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U.S Department of Health and Human Services

DEPARTMENT OF JUSTICE · OFFICE OF JUSTICE PROGRAMS

BJA
Bureau of Justice Assistance
U.S. Department of Justice

Building Safer Communities: Improving Police Response to Persons with Mental Illness

Recommendations from the IACP National Policy Summit

June 2010

Acknowlegements

The International Association of Chiefs of Police (IACP) would like to acknowledge the Bureau of Justice Assistance (BJA), JEHT Foundation, and the Substance Abuse and Mental Health Services Administration (SAMSHA) for their support of the Improving Police Response to Persons with Mental Illness Summit and the completion of this report. We would also like to thank IACP leadership, staff and the Summit Advisory Group for their contributions.

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Funding for this conference was made possible in part by support from the Substance Abuse and Mental Health Services Administration. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the U.S. Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

This project was supported by Grant No. 2008-DD-BX-0277 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime. Points of view or opinions in this document are those of the author and do not represent the official position or policies of the U.S. Department of Justice.

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Executive Summary

Every day across the country law enforcement officers respond to disturbances or crises involving a child, youth or adult with mental illness. The people experiencing a mental health crisis and their families rely on first responders, particularly law enforcement officers, to respond in an effective manner, treating the person with mental illness with compassion and respect. Law enforcement officers who face these complex situations would like to be as fully prepared as possible so that they can respond in ways that ensure the safety of the responding officers, the person in mental health crisis, and that person's family. Unfortunately, due to the current lack of consistent policy, procedure, training and education among law enforcement agencies, too many of these calls end badly for all involved. Most response calls involving persons with mental illness are not the result of criminal behavior, but of emotional crisis. While law enforcement officers have the duty to arrest anyone who is breaking the law, it is critical for the officer responding to a mental health call to have the information needed to adequately assess the situation and the support required so that a determination of appropriate action can be made in the best interests of the subject, the officer, and the public.

To address this critical law enforcement issue, the International Association of Chiefs of Police (IACP) Past President Ronald Ruecker urged that recommendations be developed that would reduce the risk of law enforcement officer and citizen injury or trauma during police response to incidents involving persons with mental illness. In an effort to make this possible, the IACP, in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA), held a roundtable discussion on the subject in September 2007, with attendees including law enforcement officers and executives, family and youth representatives, and partners from the National Federation of Families for Children's Mental Health (National Federation). The primary purpose of the roundtable was to gain the insights of children and youth with mental illness and their families regarding their perspectives on law enforcement response to crisis calls for service.

Based largely on Ruecker's Presidential Initiative and the concerns raised during the roundtable, the IACP selected "Police Response to Persons with Mental Illness" as the focus for its May 2009 National Policy Summit. The Bureau of Justice Assistance (BJA), SAMHSA, the JEHT Foundation, the National Federation, and the National Coalition of Mental Health Consumer/Survivor Organizations (NCMHCSO) partnered with the IACP to design and sponsor the summit. The scope of the summit was expanded beyond the initially proposed focus on law enforcement response to people in emotional crisis to include other ways in which law enforcement leaders and their sworn and civilian staff can contribute to enhancing communities' responsiveness to persons with mental illness or who are experiencing emotional crisis.

The IACP summit gathered over 100 leaders from across the country to share their knowledge and views on these complex issues. Participants included law enforcement executives and officers, consumers/survivors of mental health services, community and family members, mental health practitioners, representatives of courts and corrections agencies, and researchers. All participants came as equals to the discussion and collaborated to create an action agenda of collaborative solutions to the challenges confronting families, communities, law enforcement and the justice system, and the systems of care responsible for supporting those with mental illness.

This report outlines the scope of the problem, identifies factors that have contributed to current challenges and describes innovative policies, programs and practices that have emerged in recent years to provide a foundation of this blueprint for change. These promising approaches offer safer, more compassionate and often cost-effective ways for police and their community partners to respond to adults and juveniles with mental illness. Ultimately, the effectiveness of these new approaches depends on the strength of the collaborative working relationships on which they are founded and on the willingness of states and localities to invest in providing a continuum of education and training for first responders and effective services and supports for persons with mental illness and their families.

Recommendations developed by summit participants suggest ways that:

- Law enforcement leaders can establish policies, protocols, and strategies to improve their agencies' responses to persons with mental illness.

- Law enforcement officers can best prepare to de-escalate crisis situations to which they are called, to avoid injury and trauma.

- Consumers of mental health services, their families, and advocates, should be engaged in planning, delivering, and monitoring the impacts of crisis intervention training for officers and other crisis responders.

- Essential partners can be engaged to work with state, local and tribal law enforcement agencies to decriminalize (i.e., utilize non-justice system options whenever possible) responses to persons with mental illness, and the strategies these local collaboratives can employ.

- Approaches proven to be effective alternatives to arrest for persons with mental illness apprehended for minor offenses can be implemented.

- School resource officers can be involved in supporting children and youth with mental, emotional, or behavioral issues.

- The unique characteristics of children and youth with mental, emotional, or behavioral issues should be taken into account in developing effective prevention and crisis intervention approaches that will minimize trauma and stigma for these children and their families.

- Law enforcement leaders and officers can support effective reentry strategies and programs for jail and prison inmates with mental illness who are returning to their communities.

- Legislative, funding, and technical assistance initiatives at the federal, state local and tribal levels should be developed to support law enforcement agencies and their partners in enhancing responses to persons with mental illness.

- The IACP can work with its national and local partners to advance the training, policy development, and action research initiatives necessary to enhance police response to people in emotional crisis and persons with mental illness.

The final section of this report highlights recommendations that law enforcement leaders and their line staff can translate into actions that will improve their agencies' response to persons with mental illness. A central goal of these recommendations is to increase the safety of persons with mental illness, their family members, and the officers who respond to crisis calls.

This report is intended to serve as a catalyst, opening dialogue, increasing mutual understanding and strengthening collaboration among all those with a stake in the success of this endeavor – law enforcement, community residents, mental health service consumers and their families, advocacy groups and the mental health and justice systems.

Summit Background and Goals

Every day across the country there are many calls for law enforcement to respond to disturbances involving a child, youth or adult with mental illness. Law enforcement officers would of course like to be prepared to safely respond to these crisis calls in ways that result in a safer, calmer community, family, tribe, or campus. People who are experiencing a mental health crisis and their family members rely on first responders, including law enforcement officers, to respond calmly, compassionately and respectfully to all involved. Successful resolution of emotional crises also requires increased community investment in a continuum of prevention and care options that will enable law enforcement to facilitate positive outcomes in these high-risk situations.

While serving as President of the IACP, (2007-2008) and Director of Public Safety for the City of Sherwood, Oregon, Ronald Ruecker (currently an Assistant Director of the Federal Bureau of Investigation) urged the IACP to design a process to develop recommendations for enhancing police response to persons with mental illness. His Presidential Initiative centered on the goal of reducing law enforcement officer and citizen injury or trauma during police response to incidents involving persons with mental illness. He also emphasized the importance of joining the voices of law enforcement with those of mental health professionals, family members, children and youth advocates, and consumers of mental health services to devise strategies that will improve outcomes for all.

In 2007 the IACP, in collaboration with SAMHSA, held an initial roundtable discussion hosted by the U.S. Capitol Police in Washington, DC. The roundtable participants included law enforcement officers and executives, family and youth representatives, and partners from the National Federation. The primary purpose of the roundtable was to gain the insights of children and youth with mental illness and their families regarding law enforcement response to crisis calls for service. The results of that roundtable, and of a subsequent panel at the National Federation's annual conference, were clear: family members and advocates all concurred that, while they sometimes must call the police to intervene when a family crisis situation results in violence, their experiences with police intervention have often been frustrating and unsatisfying.

Based largely on Past President Ruecker's Presidential Initiative and the concerns raised during the roundtable, the IACP selected "Building Safer Communities: Improving Police Response to Persons with Mental Illness" as the focus for its May 2009 National Policy Summit, the most recent in a series of annual summits that have identified and addressed vital community and law enforcement issues since 1993. The BJA, SAMHSA, JEHT Foundation, National Federation, and the NCMHCSO partnered with the IACP to design and sponsor the summit.

The Advisory Group designing the summit recognized that law enforcement policies and priorities have an impact well beyond the individuals with mental illness to whom they respond as a result of crisis calls for service. In particular:

- Law enforcement interventions can have very different impacts on children and youth with mental, emotional, or behavioral issues in comparison to those experienced by adults with mental illness.
- Law enforcement officers responding to crisis calls for service often interact with family members of the person in crisis who have their own perspectives, resources, and needs.
- Law enforcement executives can influence and provide input to a broad range of public policy and resource allocation decisions relevant to community mental health systems and services.
- In addition to responding to individuals in emotional crisis, law enforcement officers may encounter persons with mental illness who are under justice system supervision or those who are reentering community life after a period of incarceration or residential mental health treatment.

Based on these observations, the scope of the summit was expanded beyond the initial IACP Presidential Initiative's focus on law enforcement response to people in emotional crisis to include other ways in which law enforcement leaders and their sworn and civilian staff can contribute to enhancing communities' responsiveness to persons with mental illness.

The IACP invited over 100 leaders from across the country to share their knowledge and views on these complex issues. Participants included law enforcement executives and officers, consumers/survivors of mental health services, community and family members, mental health practitioners, representatives of courts and corrections agencies, and researchers. All came as equals to the discussion and collaborated to create an action agenda of collaborative solutions to the challenges confronting families, communities, law enforcement and the justice system, and the systems of care responsible for supporting those with mental illness.

