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Police Interactions with Individuals in Psychiatric Crisis

A Briefing Prepared for Michael A. Cardozo
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Introduction

As representatives of the mental health community in New York City and New York State, we write about an issue of growing concern: whether members of the New York City Police Department (NYPD) are inadequately trained to interact with individuals experiencing a psychological crisis. In the summer of 2001, an important dialogue was started among representatives of the NYPD, the New York City Law Department and representatives of the mental health community. For understandable reasons, the events of September 11th abruptly ended that dialogue. We hope to revive those efforts at this time.

The following briefly describes what we see as nothing short of a crisis in police-community relations. While the NYPD has taken steps to improve interactions with particular community groups in New York City (*e.g.*, people of color, ethnic groups, the gay and lesbian community, victims of domestic violence), there is a pervasive fear among mental health consumers, providers and families that police officers in New York City do not receive adequate training to interact appropriately and peacefully with individuals suffering from psychiatric disabilities.

There is a painful public memory of the high profile interactions between the NYPD and individuals with psychiatric disabilities that have resulted in the death of New Yorkers over the years: Eleanor Bumpers, Gidone Busch and Kevin Cerbelli. In addition to these well-publicized incidents, many consumers and their families have had strained interactions of their own with members of the NYPD. These public and private experiences have created a perception that a cry for help to the NYPD in the event of a psychiatric crisis can have unintended results: injury

or even death. While we recognize that such outcomes are rare, they call into question the NYPD's training and protocols and create fear and uncertainty in the mental health community.

The events of September 11th have heightened such concern. Members of the NYPD experienced unspeakable personal trauma; New Yorkers of every background are dealing with psychological and emotional problems; the stressful aftermath can exacerbate the symptoms of the mentally ill. These factors, coupled with the new police commissioner's intention to crack down on "quality of life" crimes, lead us to fear an immediate increase in the number of interactions between individuals in crisis and the NYPD, at a time when the NYPD is already taxed to the limit by other critical needs.

We hope to revive our dialogue with the new mayor and police commissioner on the subject of improving police relations with the mental health community. First and foremost, we ask Mayor Michael Bloomberg to appoint a "blue ribbon" Commission to review this crisis in police-community relations. The members of this Commission would represent all sectors of the community: the NYPD, public health officials and other government representatives, educators, mental health professionals, representatives of the criminal justice system, institutional providers, consumers, family members of individuals with psychiatric disabilities and advocates for the mentally ill. They would work collaboratively to study the issues, make recommendations, propose pilot programs, and serve as an important channel for communication between the mental health community and the NYPD. The recent opening of the Mental Health Court in Brooklyn, intended to keep the mentally ill from getting trapped in revolving-door justice, suggests the timeliness of this initiative concerning the initial contacts between the mentally ill and the criminal justice system. We believe that a collective effort is the most

effective way to improve police interactions with individuals in crisis and police relations with members of the mental health community in general.

The Organization of this Report

This three-part report is meant to serve as a briefing on the status of relations between the NYPD and the mental health community in New York City.

Section 1 provides an overview of the problem and discusses the frequency of interactions between the police and individuals in psychological crisis, the NYPD training program and NYPD protocols for such interactions.

Section 2 addresses concerns we have about the adequacy of the NYPD's approach to interactions with individuals in crisis when measured against state and federal law.

Section 3 proposes the scope of the Commission's inquiries.

We conclude that improved police-community relations in this area will make New York City safer: for the police, for the general public and for individuals with psychiatric disabilities.

Section I. Overview of the Problem

The Frequency of Interactions Between the NYPD and Individuals in Crisis:

By every available indication, it appears that encounters between the NYPD and individuals in psychiatric crisis[1] -- referred to here as crisis interventions -- occur with great frequency. In 1999, the last year for which such records have been made available by the NYPD, police records indicate that the NYPD responded to approximately 64,000 emergency

calls classified by 911 dispatchers as "EDPs" (police terminology for "Emotionally Disturbed Persons"); that only 551 of the 64,000 EDP calls resulted in arrest in that year; and that 24,788 calls resulted in police-escorted transportation to hospitals. Thus, even according to its own records, in 1999 the NYPD received, on average, more than 175 such calls every day. This makes the NYPD the largest *de facto* psychiatric outreach team in the world.

