

THE CRISIS INTERVENTION TEAM (CIT) MODEL FOR LAW ENFORCEMENT: CREATIVE CONSIDERATIONS FOR ENHANCING UNIVERSITY CAMPUS POLICE RESPONSE TO MENTAL HEALTH CRISIS

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Abstract

Purpose of the article American university and college campus law enforcement, like their peers in American municipal law enforcement agencies, find themselves interacting frequently with civilians experiencing mental health disturbances. An innovative model for law enforcement, the Crisis Intervention Team (CIT) model, has been developed to address the difficulties law enforcement professionals and civilians in mental health crisis face during encounters. (Margolis & Shtull, 2012) This article explores how CIT can enhance police response to mental health crisis on the college campus.

Methodology/methods Methods of applied research were conducted, borrowing from a benchmarking model and including interviews with multiple key informants representing law enforcement and mental health. Informants were affiliated with three universities and multiple municipal jurisdictions in Virginia, USA. **Scientific goal** The goal was to assess the relevance of CIT on the college campus and explore creative approaches to enhancing campus police response to mental health crisis. **Findings** The results supported the scholarly literature regarding the efficacy of the CIT model. Creative adaptations to the CIT model for campus possibly can be implemented to address concerns of mental health crisis on campus.

Conclusions CIT is a highly innovative model requiring extensive collaboration between law enforcement, mental health agencies, and mental health advocates. As standard qualitative research was not conducted, the sample size of key informants may not have reached saturation. However, findings from the interviews support the body of literature on CIT. The implementation of CIT on the college campus could possibly help to alleviate difficulties on campus arising from mental health crisis, including reducing inappropriate arrest or disciplinary action, improving campus safety, addressing concerns related to threat assessment and management, and enhancing collaborative efforts on campus and with resources in the broader community.

Keywords: campus law enforcement, campus mental health, campus police, crisis intervention teams, mental health crisis, peer support specialist, threat assessment and management

JEL Classification: I18, I19, I23

Introduction

In recent decades the United States has faced important societal and policy changes regarding the management and care of those suffering from mental illness. Since the middle of the twentieth century, the United States has experienced the deinstitutionalization movement, increasingly stringent civil commitment procedures, and a deteriorating mental health system. It has been argued that this has lead to the shifting of the locus of management of mental health-related concerns from the health care system towards the criminal justice system and the prison industry. (Balassone, 2011; Bloom, 2010; Lurigio, 2000; Munetz & Griffin, 2006; Navasky, 2005) Furthermore, attention has been focused on encounters between persons in psychiatric distress and law enforcement professionals in part as a result of concerns regarding potentially inappropriate arrests, (Hafemeister, Garner & Bath, 2012) and in part regarding difficulties experienced by both law enforcement professionals and the distressed civilians they interact with. (Gur, 2010; Lurigio, 2010; Reuland, 2004)

At the same time, mental health related concerns have been increasing on university and college campuses. (Flatt, 2013; Margolis & Shtull, 2012) The challenges of Americans in psychiatric distress in the general population as well as municipal law enforcement professionals who interact with such individuals have relevance to the university campus setting. Yet, the university environment is unique and therefore requires special consideration when considering interactions between university-affiliated individuals and law enforcement. (Margolis & Shtull, 2012)

1.1 The Incarceration Crisis of the Mentally Ill

Currently we are seeing the acceleration of the use of law enforcement, the criminal justice system, and the prison industry to police and manage a significant portion of Americans with psychiatric illness. This has become a concern not only for those with mental illness, their families and advocates; but also for mental health and public health professionals, law and bioethics professionals, and leadership within the American prison industry, the criminal justice system, and law enforcement. (Hafemeister et al., 2012; Lurigio, 2000; Lurigio & Watson, 2010; Navasky, 2005) Increasingly, the voices of leaders within these fields almost unanimously agree that the locus of American management of mental health concerns has shifted. The ideals of mental health outpatient treatment and social services for the mentally ill within the community have been replaced by the policing of the mentally ill, particularly those with serious mental illness, to the criminal justice system and prison industry. (Hafemeister et al., 2012; Honberg & Gruttadaro, 2005; Navasky, 2005) The US Bureau of Justice reported that over half of all adult inmates report having a "mental health problem" that describes symptoms of mental illness. (James & Glaze, 2006). Unfortunately, prisons and jails are unequipped to manage mental illness and often provide an environment that exacerbates both the mental and physical health of mentally ill inmates. (Balassone, 2011; Human Rights Watch, 2003; Martinez, 2010; Navasky, 2005)

While incarcerated, the mentally ill inmate is at increased risk for violence and mistreatment at the hands of other inmates and prison staff. (Hafemeister et al., 2012) Inmates with mental illness have significantly increased rates of victimization by sexual assault while incarcerated. (Beck, 2013) Although by federal law inmates have a constitutional right to health care access, in practice health care for inmates is inadequate. This is especially true for mentally ill inmates, who are often denied many forms of psychotherapy and have limited access to psychotropic medications. (Wallace, 2012) Suicide is a leading cause of death in American jails and prisons, with most suicides occurring within the first week of incarceration. (Noonan, 2010) The disproportionate number of inmates in American jails and prisons with mental illness, which far exceeds the proportion of mentally ill individuals who have criminogenic psychopathology, has been linked in part to increased arrest rates of individuals experiencing mental illness. (Lurigio & Watson, 2010; Margolis & Shtull, 2012)

1.2 Concerns Specific to Law Enforcement Interactions with Civilians in Crisis

Individuals and organizations from a diverse range of disciplines have raised concerns regarding the ability of law enforcement professionals to appropriately manage interactions with civilians in psychiatric distress. From the perspective of those involved in mental health treatment and advocacy, arrests of individuals with mental illness are of serious concern. The National Alliance on Mental Illness (NAMI) reports that of all Americans with serious mental illness (defined as limited to diagnoses of the schizophrenic and schizoaffective spectrums, bipolar disorder, and major depression), 44% of these Americans have been arrested sometime in their lives. (Hall, Graf, Fitzpatrick, Lane & Birkel, 2003) This does not include persons with mental illness not identified as "serious mental illness", such as trauma, personality, and anxiety disorders. There is also discussion of insensitive and aggressive police interventions that lead to the escalation of the psychiatric crisis as well as to injuries and deaths to both law enforcement professionals and civilians. (Kerr, Morabito & Watson, 2010)

From the perspective of law enforcement, many frustrations have been expressed. Currently, about 10% of all calls to law enforcement involve a mental health concern in middle and large population

jurisdictions. (Teplin & Pruett, 1992; Cordner, 2006) These calls are often resource-intensive, especially in regards to the excessive time required for law enforcement to resolve these calls. (Deane, Steadman, Borum, Veysey, & Morrisey, 1999) As American society has increasingly relied on law enforcement to manage situations involving mental illness, the law enforcement professional has found him/herself thrust into the role of social service provider, or “street-corner psychiatrist”. (Teplin & Pruett, 1992) Difficulties in working with America’s troubled mental health system to refer civilians in distress to services have fueled a sense of frustration (Cooper, McLearen, & Zapf, 2004) and may incentivize law enforcement to arrest such individuals. (Margolis & Shtull, 2012)

For law enforcement professionals, mental health calls are perceived as especially dangerous. (Cordner, 2006; Federal Bureau of Investigation, 2005; Ruiz & Miller, 2004) Qualitative studies reveal that many law enforcement professionals have a lack of subjective confidence in their skills to interact with the psychiatrically distressed civilian, a lack of knowledge of mental health issues, and stigmatizing attitudes towards mental illness. (Canada, Angell, Watson, 2012; Ruiz & Miller, 2004) Law enforcement also is concerned with the potential for injuries and deaths that occur during these encounters, which has on occasion lead to civil litigation against law enforcement agencies. (Federal Bureau of Investigation, 2005; Lurigio & Watson, 2010)

1.3 The College Campus

On college and university campuses, mental health concerns present unique challenges. The rate of mental health crisis on campus has been increasing throughout the nation. (Castillo & Schwartz, 2013; Flatt, 2013; Kadison, R., 2006) Three aspects of the university student body contribute to this phenomenon. Many psychiatric disorders often first manifest in late adolescence and early adulthood, thus impacting the student body disproportionately from the general public due to the high percentage of students in this age group. Secondly, advances in psychiatric treatment have enabled more individuals with mental illness to matriculate into college and university programs and to pursue careers in academia. (Erdur-Baker, Aberson, Barrow, & Draper, 2006) Finally, veterans from the Iraq and Afghanistan conflicts are matriculating into higher education in increasing numbers. (Vacchi, 2012) These veterans have significantly increased rates of Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) as a result of their experiences during active-duty military service. (Tanielian & Jaycox, 2008)