The summit began with a keynote address that identified shared issues and promising trends, followed by a plenary panel with members who presented the perspectives of youth, consumers/survivors, family members of persons with mental illness, advocacy organizations, courts, corrections, and law enforcement. Summit participants then gathered in working groups that focused on critical issues facing law enforcement and its community partners. Areas of concern addressed by the groups were:

- Legislation and Policy
- Crisis Intervention/First Responders
- Youth
- Cross-Systems Collaboration
- Reentry into the Community

This final summit report includes recommendations for change that were developed by these working groups. The IACP offers it as a guide for the continuing work of U.S. law enforcement agencies and their community partners to improve police response to persons with mental illness at the federal, state, local, and tribal levels. The recommendations presented here are intended to aid law enforcement agencies in optimizing their crisis response training, reducing liability concerns, improving cost-effectiveness of Crisis Intervention Teams (CIT) and other crisis response programs, and enhancing officer and citizen safety in crisis situations involving persons with mental illness.

Issues and Opportunities

In order to develop a strategy for enhancing law enforcement responses to people with mental illness, it is essential first to understand the issues currently facing law enforcement and its community partners. Outlining the scope of the problem, identifying factors that have contributed to current challenges and recognizing promising policies and practices that have emerged in recent years provides the foundation of this blueprint for change.

People With Mental Illness Involved in the Justice System

Justice systems across the country, with law enforcement agencies on the front lines, have increasingly been required to respond to and intervene on behalf of people who are in emotional crisis. Many but not all of these individuals have been diagnosed with a mental illness. A 2008 BJA report on law enforcement responses to people with mental illness indicates that behaviors resulting from mental illness are a factor in 3 to 7 percent of all law enforcement calls for service. Calls for service involving people with mental illness as suspected offenders, victims or witnesses are often disproportionately time-consuming.[1] BJA reported that a very small proportion of crisis calls involving persons with mental illness tragically result in the injury or death of officers, persons with mental illness, or innocent bystanders.[2]

Persons with mental illness have been stigmatized by a false association between violence and mental illness that has been promoted by the news and entertainment media. In fact, most persons with mental illness never behave violently, and the vast majority of those people who do behave violently are not mentally ill. Research shows that people with mental illness are much more likely to be victims than perpetrators of violent crime.[3]

A number of studies also document that persons with mental illness are more likely than those without mental illness to come into contact with police as suspected offenders, most often for relatively minor offenses,[4] and to be re-arrested more frequently.[5] Some studies indicate that persons with mental illness suspected of committing offenses are more likely to be arrested, particularly if they live in communities with a limited range of community-based intervention options for individuals experiencing a mental health crisis.[6]

According to a 2006 Bureau of Justice Statistics (BJS) analysis, 24% of state prisoners report a recent history of mental illness, as do 21% of jail inmates and 14% of federal prisoners. Nearly three-quarters of these inmates also have a co-occurring substance abuse disorder.[7] About 15% of state prisoners and 24% of jail inmates interviewed for the BJS study reported current symptoms that met Diagnostic and Statistical Manual (DSM) IV criteria for a psychotic disorder, compared to just 3% of the general population.[8] Across all types of adult correctional facilities, the BJS study shows that a higher proportion of female than of male inmates are assessed as having mental health problems. These statistics should

[1] Matt Schwarzfeld, Melissa Reuland and Martha Plotkin. (2008) "Improving Responses to People with Mental Illness: The Essential Elements of a Specialized Law Enforcement-Based Program." Council of State Governments and Police Executive Research Forum, New York.

[2] "Suicide by cop" is a controversial phrase that is sometimes used inappropriately to explain incidents when deadly force was unnecessarily employed by officers responding to persons in emotional crisis. See for example: Centre for Suicide Prevention. (1999) "Suicide by Cop." Canadian Mental Health Association http://www.suicideinfo.ca/csp/assets/alert34.pdf ; and, H. Huston, et. al. (1998) "Suicide by Cop." *Annals of Emergency Medicine* 32: 665-69.

[3] Substance Abuse and Mental Health Services Administration (SAMHSA), Understanding Mental Illness: Factsheet, http://www.samhsa.gov/MentalHealth/understanding_MentalIllness_Factsheet.aspx Last updated 9/24/08.

[4] Melissa Reuland, Matthew Schwarzfeld and Laura Draper. (2009) "Law Enforcement Responses to People with Mental Illness: A Guide to Research-Informed Policy and Practice." Council of State Governments Justice Center, New York.

[5] Ann Crocker, Kathleen Harford and Lisa Haslop. (2009) "Gender Differences in Police Encounters Among Persons With and Without Serious Mental Illness." *Psychiatric Services* 60: 86-93.

[6] Amy Watson, Patrick Corrigan and Victor Ottati. (2004) "Police Responses to Person With Mental Illness: Does the Label Matter?" *The Journal of the American Academy of Psychiatry and the Law* 32:378-85; Hank Steadman, M.W. Deane. R. Borum and J. Morrissey. (2001) "Comparing outcomes of major models of police response to mental health emergencies." *Psychiatric Services* 51:645-49.

[7] Doris James and Lauren Glaze. (2006) "Mental health problems of prison and jail inmates." US Department of Justice, Bureau of Justice Statistics Special Report.

[8] Ibid.

not be interpreted as evidence that persons with mental illness are inherently likely to be lawbreakers, but rather as indicators that too many of these individuals who are unable to find supportive services behave in ways that bring them to the attention of law enforcement and the courts.

A more recent (2009) study by the Council of State Governments and Policy Research Associates shows that jail inmate populations still have a disproportionate number of persons with mental illness. Of particular interest is the finding that the percentage of female jail inmates with serious mental illness (31%) is double that of male inmates (14.5%).[9] Research on female offenders documents that women who enter the criminal justice system are more likely than male offenders to have been victims of sexual and physical abuse, and a large proportion suffer from co-occurring mental health and substance abuse disorders.[10] Despite the relatively high prevalence of mental illness among jail and prison inmates, the 2006 BJS study documented that only about one-third of state prison inmates with mental illness and one-sixth of local jail inmates with mental illness receive any type of mental health treatment while they are incarcerated. The American Psychiatric Association asserts that "being thrown into the hostile world of the prisoner is almost certain to make any existing psychiatric condition worse" and "failure to treat [can cause some inmates with mental illness to] become resistant to treatment." [11]

Compounding the problem, most inmates lose access to Medicare, Medicaid and Social Security benefits during their jail or prison term, and when they are released many do not receive timely assistance in re-applying for these entitlements. Without supportive resources, persons with mental illness released from jail or prison are at high risk of continuing to be untreated, remaining or becoming homeless, re-offending, and making extensive use of costly emergency medical services.[12]

Children and youth who are seriously emotionally disturbed and come in contact with juvenile justice system fare no better than their adult counterparts. A 2006 Office of Juvenile Justice and Delinquency Prevention report indicates that in Cook County Illinois 60 percent of male and 70 percent of female juvenile detainees meet diagnostic criteria for one or more psychiatric disorders, but receive little or no mental health treatment during their detention.[13] Even more surprising, a 2004 report to Congress by the Special Investigations Division of the House of Representatives documented that in 280 detention facilities from around the country (those able to supply data), during the first six months of 2003, nearly 15,000 children and youth with mental illness were held without charges while waiting for access to scarce community mental health services, representing 8% of the total number of juveniles held by these facilities.[14] It is likely that most of these children and youth come from poor or underinsured families unable to afford private mental health treatment or other supportive services.[15]

Causes of the Overrepresentation of People with Mental Illness in the Justice System

Many trends have converged to result in jails, prisons and juvenile detention centers housing a larger number of persons with mental illness than do publicly funded mental health treatment facilities. The Community Mental Health Centers Act (CMHCA), passed more than forty years ago, initiated the process of deinstitutionalization of the United States mental health system. Between 1955 and 2005, the national ratio of available public hospital (state and county) beds per 100,000 population decreased by 95 percent (from 340 to 17 per 100,000).[16] In contrast, the number of inmates in the nation's jails

[9] Council of State Governments Press Release 6/01/09. http://consensusproject.org/press_releases/new-study-documents-high-prevalence-of-serious-mental-illnesses-among-nations-jail-populations

[10] Barbara Bloom, Barbara Owen and Stephanie Covington. (2003) Gender Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders. National Institute of Corrections.

[11] The American Psychiatric Association (APA). (2004) "Mental Illness and the Criminal Justice system: Redirecting Resources Toward Treatment, Not Containment." Resource Document. Arlington VA.

[12] National Alliance on Mental Illness (NAMI). " CIT Toolkit: Criminalization Facts." Arlington, VA.

[13] Linda A. Teplin, Karen M. Abram, Gary M. McClelland, Amy A. Mericle, Mina K. Dulcan, and Jason J. Washburn. (2006) "Psychiatric Disorders of Youth in Detention." Office of Juvenile Justice and Delinquency Prevention Bulletin

[14] United States House of Representatives Committee on Government Reform, Special Investigations Division. (2004) "Incarceration of Youth Who Are Awaiting Community Mental Health Treatment in the United States."

[15] Op. cit., APA (2004).

[16] EF Torrey, Kurt Entsminger, Jeffrey Geller, et. al. "The shortage of public hospital beds for mentally ill persons: a report of the

and prisons tripled between 1985 and 2005, while the incarceration rate rose from 313 to 737 per 100,000.[17]

The infusion of public resources into community mental health options that was supposed to accompany deinstitutionalization has never materialized. People with mental illness who are unable to obtain effective treatment through the limited and often uncoordinated resources that are available are likely to behave in ways that bring them into contact with law enforcement. In far too many communities the local jail is the primary or only location available for police to bring those who are behaving erratically due to mental illness.

