

# EXPANSION OF THE POLICE ROLE IN RESPONDING TO MENTAL HEALTH CRISES OVER THE PAST FIFTY YEARS: DRIVING FACTORS, RACE INEQUITIES AND THE NEED TO REBALANCE ROLES

AMY C. WATSON\* & TALEED EL-SABAWI\*\*

## I

### INTRODUCTION

Tragic police shootings of people experiencing mental health crises, along with recognition of the overrepresentation of people with serious mental illnesses in the criminal legal system, have garnered several decades of research and policy attention. Substantial resources have been focused on improving law enforcement's ability to safely provide response to people experiencing mental health crises in the community, diverting people with serious mental illnesses away from the criminal legal system, and providing mental health focused programming within the criminal legal system. Despite these efforts, overrepresentation of people with serious mental illnesses remains across all points along the criminal legal continuum. Black persons and other persons of color, who are already over-policed and incarcerated, are disproportionately impacted.

It is only recently, following the murder of George Floyd and the subsequent advocacy of Black Lives Matter protesters, that policymakers have begun to take seriously demands to not just reform police, but to reimagine public safety and provide the public with alternatives to police when they are in need of help.<sup>1</sup> Just weeks after George Floyd's death, Rayshard Brooks, another Black man, was killed by an Atlanta police officer responding to a call that there was someone asleep in a Wendy's drive thru—leading some to ask: What if there were a non-

---

Copyright © 2023 by Amy C. Watson & Taleed El-Sabawi.

This Article is also available online at <http://lcp.law.duke.edu/>.

\* Professor, Helen Bader School of Social Welfare, University of Wisconsin Milwaukee.

\*\* Assistant Professor of Law, Florida International University College of Law. We would like to thank Cameron Moody for his assistance with research for this article. We would also like to thank the Wilson Center for Science and Justice, Duke University School of Law for hosting the Law and Contemporary Problems Special Issues on Policing and Behavioral Health Symposium and attendees for their insightful comments on our working draft.

1. Editorial, *Police Reform is Not Enough. We Need to Rethink Public Safety*, WASH. POST (Mar. 16, 2021), <https://www.washingtonpost.com/opinions/interactive/2021/reimagine-safety/> [<https://perma.cc/S84A-R86S>].

police response that could have been called to drive Mr. Brooks somewhere to sober up?<sup>2</sup> Or a non-police response that could have been called by family to help Danielle T. Prude, another Black man who was killed by police while he was experiencing a psychosis?<sup>3</sup> Not only are police not well-equipped to respond to such crises, police response too often causes harm, whether it be through the use of force or the fear, anxiety, and humiliation that often accompanies police presence. This begs the question: How did police become the default responders to mental health issues in the first place? The answer to this question is complex.

Deinstitutionalization and the failure to adequately fund community mental health services put people with mental illnesses at risk of police contact.<sup>4</sup> But that is only part of the story. Backlash from the Civil Rights Movement led to changes in policing that expanded the footprint of police in communities of color. Furthermore, significant racial inequities in mental health service access and quality of care put Black people and other people of color with mental illnesses at even higher risk of police contact. Codified roles for police in the civil commitment process have further centered mental health crisis response as a police responsibility. Mental health professions have not only been complacent with this arrangement, they have been complicit. They have off-loaded patients considered to be undesirable—those who are poor and not white—to police and the criminal legal system.<sup>5</sup>

In Part II, we examine the events that led to the reliance on police for mental health crisis response in general and then describe how such involvement has disproportionately affected Black persons and other persons of color experiencing mental health crises. In Part III of this article, we examine the current police role and the state of the law related to police involvement in mental health crisis response. We explain how police involvement in mental health crises has been institutionalized into state statutes, review research on the harms caused to persons with mental illnesses by maintaining police as the first responders to mental health crises, and discuss strategies to improve how police respond. In Part IV, we discuss state and federal efforts to rebalance the police role in mental health crisis response. While law enforcement will continue to have a role in responding to crisis situations presenting significant safety concerns and in enforcing the law, we argue that there is currently a window of opportunity to significantly reduce the footprint of police in mental health care. We conclude with a note on the importance of maintaining a race equity lens to ensure that previous inequities and injustices are not replicated.

---

2. *Id.*

3. *Id.* It is important to note that there were multiple opportunities to intercede before police involvement; for example, Daniel Prude had been turned away from the emergency department earlier that day.

4. H. Richard Lamb, Linda E. Weinberger & Walter J. Decuir, Jr., *The Police and Mental Health, 53 PSYCHIATRIC SERVS.* 1266, 1266–67 (2002).

5. Risdon N. Slate, *Deinstitutionalization, Criminalization of Mental Illness, and the Principle of Therapeutic Jurisprudence*, 26 S. CAL. INTERDISC. L.J. 341, 349 (2017).

## II BACKGROUND

### A. Police Involvement in Mental Health Crisis Response: How Did We Get Here?

Before diving into the historic events that led to reliance on police for mental health crisis response, it is important to first define the different ways in which police interact with people with mental illness. Police may interact with people with mental illnesses for any of the same reasons they interact with people without mental illnesses. A person with mental illness may be a crime victim, a witness, requesting assistance, or suspected of criminal behavior.<sup>6</sup> In this article, we are focused on police involvement related to mental health crises, which may take various forms. Police may respond to calls for service involving persons with mental illnesses who are suspected of committing criminal offenses that are related to symptoms of their illness. For example, a business owner may call the police to ask for the removal of a person who is experiencing symptoms of psychosis and behaving in a way that alarms others. People experiencing mental health crises may call for assistance themselves, as many mental health providers' after-hours messages direct people to call 911 if they are experiencing an acute crisis.<sup>7</sup> Family members may call for police assistance in managing their loved one's behavior, and family members and clinicians may call on police to assist with emergency detention for psychiatric treatment to transfer the person in crisis to care.<sup>8</sup> During each of these encounters, police exercise their discretion in deciding whether to do nothing or resolve the situation on scene; transport the person to care on a voluntary basis; detain the individual by putting them under arrest for the commission of a crime that may or may not be symptomatic of their illness, such as disturbing the peace or loitering; or utilize their emergency custodial detention authority—defined by most jurisdictions as being in police custody for the safety of the individual.<sup>9</sup>

More than fifty years ago, Bittner's 1967 study of police discretion in the emergency detention of people with mental illnesses described dealing with people with mental illnesses as an integral part of police work, though one that officers felt was not consistent with their scope of competence or compatible with

---

6. Amy C. Watson, Beth Angell, Theresa Vidalon & Kristin Davis, *Measuring Perceived Procedural Justice and Coercion Among Persons with Mental Illness in Police Encounters: The Police Contact Experience Scale*, 38 J. CMTY. PSYCH. 206, 216 (2010).

