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THESIS

AN ANALYSIS OF THE UNITED STATES SECRET SERVICE PROTECTIVE INTELLIGENCE DIVISION'S MENTAL ILLNESS TRAINING PROGRAM: IS THERE ROOM FOR IMPROVEMENT?

by

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This thesis analyzes the training provided by the United States Secret Service's Protective Intelligence Division (PID) to its recruits and special agents (SAs) to effectively conduct interviews with mentally ill individuals during protective intelligence (PI) investigations. These interviews are vital because they provide SAs with information to assess the risk of a subject's carrying out an attack against a Secret Service protectee. Responding to the 1960s' deinstitutionalization movement, which saw a rise in law enforcement interactions with individuals with mental illness, many agencies developed advanced mental illness training programs. The PID provides its recruits and SAs with 28 hours of mental illness and interview training, which may need to be revised given the importance of PI investigations involving mentally ill individuals. After analyzing the current PI training program, this thesis provides research and recommendations for effective mental illness training programs used by other law enforcement agencies, including the Crisis Intervention Team (CIT), DEFUSE, CIT Extension for Community Healthcare Outcomes, and Mental Health First Aid. The study recommends incorporating specific elements from these training programs into the Secret Service's PI training program to provide more comprehensive risk assessments of potential threats and unwanted outcomes against protectees when dealing with individuals with mental illness.

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ABSTRACT

This thesis analyzes the training provided by the United States Secret Service's Protective Intelligence Division (PID) to its recruits and special agents (SAs) to effectively conduct interviews with mentally ill individuals during protective intelligence (PI) investigations. These interviews are vital because they provide SAs with information to assess the risk of a subject's carrying out an attack against a Secret Service protectee. Responding to the 1960s' deinstitutionalization movement, which saw a rise in law enforcement interactions with individuals with mental illness, many agencies developed advanced mental illness training programs. The PID provides its recruits and SAs with 28 hours of mental illness and interview training, which may need to be revised given the importance of PI investigations involving mentally ill individuals. After analyzing the current PI training program, this thesis provides research and recommendations for effective mental illness training programs used by other law enforcement agencies, including the Crisis Intervention Team (CIT), DEFUSE, CIT Extension for Community Healthcare Outcomes, and Mental Health First Aid. The study recommends incorporating specific elements from these training programs into the Secret Service's PI training program to provide more comprehensive risk assessments of potential threats and unwanted outcomes against protectees when dealing with individuals with mental illness.

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LIST OF ACRONYMS AND ABBREVIATIONS

CIT	Crisis Intervention Team
CMHC	community mental health center
CMPD	Charlotte-Mecklenburg Police Department
DEFUSE	data, expectations, feelings, understanding, self-monitor, and environment
ECHO	Extension for Community Healthcare Outcomes
MHFA	Mental Health First Aid
MPDC	Metropolitan Police Department of the District of Columbia
NAMI	National Alliance on Mental Illness
NTAC	National Threat Assessment Center
PI	protective intelligence
PICAP	Protective Intelligence Clinical Assessment Program
PID	Protective Intelligence Division
RTC	Rowley Training Center
SA	special agent
UD	Uniformed Division
WFO	Washington Field Office

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EXECUTIVE SUMMARY

The purpose of this thesis was to examine whether the U.S. Secret Service provides sufficient mental illness training and support to its special agents conducting protective intelligence (PI) investigations and to determine whether incorporating elements of other mental illness training programs would improve the PI mental illness training curriculum. The failure of U.S. policymakers to provide community-based alternatives and the deinstitutionalization of individuals with mental illness have led to an increase in law enforcement interactions with mentally ill individuals. According to a 2022 report by the National Institute of Mental Health, 52.9 million adults in the United States live with a mental illness and 14.2 million suffer from a severe mental illness.[1] With a shortage of accessible health services, law enforcement contacts with mentally ill individuals have intensified, thus prompting many law enforcement agencies to include additional advanced mental illness training programs in their curricula.

The deinstitutionalization of the mentally ill, an increase in interactions between law enforcement and the mentally ill, and the need for further specialized mental illness management training for law enforcement personnel demonstrate the need to understand the basic principles as well as the current and emerging mental illness training practices of the Secret Service's Protective Intelligence Division (PID). Each year, the Secret Service conducts thousands of PI investigations—the most important type that special agents (SAs) oversee. The proliferation of mentally ill individuals living in communities with insufficient housing, treatment, and resources means that many PI investigations and interviews involve interactions with mentally ill individuals.

An analysis of the Secret Service's current PID mental illness training is necessary as the observation, detection, and management of mental illnesses are essential aspects in assessing significant intelligence on a subject's ability to carry out an attack. The current PID training program provides SA recruits with approximately 10 hours of mental health

[1] "Mental Illness," National Institute of Mental Health, January 2022, https://www.nimh.nih.gov/health/statistics/mental-illness.

training and 18 hours of interview training. However, the limited training and insufficient professional mental health assistance and in-service refresher courses hinder SAs' opportunities to enhance their PI interview skills and obtain updated guidance on medications and interactions with mentally ill individuals.

An analysis of successful advanced mental illness training programs applied by law enforcement agencies indicates that these programs deliver complex systems of training that may enhance the Secret Service's PID training curriculum. These mental illness training options include the Crisis Intervention Team (CIT) program, DEFUSE, CIT Extension for Community Healthcare Outcomes, and Mental Health First Aid (MHFA). Each program contains specific elements with valuable training and tools to effectively manage interactions with mentally ill individuals. The detailed analysis covers these training programs and provides recommendations for their implementation into the Secret Service's PI training and investigative support elements.

The analysis suggests that the Secret Service should incorporate portions of its CIT training program and the traditional 40-hour CIT instruction in the PI recruit training curriculum for all SAs. Additionally, the analysis recommends hiring additional personnel for the Protective Intelligence Clinical Assessment Program to aid SAs with PI investigations and interviews. Furthermore, it would be helpful to expand partnerships with local mental health professionals or create a new program to assist SAs in their investigations and mental illness awareness training. Finally, the Secret Service should include annual mental illness–related topics and scenario-based interview instruction during in-service training. The DEFUSE and MHFA training courses could provide the Secret Service with online or in-service training options for these purposes.

The Secret Service spends millions of dollars annually on protection details, training, the workforce, and equipment to maintain a secure environment for its protectees. While most people envision Secret Service SAs in suits, sunglasses, and earpieces in their mission to protect elected officials, there are also many SAs behind the scenes conducting PI investigations and countless interviews, ensuring future attacks do not occur. Risk assessments based on intelligence information collected during PI interviews have played a vital role in past studies on threats against Secret Service protectees. With the apparent

need for additional mental illness training in law enforcement and the increase in the number of mentally ill individuals, additional advanced mental illness training must be considered for implementation into the Secret Service's PI training curriculum. The four mental illness training programs analyzed in this thesis provide the Secret Service with options that would benefit all SAs. If the highlighted sections of these training programs were incorporated into the PI training program, they would enable Secret Service SAs to manage PI investigations and interviews with mentally ill individuals more effectively and generate more accurate risk assessments concerning future threats and unwanted outcomes against Secret Service protectees.

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I. INTRODUCTION

As outlined in the *U.S. Code*, it is a federal crime to "willfully threaten to kill, kidnap, or inflict bodily harm" on a U.S. president or former president, a vice president, a president-elect, vice president-elect, or an immediate family member; a major candidate; a spouse of a major candidate; or other persons protected by the U.S. Secret Service.[1] Secret Service special agents (SAs) are granted the authority to investigate these threats and gather the intelligence necessary to provide security to their protectees, as outlined in 18 U.S.C. § 3056.[2] When a protective intelligence (PI) interview is conducted appropriately, it enables an SA to acquire information about a subject's thinking, motives, and behaviors, which help to assess the risk of the subject.

Secret Service SAs conduct numerous PI interviews throughout their careers with subjects who pose risks of an unwanted outcome directed toward Secret Service protectees, protected facilities, or protected events. As detailed in the Protective Intelligence Division (PID) section, PID-05, of the Secret Service manual, the National Threat Assessment Center (NTAC) reports psychotic symptoms such as delusions, depression, paranoia, and hallucinations were "the most prevalent . . . among the attackers who had histories of mental illness before carrying out their attacks."[3] Furthermore, the Secret Service emphasizes the importance of the PI subject interview as the premier source of information during the risk assessment process.[4] Since the mental health assessment of a subject is a key factor during a PI interview, SAs need advanced and updated training about the detection of mental health issues and interactions with mentally ill subjects.

[1] Threats against President and Successors to the President, 18 U.S.C. § 871 (1994); Threats against Former Presidents and Certain Other Persons Protected by the Secret Service, 18 U.S.C. § 879 (1998).

[2] Powers, Authorities, and Duties of the United States Secret Service, 18 U.S.C. § 3056 (1994).

[3] U.S. Secret Service, "Protective Intelligence Investigations and Case Management," PID-05 in *Strategic Intelligence and Information Manual* (Washington, DC: U.S. Secret Service, 2021), 20.

[4] U.S. Secret Service, 3.

The Secret Service's PI curriculum does not provide an SA or recruit with ample mental illness training. The PI curriculum contains only 18 hours of interview training and 10 hours of mental health training. All 28 hours of instruction consist of classes such as an introduction to PI, PI report writing, PI advances, practical exercises, and abnormal behavior. The PI sections of the Secret Service manual dedicate approximately two pages of instruction to preparing for and interacting with a mentally ill subject during a PI interview.[5]

The Secret Service describes the Protective Intelligence Clinical Assessment Program (PICAP) as "mental health expertise to better enable [Secret Service] personnel to identify, assess, and manage subjects who pose a risk of an unwanted outcome to, or have an unusual direction of interest in, protectees or other USSS protected interests."[6] The ability to request a PICAP representative to assist with the subject's mental health issues during a case greatly benefits the SA. Although PICAP psychologists can assist with the clinical assessment of a subject, they cannot provide the SA with feedback on whether they believe the subject poses a future risk to a Secret Service protectee. The PICAP offers training on numerous topics about mental illness, diagnoses, health evaluations, pharmacological treatment, and mental health law. Advanced training on these topics and many others related to mental illness are available to all SAs but are not taught during their special agent PI training.[7] Secret Service field offices and SAs working intelligence-related cases receive such training only upon request, usually after an initial interview has already been conducted with a subject of PI interest.

The Secret Service has a "zero fail" mission, so it must always strive to improve training as necessary. According to the Secret Service, "To determine risk, agents should evaluate how the subject's mental health symptoms are influencing their thinking and behavior."[8] The two related pages of the Secret Service manual and 28 hours of total PI

[5] U.S. Secret Service, "Protective Intelligence Investigations."

[6] U.S. Secret Service, "Protective Intelligence Clinical Assessment Program Guidelines," PID-17 in *Strategic Intelligence and Information Manual* (Washington, DC: U.S. Secret Service, 2019), 4.

[7] U.S. Secret Service, 4.

[8] U.S. Secret Service, "Protective Intelligence Investigations," 20.

training for recruits are insufficient to provide SAs with the knowledge to accurately assess the thinking and behavioral processes of mentally ill subjects. An improved recognition of mental illnesses, updated knowledge of mental health prescription medications, and advanced methods for interacting with mentally ill subjects require additional training. Such training would enable the Secret Service and its SAs in the field to properly identify and assess threats made by mentally ill subjects and assist in the prevention of unwanted outcomes directed at Secret Service protectees, protected facilities, or protected events.

This thesis comprehensively examines the material in the Secret Service's PI curriculum, current and emerging training, and the PICAP program's procedures, analyzing effective mental illness training programs utilized by other law enforcement departments to provide valuable insight into a more advantageous mental illness training platform for Secret Service SAs and the PID. These insights are then analyzed within the context of the PID to provide recommendations for an ideal training regimen for mental health assessments and the utilization of available mental health resources during PI interviews and investigations.

A. RESEARCH QUESTION

Does the Secret Service's current PI training curriculum need revision? If so, what benefits would comprehensive research into existing specific mental illness training programs and assets utilized by other law enforcement departments provide to the PI training curriculum and Secret Service SAs?

B. LITERATURE REVIEW

Interacting with and managing mentally ill individuals are rising concerns in the United States and a significant issue within the law enforcement community. A Government Accountability Office report to Congress estimated that in 2016, mental illness affected over 44 million adults in the United States.[9] Four years later, the

[9] Diane Maurer, *Federal Law Enforcement: DHS and DOJ Are Working to Enhance Responses to Incidents Involving Individuals with Mental Illness*, GAO-18-229 (Washington, DC: Government Accountability Office, 2018), 6, https://www.gao.gov/assets/gao-18-229.pdf.

National Institute of Mental Health reported an increase to 52.9 million adults suffering from mental illness, of whom 14.2 million battled some form of severe mental illness.[10] Over one-third of the dispatch calls police respond directly to result from mental illness, and 25 percent of all fatalities from police interactions involve a mentally ill individual.[11]

This literature review examines scholarly journals, congressional reports, federal and state law enforcement websites, doctoral dissertations, and master's theses. These sources explain the increase in mental illness interactions with law enforcement and consider the need for more in-depth mental illness training for law enforcement personnel. It was vital to study literature that explained the sources for this increase in interactions to achieve this goal. Most of the literature also provides solutions to training necessities and includes examples from various law enforcement departments and federal agencies. This area is explored in further detail later in this thesis.