There are several reasons why we believe the numbers on both emergency calls and subsequent arrests are actually misleadingly low. First, the 911 system does not capture all crisis interventions, only those resulting from a 911 telephone call. When members of the NYPD come into contact with a consumer in crisis as a result of the officers' own observations -- for example, on a subway platform or street corner -- such interactions are not recorded in the 911 system. Indeed, as the City gears up for a new initiative on "quality-of-life" crimes, it is likely that the number of these interactions will only increase.

As to those crisis interventions that do originate in a 911 call, the initial classification of a call as an "EDP" is one made by the 911 dispatcher based on a split-second assessment of the situation; many of these calls are then re-classified by the NYPD. According to the NYPD, the responding officers may determine (1) that the classification is "unfounded" because the incident does not involve an individual in crisis, or (2) that the incident involves a crime, so that the "EDP" classification is changed to a crime, such as "resisting arrest" or "assaulting an officer." Furthermore, although the NYPD maintains that only a small percentage of so-called "EDP" calls result in an arrest, we know that literally tens of thousands of individuals with serious and persistent mental illnesses cycle through the City jail system in a given year. Indeed, a recent

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[1] Common terms used in the mental health community for individuals with psychiatric disabilities are "consumers of mental health services" or, simply, "consumers".

article announcing the opening of the Mental Health Court in Brooklyn noted that mentally ill persons represent "up to 30% of defendants arraigned in the borough . . . ."[2] We are thus compelled to reach the following conclusions: first, that the NYPD's interactions with consumers exceed the number of interactions classified as EDPs; and, second, that far more of these interactions result in arrest than the reported figures suggest.

Despite the fact that the compilation and dissemination of information, primarily through the COMPSTAT system, has been a critical tool in the reduction of crime throughout New York City, the NYPD seems resistant to develop a more accurate picture of its interactions with consumers in crisis or to disseminate publicly what little information it might have in this area. Indeed, for several years, academics, mental health professionals, advocates, family members of individuals with psychiatric disabilities who have been injured in interactions with the police, and members of the general public have attempted, with limited success, to obtain a range of information from the NYPD concerning its interactions with consumers in crisis.

The failure to capture accurate data concerning police interactions with individuals in emotional or psychiatric crisis, coupled with the NYPD's resistance to releasing what data it does collect, only exacerbates tensions in police relations with the mental health community. The NYPD currently collects a wide range of information, including the gender, race, and age of individuals with whom it comes in contact, as well as such other information as "identifying marks", "tattoos", "graffiti tags/ nicknames", height, weight, eye color, hair color, and ethnicity, to name just a few of these items. Critical to improvements in this area, the NYPD will

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[2] Denise Buffa, "Brooklyn gets 'Mental' Court," *N.Y. Post*, January 21, 2002

necessarily need to develop a comprehensive methodology for assessing both the number and outcome of crisis interventions.

NYPD Training[3]

The Academy training of recruits lasts for almost eight months. Of this training period, only 12 hours are devoted to dealing with individuals in psychiatric crisis; the content of those 12 hours appears to be relatively academic in nature, defining basic terms and learning a little about abnormal psychology.[4] To our knowledge, cadets are not given an opportunity to practice interventions with role-playing or to differentiate the tactics that might be appropriate in dealing with different symptoms of mental illness.

Every other law enforcement officer in the State, except New York City officers, receives the "Police Mental Health Training Program," a comprehensive program developed by the New York State Office of Mental Health (NYSOMH) in conjunction with the New York State Division of Criminal Justice Services (NYSDCJS), the Ulster County Department of Mental Health and the NYPD. This program is mandated by the Municipal Police Training Council for the Basic Course for Police Officers and is also used to train supervisors and for in-service training. The train-the-trainer course includes extensive role-playing of typical situations encountered by police involving civilians in a crisis and includes the participation of mental health instructors as part of the teaching team. Although the NYPD was a major participant in

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3 We admit to some ignorance about the current NYPD training materials, both at the recruit and officer levels and would welcome the opportunity to become better informed. Repeated FOIL requests have not been an effective means of educating ourselves.

