WOONSOCKET POLICE DEPARTMENT

THOMAS F. OATES, III
CHIEF OF POLICE

TYPE OF ORDER	NUMBER/SERIES	ISSUE DATE	EFFECTIVE DATE
General Order	320.03	11/18/2025	11/18/2025
SUBJECT		**PREVIOUSLY ISSUED DATES**	
Individuals Suffering from Mental Illness		7/22/2014, 11/10/2020, 11/21/2024	
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INDEX		**DISTRIBUTION**	
Patrol Functions		All Employees	

INDIVIDUALS SUFFERING FROM MENTAL ILLNESS

I. PURPOSE

This policy intends to address the varying roles Woonsocket Police employees play in their encounters with people with mental illnesses. As first responders and law enforcers, they may encounter victims, witnesses, or suspects who have mental illnesses. While the most serious consequences of officer interactions with the mentally ill are altercations or armed confrontations, other agency personnel who may come in contact with the public also need guidance and training in dealing with the mentally ill.

As first responders, the police often may be called upon to help people obtain psychiatric attention or other needed services. The Woonsocket Police Department recognizes that helping people with mental illnesses and their families obtain the services of mental health organizations, hospitals, clinics, and shelter care facilities has increasingly become a prominent role for police, and that no single policy or procedure can address all of the situations in which personnel may be required to provide. This General Order is intended to address the most common types of interactions with mentally ill persons and guide department personnel in dealing with such individuals.

II. POLICY

It is the policy of the Woonsocket Police Department to ensure a consistently high level of service is provided to all community members. Woonsocket Police Department

employees shall afford people who have mental illnesses the same rights, dignity, and access to police and other government and community services as are provided to all citizens.

The Americans with Disabilities Act (ADA) entitles people with mental illnesses or disabilities to the same services and protections that law enforcement agencies provide to anyone else. They may not be excluded from services or otherwise be provided with lesser services or protection than are provided to others. The ADA calls for law enforcement agencies to make reasonable adjustments and modifications in their policies, practices, or procedures on a case-by-case basis. For example, if a person exhibits symptoms of mental illness, expresses that they have a mental illness, or requests an accommodation for a mental illness (such as access to medication), Woonsocket Police personnel may need to modify routine practices and procedures, take more time or show more sensitivity to extend the services or protections that would be extended to someone else in a similar circumstance.

III. PROCEDURE

A. BACKGROUND

1. While many people with mental illnesses manage symptoms successfully with the use of medications, others who do not have access to mental health services, fail to take their medications, or do not recognize that they are ill, can experience psychiatric difficulties.
2. When anyone with a mental illness comes into contact with the police department, for whatever reason or circumstance, department personnel must take extra caution to ensure that the person's rights are not violated and that they understand what is occurring. Some individuals may not have educational or communication comprehension levels sufficient to fully understand the basic Miranda rights. Simply reading these rights to someone with these types of disabilities and having the individual acknowledge that they understood may not be sufficient.
3. Officers and civilian employees must ensure that people with mental illness receive the necessary assistance to access services. This may require time and patience beyond what is normally provided.
4. People with mental illness may also be suspects or arrestees and require detention, transport, and processing. Employees must familiarize themselves with the proper methods of transport, arrest, and detention to ensure officer safety while providing all reasonable support to an arrestee with a mental illness.
5. Officers and civilian employees must recognize that responses of people with certain mental illnesses may resemble those of people who have abused substances such as alcohol or drugs. Individuals may appear as though they are on a substance or intoxicated, but rather have not taken their prescribed medication for their mental illness.

B. MENTAL ILLNESS

1. Any of various conditions characterized by impairment of an individual's normal cognitive, emotional, or behavioral functioning, and caused by social, psychological, biochemical, genetic, or other factors, such as infection or head trauma. These conditions may substantially interfere with a person's ability to meet the ordinary demands of living, regardless of the cause or origin of the disease.
2. The terms "mental illness", "emotional illness", and "psychological illness" describe varying levels of a group of disabilities causing disturbances in thinking, feeling, and relating.
3. It has been estimated that ten percent of the population of the United States has some type of mental illness.