Hospital emergency rooms, another referral option used by law enforcement officers for persons with mental illness who are in crisis, are often ill-equipped to appropriately respond to these individuals. Because of the lack of crisis mental health services and outpatient and residential treatment options in communities across the country, the American College of Emergency Physicians (ACEP) documents in its 2008 survey that the number of persons with mental illness who must await appropriate placement while being "boarded" in hospital emergency rooms is significant and growing. This contributes to overloading emergency departments and negatively affects access to emergency services for all patients.[18]

Simultaneous with deinstitutionalization, court litigation was initiated on behalf of persons with mental illness that revealed inhumane and unsafe conditions in publicly funded mental hospitals and provided for the first time increased due-process safeguards that protect persons with mental illness from being subjected to such conditions. At the same time, debate has raged about the efficacy of involuntary commitment to psychiatric facilities, which has become more rare and subject to stricter court oversight.

The growing scarcity of community-based mental health services and resources has likely led some law enforcement officers to arrest persons with a mental illness who they would otherwise not have arrested in the hope that these individuals will receive services not available through other avenues. This tendency has also been cited as an unintended consequence of implementing court-based diversion programs (e.g., mental health courts) without also ensuring that community mental health and pre-booking diversion options are adequate and accessible.[19]

Another trend that has increased the likelihood that persons with mental illness will be arrested is law enforcement's increased emphasis on responding assertively to "quality-of-life" crimes. These include petty theft, aggressive panhandling, public urination, littering, and trespassing; offenses that often characterize the behavior of homeless people with untreated mental health disorders. Unless enhanced enforcement is accompanied by creative community sanctioning options and increased access to treatment and support services, persons with mental illness committing these "nuisance" offenses will likely become trapped in a repetitive cycle of arrest, short jail stays, and return to the streets *without treatment* to commit more minor illegal acts that result in their re-arrest.

Treatment Advocacy Center." Consulted June 15, 2009.
http://www.treatmentadvocacycenter.org/storage/tac/documents/the_shortage_of_publichospital_beds.pdf

[17] Bureau of Justice Statistics Key Facts at a Glance: correctional populations. Consulted June 15, 2009.
http://www.ojp.usdoj.gov/bjs/glance/tables/corr2tab.htm

[18] ACEP Psychiatric And Substance Abuse Survey 2008,
http://www.acep.org/uploadedFiles/ACEP/Advocacy/federal_issues/PsychiatricBoardingSummary.pdf

[19] Robert Bernstein and Tammy Seltzer. (2003) "The Role of Mental Health Courts in System Reform."
http://www.bazelon.org/issues/criminalization/publications/mentalhealthcourts Consulted July 21, 2009.

Promising Directions

It has become apparent that over the past several decades the United States has replaced one dysfunctional system for addressing the needs of persons with mental illness--state hospitals that were often merely warehouses for persons with mental illness--with another--local jails and state prisons that are unsuited and unable to provide adequate mental health treatment. Clearly it is time to redirect societal resources from containment to treatment of people with mental illness whose behaviors are seen as annoying, troubling or threatening.

In a number of jurisdictions, law enforcement agencies have partnered with justice system, mental health and community partners to develop more compassionate and cost-effective approaches that emphasize providing community-based treatment instead of arrest and incarceration for adults and juveniles with mental illness. Several of these promising options are briefly described below. Their effectiveness depends to a large extent on the strength of the collaborative working relationships on which they are founded.

Crisis Intervention Teams (CIT):

CIT is a pre-booking jail diversion program intended to "improve the outcomes of police interactions with people with mental illnesses"[20] by de-escalating crisis situations, decreasing the use of force by officers and increasing mental health consumers' access to community treatment options. Key to this initiative, according to the National Alliance on Mental Illness (NAMI), is ongoing collaboration between law enforcement, mental health professionals, consumers, their families and advocates.

In jurisdictions that have implemented CIT, its central feature is a 40-hour training program for law enforcement officers that includes information on how to recognize the behavioral characteristics of persons with mental illness; local mental health system characteristics; and methods of de-escalating crisis situations. In most communities, some of the training is planned and delivered by mental health consumers and family members. In some jurisdictions, only select law enforcement officers who volunteer for CIT or who carry an electronic control weapon receive the training, but in an increasing number of jurisdictions, all officers, both new recruits and veterans, are required to complete the full 40 hours of CIT training. For instance, the Southwest Louisiana CIT includes five parishes of law enforcement agencies that partner with advocacy groups, family members, and medical professionals to form their emergency response. The Calcasieu Parish Sheriff's Office and the Lake Charles Police Department coordinate a 40 hour first responder certification class, a school resource officer 40 hour certification class, and two eight hour certification classes for public safety dispatchers each year. Since its inception, Southwest Louisiana CIT has certified nearly four hundred peace officers, medical professionals, and area teachers and educators.

[20] NAMI CIT Toolkit: CIT Facts. *www.nami.org*

Law Enforcement and Mental Health Co-Responder Teams:

Initially developed in Los Angeles, this approach pairs trained police officers with mental health professionals in teams that provide specialized responses to incidents involving persons with mental illness.[21] These teams can be called in to assist when responding officers or SWAT teams are unable to de-escalate a situation involving a person known or presumed to have a mental illness. Some communities have mobile crisis teams comprised of mental health professionals who are available to respond to 911 calls at the request of responding officers. Because they take some time to mobilize, these specialized teams are not intended as alternatives to CIT but rather as supplemental resources that can assist law enforcement with resolving calls for service that are particularly challenging or threatening to suspects with mental illness, officers or bystanders.

Assertive Community Treatment (ACT) Approaches:

ACT is a model that has proven over the past three decades to be more effective than traditional office-based mental health treatment for those who are most severely disabled/affected by their mental illnesses. Key features of the ACT approach are a team approach to working with consumers in their own environment, focus on crisis prevention, and commitment to time-unlimited service and support of clients.[22] For individuals resistant to medication and treatment who come into frequent contact with law enforcement both as victims and offenders, ACT provides an option that can reduce their incidence of homelessness, emergency hospitalization and incarceration. Forensic Assertive Community Treatment (FACT) programs have been implemented by some communities as a way to break the cycle of chronic re-arrest experienced by persons with serious mental illness who have not been well-served by traditional treatment methods. These programs depend on the collaboration of mental health professionals, law enforcement, and local jails to maximize their effectiveness.

Mental Health Consumer-Driven Services:

Many consumers of mental health treatment, their families and advocates have united to urge that all services be focused on recovery rather than simply on symptom management or maintenance.[23] There are hundreds of non-profit, mental health consumer-run organizations in the U.S. and internationally with track records providing evidence that many individuals labeled with mental illnesses can and do recover.[24]

Consumer-driven approaches consistent with principles of hope, self-determination, choice, and dignity differ from traditional treatment approaches by empowering consumers/survivors to offer support to one another. Consumer-driven peer support is based on the principle that people who have experienced mental health recovery can provide effective support to others in ways that will enhance and support their own recovery. This approach encourages the development of reciprocal relationships between givers and receivers of support that enable both parties to feel valued and empowered, thus facilitating their well-being and increasing their opportunities for meaningful community integration. Peer support can reduce the risk of institutionalization and incarceration through offering a wider array of options for persons with mental illness to work with strong emotions in comfortable, non-judgmental environments. Helping individuals develop new stress management skills and options reduces the risk of them experiencing emotional crises that may require law enforcement intervention.

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[21] Op. cit. Schwarzfeld, Reuland and Plotkin. (2008).

[22] Assertive Community Treatment Association. http://www.actassociation.org/actModel Consulted July 31, 2009.

[23] Daniel Fisher and Judi Chamberlain. (2004) "Consumer-Directed Transformation to a Recovery-Based Mental Health System." National Empowerment Center, Inc.

[24] Some examples of successful consumer-drive programs are Stepping Stone Peer Support and Crisis Respite Center in Claremont NH, *www.steppingstonenextstep.org*: Main Street Housing, Inc. in Baltimore MD, *www.onourownmd.org* ; and Collaborative Support Programs of Freehold NJ, *www.cspnj.org*

Grass-roots, peer-run programs led by and for people in recovery from mental illness clearly are an important part of the continuum of services that should be offered to persons with mental illness who come into contact with law enforcement. These programs can encourage community integration in ways that are beyond the capacity of professional mental health practitioners.

Jail and Prison Reentry Programs:

Concern about how best to support people reentering society after a period of incarceration has grown substantially in recent years. Several federal initiatives have funded program planning and evaluation to determine the most effective approaches. The National GAINS Center, with funding from the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment, has developed the Assess, Plan, Identify, and Coordinate (APIC) model that can "guide transition planning for people with co-occurring mental illness and substance use disorders, improve the chances of successful reentry, and reduce relapse and recidivism."[25] Another initiative, the "Outside the Walls" project of the Urban Institute, documents the successes of a wide variety of community-based reentry programs in decreasing the recidivism of people returning from prison.[26] The success of all of these reentry initiatives depends in large part on the collaboration of local, state, federal, and tribal law enforcement with the many other agencies that must commit to ensuring that returning inmates, particularly those with mental health issues, receive appropriate support and treatment that will enable them to avoid re-offending or relapsing. For a valuable IACP resource guide on reentry strategies that have shown to improve success rates at the local level, see: http://www.theiacp.org/Portals/0/pdfs/Publications/CISOMResourceGuide.pdf

Federally Funded Initiatives:

In 2004 Congress enacted the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) which created the Justice and Mental Health Collaboration Program (JMHCP) to help states, local jurisdictions, and tribes design, implement, and enhance collaborative efforts between adult and juvenile justice and mental health systems. In 2008 Congress reauthorized the MIOTCRA at $50 million per year until the year 2013. This reauthorization expands training for law enforcement and supports development of law enforcement receiving centers to assess individuals in custody for mental health and substance abuse treatment needs.

