Policing in Geneva and Proactive Strategies for Public Safety: Mental health and care for the elderly

A report from the City of Geneva Police Budget Advisory Board*
Submitted April 26, 2023

Report summary and recommendations

That police in Geneva are doing far more than responding to or acting to prevent crime is very clear in the 2022 New York State Division of Criminal Justice Services (DCJS) report.[19] A review of more than 20 years of Geneva Police Department annual reports (most available through the Geneva Police Department (GPD) website) shows that 2021 was not an unusual year. Are we providing the GPD with sufficient support — e.g., in the form of training, responses from other City Departments, partnerships with local organizations — to effectively respond to these diverse calls? How could we as a City broaden our goal from policing, to public safety? We (the members of the Geneva Police Budget Advisory Board) believe that a shift from reactive to proactive strategies is essential, and chose to focus on two areas in this report: mental health and policing, and police interactions with the elderly. Below are our recommendations to City Council, ranging from relatively simple and low-cost actions to longer term possibilities that require further exploration. We believe that following these recommendations will both set the Geneva Police Department up for success, and also contribute to a community where all residents and visitors are safe, welcome, and cared for. Following these recommendations are two chapters reviewing current research and practices in other cities which support these recommendations. The Geneva Police Budget Advisory Board respectfully submits this report, and welcomes questions and further dialog on its contents.

Recommendations related to mental health and policing (Chapter 1):

1. The City Council fund regular replacement (according to a schedule recommended by the Chief) of the tablets currently being used to connect GPD officers and persons in crisis to mental health professionals at Clifton Springs. It is important that this tool continue to be available to the GPD.
2. While it seems that mental health calls may make up a comparatively small proportion of the annual GPD calls for service (154 in 2021, according to the DCJS report), it would be valuable to continue exploring with the Geneva Chief of Police new opportunities to reduce the need for GPD officers to respond to mental health calls. Employing mental health professionals to respond in-person to mental health crises in addition to or instead of police officers would likely require significant adjustments to the City's budget, significant partnerships with other local institutions, or significant outside funding. We do

not recommend that mental health providers be sent into situations involving a potential weapon without officer support. [similar to recommendation 12]

3. Comparatively, the number of calls for service for property checks in the city of Geneva is huge – 15,724 in 2021, according to the DCJS report. Even if these calls are shorter than others, they accounted for more than half of the calls the GPD received in 2021. We recommend exploring alternatives to reduce the GPD need to respond to property checks. For example, such calls could be further classified and the use of other City resources to alleviate the need for police to respond urgently to these calls could be explored. This would alleviate the work load of GPD officers and reduce the risk of officer burnout.
4. Include the total number of mental health calls, the number of calls that utilize CPEP, and the number of calls that result in transport to Clifton Springs in every annual GPD report.
5. Explore opportunities to enhance mental health crisis prevention in the City of Geneva. This is a proactive rather than a reactive approach to responding to mental health crises, and would further reduce the burden on the GPD. [similar to recommendation 8]
6. Ensure that mental health care for officers be readily available, and that these services are de-stigmatized and officers are encouraged to take advantage of them. Furthermore, maintain adequate staffing levels to reduce officer burnout and fatigue.

Recommendations related to public safety and our elders (Chapter 2):

These recommendations emphasize collaboration and sharing of resources to address issues that overlap, such as mental health and elder-care. This is not to minimize either these concerns or the resources needed, but to underscore their connections and the need to be sustainable. These recommendations are also intended to be proactive, even activating the tools we have. Geneva, like most of the United States, will become an older community, thus how do we prepare for that?

