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**De-Escalation: Introduction and Intention to Bridging the Divides**

Friends for a Nonviolent World seeks a world free from violence and the threat of violence. We recognize the safety threat that police brutality and excessive use of force creates in our community and the fear that community members experience as a result. We also recognize that police officers put their lives at risk to protect the community. Our intention is to start conversations, recommend policy changes and best practices, and provide training to community members about how to work with police departments and elected officials to develop best practices for public safety.

Evidence exists that specific training, resources, and support can improve community relations while protecting the lives of police officers as well as citizens (Goldstein, 2017). It is our intention to make recommendations that will improve relations between police and the community, reduce the use of excessive force and, ultimately, save lives.

**Methodology**

This is a multi-faceted issue with important perspectives from diverse populations in the community. An important Quaker practice is to listen deeply and with full attention. Listening to each other, even when we disagree, is a critical step towards understanding other perspectives. It is also difficult, especially when we are asked to listen to those who have been involved in killing members of our community, our brothers and sisters, and those we love. It takes courage to engage in this process. It is also our way forward towards a world that is free from violence.

Our recommendations are based on a national search of Police Department Use of Force Policies and Training, best practices from the Police Executive Research Forum (PERF), recommendations from the community, and recent legislation on police use of force. This is a dynamic process, and we continue to listen.

**Background**

The development of the uniformed, domestic police department in the U.S., largely in the 1800s, was controversial as some saw this as a threat to freedom and democracy. The militarization of police, including the allocation of surplus military weapons to the police in the 1990s, contributed to the public realizing these initial concerns. The subsequent "war on drugs," reduction of services for the mentally ill, racism, lack of accountability, and financial and career incentives in police departments also contributed to public concern about the role of police in communities (Stamper, 2016).

This concern has led some to advocate for eliminating the police altogether; others are calling for significant reforms, including changes in policies, hiring, training, institutional and organizational practices, accountability, and community involvement. Communities are calling for officers to be held accountable for their actions through legal channels and court actions. The broader consensus appears to reflect the belief that police are mandated "to protect and to serve" everyone with no exceptions (Liptak, 2018; Pheifer, 2018; Editorial Board, Star Tribune, 2017).

**Police and Mental Health-Based Encounters**

While there has been a lot of media coverage on individuals who have been killed by the police, news coverage has largely overlooked the alarmingly high number of individuals with a mental illness who have been fatally shot by police. At minimum, nearly one in four persons fatally shot by the police has a mental illness (Frankham, 2018). In some areas of the U.S., people with a mental illness account for 50% or more of all fatal police shootings.

The numbers across the country tell the story. Nearly 500 of approximately 2,000 people who were fatally shot by police in the U.S. between 2015 and 2016 had a mental illness. A report from San Francisco found that almost 60% of people killed by police between 2005 and 2013 had a mental illness that contributed to the tragedy. In the state of Maine, almost half of the people who were shot by police between 2000 and 2011 were mentally ill (Roth, 2018).

In addition, police in St. Paul reported that 71 of the 169 fatal police shootings in Minnesota since 2001 involved individuals who had a mental illness or who were experiencing a mental health crisis at the time of the shooting (Xiong, 2018). Although accurate official statistics reporting fatal encounters with the police are still lacking, there is abundant evidence that individuals with mental illness are disproportionately killed while being approached by a law enforcement officer in the community.

**Why Individuals with a Mental Illness Are Fatally Shot by Police**

The police frequently encounter persons with a severe mental illness, especially during a mental health crisis (Lamb, Weinberger, & Decuir, 2002). Unfortunately, this is a dangerous situation for both the responding police officers and the individual. The dismantling of preventive treatment in the past 50 years has led to nearly 4 million adults who have severe mental illness that is untreated and unmedicated (Fuller, Lamb, Biasotti, & Snook, 2015).

The National Alliance on Mental Illness (NAMI) explains that people experiencing a mental health crisis are more likely to have contact with the police rather than receiving medical help. This has resulted in 2 million people who have a mental illness being put into jails every year (National Alliance on Mental Illness [NAMI], 2019). The following statistics from NAMI help to further illustrate the problem.

