National Alliance on Mental Illness

**Statement of Laura Usher, CIT Program Manager and Ron Honberg, Director of Policy and Legal Affairs on behalf of NAMI (the National Alliance on Mental Illness) for the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights hearing on "Law Enforcement Response to Disabled Americans."**

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## Introduction

This statement is submitted on behalf of NAMI, the National Alliance on Mental Illness. NAMI is the nation's largest grassroots mental health organization representing individuals living with mental illness and families. NAMI is dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raise awareness and build a community for hope for all of those in need. NAMI is the foundation for hundreds of NAMI State Organizations, NAMI Affiliates and volunteer leaders who work in local communities across the country to raise awareness and provide essential and free education, advocacy and support group programs.

NAMI Affiliate organizations have relationships with law enforcement and mental health agencies throughout the country. Since the late 1980's, they have been deeply involved working to establish crisis intervention team (CIT) programs in their local communities. Today, there are 2800 local CIT programs around the country and NAMI Affiliates are key partners in many of them.

CIT programs are built on strong partnerships between stakeholders in communities, including NAMI Affiliates and other advocacy organizations, law enforcement agencies and mental health provider agencies. The goal of these programs is to improve police responses to people in mental health crisis situations and to connect people in crisis with mental health treatment instead of arrest and incarceration. For NAMI members, CIT programs are not just an opportunity to educate police; CIT saves lives, offers hope to desperate families and helps transform the way entire communities understand mental illness.

Two advocates from NAMI Memphis were the driving force behind the first CIT program. Ann Dino and Helen Adamo had both called police in a desperate attempt to get help when their adult children were in crisis. Outraged by the way their sons were treated, Dino and Adamo reached out to the Memphis Police and local leaders, proposing special training for police in responding to mental health crisis situations.

Soon after that, another family called the police, a mother desperate to get help for her grown son who was injuring himself in the midst of a psychiatric crisis. The community was outraged when Joseph Dewayne Robinson was shot and killed during this encounter.

In the aftermath of this tragedy, the Memphis Police Department, NAMI Memphis and the University of Tennessee Medical Center came together to form the first CIT program.

**Spread of CIT Programs**

Since the first CIT program started in Memphis, 2,800 communities nationwide have adopted CIT programs. CIT programs currently exist in 46 US States and the District of Columbia.[i] About a dozen states have well-coordinated statewide CIT efforts, usually initiated by a consortium of law enforcement agencies, criminal justice leaders, mental health providers and non-profit mental health advocacy organizations. Initially driven by the passion of NAMI members nationwide, CIT has taken on a life of its own, and many law enforcement officers, judges and other community leaders promote the program to their peers. NAMI is proud to count law enforcement leaders among our closest allies. In addition to NAMI, a handful of other organizations have been instrumental in promoting and supporting the spread of CIT nationwide: CIT International, the University of Memphis CIT Center, the International Association of Chiefs of Police, the Council of State Governments Justice Center and the Police Executive Research Forum.

**CIT Training**

The success of CIT is partly because of the innovative nature of the training program. CIT training is a 40-hour, intensive skills-based training for law enforcement officers.[ii] The training is developed at the local level and taught by a mix of local mental health professionals, law enforcement officers, individuals living with mental illness and family members. A typical training includes the signs and symptoms of common mental health conditions, including a simulation that allows officers to experience what it's like to have visual and auditory hallucinations. Officers also learn about local mental health services, including education and support offered by non-profit organizations like NAMI Affiliates, and how to connect individuals with those services. The training provides intensive scenario-based training on verbal de-escalation skills and how to talk someone down from a crisis situation without using physical force.

Finally, the training includes several hours of interacting directly with people living with mental illness and family members. For many law enforcement officers, CIT training may be the first time they interact with a person with serious mental illness who is doing well and managing the illness. Officers often have a huge shift in perspective, realizing that people living with mental illness are ordinary people with families, homes and jobs. Officers also come to understand that providing assistance to a person in crisis can be a turning point for that individual and set him or her on the road to recovery.