4 *See*, *e.g.*, Police Student's Guide, Social Science Lesson # 31 *et seq.*, Understanding Emotional Disturbance April, 1997 Revision.

the design and content of this statewide "Police Mental Health Training Program," it never implemented the program in the training of its own police recruits, for reasons now lost to history.

We believe the absence of any "hands on" training using role-playing techniques and mental health professionals are significant shortcomings in the City's training program. The NYPD curriculum appears to emphasize isolation, containment, cover, concealment and verbal commands, the very same tactics that are used in dealing with any crisis situation. Similarly, the weapons training program includes training in the use of non-lethal weapons such as tasers and pepper spray but does not attempt to distinguish the use of those weapons with individuals experiencing emotional or psychiatric crisis. Seemingly, the Academy curriculum does not offer any specialized training for techniques to use with persons in a state of psychiatric crisis. As Dr. James O'Keefe the Academy's director of training has stated, "I don't have a specific procedure that I teach about how to deal with an emotionally disturbed person."[5]

There is also a question whether the Academy's trainers or teachers are themselves adequately trained to deal with crisis interventions. Law enforcement trainers throughout the State participate in the train-the-trainer course described above under the auspices of NYSOMH and NYSDCJS. Although the NYPD has sent some officers to participate in this train-the-trainer curriculum from time to time, we believe that all officers and trainers should be enrolled in the program over a period of time. This is apparently not a financial issue, since most of the costs are assumed by the State.

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[5] David Noonan, "Is Cops' Training OK? First on the Scene Often Don't Know the Drill," *N.Y. Daily News*, September 5, 1999 at 35.

The NYPD might address any shortcomings of the Academy curriculum by offering appropriate and extensive follow-up or "in-service" training once recruits become officers in the field. Unfortunately, the NYPD offers few refresher or remedial training opportunities to officers in how to deal with these crisis situations once they leave the Academy.

In-service Tactical Training ("INTAC") is a two-day, continuing training program provided by the NYPD for experienced officers. INTAC training is a generalized program, and while not focusing specifically on dealing with situations involving a psychiatric crisis, each officer participates in one "EDP" role play scenario. As with the Academy curriculum, no attempt is made to teach responses that take into account a person's particular psychiatric disability or symptoms. In fact, a supposed EDP role-play might not include someone with a psychiatric disability at all; it could present a hostage scenario or one in which an individual is barricaded in an apartment.

Compounding matters, patrol supervisors may receive inadequate training in methods for dealing with individuals in crisis. According to police protocols, patrol supervisors -- either sergeants or lieutenants -- are alerted whenever a 911 call is identified as involving an "EDP". Although patrol supervisors purportedly carry non-lethal weapons, they are not specially trained to deal with individuals with psychiatric disabilities nor in the use of such non-lethal weapons in interactions with such individuals. Furthermore, patrol supervisors receive additional training at the NYPD's Leadership Development Institute, where they are taught to view consumers as human beings who deserve to be treated with the same respect and dignity, and in the same professional manner, as members of the general public. Aside from attempting to teach basic, non-discriminatory responses to individuals with psychiatric disabilities, a laudable goal, the supervisors receive little specialized *tactical* training in how to respond to consumers in crisis.

And, as with patrol officers, there is no indication from the NYPD that the staff used to train supervisors are properly certified or otherwise trained to conduct mental health training. Furthermore, there is no attempt to ensure that supervising officers pass on such training or techniques to officers in their command.