Federal agencies, particularly SAMHSA and BJA, continue to provide grants that support development of innovative approaches to enhancing police response to persons with mental illness (see subsequent recommendations on Legislative, Funding and Technical Assistance for more details on these and other federally sponsored initiatives). The Summit process coordinated by the IACP and summarized in this report was sponsored in part by SAMHSA and BJA.

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[25] Fred Osher, Henry J. Steadman, and Heather Barr. (2002) "A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-Occurring Disorders: The APIC Model." The National GAINS Center, Delmar NY.

[26] Amy L. Solomon, et. al. "Outside the Walls: A National Snapshot of Community-Based Prisoner Reentry Programs." *http://www.urban.org/UploadedPDF/410911_OTWResourceGuide.pdf and www.reentrymediaoutreach.org*

Summit Recommendations

Summit participants developed multifaceted recommendations for improving police response to persons with mental illness. A central goal of Summit recommendations summarized in this document is to keep people with mental illness from entering the justice system. This requires that mental health systems at the state, local, and tribal level have the resources and capabilities to provide services to all those in need. The first set of recommendations focuses on strategies to improve the quality and accessibility of community mental health services and outlines the ways that law enforcement can support these efforts.

All five working groups emphasized the fundamental importance of engaging a broad range of key stakeholders in community-wide collaborations. Since mechanisms for structuring and sustaining community-wide collaborations provide the foundation for accomplishing many other goals, recommendations to enhance local collaborations and their impacts are outlined next.

Communities vary dramatically in resources available to support local collaboratives. Recognizing that smaller and tribal communities have distinct challenges, summit participants recommended considering regional partnerships to assist smaller communities with implementing recommended training and crisis intervention strategies.

The "sequential intercept model" proposed by Munetz and Griffin provides a helpful framework for planning systems change, conceptualizing justice system decision points as a series of "filters" which can serve to divert persons with mental illness from further involvement with the justice system. Consistent with fundamental Summit goals, this model is based on the assumption that "the presence of mental illness should not result in unnecessary arrest or incarceration" simply because of lack of access to appropriate treatment, housing or other supportive services. Ideally, best clinical practices should enable most persons with mental illness to avoid any involvement with the justice system.[27]

Recommendations for justice system policy and program change in the following pages are organized according to decision points ("points of interception"), from crisis response through post-arrest diversion and reentry. Some of the proposed change strategies discussed below will best be led by law enforcement, and all others will benefit from police support.

Legislative and funding initiatives necessary to promote and enable recommended changes are described after the decision point recommendations. The report concludes with an action agenda for law enforcement leadership that summarizes recommended change strategies to be led or supported by law enforcement agencies at the state, local and tribal levels.

Improving Quality and Accessibility of Community Mental Health Services Recommendations

Ideally, the only persons with mental illness who should come into contact with law enforcement are those who are suspected of committing crimes or who are a danger to themselves or others. If mental health services and other social support systems, especially affordable housing, were functioning optimally, a much smaller proportion of persons with mental illness would likely engage in criminal, threatening or suicidal behavior. Therefore, preventing people with mental illness from coming into contact with law enforcement depends on having a mental health system that is accessible, culturally competent and effective for persons with mental health disorders, and on having triage systems in place to refer persons with mental illness to treatment and other supportive services before they behave in ways that require law enforcement intervention.

Ensuring that community mental health services have sufficient capacity has become an even more challenging task in the wake of the current recession. A recent survey by the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) reports that 32 states (of 42

[27] Mark R. Munetz and Patricia A. Griffin. "Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness." *Psychiatric Services* 57:4, April 2006. www.ps.psychiatryonline.org

responding) plan to cut funding for community mental health by an average of 14% (total for FY 2009 and 2010). In 28 of these states, Medicaid funding for mental health care is also being reduced.[28] Unless these trends are reversed and mental health care is adequately funded, a larger proportion of people with mental illness will be unable to access treatment and therefore more likely to show up in emergency rooms, to require hospitalization, and to come into contact with the justice system. The situation is critical in many states, as noted in a report on community mental health funding for the Ohio mental health system that asserts "the ability of the mental health provider network to survive cuts of this magnitude is doubtful. Provider rates have not changed since 1997. As funding for non-Medicaid services dries up and as Medicaid rates fail to keep up with inflation, more and more providers of mental health services will leave the marketplace, decreasing system capacity and consumer access."[29]

Decriminalizing mental illness is both compassionate and cost-effective. In order to accomplish this goal, law enforcement leaders must work with their community partners in local, collaborative policy development groups to ensure that community mental health services are adequately funded. Maintaining persons with mental illness in their communities costs taxpayers much less than repeatedly recycling them through the justice system.

1. **Law enforcement executives should work with other community leaders to ensure that community mental health service systems are adequate and accessible to people in need.**

   As the American Psychiatric Association states, "when best practices are deployed, people with mental illness are maintained within the health and human resources systems, treatment is provided, the cycle of recidivism never has a chance to begin, and public safety is better served."[30] As competition for increasingly scarce public funds intensifies, it will become even more important for law enforcement leadership at national, state, local, and tribal levels to advocate for full funding of mental health care.

2. **In order to keep persons with mental illness from unnecessary involvement with the justice system, mental health treatment and supportive services should be organized around programs and strategies that have been proven effective for this population.**

   An effective community-based continuum of care should include outreach services like assertive case management, use of the most effective psychiatric medications, family psychoeducation programs, consumer-run programs focusing on recovery, and integrated substance abuse and mental health treatment for those with both substance abuse issues and mental illness (the dually diagnosed), who are at greater risk of being arrested and jailed.

   In addition, the availability of safe and affordable housing and social support services is essential for many persons with major mental illnesses. There must also be adequate capacity in specialized community mental health residential facilities that provide crisis intervention, stabilization and longer-term care as needed. Finally, communities should provide mental health crisis intervention services such as crisis hotlines and mobile crisis teams that can operate without law enforcement intervention except in circumstances where individual or public safety is at issue. In rural areas, some of these services, particularly residential options, may best be provided on a regional basis, with primary health care practitioners providing their patients screening and referral to mental health services as well as ongoing case management.

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[28] National Association of State Mental Health Program Directors Research Institute, Inc. (NRI). (2008) "SMHA Budget Shortfalls: FY 2009, 2010 & 2011." *http://www.nri-inc.org/reports_pubs/2009/BudgetShortfalls.pdf*

[29] John Honeck. (2009) "Proposed Funding Levels Push Community Mental Health System to Brink of Collapse." The Center for Community Solutions.

[30] APA. (2004) Op. cit.

3. **Local multidisciplinary advisory groups (see Community-Wide Collaboration Recommendations) should develop policies and protocols for emergency dispatchers that encourage referring calls for service involving persons with mental illness who are not suspected of criminal conduct or dangerous to self or others to mobile crisis teams rather than to law enforcement.**

   An increasing number of communities across the country have implemented mobile crisis teams comprised of mental health professionals operating under the auspices of public and private non-profit agencies. These teams can be called by those who are concerned about a person with mental illness, including family members, neighbors, friends, landlords, clergy or law enforcement officers. In order to minimize trauma that can occur when law enforcement officers are first responders to a mental health crisis situation, it is desirable for mobile crisis teams to be first responders to psychiatric emergencies that do not present a safety risk, as assessed by 911 dispatch services. In communities with 311 non-emergency call service (as of September 2008, about 18% of the US population had access to the 311 number[31]), this may serve as another means of diverting persons with mental health issues from law enforcement to treatment and other supportive services.

   Research indicates that mobile crisis teams are cost-effectively reducing the use of emergency medical services and arrest, and are perceived positively by consumers and law enforcement.[32] To ensure that the unique needs of youth with mental illness in crisis are addressed, communities should provide mobile crisis teams that specialize in child and adolescent crisis intervention. Optimally, mobile crisis teams should be available 24/7 so that law enforcement does not become the default responder simply because other crisis response resources are not available. In rural areas, cities or counties can form consortiums to support mobile crisis teams able to serve large geographic areas.

4. **School personnel, including administrators, teachers, counselors and school resource officers (SROs), should be trained and supported in identifying children and youth at risk of an emotional or mental health crisis and referring them and their families to appropriate mental health treatment and other services before they are actually in crisis.**

The earlier that someone with mental illness is properly assessed, and if necessary, receives appropriate treatment and support, including particularly peer support services, the more likely it is that a potential crisis can be avoided.

Community-Wide Collaboration Recommendations

Summit participants agreed that it is vital to expand and strengthen community partnerships to help ensure that people experiencing mental health crises are diverted to non-justice system options as often as possible. There was also consensus that collaborative working relationships must be tailored to local circumstances and priorities. Specific recommendations for strengthening collaboration across agencies and within local communities follow.

1. **Law enforcement agencies should take the lead in establishing local multidisciplinary advisory groups to focus on decriminalizing responses to persons with mental illness.**

   These multidisciplinary groups should engage a broad range of stakeholders, including representatives of the local justice system (the judiciary, prosecution, defense bar, community corrections and jail), mental health agencies, health care and supportive housing providers, adult and youth mental health consumers/survivors and their families, and advocacy organizations

[31] Dispatch Magazine Online. *http://www.911dispatch.com/info/311_page.html*

[32] Roger L. Scott. (2000) "Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction." Psychiatric Services. 51: 9.

such as the National Coalition of Mental Health Consumer/Survivor Organizations (NCMHCSO). Others who may be invited to participate in selected planning and policy-making efforts include local school districts, child welfare agencies, affordable housing providers, and state corrections agencies. This stakeholder team should develop shared goals and objectives and establish a common language that will facilitate open communication and information-sharing. The group should also clarify the roles that each agency represented on the team will play in strategies designed to resolve crisis situations with non-justice system responses/interventions.