**Partnerships are the Key to CIT's Success**

Just as important as the training is the partnerships built around CIT. Training can prepare individual officers to respond to a crisis, but a network of local relationships and partnerships makes it possible for the law enforcement agency and the community to make a lasting change. The key partners are law enforcement agencies, mental health

provider agencies and advocacy organizations representing individuals living with mental illness and families. Historically, these agencies and groups often have built up resentment and misunderstanding, and the only way to resolve that is open dialogue, cross-training and an ongoing relationship.

CIT won't work if it is imposed from above. The commitment has to be rooted in the community, involving local government leaders, police and mental health professionals. This problem is not going away. Police will continue to be front-line responders to mental health crisis, until a more robust and coordinated mental health system makes it possible for people to get mental health services early and as often as needed.

To be effective, CIT officers need to be part of a coordinated system, so law enforcement agencies and mental health provider agencies typically come to an agreement about the best procedure for transferring custody of an individual to mental health services. Frequent conversation between these agencies' leaders allow for problem-solving and improvement.

Strong partnerships with mental health advocacy groups are also essential to help build the trust of the community they are serving and to educate the members of that community about what to do in a crisis. In return, advocates are the strongest boosters for CIT officers and the program, providing awards for good service, organizing community support and helping build local media attention.

CIT is unique because it brings together leaders and front-line staff from the criminal justice and mental health systems to talk about the challenges of people with mental illness in the justice system. This conversation often grows to include more initiatives for the community, for example specialized training to address the needs of veterans, youth, older adults or people with developmental and intellectual disabilities. CIT programs also frequently expand partnership and training opportunities to others in the community, including firefighters, emergency medical service, corrections officers, hospital security, campus police, school resource officers and others. Finally, CIT programs are often the impetus for local advocacy for better mental health services, especially crisis services, and for other criminal justice/mental health interventions, such as mental health courts and re-entry programs.

**Outcomes of CIT Programs; Consequences of Doing Nothing**

The goal of the first CIT program was to reduce injuries of officers and people with mental illness by training police in more humane tactics for responding to people in crisis. In this regard, the program has been very successful, with injuries to officers responding to mental health calls dropping 80% after the introduction of CIT.[iii] The program also has numerous other benefits for police, individuals living with mental illness and communities. CIT officers report feeling better prepared to respond to mental health calls[iv] and they do a better job of identifying people in mental health crisis.[v] CIT officers are more likely to transport an individual for mental health services[vi] and less likely to arrest.[vii] CIT officers are less likely to use force in responding to mental health

calls and more likely to use verbal de-escalation skills to keep a situation from spiraling out of control.[viii]

For individuals living with mental illness and their families, the presence of a CIT officer means a reduced risk of injury and arrest. Individuals and families also report feeling safer and more confident in calling the police; this is because CIT officers make a point of creating relationships in the community and often check in with individuals that they know may need mental health care. People who are diverted from jail by a CIT officer spend more time in their home and communities, get more medication and counseling, and spend less time in jail than people who interact with untrained officers.[ix]

Engagement with mental health treatment is life-saving for people with serious mental illness. Without early identification and treatment, people with mental illness are high risk for suicide[x], dropping out of school[xi], involvement in the juvenile justice[xii] and criminal justice system, becoming victims of violence[xiii], substance use and homelessness[xiv].

Equally important, involvement with the justice system often exacerbates a crisis for people living with mental illness. Most people with mental illness booked into jails are there because of non-violent crimes[xv], but once in the system are at high risk of cycling repeatedly through jails, emergency services and homeless services. In prison, people with mental illness stay longer than other inmates facing similar charges[xvi], are more likely to face sexual assault or other abuse, and are more likely to be placed in solitary confinement[xvii] because corrections officers are not equipped to respond to psychiatric symptoms. People rarely get quality mental health services while in jail, and leave jails sicker and with fewer resources to be successful. Leaving jail, individuals often have lost access to Medicaid and Social Security, and face greater barriers to housing and employment because of their criminal record.