In fact, the only members of the NYPD who receive intensive mental health training -- on a voluntary basis --are those officers assigned to the Emergency Services Unit (ESU). ESU officers, who total 400 out of a police force of roughly 40,000, are only *offered* the opportunity to receive a full week of *elective* Emergency Psychological Training, a program developed after the 1984 shooting of Eleanor Bumpers. ESU officers who choose to participate in this training are provided with instruction in the specific characteristics of particular mental illnesses so that they can recognize the symptoms of depression, schizophrenia and other illnesses and respond in a manner that accommodates and is appropriate to those disabilities. ESU training features actors who role-play various mental illnesses in frequently encountered situations and trainers from the Leadership Development Institute conduct simulations as part of ESU training. But the ESU does not serve, and was not intended to serve, as the primary response to "ordinary" EDP calls. The ESU is an elite unit, and deals primarily with the City's most dire emergencies. (Indeed, 14 of the 23 NYPD officers who died at the World Trade Center were from the ESU.) The ESU is therefore not designed to handle the large volume of daily EDP calls, most of which are routine by NYPD standards. In fact, according to NYPD data from 1999, the ESU arrived at the scene in only one of every nine EDP calls in that year. Accordingly, assuming these statistics remain consistent through the present, most consumers in crisis are denied the benefit of what special training the ESU receives.

NYPD Protocols

A review of the NYPD's crisis intervention protocols suggests several shortcomings. First and most important, there is no assurance that officers with the best training for dealing with consumers reach the scene where their expertise might be desperately needed or that those officers who do respond are equipped with the most effective non-lethal weapons. Further, the NYPD has no systematic method for referring individuals in crisis to mental health providers. The effects of these police protocols are exacerbated by hospital procedures that have a tendency to promote arrest over hospitalization, increasing the prevalence of the use of the criminal justice system as a proxy for treatment.

- ***911 Protocols for Deploying Officers***

The best trained officers, those of the ESU, are rarely available to respond to 911 "EDP" calls. ESU units are not stationed in a decentralized way throughout each borough as is the case with local precinct houses. There is only one ESU unit for every three to four precincts, and these units are stationed in centralized locations throughout the City. As a result of this centralization, ESU officers arrive on the scene in only one of every nine EDP situations, even though they are notified of an EDP emergency by the 911 dispatcher at the same time as the local precinct. Additionally, because of the decentralized location of the precincts, it is unclear if ESU officers are *ever* the first officers on the scene in EDP interventions, despite the fact that the first moments in a crisis situation can literally mean the difference between life and death.

- ***Weapons Protocols***

Under the current system, the most likely respondents to an EDP call -- ordinary patrol officers -- are the least likely to carry effective non-lethal weapons. They do not carry many of

the non-lethal weapons available to patrol supervisors and ESU officers, such as stun guns and Y-bars. Instead, patrol officers carry pepper spray, a product that can actually worsen the symptoms or increase the agitation of an individual in crisis. For these reasons, the use of pepper spray is widely discredited as a means of restraining individuals experiencing psychiatric emergencies. Notwithstanding the availability of other non-lethal weapons -- for example, the "bean bag gun" -- that briefly incapacitate but do not aggravate, the individuals upon whom they are used, it is pepper spray that the NYPD routinely uses as the weapon of choice in such situations.

Another key to the patrol officers' response to EDP calls is the "zone of safety" protocol. As part of the NYPD goal of containing an individual in crisis, officers attempt to surround him or her, maintaining a radius of 20 feet and permitting an officer to use *deadly* force if the 20-foot "zone" is compromised. The efficacy of this tactic is uncertain. Many consumers in crisis act out of fear rather than aggression. A show of force, such as surrounding someone with guns drawn (or even without guns drawn), might influence a mentally healthy person to surrender but have an adverse effect on an individual experiencing a psychiatric crisis, leaving such person less able to respond to the officers' commands.

The "zone of safety" and the use of pepper spray suffer from a common flaw: they tend to further excite or frighten someone who is already experiencing some personal crisis, leading to additional risks for the police as well as the individual.

- ***Protocols for "Unfounded" Calls***

Even in situations where officers decline to intervene -- that is, where officers arrive at the scene and determine that no police action is necessary -- the NYPD's failure to take any

action may be short-sighted. When members of the NYPD encounter an individual in crisis who is not committing a crime, they currently have two basic options: transport the person to the hospital or do nothing at all.[6] The police may only transport a person to the hospital if the officers on the scene determine that the individual presents a danger to self or others. This determination is made, far more often than not, by a front-line officer who has received no specialized training in dealing with individuals with psychiatric disabilities. If no danger is presented, the police have no option currently but to leave the scene. In most cases, the only assistance the police can offer is "non-assistance." That is, the police do nothing at all. Predictably, this pattern of non-assistance can lead to repeat incidents, often after the initial crisis has escalated. Training officers to make referrals to mental health providers in the community in situations where police intervention is not needed might decrease the number of times a consumer might spiral into crisis, thereby reducing the number of police interventions.