2. **As part of developing shared goals, the local advisory group should establish performance measures that will be used to monitor progress in improving outcomes of responses to persons with mental illness.**

   By connecting its goals and strategies to expected outcomes and defining benchmarks or indicators of progress, advisory group members can establish a system of performance measurement that will enable continued fine-tuning of the partners' approaches and protocols. As part of this work, agencies should develop mechanisms for routinely collecting, analyzing and sharing information relevant to the agreed-upon performance measures. These measures could include the proportion of crisis situations involving persons with mental illness that result in arrest and booking into jail, and the cost per case for those resolved via non-justice system responses or interventions. Carefully documenting progress toward goals will not only inform the group and its community, but will also provide practice-based evidence upon which program providers can rely in their funding requests.

3. **A central goal of local advisory groups should be collaborative development of guidelines that will inform all law enforcement encounters with persons with mental illness who are in crisis.**

   Through sharing experience and perspectives with their community partners, law enforcement agencies will be able to develop best practice policies and decision tools that lead to better outcomes for their encounters with people with mental illness. Key partners in this work are health and mental health first responders, mental health consumers and their families, and mental health agencies that provide residential and outpatient treatment options.

4. **To ensure that appropriate resources are available to law enforcement officers and others responding to persons with mental illness, local advisory groups should maintain an up-to-date inventory of available resources and develop plans for addressing identified gaps in the continuum of options.**

   First responders need to have information about options available to them when they are called to intervene in situations involving persons with mental illness. By sharing information on available resources, including eligibility criteria and capacities, advisory team members can help ensure that first responders are knowledgeable about the continuum of justice and non-justice system alternatives they can utilize to de-escalate and resolve crisis situations. Based on the results of a systematic inventory, group members can also work together to plan, advocate for and implement services that are missing from or not adequately represented in the community's continuum of mental health care.

5. **Local advisory group members should collaborate to develop educational materials and strategies to inform consumers, families and community members about mental health issues and to engage them in efforts to ensure that there is a full range of services and supports available to people with mental illness.**

   Consumers, their families, and other community members should be informed about all options available to them in mental health crisis situations, so that law enforcement will be called only when

necessary and appropriate. Community-wide education can also help to reduce stigmatization and fear of persons with mental illness and increase their acceptance in mainstream culture. Informed citizens, mental health consumers and family members are among the most effective advocates for resources and for changes in laws and policies necessary to provide cost-effective services to persons with mental illness.

Community education efforts should utilize multiple methods and venues, including but not limited to public service announcements (PSAs), presentations to civic and faith-based groups, school-based programs, and community-based print and electronic media. Many law enforcement agencies have experience with community education that will be useful to the advisory group in designing and implementing local mental health public information initiatives.

6. **Local advisory groups should review training protocols for law enforcement and other agencies that serve persons with mental illness in crisis and make recommendations to improve training curricula and methods as needed.**

   A multidisciplinary group is well-positioned to recommend topics that should comprise a comprehensive training curriculum for law enforcement and other first responders. The group can also suggest techniques and approaches that will maximize positive impacts for all participants. Participating agencies can provide qualified trainers to work with consumer representatives to provide ongoing training opportunities. (See Justice System Decision Point Recommendations, Law Enforcement Crisis Intervention Strategies, Recommendation 4 for more detailed proposals regarding content and approaches.)

7. **Law enforcement executives and other agency leaders should support and encourage their middle management and line staff in developing mutually respectful working relationships with their peers in partner agencies.**

   In a crisis situation, the quality of relationships between those who are making decisions can affect the outcomes of those decisions for all involved. Cross-training has been shown to be an effective strategy for building trust and mutual understanding among professionals from different agencies. (See Justice System Decision Point Recommendations, Law Enforcement Crisis Intervention Strategies, Recommendation 6.)

8. **Protocols enabling agencies to share essential information about persons with mental illness who are in crisis should be established and maintained by the multidisciplinary advisory group.**

   Maintaining confidentiality of consumers' mental health records is an important priority for treatment agencies, and most state statutes require patients' written consent for clinicians to share information with others.[33] Local mental health advisory groups should develop internal protocols to obtain such consent as appropriate, and establish Memoranda of Understanding (MOUs) that define the types of information that can be shared, and when, how and with whom the information will be shared. Family members may also be able to provide information in the event of a crisis involving their loved one. One local advocacy group suggests preparing a crisis file of materials that can easily be shared with treatment or law enforcement professionals who respond to a call for service.[34] The central goal of information-sharing is to ensure that law enforcement officers and/or their crisis intervention partners have knowledge that can help them to avoid injury or death and achieve a positive resolution when responding to a crisis call for service.

[33] Council of State Governments Justice Center. (2002) *The Criminal Justice / Mental Health Consensus Project Report*. http://consensusproject.org/jc_publication

[34] See, for example, NAMI of Metropolitan Baltimore's publication *Beyond Punishment: Helping Individuals with Mental Illness in Maryland's Criminal Justice System. (2008)* http://www.nami.org/Content/Microsites82/NAMI_Metropolitan_Baltimore/Home78/Mental_Health_Crisis_and_Criminal_Justice_Resources1/BeyondPunishment-Version1.2LoResforwebsiteposting(2).pdf

Justice System Decision Point Recommendations

In the "sequential intercept" framework, the overarching goal is to filter out as many people with mental illness as early as possible in the sequence of intercepts (justice system decision points). In communities with limited mental health resources and little or no collaboration between justice and mental health systems, the "filters will be porous," but as collaboration and services are enhanced, filters "will become more finely meshed, and fewer individuals will move past each intercept point."[35] Recommendations developed by Summit participants are presented by key justice system decision points.

Law Enforcement Crisis Intervention Strategies

When law enforcement officers are called to intervene in a situation involving a person with mental illness who is in crisis, the outcome of their response depends upon many variables, including the officers' training and experience, the quality of information received from dispatchers prior to entering the scene, the ability to take the time needed to make assessments, their knowledge and understanding of the community to which they are responding, their access to mental health professionals' support as needed during the call, and the availability of non-justice system referral options. Many law enforcement agencies have been working with their community partners for a number of years to improve their agencies' responses to persons with mental illness. Because law enforcement officers have discretion to choose how to intervene in a crisis situation, it is essential that they be fully informed about available options and trained to select the one most likely to be effective in safely resolving each situation.

The following recommendations were developed by Summit working groups to guide law enforcement agencies interested in further enhancing the quality and results of their mental health crisis intervention responses. These strategies are founded on the community-wide collaboration approaches outlined earlier, and assume that most law enforcement agencies will choose to adopt and sustain some form of the Crisis Intervention Team (CIT) approach briefly described earlier in this report.

1. **Law enforcement leaders should work with their personnel to establish the goals of their encounters with persons with mental illness and to put in place mechanisms for recognizing officers and other staff with exemplary skills and documented results in achieving the stated goals.**

   Summit participants recommend that officers make the safety of all who are involved in or could be affected by the crisis situation their first priority. To de-escalate situations requires that officers communicate respectfully with persons with mental illness, practice active listening, and avoid stereotyping.

   Law enforcement agencies also should strive to increase the number of persons with mental illness that officers are able to divert to non-justice system options in lieu of arrest. Another overarching objective should be to minimize the trauma that can occur when people with mental illness encounter law enforcement officers.

   These and other goals can be translated into performance measures that law enforcement agencies can use to monitor their progress and fine-tune their approaches when responding to persons with mental illness.

2. **Law enforcement leaders should consider developing mental health crisis response resources within their agencies to assist CIT officers in responding to persons with mental illness.**

   A number of law enforcement agencies around the country have not only implemented CIT but also have augmented that approach with mental health professionals hired as staff members to provide on-site and telephone consultations to officers in the field. In a few communities, mental

[35] Munetz and Griffin. (2006). Op. cit.

health agencies have located some of their staff members in law enforcement facilities to provide these services. This approach can provide more immediate access to mental health consultation than can mobile crisis teams comprised of mental health staff that may not be available 24/7 and usually cannot respond to a call for service in less than 15 minutes.

3. **Law enforcement agencies should develop detailed policies directing officers to avoid use of restraint techniques or other control mechanisms unless they determine that these are the only means to ensure the safety of those involved in a mental health crisis situation.**

   Officers should be committed to using every possible means to verbally de-escalate crisis situations and calm persons with mental illness who are agitated before resorting to use of handcuffs or other physical restraints. Electronic control weapons should be even further along the continuum of methods used to control agitated individuals, and firearms are, of course, to be used only in life-threatening situations.

4. **Law enforcement agencies should carefully review their training curricula to ensure that they collectively cover all topics necessary to prepare officers to respond to and communicate effectively with persons with serious mental illness who are in crisis.**

   Essential topics to be covered by comprehensive CIT training include behaviors associated with current Diagnostic and Statistical Manual (DSM) IV categories of serious mental illness and developmental disabilities (e.g., autism spectrum disorders); issues unique to youth with mental illness; co-occurring disorders; psychotropic medications and their effects; de-escalation techniques; communicating effectively with consumers and family members; preventing unnecessary use of force; resources available in the local community for persons with mental illness; policies, procedures and decision-making tools for responding to mental health crisis situations; cultural sensitivity guidelines; and liability issues and concerns.