7. Amy C. Watson, Leah G. Pope & Michael T. Compton, *Police Reform from the Perspective of Mental Health Services and Professionals: Our Role in Social Change*, 72 PSYCHIATRIC SERVS. 1085, 1085 (2021).

8. Mary L. Durham, Harold D. Carr & Glenn L. Pierce, *Police Involvement and Influence in Involuntary Civil Commitment*, 35 HOSP. & CMTY. PSYCHIATRY 580, 581 (1984).

9. See Linda A. Teplin, *Keeping the Peace: Police Discretion and Mentally Ill Persons*, 244 NAT'L INST. JUST. J. 8, 10–11 (2000) (describing the various formal and informal methods officers have at their disposal when resolving situations involving the mentally ill).

their conceptions of policing.<sup>10</sup> Teplin and Pruett noted the historical role of police in referring people for psychiatric treatment, particularly those within lower socioeconomic groups.<sup>11</sup> In reporting on findings from observations of police encounters with people with mental illnesses in the early 1980s, Teplin and Pruett describe the police role as that of “street corner psychiatrist,” triaging and transporting people to psychiatric treatment.<sup>12</sup> Thirty years ago, they pointed to changes in commitment criteria and reductions in inpatient beds and community mental health resources in the prior decade as factors increasing the burden on police.<sup>13</sup>

Criminalization and the frequent involvement of police with persons with mental illness has been attributed to three primary factors: (1) changes in the involuntary commitment process that increased the court’s role in commitment procedures, making it more difficult to commit someone coupled with the focus on dangerousness criteria; (2) deinstitutionalization and the failure to adequately increase outpatient treatment capacity; and (3) changes in policing. In addition to these factors, it is important to note inequities in mental health care and the complicity of mental health professionals and their willingness to hand off uninsured, complex, non-white clients to law enforcement and the criminal legal system. Each of these contributing factors will be discussed *infra*.

#### B. The Development of Procedures For Involuntary Commitment And a Role For Police

While most persons with mental illnesses now receive treatment in the community,<sup>14</sup> the mental health treatment system in the United States has its roots in paternalistic state psychiatric institutions that quickly became overcrowded custodial facilities housing people with mental illnesses, alcoholism, epilepsy, dementia, and others whose behavior was deemed problematic.<sup>15</sup> Arguably, the use of coercion and control and the stripping of autonomy and personal freedom invited, or at least was conducive to, the introduction of police officers into the mental health treatment continuum. To understand this progression, we must first understand the development of involuntary commitment processes and procedures and the laws that institutionalized them.

Psychiatric institutions have existed in the U.S. since colonial times. In the late 1700s–1800s, institutions for the care of the mentally disabled existed but

---

10. Egon Bittner, *Police Discretion in Emergency Apprehension of Mentally Ill Persons*, 14 SOC. PROBS. 278, 281 (1967); Durham, Carr & Pierce, *supra* note 8, at 581.

11. See generally Linda A. Teplin & Nancy S. Pruett, *Police as Streetcorner Psychiatrist: Managing the Mentally Ill*, 15 INT’L J.L. & PSYCHIATRY 139, 139 (1992).

12. *Id.*

13. *Id.*

14. RICHARD G. FRANK & SHERRY A. GLIED, BETTER BUT NOT WELL: MENTAL HEALTH POLICY IN THE UNITED STATES SINCE 1950, at 1 (2006).

15. Zeb Larson, *America’s Long-Suffering Mental Health System*, ORIGINS: CURRENT EVENTS HIST. PERSP. (Apr. 2018), <http://origins.osu.edu/article/americas-long-suffering-mental-health-system> [<https://perma.cc/EFQ5-R9P3>].

were few, leading to many persons in need of residential mental health care to be housed in jails.<sup>16</sup> The mid-1800s saw an increase in the number of psychiatric institutions and state financial support for those institutions. As mental health policy scholar Dr. Grob notes,

The justification for asylums appeared self-evident: they benefited the community, the family, and the individual by offering effective psychological and medical treatment for acute cases and humane custodial care for chronic cases. In providing for the mentally ill, the state met its ethical and moral responsibilities and, at the same time, contributed to the general welfare by limiting, if not eliminating, the spread of disease and dependency.<sup>17</sup>

As the number of psychiatric institutions increased, patients were often admitted to institutions for the convenience of others or to address societally undesirable behavior, as opposed to the need for treatment.<sup>18</sup> It is important to note that persons that were admitted to such facilities were primarily white persons. While psychiatric institutions for Black persons did exist, jails were often used instead.

In early American history, all that was needed to involuntarily hospitalize an adult with a mental illness was the certification of admission by a medical professional, which was often based largely on the recommendation of a family member.<sup>19</sup> Though there were legal remedies in the form of a writ of habeas corpus that could be used by the patient to challenge an unwanted hospitalization, they were rarely used.<sup>20</sup> Further, writs of habeas corpus were effectively useless, as individuals who were involuntarily hospitalized had no way to challenge their admission because such involuntary hospitalizations were misused by some individuals who were looking to punish or control others.<sup>21</sup> During this era, a physician would “don the caps of judge, jury, and executioner, as admission and length of stay would proceed, solely, by his discretion.”<sup>22</sup>

The first wave of involuntary hospitalization reform was launched by one such victim, a married woman, Mrs. E.P.W. Packard, who was involuntarily hospitalized by her husband for his personal convenience.<sup>23</sup> Cases like Mrs. Packard’s highlighted the potential abuse of involuntary hospitalization and suggested a need for oversight of the process and procedural protections for

---

16. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM: HISTORICAL TRENDS AND PRINCIPLES FOR LAW AND PRACTICE 3 (2019), <https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf> [<https://perma.cc/85X6-5ASC>].

17. Gerald N. Grob, *The Paradox of Deinstitutionalization*, 32 SOC’Y 51, 53 (1995), [https://fbaum.unc.edu/teaching/articles/Grob1995\\_Society\\_TheParadoxOfDeinstitutionalization.pdf](https://fbaum.unc.edu/teaching/articles/Grob1995_Society_TheParadoxOfDeinstitutionalization.pdf) [<https://perma.cc/68N5-ZN4F>].

18. *Wrongful Confinement to a Mental Health or Developmental Disabilities Facility*, 44 AM. JUR. 3D PROOF OF FACTS 217, 8 (1997) [hereinafter *Wrongful Confinement*].

19. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 16, at 3.

20. *Id.* at 2.

21. *Wrongful Confinement*, *supra* note 18, at 5.

22. Kamron A. Fariba & Vikas Gupta, *Involuntary Commitment*, NAT’L LIBR. MED. (Jan. 2022), <https://www.ncbi.nlm.nih.gov/books/NBK557377/> [<https://perma.cc/W9TW-J23D>].