- Approximately 46.6 million (1 in 5 adults) experience mental illness each year.
- Of that number, approximately 11.2 million (1 in 25 adults) experience a serious mental illness.
- An estimated 26% of homeless adults in shelters have a serious mental illness, and 46% have severe mental illness and/or substance use disorders.
- Approximately 20% of state prisoners have a history of mental illness.
- More than 550,000 people with a serious mental illness are in jail on any given day.
- 70% of youth in juvenile justice systems have at least one mental health condition.
- Only 62.9% of adults with a serious mental illness received mental health services in the past year.
- More than half of chronic mental illness begins by age 14, and 75% of chronic mental illness begins by age 24.
- In 2017, incarcerating people with a mental illness cost the federal (U.S.) government $80 billion and the state governments $71 billion.

- People with a mental illness are 9 times more likely to be incarcerated than to be put in the hospital.
- People with a mental illness stay in jail 4-8 times longer than someone with the same charge who doesn't have a mental illness.
- Many people with mental illness don't get the treatment they need as there can be delays as long as 10 years or more between the appearance of symptoms and effective treatment (NAMI, 2019; Zezima, 2019).

In many cases, police are called to respond to someone who is out of control and who often has a weapon. Lowry (2016) reported that nine out of 10 people with a mental illness who were killed by police had a gun or other weapon. However, individuals with a mental illness were more likely to have a knife than a gun. While this is still a dangerous situation, they were also less likely to be attacking police. However, they might be threatening suicide, and some might act to provoke police to shoot (Franklin, 2018; Peck, 2003).

Officers are legally allowed to take a person to a hospital for a mental health evaluation, but they typically have little expertise or training to manage these situations (Xiong, 2018). Police officers can and do get killed in these incidents (FBI, 2019). However, these encounters are more dangerous for people with a mental illness than for the police (Dowd, 2004; Fyfe, 2000).

**Distrust and Fear of the Police**

It is not surprising that individuals with a history of mental illness are especially distrustful of police. African Americans without a history of mental illness have a similar distrust towards the police (Thompson & Kahn, 2016). However, when police kill unarmed citizens, it also damages the mental health of citizens, particularly African Americans, who report higher levels of anxiety after such incidents (Bor, Venkataramani, Williams, & Tsai, 2018).

Overlooked in the media coverage is the fact that the majority of African Americans in high-profile cases who were fatally shot by the police were also individuals with a history of mental illness or disability. These facts were either ignored, used to evoke sympathy for the victim, used to blame the victim, or, more rarely, used to examine social contexts and intersecting forces that led to dangerous use-of-force incidents (Perry & Carter-Long, 2016).

Therefore, it is important to find ways of de-escalating police response to anyone who may be fearful of encounters with law enforcement for whatever reason. At the same time, we must recognize that police who respond to individuals who are mentally ill may not be fully trained, equipped, or prepared to manage these situations.

**Harm to Mental Health of Police Officers**

Law enforcement can also harm the mental health of police officers. More police officers die by suicide than in the line of duty, and rates of posttraumatic stress disorder (PTSD) and depression are five times higher than among civilians (Hegman, Dill, & Douglas, 2018). In addition, shame and stigma can prevent police officers from accessing needed mental health care, leading to poor physical health and impaired decision making. Police officers need regular and ongoing support to survive the stress that is a natural part of working in law enforcement (Gilmartin, 2002).

**What Can be Done to Manage Behavioral Health Crises?**

Police have become the default responders to individuals experiencing a mental health crisis, which first needs to be addressed as a medical and social services problem. It is important to recognize that mental illness is also closely related to homelessness, drug abuse, and alcohol abuse (Cordner, 2006). Substance abuse, for example, is a co-occurring problem for nearly 75% of prison inmates who also have a mental illness (Reuland & Margolis, 2003).

Deinstitutionalization returned many people with a serious mental illness to the community without adequate community-based services. This led to homelessness, unemployment, and other problems that are linked to police encounters (Marzuk, 1996). Some people with a mental illness engaged in property crimes or disorderly and disruptive behavior (Patch & Arrigo, 1999). Lacking alternatives and treatment options, people with a mental illness have been sent to jail at the same rate that they used to be institutionalized (Borum, 2000).