5. **Law enforcement executives should determine, with input from their community partners, whether all officers will be required to participate in comprehensive CIT training or whether it will be a voluntary program with some agreed-upon level of basic crisis intervention training required for all other officers.**

   Local law enforcement agencies should determine whether all line officers will be required to take comprehensive CIT training based on community needs and priorities and on the availability of crisis response capacity in the local mental health system. At a minimum, it is recommended that enough officers to cover all shifts and geographic service areas receive such training, and that sworn supervisory personnel also participate in this training. Optimally, all police personnel should receive basic training and periodic updates on mental health issues as part of academy, agency orientation, in-service and ongoing roll call trainings. Smaller, rural and tribal law enforcement agencies may find it advantageous to collaborate with nearby jurisdictions to obtain training for their personnel.

6. **Cross-training opportunities for mental health professionals and other stakeholders should be incorporated into law enforcement agencies' CIT training curricula.**

   Inviting mental health professionals and other crisis response partners (e.g., emergency service dispatchers, social workers, residential housing counselors, mental health and supportive housing case managers, nurses, emergency medical technicians, school resource officers, victim advocates, and advocates for persons with mental illness and their families) to participate in CIT training will nurture cross-system understanding, help develop a common language, and facilitate access to non-justice system options for persons with mental illness referred by law enforcement. It is also essential that people with the lived experience of mental health recovery who understand principles of self-determination and de-escalation be involved in designing and

delivering CIT training. Law enforcement agencies may choose to invite CIT training participants to join in ride-alongs to enhance their appreciation for the demands of police work and build personal rapport among crisis responders.

7. **Law enforcement leaders should ensure that emergency service dispatchers receive specialized training to familiarize them with local guidelines regarding the appropriate crisis resource to which each type of call for service involving a mental health crisis should be referred.**

   Dispatchers are quite often the first representatives of the justice system that the public contact when emergency assistance is required. They are vital gatekeepers who can help ensure that persons with mental illness in crisis are referred to sources of stabilization and care that will be optimal for their unique needs and circumstances. Initial training and ongoing consultation with mental health professionals is essential to help dispatchers discharge this vital responsibility. Law enforcement agencies should provide both dispatchers and officers with up-to-date listings of crisis resources to which persons in crisis can be referred.

8. **Law enforcement agencies should involve consumers of mental health services, their family members and advocates in planning, delivering and monitoring the impact of CIT and related training for officers and other crisis responders.**

   Those who have experienced mental illness and its impacts on individuals and families, and particularly those with the lived experience of mental health recovery, are in the best position to provide crisis responders with insight on communicating with people in crisis and de-escalating tense situations. They can also suggest consumer-driven resources that should be added to the list of potential referral options, and help to counter any stereotypes of mental illness with examples of successful recovery. Peer support specialists can also assist in providing training and consultation to CIT officers.

9. **The local advisory group should determine the capacity and accessibility of mental health resources available to law enforcement as alternatives to arrest for persons with mental illness and develop plans for building on system strengths and remedying any identified deficiencies.**

   Mental health resources that should be available for law enforcement as alternatives for persons with mental illness include mobile crisis teams (discussed previously), emergency psychiatric evaluation facilities, mental health crisis stabilization centers and respite care facilities (including peer-run respite centers). A number of communities have designated specific mental health facilities as 24/7 “drop-off” sites that guarantee there will be space for people with mental illness transported there by law enforcement. For individuals under the influence of alcohol or non-prescribed drugs, detoxification facilities may also be an appropriate placement. The collaborative relationships nurtured by the local advisory group should help agencies make the most of their collective resources and advocate for more options necessary to improve outcomes of responses to persons with mental illness who are in crisis.

10. **Law enforcement agencies should convene periodic after action reviews for all responders to calls for service involving persons with mental illness to identify successful approaches and learn from any missteps or oversights that might have occurred.**

    It is important to assess and fine-tune performance on a regular basis. Qualitative or experiential information is as important as quantitative data in analyzing outcomes and learning from mistakes and successes. Debriefings may also include family members of consumers and other community members who were present during the crisis, as well as persons with mental illness who are in recovery.

Post-Arrest Diversion Recommendations

After law enforcement officers opt to arrest persons with mental illness and charge them with criminal offenses, the role of law enforcement shifts to providing support and back-up to other justice agencies and their treatment partners. This section and the next suggest ways that law enforcement leaders and line staff can help to keep persons with mental illness from entering or returning to jails, prisons or juvenile detention/corrections facilities.

Post-arrest diversion options that prosecutors and the courts use to keep people with mental illness from progressing further into the justice system include deferred prosecution, deferred sentencing and mental health courts (which use a variety of diversion strategies). All of these diversion strategies use the leverage of the justice system to encourage persons with mental illness to voluntarily enter community-based treatment in lieu of sentencing to jail, prison or a juvenile facility. Research suggests that diversion reduces the amount of time persons with mental illness spend in confinement facilities without increasing risk to public safety. In the short run, diversion programs generally decrease justice system costs and increase mental health treatment expenditures for diverted individuals, who probably would not have received treatment had they not been placed in a diversion program. In the long run, however, overall public agency costs do not increase if diversion is successful in breaking the cycle of recidivism that characterizes many participants' criminal histories.

Law enforcement officers are a natural part of the community supervision team for individuals with mental illness diverted to community-based supervision and treatment programs. Guided by agreed-upon protocols, law enforcement officers can play an important role in helping to ensure that sanctions for violations of diversion conditions are immediate and predictable, thus increasing the likelihood that sanctions will be effective in influencing behavior. Recommendations outlining ways that law enforcement agencies can enhance the success of post-arrest diversion follow.

1. **Law enforcement leaders should support the development of a range of post-arrest diversion options that can help to break the cycle of recidivism in which too many persons with mental illness become enmeshed.**

   Through the local advisory group, law enforcement representatives should participate in the planning and ongoing monitoring of diversion options for persons with mental illness. As part of this process, law enforcement executives should work with their justice system and mental health agency partners to advocate for treatment and supportive resources necessary to effectively implement post-arrest diversion programs. Unless there are sufficient resources to serve all individuals with mental illness in a community, development of diversion options can have the unintended consequence of making it more difficult for non-participants to access treatment. This may occur either because scarce slots are filled by diversion program clients and/or because programs actively prefer to have clients who are more likely to be compliant because they are under justice system supervision.

2. **Law enforcement agencies should work with the prosecution, judiciary, and probation to clarify law enforcement's role regarding diverted individuals.**

The goal of diversion programs is to maintain persons with mental illness in the community and in treatment unless the person is dangerous to self or others or is suspected of committing a serious offense. Most programs allow for some degree of relapse tolerance and use of community-based sanctions rather than arrest and jailing for most instances of non-compliance. Law enforcement officers should be informed about program expectations so that they can help diversion programs and their clients achieve shared goals. With input from justice system partners, law enforcement agencies should establish protocols for officers to use in reporting non-compliant behaviors (e.g., intoxication) to diversion program officials. There also must be clear guidelines for officers about whether and how to respond to various levels of non-compliance, including a descriptive listing of individuals and program resources to which officers may refer diversion clients indicating which referral option is preferred for which types of non-compliance.

Reentry from Jail, Prison, or Juvenile Justice Facilities Recommendations

Reentry programs are designed to prepare inmates about to be released from jails, prisons or juvenile facilities for community life, and to support them in living law-abiding lives after release. Critical Time Intervention (CTI) is one reentry approach (in addition to the GAINS Center's APIC model discussed earlier) designed to assist persons with mental illness returning to their communities after incarceration or confinement in a secure treatment facility. CTI supports "vulnerable individuals through difficult transitions while also assuring that most basic human needs of shelter, companionship, sustenance, and a sense of purpose in life are also addressed."[36] CTI involves conducting pre-release needs assessments of inmates and engaging them with appropriate community mental health treatment providers, mental health peer-run programs, and other resources such as housing, employment and leisure activities. Another initiative, SSI/SSDI Outreach, Access and Recovery (SOAR) operates in 34 states to help homeless individuals and people returning to communities from jails, prisons and mental health facilities obtain federal SSI benefits to which they are entitled. The most recent outcome study documents that the SOAR approach expedites the application process and increases the approval rate significantly.[37]

For persons with mental illness, research suggests that effective reentry programs can reduce risk of homelessness, victimization, substance abuse and recidivism. Recommended ways that law enforcement agencies can support reentry efforts are summarized below.

1. **Law enforcement leaders should partner with their peers in corrections and detention facilities, community-based treatment and justice system agencies and community service providers to plan and implement reentry programs for all inmates returning to their communities.**

   In the absence of structured reentry programs, a high percentage of released inmates will be arrested for new offenses. A BJS study published in 2002 found that within three years of release 67.5% of state prisoners had been re-arrested and 51.8% were back in prison, half of them for technical violations of release conditions.[38] It is in law enforcement's best interests to support the development of effective reentry programs for all inmates, particularly those at highest risk of committing new offenses, i.e., those with mental illness or co-occurring disorders. The most effective reentry programs for these groups are person-centered, recovery-oriented, trauma-informed[39], risk-responsive and culturally competent.

2. **Reentry approaches for persons with mental illness should take into account their unique needs in order to maximize their likelihood of successful reintegration into community life.**

   Inmates with mental illness should be identified soon after they are incarcerated, if not before, so that appropriate treatment can be provided to them during their confinement. To ensure that persons with mental illness have access to Medicare, Medicaid and Social Security benefits immediately upon their release, the process of re-applying should begin while they are still incarcerated. Promising reentry strategies, such as CTI, and APIC should be implemented consistent with local needs and priorities.

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[36] Jeffrey Draine and Beth Angell. (2008) "Critical Time Intervention for Prison and Jail Reentry." Rutgers Center for Behavioral Health Services & Criminal Justice Research.

