

GUN VIOLENCE AND THE PSYCHOLOGICAL RESPONSE
TO MASS VIOLENCE:

A BRIEF REFERENCE SOURCEBOOK FOR
PSYCHOLOGISTS

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SERVICE PSYCHOLOGISTS

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INTRODUCTION

This resource guide is intended to assist psychologists and other mental health professionals who work with victims of gun violence, policy makers, and members of the public. Compiled rapidly in the aftermath of the mass murder at the Emanuel African Methodist-Episcopal Church on June 17, 2015 in Charleston, South Carolina, it contains a number of full text references that are in the public domain. Policy statements and documents prepared by the American Psychological Association are on the public portion of the APA's website, and those from the American Bar Association are also found on their websites. URLs are available for most electronic resources.

This document also contains a select bibliography of scholarly articles with abstracts that may assist clinicians in their work. These references were selected from PsychInfo and PubMed. If the article is available as a free full text reference, this is noted.

Of note are abstracts from a recent special issues of the journal *Behavioral Sciences & the Law*, Volume 33, Issue 2-3, June 2015, entitled Special Issue: Guns, Mental Illness and the Law, and from the *American Journal of Orthopsychiatry*, 2015, Vol. 85, Special Section on Gun Violence.

A special version of this sourcebook is prepared for psychologists in South Carolina. It contains full text versions of several recently published articles. The copyright holder of these articles, the American Psychological Association, has generously agreed to allow full-text publication of these articles for psychologists in South Carolina. If you are a recipient of the full-text articles, we ask that you respect the generosity of the APA and do not further distribute these full-text articles.

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I.
Community Resilience Teams: Leveraging Social Cohesion to
Address Gun Violence in
New Haven Neighborhoods
Conference Abstract from American Public Health Association
2014 Annual Meeting

[https://apha.confex.com/apha/142am/webprogram/Paper311863.ht
ml](https://apha.confex.com/apha/142am/webprogram/Paper311863.html)

Community Resilience Teams: Leveraging Social Cohesion to Address Gun Violence in New Haven Neighborhoods

Authors: Carley Riley, Brita Roy, Mark Abraham, Ann Greene, Nurit Harari, Georgina Lucas, Robyn Porter, Marjorie Rosenthal, Jerry Smart, Teresa A. Smith Hines, Stacy Spell, Barbara Tinney, Anita Vashi, Pina Violano, Maurice Williams, Emily Wang (2014).

Background: Gun violence is highly prevalent in New Haven and leads to high rates of morbidity and mortality, but its impact is differentially felt by various neighborhoods. While Greater New Haven experienced a violent crime rate of 4 per 1,000 residents in 2013, certain neighborhoods bore violent crime rates up to 30 per 1,000 residents. In these neighborhood especially, gun violence is a leading concern and results in high levels of chronic trauma and stress, undermining the health, capacity, and productivity of residents. In response, stakeholders from city, community, healthcare, and academic organizations created a partnership, the New Haven Violence Response Group, (NHVRG). Characterizing gun violence as chronic, man-made disasters, NHVRG adapted the RAND Roadmap to Building Community Resilience--a conceptual framework for building community resilience around natural disasters--to address gun violence. The Community Resilience Steering Committee (CRSC), a community-academic subgroup, convened to oversee an intervention strategy focused on one of the eight levers for building resilience: community engagement. We designed a two-pronged strategy aimed at the engagement lever in two pilot neighborhoods: (1) creation and door-to-door distribution of a handbook on how to prevent and respond to gun violence and (2) community activities to build social cohesion.

Methods: We evaluated this intervention using validated instruments to assess social cohesion, collective efficacy, exposure to violence, and handbook-specific behaviors. We trained 17 community members to administer the survey and are sampling 75 households in high-violence areas of the two pilot neighborhoods. We will also obtain statistics on violent crime rates and violence-related injuries from the New Haven Police Department and Yale-New Haven Hospital pre- and post the intervention. We hypothesize that at baseline areas will have low social cohesion and high levels of exposure to violence and that a year following the intervention, levels of social cohesion will increase and violent crime and injury rates will decrease. We will report baseline statistics on social cohesion, collective efficacy, exposure to violence, and violent crime and injury rates. We will use logistic regression to examine associations between social cohesion and reported exposure to violence, between collective efficacy and reported exposure to violence, as well as between social cohesion and crime and injury rates.

Results: To date, we have 35 completed surveys (78% response rate). Almost half (46%) reported knowing "none" or only "a few" neighbors, 71% felt they could not trust their neighbors, but 66% reported neighbors were willing to help neighbors. Ninety seven percent reported having heard a gunshot, and 34% were present when someone was shot. Half had a family member hurt or killed by a violent act. Additional results are pending.

Conclusion: Promoting community resilience by adapting a natural disaster framework is a novel approach to preventing and responding to gun violence. Engaging in community-based efforts to strengthen social cohesion is an innovative and potentially effective strategy to reduce violence and the associated stress experienced by affected communities.

II.

Gun Violence Laws and the Second Amendment: A Report of the
American Bar Association

February 6, 2015

ABA Standing Committee on Gun Violence

Available from the American Bar Association website at:

http://search.americanbar.org/search?q=gun+laws+and+second+amendment&client=default_frontend&proxystylesheet=default_frontend&site=default_collection&output=xml_no_dtd&oe=UTF-8&ie=UTF-8&ud=1

Gun Violence Laws and the Second Amendment: A Report of the American Bar Association

February 6, 2015

ABA Standing Committee on Gun Violence

Gun Laws and the Second Amendment

“The law should encourage intelligent discussion of possible remedies for what every American can recognize as an ongoing national tragedy.”¹

These words, written by former Supreme Court Associate Justice John Paul Stevens shortly after the Sandy Hook killings, refer to the tragedy of gun violence.

The American Bar Association has seen some use the Second Amendment to attempt to stifle this ‘intelligent discussion.’ While we respect reasoned views of all on the matter of gun violence, we reject the notion that the Second Amendment bars efforts to stem gun violence. This paper describes the ABA’s policies related to gun violence and summarizes how the majority of courts, following the seminal 2008 Supreme Court case of *District of Columbia v. Heller*, have similarly concluded that a wide variety of laws to address gun violence are constitutionally permissible.

America’s Epidemic of Gun Violence

The United States is plagued by gun violence. Over 100,000 people are victims of a gunshot wound each year and more than 30,000 of those victims lose their lives.² In 2013, the most recent year for which data is available, firearms killed 33,636 Americans – an average of more than 92 deaths each day – including 11,208 homicides, 21,175 suicides, and 505 unintentional firearm deaths.³

Children and young people are particularly vulnerable to gun violence. In 2013, children and young people under the age of 25 accounted for 36% of all firearm deaths and injuries.⁴ The presence of a gun also increases the likelihood of death in incidents of domestic violence,⁵ raises the probability of fatalities among those who attempt suicide,⁶ and disproportionately harms communities of color. In 2013, African Americans suffered over 57% of all firearm homicides, even though they make up only 13% of the population. Moreover, firearm homicide is the leading cause of death for African American males ages 15-34.⁷

In addition to the grave physical and emotional toll gun violence takes on individuals and communities nationwide, gun-related deaths and injuries burden the American public with overwhelming economic costs. Medical costs alone have been estimated at \$2.3 billion annually, half of which are borne by taxpayers.⁸ When all direct and indirect medical, legal and societal

costs are included, the estimated annual cost of gun violence in the United States amounts to \$100 billion.⁹

Guns also play an enormous role in crime in America. In 2011, firearms were used to commit over 470,000 violent crimes, and approximately 70% of all homicides that year were committed with a gun.¹⁰

The ABA's Long History of Support for Sensible Laws to Reduce Gun Violence

For nearly 50 years, the ABA has acknowledged the devastation caused by gun violence in our society and expressed strong support for meaningful reforms to our nation's gun laws. Since 1965, the ABA House of Delegates has considered and approved nearly 20 separate resolutions aimed at reducing firearm-related deaths and injuries. Those resolutions have included a variety of policy recommendations to fill dangerous gaps in federal and state gun regulations, including support for laws to prohibit gun possession by felons and domestic abusers, require background checks on all gun purchasers, ban assault weapons, and regulate guns as a consumer product. Other ABA resolutions have not related to "gun laws" as such; rather, they have expressed the ABA's support for other strategies to reduce gun violence, such as school-related programs that include peer mediation and firearm safety education.¹¹ Some of these proposals have been adopted or enacted into law; others have not.

As discussed below, the courts have held that the Second Amendment to the U.S. Constitution is consistent with a wide variety of laws to reduce gun-related deaths and injuries in our nation. Nevertheless, the ABA recognizes that confusion exists among the public, even among many lawyers, regarding whether the Second Amendment provides an obstacle to sensible laws. In its role as the nation's preeminent legal organization, the ABA seeks to educate its members, as well as the public at large, about the true meaning of the Second Amendment. Coincidentally, as the ABA was researching this issue, so was a Task Force on Gun Violence of the New York State Bar. In its draft report of January 2015, the Task Force also concluded that "[e]ven with much unsettled about the precise contours of the Second Amendment, we expect most forms of state and federal gun regulation will be upheld under the developing post-*Heller* case law."¹²

The Second Amendment: No Barrier to Common Sense Laws to Reduce Gun Violence

"A well regulated Militia, being necessary to the security of a free State, the right of the people to keep and bear Arms shall not be infringed."

The *Heller* Decision

In 2008, in *District of Columbia v. Heller*, 554 U.S. 570 (2008), a divided U.S. Supreme Court held for the first time that the Second Amendment protects a responsible, law-abiding citizen's right to possess an operable handgun in the home for self-defense. In a 5-4 ruling, the Court struck down Washington, D.C. laws prohibiting handgun possession and requiring that firearms in the home be stored unloaded and disassembled or locked at all times.

The *Heller* decision was a dramatic departure from the Supreme Court's previous interpretation of the Second Amendment in *U.S. v. Miller*, 307 U.S. 174 (1939), which held that the right guaranteed by the Constitution was related to a well-regulated militia. For almost 70 years, lower federal and state courts had relied on and ruled consistently with the *Miller* decision to reject hundreds of challenges to our nation's gun laws.

Although the *Heller* decision established a new individual right to "bear arms," the Supreme Court made clear that the Second Amendment should not be understood as conferring a "right to keep and carry any weapon whatsoever in any manner whatsoever and for whatever purpose." The Court concluded that the Second Amendment does not bar a broad range of limitations on who may possess firearms, what kinds of firearms they may possess, or where they may possess them.

In *Heller*, the Court identified a non-exhaustive list of "presumptively lawful regulatory measures," including "longstanding prohibitions" on firearm possession by felons and the mentally ill, as well as laws forbidding firearm possession in sensitive places such as schools and government buildings, and imposing conditions on the commercial sale of firearms.¹³ The Court also noted that the Second Amendment is consistent with laws banning "dangerous and unusual weapons" not in common use, such as M-16 rifles and other firearms that are most useful in military service. In addition, the Court declared that its analysis should not be read to suggest "the invalidity of laws regulating the storage of firearms to prevent accidents."¹⁴

In 2010, in *McDonald v. City of Chicago*, 561 U.S. 742 (2010), the Supreme Court held in another 5-4 ruling that the Second Amendment applies to state and local governments in addition to the federal government. The Court reiterated in *McDonald* that a broad spectrum of laws to reduce gun violence remain constitutionally permissible.

Post-Heller Litigation

In the wake of *Heller* and *McDonald*, lower courts have been flooded with lawsuits claiming that various federal, state, and local firearms laws violate the Second Amendment. Nearly all of these claims have been rejected. Courts across the country have upheld numerous common sense laws to reduce gun-related deaths and injuries, including those regulating:

- Possession of Firearms by Criminals
 - Prohibiting possession of firearms by felons¹⁵
 - Prohibiting possession of firearms by domestic violence misdemeanants¹⁶
 - Prohibiting possession of firearms by an individual who is under indictment for a felony¹⁷
 - Prohibiting possession of firearms during the commission of a crime¹⁸
- Firearm Ownership
 - Requiring background checks for private firearm transfers¹⁹
 - Requiring registration of all firearms²⁰
 - Requiring an individual to possess a license to own a handgun²¹
 - Requiring handgun permit applicants to pay a \$ 340 fee every three years²²

- Prohibiting the sale of firearms to individuals who do not reside in any U.S. state²³
- Possession of Firearms in Public
 - Requiring an applicant for a license to carry a concealed weapon to show “good cause,” “proper cause,” or “need,” or to otherwise qualify as a “suitable person”²⁴
 - Requiring an applicant to submit affidavits evidencing good character²⁵
 - Prohibiting the issuance of a concealed carry permit based on a misdemeanor assault conviction²⁶
 - Requiring an applicant to be a state resident²⁷
 - Requiring an applicant for a concealed carry license to be at least twenty-one years old²⁸
 - Allowing the revocation of the permit if law enforcement determines that the permit holder poses a material likelihood of harm²⁹
- Firearm Safety
 - Requiring the safe storage of handguns in the home³⁰
 - Prohibiting the possession of a firearm while intoxicated³¹
- Particularly Dangerous Weapons
 - Forbidding the possession, sale, and manufacture of assault weapons and large capacity ammunition magazines³²
 - Prohibiting the sale of “particularly dangerous ammunition” that has no sporting purpose³³
- Firearm Possession By Other Dangerous Individuals
 - Prohibiting the possession of firearms by individuals who have been involuntarily committed to a mental institution³⁴
 - Prohibiting possession of firearms by an unlawful user of a controlled substance³⁵
 - Prohibiting possession of firearms by individuals subject to a domestic violence restraining order³⁶
 - Authorizing the seizure of firearms in cases of domestic violence³⁷
- Conditions on the Sale of Firearms
 - Requiring a gun dealer to obtain a permit and operate its business greater than 500 feet from any residential area, school, or liquor store³⁸
 - Prohibiting the sale of firearms and ammunition to individuals younger than twenty-one years old³⁹
- Firearms in Sensitive Places
 - Prohibiting the possession of firearms within college campus facilities and at campus events⁴⁰
 - Prohibiting the carrying of a loaded and accessible firearm in a motor vehicle⁴¹
 - Forbidding possession of a firearm in national parks⁴²
 - Prohibiting the possession of firearms in places of worship⁴³
 - Prohibiting the possession of firearms in common areas of public housing units⁴⁴
 - Prohibiting the possession of guns on county-owned property⁴⁵

- Regulation of Firing Ranges⁴⁶
 - Requiring firing range patrons to be at least 18 years of age
 - Requiring that ranges not be located within 500 feet of sensitive locations
 - Construction requirements, including bullet-proof windows and doors, noise limits, plumbing and electrical requirements. and separate/interlocked ventilation systems
 - Requiring that a range master be present at all times⁴⁷

Although more than 900 post-Heller decisions have upheld a wide variety of regulations to reduce gun violence,⁴⁸ there have been a few rulings striking down certain types of firearms laws. The Seventh Circuit struck down Illinois' complete ban on the public carrying of weapons,⁴⁹ and also enjoined enforcement of a Chicago ordinance banning firing ranges within city limits where range training was a condition of lawful handgun ownership.⁵⁰ A district court in the Seventh Circuit struck down a Chicago law banning the transfer of firearms except through inheritance, but explicitly reiterated that cities and states have broad authority to regulate the commercial sale of firearms, including limits on the locations where dealers may operate.⁵¹ In addition, a district court struck down Washington, D.C.'s prohibition on all public carrying of firearms,⁵² and a divided panel of the Ninth Circuit struck down a San Diego County policy requiring an applicant for a permit to carry a concealed firearm to demonstrate "good cause" beyond a general desire for self defense.⁵³ Nonetheless, decisions striking down laws on Second Amendment grounds are quite rare.

Finally, since issuing its opinions in *Heller* and *McDonald*, the Supreme Court has repeatedly declined to hear new cases raising Second Amendment challenges. In fact, the Supreme Court has denied cert in over 60 cases, all of which involved a lower court decision rejecting a Second Amendment challenge.⁵⁴

Conclusion

In short, the U.S. Supreme Court and lower courts have made clear that the Second Amendment is consistent with and does not bar a broad array of sensible laws to reduce gun violence. Our nation's courts have repeatedly found that the types of laws supported by the ABA and introduced by legislators across America do not run afoul of the Constitution.

ABA members, as well as other legal professionals and the public at large, should feel confident knowing that the Second Amendment is not an obstacle to the legal reforms our country so clearly needs to combat firearm-related deaths and injuries in America.

¹ “Six Amendments: How and Why We Should Change the Constitution at http://www.washingtonpost.com/opinions/the-five-extra-words-that-can-fix-the-second-amendment/2014/04/11/f8a19578-b8fa-11e3-96ae-f2c36d2b1245_story.html.

² Nat’l Ctr. for Injury Prevention & Control, U.S. Centers for Disease Control and Prevention, *Web-Based Injury Statistics Query & Reporting System (WISQARS) Fatal Injury Reports, National and Regional, 1999-2013* (Feb. 2013), at http://webappa.cdc.gov/sasweb/ncipc/mortrate10_us.html, U.S. Centers for Disease Control and Prevention, *Web-Based Injury Statistics Query & Reporting System (WISQARS), Nonfatal Injury Reports, 2001 – 2013* (March 2013), at <http://webappa.cdc.gov/sasweb/ncipc/nfirates2001.html>.

³ WISQARS Fatal Injury Reports, 1999-2013, *supra* note 2.

⁴ *Id.*; WISQARS Nonfatal Injury Reports, 2001-2013, *supra* note 2.

⁵ Susan B. Sorenson, *Firearm Use in Intimate Partner Violence: A Brief Overview*, in 30 *Evaluation Review*, A Journal of Applied Social Research, Special Issue: Intimate Partner Violence and Firearms, 229, 232-33 (Susan B. Sorenson ed., 2006).

⁶ Matthew Miller et al., *The Epidemiology of Case Fatality Rates for Suicide in the Northeast*, 43 *Annals Of Emergency Med.* 723, 726 (2004).

⁷ Nat’l Ctr. for Injury Prevention & Control, U.S. Centers for Disease Control and Prevention, *Web-Based Injury Statistics Query & Reporting System (WISQARS) Leading Causes of Death Reports, National and Regional, 1999-2013* available at http://webappa.cdc.gov/sasweb/ncipc/leadcaus10_us.html.

⁸ Philip Cook et al., *The Medical Costs of Gunshot Injuries in the United States*, 282 *JAMA* 447 (Aug. 4, 1999).

⁹ Philip J. Cook and Jens Ludwig, *Gun Violence: The Real Costs* 115 (2000).

¹⁰ Bureau of Justice Statistics, U.S. Dep’t of Justice, Special Report: Firearm Violence, 1993-2011 (May 2013), at <http://www.bjs.gov/content/pub/pdf/fv9311.pdf>.

¹¹ ABA resolutions relating to gun violence may be found or summarized at the ABA Standing Committee on Gun Violence website, http://www.americanbar.org/groups/committees/gun_violence/policy.html.

¹² <http://www.nysba.org/WorkArea/DownloadAsset.aspx?id=54335>

¹³ “We identify these presumptively lawful regulatory measures only as examples; our list does not purport to be exhaustive.” *Heller*, 554 U.S. at 627 n.26.

¹⁴ *Id.* at 632.

¹⁵ See, e.g., *United States v. Pruess*, 703 F.3d 242 (4th Cir. 2012); *United States v. Moore*, 666 F.3d 313 (4th Cir. 2012); *United States v. Torres-Rosario*, 658 F.3d 110 (1st Cir. 2011); *United States v. Williams*, 616 F.3d 685 (7th Cir. 2010); *United States v. Anderson*, 559 F.3d 348 (5th Cir. 2009); *United States v. Rhodes*, 2012 U.S. Dist. LEXIS 76363 (S.D. W. Va. June 1, 2012); *United States v. Edge*, 2012 U.S. Dist. LEXIS 15002 (W.D.N.C. Feb. 8, 2012); *United States v. Loveland*, 2011 U.S. Dist. LEXIS 119954 (W.D.N.C. 2011); *United States v. Kirkpatrick*, 2011 U.S. Dist. LEXIS 82801 (W.D.N.C. July 27, 2011); *State v. Eberhardt*, 2014 La. LEXIS 1570 (La. July 1, 2014); *State v. Craig*, 826 N.W.2d 789 (Minn. Feb. 27, 2013); *Wisconsin v. Pocian*, 2012 WI App 58 (2012); *People v. Spencer*, 2012 IL App (1st) 102094 (2012); *Pohlabel v. Nevada*, 268 P.3d 1264 (Nev. 2012); see also *Schrader v. Holder*, 704 F.3d 980 (D.C. Cir. 2013) (upholding federal prohibition on firearms ownership for persons convicted of certain common law misdemeanors without a set sentence length); *Chardin v. Police Comm’r of Boston*, 2013 Mass. LEXIS 352 (June 4, 2013) (upholding prohibition on the issuance of firearm carrying permits to persons adjudicated as juvenile delinquents for felony offenses).

¹⁶ See, e.g., *United States v. Armstrong*, 706 F.3d 1 (1st Cir. 2013); *United States v. Chester*, 847 F. Supp. 2d 902 (S.D. W. Va. 2012); *United States v. Staten*, 666 F.3d 154 (4th Cir. 2011); *United States v. Skoien*, 614 F.3d 638 (7th Cir. 2010); *United States v. White*, 593 F.3d 1199 (11th Cir. 2010); *United States v. Booker*, 644 F.3d 12 (1st Cir. 2011); *Enos v. Holder*, 855 F. Supp. 2d 1088 (E.D. Cal. 2012); *United States v. Holbrook*, 613 F. Supp. 2d 745 (W.D. Va. 2009); see also *In re United States*, 578 F.3d 1195 (10th Cir. 2009).

¹⁷ *United States v. Laurent*, 861 F. Supp. 2d 71 (E.D.N.Y. 2011); *United States v. Call*, 874 F. Supp. 2d 969 (D. Nev. 2012).

¹⁸ *United States v. Jackson*, 555 F.3d 635 (7th Cir. Feb. 18, 2009) (finding no Second Amendment right to possess a firearm during the commission of a felony), *cert denied by Jackson v. United States*, 558 U.S. 857 (2009); *United States v. Darby*, 2014 U.S. Dist. LEXIS 88392 (June 27, 2014); *Roberge v. United States*, 2013 U.S. Dist. LEXIS 113014 (E.D. Tenn. Aug. 12, 2013).

¹⁹ *Colo. Outfitters Ass’n v. Hickenlooper*, 2014 U.S. Dist. LEXIS 87021 (D. Colo. June 26, 2014) (upholding Colorado’s requirement that background checks be conducted on certain private transfers of firearms).

²⁰ *Justice v. Town of Cicero*, 577 F.3d 768 (7th Cir. Ill. 2009) (finding that registration “merely regulated gun possession” rather than prohibiting it), *cert. denied*, 560 U.S. 965 (2010); *Heller v. District of Columbia* (“*Heller*

III”), 2014 U.S. Dist. LEXIS 66569 (D.D.C., 2014) (upholding all aspects of the District’s firearm registration laws under intermediate scrutiny review).

²¹ *People v. Perkins*, 880 N.Y.S.2d 209 (N.Y. App. Div. 2009).

²² *Kwong v. Bloomberg*, 723 F.3d 160 (2d Cir. 2013).

²³ *Dearth v. Holder*, 893 F. Supp. 2d 59 (D.D.C. 2012).

²⁴ *Drake v. Filko*, 724 F.3d 426 (3d Cir. 2013); *Woollard v. Gallagher*, 712 F.3d 865 (4th Cir. 2013); *Kachalsky v. County of Westchester*, 701 F.3d 81 (2d Cir. 2012); *Hightower v. Boston*, 693 F.3d 61 (1st Cir. 2012); *Young v. Hawaii*, 911 F. Supp. 2d 972 (D. Haw. 2012); *Raulinaitis v. Los Angeles Sheriff’s Dept.*, No. 11-08026 (C.D. Cal. Aug. 13, 2012); *Birdt v. Beck*, No. 10-08377 (C.D. Cal. Jan. 13, 2012); *Piszczatoski v. Filko*, 840 F. Supp. 2d 813 (D. N.J. 2012); *Kuck v. Danaher*, 822 F. Supp. 2d 109 (D. Conn. 2011); *Richards v. County of Yolo*, 821 F. Supp. 2d 1169 (E.D. Cal. 2011); *In re Patano*, 60 A.3d 507 (N.J. Super. Ct. App. Div. 2013).

²⁵ *Williams v. Puerto Rico*, 910 F. Supp. 2d 386 (D.P.R. 2012).

²⁶ *Kelly v. Riley*, 733 S.E.2d 194 (N.C. Ct. App. Nov. 6, 2012).

²⁷ *Peterson v. Martinez*, 707 F. 3d 1197 (10th Cir. 2013); *Osterweil v. Bartlett*, 819 F. Supp. 2d 72 (N.D.N.Y. 2011), vacated by *Osterweil v. Bartlett*, 738 F.3d 520 (2d Cir. 2013); *but see Palmer v. D.C.*, 2014 U.S. Dist. LEXIS 101945 (D.D.C. July 26, 2014).

²⁸ *NRA v. McCraw*, 719 F.3d 338 (5th Cir. 2013); *see also Powell v. Tompkins*, 926 F. Supp. 2d 367 (D. Mass. 2013); *United States v. Rene E.*, 583 F.3d 8 (2009).

²⁹ *Embod v. Cooper*, 2013 Tenn. App. LEXIS 343 (May 22, 2013).

³⁰ *Jackson v. City & County of San Francisco*, 746 F.3d 953 (9th Cir. 2014) (upholding San Francisco safe storage law and prohibition on hollow point ammunition); *Commonwealth v. McGowan*, 982 N.E. 2d 495 (Mass. 2013); *Commonwealth v. Reyes*, 982 N.E. 2d 504 (Mass. 2013).

³¹ *Ohio v. Beyer*, 2012 Ohio 4578 (Ohio Ct. App. 2012); *People v. Wilder*, 2014 Mich. App. LEXIS 2076 (Oct. 28, 2014) (finding no Second Amendment violation for defendant’s conviction for possessing a firearm while intoxicated); *but see Michigan v. DeRoche*, 299 Mich. App. 301 (2013) (holding that a state law prohibiting possession of a firearm by an intoxicated person was unconstitutional as applied to the defendant, who was in his own home and possession was only constructive).

³² *See, Heller v. District of Columbia (“Heller II”)*, 670 F. 3d 1244, 1260-64 (D.C. Cir. 2011) (upholding the District of Columbia’s ban on assault weapons and large capacity ammunition magazines after applying intermediate scrutiny); *N.Y. State Rifle & Pistol Ass’n v. Cuomo*, 990 F. Supp. 2d 349, 367-71 (W.D.N.Y. Dec. 31, 2013) (upholding New York’s assault weapon and large capacity ammunition magazine ban under the same standard); *Kampfer v. Cuomo*, 993 F. Supp. 2d 188, , 195-96 & n.10 (N.D.N.Y. 2014) (upholding New York’s assault weapons ban by finding it does not substantially burden Second Amendment rights); *Shew v. Malloy*, 994 F. Supp. 2d 234 (D. Conn. 2014) (upholding prohibition on assault weapons and large capacity ammunition magazines); *Colo. Outfitters Ass’n v. Hickenlooper*, 2014 U.S. Dist. LEXIS 87021 (D. Colo. June 26, 2014) (upholding Colorado’s ban on large capacity ammunition magazines); *Kolbe v. O’Malley*, 2014 U.S. Dist. LEXIS 110976 (D. Md. Aug. 12, 2014) (upholding Maryland’s ban on assault weapons and large capacity ammunition magazines); *Friedman v. City of Highland Park*, 2014 U.S. Dist. LEXIS 131363 (N.D. Ill. Sept. 18, 2014) (upholding local ordinance prohibiting assault weapons and LCAMs); *People v. James*, 174 Cal. App. 4th 662, 676-77 (2009) (upholding California’s ban on assault weapons and .50 caliber rifles); *see also United States v. Marzzarella*, 614 F.3d 85 (3d Cir. 2010) (affirming conviction for possession of a firearm with an obliterated serial number).

³³ *Jackson v. City & County of San Francisco*, 746 F.3d 953 (9th Cir. 2014) (upholding San Francisco safe storage law and prohibition on hollow point ammunition).

³⁴ *Tyler v. Holder*, 2013 U.S. Dist. LEXIS 11511 (W.D. Mich. Jan. 29, 2013).

³⁵ *See, e.g., United State v. Emond*, 2012 U.S. Dist. LEXIS 149295 (D. Me. Oct. 17, 2012); *United States v. Carter*, 669 F.3d 411 (4th Cir. 2012); *United States v. Prince*, 2009 U.S. Dist. LEXIS 54116 (D. Kan. June 26, 2009), *rev’d on other grounds*, 593 F.3d 1178 (10th Cir. 2010); *United States v. Bumm*, 2009 U.S. Dist. LEXIS 34264 (S.D. W. Va. Apr. 17, 2009); *Piscitello v. Bragg*, 2009 U.S. Dist. LEXIS 21658 (W.D. Tex. Feb. 18, 2009).

³⁶ *United States v. Luedtke*, 2008 U.S. Dist. LEXIS 117970 (E.D. Wis. 2008) (holding that Second Amendment isn’t violated by statute prohibiting firearm possession for those subject to a domestic violence restraining order).

³⁷ *Crespo v. Crespo*, 989 A.2d 827 (N.J. 2010).

³⁸ *Teixeira v. County of Alameda*, 2013 U.S. Dist. LEXIS 128435 (N.D. Cal. Sep. 9 2013)

³⁹ *Nat'l Rifle Ass'n v. Bureau of Alcohol, Tobacco, Firearms, and Explosives*, 700 F.3d 185 (5th Cir. 2012), rehearing denied, 714 F.3d 334 (2013); see also *L.S. v. State*, 2013 Fla. App. LEXIS 11592 (Jul. 24, 2013) (upholding a ban on minors possessing firearms).

⁴⁰ *Digiacinto v. Rector & Visitors of George Mason Univ.*, 704 S.E.2d 365 (Va. 2011) (noting that weapons were prohibited “only in those places where people congregate and are most vulnerable...Individuals may still carry or possess weapons on the open grounds of GMU, and in other places on campus not enumerated in the regulation.”); *Tribble v. State Bd. of Educ.*, No. 11-0069 (Dist. Ct. Idaho December 7, 2011) (upholding a University of Idaho policy prohibiting firearms in University-owned housing).

⁴¹ *Ohio v. Rush*, 2012 Ohio 5919 (Ohio Ct. App. 2012).

⁴² See, e.g., *United States v. Masciandaro*, 638 F.3d 458 (4th Cir. Va. 2011) (affirming defendant’s conviction for possession of a loaded weapon in a motor vehicle in a national park); *United States v. Parker*, 919 F. Supp. 2d 1072 (E.D. Cal. 2013); *United States v. Lewis*, 50 V.I. 995 (D.V.I. 2008).

⁴³ *GeorgiaCarry.Org, Inc. v. Georgia*, 764 F. Supp. 2d 1306 (M.D. Ga. 2011), *aff’d*, 687 F.3d 1244 (11th Cir. 2012); but see *Morris v. U.S. Army Corps of Engineers*, 2014 U.S. Dist. LEXIS 147541 (D. Idaho Oct. 13, 2014) (striking down regulations prohibiting possession and carrying of firearms on property owned by U.S. Army Corps of Engineers).

⁴⁴ *Doe v. Wilmington Hous. Auth.*, 880 F. Supp. 2d 513 (D. Del. 2012), *rev’d on other grounds*, 2014 U.S. App. LEXIS 10579 (3d Cir. June 6, 2014).

⁴⁵ *Nordyke v. King*, 681 F.3d 1041 (9th Cir. 2012) (en banc).

⁴⁶ *Ezell v. City of Chicago*, 2014 U.S. Dist. LEXIS 136954 (N.D. Ill., Sept 29, 2014) (upholding all firing range regulations except requirement that ranges only be located in manufacturing districts and limit on hours of operation from 9am to 8pm).

⁴⁷ Law Center to Prevent Gun Violence, *Post-Heller Litigation Summary*, available at <http://smartgunlaws.org/wp-content/uploads/2013/09/Post-Heller-Litigation-Summary-November-2014.pdf>.

⁴⁸ *Id.*

⁴⁹ See *Moore v. Madigan*, 702 F. 3d 933, 942 (7th Cir. 2012).

⁵⁰ See *Ezell v. City of Chicago*, 651 F.3d 684 (7th Cir. 2011).

⁵¹ See *Illinois Association of Firearms Retailers v. Chicago*, 961 F. Supp. 2d 928, at 939-47 (N.D. Ill. 2014) (“To address the City’s concern that gun stores make ripe targets for burglary, the City can pass more targeted ordinances aimed at making gun stores more secure—for example, by requiring that stores install security systems, gun safes, or trigger locks Or the City can consider designating special zones for gun stores to limit the area that police would have to patrol to deter burglaries nothing in this opinion prevents the City from considering other regulations—short of the complete ban—on sales and transfers of firearms to minimize the access of criminals to firearms and to track the ownership of firearms.”).

⁵² *Palmer v. District of Columbia*, 2014 U.S. Dist. LEXIS 101945 (D.D.C. July 26, 2014) (striking down Washington, D.C.’s prohibition on the carrying of handguns in public).

⁵³ *Peruta v. County of San Diego*, 742 F.3d 1144 (9th Cir. 2014). Note that *Peruta* may still be reviewed en banc and the mandate in this case has not yet issued.

⁵⁴ Law Center to Prevent Gun Violence, *Post-Heller Litigation Summary*, available at <http://smartgunlaws.org/wp-content/uploads/2013/09/Post-Heller-Litigation-Summary-November-2014.pdf>

III.

The APA's Disaster Response Network

<http://www.apa.org/practice/programs/drn/secure/history.pdf>

**The American Red Cross and Psychology's Disaster Response Network:
An Historical Perspective**

Richard A. Heaps, Ph.D., ABPP¹

Historically, the American Red Cross was chartered by the U.S. Congress to provide disaster relief. Until 1991, the Red Cross disaster response capability did not formally include a mental health component.

Following Hurricane Hugo and the San Francisco earthquake, the Red Cross identified a need to manage the stress experienced by Red Cross relief workers and disaster survivors. A decision was made to add a mental health component to its available services. At the time, Red Cross President Elizabeth Dole said, "We recognize that a crucial aspect of disaster relief, beyond providing food and shelter, is helping victims and survivors cope with their losses."

As a result, Disaster Mental Health Services was introduced as a new disaster relief function in late 1991. On December 13, 1991, an official Statement of Understanding (SOU) formalizing a cooperative relationship between the Red Cross and psychologists, through APA, was signed. APA's Disaster Response Network (DRN) was officially "unveiled" at the 1992 APA Convention as a special centennial gift to the nation. APA was among the first mental health associations to enter into partnership with the Red Cross.

The DRN is APA's mechanism for implementing its agreement with the Red Cross. The DRN is a state-based network of psychologists available to the Red Cross system. It relies on recruiting local volunteers to respond to disasters. In this regard, the DRN has helped the Red Cross to recruit more than 2,500 licensed psychologists around the country.

In practice, APA's DRN is comprised of state psychological association DRN programs, which are managed on a state-by-state basis. APA's DRN program is under administrative authority of APA's Committee for the Advancement of Professional Practice and the Practice Directorate and serves as an information resource and a liaison between state DRN's and the American Red Cross.

The Utah Psychological Association (UPA) informally organized its own DRN and Disaster Response Committee about 1994, after its original two APA DRN members (Laurie Hoover and Richard Heaps) taught the first two Red Cross Disaster Mental Health Service courses in Utah on the same day in Salt Lake City.

Having formal agreements and procedures already in place is a significant advantage to many state psychological associations which have neither the financial nor physical resources to provide a truly independent disaster mental health response of any duration. It is essential for most state DRN's to connect and collaborate with an organization such as the American Red Cross which has a legitimate and expected role, including a clear physical presence, at times of disaster or other traumatic events.

The Red Cross sought licensed professionals as disaster mental health responders because professional licensure was viewed as ensuring that volunteers were qualified to provide mental health services on an independent level, were bound by an ethical code, and were accountable to a state licensing board. (Note: graduate students, interns, and residents, please read the last paragraph of this article.)

Although the Red Cross does provide training to its recruited licensed psychologist volunteers, it relies on the fact that psychologists, through their doctoral education, internship and post-doctoral supervised experience, have already been adequately trained in the assessment and treatment of individuals with mental health related problems and disorders.

Training provided by the Red Cross to psychologist volunteers provides an overview of Red Cross disaster operations and identifies the various ways psychologists put their already existing mental health expertise to use in a disaster relief effort. Each volunteer is required to complete a brief Introduction to Disaster Services Course and a one-day Foundations of Disaster Mental Health course.

It is not unusual for DRN participants to obtain additional disaster mental health training through continuing education courses offered by outside organizations (e.g. the National Organization for Victims Assistance 40 hour course). Some courses now are available online (e.g., North Carolina's DRN training at <http://nccphp.sph.unc.edu/NCDRNtraining/>). Such additional training is recommended but not required by the Red Cross.

DRN members may spend their time circulating around an operations site listening to concerns, offering whatever type of support is needed, and remaining accessible in the event an emerging situation calls for a mental health intervention. They may be asked to see individuals who are overcome by grief, depression, panic or general distress in extremely stressful and often tragic circumstances.

DRN psychologists use their professional judgment, training, and clinical skills to help individuals regain composure and cope with the immediate situation. They help problem-solve, make referrals to community resources, advocate for workers' and victims' needs, provide information, and help people marshal their own coping skills. They also offer other approved interventions, as needed (www.apapractice.org/apo/disaster_network/how_to_become_a_drn.html# has a helpful link to approved Red Cross DMH interventions in a PDF file at the bottom of the page).

In addition to their work as disaster responders, DRN members may serve as American Red Cross instructors, consultants, and American Red Cross state mental health leaders.

While DRN psychologists may be deployed to the actual disaster site, they may also be asked to participate in a wide range of community venues, from shelters to family service centers, or anywhere else where they will come in contact with survivors, family members, or emergency workers.

At one time, the Red Cross estimated that the type and percentage of activities of their experienced disaster mental health professionals included, on average, 30% education, 30% direct stress-reducing interventions, 25% problem solving, 10% advocacy for services, and 5% referrals.

In reality, however, no two disasters are alike as dramatically demonstrated by recent events, and disaster responding cannot be approached in a "cookbook" fashion. DRN psychologists must remain flexible in order to be optimally useful to the Red Cross disaster relief efforts.

Although DRN members volunteer primarily through our valued partnership with the American Red Cross, some state DRN programs also have service relationships with other local community organizations (e.g., Utah Disaster Mental Health Coalition) and emergency services (e.g., police and fire departments). When psychologists choose to participate with groups outside the APA-Red Cross DRN program, their work is not covered by the Red Cross procedures, intervention standards, and liability insurance.

Disaster mental health activities continue to develop and evolve in response to increasingly complex disaster events and a growing body of research about the impact of disasters and the responses that are more helpful.

1. Richard Heaps is UPA's Disaster Response Committee Chair. He served six years as a member of APA's DRN Advisory Committee representing 13 Western States. This APA DRN committee, under the direction of Margie Schroeder, wrote several informational documents from which this article borrows liberally, with permission.

Opportunities for Psychologist Involvement in Disaster

Disasters can be divided into phases. The initial Response phase involves supporting disaster-impacted individuals and disaster workers. The following Recovery phase involves helping individuals and communities recover from the disaster impact over the long-term. The Preparedness phase involves planning for future potential disasters in ways that minimize their impact.

