a mental disability.

Juveniles may apply with parent, guardian, or next-of-kin.

2) Officers may transport persons seeking voluntary treatment for mental disability to a local mental health center or hospital emergency department. Dispatch will notify the receiving center. The officer will brief the attendant circumstances leading to the transportation and remain until the receiving center has positive control of the person.
3) If the person seeking voluntary treatment is transported by a rescue, unescorted by police, the primary police officer will brief the rescue officer or call the information into the emergency room clinician or pass on with the person the Narragansett Police Department Mental Health Assessment form, Appendix A.

e. Seek emergency mental health evaluation/involuntary admission

1) If a person meets the below criteria set forth in R.I.G.L 40.1-5-7, and refuses the opportunity for voluntary treatment an officer may make an involuntary transport and admission.
2) A qualified mental health professional (QMHP) or police officer believes the person to be in need of immediate care, and
3) One whose continued unsupervised presence in the community would create an imminent *"likelihood of serious harm"* to themselves and/or others by reason of mental disability. *"Likelihood of serious harm"* means:
    a. A substantial risk of physical harm to the person himself or herself as manifested by behavior evidencing serious threats of, or attempts at, suicide, and/or
    b. A substantial risk of physical harm to other persons as manifested by behavior or threats evidencing homicidal or other violent behavior, and/or
    c. A substantial risk of physical harm to the mentally disabled person as manifested by behavior, which has created a grave, clear, and present risk to his/her physical health and safety

4. The MHL should be contacted if on-duty, or in exigent circumstances, to facilitate the emergency certification application.

5. Narragansett Fire Department should be requested to transport for involuntary emergency evaluations. An officer will follow rescue to the hospital for these types of transports.

6. Officer should keep in mind that people with severe mental illnesses can experience intense psychotic distress that may pose a significant risk of harm to

themselves and others, to include first responders.

7. Dispatch will notify the hospital emergency department of the pending transport and purpose. Hospital security will be requested if the person is violent.

8. The officer will brief the attendant circumstances leading to the involuntary transportation and remain until the receiving center has positive control of the person and any risk of harm has passed. The officer will complete and leave a Narragansett Police Department Mental Health Assessment form, Appendix A, with hospital staff.

9. A parent/guardian will be notified if a juvenile is transported for an emergency mental health evaluation.

10. An offense report will include the likelihood of serious harm elements described above.

D. Custody

1. Taking an EDP into custody can only occur when:
    a. The person is being arrested for a crime
    b. Court ordered pursuant to RIGL 40.1-5.8 or
    c. Request in writing, by a physician or QMHP, to transport a person committed to a treatment facility, pursuant to R.I.G.L. entitled "Emergency Certification"

2. Using handcuffs on an EDP can aggravate their aggression. Officers will apply restraints when taking a person into custody charged with a crime. Officers may apply handcuffs as a temporary measure to control an EDP whose behavior appears to pose a threat to self or others.

3. EDP's subject to custodial arrest will be transported or released as described below:
    a. Summons on-scene and facilitate mental health services: The OIC must approve of this summons option and the officers intended resolution to best address the person's mental health needs.
    b. Arrested and transported to Headquarters: Upon arriving at headquarters with an EDP the officer will immediately inform the Officer-in-Charge of the prisoner's mental health issues.

4. Officers shall notify any transporting officer and the OIC that the prisoner is the subject of a CIT call so the necessary precautions can be taken to eliminate potential harm and/or suicide risk.

5. The Officer-in-Charge will determine the appropriate level of monitoring to include CCTV, frequent cell checks, an officer posted at the cell or placement in the restraint chair (consistent with policy #370.07 Emergency Restraint Chair). The OIC will also determine the appropriate disposition of an arrested EDP:
    a. Bail Hearing- If an EDP posts bail, the OIC will determine the appropriate response to the person's mental health issues given the range of options provided in this policy.
    b. Held for Court Arraignment: The OIC will inform prosecution of the arrestee's condition. Prosecution may refer case to pre-trial services assigned to the court.
    c. Transport to the Adult Correctional Institute (ACI): An arrestee in police custody at headquarters who implies/ expresses a desire to harm himself or others and failed to post bail, or is being charged on a Hold Without Bail (HWOB) warrant, will be transferred to the ACI in lieu of the hospital absent the following physical conditions:

        1) Injured and/or
        2) Drug and or/ Alcohol incapacitated

    d. Transport from Scene to SCER: An EDP arrested for the commission of a crime, and whose behavior presents an imminent likelihood of serious harm, will be transported directly to the SCER emergency room to seek an emergency mental health evaluation. The OIC will make a determination as to the arrestee's eligibility for release to the care of the hospital.

6. The OIC may authorize the arrestee be released at the hospital and an arrest warrant and affidavit pursued.

7. The OIC may authorize the arrestee be released from the hospital on a court summons.

8. The OIC may arrange for a Bail Hearing at the hospital. The arrestee will be released to the hospital for mental health evaluation and treatment if bail is posted.

9. The OIC will decide appropriate measures to monitor the subject while under our custody if the arrestee is discharged pending court arraignment.

10. Consistent with Policy #370.05 entitled, Prisoner Transportation, a "Narragansett Police Department Prisoner Transaction Form" will be completed and delivered with the prisoner to the Intake Service Center if the arrestee is transferred from the hospital to the ACI.

E. Interview and Interrogation

1. Officers must be particularly careful in advising a person believed to have a mental illness of his/her *Miranda* rights, making a determination of his/her mental capacity to understand those rights, and eliciting a decision as to whether he or she is willing to answer officers' questions without an attorney.

2. Before interviewing a suspect who is believed to have a mental illness, officers should make every effort to determine the extent to which the person's illness impairs his/her ability to comprehend and give informed consent.