In 2001, the NYPD began a pilot program under which officers in several precincts were asked to hand out a card to consumers in crisis in "unfounded" cases. On the card was information listing the phone number of "Lifenet," a mental health referral service. This program was expanded recently so that all line officers are supposed to have these cards at their disposal. It would be of great use to study the effectiveness of these efforts.

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[6] Indeed, there is a relatively new NYPD policy that discourages taking mentally ill persons to criminal facilities: "*UNDER NO CIRCUMSTANCES WILL AN EDP BE TRANSPORTED TO A POLICE FACILITY*." Police Science Course, Lesson #25 - EDPs and the Mentally Ill, May 18, 2001 revision at p. 5 (emphasis in original). We would be interested to know how this policy has worked in practice.

- ***Hospital Protocols***

If the responding officers on the scene determine that a consumer has not committed a crime but needs medical or psychiatric attention, they have the discretion to take the consumer to a local hospital. Because of present New York City Health and Hospital Corporation (HHC) protocols, however, police officers escorting consumers may not leave that individual until he or she is officially admitted. Prior to admission, the hospital medically screens the individual for infectious diseases like tuberculosis. The entire process takes hours -- sometimes over 24 hours -- and the police may not leave until it is completed. Given this practice, officers often determine that it is far easier to (1) arrest the individual and take him or her through central booking, or (2) leave the scene, once it is concluded that the individual does not pose a threat to himself or herself or others.

In 1998, the Comprehensive Psychiatric Emergency Program (CPEP) was developed by the New York City Department of Mental Health working in conjunction with other private and public groups but never implemented. CPEP involved an arrangement between hospitals and geographically related police precincts in which the police officer arriving at a psychiatric emergency room would provide a prescribed "release form" to the psychiatric staff; the hospital would accept custody of the consumer; and the police officer could then go back to his or her job. The CPEP program was created with a training film as well as the release form but, unfortunately, never fully put into effect.

Because we do not expect the NYPD to have any control over HHC protocols, representatives from the public and private hospital sector must necessarily be part of the revived efforts.

Section II. Legal Considerations

The NYPD's training programs and protocols for dealing with individuals in emotional or psychiatric crisis are not only bad policy, they may also violate federal and state law. Since we wish to pursue a constructive dialogue, not an adversary proceeding, this briefing quickly summarizes the potential legal arguments.

Federal theories

On the Federal side, there are two principal statutory remedies: the Americans with Disabilities Act (ADA) and 42 U.S.C. § 1983 (the so-called Civil Rights Act). Under the ADA, each public entity, which includes police forces, must evaluate its services to ensure compliance with the non-discrimination mandates of the ADA. Following this self-evaluation, a government entity must promulgate a "transition plan" detailing proposed changes necessary to accommodate the needs of the disabled, consistent with the ADA. Such a transition plan must contain specific proposed changes as well as timetables for such changes, and the failure of a government entity to meet these obligations is actionable. We believe the NYPD has not complied with these ADA requirements.

Under the substantive provisions of the ADA, the NYPD is required to approach crisis interventions in a manner that accommodates an individual's psychiatric disability in order to ensure that such an individual has not been discriminated against in the administration of a government program in violation of the ADA. This type of determination is necessarily made on a case-by-case basis and an individual claiming discrimination by the NYPD could assert an individual claim for relief. To assist police forces throughout the country, the U.S. Department of Justice commissioned the Police Executive Research Forum to formulate guidelines for

compliance with the ADA . Published in 1997 and entitled "The Police Response to People with Mental Illnesses", the suggested procedures have been adopted in some jurisdictions.[7] This would certainly be a place for the NYPD and the Commission to start in any review of current NYPD practices.