23. *Wrongful Confinement*, *supra* note 18, at 5.

individuals subject to it. As a result, states began establishing legal requirements for judicial oversight over involuntary hospitalization, formalizing the civil commitment process.<sup>24</sup> Such laws now exist in every state, and in addition to establishing commitment criteria and procedural protections, these laws establish the types of actors that can initiate commitment proceedings, such as physicians, family members and police officers.<sup>25</sup>

While the involvement of the judicial system in the process of involuntary hospitalization would suggest that persons who were to be committed would be afforded more civil rights protections, the judicial proceedings overseeing involuntary admissions were often “informal,” with “relaxed” rules of civil procedure, pro forma legal representation, and exceptions that allowed for patients to be excused from attending their hearing, on doctor’s orders, even if it was against their will.<sup>26</sup> In 1951, the National Institute of Mental Health (NIMH) recommended that decision-making over whom should be committed should be returned to medical professionals.<sup>27</sup> Many states followed NIMH recommendations by creating procedures for medical certifications instead of or in addition to judicial civil commitment process.<sup>28</sup> States also did away with the right to a hearing before admission, with many mandating the hearing only after admission.<sup>29</sup>

Several decades later, mental health law advocates during the Civil Rights Movement used litigation to achieve the reform of civil commitment procedures and to protect the civil rights of individuals with mental illnesses. In 1975, the Supreme Court ruled that states could not involuntarily commit non-dangerous persons<sup>30</sup> and, in 1979, required greater procedural protections in recognition of the deprivation of personal liberties that result during involuntary commitments.<sup>31</sup> The creation of stricter involuntary commitment standards made it more difficult for persons to be involuntarily committed—an outcome favored by advocates to deinstitutionalize those in psychiatric facilities. When considering how police became the primary responders to mental health crises with a central role in emergency detentions, many point to deinstitutionalization, the emptying of state psychiatric institutions, and the failures of the community mental health system to provide adequate services and support. Each of these factors contributed to this situation, but the story is more complex.

---

24. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 16, at 3.

25. See *Wrongful Confinement*, *supra* note 18, at 5. In a 1984 study, police referral for involuntary commitment at a mental health institution was the primary factor that predicted whether a referral will result in an involuntary commitment. See also Durham, Carr & Pierce, *supra* note 8, at 582 (analyzing the results of a similarly timed study on the correlation between police involvement and referral for involuntary commitment).

26. *Wrongful Confinement*, *supra* note 18, at 5.

27. NAT’L INST. MENTAL HEALTH, A DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL 6 (1952).

28. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 16, at 7.

29. *Id.*

30. O’Connor v. Donaldson, 422 U.S. 563 (1975).

31. Addington v. Texas, 441 U.S. 418, 427 (1979).

### C. Deinstitutionalization And The Failure to Create an Adequate Community Mental Health Infrastructure

The emptying of state hospitals, or deinstitutionalization, was spurred by the Community Mental Act of 1963, financial incentives to states to move people into the community, and the previously discussed civil rights challenges to commitment criteria and processes. The Community Mental Health Centers Act of 1963 represented awareness of the horrible conditions in psychiatric institutions and new optimism that people with severe mental illnesses could be better served in community settings with the use of recently approved antipsychotic medications. The Act provided funding for construction and initial staffing of 1,500 community mental health centers (CMHCs).<sup>32</sup> The introduction of Medicaid in 1965 provided financial incentives for states to shift people from institutions into the community, presumably where they would receive care from community mental health centers. Additionally, mainstream Social Security Disability (SSDI) and Supplemental Security Income (SSI) programs provided financial support for individuals with severe mental illnesses to live in the community.<sup>33</sup> Since its inception, Medicaid prohibited “payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases” except for “inpatient psychiatric hospital services for individuals under age 21.”<sup>34</sup> In addition to these public payment incentives, many private insurers began adopting managed care models that subjected all hospital stays to review for strict medically necessary criteria, leading to greater denials of coverage for in-patient psychiatric treatment.<sup>35</sup> Outpatient treatment was further incentivized by the development of effective psychotropic medications in the 1950s.<sup>36</sup> Additionally, treatments for epilepsy, mental disabilities, and dementia advanced, and long-term care facilities for the elderly were created,<sup>37</sup> addressing large proportions of the psychiatric institution population.<sup>38</sup>

---

32. Blake Erickson, *Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963*, 16 AM. J. PSYCHIATRY RESIDENTS’ J. 4, 7 (2021); Gerald N. Grob, *Mental Health Policy in America: Myths and Realities*, 11 HEALTH AFFS. 3, 13 (1992).

33. Howard H. Goldman & Gerald N. Grob, *Defining ‘Mental Illness’ in Mental Health Policy*, 25 HEALTH AFFS. 737, 742 (2006).

34. Social Security Act, 42 U.S.C. § 1396d. Institutions for mental disease defined as “hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.” *Id.* Collectively, this section is referred to as the IMD exclusion. *See id.* In 2019, Congress enacted Section 5052 of the SUPPORT for Patients and Communities Act, which amended the IMD exclusion to allow states to submit a state plan option to provide Medicaid beneficiaries with substance use disorders between the ages of twenty-one and sixty-four coverage to receive treatment in an eligible IMD between October 1, 2019 through September 30, 2023. *Id.* § 1396n.

35. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 16, at 8.

36. *Id.* at 7.

37. Grob, *supra* note 17, at 53.

38. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 16, at 8.

As discussed previously, during this period, civil rights and patient advocates challenged the constitutionality of the dangerous conditions in psychiatric institutions and the medically oriented civil commitment processes. They were successful in restraining the states' power to use coercion and in expanding the states' duty to keep people in its custody safe and provide treatment.<sup>39</sup> This made it both more difficult to institutionalize people with mental illnesses and further incentivized states to move people to the community.

In the mid-1950s, there were over half a million people institutionalized in state psychiatric facilities in the United States; by 2003, the number had dropped to 47,000. In 2018, there were a total of 36,167 public psychiatric beds in the United States that served a total of 50,200 patients.<sup>40</sup> Unfortunately, the promise of the Community Mental Health Movement was never fully realized. While the Movement was successful in decreasing the number of persons that were institutionalized, too few CMHCs were built, and those that were generally served a different population than the group being moved out of psychiatric institutions into the community.<sup>41</sup> As a result, the persons who were formerly institutionalized in state psychiatric facilities found themselves with nowhere to go for long-term treatment or care.