C. MEMORY IMPAIRED PERSONS

1. Alzheimer's disease causes intellectual deterioration in adults severe enough to dramatically interfere with occupational or social performance.
2. These disorders are not only found in older people. The youngest diagnosed case is age 22; however, most victims are people in their 40s and 50s when diagnosed. Many Alzheimer's victims tend to wander, mentally and physically, sometimes in an attempt to return to their past. The rate of deterioration differs from patient to patient.
3. Establishing a level of communication with memory-impaired persons is essential to render assistance. Caution should always be exercised when an officer encounters memory-impaired persons.
4. An important function of the officer is to assist with the reuniting of memory-impaired victims with family members or primary care providers in a timely fashion, utilizing available resources.

D. COMMON SYMPTOMS *RI 7.8(a)*

1. Although officers are not in a position to diagnose mental illness, officers shall be alert to symptoms common to such illnesses.
2. Symptoms of mental illness may vary, but all mentally ill persons have thoughts, feelings, or behavioral characteristics that result in an inability to cope with the ordinary demands of life.
3. While a single symptom or isolated event does not necessarily indicate mental illness, professional help should be sought if symptoms persist or worsen. The following may be useful in recognizing warning signs of mental illness:

    a. Social Withdrawal

        1) Sitting and doing nothing;
        2) Withdrawal from family and friends; abnormal self-centeredness;

3) Dropping out of activities such as occupations and hobbies, or
4) A decline in academic or athletic performance.

b. Depression

1) Loss of interest in once pleasurable activities;
2) Expression of hopelessness, helplessness, inadequacy;
3) Changes in appetite, weight loss, or sometimes gain;
4) Behaviors unrelated to events or circumstances;
5) Excessive fatigue and sleepiness, or an inability to sleep;
6) Pessimism; perceiving the world as "dead"; or
7) Thinking or talking about suicide.

c. Thought Disorders

1) Inability to concentrate or cope with minor problems;
2) Irrational statements. Poor reasoning, memory, and judgment. Expressing a combination of unrelated or abstract topics. Expressing thoughts of greatness, e.g., a person believes they are God. Expressing ideas of being harassed or threatened, e.g., CIA monitoring thoughts through the TV set;
3) Peculiar use of words or language structure. Nonsensical speech or chatter. Word repetition – frequently stating the same or rhyming words or phrases. Extremely slow speech. Pressured speech – expressing urgency in the manner of speaking; or
4) Excessive fears or suspiciousness. Preoccupation with death, germs, guilt, delusions, and hallucinations.

d. Expression of Feelings

1) Hostility from one formerly passive and compliant. Argumentative, belligerent, unreasonably hostile. Threatening harm to self or others. Overreacting to situations in an overly angry or frightening way;
2) Indifference, even in highly important situations. Lack of emotional response;
3) Inability to cry, or excessive crying;
4) Inability to express joy;
5) Inappropriate laughter. Reacting with the opposite of expected emotion – e.g., laughing at an auto accident; or
6) Nonverbal expressions of sadness or grief.

e. Behavior

1) Hyperactivity or inactivity, or alterations between the two. Talking excitedly or loudly. Manic behavior accelerated thinking and speaking;

2) Deterioration in personal hygiene and appearance. Bizarre clothing or makeup, inappropriate to the environment – e.g., shorts in the winter, heavy coats in the summer;
3) Involvement in automobile accidents;
4) Drug or alcohol abuse;
5) Forgetfulness and loss of valuable possessions;
6) Attempts to escape through geographic change, frequent moves, or hitchhiking trips;
7) Bizarre behavior – staring, strange postures or mannerisms, lethargic, sluggish movements, repetitious or ritualistic movements;
8) Decorations – Inappropriate use of household items, e.g., aluminum foil covering windows;
9) "Pack ratting" waste matter/trash – accumulation of trash, e.g., hoarding string, newspapers, paper bags, clutter, etc.;
10) Unusual sensitivity to noises, light, colors, clothing, or
11) Changes in sleeping and eating habits.

f. Cognitive Impairments

1) Disorientation in time, place, or person. Confusion, incoherence, and extreme paranoia;
2) Inability to find the way in familiar settings;
3) Inability to solve familiar problems;
4) Impaired memory of recent events;
5) Inability to wash and feed oneself, urinary or fecal incontinence. Presence of feces or urine on the floor or walls;
6) The degree to which these symptoms exist varies from person to person according to the type and severity of the mental illness. Many of these symptoms represent internal, emotional states that are not readily observable from a distance but are noticeable in conversation with the individual. Often, symptoms of mental illness are cyclic, varying in severity from time to time. The duration of an episode can also vary from weeks to months for some, and many years or a lifetime for others.