7. In the city's masterplan, which includes the Public Safety department, **develop shared city-wide resources**, particularly in regard to recreation that might address both ends of the age spectrum—kids and elders.
8. Develop shared resources and expertise between the GPD, other Public Safety staff, the city's other departments, and non-profits and social service agencies. **Greater public outreach** will foster better community relations with the GPD. For example, a program on computer fraud held jointly by members of the GPD and the Geneva Public Library at the Library. [somewhat similar to recommendation 5]
9. Develop a **dedicated phone number** to respond to non-emergency, non-violent circumstances involving the elderly or mentally ill.
10. **Greater training** for officers to better understand the particular (and evolving) crimes against the elderly, as well as the particular needs and best approaches for assisting the elderly. Recognizing who may be frail, who may deny the need for assistance, who insist on dignity, who may be suffering from the onset of dementia, or who may have other health issues difficult to discuss when under duress requires distinct forms of training.

11. Go beyond short-term or in-house (i.e. webinars) training for GPD officers, but **offer scholarships or assistance to officers** wishing to obtain certificates or degrees in geriatrics, social work, or other areas, including mental health and substance abuse. Offering such assistance should also help with police recruitment and retention, as these certificate or degree programs provide substantial professional development opportunities for officers, including those which could be useful in post-police careers.
12. **Hire non-officer social / public health and safety personnel** who would work with the GPD and alleviate the need for GPD officers to respond to non-criminal calls (such as calls to check on or support the elderly, or to respond to mental health crises. [similar to recommendation 2]

*A note about authorship: Amara Dunn and Andrew Spink took the lead on writing Chapter 1, while James McCorkle took the lead on writing Chapter 2. All four members of the PBAB present at the April 20, 2023 meeting approved the above recommendations, and all members of the PBAB were given the opportunity to review and offer edits to the exact wording of the final recommendations and both chapters. Thus, this report represents the opinions and recommendations of the PBAB as a whole.

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Chapter 1 - Mental health and policing

The shortcomings of a system in which police officers trained solely to respond to crime and violent offenses are also asked to respond to emergencies associated with mental health and substance use have been recognized for some time. People with untreated mental illness are 16 times more likely to be killed during a police encounter than other civilians approached or stopped by law enforcement.[18] To address this issue, municipalities have come up with approaches that fall into three general categories:

1. Crisis Intervention Training (CIT): Experienced law enforcement officers who volunteer to receive specialized training to respond to mental health calls.
2. Co-Responder Teams: Trained law enforcement officers and mental health professionals who respond to mental health calls as a team.
3. Mobile Crisis Teams: Mental health professionals working as a team with specialized training to stabilize people during crisis situations.

Programs in the second and third categories that include civilians in this response in addition to or instead of police exist across the United States, including in New York City, NY[1], Minneapolis, MN[2], Montgomery County (Maryland)[3], Denver, CO[4], Missoula, MT (one of at least six in the state)[5], San Francisco, CA[6], Oakland, CA[7], Austin, TX[8], Tucson, AZ[8], Lynn, MA[9], and Biddeford, ME.[9] At least two universities (University of Utah and University of Colorado at Boulder) have partnerships between campus police and mental health professionals.[8] The CAHOOTS (Crisis Assistance Helping Out On The Streets) program seems to be one of the older programs of its kind, and is often cited as a model for other systems. It has been serving Eugene, OR since 1990.[9] It should be noted that the above listed municipalities are all larger than the City of Geneva. The municipality with the smallest population from the above list is Biddeford, ME with a population of 22,500. As of 2021, they were employing three mental health counselors to respond to mental health crises.[9]

These programs seem to have in common a reliance on local 911 dispatchers to correctly direct some incoming calls to crisis response teams, instead of a response from only police officers. Teams may respond to mental health crises, calls relating to substance use, or family disturbances. The qualifications of those participating in responses varies. There are many successful programs using the Mobile Crisis Team model, where mental health professionals and/or social workers may respond alone[2,3,4,9], with a paramedic (perhaps from the local fire department).[1,5,6] Others use the co-response model where mental health professional are deployed with police[2,5,8]. In one program, only peers who have experienced mental health crises themselves (and not mental health professionals or police) are part of the responding team. [7] In Austin, TX people who call 911 can choose who they want to respond to their call – police, mental health professionals, medical professionals, or firefighters.[8] Teams are generally unarmed (perhaps with the exception of those teams that include a police officer) and may not wear badges or uniforms. The program in Austin, TX is apparently hoping to transition from sending mental health professionals with police, to sending mental health professionals alone.[8] Police officers train the mental health professionals who serve on the Mental Health Support Team in Tucson, AZ.[8] The CAHOOTS program is sometimes (but not usually) backed up by police.[9]