Treatment for mental illness in community-based mental health care has become challenging. Treatment compliance is a problem. People with a mental illness often don't take their prescribed medications regularly due to the high cost of the medication, negative side effects, abuse of drugs and alcohol, and/or lack of support and monitoring (Cordner, 2006). Until society can address the medical and treatment needs of people who are mentally ill, police will continue to be the frontline responders for managing behavioral problems and crises that impact the community.

**Guiding Principles for Police Use of Force**

The Guiding Principles developed by the Police Executive Research Forum (PERF) serve as a foundation for police use-of-force policies. They emphasize the role of the police to protect the public. These guidelines were written with the intention to provide a "blueprint" (PERF, 2016, p. 30) for police departments to make operational and cultural changes that will make policing safer for everyone. A complete list of the "30 Guiding Principles" has been included at the end of this paper.

Although these principles do propose some significant changes in use-of-force policies, training, tactics, and equipment, the report suggests that these concepts are not completely foreign to police officers. Chuck Wexler, Executive Director at PERF, asserts that highly trained "elite" officers are already using many of these concepts and that the real challenge is to transfer these principles and strategies to the entire police department and, specifically, to officers who are first to respond to critical incidents (PERF, 2016, pp. 29-32).

Key concepts that are critical to changing police culture on the use of force include the following:

- Since the highest priority of the police department is the preservation of human life, all policies and training will emphasize the importance of treating all persons with dignity and respect.
- The use of force by police on individuals will only be used when absolutely necessary.
- Officers need specific training on how to diffuse tense situations. When it is possible to slow down the situation, and is it safe to do so, officers can use effective communication to resolve many situations (PERF, 2016, pp. 34-40; 54-55).

**Policy Guidelines for Use of Force with Individuals Who Are Mentally Ill**

It is important to have effective policies and systems that support changes in police use of force. We agree with the PERF's recommendation to draft policy that prohibits the use of deadly force against individuals who only pose a threat to themselves (PERF, 2016, p. 48). We also support the consideration of less lethal options to manage individuals who are not a danger to members of the public or to officers. This may include preparing officers "to wait as long as necessary so that the situation can be resolved peacefully" (PERF, 2016, p. 48).

**De-escalation as a Core Strategy**

De-escalation is an important communication tool to use in crisis situations with persons who are suffering from mental illness, substance abuse, developmental disabilities, or other conditions that may cause combative, erratic, or dangerous behavior (PERF, 2016, p. 33). It takes training and practice for officers to remain calm and manage a crisis situation. Every officer needs training in de-escalation tactics and practice using the lowest level of force needed for the situation and re-evaluating as required.

A strategy central to de-escalation is slowing down a situation; by doing this, officers buy themselves more time to call additional officers or specialty units. Additional de-escalation tactics include: using a calm tone of voice, speaking slowly, using non-confrontational verbal skills, actively listening, using empathy, using persuasion, keeping distance, paying attention to body language (non-verbal), and giving clear directions as needed (PERF, 2016, p. 40).

**Response to Mental Health Crises: De-escalation Training**

All officers who are first responders need de-escalation training and specific tools and skills for defusing agitated individuals during a mental health crisis. Training may include processes for making decisions about how to safely mitigate a threat, speaking slowly with a calm tone of voice, how to use less lethal equipment and personal protection shields, slowing down situations that do not pose an immediate threat, and re-evaluating the situation as threats change (PERF, 2016, pp. 50-54).

In addition, police officers need basic training in how to recognize that a person may have a mental illness or is under the influence of drugs or alcohol and not able to comprehend verbal orders. The NAMI suggests that police may believe the person with a mental illness is deliberately disobeying orders and increase orders to comply, which can intensify the situation. De-escalation techniques, such as keeping distance, using a conversational tone of voice, and validating feelings can reduce the level of force by police and result in a safer outcome for all (NAMI, 2018).