Response Phase Activities

- Serve as a disaster mental health volunteer with the American Red Cross
- Be a disaster mental health responder with another disaster response group
- Serve as a disaster mental health responder with your SPTA DRN
- Provide interviews with the media about disaster impact and coping strategies
- Provide support to disaster-affected persons by donating to relief agencies

Recovery Phase Activities

- Provide *pro bono* psychological services to disaster-affected individuals
- Join rebuilding teams that deploy to disaster-affected regions
- Provide APA public education programs (e.g., resilience)
- Present disaster recovery tips at health fairs, school gatherings, and other forums

Preparedness Phase Activities

- Serve on a committee to plan mental health responses to future disasters
- Provide interviews to the media on disaster preparedness topics
- Offer disaster preparedness trainings to mental health professionals
- Present disaster preparedness information to community groups, agencies, etc.
- Participate in a local, state, or regional disaster planning group
- Develop a list of local mental health referral sources for use during disaster
- Prepare disaster mental health materials for dissemination during disaster

How to Prepare Yourself for Participation in Disaster Activities

- Determine compatibility of your personal and work life with disaster activities
- Expand your disaster knowledge and skills through training and CE activities
- Attend trainings in related topics (trauma, diversity, crisis intervention, etc.)
- Build relationships with disaster response and planning personnel
- Obtain credentials to allow access to disaster sites (join a response network)
- Engage in personal preparedness (create a “go kit”, have a disaster plan)
- Address potential consequences of disaster work (vicarious traumatization)

(Prepared for dissemination at 2007 APA SLC for DRN Coordinators)

Opportunities for Organizational Partnerships

Many SPTA DRNs have established formal or informal organizational partnerships to provide disaster preparedness, response, and recovery services. Following is a partial list of agencies and organizations with which individual psychologists or DRNs might wish to establish relationships.

Disaster response groups:

- American Red Cross
- Community Emergency Response Teams (CERT)
- Dept. of Homeland Security trauma response teams
- Medical Corps/ Reserve
- National Disaster Medical System teams
- National Organization for Victim Assistance (NOVA) crisis teams

Other crisis support teams

Government agencies (operating at the state, county and city level):

Dept of Health, Department of Public Health

Dept of Homeland Security

Dept of Human Services, Mental Health System

Emergency Management

Military support services

Community agencies and organizations:

Emergency medical services

Employee Assistance Programs (EAP)

Fire departments

Hospitals and medical clinics

Law enforcement

Media outlets

Mental health agencies

Social service agencies with emergency response services

Universities

Collaborative groups:

Local disaster mental health coalitions

Statewide disaster mental health coalitions

Voluntary Organizations Active in Disaster (VOAD)

IV.

Gun Violence: Prediction, prevention and policy: APA Panel of Experts Report

<http://www.apa.org/pubs/info/reports/gun-violence-prevention.aspx>

GUN VIOLENCE: PREDICTION, PREVENTION, AND POLICY

APA PANEL OF EXPERTS REPORT

American Psychological Association
Washington, DC

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AMERICAN
PSYCHOLOGICAL
ASSOCIATION

GUN VIOLENCE: PREDICTION, PREVENTION, AND POLICY

APA PANEL OF EXPERTS REPORT

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GUN VIOLENCE: PREDICTION, PREVENTION, AND POLICY

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SUMMARY: CONCLUSIONS AND RECOMMENDATIONS

Gun violence is an urgent, complex, and multifaceted problem. It requires evidence-based, multifaceted solutions. Psychology can make important contributions to policies that prevent gun violence. Toward this end, in February 2013 the American Psychological Association commissioned this report by a panel of experts to convey research-based conclusions and recommendations (and to identify gaps in such knowledge) on how to reduce the incidence of gun violence—whether by homicide, suicide, or mass shootings—nationwide.

Following are chapter-by-chapter highlights and short summaries of conclusions and recommendations of the report's authors. More information and supporting citations can be found within the chapters themselves.

ANTECEDENTS TO GUN VIOLENCE: DEVELOPMENTAL ISSUES

A complex and variable constellation of risk and protective factors makes persons more or less likely to use a firearm against themselves or others. For this reason, there is no single profile that can reliably predict who will use a gun in a violent act. Instead, gun violence is associated with a confluence of individual, family, school, peer, community, and sociocultural risk factors that interact over time during childhood and adolescence. Although many youths desist in aggressive and antisocial behavior during late adolescence, others are disproportionately at risk for becoming involved in or otherwise affected by gun violence. The most consistent and powerful predictor of future violence is a history of violent behavior. **Prevention efforts guided by research on developmental risk can reduce the likelihood that firearms will be introduced into community and**

family conflicts or criminal activity. Prevention efforts can also reduce the relatively rare occasions when severe mental illness contributes to homicide or the more common circumstances when depression or other mental illness contributes to suicide. Reducing incidents of gun violence arising from criminal misconduct or suicide is an important goal of broader primary and secondary prevention and intervention strategies. Such strategies must also attend to redirecting developmental antecedents and larger sociocultural processes that contribute to gun violence and gun-related deaths.

ANTECEDENTS TO GUN VIOLENCE: GENDER AND CULTURE

Any account of gun violence in the United States must be able to explain both why males are perpetrators of the vast majority of gun violence and why the vast majority of males never perpetrate gun violence. Preliminary evidence suggests that changing perceptions among males of social norms about behaviors and characteristics associated with masculinity may reduce the prevalence of intimate partner and sexual violence. Such interventions need to be

further tested for their potential to reduce gun violence. **The skills and knowledge of psychologists are needed to develop and evaluate programs and settings in schools, workplaces, prisons, neighborhoods, clinics, and other relevant contexts that aim to change gendered expectations for males that emphasize self-sufficiency, toughness, and violence, including gun violence.**

WHAT WORKS: GUN VIOLENCE PREDICTION AND PREVENTION AT THE INDIVIDUAL LEVEL

Although it is important to recognize that most people suffering from a mental illness are not dangerous, for those persons at risk for violence due to mental illness, suicidal thoughts, or feelings of desperation, mental health treatment can often prevent gun violence. Policies and programs that identify and provide treatment for all persons suffering from a mental illness should be a national priority. Urgent attention must be paid to the current level of access to mental health services in the United States; such access is woefully insufficient. Additionally, it should be noted that behavioral threat assessment is becoming a standard of care for preventing violence in schools, colleges, and the workplace and against government and other public officials. Threat assessment teams gather and analyze information to assess if a person poses a threat of violence or self-harm, and if so, take steps to intervene.

WHAT WORKS: GUN VIOLENCE PREVENTION AT THE COMMUNITY LEVEL

Prevention of violence occurs along a continuum that begins in early childhood with programs to help parents raise emotionally healthy children and ends with efforts to identify and intervene with troubled individuals who are threatening violence. The mental health community must take the lead in advocating for community-based collaborative problem-solving models to address the prevention of gun violence. Such models should blend prevention strategies in an effort to overcome the tendency within many community service systems to operate in silos. There has been some success with community-based programs involving police training in crisis intervention and with community members trained in mental health first aid. These programs need further piloting and study so they can be expanded to additional communities as appropriate. In addition, public health messaging campaigns on safe gun storage are needed. The practice of keeping all firearms appropriately stored and locked must become the only socially acceptable norm.

WHAT WORKS: POLICIES TO REDUCE GUN VIOLENCE

The use of a gun greatly increases the odds that violence will lead to a fatality: This problem calls for urgent action. **Firearm prohibitions for high-risk groups—domestic violence offenders, persons convicted of violent misdemeanor crimes, and individuals with mental illness who have been adjudicated as being a threat to themselves or to others—have been shown to reduce violence.** The licensing of handgun purchasers, background check requirements for all gun sales, and close oversight of retail gun sellers can reduce the diversion of guns to criminals. Reducing the incidence of gun violence will require interventions through multiple systems, including legal, public health, public safety, community, and health. Increasing the availability of data and funding will help inform and evaluate policies designed to reduce gun violence.

Gun violence is an important national problem leading to more than 31,000 deaths and 78,000 nonfatal injuries every year. Although the rate of gun homicides in the United States has declined in recent years, U.S. rates remain substantially higher than those of almost every other nation in the world and are at least seven times higher than those of Australia, Canada, France, Germany, India, Italy, Japan, South Korea, Spain, Sweden, the United Kingdom, and many others (see Alpers & Wilson, 2013).

Guns are not a necessary or sufficient cause of violence and can be used legally for a variety of sanctioned activities. Still, they are an especially lethal weapon used in approximately two thirds of the homicides and more than half of all suicides in the United States. Every day in the United States, approximately 30 persons die of homicides and 53 persons die of suicides committed by someone using a gun (Centers for Disease Control and Prevention [CDC], 2013a). Guns also provide individuals with the capacity to carry out multiple-fatality shootings that inflict great trauma and grief on our society, and the public rightly insists on action to make our communities safer.

Every day in the United States, approximately 30 persons die of homicides and 53 persons die of suicides committed by someone using a gun.

Gun violence demands special attention. At the federal level, President Barack Obama announced a new “Now Is

the Time” plan (White House, 2013) to address firearm violence to better protect children and communities and issued 23 related executive orders to federal agencies. The importance of continued research to address firearm violence is reflected in the 2013 report of the Institute of Medicine (IOM) and the National Research Council (NRC) *Priorities for Research to Reduce the Threat of Firearm-Related Violence*. This report calls for a public health approach that emphasizes the importance of accurate information on the number and distribution of guns in the United States, including risk factors and motivations for acquisition and use, the association between exposure to media violence and any subsequent perpetration of gun violence, and how new technology can facilitate prevention. The report also outlines a research agenda to facilitate programs and policies that can reduce the occurrence and impact of firearm-related violence in the United States.

Psychology can make an important contribution to policies that prevent gun violence. Rather than debate whether “people” kill people or “guns” kill people, a reasonable approach to facilitate prevention is that “people with guns kill people.” The problem is more complex than simple slogans and requires careful study and analysis of

the different psychological factors, behavioral pathways, social circumstances, and cultural factors that lead to gun violence. Whether prevention efforts should focus on guns because they are such a powerful tool for violence, on other factors that might have equal or greater impact, or on some combination of factors should be a scientific question settled by evidence.

Toward this end, the American Psychological Association (APA) commissioned this report, with three goals. First, this report is intended to focus on gun violence, recognizing that knowledge about gun violence must be related to a broader understanding of violence. Second, the report reviews what is known from the best current science on antecedents to gun violence and effective prevention strategies at the individual, community, and national levels. Finally, the report identifies policy directions, gaps in the literature, and suggestions for continued research that can help address unresolved questions about effective strategies to reduce gun violence. For over a decade, research on gun violence has been stifled by legal restrictions, political pressure applied to agencies not to fund research on certain gun-related topics, and a lack of funding. The authors of this report believe the cost of gun violence to our society is too great to allow these barriers to remain in place.

For over a decade, research on gun violence has been stifled by legal restrictions, political pressure, . . . and a lack of funding. The authors of this report believe the cost of gun violence to our society is too great to allow these barriers to remain in place.

THE ROLE OF MENTAL HEALTH AND MENTAL ILLNESS

An important focus of this report is the role that mental health and mental illness play in why individuals commit firearm-related violence and how this can inform preventive efforts. This focus undoubtedly brings to mind shootings such as those in Newtown, CT, Aurora, CO, and Tucson, AZ. However, it is important to realize that mass fatality incidents of this type, although highly publicized, are extremely rare, accounting for one tenth of 1% of all firearm-related homicides in the United States (CDC, 2013a). Moreover, serious mental illness affects a significant percentage of the U.S. population, with prevalence estimates in the general population as high as 5%

(Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). This is quite significant, given that the term *serious mental illness* is typically reserved for the most debilitating kinds of mental disorder, such as schizophrenia, bipolar disorder, and the most severe forms of depression, but can include other mental disorders that result in acute functional impairment.

Although many highly publicized shootings have involved persons with serious mental illness, it must be recognized that persons with serious mental illness commit only a small proportion of firearm-related homicides; the problem of gun violence cannot be resolved simply through efforts focused on serious mental illness (Webster & Vernick, 2013a). Furthermore, the overwhelming majority of people with serious mental illness do not engage in violence toward others and should not be stereotyped as dangerous (Sirotych, 2008).

It also is important to recognize that for the small proportion of individuals whose serious mental illness does predispose them to violence, there are significant societal barriers to treatment. Psychiatric hospitalization can be helpful, but treatment can be expensive, and there may not be appropriate follow-up services in the community. Civil commitment laws, which serve to protect individuals from being unreasonably detained or forced into treatment against their will, can also prevent professionals from treating someone who does not recognize his or her need for treatment.

Other kinds of mental disorders that do not rise to the level of serious mental illness also are associated with gun violence and criminal behavior generally. For example, conduct disorder and antisocial personality disorder are associated with increased risk for violence. (This link is not surprising because violent behavior is counted as one of the symptoms that helps qualify someone for the diagnosis.) Nevertheless, there are well-established, scientifically validated mental health treatment programs for individuals with these disorders, such as multisystemic therapy, that can reduce violent recidivism (Henggeler, 2011). Substance abuse is another form of mental disorder that is a risk factor for violence in the general population and also increases the risk for violence among persons with serious mental illness (Van Dorn, Volavka, & Johnson, 2012).

These observations reflect the complexity of relationships among serious mental illness, mental disorders, and violence. In contrast to homicide, suicide accounts for approximately 61% of all firearm fatalities in the United States (CDC, 2013a), and more than 90% of persons who commit suicide have some combination of depression, symptoms of other mental disorders,

and/or substance abuse (Moscicki, 2001). This suggests that mental health and mental illness are especially relevant to understanding and preventing suicide, the leading type of firearm-related death.

PREDICTION AND PREVENTION

The prediction of an individual's propensity for violence is a complex and challenging task for mental health professionals, who often are called upon by courts, correctional authorities, schools, and others to assess the risk of an individual's violence. Mental health professionals are expected to take action to protect potential victims when they judge that their patient or client poses a danger to others. However, decades of research have established that there is only a moderate ability to identify individuals likely to commit serious acts of violence. Much depends on the kind of violence and the time frame for prediction. For example, there are specialized instruments for the assessment of violence risk among sex offenders, civilly committed psychiatric patients, and domestic violence offenders. However, the time frame and focus for these predictions often are broadly concerned with long-term predictions that someone will ever be violent with anyone rather than whether a person will commit a particular act of targeted violence.

Research has moved the field beyond the assessment of "dangerousness" as a simple individual characteristic applicable in all cases to recognize that predictive efforts must consider a range of personal, social, and situational factors that can lead to different forms of violent behavior in different circumstances. Moreover, risk assessment has expanded to include concepts of risk management and interventions aimed at reducing risk.

Decades of research have established that there is only a moderate ability to identify individuals likely to commit serious acts of violence.

In making predictions about the risk for mass shootings, there is no consistent psychological profile or set of warning signs that can be used reliably to identify such individuals in the general population. A more promising approach is the strategy of *behavioral threat assessment*, which is concerned with identifying and intervening with individuals who have communicated threats of violence or engaged in behavior that clearly indicates planning or preparation to commit a violent act. A threat assessment approach recognizes that individuals who threaten targeted violence are usually troubled, depressed, and despondent over their circumstances in life. A threat

assessment leads to interventions intended to reduce the risk of violence by taking steps to address the problem that underlies the threatening behavior. Such problems can range from workplace conflicts to schoolyard bullying to serious mental illness. One of the most influential threat assessment models was developed by the U.S. Secret Service (Fein et al., 2002; Vossekuil, Fein, Reddy, Borum, & Modzelski, 2002) and has been adapted for use in schools, colleges, business settings, and the U.S. military.

The limited ability to make accurate predictions of violence has led some to question whether prevention is possible. This is a common misconception, because *prevention does not require prediction of a specific individual's behavior*. For example, public health campaigns have reduced problems ranging from lung cancer to motor vehicle accidents by identifying risk factors and promoting safer behaviors even though it is not possible to predict whether a specific individual will develop lung cancer or have a motor vehicle accident (Mozaffarian, Hemenway, & Ludwig, 2013). A substantial body of scientific evidence identifies important developmental, familial, and social risk factors for violence. In addition, an array of rigorously tested psychological and educational interventions facilitate healthy social development and reduce aggressive behavior by teaching social skills and problem-solving strategies. It is important that policymakers and stakeholders recognize the value of prevention.

Prevention measures also should be distinguished from security measures and crisis response plans. Prevention must begin long before a gunman comes into a school or shopping center. Prevention efforts are often conceptualized as taking place on primary, secondary, and tertiary levels:

- *Primary prevention* (also called universal prevention) consists of efforts to promote healthy development in the general population. An example would be a curriculum to teach all children social skills to resist negative peer influences and resolve conflicts peacefully.
- *Secondary prevention* (also called selective prevention) involves assistance for individuals who are at increased risk for violence. Mentoring programs and conflict-mediation services are examples of such assistance.
- *Tertiary prevention* (also called indicated prevention) consists of intensive services for individuals who have engaged in some degree of aggressive behavior and could benefit from efforts to prevent a recurrence or escalation of aggression. Programs to rehabilitate juvenile offenders are examples.

Throughout this report, we discuss evidence-based prevention programs relevant to the issue of firearm-related violence.

Research can help us understand and prevent gun violence. The psychological research summarized in this report can inform public policy and prevention efforts designed to promote public safety and reduce violence. Gun violence is not a simple, discrete category of crime; it shares characteristics with other forms of violence, and it can be a product of an array of cultural, social, psychological, and situational factors. Nevertheless, there is valuable psychological knowledge that can be used to make our communities safer.

ANTECEDENTS TO GUN VIOLENCE: DEVELOPMENTAL ISSUES

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Youth gun violence is often sensationalized and misunderstood by the general public, in part because of increasingly public acts of violence and related media coverage (Snyder & Sickmund, 2006; Williams, Tuthill, & Lio, 2008). In truth, only a small number of juvenile offenders commit the majority of violent juvenile crimes in the United States (Williams et al., 2008). Most juvenile offenders commit “nonperson” offenses, usually in terms of property and technical (parole) violations (Sickmund, Sladky, Kang, & Puzzanchera, 2011).

For example, in 2010, the majority of juvenile offenses were nonperson offenses such as property offenses (27.2%), drug offenses (8.4%), public order offenses (10.7%), technical violations (14.4%), and status offenses (4.6%)—that is, crimes defined by minor (under age 18) status, such as alcohol consumption, truancy, and running away from home (Sickmund et al., 2011). Additionally, young adults between the ages of 18 and 34 are the most likely to commit violent crimes like homicide and to do so using a gun, compared with individuals under 18 (Cooper & Smith, 2011).

A subgroup of youth is particularly vulnerable to violence and victimization. Minority males constitute a disproportionate number of youths arrested and adjudicated, with 60% of all arrested youths identifying as part of a racial/ethnic minority group (Sickmund et al., 2011). Males also outnumber females in arrest rates for every area except status offenses and technical violations. Urban African American males are at substantially greater risk for involvement in gun-related homicides as perpetrators and as victims (CDC, 2013a; Spano, Pridemore, & Bolland, 2012). However, the majority of the infrequent but highly publicized shootings with multiple fatalities, such as those at Sandy Hook Elementary School

or the Aurora, CO, movie theater, have been committed by young White males.

But it also is important to understand that most young males of all races and ethnicities—and most people in general—are not involved in serious violence and do not carry or use guns inappropriately.

This presents a picture of a small number of youths and young adults who are at an increased risk for involvement in gun violence. In the United States, these youths are somewhat more likely to be males of color growing up in urban areas. But it also is important to understand that most young males of all races and ethnicities—and most people in general—are not involved in serious violence and do not carry or use guns inappropriately.

How did this small subset of youths and young adults come to be involved in serious gun violence? Is there a

“cradle-to-prison” pipeline, particularly for youths of color living in poverty and in disadvantaged urban areas, that triggers a cascade of events that increase the likelihood of gun violence (Children’s Defense Fund, 2009)? A developmental perspective on antecedents to youth gun violence can help us design more effective prevention programs and strategies.

Developmental factors beginning in utero may increase the risk of aggressive behavior and lead to gun violence—especially when guns are readily available and part of an aggressive or delinquent peer culture.

This chapter describes the biological and environmental risk factors that begin early in development and continue into adolescence and young adulthood. Developmental studies that link children’s aggressive behavior to more serious involvement in the criminal justice system suggest the accumulation and interaction of many risks in multiple contexts (Dodge, Greenberg, Malone, & Conduct Problems Prevention Research Group, 2008; Dodge & Pettit, 2003). There is no single biological predisposition, individual trait, or life experience that accounts for the development and continuity of violent behavior or the use of guns. Rather, violence is associated with a confluence of individual, family, school, peer, community, and sociocultural risk factors that interact over time during childhood and adolescence (Brennan, Hall, Bor, Najman, & Williams, 2003; Dodge & Pettit, 2003). Risk for gun violence involves similar risk processes, although the complexity and variability of individuals means there is no meaningful profile that allows reliable prediction of who will eventually engage in gun violence. Nevertheless, developmental factors beginning in utero may increase the risk of aggressive behavior and lead to gun violence—especially when guns are readily available and part of an aggressive or delinquent peer culture.

EARLY-ONSET AGGRESSION

Early onset of aggressive behavior significantly increases risk for later antisocial behavior problems. The most consistent and powerful predictor of future violence is a history of violent behavior, and risk increases with earlier and more frequent incidents. Longitudinal work has shown that having a first arrest between 7 and 11 years of age is associated with patterns of long-term adult offending (Loeber, 1982). Children who are highly aggressive throughout childhood and continue to

have serious conduct problems during adolescence have been identified as “life-course persistent” (LCP) youths (Moffitt, 1993). Examining longitudinal data from a large birth cohort in New Zealand, Moffitt (1993) created a taxonomy of antisocial behavior that differentiates LCP youths from an “adolescence-limited” subgroup. The latter subgroup characterizes those who engage in antisocial behaviors during adolescence and usually desist by adulthood. By contrast, LCP youths display more severe early aggression in childhood and develop a pattern of chronic violence during adolescence and into adulthood.

Both biological and environmental risks during prenatal development, infancy, and early childhood contribute to the development of early-onset aggression and the LCP developmental trajectory (Brennan et al., 2003; Dodge & Pettit, 2003; Moffitt, 2005). Pre- and postnatal risks associated with early-onset aggression include maternal substance abuse during pregnancy, high levels of prenatal stress, low birth weight, birth complications and injuries (especially those involving anoxia), malnutrition, and exposure to environmental toxins like lead paint (Brennan et al., 2003; Dodge & Pettit, 2003). According to Moffitt (1993), these early developmental risks disrupt neural development and are associated with neuropsychological deficits, particularly in executive functioning and verbal abilities.

Along with neuropsychological deficits, poor behavioral control and a difficult temperament are associated with the development of early-onset aggression (Dodge & Pettit, 2003; Moffitt, 1993). Children with difficult temperaments are typically irritable, difficult to soothe, and highly reactive. These patterns of behavior often trigger negative and ineffective reactions from parents and caregivers that can escalate into early aggressive behavior (Dodge & Pettit, 2003; Wachs, 2006). Family influences, such as familial stress and negative parent–child interactions, can interact with a child’s individual characteristics, leading to increased aggressive behavior during childhood.

FAMILY INFLUENCES

Highly aggressive children who engage in serious acts of violence during later childhood and adolescence also are exposed to continued environmental risks throughout development (Dodge et al., 2008). The family context has been found to be quite influential in the development and continuity of antisocial behavior. Particularly for early-onset aggressive youths raised in families that are under a high degree of environmental stress, aggressive child behavior and negative parenting practices interact to amplify early-onset aggression. Examples of family risk factors include low parent–child synchrony and warmth, poor or disrupted attachment, harsh or inconsistent discipline (overly strict or permissive), poor

parental monitoring, the modeling of antisocial behavior, pro-violent attitudes and criminal justice involvement, and coercive parent-child interaction patterns (Dodge & Pettit, 2003; Farrington, Joffe, Loeber, Stouthamer-Loeber, & Kalb, 2001; Hill, Howel, Hawkins, & Battin-Pearson, 1999; Patterson, Forgatch, & DeGarmo, 2010).

Prevention research has shown that intervening with at-risk families to improve parenting skills can disrupt the pathway from early-onset aggressive behavior to delinquency in adolescence.

Coercive parent-child interactions have been associated with the emergence of aggressive behavior problems in children (Patterson et al., 2010). In these interactions, children learn to use coercive behaviors such as temper tantrums to escape parental discipline. When parents acquiesce to these negative behaviors, they inadvertently reward children for coercive behaviors, reinforcing the idea that aggression or violence is adaptive and can be used instrumentally to achieve goals. These interaction patterns tend to escalate in their severity (e.g., from whining, to temper tantrums, to hitting, etc.) and frequency, leading to increased aggression and noncompliance (Patterson et al., 2010). Such behaviors also generalize across contexts to children's interactions with others outside the home, including with teachers, other adults, and peers. Indeed, prevention research has shown that intervening with at-risk families to improve parenting skills can disrupt the pathway from early-onset aggressive behavior to delinquency in adolescence (Patterson et al., 2010).

Other family risk factors for youths with early predispositions to aggression may be especially relevant to increased risk for gun violence. For instance, research has shown that many families with children own firearms and do not keep them safely stored at home (Johnson, Miller, Vriniotis, Azrael, & Hemenway, 2006). Although keeping firearms at home is not a direct cause of youth gun violence, the rates of suicides, homicides, and unintentional firearm fatalities are higher for 5–14-year-olds who live in states or regions in which rates of gun ownership are more prevalent (Miller, Azrael, & Hemenway, 2002). Poor parental monitoring and supervision, which are more general risk factors for involvement in aggression and violent behaviors (Dodge et al., 2008), may be especially salient in risk for gun violence. For example,

impulsive or aggressive children who are often unsupervised and live in a home with access to guns may be at risk.

The family also is an important context for socialization and the development of normative beliefs or perceptions about appropriate social behavior that become increasingly stable during early development and are predictive of later behavior over time (Huesmann & Guerra, 1997). These beliefs shape an individual's social-cognitive understanding about whether and under what circumstances threatened or actual violence is justified. Children who develop beliefs that aggression is a desirable and effective way to interact with others are more likely to use coercion and violence instrumentally to achieve goals or solve problems (Huesmann & Guerra, 1997). Antisocial attitudes and social-cognitive distortions (e.g., problems in generating nonviolent solutions, misperceiving hostile/aggressive intent by others, justifying acts of violence that would be criminal) can also increase risk for violence (Borum & Verhaagen, 2006; Dodge & Pettit, 2003).

Families can play a role in establishing and maintaining normative beliefs about violence and gun usage. For example, pro-violence attitudes and the criminality of parents and siblings during childhood have been found to predict adolescent gang membership and delinquency (Farrington et al., 2001; Hill et al., 1999). Youths from families that encourage the use of guns for solving problems also may be exposed to such attitudes in other contexts (in communities, with peers, and in the media) and may perceive firearms to be an appropriate means to solve problems and protect themselves.

SCHOOL AND PEER INFLUENCES

The school setting is another important context for child socialization. Children who enter school with high levels of aggressive behavior, cognitive or neurobiological deficits, and poor emotional regulation may have difficulty adjusting to the school setting and getting along with peers (Dodge et al., 2008; Dodge & Pettit, 2003). Highly aggressive children who have learned to use aggression instrumentally at home will likely use such behavior with teachers, increasing the chances that they will have poor academic experiences and low school engagement (Patterson et al., 2010). Academic failure, low school interest, truancy, and school dropout are all correlated with increased risk for problem behavior and delinquency, including aggression and violence (Dodge & Pettit, 2003). This risk is strongest when poor academic achievement begins in elementary school and contributes to school underachievement and the onset of adolescent problem behaviors, such as substance use and drug trafficking, truancy, unsafe sexual activity, youth violence, and gang involvement (Dodge et al., 2008; Guerra & Bradshaw, 2008).

Involvement in these risk behaviors also is facilitated by affiliation with deviant peers, particularly during adolescence (Dodge et al., 2008). Research has shown that children who are aggressive, victimized, and academically marginalized from the school setting may suffer high levels of peer rejection that amplify preexisting aggressive behaviors (Dodge et al., 2008; Dodge & Pettit, 2003). Longitudinal work indicates that experiences of academic failure, school marginalization, and peer rejection interact to produce affiliations with similarly rejected, deviant, and/or gang-involved peers. Friendships between deviant peers provide youths with “training” in antisocial behaviors that reinforce and exacerbate preexisting aggressive tendencies (Dishion, Véronneau, & Meyers, 2010; Dodge et al., 2008). Peer deviancy training is a primary mechanism in the trajectory from overt, highly aggressive behaviors during childhood to more covert processes during adolescence, such as lying, stealing, substance use, and weapon carrying (Dishion et al., 2010; Patterson et al., 2010).

Schools that provide safe environments that protect students from bullying or criminal victimization support student engagement, reduce incidents of student conflict that could result in volatile or violent behavior, and diminish risks that students will bring weapons to school.

The larger school context also can interact with youths’ experiences of academic failure, peer rejection, and deviant peer affiliations to influence the continuity of antisocial behavior. Poorly funded schools located in low-income neighborhoods have fewer resources to address the behavioral, academic, mental health, and medical needs of their students. In addition, these schools tend to have stricter policies toward discipline, are less clinically informed about problem behaviors, and have stronger zero tolerance policies that result in more expulsions and suspensions (Edelman, 2007). This contextual factor is important, as youths who are attending and engaged in school are less likely to engage in delinquent or violent behavior, whereas marginalized and rejected youths, particularly in impoverished schools, are at increased risk for aggression and violence at school and in their communities. Schools that provide safe environments that protect students from bullying or criminal victimization support student engagement, reduce incidents of student conflict that could result in volatile or

violent behavior, and diminish risks that students will bring weapons to school.

Although few homicides (< 2%) and suicides occur at school or during transportation to and from school (Roberts, Zhang, & Truman, 2012) and widely publicized mass school shootings are rare, research indicates that a small number of students do carry guns or other weapons. In 2011, 5.1% of high school students in Grades 9–12 reported carrying a gun in the 30 days prior to the survey, and 5.4% of students had carried a weapon (gun, knife, or club) on school grounds at least once in the 30 days prior to the survey (Eaton et al., 2012). Studies show that youths who carry guns are more likely to report involvement in multiple problem behaviors, to be affiliated with a gang, to overestimate how many of their peers carry guns, and to have a high need for interpersonal safety. For instance, student reports of involvement in and exposure to risk behaviors at school such as physical fighting, being threatened, using substances, or selling drugs on school grounds have been positively correlated with an increased likelihood of carrying weapons to school (Furlong, Bates, & Smith, 2001).

In another study of high school students, 5.5% of urban high school students reported that they carried a gun in the year prior to the study, but students estimated that 32.6% of peers in their neighborhoods carried guns, a substantial overestimation of the actual gun-carrying rates. Lawful, supervised gun carrying by juveniles is not the concern of this line of research; however, when unsupervised youths carry guns in high-violence neighborhoods, they may be more likely to use guns to protect themselves and resolve altercations. Gun-carrying youths in this study had higher rates of substance use, violence exposure, gang affiliation, and peer victimization (Hemenway, Vrinotis, Johnson, Miller, & Azrael, 2011). Additionally, many gun-carrying youths had lower levels of perceived interpersonal safety (Hemenway et al., 2011). Research has also revealed that deviant peer group affiliations during specific periods of adolescent development may increase the risk for gun violence. For example, research findings have shown that gang membership in early adolescence is significantly associated with increased gun carrying over time. This changes somewhat in late adolescence and young adulthood, when gun carrying is linked more to involvement in drug dealing and having peers who illegally own guns (Lizotte, Krohn, Howell, Tobin, & Howard, 2000).

COMMUNITIES MATTER

The community context is an additional source of risk for the development and continuity of antisocial behavior. Living in extremely disadvantaged, underresourced communities with

high levels of crime and violence creates serious obstacles to healthy development. Recent estimates show that currently in the United States, 16.4 million children live in poverty and 7.4 million of those live in extreme poverty (i.e., an annual income of less than half of the federal poverty level; Children's Defense Fund, 2012). One in four children under 5 years of age is poor during the formative years of brain development. In addition, 22% of children who have lived in poverty do not graduate from high school, compared with 6% of children who have never been poor (Children's Defense Fund, 2012). For families and youths, living in poverty is associated with high levels of familial stress, poor child nutrition, elevated risks of injury, and limited access to adequate health care (Adler & Steward, 2010; Patterson et al., 2010). Ethnic minority youth in the United States are overrepresented in economically struggling communities. These environmental adversities can, in turn, compromise children's health status and functioning in other environments and increase the risk for involvement in violent behaviors, contributing significantly to ethnic and cultural variations in the rates of violence (Borum & Verhaagen, 2006).

In a community context, the degree to which children have access to adequate positive resources (e.g., in terms of health, finances, nutrition, education, peers, and recreation), have prosocial and connected relationships with others, and feel safe in their environment can significantly affect their risk for involvement in violent behaviors. Aggressive children and adolescents who are living in neighborhoods with high levels of community violence, drug and firearm trafficking, gang presence, and inadequate housing may have increased exposure to violence and opportunities for involvement in deviant behavior. Compared with communities that have better resources, disenfranchised and impoverished communities may also lack social, recreational, and vocational opportunities that contribute to positive youth development. Youths with high levels of preexisting aggressive behavior and emerging involvement with deviant or gang-involved peers may be especially at risk for increased violent behavior and subsequent criminal justice involvement when exposed to impoverished and high-crime communities.

Exposure to violence in one's community, a low sense of community safety, unsupervised access to guns, and involvement in risky community behaviors . . . all contribute to youths' involvement in gun carrying and gun violence.

Exposure to violence in one's community, a low sense of community safety, unsupervised access to guns, and involvement in risky community behaviors such as drug dealing all contribute to youths' involvement in gun carrying and gun violence. Decreased community perceptions of neighborhood safety and higher levels of social (e.g., loitering, public substance use, street fighting, prostitution, etc.) and physical (e.g., graffiti, gang signs, and discarded needles, cigarettes, and beer bottles) neighborhood disorder have been associated with increased firearm carrying among youths (Molnar, Miller, Azrael, & Buka, 2004). A study of African American youths living in poverty found that those who had been exposed to violence prior to carrying a gun were 2.5 times more likely than nonexposed youths to begin carrying a gun at the next time point, even when controlling for gang involvement (Spano et al., 2012). This study also indicated that after exposure to violence, youths were more likely to start carrying guns in their communities (Spano et al., 2012).

Studies have shown that apart from characteristics like conduct problems and prior delinquency, youths who are involved in gang fighting and selling drugs are also more likely to use a gun to threaten or harm others (e.g., Butters, Sheptycki, Brochu, & Erikson, 2011). Involvement in drug dealing in one's community appears to be particularly risky for gun carrying during later adolescence and early adulthood, possibly due to an increased need for self-protection (Lizotte et al., 2000). Taken together, these studies show that firearm possession may be due to interactions between the need for self-protection in violent communities and increased involvement in delinquent behaviors.

SOCIOCULTURAL CONTEXT: EXPOSURE TO VIOLENT MEDIA

Child and adolescent exposure to violent media, a more distal, sociocultural influence on behavior, is also important when considering developmental risks for gun violence. Decades of experimental, cross-sectional, and longitudinal research have documented that exposure to violent media, in movies and television, is associated with increased aggressive behaviors, aggressive thoughts and feelings, increased physiological arousal, and decreased prosocial behaviors (e.g., Anderson et al., 2003; Anderson & Bushman, 2001; Huesmann, 2010; Huesmann, Moise-Titus, Podolski, & Eron, 2003). In light of ongoing advances in technology, research has been expanded to include violent content in video games, music, social media, and the Internet (Anderson et al., 2010; IOM & NRC, 2013).

Findings on associations between violent media exposure and aggressive behavior outcomes have held across differences

in culture, gender, age, socioeconomic status, and intellect (e.g., Anderson et al., 2010; Huesmann et al., 2003). Social-cognitive theory on violent media exposure suggests that these images are part of children's socialization experiences, similar to violence exposure in interpersonal and community contexts (Huesmann, 2010). The viewing of violent images can serve to desensitize children to violence and normalize violent behavior, particularly when children have previously developed beliefs that aggression and violence are an acceptable means of achieving goals or resolving conflicts.

It is important to note that the link between violent media exposure and subsequent violent behaviors does not demonstrate a direct causal effect but instead shows how some children may be more susceptible to this risk factor than others. For instance, Huesmann et al. (2003) found that identification with aggressive characters on television and the perception that television violence was real were robust predictors of later aggression over time. Additionally, there is no established link between violent media exposure and firearm usage in particular. However, given the substantial proportion of media that includes interactions around firearms (e.g., in video games, movies, and television shows), the IOM and NRC (2013) recently identified a crucial need to examine specific associations between exposure to violent media and use of firearms. Exposure to violent media, especially for youths with preexisting aggressive tendencies and poor parental monitoring, may be an important contextual factor that amplifies risk for violent behavior and gun use.

Exposure to violent media, especially for youths with preexisting aggressive tendencies and poor parental monitoring, may be an important contextual factor that amplifies risk for violent behavior and gun use.

SUMMARY AND CONCLUSIONS

The relatively small number of youths most likely to persist in serious acts of aggression (including increased risk of gun violence) have often experienced the following:

- Early childhood onset of persistent rule-breaking and aggression
- Socialization into criminal attitudes and behaviors by parents and caretakers who themselves are involved in criminal activities

- Exposure in childhood to multiple adverse experiences in their families and communities
- Social dislocation and reduced opportunities due to school failure or underachievement
- Persisting affiliation with deviant peers or gangs engaged in delinquent/criminal misconduct and with attitudes and beliefs that support possession and use of guns
- Broad exposure to sociocultural influences such as mass media violence and depictions of gun violence as an effective means of achieving goals or status

Most youths—even those with chronic and violent delinquent misconduct—desist in aggressive and antisocial behavior during late adolescence, and no single risk factor is sufficient to generate persisting violent behavior. Still, many are disproportionately at risk for becoming perpetrators or victims of gun violence. Homicide remains the second leading cause of death for teens and young adults between the ages of 15 and 24. In 2010, there were 2,711 infant, child, and adolescent victims of firearm deaths. In that year, 84% of homicide victims between the ages of 10 and 19 were killed with a firearm, and 40% of youths who committed suicide between the ages 15 and 19 did so with a gun (CDC, 2013a).¹

There is no one developmental trajectory that specifically leads to gun violence. However, prevention efforts guided by research on developmental risk can reduce the likelihood that firearms will be introduced into community and family conflicts or criminal activity. Prevention efforts can also reduce the relatively rare occasions when severe mental illness contributes to homicide or the more common circumstances when depression or other mental illness contributes to suicide.

Reducing incidents of gun violence arising from criminal misconduct or suicide is an important goal of broader primary and secondary prevention and intervention strategies. Such strategies must also attend to redirecting developmental antecedents and larger sociocultural processes that contribute to gun violence and gun-related deaths.

¹ The 2010 data shown here are available at http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html.

Any account of gun violence in the United States must consider both why males are the perpetrators of the vast majority of gun violence and why the vast majority of males never perpetrate gun violence. An account that explains both phenomena focuses, in part, on how boys and men learn to demonstrate and achieve manhood through violence, as well as the differences in opportunities to demonstrate manhood among diverse groups of males. Although evidence exists for human biological and social-environmental systems interacting and contributing to aggressive and violent behavior, this review focuses on the sociocultural evidence that explains males' higher rates of gun violence.