CAHOOTS workers will assess a situation and call for police backup, if necessary, otherwise they will stabilize an individual within the community. In 2019, of the 24,000 CAHOOTS calls received, police backup was requested only 150 times.[18]

In some programs, calls for service that involve some sort of danger, such as a person with a weapon, do not involve these specialized teams, and instead are handled only by traditional law enforcement.[8] However, when a mental health professional accompanies an officer to address a person who has a weapon, the mental health professional is often able to diffuse situations with crisis intervention techniques.[16] A co-responder program in New Jersey of mental health professionals together with police officers allowed officers more options in situations where a person had a weapon, and resulted in a reduction of arrests and an increase in people being transferred to medical facilities.[16]

According to an article from 2021, there is not yet sufficient data to conclusively determine which crisis response team composition yields the best results.[5] However, the Substance Abuse and Mental Health Services Administration does offer guidelines for minimum requirements for these teams.[11]

These programs are funded from a variety of sources. The state of Montana has been offering grants to help communities start crisis response teams.[5] Denver, CO is providing some funding for their Support Team Assisted Response (STAR) and is considering a "mental health sales tax" to help fund the program.[4] The American Rescue Plan offers a funding avenue through Medicaid.[10] Montgomery County in Maryland has reportedly considered reducing the number of police officers it employs in order to fund their crisis response team.[3] Funding non-police teams who can respond to non-violent emergency or crisis calls can certainly be a challenge for municipalities.[5,6]

Metrics assessing the success of these programs were not always reported, probably in at least some instances because the programs are relatively new. New York City's Behavioral Health Emergency Assistance Response Division (B-HEARD) received about 25% of the calls that came in to 911 during the period the program was being studied, and calls that were handled by B-HEARD were less likely to result in transportation to a hospital (50% versus 82% of calls).[1] The STAR team in Denver, CO received 750 calls in 6 months, and none of the calls resulted in arrests.[4] The Eugene, OR police department sends 8% of calls it receives to the CAHOOTS program[9], and the value of the calls CAHOOTS handles (instead of the local police) is estimated at $8.5 million per year.[8] It is not clear how many calls are routed to CAHOOTS through channels other than the local police department.

An alternative to sending mental health professionals or peers to respond to mental health and substance use crises is the Crisis Intervention Training (CIT) model. It was first used in 1989, around the same time the CAHOOTS program began, in response to a police shooting of a young man experiencing a mental health and substance use crisis in Memphis, TN.[12] A literature review of the efficacy of the CIT model found very few studies that reported quantifiable metrics of sufficient quality to assess efficacy.[12] The authors also noted that use of force (especially deadly force) by police is likely underreported, and that deadly use of force by police is relatively rare compared to all police interactions with the public. Thus, small differences in the frequency of such a rare event would be difficult to detect between CIT and non-CIT officers. The authors report that the use of CIT in police departments does lead to officers feeling better and perceiving that they use less force. They also report that the model results in more people being sent to

mental health facilities, rather than to jail. Similarly, the Miami-Dade County police department (FL) utilizes the CIT system and has reported a reduction in "unnecessary" arrests and shootings, as well as a decrease in workers' compensation claims from police officers, presumably because of fewer physical interactions between police and the public.[8] The authors of the review did not find evidence that the use of CIT in a department decreased use of force against people with mental illness, or citizen injury.[12]

