Chapter 5
Policing and Special Populations: Strategies to Overcome Policing Challenges Encountered with Mentally Ill Individuals

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Introduction

The intersection of the criminal justice system and the public health system has increased in recent years, mostly as a result of the deinstitutionalization process of those with mental illness in the 1950s. In the United States, deinstitutionalization occurred by reducing the population of individuals residing in mental institutions by releasing patients, shortening the length of stay and reducing both admissions and readmission rates to the facility. As of 2012, the number of patients in state-run psychiatric facilities was 35,000 (Mencimer 2014). This number represents less than a tenth of the number of patients that were in state-run psychiatric facilities in 1955. The aim of deinstitutionalization was to move the care of patients in the state-run psychiatric institutions to less isolated community mental health services. Many of these individuals were increasingly cared for at home or in halfway houses, group homes, clinics and regular hospitals.

One of the unintended consequences of closing these state-run mental hospitals, without ensuring that all patients were connected to services was homelessness, which became a national issue upon deinstitutionalization. Not all of the formerly hospitalized individuals had the resources to live independently and moved to the streets, making up a growing portion of the homeless population. A 2015 survey based on a one-night count of people sleeping on the streets estimated that 564,708

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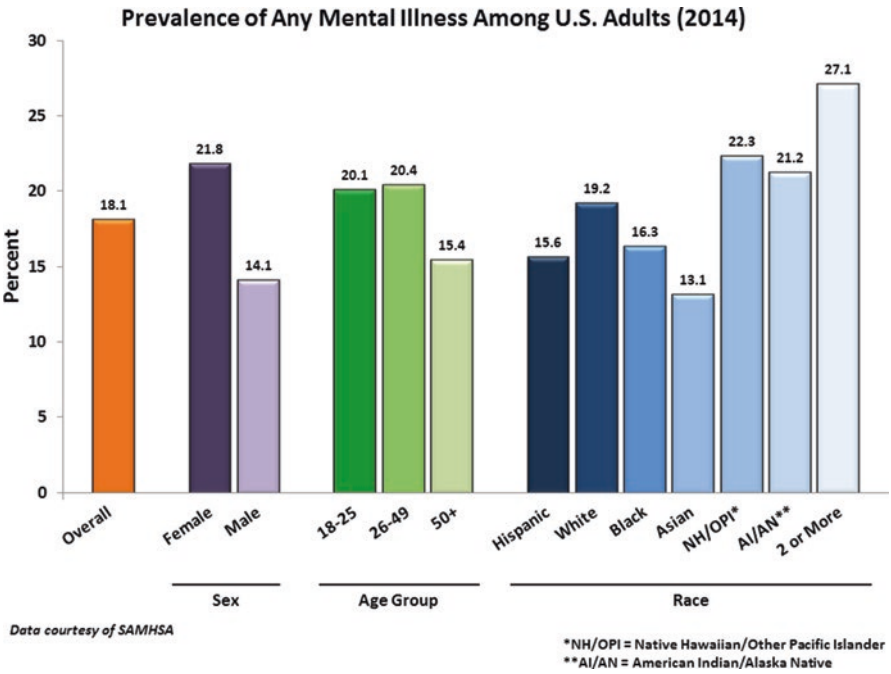
people in the United States were homeless (436,921 of them adults). Of these, 104,083 (24%) were identified as severely mentally ill.

According to the National Alliance on Mental Illness (2015), when a person is in a mental health crisis, they are more likely to encounter police than get medical help. Given this statement and the mental health crisis that has arisen in the United States, part of the solution resides in the collaboration of both the mental health system and the criminal justice system collaborating to address the growing issue of people with mental illness and the response by police departments nationwide. This intersection requires new strategies by both systems, but in particular for those situations in which the police are the first responders to people requiring mental health services. In many places in the United States there has been a growing desire to train police officers on mental health as law enforcement, often the first responders to people with mental illness, has become the de facto provider or connector to mental health services. Many people believe that this has led to the criminalization of mental illness. Although there are issues to be addressed jointly by the public health system and the criminal justice system, the focus of this chapter is on what law enforcement around the country is doing in response to the growing number of calls for people in mental health crises, ranging from children with developmental disabilities to those adults diagnosed with bipolar disorder.

Context

The prevalence of mental illness in the United States is widespread, crossing ethnic, gender and age groups. In a 2015 report, the National Alliance on Mental Illness (NAMI) reported that one in five adults experience a mental health condition every year, and one in twenty live with a serious mental illness such as schizophrenia or bipolar disorder. The 2016 National Survey on Drug Use and Health (NSDUH) reported that one in one hundred (2.4 million) American adults live with schizophrenia, 2.6% (6.1 million) of American adults live with bipolar disorder, 6.9% (16 million) of American adults live with major depression, and 18.1% (42 million) of American adults live with anxiety disorders. These statistics give perspective to the enormous need for community mental health programs, as deinstitutionalization in the 1950s in the United States removed people with severe mental illness from state managed care to community outpatient mental health clinics (Jimenez 2010).