The increase in law enforcement encounters with mentally ill individuals is attributed to the unconstructive transformations of the mental health system's policies concerning both the commitment of the mentally ill and their treatment options. Wood and Watson discuss the evolving techniques that law enforcement has used to counter the rise in mental illness due to the "de-institutionalization of mental health services" that have exacerbated the number of those without treatment.[12] Davidson, a criminal justice scholar, agrees with this idea: "Due to dramatic policy changes in the mental health field over the last few decades, agents of the criminal justice system are now frequently faced with the challenge of intervening and managing situations involving

10 "Mental Illness," National Institute of Mental Health, January 2022, https://www.nimh.nih.gov/health/statistics/mental-illness.

11 Robyn L. Hacker and John J. Horan, "Policing People with Mental Illness: Experimental Evaluation of Online Training to De-escalate Mental Health Crises," *Journal of Experimental Criminology* 15, no. 4 (December 2019): 552, https://doi.org/10.1007/s11292-019-09380-3.

12 Jennifer D. Wood and Amy C. Watson, "Improving Police Interventions during Mental Health-Related Encounters: Past, Present and Future," *Policing and Society* 27, no. 3 (2017): 290, https://doi.org/10.1080/10439463.2016.1219734.

persons with a mental illness."[13] Research indicates that law enforcement entities increasingly find themselves interacting with individuals dealing with mental illness and that close to 10 percent of all calls deal with a mentally ill individual.[14] This subject is discussed in detail in the Government Accountability Office's 2018 report to Congress. Davidson reports that most law enforcement officers interact with mentally ill individuals because they are the victim, witness, subject of a crime, or a "danger to themselves or others."[15] A lack or inadequacy of community-based alternatives for treatment has left the individuals in a precarious position, exposed to more encounters with law enforcement.[16] Numerous sources underline the foundation of the problem initiating this conflict between the mentally ill and law enforcement. Fortunately, these sources also contribute the solutions they believe will minimize future issues.

Scholars in criminal justice research suggest that more in-depth training on mental illness is a requisite for law enforcement officers. Law enforcement personnel lack the training necessary to effectively interact with and reduce aggressive or misunderstood behaviors of mentally ill individuals.[17] John Milby's Naval Postgraduate School master's thesis concerning risk assessments of mentally ill individuals exposes the need for additional training by listing law enforcement officers' limited options.[18] Likewise, Hacker and Horan's research highlights the insufficient training of officers dealing with mentally ill individuals. They further note that barbers and cosmetologists

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[13] Megan L. Davidson, "A Criminal Justice System–Wide Response to Mental Illness: Evaluating the Effectiveness of the Memphis Crisis Intervention Team Training Curriculum among Law Enforcement and Correctional Officers," *Criminal Justice Policy Review* 27, no. 1 (2016): 47, https://doi.org/10.1177/0887403414554997.

[14] Jeannine S. Loucks, "Educating Law Enforcement Officers about Mental Illness: Nurses as Teachers," *Journal of Psychosocial Nursing and Mental Health Services* 51, no. 7 (July 2013): 43, https://doi.org/10.3928/02793695-20130503-03; John D. Milby, "Preempting Mass Murder: Improving Law Enforcement Risk Assessments of Persons with Mental Illness" (master's thesis, Naval Postgraduate School, 2015), 29, http://hdl.handle.net/10945/45227.

[15] Davidson, "A Criminal Justice System–Wide Response to Mental Illness," 47.

[16] Wood and Watson, "Improving Police Interventions," 290; Davidson, "A Criminal Justice System–Wide Response to Mental Illness," 47.

[17] Rachael Elaine Hatfield, "Training Law Enforcement in Mental Health: A Broad-Based Model" (PhD diss., Marshall University, 2014), 1, https://mds.marshall.edu/etd/485.

[18] Milby, "Preempting Mass Murder," 30.

receive more hours of overall training for their professions than most law enforcement recruits receive in basic training.[19] Analyses of law enforcement departments, including those in Portland, San Francisco, San Mateo, and New York, spotlight examples where additional training might have prevented the use of deadly force during officers' altercations with mentally ill individuals.[20] Campbell et al. discuss this issue in a case study of the 2015 legislation passed in California that required officers to receive additional training focused on de-escalation skills and the recognition of mentally ill individuals. To illustrate the effectiveness of this legislation, Campbell et al. indicate that in Los Angeles County, the number of additional training hours required for officers paired with new mental health treatment options helped lower conflicts between law enforcement officers and mentally ill individuals.[21]

Since the 1960s, the management of the mentally ill has consistently declined. The deinstitutionalization movement transferred many mentally ill individuals from mental institutions into surrounding communities. The failures of the reform were illustrated by the lack of community-based alternatives and resources, which drove many mentally ill people to search for new treatments and affordable housing.[22] The government's negligence resulted in concerned citizens relying more heavily on law enforcement officers to resolve disorderly situations involving mentally ill individuals.[23]

The need for additional training for law enforcement officers is a central topic of concern among many criminal justice sources. The good news is that most law enforcement departments, agencies, and congressional committees are aware of this

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19 Hacker and Horan, "Policing People with Mental Illness," 552.

20 Hatfield, "Training Law Enforcement in Mental Health," 2–4.

21 Jorien Campbell et al., "Building on Mental Health Training for Law Enforcement: Strengthening Community Partnerships," *International Journal of Prisoner Health* 13, no. 3/4 (2017): 208–10, https://doi.org/10.1108/IJPH-10-2016-0060.

22 Chris Koyanagi, *Learning from History: Deinstitutionalization of People with Mental Illness as Precursor to Long-Term Care Reform* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2007), 1–17, https://www.kff.org/medicaid/report/learning-from-history-deinstitutionalization-of-people-with/.

23 Davidson, "A Criminal Justice System–Wide Response to Mental Illness," 47.

situation and are actively attempting to address the lack of training. The Council of State Governments Justice Center is an online resource dedicated to tracking mental health learning programs initiated by various law enforcement departments across the country. According to the Justice Center, "Law enforcement-mental health learning sites are a resource for agencies looking to tailor successful implementation strategies and response models to address their distinct problems and circumstances."[24] The nation's current awareness of inadequate training for law enforcement personnel, coupled with the increasing number of mental health education programs, will help institute a new outlook on police interaction with the mentally ill and hopefully produce positive changes in law enforcement's interactions with and management of mentally ill individuals.

C. RESEARCH DESIGN

This research sets out to determine whether the Secret Service's current PI training curriculum needs revision. I first validate the increase in law enforcement's interactions with mentally ill individuals due to the deinstitutionalization movement. My research then analyzes the current PI training curriculum and operations. The research presents the training and mental health resources available to Secret Service SAs and then assesses whether the contemporary training, materials, and resources are sufficient or require revision. Third, it analyzes current successful mental illness training programs instituted by other law enforcement departments. In conclusion, it evaluates the effectiveness of the training options researched to provide recommendations to incorporate into the Secret Service PID training curriculum.

A blend of thematic and qualitative analyses of open-source material on law enforcement interactions with mentally ill individuals, coupled with data from scholarly journals and primary sources, establishes a sound knowledge of the origin of law enforcement's issues with the mentally ill. This research does not intend to reveal the

[24] "Law Enforcement-Mental Health Learning Sites Program," Council of State Governments Justice Center, accessed May 15, 2022, https://csgjusticecenter.org/projects/law-enforcement-mental-health-learning-sites/.

cause of mental illness; instead, it establishes what elements promote increased interactions between law enforcement personnel and mentally ill individuals. Given the frequency of police interactions with mentally ill individuals, my research includes two examples of violent altercations between police and mentally ill individuals as described by various media outlets. Hopefully, such cases will demonstrate the danger posed when law enforcement officers lack training in dealing with mentally ill individuals. This phase introduces the value of mental illness training for law enforcement personnel and evaluates the relevance of the training concerning the PID's responsibilities and operations presented in the next stage.

The next phase clarifies the PID's purpose and priority in its mission. The research uses relevant sections of the Secret Service's *Strategic Intelligence and Information Manual*, regarding Protective Intelligence Investigations and Case Management and Protective Intelligence Assessment Program guidelines. The research for this chapter focuses on the current interview procedures and guidance on interactions with mentally ill subjects; the content of the current Secret Service training curriculum; emerging Crisis Intervention Team training programs; and the elements of guidance, assistance, and additional resources that PICAP supplies in the Secret Service manual.

This research does not seek to provide the elements of the intricate step-by-step process of a PI case. Still, it does highlight sections of a PI case that employ mental illness training and where functions of PICAP could assist with SAs' interactions with and risk assessments of mentally ill individuals. The information discussed about PICAP is a central component in establishing the core training and assets available for Secret Service SAs. This information is compared to other benefits and concerns of select law enforcement departments' present mental illness training programs.

The information found regarding the current assets and training available for Secret Service SAs' interactions with mentally ill individuals is compared with some, but not all, of the existing mental illness training programs instituted by other law enforcement departments. To effectively compare these training programs with the Secret Service's current PI training curriculum, I accessed information that conveys the various programs' training material and benefits. The research plan for this phase uses

sources of evidence from mental health professionals' websites, criminal justice scholarly journals, criminal justice training websites on mental illness training programs, and reports from the Department of Justice. The evaluation criteria for the effectiveness of these programs are based on reviews from medical and criminal justice professionals, the compatibility of their implementation into the PID, and the positive results of the training. The information obtained from the research on these law enforcement departments' programs provides a baseline of mental illness training to associate with the Secret Service's PI training curriculum. After evaluating the effectiveness of current training programs' successes, a final suggestion is provided for the PID training curriculum.

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II. LAW ENFORCEMENT'S HISTORY WITH MENTALLY ILL SUBJECTS

The deinstitutionalization of the mentally ill and the failure of U.S. policymakers to provide community-based alternatives have escalated law enforcement interactions with mentally ill subjects. A 2022 report by the National Institute of Mental Health reveals that the United States is home to 52.9 million adults living with a mental illness, of whom 14.2 million suffer from a severe mental illness.[25] A disproportionately high number of mentally ill individuals currently live in a society lacking accessible mental health services. With a shortage of community-based health and social service systems available to the millions of U.S. citizens battling mental illness, law enforcement contact with mentally ill individuals has intensified.

This chapter describes the cause of deinstitutionalization, its impact on law enforcement and mentally ill individuals, and the importance for law enforcement departments to incorporate adequate, updated training to resolve issues that might develop with the mentally ill. These issues reveal areas of responsibility that the Secret Service must consider with its current training curriculum. Mental illness is a significant concern with the Secret Service's mission of PI investigations. Current issues evident in law enforcement's association with mentally ill individuals correlate with the Secret Service's existing mental illness training, interactions with mentally ill subjects, and the need for advanced training.

A. DEINSTITUTIONALIZATION OF MENTALLY ILL INDIVIDUALS

In the early 19th century, states established mental hospitals to care for mentally ill individuals who had previously been mistreated and abused.[26] This reform evolved from concerns about the treatment of the mentally ill. An idea generated by multiple medical professionals incorrectly claimed that mental illness resulted from disease and living

[25] National Institute of Mental Health, "Mental Illness."

[26] Sandra Wachholz and Robert Mullaly, "Policing the Deinstitutionalized Mentally Ill: Toward an Understanding of Its Function," *Crime, Law and Social Change* 19, no. 3 (April 1993): 282–83, https://doi.org/10.1007/BF01844063.

environments. This false concept spawned the belief that mental hospitals could offer treatment through regulation and instruction.[27]

The claim that this treatment yielded a high cure rate led to the establishment of numerous mental health institutions across the United States.[28] These mental health institutions ultimately provided minimally effective treatment. They became housing facilities for mentally ill patients abandoned by lower-income families or shunned by their communities.[29] Through the 1960s, an awareness of the mistreatment of mentally ill patients grew. The public's consciousness regarding people with mental health conditions housed in state mental institutions promoted the deinstitutionalization movement. Through reform strategies, federal government involvement, judicial rulings, advanced psychotic drug options, and economic motivations, mentally ill patients transitioned from treatment in mental institutions to alternative options in their communities.

1. Reform Strategies

The deinstitutionalization movement in the United States began in the late 1950s to early 1960s. In 1955, state hospitals in the United States housed over 550,000 individuals.[30] This overpopulation led to a general awareness and dissatisfaction about the mistreatment of individuals housed in state mental hospitals.[31] The discontent initially started with the publication of articles related to the environment in mental institutions and

[27] J. R. Elpers, "Are We Legislating Reinstitutionalization?," *American Journal of Orthopsychiatry* 57, no. 3 (July 1987): 441–46, https://doi.org/10.1111/j.1939-0025.1987.tb03554.x; Donald H. Williams, Elizabeth C. Bellis, and Sheila W. Wellington, "Deinstitutionalization and Social Policy: Historical Perspectives and Present Dilemmas," *American Journal of Orthopsychiatry* 50, no. 1 (January 1980): 54–64, https://doi.org/10.1111/j.1939-0025.1980.tb03262.x.

[28] Elpers, "Are We Legislating Reinstitutionalization?"

[29] Charles A. Kiesler et al., "Federal Mental Health Policymaking: An Assessment of Deinstitutionalization," *American Psychologist* 38, no. 12 (1983): 1292–97, https://doi.org/10.1037/0003-066X.38.12.1292.

[30] Koyanagi, *Learning from History*, 4.