The involvement of people with mental illness in the justice system is a national crisis, because about 1 in 5 jail and prison inmates have a serious mental illness.[xviii] Incarcerating these individuals when they have not committed serious crimes is ineffective and a waste of taxpayer money.

CIT programs, paired with strong crisis mental health services and supports for people with serious mental illness, are the first line of defense to prevent these tragic outcomes.

**CIT in Jails and Prisons**

Jails and prisons have tragically become de-facto “mental health treatment facilities” in many parts of the country. The Cook County jail, Twin Towers jail in Los Angeles, and Riker’s Island in New York City have been characterized as the largest “psychiatric hospitals” in the country. Characterizing these correctional settings as mental health treatment facilities is a misnomer, because they are generally ill equipped to provide quality psychiatric treatment. On the contrary, the stresses and dangers of correctional settings frequently exacerbate psychiatric crises and worsen symptoms. The response of

correctional officers is too frequently punitive, placement (sometimes for weeks, months or even years) of inmates with serious mental illness in solitary confinement or other forms of administrative segregation.

In an effort to create alternatives to solitary confinement and teach de-escalation techniques to correctional officers, CIT is now offered to correctional officers in many parts of the country. CIT training for corrections officers addresses conditions in the correctional facility.

An evaluation of CIT training for corrections officers in Maine showed that CIT trained officers were twice as likely to use verbal de-escalation than physical force in resolving mental health incidents.[xix] This evaluation also stated that after CIT training, jail staff in Maine did a better job of identifying people in need of mental health services. Anecdotal evidence from CIT for corrections programs in Indiana suggests a dramatic drop in the use of force by corrections officers in dealing with mental health incidents.

While there are not a lot of published studies of the outcome of CIT in correctional settings, this is a promising practice with the potential to reduce use of force in correctional facilities and connect individuals with mental health services. There is a dire need to improve treatment of people with mental illness in jails and prisons, where people rarely receive adequate mental health services and are too frequently subjected to solitary confinement. [xx]

**Urgent Needs**

Currently, most CIT programs operate with in-kind services from the partners agencies, or by cobbling together small amounts of state funding, foundation grants and the occasional federal grant. Many programs also receive technical assistance from non-profit agencies, including NAMI and NAMI State Organizations, The University of Memphis CIT Center and CIT International. In focus groups, CIT program leaders identified several areas where they need additional funding or technical assistance.

Technical Assistance

First, CIT programs need hands-on assistance and replicable models for building strong local partnerships, long-term planning, needs assessments and evaluation. National organizations provide technical assistance but that work has no sustainable source of funding, and most assistance is limited. CIT partnerships require constant nurturing and so it is vital for CIT leaders to have access to a community of their peers, through organizations like NAMI and CIT International. Several states have coordinated statewide efforts to promote and expand CIT. This approach provides local programs with structure and support, and support for statewide initiatives would help in many states.

Funding for CIT programs

CIT programs also identified a need for funding for training and operational costs. For training, the greatest funding need is to cover the costs of backfilling shifts while officers are in training. Programs also typically need a permanent CIT coordinator position, to support CIT officers and serve as a liaison between partner agencies.

The Justice and Mental Health Collaboration Program (JMHCP) grants, created by the Mentally Ill Offender Treatment and Crime Reduction Act, currently fund some CIT programs, along with other interventions in criminal justice/mental health, but no funds are specifically set aside for CIT. The JMHCP's emphasis on local cross-system collaboration is particularly relevant to CIT. Although this program is authorized to $50 million a year, JMHCP has been funded at between $9 million and $12 million for the past several years.