E. COMMON ENCOUNTERS

1. Officers should be prepared to encounter a person with a mental illness at any time.
2. Common situations in which such individuals may be encountered include, but are not limited to, the following:

a. Seizures: Mentally ill persons are more subject to seizures and may be found in medical emergencies.

b. Disturbances: Disturbances may develop when caregivers are unable to maintain control over mentally ill persons engaging in self-destructive behaviors.
c. Wandering: Individuals with mental challenges may be found wandering or engaging in repetitive or bizarre behaviors in a public place.
d. Strange behaviors: Repetitive and seemingly nonsensical motions and actions in public places, inappropriate laughing or crying, and personal endangerment; and
e. Offensive or suspicious persons: Socially inappropriate or unacceptable acts, such as ignorance of personal space, the annoyance of others, and inappropriate touching of oneself or others, are sometimes associated with the mentally ill person who is not conscious of acceptable social behaviors.

F. RESPONSE TO PEOPLE WITH MENTAL ILLNESS *RI 7.8(b)*

1. People with mental illness can be easily upset and may engage in tantrums or self-destructive behavior. Minor changes in daily routines may trigger these behaviors.
2. Frequently, a family member or friend is of great value in calming an individual exhibiting unusual behavior as a result of mental or emotional impairment.
3. The following guidelines detail how to approach and interact with people who may have a mental illness, and who may be a crime victim, witness, or suspect. These guidelines should be followed in all contacts, whether on the street or during more formal interviews and interrogations. While protecting their safety, the safety of the person with mental illness and others at the scene, the officer should:

    a. Speak calmly: Loud, stern tones will likely have either no effect or a negative effect on the individual.
    b. Use non-threatening body language: Keep your hands by your sides if possible;
    c. Eliminate commotion: Eliminate, to the degree possible, loud sounds, bright lights, sirens, and crowds, moving the individual to a calm environment, if possible;
    d. Keep animals away: Individuals with mental illness are often afraid of dogs or other large animals;
    e. Look for personal identification: Medical tags or cards often indicate mental illness and will supply a contact name and telephone number.
    f. Call the caregiver: The caregiver is often the best resource for specific advice on calming the person and ensuring the officer's safety until the contact person arrives.
    g. Prepare for a lengthy interaction: Mentally ill individuals should not be rushed unless there is an emergency. Repeat short, direct phrases: Too much talking can distract the mentally ill individual and confuse the situation.
    h. Be attentive to sensory impairments: Many mentally ill individuals have sensory impairments that make it difficult to process information. Officers

should not touch the person unless necessary, use soft gestures, avoid quick movements, use simple and direct language, and don't automatically interpret odd behavior as belligerent.

i. In many situations, and particularly when dealing with someone who is lost or has run away, the officer may gain an improved response by accompanying the person through a building or neighborhood to seek visual clues.
j. Be aware of the different forms of communication. Mentally ill individuals often use signals or gestures instead of words or demonstrate limited speaking capabilities;
k. Don't get angry, maintain a safe distance, and
l. Once sufficient information has been collected about the nature of the situation and the situation has been stabilized, there is a range of options officers should consider when selecting an appropriate disposition. These options include the following:

1) Refer or transport the person for medical attention if they are injured or abused;
2) Outright release;
3) Release to the care of family, caregiver, or mental health provider;
4) Refer or transport to substance abuse services;
5) Assist in arranging voluntary admission to a mental health facility if requested;
6) Transport for involuntary emergency psychiatric evaluation if the person's behavior meets the criteria for this action; or
7) Arrest if a crime has been committed.

4. Use of Force Encounters: Officers will only use that amount of force that is objectively reasonable given the circumstances and consistent with General Order *300.01 Response to Resistance.* *RI 7.8(d)*

G. RESPONDING TO A MISSING CHILD WITH AUTISM

1. Most children with autism tend to look for sensory stimulation when they are going through an episode. Statistics show children with autism tend to go towards water, as the sun or light flickering off the water is a sensory stimulation to them. Some will enter the water and sink to the bottom, and just look up at the light flickering off the water, as it is a form of their sensory stimulation, ultimately leading to them drowning.
2. Communications Center Responsibilities

a. Dispatch all available units to the area to include Detectives and all other available units.