[31] Anne M. Lovell and Nancy Scheper-Hughes, "Deinstitutionalization and Psychiatric Expertise: Reflections on Dangerousness, Deviancy, and Madness," *International Journal of Law and Psychiatry* 9, no. 3 (January 1986): 361–81, https://doi.org/10.1016/0160-2527(86)90030-0.

the care afforded to mentally ill individuals.[32] A combination of this awareness campaign and specific reform strategies challenged the effectiveness of state mental hospitals. As a result, the deinstitutionalization movement commenced and pursued the establishment of the following principles:

1. Provide community-based alternatives to mentally ill patients as an option for treatment;
2. Release institutionalized patients back to their communities after proper training and preparation; and
3. Institute systems of support for mentally ill individuals who obtain additional medical services in their community.[33]

2. Federal Government Involvement

Federal government involvement played a vital role in the deinstitutionalization movement. From 1956 to 1962, the movement commenced slowly, with the number of mental hospital patients decreasing from 559,000 to 505,000. In the late 1960s and 1970s, the campaign received a notable boost in activity and became a national policy after the federal government instituted various regulations.[34] The movement became national policy after the Joint Commission on Mental Health published *Action for Mental Health.*[35] This report highlighted the importance of establishing community-based clinics designed to treat mentally ill individuals after deinstitutionalization. Chris Koyanagi, author of the Kaiser Commission's report *Learning from History: Deinstitutionalization of People with Mental Illness as Precursor to Long-Term Care Reform*, stated the goal of *Action for Mental Health* was "for clinic care to furnish prevention and early intervention services in

[32] Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Doubleday, 1990); Thomas S. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, updated ed. (New York: Harper Perennial, 2010).

[33] Peter Braun et al., "Deinstitutionalization of Psychiatric Patients: A Critical Review of Outcome Studies," *American Journal of Psychiatry* 138, no. 6 (1981): 739.

[34] Koyanagi, *Learning from History*, 4.

[35] Joint Commission on Mental Illness and Health, *Action for Mental Health: Final Report of the Joint Commission on Mental Illness and Health* (New York: Basic Books, 1961).

order to reduce mental disability in the future and to promote mental health. A further goal was to improve hospitals for those disabled by mental illness."[36]

The federal government implemented specific policies based on the Joint Commission's report but failed to follow its recommendations completely. In 1963, President Kennedy urged Congress to enforce new policies to establish community-based programs that would replace the treatment provided by mental institutions. These community-based programs would provide mentally ill individuals the options of treatments without institutional housing, provide foster homes, and educate the public about mental health. The funding involved with this new policy went to hospitals and nonprofit community agencies responsible for providing community-based treatment. The state institutions did not receive the funding but were still responsible for the long-term care required for specific mentally ill individuals.[37]

In response to these policies, federal law established funding for community mental health centers (CMHCs) to provide specific services to mentally ill individuals. According to Koyanagi, these CMHC services included "inpatient, outpatient, emergency, partial hospitalizations (day or night), and consultation on education on mental health."[38] Although state hospitals did not receive this funding, Koyanagi reported that most states established comparable mental health programs.[39] The federal government involvement that began in 1963 and other specific factors assisted with deinstitutionalization. As a result of the implementation of national policies, by the late 1970s, 650 community health centers were treating 1.7 million people a year.[40] By 1998, with the federal government's influence, the number of mentally ill individuals living in state mental hospitals had decreased to 57,151.[41]

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[36] Koyanagi, *Learning from History*, 5.

[37] Henry A. Foley and Steven S. Sharfstein, *Madness and Government: Who Cares for the Mentally Ill?* (Washington, DC: American Psychiatric Press, 1983), 50.

[38] Koyanagi, *Learning from History*, 5.

[39] Koyanagi, 5.

[40] Foley and Sharfstein, *Madness and Government*, 103.

[41] H. Richard Lamb and Leona L. Bachrach, "Some Perspectives on Deinstitutionalization," *Psychiatric Services* 52, no. 8 (August 2001): 1039, https://doi.org/10.1176/appi.ps.52.8.1039.

3. Judicial Rulings

Specific judicial rulings also encouraged the deinstitutionalization movement. Concerns about the treatment of individuals living in mental institutions led to judicial rulings that promoted the rights of the mentally ill. The orders tightened restrictions on institutionalizing mentally ill individuals against their will and established basic guidelines that had to be followed if an individual was admitted.[42] This committal criterion resulted primarily from the 1975 Supreme Court ruling in *O'Connor v. Donaldson*.[43] As stated by Sandra Wachholz and Robert Mullaly in their article for *Crime, Law and Social Change*, this case "won the right for non-dangerous patients to refuse treatment if they could survive safely in the community, had the cumulative effect of tightening commitment criteria, and thus provided a step toward noninstitutional care."[44] With further limitations on committing individuals to institutions and judicial orders stipulating that treatment must be offered in a minimally constraining environment, the deinstitutionalization movement progressed with its agenda of moving patients out of institutions and back into their communities.[45]

4. Psychotropic Drugs

The emergence of new psychotropic drugs that positively affected mentally ill patients furthered the deinstitutionalization movement.[46] Psychotropic drugs such as chlorpromazine and reserpine transformed patients from unruly and disturbed to manageable, compliant, and socially acceptable. Policymakers utilized this advancement in managed behavior as a platform to further promote deinstitutionalization. The 1961 Joint Commission on Mental Illness and Health stated, "Drugs have revolutionized the management of psychotic patients in American mental hospitals and probably deserve

[42] Samuel J. Brakel and Ronald S. Rock, eds., *The Mentally Disabled and the Law*, 3rd ed. (Chicago: University of Chicago Press, 1985), 73–99.

[43] O'Connor v. Donaldson, 422 U.S. 563 (1975).

[44] Lovell and Scheper-Hughes, "Deinstitutionalization and Psychiatric Expertise," 361–81.

[45] Brakel and Rock, *The Mentally Disabled and the Law*, 73–99.

[46] Wachholz and Mullaly, "Policing the Deinstitutionalized Mentally Ill," 283.

primary credit for the reversal of the upward trend of the upward spiral in the state inpatient load."[47] In President Kennedy's 1963 decisive speech to Congress about deinstitutionalization and the need for community-based treatment alternatives, he identified psychotropic drugs as the primary ingredient.[48] The promotion and availability of these new drugs presented a viable solution to a problem that had haunted state hospitals for decades. Utilizing these new drugs improved patients' demeanor and allowed them to be accepted back into society while advancing the agenda of policymakers and the deinstitutionalization movement.[49]

5. Economic Motivations

Economic motivations played a primary role in the deinstitutionalization movement by providing mentally ill individuals with new alternatives for community-based treatment. State hospitals realized inpatient care costs were more expensive than alternatives utilized in the patients' communities. With federal subsidies available such as Medicaid, Supplemental Security Income, and Social Security Disability Insurance, state administrators used the promotion of deinstitutionalization to their advantage. They moved patients from state hospitals to general hospitals and nursing homes. This action decreased costs in their mental institutions while they collected federal funding for patients receiving treatment in so-called community-based alternatives and other CMHCs.[50]

B. IMPACT OF DEINSTITUTIONALIZATION ON THE MENTALLY ILL

The deinstitutionalization movement concentrated on the removal of mentally ill patients from mental institutions to provide more humane treatments afforded through community-based alternatives. The foundation of this movement and mentally ill patients across the United States depended on funding from the federal government to achieve this

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[47] Joint Commission on Mental Illness and Health, *Action for Mental Health*, 39.

[48] Foley and Sharfstein, *Madness and Government*, 165.

[49] William Gronfein, "Psychotropic Drugs and the Origins of Deinstitutionalization," *Social Problems* 32, no. 5 (June 1985): 442–43, https://www.jstor.org/stable/800774.

[50] Koyanagi, *Learning from History*, 6; Wachholz and Mullaly, "Policing the Deinstitutionalized Mentally Ill," 284.

goal. With each new administration came varying ideas on government control and funding for such treatments. The National Institute of Mental Health's community support program was established in 1975 to provide grants to assist mentally ill patients with community-based support and treatment. It also provided additional assistance programs through Medicaid, Medicare, and Supplemental Security Income but ultimately received inadequate funding to efficiently accomplish the goal that policymakers established for the deinstitutionalization movement.[51] Deficient funding for the deinstitutionalization movement impacted countless mentally ill individuals through insufficient community-based alternatives and a culture that criminalized their circumstances.

1. Lack of Community-Based Alternatives

A deterioration of available community-based treatment caused by a lack of funding and cultural awareness left mentally ill individuals without suitable living situations, critical resources, and services after their release from mental institutions.[52] In the 1980s, federal funding for mentally ill individuals living in low-income housing was reduced by 25 percent, and the Mental Health Systems Act was repealed. This funding void left states responsible for providing housing and community-based treatments. Even before the reduction of federal funding, the movement had underestimated the importance of coordination with communities to provide the support necessary to implement deinstitutionalization successfully. Deinstitutionalization relied on the crucial asset of supportive housing arrangements for mentally ill individuals returning to society. A poorly underfunded deinstitutionalization movement left many mentally ill individuals with deprived living situations and underdeveloped community assistance. Instead of communities funded to provide support, former institutionalized patients and other mentally ill individuals acquired ineffectual residencies in nursing homes, isolated apartment housing, and boarding rooms. These living conditions provided a marginal solution for individuals requiring affordable housing and demonstrated inadequate

[51] Edwin F. Torrey, *Nowhere to Go: The Tragic Odyssey of the Homeless Mentally Ill* (New York: Harper & Row, 1988); Koyanagi, *Learning from History*, 7–8.

[52] Koyanagi, *Learning from History*, 11–13.

supportive care in efforts to encourage further medical treatment with a critically prescribed medication regimen.[53] Deinstitutionalization ultimately left mentally ill individuals struggling while they sought assistance in impecunious neighborhoods. These communities were inept at providing the essential medical services and resources for most mentally ill individuals to maintain a healthy and productive lifestyle.

2. Lack of Resources

The lack of resources subsidized for community-based treatment options also impacted mentally ill individuals displaced from mental institutions. From the beginning of the deinstitutionalization movement, there was a disconnect between state and federal policy concerning community alternatives. CMHCs did not have strict requirements related to preadmission screenings or developmental care. The mismanagement of state funds intended for community treatment alternatives, federal funds falling short of their pledged allocation, and insurance companies providing minimal coverage for mental illness treatment left many mentally ill individuals lacking treatment and medications needed to sustain a normal lifestyle.[54] Deficient resources and funding for their implementation forced many mentally ill individuals to live on the streets if they could not obtain vital prescriptions to improve their mental health or seek proper medical attention.[55]

3. Homelessness

A lack of housing options and resources for proper medical assistance led to homelessness for many mentally ill individuals. The failure of the deinstitutionalization movement to provide adequate assets to assist mentally ill individuals pushed many of them to the streets and to live the life of vagrants. In their article for *Psychiatric Services*, Lamb and Bachrach state, "A third to a half of all homeless adults in the United States have major mental illness—schizophrenia, schizoaffective disorder, bipolar disorder, or major depressive disorder—and up to 75 percent have major mental illness, severe substance use

[53] Koyanagi, *Learning from History*, 11; Wachholz and Mullaly, "Policing the Deinstitutionalized Mentally Ill," 294.

[54] Koyanagi, *Learning from History*, 11.

[55] Lamb and Bachrach, "Some Perspectives on Deinstitutionalization," 1041.

disorders, or both."[56] A combination of untreated mental illness, a lack of proper housing, insufficient resources, and substance abuse have negatively impacted the mentally ill community. These factors have led to the criminalization of mental illness and increased law enforcement's interactions with individuals who suffer from it.

C. IMPACT OF DEINSTITUTIONALIZATION ON LAW ENFORCEMENT

Failed deinstitutionalization policies have significantly impacted law enforcement personnel's contact with mentally ill individuals. Two substantial areas that have affected law enforcement include the demand for their interaction with mentally ill individuals and the need for additional training to control situations with mentally ill individuals effectively. When mentally ill individuals commit minor crimes, it is often due to behavior relating to their condition.[57] Communities' intolerance of this behavior and the criminal activity of mentally ill individuals usually result in law enforcement's responsibility to interact with and resolve the situation.[58]

1. Demand for Law Enforcement Interaction and the Criminalization of Mental Illness

Most of the pressure to deal with situations involving mentally ill individuals due to insufficient options falls on law enforcement. With many communities depleted of funding to support mental health treatment, citizens typically turn to law enforcement for assistance when facing a situation involving a mentally ill individual. These encounters with law enforcement leave officers with limited alternatives. The options include arresting individuals, transporting them to a hospital emergency room for evaluation, or departing the scene and leaving the community with people potentially dangerous to themselves or

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[56] Lamb and Bachrach, 1041.

[57] H. Richard Lamb et al., "Outcome for Psychiatric Emergency Patients Seen by an Outreach Police–Mental Health Team," *Psychiatric Services* 46, no. 12 (December 1995): 1267–71, https://doi.org/10.1176/ps.46.12.1267; Lamb and Bachrach, "Some Perspectives on Deinstitutionalization," 1042.

[58] Edwin F. Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis* (New York: Wiley, 1997); Linda A. Teplin, "Prevalence of Severe Mental Disorder among Male Urban Jail Detainees: Comparison with the Epidemiologic Catchment Area Program," *American Journal of Public Health* 80, no. 6 (June 1990): 663–69.

society.[59] Since additional formal standards are required to commit an individual to a mental institution, law enforcement depends on incarceration as the primary choice to resolve the issue.[60]

The limited supportive options and the time necessary to obtain proper treatment have developed into the criminalization of mental illness.[61] Some research suggests that 90 percent of all police officers have interacted with mentally ill individuals while on patrol and that 5–20 percent of all requests for police officer interaction comprise mental health–related service calls.[62] Elevated law enforcement involvement, combined with minimal resolution options and a lack of practical training, has resulted in three times as many mentally ill individuals living in prisons and jails as in mental institutions.