Background

On September 24, 1987, Memphis police officers responded to a call and encountered a man, later identified as Joseph DeWayne Robinson, a person with mental illness, who was high on cocaine. He was cutting and stabbing himself with a footlong butcher knife, inflicting as many as 120 wounds on his body. The call for assistance came from Mr. Robinson's mother. As four police officers surrounded him outside his apartment in the LeMoyne Gardens public housing project, the 27 year-old man lunged toward them. The officers discharged their firearms ten times and Mr. Robinson died. This incident – between responding police officers and a person with mental illness – spurred an outcry from mental health officials and advocates who said the police did not know how to handle people with mental illness, especially those in the crisis situations. The National Alliance for Mental Illness lead the charge and were among a group of advocacy groups willing to work with the Memphis Police Department to improve the department's response to mental health crisis calls.

Major Sam Cochran became the Memphis Police Department's choice to coordinate the department's new response. He is known nationally for developing the Crisis Intervention Team (CIT) model which was introduced in 1988 and now is considered "best practice" for law enforcement agencies worldwide. The purpose of the CIT training is to improve the responding officers' ability to safely intervene to people with mental illness, provide linkage to mental health services, and when appropriate, divert the individual from the criminal justice system (Compton et al. 2015).

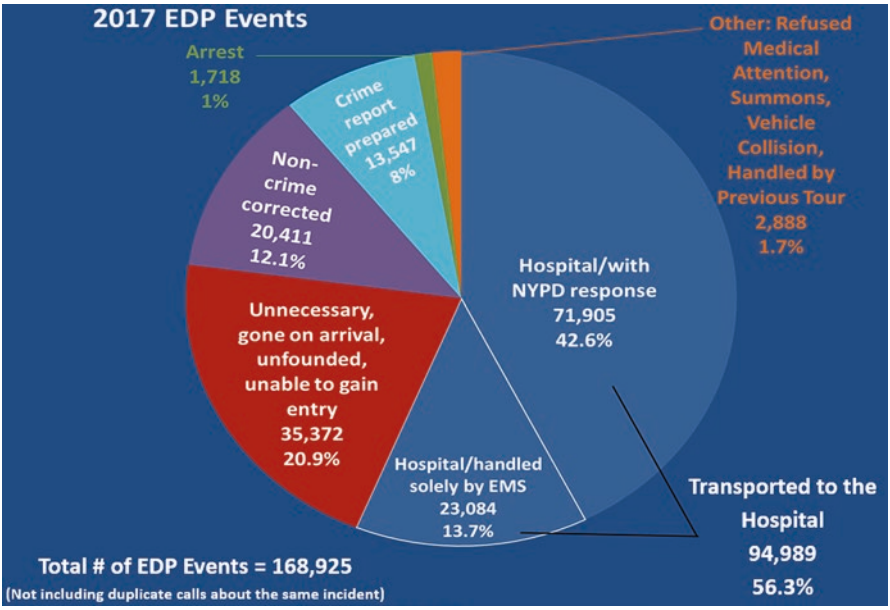
New York City

In 2017, the New York City Police Department received close to 169,000,911 calls for "emotionally disturbed person."[1] Of prime importance was the final disposition of calls, which included:

- the EDP being brought to/or refusing the hospital;
- these incidents were classified as unnecessary, which includes the dispositions of gone on arrival, unable to gain entry, and unfounded;
- non-crime situations which were handled or referred to a different agency;
- a crime report prepared;
- a non-crime condition being corrected; and
- an arrest.

The dispositions for the calls in 2017 are illustrated in the pie chart below. The disposition of those incidents which were classified as "unnecessary" would include a situation in which a person was walking down the block speaking in an exaggerated manner to no one, causing a person to call 911 only to find out upon the arrival of the police, that the person was speaking on their cell phone via Bluetooth. Generally, the call disposition of "handled or referred to a different agency" refers to those cases in which an Emergency Medical Services responded and handled the call prior to the NYPD's response. An example of "a non-crime condition being corrected," would be a person who is directing traffic at an intersection and is told by police to stop doing so because it unnecessarily places the person in danger and the person complies.

[1] The New York City Police Department defines an emotionally disturbed person as, "A person who appears to be mentally ill or temporarily deranged and is conducting himself in a manner which a police officer reasonably believes is likely to result in serious injury to himself or others." New York City Police Department Patrol Guide Procedure 221–13 p. 1.



911 Calls to the New York City Police Communications Division for Emotionally Disturbed Persons

As is noted in the above table, the majority of EDP calls result in the individual being transported to the hospital, followed by those calls deemed to be unnecessary, gone on arrival, unfounded or unable to gain entry. One percent of the calls (1718) resulted in an arrest.