F. Confidentiality

1. Employees having contact with a person who has a mental illness will keep related information confidential except to the extent that revealing information is necessary to conform to departmental reporting procedures or official mental health/medical proceedings.

G. Training

1. All entry-level employees will receive documented training regarding the interaction of agency personnel with persons suspected of suffering from mental illness.

2. The Training Officer will ensure officers and non-sworn employees with public contact receive refresher training annually. Training to be documented in Power-DMS.

H. Responsibilities of Mental Health Liaison (MHL)

1. Daily supervision of the MHL will fall under the Dayshift Lieutenant as part of the community police function. The MHL will also answer to the patrol OIC or any on-scene supervisor.

2. Broader coordination for the department will be the responsibility of the CIT Supervisor described in Subsection I of this policy.

3. The MHL will have full access to the building as an employee and will conduct his/her job functions in collaboration with the CIT Supervisor, on-duty officers, CIT officers and with medical service providers.

4. The MHL will be escorted by an officer at crime scenes, critical incidents, crisis situations, interviews with violent persons, interviews in holding or jail facilities, or anytime deemed necessary for his/her safety.

5. The MHL will review arrest and offense reports, call logs, and related documents to the extent permitted by applicable law, controlling regulations, and department policy.

6. The MHL will monitor the police radio frequencies and respond to calls as needed or requested. The MHL will monitor and analyze CIT calls and present necessary reports to aid in measuring CIT program outcomes.

7. The MHL will support the department's mental health response strategy by:

    a. Providing crisis evaluation and support for involuntary certifications
    b. Assisting with hospitalization coordination and follow up
    c. Act as a point of contact for social service agencies, especially concerning referrals
    d. Collaboration with probation, parole, prosecution and pretrial services
    e. Care coordination and follow up
    f. Providing bereavement or traumatic incident support to officers and citizens
    g. Assist the department’s efforts to serve the homeless, the narcotic addicted and elderly affairs

8. Specific job functions and limitations of the MHL will be enumerated in a Memorandum of Understanding (MOU) with the Narragansett Police Department.

I. The Crisis Intervention Team (CIT)

1. CIT is voluntary and members will be selected upon demonstrated suitability and needed department assignment. The department shall maintain at least 25% of the patrol division in CIT.

2. Team members will attend approved CIT certification programs and receive in-service training.

3. Team members will volunteer their specialized skill set for CIT related calls as outlined above and assist with follow up on their own or in conjunction with the MHL.

4. CIT members will attend scheduled meetings to share information about recent CIT cases with other agencies as well as with other members of the team. Mental health related trainings may also be conducted at meetings.

5. CIT members, at the discretion of the Chief of Police, will be allowed to assist at the Rhode Island Municipal Police Training Academy and be allowed to assist at Mental Health trainings at other agencies within the state. Role playing is considered training time for CIT members and will be logged as such.

J. Responsibilities of the CIT Supervisor

1. The Chief of Police will designate a CIT Supervisor. The CIT Supervisor will serve as a liaison between the police department, the MHL and its mental health partners and community stakeholders. The coordinator will handle issues arising from the implementation of the CIT Program.

2. The CIT Supervisor will review reports, evaluate outcomes, prepare and forward reports as necessary; outlining the status of the team, respond to calls for CIT service statistics, and issues/recommendations.

3. The CIT Supervisor will maintain a list of the active members of the CIT and enter it into the Guardian Tracking accounts of those officers as an administrative entry.

4. The CIT Supervisor will provide an update via E-Email to keep members of the NPD updated on recent CIT calls.

5. The CIT Supervisor will coordinate all certification and in-service training for CIT members and will coordinate the department's Community Resiliency Program (PRP).

K. Community Resiliency Program (CRP)

1. A program will be instituted to support the department's mental health response strategy. The purpose of the program is to move from the standard reactive response by officers with standard mental health police skills to a proactive and planned response. This proactive response will consist of planned, coordinated and regular follow up contacts by CIT and the MHL.

2. The follow up contacts will be conducted off duty hours for compensatory time, as determined by the CIT Supervisor.

3. Pairs of officers, with the MHL, will conduct the follow up contacts with those persons selected from past CIT contacts.

4. The follow up contacts will be an outreach from the police and not enforcement related. The purpose of the contacts is to keep a check on a distressed person's status, to offer further social services, check on treatment progress and maintain a positive police relationship with those persons and their friends and family.

L. Available Resources

1. Kasey Sarazin, LCSW, LCDP, CFRC, QMHP- is the Mental Health Liaison (MHL) for the Department.

   - Contact Info:
      a. E-mail: ksarazin@narragansettri.gov

2. Gateway Health Care- 4705A Old Post Rd, Charlestown RI 02813 and 55 Cherry Ln C8, Wakefield RI 02879 (401)-364-7705 or (401) 789-1367 http://www.ssmhc.org/.
    a. Emergency Services are on-call 24/7 and can assist the officer with appropriate referrals. The officer should call the center and talk to a counselor about the situation. The counselor can assist with housing, therapy, treatment referrals, and mental health evaluations. (24-hour emergency # 401-364-7705).

3. National Alliance for the Mentally Ill of Rhode Island (NAMI) 154 Waterman St., unit 5b, Providence, RI, 02906. (401)-331-3060, 1-800-749-3197, www.namirhodeisland.org.

4. Lifespan Outpatient Psychiatry and Urgent Care- 1454 South County Trail East Greenwich, RI, 02818. Crisis telephone support 24 hours a day, 7 days a week: 401-723-1915 or 401-553-1031 http://www.lifespan.org/Outpatient-Psychiatry-and-Urgent-Care.html.

By Order of:

Chief of Police