POLICY AND PROCEDURE NO. 448

Crisis Intervention Team

Massachusetts Police Accreditation Standards:
N/A – No applicable MPAC standards

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1. PURPOSE:

The purpose of this policy is to establish the structure and operations of the Worcester Police Department's Crisis Intervention Team (CIT) and Co-Response Program, in which CIT-trained officers' partner with embedded mental health clinicians to provide specialized response to persons experiencing mental health crises, mental illness, substance-use disorders, or emotional distress.

2. POLICY:

It is the policy of the Worcester Police Department to treat persons experiencing behavioral health crises with dignity, respect, and regard for their safety. The Department is committed to de-escalation as the preferred initial response strategy, to connecting individuals with appropriate community-based services rather than unnecessary criminal justice involvement or emergency department admission, and to reducing the likelihood of use of force during encounters involving behavioral health issues. The Department operates, subject to available resources, a Crisis Intervention Team and Co-Response Program to provide specialized, clinician-supported crisis response.

3. SCOPE:

This policy applies to designated CIT officers, embedded Co-Response clinicians, case managers assigned to the CIT program, and to supervisors and personnel coordinating with CIT resources. Sections governing on-scene response, disposition, supervisory notification, and documentation apply to any sworn officer who handles a call involving a behavioral health component. Dispatch and communications center procedures are governed by the Department of Emergency Communications, a separate city agency, and are not addressed by this policy.

4. DEFINITIONS:

A. Behavioral Health Crisis

Any situation in which an individual's mental health condition, substance use, emotional distress, or developmental disability significantly impairs their ability to function safely or poses a risk of harm to themselves or others.

B. Mental Health Condition

An umbrella term encompassing mental illness, substance-use disorders, behavioral health conditions, and co-occurring disorders.

C. Crisis Intervention Team (CIT) Officer

A sworn officer who has completed a Massachusetts Department of Mental Health (DMH)–approved 40-hour CIT training program in crisis de-escalation, mental health, substance-use disorders, trauma-informed response, and community service coordination, and who maintains current CIT certification.

D. Co-Response Clinician

A master's-level licensed mental health clinician embedded in the Department who responds in the field with CIT officers to behavioral health–related calls for service.

E. Case Manager

A professional with a minimum of a bachelor's degree and a background in human services, employed for the purpose of assisting with community referrals, follow-up contacts, data collection, and program reporting.

F. Emergency Evaluation (Section 12(a))

An emergency restraint and hospitalization procedure authorized under MGL c. 123 § 12(a), permitting a physician, an advanced practice registered nurse, a qualified psychologist, a licensed independent clinical social worker, or a police officer to restrain and transport an individual to an approved facility for evaluation when the individual's behavior presents a likelihood of serious harm by reason of mental illness.

G. Section 35 Commitment

An involuntary commitment for substance-use disorder treatment authorized under MGL c. 123 § 35, initiated by petition to the court when a person's alcohol or substance use puts themselves or others at risk of serious harm.

H. Likelihood of Serious Harm

As defined under MGL c. 123 § 1, any of the following: (1) a substantial risk of physical harm to the person as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm; (2) a substantial risk of physical harm to other persons as manifested by evidence of homicidal or violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm; or (3) a very substantial risk of physical impairment or injury to the person as manifested by evidence that the person's judgment is so affected that the person is unable to protect themselves in the community and reasonable provision for their protection is not available in the community.

I. Diversion from Arrest

A decision, exercised through officer discretion, to emphasize treatment, community support, and the individual's behavioral health needs as an alternative to traditional arrest and prosecution, when permitted by law and consistent with public safety.

5. RECOGNIZING BEHAVIORAL HEALTH CRISES:

Officers should be familiar with common indicators that an individual may be experiencing a behavioral health crisis. The presence of one or more of the following indicators does not confirm a mental health diagnosis but should alert the officer that a behavioral health component may be present and that de-escalation strategies and CIT resources should be considered.

A. Behavioral Indicators

Indicators may include, but are not limited to: disorganized or incoherent speech; talking to persons not present or responding to internal stimuli (auditory or visual hallucinations); extreme paranoia or irrational fear; rapid or pressured speech with grandiose claims; flat or inappropriate emotional affect; inability to follow simple commands or engage in conversation; agitation or pacing without apparent cause; severe confusion or disorientation to time, place, or identity; catatonic behavior or complete unresponsiveness; and self-injurious behavior such as cutting, head-banging, or statements of suicidal intent.