For the student body, suicidality and substance abuse figure prominently. Young adult college students have lower rates of suicide than their cohort in the general population. (Shadick & Akhter, 2014) However, suicide is currently the second leading cause of death in American college and university students. (NAMI on Campus, 2012) Substance abuse can exacerbate underlying psychiatric conditions and can lead, in itself, to a psychiatric and non-psychiatric health crisis. (Duckworth & Freedman, 2013). Evidence-based research has demonstrated a positive causal relationship between the presence of comorbid psychiatric and substance abuse disorders and violence perpetration. (Soyka, 2000) Sexual assault is also a significant problem on college campus, with 20-25% of college and university female students experiencing sexual assault at some point during their time as undergraduate students. (Krebs, Lindquist, Warner, Fisher, & Martin, 2009a; Krebs et al., 2009b) The crisis of sexual assault on American campuses has become so problematic that it has prompted presidential action. (Obama, 2014) With military sexual assault prominent in the ranks of American military forces, veterans returning to campus may have trauma associated with rape in addition to combat-associated trauma. (Bell & Reardon, 2011) Furthermore, with the deterioration of mental health services in the broader community, campus law enforcement also have found themselves responding to mental health calls that do not involve an affiliated campus member, but rather a member of the surrounding community that has come onto the college campus. (Margolis & Shtull, 2012)

As a result of mass shootings on college campuses by students or former students, crisis management and threat assessment teams have been implemented on campuses throughout the nation. (Keller, Hughes, & Hertz, 2010) In particular, The Virginia Tech mass shooting murder tragedy of 2007

prompted institutions of higher learning throughout the United States to pursue creative approaches to address future threats of campus violence. (Nolan, Dinse, & McAndrew, 2014) Campus crisis management teams, also known as threat assessment and management teams, are multidisciplinary and involve the participation of campus law enforcement. (Pollard, Nolan, & Deisinger, 2012) Although the correlation between the overwhelming majority of psychiatric diagnoses and outwardly directed violence is low (Lipson, Turner, & Kasper, 2010), mass shootings have created for universities and colleges a strong priority to address and intervene in possible threats. (Pollard et al., 2012; Keller & Hughes, 2010)

Threat assessment and management teams address a broad array of outwardly directed violence. This includes not only intervening to prevent a potential campus shooting, but also to intervene in domestic and dating violence, sexual assault, and terrorism. Threat assessment and management teams also assess and work with, or monitor, campus-affiliated individuals who pose a risk for suicide, but who don't necessarily present a risk of outwardly directed violence. (Anonymous campus threat assessment and management police detective, personal communication, May 4, 2014)

The most common form of mass murder in the United States, defined as the murder of at least four victims in a specified short amount of time, is more associated with male-on-female intimate partner violence as opposed to mental illness. "Family annihilators", a subset of mass murderers who commit suicide after the murders, constitute about a third of domestic violence related mass murders. Family annihilators often have depression coupled with indicators consistent with pathological narcissism, but not necessarily Narcissistic Personality Disorder *per se*. (Campbell, 2008) As mass murders involving non-familial members such as campus shootings are fairly rare, research into the profile of this category of mass murderers is somewhat limited. Generally speaking, these mass murderers do not have mania or formal thought disorders such as schizophrenia. Although depression may be a complicating factor in the profile of the campus mass murderer, the mass murderer appears to be more motivated to commit his crime due to core personality disturbances that are largely explained from the discipline of psychoanalysis. He may have psychological indicators consistent with paranoia and/or pathological narcissism. Outside of, possibly, Antisocial Personality Disorder, generally speaking most other personality disorders do not appear to correlate with an increased risk of perpetration of campus mass murder. Although the non-familial mass murderer may have an increased risk for depression, depression alone in itself does not appear to increase the risk of becoming a mass murderer. (Ferguson, Coulson, & Barnett, 2011; Knoll, 2013; Meloy, Hempe, Mohandie, Shiva & Gray, 2001) Other factors must be present to present a risk. (Anonymous threat assessment psychologist, personal communication, April 15, 2014; Ferguson et al., 2011; Knoll, 2013) Unfortunately, due to the high level of media attention to non-domestic violence related mass murders, coupled with irresponsible media coverage reporting a strong link between mental illness in general and mass murderers, the public has been misled to believe that the mass murderer is often afflicted with "serious" mental illness, such as schizophrenia or bipolar disorder. (Barry, 2013)

1.4 The Crisis Intervention Team Model for Law Enforcement

There are a number of creative strategies that target law enforcement agencies to improve their ability to serve civilians with mental illness. Strategies include mental health professional/law enforcement collaborative teams and mobile crisis teams. One particularly innovative strategy is the Crisis Intervention Team (CIT) model, which has received more attention by both research scientists and policy makers than the other two strategies. (Gur, 2010; Margolis & Shtull, 2012; Morabito, Watson, & Draine, 2013) Although CIT does not meet the criteria for being considered an evidence-based practice, sufficiently positive research results have qualified it as a best practice for law enforcement by a number of criminal justice, law enforcement, and mental health organizations. (Watson & Fulambarker, 2012; Jines, n.d.)

The CIT model was first implemented in Memphis, Tennessee in response to the tragic fatal shooting of a suicidal civilian by law enforcement. Since its first implementation in 1988, this model has

been adopted in jurisdictions throughout the nation. (University of Memphis CIT Center, n.d.c) The CIT model has been endorsed by local and state policy in a number of jurisdictions and receives support at the national level from both governmental and non-governmental organizations (University of Memphis CIT Center, n.d.b; Virginia CIT coalition, n.d.) The CIT model targets law enforcement professionals in order to empower them to safely and effectively handle encounters with the civilian exhibiting signs of mental illness. (University of Memphis CIT Center, n.d.d) Currently over 2000 local programs and 325 regional programs in the United States have adopted this model to some degree. (University of Memphis CIT center, n.d.c) CIT has also been implemented by a number of university and college campus police departments. (Margolis & Shtull, 2012) Often this is established through the mentorship of the municipal law enforcement agency in the city or county that the university is located in. (NAMI Central Virginia Chapter presentation, 2013)

2 Health Theories/Models that Support the Implementation of Crisis Intervention Teams

A number of health theories and models can be applied to the problems that the CIT model addresses. Social Determinants of Health, the Social Ecological Model of Health, and the Sequential Intercept Model have direct relevance to the public health concerns surrounding high arrest and incarceration rates of the mentally ill, as well as officer and civilian safety.

2.1 The Theory of Social Determinants of Health

The World Health Organization and the Centers for Disease Control and Prevention have adopted the model of social determinants of health in order to understand how social issues impact public health. This allows for policy and intervention on a broad range of public health issues. (Centers for Disease Control and Prevention, 2014; World Health Organization, 2008) As will be explained, the intersection of law enforcement and mental health crisis can be understood through this framework.

Social determinants of health are those factors that impact health outcomes, such as mortality and morbidity, and are not directly explained by pathophysiology. (Marmot & Wilkinson, 2006; Bradley & Taylor, 2013) Determinants can be categorized into eight clusters. Clusters are labeled accordingly: food and agriculture, employment, housing, water and sanitation, health care services, education, work environment, and living and working conditions. (Marmot & Wilkinson, 2006) The inappropriate arrest, prosecution, and incarceration of those with mental illness profoundly and adversely impact all eight categories of determinants, directly or indirectly.

Social exclusion is an important factor, and can result from a variety of circumstances, from minority status to income status. Because there is great stigma against mental illness, people with mental illness are socially excluded on a global scale. (World Health Organization, 2002) Stigma impacts not only the high incarceration of the mentally ill in the United States, but also the mentally ill person's ability to obtain education, employment, social networking, and health care access. (Cummings, Lucas, & Druss, 2013)

The presence of mental illness can on occasion impair a person's parenting ability. Parental mental illness presents legal barriers to custody or visitation in family courts. (Hollingsworth, Swick, & Choi, 2013) Because of stigma within American family court systems, sometimes children are removed from a mentally ill parent's custody regardless of whether symptoms of the mental illness are adequately controlled. (Marsh, 2009) Obviously, incarcerated parents are separated from their children. Single mother households may be especially be impacted, given the higher rate of mental illness for American female inmates with in comparison to American male inmates. While estimates for serious mental illness among incarcerated adult men stand at about 14.5%, for incarcerated adult women it is at 31%. (Hafemeister et al., 2012) The Bureau of Justice reports that 73-75% female inmates have significant symptoms of mental illness in general, which is a higher rate than for male inmates. (James & Glaze, 2006) In the juvenile incarcerated population, the gender disparity is also reflected, as mental illness in general is estimated at about 66% for boys and 74% of girls. (Telpin, Abram, McClelland, Dulcan &

Mericle, 2002) Parental incarceration can severely disrupt the emotional well being of children, and can cause prolonged separation post-incarceration due to legal custody barriers even when parents do not have mental illness. (Midley, 2013; Abramowicz, 2013) Thus, incarceration of the mentally ill parent can possibly have more profoundly devastating consequences for children, even if psychiatric symptoms in the parent are being managed effectively or become stabilized, through prolonged separation from the parent. Social exclusion as a result of incarceration and adverse conditions of other social determinants of health, therefore, can have profound effect for parents with mental illness, particularly single mothers, and their children.