Section 1983 of the Civil Rights Act of 1871 is the best known remedy through which private citizens pursue municipal liability for constitutional or statutory violations. We believe that police officers acting under "color of law" who deprive mentally ill New Yorkers of "rights, privileges, or immunities secured by the Constitution or laws of the United States" might be legally responsible under 42 U.S.C. § 1983. In particular, a municipality's failure to provide adequate training may be found tantamount to an official policy where "the need for more or different training" of municipal officers is "so obvious" and "the inadequacy so likely to result in the violation" of constitutional or statutory rights, that the municipal policymakers "can reasonably be said to have been deliberately indifferent to the need."[8] In crisis interventions involving unreasonable and unnecessary force or violations of the ADA, Section 1983 would be a possible avenue for redress for such conduct. The Second Circuit has recognized that a "failure to train" claim may sometimes give rise to a § 1983 violation where: first, the policymaker knows "to a moral certainty" that the employees will confront a given situation; second, that the

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7 The Police Executive Research Forum is currently engaged in a "Criminal Justice/Mental Health Consensus" project in partnership with the Council of State Governments, Pre-Trial Resource Center, the Association of State Correctional Administrators and the National Association of State Mental Health Program Directors. Working through advisory groups, this consortium hopes to develop detailed, bipartisan recommendations which would improve the Criminal Justice System's response to individuals with mental illness.

8 *City of Canton v. Harris*, 489 U.S. 378, 390 (1989).

situation is amenable to training and supervision and there is a history of employees mishandling the situation; and third, where the wrong or difficult choice by an ill-trained employee will frequently cause the deprivation of a citizen's constitutional or statutory rights. *Walker v. City of New York*, 974 F.2d 293, 297 (2d Cir. 1992). We believe this theory of § 1983 liability would be applicable to facts common in crisis interventions.

State theories

State law establishes minimum training requirements for new and veteran police officers throughout the state and course requirements that are mandatory unless a municipality has received an exemption. Our review of the New York State Executive Law coupled with some FOIL responses convince us that the NYPD is required to adopt the "Police Mental Health Training Program" created by the NYSOMH and DCJS and that no exemption has ever been obtained.

Statutory analysis begins with New York State Executive Law § 839 which establishes a Municipal Police Training Council (MPTC) under the auspices of the State Division of Criminal Justice Services (NYSDCJS). The MPTC is authorized under Executive Law § 840 to establish minimum training requirements for the police and their instructors. Only if the MPTC determines that New York City ("any city having a population of one million or more") has a training program that exceeds the State's standards, may it exempt the City from MPTC's requirements.

Comprehensive state regulations spell out course requirements. These include a "basic course for police officers" described in Part 6020 of the NYCRR Article 2. Unit 20 of the Basic Course deals with "Mental Illness," its purpose to provide "guidance in the area of dealing with

emotionally disturbed/mentally ill persons" and "procedures for taking persons into custody" under the Mental Hygiene Law. Unit # 20 incorporates the "Police Mental Health Training Program" and required use of those materials. The regulation states that the mental illness section "should be taught" by an individual "that has been specifically trained and certified as a Police-Mental Health Instructor" by the NYSDCJS. We conclude that in the absence of an exemption based on an explicit finding that the NYPD standards are "higher" than the statewide standards, that the NYPD is required to adopt them and to use "Police-Mental Health Instructors."

There are undoubtedly additional state and federal legal theories available to force a thorough review of the adequacy of the NYPDs training programs and protocols for crisis interventions. However, since we believe that a multi-disciplinary approach may offer greater opportunities for practical reform than litigation, we turn now to recommendations premised on that philosophy.

Section III. Recommendations

We strongly urge the Mayor to consider the appointment of a Commission that will analyze the issue of police interactions with individuals in psychiatric crisis. Now is the time -- at the outset of Mayor Bloomberg's administration -- to appoint a blue ribbon Commission to study the subject of police interactions with individuals in psychiatric crisis, and make recommendations The Commission should be broad-based, with representation by all affected groups: the NYPD, the mental health community, educators, the private and public hospital system and professionals with expertise in training programs and crisis interventions. We envision a Commission that looks forward, not back, making recommendations that will ensure

that the NYPD is well-trained and equipped for dealing with these challenging situations. These are some of the subjects that the Commission should consider:

Data Collection and Review

There needs to be a way of collecting data concerning crisis interventions with mentally ill individuals in order to figure out the scope of the problem and conduct incident reviews. One place to start would be through the "aided reports" that officers are supposed to fill out whenever they come in contact with someone needing "assistance" other than arrest. Currently, officers are suppose to indicate whether an individual is an "EDP," what medical history he or she might have and what sort of behavior was exhibited in the interaction with the Police. The Commission could review these forms, make suggestions, and then encourage a comprehensive study of the information gathered through their use. While the classification of 911 calls is a start, it is clearly imperfect, both under-conclusive as well as over-conclusive. Given (i) the significant statistic that up to 30,000 individuals with serious and persistent mental illness cycle through the City jail system in a given year, (ii) the correlation between New York City's homeless population and the mentally ill and (iii) the emptying out of New York State psychiatric institutions, we suspect that accurate data on the number of interactions and their outcomes will provide invaluable data to policymakers and the affected parties.

The Commission might also focus on the safety of police involved in crisis interventions by gathering statistics on the frequency with which individual officers sue or submit Worker's Compensation claims in connection with injuries incurred in an EDP situation.

Training

There should be a comprehensive review of the cadet training that takes place at the Police Academy and the in-service training available to officers to make sure that New York City is offering its police the best curriculum available. The Commission would also be an appropriate group -- assuming there were professional experts on board -- to compare the NYPD training program on crisis interventions with the "Police Mental Health Training Program" of the NYSOMH and NYSDCJS.

We recognize that New York City is unique and that intervention responses in other communities may not be appropriate here. Nevertheless, the sheer volume of crisis interventions and risks of physical injury require that the NYPD is trained to respond with the latest techniques and equipment. This is a subject that has been studied and is being studied on the national level. New York City cannot afford to be parochial.

Follow-up, in-service training should also be considered. Once a new officer is exposed to crisis interventions in the community, post-Academy education would be tremendously useful. And, if such confrontations are as frequent as we believe, officers should be as well versed in de-escalating a crisis with a mentally ill person as in using firearms.

Crisis Intervention Protocols

The NYPD protocols for dealing with crisis interventions and the extent to which weapons and other tactics should be used should be reviewed by the Commission in light of the needs and special circumstances presented by New York City, including budgetary constraints. Such a review might take into account the NYPD's procedures, staffing patterns, training and practices for dealing with "domestic violence" situations, which might present ideas and techniques that are transferable to dealing with individuals in a psychiatric crisis.

The Commission might compare the NYPD's written policy on the use of lethal force in crisis interventions with other jurisdictions to determine what approach is most appropriate for New York City's special circumstances. Further, the Commission might survey non-lethal techniques and weapons available for those incidents involving consumers to see whether there are ideas, techniques or equipment for New York City to "borrow."

Indeed, there are several existing models of crisis intervention used by other police departments around the country, including the Memphis Model (using a crisis intervention team approach), the Birmingham Model (using a community service officer model), and the Knoxville Model (using a mobile crisis unit model). The Memphis Model has been used in Seattle, Washington; Albuquerque, New Mexico; and Portland, Oregon; and has even been studied by the NYPD. The Memphis Model includes the creation of a specially trained corps of police officers who have expressed interest in working with individuals with psychiatric disabilities and who undergo a 40-hour program conducted, in part, by mental health providers and mental health consumers. These specially trained officers become members of the "Crisis Intervention Team" (CIT) and each CIT performs normal police duties but responds to EDP calls from Memphis dispatchers, as well. Since there is a CIT deployed in each local precinct and on every shift, a CIT can respond to virtually all EDP calls. Many elements of the Memphis Model are currently used by the NYPD in its domestic violence protocols.

The Birmingham and Knoxville Models use mental health experts in responding to crisis interventions. The Birmingham Model places civil social workers who are police department employees in police precincts to accompany the police in responding to EDP, domestic violence and other calls. The Knoxville Model employs mental health experts who are not department employees but merely on-call to the police department. Whether any of the components of the

Memphis, Birmingham and Knoxville Models are appropriate for New York City would be a judgment for a Commission that includes both police and non-police professionals.