Changing Response

In 2014, the New York City Police Department made a commitment to seek out the best practices nationwide of how police departments were responding to people with mental illness and various other people with special needs. In partnership with the Department of Health and Mental Hygiene (DOHMH), personnel from the NYPD visited several cities that had noteworthy training, programs and innovative approaches to addressing these issues. Among the cities visited were Los Angeles, Tempe, Phoenix, Houston and Tucson. The purpose was to examine what other jurisdictions were doing, determine if it could be adjusted to work in New York City and speak to the first responders, both police offices and in some cities, mental health clinicians, about what they believed was working and what could be improved upon.

The exposure was both informative and invigorating. Based on observations, sitting through some of the crisis intervention team trainings and responding with trained officers, the NYPD created its own Crisis Intervention Team training which began in the summer of 2015. There are some staples that were part of each cities training. Among them were: keeping the class size small so that each participant would be involved; ensure that there is interaction with consumers of mental health services and class participants; and, have each trainee participate in scenario based training.

Some of these ideas are wonderful in concept, but posed issues in operationalization. For instance, having a class size of thirty participants is great, but with a department comprised of over 35,000 uniform members, with the goal of training all, the task required creative thinking. Other ideas were a sure fit for the NYPD. Having trainees participate in scenario based training was ideal in the NYPD's new Police Academy located in College Point, Queens. The designers of the academy had the foresight to build in scenario-based space which includes a bank, an apartment, a bodega, a café, and a portion of a subway car, among other mock scenario rooms.

NYPD's CIT Program

In partnership with DOHMH's training academy, the Center for Urban Community Services (CUCS), and NYPD instructors, the CIT training curriculum was developed. The course is 4 days and co-taught by a certified clinician and a tenured NYPD Police Academy instructor. Each day after the first, a review of each topic presented on the previous day is conducted and clarification of any issues that require further discussion is provided. Instructors encourage and sustain an open discussion format with the trainees. The following is an overview of the program, including the various modules incorporated.

Introduction

The program begins with an introduction to the Crisis Intervention Team (CIT) Training Program, informing the participants that the training is based on the Memphis Model, and designed to efficiently and effectively assist individuals in the community who are in crisis due to mental health, behavioral health, or developmental disorders. CIT is a collaborative program with a broad reach that relies strongly on community partnerships and a vibrant crisis intervention system that understands and responds to the needs of the community and law enforcement officers alike. CIT training encourages officers to utilize the mental health crisis facilities located throughout the city in order to redirect individuals away from the criminal justice system, when appropriate. Upon completion of CIT training, officers are provided with a printed directory of local, state and national social service providers that can

be offered to individuals in crisis or their family members as an additional resource. Moreover, officers are oriented to the services offered by the NYPD, other city agencies and other field-based care coordination models. CIT training focuses intently on the safety of the person in crisis, the officers involved, and the general public by teaching officers a best practices approach to de-escalating persons in crisis within the Department's response framework with voluntary compliance as the end goal. CIT training aims to reduce the stigma related to mental illness and decreases the need for further involvement within the criminal justice system by ending the revolving door many individuals in crisis routinely find themselves in.

NYPD Protocols

The NYPD's policy, procedures and tactics are reviewed. This module provides officers with an overview of the Department's emotionally disturbed person incident response framework and includes policies, procedures, and tactical recommendations as outlined in the NYPD's Patrol Guide's Tactical Operations. The trainees are reminded that the ultimate goal in these critical incidents is to gain the voluntary compliance of the subject while ensuring the safety of the public and responding officers. This is accomplished through the effective use of de-escalation techniques; a term of art that includes a wide array of skills including crisis communication techniques, emotional response regulation (both for the officer and the subject), and proper tactical management of the incident scene. Furthermore, the trainees are reminded of the Department's general use of force policy, availability of protective equipment, and less lethal device options. Emphasis is added on the need to collaboratively create and employ a coordinated tactical response plan with de-escalation and the deceleration of pace as the primary considerations. The training also promotes and reinforces that the proper handling of these critical incidents increases the Department's standing in the community as a legitimate and procedurally just agency that places a high priority on the safety of its citizens whom the NYPD is called upon to help in a time of crisis. Towards that end, the training reinforces these skills during the subsequent scenario-based exercises where the instructors specifically critique the trainee's performance as it pertains to de-escalation and their employment of a coordinated tactical plan that includes but is not limited to: deceleration, protective equipment, less lethal force options, firearms control, zones of safety,[2] isolation and containment, and leveraging the knowledge and skills of specialty units and supervision when needed. Trainees are also instructed on the

[2] Zone of Safety is the distance to be maintained between the EDP and the responding member(s) of the service. This distance should be greater than the effective range of the weapon (other than a firearm), and it may vary with each situation (e.g. type of weapon possessed, condition of EDP, surrounding area, etc.). A minimum distance of twenty feet is recommended. An attempt will be made to maintain the "zone of safety" if the EDP does not remain stationary. New York City Police Department Patrol Guide Procedure 221–13 p. 1.

benefits of conducting a post-incident supervisor-led debriefing of the incident with the purpose of improving our collective response to these critical incidents by analyzing the team's performance and identifying training issues or other deficiencies.