Besides the impact of stressful circumstances such as incarceration or other social aspects (such as unemployment or discrimination) on the mental and physical health of the mentally ill, incarceration and obtaining a criminal record can have lifelong consequences. In the framework of the model of social determinants of health, this can increase a mentally ill person's risk for morbidity and mortality on a broad range of health conditions. (Marmot & Wilkinson, 2006) Once the mentally ill defendant is on parole or probation, he or she is often not able to meet the conditions of his or her parole. This is because most jurisdictions do not take into account the challenges mental illness presents for parolees, and require compliance with inappropriate measures. As a result, mentally ill parolees find themselves re-arrested at higher rates than their non-mentally ill cohort members. (Gur, 2010; Hafemeister et al., 2012; Navasky, 2005) Incarceration disrupts the mentally ill person's social and insurance benefits, such as Medicaid and Medicare. (Koyanagi, n.d.) Upon release from incarceration, the mentally ill parolee may find that he or she may no longer be eligible for a broad range of services, including mental health services, depending on the nature of the crimes he or she has been convicted of. (Koyanagi, n.d.; Yoon & Bruckner, 2009) A criminal record decreases employment opportunities and may bar entrance into certain professions. Ironically, the mentally ill parolee may find him or herself imprisoned again because of the inability to meet the employment condition of his or her probation agreement. (Hafemeister et al., 2012; Navasky, 2005)

Likewise, the law enforcement professional's perceived sense of dangerousness regarding mental illness and lack of skills to interact effectively with civilians in crisis can possibly affect officer health. These factors can lead to an increased risk of force in encounters, which in turn increases the risk of physical injury or death to officers. (Kerr et al., 2010) Psychological stress has been directly linked to higher rates of mortality and morbidity in many health conditions; thus, officers who are unable to appropriately interact with the mentally ill individual may, as a result of stress, have increased health concerns in general. (Marmot & Wilkinson, 2006)

The inappropriate prosecution and incarceration of the mentally ill affects social determinants of health for the entire macroscopic community. Incarceration is financially costlier than services such as housing and health care, including substance abuse treatment. (Gur, 2010; McVay, Schiraldi, & Ziedenberg, 2004) The economic welfare of a population directly impacts health indicators. (Bradley & Taylor, 2013; Marmot & Wilkinson, 2006) Undo economic stressors, therefore, negatively impact every member of society.

The model of social determinants of health incorporates a diverse range of social concerns. Racial prejudice, gender bias, and the social exclusion of the economically disadvantaged all can impact the mentally ill individual and his/her family. Likewise, adverse life circumstances, such as traumatic experiences, are quite profound influences on human health. (Marmot & Wilkinson, 2006; Shim et al., 2014) Given the impact of difficult interactions between mentally ill civilians and police as well as unnecessary incarceration of the mentally ill on both microscopic and macroscopic public health concerns, it is of utmost importance to address these concerns in all sectors of American life, including the university setting.

2.2 The Social Ecological Model of Health

The social ecological model of health addresses health on both the microscopic and macroscopic levels. Five levels are identified in society. These include a person's individual health risks, such as genetic predisposition to medical conditions and individual health behaviors. Interaction between the individual and his or her social support network, neighborhood, and community are also incorporated into the model. Finally, broad macroscopic concerns can influence public policy at a national level that impacts the health of individuals and communities. (Bronfenbrenner, 1979; Ruderman, 2013)

The interaction between law enforcement and the civilian in psychiatric distress touches upon all five levels. Macroscopically, policy can be implemented to address these concerns. The endorsement of the crisis intervention team model in Virginia state legislation is one such example. (Va. Code Ann §9.1-187-§9.1-190, 2009) On a more microscopic or practical/clinical level, the Crisis Intervention Team model addresses the health of individuals with mental illness, their families, and law enforcement professionals. The CIT training, through incorporating presentations of persons with lived experience of mental illness and family members, sensitizes officers to these concerns. Creative approaches to de-escalation techniques in the CIT model protect both officer and civilian from the adverse health outcomes of difficult interactions that may result in increased psychological stress, injury or death. Furthermore the CIT model, as a jail diversion method, may positively impact those with mental illness and their families by reducing arrests in this population. (Skeem & Bibeau, 2008)

2.3 The Sequential Intercept Model

The Sequential Intercept Model was specifically designed to address incarceration of those with mental illness. Five intercepts are identified during the incarceration process that can be addressed with jail diversion methods. For instance, one intercept is identified after arrest, and alternative courts such as mental health courts can target this intercept for jail diversion. The CIT model intervenes at the first intercept: pre-arrest jail diversion. All professionals involved with CIT are familiar with this model, and the importance of CIT in addressing pre-arrest jail diversion. (Munetz & Griffin, 2006)

3 Identifying Best Practices of the CIT Model

Identification of best practices of the CIT model through applied research was aided with a modified methodology from the benchmarking model as outlined by Robert D'Amelio in his book, "The Basics of Benchmarking". (D'Amelio, 1995) Using select tools as described in the benchmarking process, information regarding a university campus that does not implement CIT was collected. This included interviews with two campus non-CIT trained law enforcement professionals, one campus detective with some CIT training, and one university-affiliated psychologist. The psychologist and the detective are members of the threat assessment and management team.

Data collection on the best practices of CIT involved extensive research into the literature of CIT. Further exploration into the efficacy of the CIT program in obtaining its stated objectives was accessed through a review of the scholarly literature. Key informants were identified and interviewed. This included interviews with two law enforcement professionals of high rank employed with universities that have implemented the CIT model. Two mental health professionals on CIT municipal teams were also interviewed. A peer support specialist with a municipal CIT program (that includes in its jurisdiction a university) was interviewed. Furthermore, one NAMI-affiliated advocate who serves as a presenter in the CIT training and one university student activist were interviewed. The student activist serves at a high level of rank and involvement with the university's Active Minds chapter. (Active Minds is a national mental health awareness university student organization.) This student activist attends a university that has not implemented CIT. Key informants volunteer in mental health advocacy or are employed in positions that directly involve the management of mental health crisis from a law enforcement perspective, and represent three Virginian universities as well as a number of Virginian municipal jurisdictions. Among this sample, all interviews with law enforcement professionals as well as the peer support specialist were audiotaped after obtaining consent. In total, all interviews with law enforcement

professionals in the entire sample, both professionals in police departments that had implemented CIT and those departments that had not, were audiotaped with consent, with the exception of the campus detective, who declined consent for audiotape.

3.1 CIT: Identified Best Practices

The Memphis CIT model, which serves as the prototype for all other CIT models nationally, has two stated objectives: pre-arrest jail diversion of individuals with mental illness to mental health services, and enhanced officer and civilian safety. (Dupont, Cochran, & Pillsbury, 2007) The Virginia CIT coalition includes eleven additional objectives. These additional goals include decreased response time for law enforcement involving mental health calls and decreased stigma of mental illness in the law enforcement professional culture. (Virginia CIT Coalition, n.d.)