The CIT model relies on three parts: (1) 40 hours of training for officers; (2) training for 911 call dispatchers so that they can direct incoming calls related to mental health or other non-violent crises to CIT officers; and (3) a local mental health facility at which people can be dropped off by CIT officers (as an alternative to jail).[12] Failures in implementation of the CIT model could be the reason for unsatisfactory police responses to mental health and other crises, or a lack of improved outcomes for the public, especially those experiencing a crisis. This could include an insufficient number of officers being trained in CIT, or insufficient training for 911 dispatchers. The authors of the review also note that a CIT model is easier to implement in a more centralized or urban municipality.[12] Ron Bruno was a police officer for 25 years before becoming executive director of Crisis Intervention Team International and expressed concerns about insufficient integration of the CIT model into other resources and structures for addressing mental health in the community. He said, "If you keep throwing money at training officers, and that's all you do, and not address the system around mental health care, you'll continue to have nothing but problems."[13]

The authors of the review cite other concerns about the CIT model and its ability to positively impact policing outcomes for civilians.[12] They hypothesize that the 40 hours of officer training required for CIT certification may not be sufficient to override the trained police response to the other characteristics of a situation, since CIT represents only a very small part of police training. Furthermore, if CIT succeeds in one of its primary goals – diverting people from jails to mental health facilities – then it may be shifting the costs of responding to mental health crises from police departments to local mental health facilities. In many cases, public funding for local police departments is much more popular than funding for local mental health services. The authors also note that money spent on implementing CIT is not available to prevent mental health crises, thereby constituting an opportunity cost to using CIT. Others have pointed out that preventing mental health crises through better preventative care and support would be an even better response than hiring mental health professionals to respond to people in crisis.[6]

There is reason to believe that further implementation of the CIT model in the Geneva Police Department may not be a sufficient solution to concerns about police responses to mental health or substance use crises. The numerous tragedies involving police and people with mental illness since CIT was first implemented suggest that either the model or its implementation is insufficient. It is worth noting that the Rochester Police Department was one of the first in New York State to implement the CIT model (2004), and that this did not prevent the killing of Daniel Prude in 2020.[13] And while the January 2023 police beating death of Tyre Nichols was not related to a mental health crisis, it is disheartening that this incident occurred in the very city that developed the CIT model.[14]

A county sheriff in Montana saw value in having mental health professionals assist with police responses, in spite of the fact that all deputies in his department had also received CIT.[5] He commented that "I hear deputies say the mental health provider is a godsend, or they came

in and were able to extend the capabilities of the response. …I hear that routinely now." Similarly, Chief Passalacqua has reported to the PBAB that the ability to contact mental health professionals at Clifton Springs via iPads through the Comprehensive Psychiatric Emergency Program (CPEP) is very valuable to the GPD. Through this system, GPD officers can (with the consent of the person to whom they are responding) request a call on an iPad from a mental health professional at Clifton Springs.[15] Chief Passalacqua reports that this system is used in a majority of instances in which "the individual in crisis is able and willing to speak to the professionals at CPEP virtually." He also reports that the GPD has sufficient tablets to continue using this program, and that no special training is required to use the CPEP system. Occasionally there are short delays due to the availability of mental health professionals to take a call, or a poor connection, but typically these issues can be corrected quickly.

Finally, the mental health of officers themselves must be taken into consideration. Long hours and excess overtime can have a detrimental effect on officer mental health, which may increase the chances of poor outcomes in interactions with the community. The GPD, in particular, has had a delay in filling officer positions in recent years, and it is possible these staffing shortages are negatively affecting officer morale and mental health. It should be normalized rather than stigmatized for officers to seek psychological services, and one suggestion would be for officers to meet with a psychologist quarterly, not just when a use-of-force incident occurs.[17] Research has shown that in a survey of police officers, nearly 80% report experiencing critical stress on the job, which led to recurring memories of incidents, anger issues, sleep problems, and/or family and relationship problems.[17] Furthermore, 90% reported a stigma in seeking therapy.[17] This stigma has resulted in officers being more likely to talk to clergy about issues and feelings rather than family or other officers, and officers may be more likely to speak to each other in a bravado manner to maintain reputation.[17] We recommend that City Council ensure that GPD officers have everything they need to maintain wellbeing, including availability of and de-stigmatization of mental health services.