B. Substance-Related Indicators

Indicators of substance-induced behavioral disturbance may include: extreme agitation disproportionate to the situation, signs of intoxication coupled with combativeness or self-harm, signs of withdrawal (tremors, sweating, seizure activity), and behavior consistent with stimulant-induced psychosis.

C. Contextual Factors

Officers should also consider contextual factors such as: the location of the encounter (e.g., near a behavioral health facility, shelter, or known service area); information from callers, family members, or caregivers indicating a mental health history; recurrent calls for service at the same address involving behavioral health concerns; and the individual's possession of medications associated with psychiatric treatment.

6. GUIDELINES DURING INTERVIEWS AND INTERROGATIONS:

When a person suspected of suffering from a mental health condition is the subject of an interview or interrogation, officers shall consider the following guidelines in addition to the constitutional protections required under Policy 503 (Criminal Investigations) and applicable law.

A. Assessment of Capacity

Before beginning or continuing an interview or interrogation, the interviewing officer should assess whether the individual appears to understand the nature of the questions, the Miranda warnings (if applicable), and the consequences of their statements. If there is reason to believe the individual lacks the capacity to understand these matters due to a mental health condition, officers should consult with a supervisor and, when available, request CIT clinician assessment before proceeding.

B. Interview Accommodations

Officers should: use simple, direct questions and avoid compound or leading questions; allow additional time for the individual to process questions and formulate responses; take breaks if the individual becomes agitated, confused, or distressed; document observable signs of mental

health impairment during the interview; and consider the presence of a support person, advocate, or clinician when appropriate and consistent with the integrity of the investigation.

C. Voluntariness of Statements

Officers shall be mindful that statements made by individuals experiencing active psychiatric symptoms may be subject to heightened scrutiny regarding voluntariness. If an individual's mental health condition raises concerns about the voluntariness or reliability of their statements, the officer shall document those observations and consult with a supervisor. The decision to continue the interview rests with the investigator and supervisor, informed by the totality of the circumstances.

7. CRISIS INTERVENTION TEAM (CIT) AND CO-RESPONSE PROGRAM:

A. Activation

CIT response should be requested for the following call types, and CIT officers and Co-Response clinicians, when on duty and available, should respond to: suicidal ideation or self-harm behavior; cell room evaluations; severe mental illness symptoms such as psychosis, mania, or major depression; substance-induced behavioral disturbances; well-being checks with a behavioral health component; recurrent calls at addresses with known mental health concerns; requests from responding officers once the scene is determined safe; assistance with Section 35 petitions when the subject is known to the clinician; and barricaded subjects or other crisis negotiations as described in Policy 442 (Crisis Negotiations), where a licensed clinician should be present on site when feasible.

B. Scene Safety and Clinician Entry

The route officer shall respond to the call and conduct a preliminary assessment before requesting CIT. The route officer shall conduct an initial safety assessment and ensure the scene is safe before the Co-Response clinician enters. Clinicians shall not enter a scene that presents imminent risk of physical harm until officers determine it is safe. Officers retain authority over all safety decisions regardless of clinical assessment.

C. CIT Officer Responsibilities

The CIT officer shall: assume command of the scene upon arrival; prioritize de-escalation techniques; protect the clinician and all involved parties; conduct criminal and safety assessments; arrange transportation if emergency evaluation is required; and complete a supplemental report. The route officer shall complete the initial incident report.

D. Clinician Responsibilities

The Co-Response clinician shall: lead the behavioral health assessment and crisis evaluation; determine the clinical risk level, including suicidality, potential for violence, and inability to care for self; provide immediate crisis intervention and safety planning; coordinate services, referrals, and follow-up care; assist officers in determining appropriate disposition; provide support and education to family members and others connected to the person in crisis; and provide follow-up services after the acute crisis as clinically appropriate.

8. USE OF FORCE:

The Department's Use of Force policy (Policy 400 series) applies in full to all encounters involving persons in behavioral health crisis. A behavioral health crisis does not preclude the use of lawful force when necessary. Officers shall continue to prioritize de-escalation consistent with MGL c. 6E § 14 but retain full authority to use force proportionate to any threat presented. When force is used during a behavioral health encounter, the officer shall document the de-escalation strategies attempted and the circumstances necessitating force.