One core element of all CIT models requires that a certain percentage of patrol officers are CIT trained so as to be able to cover all areas of the jurisdiction at all times. The Memphis model states that at least 25% of a police force should be trained for this purpose; scholars in the field have suggested this percentage should be set at a higher level for rural areas and jurisdictions with smaller police forces. The Memphis model maintains that CIT training should be voluntary and officers wishing to be CIT-trained be adequately screened. (Dupont et al., 2007) However, some American jurisdictions have opted to mandate training to all officers in their law enforcement agencies. (Margolis & Shtull, 2012) In Virginia, many jurisdictions have aimed to have 100% of the force trained. Rationale for this is that as not all police calls can be accurately identified as a mental health call. Since all police may encounter persons exhibiting mental illness in their general duties, this necessitates the need for all police officers to have CIT training. (NAMI Central Virginia, 2013) In one Virginian jurisdiction, the responsiveness of police officers to the CIT program was very high. This incentivized increased officer participation in training. (Anonymous campus law enforcement professional, personal communication, May 9, 2014) Such enthusiasm among police officers is reflected in a recent study from Chicago. (Morabito et al., 2013)

3.2 Efficacy of the CIT Model

The research to date on the efficacy of CIT programs in municipal jurisdictions is limited but promising. Currently there are few scholarly articles specifically addressing CIT programs on college and university campuses. (Margolis & Shtull, 2012) Scholarly literature yields that the most positive results of CIT programs involve decreased stigma of mental illness in the law enforcement professional culture; (Browning, Van Hasselt, Tucker, & Vecchi, 2011; Demir, Broussard, Goulding, & Compton, 2009) subjective increased confidence on the part of patrol officers in their ability to appropriately manage interactions with civilians exhibiting mental illness and/or substance abuse; (Ritter, Teller, Munetz & Bonfine, 2010) decreased use of force and subsequent injuries to officers; (Skeem & Bibeau, 2008; Von Hemert, 2012) decreased time for law enforcement to resolve a mental health call; (Department of Criminal Justice Services and Department of Behavioral Health and Developmental Services, 2011) and enhanced referrals to mental health services in the community for civilians. (Department of Criminal Justice Services and Department of Behavioral Health and Developmental Services, 2011) There is less evidence to support that CIT is successful in obtaining its jail diversion objective; however, a number of studies have indicated that jail diversion through decreased arrests are occurring as a result of CIT implementation in a number of jurisdictions. (Franz & Borum, 2011; Von Hemert, 2012; Watson et al., 2010)

4 Best Practices of the Prototypal CIT Model

All CIT programs are based on the Memphis model. (University of Memphis CIT, n.d.e) This model requires a number of practices that can be creatively enhanced in local jurisdictions to fit the needs of local populations. (Reuland, Draper, & Norton, 2010)

4.1 Early and Sustained Collaboration with Stakeholders

The CIT model requires that police agencies collaborate closely with key stakeholders in a sustained manner from the beginning of the planning stage. Of utmost importance is collaboration with the local mental health system. A memorandum of understanding ideally must be established between the police agency and a health facility that can treat mental health crisis, such as a hospital. This single point of entry facility must adopt a no-refusal policy. The facility must also adopt police-friendly policies, such as decreasing the time an officer needs to stay with the civilian at the facility. In some jurisdictions, hospital emergency rooms may implement a “crisis assessment center” specifically for persons brought to the hospital by CIT law enforcement officers. Early and sustained collaboration with other stakeholders, particularly mental health advocacy organizations, is also crucial. NAMI has been particularly active on national, state, and local levels in this collaboration, and has also contributed to funding for CIT programs. Mental Health America is another national advocacy organization that serves as a key stakeholder. Governmental agencies such as state and federal criminal justice agencies, as well as the Substance Abuse and Mental Health Services Administration (SAMHSA), have been involved in advocating for policy regarding CIT and providing funding. Local advocacy groups also are included as key stakeholders for CIT implementation. (Dupont et al., 2007) (Virginia CIT coalition, n.d.)

4.2 CIT Training

CIT training must be offered to patrol officers and dispatchers. For patrol officers, the training requires 40 hours conducted within a week. The officers must be educated in didactic classes on psychiatric diagnoses, signs, and symptoms as well as psychiatric crises and substance abuse. In the training, officers are challenged regarding their views and attitudes towards mental illness. This is specifically designed to help destigmatize mental illness, and to debunk popular myths surrounding mental illness. Psychiatric concerns related to veterans are taught. Site visits to local mental health services as well as presentations by community members living with mental illness and their families are included. Finally, de-escalation methods are taught to the officers through role-play simulating a diverse variety of situations that the officer may encounter with a psychiatrically distressed civilian. Included in role-play are situations requiring advanced police techniques. These scenarios simulate incidents involving subjects at risk for suicide by cop and suicide by bridge, as well as situations involving hostages or barricading. (Anonymous CIT professional, personal communication, April 14, 2014; Dupont et al., 2007; Virginia CIT Coalition, n.d.) For dispatchers, it is recommended that they receive 20 hours to better identify mental health calls, appropriately dispatch CIT-trained officers, and to verbally interact with callers in a manner that does not exacerbate the crisis. Cultural diversity is incorporated into the training. (Dupont et al., 2007; Virginia CIT Coalition, n.d.)

The Memphis model recommends refresher courses every two years. Local programs can enhance this basic training with elective subjects, such as working with individuals with developmental or intellectual disability. Elective topics are often tailored to the needs of the jurisdiction’s population served. For instance, in a jurisdiction with a large homeless population, the local CIT training can incorporate a more extensive education regarding homelessness. Advanced training for CIT graduates can be offered. These classes often touch on topics not given extensive discussion in the basic 40-hour training, such as Alzheimer’s dementia and trauma-informed practice. (Dupont et al., 2007; Virginia CIT Coalition, n.d.)

Great emphasis is placed on how to resolve an incident using the least amount of force necessary, and how to interact with a civilian in crisis in a manner that promotes de-escalation. This includes verbal and nonverbal de-escalation techniques. (Dupont et al., 2007; Virginia CIT Coalition, n.d.) De-escalation techniques require the officer to use a different approach to the civilian in crisis than the approach used when interacting with a criminal suspect. For instance, verbal protocol in introducing oneself to the civilian in crisis has been standardized to promote a calm and non-confrontative approach. Nonverbal techniques, such as being mindful in regards to avoiding resting one’s hand on one’s gun, are also taught.

Such techniques help to lower resistance from civilians in distress. As preliminary research has linked increased civilian resistance to the use of force and subsequent injuries, de-escalation techniques constitute core skills that aid in enhancing safety and could possibly aid in pre-arrest jail diversion. (Morabito et al., 2012)

One training technique is required participation in “Hearing Disturbing Voices” simulation. The students are given headphones that simulate auditory hallucinations. Towards the end of the simulation, with the headphones still in place, these students are then asked to perform a number of tasks commonly asked by police and mental health professionals. This experience gives students the ability to understand how difficult it could be following commands and answering questions while experiencing auditory hallucinations. (Reuland & Schwartzfeld, 2008) However, research results suggest contradictory impact of auditory hallucination simulations, and caution should be taken when employing this technique. (Ando, S., 2011; Brown, 2010)

5 Additional Identified Potential Best practices of Select Jurisdictions in Virginia

Some jurisdictions have included as stakeholders fire and rescue professionals, who go through the CIT training. These jurisdictions also encourage emergency department nurses and mental health professionals that are involved in crisis intervention to go through the 40-hour training along with the police officers. (Anonymous multiple key informants, personal communication, 2014; NAMI Central Virginia Chapter, 2013) The two university campus police agencies that have implemented the CIT model work closely with university services, including the Dean’s office, human resources, and the student counseling services. All three university police agencies surveyed have collaboration with the local municipal law enforcement agencies that the university is located in, including implementation of mutual benefit. However, the two universities with CIT implementation appear to have enhanced collaboration with other university services. This is despite the fact that the university that does not have CIT implementation has collaboration between university counseling and campus police for psychiatric crisis.

5.1 The Role of the Peer Support Specialist

Peer support specialists are mental health paraprofessionals who have lived personal experience with mental illness and/or substance abuse. This profession has grown from the peer recovery movement, and requires specialized training for peer support specialists, as well as certification in many states. For candidates of peer support specialist training, usually a high school degree is required in addition to lived experience with mental illness and/or substance abuse. Peer support specialists most commonly work with people who are not in crisis but are experiencing significant mental health and/or substance abuse challenges. Research into the efficacy of the peer support specialist role in these settings has been positive, and demonstrates that peer recovery in general and peer support specialists in particular have a significantly positive impact in the recovery of individuals from mental illness and/or substance abuse. (Pitt et al., 2013; Salzer, Katz, Kidwell, Federici, & Ward-Colasante, 2009)

Recently, peer support specialists are beginning to be employed for psychiatric crisis situations. There is at least one jurisdiction in Virginia that employ a peer support specialist as part of the CIT team. These peer specialists are employed through the local public mental health services and often serve in the hospital emergency department setting. In crisis settings, they support both persons in crisis as well as family members who are present. They are part of the mental health team in the emergency room, and collaborate strongly with emergency room staff and other mental health professionals. As members of the mental health team, they interact with and collaborate strongly with officers who take persons in crisis to the emergency room. (Anonymous peer support specialist, personal communication, April 30, 2014; NAMI Central Virginia Chapter, 2013) The peer support specialist interviewed also presents regularly in the CIT training. This can aid in reducing stigma against mental illness among officers, as well as offsetting frustration officers can feel when they interact with individuals in crisis. Officers, through the presentation of the peer support specialist, are then exposed to a person who has had a significant

psychiatric history, including psychiatric crisis and a history of psychiatric hospitalization, who has achieved recovery. As officers often have exposure to mental illness only in the context of a mentally ill person being actively symptomatic or in crisis, this helps officers to understand that recovery is possible even in individuals with serious mental illness.