2. Demand for Effective Training for Police Officer Interactions with the Mentally Ill

Over the past decade, there has been a growing realization of the necessity for more effective training for law enforcement officers interacting with mentally ill individuals. Law enforcement has dealt with the new arduous challenges of more mentally ill individuals in society and more untreated mental illnesses due to a lack of community-based alternatives. Basic law enforcement training has shown itself ineffective in combating the mounting interactions with mentally ill individuals. Many incidents involving law enforcement and mentally ill individuals have led to public safety issues, complicated use-of-force incidents, and time-consuming officer conflict resolution.[63]

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[59] Bureau of Justice Assistance and Council of State Governments Justice Center, *Police–Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Responses for People Who Have Mental Health Needs* (New York: Council of State Governments Justice Center, 2019), 1.

[60] Linda A. Teplin, Karen M. Abram, and Gary M. McClelland, "Prevalence of Psychiatric Disorders among Incarcerated Women: I. Pretrial Jail Detainees," *Archives of General Psychiatry* 53, no. 6 (1996): 505–12, https://doi.org/10.1001/archpsyc.1996.01830060047007.

[61] Lamb and Bachrach, "Some Perspectives on Deinstitutionalization," 1042.

[62] Koyanagi, *Learning from History*.

[63] Bureau of Justice Assistance and Council of State Governments Justice Center, *Police–Mental Health Collaborations*, 1; Kimberly Kindy et al., "Fatal Police Shootings of Mentally Ill People More Likely in Small and Midsized Areas," *Washington Post*, October 17, 2020, https://www.washingtonpost.com/national/police-mentally-ill-deaths/2020/10/17/8dd5bcf6-0245-11eb-b7ed-141dd88560ea_story.html.

Officers have faced difficult situations with mentally ill individuals who are not taking proper medications or who are abusing various substances. These situations have produced intense interactions in which police—devoid of appropriate training or the ability to detect mental illnesses—demand that mentally ill individuals obey commands they could not possibly comprehend or follow. According to National Public Radio's Eric Westervelt, "Since 2015, nearly a quarter of all people killed by police officers in America have had a known mental illness."[64] Wood and Watson indicate that mentally ill individuals are 16 times more likely to be shot and killed by law enforcement.[65] Moreover, *New York Post* journalist Stephen Eide argues that although police officers are qualified to deal with mental illness issues, they need updated training. Eide's article sheds light on the nearly 250 deadly police shootings involving mentally ill individuals every year in the United States. Citing the *Washington Post*'s research into law enforcement's interactions with these individuals from 2015 to 2021, Eide reveals that 1,400 fatal police shootings involved individuals with mental illness.[66] This increase in violent outcomes has spurred law enforcement departments nationwide to seek additional, practical training to assist their officers with situations involving mentally ill subjects.

Since the late '90s, some law enforcement agencies have implemented advanced training to teach officers to communicate and intervene appropriately during interactions with mentally ill individuals. Additional efforts have continued to improve on officer interactions. Some of the mental health training has incorporated crisis intervention and stabilization. The Council of State Governments Justice Center defines stabilization training as "tactics used to defuse and minimize any harmful or potentially dangerous behavior an individual might exhibit during a call for service."[67] American society has

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[64] Eric Westervelt, "Mental Health and Police Violence: How Crisis Intervention Teams Are Failing," National Public Radio, September 18, 2020, para. 2, https://www.npr.org/2020/09/18/913229469/mental-health-and-police-violence-how-crisis-intervention-teams-are-failing.

[65] Wood and Watson, "Improving Police Interventions," 293.

[66] Stephen Eide, "Police Are Still the Most Qualified Mental Illness Responders," *New York Post*, December 27, 2021, https://nypost.com/2021/12/27/police-are-still-the-most-qualified-mental-illness-responders/.

[67] Adapted from Bureau of Justice Assistance and Council of State Governments Justice Center, *Police–Mental Health Collaborations*.

diverted its attention from what has diminished mental illness treatment alternatives to how law enforcement officers have handled mental illness situations in communities. This scrutiny has motivated law enforcement agencies to cultivate advanced training to support their officers in the field.[68] Table 1 presents three categories that have been incorporated into advanced training for an effective response.

Table 1. Advanced Training for an Effective Response.[69]

1.	Interagency agreements with mental health agency-based mobile crisis teams.
2.	Mental health clinicians embedded in police agencies to consult with officers in the field.
3.	Specially trained police officers who provide initial crisis response in the field and liaise with mental health providers to resolve calls.

Even though select law enforcement agencies have identified the need for advanced training to interact with mentally ill individuals appropriately and have implemented changes, fatal encounters between law enforcement and mentally ill individuals occur far too regularly. Although some tragedies are unavoidable, each violent or fatal encounter is a reminder that additional advanced training and yearly refresher training are essential for adequately preparing law enforcement to manage situations with mentally ill individuals.

3. Law Enforcement Interactions with the Mentally Ill That Indicate a Lack of Mental Illness Training

In 1987, Memphis police officers were called to a scene involving a mentally ill young man who had threatened to harm himself with a knife. Despite commands to drop the weapon, the individual charged at the officers in a state of agitation and anger. The officers, following their training to use deadly force when their or others' lives were in danger, shot and killed the man. This incident sparked criticism and led to the creation of the Crisis Intervention Team program, also known as the Memphis model. This program,

[68] Wood and Watson, "Improving Police Interventions," 291.

[69] Source: Wood and Watson, 291–92.

in collaboration with local universities, mental health professionals, and the National Alliance on Mental Illness (NAMI), has aimed to provide officers with the skills to safely handle incidents involving individuals with mental illness. The program's success in Memphis led to its implementation in law enforcement agencies in 40 states across the country.[70]

In September 2020, tragedy struck in Salt Lake City from a lack of mental health training among law enforcement officers. In an article for *USA Today*, author N'dea Yancey-Bragg wrote that a 13-year-old autistic boy, Linden Cameron, began suffering mental health complications due to separation from his mother. Golda Barton, Linden's mother, contacted the police for assistance because she was at work during her son's mental health episode. As described by Yancey-Bragg, Barton informed the police that her son—"a kid trying to get attention"—was unarmed and that his behavior was a result of his "just getting mad and yelling and screaming" and not knowing "how to regulate."[71]

Body camera footage released to the public, as reported by CNN, revealed that Barton had warned the Salt Lake City police officers of her son's violent threats and behavior during a mental health episode. She also informed the officers that her son had access to a BB gun in the house, but she did not believe he had any real firearms. Additionally, as reported by the *Salt Lake City Tribune*, Barton expressed concern that her son, who had had negative experiences with law enforcement previously, might attempt to flee the house in the presence of police. She also highlighted that her son's grandfather had been killed by police in an interaction with Nevada law enforcement earlier that year.[72]

The body camera footage that was released also showed the officers discussing the situation and their concerns about the possible mental conditions of the 13-year-old boy.

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[70] "CIT History," Crisis Intervention Team Inc., accessed January 14, 2023, http://www.gocit.org/crisis-intervention-team-history.html.

[71] N'dea Yancey-Bragg, "A Mom Called 911 to Help Her 13-Year-Old with Autism, Utah Police Shot Him," *USA Today*, September 8, 2020, https://www.usatoday.com/story/news/nation/2020/09/08/utah-police-shot-13-year-old-autism-after-mom-call/5745028002/.

[72] Peighten Harkins, "Salt Lake City Reaches $3M Settlement with Parents of Unarmed, Autistic Child Shot by Police," *Salt Lake Tribune*, September 20, 2022, https://www.sltrib.com/news/2022/09/20/salt-lake-city-reaches-3m/.

Audio captured from the footage revealed a conversation between the two responding officers in which they discussed the need to call their sergeant due to questions about the boy's mental illness and the possibility that the altercation would lead to a shooting, as the boy reportedly had hatred for the police. Moments later, the boy fled his house, and the officers pursued him. Upon catching up with him, one of the officers commanded the boy to get on the ground, but the boy's failure to obey or confusion due to his mental state resulted in the officer's shooting him 11 times.[73]

Two years later, the Salt Lake City Police Department settled a lawsuit for the officers' failed response that resulted in a mentally ill 13-year-old being shot and severely injured. According to Peighten Harkins with the *Salt Lake City Tribune*, Cameron's family admitted this settlement was a "crucial step towards increasing awareness for those with mental health challenges."[74] One month after the tragic altercation, the Salt Lake City Police Department initiated a collaboration with KultureCity, an organization that assists first responders with training in how to manage situations with individuals experiencing different mental illnesses. One study conducted by the *Salt Lake City Tribune* reported that 40 percent of Salt Lake City police encounters with the public from 2010 to 2020 had involved an individual with a mental illness. The Salt Lake City Police Department continues to provide all its first responders with training from KultureCity, and Cameron's family has encouraged all law enforcement departments nationwide to adopt additional training to effectively manage incidents with mentally ill individuals.[75]

D. CONCLUSION

The deinstitutionalization movement has left law enforcement in a precarious position. If law enforcement fails to realize the necessity of advanced mental illness training for its personnel, the impact could be devastating and result in loss of life. Advanced training and proper interview skills can provide officers with effective tools to mitigate violent interactions with mentally ill subjects or enable them to procure vital

[73] Harkins.

[74] Harkins.

[75] Harkins.

information during interviews. This same attention to advanced mental illness training should be a focus for the Secret Service as well. The Secret Service PID requires SAs to investigate and interview individuals suspected of threatening designated elected officials, so a lack of proper training and poor interview skills might be a determining factor in mitigating a future attack.

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III. THE SECRET SERVICE'S PROTECTIVE INTELLIGENCE DIVISION

Understanding the basic principles as well as the current and emerging training practices of the Secret Service's PID is crucial concerning the deinstitutionalization of the mentally ill, increased interactions between law enforcement and those with mental illness, and the need for further specialized training for law enforcement personnel. Given the proliferation of mentally ill individuals living in communities with insufficient housing, treatment, and resources, a higher allocation of Secret Service PI investigations involve interactions with mentally ill individuals. Secret Service SAs receive instructions and guidance about their available resources with protective intelligence–related issues through the PID section of the Secret Service manual, along with information taught during their seven months of training as recruits. This chapter presents the information in the PID section of the Secret Service manual and training curriculum to support the claim that SAs need more advanced training for interactions with mentally ill individuals.

A. PURPOSE AND PRIORITY

The Secret Service has deemed the PI investigation the SA's most crucial inquiry. This essential investigation originates from information reported to a Secret Service member or field office concerning a possible threat; an inappropriate interest; or an unusual behavior toward a Secret Service protectee, protected facility, or protected event.[76] Section PID-05 of the Secret Service manual states, "A subject's interests may take many forms, to include, but not limited to: intended violence; a perceived special relationship or romantic interest with a protectee; a desire to receive assistance from or voice a complaint to a protectee; or a desire to obtain notoriety."[77] The subject's interests and intentions are the primary focus of the investigation to determine whether a potential threat is involved.

The principal purpose of the PID is to investigate and prevent any potential attack posed by a reported threat. Individuals or groups that threaten Secret Service protectees are

[76] U.S. Secret Service, "Protective Intelligence Investigations," 1.

[77] U.S. Secret Service, 1.

scrutinized through an extensive investigation to determine whether they pose any risk or danger.[78] PI investigations are not limited to subjects that make a direct threat; they also involve subjects who present an unusual direction of interest toward a protectee. PID-05 describes an unusual direction of interest as "a perceived special or romantic relationship, attempts to make contact or offer assistance, attempting to address a grievance, or attempting to penetrate security."[79] After a PI investigation concludes, a proper assessment is prepared. If the subject presents a threat, the Secret Service will develop a plan to supervise the subject and intercede to prevent an attack. During this phase, various aspects are reviewed and considered to manage the potential threat.[80]

The Secret Service deems mental health issues to be a potential factor in threatening behavior or an attack against one of its protectees. As the observation, detection, and management of mental illnesses present an important aspect of significant intelligence about subjects and their abilities to carry out an attack, the Secret Service offers several modes of assistance for SAs conducting a PI investigation and interview with a mentally ill subject. The first way is via instructions in the Secret Service manual's PID section. This section contains written instructions and guidelines for agents to follow for PI investigations, PI interviews, and involvement with mentally ill individuals, as well as methods whereby the Secret Service can assist during a PI interview. The second mode is through classroom instruction and practical exercises delivered during a designated section of SAs' recruit training at the beginning of their career. The third mode is through the PID's 24-hour duty desk and Risk Assessment Branch. These sections of the PID can provide SAs with advice, guidance, and assistance as needed to complete a successful PI investigation.

The PID section of the Secret Service manual specifies an implemented information-gathering system protocol to assist SAs conducting PI investigations. This

78 U.S. Secret Service, 15.

79 U.S. Secret Service, 15–16.

80 Robert A. Fein and Bryan Vossekuil, *Protective Intelligence and Threat Assessment Investigations: A Guide for State and Local Law Enforcement Officials* (Washington, DC: National Institute of Justice, 1998), 7.

system encompasses a checklist revealing standard methods for obtaining information about a subject. These systems include the following:

- Community
- Family/Relatives
- Employment
- Social
- Spiritual
- Mental Health Professionals
- Judicial Records
- Law Enforcement Encounters/Arrests
- Education
- Social Services
- Online Activities[81]

Information gathered from these systems enables the investigating SA to compare the subject's mental status with possible changes over time. It also allows the SA to validate any information the subject has provided during initial interviews. Information obtained from the assortment of systems assists the SA in developing a comprehensive representation of the subject.[82]

The PI interview is vital to an SA's investigation. It can reveal the purpose of a subject's direction of interest, but it also allows the subject to explain one's reasoning and motivation for the reported threat. SAs are reminded that their safety is of utmost importance and that an additional agent or local law enforcement officer should be present while conducting a PI interview.[83]

B. SECRET SERVICE PI INTERVIEWS: SUBJECTS EXHIBITING MENTAL ILLNESS

Since the PI investigations of Secret Service SAs often deal with mentally ill subjects, one section of the Secret Service PI manual specifies protocols for detecting and interviewing mentally ill subjects. Section PID-05 maintains that a PI subject interview is

[81] U.S. Secret Service, "Protective Intelligence Investigations," 16.