Reducing the propensity for some males to engage in violence will involve both social and cultural change. Hence, this section reviews existing research on the relationships between sex, gender (i.e., masculinity), and the perpetration and victimization of gun violence in the United States. The intersection of gender, race, ethnicity, and economic disadvantage is also considered in explaining the rates of gun violence across diverse communities. Finally, the relationships between masculinity, gender socialization, and gun violence are analyzed to identify gender-related risk factors for gun violence that can be targeted for prevention strategies and social policy.

SEX DIFFERENCES IN GUN VIOLENCE

Prevalence and Risk

Men represent more than 90% of the perpetrators of homicide in the United States and are also the victims of the large majority (78%) of that violence (Bureau of Justice Statistics, 2008; Federal Bureau of Investigation [FBI], 2007). Homicide by gun is the leading cause of death among Black youth, the second leading cause of death among all male youth, and the second or third leading

cause of death among female youth (depending on the specific age group) (e.g., Miniño, 2010; Webster, Whitehill, Vernick, & Curriero, 2012). In addition, roughly four times as many youths visit hospitals for gun-induced wounds as are killed each year (CDC, 2013a).

Even more common than homicide, suicide is another leading cause of death in the United States, and most suicides are completed with a firearm. Males complete the large majority of suicides; depending on the age group, roughly four to six times as many males as females kill themselves with firearms (CDC, 2013a). Among youth, suicide ranks especially high as a cause of death. It is the third leading cause of death of 15–24-year-olds and the sixth leading cause of death for 5–14-year-olds. However, the rate of suicide and firearm suicide gradually increases over the lifespan. In addition to gender and age differences in prevalence, sizable differences also exist among ethnic groups. Firearm suicide generally is at least twice as high among Whites than among Blacks and other racial groups from 1980 to 2010 (CDC, 2013a), and White males over the age of 65 have rates that far exceed all other major groups.

Perpetrator–Victim Relationship and Location

The prevalence of gun violence strongly depends not only on the sex of the offender but also on the offender's relationship to the victim and the location of the violence (Sorenson, 2006). Both men and women are more likely to be killed with firearms by someone they know than by a stranger. Specifically, men are most likely to be killed in a public place by an acquaintance, whereas women are most likely to be killed in the home by a current or former spouse or dating partner (i.e., "intimate partner"). Women compared with men are especially likely to be killed by a firearm used by an intimate partner.

Women are killed by current or former intimate partners four to five times more often than men (Campbell, Glass, Sharps, Laughon, & Bloom, 2007), including by firearm. These sex differences in victimization do not appear to hold in the limited data available on same-sex intimate partner homicide; it is more common for men to kill their male partners than for women to kill their female partners (Campbell et al., 2007). Notably, these sex differences in gun violence, as a function of the type of perpetrator–victim relationships, are also found in nonfatal gun violence when emergency room visits are examined (Wiebe, 2003).

A disproportionate number of gun homicides occur in urban areas. Conversely, a disproportionate number of firearm suicides occur in rural (compared with urban) areas (Branas, Nance, Elliott, Richmond, & Schwab, 2004). Although they are highly publicized, less than 2% of the homicides of children occur in schools (Borum, Cornell, Modzeleski, & Jimerson, 2010; CDC, 2008, 2013b). There are even fewer "random" or "mass" school shootings in which multiple victims are killed at the same time. In contrast to patterns of gun homicide more generally, such shootings in U.S. middle and high schools have been disproportionately concentrated in rural and suburban regions (Kimmel & Mahler, 2003).

Gun Access and Possession

A person must own or obtain a gun to be able to commit gun violence. Research shows that there are sex differences in access to and carrying a gun. Males are roughly two to four times as likely as females to have access to a gun in the home or to possess a gun (Swahn, Hamming, & Ikeda, 2002; Vaughn et al., 2012). In turn, gun carrying is a key risk factor for gun violence perpetration and victimization. For example, gun carrying is associated with dating violence victimization among adolescents, with boys more likely to be victimized than girls (Yan, Howard, Beck, Shattuck, & Hallmark-Kerr, 2010).

Conclusions based on sex differences in access to guns should be drawn with some caution, given that there also appear to be sex differences in the reporting of guns in the home. Men

report more guns in the home than do women from the same household (e.g., Ludwig, Cook, & Smith, 1998; Sorenson & Cook, 2008), a sex difference that appears to stem specifically from the substantially higher level of contact with and experience in handling and using guns among boys than girls in the same household (Cook & Sorenson, 2006). Nonetheless, the presence of guns in the home remains predictive of gun violence.

The presence of guns in the home remains predictive of gun violence.

GENDER AND GUN VIOLENCE

Robust sex and race differences in firearm violence have been established. Examined next is how the socialization of men as well as differences in living conditions and opportunities among diverse groups of boys and men help explain why these differences occur.

Making Gender Visible in the Problem of Gun Violence

Gender remains largely invisible in research and media accounts of gun violence. In particular, gender is not used to explain the problem of "school shootings," despite the fact that almost every shooting is perpetrated by a young male. Newspaper headlines and articles describe "school shooters," "violent adolescents," and so forth, but rarely call attention to the fact that nearly all such incidents are perpetrated by boys and young men. Studies of risk factors for school shootings may refer accurately to the perpetrators generally as "boys" but largely fail to analyze gender (e.g., Verlinden, Hersen, & Thomas, 2000).

The large sex differences in gun violence should not be overlooked simply because the vast majority of boys and men do not perpetrate gun violence or excused as "boys will be boys." The size of sex differences in the prevalence of gun violence differs substantially within regions of the United States (Kaplan & Geling, 1998) and across countries (e.g., Ahn, Park, Ha, Choi, & Hong, 2012), which further suggests that gender differences in sociocultural environments are needed to explain sex differences in gun violence.

Masculinity, Power, and Guns

Status as a "man" is achieved by the display of stereotypically masculine characteristics, without which one's manhood is contested. Although the particular characteristics defining manhood and the markers of them can vary across subcultural contexts (Connell, 1995), masculinity has, historically, generally been defined by aggressive and risk-taking behavior, emotional restrictiveness (particularly the vulnerable emotions of fear and

sadness, and excepting anger), heterosexuality, and successful competition (Brannon, 1976; Kimmel, 1994; O'Neil, 1981). Such normative characteristics of traditional masculinity are in turn directly related to numerous factors that are associated with gun violence. For example, risk taking is associated with adolescent males' possession of and access to guns (Vittes & Sorenson, 2006).

Social expectations and norms, supported by social and organizational systems and practices, privilege boys who reject or avoid in themselves anything stereotypically feminine, act tough and aggressive, suppress emotions (other than anger), distance themselves emotionally and physically from other men, and strive competitively for power. Men of color, poor men, gay men, and men from other marginalized groups differ substantially in their access to opportunities to fulfill these manhood ideals and expectations in socially accepted ways. For example, men with less formal educational and economic opportunity, who in the United States are disproportionately Black and Latino, cannot fulfill expectations to be successful breadwinners in socially acceptable ways (e.g., paid, legal employment) as easily as White men, and gay men have less ability to demonstrate normative heterosexual masculinity where they cannot legally marry or have children.

At the same time, higher levels of some forms of violence victimization and perpetration (including suicide) are found among these disadvantaged groups. For example, gay youth are more likely than heterosexual males to commit suicide, and African American male youth are disproportionately the victims of gun violence. Such structural discrimination can be seen reflected in implicit cognitive biases against these group members. Virtual simulations of high-threat incidents, such as those used to train police officers, reliably demonstrate a "shooter bias" in which actors are more likely to shoot Black male targets than those from other race-gender groups (i.e., Black women, White men, and White women) (Plant, Goplen, & Kunstman, 2011).

Even to the extent that it is achieved, manhood status is theorized as precarious, needing to be protected and defended through aggression and violence, including gun violence, in order to avoid victimization from (mostly) male peers (Connell, 1995). Paradoxically, as in all competition, the more convincingly manhood is achieved, the more vulnerable it becomes to challenges or threats and thus requires further defending, often with increasing levels and displays of toughness and violence. The dynamic of these expectations of manhood and their enforcement is like a tight box (Kivel, 1998). Boys and men are either trapped inside this box or, in violating the expectations by stepping out of the box, risk being targeted by threats, bullying, and other forms of violence.

Adherence to stereotypic masculinity, in turn, is commonly associated with stress and conflict, poor health, poor coping and relationship quality, and violence (Courtenay 2000; Hong, 2000). Men's gender role stress and conflict are directly associated with various forms of interpersonal aggression and violence, including the perpetration of intimate partner violence and suicide (Feder, Levant, & Dean, 2010; Moore & Stuart, 2005; O'Neil, 2008). Men with more restricted emotionality and more restricted affection with other men are more likely to be aggressive, coercive, or violent (O'Neil, 2008). These dimensions of masculinity also are related to a number of other harmful behaviors that are, in turn, associated directly with gun violence and other forms of aggression (see O'Neil, 2008, for a review). For example, the effect of alcohol consumption on intimate partner violence is greater among men than women (Moore, Elkins, McNulty, Kivisto, & Handsel, 2011), and alcohol consumption may be associated with lethal male-to-male violence at least partly because it is associated with carrying a gun (Phillips, Matusko, & Tomasovic, 2007).

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In addition, accumulating research evidence indicates a relationship between gender and many of the factors that are associated with suicide (e.g., substance abuse, unemployment; Payne, Swami, & Stanistreet, 2008). Beliefs in traditional masculinity are related to suicidal thoughts, although differently across age cohorts (Hunt, Sweeting, Keoghan, & Platt, 2006). Men's historic role as economic providers in heterosexual families typically ends with their retirement from the workforce. Suicide rates, including firearm suicide, increase dramatically at precisely this point in the life course (i.e., age 65 and older), whereas they decrease among women this age. The increase in suicide rates among White men at age 65 and older does not occur among Black men, who as a group have much higher levels of unemployment throughout their lives and consequently may not experience the same sense of loss of meaning or entitlement. Male firearm suicide also increases dramatically in adolescence and early adulthood, precisely the years during which young men's sense of manhood is developing.

Beliefs about gender and sexual orientation also help explain sex differences in fatal hate crimes involving guns. Key themes in male gender role expectations are anti-femininity

(Brannon, 1976) and homophobia (Kimmel, 1994). Boys are expected to rid themselves of stereotypically feminine characteristics (e.g., “you throw like a girl,” “big boys don’t cry”). Gun violence against lesbian, gay, bisexual, and transgendered persons can be understood in this context. One explanation of these hate crimes is that they are perpetrated to demonstrate heterosexual masculinity to male peer group members. These homicides, compared with violent crimes in which the victim is (or is perceived to be) heterosexual, often are especially brutal and are more commonly perpetrated by groups of men rather than individual men or women. However, such homicides appear to be perpetrated less often using firearms, which suggests motives beyond a desire to kill—for example, expressing intense hatred or transferring negative affect directly onto the victim (Gruenwald, 2012).

Male role expectations for achievement of success and power, combined with restricted emotionality, may have dangerous consequences, particularly for boys who suffer major losses and need help.

Male role expectations for achievement of success and power, combined with restricted emotionality, may have dangerous consequences, particularly for boys who suffer major losses and need help. A majority of the males who have completed homicides at schools had trouble coping with a recent major loss. Many had also experienced bullying or other harassment (Vossekuil et al., 2002). Such characteristics cannot and should not be used to develop risk profiles of attackers because school shootings are such rare events, and so many men who share these same characteristics never will perpetrate gun violence. However, when male gender and characteristics associated with male gender are highly common among attackers, it is responsible to ask how male gender contributes to school shootings and other forms of gun violence.

In their case studies of male-perpetrated homicide-suicides at schools, Kalish and Kimmel (2010) speculated that a sense of “aggrieved entitlement” may be common among the shooters. In this view, the young men see suicide and revenge as appropriate, even expected, responses for men to perceived or actual victimization. Related findings emerged from a similar analysis of all “random” school shootings (those with multiple, nontargeted victims) from 1982 to 2001 (Kimmel & Mahler, 2003). With a small number of exceptions, the vast majority were committed by White boys (26 of 28) in suburban or rural (not urban) areas (27 of 28). Many of these boys also had experienced homophobic bullying.

Masculinity and Beliefs About Guns

Sex differences in beliefs about guns may begin at an early age as a function of parental socialization and attitudes. Fathers, particularly White fathers, are more permissive than mothers of their children, particularly sons, playing with toy guns (Cheng et al., 2003). Through the socialization of gender, boys and men may come to believe that displaying a gun will enhance their masculine power. Carrying a weapon is, in fact, instrumental in fulfilling male gender role expectations. Estimates of a person’s physical size and muscularity are greater when they display a gun (or large knife) than other similarly sized and shaped objects (e.g., drill, saw), even when the person is only described and not visible. This perception persists despite no apparent correlation between actual gun ownership and size or muscularity (Fessler, Holbrook, & Snyder, 2012). Guns symbolically represent some key elements of hegemonic masculinity—power, hardness, force, aggressiveness, coldness (Connell, 1995; Stroud, 2012).

IMPLICATIONS FOR PREVENTION AND POLICY

Sex Differences in Attitudes Toward Gun Policies

Policies and laws addressing the manufacture, purchase, and storage of guns have been advocated in response to the prevalence of gun violence. Perhaps reflecting their differential access to firearms and differential perpetration and victimization rates, men and women hold different attitudes about such gun control policies. Females are generally much more favorable toward gun restriction and control policies (e.g., Vittes, Sorenson, & Gilbert, 2003).

Prevention Programs Addressing Gender

The foregoing analysis of the link between gender and gun violence suggests the potential value of addressing gender in efforts to define the problem of gun violence and develop preventive responses. Preliminary evidence suggests that correcting and changing perceptions among men of social norms regarding beliefs about behaviors and characteristics that are associated with stereotypic masculinity may reduce the prevalence of intimate partner and sexual violence (Fabiano, Perkins, Berkowitz, Linkenbach, & Stark, 2003; Neighbors et al., 2010). However, the effect of such interventions in specifically reducing gun violence remains to be tested. The skills and knowledge of psychologists are needed to develop and evaluate programs and settings in schools, workplaces, prisons, neighborhoods, clinics, and other relevant contexts that aim to change gendered expectations for males that emphasize self-sufficiency, toughness, and violence, including gun violence.

WHAT WORKS: GUN VIOLENCE PREDICTION AND PREVENTION AT THE INDIVIDUAL LEVEL

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A natural starting point for the prevention of gun violence is to identify individuals who are at risk for violence and in need of assistance. Efforts focused on at-risk individuals are considered secondary prevention because they are distinguished from primary or universal prevention efforts that address the general population. Secondary prevention strategies for gun violence can include such actions as providing prompt mental health treatment for an acutely depressed and suicidal person or conducting a threat assessment of a person who has threatened gun violence against a spouse or work supervisor.

To be effective, strategies to prevent gun violence should be tailored to different kinds of violence. One example is the distinction between acts of *impulsive violence* (i.e., violence carried out in the heat of the moment, such as an argument that escalates into an assault) and acts of *targeted or predatory violence* (i.e., acts of violence that are planned in advance of the attack and directed toward an identified target). The incidents of mass casualty gun violence that have garnered worldwide media attention, such as the shootings at Sandy Hook Elementary School in Newtown, CT, at a movie theater Aurora, CO, at the Fort Hood military base, and at a political rally in a shopping center in Tucson, AZ, are all examples of targeted or predatory violence. Distinguishing between impulsive violence, targeted/predatory violence, and other types of violence is important because they are associated with different risk factors and require different prevention strategies.

PREDICTING AND PREVENTING IMPULSIVE GUN VIOLENCE

Research on impulsive violence has enabled scientists to develop moderately accurate predictive models that can

identify individuals who are more likely than other persons to engage in this form of violence. These models cannot determine with certainty whether a particular person *will* engage in violence—just whether a person is at greater likelihood of doing so. This approach is known as a *violence risk assessment* or *clinical assessment of dangerousness*. A violence risk assessment is conducted by a licensed mental health professional who has specific training in this area. The process generally involves comparing the person in question with known base rates for those of the same age/gender who have committed impulsive violence and then determining whether the person in question has individual risk factors that would increase that person's likelihood of engaging in impulsive violence. In addition, the process involves examining individual protective factors that would decrease the person's overall likelihood of engaging in impulsive violence. Research that has identified risk and protective factors for impulsive violence is limited in that more research has been conducted on men than women and on incarcerated or institutionalized individuals than on those in the general population. Nevertheless, this approach can be effective for determining someone's relative likelihood of engaging in impulsive violence.

Some risk factors for impulsive violence are static—for example, race and age—and cannot be changed. But those factors that are dynamic—for example, unmet mental health needs for conditions linked with violence to self (such as depression) or others (such as paranoia), lack of mental health care, abuse of alcohol—are more amenable to intervention and treatment that can reduce the risk for gun violence. Secondary prevention strategies to prevent impulsive gun violence can include having a trained psychologist or other mental health professional treat the person's acute mental health needs or substance abuse needs. There must be a vigorous and coordinated response to persons whose histories include acts of violence, threatened or actual use of weapons, and substance abuse, particularly if they have access to a gun. This response should include a violence risk assessment by well-trained professionals and referral for any indicated mental health treatment, counseling and mediation services, or other forms of intervention that can reduce the risk of violence.

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Youths and young adults who are experiencing an emerging psychosis should be referred for prompt assessment by mental health professionals with sufficient clinical expertise with psychotic disorders to craft a clinical intervention plan that includes risk management. In some cases, secondary prevention measures may include a court-ordered emergency psychiatric hospitalization where a person can receive a psychiatric evaluation and begin treatment. Criteria for allowing such involuntary evaluations vary by state but typically can occur only when someone is experiencing symptoms of a serious mental illness and, as a result, potentially poses a significant danger to self or others. There is an urgent need to improve the effectiveness of emergency commitment procedures because of concerns that they do not provide sufficient services and follow-up care.

PREDICTING AND PREVENTING TARGETED OR PREDATORY GUN VIOLENCE

Acts of targeted or predatory violence directed at multiple victims, including crimes sometimes referred to as rampage shootings and mass shootings,² occur far less often in the United States than do acts of impulsive violence (although targeted violence garners far more media attention). Acts of targeted violence have not been subject to study that has developed statistical models like those used for estimating a person's likelihood of impulsive violence. Although it seems appealing to develop checklists of warning signs to construct a profile of individuals who commit these kinds of crimes, this effort, sometimes described as psychological profiling, has not been successful. Research has not identified an effective or useful psychological profile of those who would engage in multiple casualty gun violence. Moreover, efforts to use a checklist profile to identify these individuals fail in part because the characteristics used in these profiles are too general to be of practical value; such characteristics are also shared by many nonviolent individuals.

Because of the limitations of a profiling approach, practitioners have developed the behavioral threat assessment model as an alternative means of identifying individuals who are threatening, planning, or preparing to commit targeted violence. Behavioral threat assessment also emphasizes the need for interventions to prevent violence or harm when a threat has been identified, so it represents a more comprehensive approach to violence prevention. The behavioral threat assessment model is an empirically based approach that was developed largely by the U.S. Secret Service to evaluate threats to the president and other public figures and has since been adapted by the U.S. Secret Service and U.S. Department of Education (Fein et al., 2002; Vossekuil et al., 2002) and others (Cornell, Allen, & Fan, 2012) for use in schools, colleges and universities, workplaces, and the U.S. military. Threat assessment teams are typically multidisciplinary teams that are trained to identify potentially threatening persons and situations. They gather and analyze additional information, make an informed assessment of whether the person is on a pathway to violence—that is, determine whether the person poses a threat of interpersonal violence or self-harm—and if so, take steps to intervene, address any underlying problem or treatment need, and reduce the risk for violence.

² The FBI (n.d.) defines *mass murder* as incidents that occur in one location (or in closely related locations during a single attack) and that result in four or more casualties. Mass murder shootings are much less common than other types of gun homicides. They are also not a new phenomenon. Historically, most mass murder shootings occurred within families or in criminal activities such as gang activity and robberies. *Rampage killings* is a term used to describe some mass murders that involve attacks on victims in unprotected settings (such as schools and colleges, workplaces, places of worship) and public places (such as theaters, malls, restaurants, public gatherings). However, these shootings are often planned well in advance and carried out in a methodical manner, so the term *rampage* is a misnomer.

Behavioral threat assessment is seen as the emerging standard of care for preventing targeted violence in schools, colleges, and workplaces, as well as against government officials and other public figures. The behavioral threat assessment approach is the model currently used by the U.S. Secret Service to prevent violence to the U.S. president and other public officials, by the U.S. Capitol Police to prevent violence to members of Congress, by the U.S. State Department to prevent violence to dignitaries visiting the United States, and by the U.S. Marshals Service to prevent violence to federal judges (see Fein & Vossekuil, 1998). The behavioral threat assessment model also is recommended in two American national standards: one for higher education institutions (which recommends that all colleges and universities operate behavioral threat assessment teams; see ASME-Innovative Technologies Institute, 2010) and one for workplaces (which recommends similar teams to prevent workplace violence; see ASIS International and Society for Human Resource Management, 2011). In addition, a comprehensive review conducted by a U.S. Department of Defense (2010) task force following the Fort Hood shooting concluded that threat assessment teams or threat management units (i.e., teams trained in behavioral threat assessment and management procedures) are the most effective tool currently available to prevent workplace violence or insider threats like the attack at Fort Hood.

Empirical research on acts of targeted violence has shown that many of those attacks were carried out by individuals motivated by personal problems who were at a point of desperation. In their troubled state of mind, these individuals saw no viable solution to their problems and could envision no future. The behavioral threat assessment model is used not only to determine whether a person is planning a violent attack but also to identify personal or situational problems that could be addressed to alleviate desperation and restore hope. In many cases, this includes referring the person to mental health services and other sources of support. In some of these cases, psychiatric hospitalization may be needed to address despondence and suicidality. Nonpsychiatric resources also can help alleviate the individual's problems or concerns. Resources such as conflict resolution, credit counseling, job placement assistance, academic accommodations, veterans' services, pastoral counseling, and disability services all can help address personal problems and reduce desperation. When the underlying personal problems are alleviated, people who may have posed a threat of violence to others no longer see violence as their best or only option.

UNDERSTANDING SCHOOL SHOOTINGS

Thirteen years before the shooting at Sandy Hook Elementary School, the Columbine High School shootings (in April 1999) shocked the American public and galvanized attention on school shootings. The intensified focus led to landmark federal research jointly conducted by the U.S. Secret Service and the U.S. Department of Education (Fein et al., 2002; Vossekuil et al., 2002) that examined 37 incidents of school attacks or targeted school shootings and included interviews with school shooters. Known as the Safe School Initiative, the findings from this research shed new light on ways to prevent school shootings, showing that school attacks are typically planned in advance, the school shooters often tell peers about their plans beforehand and are frequently despondent or suicidal prior to their attacks (with some expecting to be killed during their attacks), and most shooters had generated concerns with at least three adults before their shootings (Vossekuil et al., 2002). This research and subsequent investigations indicate that school attacks—although rare events—are most likely perpetrated by students currently enrolled (or recently suspended or expelled) or adults with an employment or another relationship to the school. The heterogeneity of school attackers makes the development of an accurate profile impossible. Instead, research supports a behavioral threat assessment approach that attends to features such as:

- threats, including behaviors or statements reflecting thoughts or plans for a school attack (often these are confided to peers);
- ready access to a firearm or other lethal weapon and unusual preparation or practice for use; and
- mental health symptoms, including depression with accompanying feelings of desperation and despondency.

These findings led to the development of the U.S. Secret Service/ U.S. Department of Education school threat assessment model (Vossekuil et al., 2002) and similar models (see, for example, the *Virginia Student Threat Assessment Guidelines*; Cornell et al., 2012). After the shooting at Sandy Hook Elementary School in 2012, Virginia passed a law requiring threat assessment teams in Virginia K-12 public schools. Threat assessment teams were already required by law for Virginia's public colleges and universities following the Virginia Tech shootings in 2007. Other states have passed or are debating similar measures for their institutions of higher education and/or K-12 schools. Threat assessment teams are recommended by the new federal guides on high-quality emergency plans for schools and for colleges and universities (U.S. Department of Education, 2013).

PREDICTING AND PREVENTING VIOLENCE BY THOSE WITH ACUTE MENTAL ILLNESS

When treating a person with acute or severe mental illness, mental health professionals may encounter situations in which they need to determine whether their patient (or client) is at risk for violence. Typically, they would conduct a violence risk assessment if the clinician's concern is about risk for impulsive violence, as discussed previously. Clinicians also can conduct—or work with a team to help conduct—a threat assessment if their concern involves targeted violence. The available research suggests that mental health professionals should be concerned when a person with acute mental illness makes an explicit threat to harm someone or is troubled by delusions or hallucinations that encourage violence, but even in these situations, violence is far from certain. Although neither a violence risk assessment nor a threat assessment can yield a precise prediction of someone's likelihood of violence, it can identify high-risk situations and guide efforts to reduce risk. It is important to emphasize that prevention does not require prediction; interventions to reduce risk can be beneficial even if it is not possible to determine who would or would not have committed a violent act.

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When their patients (or clients) pose a risk of violence to others, mental health professionals have a legal and ethical obligation to take appropriate action to protect potential victims of violence. This obligation is not easily carried out for several reasons. First, mental health professionals have only a modest ability to predict violence, even when assisted by research-validated instruments. Mental health professionals who are concerned that a patient is at high risk for violence may be unable to convince their patient to accept hospitalization or some other change in treatment. They can seek involuntary hospitalization or treatment, but civil commitment laws (that vary from state to state) generally require convincing evidence that a person is imminently dangerous to self or others. There is considerable debate about the need to reform civil commitment laws in a manner that both protects individual liberties and provides necessary protection for society.

There is no guarantee that voluntary or involuntary treatment of a potentially dangerous individual will be effective in reducing violence risk, especially when the risk for violence does not arise from a mental illness but instead from intense desperation resulting from highly emotionally distressing circumstances or from antisocial orientation and proclivities for criminal misconduct. When individuals with prior histories of violence are released from treatment facilities, they typically need continued treatment and monitoring for potential violence until they stabilize in community settings. Jurisdictions vary widely in the resources available to achieve stability in the community and in the legal ability to impose monitoring or clinical care on persons who decline voluntary services.

Furthermore, if unable to obtain civil commitment to a protective setting, mental health professionals must consider other protective actions permitted in their jurisdictions, which may include warning potential victims that they are in danger or alerting local law enforcement, family members, employers, or others. Whether their particular jurisdiction mandates a response to “warn or protect” potential victims or leaves this decision to the discretion of the clinician, mental health professionals are often reluctant to take such actions because they are concerned that doing so might damage the therapeutic relationship with their patient and drive patients from treatment or otherwise render effective treatment impossible.

Another post-hospitalization strategy is to prohibit persons with mental illness from acquiring a firearm. The Gun Control Act of 1968 prohibited persons from purchasing a firearm if they had been involuntarily committed to a psychiatric inpatient unit. The Brady Handgun Violence Act (1994), known as the Brady Law, began the process of background checks to identify individuals who might attempt to purchase a firearm despite prohibitions. There is some evidence that rates of gun violence are reduced when these procedures are adequately implemented, but research, consistent implementation, and refinement of these procedures are needed (Webster & Vernick, 2013a).

PREDICTING AND PREVENTING GUN-BASED SUICIDE

Suicide accounts for approximately 61% of all firearm fatalities in the United States—19,393 of the 31,672 firearm deaths reported by the CDC for 2010 (Murphy, Xu, & Kochanek, 2013). When there is concern that a person may be suicidal, mental health professionals can conduct suicide screenings and should rely on structured assessment tools to assess that person's risk to self. Behavioral threat assessment also may be indicated in such situations if the potentially suicidal individual may also pose a threat to others.

More than half of suicides are accomplished by firearms and most commonly with a firearm from the household (Miller, Azrael, Hepburn, Hemenway, & Lippmann, 2006). More than 90% of persons who commit suicide had some combination of symptoms of depression, symptoms of other mental disorders, and/or substance abuse (Moscicki, 2001). Ironically, although depression is the condition most closely associated with attempted or completed suicide, it is also less likely than schizophrenia or other disorders to prompt an involuntary civil commitment or other legal triggers that can prevent some persons with mental illness from possessing firearms. As in behavioral threat assessment, suicide risk may be reduced through identifying and providing support in solving the problems that are driving a person to consider suicide. In many cases the person may need a combination of psychological treatment and psychiatric medication.

Tragic shootings like the ones at Sandy Hook Elementary School and the movie theater in Aurora, CO, spark intense debate as to whether specific gun control policies would significantly diminish the number of mass shooting incidents. This debate includes whether or how to restrict access to firearms, especially with regard to persons with some mental illnesses. Another line of debate concerns whether to limit access to certain types of firearms (e.g., reducing access to high-capacity magazines). Empirical evidence documents the efficacy of some firearms restrictions, but because the restrictions often are not well implemented and have serious limitations, it is difficult to conduct the kind of rigorous research needed to fairly evaluate their potential for reducing gun violence.

Despite these limitations and gaps, there is some scientific evidence that background checks reduce the rate of violent gun crimes by persons whose mental health records disqualify them from legally obtaining a firearm.

The often-debated Brady Law (1994) does not consistently prevent persons with mental illness from acquiring a firearm. The prohibition applies only to persons with involuntary commitments and omits both persons with voluntary admissions and those with no history of inpatient hospitalization. The law does not prevent a person with a history of involuntary commitment from obtaining a previously owned firearm or one possessed by a friend or relative. Additional problems with implementing the Brady Law include incomplete records

of involuntary commitments, background checks limited to purchases from licensed gun dealers, and exceptions from background checks for firearms purchased during gun shows.

Despite these limitations and gaps, there is some scientific evidence that background checks reduce the rate of violent gun crimes by persons whose mental health records disqualify them from legally obtaining a firearm. A study of one state (Connecticut) found that the risk of violent criminal offending among persons with a history of involuntary psychiatric commitment declined significantly after the state began reporting these individuals to the National Instant Criminal Background Check System (Swanson et al., 2013). This study supports the value of additional research to investigate strategies for limiting access to firearms by persons with serious mental illness.

In contrast, access to appropriate mental health treatment *can* work to reduce violence at the individual level. For example, one major finding of the MacArthur Risk Assessment study (Monahan et al., 2001) was that getting continued mental health treatment in the community after release from a psychiatric hospitalization reduced the number of violent acts by those who had been hospitalized. In other studies, outpatient mental health services, including mandated services, have been effective in preventing or reducing violent and harmful behavior (e.g., New York State Office of Mental Health, 2005; N.Y. Mental Hygiene Law [Kendra's Law], 1999; O'Keefe, Potenza, & Mueser, 1997; Swanson et al., 2000).

There is abundant scientific research demonstrating the effectiveness of treatment for persons with severe mental illness such as schizophrenia and bipolar disorder. However, there are social, economic, and legal barriers to treatment. First, there is a persistent social stigma associated with mental illness that deters individuals from seeking treatment for themselves or for family members. Public education to increase understanding of and support for persons with serious mental illness and to encourage access to treatment is needed.

Second, mental health treatment, especially inpatient hospitalization, is expensive, and persons with mental illness often cannot access this level of care or afford it. Commercial insurers often have limitations on hospital care or do not cover intensive services that are alternatives to inpatient admission. Public sector facilities such as community mental health centers and state-operated psychiatric hospitals have experienced many years of shrinking government support; demand for their services exceeds their capacity. Many mental health providers limit their services to the most acute cases and cannot extend services after the immediate crisis has resolved.

Third, there are complex legal barriers to the provision of mental health services when an individual does not desire treatment or does not believe he or she is in need of treatment. A severe mental illness can impair an individual's understanding of his or her condition and need for treatment, but a person with mental illness may make a rational decision to refuse treatment that he or she understandably regards as ineffective, aversive, or undesirable for some reason (e.g., psychiatric medications can produce unpleasant side effects and hospitalization can be a stressful experience).

When an individual refuses to seek treatment, it may be difficult to determine whether this decision is rational or irrational. To protect individual liberties, laws throughout the United States permit involuntary treatment only under stringent conditions, such as when an individual is determined to be imminently dangerous to self or others due to a mental illness. People who refuse treatment but are not judged to be imminently dangerous (a difficult and ambiguous standard) fall into a "gray zone" (Evans, 2013). Some individuals with serious mental illness pose a danger to self or others that is not imminent, and often it is not possible to monitor them adequately or determine precisely when they become dangerous and should be hospitalized on an involuntary basis. In other situations, the primary risk posed by the individual does not arise from mental illness but from his or her willingness to engage in criminal misconduct for personal gain.

Some individuals with serious mental illness pose a danger to self or others that is not imminent, and often it is not possible to monitor them adequately or determine precisely when they become dangerous and should be hospitalized on an involuntary basis.

Furthermore, when a person is committed to a psychiatric hospital on an involuntary basis, treatment is limited in scope. Once the person is no longer regarded as imminently dangerous (the criteria differ across states), he or she must be released from treatment even if not fully recovered; that person may be vulnerable to relapse into a dangerous state. In some cases of mass shootings, persons who committed the shooting were known to have a serious mental illness, but authorities could not require treatment when it was needed. In other cases, authorities were not aware of an individual's mental illness before the attempted or actual mass shooting incident.

A related problem is that the onset or recurrence of serious mental illness can be difficult to detect. Symptoms of mental illness may emerge slowly, often in late adolescence or early adulthood, and may not be readily apparent to family members and friends. A person hearing voices or experiencing paranoid delusions may hide these symptoms and simply seem preoccupied or distressed but not seriously ill. A person who has been treated successfully for a serious mental illness may experience a relapse that is not immediately recognized. There is a great need for public education about the onset of serious mental illness, recognition of the symptoms of mental illness, and increased emphasis on the importance of seeking prompt treatment.

WHAT WORKS: GUN VIOLENCE PREVENTION AT THE COMMUNITY LEVEL

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Prevention of violence occurs along a continuum that begins in early childhood with programs to help parents raise healthy children and ends with efforts to identify and intervene with troubled individuals who threaten violence.

A comprehensive community approach recognizes that no single program is sufficient and there are many opportunities for effective prevention. Discussion of effective prevention from a community perspective should include identification of the community being examined. Within the larger community, many stakeholders are affected by gun violence that results in a homicide, suicide, or mass shooting.

Such stakeholders include community and public safety officials, schools, workplaces, neighborhoods, mental health and public health systems, and faith-based groups. Some gangs might be viewed as a community. When it comes to perpetrating gun violence, however, a common thread that exists across community groups is the recognition that someone, or possibly several people, may have heard something about an individual's thoughts and/or plans to use a gun. Where do they go with that information? How do they report it so that innocent people are not targeted or labeled unfairly—and how can their information initiate a comprehensive and effective crisis response that prevents harm to the individual of concern and the community?

To date, there is little research to help frame a comprehensive and effective prevention strategy for gun violence at the community level. One of the most authoritative reviews of the body of gun violence research comes from the National Research Council of the National Academy of Sciences (see Wellford, Pepper, & Petrie, 2004). In reviewing a range of criminal justice initiatives designed to reduce gun violence, such as gun courts, enhanced sentencing, and problem-based policing, Wellford et al. concluded that problem-oriented policing, also

known as place-based initiatives or target policing, holds promise, particularly when applied to “hot spots”—areas in the community that have high crime rates. They included studies on programs such as the Boston Gun Project (see Kennedy, Braga, & Piehl, 2001), more commonly known as Operation Ceasefire, in their review and concluded that although many of these programs may have reduced youth homicides, there is only modest evidence to suggest that they effectively lowered rates of crime and violence, given the confounding factors that influence those rates and are difficult to control. In other words, the variability in the roles of police, prosecutors, and the community creates complex interactions that can confound the levels of intervention and affect sustainability.

Wellford et al.'s (2004) conclusions were supported by the findings of the 2011 Firearms and Violence Research Working Group (National Institute of Justice, 2011), which also questioned whether rigorous evaluations are possible given the reliability and validity of the data. Wellford et al. advocated for continued research and development of models that include collaboration between police and community partners and for examination of different evaluation methodologies.

There are varied prevention models that address community issues. When it comes to exploring models that specifically address preventing the recent episodes of gun violence that have captured the nation's attention, however, the inevitable conclusion is that there is a need to develop a new model that would bring community stakeholders together in a collaborative, problem-solving mode, with a goal of preventing individuals from engaging in gun violence, whether directed at others or self-inflicted. This model would go beyond a single activity and would blend several strategies as building blocks to form a workable systemic approach. It would require that community service systems break their tendencies to operate in silos and take advantage of the different skill sets already available in the community—for example:

- Police are trained in crisis intervention skills with a primary focus on responding to special populations such as those with mental illness.
- Community members are trained in skilled interventions such as Emotional CPR (<http://www.emotional-cpr.org>) and Mental Health First Aid (<http://www.mentalhealthfirstaid.org>)—consumer-based initiatives that use neighbor-to-neighbor approaches that direct people in need of care to appropriate mental health treatment.
- School resource officers are trained to show a proactive presence in schools.

Some models developed through the community policing reform movement may be relevant because they are generally acknowledged to have been useful in reducing violence against women and domestic violence and in responding to children exposed to violence.

Each group may provide a solution to a piece of the problem, but there is nothing connecting the broad range of activities to the type of collaborative system needed to implement a comprehensive, community-based strategy to prevent gun violence. From a policy and practice perspective, no one skill set or one agency can provide the complete answer when it comes to developing a prevention methodology. However, some models developed through the community policing reform movement may be relevant because they are generally acknowledged to have been useful in reducing violence against women and domestic violence and in responding to

children exposed to violence. These community policing models involve collaborative problem solving as a way to safeguard the community as opposed to relying only on arrest procedures. Moreover, they engage the community in organized joint efforts to produce public safety (Peak, 2013).

Another initiative, Project Safe Neighborhoods (PSN; www.psn.gov), is also relevant. PSN, a nationwide program that began in 2001 and was designed specifically to reduce gun violence, has some similarity to the community policing model. PSN involved the 94 U.S. attorneys in cities across the country in a prominent leadership role, ensured flexibility across jurisdictions, and required cross-agency buy-in, though there seems to have been less formalized involvement with mental health services. Nevertheless, it used a problem-solving approach that was aimed at getting guns off the streets, and the results of varied outcome assessments demonstrate that it was successful in reducing gun violence, particularly when the initiatives were tailored to the gun violence needs of specific communities (McGarrell et al., 2009).

A common approach used by PSN involved engaging the community to establish appropriate stakeholder partnerships, formulating strategic planning on the basis of identification and measurement of the community problem, training those involved in PSN, providing outreach through nationwide public service announcements, and ensuring accountability through various reporting mechanisms. The PSN problem-solving steps, with some adaptations, could provide a useful strategy for initiating collaborative problem solving with relevant community stakeholders in the interest of reducing gun violence and victimization through prevention.

The models discussed here illustrate how community engagement and collaboration helped break new ground in response to identified criminal justice problems, but they could be strengthened considerably by incorporating the involvement of professional psychology. The need for collaboration was again highlighted at a Critical Issues in Policing meeting (Police Executive Research Forum, 2012) as part of a discussion on connecting agency silos by building bridges across systems. Because police and mental health workers often respond to the same people, there is a need for collaboration on the best way to do this without compromising their roles. This emphasis takes the discussion beyond the student/school focus and expands it to include the use of crisis intervention teams (CIT) and community advocacy groups as additional resources for achieving the goal of preventing violence in the community.