[37] For more information, see *http://www.prainc.com/soar*

[38] BJS Recidivism Study Overview. (2002) *http://www.cor.state.pa.us/stats/lib/stats/BJS%20Recidivism%20Study.pdf*

[39] See *http://mentalhealth.samhsa.gov/nctic/trauma.asp* for a wealth of information on trauma-informed care and trauma-specific interventions for persons with mental illness and substance abuse disorders.

3. **Law enforcement agencies should be involved in all stages of the reentry process, including prerelease assessment and service planning as well as ongoing monitoring of the releasees' progress toward full reintegration.**

   As part of the community team working with inmates while they are preparing for their reentry, law enforcement officers can offer their insights into community life and learn about the goals that reentry professionals have for returning inmates. Once releasees with mental illness are back in their communities, officers can help them to succeed by sharing with them information about community resources, protecting them from victimization and

   providing treatment professionals, peer support people and family members with early warning of observed problems so that crises can be prevented. When persons with mental illness involved in reentry programs experience crises, law enforcement officers can prevent these persons from re-entering the justice system by exercising discretion to divert them to non-justice options if at all possible. For additional resources on this topic, go to: http://www.theiacp.org/Portals/0/pdfs/Publications/CISOMResourceGuide.pdf

4. **Law enforcement leaders should encourage their communities to invest in providing the supportive resources necessary to ensure that persons with mental illness are reintegrated into the community in a manner that respects their dignity and assists them to become and remain stable, law-abiding and contributing citizens.**

   Just as at the federal level the Departments of Justice, Education, Health and Human Services, Housing and Urban Development and Labor work to coordinate their efforts to reintegrate released inmates, so too should local agencies collaborate to provide reentering persons with mental illness with housing, education and vocational assistance, health care, and substance abuse and mental health treatment. Working together, this coordinated effort

   can significantly reduce the risk of relapse and recidivism. Law enforcement agencies can be very effective advocates for strengthening collaboration and for allocating the resources necessary to implement effective reentry strategies.

Legislative, Funding, and Technical Assistance Support

Legislative and funding support is essential to the success of local efforts to build safer communities by enhancing police response to persons with mental illness. As discussed earlier in this report, communities must have adequate resources for treatment, housing and other supportive services so that law enforcement officers can help prevent criminalization of mental illness by diverting eligible individuals to these non-justice alternatives. Law enforcement and other justice system agencies also must have sufficient resources to expand and sustain their collaborative efforts to improve their crisis responses and decision-making about persons with mental illness.

Laws and policies that regulate access to Medicaid, Medicare and Social Security should be carefully crafted to ensure that persons with mental illness can readily access benefits to which they are entitled both before and after incarceration. Regulations that protect consumers' privacy and dignity of choice should also permit necessary and appropriate information-sharing across agencies when it can positively affect intervention outcomes. These and other policy issues should be addressed by Congress and state legislatures with assistance from national organizations with expertise in relevant areas.

There are many agencies and organizations currently engaged in national policy-making efforts in areas relevant to decriminalizing mental illness. Some are also funding pilot projects that test new ways of supporting the recovery of persons with mental illness. These include:

- **SAMHSA's GAINS Center:** Has a variety of research and practice initiatives focusing on persons with mental illness and co-occurring disorders
- **BJA, OJP:** The Second Chance Act authorized the Department of Justice to provide federal funding for reentry initiatives at the state and local levels
- **The Council of State Governments:** The Criminal Justice / Mental Health Consensus Project and the Reentry Policy Council
- **NCMHCSO:** Advocacy for consumer-driven, holistic treatment approaches, a variety of public information and training initiatives including certification in Emotional CPR designed to assist people through emotional crises
- **NAMI:** A variety of public information, advocacy and training initiatives around programs such as CIT, ATC and consumer-led support groups
- **National Federation of Families for Children's Mental Health:** Advocacy for family-driven care, youth-centered treatment approaches, and consumer involvement in planning, implementing and evaluating mental health treatment for children and youth
- **Office of Juvenile Justice and Delinquency Prevention:** Various initiatives and publications related to identifying youth with disabilities and mental health issues as early as possible and preventing their involvement with the juvenile justice system, as well as facilitating reentry of youth from detention and corrections facilities
- **National Association of Counties and BJA:** Transition Planning for Jail Inmates with Co-Occurring Substance Abuse and Mental Illness Disorders
- **National Institute of Corrections and Urban Institute:** Transition from Jail to Community and Transition from Prison to Community Technical Assistance Projects

While it is very encouraging that so many organizations are committed to this work, much more remains to be done.

The IACP and its national partners can best support the work of state, local and tribal law enforcement agencies and their many community partners through:

- Formulating, promoting and supporting model legislation, policies and training curricula
- Advocating for federal funding for pilot projects and evaluation research
- Offering technical assistance in planning, implementing and evaluating programs that can both enhance police response to persons with mental illness and improve communities' capacity to support them in avoiding criminal justice system involvement.

Recommendations for Legislative, Funding, and Technical Assistance Support

Summit participants developed several recommendations regarding the legislative, funding and technical assistance support necessary to accomplish the policy and program goals discussed earlier in this report.

1. **A coalition of national law enforcement, justice system, mental health system and advocacy organizations should develop and promote behavioral health legislation that can be integrated with the federal health care reforms currently being developed by Congress.**

   It is essential that national health care reform include provisions for behavioral health care that support the decriminalization of mental illness by providing access to appropriate community-based crisis intervention (including 24/7 crisis centers) and treatment for all persons with mental illness and those with co-occurring disorders.

2. **In partnership with BJA, SAMHSA and HUD, the IACP should identify funding streams and delineate best practices that can eliminate barriers to successful reentry for persons with mental illness and co-occurring disorders.**

   Barriers that can impede reintegration include limited availability of affordable housing and transportation as well as lack of access to public benefits, health and mental health care, substance abuse treatment, educational opportunities and vocational assistance.

3. **Congress and executive branch agencies responsible for administering Medicaid, Medicare and Social Security benefits should modify laws, policies and procedures as needed to ensure that these benefits can be easily restored to individuals reentering communities from jails, prisons or juvenile detention/corrections facilities.**

   Persons with mental illness and co-occurring disorders are particularly vulnerable to relapse and recidivism upon release from incarceration if they are unable to obtain benefits to which they are entitled. Current application and re-application processes can be dauntingly complex for individuals who are already overwhelmed with the demands of transition from confinement to community life.

4. **The IACP should collaborate with BJA to encourage changes in HUD and other public housing regulations to permit ex-offenders with mental illness to reside in public housing.**

   To ensure that reentering inmates with serious mental illness do not become homeless and thus at greater risk of relapse and recidivism, it is essential to reconsider regulations that prevent them, as ex-offenders, from being housed in publicly-funded projects. It is also important to adjust definitions of "chronic homelessness" to include those who were homeless prior to incarceration, so that individuals do not lose eligibility for certain funding streams simply because of their temporary confinement in jail, prison or a juvenile facility.

5. **The IACP should join with SAMHSA and HUD to encourage expansion of Housing First options for persons with mental illness who are diverted from or returning after incarceration in justice system facilities.**

   The Housing First approach has proven to be successful in "promoting housing stability and other positive outcomes" for persons with serious mental illness and co-occurring substance

disorders. Housing First elements that lead to these positive outcomes include the lack of prerequisites (sobriety or treatment participation), availability of supportive services that use client-driven approaches, and the capacity to access a variety of funding streams to sustain supportive interventions. [40]

6. **The IACP, with input from relevant stakeholders, should update its model policy on police response to children, youth and adults with mental illness to reflect the current consensus on best practices.**

   NAMI, NFFCMH and NCMHCSO should collaborate with the IACP and other partners to review the IACP's current policy and suggest revisions that will make it more useful to law enforcement and partner agencies working to enhance responses to people with mental illness.

7. **The IACP and its partners, including consumers, family members and advocates, should develop recommendations to Congress and regulatory authorities, possibly including revisions of HIPAA rules, which will facilitate sharing information about persons with mental illness in crisis situations.**

   The importance of preserving client confidentiality must be weighed against crisis responders' need for background information about persons with mental illness who are in need of assistance. Clarifying the types of information that can be shared with crisis responders under what circumstances is an important and necessary refinement of confidentiality and information-sharing protocols.

8. **The IACP should work with CALEA to establish a model curriculum that law enforcement agencies can use in implementing, expanding or maintaining CIT programs.**

   There are many good examples of CIT curricula that have been developed and used by law enforcement agencies across the country. It is time to build on the experience of these agencies to create a model curriculum that can be adapted and used by a wide variety of agencies at the state, local and tribal levels. The curriculum should also tap other sources, such as the NCMHCSO's Emotional CPR (eCPR) curriculum, to enrich the model. This curriculum should be both comprehensive and flexible so that it can support a range of training opportunities from 40-hour academy training engagements to in-service updates and roll call briefings.

9. **The IACP should collaborate with BJA and SAMHSA to develop public information strategies that will counteract negative stereotypes of persons with mental illness and highlight the importance of decriminalizing mental illness.**

   Improving the outcomes of law enforcement responses to persons with mental illness depends in large part upon the extent to which communities are willing and able to support the requisite policies and programs. People who understand the challenges faced by those who are mentally ill and appreciate the contributions that they can make to community life are more likely to support mental health treatment and other essential community services with their taxes and their advocacy.

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[40] Carol L. Pearson, Gretchen Locke, Ann Elizabeth Montgomery and Larry Buron. (2007) **The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness: Final Report.** Department of Housing and Urban Development. *http://www.huduser.org/Publications/pdf/hsgfirst.pdf*

Law Enforcement Action Agenda

This section highlights recommendations that law enforcement leaders, supervisors and line staff can translate into actions that will enhance their agencies' response to persons with mental illness. Rationales and suggested approaches are described in greater detail in the body of this report.