[82] U.S. Secret Service, 16.

[83] U.S. Secret Service, 3.

the most vital element for obtaining intelligence during an investigation.[84] PID-05 also provides SAs with recommendations for conducting their PI interviews with mentally ill subjects while highlighting specific information that agents should observe or obtain. An SA is tasked with obtaining the following information during a PI interview:

- The subject's thinking;
- The subject's motives for his or her behavior that resulted in the investigation;
- Additional behaviors or concerning actions; and
- Supplemental information that will aid the investigation, including points of contact for corroborative interviews and previous interactions with law enforcement entities and mental health establishments.[85]

The PID section of the Secret Service manual provides SAs with a few principles to retain when interacting with a mentally ill subject during a PI interview. SAs are reminded that mentally ill subjects respond to their perceived reality. For example, according to the manual, a mentally ill subject might believe that aliens control her mind and have commanded the subject to attack the president, a delusion that might influence the subject to stalk the president. Suppose an interviewing agent deems these statements and beliefs absurd and foolish talk. In that case, the agent might mistakenly perceive the subject as innocuous and inadvertently overlook the natural prospective risk factors posed by the subject.[86]

Also, during an interview with a mentally ill subject, the PID section of the Secret Service manual instructs SAs to be concise and respectful of the subject. This instruction aids an SA in obtaining worthwhile material from the subject to complete the investigation. As section PID-05 describes, "An agent should be an active listener and communicate a

[84] U.S. Secret Service, 3.

[85] U.S. Secret Service, 3.

[86] U.S. Secret Service, 4.

genuine interest in hearing and understanding the subject's story, no matter how outlandish it may seem."[87] A respectful attitude during an interview will encourage the subject to be more forthcoming with crucial information.

Another critical aspect included in the PID section of the Secret Service manual is the significance of the mental illness the subject may possess during a PI interview. The manual suggests that SAs should not determine the risk a mentally ill subject poses based exclusively on the person's mental illness status. It warns that a subject's mental health during a PI interview could either support or diminish the level of risk presented to a Secret Service protectee. Agents should inquire about the subjects' mental health treatment and whether they comply with their prescribed medications or treatments. It is paramount that the interviewing agent obtain information on the mentally ill subject's support system and available resources to assist with the positive control of the illness.[88]

The PID section of the manual contains the following standard questions that all SAs should ask themselves during a PI interview with a mentally ill subject:

1. Are there any observable signs that the subject is battling a mental illness?
2. If there is evidence of mental illness, how does it affect their actions and reasoning?
3. Is the subject currently being treated for a mental illness? Is it effective?
4. Is the subject exhibiting signs of despondency?
5. Does the subject have a history of suicidal thoughts, past or present?[89]

The Secret Service manual dedicates a portion of PID-05 to describing several major mental illnesses an SA may observe while conducting a PI interview. This passage prompts SAs to assess PI subjects' mental health status and concentrate on observable indicators that may present signs of a mental illness influencing their thoughts and behavior. For example, as detailed in PID-05, a mentally ill person might experience

[87] U.S. Secret Service, 4.

[88] U.S. Secret Service, 4.

[89] U.S. Secret Service, 20.

command hallucinations, voices in his mind, and believe he must travel to the White House to deliver a letter to the president.[90]

The most common symptoms experienced by individuals battling mental illness who might interact with Secret Service SAs derive primarily from psychotic indicators, including hallucinations, paranoia, and delusions, and depression. PID-05 explains, "NTAC research has shown these to be the most prevalent symptoms among the attackers who had histories of mental illness before carrying out their attacks."[91] This section details indicators of mental illnesses with a brief explanation of each of the prevalent symptoms SAs might encounter.

Secret Service guidance recommends that if the subject exhibits despondency, the interviewing agent should interpret this behavior as either potential mental illness or consequences of the subject's situation. SAs need to inquire about possible recent experiences causing distress in the subject's life (e.g., the loss of life, romantic relationship issues, the loss of a job, or humiliating life experience) that could promote desperate feelings and generate unusual interest or behavior toward Secret Service protectees or facilities. These "triggering" events may lead a mentally ill subject to believe an attack on a protectee is the only way to eliminate unwanted stress and despair. This is especially true if a mentally ill subject is suicidal and attempts to approach a Secret Service protectee's security detail with the intention of being killed while attempting harm. This possibility illustrates the crucial reason behind the Secret Service's emphasis on the PI interview and assessment when interacting with a mentally ill subject.[92]

After SAs assess a subject's mental health symptoms, they should determine whether the subject has actively reacted to the symptoms. A subject who experienced hallucinations and has a history of violent tendencies is usually at a higher risk of an unwanted outcome than another subject experiencing the same symptoms yet has no violent past. After collecting data about the subject's hallucinations or delusions, the SA

[90] U.S. Secret Service, 20.

[91] U.S. Secret Service, 20.

[92] U.S. Secret Service, 20.

must investigate the subject's historical reactions to the hallucinations and history of compliance with medical treatment. The Secret Service manual presents questions for different scenarios, for example, about whether subjects felt forced to travel, and it was out of their control; whether the subjects felt forced to commit violent acts due to a command; or whether the subjects felt under attack from an outside entity. Finally, the interviewing agent must determine whether the subject has been involuntarily committed previously by a court due to mental health issues stemming from violence to themselves or others.[93]

This valuable information is essential for the final assessment of the level of risk the subject may pose. Information provided by a subject during an interview may be incorrect or irrelevant. Whether intentional or accidental, the points of contact for corroborative interviews with friends, family, neighbors, local law enforcement, or mental health establishments (with legally signed documentation) provide added essential elements for the agent when judging the subject's statements and motivations.[94]

C. SECRET SERVICE PI TRAINING CURRICULUM

The Secret Service's current PI instruction takes place at the Rowley Training Center (RTC) during agent recruit training. Although the Secret Service maintains a conservative posture in disclosing information about its PI training while at RTC, some of the classes of instruction include Introduction to Protective Intelligence, Protective Intelligence Report Writing, Protective Intelligence Advances, Protective Intelligence Practical Exercises, and Abnormal Behavior.

Secret Service SA recruits receive approximately 18 hours of interview training and 10 hours of mental health training. One segment of mental illness training involves instruction on tactics when interviewing mentally ill individuals and procuring valuable information that can benefit a PI investigation. The information taught also assists trainees in detecting common symptoms mentally ill individuals may exhibit. One helpful way to

[93] U.S. Secret Service, 20–21.

[94] U.S. Secret Service, 3.

provide SA trainees with real-life scenarios is their participation in practical exercises.[95] These scenarios involve trainees interviewing role players who represent mentally ill individuals with schizophrenia, bipolar disorder, and paranoid disorder.[96] An additional section of PI training involves a medical professional as a guest speaker to review specific mental illnesses and their symptoms and understand how a potential PI subject's attitude, demeanor, and thought process may materialize during a PI interview. This specific instruction segment is provided only for a couple hours on one day of the training schedule.

D. SECRET SERVICE CRISIS INTERVENTION TEAM PROGRAM

In July 2021, the Secret Service started its own version of the Crisis Intervention Team (CIT) program, geared toward the needs of both Secret Service Uniformed Division (UD) officers and SAs working in the Washington Field Office (WFO)'s PI squad. These officers and SAs guard the outer perimeter of the White House and other sensitive locations in Washington, DC. Secret Service officers and SAs assigned to these areas are often tasked with interacting with and interviewing individuals with mental illnesses. In 2019, Secret Service UD officers assigned to the White House Branch interacted with over 500 mentally ill individuals.[97] The Secret Service CIT program is similar to the 40-hour CIT training program utilized by many law enforcement agencies but is fashioned specifically for the Secret Service mission. It also incorporates partnerships with more than 12 entities and advocacy groups, including the Metropolitan Police Department of the District of Columbia (MPDC) and NAMI.[98] As described by the Secret Service in its fiscal year 2021 report, "This program and these trainings utilize Secret Service expertise, as well as that of the CIT program partners, such as law enforcement, social services, homeless outreach teams, and behavioral healthcare providers."[99]

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[95] Maurer, *DHS and DOJ Are Working to Enhance Responses*, 18.

[96] Maurer, 18.

[97] Richard Allwein, U.S. Secret Service Uniformed Division, personal communication, February 2, 2023.

[98] U.S. Secret Service, *FY 2021 Annual Report* (Washington, DC: U.S. Secret Service, 2022), 10–12, https://www.secretservice.gov/sites/default/files/reports/2022-05/2021%20Annual%20Report.pdf.

[99] U.S. Secret Service, 12.

The Secret Service CIT program assists officers and SAs assigned to areas of DC with a localized approach to handling encounters with mentally ill individuals. The partnership with additional organizations permits them to provide mentally ill individuals with the opportunity to contact family and friends and seek various treatments or alternatives to incarceration or involuntary committals. The program provides instruction to Secret Service officers and SAs on effective techniques used for de-escalation and establishes a CIT Task Force Meeting platform that allows officers to discuss methods of approach and action for specific mentally ill individuals who frequent the DC area.[100]

Although the Secret Service CIT program is not currently offered to SA recruits or SAs in field offices across the country, it has been a successful program in the DC area. The program trains 17 officers and three Washington Field Office SAs each quarter, with instruction developed specifically for the National Capital Region. A condensed eight-hour version of the program is delivered to Secret Service UD officer recruits. The Secret Service training division also plans to incorporate this eight-hour training into the SA recruits' PI training.[101] The following topics show a collection of selected material taught in the Secret Service CIT program:

- Mental illness
- Distressing voices simulations
- Mental health treatments
- Signs and symptoms of mental illness
- Crisis/trauma/PTSD
- Active listening skills
- Scenario-based training
- Involuntary committal instruction
- National Capital Region familiarization
- NAMI advocacy group.[102]

The UD's CIT-trained officers also have access to the CIT mobile app on the Secret Service intranet webpage. This app grants access to CIT-trained officers to record encounters they experience with mentally ill individuals and share details of the

[100] U.S. Secret Service, 11.

[101] Allwein, personal communication.

[102] Allwein.

interactions along with their disposition. This app also provides UD management with a method to measure its public service around the White House Branch and utilize assets from the MPDC if necessary.[103]

E. SECRET SERVICE PICAP GUIDELINES

Secret Service PID offers SAs conducting PI investigations with mental health expertise and consultations through PICAP. Section PID-17, "Protective Intelligence Clinical Assessment Program Guidelines," of the Secret Service's manual details that "PICAP personnel assist agents with consultation on PI cases, training related to psychological concepts, and conducting liaison activities."[104] This mental health expertise, provided by professional psychologists employed by the Secret Service, assists agents in detecting and evaluating subjects who may pose a risk or have an unusual direction of interest in a Secret Service–protected individual, event, or site. SAs are encouraged to access PICAP's three main sections: case consultation, training, and professional liaison.[105]

For PICAP to assist through case consultations, an SA must request that one of the Secret Service–licensed psychologists review the information obtained during the investigation and interviews. It is not an automatic procedure. Case consultations allow PICAP personnel to provide guidance to SAs on current mental health laws that may benefit an investigation and risk assessment.[106] Most agents do not have a formal academic medical background but must conduct PI investigations with subjects who suffer from mental illnesses. PID-17 explains that PICAP medical professionals "may be able to offer insight into a PI subject's mental status, symptoms, and factors that mitigate or aggravate the subject's associated risk for violence and other unwanted outcomes."[107] Table 2 lists the available PICAP resources that agents may utilize during a PI investigation.

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[103] Allwein.

[104] U.S. Secret Service, "Protective Intelligence Clinical Assessment," 1.

[105] U.S. Secret Service, 1.

[106] U.S. Secret Service, 1.

[107] U.S. Secret Service, 2.

Table 2. PICAP Resources for SAs.[108]

1.	Interpreting mental health concepts (review case considering mental health disorder symptoms and their expression).
2.	Reviewing assessments and/or the results of psychological testing conducted by other mental health professionals who have evaluated a particular subject.
3.	Assessing likely scenarios about a subject based on clinical data concerning prior mental health history, stressors, and situational variables.
4.	Suggesting additional questions, lines of inquiry, or hypotheses that the case agent could use in the investigation.
5.	Interviewing the subject to gather additional information to support the case agent's decision-making.
6.	Understanding statutes, regulations, and case law that govern access to mental health records, civil procedures, and related legal issues.

PICAP personnel are not directly involved with PI interviews, nor do they proactively engage with agents or field offices about PI investigations. The PICAP instruction offered in PID-17 directs field offices to request PICAP support for the clinical evaluation of PI subjects when a psychologist's opinion would benefit the investigation. The following examples, provided in PID-17, describe when a psychologist's judgment might assist an agent's PI investigation:

- A PI subject refuses an interview with an agent;
- There is no record of a PI subject's current mental health evaluation;
- There is no record of a PI subject's mental health history;
- Various information is obtained on a PI subject's mental health history; or
- The PI subject's current mental health or history is complicated, and an agent's knowledge of the PI subject's potential behavior is limited.[109]

[108] Source: U.S. Secret Service, 2.