The CIT model was another result of community policing reform that brought police and mental health services together to provide a more effective response to the needs of special

populations, particularly mental health-related cases. Developed in Memphis in 1988 but now deployed in many communities across the country, the CIT model trains CIT officers to deescalate situations involving people in crises and to use jail diversion options, if available, rather than arrests. Although research on the effectiveness of CITs is generally limited to outcome studies in select cities, the model continues to gain prominence. In fact, the National Alliance on Mental Illness (NAMI) has established a NAMI CIT Center and is promoting the expansion of CIT nationwide. Studies by Borum (2000), Steadman, Deane, Borum, and Morrissey (2000), and Teller, Munetz, Gil, and Ritter (2006) have illustrated that high-risk encounters between individuals with mental illness and police can be substantially improved through CIT training, particularly when there are options such as drop-off centers, use of diversion techniques, and collaborations between law enforcement, mental health, and family members. Each plays a significant role in ensuring that city or county jails do not become de facto institutions for those in mental health crises.

Crisis intervention teams were also a major focus of a 2010 policy summit (International Association of Chiefs of Police [IACP], 2012). The summit, hosted by SAMHSA, the Bureau of Justice Assistance, and IACP, produced a 23-item action agenda. Although the summit focused on decriminalizing the response to persons with mental illness and was not directed specifically at dealing with people who perpetrate gun violence, some of their recommendations did apply. The central theme of the agenda encouraged law enforcement and mental health service systems to engage in mutually respectful working relationships, collaborate across partner agencies, and establish local multidisciplinary advisory groups. These partnerships would develop policy, protocols, and guidelines for informing law enforcement encounters with persons with mental illness who are in crisis, including a protocol that would enable agencies to share essential information about those individuals and whether the nature of the crisis could provoke violent behavior. They further recommended that these types of protocols be established and maintained by the multidisciplinary advisory group and that training be provided in the community to sensitize community members to signs of potential danger and how to intervene in a systematic way.

A Police Foundation (2013) roundtable on gun violence and mental health reported that some police departments have reached out to communities and offered safe storage of firearms when community members have concern about a family member's access to firearms in the home. As a service to the community, the police would offer to keep guns secured in accessible community locations until the threat has subsided and the community member requests the return. The police

would also confer with mental health practitioners regarding a designated family or community member on an as-needed basis. This strategy is consistent with a community threat assessment approach in which law enforcement authorities engage proactively with the community to reduce the risk of violence when an individual poses a risk.

GUN VIOLENCE IN SCHOOLS

Gun violence in schools has been a national concern for more than 2 decades. Although school shootings are highly traumatic events and have brought school safety to the forefront of public attention, schools are very safe environments compared with other community settings (Borum et al., 2010). Less than 2% of homicides of school-aged children occur in schools. Over a 20-year period, there have been approximately 16 shooting deaths in U.S. schools each year (Fox & Burstein, 2010), compared with approximately 32,000 shooting deaths annually in the nation as a whole (Hoyert & Xu, 2012).

Although school shootings are highly traumatic events and have brought school safety to the forefront of public attention, schools are very safe environments compared with other community settings.

The Gun-Free Schools Act of 1994 made federal education funding contingent upon states requiring schools to expel for at least one year any student found with a firearm at school. This mandate strengthened the emerging philosophy of zero tolerance as a school disciplinary policy. According to the APA Zero Tolerance Task Force (2008), this policy was predicated on faulty assumptions that removing disobedient students would motivate them to improve their behavior, deter misbehavior by other students, and generate safer school conditions. The task force found no scientific evidence to support these assumptions and, on the contrary, concluded that the practice of school suspension had negative effects on students and a disproportionately negative impact on students of color and students with disabilities.

After the 1999 shooting at Columbine High School, both the FBI (O'Toole, 2000) and the U.S. Secret Service (Vossekuil et al., 2002) conducted studies of school shootings and concluded that schools should not rely on student profiling or checklists of warning signs to identify potentially violent students. They cautioned that school shootings were statistically

too rare to predict with accuracy and that the characteristics associated with student shooters lacked specificity, which means that numerous nonviolent students would be misidentified as dangerous. Both law enforcement agencies recommended that schools adopt a behavioral threat assessment approach, which, as noted in Chapter 4, involves assessment of students who threaten violence or engage in threatening behavior and then individualized interventions to resolve any problem or conflict that underlies the threat. One of the promising features of threat assessment is that it provides schools with a policy alternative to zero tolerance. Many schools across the nation have adopted threat assessment practices. Controlled studies of the *Virginia Student Threat Assessment Guidelines* have shown that school-based threat assessment teams are able to resolve student threats safely and efficiently and to reduce school suspension rates (Cornell et al., 2012; Cornell, Gregory, & Fan, 2011; Cornell, Sheras, Gregory, & Fan, 2009).

THE ROLE OF HEALTH AND MENTAL HEALTH PROVIDERS IN GUN VIOLENCE PREVENTION

The health care system is an important point of contact for families regarding the issue of gun safety. Physicians' counseling of individuals and families about firearm safety has in some cases proven to be an effective prevention measure and is consistent with other health counseling about safety. According to the 2012 policy statement of the American Academy of Pediatrics (AAP):

The AAP supports the education of physicians and other professionals interested in understanding the effects of firearms and how to reduce the morbidity and mortality associated with their use. HHS should establish a program to support gun safety training and counseling programs among physicians and other medical professionals. The program should also provide medical and community resources for families exposed to violence.

The AAP's *Bright Futures* practice guide (see <http://brightfutures.aap.org>) urges pediatricians to counsel parents who possess guns that storing guns safely and preventing access to guns reduce injury by as much as 70% and that the presence of a gun in the home increases the risk for suicide among adolescents. A randomized controlled trial indicates that health care provider counseling, when linked with the distribution of cable locks, has been demonstrated to increase safer home storage of firearms (Barkin et al., 2008). The removal of guns or the restriction of access should be reinforced for children and adolescents with mood disorders, substance abuse (including alcohol), or history of suicide attempts (Grossman et al., 2005). Research is needed to identify the best ways to avoid unintended consequences while achieving intended outcomes.

In recent years, legal and legislative challenges have emerged that test the ability of physicians and other medical professionals to provide guidance on firearms. For example, in 2011 the state of Florida enacted the Firearm Owners' Privacy Act, which prevented physicians from providing such counsel under threat of financial penalty and potential loss of licensure. The law has been permanently blocked from implementation by a U.S. district court. Similar policies have been introduced in six other states: Alabama, Minnesota, North Carolina, Oklahoma, Tennessee, and West Virginia. The fundamental right of all health and mental health care providers to provide counseling to individuals and families must be protected to mitigate risk of injury to people where they live, work, and play.

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It is apparent that long before the events at Sandy Hook Elementary School, many public health and public safety practitioners were seeking strategies to improve responses to violence in their communities and have experienced some success through problem-solving projects such as PSN and CIT. Yet there is still a need to rigorously evaluate and improve these efforts. In the meantime, basic safety precautions must be emphasized to parents by professionals in health, education, and mental health.

Public health messaging campaigns around safe storage of firearms are needed. The practice of keeping firearms stored and locked must be encouraged, and the habit of keeping loaded, unlocked weapons available should be recognized as dangerous and rendered socially unacceptable. To keep children and families safe, good safety habits have to become the only socially acceptable norm.

WHAT WORKS: POLICIES TO REDUCE GUN VIOLENCE

Susan B. Sorenson, PhD, and Daniel W. Webster, ScD, MPH

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The use of a gun greatly increases the odds that violence will result in a fatality. In 2010, the most recent year for which data are available, an estimated 17.1% of the interpersonal assaults with a gunshot wound resulted in a homicide, and 80.7% of the suicide attempts in which a gun was used resulted in death (CDC, 2013a). By contrast, the most common methods of assault (hands, fists, and feet) and suicide attempt (ingesting pills) in 2010 resulted in death in only 0.009% and 2.5% of the incidents, respectively (CDC, 2013a).³

As shown in Figure 1, in the past 30 years, the percentage of deaths caused by gunfire has stabilized to about 68% for homicides and, as drug overdoses have increased, dropped to 50% for suicide. There are more gun suicides than gun homicides in the United States. In 2010, 61.2% (19,392) of the 31,672 gun deaths in the United States were suicides (CDC, 2013a).

Much of the public concern about guns and gun violence focuses on interpersonal violence, and public policy mirrors this emphasis. Although there is no standard way to enumerate each discrete gun law, most U.S. gun laws focus on the user of the gun. Relatively few focus on the design, manufacture, distribution, advertising, or sale of firearms (Teret & Wintemute, 1993). Fewer yet address ammunition.

The focus herein is on the lifespan of guns—from design and manufacture to use—and the policies that

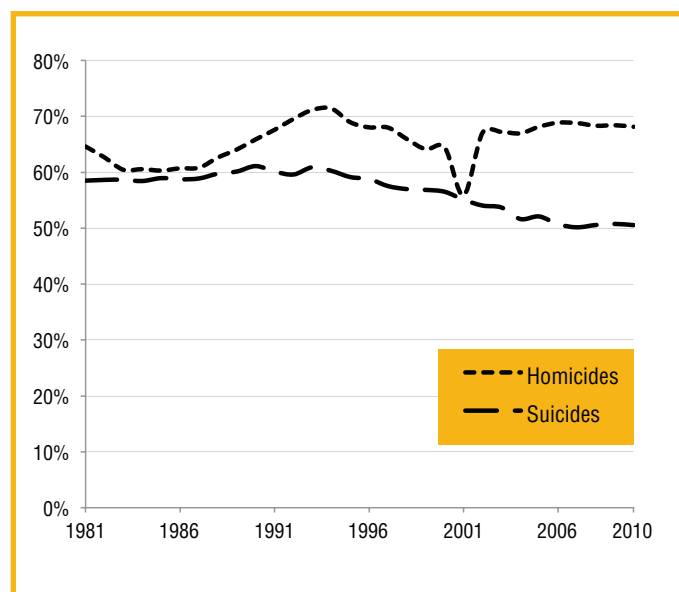


Figure 1. Deaths Attributed to Firearms, 1981–2010

Note. The data are from the Web-Based Injury Statistics Query and Reporting System (WISQARS™), Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2013. Retrieved from <http://www.cdc.gov/injury/wisqars/fatal.html>

³ The 2010 data used to calculate current rates shown here are available at http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html and <http://www.cdc.gov/injury/wisqars/nonfatal.html>.

could address the misuse of guns. It is critical to understand how policies create conditions that affect access to and use of guns. Because they constitute the largest portion of guns used in homicides (FBI, 2012a), handguns are the focus of most laws. Despite the substantial human and economic costs of gun violence in the United States and the ongoing debate about the effectiveness of gun regulations, scientifically rigorous evaluations are not available for many of these policies (Wellford et al., 2004). The dearth of such research on gun policies is due, in part, to the lack of government funding on this topic because of the political influences of the gun lobby (e.g., Kellermann & Rivara, 2013).

DESIGN AND MANUFACTURE

The type of handguns manufactured in the United States has changed. Pistols overtook revolvers in manufacturing in the mid-1980s. In addition, the most widely sold pistol went from a .22 caliber in 1985 to a 9 mm or larger (e.g., .45 caliber pistols) by 1994 (Wintemute, 1996), with smaller, more concealable pistols favored by permit holders as well as criminals. This shift has been described as increasing the lethality of handguns, although, according to our review, no research has examined whether the change in weapon design has led to an increased risk of death. Such research may not be feasible given that the aforementioned weapons—that is, small, concealable pistols—still likely constitute a small portion of the estimated 283 million guns in civilian hands in the United States (Hepburn, Miller, Azrael, & Hemenway, 2007). The disproportionate appearance of such pistols among guns that were traced by law enforcement following their use in a crime has been attributed to the ease with which smaller guns can be concealed and their low price point (Koper, 2007; Wright, Wintemute, & Webster, 2010).

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Ammunition, by contrast, is directly related to lethality. Hollow-point bullets are used by hunters because, in part, they are considered a more humane way to kill. The physics of hollow-point bullets are such that, upon impact, they will tumble inside the animal and take it down. Some bullets have been designed to be frangible, that is, to break apart upon impact and thus cause substantial internal damage. By

contrast, the physics of full metal jacket bullets are such that, unless they hit a bone, they are likely to continue on a straight trajectory and pass through the animal, leaving it wounded and wandering. Hollow-point bullets are used by law enforcement to reduce over-penetration (i.e., when a bullet passes through its intended target and, thus, risks striking others).

Some design features would substantially reduce gun violence. One of the most promising ideas is that of “smart guns” that can be fired only by an authorized user. For example, young people, who are prohibited due to their age from legally purchasing a firearm, typically use a gun from their own home to commit suicide (Johnson, Barber, Azrael, Clark, & Hemenway, 2010; Wright, Wintemute, & Claire, 2008) and to carry out a school shooting (CDC, 2003). If personalized to an authorized adult in the home, the gun could not be operated by the adolescent or others in the home, thus rendering it of little use to the potential suicide victim or school shooter. During the Clinton administration, the federal government made a modest investment in the research and development of personalized firearms. There also was considerable private investment in technologies that would prevent unauthorized users from being able to fire weapons. Efforts to create these “smart guns” have resulted in multiple patent applications. Armatix GmbH, a German company, has designed and produced a personalized pistol that is being sold in several Western European nations and has been approved for importation to the United States. Although the cost of this new personalized gun is very high, it is believed that personalized guns can be produced at a cost that would be affordable by many (Teret & Merritt, 2013).

The assault weapons ban (the Violent Crime Control and Law Enforcement Act of 1994), enacted for a 10-year period beginning in 1994, provided a good opportunity to assess the effectiveness of restricting the manufacturing, sale, and possession of a certain class of weapons. “Assault weapons,” however, are difficult to conceal and are used rarely in most street crime or domestic violence. Assault weapons are commonly used in mass shootings in which ammunition capacity can determine the number of victims killed or wounded. Because multiple bullets are not an issue in suicide, one would not expect changes in such deaths either. Perhaps not surprisingly, an effect of the ban could not be detected on total gun-related homicides (Koper, 2013; Koper & Roth, 2001).

Unfortunately, prior research on the effects of the federal assault weapons ban did not focus on the law’s effects on mass shootings or the number of persons shot in such shootings. Assault weapons or guns with large-capacity ammunition feeding devices account for half of the weapons used in mass shootings such as at Sandy Hook Elementary School (see Follman & Aronson, 2013). Mass shootings with these types

of weapons result in about 1.5 times as many fatalities as those committed with other types of firearms (Roth & Koper, 1997).

DISTRIBUTION

The distribution of guns is largely the responsibility of a network of middlemen between gun manufacturers and gun dealers. When a gun is recovered following its use (or suspected use) in a crime, law enforcement routinely requests that the gun be traced—that is, the serial number is reported to the manufacturer, who then contacts the distributor and/or dealer who, in turn, reviews records to determine the original purchaser of a specific weapon. The number of gun traces is such that the manufacturers get many calls about their guns each day. One researcher estimated that Smith and Wesson, with about 10% of market share, received a call every 7–8 minutes about one of their guns (Kairys, 2008). Thus, one could reasonably expect that manufacturers would have some knowledge of which distributors sell guns that are disproportionately used in crime, and distributors would, in turn, know which retailers disproportionately sell guns used in crime.

Following in the footsteps of cities and states that had successfully sued the tobacco industry under state consumer protection and antitrust laws for costs the public incurred in caring for smokers, beginning in the late 1990s cities and states began to file claims against firearm manufacturers in an attempt to recover the costs of gun violence they incurred. In response, in 2005, Congress enacted and President George W. Bush signed the Protection of Lawful Commerce in Arms Act, which prohibits civil liability lawsuits against “manufacturers, distributors, dealers, or importers of firearms or ammunition for damages, injunctive or other relief resulting from the misuse of their products by others” (15 U.S.C. §§ 7901–7903). Thus, the option of using litigation, a long-standing and sometimes controversial tool by which to address entrenched public health problems (e.g., Lytton, 2004), was severely restricted.

ADVERTISING

Advertisements for guns have largely disappeared from classified ads in newspapers. By contrast, advertising in magazines, specifically gun magazines, is strong (Saylor, Vittes, & Sorenson, 2004). Such advertising is subject to the same Federal Trade Commission (FTC) regulations as other consumer products. In 1996, several organizations filed a complaint with the FTC after documenting multiple cases of what they asserted to be false and misleading claims about home protection (for specific examples, see Vernick, Teret, & Webster, 1997). As of November 1, 2013, the FTC had not

ruled on the complaint. However, the firearm industry changed its practices such that by 2002, self-protection was an infrequent theme in advertisements for guns (Saylor et al., 2004). To our knowledge, current advertising has not been studied. New issues relevant to the advertising of guns include online advertisements by private sellers who are not obligated to verify that purchasers have passed a background check, online ads from prohibited purchasers seeking to buy firearms, the marketing of military-style weapons to civilians, and the marketing of firearms to underage youth (for examples and more information, see Kessler & Trumble, 2013; Mayors Against Illegal Guns, 2013; McIntire, 2013; Violence Policy Center, 2011).

SALES AND PURCHASES

Gun sales have been increasing in the United States. The FBI reported a substantial jump in background checks (a proxy for gun sales) in the days following the Sandy Hook Elementary School shootings. In fact, of the 10 days with the most requests for background checks since the FBI started monitoring such information, 7 of them were within 8 days of Sandy Hook (FBI, 2013). Guns can be purchased from federally licensed firearm dealers or private, unlicensed sellers in a variety of settings, including gun shows, flea markets, and the Internet.

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Responsible sales practices (for examples, see Mayors Against Illegal Guns, n.d.) rely heavily on the integrity of the seller. And usually that responsibility is well placed: Over half (57%) of the guns traced (i.e., submitted by law enforcement, usually in association with a crime, to determine the original purchaser of the weapon) were originally sold by only 1.2% of federally licensed firearm dealers (Bureau of Alcohol, Tobacco and Firearms [ATF], 2000). However, there are problems. Sometimes a person who is prohibited from purchasing a gun engages someone else, who is not so prohibited, to purchase a gun for him or her. The person doing the buying is called a “straw purchaser.” Straw purchase attempts are not uncommon; in a random sample of 1,601 licensed dealers and pawnbrokers in 43 states, two thirds reported experiencing straw purchase attempts (Wintemute, 2013b).

Two studies tested the integrity of licensed firearm dealers by calling the dealers and asking whether they could purchase a handgun on behalf of someone else (in the studies, a boyfriend or girlfriend), a straw purchase transaction that is illegal. In the study of a sample of gun dealers listed in telephone directories of the 20 largest U.S. cities, the majority of gun dealers indicated a willingness to sell a handgun under the illegal straw purchase scenario (Sorenson & Vittes, 2003). In a similar study of licensed gun dealers in California, a state with relatively strong regulation and oversight of licensed gun dealers, one in five dealers expressed a willingness to make the illegal sale (Wintemute, 2010). Programs such as the ATF and National Sports Shooting Council's "Don't Lie for the Other Guy," which provides posters and educational materials to display in gun stores as well as tips for gun dealers on how to identify and respond to straw purchase attempts, have not been evaluated.

It is important to be able to identify high-risk dealers because, in 2012, the ATF had insufficient resources to monitor federally licensed gun dealers (Horwitz, 2012); there were 134,997 unlicensed gun dealers in April 2013 (ATF, 2013). Some states have recognized the limited capacity of the ATF and the weaknesses of federal laws regulating gun dealers and enacted their own laws requiring the licensing, regulation, and oversight of gun dealers (Vernick, Webster, & Bulzacchelli, 2006) and, when enforced, these laws appear to reduce the diversion of guns to criminals shortly after a retail sale (Webster, Vernick, & Bulzacchelli, 2009). Undercover stings and lawsuits against gun dealers who facilitate illegal straw sales have also been shown to reduce the diversion of guns to criminals (Webster, Bulzacchelli, Zeoli, & Vernick, 2006; Webster & Vernick, 2013b).

Misdemeanants who were legally able to purchase handguns committed crimes involving violence following those purchases at a rate 2–10 times higher than that of handgun purchasers with no prior convictions.

To help ensure that guns are not sold to those who are prohibited from purchasing them, the National Instant Criminal Background Check System ([NICS], part of the Brady Law) was developed so that the status of a potential purchaser could be checked immediately by a federally licensed firearm dealer. Prohibited purchasers include, but are not limited to, convicted felons, persons dishonorably discharged from the military, those under a domestic violence restraining

order, and, in the language of the federal law, persons who have been adjudicated as mentally defective or have been committed to any mental institution (see 18 U.S.C. § 922(g) (1)–(9) and (n)). About 0.6% of sales have been denied on the basis of these criteria since NICS was established in 1998 (FBI, 2012b).

A substantial portion of firearm sales and transfers, however, is not required to go through a federally licensed dealer or a background check requirement; this includes, in most U.S. states, private party sales including those that are advertised on the Internet and those that take place at gun shows where licensed gun dealers who could process background checks are steps away. Some evidence suggests that state policies regulating private handgun sales reduce the diversion of guns to criminals (Vittes, Vernick, & Webster, 2013; Webster et al., 2009; Webster, Vernick, McGinty, & Alcorn, 2013).

The ability to check the background of a potential purchaser nearly instantly means that in many states, someone who is not a prohibited purchaser can purchase a gun within a matter of minutes. Ten states and the District of Columbia have a waiting period (sometimes referred to as a "cooling-off" period) for handguns ranging from 3 (Florida and Iowa) to 14 (Hawaii) days (Law Center to Prevent Gun Violence, 2012). The efficacy of waiting periods has received little direct research attention.

With the exception of misdemeanor domestic violence assault, federal law and laws in most states prohibit firearm possession of those convicted of a crime only if the convictions are for felony offenses in adult courts. Research has shown that misdemeanants who were legally able to purchase handguns committed crimes involving violence following those purchases at a rate 2–10 times higher than that of handgun purchasers with no prior convictions (Wintemute, Drake, Beaumont, & Wright, 1998). Wintemute and colleagues (Wintemute, Wright, Drake, & Beaumont, 2001) examined the impact of a California law that expanded firearm prohibitions to include persons convicted of misdemeanor crimes of violence. In their study of legal handgun purchasers with criminal histories of misdemeanor violence before and after the law, denial of handgun purchases due to a prior misdemeanor conviction was associated with a significantly lower rate of subsequent violent offending.

Persons who are legally determined to be a danger to others or to themselves as a result of mental illness are prohibited by federal law from purchasing and possessing firearms. A significant impediment to successful implementation of this law is that the firearm disqualifications due to mental illness often are not reported to the FBI's background check system. As mentioned in Chapter 4, in 2007 Connecticut began reporting

these disqualifications to the background check system. In a ground-breaking study, Swanson and colleagues (2013) studied the effects of this policy change on individuals who would most likely be affected—that is, those who were legally prohibited from possessing firearms due solely to the danger posed by their mental illnesses. They found that the rate of violent crime offending was about half as high among those whose mental illness disqualification was reported to the background system compared with those whose mental illness disqualification was not reported.

Federal law allows an individual to buy several guns, even hundreds, at once; the only requirement is that a multiple-purchase form be completed (18 U.S.C. § 923(g)(3)(A)(2009)). Large bulk purchases have been linked to gun trafficking (Koper, 2005). Policies such as one-handgun-a-month have rarely been enacted. Evaluations of these laws document mixed findings (Webster et al., 2009, 2013; Weil & Knox, 1996).

The United States was one of the signers of the Geneva Convention, which prohibits the use of hollow-point bullets in war (the goal being to wound but not kill wartime enemies), but hollow-point bullets are available to civilians in the United States. A hunting license is not a prerequisite for the purchase of hollow-point bullets in the United States. California passed a law requiring a thumbprint for ammunition purchases; the law was ruled “unconstitutionally vague” by a Superior Court judge in 2011, but some municipalities (e.g., Los Angeles, Sacramento) have similar local ordinances in effect.

OWNER

In 2004, a national survey found that 20% of the U.S. adult population reported they own one or more long-guns (shotguns or rifles), and 16% reported they own a handgun (Hepburn et al., 2007). Self-protection was the primary reason for owning a gun. Most people who have a gun have multiple guns, and half of gun owners reported owning four or more guns. In fact, 4% of the population is estimated to own 65% of the guns in the nation.

Nationally representative studies suggest that the mental health of gun owners is similar to that of individuals who do not own guns (Miller, Barber, Azrael, Hemenway, & Molnar, 2009; Sorenson & Vettes, 2008). However, gun owners are more likely to binge drink and drink and drive (Wintemute, 2011).

In perhaps the methodologically strongest study to date to examine handgun ownership and mortality, Wintemute and colleagues found a strong association between the purchase of a handgun and suicide: “In the first year after the purchase of a handgun, suicide was the leading cause of death among

handgun purchasers, accounting for 24.5 percent of all deaths” (Wintemute, Parham, Beaumont, Wright, & Drake, 1999). The risk of suicide remained elevated (nearly twofold and sevenfold, respectively, for male and female handgun purchasers) at the end of the 6-year study period. Men’s handgun purchase was associated with a reduced risk of becoming a homicide victim (0.69); women’s handgun purchase, by contrast, was associated with a 55% increase in risk of becoming a homicide victim. A waiting period may reduce immediate risk but appears not to eliminate short- or long-term risk for suicide.

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Risk can extend to others in the home. Efforts to educate children about guns (largely to stay away from them), when tested with field experiments, indicate they are generally ineffective (e.g., Hardy, 2002). Child Access Prevention (CAP) laws focus on the responsibilities of adults; adults are held criminally liable for unsafe storage of firearms around children. CAP laws have been associated with modest decreases in unintentional shootings of children and the suicides of adolescents (Webster & Starnes, 2000; Webster, Vernick, Zeoli, & Manganello, 2004).

USER

Most gun-related laws focus on the user of the gun (e.g., increased penalties for using a gun in the commission of a crime). Some research suggests that having been threatened with a gun, as well as the perpetrator’s having access to a gun and using a gun during the fatal incident, is associated with increased risk of women becoming victims of intimate partner homicide (Campbell et al., 2003). Regarding sales, note that persons with a domestic violence misdemeanor or under a domestic violence restraining order are prohibited by federal law from purchasing and possessing a firearm and ammunition. Research to date indicates that firearm restrictions for persons subject to such laws have reduced intimate partner homicides by 6% to 19% (Vigdor & Mercy, 2006; Zeoli & Webster, 2010).

As with initial discussions about motor vehicle safety, which focused on what was then referred to as the “nut behind the wheel,” current discussions about gun users sometimes involve terms such as “good guys” and “bad guys.” Although intuitively appealing, such categories seem to assume a static label and do not take into account the fact that “good guys” can become “bad guys” and “bad guys” can become “good guys.” One way an armed “good guy” can become a “bad guy” is to use a gun in a moment of temporary despondence or rage (Bandeira, 2013; Wintemute, 2013a).

Research on near-miss suicide attempts among young adults indicates that impulsivity is of concern. About one fourth of those whose suicide attempt was so severe they most likely would have died reported first thinking about suicide 5 minutes before attempting it.

Research on near-miss suicide attempts among young adults indicates that impulsivity is of concern. About one fourth of those whose suicide attempt was so severe they most likely would have died reported first thinking about suicide 5 minutes before attempting it (Simon et al., 2001). Although an estimated 90% of those who attempt suicide go on to die of something else (i.e., they do not subsequently kill themselves; for a review, see Bostwick & Pankratz, 2000), for those who use a gun, as noted in opening paragraph of this chapter, there generally is not a second chance.

CONCLUSION

Given the complexity of the issue, a multifaceted approach will be needed to reduce firearm-related violence (see, for example, Chapman & Alpers, 2013). Not all ideas that on the surface seem to be useful actually are. For example, gun buyback programs may raise awareness of guns and gun violence in a community but have not been shown to reduce mortality (Makarios & Pratt, 2012). Such data can inform policy. President Obama’s January 2013 executive orders about gun violence include directing the CDC to research the causes and prevention of gun violence. The federal government has since announced several funding opportunities for research related to gun violence. And the recent Institute of Medicine and National Research Council (2013) report called for lifting access restrictions on gun-related administrative data (e.g., data related to dealers’ compliance with firearm sales laws, gun trace

data) that could be used to identify potential intervention and prevention points and strategies. So perhaps more data will be available to inform and evaluate policies designed to reduce gun violence.

The focus of this section has largely been on mortality. The scope of the problem is far greater, however. For every person who dies of a gunshot wound, there are an estimated 2.25 people who are hospitalized or receive emergency medical treatment for a nonfatal gunshot wound (Gotsch, Annest, Mercy, & Ryan, 2001). And guns are used in the street and in the home to intimidate and coerce (e.g., Sorenson & Wiebe, 2004; Truman, 2011).

Single policies implemented by themselves have been shown to reduce certain forms of gun violence in the United States. Adequate implementation and enforcement as well as addressing multiple intervention points simultaneously may improve the efficacy of these laws even more. After motor vehicle safety efforts expanded to include the vehicle, roadways, and other intervention points (vs. a focus on individual behavior), motor vehicle deaths dropped precipitously and continue to decline (CDC, 1999, 2013a). A multifaceted approach to reducing gun violence will serve the nation well.

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V.

APA Written Statement of Gwendolyn Puryear Keita, PhD, for
President's Task Force on 21st Century Policing

<http://www.apa.org/about/gr/pi/news/2015/police-community-comments.aspx>

APA Written Statement of Gwendolyn Puryear Keita, PhD, for President's Task Force on 21st Century Policing

Feb. 17, 2015

Commissioner Ramsey, Ms. Robinson, and members of the Task Force, thank you for the opportunity to submit comments on behalf of the nearly 130,000 members and affiliates of the American Psychological Association (APA). APA is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. Comprised of researchers, educators, clinicians, consultants, and students, our association works to advance psychology as a science, a profession, and as a means of promoting health, education, and human welfare.

APA has long been committed to human rights and to ensuring that bias based on ethnicity, race, gender and gender identity, age, disability status, and sexual orientation is eliminated from government policies and actions. To that end our association has issued a variety of policy statements and supported federal policies to eliminate ethnic and racial discrimination, racial profiling, and supporting full access of all Americans to the benefits of our society.

APA is committed to policies that ensure that all Americans are treated fairly under the law. Psychological research can provide insights to better understand these issues and inform possible remedies. Our comments will highlight the importance of psychological research in building positive relationship between police and communities of color as well as providing support to those in law enforcement.

First, APA would like to thank the Task Force for already recognizing the contribution of psychology and social and behavioral science. The testimony of Jennifer Eberhardt, PhD and Tom Tyler, PhD, JD highlights the importance of psychological research on perception, implicit bias, and equitable policing on police departments and the communities they serve. Our statement is based on their work and that of other psychologists. The Task Force clearly understands that collaboration between psychologists and other behavioral scientists and law enforcement are essential for resolving these problems. Deputy Chief Alexander, a member of the Task Force, with long service in law enforcement and who holds a doctorate in psychology clearly personifies that cross-fertilization.

Psychological research can provide direction for law enforcement efforts to reduce crime and increase community trust. In recent years, there have been repeated instances of violent conflicts between police and civilians, most recently involving police officers and people of color. Events such as Ferguson, MO, and Staten Island, NY reflect a relationship between the police and particular communities that is characterized by mutual mistrust. The police are suspicious of the members of the community, while members of the community have low levels of trust in the motives of the police. Public distrust of the police is important because research shows that low trust leads to high conflict.

Public mistrust of the police has been reinforced in recent years as the "broken windows" approach to policing has gained ascendancy. Under this approach, the police seek to maintain order by focusing upon confronting, questioning, searching, and arresting large numbers of civilians on the street who are committing minor crimes. The broken windows model of policing justifies the widespread practice of repeatedly stopping, questioning, frisking, and often detaining and arresting members of the community, in particular the African-American and Latino communities, in an effort to reduce crime. The police in many cities have dropped any pretext of stopping only those who are actually involved in criminal activity, however minor. Instead, they repeatedly stop innocent community residents on the streets and through their actions create fear, which they believe deters criminal behavior. While the police defend their current practices as necessary, these practices have not been shown to lower the rate of crime.

Research shows that a key factor shaping whether people obey the law is whether they trust the law and legal authorities. Studies of the police indicate that whether people break the law and commit crimes is more strongly shaped by whether people trust the police than by whether people believe that they are likely to be caught and punished if they break the law. Distrust also makes controlling crime more difficult because it lowers the willingness of community members to help the police solve crimes or identify criminals. In the absence of trust, events of this type too often escalate to violence. Lacking faith in the intentions of the authorities, people give in to expressions of frustration and anger. As was demonstrated in Ferguson, it is difficult to foster trust after such events have occurred, if the police have not worked to develop relationships and build trust in advance.

How can the police build trust? A number of studies consistently show that the most important factors related to public evaluations of the police are whether they believe that the police are exercising their authority fairly. This means that police are not making decisions about who to stop based upon race; that they are willing to listen to people when they stop them; that they apply the law consistently and without prejudice; and that they take time to explain the reasons for their actions. Most importantly, the police need to treat people in the community with respect and courtesy.

Going forward, psychological research indicates that effective strategies to prevent events such as those that occurred in Ferguson, MO, include: collaborative police-community partnerships, procedurally fair applications of the law, community outreach activities, including community education; recruitment strategies to ensure that the police department reflects the demographics of the community, and training to reduce police and community stereotypes.

These policies are present in community oriented policing, which exemplifies a philosophy that addresses public safety by promoting organizational strategies that support systematic collaborative partnerships to engage in problem solving. This approach stresses law enforcement activities such as community outreach, communication, and participation. These types of activities emphasize police and community partnerships and dialogue.

Equally important, communities must recognize the challenges facing police and the stress and dangers they face. Beginning during the selection phase, initial training for officers, and continued through in-service, roll-call, supervisor and management training, it is beneficial to incorporate behavioral health concepts and information about coping methods, responding to stress, as well as supporting others (e.g. family and friends) within the police community. Such training helps prepare new officers for the demands of their career, encourages existing officers to utilize tools and resources to deal with on-going challenges, and reminds supervisors and managers to focus on the well-being of their employees. It is very useful to have the psychologist/behavioral health specialists who provide services to the agency involved in the trainings, so that they are familiar to the employees and knowledgeable about the workings of the agency.

For example, Lorraine Greene, PhD is a police psychologist who served as the first manager of the Nashville police department's behavioral health services division. With her involvement and the support of the department leadership a variety of initiatives were launched to improve police-community relations. Initiatives included surveying community members and holding focus groups of police officers, local residents and researchers. The data collected was then used to create training for police and citizens, as well, which lead to better mutual understanding. In addition, Dr. Greene has collaborated with fellow police psychologist Ellen Kirschman, PhD to develop resources for families of police officers including mental health information and access to online family support services. Increasing the emotional supports available to police offices, reducing stress experienced by families and improving morale and reducing burn-out can lead to better policing and potentially reduce conflictual police-community encounters.

Recommendations

APA recommends that law enforcement agencies increase the number of mental health professionals on staff. Mental and behavioral health professionals can provide training and resources to help identify and diffuse potential conflicts between law enforcement and the community. They are also skilled in identifying and addressing issues affecting police officers and staff including stress and trauma and family support and education. Recognizing the challenges of 21 st Century policing for law enforcement personnel can reduce the stress of policing and improve the ability of police to respond to community challenges.

To that end, law enforcement agencies can benefit from involving highly knowledgeable and skilled police and public safety psychologists as part of multidisciplinary teams to address the needs of implementing constitutional policing through police reform. Whether hiring the right people, training them appropriately, providing wellness services, or engaging in a range of organizational transformations that increase transparency and accountability to the community, psychologists' professional expertise and research evidence may prove particularly valuable to those agencies mandated to make change in accordance with a DOJ Consent Decree or Memorandum of Agreement. Or, to those agencies that seek to implement police reforms in order to create stronger organizations devoted to policing within the rule of law with respect for the constitutional rights of all people in communities across the country. These relationships can take the form of private/public partnerships between mental health organizations in the public and private sector and local law enforcement. These partnerships can develop best practices for addressing community and police relations that can be disseminated widely across the nation to police departments and mental health facilities.

In closing, knowledge gained from psychological research can be used to address community concerns about the police while providing support and training to law enforcement. APA and the psychological community stand ready to work with the task force and the administration on these important issues.

If you have any questions or comments, please feel free to contact [Stefanie Reeves](#), MA, Senior Legislative and Federal Affairs Officer or [Judith M. Glassgold](#), PsyD, Associate Executive Director in APA's Public Interest Government Relations Office.

Find this article at:

<http://www.apa.org/about/gr/pi/news/2015/police-community-comments.aspx>

VI.

Written Statement of the American Psychological Association at a Hearing "The State of Civil and Human Rights in the United States"

Source: American Psychological Association Public Interest Directorate website

<http://www.apa.org/about/gr/pi/news/2014/testimony-police-relations.aspx>

Written Statement of the American Psychological Association at a Hearing "The State of Civil and Human Rights in the United States"

U.S. Senate Judiciary Subcommittee on the Constitution, Civil Rights and Human Rights

Dec. 9, 2014

The 132,000 members and affiliates of the American Psychological Association (APA) thank Chairman Durbin, Ranking Member Cruz, and members of the Subcommittee on the Constitution, Civil Rights, and Human Rights for the opportunity to submit testimony for the hearing entitled "The State of Civil and Human Rights in the United States." APA is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. Comprising researchers, educators, clinicians, consultants, and students, our association works to advance psychology as a science, a profession, and as a means of promoting health, education, and human welfare.

Introduction

APA has long been committed to advancing civil and human rights and to ensuring that bias based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language and socioeconomic status is eliminated. To that end, our association has issued [policy statements](#), filed [amicus briefs](#), and [supported federal policies](#) that aim to eliminate discrimination, reduce the impact of social stigma and prejudice, and support civil and human rights. APA welcomes the opportunity to highlight some of our efforts on pressing civil and human rights concerns and to present an evidenced-based perspective on related policy issues.

Psychological research provides insights into many areas of civil and human rights that can inform policy development. One of the earliest applications of psychological research to address civil and human rights focused on the effects of segregated schools on African American children. In the 1940's and 1950's, Drs. Kenneth and Mamie Clark found that segregation harmed African American children and led to feelings of inferiority.ⁱ Their work influenced lower court rulings and was cited in the *Brown v. Board of Education* decision finding school segregation unconstitutional. Chief Justice Warren stressed these findings in his opinion: "To separate them [children] from others of similar age and qualifications solely because of their race generates a feeling of inferiority as to their status in the community that may affect their hearts and minds in a way unlikely to ever be undone."ⁱⁱ

Modern day psychological research continues to wield significant influence. Some of APA's current applications of research to inform federal civil and human rights policies include:

- The protection of [children and youth](#) in juvenile justice and child welfare settings, including protection from violence, adequate mental health and physical health treatment, and protection from cruel and unusual punishment in sentencing (i.e., the consideration of the death penalty and life imprisonment).
- Ensuring that children and youth in juvenile justice, child welfare, and educational settings are treated equitably, and have developmentally-appropriate behavioral health treatment.
- Contributing to the welfare of individuals with disabilities and those with mental illness, providing psychological evidence to support the position that involuntarily-committed patients of mental institutions who were deprived of adequate treatment were being deprived of liberty without due process.
- Providing psychological evidence regarding whether individuals with intellectual disabilities possess adequate culpability to be subject to the death penalty.
- Based on psychological research, joining with disability, veterans and civil rights groups calling on the U.S. Senate to ratify the UN Convention on the Rights of Persons with Disabilities.
- Combatting prejudice, stereotypes and discrimination of ethnic and racial minorities, through research on the psychological underpinnings of racial discrimination and racial profiling. APA issued a report "[Dual Pathways to a Better America: Preventing Discrimination and Promoting Diversity](#)" that clearly explains the nature of prejudice and offers tools to mitigate its effects.
- Contributing research evidence on how diversity in education benefits both majority and minority groups. Psychological research has found that: a) underrepresentation of minority groups can inhibit academic performance, foster prejudice and hinder cognitive function; and, b) subconscious racial bias can interfere with the effective education of nonminority students.
- Applying psychological research to policies on the [equal rights for women](#) (PDF, 251KB), including education, employment, civil rights, preventing violence against women. Psychological research contributes relevant information on current policy initiatives on workplace fairness, sexual harassment and violence on college campuses, and human trafficking.
- Ensuring that public policy reflects scientific findings on human sexual orientation. APA has applied psychological research to the civil and human rights of all individuals regardless of [sexual orientation](#), APA has filed [amicus briefs](#) that oppose the criminalization of homosexuality and discrimination based on sexual orientation and gender identity in education, employment, and in military service. APA continues to provide research evidence to inform civil rights issues such as federal protections against employment discrimination and the right to marry.