Recommendations:

1. The City Council fund regular replacement (according to a schedule recommended by the Chief) of the tablets currently being used to connect GPD officers and persons in crisis to mental health professionals at Clifton Springs. It is important that this tool continue to be available to the GPD.
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Chapter 2 - Public Safety and our Elders

In 2002, Lamar Jordan wrote in the *FBI Law Enforcement Bulletin*, "Working with older people will become a necessity for almost all law enforcement agencies. Those departments with community policing objectives should develop special service and crime prevention programs to assist members of the older population." Given finite resources and increasingly more specialized training, is it advisable, even ethical, for the police to act as the first contact or that older folks be essentially confined to a single option? This report attempts a holistic approach to elder care within the realm of public safety and policing and should be considered as part of a broad approach to sustainable public well-being.

Defining the needs of elders within the domain of public safety is complicated. There is a discrepancy, as reported by Brian Payne, between what police consider primary forms of elder abuse worth prosecuting (street offences and white-collar crime) and what social services and health care ombudspeople see as more concerning to elders (nursing home abuse, intimate partner abuse). And then, the interactions of the police and the elderly occur at the more mundane level of property checks (why are newspapers piling up at the front door?) or well-being checks (the older neighbor in apparent distress or confusion) that may elude documentation. So we are confronted with questions of priority and definition of the ways the elderly and the police interact. In turn, this raises the important question of the distinction between *policing* and *public safety* and how resources are distributed to meet the needs of the community.

Turning to Geneva, over the past twenty years, despite a declining but diversifying population, older folks—those 65 or older—remain a steady portion of the overall population of Geneva; 14.8% in the 2022 census. How long this will remain the same given the aging of the overall US population is unknown. Generally, the older population is less affluent (relying on fixed incomes) and less mobile, and have particular needs that often comes with aging, which includes medical care, housing care, transportation. Nearly a quarter of those living at or below the poverty level are 55 or older.[1]

Taken alone, 15% of the population may seem, especially in a small city with finite resources, perhaps not quite rising to immediate attention. But, if we were to combine the needs of older folks, with a poverty rate that is nearly one out of five Genevans, and a large but largely underserved population of Genevans under 18 (also nearly one of every five Genevans is 18 or younger), we may find many synergies that could help redefine the basic sustainable needs of the city and redefine what constitutes "public safety." This is a holistic view—one that extends beyond the police department.

When we turn our attention to concerns more specific to policing, we note that the particular concerns for the elderly are financial fraud, physical and mental abuse, neglect and isolation, and medical neglect. A 2011 study found that only one in twenty-four cases of EM (elderly mistreatment) are reported to social services, police, or other legal authorities (Lifespan of

Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University, New York City Department for the Aging, 2011). Thus we may wish to consider ways that the Geneva Police Department may develop within the department means to address issues facing elders (such as emotional and physical abuse) and fraud whether through training or through social technology. But we may also wish to consider how the GPD could partner with services found in other groups in our community. Or if there are latent structures within the city that could be activated, that could alleviate some potential burdens for the GPD.

While anecdotes may be dismissed as outliers, one can use anecdotes to test a system's ability to provide and support public safety. Jeannie Jennings Beilder, from George Mason University, describes in "We are Family: When Elder Abuse, Neglect, and Financial Exploitation Hit Home," the failure of the local police to intervene, the difficulty of the judicial system to offer protection, and the lack of communication between social services to assist with alacrity the needs of her own grandparents. (Her grandparents provided housing for a relative who became violently exploitive, and the grandparents fell into profound emotional neglect as their physical health and property deteriorated.) Beilder's narrative indicates that elder mistreatment may go substantially under-reported as incidents such as hers do not enter into the police record; the only public record is her 911 call. Though one case, Beilder describes the multiple concerns confronting elders (physical and emotional abuse, financial exploitation, and isolation), the inertia of existing services, whether the local police or Adult Protective Services, and the barriers concerned family members confront in seeking aid. We need to ask if our community would have acted more swiftly.