6 Discussion: Considerations for Enhanced Police Response to Psychiatric Crisis on College Campuses

6.1 Jail Diversion

The university environment differs somewhat from municipal settings because of its unique nature. The university environment encourages diversity and openness of expression for faculty and students alike. Increased collaboration among campus services for students and employees are often more prominent than within the non-college community environment. (Margolis & Shtull, 2012) On the surface, such characteristics may appear to deter campus police from making arrests of campus-affiliated individuals exhibiting signs of mental illness and/or substance abuse.

Although standard qualitative research was not conducted, interviews of law enforcement personnel revealed different attitudes regarding arrest or referral to university disciplinary procedures of individuals who are presenting in psychiatric crisis. As part of the interview for law enforcement professionals, two vignettes were explained and responses were audio recorded (with the exception of the campus detective, who declined to be audiotaped,) after receiving consent. The first vignette involved a possible low-level misdemeanor charge. The example given described a student experiencing his first psychotic break. The student believes there are cameras in the walls of his dorm room that are spying on him, so he punches holes in the walls. This technically could lead to a misdemeanor charge of vandalism. Non-CIT professionals indicated that this situation would result in diversion to the university's judicial review, and that this diversion would be initiated by the campus police. CIT professionals responded that no arrests would occur and no disciplinary action would be initiated by law enforcement; and that they would defer to the University Dean regarding disciplinary action.

The second vignette involved a situation that, without mental illness as a factor, would constitute a violent felony crime. An acutely manic student is agitated, and during the course of police intervention, the student hits a police officer. Non-CIT officers indicated that an arrest would be made in this situation. As one non-CIT trained law enforcement professional put it, "If it's a crime, then we will arrest."

CIT officers, however, had a different attitude. An arrest in this situation would generally speaking not result in an arrest if the assault were perceived as the result of psychiatric disturbance. As CIT training improves the officer's ability to discern if such an act is the result of criminal intent or the result of psychiatric disturbance, this may be a strong variable explaining this phenomenon.

The CIT approach is demonstrated in this interview with one campus law enforcement professional:

We don't want to punish kids for something that they're going through at the time whether it is [substance abuse] or whether its too many classes or whether its just any kind of...influence or something that's going on with them, we don't want to throw them in jail for it, we want to help them in anyway possible. So that's why I really like the CIT program because... we're not arresting people just because they're acting, you know, inappropriately and when someone thinks its trespassing, drunk in public. I had an incident where a kid [university student] was walking in the middle of the roadway and a taxi cab driver called in and said he's drunk, he needs to be arrested. The first officer that showed up, he was not CIT trained, but that was my sector so I was there. So I was the one taking the call. The officer says lets just DIP [charge him with drunk in public] him and lets go ... so I started talking to the kid and come to find out that he was standing in

the middle of the road because he wanted a car to run him over, he wanted to die, because he was failing...He was not accepted into a fraternity because he was different, so he was medicating himself with alcohol, wanted to die. I talked to him; I got him to go to the hospital voluntarily and once again he straightened up and was able to graduate, and I didn't arrest him for drunk in public. He didn't need that. Could I have? Sure, he was drunk in public. But that wouldn't have helped him. He would have slept it off in the hospital or in the jail, he woke up the next day just as depressed as he was when he went in...I have tons of these stories of these students, they're breaking the law, that's not what they need [arrest and criminal prosecution].

This law enforcement professional further elaborated on his opinion the importance of jail diversion:

And that's some of the things I, as trained prior to CIT, I was working at [a state psychiatric hospital], I would see these people with these dumb charges...There was a guy who was in the hospital; he was NGRI [not guilty by reason of insanity], but he was arrested for trespassing because he had broken into a army recruiting office and was waiting on them to come in because he wanted to be in the military so bad, but, and he could just not rationalize the fact that he broke the law. He was that much thinking about joining the military. And so the local jurisdiction arrested this poor guy, and you know he went to jail for no reason, and he's sitting in there without his medications. He was mistreated by other inmates. He was just delayed his...everything when he could have just been [taken to the hospital by police] and you know, started the process without all the charges; with his medication, without being mistreated, and we would never had to pay for it and send him to jail.

Although the research regarding the CIT objective of jail diversion is more limited and less promising than the research regarding other CIT objectives, the interviews confirmed formal qualitative studies that demonstrate the ability of CIT to positively impact police attitudes towards jail diversion when not actively confronted with a crisis. Such perspectives could have an important influence on how officers perceive the appropriateness not only of arrest, but how officers communicate the need for criminal justice intervention to a prosecuting attorney. In the university setting, enhanced understanding of how mental illness and/or substance abuse contribute to socially aberrant behavior can enable campus police to better communicate cases that may require intervention through the university's disciplinary review or threat assessment and management team.

6.2 Trauma-Informed Practice

The CIT model, as discussed above, addresses the unique experiences of military veteran survivors of combat that could lead to the development of PTSD. CIT training gives special attention to veterans related issues. However, after surveying CIT training schedules and the scholarly literature, non-combat trauma concerns were noticeably absent from the didactic component. Interviews with CIT-trained informants confirmed the relative lack of attention to trauma in the non-military population, and one informant felt that there needed to be more emphasis on non-combat related trauma.

The Substance Abuse and Mental Health Services Administration has identified trauma-informed intervention as a best practice. Mental health crisis in itself can have traumatizing effects. One best practice identified by SAMHSA in regards to professionals who work with individuals in psychiatric crisis relates to trauma-informed concerns. This practice acknowledges that individuals in crisis may have a trauma history, and that the crisis itself can cause both physical and psychological trauma. Professionals are urged to take this into consideration when interacting with persons in crisis, and to incorporate trauma-informed interventions during the crisis as well as once the situation has been stabilized.

(SAMHSA, 2009). Police and mental health professional interventions that inadvertently cause distress to the civilian in crisis may impact recovery and impart in the civilian wariness of first responder professionals, including police officers and emergency room or mental health professionals. Given the high rate of non-combat related traumatic experiences in the general psychiatric population, (Musket, 2014; O'hare, & Sherrer, 2013) incorporating trauma-informed practice for both health professionals and law enforcement professionals could improve outcomes in mental health crisis interventions.

6.3 The Peer Support Specialist

The peer support specialist can be an asset in the university environment given the unique nature of the university student population. Peers are typically involved when a student is experiencing psychiatric crisis. As a result, the student organization Active Minds has implemented a program for lay students to better learn how to help peers in psychiatric crisis, particularly if it involves suicidal ideation. These students who receive this instruction are designated as “gatekeepers”. (Active Minds, n.d.)

Although currently peer support specialist training and certification does not require a college degree, a peer support specialist who has gone through the college experience could provide enhanced response to university-affiliated members with mental illness, whether in acute crisis or not. The combination of peer recovery/support training with lived experience regarding mental illness/substance abuse poises the peer support specialist to be able to enhance mental health interventions, possibly including in the crisis setting. A peer support specialist who has had a college experience, or receives training regarding the college experience, could possibly present an important creative intervention for mental health issues on campus.

6.4 Enhanced Collaboration with Student Organization Stakeholders

As noted above, a crucial aspect in the successful implementation of the CIT model requires early and sustained collaboration with mental health advocacy groups. For the university setting, the implementation of a CIT model could possibly be enhanced by collaborating with student organizations. These groups ideally would not be limited to mental health awareness and advocacy groups, such as Active Minds, although such organizations would be particularly important in stakeholder involvement. Other student organizations that address subjects such as substance abuse, domestic violence, and student/employee veterans also could have important contributions to make.