9. DISPOSITION OPTIONS:

The following disposition options are available for any officer handling a behavioral health encounter, whether or not CIT is on scene. When a CIT unit is present, the clinician shall assist in determining the appropriate disposition.

A. Resolve on Scene

When the individual does not meet criteria for emergency evaluation and does not pose an immediate safety risk, officers or the CIT team may: provide brief intervention and verbal reassurance; develop or update a safety plan; and connect the individual with outpatient care, a partial program, a Community Behavioral Health Center (CBHC), or other non-acute services. Officers who resolve a call on scene involving a behavioral health component should refer the individual for CIT follow-up through the CIT unit via the initial report.

B. Voluntary Evaluation or Transport

When the individual consents to evaluation or treatment, officers or the CIT team may facilitate transportation to a crisis stabilization center, emergency department, or Community Behavioral Health Center, or facilitate admission to a detoxification or substance-use treatment program. Voluntary transport should be arranged by ambulance when medically appropriate. When transport by a Department vehicle is necessary, it shall be conducted in accordance with Policy 701 (Detainee Transportation & Guard Protocol).

C. Involuntary Emergency Evaluation (Section 12(a))

When an individual's behavior demonstrates a likelihood of serious harm by reason of mental illness as defined in MGL c. 123 § 1, a police officer, a physician, an advanced practice registered nurse, a qualified psychologist, or a licensed independent clinical social worker may apply for emergency restraint and hospitalization under MGL c. 123 § 12(a). When a Co-Response clinician is on scene, the clinician should execute the Section 12(a) application when clinically appropriate. Officers retain independent statutory authority to execute a Section 12(a) application at any time, including when no clinician is available. The application shall specify the facts and circumstances establishing the likelihood of serious harm. Transport shall be to the nearest appropriate facility authorized to receive Section 12(a) patients. Transport shall be by ambulance unless exigent circumstances require Department transport in accordance with Policy 701 (Detainee Transportation & Guard Protocol).

D. Section 35 Petition

When an individual's alcohol or substance use puts themselves or others at risk of serious harm, the CIT clinician, a family member, a physician, or a police officer may petition the court for involuntary commitment under MGL c. 123 § 35. Officers assisting with Section 35

petitions should coordinate with the CIT clinician when available and follow court filing procedures established by the district court.

E. Diversion from Arrest

When criminal behavior is minor and the individual's mental health or substance-use condition is the primary factor driving the behavior, officers may exercise discretion to prioritize treatment over arrest when permitted by law and consistent with public safety. The decision to divert rests with the officer, not the clinician. Officers electing to divert shall document the diversion decision, the offense involved, and the alternative disposition in the incident report. Diversion is not appropriate for offenses involving violence against people, domestic violence, or offenses where the victim's rights require arrest or complaint application.

10. AFTER-HOURS AND CIT UNAVAILABILITY:

When a CIT unit is not available due to scheduling, workload, or other operational factors, the responding officer shall: manage the situation using de-escalation strategies; notify a supervisor for any situation involving an involuntary evaluation, use of force, or a high-risk individual, and request supervisor response when circumstances warrant; consult with the on-call CIT clinician by phone when available for guidance on disposition; exercise independent authority to execute a Section 12(a) application when the criteria in Section 9(C) are met; and refer the individual for CIT follow-up through the CIT unit for non-emergency situations. Route officers shall not delay emergency intervention while awaiting CIT availability.

11. SUPERVISORY NOTIFICATION:

Officers shall notify a supervisor for any of the following: any involuntary Section 12(a) application, whether executed by an officer or a clinician; any use of force during a behavioral health encounter; any refusal of services by an individual assessed as high-risk by the CIT clinician; any behavioral health encounter involving a juvenile; any encounter resulting in transport to a medical facility; and any incident in which the CIT clinician or officer identifies a significant safety concern that was not resolved on scene.