1. **Law enforcement executives should work with other community leaders to ensure that community mental health service systems are adequate and accessible to people in need.**

2. **Law enforcement agencies should take the lead in establishing local multidisciplinary advisory groups to focus on decriminalizing responses to persons with mental illness.**

3. **Local multidisciplinary advisory groups should develop policies and protocols for emergency dispatchers that encourage referring calls for service involving persons with mental illness who are not suspected of criminal conduct or dangerous to self or others to mobile crisis teams rather than to law enforcement.**

4. **A central goal of local advisory groups should be collaborative development of guidelines that will inform all law enforcement encounters with persons with mental illness who are in crisis.**

5. **To ensure that appropriate resources are available to law enforcement officers and others responding to persons with mental illness, local advisory groups should maintain an up-to-date inventory of available resources and develop plans for addressing identified gaps in the continuum of options.**

6. **Local advisory groups should review training protocols for law enforcement and other agencies that serve persons with mental illness in crisis and make recommendations to improve training curricula and methods as needed.**

7. **Law enforcement executives should support and encourage their middle management and line staff in developing mutually respectful working relationships with their peers in partner agencies.**

8. **Protocols enabling agencies to share essential information about persons with mental illness who are in crisis should be established and maintained by the multidisciplinary advisory group.**

9. **Law enforcement leaders should work with their personnel to establish the goals of their encounters with persons with mental illness and to put in place mechanisms for recognizing officers and other staff with exemplary skills and documented results in achieving the stated goals.**

10. **Law enforcement leaders should consider developing mental health crisis response resources within their agencies to assist CIT officers in responding to persons with mental illness.**

11. **Law enforcement agencies should develop detailed policies directing officers to avoid use of restraint techniques or deadly force unless they determine that these are the only means to ensure the safety of those involved in a mental health crisis situation.**

12. **Law enforcement agencies should carefully review their training curricula to ensure that they collectively cover all topics necessary to prepare officers to respond to and communicate effectively with persons with serious mental illness who are in crisis.**

13. **Law enforcement executives should determine, with input from their community partners, whether all officers will be required to participate in comprehensive CIT training or whether it will be a voluntary program with some agreed-upon level of basic crisis intervention training required for all other officers.**

14. **Cross-training opportunities for mental health professionals, family members of consumers and other stakeholders should be incorporated into law enforcement agencies' CIT training curricula.**

15. **Law enforcement leaders should ensure that emergency service dispatchers serving their agencies receive specialized training to familiarize them with local guidelines regarding the appropriate crisis resource to which each type of call for service involving a mental health crisis should be referred.**

16. **Law enforcement agencies should involve consumers of mental health services, including youth and their family members and advocates in planning, delivering and monitoring the impact of CIT and related training for officers and other crisis responders.**

17. **The local advisory group should determine the capacity and accessibility of mental health resources available to law enforcement as alternatives to arrest for persons with mental illness and develop plans for building on system strengths and remedying any identified deficiencies.**

18. **Law enforcement agencies should convene periodic debriefings for all responders to calls for service involving persons with mental illness to identify successful approaches and learn from any missteps or oversights that might have occurred.**

19. **Law enforcement leaders should support the development of a range of post-arrest diversion options that can help to break the cycle of recidivism in which too many persons with serious mental illness become enmeshed.**

20. **Law enforcement agencies should work with the prosecution, judiciary, and probation to clarify law enforcement's role regarding diverted individuals.**

21. **Law enforcement leaders should partner with their peers in corrections and detention facilities, community-based treatment and justice system agencies and community service providers to plan and implement reentry programs for all inmates returning to their communities.**

22. **Law enforcement agencies should be involved in all stages of the reentry process, including prerelease assessment and service planning as well as ongoing monitoring of releasees' progress toward full reintegration.**

23. **Law enforcement leaders should encourage their communities to invest in providing the supportive resources necessary to ensure that persons with mental illness can become and remain stable, law-abiding and contributing citizens.**

Glossary of Terms

The IACP has compiled this list of terms and acronyms from law enforcement, consumer, and youth perspectives. This glossary is not intended to be comprehensive or exhaustive, but rather to foster a shared language that can be used by all who are concerned with improving police responses to persons with mental illness.

72 Hour Evaluation – If it is determined that an individual is a danger to themselves or others a law enforcement officer can transport the person to an appropriate facility to be held up to 72 hours for an evaluation by mental health professionals.

BJA – The Bureau of Justice Assistance of the U.S. Department of Justice.

Board and Care Facility – Independently operated temporary housing available to people with mental illness and/or those recovering from substance abuse.

CIT/CRT – Crisis Intervention Teams (also known as Crisis Response Teams) are based on community partnerships between a police department, local mental health providers, mental health consumers, and family members. CIT/CRT officers receive specialized training in how to calmly and safely approach mental health crisis events.

Consumer or Mental Health Consumer – A person who has used or is currently using mental health services. It generally means that the person has had a significant period when they were unable to fulfill their major life role (e.g., worker, student, and/or parent) and experienced severe emotional distress.

Crisis Plan – Plans for providing assistance and support during a crisis.

DSM – The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, describes the symptoms, causes and prognoses of known mental disorders.

Dual Diagnosis – When an individual is diagnosed with a mental illness as well as addiction to alcohol and/or street or prescription drugs.

EPU – An Emergency Psychiatric Unit is the most likely location that law enforcement can take an individual in mental health crisis for a 72 hour evaluation.

Evidence-Based Treatment – Treatment for mental illness deemed effective through clinical research methods. Exact criteria for what is considered "evidence-based" varies across states and agencies.

NFFCMH – National Federation of Families for Children's Mental Health.

Family Member – A person who is raising or has raised a child with a mental, emotional, or behavioral disorder.

IACP – The International Association of Chiefs of Police

IEP – Individualized Education Plans are governed by federal legislation. They are individual plans tailored to the needs and unique challenges of students with disabilities.

NAMI – National Alliance on Mental Illness

Peer-Run Respite – A peer-run alternative to hospitalization based on the principles of recovery and self-determination. On average respite services cost 25% less than psychiatric hospitalization.

Peer Support – Individuals helping one another to achieve their own goals. Peer supporters, whether volunteer or paid, assist and encourage people to define what they want in life and help them learn to advocate for themselves. Peer supporters also function as role models, demonstrating that it is possible for people with mental illness to live fuller and more satisfying lives.

Person First Language – A person should not be solely defined or labeled either by their abilities or disabilities. Person first language is the respectful way to address people with disabilities, mental illness, or who are involved in a crisis situation. For example, "people with mental illness" is more appropriate than the generalized label "the mentally ill".

SAMHSA – The Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services.

Self Medication – Using alcohol and/or narcotics (prescription or non-prescription) in an attempt to mitigate the symptoms of mental illness or feelings of emotional crisis.

Serious Emotional Disorder (SED) – Mental illness or mental, emotional, and behavioral disorders. Similar terms are used for mental health issues as they relate to children and youth (e.g. "seriously emotionally disturbed"). While SED is a term that is controversial among consumers and family members, it is the term used in the Federal Registry and many federal funding opportunities.

Severe Emotional Distress – A temporary emotional state or distress that no reasonable person is expected to endure and typically caused by a traumatic event that a person is either experiencing in the present moment or re-experiencing internally.

Wraparound – A team approach by mental health professionals and family members that is focused on identifying and enhancing the natural, informal support systems of children, youth and adults with mental illness to help them avoid or address crises and remain in their home communities.

Youth/Juvenile – In mental health systems, youth are most commonly defined as persons under 14 years of age, though this differs somewhat among advocacy organizations and public agencies. Each state determines sentencing rules for juveniles and it varies. In the majority of states, the juvenile court can retain jurisdiction over individuals who are convicted and sentenced as juveniles until age 20, and even up to age 24 in some states. In other states, juveniles at age 15 can be sentenced in adult court, depending on offense.

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The International Association of Chiefs of Police

The International Association of Chiefs of Police is the world's oldest and largest nonprofit membership organization of police executives, with over 20,000 members in over 100 different countries. IACP's leadership consists of the operating chief executives of international, federal, state and local agencies of all sizes.

Founded in 1893, the association's goals are to advance the science and art of police services; to develop and disseminate improved administrative, technical and operational practices and promote their use in police work; to foster police cooperation and the exchange of information and experience among police administrators throughout the world; to bring about recruitment and training in the police profession of qualified persons; and to encourage adherence of all police officers to high professional standards of performance and conduct.

Since 1893, the International Association of Chiefs of Police has been serving the needs of the law enforcement community. Throughout the past 114 years, we have been launching historically acclaimed programs, conducting ground-breaking research and providing exemplary programs and services to our membership across the globe.

Professionally recognized programs such as the FBI Identification Division and the Uniform Crime Records system can trace their origins back to the IACP. In fact, the IACP has been instrumental in forwarding breakthrough technologies and philosophies from the early years of our establishment to the present. From spear-heading national use of fingerprint identification to partnering in a consortium on community policing to gathering top experts in criminal justice, the government and education for summits on violence, homicide, and youth violence, IACP has realized our responsibility to positively effect the goals of law enforcement.

Even with such an esteemed history, we are continually initiating programs to address the needs of today's law enforcement professionals. Our members have let us know that they consider IACP to be a progressive organization, successfully advancing the law enforcement profession.

If you would like additional information about the IACP, please contact IACP Headquarters at 1-800-THE-IACP (1-800-843-4227) or visit our website at www.theiacp.org

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