**Response to Mental Health Crises: Strategies for Maximizing Safety**

Every situation requires officers to consider a variety of variables in choosing the safest and most effective action. The following guidelines and strategies, adapted from the Seattle Police Department Manual on De-escalation (2019), are important considerations that can be used to maintain safety for both police officers and citizens:

- "Considering whether any lack of compliance is a deliberate attempt to resist rather than an inability to comply based on factors including, but not limited to: medical conditions,

mental impairment, developmental disability, physical limitation, language barrier, drug interaction, behavioral crisis, or fear or anxiety" (section 1).

- Slowing down the immediacy of the threat to give officers time to utilize extra resources and call for more officers or specialty units to arrive on the scene.
- Recognition that the number of officers on the scene may increase the available options if force is needed and may increase the ability to reduce the overall force used.
- "Using verbal techniques" from a safe position "to calm an agitated subject and promote rational decision making" (section 1).
- "Placing barriers between an uncooperative subject and officers" (section 4).
- Moving from a position that exposes officers to potential threats to a safer position.
- "Avoiding or minimizing physical confrontation, unless necessary (for example, to protect someone, or stop dangerous behavior)" (section 2).
- Calling for extra resources to assist, such as: more officers, officers with advanced training in managing crises, officers equipped with less lethal tools, and any other tactics and approaches that attempt to achieve law enforcement objectives by gaining the compliance of the subject.

**Response to Mental Health Crises: Develop Mental Health Resources**

De-escalation training by itself is not enough to manage the issue of police encounters with persons who are mentally ill. Some argue that cops are being asked to do too much, especially in the area of mental health response (Hodges, 2017). Even with 40 hours of crisis intervention training (which is more than most police officers receive), Hodges notes that it is unrealistic to expect police officers to handle mental health calls with the same expertise as a licensed mental health professional who has had between 7-8 years of college education and hundreds of hours of supervised training.

Some police departments are developing additional mental health resources. One idea is to develop Mental Health Care Response Teams within the police department. These are teams of mental health professionals who are available 24 hours to respond to calls. They may be deployed directly in place of officers for a non-violent call. They may also help to manage care for individuals who have been violent after police officers have defused the threat (Hodges, 2017). This is in addition to having a subset of officers who have advanced training in crisis intervention, de-escalation, and communication strategies who are available at all times (PERF, 2016, p. 57).

**Support for Officers**

Training of individual officers is necessary but not sufficient. Leadership and the culture of the department must be absolutely committed to these core concepts and approaches in order to ensure officer safety and effectiveness during de-escalation training. This includes providing a supportive environment with resources and training for officers in wellness and resilience to help officers maintain their own health and well-being (PERF, 2016, pp. 23-24). The San Diego Police Department, under the leadership of Assistant Chief Sarah Creighton, created a groundbreaking Wellness Unit for officers in 2011. Creighton writes:

> "Law enforcement agencies that intend to bring about changes in the way officers approach residents need to equip their officers to be able to examine their own biases, predisposition, and emotions, not just the community member's behavior...organizations that maintain a culture of wellness improve officer safety and increase the likelihood of nonviolent police encounters with the community." (PERF, 2016, pp. 24)

In addition, a strong supervisory response is recommended for critical incidents, with support and back-up resources available as needed to reduce the likelihood of unnecessary force. This includes calling a specially trained officer to any scene with a report of a weapon, a person experiencing a mental health crisis, or a known potential for use of force (PERF, 2016, pp. 24-29).

**Mental Health Co-Responder Teams**

Teams of police officers and mental health professionals can also work together to identify and manage underlying issues, such as helping with access to treatment. These efforts could potentially prevent violence by managing mental illness before the person gets into a crisis. Mental health professionals in the police department could also assist with training officers in de-escalation and communication skills for interacting with people who struggle with mental health or substance abuse issues.

Having teams that include mental health professionals and police officers working together can also foster relationships that will help to build partnerships with local mental health services in the community. In addition, local mental health services can assist the police by training police officers to recognize mental illness and substance abuse. In some circumstances, mental health providers can train police officers in how to manage individuals with mental illnesses who are acting violently by using non-violent strategies. In addition, mental health providers can help officers by treating people who need medical help rather than incarceration. To this end, the broader community needs to assist with providing resources and medical care for persons who suffer from mental illness.