6.5 Threat Assessment and Management on Campus

The objectives of the CIT model and threat assessment/management teams are different. However, CIT implementation on campuses could possibly have a positive impact on the objectives of threat assessment and management teams. Because CIT training sensitizes law enforcement professionals to mental health concerns, CIT-trained officers have been shown in the literature to have a better understanding of the true nature of outwardly-directed violence or dangerousness associated with mental illness. This can enable campus police to more accurately identify the possibility of an individual in crisis requiring assessment and intervention by the threat assessment and management team. Conversely, CIT could also enable police to help rule out concerns of a risk for outwardly-directed violence in an individual in crisis. The literature reveals many ethical, legal, and privacy concerns regarding threat assessment and management teams. (Eells & Rockland-Miller, 2011; Ferguson et al., 2011; Stuart, 2012) By empowering campus police to appropriately determine if an individual presents as a subject of concern for threat assessment, police can possibly have an impact on these ethical concerns. Furthermore, because CIT incorporates advanced techniques including hostage taking and barricading, CIT training may be particularly relevant in the event of an actual outwardly-direct violence crisis.

One of the key informants, a CIT-trained campus law enforcement professional, indicated that the threat assessment and management team at his university currently does not have a CIT-trained law enforcement representative. He suggested that a representative from the university’s CIT law enforcement

professionals be included on the threat assessment and management team. He felt that this could enhance objectives, particularly regarding accurate identification of risk, for threat assessment and management teams. It may be prudent to take this professional's suggestion into account when structuring threat assessment and management teams.

Conclusion

That [university counseling services] and the vet place over there in [the student center]...I seriously think that those two need to get together and talk and possibly come up with a support group...there's nothing here [locally]...why aren't we helping them with a support group for the combat situations they saw, their PTSD, their TBI's? ... Common popularity is, oh my God, he's got PTSD, he's gonna snap and kill everybody. Why, because he's a soldier? No. PTSD is not just a combat-related PTSD. If you've been raped, beat up, you could have a serious car accident...you could end up with PTSD. So why don't we have a support group for these people instead of waiting for something to happen because like, oh yeah, man, that guy's crazy as hell [because] he's over in Iraq, and this girl's crazy because she got raped in high school and she's been crazy ever since. Why does society do that?

The above poignant statement by one of the key informants powerfully sums up so much of what the research literature addresses regarding mental illness. Although the statement specifically addresses PTSD and TBI, the key informant's concerns can easily be applied to everyone experiencing mental health disturbances. The discussion of stigma of those with mental illness as perceived by the general public as "crazy", violent, and dangerous is emphasized as it also is in the scholarly literature and among mental health professional and advocacy disciplines. It also demonstrates concern for the lack of interventions and collaboration among service providers for individuals experiencing mental illness. The key informant expresses the urgency for enhanced collaboration of campus services for campus-affiliated individuals experiencing mental illness. Although generally speaking universities often have extensive collaboration of services as compared to the general public, more work can be done in this area to improve the quality of life on the college campus. As the CIT model requires thorough collaboration of services, the CIT model could improve campus collaboration. As universities already have much collaboration, the campus setting may be primed to more easily incorporate the CIT model.

The CIT model can also enhance collaboration between universities and local community services. Not only would CIT improve collaboration between campus and municipal police departments, but also it could possibly address mental illness that cannot be addressed with university services. In particular, CIT can help to initiate or strengthen ties to local community mental health services. This includes hospital and emergency mental health services, particularly for universities that do not have a hospital health system. It can also give options for students whose mental health concerns go beyond what university counseling services can provide. By connecting with local public and private mental health services, sometimes a student can then be referred to treatment not offered at the university. An example of this would be Dialectical Behavioral Therapy (DBT) access for students with Borderline Personality Disorder and other mental health conditions that can be treated with DBT. (Tene et al., 2011)

The importance of mental health advocacy organizations in the collaborative effort of the CIT model cannot be stressed enough. This has implications for the university campus in relation to student organizations. Collaborations could be improved by not only including student mental health advocacy organizations such as Active Minds, but also student organizations that address veteran, sexual assault, and dating violence concerns. CIT, especially when incorporated with consideration for threat assessment and management teams, can provide the framework for enhanced dialogue, accuracy of cases involving

persons of concern for threat assessment, and forge ties among a diverse array of services and organizations that are impacted by psychiatric crisis.

The university population can also be served by incorporating peer-related services and ideas, such as consideration of the peer recovery movement and employment of a peer support specialist. Families of persons with mental illness also can benefit from such activities. NAMI has begun a campus organization, NAMI on Campus, which could be instrumental to helping universities manage psychiatric concerns. (NAMI on Campus, n.d.) As NAMI already has been highly involved in the CIT model from its very inception in Memphis, NAMI could and should be considered in inclusion of university efforts.

Finally, the criminalization of mental illness has had a profoundly tragic impact on the quality of life and health status of literally millions of Americans. Universities and colleges are not immune to this problem. Although the research on CIT's ability to attain its jail diversion objective is somewhat inconclusive, there are many studies demonstrating that this objective may indeed be being met in a number of jurisdictions. The research indicates that, paramount to achievement of this goal, correct implementation of CIT, especially collaboration with the mental health system, is vital. Memorandums of understanding between police departments and health facilities are very important in this endeavor. CIT can also enhance disciplinary procedures on campus. The model can aid in non-punitive intervention targeting individuals who engage in socially aberrant or disruptive behavior due to mental illness, and possibly can help divert such individuals away from formal disciplinary sanctions and into mental health services. This could enhance efficacy of universities to manage such behaviors, not only to reduce incidence of disruptive behaviors, but also to reduce stigma.

Advocating for implementation of CIT in the campus setting does not invalidate the collaborative efforts already in place between university mental health professionals, campus law enforcement, and other university services. Rather, the CIT model is a creative approach that can enhance these collaborative efforts already in place. Currently there appears to be enough scientific and anecdotal evidence to support CIT implementation not only throughout municipal districts, but also the college campus. Even as researchers continue to gather results examining the CIT model's success, CIT has so much to offer the university environment that all universities and colleges have much to gain from this model. For American universities and colleges, CIT can only enhance the academic experience for everyone on campus.

References

Abramowicz, S. (2013). A family law perspective on parental incarceration. *Family Court Review*, 50(2), 228-240.

Active Minds. (2014). *Active minds: changing the conversation about mental health*. Retrieved from <http://www.activeminds.org>

Active Minds (n.d.) *Gatekeeper training to prevent campus suicide*. Retrieved from <http://www.activeminds.org/component/content/article/939>

Ando, S., Clement, S., Barley, E.A., & Thornicroft, G. (2011). The simulation of hallucinations to reduce the stigma of schizophrenia: a systematic review. *Schizophrenia Research*, 133(1-3), 8-16.

Balassone, M. (2011). Jails, prisons increasingly taking care of mentally ill. The Washington Post, January 23, 2011, Sunday, A-SECTION; A04.

Barry, C. (2013). *Media Coverage of Mass Shootings Contributes to Negative Attitudes towards Mental Illness*. Retrieved from http://www.jhsph.edu/news/news-releases/2013/webster_mass_shootings_mental_illness.html

Beck, A.J. (2013) Prison rape elimination act of 2013: PREA data collection activities. United States Bureau of Justice Statistics. Retrieved from <http://www.bjs.gov/content/pub/ascii/svpjri1112.txt>

Bell, M. E., & Reardon, A. (2011). Experiences of sexual harassment and sexual assault in the military among OEF/OIF veterans: implications for health care providers. *Social Work in Health Care*, 50(1), 34-50.

Bloom, J. (2010). The incarceration revolution: the abandonment of the seriously mentally ill to our jails and prisons. *Journal of Law, Medicine and Ethics*, 38(4), 727-734.

Bradley, E.H. & Taylor, L.A. (2013). *The American health care paradox: Why spending more is getting us less*. Public Affairs: New York.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press: Cambridge.

Brown, S.A. (2010). Implementing a brief hallucination simulation as a mental illness stigma reduction strategy. *Community Mental Health*, 46(5), 500-504.

Browning, S., Van Hasselt, V., Tucker, A., & Vecchi, G. (2011). Dealing with individuals who have mental illness: the crisis intervention team (CIT) in law enforcement. *British Journal of Forensic Practice*, 13(4), 235-243.

Campbell, J. (2008). Proceedings from Jewish Women International teleconference '08: *Danger Assessment: A Tool to Help Identify the Risk of Intimate Partner Homicide and Near-Homicide*.

Canada, K.E., Angell, B., & Watson, A.C. (2012). Intervening at the entry point: differences in how CIT trained and non-CIT trained officers describe responding to mental health-related calls. *Community Mental Health*, 48(6), 746-755.

Castillo, L.G., & Schwartz, S.J. (2013). Introduction to the special issue on college student mental health. *Journal of Clinical Psychology*, 69(4), 291-297.