Psychological research is particularly relevant to this hearing's focus. For over fifty years, psychology has studied the nature of prejudice and stereotypes and their impact on shaping human actions, emotions, and judgments. Psychological research has also explored how to mitigate the influence of prejudice and stereotypes on human and

organizational behaviors. Thus, psychological research can inform our understanding of racial profiling, police-community relations, criminal justice policies, educational policies, employment discrimination, and workforce policies. By providing tools for change, as well as evidence-based analysis, psychological research can play a role in advancing civil and human rights.

Additionally, the psychological research literature clarifies the negative effects of prejudice, discrimination and perceived discrimination on mental and physical health.^{iv} Perceived discrimination produces significantly heightened stress responses and is related to participation in unhealthy behaviors and nonparticipation in healthy behaviors. Additionally, increased stress due to violence, harassment and other factors can contribute to poor mental and physical health in minority communities.

Given the recent events and public concern regarding racial tensions and police-community relations, this testimony will now highlight the relevant psychological literature on prejudice and police/community relations, including: a) the nature of bias, prejudice, and stereotyping, including implicit prejudice; b) evidence-based strategies for bias reduction, and c) policy strategies to enhance civil rights.

Research on Bias, Prejudice and Stereotyping

Understanding Prejudice

Prejudice is commonly defined as an unfair negative feeling or attitude toward a social group or a member of that group. Stereotypes are overgeneralizations about a group or its members that are factually incorrect and excessively rigid and are a set of beliefs that accompany prejudices.^v Overt expressions of prejudice have declined in the United States over the last fifty years; however, contemporary forms of prejudice continue to exist in more subtle and nuanced forms. There is substantial psychological research demonstrating that even well intentioned and non-prejudiced people have biases that are unconscious and these are considered to be a human attribute, termed "implicit" bias.^{vi} Implicit biases are beliefs (stereotypes) and feelings (prejudice) that are activated without intent and control and are often outside of conscious awareness and with limited conscious control. For example, Dr. Jennifer Eberhardt (Stanford University) found that simply viewing an African American man's face made people (including police officers) more likely to "perceive" a gun that wasn't there.^{vii} Dr. Phillip Atiba Goff's (UCLA) research showed that police officers and others saw African American boys — as young as 10 — as older and less innocent than white boys the same age.^{viii} A recent research study found that white subjects who saw pictures of African American voters were more likely to express support for voter ID laws than those who did not see such an image, or saw an image of a white individual, indicating that voter ID laws may become influenced by racial stereotypes.^{ix}

Evidence-Based Strategies for Bias Reduction

There are different evidence-based approaches to reducing prejudice. The more explicit form of prejudice can be reduced by providing educational strategies that improve knowledge and appreciation of other groups, including counter-stereotypic information about group members.^x Implicit prejudice is more complex to address, as many individuals who endorse egalitarian, non-prejudiced views may be shaped by unconscious stereotyped attitudes. In many instances, revealing implicit prejudices to the individual can lead to self-knowledge and personal change,^{xi} however, positive intergroup contacts, under certain conditions, can reduce prejudice more broadly than individual interventions. Activities that are sanctioned by authorities, increase personal acquaintance, have egalitarian norms, and encourage cooperative intergroup interactions toward mutual goals have been shown to reduce implicit prejudices.^{xii} Such activities are common in certain work environments, but can also be created through community activities, including community-police partnerships.

Not all intergroup contacts with different groups lead to positive outcomes. Some studies indicate that certain types of contacts can reaffirm stereotypes.^{xiii} Interpersonal interactions that leave an individual uncomfortable, angry, and scared or reaffirm stereotypes can increase prejudice. This research can help explain the potential negative effects of conflict-oriented police-community interactions. Police-community interactions that focus on crime prevention, such as command and control approaches or "stop and frisk policies," may reaffirm stereotypic beliefs on both sides.

Other interactions such as policy-community partnerships encouraged by the Community Oriented Policing Office (COPS) of the Department of Justice (e.g., athletic leagues) can decrease stereotypes.

Policy Strategies to Enhance Civil Rights^{xiv}

Psychological research can also provide direction for law enforcement efforts to reduce crime and increase community trust. In recent years, there have been repeated instances of violent conflicts between police and civilians, most frequently involving police officers and young minority men.

These events reflect a conflictual relationship between the police and the public that is characterized by mutual mistrust. The police are suspicious of the people they deal with on the street, while members of the public have low levels of trust in the motives of the police. This is particularly true of the members of minority groups, who are found to be 20-30% less likely than Whites to indicate that they have confidence in the police.^{xv}

Public distrust of the police is important because research shows that low trust leads to high conflict. People on the street who mistrust the police are more likely to push back against police authority, to become angry and confrontational, and to engage in verbal and physical combat with police officers rather than accept police authority. Police officers who distrust the public are more likely to engage in tactics of domination and

intimidation backed by the threat or use of force, which then can escalate tension and heighten the likelihood of violent confrontation and conflict. The events in Ferguson reflect the consequences of a general climate of mistrust in the police that is commonly found in minority communities. Similar events can and have occurred in any number of American cities.

Public mistrust of the police has been reinforced in recent years as the "broken windows" view of policing has gained ascendancy. Under this approach, the police seek to maintain order by focusing upon confronting, questioning, searching, and arresting large numbers of civilians on the street who are committing minor crimes. The broken windows model of policing justifies the widespread practice of repeatedly stopping, questioning, frisking, and often detaining and arresting members of the community, in particular the African-American community, in an effort to reduce crime. The police in many cities have dropped any pretext of stopping only those who are actually involved in criminal activity, however minor. Instead, they repeatedly stop innocent community residents on the streets and through their actions create fear, which they believe deters criminal behavior.

While the police defend their current practices as necessary, these practices have not been shown to lower the rate of crime. Research shows that a key factor shaping whether people obey the law is whether they trust the law and legal authorities. Studies of the police indicate that whether people break the law and commit crimes is more strongly shaped by whether people trust the police than by whether people believe that they are likely to be caught and punished if they break the law. Distrust also makes controlling crime more difficult because it lowers the willingness of community members to help the police solve crimes or identify criminals. In the absence of trust, events of this type too often escalate to violence. Lacking faith in the intentions of the authorities, people give in to expressions of frustration and anger. As was demonstrated in Ferguson, it is difficult to foster trust after such events have occurred, if the police have not worked to develop relationships and build trust in advance.

How can the police build trust? A number of studies consistently show that the most important factors related to public evaluations of the police are whether they believe that the police are exercising their authority fairly.^{xvi} This means that police are not making decisions about who to stop based upon race; that they are willing to listen to people when they stop them; that they apply the law consistently and without prejudice; and that they take time to explain the reasons for their actions. Most importantly, the police need to treat people in the community with respect and courtesy.

Going forward, psychological research indicates that effective strategies to prevent events such as those that occurred in Ferguson, MO, include: collaborative police-community partnerships, procedurally fair applications of the law, community outreach activities, including community education; recruitment strategies to ensure that the police department reflects the demographics of the community, and training to reduce police and community stereotypes.

These policies are present in community oriented policing, which exemplifies a philosophy that addresses public safety by promoting organizational strategies that support systematic collaborative partnerships to engage in problem solving. This approach stresses law enforcement activities such as community outreach, communication, and participation. These types of activities emphasize police and community partnerships and dialogue. The COPS program is an excellent example of this approach and provides grants to states, local governments, and tribal authorities to implement these policies. The DOJ Community Relations Service (CRS) helps local communities address community conflicts and tensions arising from differences.

Recommendations

The APA recommends that the following policies be adopted at both the state and federal level to enhance law enforcement and community relations, improve public safety, and reduce the risks of violence and escalation of aggression that can emerge from the militarization of law enforcement.

- Encourage the development of community-driven responses that empower communities with limited resources to advocate for the resources they need, including improved policing and more accountability (e.g., citizen representation on review boards);
- Implement community-based policing nationwide and train law enforcement personnel on how stereotypes, including implicit bias, affect their and others' perceptions and decisions;
- Require law enforcement departments that receive supplies and military equipment to implement community-based policies, procedural justice initiatives, and training on bias-free policing;
- Provide support to Department of Justice initiatives such as COPS and CRS;
- Collect complete data at the federal level on all police shootings and on the racial/ethnic makeup of citizens involved in incidents, such as "stop-and-frisk," to better understand these issues.

In closing, knowledge gained from psychological research can inform public policies to improve the lives of all Americans and protect and enhance human rights. APA and the psychological community stand ready to work with Congress to advance civil and human rights.

For further information or questions, please contact [Judith M. Glassgold](#), PsyD, Associate Executive Director, Government Relations, Public Interest Directorate, 202-336-6104).

Footnotes

ⁱClark, K. B. and Clark, M. P. (1947). "Racial identification and preference among negro children." In E. L. Hartley (Ed.) *Readings in Social Psychology*. New York: Holt, Rinehart, and Winston.<http://i2.cdn.turner.com/cnn/2010/images/05/13/doll.study.1947.pdf>

ⁱⁱhttp://www.encyclopedia.com/topic/Kenneth_Bancroft_Clark.aspx#1-1G2:2870700021-full

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^xDovidio, J.F. and Gaertner, S.L. (nd). Reducing prejudice: Combating intergroup biases. <http://www.snow.edu/davida/2400/reducing.pdf> .

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^{xiii}Stephan, W. G., et al. (2002). The role of threats in the racial attitudes of blacks and white. *Personality and Social Psychology Bulletin*, 28 , 1242-1254.

^{xiv}The following section is based on the work of Tom Tyler, Yale Law School and Department of Psychology Yale University.

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^{xvi}Tyler, T.R. (2001). Trust and law abiding behavior. Building better relationships between the police, the courts, and the minority community. *Boston University Law Review*, 81, 361-406.

Find this article at:

<http://www.apa.org/about/gr/pi/news/2014/testimony-police-relations.aspx>

VII.

IMPROVING RESPONSES TO PEOPLE WITH MENTAL
ILLNESS: TAILORING LAW ENFORCEMENT
INITIATIVES TO INDIVIDUAL JURISDICTIONS:
US DEPARTMENT OF JUSTICE
BUREAU OF JUSTICE ASSISTANCE

<http://csgjusticecenter.org/law-enforcement/publications/improving-responses-to-people-with-mental-illnesses-tailoring-law-enforcement-initiatives-to-individual-jurisdictions/>

Improving Responses to People with Mental Illnesses

Tailoring Law Enforcement
Initiatives to Individual Jurisdictions



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Bureau of Justice Assistance
U.S. Department of Justice

JUSTICE ★ **CENTER**
THE COUNCIL OF STATE GOVERNMENTS

Improving Responses to People with Mental Illnesses

Tailoring Law Enforcement Initiatives to Individual Jurisdictions

A report prepared by the
Council of State Governments Justice Center
and the Police Executive Research Forum

for the

Bureau of Justice Assistance
Office of Justice Programs
U.S. Department of Justice

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 - Deputy Chief Dottie Davis, Director of Training, Fort Wayne (Ind.) Police Department
 - Captain Richard Wall, Los Angeles (Calif.) Police Department
 - Sergeant Michael Yohe, CIT Coordinator, Akron (Ohio) Police Department
- (A complete list of contributors, by jurisdiction, can be found in appendix A.)

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- Baltimore County (Md.) Police Department
- Birmingham (Ala.) Police Department
- City of Lorain (Ohio) Police Department
- Fort Lauderdale (Fla.) Police Department
- Houston (Tex.) Police Department
- Jackson County (Mo.) Sheriff’s Office
- Jacksonville (Fla.) Sheriff’s Office
- Kansas City (Mo.) Police Department

*Representatives’ titles and agency affiliations reflect the positions they held at the time this document was published, which may differ from titles listed in appendix A.

- Lees Summit (Mo.) Police Department
- Lincoln (Nebr.) Police Department
- Long Beach (Calif.) Police Department
- Montgomery County (Md.) Police Department
- New London (Conn.) Police Department
- Portland (Ore.) Police Bureau
- Portland (Maine) Police Department
- San Diego (Calif.) City Police and County Sheriff's Department

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Introduction

A growing number of law enforcement agencies have partnered with mental health agencies and community groups to design and implement innovative programs to improve encounters involving people with mental illnesses. These “specialized policing responses” (SPRs) are designed to produce better outcomes from these encounters by training responders to use crisis de-escalation strategies and prioritize treatment over incarceration when appropriate.¹

Effective SPRs share many common features, but programs also differ in some important ways. These programmatic variations generally stem from a community’s unique needs, opportunities, and limitations. For example, officers in rural areas may have difficulty connecting people to a full range of mental health services, whereas officers in large urban areas may spend hours out of service trying to transport people to mental health facilities through traffic-congested areas. Some jurisdictions may spend tremendous resources responding repeatedly to a small number of locations or individuals. Other communities may face significant concerns about responding appropriately to particular groups of individuals, such as people with mental illnesses who are homeless.

SPOTLIGHT

Different Jurisdictions, Different Program Models

Two of the most common law enforcement-based specialized response programs are the Crisis Intervention Team (CIT) model and the co-responder model. Each program model was developed based on a jurisdiction’s unique circumstances, reflecting the need for a flexible decision-making process.

Memphis (Tenn.) police leaders, mental health professionals and advocates, city hall officials, and other key stakeholders were spurred to action following a tragic incident in which an officer killed a person with a mental illness. In response, the Memphis Police Department established the first law enforcement-based CIT in 1988, which was designed to improve safety during these encounters by enhancing officers’ ability to de-escalate the situation and providing community-based treatment alternatives to incarceration.

Los Angeles and San Diego (Calif.) initiative leaders recognized that officers encountered many people with mental illnesses who were not engaged with treatments and services. To address this problem, law enforcement agencies collaborated with the mental health community to form teams in which officers and treatment professionals respond together at the scene to connect these individuals with community-based services more effectively.

1. There has been a trend toward categorizing any response in which law enforcement plays a central role in addressing people with mental illnesses as a “crisis intervention team (CIT)” approach. To avoid confusion, this publication refers to all law enforcement-based responses as “specialized policing responses” or SPRs (pronounced *spurs*). The term encompasses both “CIT” and “co-responder” approaches. Those terms can then be preserved to describe accurately the scope and nature of those models.

Law enforcement agencies have identified a variety of ways to respond that recognize the unique opportunities and limitations presented by each of their jurisdictions. Some agencies have replicated existing models from other jurisdictions—such as the Memphis CIT Model—to improve their responses to people with mental illnesses. Other agencies have determined that specific community characteristics and law enforcement resources (for example, the lack of a single mental health facility or the tremendous size of a policing agency) require adaptations and additions to existing models—such as implementing a mental health outreach team in addition to an existing CIT program.

To determine the best possible response model that will meet local needs, each jurisdiction should work through a program design process. This is not to say that they should reinvent the wheel, but rather they should not skip the critical program planning and development steps that ensure a program will reflect their unique community characteristics. Program design decisions should be made in the context of a collaborative planning process that includes a wide variety of stakeholders—a practice that most communities committed to specialized responses undertake.² Beyond a commitment to collaboration, however, little is known about the steps law enforcement professionals and community members take to tailor other jurisdictions' models to their own distinct problems and circumstances. This publication addresses that gap and provides guidance for jurisdictions that want to improve their law enforcement interactions with people who have mental illnesses.

About this Report

This report is the result of a project supported by the Bureau of Justice Assistance (BJA), U.S. Department of Justice. It explores the program design process, including detailed examples from several communities from across the country.³ It is meant to assist initiative leaders and agents of change who want to select or adapt program features from models that will be most effective in their communities. To ensure that this material has practical value, staff members from the Council of State Governments (CSG) Justice Center and the Police Executive Research Forum (PERF) visited four jurisdictions with extensive experience with SPRs to examine their decision-making and program development processes (selected based on a range of characteristics such as diverse objectives, jurisdiction size, and program model type).⁴ During each visit, project staff interviewed relevant stakeholders and observed

2. Throughout this document, the term “stakeholders” is used to describe the diverse group of individuals affected by law enforcement encounters with people with mental illnesses, such as criminal justice and mental health professionals; myriad other service providers, including substance abuse counselors and housing professionals; people with mental illnesses (sometimes referred to as “consumers”) and their loved ones; crime victims; and other community representatives.

3. The examples included in this guide reflect various types of efforts that involve partnerships, programs, or practices for other communities to consider as they develop responses to people with mental illnesses. By highlighting this sampling of approaches, however, the authors are not necessarily promoting them as “best practices.”

4. For information on when the site visits were conducted and the personnel interviewed, see appendix A. This document also includes program examples from several other jurisdictions interviewed but not visited for this project, as well as several communities that have received grants through BJA's Justice and Mental Health Collaboration Program (JMHC). See www.ojp.usdoj.gov/BJA/grant/JMHCprogram.html for more information about JMHC.

initiative activities.⁵ The four jurisdictions selected were Akron, Ohio; Fort Wayne, Ind.; Los Angeles, Calif.; and New River Valley, Va.

This report is divided into two sections: 1) *Step by Step: The Program Design Process*, and 2) *From the Field: Program Design in Action*. The first section articulates the seven steps involved in shaping a program that best address a jurisdiction's distinct resources and needs, and within each step provides questions to help guide the planning process. This section is

SPOTLIGHT

About the Four Sites

Akron (Ohio) provides an example of a program that has remained true to the Memphis model of a Crisis Intervention Team (CIT), transplanting it to a new jurisdiction. This agency has collected a substantial amount of data, which has shown this program to be an effective solution to its jurisdictional needs. Agency representatives identified the need to augment CIT with follow-up program activities to address a broader range of problems in their jurisdiction.

Fort Wayne (Ind.) operates a traditional CIT program with a focus on schools and juveniles. School Resource Officers (SROs) are trained to recognize and respond to a range of self-destructive behaviors (such as self-mutilation), and CIT officers coordinate with school administrators to identify youth who would be best served by mental health services rather than the juvenile justice system. Data collection processes are advanced and thorough, which allows program policymakers to evaluate the initiative's progress.

Los Angeles (Calif.) has implemented a wide variety of adaptations to address the unique needs of its jurisdiction, focusing on a co-responder model, while incorporating elements of the CIT model into patrol operations, as well as creating a new program focusing on a priority population. Their experience illustrates the difficulties some large jurisdictions have had in implementing the CIT model citywide. Due to its sheer size, both in area and in population, the CIT approach alone did not effectively address the community's problems. In response, the department believes it developed a more robust and multifaceted strategy.

New River Valley (Va.) represents a rural, multi-jurisdictional CIT program that includes fourteen different law enforcement agencies contained in four counties and one city.⁶ The challenges facing these non-urban communities and the state law requiring that law enforcement take custody of a person meeting the criteria for an emergency mental health assessment have led to the need for several adaptations to the CIT model.

For more information on how these sites were selected, see appendix B.

5. Some practitioners are concerned that law enforcement not just conduct "programs" that are a discrete set of activities, instead stressing that agencies should develop broader "initiatives" in which an agency engages in a comprehensive effort that includes meaningful partnerships with the community and other agencies. Because practitioners in the field used these terms interchangeably in interviews, this report also uses both to refer to efforts to improve responses to people with mental illnesses and instead qualifies or describes the level of agency engagement and commitment from a community.

6. The fourteen law enforcement agencies that comprise the New River Valley (NRV) CIT are the Blacksburg Police Department, Christiansburg Police Department, Dublin Police Department, Floyd County Sheriff's Office, Giles County Sheriff's Office, Montgomery County Sheriff's Office, Narrows Police Department, Pearisburg Police Department, Pulaski Police Department, Pulaski County Sheriff's Office, Radford City Police Department, Radford City Sheriff's Office, Radford University Police Department, and Virginia Tech Police Department.

most useful for policymakers and practitioners interested in learning how to design or revise a program—whether it is a CIT, a co-responder model, or some combination or variation of these models—that takes into full account the specific factors that drive their jurisdiction’s problems associated with law enforcement interactions with people who have mental illnesses.

The second section provides two overview charts—one about problems that affect program design and the other about jurisdiction characteristics that can affect initiative plans. It also provides specific examples that illustrate how program design processes are translated into activities in the field, drawing on information provided during interviews and site visits. It describes how program elements are tailored to a jurisdiction’s problems and specific characteristics when implemented.

The information collected from the four sites reveals a blurring of the two main models. In some cases, it is not possible to use the terms “CIT” or “co-responder” to describe the entirety of a jurisdiction’s responses; communities are now implementing a combination of both approaches. This section will help individuals interested in learning more about how other agencies throughout the country have navigated the program design process to develop these evolving initiatives.

As discussed more fully below, this report delves into some of the other ten “essential elements” of a successful SPR to people with mental illnesses that are identified and outlined in a previous publication.⁷ Whenever applicable, references to these elements are highlighted in the text. The material that follows also includes sidebar articles on related topics that often include references to additional sources of information.

Related Resources

This publication is just one in a series that addresses how law enforcement responds to people with mental illnesses. The Justice Center, in partnership with PERF and with support from BJA, has developed a collection of resources for law enforcement practitioners and their community partners.⁸ The centerpiece of the *Improving Responses to People with Mental Illnesses* suite of materials is the publication, *The Essential Elements of a Law Enforcement-Based Program*.⁹ The other documents build on this essential elements publication. For example, one of the ten essential elements describes the need for specialized officer training that is tailored to the law enforcement audience. It is a very concise description of why training is needed and highlights some key challenges to overcome. Another publication, *Strategies for Effective Law Enforcement Training*, explores these training issues in greater depth and

7. Readers are encouraged to review *Improving Responses to People with Mental Illnesses: The Essential Elements of a Specialized Law Enforcement-Based Program* to better understand how program design and decision making fit within a broader context. To download a copy, visit www.consensusproject.org/issue_areas/law-enforcement.

8. The project and publication were completed as part of BJA’s Law Enforcement/Mental Health Partnership Program. The resources developed as part of this suite of materials are available for free download at the law enforcement issues page on the Justice Center’s Consensus Project website (www.consensusproject.org).

9. The ten essential elements presented in this document are Collaborative Planning and Implementation; Program Design; Specialized Training; Call-Taker and Dispatcher Protocols; Stabilization, Observation, and Disposition; Transportation and Custodial Transfer; Information Exchange and Confidentiality; Treatment, Supports, and Services; Organizational Support; and Program Evaluation and Sustainability.

raises additional matters that must be considered in training law enforcement officers. This document's focus on tailoring specialized responses provides a similar level of discussion and guidance for readers who want to drill down to the details and implementation options for the essential element that encourages thoughtful, collaborative program design. These written materials are complemented by web-based information on statewide efforts to coordinate law enforcement responses and by an online Local Programs Database.¹⁰

**Essential
Element
2**

Program Design¹¹

The planning committee designs a specialized law enforcement-based program to address the root causes of the problems that are impeding improved responses to people with mental illnesses and makes the most of available resources.

10. The Local Programs Database, formerly referred to as the Criminal Justice/Mental Health Information Network (InfoNet), was made possible through the leadership, support, and collaboration of key federal agencies and private foundations, including the Bureau of Justice Assistance (BJA) and the National Institute of Corrections (NIC). The database was created to foster peer-to-peer learning among agencies across the country. The database is interactive and entries include contact information to facilitate information sharing, as well as easily searchable fields on key topics. The database is available through the Consensus Project website at www.consensusproject.org and can be searched for information on other programs or accessed to create a new program profile.

11. This and other elements reflect a consensus of experts, including a broad range of policymakers, practitioners, advocates, and researchers, whose recommendations are captured in the *Essential Elements* report.

Section I

Step by Step: The Program Design Process

Designing a program specific to a community's unique needs is a complex process. Identifying and implementing a collaborative partnership is the first hurdle, but once stakeholders are involved and committed to the issue, the question remains, “What next?”

It is critical that a planning committee (and its program coordination group) develop a strong level of collaboration among stakeholders, yet the process can be fraught with significant challenges. Personnel from the four featured sites shared how they have successfully engaged people who are vested in the outcomes of law enforcement interactions involving people with mental illnesses and established lasting frameworks to maintain their programs' integrity. The keys to their success include the following:

- **Gain the support of law enforcement leaders through the involvement of other law enforcement leaders.** In deciding whether to participate in the New River Valley CIT program, the Chief of the Pearisburg (Va.) Police Department was influenced by both the chief law enforcement executive in Radford (Va.) and Major Sam Cochran, the former CIT Coordinator for the Memphis (Tenn.) Police Department, who were each able to explain—from one law enforcement official to another—the importance and benefits of specialized responses to people with mental illnesses.

Essential Element 1

Collaborative Planning and Implementation

Organizations and individuals representing a wide range of disciplines and perspectives and with a strong interest in improving law enforcement encounters with people with mental illnesses work together in one or more groups to determine the response program's characteristics and guide implementation efforts.

Keys to Collaboration

The **planning committee** is composed of leaders from each of the stakeholder agencies who have operational decision-making authority and community representatives. This executive-level committee should examine the nature of the problem and help determine the program's objectives and design.

The **program coordination group** is made up of staff members from stakeholder agencies. This group should oversee officer training, measure the program's progress toward achieving stated goals, and resolve ongoing challenges to program effectiveness.

In some jurisdictions, the two bodies may be the same—particularly those with small agencies, in rural areas, or with limited resources.

- **Develop a subcommittee structure within the larger planning committee or program coordination group to support targeted issue areas and make collaboration more efficient.** In addition to their participation in a multidisciplinary coalition in the New River Valley CIT program, initiative planners developed a “Law Enforcement and Mental Health Services Coalition,” which meets quarterly to discuss mental health issues related specifically to law enforcement. In Fort Wayne (Ind.), a subcommittee composed of individuals from law enforcement, mental health, and advocacy meets separately to focus on training development and then to prepare and host training sessions several times each year. The training committee in Akron (Ohio), which meets twice yearly, manages the iterative process of refreshing the curriculum to ensure it reflects the most current policies and procedures.
- **Designate staff members to focus on accountability and to maintain connections among stakeholders in the collaboration.** The planning committee can designate staff members in the program coordination group to manage the logistics of partnerships. Identified personnel can ensure that there is an emphasis on collaboration from the start of the program.
- **Exchange meaningful information to measure outcomes and foster necessary program changes.** Stakeholders will be more likely to maintain their involvement if they find the meetings provide meaningful information and accomplish specific tasks. In Los Angeles, the police department shares information with its mental health advisory board about their use-of-force trends and reports, for example.

What Next, After Collaboration?

This section outlines seven key steps involved in the collaborative program design process. Each step includes a series of questions designed to help planning and coordination groups structure their discussions and advance their thinking about related issues.¹²

Step 1: Understand the problem

Step 2: Articulate program goals and objectives

Step 3: Identify data-collection procedures needed to revise and evaluate the program

Step 4: Detail jurisdictional characteristics and their influence on program responses

Step 5: Establish response protocols

Step 6: Determine training requirements

Step 7: Prepare for program evaluation

In each of the four jurisdictions—Akron, Fort Wayne, Los Angeles, and New River Valley—initiative leaders found that the challenges their community faced were inter-related, multilayered, and required similarly complex and nuanced responses. In addition, those

¹². For a worksheet that provides the questions that guide the design process without the narrative explanation, see appendix C.

who had created programmatic responses found that it was an iterative process, rather than a simple linear approach. Accordingly, the steps recommended in this guide are designed to be revisited as needed to fine-tune efforts and remain responsive to conditions and resources in a jurisdiction. Program design does not end when the seven steps are complete, but rather requires an *ongoing* effort to evaluate and adjust program responses as the community's landscape changes.

STEP 1:

Understand the problem¹³

Program development is often initiated in reaction to a terrible tragedy in the community, impending litigation, or another event. Partners involved in the collaboration should start the program design process by researching and then moving beyond the initial impetus to develop a common and comprehensive understanding of the legal, clinical, and community circumstances that make it so challenging to effectively respond to people with mental illnesses encountered by law enforcement officers.

It is important to stress from the outset that research does not support the stereotype that people with mental illnesses are more violent than individuals in the general population.¹⁴ Accordingly, police use of force is usually not needed. Yet even though the occurrence is infrequent for there to be law enforcement shootings involving people with mental illnesses, the impact of such events on the officer, the individual's family, and the community—and even on other communities not directly involved—is profound and

“We ask ourselves, and other agencies ask, too, would these terrible incidents have happened [where someone is shot and killed] had this program been in place at that time? We paid a terrible price. Why would an agency choose to do otherwise? How could they see what has happened here and in LA County and knowingly choose not to do this program? It makes no sense to me.”

**—ASSISTANT CHIEF
EARL PAYSINGER**

Director, Office of Operations,
Los Angeles (Calif.) Police Department

13. Gary Cordner's report "People with Mental Illness" also emphasizes the need for decision-makers to understand the problem in their local community to design an effective response strategy. He provides detailed questions that planners should ask to better understand the impact of incidents, stakeholders, victims, offenders, and locations/times. Gary Cordner, "People with Mental Illness," *Problem-Oriented Guides for Police Problem-Specific Guides Series*, Number 40, U.S. Department of Justice (Washington, DC: Office of Community Oriented Policing Services, 2006), www.popcenter.org/problems/mental_illness.

14. For a scholarly review, see A. Harris and A.J. Lurigio, "Mental illness and violence: A brief review of research and assessment strategies," *Aggressive and Violent Behavior* 12(5) 2007: 542–51. Several large-scale research projects found a weak statistical association between mental illness and violence (M.C. Angermeyer, B. Cooper, and B.G. Link. "Mental disorder and violence: Results of epidemiological studies in the era of deinstitutionalization," *Social Psychiatry and Psychiatric Epidemiology* 33(13) 1998: S1–S6). The association becomes stronger, however, when a person with a mental illness has a co-occurring substance use disorder and/or is not taking his or her medication (H.J. Steadman, E.P. Mulvey, J. Monahan, P.C. Robbins, P.S. Appelbaum, T. Grisso, L.H. Roth, and E. Silver, "Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods," *Archives of General Psychiatry* 55 1998: 393–401; M.S. Swartz, J.W. Swanson, V.A. Hiday, R. Borum, H.R. Wagner, and B.J. Burns. "Violence and severe mental illness: The effects of substance abuse and nonadherence to medication," *American Journal of Psychiatry* 155 1998: 226–31).

far-reaching. The following questions can prompt planners to investigate the scope and nature of the challenges officers face in incidents involving people with mental illnesses and design appropriate responses.

Question 1: What forces are driving current efforts to improve the law enforcement response to people with mental illnesses?

Stakeholders should contribute their individual perspectives to answer this question. Law enforcement line staff may voice concern about the many challenges they face during encounters involving people with mental illnesses—many agree that these calls are often time-consuming and frustrating. Patrol officers may spend long periods of time attempting to link a person in crisis to an appropriate mental health resource, and also may find themselves responding repeatedly to the same individuals without seeing any improvement in the outcomes. From another perspective, consumers of mental health services and their families might identify the need for change because of the limited treatment and response options for people with mental illnesses at risk of criminal justice involvement. They may not have any other options when a loved one is in crisis, but are disappointed by the results of law enforcement engagement. Both stakeholder groups would likely agree that the person's mental health and related calls for service are not improved through the more *traditional* interactions with police. It is important both to recognize the legitimacy of each argument and the need to reach consensus around the issues influencing the reasons for change. (Section II of this report provides more detail about the specific problems and the contributing factors that various jurisdictions have encountered.)

Question 2: What data can planning committee members examine to understand the factors influencing law enforcement responses to people with mental illnesses?

Effective program design hinges on accurately identifying the causes of the problems communities face. For example, if a community is responding to a tragic incident, stakeholders must explore the circumstances that led up to and occurred during the incident. They will also want to look for more systemic issues that go beyond those involved in the particular incident. This exploration may include interviews with the involved parties and a review of law enforcement and mental health system protocols and procedures (including response practices and training), as well as an assessment of resource gaps that may be hindering better responses to people with mental illnesses.

Among the law enforcement data that should be considered when defining the scope and nature of the problem are the number and types of calls related to people with mental illnesses, duration of the responses, and related use-of-force information. It may be important to note whether officers are responding repeatedly to the same individuals and locations to determine if interventions are needed to produce better results. One option is to examine computer-aided dispatch (CAD) data. If possible, efforts should be made to understand outcomes of calls for service through forms used to track the disposition of calls.

Valuable information should also be gleaned about the mental health system response. For example, planners can review the number and type of admissions at the receiving psychiatric facilities, and gather feedback on this process from officers, mental health professionals, family members, and consumers that has been collected through focus groups, surveys, or interviews.¹⁵ Data should be collected on how long officers spend at the mental health facility and problems experienced in transferring custody as well. It is also important to catalog the types of services provided by community mental health centers and other providers, their availability, and their capacity to address the individuals' needs. Together, this information can then inform needed changes in responses.

(Problems that are related to *community and agency characteristics*, such as lack of mental health resources uncovered by cataloging the number and kind of available providers and their admission criteria, are addressed in Step 4: Question 2.)

Question 3: What are the data limitations, and how can they be overcome?

Stakeholders should identify the limitations of various data sources, such as the scant reporting on perceived mental illness in CAD databases or the failure of mental health intake records to account for the involvement of law enforcement. Law enforcement and community stakeholders should explore why officers may not be reporting encounters they resolve at the scene, what system limitations there are that make it difficult to capture relevant information when clearing a call or ending a field interaction, and other problems with gathering information on these interactions. Efforts should be made to resolve these issues and gain a better understanding of whether repeat calls for service, or particularly difficult incidents, center on a particular subgroup of individuals, such as people in a particular beat, men with substance abuse problems, or women who are homeless.

A critical component of the program design process is to ensure that goals, objectives, policy and practice reforms, and measures of success are all data-driven and tailored to a particular jurisdiction's distinctive needs. Because of problems with underreporting and other collection barriers mentioned previously, data should be interpreted with these limitations in mind. They are, however, still useful sources of information that provide a starting point for program design. To enhance the reliability of the information, stakeholders should consult multiple sources of data.

15. "Receiving psychiatric facilities" include all medical facilities that will receive, assess, and treat someone in a mental health crisis, including hospital emergency rooms, psychiatric hospitals, and crisis drop-off centers. Most medical information is protected under federal and state privacy laws. If stakeholders wish to examine protected health information during this process, they should take into account laws governing this information exchange. For an overview of the federal laws, see John Petrila, "Dispelling the Myths about Information Sharing between the Mental Health and Criminal Justice Systems," National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness (February 2007). Petrila also participated in a webinar, "HIPAA: Myths, Facts, and Cross-systems Collaboration" (March 23, 2009). The associated presentation is available at www.consensusproject.org/features/hipaappt.

STEP 2:

Articulate program goals and objectives

Once the collaborative planning group has a firm grasp on the challenges facing the community, they should establish the program's goals and objectives. Program goals capture the “big picture” of the good that the effort is meant to achieve, whereas objectives outline program activities that, if achieved, would meet those goals. A shared statement of the program goals will advance the discussion around program design. The objectives will not only detail the mechanisms for achieving a program goal, but will also provide a framework for developing evaluation measures. Program planners should articulate realistic goals and objectives, and avoid terminology that suggests problems will be “eliminated” or that all individuals will benefit from improved responses. It is advisable to establish both short- and long-term goals and objectives to help ensure early successes and sustainability.

Question 1: What are the program's overarching goals?

The program's goals reflect the desired outcome of the initiative on the primary problems identified by the planning group and other stakeholders in the community. For example, if the community is responding to a tragic incident involving law enforcement and a person with mental illness, the program goals might include improving officer and community safety. The goals should be well-articulated in writing and shared among all partners and the community, and should be reviewed periodically.

Other goals might include reducing arrests for minor offenses, lowering the number of repeat calls for service involving people with mental illnesses, decreasing the use of force by law enforcement, incurring fewer injuries among all involved at the scene, increasing the numbers of people diverted to mental health treatment when warranted, or cutting law enforcement agency costs.

Question 2: What are the program's objectives?

Objectives capture the specific program activities needed to achieve the stated goals. For example, if stakeholders identify improved safety as the program goal, providing effective agency training on de-escalation will be a key program objective. Objectives should be as specific as possible. In this example, the objective could be to train a certain proportion of the primary and secondary responders or a particular subset of individuals.¹⁶ If the goal is to address strains on law enforcement resources, one objective might be reducing the amount of time officers spend attempting to link people with mental illnesses to mental health services to a target number (for example, 15–30 minutes).

¹⁶ Examples that include specific numbers or percentages included in this section are not intended as recommendations, but are included only to highlight the value of setting specific goals within the agency to monitor improvement and to evaluate the extent to which the program is implemented.

STEP 3:

Identify data-collection procedures needed to revise and evaluate the program¹⁷

Once program goals and objectives are set, law enforcement and their partners can use them to identify what information they should collect and how they should collect it.¹⁸ Data collection practices should take into account both process and outcome measures. Evaluating a program's *process* will allow coordinators to assess whether the proposed activities are being carried out (how many individuals were trained, how many calls were answered by an officer with training, and more) so planners can revise day-to-day program functioning and the reach of the initiative. It is also critical that the evaluation determine whether the activities are having the intended *outcome* (that is, the impact that planners hoped to achieve for people with mental illnesses, officers, and the community)—information needed not only to assess true advances, but also to secure funding and ensure program sustainability over time.

Question 1: What data will be collected to measure whether goals and objectives have been achieved?

Once goals and objectives have been articulated clearly, determining what information is required to measure them will be generally straightforward. For example, if a goal is to increase safety, an agency would want to collect data on injuries or deaths, use of force, and citizen complaints to see if that has been attained. If a related objective is to train all recruits, the agency or its partners will need to track the number of recruits who complete the curriculum or successfully pass a test. Most initiatives will want to address many of the issues raised previously that relate to using scarce law enforcement resources to better identify and safely serve people with mental illnesses—particularly those who should appropriately be diverted to the mental health system. Accordingly, the collaborative planning group and other stakeholders will want to collect data such as the frequency of calls for service involving people with mental illnesses, including how many are to the same individuals or locations; the types and frequency of disposition decisions; the percentage of calls that specially trained personnel handle and the portion that involve routine responses, and the duration of those responses; and any injuries or fatalities suffered during law enforcement encounters involving people with mental illnesses.