Support for Needs Assessment and Evaluation

Even with leadership and a good faith effort by all partners, many programs simply do not have the expertise to collect data, conduct an evaluation or a needs assessment. Programs need this expertise to ensure they are successful and sustainable in the long term.

Funding for Mental Health Services

CIT program leaders also need further support for community mental health services. Many law enforcement agencies are doing everything they can to help people experiencing mental health crisis, but still find that there simply aren't crisis mental health services to assist people. Virginia has a promising model for addressing this concern: the state has created a competitive grant program that funds crisis assessment centers, designed to help people in crisis get an assessment and get connected to a confusing array of inpatient and outpatient services. Crisis assessment center work closely with law enforcement, but also accept walk-ins and voluntary admissions. Unfortunately, most states do have not adequate crisis services.

A Verbal De-escalation Training Curriculum

CIT programs typically develop training at the local level, which provides officers access to the experts and community leaders in their community. However, many programs would welcome a train-the-trainer program specific for the teaching of verbal de-escalation, to prepare local trainers to teach these complex skills.

**Policy Recommendations**:

Adopt CIT nationwide. CIT programs are proven effective at reducing arrests, injuries and other tragic outcomes of police responses to mental health crisis, but currently CIT is only available in 15% of law enforcement jurisdictions. Every law enforcement agency should engage in planning and partnership with mental health systems and advocates to address mental health crisis situations. Congress should support this expansion by providing funding incentives specifically for local jurisdictions to start CIT programs and supporting national or regional technical assistance centers to help programs get started. Congress should also pass S. 162/H.R. 401, the Justice and Mental Health Collaboration

Act of 2013 (JMHCA) which reauthorizes the Justice and Mental Health Collaboration grants. Congress should also pass provisions in HR 3717, the "Helping Families in Mental Health Crisis Act of 2013 which would allow the federal Edward R. Byrne Justice Assistance Grants (JAG) to be used for training to law enforcement and correctional officers on mental health and crisis intervention techniques. Similar provisions in HR 3717 allow the Staffing for Adequate Fire and Emergency Response Modifications (SAFER) program grants to be used for crisis intervention training to firefighters and other first responders.

Strengthen crisis mental health services. The mental health system in this country is broken. CIT can help address an immediate mental health crisis, but officers and families often have nowhere to go in the aftermath of crisis. Congress should support the creation of robust crisis mental health services in every community, including hotlines, psychiatric ERs or crisis assessment centers, crisis stabilization units, peer support services and crisis respite centers. Congress should also support intensive supports that are shown effective at serving people with mental illness who are high risk of arrest, such as Forensic Assertive Community Treatment (FACT) and supportive housing. No individual in crisis should have to sit in a crowded emergency room for days on end when the best possible outcome they can hope for is a stay in a hospital hundreds of miles from home.

Support data collection. National studies show that CIT is effective, but local CIT programs urgently need assistance in documenting the outcomes of their programs, to help improve programs and sustain community support. The U.S. Department of Justice should work with the research community, local law enforcement agencies, and others on developing a robust system for collecting data on law enforcement interactions with people living with mental illness. This should include data on deaths and serious injuries of people with mental illness and law enforcement officers responding to crises situations. This should also include national data on CIT programs and the outcomes of these programs over time in terms of disposition of cases, deaths, and serious injuries.

**Conclusion**

Police are often the first responders when a person is in psychiatric distress. Every community owes it to them to provide the knowledge and training to handle safely and compassionately mental health crisis situations. At the same time, people living with mental illness—through no fault of their own—deserve to be helped through appropriate understanding and de-escalation tactics. Ultimately, we should be promoting treatment rather than warehousing them in jails and prisons.

Crisis intervention teams are a proven model for improving interactions with law enforcement and people experiencing mental health crisis. The programs benefit law enforcement, individuals with mental illness and their families and mental health provider agencies by helping get people to needed mental health treatment as quickly as possible. CIT programs are local initiatives that require local leadership and partnership, but Congress should step up to promote their expansion nationwide.

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