Centers for Disease Control and Prevention. (2014). *Social determinants of health*. Retrieved from <http://www.cdc.gov/socialdeterminants/>

Code of Virginia 2009 Annotated §9.1-187-§9.1-190. Retrieved from <http://leg1.state.va.us/cgi-bin/legp504.exe?091+ful+SB1294ER>

Cooper, V.G., McLaren, A.M., & Zapf, P.A. (2004). Disposition decisions with the mentally ill: police perceptions and characteristics. *Police Quarterly*, 7(3), 295-310.

Council of State Governments Justice Center. (2008). *Improving responses to people with mental illnesses: The essential elements of a specialized law enforcement-based program*. New York:

Schwarzfeld, M., Reuland, M., Plotkin, M., Cordner, G. (2006). People with a mental illness: Problem oriented guides for the police. Washington, DC: Office of Community Oriented Policing Services.

Cummings, J.R., Lucas, S.M., & Druss, B.G. (2013). Addressing stigma and disparities among persons with mental illness: the role of federal policy. *American Journal of Public Health*, 103(5), 781-785.

Damelio, R. (1995). *The basics of benchmarking*. Portland, Oregon: Productivity Press.

Deane, M. W., Steadman, H. J., Borum, R., Veysey, B. M., & Morrisey, J. P. (1999). Emerging partnerships between mental health and law enforcement. *Psychiatric Services*, 50(1), 99– 102.

Department of Criminal Justice Services and Department of Behavioral Health and Developmental Services. (2011, 11 15). Assessing the impact and effectiveness of Virginia's crisis intervention team programs FY 2011. Virginia, USA.

Demir, B., Broussard, B., Goulding, S. M., & Compton, M. T. (2009). Beliefs about causes of schizophrenia among police officers before and after crisis intervention team training. *Community Mental Health Journal*, 45(5), 385-392.

Duckworth, K., & Freedman, J.L. (2013). *Dual diagnosis: substance abuse and mental illness*. Retrieved from http://www.nami.org/Template.cfm?Section=By_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=23049

Dupont, R., Cochran, S., & Pillsbury, S. (2007). *Crisis Intervention Team core elements*. Memphis, TN: The University of Memphis School of Urban Affairs and Public Policy, Department of Criminology and Criminal Justice, CIT Center. Retrieved from http://www.cit.memphis.edu/information_files/CoreElements.pdf

Eells, G. T., & Rockland-Miller, H. S. (2011). Assessing and Responding to Disturbed and Disturbing Students: Understanding the Role of Administrative Teams in Institutions of Higher Education. *Journal Of College Student Psychotherapy*, 25(1), 8-23

Erdur-Baker, O., Aberson, C.L., Barrow, J.C., & Draper, M.R. (2006). Nature and severity of college students' psychological concerns: a comparison of clinical and nonclinical national samples. *Professional Psychology: Research and Practice*, 37(3), 317-323.

Federal Bureau of Investigation (2005). *Law enforcement officers killed and assaulted*. Washington, DC: United States Department of Justice.

Ferguson, C.J., Coulson, M., & Barnett, J. (2011). Psychological profiles of school shooters: positive directions and one big wrong turn. *Journal of Police Crisis Negotiations*, 11(2), 141-158.

Flatt, A.K. (2013). A Suffering Generation: Six factors contributing to the mental health crisis in North American higher education. *College Quarterly*, 16(1), p1-1.

Franz, S., & Borum, R. (2011). Crisis intervention teams may prevent arrests of people with mental illnesses. *Police Practice and Research*, 12(3), 265-272.

Gur, O. (2010). Persons with mental illness in the criminal justice system: police intervention to prevent violence and criminalization. *Journal of Police Crisis Negotiations*, 10(1/2), 220-240.

Hafemeister, T., Garner, S., & Bath, V. (2012). Forging links and renewing ties: applying the principles of restorative and procedural justice to better respond to criminal offenders with a mental disorder. *Buffalo Law Review*, 60(1), 147.

Hall, L., Graf, A., Fitzpatrick, M., Lane, T., & Birkel, R. (2003). Shattered lives: Results of a national survey of NAMI members living with mental illnesses and their families: TRIAD report. Arlington, Virginia: National Alliance of the Mentally Ill.

Hollingsworth, L.D., Swick, D., & Choi, Y.J. (2013). The role of positive and negative social interactions in child custody outcomes: voices of US women with serious mental illness. *Qualitative Social Work*, 12(2), 153-169.

Honberg, R., & Gruttadaro, D. (2005). Flawed mental health policies and the tragedy of criminalization. *Corrections Today*, 67(1), 23-27.

Human Rights Watch. (2003). *Ill-equipped: US prisons and offenders with mental illness*. Retrieved from <http://www.hrw.org/sites/default/files/reports/usa1003.pdf> on April 12, 2014

James, D.J., & Glaze, L. (2006). Bureau of Justice statistics special report: Mental health problems of prison and jail inmates. Retrieved from <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>

Jines, J. (n.d.). Crisis Intervention Teams: Responding to Mental Illness Crisis Calls. Retrieved 3 22, 2013, from Federal Bureau of Investigation: www.fbi.gov/stats-services/publications/law-enforcement-bulletin/crisis-intervention-teams-responding-to-mental-illness-crisis-calls

Kadison, R. (2006). "College psychiatry 2006: challenges and opportunities." *Journal of American College Health*, 54(6), 338-340.

Keller, E.W., Hughes, S., & Hertz, G. (2010). A model for assessment and mitigation of threats on the college campus. *Journal of Educational Administration*, 49(1), 76-94.

Kerr, A.N., Morabito, M., & Watson, A.C. (2010). Police encounters, mental illness, and injury: an exploratory investigation. *Journal of Police Crisis Negotiations*, 10(4), 116-132.

Knoll, J. (2013). The "pseudocommando" mass murderer, part 1: the psychology of revenge and obliteration. *Journal of the American Academy of Psychiatry and the Law*, 38(1), 87-94

Koyanagi, C. (2007). Learning from history: Deinstitutionalization of people with mental illness as precursor to long-term care reform. The Henry J Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured.

Koyanagi, C. (n.d.). What happens to your benefits if you go to jail or prison? A guide to the federal rules on SSI, SSDI, Medicaid, Medicare, and veterans' benefits for adults with disabilities. Washington, D.C.: Judge David L. Bazelon Center for Mental Health Law.

Krebs, C. P., Lindquist, C. H., Warner, T. A., Fisher, B. S., & Martin, S. L. (2009a). College women's experiences with physically forced, alcohol or drug-enabled, and drug-facilitated sexual assault before and since entering college. *Journal of American College Health*, 57(6), 639-47.

Krebs, C. P., Lindquist, C. H., Warner, T. D., Fisher, B. S., & Martin, S. L. (2009b). The differential risk factors of physically forced and alcohol or other drug enabled sexual assault among university women.

Violence and Victims, 24(3) 302-321.

Lipson, G.S., Turner, J.T., & Kasper, R. (2010). A strategic approach to police interactions involving persons with mental illness. *Journal of Police Crisis Negotiations*, 10(1/2), 30-38.

Lurigio, A.J. (2000). Persons with serious mental illness in the criminal justice system: background, prevalence, and principles of care. *Criminal Justice Policy Review*, 11(4), 312-328.

Lurigio, A.J., & Watson, A.C. (2010). The police and people with mental illness: new approaches to a longstanding problem. *Journal of Police Crisis Negotiations*, 10(1-2), 3-14.

Margolis, G.J., & Shtull, P.R. (2012). The police response to mental illness on campus. *Journal of College Student Psychotherapy*, 26(4), 307-321.

Marmot, M., & Wilkinson, R.G. (2006). *Social determinants of health*. Oxford: Oxford University Press.

Marsh, D.T. (2009). Parental mental illness: issues in custody determinations. *American Journal of Family Law*, 23(1), 28-36.

Martinez, L.E. (2010). Police departments' response in dealing with persons with mental illness. *Journal of Police Crisis Negotiations*, 10(1/2), 166-174.

McVay, D., Schiraldi, V. & Ziedenberg, J. (2004). Treatment or incarceration? National and state findings on the efficacy and cost-savings of drug treatment versus imprisonment. Washington, D.C.: Justice Policy Institute.

Meloy, J.R., Hempel, A.G., Mohandie, K., Shiva, A.A., & Gray, B.T. (2001). Offender and offense characteristics of a nonrandom sample of adolescent mass murderers. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40(6), 719-728.

Morabito, M. S., Kerr, A. N., Watson, A., Draine, J., Ottati, V., & Angell, B. (2012). Crisis Intervention Teams and People With Mental Illness: Exploring the Factors That Influence the Use of Force. *Crime & Delinquency*, 58(1), 57-77.

Morabito, M. S., Watson, A., & Draine, J. (2013). Police officer acceptance of new innovation: the case of crisis intervention teams. *Policing*, 36(2), 421-436.