12. DOCUMENTATION:

A. Officer Documentation

For each call involving a behavioral health component, the assigned officer shall complete an incident report in the Department's records management system documenting, at minimum: the names, dates of birth, addresses, and contact information for all parties involved; observed behaviors and statements made by the subject; de-escalation strategies used and their outcomes; any use of force and the justification; the involvement of CIT officers and/or clinicians; the disposition, including on-scene resolution, transport destination, arrest, or diversion; and, if a Section 12(a) was executed by the officer, the facts establishing likelihood of serious harm. When a CIT officer responds, the route officer shall complete the initial report, and the CIT officer shall complete a supplemental report.

B. Clinician Documentation

Co-Response clinician documentation is governed by clinical supervision and applicable licensing board requirements, not by this policy. Clinician documentation shall include, at

minimum, the information necessary to support the clinical disposition and any Section 12(a) application executed by the clinician. All Section 12(a) evaluations executed by a clinician shall be completed by end of the clinician's shift and forwarded to the receiving facility. All other clinician documentation should be completed within 24 hours. Officers are not responsible for ensuring completion of clinician documentation. Clinical documentation will be maintained within their own database, not the department's records management system.

C. Body-Worn Camera

Officers shall activate body-worn cameras consistent with Policy 403 (Body Worn Cameras) for all behavioral health encounters. Officers should be aware that recordings of behavioral health encounters may contain information protected under HIPAA and state mental health privacy laws. Access to and release of body-worn camera footage from behavioral health encounters shall comply with Policy 403 and applicable law.

13. FOLLOW-UP AND CASE MANAGEMENT:

The CIT clinician and/or case manager shall: provide follow-up contact within 24 to 72 hours for high-risk individuals referred by officers or other Department personnel; coordinate with community partners, outpatient providers, and family members with appropriate consent; maintain case management records for frequent utilizers of emergency services; and participate in multidisciplinary team reviews as scheduled by the CIT program.

14. COMMUNITY MENTAL HEALTH RESOURCES:

The Department shall maintain a current resource list of community mental health services available to officers and clinicians in the field. The CIT program coordinator shall update this list at least annually. Resources may include but are not limited to: Community Behavioral Health Centers (CBHCs), crisis stabilization units, emergency services programs (ESPs), detoxification and substance-use treatment programs, outpatient mental health providers, the 988 Suicide and Crisis Lifeline, the Massachusetts Substance Use Helpline, mobile crisis intervention teams operated by community agencies, and housing and social service agencies. The current resource list shall be accessible to officers through the Department's records management system or mobile data terminals.

15. CONFIDENTIALITY:

Co-Response clinicians shall comply with HIPAA, state mental health privacy laws, and their applicable licensing board requirements regarding confidentiality. Clinical information may be shared with officers only when necessary to ensure the safety of the individual, officers, or the public, or to provide essential care. Officers shall treat all health-related information obtained during behavioral health encounters as confidential and shall not disclose such information except as required for documentation, criminal proceedings, or as otherwise authorized by law.

16. PROGRAM OVERSIGHT:

The CIT program coordinator and the designated unit supervisor shall: monitor program performance metrics; review critical incidents involving CIT responses; maintain data on outcomes, diversions, and frequent utilizers; provide performance data and reports to command

staff upon request; provide required data to funding sources as specified in grant or contract agreements; maintain a current roster of CIT-trained officers, accessible to supervisors and the on-duty patrol commander; and meet at least monthly to review program efficacy, staffing, and operational needs.

17. TRAINING:

A. CIT Officers

Officers assigned to the CIT program shall complete a 40-hour CIT certification program through the Department of Mental Health (DMH) and maintain current certification as required by the program. CIT officers should receive refresher training in de-escalation and behavioral health response as directed by the CIT program coordinator and should pursue additional mental health–related training as scheduling and funding permit.

B. Co-Response Clinicians

Clinicians assigned to the Co-Response program shall complete: an orientation to police operations and safety procedures, including situational awareness; annual CJIS training to maintain access and awareness of system policies; ride-along training as determined by the clinical supervisor; periodic briefings on Department policy and legal standards as directed by the unit supervisor; and continuing education units (CEUs) as required by their licensing board, with at least one training related to crisis response, law enforcement collaboration, or cultural competency.

C. Updated Policy Training

Training on this policy, including training of affected personnel upon implementation of new or updated policy language, is governed by Policy 830 (Emergency Mental Health Procedures).

Per:

Paul B. Saucier
Chief of Police