Each day of the course has scenario-based training which are held in mock environments. The state-of-the art NYPD Police Academy has mock-environment training rooms including a precinct station house, multi-family residence, grocery store, restaurant, park, court room, bank, and a subway car and platform. The focus of the scenarios is to provide the opportunity for the trainees to put into practice the best tactics, de-escalation skills and engagement skills they have acquired in the lecture component of the training. Reviews of the scenario and safety instruction are included prior to the exercise commencing. Professional actors are employed to role-play the disorders the trainees have just learned and then by acting them out, the trainees are taught how to identify the disorder, use the appropriate tools to deescalate and gain voluntary compliance. Instructors conduct a supervisor-led discussion detailing the scenario-based training regimen and the safety protocols involving the professional actors and Police Academy facility. Attentive observation, team-centered feedback, and the acceptance of constructive criticism are emphasized. The role of the safety officer is clearly described to the trainees along with the paramount importance of firearms-related security. Following is an example of a scenario utilized during the post-traumatic stress disorder module.

Scenario-Based Training

When teaching students about post-traumatic stress disorder, an overview of the illness is given. The following information is given regarding the pathology. Traumatic events can have long-lasting negative effects. Sometimes our biological responses and instincts, which can be life-saving during a crisis, leave people with ongoing psychological symptoms because they are not integrated into consciousness. Because the body is busy increasing the heart rate, pumping blood to muscles for movement and preparing the body to fight off infection and bleeding in case of a wound, all bodily resources and energy get focused on physically getting out of harm's way. This resulting damage to the brain's response system is called Posttraumatic Stress Response or Disorder, also known as PTSD. PTSD affects 3.5% of the U.S. adult population—about 7.7 million Americans—but women are more likely to develop the condition than men. About 37% of those cases are classified as severe. While PTSD can occur at any age, the average age of onset is in a person's early 20s.

Additionally, the symptoms of PTSD are also taught, indicating that people experiencing PTSD may have intrusive memories, which can include flashbacks of reliving the moment of trauma, disturbing dreams and scary thoughts. They may also utilize avoidance, which can include staying away from certain places or objects that are reminders of the traumatic event. A person may also feel numb,

guilty, worried or depressed or having trouble remembering the traumatic event. Additionally the person may experience dissociation which can include out-of-body experiences or feeling that the world is "not real" (derealization) or be hypervigilant, which can include being startled very easily, feeling tense, and the person may have trouble sleeping or outbursts of anger. The medications prescribed for PTSD, namely antidepressants (Prozac, Wellbutrin), Alpha- and Beta Blockers (propranolol, atenolol), and mood stabilizers, are also taught to the participants so that they may become familiar with the names of the medications prescribed for various mental illnesses.

One of the scenarios used for PTSD involves two actors inside an apartment. One actor has PTSD from a previous trauma which can include military service, serious assault, rape, child abuse, robbery, or terrorist attack. The actor has not been taking their prescribed medication due to side effects and is utilizing alcohol to mitigate symptoms. The other actor will be a family member who is currently living with actor suffering from PTSD. The two actors will engage in a disagreement and the actor with PTSD will display a flashback. The 911 call will come over as a noise complaint from a neighbor.

At this point, two of the class's participants respond to the scene. The instructor will be looking for active listening skills (emotional labeling, open ended questions, paraphrasing, minimal encourages, etc.) utilized during the scenario. Additionally, the instructor will be looking for the officers to reorient the subject and speak in a calm tone. The officers should be as concrete as possible when orienting the actor with PTSD. For example, the officers should introduce themselves by rank and name and state that they are police officers with the NYPD. The officer should also ask the family member about any information regarding medical or psychiatric history of the subject, as well as asking if any medication is prescribed and whether or not it is taken. Tactically, the officers should ask the family member if there are any weapons in the house, acknowledging that the family member may not know for sure. When the officers approach the subject they should proceed with caution and look for the subject's hands for any weapon or instrument that could cause injury. When the actor with PTSD comes out of the flashback and appears to be embarrassed, the officers should reassure the actor that they are okay.

Based on the participant's ability to deescalate the situation, there are different potential outcomes. One may be that the actor suffering from PTSD may go into a bedroom and the scenario is transformed into a barricaded/armed person situation and different NYPD protocols are put in motion. Another may be that an ambulance is called and the actor voluntarily goes to the hospital. The key topics that are reviewed are: the effective utilization of crisis communication skills; the proper identification of all potential resources at the scene for gathering possible intelligence about the actor with PTSD prior to engaging or moving forward with the scenario; a coordinated tactical plan; the appropriate de-escalation techniques; utilization of the necessary equipment; and, the implementation of the proper NYPD procedure given the situation.