**Dispatchers and Community Calls**

Getting accurate information to responding police officers is critical. Training and resources are needed for dispatchers to gather and forward accurate information to responding officers. This may include having a protocol for dispatchers to ask clarifying questions to help determine what type of response is appropriate. This information can also be used to assist supervisors with planning a team response that deploys the best personnel and equipment for the situation (PERF, 2016, p. 62).

Education is also needed for the community to provide relevant information to the police about individuals who may suffer from mental illness, substance abuse, developmental disabilities, or other conditions that may cause individuals to behave erratically. Members of the community may know the history of these individuals, along with strategies and tactics that have successfully defused agitated behavior during past incidents. This information can be given to police so alternative interventions may be used as appropriate.

## Use of Technology

Technology may also assist officers to bridge the communication gap for officers responding to calls related to vulnerable individuals living with emotional, mental, or developmental disabilities. One such app allows individuals registered with the service "to upload photos, videos, diagnoses, personalized de-escalation techniques, medication lists, behavioral triggers, and caregiver contact information" (Hennen, 2019, p. 15). Officers using this app receive a notification about how best to interact with the individual when they are responding to a call.

## Training in Diversity and Implicit Bias

Understanding cultural diversity and implicit bias are critical to improving relationships with the community and to de-escalating crisis situations. Recognizing this need, the state of Minnesota added new training requirements, effective in July 2018, that require 16 continuing education credits of training in de-escalation principles and tactics, diversity and implicit bias, and response to a mental health crisis ("Training in Crisis Response," 2018). These requirements are minimal, and more training in each of these areas is recommended.

## Summary

We need to reduce fatal police shootings of people with mental illness and also to reduce risks to officers who are putting their lives on the line to protect the communities they serve. A multi-faceted approach includes: training police officers in de-escalation techniques and mental illness, developing mental health resources for the police department, collaborative partnerships between mental health services in the community and the police, and new policy guidelines for working with individuals with mental illness. This is a complex problem and requires dedication and collaboration between the police, medical and mental health services, social services, and support from the broader community to make significant progress.

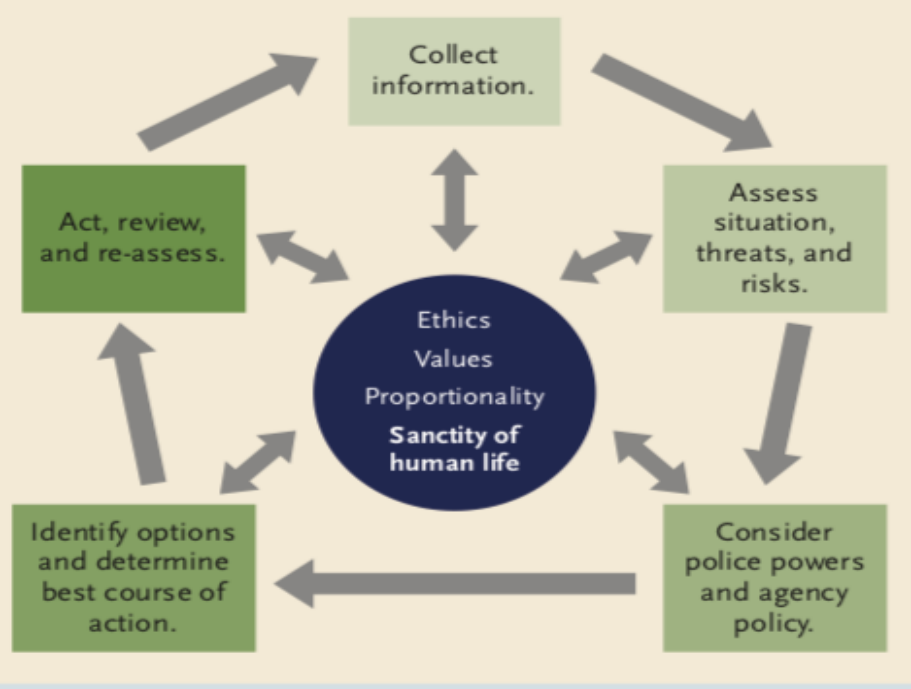
## Changing Police Culture Through Use of New Models and Processes

In addition to specific strategies and tactics for de-escalation, models and processes are being used to train officers to make decisions about the interventions and actions needed for different situations. These are dynamic processes that require ongoing reassessment of critical incidents. In addition, many police departments are trying new strategies and processes, like the ones described here, to manage community issues without the use of force.