17. Cordner's "People with Mental Illness" provides additional information on measures that could be used to evaluate the effectiveness of the SPR. Cordner, "People with Mental Illness." For a detailed guide to program evaluation, consult such resources as Richard A. Berk and Peter H. Rossi, *Thinking about Program Evaluation 2* (Thousand Oaks, CA: Sage Publications, 1999); Robert H. Langworthy, ed. *Measuring What Matters: Proceedings from the Policing Research Institute Meetings*, (Washington, DC: U.S. Department of Justice, National Institute of Justice, 1999); Kristin Ward, Susan Chibnall, and Robyn Harris. *Measuring Excellence: Planning and Managing Evaluations of Law Enforcement Initiatives* (Washington, DC: U.S. Department of Justice Office of Community Oriented Policing Services, 2007).

18. Law enforcement agencies may want to partner with a local college or university to assist with identifying what data to collect. Academic partners should be included from the beginning of the planning stages to provide guidance during this step.

Question 2: What data collection strategies will be used?

Many existing data sources—such as CAD data, Emergency Medical Services (EMS) logs, and Emergency Room records—can provide useful information. These data systems typically were designed, however, to capture information for purposes other than law enforcement/mental health program improvement or evaluation. As a result, specialized law enforcement-based programs almost always require collecting new information, and often from different sources or in novel ways.

Collecting the necessary information has proven difficult for many agencies. Each of the four agencies featured in this report had varying levels of success capturing data consistently from both law enforcement officers and mental health providers. The two major limitations are 1) inconsistency in call identification and 2) paperwork noncompliance. Most agencies do not have a reliable method to label calls for service involving people with mental illnesses at the time of dispatch, nor an ability to update the codes in the CAD system retroactively to reflect new information relating to mental health status.¹⁹ In terms of noncompliance with record-keeping or reporting practices, law enforcement officers have an enormous amount of paperwork to complete for all incidents, particularly those involving serious crimes or arrests, and may feel that the time needed to complete an additional form is in conflict with their other policing duties. Both of these factors can result in missing or incomplete data in law enforcement systems. Mental health providers may also experience problems with trying to maintain updated, accurate information in their systems given their often overwhelming caseloads. Departments must be creative and persistent in overcoming these challenges.

“Every time there is a CIT encounter, there is a stat sheet completed. This is a police department document, which can be shared internally and also with mental health partners. These sheets are used to identify problems so we can address them.”

—DR. MARK MUNETZ

Chief Clinical Officer, Summit County (Ohio) Alcohol, Drug Addiction and Mental Health Services Board

PROGRAM EXAMPLE: Addressing barriers to data collection, Philadelphia (Pa.)

In 2006, Philadelphia received a Justice and Mental Health Collaboration Program (JMHP) grant from the Bureau of Justice Assistance. Initiative leaders decided to use this funding to plan and implement a CIT program in the Philadelphia Police Department—pilot-testing the program in a single division and addressing any challenges before expanding it department-wide.

According to coalition members, one of the main difficulties the planners faced was obtaining information directly from the CIT officers about their encounters with people with mental illnesses. In response, they decided to change their data-reporting system from a paper-based system to a call-in system. At this writing, officers call the CIT coordinator to complete the necessary form by phone, and then the coordinator collects and files the reports.

For more information about Philadelphia's program, see the program entry in the Local Programs Database available at www.consensusproject.org.

19. The majority of police action related to people with mental illnesses in the four sites studied was based on responding to calls for service rather than incidents observed during the course of routine patrol.

STEP 4:

Detail jurisdictional characteristics and their influence on program responses

For this discussion, “jurisdictional characteristics” refers to those aspects of a community that are difficult to change, often requiring long-term efforts. Based on information gathered during the site visits, project staff found these characteristics fall into four categories relating to 1) the law enforcement agency, 2) the mental health system, 3) state laws, and 4) geography and demography. Each of these categories should be considered when designing a program.

Question 1: What characteristics of the law enforcement agency are relevant in planning a specialized response to people with mental illnesses?

The planning group and stakeholders should consider the following during the design stage:

- **Agency resources**, which include staffing levels, data management structures, training expertise and capacity, and availability of less-lethal technologies.
- **Relevant policies and regulations**, such as use-of-force guidelines, discretion in making arrests, policies on diversion, reporting requirements, information-sharing policies, and requirements for handcuffing during custodial transport.
- **Leadership styles**, which may dictate the number of officers a program seeks to train, either focusing on a small self-selecting group or providing training to an entire department. Some law enforcement executives believe a subset of officers must become “specialists” who are dedicated to particular areas of expertise (such as domestic violence) because the additional information they obtain will help them respond to those situations more effectively. Other chiefs or agency executives believe all officers should be prepared to respond to all situations they will encounter. Leadership must believe there is a compelling need to prioritize limited resources to address this issue. And they must be willing to designate someone within the agency to help provide oversight and support to the effort, to work collaboratively with the mental health community, and to garner support among policymakers to ensure sustainability. The agency should have leaders who are willing to even reconsider officer evaluation criteria that is

“I talk about the three Cs of program success: compassion, constitutionality, and consistency. Compassion is brought by people who want to be [in a specialized assignment]. Constitutionality and consistency are greatly enhanced when the department provides resources.”

—CHIEF WILLIAM BRATTON
Los Angeles (Calif.)
Police Department

“Working on the CIT Outreach Team provides great satisfaction, but it should remain voluntary—it requires a certain kind of officer who is internally motivated.”

—OFFICER FORREST KAPPLER
CIT Officer, Akron (Ohio)
Police Department

more in keeping with community policing principles—in which officers are reviewed for their problem-solving and de-escalation skills instead of the number of arrests they make.

Question 2: *What mental health system characteristics are relevant in planning a specialized response to people with mental illnesses?*

As part of the program design process, stakeholders should catalog available mental health resources in the community, identify the criteria for or any restrictions to accessing them, and describe their capacity and availability. For example, if there are no twenty-four-hour facilities to receive people with mental illnesses except emergency rooms, and officers are required to wait hours with the individual to be seen, alternatives can be explored. And if facilities will only accept individuals who meet specific eligibility criteria, such as only individuals not under the influence of drugs or alcohol, it becomes clear that other options must be identified to support officers when they encounter these individuals.

The planning group and relevant stakeholders should then identify service gaps. Community mental health resources might include emergency departments, inpatient and outpatient treatment programs, crisis response services, emergency receiving centers, family support programs, telephone hotlines, clubhouses and other peer-to-peer supports, and ancillary services such as housing assistance and income and entitlement support.²⁰ Throughout this review, the planning group should work with policymakers and other key groups to examine the structure of the mental health system and understand variations in catchment areas (municipal vs. county) and revenue sources (private vs. public). These variations may affect law enforcement responses by impacting where officers can transport a person in crisis.

Beyond identifying available mental health resources, stakeholders should become familiar with the avenues available to law enforcement officers to access these services (whether in person, by telephone, or through a referral mechanism), understand the requirements for medical clearance, and clarify existing protocols or procedures for voluntary and involuntary admissions for mental health evaluations and assessments.

Question 3: *What state laws are relevant in planning a specialized response to people with mental illnesses?*

State laws can address a range of issues relating to the law enforcement response. For example, they can mandate law enforcement training and dictate the criteria that must be met and the protocols that must be followed for an emergency mental health evaluation. Local law enforcement officers can play a critical role in this process. In Nebraska, for

²⁰. According to the International Association of Clubhouse Development, a clubhouse is “a community intentionally organized to support individuals living with the effects of mental illness. Through participation in a clubhouse people are given the opportunities to rejoin the worlds of friendships, family, important work, employment, education, and to access the services and supports they may individually need.” More information is available at www.iccd.org.

example, a sworn law enforcement officer is required to determine if a person meets the criteria for involuntary emergency evaluation, to maintain custody of the person, and to transport the person to the mental health receiving facility. In other states, a magistrate or clinician might be required to make the commitment determination. States may have outpatient commitment laws that can be enforced prior to consumers becoming dangerous to themselves or others. Consumers may develop advance directives that provide instructions for how they wish to be treated if they decompensate. These mandates and regulations can present both an opportunity and a burden on law enforcement officers, and should be considered fully by planners.

Question 4: *What demographic and geographic community characteristics are relevant in planning a specialized response to people with mental illnesses?*

A jurisdiction's population, population density, land area, and crime patterns can present important constraints or benefits to developing specialized response programs. For example, a jurisdiction whose only emergency mental health resources are located far from particular law enforcement beats or districts will require officers to spend long periods out of service transporting individuals, particularly if they have to pass through densely populated, traffic-congested areas. Rural and urban areas may have very different problems that will affect dispatch and response times. Some rural areas may be dependent on only phone access to mental health professionals who can direct emergency evaluations. Further, an area that is populated primarily by seniors may have very different needs than those that are generally young families with children, or that have a large number of homeless individuals. Although jurisdictions of every size can struggle with inadequate resources (especially when budget cuts directly impact state and community mental health services), these considerations should be addressed carefully when shaping a law enforcement initiative.

STEP 5:

Establish response protocols

At this stage of design, the planning group will understand how law enforcement, mental health, and other community-based providers are currently responding to people with mental illnesses who are at risk of criminal justice involvement. Based on the community's characteristics, it should be possible to see how these can be better integrated and shaped to address identified problem areas and service gaps. Program development decisions at this point in the process should focus on which law enforcement and mental health responses are needed, both individually and collectively, and what resources are needed to support them.

Question 1: *What law enforcement responses are necessary?*

There are three main categories of law enforcement first-responder activities that require consideration and planning—call-taker and dispatcher protocols; on-scene activities

(stabilization, observation, and disposition); and transportation and custodial transfer.²¹ Planners must decide which personnel will serve as primary responders to scenes involving a person in a mental health crisis, and how they will be dispatched. Based on the review of the law enforcement/mental health problems and community characteristics, they may choose to train a subset of officers for this responsibility, train all officers, or pair officers with mental health clinicians or caseworkers. In addition to these activities, planners may also choose to involve law enforcement officers in follow-up activities not generated by a call for service.

“There are immeasurable benefits to officers who travel with mental health professionals on the SMART teams both for the officers and the clinicians in terms of information exchange and awareness.”

—**COMMANDER HARLAN WARD**
Assistant Commanding Officer of
Valley Bureau, Los Angeles (Calif.)
Police Department

Question 2: *What mental health system responses are necessary?*

Mental health personnel may be involved in a variety of ways, including providing information to dispatchers, co-responding to calls for service involving a person with mental illness, acting as a remote resource if no on-scene professional can be available, helping to train or cross-train personnel, and coordinating a follow-up effort, particularly with people

Essential Elements 4–6

Essential Element 4—Call-Taker and Dispatcher Protocols

Call takers and dispatchers identify critical information to direct calls to the appropriate responders, inform the law enforcement response, and record this information for analysis and as a reference for future calls for service.

Essential Element 5—Stabilization, Observation, and Disposition

Specialized law enforcement responders de-escalate and observe the nature of incidents in which mental illness may be a factor using tactics focused on safety. Drawing on their understanding and knowledge of relevant laws and available resources, officers then determine the appropriate disposition.

Essential Element 6—Transportation and Custodial Transfer

Law enforcement responders transport and transfer custody of the person with a mental illness in a safe and sensitive manner that supports the individual's efficient access to mental health services and the officers' timely return to duty.

21. Each of these three categories represents one of the ten elements in *The Essential Elements of a Specialized Law Enforcement-Based Response*. For more information, see http://consensusproject.org/jc_publications/le-essentialelements.pdf.

identified as high utilizers of emergency mental health services. Collaboration for certain activities may be best achieved through co-location of law enforcement and mental health coordinators or such mechanisms as merged or integrated databases that are consistent with privacy laws.

As the Justice Center's *Essential Elements* publication indicates, individuals with mental illnesses often require an array of services and supports, which can include medications, counseling, substance abuse treatment, income supports and government entitlements, housing, crisis services, peer supports, case management, and inpatient treatment. Planners of the SPR program should anticipate the treatment needs of the individuals with whom law enforcement will come in contact and work with service providers in the community to ensure these needs can be met and coordinated.

Because many individuals with mental illnesses who come into contact with law enforcement have co-occurring substance use disorders, the availability of integrated treatment approaches is essential to achieve clinical and public safety objectives. Accordingly, stakeholders should consider how the program can help connect individuals with co-occurring disorders to integrated treatment and should advocate for greater access to this and other evidence-based practices.²² Histories of trauma and post-traumatic stress disorder are common in criminal justice-involved populations. As such, both the on-scene response of law enforcement and subsequent clinical responses must be trauma-informed. Planners should pay special attention to the service needs of racial and ethnic minorities and women by making culturally competent and gender-sensitive services available to the extent possible.

Stakeholders should also identify ways to improve the efficiency of access to needed services. This may entail broader system changes and agreements, such as streamlining the custody transfer process at a mental health intake facility through memoranda of agreement (MOAs) and revised protocols. Law enforcement should have within easy reach twenty-four-hour drop-off facilities or emergency room(s) designated to expedite the transfer of custody to ensure the individual receives swift mental health services and allow officers to return quickly to duty.²³

“We need to create drop-off stations at the hospital to receive people in crisis. This requires not only trained law enforcement staff, but also an appropriate space—a space where we can safely manage the behavior of people who are out of control.”

—MARIE MOON PAINTER

Clinical Team Leader for
CONNECT, Carilion St. Albans
Behavioral Health, Virginia

22. Evidence-based practices (EBPs) are mental health service interventions for which consistent scientific evidence demonstrates their ability to improve consumer outcomes. R.E. Drake, H.H. Goldman, H.S. Leff, A.F. Lehman, L. Dixon, K.T. Mueser, and W.C. Torrey, “Implementing Evidence-Based Practices in Routine Mental Health Service Settings,” *Psychiatric Services* 52 (2001): 179–82. Other EBPs include assertive community treatment, psychotropic medications, supported employment, family psychoeducation, and illness self-management, see Fred C. Osher and Henry J. Steadman: “Adapting Evidence-Based Practices for Persons with Mental Illness Involved with the Criminal Justice System,” *Psychiatric Services* 11 (2007), 1472–78.

23. For more information about the role of specialized crisis response sites, see Henry J. Steadman, Kristin A. Stainbrook, Patricia Griffin, Jeffrey Draine, Randy Dupont, and Cathy Horey. “A Specialized Crisis Response Site as a Core Element of Police-Based Diversion Programs,” *Psychiatric Services* 52 (2001): 219–22.

Question 3: What other responses or resources are necessary?

While law enforcement agencies and mental health professionals can provide the majority of responses that the planners will prioritize, other partner organizations and their resources may be required to address the problem faced by the community. For example, consumer- or advocate-led organizations, such as clubhouses, can provide essential support to people in crisis and supplement limited mental health resources. Non-law enforcement criminal justice professionals, such as judges, magistrates, and jail personnel, can play an important role in identifying and assessing individuals who may be in need of emergency mental health evaluations.

The planning committee also should identify the availability of community and government resources that focus on critical issues that disproportionately tend to affect people with mental illnesses (such as housing, employment, education, substance abuse treatment, and veterans' services). An assessment of their accessibility in the community should be part of the planning process.

SPOTLIGHT

Systemwide Solutions

The 2002 landmark *Consensus Project Report*—written by Justice Center staff and representatives of 100 leading criminal justice and mental health policymakers, practitioners, and advocates from across the country—provides policy guidelines and practical recommendations for improving the criminal justice system's response to people with mental illnesses. The policy statements and recommendations span the entire criminal justice continuum, from the law enforcement encounter, through court involvement and incarceration, to the individual's reentry into the community. The success of recommended efforts is dependent on collaboration and partnership among the full range of criminal justice agencies and their community partners. It recognizes that law enforcement, courts, or corrections officials' actions have ramifications for the rest of the criminal justice system.

This interconnectedness highlights the value of creating a systemwide commitment to change, in which reforms at each point of contact between the individual with mental illness and a different criminal justice agency are woven together. There is a wide variety of program models that focus on a different point of intercept in the criminal justice system, including the following:

- **Law enforcement specialized responses**, which use specially trained law enforcement officers to de-escalate incidents involving people with mental illnesses and divert them to services when appropriate.
- **Mental health courts**, which are specialized dockets that link defendants with mental illnesses to court-supervised, community-based treatment in lieu of traditional case processing when warranted.
- **Post-booking jail diversion programs**, which screen and assess people with mental illnesses in the jail, and divert them to community-based services when suitable.
- **Specialized probation caseloads**, which integrate community corrections supervision strategies with community-based mental health treatment and services through a variety of methods.

For more information on the Consensus Project report and the many program models, see www.consensusproject.org.

STEP 6:

Determine training requirements

Once planners determine which types of responses are best suited to their local needs and resources (such as a specially trained unit, co-responder model for a subset of officers, or all officers who respond with special unit backup), the group can begin developing a training curriculum and schedules. Both law enforcement and mental health agencies or providers will have concerns about their ability to afford and prepare quality training, including how to address such issues as compensation for trainers, continued education accreditation, and covering shifts for officers in training or fitting it into already packed recruit training schedules. These concerns need to be factored into decisions about how many and how often first-responders are trained.

Question 1: *How much training will be provided and to which law enforcement personnel?*

How much training is not only a question of hours spent in the classroom, but also of the number of officers trained and of how often training is held. Many agencies with specialized law enforcement-based response programs require that 20 percent of the department's officers receive forty hours of training.²⁴ However, there are other approaches that planners can consider, including increased training on mental health issues for recruits or ongoing education requirements for all officers. Dispatchers and call takers will also require training on the program model, to help them identify calls for service that may involve a person with mental illness and then to dispatch the correct personnel to the scene. They may also be able to ask questions that can help officers who arrive at the scene, and to collect information about

“Some law enforcement agencies only send officer volunteers to attend the training, while others send all officers. There are always some officers at the training who don't want to be there. After a day or two, though, even reluctant officers understand that this program is about officer safety.”

—PATRICK HALPERN

Executive Director, Mental Health Association of the New River Valley, Inc., Virginia

Essential Element 3

Specialized Training

All law enforcement personnel who respond to incidents in which an individual's mental illness appears to be a factor receive training to prepare for these encounters; those in specialized assignments receive more comprehensive training. Dispatchers, call takers, and other individuals in a support role receive training tailored to their needs.²⁵

24. The CIT Center at the University of Memphis has released the “Crisis Intervention Team Core Elements” (available at <http://cit.memphis.edu/CoreElements.pdf>), which outlines their suggestions for length of training (forty hours) and the number of officers trained within an agency's patrol division (20 to 25 percent). The guide provides detailed information about the Memphis CIT Model.

25. To learn more, download *Improving Responses to People with Mental Illnesses: Strategies for Effective Law Enforcement Training* from www.consensusproject.org/issue_areas/law-enforcement.

the disposition of calls involving people with mental illnesses to help administrators determine the number and effectiveness of specialized responses.

Question 2: What topics should training cover?

Training curricula should be geared toward the particular law enforcement personnel (line-level, special teams, dispatchers) and include information specific to the jurisdiction (for example, state commitment laws and local resources). Although there is no single curriculum that will address the needs of all jurisdictions, several training topics form the foundation of a comprehensive training program. These include understanding mental illness, statutory authorities governing law enforcement responses, the law enforcement response to calls for service, community policing/problem solving, and use of force.²⁶ The training is not intended to turn law enforcement officers into diagnosticians, but rather to train them to look for behaviors associated with mental illnesses and determine the best way to address those behaviors. Specific skills training may include a combination of verbal de-escalation techniques and suicide prevention methods.

“Because of the limitations posed by our jurisdiction’s size, in addition to forty hours of training for officers on our special teams, we decided to provide twenty-four hours of online training to all of our officers on mental health de-escalation techniques.”

—COMMANDER HARLAN WARD
Assistant Commanding Officer of
Valley Bureau, Los Angeles (Calif.)
Police Department

“It is important to provide training to all officers on encounters with people with mental illnesses, and e-learning has an important place in the picture.”

—MARK GALE
Member, Board of Directors,
NAMI-California

Question 3: Who will provide the training?

Training for law enforcement officers on effective responses to people with mental illnesses must draw on a diverse range of expertise and perspectives to cover a broad range of topics, from recognizing signs of mental illness to understanding the state’s emergency evaluation laws. Many of these topics may be better taught by experts from disciplines other than law enforcement. For example, signs of mental illnesses may be taught by a psychiatrist or mental health clinician, whereas de-escalation techniques may be best taught by a seasoned law enforcement officer who can provide real-life examples. Consumers and family members can provide a face and a voice for people struggling with mental illnesses, and they are uniquely qualified to promote a compassionate response from officers who often see people with mental illnesses only when these individuals are in crisis. Training coordinators might not know who would be a good fit to teach all modules, so it is important that coordinators reach out to community partners to collaborate on identifying trainers or facilitators.²⁷

²⁶. This list is drawn from *Improving Responses to People with Mental Illnesses: Strategies for Effective Law Enforcement Training*, “Appendix B: Suggested Training Topics,” page 41.

²⁷. For more information on how to identify trainers, see “Chapter 1: Identifying Trainers” on page 8 of *Improving Responses to People with Mental Illnesses: Strategies for Effective Law Enforcement Training*.

Question 4: What training strategies will be employed?

Effective training strategies are critical to a specialized law enforcement-based program. These strategies may include short lectures that focus on behaviors and plain language rather than diagnoses and medical terms; site visits to some of the mental health facilities where they will do custodial transfers or refer individuals for treatment or support; role plays to engage officers in real-life interactions that can be acted out and corrected in a safe environment; and question-and-answer sessions to prompt officers to consider and discuss their own experiences, preconceptions, and concerns. Traditional classroom-style training is invaluable, but as a supplement, many agencies have started to develop e-learning platforms to engage personnel who work nontraditional hours and to increase access to specialized training topics.²⁸

“We trimmed the forty-hour training curriculum by determining what course content the officers really needed. We had a four and one-half-hour block on psychopharmacology, and while it is important to understand what these drugs are, the reason the police officer is there is because the person is NOT taking their medications. We now tell officers what these medications are, what they do, and give them a card to refer to.”

—DR. LUANN PANNELL
Director of Police Training and Education, Los Angeles (Calif.) Police Department

STEP 7:

Prepare for program evaluation

It is not enough to simply identify what information will be collected (as outlined in Step 3) to ensure effective evaluations will be conducted. It is important for planners to prepare for a program evaluation as part of the design process. As previously mentioned, the program evaluation should contain both a process assessment as well as an assessment of outcomes. This evaluation will be needed to make revisions to the activities that may be experiencing difficulties and to enhance those that are effective, as well as to provide proof of the program's success to foster sustainability.

Question 1: What resources need to be set aside or identified for an evaluation?

A thorough program evaluation will require the allocation of resources to analyze the data collected. Agencies with planning and research divisions may want to identify department staff and allocate a percent of their time during the program design phase to coordinate or conduct these evaluations. Agencies without research capacity may benefit from outside assistance in aggregating, deciphering, and interpreting the data to determine program effectiveness. Because of the challenges associated with data collection, as well as the difficulties in analyzing often incomplete data, many law enforcement agencies partner with a local college or university to assist with this process. Academic partners may require compensation for which law enforcement agencies may need to find sources of support,

28. For more information on training strategies, see “Chapter 2: Effective Training Techniques” on page 22 of *Improving Responses to People with Mental Illnesses: Strategies for Effective Law Enforcement Training*.

including submitting joint grant proposals. If the department chooses to engage an external research partner, these outside teams will need to work closely with law enforcement and their collaborators during the evaluation process, and this staff time commitment should be considered at the planning stage.

Question 2: *Are there individuals designated to oversee the evaluation?*

Law enforcement agencies should designate a staff person who will work with a subcommittee on evaluation issues. In addition to helping to ensure that all agencies that are contributing data are using sound and accurate collection and reporting practices, this group can determine how the evaluation results will be used, how they will be disseminated, and who should be brought to the table during the evaluation process to review interim reports and the interpretations of the data.

Conclusion

The seven steps to program design summarized in this section may seem straightforward. They are not. Law enforcement agencies and their community partners are struggling to navigate the many issues that are involved in making the proper decisions at each stage in the process. And as new information is made available, it is necessary to revisit previous steps. To fully grasp the challenges in following these design steps, policymakers and planners interested in exploring a specialized policing response to people with mental illnesses must operate within a framework defined by two complex forces—the nature of the problem and the jurisdiction’s distinct characteristics.

Though the *problem* frequently relates to safety concerns and strains on police resources that do not result in good outcomes for law enforcement, the individual, or the community, jurisdictions may find that data and discussions lead them to other issues or sub-issues that need particular attention. Crafting the solutions to these problems—including changes to law enforcement training, policies, and procedures—cannot be shaped in a vacuum. Training officers on diversion and other strategies, for example, will be ineffective if mental health resources in the community are not available or lack the capacity to support increased referrals and placements. Accordingly, jurisdictions will be limited by the resources they have or believe they can create or expand.

The following section explores how various problems and community characteristics have shaped responses in the agencies studied and how other jurisdictions might expect these factors to influence their own program design and enhancements.

Section II

From the Field: Program Design in Action

This section provides practical advice on how to consider common problems as experienced by the four sites studied. It also considers various law enforcement, mental health, and other community characteristics, and their relative impact on program design. Examples from the field are included to illustrate how these problems and characteristics are reflected in program implementation.

Tailoring Specialized Policing Response Programs to Specific Problems²⁹

The three most commonly encountered problems found in the four communities studied were unsafe encounters, frequent arrests of people with mental illnesses and the strains on law enforcement resources, and high utilization of emergency services. It is important to note that this separation of problems into distinct categories is somewhat artificial, as they often overlap and relate to one another. Other communities may find their data lead them to identify different problems beyond these three types. The chart that follows provides an overview of how the four sites tailored their responses to their community's problems.

“If you want it to be collaborative, you need to be flexible and adapt this program to your local community.”

—**SGT. MICHAEL YOHE**
CIT Coordinator, Akron (Ohio)
Police Department

“CIT is a godsend. The community of people with mental illnesses was getting badly treated and CIT has been an undisputed success. There are very few situations where the response is poor.”

—**TOM**
Consumer, Carriage House
(Fort Wayne, Ind.)

“It may well take a tragedy to mobilize the resources....”

—**ASSISTANT CHIEF
JIM McDONNELL**
1st Assistant Chief, Chief of Staff, Los
Angeles (Calif.) Police Department

“I feel that CIT changed our understanding of what the police officers are capable of doing with de-escalation and compassion.”

—**JIM RANDALL**
President, NAMI—San Fernando Valley (Calif.)

²⁹. Cordner's guide, "People with Mental Illness," outlines a variety of response strategies that decision-makers can consider when choosing how to best respond to the problem they are facing in their local community. These response strategies are also summarized in a table that presents the response type, how it works, when it works, and additional considerations to take into account.

The Impact of Problem Type on SPR Programs³⁰

PROBLEM TYPE	JURISDICTIONS	SPR PROGRAM ACTIVITIES
Unsafe Encounters	Los Angeles, Calif. Akron, Ohio Fort Wayne, Ind. New River Valley, Va.	Officers trained on mental health issues respond to the scene when dispatched. (In the LAPD, a call can also be triaged to dispatch a special co-response unit. See box below.)
		Related issues are addressed during training for officers on mental health topics.
		Training is provided for dispatchers.
Frequent Arrests and Strains on Police Resources	Los Angeles, Calif.	Co-responder teams are dispatched to the scene when requested by a first-responder. Crisis mental health clinicians also respond to the scene. Additional dispatch capability is used to “triage” incidents requiring the co-response team.
	Akron, Ohio Fort Wayne, Ind. New River Valley, Va.	Related issues are addressed within the forty hours of training for officers. Emergency psychiatric facilities streamline intake procedures for law enforcement.
High Utilization of Emergency Resources	Los Angeles, Calif. Akron, Ohio	Follow-up teams of law enforcement personnel and mental health clinicians work on case management for referred cases, including cases brought to their attention by involved stakeholders.

“Relatives of consumers are now less reluctant to involve the police because family members realize that a compassionate officer will respond to the call. Consequently, families do not wait until the situation has escalated, and officers now respond to less threatening calls. This allows them to intervene at an earlier point. No CIT officer has been injured when responding to a person with mental illness.”

—LIEUTENANT MIKE WOODY (RET.)

Law Enforcement Liaison, Ohio Criminal Justice Coordinating Center of Excellence

³⁰. Many of the “SPR Program Activities” listed here address more than one problem. In practice, these responses often straddle the goals of improving safety, reducing frequent calls for service, and decreasing the use of emergency resources.

Problem: *Unsafe outcomes of encounters between law enforcement and people with mental illnesses*

When communities experience a tragedy related to a law enforcement encounter involving a person with mental illness, there is often a flurry of activity to determine what factors contributed to that outcome and to ensure it will not happen again. Several factors seem to affect safety at the scene. Many community members interviewed for this project noted that when consumers have had previous negative encounters with law enforcement, they become fearful and distrusting during subsequent interactions. A person's fear can then be exacerbated by the officer's uniform and an authoritarian approach. Even individuals in crisis with no previous contact with officers may have extreme reactions to being crowded or subjected to officers' commands.

Community members interviewed also recognized that traditionally trained law enforcement officers often lack information about mental illnesses, particularly information about strategies to calm crisis behavior and avoid use of force. Without adequate training, officers may also be fearful of individuals with mental illness and may misperceive them as more dangerous, affecting officer posturing and reactions. It is important to recognize that much of an officers' academy training is oriented toward taking control of a situation and resolving it as quickly as possible—which may run counter to specialized response strategies. These factors, together with dynamics such as the level of access to mental health supports, guidelines on less-lethal weaponry and tactics, and whether the individual is taking medications or is abusing drugs or alcohol, can all contribute to concerns about the safety of all those involved in these encounters.

Tailored Responses

Based on the sites visited and related project research, programs designed to respond to safety concerns during these encounters were found to be aimed primarily at officer education and quick, on-scene de-escalation of crisis behavior. Other responses include the training on and use of less-lethal weapons, helping call takers and dispatchers get the best possible information to the

“One of the largest complaints by NAMI and other advocates was the lack of understanding by the officers of how to communicate with people with mental illnesses.”

—**COMMANDER HARLAN WARD**

Assistant Commanding Officer of
Valley Bureau, Los Angeles (Calif.)
Police Department

“There are times when the police must run from call to call. But there will come a time when an officer's compassion will be necessary to resolve a situation, and the officer will need to step up and come through.”

—**BERNIE**

Mental Health Consumer (Akron, Ohio)

“Injury on the job could lead to job loss—therefore, any opportunity to learn additional officer safety techniques is a plus.”

—**OFFICER LORI NATKO**

CIT Officer, Akron (Ohio)
Police Department

“CIT provides the opportunity to really sit and listen more than talk. Usually we just tell people what we are going to do. I plan to try to volunteer for as long as I can—I see different things all the time.”

—**OFFICER MARK BIEKER**

CIT Officer, Fort Wayne (Ind.)
Police Department

Akron Tailors Response to Safety Concerns and Repeat Calls for Law Enforcement and Mental Health Services*

Quick Facts

Government type: Municipal

Jurisdiction type: Urban

Population in 2007: 207,934 (estimate)

Area of Akron in square miles: 62.4

Number of sworn personnel in 2006: 451

Number of civilian personnel in 2006: 43

Program name: Crisis Intervention Team (CIT)

Program start date: 2000

Overview

The Akron (Ohio) Crisis Intervention Team (CIT) was one of the first agencies to replicate the Memphis CIT Model. Although this community maintains fidelity to the model, they have made several adjustments to the core elements. For example, CIT Officers in Akron have access to four emergency resources, rather than the single point of entry available in Memphis. This adaptation was made to ease the burden on any single mental health facility. Akron has also modified the CIT training to include a segment about being a CIT officer, including safety issues, duties, and officers' experiences.

Tailored Responses

Once CIT was implemented, Akron stakeholders determined the need for a supplemental program to address the needs of their "at-risk" population—those individuals who are repeat clients of both the criminal justice and mental health systems and who often fall through the systems' cracks. The "CIT Outreach Program" consists of a group of officers who team up with an outreach worker from Community Support Services (CSS). Officers in uniform ride together with a CSS worker in a marked cruiser to contact referrals and attempt to engage people in services. Akron reported that pairing a law enforcement officer with a case worker to conduct follow-up can also facilitate information sharing, locating individuals, and increasing the safety of encounters.

Outreach teams can refer individuals to mental health and other services, such as elder care and drug addiction services. When the team encounters someone who does not qualify for an involuntary commitment order, they are often able to persuade the person to voluntarily go to CSS, where they are welcomed in the back door with dignity and discretion.

Unique Program Features

The CIT program coordinator in Akron maintains his patrol duties, which lends credibility to the program and assists in soliciting officer involvement. When the outreach team transports an individual in a marked cruiser, he or she rides without handcuffs in the back seat with the mental health case manager. The person may meet criteria for emergency mental health evaluation, but the officer allows the person to ride without handcuffs when the situation is under control. If the person is at risk of harming him- or herself or others, or attempts to leave, the police will then use handcuffs and transport as needed.

* Dates and figures in this sidebar are consistent with the most recent information available at the time of this writing.

Fort Wayne Tailors Response to Safety Concerns and Problems in Schools*

Quick Facts

Government type: Municipal

Jurisdiction type: Urban

Population in 2007: 251,247 (estimate)

Area of Fort Wayne in square miles: 79.12

Number of sworn personnel 2006: 435

Number of civilian personnel 2006: 100

Program name: Crisis Intervention Team (CIT)

Program start date: 2001

Overview

Fort Wayne (Ind.) operates a traditional CIT program. Law enforcement plays a primary role in the program, but it is also shaped by mental health consumers, available resources, and a strong NAMI presence. Fort Wayne made several adjustments to the traditional CIT model. CIT officers in Fort Wayne have access to two hospitals and a transitional care center, where Memphis has only a single point of entry to mental health emergency services. This change broadens the range of services available to CIT officers, and the hospital and transitional care center staffs assist in transporting consumers to the hospital where they may have received services in the past. Fort Wayne also added training topics on problems of concern that were not required in the Memphis curriculum, such as a unit on autism.

Tailored Responses

After implementation of the CIT program, Fort Wayne identified several problem behaviors among middle and high school students. In some cases, self-mutilating behavior was detected, and in other cases, schools were struggling to manage the behavior of “bad kids.” Their only options at that time were to expel these students or have police arrest them for such acts as vandalism.

To address these school problems, CIT program planners began providing CIT training to all of the School Resource Officers (SROs). In addition, a CIT-trained officer has helped identify high school students who might benefit from mental health services. This officer’s training enabled him to recognize that some students were not simply acting out, but may have serious mental health problems. On more than one occasion, this officer used his training to gain a student’s trust, so the student could talk openly about what was happening in his or her life and get help.

Unique Program Features

Fort Wayne is fortunate to have the extensive involvement of a judge who reviews all civil commitment hearings and participates in officer training. Their program also uses a “stat sheet” to collect information on the number of calls the police get, how many are diverted at the scene, how many are brought to the hospital for twenty-four-hour observation, and how many are kept for seventy-two-hour holds. The form also collects data on the presence of weapons and whether the case involved a suicide attempt. This stat sheet then follows the consumer through the mental health system. If he or she is brought to the emergency room and a need for detention is identified, the stat sheet becomes the “face sheet” for the seventy-two-hour hold and is faxed to the judge for review. All face sheets are retained in the police department’s records, are analyzed on a monthly basis to track program responses, and are reviewed by the Judge and CIT Sergeant for accuracy. Summary data are shared appropriately to keep all stakeholders routinely informed about program progress.

* Dates and figures in this sidebar are consistent with the most recent information available at the time of this writing.

officers suited to address the situation, developing means for capturing information that will improve safety for repeat calls for service, and involving a secondary mental health response.

Programs that respond to safety concerns emphasize specialized training on policies and practices designed to help law enforcement officers take adequate time and steps to identify the signs and symptoms of mental illnesses. These programs reflect the understanding that these behaviors may be the result of an illness, draw on effective communication and behavioral strategies, and familiarize officers with less-lethal force options. Training includes the opportunity for role-play scenarios that enable officers to practice and hone their skills in addressing “real-world” crises before applying them in the field. These skills include those involved in maintaining the safety of all involved and determining whether the person meets the criteria for emergency mental health evaluation. Specially trained law enforcement officers apply their new skills in the field to determine if the situation involves a person who may have a mental illness. If it does, officers are trained to de-escalate the person’s behavior and to connect him or her to treatment when appropriate. When safety concerns involve educational institutions, additional personnel may receive specialized training. In Fort Wayne, for example, the department requires that all school resource officers (SROs) attend CIT training.

Specialized training for call takers and dispatchers is critical to officer and consumer safety. This training provides tools for call takers to identify calls that may involve a person with a mental illness, gather important information about the situation from the caller (for example, when possible, the person’s previous reactions to law enforcement, the person’s medication status, any history of violence) and provide that information to responding officers. Dispatchers follow specific protocols to help ensure that specially trained officers respond quickly to incidents they believe may involve a person with a mental illness.

Call takers clear calls and make notations in the CAD system about the involvement of weapons or violence to enhance safety should this location draw future calls for service. For example, in Akron, dispatchers

“The police response has become seamless and is totally accepted. Consumers even call police themselves now, which would not have happened prior to CIT.”

—JANE NOVAK
Member, NAMI-Indiana

“Our dispatchers are trained in verbal de-escalation and can sometimes avoid dispatching the police by talking down the individual on the phone.”

—LORIE WITCHEY
Dispatcher, Akron (Ohio)
Police Department

“I was a practicing public defender for ten years and saw how many clients had real issues with mental health and co-occurring substance use disorders. I knew these people would benefit from treatment and should not be in jail. Once they were in jail, they got stuck there.”

—VICTORIA COCHRAN
Chair, State Mental Health,
Mental Retardation and
Substance Abuse Services Board

“Don’t let anyone tell you we did not have a problem with arresting people who were mentally ill. Our people didn’t realize they had a mental illness and we were putting them in jail when they were sick.”

—OFFICER DANNY RATCLIFFE
CIT Officer, Pearisburg (Va.)
Police Department (NRV)

review incident reports and flag locations relating to a person with mental illness, focusing on the presence of a weapon or specific strategies that may have proven successful in de-escalating an encounter with the subject of the call for service. This information can be used to improve the dispatching and response of officers for any future calls to that location.

When tailoring a response program to safety concerns, the interviewed sites only included on-scene mental health experts as a secondary response. For example, in the agencies studied, a mental health professional might come to the scene, but only after the

“People were going to jail when they should not have. If you are mentally ill, jail is not the solution.”

—AMY TYLER

Director of Behavioral Health,
St. Joseph Hospital (Fort Wayne, Ind.)

New River Valley Tailors Response to Safety Concerns in Rural and Small Communities*

Quick Facts†

Government type: County, Municipal

Jurisdiction type: Rural, multi-jurisdictional

Population in 2007: 172,255 (estimate)

Area of New River Valley in square miles:
1,469 (estimate)

Program name: New River Valley Crisis
Intervention Team

Program start date: 2002

Overview

In response to growing concerns about the number of people with mental illnesses in the criminal justice system, program planners in New River Valley, Va., developed a multi-jurisdictional CIT that involves fourteen different law enforcement agencies within four counties and one city in a largely rural area. These agencies have found it difficult to implement state mandates that people with mental illnesses who qualify for emergency assessment must remain in the custody of law enforcement officers until an emergency service clinician can complete the assessment, and if necessary arrange for mental health services. Prior to the site visit, law enforcement custody could last up to four hours and individuals could not be placed in jail. (Legislation in 2008 increased the mandatory custody up to six hours to provide sufficient time for the provision of medical clearance.) Mental health resources are limited and the rural nature of the community requires emergency service clinicians and law enforcement officers to travel long distances to conduct assessments and then transport individuals to available inpatient facilities. The Mental Health Association (MHA) in Blacksburg, Va., funds a CIT coordinator, whose responsibilities include arranging for CIT training.

continued on next page

* Dates and figures in this sidebar are consistent with the most recent information available at the time of this writing.