[109] U.S. Secret Service, 2.

Although assistance from PICAP's mental health professionals is encouraged, the Secret Service manual reminds field offices and agents that the exclusive mission of PICAP psychologists is to provide a clinical assessment. PICAP does not provide an opinion for the investigation about whether the PI subject poses a risk of an unwanted outcome. The evaluation and final determination of a PI subject, with or without mental illness, depends on the information the case agent obtains during the investigation.[110]

PI interview skills and mental illness awareness training are provided during SAs' basic training during the first few months of their career. Besides this brief training section, SAs do not receive mandatory updated guidance or training with interview skills or interactions with mentally ill subjects. If a field office desires additional PI training for its SAs, each office is encouraged to contact the PICAP program coordinator for assistance on several unique topics. PID-17 suggests contacting PICAP for training in "concepts of mental illness, understanding psychiatric/medical terminology, interviewing the mentally ill, mental health evaluations and diagnoses, principles of risk assessment, and pharmacologic treatment and side effects."[111] Advanced training is offered only upon request and not during an agent's basic training. This advanced training relates to managing PI cases and mental health care system issues. The following topics are included in the advanced training:

- Better judgment on the accuracy of mental diagnoses and medical reports for SAs;
- Overview of mental health care assets;
- Relationships between mental health professionals and law enforcement;
- Statutes for mental health records accessibility and commitment of mentally ill individuals;
- Presentations on research conducted for previous cases; and

[110] U.S. Secret Service, 2.

[111] U.S. Secret Service, "Protective Intelligence Investigations," 4.

- Evaluation of risk and violence and the process of management.

PICAP's psychologists, when solicited, also provide field offices with practical liaison activities with local mental health professionals, organizations, and institutions. These psychologists may assist field offices with the following liaison activities:

- Selection of critical targets for the Secret Service among regional and local professional groups;
- PICAP presentations for field offices or local mental health institutions;
- Submissions to mental health publications to educate the medical field about the Secret Service's relationship with the mental health field;
- Coordination between local professional mental health assets and Secret Service field offices when necessary;
- Visits to Secret Service field offices and presentations to other mental health professionals and organizations related to the PI mission; and
- Liaising with mental health organizations, medical institutions, and local universities to provide opportunities for further professional mental health education.[112]

PICAP and its availability to field offices and agents have the potential to relieve difficulties faced during a PI investigation. The case consultation and assessment for a PI subject's mental health status or history, advanced mental illness training provided to field offices, and liaison activities with field offices' local mental health professionals deliver a substantial upgrade to an SA's PI investigation. PICAP also supports the additional knowledge and training needed for an SA to assess the risk that a PI subject may pose. While these assets assist an SA's PI investigation, most must be requested through the PICAP program coordinator or protective intelligence research specialist assigned to an agent's specific case. Based on this author's previous experiences and discussions with

[112] U.S. Secret Service, "Protective Intelligence Clinical Assessment," 4–5.

other Secret Service agents, most PICAP training would prove incredibly beneficial to a PI investigation and interview process if provided before the initial interaction with a mentally ill PI subject or provided to field offices routinely each year.

F. CONCLUSION

Although the Secret Service's resources for PID and SAs are legitimately thorough, research that considers emergent mental health resources and efficient training is warranted. The Secret Service consistently updates training and resources dedicated to improving technology, firearm skills, and physical protection methods and enhancing investigative resources and guidance. Innovative and successful mental illness training currently utilized by other law enforcement agencies, along with comparable mental health and technological resources available for use, must also be considered to provide SAs with current, effective training to support a critical function in the security of the world's top political figures and establishments.

IV. MENTAL ILLNESS TRAINING OPTIONS AND ASSETS

Advanced mental illness training can further aid SAs in their risk assessments of and engagement with mentally ill individuals during interviews. The primary goal of a PI investigation is to prevent an attack on a Secret Service protectee.[113] SAs obtain useful information during PI interviews while utilizing various techniques to assess a person's risk of carrying out an attack. One vital piece of information that can affect a PI investigation and interview is the mental status of the subject under investigation. A Secret Service study conducted in 1997 found that 34 percent of attacks on public officials targeted the president, and an additional 14 percent targeted other Secret Service protectees.[114] Citing statistics from the U.S. Attorney's Office, Riess, Gonzalez, and Korenis, in their article for *Frontiers in Psychology*, reveal 75 percent of individuals who make threats against the president have a mental illness.[115] With an increasing number of mentally ill individuals in society and 24-hour news coverage of political figures, advanced mental illness training for the Secret Service is crucial.

This chapter examines several training programs for mental illness interactions that have the potential to improve the current training provided to Secret Service recruits and SAs. Law enforcement agencies now incorporate such programs as CIT, DEFUSE training, CIT Extension for Community Healthcare Outcomes, and Mental Health First Aid in their recruitment and ongoing training. The research presented in this chapter highlights the most effective aspects of these programs and the beneficial elements they may provide to PI investigations and interviews conducted by the Secret Service.

113 Fein and Vossekuil, *Protective Intelligence and Threat Assessment Investigations*, 39.

114 Fein and Vossekuil, 3–5.

115 Paulina Riess, Luisa Gonzalez, and Panagiota Korenis, "Management of Patients Who Make Threats against Elected Officials: A Case Report," *Frontiers in Psychiatry* 9 (2018): 1, https://doi.org/10.3389/fpsyt.2018.00177.

A. CIT PROGRAM

The curriculum for the CIT program, developed through collaboration between the Memphis Police Department and mental health experts and advocates, teaches law enforcement officers how to effectively interact with individuals with mental illness and gather necessary information during interviews.[116] Specific elements of the CIT program could prove beneficial to the Secret Service's PID if provided to all SAs while in recruit training. While the 40-hour CIT program includes some areas that do not apply to SAs' PI investigations, the training curriculum covers topics that the Secret Service could use to improve its PI training (see Table 3).

Table 3. CIT Program Curriculum.[117]

1.	Instruction and lectures on aspects of mental illness.
2.	Incorporation of medical professionals and the mental health community.
3.	Site visits to mental institutions/medical establishments.
4.	Testimonials from mentally ill individuals, family members, medical professionals.
5.	Practical skills training integrated with scenarios/simulations.
6.	Enhanced in-service training.

1. Instruction and Lectures on Aspects of Mental Illness

The following suggested topics delivered through classroom instruction and lectures in the CIT program are viable selections for Secret Service mental illness training:

- Side effects of medications used by mentally ill patients,
- Diversification of mental health,
- Personality disorders,

116 Crisis Intervention Team Inc., "CIT History."

117 Adapted from Randolph Dupont, Sam Cochran, and Sarah Pillsbury, *Crisis Intervention Team Core Elements* (Memphis: University of Memphis, 2007), 5–19, http://cit.memphis.edu/CoreElements.pdf.

- Post-traumatic stress disorder,
- Detection of suicidal characteristics,
- Testimonials of mentally ill individuals' families,
- Policies and procedures when interviewing a mentally ill individual,
- Legal responsibilities,
- Assets available in different communities/districts,
- Mental illness issues, and
- Alcohol and drug-related issues.[118]

Alexander Rohrer, in an article for the *Journal of Police and Criminal Psychology*, describes the two primary goals of the CIT program: enhancing knowledge while altering attitudes and reducing the occurrence of negative behavioral responses. Rohrer states, "By better understanding the symptoms and presentation of mental illness, . . . officers are increasingly equipped to classify behaviors as symptoms rather than violent resistance."[119] According to a study by Compton et al. published in *Psychiatric Services*, CIT training significantly improved officers' understanding and perceptions of mental illness, as well as their ability to de-escalate situations, and reduced negative stereotypes of individuals living with mental illness.[120] Advanced training and an increased focus on specific topics taught in the CIT program's classroom instruction and lectures will better equip recruits to communicate effectively and gather information from individuals with mental illness who may pose a threat to Secret Service protectees or establishments.

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[118] Dupont, Cochran, and Pillsbury, 14.

[119] Alexander J. Rohrer, "Law Enforcement and Persons with Mental Illness: Responding Responsibly," *Journal of Police and Criminal Psychology* 36, no. 2 (June 2021): 344, https://doi.org/10.1007/s11896-021-09441-2.

[120] Michael T. Compton et al., "The Police-Based Crisis Intervention Team (CIT) Model: I. Effects on Officers' Knowledge, Attitudes, and Skills," *Psychiatric Services* 65, no. 4 (April 2014): 517–22, https://doi.org/10.1176/appi.ps.201300107.

2. Incorporation of Advocacy Groups, Medical Professionals, and the Mental Health Community

The CIT program depends greatly on law enforcement's relationship with local advocacy groups and mental health institutions. Nonprofit groups such as NAMI and the National Mental Health Association are advocacy groups dedicated to assisting the CIT program. These groups provide law enforcement agencies with instruction and training on mental illnesses, facilitate informative presentations by mentally ill subjects, and present accounts from family members who have first-hand experience living with mentally ill individuals.[121]

Collaboration between law enforcement and the mental health community is another key element taught in the CIT program. Officers have immediate access to knowledge, training, and assistance for mental illnesses when law enforcement agencies have established relationships with their local medical and mental health professionals, including local psychiatrists, counselors, social workers, psychologists, medical physicians, mental health centers, intake facilities, hospitals, and criminologists. These valuable partnerships are a vital aspect of the CIT program and a major asset for updated mental illness training and successful interactions with mentally ill individuals.[122]

3. Site Visits to Local Mental Institutions/Medical Establishments

The CIT program focuses on educating trainees about mental illness, eradicating false beliefs about mentally ill individuals, and stimulating productive interactions between law enforcement and mentally ill individuals. Site visits to mental health establishments, such as emergency rooms, crisis stabilization entities, mental institutions, and drop-in organizations, allow CIT program trainees to obtain first-hand knowledge about mentally ill individuals and provide trainees with opportunities to observe the hardships of living with a mental illness. Drop-in centers provide an ideal learning environment for CIT trainees. These centers are utilized primarily for mentally ill individuals capable of living

[121] Dupont, Cochran, and Pillsbury, *Crisis Intervention Team Core Elements*, 7; "NAMI Affiliates Play a Key Role in the Success of CIT," *National Alliance on Mental Illness* (blog), October 20, 2015, https://nami.org/Blogs/NAMI-Blog/May-2014/NAMI-Affiliates-Play-A-Key-Role-In-The-Success-Of.

[122] Dupont, Cochran, and Pillsbury, *Crisis Intervention Team Core Elements*, 8.

independently in society.[123] As described by Sam Cochran, CIT coordinator of the Memphis Police Department,

> We meet with consumers at the local clubhouse [drop-in center]. The intent of these meeting is not just to hear stories; the intent is to see the human side of mental illness and the human side of policing. This exchange is a great learning experience because we usually see people when they are at their worst. When we meet at the clubhouse, we see a diversity of people who have [an] illness and the diversity of their lives.[124]

Site visits also allow CIT program trainees to meet with a variety of mental health professionals, allowing both parties to discuss their roles and responsibilities, the restrictions they experience with their roles, and the difficulties they endure.[125] As Joan Logan, CIT coordinator of the Montgomery County Police Department in Maryland, attests, "This training contains a large amount of subject matter and participants can get overloaded with the information. The best way to reinforce the material is to do it or see it. People learn differently, and if you are going to reach everybody in that room, you need to go on site visits."[126]

4. Testimonials from Mentally Ill Individuals, Their Family Members, and Medical Professionals

The CIT program considers testimonials from mentally ill individuals, their family members, and medical professionals a crucial component and enables trainees to understand mentally ill individuals as human beings rather than mere statistics or special cases. These testimonials also allow trainees to hear stories from mentally ill individuals who successfully manage their illnesses and lead fulfilling lives in their communities. According to Frank Webb, CIT coordinator of the Houston Police Department, "The consumer [mentally ill individual] does more to change attitudes than anything we do."[127]

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[123] Melissa Reuland and Matt Schwarzfeld, *Improving Responses to People with Mental Illness: Strategies for Effective Law Enforcement Training* (New York: Council of State Governments Justice Center, 2008), 30, https://permanent.fdlp.gov/LPS116900/Strategies_%20for_LE_Training.pdf.

[124] Reuland and Schwarzfeld, 30.

[125] Reuland and Schwarzfeld, 32–33.

[126] Reuland and Schwarzfeld, 29.

[127] Reuland and Schwarzfeld, 30.

5. Practical Skills Training Integrated with Scenarios/Simulations

The simulation exercises used in CIT training allow trainees to experience what indicators and feelings a mentally ill individual endures every day. These simulated sensations have successfully stimulated empathy and helped trainees comprehend the difficulties associated with mental illness. One simulator used in the CIT program involves hearing distressing voices. Trainees in this learning module must perform everyday tasks, such as grocery shopping, attending an interview, and other duties using their cognitive abilities, all the while listening to disturbing voices. These tasks are performed at stations operated by training personnel who show indifference toward the trainees' struggles.[128] Joan Logan confirms that "officers will tell us how important [the simulation of hearing distressing voices] was; many say it was a life-changing event."[129]

Another exercise in CIT training involves hallucinations through a virtual reality–based simulator that allows trainees to hear and see forms of hallucinations that mentally ill individuals might experience. Some trainees have indicated that these simulators are so realistic that trainees undergo bodily and psychological reactions. Combining everyday life scenarios with auditory and visual inducements breeds empathy and awareness for people battling mental illness.[130]

Debriefs after simulation exercises are an important factor in the success of this section of the CIT program. The CIT program claims the simulation exercises should be discussed by trainees and instructors to communicate what they experienced and the knowledge they consumed from the exercise. Instructors also receive feedback from trainees in a classroom setting about how they overcame complications, stresses, confusion, auditory commands, and visual hallucinations. As Kate Farinholt, executive director of NAMI–Metropolitan Baltimore, describes, "We ask the officers how they dealt with the voices. Some tell us they tried to tune [the voices] out, some say that they whistled.