Peer Panel

One of the most important modules is the peer panel discussion. A group of peer panelists with lived experience relating to mental illness visit the training environment. They share details with the trainees about their personal experiences with mental illness and how their disorder has affected them and their family. Panelists also debrief their experiences in dealing with law enforcement officers while they were in crisis and how those officers performed; both positive and negative aspects of these experiences are discussed. An instructor facilitated discussion is then conducted where each panelist is encouraged to engage the trainees in an authentic and thought provoking manner. As part of the panel discussion the concepts of police legitimacy, procedural justice, stigma, and implicit bias are introduced. The panelists also assist the instructors in highlighting the significance of the NYPD performing in a procedurally just way when responding to critical incidents involving persons in crisis, one that is viewed as fair, impartial, and transparent and that acknowledges the community's voice in the method of getting an individual the assistance they require.

Crisis Communication

Using a behavioral influence model developed by Dr. Gregory M. Vecchi, formerly a Special Agent in the Federal Bureau of Investigation who served as the Chief of the Behavioral Sciences Unit and as a negotiator in the Crisis Negotiation Unit, the Behavior Change Stairway Model (BCSM)[3] establishes the foundation of the crisis communication skills that are utilized throughout the CIT training program. The skills are adapted from crisis and hostage negotiation training and are grounded in extensive research on how to effect a behavioral change. The training emphasizes the use of communication techniques in a calm and courteous manner with the ultimate goal of changing the subject's behavior and gaining their voluntary compliance. Voluntary compliance is achieved through the utilization of a variety of de-escalation and communication techniques that are outlined below. This module entails both a lecture presentation and numerous interactive elements where the trainees practice the skills being reviewed.

The core topics discussed include the following:

Active Listening – An important set of crisis communication skills that greatly contributes to each of the below elements. Active listening is the most critical set of skills a person needs to effectively communicate during a crisis situation.

[3] Vecchi, G. M., Van Hasselt, V. B., & Romano, S. J. (2005). Crisis (hostage) negotiation: Current strategies and issues in high-risk conflict resolution. Aggression and Violent Behavior, 10(5), 533–551.

Deceleration and utilization of time – Officers are instructed on how to slow the pace of an incident and not rush towards a quick resolution, whenever possible. Rapidly made decisions, when not required due to an immediate safety concern, lessen an officer's reaction time, prompts an uninformed decision making process, and may provoke an individual who is already in a crisis state. Decelerating the process contributes to achieving a successful outcome by allowing time for more informed decisions to be made that include the person in crisis as the primary stakeholder in the overall process.

De-escalation – Slowing the process down through active listening and crisis communication naturally de-escalates a critical incident and reduces the effect of the emotions the subject is experiencing. These emotions directly influence the subject's actions and must be addressed.

Additionally, the emotional contagion experienced by responding officers is also addressed as they are active participants in the incident and are subject to making poor decisions due to their own emotional fluctuations and perceived challenges to their ego. The final component of de-escalation discussed in this module includes the importance of proper tactical management of the incident scene and the effective utilization and deployment of necessary resources (NYPD and others) which help minimize any potential uses of force, if required.

Participants are also taught about empathy and rapport. Basic psychology and negotiation research demonstrates that in order to change a person's current behavior you need to understand their perspective. This is what true empathy entails. Engaging the subject in a respectful and positive manner builds rapport and increases our legitimacy with the subject and any other persons involved or observing the incident. In order to change a person's behavior and gain voluntary compliance, the officer must be able to positively influence, not manipulate, the individual to change their current behavior and actions. The purpose of demonstrating empathy and building rapport is to eventually influence the person to the point of behavioral change, getting them to voluntarily do what the officer needs him or her to do at that time. Through this process, the officer's actions clearly demonstrate a willingness to help the individual through the process by listening and offering assistance. For responding officers, a critical incident frequently entails a feeling of lack of control over the situation and its participants. The officer, by effectively utilizing the above skillset and techniques, can often regulate the incident and reestablish a sense of order without diminishing their own tactical control over the scene or using force on the subject. Throughout this module, repeated connections are made to the policy, procedure and tactics module in order to underscore the importance of employing a coordinated tactical plan containing de-escalation and deceleration techniques while simultaneously maintaining full situational awareness.

An introduction to both the mental health and criminal justice system is given on the second day of training. This provides trainees with a brief examination and overview of the mental and behavioral health industry, the laws governing the taking of persons into protective custody, and how these issues intersect with the criminal

justice system. Instructors address the issues of limited access to and the use of mental health services, mental illness stigma and attitudes towards individuals with mental health issues, recidivism rates, and the frequency of calls for service.

Modules

The following are the mental and behavioral modules covered over the rest of the course. Each module has various scenarios that will be employed in the mock scenarios.