In an effort to address gaps in care and improve CMHC's role in caring for people with severe mental illnesses in the 1970s, the National Institute of Mental Health issued Community Support Program grants to communities and, in 1980, the Mental Health Systems Act included recommendations on services for people with severe mental illnesses. However, when Ronald Reagan became president, most of the provisions of the Mental Health Systems Act were repealed with the Omnibus Budget Reconciliation Act of 1981 and appropriations were replaced with mental health and substance abuse block grants, representing a reduction in

---

39. See, e.g., *Lessard v. Schmidt*, 349 F. Supp. 1078, 1104 (E.D. Wis. 1972) (finding the Wisconsin civil commitment procedure is constitutionally defective); *Addington v. Texas*, 441 U.S. 418, 433 (1979) (finding that the reasonable doubt standard is inappropriate in civil commitment proceedings); *O'Conner v. Donaldson*, 422 U.S. 563, 576 (1975) (holding that "a State cannot constitutionally confine, without more, a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."); *Wyatt v. Stickney*, 344 F. Supp. 387, 393 (M.D. Ala. 1972) (holding that "minimum standards for constitutional care and training must be effectuated at Partlow"); *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982) (holding that patients enjoy "constitutionally protected interests in conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests").

40. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., NATIONAL MENTAL HEALTH SERVICES SURVEY (N-MHSS): 2018, DATA ON MENTAL HEALTH TREATMENT FACILITIES 58 (2019), <https://www.samhsa.gov/data/report/national-mental-health-services-survey-n-mhss-2018-data-mental-health-treatment-facilities> [https://perma.cc/Y242-HF5N]. However, if including private, general and Veterans Administration psychiatric beds, the total number of beds and patients was 109,241 and 129,115 respectively. *Id.* at 2, 43.

41. See Grob, *supra* note 32, at 19 (noting that "the main focus was on providing therapeutic services in outpatient settings to a broad rather than a defined population. Consequently, the social and human needs of the most severely and especially chronically mentally ill . . . were often ignored or overlooked"). See also Goldman & Grob, *supra* note 33, at 740 (noting that "the resident population of state mental hospitals was falling in relation to the increase in the number of CMHCs. . . . By the mid-1970s, the NIMH realized that it needed to improve CMHCs' role in caring for people with more-severe disorders").



funding to the states.<sup>42</sup> Subsequently, advocates brought lawsuits seeking entitlements to community care and housing, but were unsuccessful in getting the courts to extend the constitutional guarantees of treatment to the community setting.<sup>43</sup> Furthermore, while SSDI and SSI remain important supports for people with serious mental illnesses in the community, the cost of rent in most communities exceeds the average SSDI and SSI payments, leaving many with serious mental illnesses without access to stable housing.<sup>44</sup>

In 1980, Congress passed the Civil Rights of Institutionalized Persons Act of 1980 (CRIPA), which authorizes the U.S. Attorney General to investigate conditions of confinement in psychiatric institutions—among other institutions—and to take enforcement action if institutions are engaged in patterns and practices that violate individuals’ Constitutional and federal rights, including those provided by Section 504 of the Rehabilitation Act.<sup>45</sup> The Americans with Disabilities Act (ADA) was passed in 1991 and “guarantees that people with disabilities have the same opportunities as everyone else to participate in the mainstream of American life—to enjoy employment opportunities, to purchase goods and services, and to participate in State and local government programs and services.”<sup>46</sup> Title II of the ADA includes an integration mandate, which states that public entities must “administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”<sup>47</sup> An integrated setting is one that “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible . . . .”<sup>48</sup> In 1999, the Supreme Court held in *Olmstead v. L.C.* that the integration

---

42. Goldman & Grob, *supra* note 33, at 741–42.

43. Antony B. Klapper, *Finding a Right in State Constitutions for Community Treatment of the Mentally Ill*, 142 U. PENN. L. REV. 739, 780 (1993).

44. See *Out of Reach: The High Cost of Housing*, NAT’L LOW INCOME HOUS. COAL., [https://nlihc.org/sites/default/files/2022-07/OOR\\_2022\\_Figure-1.pdf](https://nlihc.org/sites/default/files/2022-07/OOR_2022_Figure-1.pdf) [<https://perma.cc/M8ZL-WT6M>] (last visited Nov. 24, 2022); Sonya Acosta & Erik Gartland, *Families Wait Years for Housing Vouchers Due to Inadequate Funding*, CTR. ON BUDGET & POL’Y PRIORITIES (July 22, 2021), <https://www.cbpp.org/research/housing/families-wait-years-for-housing-vouchers-due-to-inadequate-funding> [<https://perma.cc/FS9A-MLFA>] (noting that while housing subsidy programs through the U.S. Department of Housing are available, the demand for such programs and available housing exceed the supply).

45. 34 C.F.R. § 104.4 (1973). Section 504 of the Rehabilitation Act was passed in 1973 and prohibits the discrimination on the basis of disability (including mental illnesses) by programs and activities that receive federal assistance. See 34 C.F.R. § 104.3(j)(2)(i) (noting that “physical or mental impairment” includes “mental illness”).

46. *Introduction to the ADA*, U.S. DEP’T OF JUST., C.R. DIV., [https://www.ada.gov/ada\\_intro.htm](https://www.ada.gov/ada_intro.htm) [<https://perma.cc/HJ9R-VDBS>] (last visited Oct. 5, 2022).

47. 28 C.F.R. § 35.130(d) (2022).

48. 28 C.F.R. pt. 35 app. B (2021). By contrast, “[s]egregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals’ ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.” *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.*, U.S. DEP’T

mandate found in Title II of the ADA required public entities to provide services in the community when appropriate, in alignment with the wishes of the affected persons, and when community-based services can be provided, after taking into account the financial ability to provide such services of the institution and the needs of others receiving services.<sup>49</sup> The Court made clear that

[i]nstitutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life, cf., e.g., *Allen v. Wright*, 468 U.S. 737, 755; and institutional confinement severely diminishes individuals' everyday life activities.

Following the passage of the Americans with Disabilities Act and *Olmstead*, advocates have had some successes expanding services for people at risk of institutionalization.<sup>50</sup>

Thus, while there has been some success in addressing the failures of the community mental health system, people with serious mental illnesses remain at increased risk for police contact, and police are a pathway to psychiatric care for many, particularly people of color. Reviewing studies examining experiences of people with serious mental illnesses, Livingston found that amongst studies conducted in the United States, twenty-nine percent of participants indicated police involvement in their pathway to care. Factors associated with police involvement in pathways to care included male gender, Black race, substance use problems, aggressive or violent behavior, psychosis, severe impairment, and involuntary service use.<sup>51</sup> Frank and Glied indicate that, while people with serious mental illnesses may be “better” off now than sixty years ago, the lack of adequate community mental health services, income support, and housing leaves them “not well,”<sup>52</sup> and at risk for crisis and police contact in the community. Further, Black persons and persons of color fare worse, due in part to the additional barriers to outpatient treatment access and the concomitant increased risk in police contacts.