As previously mentioned, the Police Executive Research Forum has partnered with the Council of State Governments on an ongoing project to formulate a "Criminal Justice/Mental Health Consensus" on subjects such as the establishment of a cross-system training program for police offices and mental health service providers and advocates; the establishment of practical guide lines to police officers instructing them on how to respond to people with mental illnesses, including referral and diversion mechanisms where appropriate; the establishment of partnerships with consumers and local mental health advocacy organizations to improve information sharing and utilization; and evaluating qualitatively and quantitatively the police response to calls involving people with mental illnesses. New York City and the Commission must share the benefit of this ongoing work.

The Commission might likewise review the NYPD's weapons protocols for crisis interventions and make recommendations as to whether there are available verbal techniques that might be employed before the use of any weapons; whether the NYPD's continued use of pepper spray and tasers as the non-lethal weapons of choice should be superceded by a newer generation of non-lethal weapons; and whether officers have at their ready disposal appropriate non-lethal weapons.

Pilot Programs

The Commission might be asked to recommend pilot programs in precincts that experience a high volume of EDP calls or which might be expected to have a high incidence of crisis interventions, such as the Midtown North Precinct which covers the Port Authority as well

as Penn Station and Grand Central Station. Mental health crisis intervention projects might include outreach advocacy and referral services designed (1) to ensure that members of the police department, employees of service providers, mental health consumers and their families, and other members of the mental health community are fully aware of the services available to people with mental illness in the community; and (2) to facilitate better access to such services for individuals and families that might otherwise interact with the police only in a crisis situation.

Pilot programs offer real opportunities for experimentation and change, and the NYPD has demonstrated that it is receptive to appropriate programs. Several years ago the NYPD participated in the Fountain House/Midtown North Mental Health Program, which included a dialogue about the issues faced by consumers in crisis. Fountain House, a mental health provider, has reported that as a result of the program police officers respond quickly and courteously to crisis intervention situations. Similarly, in the 25th Precinct, the NYPD is engaged in a joint project with St. Luke's Roosevelt Crime Victims Treatment Center and the Urban Justice Center dealing with domestic violence and known as the Coordinated Action Against Violence Program (CAAV). The CAAV Program permits advocates to receive notice of domestic violence interventions in the precinct and provide follow-up service to victims.

These examples of pilot programs suggest that the NYPD, in conjunction with service providers and advocates, might try out projects on a small scale that can then be replicated.

Conclusion

Through an interdisciplinary collaboration including police personnel, mental health professionals, consumers and family members, it is our belief that improved crisis intervention approaches will accomplish the following:

Reduced EDP crisis intervention calls because of outreach to mental health consumers, their family members and providers in the community to help identify individuals in need of services before their unmet needs develop into a crisis requiring police intervention;

Lowered quality-of-life crime rates as individuals in need of services will obtain professional assistance in accessing services before they take actions, because of their illness, that might otherwise constitute criminal behavior;

Fewer dangerous interactions between police personnel and people with mental illness in crisis because of outreach to and orientation with members of the police to assist them in (1) identifying the warning signs when an individual with mental illness might be in a crisis state and (2) developing methods for de-escalating crisis situations;

Improved police-community relations as the police, local service providers, consumers and family members work together to ensure that crisis situations involving people with mental illness can be avoided and people can gain access to the services they need;

Greater cost-savings, both to the NYPD as well as hospital-based providers, as early interventions will reduce not only the need for repeated emergency room visits and hospitalizations but also the time spent by uniformed officers escorting and monitoring individuals when they are brought to local hospitals awaiting medical clearance and hospital admittance.

In conclusion, through improved police-community relations between the NYPD and the mental health community, it is our firm belief that we can improve the services that reach individuals experiencing psychiatric crisis while improving public safety. We hope that this briefing is a starting point for continuing dialogue from which a true collaborative and interdisciplinary approach will evolve. Just such a collaborative approach is being initiated with the opening of the first Mental Health Court in Brooklyn, a joint project of the courts and New York State Office of Mental Health. That initiative to link defendants with persistent mental illness to long-term treatment as an alternative to incarceration, should be an inspiration in dealing with crisis interventions that are often the prelude to the criminalization of mental illness.

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