Psychotic Disorders – In this module the clinicians define psychosis and provide statistics on its prevalence in society. They also explain how psychosis affects an individual cognitively and behaviorally. The central mental illness discussed during this module is schizophrenia. The trainees are provided with a list of indicators of the illness and guidance is provided on how to effectively communicate with someone who is symptomatic. The trainees participate in an auditory hallucination exercise which aids in building empathy and rapport between law enforcement and this population. The exercise entails the participants using MP3 players which simulate typical schizophrenia symptoms (e.g. voices) playing constantly in their ear; they are then asked to perform simple tasks. It has proven to be a very effective exercise, as the trainees are not capable of performing the tasks.

Mood Disorders –This module provides the trainees with the knowledge, skills, and abilities to recognize the signs and symptoms of commonly occurring mood disorders and how to safely and effectively render assistance to those persons in crisis. The major disorders that are presented in this module are depression and bipolar disorder. The impact of these and similar disorders among the homeless population is discussed. The trainees are advised that persons with bipolar disorder can have intermittent periods of psychosis and are reminded to employ proper crisis communication strategies and tactics, when applicable.

Suicide Indicators and Prevention – The purpose of this module is to provide the trainees with an overview of suicide that includes the features of ideation, common risk factors, assessment tools, intervention techniques, and prevention strategies. Each year more than 34,000 individuals take their own life, leaving behind thousands of friends and family members to navigate the tragedy of their loss. Suicide is the 10th leading cause of death among adults in the U.S. and the 3rd leading cause of death among adolescents. Suicidal thoughts or behaviors are both damaging and dangerous and are therefore considered a psychiatric emergency (NAMI 2015).

The trainees are instructed to communicate clearly and to deliberately ask the individual in crisis if they want to kill themselves, if they have a plan, and if so, why they want to carry it out on this particular day. The class reviews several positive communication strategies and how to decipher what a protective factor (a reason to live such as family, education, work, etc.) is versus a hot button issue (a topic that will drive the person further into crisis). The impact of suicidal tendencies among

the homeless population is also discussed during this presentation. Suicide risks among law enforcement officers are examined and the numerous resources available to assist with handling such a crisis are presented.

Personality Disorders – This module provides officers with the knowledge, skills, and abilities to recognize the signs and symptoms of commonly occurring personality disorders. The major disorders discussed are borderline personality and narcissistic personality disorders. The training program stresses that personality disorders are deeply ingrained maladaptive patterns of thinking and behaving that are inflexible and which generally lead to impaired relationships with others. Communication strategies are discussed and the trainees are advised on the most effective methods to interact with an individual they suspect of having a personality disorder.

Anxiety Disorders – This module presents the signs and symptoms of generalized anxiety as well as several sub-types of common anxiety disorders. The trainees are provided with direction on effective methods for rendering assistance to individuals experiencing intense anxiety. Panic attacks are discussed in depth and the trainees are taught several communication strategies that are effective with this population.

Post-Traumatic Stress Disorder – This module provides the trainees with the knowledge, skills, and abilities to recognize the signs and symptoms of post-traumatic stress disorder and acute stress disorder in an individual experiencing a crisis. Statistics outlining the prevalence of post-traumatic stress disorder among US military veterans and law enforcement officers are discussed. The trainees are provided with direction on effective methods for rendering assistance to individuals with post-traumatic stress disorder.

Mindfulness – This module discusses the basic concepts of mindfulness and examines valuable connections to the work of law enforcement officers. Specifically, a model called Mindfulness Based Stress Reduction is reviewed along with information about the demonstrated efficacy of mindfulness in promoting officer wellness. A brief guided mindfulness exercise created specifically for law enforcement is conducted and information about additional exercises is provided.

Developmental Issues and Childhood / Adolescent Behavior Disorders – The purpose of this module is to provide officers with the knowledge, skills, and abilities to recognize the signs and symptoms of young members of the community who are in crisis. Generally, these mental health issues originate in childhood and may involve a significant impairment of function in different areas that may continue through adult life. The specific disorders covered are conduct disorder, oppositional defiant disorder and antisocial personality disorder. The NYPD's policies and procedures regarding juvenile detention and arrest are also reviewed as many of these critical incidents occur in public schools. The trainees are provided with direction on effective methods for rendering assistance to adolescents in crisis.

Autism Spectrum Disorder – This module provides information about the signs and symptoms of someone living with Autism Spectrum Disorder. Generally, the most significant impairments are in the areas of communication and adaptability to change or unforeseen circumstances. The trainees are provided with general guidelines

for effective communication and incident scene management. Additionally, a discussion about the impact Autism Spectrum Disorder has on caregivers and family is facilitated. This module has a particular emphasis since the disappearance of Avonte Oquendo, an autistic 14 year-old boy who went missing from his Long Island City school in Queens on October 4, 2013. The NYPD, working with other governmental agencies, took extraordinary steps. Over 100 NYPD officers were assigned to search for him, the Metropolitan Transportation Agency (MTA) took the unprecedented step of halting overnight track maintenance and ordered at least 200 workers to instead scour the tunnels for him and the NYPD Harbor Unit combed the shoreline. It wasn't until January 17, 2014 that searchers began finding clothing and body parts on a set of rocks along the shoreline in College Point. The following week the Medical Examiner confirmed that the remains where those of Avonte Oquendo. The population of people with autism grows, as the Centers for Disease Control and Prevention (CDC) estimates autism's prevalence as 1 in 59 children in the United States, which includes 1 in 37 boys and 1 in 151 girls,[4] and police interactions increase, the more skills police are taught, the better these interactions will be.