In a report published in 2014 based on a survey of 141 San Franciscan police officers, authors Rebecca Brown et al., found that "Although 84% of police reported prior training in working with older adults, only 32% rated themselves as knowledgeable about aging-related health." Furthermore, to address challenges often found among elders, officers recommended developing trainings focused on recognizing and responding to aging-related conditions and improving police knowledge of community resources for older adults. They also called for enhanced communication and collaboration between police and clinicians. But we would note that many conditions facing elders, such as mental well-being and social isolation, are not age-governed but are found across the population, and thus there may be important overlaps of care.

In their article, John Schumacher et al., report the rise of geriatric emergency departments in response to the 20 million older adults seeking emergency medical treatment annually in US hospitals over the past seven years. While focusing on enhanced emergency care and specialized personnel for older people within the confines of the hospital, we might consider this as another indication of a much broader social need, in which the typical police department may be the initial but ill-prepared first contact.

Brad Cannell, Lori Mars, and Julie Schoen report in *Generations: The Journal of the American Society on Aging*, that the Elder Abuse Guide for Law Enforcement (EAGLE) is an online resource designed to support officers in detecting and intervening in cases of elder mistreatment. The Detection of Elder abuse Through Emergency Care Technicians (DETECT) project is designed to

help medics identify, document, and report instances of potential mistreatment and neglect occurring in the community. Thus there are programs, protocols, and training available—and no doubt as the awareness of elder mistreatment grows, more will be developed.

With 1 in 4 women experiencing intimate partner abuse and the growing rate of elder abuse, Amanda Chapman in "Police Practice" reports on Jeffersontown, KY's police department (JPD) in conjunction with the 911 Cell Phone Bank (CPB) program to provide cell phone devices or lifelines to vulnerable groups, including the elderly, the unhoused, and abused partners. She concluded: "The JPD began a community drive to collect phones and within a week had collected over 70 to donate to the CPB. This led to another unanticipated benefit—the positive publicity that resulted in community awareness of an effective police program to assist victims. In addition, citizens contributed to the effort by donating unused devices."

Highlighting the Abington, MA police department (APD), Justin Simmons, describes an outreach program hosted by the police for older residents on financial fraud and various scams directed at older folks; a problem that has been increasing with the aging of the general population. This outreach program has expanded to include information on elder mistreatment and exploitation; thus increasing community trust in the APD.

These two reports describe forms of assistance with minimal expense, but also a building of trust between the community and their police departments. They also require the police to integrate an ethics of care into their interactions with the community—indeed to be in the community.

Funding for increased elder care has generally received exceptionally strong support as evidenced from data from Ohio counties. Property tax levies supporting services for the aging were approved 98% of the time in Ohio, according to a study by Robert Applebaum and Chelsea Goldstein, dispelling the myth that Americans believe older folks are already sufficiently compensated and that taxation supporting local human services is excessive. The rate of passage of levies for aging services was 98.4% compared to parks and recreation at 94.3% and police/fire/emergency at 92.3%. Nonetheless, as Applebaum and Goldstein note, all services were well-received, particularly when it was clear that the services would impact the local community.

The city of Albuquerque, instituted Albuquerque Community Safety, as an independent department intended to replace the police for many of the request-for-service calls, particularly those involving a mental health crisis. This program is much like those in Denver (STAR) and Eugene (CAHOOTS). However funding to meet the demand is an issue, as Murat Oztaskin reported in the *New Yorker* in 2023, "[Barron] Jones, of the A.C.L.U., said that for A.C.S. to start making a significant impact its funding needs to be "orders of magnitude above where it's at right now." A.C.S.'s 2023 budget is $11.7 million. The Albuquerque police budget is more than twenty times larger: two hundred and sixty-two million dollars for 2023. It has increased twenty-five per cent since 2020, when the creation of A.C.S. was announced." And in the anecdotes that Oztaskin notes, the A.C.S. is often hamstrung by regulatory barriers (who is allowed to commit a person to a hospital during a mental health crisis) and slow (almost to the point of disregard) police

response times when backups to the A.C.S. are requested. Adequate funding and cohesive, rather than antagonistic, work with the local police department are essential. But it is clear that even with a budget twenty times the size of the A.C.S. budget, the Albuquerque police were not fulfilling the needs of vulnerable residents and considered the A.C.S. as an easy way to shed some of its more time-consuming responsibilities. And it should be noted, the A.C.S. addressed mental health crises, housing crises, immigration issues, and elder care issues.