1) Obtain as much information as possible on the missing autistic juvenile.
a) Age

b) Height
c) Weight
d) Any marks that may help identify the juvenile
e) The clothes the juvenile was wearing last
f) The time the juvenile was last seen, and
g) If the juvenile has any major illnesses or any important medications, and
h) If the autistic juvenile is verbal or non-verbal.

2) Send one (1) unit to the house to meet with the family and check the house/yard. If there is a pool at the house, have the officer check that first.

b. Communications personnel should pull up Google Maps and type in the address where the autistic juvenile lives and view the map from the satellite view.

1) Communications personnel should start checking Google Maps for any houses in the proximity of the missing autistic juvenile's house and look for houses with pools or any other major body of water.
2) Send a unit to each house with a pool or a body of water.

c. Communications personnel should log each house that is checked by an officer.
d. Once all houses with pools and bodies of water are checked, normal searches for the missing autistic juvenile can proceed.

3. Responding Officer's Procedure:

a. The primary officer will respond to the house from which the autistic juvenile is missing and immediately check if there is a pool. The pool should be checked before going into the house and speaking with the family.
b. Once the pool is checked, if there is one, the primary officer should immediately obtain as much pertinent information to confirm the information dispatch received is accurate and check the residence to see if the juvenile is hiding. If there are any sheds, campers, boats, etc., those should be checked as well.
c. All responding units will begin to check the areas assigned to them that have pools and bodies of water near the missing juvenile's house or the area from which the juvenile is missing.
d. Once all the bodies of water are checked, then normal checks of parks, family member houses, and other places that the missing juvenile frequents.
e. If the juvenile is located, immediately advise the Communications Center and request a rescue for an evaluation of the missing juvenile.
f. All cruisers have the "Found Child Program" packets in them.

1) Officers should provide the family with a packet after the juvenile is located.
2) A picture should be taken of the juvenile in the event they go missing again.
3) The packet should be returned to Dispatcher Roy or Detective Johnson so it can be placed in the "Found Child Program" binder.

g. The drone, as well as a K9 team, can be activated upon supervisor approval.

H. INTERVIEW AND INTERROGATION

1. Officers attempting to interview a mentally ill individual should consult a mental health professional and the Attorney General's office to determine if the person understands Miranda rights.
2. If the mentally ill person is a witness, officers should:

   a. Not interpret lack of eye contact or strange actions as indications of deceit;
   b. Use straightforward language;
   c. Do not employ common interrogation techniques, suggest answers, attempt to complete thoughts of persons slow to respond, or pose hypothetical conclusions; and
   d. Recognize that the individual might be easily manipulated and highly suggestible.

I. CUSTODY

1. If an individual with a mental, emotional, or psychological illness is taken into custody, officers will make a responsible effort to use the least restraint possible and protect the arrestee from self-injury, while taking all necessary precautions. The overall circumstance and the person's potential for violence will determine if handcuffs will be used as a temporary measure to prevent injury to the individual or officer.
2. In a misdemeanor incident where an individual is mentally ill, officers may seek non-arrest resolutions. The most desired resolution is voluntary admission to an appropriate mental health facility. However, when public safety is at issue, officers will follow RI General Law §40.1-5-7, regarding involuntary emergency evaluation:

J. VOLUNTARY ADMISSION

The three following scenarios would indicate minimal officer involvement.

1. Persons who appear to need psychiatric evaluation and do not appear to pose an imminent danger to themselves or others should be referred to a mental health facility. (A family member or other responsible person is often available to assist

the disturbed person in seeking such treatment and should be provided with the information necessary to secure the needed help.)

2. Persons who have been or are under the care of a private physician should be referred to the physician if possible.
3. Persons who voluntarily agree to a psychiatric evaluation will be taken to the Landmark Medical Center, Community Care Alliance, or another appropriate facility.

K. INVOLUNTARY ADMISSION

1. A higher level of law enforcement intervention will be required when officers encounter the following scenarios:

    a. The person is imminently dangerous to self or others;
    b. The person is unable to care for themself (unable or refuses to accept intervention which would meet minimum needs for food, clothes, shelter, or physical well-being); or
    c. The person is suffering substantial physical deterioration and shows an inability to function if not treated immediately.