Alzheimer's Disease and Other Dementias –This module reviews several different types of dementia that may be encountered by the trainees while carrying out their duties. The emotional impact of losing one's memory is discussed as it can manifest quite seriously during crisis situations. As with Autism Spectrum Disorder, an examination of the impact on caregivers and family is provided for the officers. The class reviews several positive communication strategies for dealing with someone suffering from dementia. Additionally, the NYPD is examining the ways in which technology can aid in tracking individuals with Alzheimer's when they go missing.

Substance Use Disorder and Co-Occurring Disorders –The purpose of this module is to provide the trainees with the knowledge, skills, and abilities to recognize the signs and symptoms of individuals experiencing a crisis due to impairment by a legal or illegal substance. The prevalence rate of substance abuse and co-occurring disorders is discussed. The trainees are given communication strategies that will assist in determining if the individual has a mental health disorder and / or a substance abuse disorder. A discussion is facilitated about how there is a greater risk of violence and suicide when a subject abuses a substance. Synthetic cannabinoids and opioid pain medications are discussed in detail as this is a current phenomenon impacting many of our local communities. The link between substance abuse and the homeless population is also discussed. Finally, the impact of substance use on law enforcement professionals is discussed along with information about what treatment and recovery options are available. The trainees are provided with direction on effective methods for rendering assistance to individuals with substance use disorder.

[4] Centers for Disease Control April 27, 2018 / 67(6); 1–23 (2017).

Participant Feedback

Upon completion of the course, participants are requested to anonymously complete a 14 question survey via survey monkey. The survey requests their feedback on the course instructors, the NYPD instructors and clinicians, actors and peer panelists, and in regards to their ability to communicate the content of the course effectively, as well as the opportunities for the participants to ask questions and express their thoughts and ideas. Other survey questions request their opinion as to the relevancy of the course to their work on patrol and whether it will improve most NYPD officers' ability to interact with a person in crisis. Additionally, comments of the course are sought and often provide helpful insights.

The course is consistently well received, with the overwhelming stating that they would recommend the course to other members of the NYPD, as well as the participants belief that the course will have a positive impact on the Department and its relationship to the community. Here are some of the comments posted after attending the course:

- Learning key points about different psychiatric disorders, how we can identify those disorders, and things we can do or say to deescalate encounters with people in crisis is valuable. The most valuable however, was the focus on our own physical and mental wellness, being that we encounter crisis both in our personal lives and every day at work. Excellent course!
- Scenarios were great, lots of useful information.
- Provides really good foundation on mental health issues removing the stigma associated with mental health. The instructors are top notch and it was a very informative course.
- This is the second time I've done this training and I still find it very intriguing. The scenarios are done very well and have helped me in the field already when I encountered someone with autism.
- I thought hearing from the peer panelists was a great idea because it allows us to hear about their own personal experiences. It also helps us see them in other than crisis moments where we see them as people and not just EDPs.
- The panelists showed the human side of mental illness and brought a personal level that I have not seen before.

Since the course began in the NYPD in June, 2015 all lieutenants and sergeants – the NYPD's front line supervisors have all been trained in CIT. The dispatcher at the NYPD Communications Division automatically directs that the patrol supervisor and the Emergency Service Unit to respond to any call of an emotionally disturbed person. While the Emergency Service Unit is equipped with a host of equipment that can be utilized, the patrol supervisor's vehicle is also equipped with less lethal devices to assist in the containment and control of an EDP. The only time a patrol unit can take the EDP into custody without the specific direction of a supervisor is when the EDP is unarmed, not violent and is willing to leave voluntarily. In all other cases, where the EDP's actions do not constitute an immediate threat of serious

physical injury or death to him/herself or others, the officers will attempt to isolate and contain the EDP after establishing a zone of safety until the arrival of the patrol supervisor and Emergency Service Unit. An ambulance will also be requested. As the aim is to help officers effectively handle EDP situations, it is the NYPD's goal to train all members of the department in CIT.