### *Critical Decision-Making Model (adapted from the United Kingdom's National Decision Model)*

This is "a logical, easy-to-use thought process for quickly analyzing and responding appropriately to a range of incidents" (PERF, 2016, p. 41) that guides officers through a circular five-step process of: "collecting information, assessing the situation, threats, and risks, considering police powers and agency policy, identifying options and determining the best course of action, and acting, reviewing, and re-assessing the situation" (PERF, 2016, p. 41). The

figure below is a diagram of this model. Variations of this model exist, but all follow essentially the same process.




(Image Source: Police Executive Research Forum (PERF), 2016, p. 81)

*ICAT (Integrating Communications, Assessment, Tactics)*

The ICAT is a training program for police officers to safely defuse critical incidents. It was developed to train officers who are interacting with persons with mental illnesses or persons who are unarmed or armed with a knife or other weapons, but not a firearm. The ICAT is based on the Critical Decision-Making Model, which emphasizes assessing situations and making safe and effective decisions. The ICAT model combines training in "critical thinking, crisis intervention, communications, and tactics" in an integrated approach that emphasizes scenario-based training. (PERF, 2018, para. 1).

*Reality-Based Scenario Training*

This approach recognizes the need for new types of training on the use of force that are based on scenarios. Reality-based scenario training gives officers experience making decisions and responding to critical incidents during a training environment that is as close to a real incident as possible. This training encourages officers to use strategies such as finding cover, moving away from dangerous suspects, and evaluating alternatives to shooting (PBS NewsHour, 2016).

*Problem-Oriented Policing (Community Policing*)

Police departments have begun to work in partnership with the community to identify problems and to find effective solutions. This approach, which involves citizens in designing, implementing, and evaluating law-enforcement programs, has been found to have a positive effect on public trust in the police and citizen satisfaction (Maximino, 2015). Problem-oriented policing encourages law enforcement and residents in the community to work together proactively to identify issues, prevent crime, and resolve problems.

This may include establishing relationships in the community, analyzing community needs, partnering with social or health agencies, and becoming a visible, positive force in the community. An example of a strategic template used for guiding problem-oriented policing is SWOT (Strengths, Weaknesses, Opportunities, Threats). After implementation, police must monitor and adapt the plan as needed, whether as part of police reform, community policing, or used for de-escalation (Froggé, 2018).

### *Crisis Intervention Training*

It seems important that all police officers have basic training in crisis intervention to manage critical incidents involving persons with a mental illness. This training is not intended to replace specialty trained officers who have expertise beyond this minimum. It also does not reduce collaboration with social workers or mental health professionals who may support the work of the police department.

During crisis intervention training, officers are taught to stay calm, manage their own responses, set limits, handle challenging questions, and prevent physical confrontations. Crisis intervention training also includes skills for talking to people with psychiatric problems, such as active listening, asking about family and friends, and using open body language. Examples of things not to do include the use of dominating body language, telling people to “calm down,” and mirroring agitated voice or posture (PERF, 2016).

## Use of Force Accountability and Expected Behavioral Outcomes

In order to build trust between police officers and the communities they serve, it is important to have accountability on police use of force. This includes policies that require accountability within law enforcement as well as to the larger community. It also requires reports with data on use of force that the community can easily access.

### *Accountability Through Policy and Culture Changes*

Police department policies that require officers to be held accountable for their use of force not only builds trust with the community but also protects the officers by requiring adequate supervision and a supportive culture. To achieve this, we support the following recommended policies:

- Supervisory support during critical incidents to assist officers with developing a plan of action that focuses on de-escalation whenever possible
- Use-of-force policy that requires officers to report abuse
- Require officers to intervene if they see a colleague using excessive force
- Have procedures to document and review use-of-force incidents, including processes to ensure that use of force was appropriate and non-discriminatory

- Issue regular reports to the public on use-of-force incidents (PERF, 2016, pp. 48-49).