#### D. Inequities in Mental Health Care

There is substantial evidence of race inequities in access to mental health care. In 2019, only thirty-three percent of Black and thirty-four percent of Latinx

---

OF JUST., C.R. DIV., [https://archive.ada.gov/olmstead/q&a\\_olmstead.htm](https://archive.ada.gov/olmstead/q&a_olmstead.htm) [<https://perma.cc/NND2-TFYC>] (last visited Feb. 2, 2023).

49. *Olmstead: Community Integration for Everyone*, U.S. DEP'T OF JUST., C.R. DIV., [https://www.ada.gov/olmstead/olmstead\\_about.htm](https://www.ada.gov/olmstead/olmstead_about.htm) [<https://perma.cc/JW4P-VM9K>] (last visited Oct. 5, 2022).

50. See Sara Rosenbaum, *Using the Courts to Shape Medicaid Policy: Olmstead v. L.C. by Zimring and Its Community Integration Legacy*, 41 J. HEALTH POL., POL'Y & L. 585, 587 (2016); John Petrila, *Law & Psychiatry: Has the ADA Been Reborn as a Tool of Broad Community Change for People With Mental Disabilities?*, 65 PSYCHIATRIC SERVS. 847, 847 (2014) (“[T]wo recent settlement agreements between the U.S. Department of Justice and the states of New York and Rhode Island promise sweeping change in housing and employment for thousands of individuals with mental disabilities.”).

51. James D. Livingston, *Contact Between Police and People with Mental Disorders: A Review of Rates*, 67 PSYCHIATRIC SERVS. 850, 852 (2016).

52. See FRANK & GLIED, *supra* note 14, at xiv, 137–138.

adults with mental health problems received any care. For adults with serious mental illnesses, the percentages were fifty-eight percent and fifty-two percent respectively.<sup>53</sup> While many factors may impede access to mental health services, Black adults cite the cost as the most common barrier.<sup>54</sup> Shim points to deeply ingrained structural racism in both society and the psychiatric profession.

Within the United States, the mental health system is a broken patchwork of siloed services, resulting in a significant number of psychiatrists who do not take insurance, because of a number of factors, including low reimbursement rates (43). These policies and practices govern a deeply inequitable, socially unjust mental health system in the United States, where minoritized communities are unable to afford high quality mental health services.<sup>55</sup>

Further inequities are evident when Black and ethnic minority patients access mental health care. Members of racial and ethnic minorities are afforded less access to psychotropic medications and outpatient mental health appointments and are less likely to receive specialty care compared to White patients.<sup>56</sup> When presenting for emergency psychiatric evaluation, Black patients are more likely than White patients to have physical and chemical restraints used on them, and Black and ethnic minority patients are more likely to be served in inpatient settings with rates of complaints related to the use of restraint and seclusion.<sup>57</sup> Specific to the focus of this article, Black patients are more likely to access services via law enforcement involvement and involuntary commitment procedures.<sup>58</sup>

---

53. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2020 NATIONAL SURVEY OF DRUG USE AND HEALTH: DETAILED TABLES 1377 (2022), <https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020.pdf> [https://perma.cc/6PJJ-QLCE].

54. See generally Sirry M. Alang, *Mental Health Care Among Blacks in America: Confronting Racism and Constructing Solutions*, 54 HEALTH SERVS. RSCH. 346 (2019).

55. Ruth S. Shim, *Dismantling Structural Racism in Psychiatry: A Path to Mental Health Equity*, 178 AM. J. PSYCHIATRY 592, 595 (2021).

56. See Kevin Fiscella & Mechelle R. Sanders, *Racial and Ethnic Disparities in the Quality of Health Care*, 37 ANN. REV. PUB. HEALTH 375, 382 (2016) (“Robust evidence indicates that minority populations use behavioral health services, including mental and substance use disorder treatment, less often than do non-Latino whites.”); Kimberly Narain, Haiyong Xu, Francisca Azocar & Susan L. Ettner, *Racial/Ethnic Disparities in Specialty Behavioral Health Care Treatment Patterns and Expenditures Among Commercially Insured Patients in Managed Behavioral Health Care Plans*, 54 HEALTH SERVS. RSCH. 575, 581 (2019) (“Among women and men, Asian non-English speakers had significantly lower utilization and expenditures than whites in all categories, with the exception of inpatient care. . . . Among women, Hispanic English speakers had significantly lower expenditures and fewer psychotropic drug management and individual and group psychotherapy visits than whites. Among men, Hispanic English speakers also had significantly lower psychotropic drug management and individual and family psychotherapy visits than whites.”).

57. Colin M. Smith et al., *Association of Black Race with Physical and Chemical Restraint Use Among Patients Undergoing Emergency Psychiatric Evaluation*, 73 PSYCHIATRIC SERVS. 730, 730 (2022); Morgan C. Shields, *Patient Characteristics Associated with Admission to Low-Safety Inpatient Psychiatric Facilities: Evidence for Racial Inequities*, 72 PSYCHIATRIC SERVS. 1151, 1151 (2021).

58. Marvin S. Swartz, *The Urgency of Racial Justice and Reducing Law Enforcement Involvement in Involuntary Civil Commitment*, 71 PSYCHIATRIC SERVS. 1211, 1211 (2020).

### E. Changes in Policing Coinciding With Deinstitutionalization

Deinstitutionalization and the failure to develop a robust community mental health system left many people with serious mental illnesses in the community without adequate supports and services, and limited options for accessing care during a crisis. Additionally, changes in policing facilitated an expanded role, particularly in communities of color and in managing the behaviors and responding to the needs of people with serious mental illnesses. In 1971, President Nixon officially announced the War on Drugs, an initiative which Nixon's Assistant for Domestic Affairs, John Ehrlichman later revealed was really a war on Black people and the anti-war left. This set the pattern for the drug war that was continued by Presidents Reagan, Bush, and Clinton.

Federal, state and local mandates related to the War on Drugs put pressure on police agencies to show results, prompting the targeting of policing activities in low income and communities of color, and resulting in intensified racialized mass incarceration. This has produced devastating effects in Black neighborhoods and exacerbated existing patterns of social disorganization.<sup>59</sup> Co-occurring substance use disorders are common among people with serious mental illnesses, thus the War on Drugs also disproportionately brought people with serious mental illnesses in contact with police and into the criminal legal system.<sup>60</sup>

During this same period, Kelling and Wilson introduced the Broken Windows Theory, which maintains that policing methods targeting lower-level, quality of life crimes will prevent more serious crimes. In their 1982 Atlantic Monthly article, they encourage policing focus on people who are “[n]ot violent people, nor necessarily, criminals, but disreputable or obstreperous or unpredictable people: panhandlers, drunks, addicts, rowdy teenagers, prostitutes, loiterers, the mentally disturbed.” They further indicate, “Of course, agencies other than the police could attend to the problems posed by drunks or the mentally ill, but in most communities especially where the ‘deinstitutionalization’ movement has been strong—they do not.”<sup>61</sup> Broken windows policing was popularized in the 1990s by New York City Police Commissioner Bill Bratton and was subsequently adopted by nearly every major city in the country. Empirical research has found little evidence that broken windows strategies reduce serious crime. Not surprisingly, the targets of broken windows strategies have overwhelmingly been

---

59. Lawrence D. Bobo & Victor Thompson, *Unfair by Design: The War on Drugs, Race, and the Legitimacy of the Criminal Justice System*, 73 SOC. RSCH. 445, 452–53 (2006).

60. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2020 NATIONAL SURVEY ON DRUG USE AND HEALTH 35 (2020) (noting the percentage of people with serious mental illnesses and co-occurring substance use disorders).

61. George L. Kelling & James Q. Wilson, *Broken Windows*, ATLANTIC (May 1982), <https://www.theatlantic.com/magazine/archive/1982/03/broken-windows/304465/> [<https://perma.cc/4QR2-ZJV2>].

people and communities of color,<sup>62</sup> and include many individuals with mental and behavioral health conditions.

### III

#### THE CURRENT POLICE ROLE

##### A. Civil Commitment And The Police Role

Though state laws differ, all states must abide by the due process guarantees under the Fourteenth Amendment of the Constitution and the Supreme Court's interpretations of its protections. Generally speaking, in order for a person to be properly committed in accordance with state law they must constitute a danger to themselves, to another person, or to property because of a mental disorder.<sup>63</sup> The component parts of most state laws can be broken down into four elements: (1) presence of a mental illness,<sup>64</sup> (2) need for inpatient treatment,<sup>65</sup> and (3) dangerousness to self or others. Some states also permit commitment based on grave disability, or the inability to provide for basic needs.<sup>66</sup> In addition to these components, some states require a showing that the inpatient setting is the least restrictive means possible.<sup>67</sup>

At least twenty-five states explicitly include police officers or peace officers as persons who can initiate emergency commitments or short-term involuntary commitments.<sup>68</sup> Twenty-two states allow “any interested person”—which can include police officers—to initiate such proceedings.<sup>69</sup> Of the states that permit police or peace officers to initiate emergency commitments, two require the

---

62. RANDALL SHELDEN, *CTR. ON JUV. & CRIM. JUST., ASSESSING “BROKEN WINDOWS”: A BRIEF CRITIQUE* 11 (2004), <http://www.cjcrj.org/uploads/cjcrj/documents/broken.pdf> [<https://perma.cc/BU27-NTGW>].

63. J. Howard Ziemann, *Incompetency and Commitment Proceedings*, 8 AM. JUR. TRIALS 483 § 3, Westlaw (database updated Feb. 2023). It is not enough to show that the person who is committed was a danger to themselves or others in most states. They must show that the danger was caused by the mental illness. Practically speaking, this prevents the commitment of persons who may be “dangerous” but not mentally ill.

64. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 16, at 1 n.1 (noting that most states require that the illness be a “serious mental illness” and exclude substance use disorders from that definition. Persons with mental disabilities may also be involuntarily committed but the requirements for such a commitment can differ).

65. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 16, at 10 (explaining that the need for inpatient treatment is demonstrated by showing that a person has a mental illness for which care and treatment as a patient in a hospital is essential to the person's welfare, and that his judgment is so impaired that he is unable to understand the need for such care and treatment); see also *id.* at 12 (noting that the need for inpatient treatment is required in almost every state; though, at times, it is not listed as a separate element, but rather subsumed in the definition of mental illness).

66. *Id.* at 12.

67. See *Wrongful Confinement*, *supra* note 18, at 9.

68. John P. Petrila & Jeffrey W. Swanson, *Short-Term Emergency Commitment Laws*, L. ATLAS, <https://lawatlas.org/datasets/short-term-civil-commitment> [<https://perma.cc/X4E2-32F9>] (last visited Oct. 5, 2022).

69. *Id.*

participation of police or peace officers: Wisconsin and Michigan. For example, in Wisconsin, law enforcement are instructed to not only take persons into custody pursuant to a custody order, they can also detain persons without a court order “if the law enforcement officer has cause to believe that the subject individual is mentally ill, drug dependent or developmentally disabled and is eligible for commitment.”<sup>70</sup> Most states call for law enforcement personnel to transfer individuals to the hospital and some even permit the use of force.<sup>71</sup> Five states allow police officers to initiate long-term involuntary commitment proceedings.<sup>72</sup> Three states allow for peace officers to initiate the long-term proceedings.<sup>73</sup> Thirty-eight states allow for any adult to initiate long-term involuntary commitment proceedings.<sup>74</sup>

All states except Rhode Island and Connecticut have involuntary out-patient commitment laws.<sup>75</sup> Of these states, statutes in Maine<sup>76</sup> and Virginia<sup>77</sup> explicitly permit police or peace officers to initiate involuntary commitment proceedings.<sup>78</sup> Some states allow for police involvement by permitting any interested person to file a petition.<sup>79</sup> These states do not *require* police involvement to initiate a petition. Even if police officers are not involved in initiating the involuntary commitment proceedings, they may be tasked with transferring the individual to undergo a psychiatric assessment.<sup>80</sup>

The role of police in commitment processes stems from their legal authority to take people into custody and likely the ubiquity of supposed dangerousness in the world of commitment. However, dangerousness is no longer the sole criteria for civil commitment in most states and dangerousness need not be a risk of violent behavior. Regardless, the role of police in responding to people with mental illnesses and those experiencing mental health crises in the community extends well beyond situations related to civil commitment processes. This is

---

70. WIS. STAT. ANN. § 51.20 (West 2020).

71. *See, e.g.*, MICH. COMP. LAWS ANN. § 330.1427a (West 2022) (“If a peace officer is taking an individual into protective custody, the peace officer may use that kind and degree of force that would be lawful if the peace officer were effecting an arrest for a misdemeanor without a warrant.”).

72. John P. Petrilá & Jeffrey W. Swanson, *Long-Term Involuntary Commitment Laws*, L. ATLAS, <https://lawatlas.org/datasets/long-term-involuntary-commitment-laws> [https://perma.cc/5WC7-R3CV] (last visited Nov. 11, 2022).

73. *Id.*

74. *Id.*

75. *See id.* The Law Atlas website is only updated through 2016. Since then, N.M. STAT. ANN. § 43-1B-3 and D.C. CODE ANN. § 21-545(b)(2) have passed.

76. ME. STAT. tit. 34-B, § 3873-A (2020).

77. VA. CODE ANN. § 37.2-800 (West 2022).

78. *Compare* NEV. REV. STAT. § 433A.200 (2017) (permitting police officers to initiate involuntary outpatient commitment), *with* NEV. REV. STAT. § 433A.200 (2021) (removing “an accredited agent of the Department or by any officer authorized to make arrests in the State of Nevada” from the list of acceptable petitioners for involuntary outpatient commitment).