Success Stories

On a frigid January night, officers responded to an incident in the Bronx involving an emotionally distressed woman armed with several knives. The radio dispatcher advised the responding patrol officers that a woman with a history of psychological issues was threatening to kill her father. At the scene the 40 year-old woman in crisis was actively threatening her father's life and daring the officers to shoot her. While maintaining their zone of safety, officers attempted to calm the distraught woman by using numerous communication techniques including reassuring her that they did not intend to harm her. The officers, some who were Crisis Intervention Team trained, worked together combining de-escalation strategies with physical tactics. While one officer continued to seek voluntary compliance by communicating with the woman, while two other officers provided tactical cover. Additional units, including Emergency Service Unit, arrived on the scene and after repeated attempts to get the woman to drop the knives were not successful, an officer utilized their Department issued taser. The woman dropped the knives and was safely subdued. The woman was brought to the ambulance and transported to the hospital. A later conversation with the distressed woman's family revealed that she had intended for the police to kill her when she called 911.

In another instance, police officers responded to a hospital to assist a distressed person in the waiting rom. They observed a 37 year-old woman holding two large knives pressed to her throat. One of the responding officers reflected on how his training in the CIT training helped him and the other officers calm the situation. By maintain their emotional and situational control, the officers immediately attempted to establish a dialogue with her. The officers slowed the situation down by utilizing crisis communication skills including active listening in order to de-escalate the tense situation. Their patience and training paid off when the lady calmed down and dropped the knives to the floor. The woman was then removed to a psychiatric unit for evaluation.

In a story which made media headlines, a newly trained CIT police officer responded to the scene of a suicidal woman on the Upper West Side of Manhattan. The woman, zipped inside of a sleeping bag, with a hood over her head, was standing on a three inch wide ledge below, dangling from the window. She was wrapped in the sleeping bag because she "didn't want to make a mess" (Musumeci and Balsamini 2016). The officer engaged the woman in conversation using flowers as the topic of conversation after the suicidal woman told the officer wanted flowers

from Central Park. The officer, Nina Friberg, was able to engage the heavily sedated woman in conversation for approximately 10 min until Emergency Services Unit officers arrived.

Officer Nina Friberg, 35, was among the first rescuers at the scene. She engaged the desperate woman in conversation about flowers in Central Park for 10 min until Emergency Services Unit officers arrived. Because the woman had climbed out of the window through a stairwell in the building, there were no adjoining windows which forced the responding Emergency Service Officer, Detective Randy Miller, to lie on his stomach on the landing of the stairwell in order to see her. As the woman became to doze off, she let go of one hand holding onto the windowsill. At this point, Detective Miller saw her knuckles start to turn white, and he grabbed her hand. Other Emergency Services Officers pulled her to safety through a window one story below. Detective Miller stated it was a coordinated effort and credits Officer Friberg's ability to keep the suicidal woman talking that allowed for them to grab and save her.

Looking to the Future

So, where do we go from here? As the calls for a police response to people with mental illness continues to increase, there are several innovative programs which, although only in their pilot phase, give hope to increasing peaceful and voluntary resolution. In partnership with DOHMH, the NYPD has begun several new initiatives.

In March 2016, the NYPD and DOHMH created co-response teams, comprised of two NYPD uniform officers and one DOHMH clinician. The units respond to referrals from police commanders, service providers, and NYC-Well, another new initiative described below. The co-response teams are utilized as a preventive measure, reaching out to people known to have a mental illness and are exhibiting escalating violence. Since its inception, the co-response teams have had over 1000 contacts, with the vast majority resulting in a positive outcome.

The co-response team is directed by the Triage Desk, which receives real-time information and is staffed by a DOHMH clinician and an NYPD officer. Once a referral is received, the person's health history is obtained by the clinician and, due to the Health Insurance Portability and Accountability Act (HIPPA), shared only with the responding clinician in the field. Additionally, the person's interaction with the police is also obtained by the Triage Desk officer. This report contains information on how often the person received help from the NYPD for an injury or other health related issues in New York City, had a vehicle accident, as well as a criminal justice history, indicating arrests, warrants and summonses. This information is also relayed to the responding co-response team, to best prepare an appropriate response by the team.

NYC-Well is New York City's 24 h connection to free, confidential mental health support. It enables people to speak to a counselor via phone, text or chat and get access to mental health. At any hour of any day, in almost any language, from phone,

tablet or computer, NYC Well is the community's connection to get the help needed. It provides:

- Suicide prevention and crisis counseling
- Peer support and short-term counseling via telephone, text and web
- Assistance scheduling appointments or accessing other mental health services
- Follow-up to check that a person has connected to care and it is working for the person.

Lastly, the NYPD is working with DOHMH in developing diversion centers. These centers are being designed to provide alternatives for officers responding to people with mental health and substance abuse issues. Currently, the only options for officers are to either arrest people when there is a low level offense, but the underlying cause is some mental health issue or bring the person to the hospital. The diversion centers will be fully staffed with medical personnel and case managers and operate 24 h a day/7 days a week, 365 days a year. The potential of the diversion centers has many people in the NYPD optimistic in changing how both the public safety and public health systems respond to people in behavioral crisis.

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