† Population and area figures of the New River Valley are aggregate numbers for the jurisdictions that make up the “valley”: Montgomery County, Pulaski County, Floyd County, Giles County, and the independent City of Radford. Given the multi-jurisdictional structure of the region, data were not available on the number of law enforcement personnel.

New River Valley continued

Tailored Responses

The New River Valley CIT brought together fourteen jurisdictions that all fell within one of Virginia's mental health catchment areas. The goal of bringing the smaller, rural communities together was to capitalize on shared resources. For example, agencies created agreements to allow officers to cross jurisdictions and serve each other's residents, and developed a plan to provide CIT training to approximately 25 percent of the total number of patrol officers from the combined forces to have sufficient coverage of shifts and locations.

To address the burdens placed on law enforcement and emergency service clinicians who must travel long distances and spend hours maintaining custody of people who are in crisis, program planners also intend to streamline procedures so that law enforcement officers can take a person in crisis to a mental health facility and transfer custody to another designated law enforcement officer stationed at the hospital. The hospital would then arrange for appropriate assessment and placement if needed.

Unique Program Features

Stakeholders in the New River Valley note the profound impact the Virginia Tech shooting in April 2007 had on mental health resources, particularly on inpatient hospitalizations. According to the director of the New River Valley Community Services, there was a 99 percent increase in hospitalization rates for children and youth after the shooting incident. Another significant outcome of this tragic event was the enactment of new legislation that increased—from four to six hours—the amount of time a person in mental health crisis could be detained. To offset the demand this placed on law enforcement, the new legislation also allows “trained security officers” to accept people who have an emergency custody order and to do paperwork for emergency custody orders.

Due to differences in staffing and leadership styles, the participating law enforcement agencies vary in their perspectives about how many—and which—officers in their agencies should get CIT training. Consequently, the MHA trains some officers who do not volunteer for the assignment and trains all officers from some of the agencies. The MHA director notes that although some participants appear reluctant at the outset of training, two strategies tend to transform them. First, even people who don't want to participate in the CIT program have a very different attitude about mental health consumers once they have been to the site visits, where they meet with people who have mental illnesses who are doing well. Second, information that stresses the impact of the CIT approach on officer safety can change the minds of trainees who are otherwise disinclined to support a SPR.

“*The biggest problem with small departments is if we get taken on a call where the person needs placement in a hospital, the officer will be off-road for a whole shift. Oftentimes, we may only have a total of two or three officers on a shift.”*

—OFFICER DANNY RATCLIFFE

CIT Officer, Pearisburg (Va.) Police Department (NRV)

person's behavior is stable and the officer is in control of the situation. Typically in these response models, officers will transport the person to a mental health facility where mental health experts can conduct further assessment if needed. Individuals interviewed in the studied sites underscored that it is essential that these facilities allow law enforcement officers efficient access to a wide range of services.

Problem: *Frequent arrests of people with mental illnesses and strains on police resources*

Officers typically have three options when they encounter someone with a mental illness whose behavior is erratic—they can arrest the person if there is evidence a crime was committed, transport the person to a mental health facility in accordance with applicable legal mandates, or stabilize the situation and leave the person at the scene. Community members in each of the four sites identified several problems related to the limited options available for officers when encountering people with mental illnesses. Some stakeholders believed officers arrested people with mental illness who had committed minor offenses much too frequently. In most of these cases, individuals reported that the person's behavior may have been too disruptive for the officer to leave him or her alone at the scene, and the officer did not have adequate information about—or efficient access to—available mental health resources.

In other communities, stakeholders noted problems that occur when an officer must either remain with the person in crisis until a mental health professional arrives to conduct an assessment or transport the person to an emergency room, where they may spend additional hours waiting for the assessment to take place.

Tailored Responses

Programs developed in response to inefficient access to mental health resources use strategies to make these facilities more “officer-friendly.” In Fort Wayne, for example, the receiving facilities’ administrators adapted their procedures to prioritize intake for consumers who officers bring to the facility, allowing the officers to complete paperwork quickly and return to other

“ Law enforcement officers felt isolated from other service providers before CIT, and their knowledge of available resources was limited.”

—SGT. MICHAEL YOHE

CIT Coordinator, Akron (Ohio)
Police Department

“ Before CIT, officers were frustrated they had to wait a long time before transferring custody. With CIT, they could drop their paperwork off and scoot.”

—AMY TYLER

Director of Behavioral Health, St. Joseph Hospital (Fort Wayne, Ind.)

“ Our CIT program has diverted a fair number of people from jail to the mental health system, which is improving the balance between the legal system and the mental health systems.”

—DEB RICHEY

Nursing Director of Emergency Services, Parkview Hospital (Fort Wayne, Ind.)

“ Since CIT was implemented, fewer people are going to jail. The contacts are better and there are fewer arrests.”

—ANDY WILSON

Executive Director, Carriage House (Fort Wayne, Ind.)

duties. In addition to minimizing the strain on law enforcement time and resources, these efficiencies can decrease the number of people who may otherwise be taken to jail for minor offenses. When coupled with officer training on local mental health resources and de-escalating behaviors that might otherwise result in more serious charges against the individual, these changes can improve outcomes for the person with mental illness and the law enforcement first-responders.

Law enforcement responses that address poor knowledge about and limited access to mental health resources can also pair a law enforcement officer and mental health service provider to respond together to calls involving someone with a mental illness. In most cases, co-responder teams are dispatched as a “secondary” response. For example, in Los Angeles, patrol units are dispatched to calls based on priority, as is the usual practice.³¹ Once the patrol officer gets to the scene, he or she will make a determination about whether mental illness may be a factor and if the co-response team is needed. When the co-responder team arrives, the initial responding patrol officer manages safety concerns. The co-response team—both the law enforcement officer and the mental health clinician—focuses on the person with mental illness, making decisions about an assessment, referral for service, and placement.³²

In Los Angeles, an additional layer of dispatch is in place to facilitate this model. Law enforcement first-responders can ask patrol dispatchers for a Systemwide Mental Assessment Response Team (SMART); the dispatchers then route their call to the “Triage Center” of the Mental Evaluation Unit (MEU), where an officer assesses when to send out teams. This triage officer can access the MEU database to gather information on the criminal justice history for the subject of the call for service. The forensic nurse, who is co-located in this unit, can access the Department of Mental Health (DMH) records. Both

“It is the chief’s responsibility to balance resources, which involves practice, vision, and creativity. There is a resource benefit to the co-responder model: pairing a civilian with a sworn officer frees up other two-officer cars.”

—**CHIEF WILLIAM BRATTON**
Los Angeles (Calif.) Police Department

“Officers in [the CIT] program come to recognize the weaknesses in the mental health system and how to navigate them to benefit the consumer.”

—**RON RETT**
Member, NAMI-Ohio

“Through the partnership, police officers often learn to mirror the techniques that the mental health practitioners use in handling situations with people with mental illnesses.”

—**DR. TONY BELIZ**
Deputy Director, Emergency Outreach Bureau, Department of Mental Health, Los Angeles County (Calif.)

“Patrol commanders and those who respond to critical incidents are learning that mental health components are regularly an issue, and therefore, they recognize the value of MEU on these scenes.”

—**LT. MICHAEL ALBANESE (RET.)**
SWAT Commander, Los Angeles (Calif.) Police Department

³¹. When a call for service involves a person or place that has generated a high volume of previous police responses, the dispatch system flags any mental health issues and the dispatcher shares that information with the responding officers.

³². The Los Angeles County Department of Mental Health not only coordinates response teams with the Los Angeles Police Department, but also with agencies in Long Beach and Pasadena.

sources of information can guide the triage and ensure the responding team will have a more comprehensive history on the individual. When SMART is dispatched, the first-responder officers stay at the scene until the person in crisis has been stabilized. This provides support and backup to the SMART officer and the mental health clinician.

Even in agencies where there is no co-location of law enforcement and mental health personnel, co-responder teams can improve linkages to mental health or substance abuse treatment. Because the mental health professional has access to the person's mental health history, the team may be able to reconnect the person to a clinician who has previously treated him or her. In addition, mental health professionals working with law enforcement are knowledgeable about a wider range of services and supports, so they can find the most suitable mental health approach to the individual's needs. According to those interviewed for the project, co-responder teams can also assist in transportation to a mental health facility for a greater range of situations than law enforcement could alone. For example, the team may have more time to transport people who meet the criteria for involuntary evaluation to the mental health facility, which frees the first responding officer to return to patrol. In addition, because of the involvement of a mental health professional at the scene, co-responder teams may be able to transport people voluntarily to services and supports that would otherwise rely on a family member or public transportation.

Problem: High utilization of emergency resources

Many communities experience a large number of law enforcement calls to the same locations, involving the same people with mental illnesses without positive effect. Many of these same individuals have been found to also repeatedly need emergency medical services. This small group of consumers, often referred to as "high utilizers" of emergency services, typically represents people who are difficult to keep connected with nonemergency services, including continuous treatment that is effective in relieving their symptoms. In some cases, these individuals have co-occurring substance use disorders, are homeless, or both. They may cycle in

“ Law enforcement leadership must know how to apply the necessary resources to solving crimes [and disorder]. The best way to apply limited resources is to focus on the 10 percent of the population that uses the greatest amount of resources.”

—CHIEF WILLIAM BRATTON

Los Angeles (Calif.) Police Department

“ One challenging population is [the group of individuals] who are drug- or alcohol-dependent. They are only at our hospital for a short period of time and a large group does not follow through with treatment recommendations. This can result in a revolving door. The officer goes to the scene, brings the person in, we end up admitting them, and discharge them two to three days later. When they do not follow through with treatment, they will be back.”

—PATSY HENDRICKS

Director of Clinical Services, Parkview Behavioral Health (Fort Wayne, Ind.)

“ I believe it is in part because of our CAMP program that L.A. hasn't had [a mass shooting incident]. Once we identify someone who has mental illness [that puts them at risk of criminal justice involvement] and put them in the CAMP program, we monitor them to make sure they get medications, have housing, go to work, and can take care of themselves.”

—CAPTAIN ANN YOUNG

Commanding Officer, Detective Support and Vice Division, Los Angeles (Calif.) Police Department

Los Angeles Tailors Response to Safety Concerns and High Utilization of Emergency Services*

Quick Facts

Government type: Municipal

Jurisdiction type: Urban

Population in 2007: 3,834,340 (estimate)

Area of City of Los Angeles in square miles: 498.3

Number of sworn personnel: 9,883

Number of civilian personnel: 3,263

Program names: Systemwide Mental Assessment Response Teams (SMART) and Case Assessment Management Program (CAMP)

Program start dates: 1993 and 2005, respectively

Overview

Los Angeles has implemented several complementary program responses to address the complex needs of the jurisdiction. Los Angeles was one of the first communities to develop the police/mental health co-responder teams (SMART) in 1993. This program was designed to better link people with mental illnesses with appropriate mental health services. When the department came under a U.S. Department of Justice consent decree in 2001, one provision directed the agency to improve safety for all involved in officer encounters with people with mental illnesses. At that time, the department also began implementing a CIT program in pilot locations. However, due to its sheer size, both in area and in population, training the recommended 20 percent of its officers in CIT protocols could not effectively cover rapid responses. As a result, department leaders chose to prioritize CIT training for officers most likely to come in contact with people in a mental health crisis, although the training is not limited to these officers.

Tailored Responses

After implementation of CIT training and the SMART teams, a serious problem remained. A group of people with mental illnesses who called the police repeatedly, or were the subject of many calls for service, were costing the city millions of dollars in emergency resources. Further, a large percentage of SWAT call-outs involved someone with a mental illness. The police department developed the Case Assessment and Management Program (CAMP) to identify and track the subjects of these repeat calls, and construct customized responses to their problems. The program co-locates a police detective with psychologists and social workers from the county mental health agency in the police department facility. This team develops long-term solutions to an individual's needs on a case-by-case basis. In particularly complex situations, team members have conducted home visits on a daily basis, linked a person to service provision in his or her home, provided transportation assistance, or made appointments for services or treatment. The team members focus on developing trusting relationships with people in need and few resist the help.

The CAMP program receives referrals from both SMART officers and mental health professionals. When CAMP receives a referral, the psychologist reviews the information, accesses the Department of Mental Health (DMH) records, and reviews the person's history with the police. The psychologist makes the determination about whether the person qualifies for CAMP. For example, someone may qualify if incidents with the police have been high profile, if the person is accessing more than three emergency resources, or the person has a large number

continued on next page

* Dates and figures in this sidebar are consistent with the most recent information available at the time of this writing.

Los Angeles continued

of calls to the police over a short period. CAMP cases are worked by the psychologist, a detective, and a police officer. At this initial stage (level 1) the team develops and implements a plan for mental health treatment and strategies for managing services. When the person stabilizes (level 2), the case shifts to periodic monitoring. For example, the detective may contact some clients every week to check in, or stop by once a month. If the person remains stable and the family does not need help, the case becomes inactive (level 3) and is filed.

Unique Program Features

The department formed the “Mental Evaluation Unit (MEU)” to oversee all of these programs and manage points of intersection. The MEU contains a triage unit that fields calls from patrol officers who have questions about what to do in certain situations involving people with mental illnesses. In these circumstances, the triage officer consults the MEU database (separate from the CAD system and protected from access outside the unit) to learn this person’s history with the police. A triage mental health nurse sits alongside this officer and can check the DMH databases to determine the person’s case manager, psychiatrist, or treatment centers. The triage staff determines together whether to send out a SMART team or have the officer take the person directly to a mental health facility. If the triage unit determines that this person has repeatedly contacted police (or been the subject of frequent calls for intervention), they will refer the person to the CAMP coordinator for follow-up.

and out of treatment, and many do not follow through with treatment plans independently, including taking prescribed medications.

Tailored Responses

In Los Angeles, repeat calls for service led to the creation of the Case Assessment and Management Program (CAMP), which is a response strategy that focuses on proactive efforts to resolve the issues that generate repeat calls to police and others, including mental health case management and rigorous follow-up. CAMP teams include detectives from the police department and mental health clinicians, who work together to create customized plans for identified individuals. The CAMP team, which is located in the MEU area of the police department, receives referrals from many sources, including SMART officers, the Los Angeles Fire Department, school police, other city police officers, other LAPD detectives/investigators, and from mental health department personnel.

“The outreach team allows officers to see people when they are not in crisis—to see them as people. It also allows the consumers to have a positive and compassionate experience with the officers.”

—HELEN REEDY
Member, NAMI-Ohio

“There is pressure to handle a high volume of calls for service, and short-term fixes are often a reality. The outreach team follow-up with a consumer allows the police to start implementing longer-term solutions.”

—SGT. MICHAEL YOHE
CIT Coordinator, Akron (Ohio)
Police Department

In Akron, a similar experience with “repeat callers” prompted the creation of CIT Outreach Teams, which consist of a law enforcement officer who partners with a mental health case manager to conduct follow-up with consumers in the community. This is not a routine assignment for the officers; they must choose it as an off-duty assignment. Outreach Team assignments come from referrals from mental health service providers, probation officers, and from law enforcement officers who identify individuals who would benefit from follow-up visits. The CIT coordinator at Community Support Services (CSS) prioritizes the referrals based on mental health and criminal justice history. A list of repeat call locations is also provided for follow-up and prevention efforts. Follow-up visits can result in a transport to CSS, where psychiatrists or case workers can provide additional treatment and support, or directly admit the individual to a hospital.

PROGRAM EXAMPLE: Responding to homelessness, Fort Lauderdale (Fla.)

Given that a large number of homeless individuals suffer from mental health issues, Fort Lauderdale (Fla.) created a Homeless Outreach Unit to bring shelter, assistance, and understanding to the homeless population. The outreach team includes an officer and a mental health worker who try to address the myriad needs of the “homeless mentally ill population.” The officer’s assignment is voluntary because participating in the program requires a sincere compassion and commitment to assist people in crisis. The team’s officer confirmed that “these people have complex problems, they need medications they cannot afford, and the team needs to empathize with them.”

The team gets referrals from law enforcement officers, but also establishes a pick-up location for three hours each day to assist people who are homeless or have just been released from long-term programs. The officer interviews them and tries to link them with social services and shelters.³³

“I have responded to fewer CIT calls over time because of the positive effect of the outreach teams in decreasing repeat callers.”

—OFFICER LORI NATKO
CIT Officer, Akron (Ohio)
Police Department

“The outreach teams served as a natural complement to the CIT program. Referrals did not only come from mental health service providers, but also from officers who identify individuals that would benefit from follow-up visits.”

—RAGAN LEFF
CIT Coordinator, Community Support
Services (Akron, Ohio)

“CAMP team members develop responses on a case-by-case basis, and they range considerably. For complex cases, we conduct home visits—as often as daily—to link the person to services, in their home if needed, and obtain consent for our clinicians to speak to the person’s psychologist to check on whether the person is making and keeping appointments.”

—DETECTIVE TERESA IRVIN
CAMP Coordinator, Los Angeles (Calif.) Police Department

33. The information presented in this program example was developed based on a phone interview conducted during the information-gathering phase of this project. For more information about the Fort Lauderdale Homeless Outreach Unit, see the profile available on the Local Programs Database at www.cjmh-infonet.org/main/show/2071.

The Impact of Jurisdictional Characteristics on SPR Programs

CHARACTERISTIC	SPECIFIC JURISDICTIONAL CHARACTERISTICS	JURISDICTIONS	SPR ACTIVITIES
Law Enforcement Agency	Leadership style is consistent with “specialist” approach	Akron, Ohio Fort Wayne, Ind. Los Angeles, Calif. New RiverValley, Va.	A subset of self-selected law enforcement officers are assigned to teams.
	Leadership style is consistent with “generalist” approach	Los Angeles, Calif. New RiverValley, Va.	All officers receive training in basic de-escalation and recognizing mental illness.
	Conducted Energy Devices (CEDs) are used broadly as part of departmentwide use-of-force protocols	Akron, Ohio	Only CIT officers are provided with CEDs. ³⁴
	Conducted Energy Devices (CEDs) are used infrequently as part of departmentwide use-of-force protocols	Fort Wayne, Ind.	CIT officers are not provided with CEDs.
Mental Health System	Medical clearance is required before admission to a mental health facility	Fort Wayne, Ind.	Hospital emergency room protocols provide quick medical and mental health assessments in a secure area.
	Mental health resources are extremely limited/inaccessible	New RiverValley, Va.	Officers are trained to identify better those in need of emergency mental health assessments.
State Laws	Involuntary emergency mental health assessment requires extended police custody	New RiverValley, Va.	Officers are trained on de-escalation to enable them to manage safety concerns during custodial period. Law enforcement officers can be stationed at an emergency psychiatric facility to receive custody from patrol, freeing them to return to routine duties.
Demography and Geography	Large, urban jurisdictions	Los Angeles, Calif.	SMART units are assigned specific areas of responsibility and work in conjunction with the more than 800 officers who receive some mental health training to provide citywide coverage. All officers receive some online training.
	Small, rural jurisdictions	New RiverValley, Va.	The forces of multiple jurisdictions are combined to increase the number of trained officers who can respond to a large area.
	Medium, urban jurisdictions	Akron, Ohio	Department trained 19 percent of total sworn personnel in the department to respond.
		Fort Wayne, Ind.	Department trained nearly 20 percent of total sworn personnel in the department to respond.

34. Although accurate at the time of the interviews in 2007 and 2008, both the Akron Police Department and Fort Wayne Police Department have since revised their respective policies on CEDs. See page 35 for more information about the evolution of these changes.

Tailoring Specialized Policing Response Programs to Jurisdictional Characteristics

As distinct from the previous discussion about *problems* and their impact on the specialized response program, *jurisdictional characteristics* are largely static features in a community or agency, which policymakers and planners must consider in program design and implementation. (These are reviewed briefly in Section I.) The following discussion examines how the jurisdictional characteristics, such as those outlined in the summary chart on the previous page, shaped program responses. These factors include law enforcement agency characteristics (such as leadership and use-of-force protocols), mental health system characteristics (such as resources and medical clearance requirements), state law (such as those regarding emergency custody orders), and demographics and geography.

Jurisdictional characteristic: Law enforcement agency leadership

The predominant law enforcement agency characteristic that affected program development in the four studied sites was leadership style. According to those interviewed at the study sites, at the foundation of these preferences are law enforcement chief executives' opinions about the necessity of particular personality traits among personnel for carrying out specific tasks. For example, many in the field report that there are senior law enforcement officials who believe that officers trained for the specialized response, particularly special units, should be volunteers, self-selected to have compassion for people with mental illnesses. Others may feel that all first-responders should be educated about mental illnesses and trained to de-escalate crisis situations using appropriate procedures. Still others believe that some basic training for all first-responders is in order, with more intensive preparation for voluntary special unit personnel. Though concerns about training budgets, priorities for limited resources, size of jurisdiction, and other factors may be considered in determining who is trained and dispatched, many of the individuals interviewed in the study sites felt that the perspective of the agency's leaders largely determined how the response would be shaped.

Tailored Responses

Each of the four jurisdictions developed training approaches that were consistent with the agency leader's style. This was most notable in the regional New River Valley CIT program, where variation exists among the police leadership in the fourteen jurisdictions involved in the program. Each jurisdiction determines which and how many of its officers will be trained, resulting in differences among them. Leaders in the Los Angeles Police

“Not all officers can be CIT officers, because it requires a personal commitment and compassion that cannot be taught or forced. Still, because the skills are so generalizable, they can be applied, in part, on calls such as responding to people with mental retardation and developmental disabilities, domestic violence calls, or people who are intoxicated—all officers should have a basic understanding of them.”

—LT. RICHARD EDWARDS
Public Information Officer, Akron
(Ohio) Police Department

Department chose to provide some training on mental health issues to all patrol officers (twenty-four hours) because all officers must be prepared to handle the wide range of calls to which they respond. This agency also provides a full forty hours of “specialized” training to officers involved in its MEU, SMART, and CAMP strategies, and officers who receive CIT training for use in designated areas of the city.

Jurisdictional characteristic: Law enforcement agency use-of-force protocols

Department policies and practices on the use of force, particularly less-lethal technologies, also can play a role in program design. Police agencies must develop policies on how and when officers use a range of force options through a complex and careful process that takes into account factors such as officer training and the circumstances during the encounter. Many communities are grappling with the use of conducted energy devices (CEDs), such as Tasers,[™] during encounters with people with mental illnesses as a way to reduce the likelihood of serious injury or death during these incidents.

Tailored Responses

These policies differed significantly across jurisdictions visited for this study. For example, at the time of the site visits, the Akron Police Department provided CEDs *only* to CIT-trained officers, and the Fort Wayne Police Department *never* provided them to CIT officers. These policies have since changed, but the thinking behind these early policies on CEDs can be instructive for other agencies. Akron believed that the training provided to CIT officers uniquely positioned them either to use the device very judiciously or to de-escalate a situation so that a CED would not be needed. (Since the time of the visit, Akron has extended the use of CEDs to other officers with proper training.) In contrast, Fort Wayne believed that officers trained in CIT would be the least likely to need the device due to their training in de-escalation and that backup could be provided by another patrol officer on the scene. Fort Wayne Police Department leaders have since decided that

Tasers[™] are critical to the success and safety of CIT. Although applying CIT knowledge and communications skills are highly effective at de-escalation, no technique is 100 percent reliable. Having a less-lethal option available to CIT officers is an obvious way to increase everyone’s safety in handling many crisis calls. This is especially true considering that a significant number of these calls involve suicides-in-progress, and Tasers[™] may provide one of the few options to safely stop individuals from harming themselves. The conversation about less-lethal devices must be tied in with the CIT conversation.”

—SGT. MICHAEL YOHE

CIT Coordinator, Akron (Ohio)
Police Department

Though the Fort Wayne Police Department did not prioritize Tasers[™] for CIT officers, in part because they could be provided backup by other officers, they now have the same opportunity to request and train for the use of these less-lethal devices.”

—DEPUTY CHIEF DOTTIE DAVIS

Director of Training, Fort Wayne (Ind.)
Police Department

CIT training will not be a determining factor when selecting who in the department will be issued a CED.

If a department's leadership team decides that CEDs can make situations involving people with mental illnesses safer for all involved, law enforcement should work with their partners to develop protocols and policies, appropriate training, and supervision.³⁵

Jurisdictional characteristic: Mental health resources

Specialized policing response programs hinge on the availability of mental health resources to serve as an alternative to criminal justice system involvement when warranted. Although some communities manage to increase the available mental health resources, or shift them, many communities must work with what resources are available in their jurisdiction. As a consequence, stakeholders must develop strategies to manage increases in volume that result from law enforcement transports or referrals. Among the issues to be considered are whether any changes can be made in triaging to ensure the highest levels of care match those most in need, evaluating admission criteria and accessibility issues, easing contact and increasing efficiency for law enforcement personnel, and addressing any commensurate increases in costs related to caring for people with mental illnesses at risk of continued criminal justice involvement, many of whom are uninsured.

Tailored Responses

In Los Angeles and New River Valley, specialized policing response programs reduce some demands on limited mental health resources by relying on

“The main problem in Los Angeles is a lack of available resources—even trained officers have nowhere to transport individuals. Not only can the officers not transport anyone, there are no services to recommend to family members anymore. Psychiatric emergency rooms and psychiatric inpatient units are located in the county hospital, and one county hospital has closed completely.”

—NANCY CARTER

Executive Director, NAMI–Urban
Los Angeles (Calif.)

“The number of scenarios that involve custody was a lot more before the CIT training. Officers can now better identify people who need to be taken into custody because they know what to look for. Fewer people are taken into custody, and more people are taken appropriately.”

—OFFICER DANNY RATCLIFFE

CIT Officer, Pearisburg (Va.)
Police Department (NRV)

35. For more information about standards and guidelines for CED use, the Police Executive Research Forum (PERF), with support from the Office of Community Oriented Policing Services (COPS Office), has created a resource on the topic. See James M. Cronin and Joshua A. Ederheimer, *Conducted Energy Devices: Development of Standards for Consistency and Guidance* (Washington, DC: U.S. Department of Justice, Office of Community Oriented Policing Services and Police Executive Research Forum, 2006), www.ojp.usdoj.gov/BJA/pdf/CED_Standards.pdf.

well-trained officers and effective information-gathering to help properly assess individuals' need for emergency evaluations, and whenever possible, connect people with care providers outside of the emergency response networks. As mentioned previously, in Los Angeles, the SMART officers work with their triage unit to access a database with an individual's history while the forensic nurse in this unit can access the mental health records. In the New River Valley, CIT officers are trained to screen people for the need for hospitalization, so fewer people are taken into custody. In both jurisdictions, law enforcement is working with the mental health community to make the most of limited resources.

In one hospital in Fort Wayne, the volume of mental health patients increased significantly as a result of the implementation of the CIT program. The number of twenty-four-hour mental health assessment holds brought to the hospital by police doubled—from 600 in 1998 to 1,200 in 2007. The stakeholders in this community also eventually determined that a subgroup of people had been invoking a seventy-two-hour hold repeatedly when they did not have a mental illness. These individuals had primary substance abuse issues and many were attempting to avoid arrests for DUI. The facility arranged with the judge who oversees the commitment hearings to limit the number of times a person could be admitted consecutively based on an emergency custody order to eliminate those who were not in need of mental health treatment. This resulted in increased availability of services for those who appropriately needed mental health care.

To manage costs, the inpatient mental health providers in Fort Wayne have developed a mechanism to enroll people in benefit programs, such as Medicaid. The hospital contracts with a for-profit business that charges a fee to enroll qualified individuals in Medicaid programs. The contractors working at Parkview Behavioral Health have converted 52 percent of the people who were admitted without insurance to become covered by Medicaid, which has significantly reduced the hospital's burden of providing uncompensated care.³⁶

Clinicians now recognize the CIT officer and take more stock in what a CIT officer is saying. The clinicians also recognize the added benefit that the officer provides by de-escalating the situation before the clinician gets there."

—DEPUTY CHIP SHRADER

Montgomery County (Va.)
Sheriff's Office (NRV)

The biggest fear was that this was going to cost more money. Parkview became creative with funds and implemented programs—with social workers getting . . . Medicaid for clients—to get the ball rolling."

—JAMES WHITE

Service Coordinator/Security
Lead Staff, Park Center Inc.
(Fort Wayne, Ind.)

The other issue that providers need to be aware of is that this will impact their payer mix—many people in this population are underinsured or not insured. If you are using the ER as the access point, this can be costly."

—CHUCK CLARK

Executive Director, Parkview
Behavioral Health (Fort Wayne, Ind.)

36. For more information about connection to federal benefits, particularly for people with mental illnesses who are returning to the community from prison or jail, see www.reentrypolicy.org/issue_areas/reentry_federal_benefits.

Although the communities visited were not able to create entirely new mental health resources, they were successful in maximizing the use of existing resources through two particular strategies: First, planners stretched resources by training officers and others to identify more accurately those people who needed emergency mental health services. Second, planners developed strategies to enroll qualified individuals in benefits programs to improve payment of needed mental health services. In the New River Valley, law enforcement agencies also shared resources throughout the region, making it easier to access and sustain them.

“The biggest challenge is bringing all the people in through the ER. The ER was identified as the access point for all psychiatric patients; it is expensive and not best for patients to have to wait three or four hours for an assessment.”

—CHUCK CLARK

Executive Director, Parkview Behavioral Health (Fort Wayne, Ind.)

Jurisdictional characteristic: Medical clearance requirements

In the New River Valley and in Fort Wayne, mental health system stakeholders were hesitant to accept someone into a mental health facility who might have a medical condition that requires priority treatment. This concern is shared by many communities across the country, and program models typically require law enforcement officers to transport the person in mental health crisis first to a hospital emergency room for medical clearance. In these cases, mental health services are provided after a physician determines the person is well enough for psychiatric assessment.

The necessity of medical clearance requires program planners to develop procedures to guarantee a safe and timely medical assessment, to ensure the safety needs of other patients and staff, and to create a smooth transition to the appropriate mental health resource.

Tailored Responses

In Fort Wayne, law enforcement officers bring the person in crisis to the emergency room of the local hospital through the ambulance entry to one of three secure rooms. This allows privacy and security. The individuals in the care of officers get priority treatment and officers talk directly with the mental health counselors. Once the physician determines the individual's medical condition is stable, the mental health clinicians assess the needed level of care.

To enable officers to return to other duties, the hospitals in Fort Wayne employ security staff to monitor the patient's safety and the safety of others in the emergency room. The hospital worked with their legal counsel to develop clear guidelines on holding, restraining, and detaining patients, and to make sure that hospital security is not held liable for injuries that may result. Although the goal in these hospitals is to err on the side of protecting patients from harming themselves or others, their care, dignity, and privacy were considered in developing these guidelines.

Jurisdictional characteristic: State laws

Requirements in state laws regarding law enforcement officers' role in emergency mental health evaluations must be addressed in designing and implementing specialized policing responses. These laws may affect program design by mandating certain types or the scope of training. They can also spell out under what circumstances officers are permitted to transport or take into custody individuals with mental illnesses who meet specific standards (such as imminent harm to themselves or others).

Among the many state mandates that can affect program design, the one that was most at issue in the four-site study involved officers taking custody of individuals with mental illnesses for emergency evaluation. As described, in Virginia, for example, a law enforcement officer is authorized to determine if a person meets the criteria for an "emergency custody order" (ECO) without taking the person in front of a magistrate. The ECO lasts up to six hours (previously mandated at four hours), and state law requires that the officer maintain custody of the person with mental illness while they wait for a mental health crisis worker to arrive and complete a mental health assessment, and find a treatment bed if needed. Officers may not detain the person in jail during this time, which means law enforcement agencies must designate a place where the officer can stay with the person in crisis until a clinician arrives. Oftentimes, this space becomes a multipurpose room (the same area may serve as a waiting area for a person who has been served a warrant and for someone who has come to the department to report a crime). If the six-hour period elapses without an assessment or an available place for treatment, the person must be released.

During the ECO time period, crisis workers assess the person's status, gather collateral information, and decide if the person meets the criteria to be committed. If the criteria are met, the clinician tries to facilitate an admission to an inpatient facility—either into a public or private facility—or diverts the individual back to the community to receive services and supports. The majority of the calls are handled within the six-hour period.

Tailored Responses

One goal of the New River Valley CIT program is to address the strain on law enforcement personnel created by this law. At this writing, there is legislation in place in Virginia that would allow for a CIT officer to be stationed in the hospital emergency room to accept custody of the incoming person in mental health crisis, and allow the transporting officers to return to patrol. Alternatively, if the hospital has a police or security department of its own,

In 2008, hospitals were faced with national patient safety goal #15, which requires a system for screening patients for suicide risk. They must be screened appropriately and the hospital must provide 'continuity of care' so that when the person returns to the community it must be with a safety net in place.

Mental health clients are no longer what we do at the end of the day when we are done with everything else. This hospital is now making psychiatric services a priority and we are committed to quality services."

—DEB RICHEY

Nursing Director of Emergency Services, Parkview Hospital (Fort Wayne, Ind.)

the new legislation allows “willing and able” hospital security staff to extend their duties to include managing the ECO process.³⁷

For law enforcement officers in Fort Wayne, the ECO under state law has been limited to a twenty-four-hour hold and it has been an effective tool for reducing the time officers spend waiting at community facilities with people who need a mental health assessment. This statute was originally underutilized because officers were not comfortable making decisions regarding mental health assessment criteria. Now that they have received specialized training on the issue, they are more likely to invoke the ECO law that authorizes them to transport that person to the emergency room without the officer needing to retain custody. Although this ECO is designed primarily for medical observation, it can be converted into a seventy-two-hour commitment for mental health evaluation upon judicial order.

“There was a statutory twenty-four-hour hold on the books since 1969. The reason it was not used was because police officers were not trained. Before CIT, officers had to wait hours with the person in crisis until a mental health professional could come and conduct the assessment. Now, along with CIT, we are using this hold so that officers have the authority to take the person to a mental health facility for assessment, where better procedures reduce the amount of time officers must wait with the person. This has added a great efficiency to our processes.”

—JAMES WHITE

Service Coordinator/Security
Lead Staff, Park Center Inc.
(Fort Wayne, Ind.)

PROGRAM EXAMPLE: Working collaboratively to meet legal guidelines, Lincoln (Nebr.)³⁸

In Nebraska, law enforcement and correctional officers are the only authorities who can take people into emergency protective custody (EPC) for involuntary mental health evaluation. Within thirty-six hours, a county attorney will determine whether to proceed with the involuntary commitment process. Nebraska is divided into six regions, each of which has a dedicated facility to receive people placed into EPC by law enforcement. Police officers in the City of Lincoln have round-the-clock access to mental health professionals in their region to assist them in deciding whether the person warrants custody or to determine an appropriate alternative. The Lancaster County Mental Health Agency, which serves Lincoln, is available 24/7 either by phone, in-person in the field, or at the police station. The officer can also take individuals directly to the mental health agency during business hours.

The City of Lincoln has also created a new process that has reduced by half the number of EPC orders officers do in a year. The key is to provide information to officers in the field about consumer involvement in programs like Assertive Community Treatment (ACT) to maintain their connection to these programs. Consumers can sign a waiver to put their participation in ACT in a police database. When officers conduct a routine warrant search, they get a message to contact the person's case manager, rather than taking the person into the emergency mental health system, where they will have to start over.

³⁷. At press time, this legislation had been passed and the leadership in New RiverValley were working toward implementing this practice.

³⁸. The information presented in this program example was developed based on a phone interview conducted during the information-gathering phase of this project. For more information about the Lincoln Police Department's efforts, see the profile available on the Local Programs Database at www.cjmh-infonet.org/main/show/2103.

Jurisdictional characteristic: Demography and geography

A jurisdiction's population size and density, land area, traffic patterns, and crime problems present important constraints on specialized responses. Jurisdictions of all sizes, particularly those at either end of the range, struggle with the adequacy of community-based resources, the ease of accessing them, and the allocation of officers to work with them.

Tailored Responses

In Los Angeles, one of the strategy impetuses was concern over safety for all individuals involved in police encounters, which resulted in recommendations to implement CIT. However, the size of the police department limited the agency's ability to train the recommended benchmark of 20 percent of the officers to work full time on crisis intervention calls.³⁹ The jurisdiction's large geographic area also made deploying the CIT-trained officers difficult. They found during pilot testing in one area that the 20 percent of the officers they were able to train in just that district still were only able to respond to 20 percent of the calls involving people with mental illnesses. In large part, this occurred because transportation to psychiatric emergency centers kept CIT officers in the hospital for three to four hours, unable to respond to other mental health calls.

In response, LAPD tailored its strategy to focus on the co-response model—increasing the number of personnel assigned to SMART and expanding the hours of operation. The co-responder teams are assigned to patrol areas with overlapping response protocols, which ensures citywide coverage. The linchpin to this strategy is the MEU “triage desk,” with staff that provides advice to primary responders, dispatches SMART units, controls the flow of individuals who have received law enforcement responses to county psychiatric emergency departments, and maintains a database of law enforcement contacts. In addition, Los Angeles decided to train all officers with twenty-four hours of online training on crisis intervention tactics, and the department offers a CIT course each quarter that is open to all first-responders, although priority is given to those officers most likely to encounter people with mental illnesses. This training

“ [One] reason larger cities are challenged to maintain CIT is because geography and the sheer number of calls to which they must respond can prohibit relationship-building. With three county hospitals, CIT police officers are unable to form necessary relationships with hospital personnel because they are limited by time.”

—LINDA BOYD

Manager of Law Enforcement Mental Health Programs, Department of Mental Health, Los Angeles County (Calif.)

“ My officers can spend up to twelve hours on night shift dealing with a call involving a mental health assessment. This is the biggest problem our small department faces. If we get taken on a call like that, a whole shift is off-road all night and we may only have two or three deputies on duty.”

—CHIEF JACKIE MARTIN

Pearisburg (Va.) Police Department (NRV)

39. The recommendation to train 20 to 25 percent of a law enforcement agency is proposed by the CIT Center at the University of Memphis in the “Crisis Intervention Team Core Elements,” <http://cit.memphis.edu/CoreElements.pdf>.

is a key component of LAPD's strategy because any officer may encounter someone whose mental illness is a factor in the call for police involvement. The department's leaders believed all officers would benefit from knowledge of these techniques. So the LAPD based its decisions to build a multi-tiered response model on the size of the jurisdiction, data that identified a particular geographic area that generated repeat calls for service, leadership style, and many of the other characteristics discussed previously.

The New River Valley CIT brought together fourteen jurisdictions in its area because they all fell within one of Virginia's mental health catchment areas.⁴⁰ The goal of bringing the smaller, rural communities together was to capitalize on shared resources. For example, agencies created agreements to allow officers to cross jurisdictions and serve each other's residents, and planned to train 25 percent of the total number of patrol officers from the combined forces to have sufficient coverage of shifts and geography.

In New River Valley, these communities have focused on developing better relationships between law enforcement and consumers of mental health services. Because of the CIT program and officer training, stakeholders note that consumers are less reluctant to interact with law enforcement officers, are less fearful of officers, and even recognize CIT officers as helpful. Although this improved relationship may not change the fact that law enforcement must stay with the person for up to six hours, and may not have a nearby facility to take them, it does help officers communicate with consumers and understand how to resolve problems. According to those interviewed in the study site, the improved rapport and trust between officers and clinicians, consumers, and citizens who call for assistance has also boosted the credibility of law enforcement observations in the eyes of mental health professionals.