79. 405 ILL. COMP. STAT. ANN. 5/3-751 (West 2011) (permitting “[a]ny person 18 years of age or older [to] execute a petition asserting that another person is subject to involuntary admission on an outpatient basis”).

80. *E.g.*, N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2022).

perhaps, by default, due to the lack of mental health system resources to respond, and when necessary, transport people for psychiatric care. Additionally, as Murray and colleagues suggest:

A role for transportation falls on police due to qualified immunity, which protects law enforcement officials from unjustified lawsuits (Warren & Supreme Court of the United States, 1966). In other words, providers and their organizations prefer police responses over potential lawsuits, even if it might result in dangerous outcomes to individuals living with mental illness.<sup>81</sup>

Reliance on police for mental health response is entangled with long standing assumptions that people with mental illnesses are dangerous. This assumption has dominated policy arguments and continues to be used to justify coercive treatment for people with mental illnesses and to be reflected in court rulings,<sup>82</sup> despite studies indicating only a modest relationship between serious mental illness and violence.<sup>83</sup> Police reliance is further entangled at the intersection of race and mental illness. The racialization of schizophrenia as a Black disease associated with violence,<sup>84</sup> the significant inequities in mental health care, and policing practices targeting Black communities put Black people at high risk of police involvement in mental health crisis situations. As Jordan and colleagues argue, “[e]xtraordinary risk lies at the nexus of mental illness, Black identity, and encounters with law enforcement.”<sup>85</sup>

---

81. Conor H. Murray et al., *Behavioral Crisis and First Response: Qualitative Interviews with Chicago Stakeholders*, 59 CMTY. MENTAL HEALTH J. 77, 82 (2023).

82. See JOHN P. PETRILA & JEFFREY W. SWANSON, MENTAL ILLNESS, LAW, AND A PUBLIC HEALTH LAW RESEARCH AGENDA 22 (2010), <https://phlr.org/product/mental-illness-law-and-public-health-law-research-agenda> [<https://perma.cc/TQX7-M4GD>] (finding that courts often accept the general assumption that people with mental illnesses are dangerous).

83. See H. J. Steadman et al., *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES GEN. PSYCHIATRY 393, 400 (1998) (finding that among a sample of patients discharged from an inpatient psychiatric hospital there was a moderately increased rate of committing serious violence when compared to residents in their same neighborhoods. This elevated risk, however, was only present among those with co-occurring substance use disorders). See also Eric B. Elbogen & Sally C. Johnson, *The Intricate Link Between Violence and Mental Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions*, 66 ARCHIVES GEN. PSYCHIATRY 152, 154–59 (2009) (finding that severe mental illness on its own did not predict future violence; however, severe mental illness and co-occurring substance use disorder did modestly increase future violence risk); Jeffrey W. Swanson et al., *The Social–Environmental Context of Violent Behavior in Persons Treated for Severe Mental Illness*, 92 AM. J. PUB. HEALTH 1523, 1523 (2002); Jeffrey W. Swanson et al., *Alternative Pathways to Violence in Persons with Schizophrenia: The Role of Childhood Antisocial Behavior Problems*, 32 L. & HUM. BEHAV. 228, 231 (2008). Furthermore, studies have demonstrated the influence of criminogenic and social–environmental factors that influence violence risk among people with serious mental illness also influence violence risk among the general population.

84. JONATHAN M. METZL, THE PROTEST PSYCHOSIS: HOW SCHIZOPHRENIA BECAME A BLACK DISEASE 95–108 (2009).

85. Ayana Jordan, AZA Stephen Allsop & Pamela Y. Collins, *Decriminalizing Being Black with Mental Illness*, 8 LANCET PSYCHIATRY 8, 8 (2021).

## B. Frequency of Contact

In recent decades, there has been continued recognition that law enforcement has frequent encounters with people with serious mental illnesses. However, reliable data on this frequency has been difficult to locate, as many agencies do not document, or code, calls based on mental health-related factors. To estimate police contact with persons with mental illnesses, researchers have used a variety of resources, each with their own limitations. Several very recent studies have used 911 call center data and produced quite varied rates, with some finding as high as 10.8 percent of all law enforcement contacts with the public involving a person with serious mental illness<sup>86</sup> and others, such as Lum and colleagues, finding “mental distress” coded calls comprised only 1.3 percent of all calls for service.<sup>87</sup> However, in-depth analysis of both call codes—codes assigned by 911 dispatchers—and freeform text notes, as opposed to just the initial call code assigned by 911 dispatchers, suggest that relying solely on initial call codes, as Lum and colleagues did, results in a vast undercounting of the number of law enforcement interactions with persons with mental illness.<sup>88</sup> Regardless of the specific frequency, there is evidence that people with mental illnesses have contact with police at higher rates than people without mental illnesses.<sup>89</sup>

---

86. Jacek Koziarski, Lorna Ferguson & Laura Huey, *Shedding Light on the Dark Figure of Police Mental Health Calls for Service*, POLICING: J. POL'Y & PRAC., Feb. 2022, at 8.

87. Cynthia Lum, Christopher S. Koper & Xiaoyan Wu, *Can We Really Defund the Police? A Nine-Agency Study of Police Response to Calls for Service*, 25 POLICE Q. 255, 266 (2022) (acknowledging the limitations of relying on 911 call codes, but concluding that the low frequency indicates that shifting response resources away from police agencies to expand response resources in the mental health system would be misguided). See generally Taleed El-Sabawi & Amy C. Watson, *The Risk of Relying on Existing 911 Data to Estimate Behavioral Health-Related Call Volume* (Fla. Int'l Univ. Legal Rsch. Paper No. 22-13, 2022), <https://papers.ssrn.com/abstract=4223717> [<https://perma.cc/4NYD-Z3BY>] (examining the risks of relying on 911 data in a behavioral-health context).

88. Renèe J. Mitchell, Sean Wire & Alan Balog, *The 'Criminalization' of the Cop: How Incremental, Systematic Flaws Lead to Misunderstanding Police Calls for Service Involving Persons with Mental Illness*, 16 POLICING: J. POL'Y & PRAC. 370, 378 (2022). For example, Lum, Koper & Wu, *supra* note 87, used data from nine 911 call centers and, based on call codes alone, estimated that only 1.3 percent of calls for service involved “mental distress.” Koziarski, Ferguson & Huey, *supra* note 86, examined all calls for service (42,996) in 2019 from a municipal police service in Canada. While only 0.9% of calls were coded as “mental health,” an examination of text appended to calls for service indicated that 10.8 percent of calls involved people with mental illnesses. Similarly, Mitchell, Wire & Balog, *supra*, examined 2019 call for service data, which included codes and text from the Burlington Police Department in North Carolina. They concluded that relying on initial call codes led to significant undercounting of mental health-related calls for service. Acknowledging their approach to counting mental health related calls is imperfect (perhaps still resulting in undercounting) they do not present an overall estimate of the percentage of mental health-related calls in their paper. However, they identified 2,398 mental health-related calls, compared to the 1,007 identified based on call codes alone, in a total of 60,662 valid calls for service, or approximately four percent. Discrepancies between the two studies that looked further than initial call codes could be the result of different definitions (calls involving persons with mental illnesses versus mental health-related calls) or true differences between the locations in calls for service.