Munetz, M.R., & Griffin, P. A. (2006). Use of the sequential intercept model as an approach to the decriminalization of people with serious mental illness. *Psychiatric Services*, 57(4), 544-549.

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal Of Mental Health Nursing*, 23(1), 51-59.

National Alliance on Mental Illness (NAMI)- Central Virginia chapter meeting. (2013, 3 14). Henrico County Crisis Intervention Team, Richmond, Virginia.

National Alliance on Mental Illness on Campus. (n.d.). *NAMI on Campus*. Retrieved from http://www.nami.org/Template.cfm?Section=NAMI_on_Campus1

National Alliance on Mental Illness on Campus (2012). *NAMI on campus: suicide*. Retrieved from http://www.nami.org/Content/NavigationMenu/Find_Support/NAMI_on_Campus1/Mental_Illness_Fact_Sheets/Suicide.pdf

Navasky, M. (Producer). (2005, May 10). *The New Asylums*. [television investigative documentary]. Boston, MA: Public Broadcasting System/Frontline/WGBH Educational Foundation. Retrieved from www.pbs.org/wgbh/pages/frontline/shows/asylums/

Nolan, J.J., Dinse, K., & McAndrew, P.C. (2014). Human resources, threat assessment, and law: an interdisciplinary approach to implementing threat assessment and management best practices in the education workplace. Proceedings from Virginia Center for School and Campus Safety Threat Assessment Conference 2014: *Virginia Center for School and Campus Safety Threat Assessment Conference*: undisclosed location.

Noonan, M. (2010). Mortality in local jails and state prisons, 2000-2010- statistical tables. US Department of Justice, Bureau of Justice Statistics. Washington, D.C.: US Department of Justice.

Obama, B. (2014). *Memorandum: establishing a white house task force to protect students from sexual assault*. Retrieved from <http://www.whitehouse.gov/the-press-office/2014/01/22/memorandum-establishing-white-house-task-force-protect-students-sexual-a>

O'hare, T., & Sherrer, M.V. (2003). Lifetime traumatic events and high risk behaviors as predictors of PTSD symptoms in people with severe mental illnesses. *Social Work Research*, 33(4), 209-218.

Pitt, V., Lowe, D., Hill, S., Prictor, M., Hetrick, S.E., Ryan, R., & Berends, L. (2013). Consumer-providers of care for adult clients of statutory mental health services (Review). The Cochrane Library, 2013(3), 1-105.

Pollard, J.W., Nolan, J.J., & Deisinger, E.R.D. (2012). The practice of campus-based threat assessment: an overview. *Journal of College Student Psychotherapy*, 26(4), 263-276

Reuland, M., Draper, L., & Norton, B. (2010). Improving responses to people with mental illnesses: Tailoring law enforcement initiatives to individual jurisdictions. Council of State Governments Justice Center: New York. Retrieved from <http://vacitcoalition.org/Research/CSG LE Tailoring.pdf>

Reuland, M., & Schwarzfeld, M. (2008). Improving responses to people with mental illnesses: Strategies for effective law enforcement training. New York: Council of State Governments Justice Center.

Ritter, C., Teller, J., Marcussen, K., & Munetz, M.T. (2011). Crisis intervention team officer dispatch, assessment, and disposition: interactions with individuals with severe mental illness. *International Journal of Law and Psychiatry*, 34(1), 30-38.

Ruiz, J., & Miller, C. (2004). An exploratory study of Pennsylvania police officers' perceptions of dangerousness and their ability to manage persons with mental illness. *Police Quarterly*, 7(3), 359-371.

Royland, M., Schwartzfeld, M., & Draper, L. (2009). Law enforcement responses to people with mental illness: a guide to research-informed policy and practice. State Government Justice Center, the Council of State Governments, New York, NY.

Ruderman, M. (2013). *The ecological model in public health*. Retrieved from <http://www.jhsph.edu/research/centers-and-institutes/womens-and-childrens-health-policy-center/eco-model/eco-model.html>

Salinsky, E., & Loftis, C. (2007). Shrinking inpatient psychiatric capacity: cause for celebration or concern? National Health Policy Forum, George Washington University, Issue Brief, no. 823.

Salzer, M. S., Katz, J., Kidwell, B., Federici, M., & Ward-Colasante, C. (2009). Pennsylvania Certified Peer Specialist Initiative: Training, Employment and Work Satisfaction Outcomes. *Psychiatric Rehabilitation Journal*, 32(4), 301-305.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2009). *Practice Guidelines: Core Elements for Responding to Mental Health Crises*. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Shadick, R., & Akhter, S. (2014) Suicide prevention with diverse college students. *Journal of College Student Psychotherapy*, 28(2), 117-131

Shim, R., Koplan, C., Langheim, F.J.P., Manseau, M.W., Powers, R. A., & Compton, M.T. (2014). The social determinants of mental health: an overview and call to action. *Psychiatric Annals*, 44(1), 22-26.

Skeem, L., & Bibeau, L. (2008). How does violence potential relate to crisis intervention team responses to emergencies? *Psychiatric Services*, 59(2), 201-204.

Soyka, M. (2000). Substance misuse, psychiatric disorder and violent and disturbed behaviour. *British Journal of Psychiatry*, 176(4), 345-350.

Stuart, S.P. (2012). Hope and despondence: emerging adulthood and higher education's relationship with its nonviolent mentally ill students. *Journal of college and university law*, 38 (2), 319 - 379.

Tanielian, T.L., & Jaycox, L. (2008). Invisible Wounds of War: Psychological and Cognitive Injuries, their Consequences, and Services to Assist Recovery. RAND Center for Military Health Policy Research, Santa Monica, CA.

Tene, O., Har-Even, A., Dahan, E., Babokshin, Y., Reuveni, I., Penrovski, B., Rosman, V., & Gluzman, L. (2011). Dynamic psychotherapy or dialectical behavioral therapy: which is better for borderline personality disorder? *The Israel Journal Of Psychiatry And Related Sciences*, 48(2), 138-139.

Teplin, L.A., & Pruett, N.S. (1992). Police as streetcorner psychiatrist: managing the mentally ill. *International Journal of Law and Psychiatry*, 15(2), 139-156.

Teplin, L., Abram, K., McClelland, G., Dulcan, M., & Mericle, A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry*, 59(12), 1133-1143

Vacchi, David T. (2012). Considering student veterans on the twenty-first century college campus. *About Campus*, 17(2), 15-21

Virginia CIT Coalition. (n.d.) *Essential elements of Virginia CIT*. Retrieved from http://vacitcoalition.org/essential_elements_of_virginia_cit

University of Memphis CIT Center. (n.d.a) *The CIT program: background*. Retrieved from <http://cit.memphis.edu/overview.php?page=1>

University of Memphis CIT Center. (n.d.b) *Overview of CIT*. Retrieved from <http://cit.memphis.edu/overview.php>

University of Memphis CIT Center. (n.d.c) *Welcome to the University of Memphis CIT center: a resource for CIT programs across the nation*. Retrieved from <http://www.cit.memphis.edu>

University of Memphis CIT Center. (n.d.d) *Memphis model*. Retrieved from <http://www.cit.memphis.edu/overview.php?page=2>

University of Memphis CIT Center. (n.d.e) *National model*. Retrieved from <http://www.cit.memphis.edu/overview.php?page=7>

Von Hemert, T. (2012). *Thomas Jefferson area crisis intervention team*. Retrieved from http://cit.memphis.edu/information_files/Spring2012newsletter.pdf on April 10, 2014.

Wallace, G. (2012). The real lethal punishment: the inadequacy of prison health care and how it can be fixed. *Faulkner Law Review*, 4(1), 265-297.

Watson, A. C., & Fulambarker, A. J. (2012). The crisis intervention team model of police response to mental health crises: a primer for mental health practitioners. *Best Practice In Mental Health*, 8(2), 71-81.

Watson, A.C., Ottati, V.C., Morabito, M., Draine, J., Kerr, A.N., & Angell, B. (2010). Outcomes of police contacts with persons with mental illness: the impact of CIT. *Administration & Policy In Mental Health & Mental Health Services Research*, 37(4), 302-317.

World Health Organization. (2002). *Mental health global action program (mhGAP): close the gap, dare to care*. Retrieved from http://www.who.int/mental_health/media/en/265.pdf

World Health Organization. (2008). Social determinants of health: key concepts. Retrieved from http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/

Yoon, J., & Bruckner, T.A. (2009). Does deinstitutionalization increase suicide? *Health Services Research*, 44(4), 1385-1405.

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