“One of the advantages to large jurisdictions is that there are many resources to tap and many community members to assist and many officers committed to working with this population.”

—CHIEF WILLIAM BRATTON
Los Angeles (Calif.) Police Department

“The very nature of the rural community creates challenges—the distances are long and there is almost no public transportation [to help people access services easily].”

—HARVEY BARKER
Director, New River Valley (Va.)
Community Services (NRV)

“It used to be mental health on one side, law enforcement on the other. They looked at us as yanking people out, and we looked at them and thought: I've had to fight this guy to get him to the department and you want to be all touchy feely. The trip we all took to Memphis brought us together and created a lasting bond. We gained a lot of respect for each other during that time.”

—DEPUTY CHIP SHRADER
Montgomery County (Va.)
Sheriff's Office (NRV)

40. Because mental health services are organized along different geographic lines than law enforcement services, it can be difficult to develop coordinated service delivery strategies. Jurisdictions need to consider their respective catchment areas when setting up collaborative initiatives.

PROGRAM EXAMPLE: Tailoring to a large rural region, Piscataquis County (Maine)⁴¹

Piscataquis County (Maine) is the only “frontier county” east of the Mississippi. According to Sgt. Robin Gauvin of the Portland, Maine, Police Department, this equates to a population density of less than one person per square mile. This county has three municipal police departments that determined a need to improve their response to people with mental illness in this rural area. This program has focused on creating force multipliers to boost the law enforcement response capacity.

For example, in 2003 the law enforcement agencies began partnering with Emergency Medical Services so that ambulances co-respond with police on situations involving someone with a mental illness. When an area has only one deputy in charge of 400 square miles, this agreement translates to the addition of three or four emergency medical technicians who can be called upon to assist. The involvement of the ambulance staff assists with de-escalation and transportation. The officer can arrive at a scene within ten minutes and an ambulance can arrive in twenty to thirty minutes, but mobile crisis workers would take more than an hour to reach most areas. Call takers and dispatchers are also part of expanding capacity to respond. They are now trained to ask for more information, give options to help, and ask questions once thought dangerous to ask a caller expressing thoughts of suicide.

Conclusion

SPR program development should be guided by both the problem in the community and the specific characteristics of the jurisdiction. There is no “one-size-fits-all” response that will work in every community. It is vital that leaders in law enforcement, mental health, and consumer advocacy understand what obstacles there are to providing sensitive and appropriate responses to people with mental illnesses, and then assess what resources and agency strengths can overcome them.

The program activities presented in this guide hint at the efforts being made around the country to improve law enforcement responses to people with mental illnesses. They should not be considered a complete catalog of all possible options, but rather are included to highlight common themes and promising approaches to problems faced by agencies with varying demographics. The examples from the sites, and the discussions of selected problems and factors that should influence program planning, are provided to underscore the need to truly understand what responses will make the most sense in a particular jurisdiction. It is hoped that policymakers and planners from any agency can use this guide as a starting point to design or enhance a SPR program that will result in better outcomes for people with mental illnesses, a more effective and rewarding use of law enforcement resources, and improved safety of all involved in these encounters.

41. The information presented in this program example was developed based on a phone interview conducted during the information-gathering phase of this project. For more information about the Piscataquis Sheriff's Office Crisis Intervention Team, see the profile available on the Local Programs Database at www.cjmh-infonet.org/main/show/3137.

Appendix A

Site Visit Information

Titles and agency affiliations reflect the positions held at the time the interviews were conducted.

Akron (Ohio)

Site Visit Dates: December 5–7, 2007

Interviews Conducted

- Chief Michael Matulavich, Akron Police Department
- Lieutenant Richard Edwards, Public Information Officer, Akron Police Department
- Lieutenant Mike Woody (retired), Law Enforcement Liaison, Ohio Criminal Justice Coordinating Center of Excellence
- Sergeant Michael Yohe, CIT Coordinator, Akron Police Department
- Officer Lori Natko, CIT Officer, Akron Police Department
- Officer Forrest Kappler, CIT Officer, Akron Police Department
- Ms. Lorie Witche, Dispatcher, Akron Police Department
- Dr. Mark Munetz, Chief Clinical Officer, Summit County (Ohio) Alcohol, Drug Addiction and Mental Health Services Board
- Kim Shontz, Director of Outpatient Services, Community Support Services
- Joan “Ragan” Leff, CIT Coordinator, Community Support Services
- Ron Rett, Member, NAMI–Ohio
- Mel and Helen Reedy, Members, NAMI–Ohio
- Bernie, Consumer

Fort Wayne (Ind.)

Site Visit Dates: February 20–21, 2008

Interviews Conducted

- Deputy Chief Dottie Davis, Director of Training, Fort Wayne Police Department
- Officer Mark Bieker, CIT Officer, Fort Wayne Police Department
- Teresa Hatten, President, NAMI–Indiana
- Jane Novak, Member, NAMI–Indiana
- Deb Richey, Nursing Director of Emergency Services, Parkview Hospital (Fort Wayne)
- Marcy Malloris, Transitional Care Services Manager, Park Center Inc. (Fort Wayne, Ind.)
- James White, Service Coordinator/Security Lead Staff, Park Center Inc. (Fort Wayne, Ind.)

- Chuck Clark, Executive Director, Parkview Behavioral Health (Fort Wayne)
- Patsy Hendricks, Director of Clinical Services, Parkview Behavioral Health (Fort Wayne)
- Amy Tyler, Director of Behavioral Health, St. Joseph Hospital (Fort Wayne)
- Joe Louraine, Assessment Specialist, St. Joseph Hospital (Fort Wayne)
- Andy Wilson, Executive Director, Carriage House (Fort Wayne)
- Tom, Consumer, Carriage House (Fort Wayne)
- John, Consumer, Carriage House (Fort Wayne)
- Joe, Consumer, Carriage House (Fort Wayne)

Los Angeles (Calif.)

Site Visit Dates: December 11–14, 2007

Interviews Conducted

- Chief William Bratton, Los Angeles Police Department
- Assistant Chief Jim McDonnell, 1st Assistant Chief, Chief of Staff, Los Angeles Police Department
- Assistant Chief Earl Paysinger, Director, Office of Operations, Los Angeles Police Department
- Commander Harlan Ward, Assistant Commanding Officer of Valley Bureau, Los Angeles Police Department
- Captain Ann Young, Commanding Officer, Detective Support and Vice Division, Los Angeles Police Department
- Lieutenant Rick Wall, Mental Evaluation Unit, Los Angeles Police Department
- Lieutenant Michael Albanese (ret.), SWAT Commander, Los Angeles Police Department
- Detective Teresa Irvin, CAMP Coordinator, Los Angeles Police Department
- Dr. Luann Pannell, Director of Police Training and Education, Los Angeles Police Department
- Dr. Tony Beliz, Deputy Director, Emergency Outreach Bureau, Department of Mental Health, Los Angeles County
- Linda Boyd, Manager of Law Enforcement Mental Health Programs, Department of Mental Health, Los Angeles County
- Nancy Carter, Executive Director, NAMI–Urban Los Angeles
- Jim Randall, President, NAMI–San Fernando Valley
- Mark Gale, Member, Board of Directors, NAMI–California

New River Valley (Va.)

Site Visit Dates: March 6–7, 2008

Interviews Conducted

- Victoria Cochran, Chair, State Mental Health, Mental Retardation and Substance Abuse Services Board
- Chief Jackie Martin, Pearisburg Police Department
- Chief Gary Roche, Pulaski Police Department
- Lt. Brad St. Clair, Montgomery County Sheriff's Office
- Deputy Chip Shrader, Montgomery County Sheriff's Office
- Officer Danny Ratcliffe, CIT Officer, Pearisburg Police Department
- Patrick Halpern, Executive Director, Mental Health Association of the New River Valley, Inc.
- Dr. Harvey Barker, Executive Director, New River Valley Community Services
- Marie Moon Painter, Clinical Team Leader for CONNECT, Carilion St. Albans Behavioral Health

Appendix B

Document Development

This document was developed based on information gathered in several communities throughout the country, which were selected to represent a range of characteristics—diverse objectives, jurisdiction sizes, and program models. The site selection process began with an in-depth review to identify jurisdictions with an active law enforcement-based specialized response program—including mining the Local Programs Database, examining literature published on existing programs, and consulting with national experts. Once a comprehensive list was compiled, programs were screened for inclusion based on three important features—the program had to be *law enforcement-based*, in existence for at least *five years*, and designed *independently* based on the jurisdiction's *specific circumstances*.

Why these three characteristics?

- 1) Many communities have developed teams of community mental health professionals, such as mobile crisis or assertive community treatment teams, to assist officers at the scene. Although these models are undoubtedly a valuable resource for many communities and departments, they do not require significant policy and procedural changes in the law enforcement agency, and therefore are not *law enforcement-based* and are not within the scope of this document.
- 2) Anecdotal evidence suggests that during the first five years of an initiative, program practices and policies undergo an iterative process of development, building on the program's successes and failures over time. Based on this finding, jurisdictions needed to have an operational program for at least five years to be considered.
- 3) Several state governments have coordinated efforts to proliferate a specific model throughout jurisdictions in their state. These states should be applauded for these efforts, but jurisdictions that selected and implemented a program based on state policymakers' influence did not go through an independent program design process. Because the intention of this report is to identify and describe the various methods of program design, only jurisdictions that designed the program based on *specific circumstances and characteristics* were included.

The initial screening process left a short list of jurisdictions that fit the three primary criteria. Interviews were conducted with representatives from the remaining programs, and were centered on four main questions:

1. How was the program developed?
2. Is there a priority population involved in the strategy?
3. What is the nature and strength of the criminal justice/mental health collaboration?
4. How are data collected and analyzed?

Information gleaned from these telephone interviews was considered in the context of remaining selection criteria: variation in program model and jurisdiction type (e.g., demographic features and geography), mental health delivery styles, field familiarity (e.g., highlighting less-known programs), and usefulness and applicability to the field. Based on this review process, Akron (Ohio), Fort Wayne (Ind.), Los Angeles (Calif.), and New River Valley (Va.) were selected to be visited for this report.

Appendix C

Program Design Worksheet

Step 1: Understand the problem

1. What forces are driving current efforts to improve the law enforcement response to people with mental illnesses?
2. What data can planning committee members examine to understand the factors influencing law enforcement responses to people with mental illnesses?
3. What are the data limitations, and how can they be overcome?

Step 2: Articulate program goals and objectives

1. What are the program's overarching goals?
2. What are the program's objectives?

Step 3: Identify data-collection procedures needed to revise and evaluate the program

1. What data will be collected to measure whether goals and objectives have been achieved?
2. What data collection strategies will be used?

Step 4: Detail jurisdictional characteristics and their influence on program responses

1. What characteristics of the law enforcement agency are relevant in planning a specialized response to people with mental illnesses?
2. What mental health system characteristics are relevant in planning a specialized response to people with mental illnesses?
3. What state laws are relevant in planning a specialized response to people with mental illnesses?
4. What demographic and geographic community characteristics are relevant in planning a specialized response to people with mental illnesses?

Step 5: Establish response protocols

1. What law enforcement responses are necessary?
2. What mental health system responses are necessary?
3. What other responses or resources are necessary?

Step 6: Determine training requirements

1. How much training will be provided and to which law enforcement personnel?
2. What topics should training cover?
3. Who will provide the training?
4. What training strategies will be employed?

Step 7: Prepare for program evaluation

1. What resources need to be set aside or identified for an evaluation?
2. Are there individuals designated to oversee the evaluation?

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VIII.

ABSTRACTS FROM SPECIAL ISSUE OF THE
AMERICAN JOURNAL OF ORTHOPSYCHIATRY, 2015,
SPECIAL SECTION ON GUN VIOLENCE

*ABSTRACTS FROM SPECIAL ISSUE OF THE AMERICAN JOURNAL OF
ORTHOPSYCHIATRY, 2015, SPECIAL SECTION ON GUN VIOLENCE*

Goss, Kristin A. (2015) Defying the odds on gun regulation: The passage of bipartisan mental health laws across the States. *American Journal of Orthopsychiatry*, 85, 203-210. <http://dx.doi.org/10.1037/ort0000068>
Special Section: Gun Violence.

Abstract: This article documents an important exception to the conventional wisdom that politicians just will not tighten gun laws. Over the past decade, and mostly under the radar, both state and federal legislators have enacted more than 80 laws designed to regulate access to guns by people with mental illness and to support programs to reduce gun violence within that population. This study begins with a brief overview and evaluation of the barriers to enacting firearms regulations (of all sorts) in America. The author next reviews lawmaking at the nexus of mental health and firearms over the past decade. The author provides an overview of the types of laws that have been enacted and the political circumstances that have facilitated their passage. The author concludes with some thoughts about whether these cases provide any generalizable lessons for consensus-based policymaking on guns. (PsycINFO Database Record (c) 2015 APA, all rights reserved)

Hargrove, D. S., Perdue, R. P. (2015). A broader perspective of gun control. *American Journal of Orthopsychiatry*, 85, 225-227. <http://dx.doi.org/10.1037/ort0000066>
Special Section: Gun Violence.

Abstract: The point of this commentary is not to advocate for either position. Rather, the aim is to put the matter of gun control into a broader context, inclusive of a theological and spiritual perspective. Shining a different light on the roots of gun control provides a different understanding of it. A different understanding has the potential to change the tone of the national debate. It is the authors' belief that the tone and complexity of the national debate does not stem from the content of the issue but from the emotionality. The perspective of this comment is taken from a systems view of life in America that includes an attempt to move away from an individual perspective. (PsycINFO Database Record (c) 2015 APA, all rights reserved)

Hodges, H. J.; Scalora, M. J. (2015). Challenging the political assumption that "Guns don't kill people, crazy people kill people!" *American Journal of Orthopsychiatry*, 85, 211-216. <http://dx.doi.org/10.1037/ort0000069>
Special Section: Gun Violence.

Abstract: Presumptions that mental illness is causally tied to firearm violence and that guns are too easily acquired by such persons have given rise to laws that categorically restrict people with mental health concerns from exercising a Constitutional right. Underlying these reforms appears to be a revised idiom, "Guns don't kill people—crazy people kill people." The purpose of this commentary is to address these assumptions and provide suggestions for managing this critical threat. (PsycINFO Database Record (c) 2015 APA, all rights reserved)

IX.

ABSTRACTS FROM SPECIAL ISSUE OF BEHAVIORAL
SCIENCES AND THE LAW, SPECIAL ISSUE, “GUNS,
MENTAL ILLNESS, AND THE LAW” (2015)

Frattaroli, S., McGinty, E.E., Barnhorst, A., & Greenberg, S. (2015). Gun Violence Restraining Orders: Alternative or Adjunct to Mental Health-Based Restrictions on Firearms? *Behavioral Sciences and the Law*, 19. doi: 10.1002/bsl.2173. [Epub ahead of print]

The gun violence restraining order (GVRO) is a new tool for preventing gun violence. Unlike traditional approaches to prohibiting gun purchase and possession, which rely on a high threshold (adjudication by criminal justice or mental health systems) before intervening, the GVRO allows family members and intimate partners who observe a relative's dangerous behavior and believe it may be a precursor to violence to request a GVRO through the civil justice system. Once issued by the court, a GVRO authorizes law enforcement to remove any guns in the respondent's possession and prohibits the respondent from purchasing new guns. In September 2014, California's governor signed AB1014 into law, making California the first U.S. state to enact a GVRO law. This article describes the GVRO and the rationale behind the concept, considers case examples to assess the potential impact of the GVRO as a strategy for preventing gun violence, and reviews the content of the California law. Copyright © 2015 John Wiley & Sons, Ltd.

Swanson, J. W., & Felthous, A. R. (2015). Guns, mental illness, and the law: Introduction to this issue. *Behavioral Sciences & the Law*, No Pagination, <http://dx.doi.org/10.1002/bsl.2178>

Firearm violence is a top-tier public health problem in the U.S., killing 33,563 and injuring an additional 81,396 people in 2012 (Centers for Disease Control and Prevention, CDC, [2015]). Given constitutional protection and the cultural entrenchment of private gun ownership in the U.S., it is likely that guns will remain widely accessible – and largely unrestricted – for the foreseeable future. Therefore, most policies and laws intended to reduce firearm violence focus selectively on preventing “dangerous people” from having access to guns. That is a formidable challenge. How do we think productively about guns and mental illness in this context, and about the role of law in lessening the toll of gun violence? Copyright © 2015 John Wiley & Sons, Ltd. (PsycINFO Database Record (c) 2015 APA, all rights reserved)

Swanson, J. W. Sampson, N. A.; Petukhova, M. V. Zaslavsky, A. M. Appelbaum, P. S. Swartz, M. S., & Kessler, R. C. (2015). Guns, impulsive angry behavior, and mental disorders: Results from the national comorbidity survey replication (ncs-r). *Behavioral Sciences & the Law*, <http://dx.doi.org/10.1002/bsl.2172>

Analyses from the National Comorbidity Study Replication provide the first nationally representative estimates of the co-occurrence of impulsive angry behavior and possessing or carrying a gun among adults with and without certain mental disorders and demographic characteristics. The study found that a large number of individuals in the United States self-report patterns of impulsive angry behavior and also possess firearms at

home (8.9%) or carry guns outside the home (1.5%). These data document associations of numerous common mental disorders and combinations of angry behavior with gun access. Because only a small proportion of persons with this risky combination have ever been involuntarily hospitalized for a mental health problem, most will not be subject to existing mental health-related legal restrictions on firearms resulting from a history of involuntary commitment. Excluding a large proportion of the general population from gun possession is also not likely to be feasible. Behavioral risk-based approaches to firearms restriction, such as expanding the definition of gun-prohibited persons to include those with violent misdemeanor convictions and multiple DUI convictions, could be a more effective public health policy to prevent gun violence in the population. Copyright © 2015 John Wiley & Sons, Ltd. (PsycINFO Database Record (c) 2015 APA, all rights reserved)

X.

OTHER REFERENCES

Other References and abstracts. Free full text is available as noted

- Braga, A. A., & Weisburd, D. L. (2015). Focused deterrence and the prevention of violent gun injuries: Practice, theoretical principles, and scientific evidence. *Annual Review of Public Health*, 36, 55-68, <http://dx.doi.org/10.1146/annurev-publhealth-031914-122444>

Focused deterrence strategies are a relatively new addition to a growing portfolio of evidence-based violent gun injury prevention practices available to policy makers and practitioners. These strategies seek to change offender behavior by understanding the underlying violence-producing dynamics and conditions that sustain recurring violent gun injury problems and by implementing a blended strategy of law enforcement, community mobilization, and social service actions. Consistent with documented public health practice, the focused deterrence approach identifies underlying risk factors and causes of recurring violent gun injury problems, develops tailored responses to these underlying conditions, and measures the impact of implemented interventions. This article reviews the practice, theoretical principles, and evaluation evidence on focused deterrence strategies. Although more rigorous randomized studies are needed, the available empirical evidence suggests that these strategies generate noteworthy gun violence reduction impacts and should be part of a broader portfolio of violence prevention strategies available to policy makers and practitioners. (PsycINFO Database Record (c) 2015 APA, all rights reserved)

- Butts, J A., Roman, C. G., Bostwick, L. Porter, J. R. (2015). Cure violence: A public health model to reduce gun violence. *Annual Review of Public Health*, 36, 39-53. <http://dx.doi.org/10.1146/annurev-publhealth-031914-122509>

Scholars and practitioners alike in recent years have suggested that real and lasting progress in the fight against gun violence requires changing the social norms and attitudes that perpetuate violence and the use of guns. The Cure Violence model is a public health approach to gun violence reduction that seeks to change individual and community attitudes and norms about gun violence. It considers gun violence to be analogous to a communicable disease that passes from person to person when left untreated. Cure Violence operates independently of, while hopefully not undermining, law enforcement. In this article, we describe the theoretical basis for the program, review existing program evaluations, identify several challenges facing evaluators, and offer directions for future research. (PsycINFO Database Record (c) 2015 APA, all rights reserved).

- Hall, R.C., & Friedman, S.H., (2013). Guns, schools, and mental illness: potential concerns for physicians and mental health professionals. *Proceedings of the Mayo Clinic*, 88, 1272-1283. doi: 10.1016/j.mayocp.2013.08.016. Epub 2013 Oct 16.

Since the recent shootings in Tucson, Arizona; Aurora, Colorado; and Newtown, Connecticut, there has been an ever-increasing state and national debate regarding gun control. All 3 shootings involved an alleged shooter who attended college, and in hindsight, evidence of a mental illness was potentially present in these individuals while in school. What appears to be different about the current round of debate is that both pro-gun control and anti-gun control advocates are focusing on mentally ill individuals, early detection of mental illness during school years, and the interactions of such individuals with physicians and the mental

health system as a way to solve gun violence. This raises multiple questions for our profession about the apparent increase in these types of events, dangerousness in mentally ill individuals, when to intervene (voluntary vs involuntary), and what role physicians should play in the debate and ongoing prevention. As is evident from the historic Tarasoff court case, physicians and mental health professionals often have new regulations/duties, changes in the physician-patient relationship, and increased liability resulting from high-profile events such as these. Given that in many ways the prediction of who will actually commit a violent act is difficult to determine with accuracy, physicians need to be cautious with how the current gun debate evolves not only for ourselves (eg, increased liability, becoming de facto agents of the state) but for our patients as well (eg, increased stigma, erosion of civil liberties, and changes in the physician-patient relationship). We provide examples of potential troublesome legislation and suggestions on what can be done to improve safety for our patients and for the public. Copyright © 2013 Mayo Foundation for Medical Education and Research. Published by Elsevier Inc. All rights reserved.

Karch, D.L., Logan, J., McDaniel, D., Parks, S., & Patel N., (2012). Surveillance for violent deaths--National Violent Death Reporting System, 16 states, 2009. *MMWR Surveillance Summary*, 61, 1-43.

An estimated 50,000 persons die annually in the United States as a result of violence-related injuries. This report summarizes data from CDC's National Violent Death Reporting System (NVDRS) regarding violent deaths from 16 U.S. states for 2009. Results are reported by sex, age group, race/ethnicity, marital status, location of injury, method of injury, circumstances of injury, and other selected characteristics.

NVDRS collects data regarding violent deaths obtained from death certificates, coroner/medical examiner reports, and law enforcement reports. NVDRS data collection began in 2003 with seven states (Alaska, Maryland, Massachusetts, New Jersey, Oregon, South Carolina, and Virginia) participating; six states (Colorado, Georgia, North Carolina, Oklahoma, Rhode Island, and Wisconsin) joined in 2004, four (California, Kentucky, New Mexico, and Utah) in 2005, and two (Ohio and Michigan) in 2010, for a total of 19 states. This report includes data from 16 states that collected statewide data in 2009. California is excluded because data were collected in only four counties. Ohio and Michigan are excluded because data collection did not begin until 2010.

For 2009, a total of 15,981 fatal incidents involving 16,418 deaths were captured by NVDRS in the 16 states included in this report. The majority (60.6%) of deaths were suicides, followed by homicides and deaths involving legal intervention (i.e., deaths caused by police and other persons with legal authority to use deadly force, excluding legal executions) (24.7%), deaths of undetermined intent (14.2%), and unintentional firearm deaths (0.5%). Suicides occurred at higher rates among males, non-Hispanic whites, American Indians/Alaska Natives, and persons aged 45-54 years. Suicides occurred most often in a house or apartment and involved the use of firearms. Suicides were preceded primarily by mental health, intimate partner, or physical health problems or by a crisis during the previous 2 weeks. Homicides occurred at higher rates among males and persons aged 20-24 years; rates were highest among non-Hispanic black males. The majority of homicides involved the use of a firearm and occurred in a house or apartment or on a street/highway. Homicides were preceded primarily by arguments and interpersonal conflicts or in conjunction with another crime. Characteristics associated with other manners of death, circumstances preceding death, and special populations also are highlighted in this report. This report provides a detailed summary of data from NVDRS for 2009. The results indicate that violent deaths resulting from self-inflicted or interpersonal violence disproportionately affected adults aged <55 years, males, and certain racial/ethnic minority populations. For homicides and suicides, relationship problems, interpersonal conflicts, mental health problems, and recent crises were among the primary factors that might have precipitated

the fatal injuries. Because additional information might be reported subsequently as participating states update their findings, the data provided in this report are preliminary. For the occurrence of violent deaths in the United States to be better understood and ultimately prevented, accurate, timely, and comprehensive surveillance data are necessary. NVDRS data can be used to monitor the occurrence of violence-related fatal injuries and assist public health authorities in the development, implementation, and evaluation of programs and policies to reduce and prevent violent deaths at the national, state, and local levels. The continued development and expansion of NVDRS is essential to CDC's efforts to reduce the personal, familial, and societal costs of violence. Additional efforts are needed to increase the number of states participating in NVDRS, with an ultimate goal of full national representation.

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McGinty E. E., Frattaroli, S., Appelbaum, P.S., Bonnie, R.J., Grilley, A., Horwitz, J., Swanson, J.W., & Webster, D. W. (2014). Using research evidence to reframe the policy debate around mental illness and guns: process and recommendations. *American Journal of Public Health, 104*, e22-6. doi: 10.2105/AJPH.2014.302171. Epub 2014 Sep 11.

Recent mass shootings have prompted a national dialogue around mental illness and gun policy. To advance an evidence-informed policy agenda on this controversial issue, we formed a consortium of national gun violence prevention and mental health experts. The consortium agreed on a guiding principle for future policy recommendations: restricting firearm access on the basis of certain dangerous behaviors is supported by the evidence; restricting access on the basis of mental illness diagnoses is not. We describe the group's process and recommendations.

McGinty, E.E., Webster, D.W., & Barry, C. L. (2014). Gun policy and serious mental illness: priorities for future research and policy. *Psychiatric Services, 65*, 50-58. doi: 10.1176/appi.ps.201300141.

In response to recent mass shootings, policy makers have proposed multiple policies to prevent persons with serious mental illness from having guns. The political debate about these proposals is often uninformed by research. To address this gap, this review article summarizes the research related to gun restriction policies that focus on serious mental illness.

Gun restriction policies were identified by researching the THOMAS legislative database, state legislative databases, prior review articles, and the news media. PubMed, PsycINFO, and Web of Science databases were searched for publications between 1970 and 2013 that addressed the relationship between serious mental illness and violence, the effectiveness of gun policies focused on serious mental illness, the potential for such policies to exacerbate negative public attitudes, and the potential for gun restriction policies to deter mental health treatment seeking.

Limited research suggests that federal law restricting gun possession by persons with serious mental illness may prevent gun violence from this population. Promotion of policies to prevent persons with serious mental illness from having guns does not seem to exacerbate negative public attitudes toward this group. Little is known about how restricting gun possession among persons with serious mental illness affects suicide risk or mental health treatment seeking.

Future studies should examine how gun restriction policies for serious mental illness affect suicide, how such policies are implemented by states, how persons with serious mental illness perceive policies that restrict their possession of guns, and how gun restriction policies influence mental health treatment seeking among persons with serious mental illness.

Melamed, Y., Bauer, A., Kallian, M., Rosca, P., & Mester R. (2011). Assessing the risk of violent behavior before issuing a license to carry a handgun. *Journal of the American Academy of Psychiatry and the Law*, 39, 543-548.

Handguns are intended to be used for protection, but they can also be used as weapons of assault that may endanger others or inflict self-harm and facilitate suicide. Research has revealed a direct correlation between firearm availability and suicide risk. Gun control is intended to reduce violence through legislation that restricts ownership and use of firearms. How can we ensure that firearms will not reach the hands of individuals who may pose a danger to themselves or to others, without infringing on the rights of other citizens to carry guns for protection, which is in the public interest? The potential to commit a crime will materialize, depending on dynamic interactions among personality factors, environmental factors, and the individual's history of offending. We present illustrative cases involving various aspects of gun control and a description of instruments for the assessment of dangerousness that can facilitate the licensing process for carrying and using firearms.

Metzl, J.M., & MacLeish, K.T. (2015). Mental illness, mass shootings, and the politics of American firearms. *American Journal of Public Health*, 105, 240-249. doi: 10.2105/AJPH.2014.302242.

Four assumptions frequently arise in the aftermath of mass shootings in the United States: (1) that mental illness causes gun violence, (2) that psychiatric diagnosis can predict gun crime, (3) that shootings represent the deranged acts of mentally ill loners, and (4) that gun control "won't prevent" another Newtown (Connecticut school mass shooting). Each of these statements is certainly true in particular instances. Yet, as we show, notions of mental illness that emerge in relation to mass shootings frequently reflect larger cultural stereotypes and anxieties about matters such as race/ethnicity, social class, and politics. These issues become obscured when mass shootings come to stand in for all gun crime, and when "mentally ill" ceases to be a medical designation and becomes a sign of violent threat.

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Ruggles, K.V., & Rajan, S. (2014). Gun possession among American youth: a discovery-based approach to understand gun violence. *PLoS One*, 9(11):e111893. doi: 10.1371/journal.pone.0111893. eCollection 2014.

To apply discovery-based computational methods to nationally representative data from the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System to better understand and visualize the behavioral factors associated with gun possession among adolescent youth. Our study uncovered the multidimensional nature of gun possession across nearly five million unique data points over a ten year period (2001-2011). Specifically, we automated odds ratio calculations for 55 risk behaviors to assemble a

comprehensive table of associations for every behavior combination. Downstream analyses included the hierarchical clustering of risk behaviors based on their association "fingerprint" to 1) visualize and assess which behaviors frequently co-occur and 2) evaluate which risk behaviors are consistently found to be associated with gun possession. From these analyses, we identified more than 40 behavioral factors, including heroin use, using snuff on school property, having been injured in a fight, and having been a victim of sexual violence, that have and continue to be strongly associated with gun possession. Additionally, we identified six behavioral clusters based on association similarities: 1) physical activity and nutrition; 2) disordered eating, suicide and sexual violence; 3) weapon carrying and physical safety; 4) alcohol, marijuana and cigarette use; 5) drug use on school property and 6) overall drug use. Use of computational methodologies identified multiple risk behaviors, beyond more commonly discussed indicators of poor mental health, that are associated with gun possession among youth. Implications for prevention efforts and future interdisciplinary work applying computational methods to behavioral science data are described.

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Shultz, J.M., Thoresen, S., Flynn, B.W., Muschert, G.W., Shaw, J.A., Espinel, Z., Walter, F. G., Gaither, J.B., Garcia-Barcena, Y., O'Keefe, K., & Cohen, A.M. (2014). Multiple vantage points on the mental health effects of mass shootings. *Current Psychiatry Reports*, 16(9), 469. doi: 10.1007/s11920-014-0469-5.

The phenomenon of mass shootings has emerged over the past 50 years. A high proportion of rampage shootings have occurred in the United States, and secondarily, in European nations with otherwise low firearm homicide rates; yet, paradoxically, shooting massacres are not prominent in the Latin American nations with the highest firearm homicide rates in the world. A review of the scientific literature from 2010 to early 2014 reveals that, at the individual level, mental health effects include psychological distress and clinically significant elevations in posttraumatic stress, depression, and anxiety symptoms in relation to the degree of physical exposure and social proximity to the shooting incident. Psychological repercussions extend to the surrounding affected community. In the aftermath of the deadliest mass shooting on record, Norway has been in the vanguard of intervention research focusing on rapid delivery of psychological support and services to survivors of the "Oslo Terror." Grounded on a detailed review of the clinical literature on the mental health effects of mass shootings, this paper also incorporates wide-ranging co-author expertise to delineate: 1) the patterning of mass shootings within the international context of firearm homicides, 2) the effects of shooting rampages on children and adolescents, 3) the psychological effects for wounded victims and the emergency healthcare personnel who care for them, 4) the disaster behavioral health considerations for preparedness and response, and 5) the media "framing" of mass shooting incidents in relation to the portrayal of mental health themes.

Swanson, J.W., McGinty, E.E., Fazel, S., & Mays, V. M. (2015). Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. *Annals of Epidemiology*, 25, 366-76. doi: 10.1016/j.annepidem.2014.03.004. Epub 2014 Apr 29.

This article describes epidemiologic evidence concerning risk of gun violence and suicide linked to psychiatric disorders, in contrast to media-fueled public perceptions of the

dangerousness of mentally ill individuals, and evaluates effectiveness of policies and laws designed to prevent firearms injury and mortality associated with serious mental illnesses and substance use disorders.

Research concerning public attitudes toward persons with mental illness is reviewed and juxtaposed with evidence from benchmark epidemiologic and clinical studies of violence and mental illness and of the accuracy of psychiatrists' risk assessments. Selected policies and laws designed to reduce gun violence in relation to mental illness are critically evaluated; evidence-based policy recommendations are presented.

Media accounts of mass shootings by disturbed individuals galvanize public attention and reinforce popular belief that mental illness often results in violence. Epidemiologic studies show that the large majority of people with serious mental illnesses are never violent.

However, mental illness is strongly associated with increased risk of suicide, which accounts for over half of US firearms-related fatalities.

Policymaking at the interface of gun violence prevention and mental illness should be based on epidemiologic data concerning risk to improve the effectiveness, feasibility, and fairness of policy initiatives.

Steadman, HJ, Monahan J, Pinals DA, Vesselinov R, Robbins PC (2015). Gun Violence and Victimization of Strangers by Persons With a Mental Illness: Data From the MacArthur Violence Risk Assessment Study. *Psychiatric Services*, Jun 15:appips201400512. [Epub ahead of print]

Highly publicized incidents in which people with apparent mental illnesses use guns to victimize strangers have important implications for public views of people with mental illnesses and the formation of mental health and gun policy. The study aimed to provide more data about this topic. MacArthur Violence Risk Assessment Study data were analyzed to determine the prevalence of violence by 951 patients after discharge from a psychiatric hospital, including gun violence, violence toward strangers, and gun violence toward strangers. Two percent of patients committed a violent act involving a gun, 6% committed a violent act involving a stranger, and 1% committed a violent act involving both a gun and a stranger. When public perceptions and policies regarding mental illness are shaped by highly publicized but infrequent instances of gun violence toward strangers, they are unlikely to help people with mental illnesses or to improve public safety.

Tigri, H. B.; Reid, S., Turner, M. G., & Devinney, J. M. (2015). Investigating the relationship between gang membership and carrying a firearm: Results from a national sample. *American Journal of Criminal Justice*, 2015, No Pagination Specified. <http://dx.doi.org/10.1007/s12103-015-9297-3>

While there is evidence that gang membership impacts an individual's gun carrying proclivities, existing research has largely focused only on males and at-risk youth. The present study investigates the role of gang membership, peer gang membership, and delinquency on whether individuals carry a firearm using data from the National Longitudinal Survey of Youth 1997. Carrying a firearm was associated with involvement in delinquency, peer gang membership, and respondent gang membership. The association between gang membership and carrying a firearm weakened with age. Few significant differences across categories of sex and race emerged suggesting that the relationship between gang membership and carrying a firearm is equivocal across these groups.

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Webster, D. W. (2015). Commentary: Evidence to guide gun violence prevention in America. *Annual Review of Public Health*, 36, 1-4.
<http://dx.doi.org/10.1146/annurev-publhealth-031914-122542>

Gun violence is a major threat to the public's health and safety in the United States. The articles in this volume's symposium on gun violence reveal the scope of the problem and new trends in mortality rates from gunfire. Leading scholars synthesize research evidence that demonstrates the ability of numerous policies and programs—each consistent with lessons learned from successful efforts to combat public health problems—to prevent gun violence. Each approach presents challenges to successful implementation. Future research should inform efforts to assess which approaches are most effective and how to implement evidence-based interventions most effectively. (PsycINFO Database Record (c) 2015 APA, all rights reserved)

BOOK: Webster, D. W. & Vernick, J. S (2013). *Reducing gun violence in America: informing policy with evidence and analysis*. Baltimore, (MD): Johns Hopkins University Press.

Pt. I Gun policy lessons from the United States : keeping guns from high-risk individuals -- pt. II. Making gun laws enforceable -- pt. III. Gun policy lessons from the United States : high-risk guns -- pt. IV. International case studies of responses to gun violence -- pt. V. Second amendment -- pt. VI. Public opinion on gun policy.

Weinberger, S.E., Hoyt, D.B., Lawrence, H. C. 3rd, Levin, S., Henley, D. E., Alden, E.R, Wilkerson, D., Benjamin, G.C., & Hubbard, W. C. (2015). Firearm-related injury and death in the United States: a call to action from 8 health professional organizations and the American Bar Association. *Annals of Internal Medicine*, 162, 513-6. doi: 10.7326/M15-0337.

Deaths and injuries related to firearms constitute a major public health problem in the United States. In response to firearm violence and other firearm-related injuries and deaths, an interdisciplinary, interprofessional group of leaders of 8 national health professional organizations and the American Bar Association, representing the official policy positions of their organizations, advocate a series of measures aimed at reducing the health and public health consequences of firearms. The specific recommendations include universal background checks of gun purchasers, elimination of physician "gag laws," restricting the manufacture and sale of military-style assault weapons and large-capacity magazines for civilian use, and research to support strategies for reducing firearm-related injuries and deaths. The health professional organizations also advocate for improved access to mental health services and avoidance of stigmatization of persons with mental and substance use disorders through blanket reporting laws. The American Bar Association, acting through its Standing Committee on Gun Violence, confirms that none of these recommendations conflict with the Second Amendment or previous rulings of the U.S. Supreme Court

Wintemute, G.J. (2014). Support for a comprehensive background check requirement and expanded denial criteria for firearm transfers: findings from the firearms licensee survey. *Journal of Urban Health*, 91, 303-19. doi: 10.1007/s11524-013-9842-7.

Federal and state policies on eligibility to purchase and possess firearms and background check requirements for firearm transfers are undergoing intensive review and, in some cases, modification. Our objective in this third report from the Firearms Licensee Survey (FLS) is to assess support among federally licensed firearms retailers (gun dealers and pawnbrokers) for a background check requirement on all firearm transfers and selected criteria for denying the purchase of handguns based on criminal convictions, alcohol abuse, and serious mental illness. The FLS was conducted by mail during June-August, 2011 on a random sample of 1,601 licensed dealers and pawnbrokers in 43 states who were believed to sell at least 50 firearms annually. The response rate was 36.9%, typical of establishment surveys using such methods. Most respondents (55.4%) endorsed a comprehensive background check requirement; 37.5% strongly favored it. Support was more common and stronger among pawnbrokers than dealers and among respondents who believed that "it is too easy for criminals to get guns." Support was positively associated with many establishment characteristics, including sales of inexpensive handguns, sales that were denied when the purchasers failed background checks, and sales of firearms that were later subjected to ownership tracing, and were negatively associated with sales at gun shows. Support for three existing and nine potential criteria for denial of handgun purchase involving criminal activity, alcohol abuse, and mental illness exceeded 90% in six cases and fell below 2/3 in one. Support again increased with sales of inexpensive handguns and denied sales and decreased with sales of tactical (assault-type) rifles. In this survey, which was conducted prior to mass shootings in Aurora, Colorado; Oak Creek, Wisconsin; Newtown, Connecticut; and elsewhere, licensed firearm sellers exhibited moderate support for a comprehensive background check requirement and very strong support for additional criteria for denial of handgun purchases. In both cases, support was associated with the intensity of respondents' exposure to illegal activities.

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