*Expected Behavioral Outcomes*

Ultimately, it is important to have measurable outcomes to demonstrate real change. Some of this data may already be collected. It is also likely that new surveys or methods will need to be developed to collect the data. Some of the important data to be reported includes:

- Reduction in use of force against citizens, with demographic information such as race and people with mental illnesses who are unarmed (with no gun)
- Reduction in violence against police (police killed or injured in the line of duty)
- Reduction in arrests of certain segments of the community that is proportionate to the population
- Improved overall safety of the community
- Improved relations between police and the community

**Conclusion**

We recognize that some of the distrust and conflicts between police and the communities they serve are deep seated. Building relationships and trust to improve relationships is not an easy task. It requires diligence, hard work, and courage. However, dedicated police officers and community leaders have already begun to have courageous conversations and to build the framework to make positive changes. It is our intention to share this information and put forth these recommendations to further these efforts to build community and to save lives.

**Police Executive Research Forum's 30 Guiding Principles on Use of Force**

#1 "The *sanctity of human life* should be at the heart of everything an agency does" (p. 34).
#2 "Agencies should continue to develop best policies, practices, and training on use-of-force issues that go beyond the minimum requirements of *Graham v. Connor*" (p. 35).
#3 "Police use of force must meet the test of *proportionality*" (p. 38).
#4 "Adopt *de-escalation* as formal agency policy" (p. 40).
#5 "The *Critical Decision-Making Model* provides a new way to approach critical incidents" (p. 41).
#6 "*Duty to intervene*: Officers need to prevent other officers from using excessive force" (p. 41).
#7 "Respect the sanctity of life by promptly *rendering first aid*" (p. 43).
#8 "*Shooting at vehicles* must be prohibited" (p. 44)
#9 "Prohibit use of deadly force against individuals *who pose a danger only to themselves*" (p. 48).
#10 "*Document* use of-force incidents, and review data and enforcement practices to ensure that they are *fair and non-discriminatory*" (p. 48).
#11 "To build understanding and trust, agencies should issue *regular reports to the public* on use of force" (p. 49).
#12 "All critical police incidents resulting in death or serious bodily injury should be *reviewed by specially trained personnel*" (p. 51).
#13 "Agencies need to be *transparent* in providing information following use-of-force incidents" (p. 52).
#14 "Training *academy content and culture* must reflect agency values" (p. 52).
#15 "Officers should be trained to use a *Critical Decision-Making Model*" (p. 53).
#16 "Use *Distance, Cover, and Time* to replace outdated concepts such as the '21-foot rule' and 'drawing a line in the sand' (p. 54).
#17 "*De-escalation* should be a core theme of an agency's training program" (p. 54).
#18 "De-escalation starts with *effective communications*" (p. 56).
#19 "Mental Illness: Implement a *comprehensive agency training program* on dealing with people with mental health issues" (p. 57).
#20 "*Tactical training and mental health training need to be interwoven* to improve response to critical incidents" (p. 60).
#21 "*Community-based outreach teams* can be a valuable component to agencies' mental health response" (p. 61).
#22 "Provide a *prompt supervisory response to critical incidents* to reduce the likelihood of unnecessary force" (p. 62).
#23 "*Training as teams* can improve performance in the field" (p. 64).
#24 "*Scenario-based training* should be prevalent, challenging, and realistic" (p. 64).
#25 "Officers need *access to and training in less-lethal options*" (p. 65).
#26 "Agencies should consider *new options for chemical spray*" (p. 66).
#27 "An ECW [Electronic Control Weapon] deployment that is not effective does not mean that officers should automatically move to their firearms" (p. 67).
#28 "*Personal protection shields* enhance officer safety and may support de-escalation efforts during critical incidents, including situations involving persons with knives, baseball bats, or other improvised weapons that are not firearms" (p. 68).

#29 “*Well-trained call-takers and dispatchers* are essential to the police response to critical incidents” (p. 68).
#30 “*Educate the families of persons with mental illness* on communicating with call-takers" (p. 71).

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