[128] Reuland and Schwarzfeld, 31.

[129] Reuland and Schwarzfeld, 31.

[130] Reuland and Schwarzfeld, 31.

. . . This is another way to demonstrate different coping techniques" (original brackets).[131] Another important aspect of the debrief is the chance for trainees to share how the perceptions and experiences they endured will change their attitudes and interactions with mentally ill individuals in the future.[132]

6. Enhanced In-Service Training

An important attribute of the CIT program is the awareness of needing additional systematic in-service training beyond the 40-hour course. During in-service CIT training, supplementary courses provide officers with instruction to sustain their knowledge and skills. The topics included in the accompanying advanced training provide updates and evolving material associated with the mental health field (see Table 4).

Table 4. CIT Program In-Service Training Topics.[133]

1.	Extended/Advanced Suicide Crisis Intervention Training
2.	Advanced Developmental Disabilities
3.	New Developments in Psychiatric Medications
4.	Advanced Verbal Skill Training (Crisis Hotline)
5.	Advanced Scenario Training

The deinstitutionalization movement spawned a new concern for law enforcement agencies' interactions and conflict resolution with mentally ill citizens in their communities. The CIT program presents law enforcement agencies that seek an effective training program with a 40-hour course designed to provide officers with advanced knowledge and skills to effectively de-escalate adverse confrontations, comprehend mental illnesses and their effects, and manage mental health crises. Although there has been minimal research about the CIT program since its creation by the Memphis Police Department in 1987, over 2,700 communities have reported experiencing positive results

131 Reuland and Schwarzfeld, 34.

132 Reuland and Schwarzfeld, 34–35.

133 Source: Dupont, Cochran, and Pillsbury, 18.

with law enforcement agencies that adopted the training program.[134] The CIT program is not the only mental illness training available for law enforcement curricula, but elements of the program have helped to develop beneficial, effective skills in trainees to apply while interacting with mentally ill individuals in their communities.

B. DEFUSE TRAINING PROGRAM

The DEFUSE training course—DEFUSE standing for data, expectations, feelings, understanding, self-monitor, and environment—is another option available to assist law enforcement with mental illness detection and interactions. DEFUSE is a two-hour interactive training course online, developed with assistance from multiple law enforcement professionals, with two main segments focusing on mental illness and de-escalation skills.[135] DEFUSE is designed to improve individual skills and knowledge about mental illness and provide scenario-based trials integrated into a stress-induced environment.[136]

The first section of DEFUSE concentrates on mental illness and begins by discussing society's negative attitudes toward people with mental illnesses and the symptoms they experience. The training educates law enforcement on their duty, whenever feasible, to steer mentally ill individuals away from the criminal justice system and toward appropriate mental health care options. Topics in this section include law enforcement responsibilities during interactions with mentally ill individuals and the awareness of acute symptomology. These themes are presented to trainees through real-life depictions, videos, and instructional-based teaching platforms.[137]

The second portion of the mental illness section provides training about common mental illnesses such as hallucinations, anxiety, mania, sadness, delusions, and anger. An integral part of this section teaches trainees about the observation and recognition of a

134 "Crisis Intervention Team (CIT) Programs," National Alliance on Mental Illness, accessed March 12, 2023, https://nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs.

135 Hacker and Horan, "Policing People with Mental Illness," 553.

136 Donald H. Meichenbaum and Jerry L. Deffenbacher, "Stress Inoculation Training," *Counseling Psychologist* 16, no. 1 (January 1988): 69–90, https://doi.org/10.1177/0011000088161005.

137 Hacker and Horan, "Policing People with Mental Illness," 558.

variety of symptoms potentially portrayed by mentally ill individuals. The information on specific symptoms aligns with the standards presented in the *Diagnostic and Statistical Manual of Mental Disorders*. Portions of the training involve trainees' experiencing symptoms of mental illness, such as performing a word search review while hearing auditory hallucinations. At the conclusion of these mental illness demonstrations, trainees attend a presentation that evaluates their performance and reiterates the significant material taught during the course.[138]

The next section of training encompasses de-escalation instruction comprising the six skills of the DEFUSE acronym. Hacker and Horan, in their article for the *Journal of Experimental Criminology*, state that this section "teaches learners [to] . . . gather data and document, set expectations, figure out feelings of the subject, demonstrate understanding, self-monitor, and use the environment."[139] The organization of this section is designed to strengthen trainees' self-confidence during interactions with mentally ill individuals. After receiving instruction on each of the six skills, trainees watch detailed video scenarios that combine the de-escalation skills used to interact with individuals experiencing symptoms of the common mental illnesses taught earlier in the program. At the conclusion of each scenario, trainees are asked to identify the skills and explain each observation. After a few iterations of this exercise, trainees can practice the skills with role players. Feedback on performance and suggestions for improvement are provided to trainees at the end of each role-playing exercise.[140]

The last segment of the de-escalation skills training focuses on trainees' self-awareness of their physical constraints and sentiments. Instruction on self-awareness techniques, such as meditation and breathing exercises, is provided after an analysis of the psychoeducation of the topics discussed. The de-escalation skills module stresses the importance of trainees' practicing patience, avoiding internalization, using repetitive

[138] Hacker and Horan, 558.

[139] Hacker and Horan, 558.

[140] Hacker and Horan, 558.

communication, and utilizing progressive communication tactics for positive interactions with mentally ill individuals.[141]

DEFUSE training presents law enforcement agencies with an additional option to supplement their existing mental illness training curricula. In Hacker and Horan's article, they explain the results of their research, which compares DEFUSE training to the CIT program. They report that "DEFUSE produced significant beneficial effects on all CIT measures (empathy, stigma, self-efficacy, and behavioral self-report) as well as the knowledge and satisfaction outcomes targeted by DEFUSE."[142] Furthermore, DEFUSE provides law enforcement agencies with a beneficial program that can be accessed online at any location. The two-hour program is less resource-intensive than the CIT program and costs 90 percent less. This program is a promising tool for quick and effective mental illness training. Future variations of this program will incorporate topics recommended by trainees and additional medical issues in developmental disabilities, addiction, and trauma.[143] The knowledge and skills taught in this program ultimately afford trainees influential techniques to manage interactions with mentally ill individuals to obtain important information vital to conducting interviews and investigations. See Figure 1 for a depiction of the DEFUSE training objectives.

[141] Hacker and Horan, 558–59.

[142] Hacker and Horan, 562.

[143] Hacker and Horan, 563.

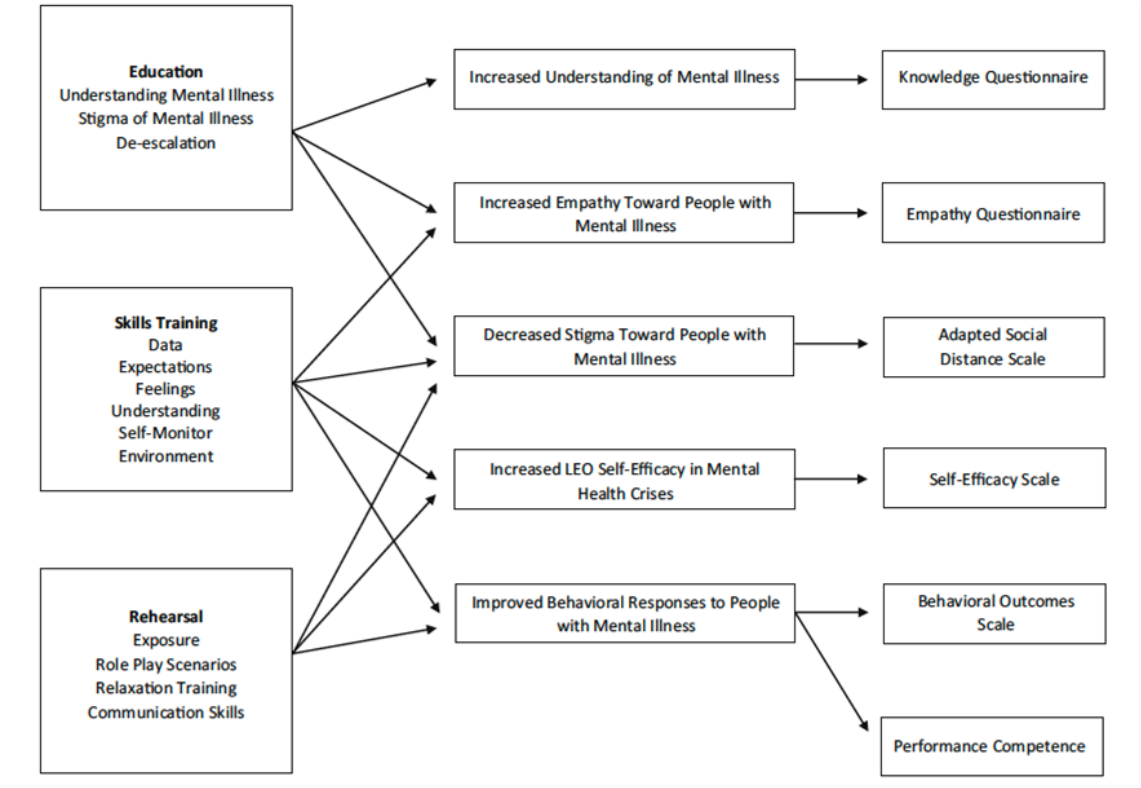

Figure 1. DEFUSE Training Objectives.[144]

C. CIT EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES

The CIT Extension for Community Healthcare Outcomes (ECHO) is a videoconferencing platform that allows law enforcement, mental health professionals, and CIT professionals to collaborate and continue discussions on topics covered in the 40-hour CIT training program.[145] In an article for the *Journal of Police and Criminal Psychology*, Crisanti et al. state that the mission of CIT ECHO is to "provide an opportunity for ongoing training in CIT best practices and to develop a network where [law enforcement officers] have regular and frequent opportunities to communicate with mental health experts and other officers."[146] The CIT ECHO program allows law enforcement agencies to provide

144 Source: Hacker and Horan, 554.

145 Annette S. Crisanti et al., "Evaluation of Ongoing Crisis Intervention Team (CIT) Training for Law Enforcement Using the ECHO Model," *Journal of Police and Criminal Psychology* 37, no. 4 (2022): 864, https://doi.org/10.1007/s11896-022-09529-3.

146 Crisanti et al., 870.

weekly reports about CIT-relevant issues to all attendees in the network. The attendees present specific cases or topics related to mental health issues and then coordinate various discussions. The videoconferencing aspect enables attendees to access the forum virtually, via patrol laptops or mobile phones, for example.[147]

The CIT ECHO program is a collaboration between Crisis Intervention Team Inc., the Albuquerque Police Department, and the University of New Mexico's Project ECHO.[148] The weekly sessions consist of a three-tiered, 90-minute conference, typically with a predetermined format. The first 30 minutes involve a CIT or mental health issue presented by a guest speaker.[149] Guest speakers' presentations focus on the following specialized areas:

- CIT Policing
- Resources
- Psychiatric Diagnosis
- De-escalation and Communication Skills
- Officer Self-Care
- Substance Use
- Special Training.[150]

The middle and final sections of the session contain a presentation, delivered by law enforcement personnel, about a specific mental health case, followed by a conversation between mental health professionals and law enforcement personnel about information pertinent to that session's topic.[151]

An evaluation of this program by Crisanti et al. reveals that CIT ECHO has increased attendees' knowledge of mental illnesses and available mental health resources. The program has also improved attendees' self-efficacy during interactions with mentally ill individuals. The authors' findings, which cover 113 weekly sessions of CIT ECHO from

147 Crisanti et al., 864.

148 "CIT ECHO," Crisis Intervention Team Inc., accessed January 19, 2023, http://www.gocit.org/about-echo.html.

149 Crisanti et al., "Ongoing Crisis Intervention Team Training," 864.

150 Crisanti et al., 865.

151 Crisanti et al., 864–65.

2017 to 2020, show that 89.7 percent of attendees feel more comfortable interacting with mentally ill individuals after attending the videoconference training.[152]

CIT ECHO is one of the only programs that provides law enforcement with continuous mental illness updates and training. The program is free to law enforcement personnel, has no limit to the number who can attend, requires no travel, and is proven to increase knowledge and self-awareness during interactions with mentally ill individuals.[153] With CIT ECHO's information on CIT-related issues, access to mentorship from CIT personnel, forums dedicated to mental health conversations, and instant advice from mental health professionals and subject-matter experts, law enforcement personnel receive open access to a valuable mental illness training program.[154]

D. MENTAL HEALTH FIRST AID TRAINING

Mental Health First Aid (MHFA) is a course offered both online and in classroom environments by various medical health organizations. It is designed to assist trainees with comprehending, identifying, and reacting to mental illnesses. The online training is typically free and involves training on common mental illnesses, substance abuse, and risk factors and warning signs. Part of the MHFA's action plan also teaches trainees how to assess an individual for the risk of suicide or self-harm and incorporates nonjudgmental listening techniques to assist with interactions.[155]

The Charlotte-Mecklenburg Police Department (CMPD), a police force with almost 2,000 officers, implemented the MHFA program into its mental illness training program in 2016. Considering the time and manpower involved with participation in a CIT program, the CMPD decided to require MHFA training for all recruits entering the police academy. As detailed by Veronica Foster, assistant chief of the CMPD,

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[152] Crisanti et al., 871.