These training and outreach programs—whether providing more training on medical needs of the elderly or providing lifeline cell phones to vulnerable individuals, for example—offer relatively low-cost interventions. Training existing police officers on areas outside of conventional policing has a questionable efficacy. When questioned at her public lecture at Hobart and William Smith in October 2022 about policing, Linda Dynel, a nationally known advocate for victims of domestic and gender-defined violence, has found training police on the nature of domestic violence and useful interventions to have a minimal effect in changing police behavior among well-established officers. So as Geneva may be embarking on hiring new officers, reconsidering the academic training—does a prospective officer have a BA in an age-related field or MSW—would be necessary. But we should be aware that the GPD's annual budgets have historically placed little emphasis on training—somewhere in the range of 1 to 2% typically. Thus even by their numbers, training (whether firearms or other) is not viewed as essential. There are no funds—as far as this writer could discern—for officers to pursue additional educational training (an MSW, for example, or a certificate in gerontology [an online certificate program is offered by the University of Florida]).

The 2021 Geneva Police Report's detective bureau's table notes that there was only one (1) case of elder abuse investigated. (In contrast, 5 internet cases were under investigation, 120 road assist cases, 163 non-DEU narcotic investigations, and 158 Drug Task Force investigations were listed.) One might argue that narcotic use, for example, is of most concern for the GPD, and elder abuse statistically unimportant. We should, however, reflect that a) reporting elder abuse is difficult for victims of elder mistreatment, who, much like victims of domestic abuse, fear stigmatization, further abuse, or engage in self-denial; b) police, in general, are not trained to recognize it unless it is manifested in pre-conceived forms (i.e. electronic fraud or purse-snatching); and c) the public is not aware of how elder mistreatment is manifested. We must also acknowledge that our culture, rightly or wrongly, assigns priorities (hence budgetary resources) to certain concerns and not others. Casting all of these societal issues as criminalized issues, and not matters of healthcare or economic disparity, is a fundamental problem, but one that can only be noted here.

But there is another story. If we look at the calls for service the GPD receive, included in the 2022 New York State Division of Criminal Justice Services (DCJS) report on the GPD, in 2021 there were 28,843 calls for service. If one excluded property checks, the total fell to 14,631. The DCJS added back 1/3 of property checks—assuming that each required only about 10 minutes to complete, rather than the 30 minutes assumed for other calls—totaling 5,241 property checks. Even the revised property checks account for 27% of police calls for service (using the above assumptions).

Without that adjustment, the percentage of property checks swells to 54.5% of the total calls for service.

Available data do not distinguish who those 5,241 (or 15,724 without the filter) were from or the specific nature of "property checks." Property checks might range from mail and newspapers piling up on the front porch, an unmown yard and no one around—any number of concerns that a caring community seeks to have addressed—but who is best suited for addressing these concerns?

The next largest line item in the DCJS report is "Stopping vehicle" at 1085, followed by "Assist Citizen," with 1030 calls-for-service. Defining what public safety means requires that we begin to understand what occupies, at least in this raw data, much of the energy of the GPD. How much might "property checks" and "assisting citizens" involve concerns often focused on elders and thus the particular difficulties many elders may confront? How much might issues elders face overlap with mental health and physical wellness concerns in the Geneva community? How might intimate partner violence overlap with elder mistreatment? How might the crisis of isolation that many older people face parallel the crisis of isolation teenagers face? The demise of the city's recreation department affects not just kids but seniors, too.