2. Officers can respond with the most appropriate of the following alternatives for involuntary admissions to a psychiatric hospital:

    a. Police Officers, who have personally observed the actions of the individual and have reason to believe that the person is in clear and imminent danger of causing personal harm to themself or others, shall ensure the individual is evaluated. The normal procedure will be to have rescue transport the individual.

    b. Officers should consider and weigh the possible outcomes of any enforcement actions under this provision and whether those actions are likely to create a greater likelihood of potential harm to the individual in crisis or to officers than would exist if they were to leave the individual in their current state in the hope that their condition would alleviate on its own. If officers and/or mental health professionals conclude that police involvement is more likely to result in harm to the individual, officers, or the community, then the safest and most reasonable and prudent decision may be to allow the individual to remain where they are and urge them to seek voluntary mental health treatment.

        1) For example, if an individual communicates in some form that they are contemplating self-harm, but do not appear to have the means, willingness or opportunity to follow through with those statements, officers forcing entry into a residence or other building to make contact with the individual may result in a force encounter that is more likely to lead to injury to the

individual or others than if no entry was made and officers vacated the scene after offering access to voluntary treatment.

c. Landmark Medical Center in Woonsocket is the primary hospital. However, rescue personnel make the determination of which hospital the patient is ultimately transported to (considering hospital status, medical injuries, etc.).
d. Rescue personnel should be informed of the observations of the officer that led to the evaluation request.
e. Based on the demeanor of the patient and the patient's report to the officer(s), Police and rescue personnel should work together to determine the best course of police involvement in the transport.

    1) Ex. The police may ride in the rescue, follow the rescue to the hospital, or not be involved in the transport.

f. The officer must complete an incident report detailing the circumstances of the event(s) they observed, which led to the involuntary admission evaluation.

L. AVAILABLE RESOURCES *RI 7.8(c)*

1. Landmark Medical Center Psychiatric Unit (401) 769-4100
2. Community Care Alliance, Woonsocket (401)-235-7121 for non-emergency screening and intake services.

    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 # 401-235-7120)

3. National Alliance for the Mentally Ill of Rhode Island (NAMI) 82 Pitman St. Providence, RI, 02906. (401)-331-3060, 1-800-749-3197, namirhodeisland.org

    a. Assists local affiliates in providing information and support for hundreds of Rhode Island families living with mental illness.
    b. Present education programs, including a family-to-family education course, presentations in schools, and training for mental health professionals. They also run lectures, workshops, and a yearly conference.
    c. Advocate with policymakers, legislators, and opinion leaders for the interests of people with mental illness.
    d. Promotes expanded research into mental illness and spreads the word when new developments occur.
    e. Monitor state and local mental health care facilities and agencies to ensure quality care and to promote good relations between families and professionals.

4. Mental Health Association of Rhode Island, Mental Health Association of Rhode Island 345 Blackstone Blvd., Sawyer Bldg., Room 310 Providence, RI 02906, (401)-726-2285 mhari.org

M. TRAINING *RI 7.8(e)*

1. To prepare personnel who, during their duties, may have to deal with persons with mental illnesses appropriately, the Woonsocket Police Department shall provide entry-level personnel with training on this subject and will provide refresher training annually.

    a. Newly hired personnel shall receive training in department procedures outlined in this General Order as part of the Field Training Program.
    b. Refresher training for all personnel will include, but not be limited to, Policy review during staff meetings, roll call training, and in-service programs.

Per order,

Thomas F. Oates, III

Chief of Police

Written directives published within PowerDMS are in full force and effect on the referenced dates and have been approved by the Chief of Police.

§ 40.1-5-7 Emergency certification. – *(a) Applicants.* (1) Any physician, who after examining a person, has reason to believe that the person requires immediate care and treatment, and is one whose continued unsupervised presence in the community would create an imminent likelihood of serious harm because of mental disability, may apply at a facility for the emergency certification of the person thereto. The medical director or any other physician employed by the proposed facility for certification may apply under this subsection if no other physician is available and they certify this fact. If an examination is not possible because of the emergency nature of the case and because of the refusal of the person to consent to the examination, the applicant based on their observation may determine, per the above, that emergency certification is necessary and may apply therefore. If no physician is available, a qualified mental health professional or police officer who believes the person to be in need of immediate care and treatment, and one whose continued unsupervised presence in the community would create an imminent likelihood of serious harm because of mental disability, may make the application for emergency certification to a facility. Application shall in all cases be made to the facility which in the judgment of the applicant at the time of application would impose the least restraint on the liberty of the person consistent with affording him or her the care and treatment necessary and appropriate to their condition.