[153] Crisanti et al., 873.

[154] Crisis Intervention Team Inc., "CIT ECHO."

[155] "Mental Health First Aid," National Council for Mental Wellbeing, accessed January 19, 2023, https://www.thenationalcouncil.org/our-work/mental-health-first-aid/.

> We realized our force didn't have the expertise and information needed to interact with mentally ill people. . . . Being such a large police force, it would have been impossible to train everyone in CIT—it would be hard to do on a large scale since it's so intensive. Mental Health First Aid was exactly what we needed, something relatively short and scalable to our entire force, but still effective in providing our officers with the know-how to handle sensitive situations.[156]

The CMPD reports that the training has greatly benefited the department by enabling its officers to identify mental illness during interactions with subjects and de-escalate situations involving mentally ill individuals.[157]

E. CONCLUSION

These training options comprise specific, successful elements that, when utilized appropriately, provide law enforcement agencies with valuable training and tools to effectively manage interactions with mentally ill individuals. Whether improving knowledge and overall attitudes toward mentally ill individuals or establishing working relationships with medical and mental health professionals, the CIT program has been implemented in law enforcement agencies across the country with positive results. DEFUSE and MHFA offer quicker, cheaper alternatives to the CIT program, allowing agencies to provide training and knowledge on topics of mental illness necessary for improved interactions between officers and mentally ill individuals. CIT ECHO launched as a small training asset in New Mexico and has now flourished into a useful online training platform that allows officers across the country to receive, discuss, and present relevant information with mental health professionals and subject-matter experts. Descriptions of these training options and their successful endeavors were explored to provide the Secret Service with supplementary advanced training for its PI curriculum. An assortment of recommendations delivered in the next chapter shows which elements could be implemented into the Secret Service PI training curriculum and why they would be advantageous additions.

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156 Mark, "Case Studies: Charlotte-Mecklenburg Police Department," National Council for Mental Wellbeing, March 20, 2018, para. 3, https://www.mentalhealthfirstaid.org/case-studies/charlotte-mecklenburg-police-department/.

157 Mark.

V. CONCLUSION

The analysis of the Secret Service's current PI training curriculum and research on its mental illness instruction revealed that the Secret Service recognizes the necessity of advanced training for its officers and SAs. The Secret Service has addressed some areas where mental illness training is inadequate and recently instituted its own version of the CIT program. This program has been adapted exclusively for the Secret Service's needs in the National Capital Region and is available only for select Secret Service UD officers and WFO SAs. Secret Service SAs across the country conduct interviews and provide risk assessments for PI investigations by the PID each year, yet these SAs are not provided with additional mental illness training such as the CIT program. The Secret Service's *FY 2021 Annual Report* revealed that the organization conducted over 6,000 PI investigations in 2019.[158] The SAs across the country involved with these assignments would benefit significantly from elements taught in mental illness training programs like those described in Chapter IV. If additional advanced mental illness training were incorporated into SAs' recruit training and enhanced through in-service training, it would impart significant knowledge for SAs during their interviews with mentally ill individuals.

This thesis began with an analysis of the history of deinstitutionalization and the impacts it has had on law enforcement. These impacts demonstrate the need for further mental illness training for law enforcement agencies. The thesis then presented the Secret Service's current PI training program, PICAP's function, and the guidance SAs receive in preparing for interactions with mentally ill individuals. Additional research then focused on select successful mental illness training programs implemented by various law enforcement entities. This part of the thesis delivered valuable suggestions for Secret Service training options in several exclusive areas, which are discussed in this chapter's recommendations for PID training for recruits, in-service training, and additional assets for SAs throughout their investigative assignments. If the Secret Service integrated these mental illness training programs into its PI training curriculum and for all SAs during their

158 U.S. Secret Service, *FY 2021 Annual Report*, 5.

recruit and in-service training phases, the organization would reap the benefits of more effective PI investigations, interviews, and risk assessments.

A. RECOMMENDATIONS

The Secret Service's PI mental illness and interview training currently provides a recruit with only 18 hours of interview training along with 10 hours of mental health training. If the PI training section provided SA recruits with the specialized areas of knowledge included in the CIT program, which select UD officers and WFO SAs receive; added routine in-service PI mental illness and interview training; employed additional PICAP personnel; and incorporated a 24/7 mental illness assistance platform, the Secret Service could augment SAs' comprehension of interviews with mentally ill individuals and generate a well-versed SA prepared to handle a wide range of PI situations.

1. Provide All SAs with Portions of the Secret Service CIT Program and Incorporate Traditional CIT Training

Current Secret Service PI mental health and interview training does not provide recruits or SAs in the field with real-world experiences with people living with mental illness, so the first recommendation involves providing all SAs with portions of the Secret Service's CIT Program and incorporating other specified instruction from the traditional 40-hour CIT training program into the PI recruit training curriculum. Current PI training course material provides recruits with instruction on common mental illnesses but does not include opportunities for recruits to witness and communicate with mentally ill individuals and discuss various aspects of mental illness with medical health professionals. The section of the CIT program that institutes site visits to various mental health establishments could develop in Secret Service recruits realistic expectations of PI interviews with mentally ill individuals and help them understand the responsibilities of medical health professionals.

Incorporating roundtable discussions and testimonials would also be invaluable in creating competent SAs for PI investigations. The addition of roundtable discussions held with mental health professionals would provide recruits and SAs with opportunities to understand the medical field's responsibilities and how its expertise might assist with PI investigations. Integrating testimonials of people who have experienced various mental

illnesses into PI training would also be an effective approach. Including personal accounts from mentally ill individuals describing their interactions with law enforcement would help trainees understand how both positive and negative encounters with law enforcement could significantly affect the lives of individuals with mental illness.[159]

The training program for PI currently focuses on identifying potential risks when interviewing individuals with mental illnesses and interacting with them. In order to enhance the knowledge, abilities, and empathy of SAs during interviews, the following section of the CIT's training, as described by Dupont, Cochran, and Pillsbury, should be integrated into the Secret Service's PI training regimen:

- Crisis De-Escalation Training Part I
  Basic Strategies
- Crisis De-Escalation Training Part II
  Basic Verbal Skills
- Crisis De-Escalation Training Part III
  Stages/Cycle of a Crisis Escalation
- Crisis De-Escalation Training Part IV
  Advanced Verbal Skills
- Crisis De-Escalation Training Part V
  Advanced Strategies: Complex Scenarios[160]

These courses of instruction will enrich the Secret Service's PI training and help SAs effectively manage different interview circumstances and gain valuable information about individuals who may pose a threat to a Secret Service protectee.

The Secret Service's PI training curriculum does not currently include simulated exercises that promote experiential learning for mental illness symptoms. These simulations, such as those designed to replicate distressing voices or other hallucinations, could prove another beneficial experience for SAs to empathize with and comprehend the symptoms that mentally ill subjects present.

Supplemental instruction and lectures on the following topics taught during CIT training will assist SAs throughout their careers during PI investigations and interviews:

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[159] Reuland and Schwarzfeld, *Improving Responses to People with Mental Illness*, 30–31.

[160] Dupont, Cochran, and Pillsbury, *Crisis Intervention Team Core Elements*, 15. Original formatting and emphasis retained.

- Side effects of medications,
- Personality disorders,
- Post-traumatic stress disorder,
- Suicidal characteristics,
- Mental illness issues, and
- Assets available to assist with mental illness.

2. Hire Additional PICAP Professionals to Aid SAs Working PI Investigations/Interviews

The Secret Service's PICAP is based in Washington, DC, and currently maintains only one main psychologist to handle all mental health and behavioral issues. In the past, the Secret Service contracted vetted psychologists from across the country to assist SAs with PI investigations dealing with subjects experiencing mental illnesses. The Secret Service ended this partnership over 15 years ago and established the PICAP, which is operated by Secret Service mental health professionals. Sadly, the number of PICAP mental health professionals available to assist SAs in the field have dwindled. This predicament has left SAs with limited resources and a larger workload for current PICAP personnel.[161]

The Secret Service should consider expanding partnerships with local mental health professionals or creating a new program to aid SAs in their PI investigations and mental illness awareness training. SAs may need to quickly interview an individual suspected of threatening a Secret Service protectee and require the expertise of a mental health professional, especially if the individual is experiencing a mental illness. PICAP professionals in Washington, DC, may not always be available for 24/7 assistance. This approach enables SAs to obtain immediate support with questions or concerns during interviews, no matter the time or location. Critical aspects of data are collected and

[161] Michelle Keeney, U.S. Secret Service PID/PICAP, personal communication, December 27, 2022.

evaluated during these interviews, and prompt support is vital in the event of potential emergency situations during interviews with individuals suffering from mental illness.

The Secret Service and PICAP should develop a web-based training and assistance platform like New Mexico's CIT ECHO. If developed appropriately, the Secret Service could collaborate with PICAP, additional mental health professionals, and law enforcement to deliver training options for all SAs. These options would keep SAs apprised of current PI-related activity, relative PI investigation case material, updated mental illness information, guidance on available resources, chat rooms concerning PI cases and topics, and presentations by subject-matter experts. The Secret Service's intranet does reserve a designated section on the PID's homepage for online training. Although this section is not a functioning tool for SAs as of this writing, it could prove a valuable location to integrate this training in the future.

3. Provide SAs with In-Service Training, Including Mental Illness Topics and Scenario-Based Interview Training

Secret Service SAs do not receive updated training about PI-related matters, mental illnesses, or interview skills. Implementing an online or in-service training option run by the Risk Management Branch and PICAP personnel could deliver this valuable training to revitalize SAs in the field needing updated training concerning mental illness interactions. DEFUSE training is one online option that could be adopted by the Secret Service and easily accessed by all SAs. The two-hour course would be a productive refresher to refine SAs' de-escalation skills and mental illness information through DEFUSE's use of real-life depictions, videos, and instructional-based teaching.

The MHFA training course could also provide the Secret Service with an online or in-service training option. This training is free and could be accessed or delivered to all SAs for training on the comprehension, identification, and reactions to mental illnesses. The training also entails instruction on listening techniques to assist with interactions. These training options provide useful instruction for all SAs during PI investigations and interviews with mentally ill individuals. Updated training and skill development are provided for firearms and protection assignments. Incorporating a mental illness refresher

into the annual training for SAs would give them recurring opportunities to enhance their skills in conducting PI interviews and interacting with individuals with mental illnesses.

B. LIMITATIONS AND FUTURE RESEARCH

This research into advanced mental illness training options was limited to a few select programs. These training programs received positive reviews from various law enforcement entities and possessed potential significant advantages for application in the Secret Service's PI training curriculum. Each year, mental illness training courses are generated and offered by mental health professionals and nonprofit companies. Law enforcement agencies have started to incorporate a wide range of unique mental illness training programs designed to fit their budgets and direct needs in managing interactions with mentally ill individuals. The numerous training programs available through online instruction, classroom settings, professional medical establishments, and universities presented a challenge. The scope of the material researched was restricted to elements of four popular training programs with positive reviews after testing or implementation.

The research entailed in this thesis did not discuss the policy or budget aspects of incorporating these training options. Future research that analyzes cost comparisons, manpower requirements, policy issues, and positive outcomes from mental illness encounters may deliver comprehensive data on the best training option to incorporate into desired areas of the Secret Service's PI mental illness training curriculum. Future research and the evaluation of the CIT program adopted by the Secret Service will also allow the PID to assess the effectiveness of the instruction and content entailed in generating productive encounters and interviews with mentally ill individuals.

C. SUMMARY AND CONTRIBUTIONS

The Secret Service spends millions of dollars each year on protection details, training, manpower, and equipment to maintain a secure environment for its protectees. While most people envision SAs in suits, sunglasses, and earpieces when they think of the Secret Service and its mission of protecting elected officials, many SAs behind the scenes conduct PI investigations and countless interviews to ensure that future attacks do not occur. Risk assessments based on intelligence collected during these interviews have

played a key role in past investigations of threats against Secret Service protectees. A recent study conducted by the Secret Service's NTAC shows that out of the 180 subjects involved in coordinating a mass attack between 2016 and 2020, 58 percent had symptoms related to mental illness before the attack, with several experiencing multiple mental health disorders.[162] The Secret Service promotes no preconceived notions of guilt of mentally ill subjects during PI investigations or interviews, but it does consider mental health issues as potential contributing factors in threatening behaviors or attacks against its protectees.[163]

With the obvious need for additional mental illness training in law enforcement and the increase in the number of mentally ill individuals, more advanced mental illness training must be considered for implementation into the Secret Service's PI curriculum. The four training options explored in this thesis are applicable and provide the Secret Service with respected mental illness training programs that would benefit all SAs. If implemented, the training programs would enable Secret Service SAs to manage PI investigations and interviews more effectively and produce more accurate risk assessments of threats and unwanted outcomes against Secret Service protectees.

[162] Ana Carlock and Meagen Cutler, *Mass Attacks in Public Spaces: 2016–2020* (Washington, DC: U.S. Secret Service, National Threat Assessment Center, 2023), 24, https://www.secretservice.gov/sites/default/files/reports/2023-01/usss-ntac-maps-2016-2020.pdf.

[163] Carlock and Cutler, 24.

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