Large cities have various social services—whether housing or health, for example, but volunteer city commissions are another model. They often co-exist with established programs and serve to coordinate services as well as provide a clearinghouse for enquiries. For example, the Advisory Commission on Aging in St. Petersburg, FL includes physicians, health-care providers, and other civic leaders who advocate for elders by seeking grants, collaboration with other governmental entities, and addressing needs.
While this is feasible because St. Petersburg is a large city, and one with a historically older population, such a program could operate in Geneva in tandem with other Finger Lakes communities. Given Geneva's finite resources, how we define and provision public safety is essential; how we consider serving our elders becomes a test for how we treat all.

Geneva is often described as having an acute food-desert problem—lack of grocery stores and public transportation—but we may also consider that we may also face an ethics-of-care desert. No matter what individual non-profits can offer, the community as represented by the city's municipal services might redefine public safety not as police intervention and criminalization, but redirecting those budget outlays (what fiscally does 15,724 "property check" calls represent?) toward a community ethics of care.

Recommendations

These recommendations emphasize collaboration and sharing of resources to address issues that overlap, such as mental health and elder-care. This is not to minimize either these concerns or the resources needed, but to underscore their connections and the need to be sustainable. These recommendations are also intended to be proactive, even activating the tools we have. Geneva, like most of the United States, will become an older community, thus how do we prepare for that?

7. In the city's masterplan, which includes the Public Safety department, **develop shared city-wide resources**, particularly in regard to recreation that might address both ends of the age spectrum—kids and elders.
8. Develop shared resources and expertise between the GPD, other Public Safety staff, the city's other departments, and non-profits and social service agencies. **Greater public outreach** will foster better community relations with the GPD. For example, a program on computer fraud held jointly by members of the GPD and the Geneva Public Library at the Library.
9. Develop a **dedicated phone number** to respond to non-emergency, non-violent circumstances involving the elderly or mentally ill.
10. **Greater training** for officers to better understand the particular (and evolving) crimes against the elderly, as well as the particular needs and best approaches for assisting the elderly. Recognizing who may be frail, who may deny the need for assistance, who insist on dignity, who may be suffering from the onset of dementia, or who may have other health issues difficult to discuss when under duress requires distinct forms of training.
11. Go beyond short-term or in-house (i.e. webinars) training for GPD officers, but **offer scholarships or assistance to officers** wishing to obtain certificates or degrees in geriatrics, social work, or other areas, including mental health and substance abuse. Offering such assistance should also help with police recruitment and retention, as these certificate or degree programs provide substantial professional development opportunities for officers, including those which could be useful in post-police careers.
12. **Hire non-officer social / public health and safety personnel** who would work with the GPD and alleviate the need for GPD officers to respond to non-criminal calls (such as calls to check on or support the elderly, or to respond to mental health crises.

Notes

1. According to the US Census, as of July 2022, Geneva had a population of 12,432, of whom 14.8% were 65 or older (1840 people); 17.2% of the population were 18 or younger. In comparison, according to the 2000 Census, 15.5% the population was 65 or older (or 2109 of an overall population of 13,617). According to the 2022 Census, compared to neighboring municipalities the city of Geneva is a diverse community, with 76% identifying as white. Nearly half the city lives in owner-occupied housing. Almost 11% of the population under the age of 65 identifies as having a disability. According to DataUSA, in 2020 Geneva had a poverty rate of 18.8 % or nearly 2000. Of that 5% of males, and 7% of females, 65 years and older in the City of

Geneva, live at or below the poverty rate. Another 16%, combined of men and women, between the ages of 55 and 64 live at or below the poverty rate. Also according to DataUSA, those living in poverty are mainly white (identifying as white alone is approximately 28%, Hispanic 15%, and Black 7.5%).

Demographic Information

DataUSA, age and poverty: https://university.datausa.io/profile/geo/geneva-ny?redirect=true&sexAgeRacePoverty=ageSexOption

DataUSA, Race and poverty: https://university.datausa.io/profile/geo/geneva-ny?redirect=true&sexAgeRacePoverty=raceOption

2022 US Census: https://www.census.gov/quickfacts/genevacitynewyork

2000 US Census: https://ontariocountyny.gov/DocumentCenter/View/843/City_Geneva?bidId

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