89. Jeffrey S. Hoch, Kathleen Hartford, Lisa Heslop & Larry Stitt, *Mental Illness and Police Interactions in a Mid-Sized Canadian City: What the Data Do and Do Not Say*, 28 CAN. J. COMTY. MENTAL HEALTH 49, 50 (2009).



### C. Negative Consequences

Police contact can result in a variety of negative consequences for people with mental illnesses that include arrest, injury, and death, and negative mental health consequences. The likelihood of arrest and experiencing negative consequences of police interaction are even greater for Black persons. There is evidence that people with serious mental illnesses are significantly overrepresented among arrestees; they are three times more likely to be arrested compared to the general population.<sup>90</sup> One in four people with serious mental illness report at least one lifetime arrest, with factors associated with arrest including male gender, Black race, bipolar disorder or manic symptoms, involuntary hospitalization, substance use problems, unemployment, low socio-economic status, and homelessness.<sup>91</sup> As a result, they are significantly over-represented in jail and prison populations, and, once they enter the criminal legal system, they stay longer than people without mental illnesses.<sup>92</sup>

People with mental illness are also at elevated risk of having force used on them, being injured, and being killed in police encounters. Laniyonu and Goff examined police uses of force and injuries across nine cities, finding people with serious mental illnesses were twelve times more likely to have force used and ten times more likely to be injured than people without serious mental illnesses.<sup>93</sup> Similarly, Rossler found police used higher levels of force with people with serious mental illness; however, this did not result in higher levels of injury.<sup>94</sup> Furthermore, cases involving police responses to people experiencing mental distress may be more likely to have electronic control devices used on them and to be subjected to more shocks than cases that involve the arrest for a criminal offense.<sup>95</sup> Most tragically, at least one in four people killed in interactions with police display signs of mental illness, and among those killed, those with mental illnesses are more likely to be killed in their homes and to not have a firearm. African Americans displaying signs of mental illness have the highest death rates in police encounters.<sup>96</sup>

---

90. *Id.* See also Lauren A. Magee et al., *Two-Year Prevalence Rates of Mental Health and Substance Use Disorder Diagnoses Among Repeat Arrestees*, 9 HEALTH & JUST., Jan. 2022, at 2.

91. Livingston, *supra* note 51, at 851–53.

92. Magee et al., *supra* note 90, at 5–9; Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVS. 761, 761 (2009); Seth J. Prins, *Does Transinstitutionalization Explain the Overrepresentation of People with Serious Mental Illnesses in the Criminal Justice System?*, 47 CMTY. MENTAL HEALTH J. 716, 720 (2011).

93. See generally Ayobami Laniyonu & Phillip Atiba Goff, *Measuring Disparities in Police Use of Force and Injury Among Persons with Serious Mental Illness*, 21 BMC PSYCHIATRY 4 (Oct. 21, 2021), <https://bmcp psychiatry.biomedcentral.com/articles/10.1186/s12888-021-03510-w> [https://perma.cc/3E7S-EHHT].

94. Michael T. Rossler & William Terrill, *Mental Illness, Police Use of Force, and Citizen Injury*, 20 POLICE Q. 189, 192–93 (2017).

95. Nutmeg Hallett et al., *Taser Use on Individuals Experiencing Mental Distress: An Integrative Literature Review*, 28 J. PSYCHIATRIC MENTAL HEALTH NURSING 56, 65–66 (2020).

96. Amam Z. Saleh et al., *Deaths of People with Mental Illness During Interactions with Law Enforcement*, 58 INT'L J.L. & PSYCHIATRY 110, 114 (2018).

In studies that have examined the experiences of people with serious mental illnesses in police encounters, such people report negative experiences.<sup>97</sup> They report feeling extremely vulnerable and fear being hurt or killed or unjustly arrested; also, consistent with procedural justice theory, they indicate how officers treat them matters in terms of their experience of the encounter and the extent to which they cooperate with the officer.<sup>98</sup> Several qualitative studies suggest youth and adults with mental illnesses and their family members find police involvement in mental health crisis to be stigmatizing, humiliating, and traumatic.<sup>99</sup>

A growing body of research suggests that police contact itself results in negative mental health consequences, particularly for young men of color.<sup>100</sup> Geller and colleagues found police contact to be associated with anxiety and trauma symptoms that increased with the number of police stops in a sample of predominantly persons of color.<sup>101</sup> Examining exposure to police violence among adults in Baltimore and New York, DeVlyder and colleagues found the highest exposures among men, people of color, and those identifying as homosexual and transgender. Additionally, there was an association between recent exposure and psychotic experiences, suicide ideation, and suicide attempts. Experiences of all forms of police violence were associated with subsequent psychotic experiences, with a linear dose effect. The authors argue that police victimization is experienced as social defeat, which may elevate risk for psychotic experiences among vulnerable individuals.<sup>102</sup> In an invited commentary in the same issue of *Schizophrenia Bulletin*, Swanson points out the limitations of DeVlyder and colleagues' cross sectional survey for drawing causal conclusions and suggests potential alternative explanations. However, he does acknowledge the potential harms of police encounters, indicating, “[w]hatever the causal model, the stress

---

97. James D. Livingston et al., *Perceptions and Experiences of People with Mental Illness Regarding their Interactions with Police*, 37 INT'L J.L. & PSYCHIATRY 334, 335 (2014).

98. Amy C. Watson & Beth Angell, *The Role of Stigma and Uncertainty in Moderating the Effect of Procedural Justice on Cooperation and Resistance in Police Encounters with Persons with Mental Illnesses*, 19 PSYCH., PUB. POL'Y, & L. 30, 31 (2013); Amy C. Watson, Beth Angell, Melissa Schaefer Morabito & Noel Robinson, *Defying Negative Expectations: Dimensions of Fair and Respectful Treatment by Police Officers as Perceived by People with Mental Illness*, 35 ADMIN. & POL'Y MENTAL HEALTH & MENTAL HEALTH SERVS. RSCH. 449, 455–56 (2008).

99. Joanne Bradbury, Marie Hutchinson, John Hurley & Helen Stasa, *Lived Experience of Involuntary Transport Under Mental Health Legislation*, 26 INT'L J. MENTAL HEALTH NURSING 580, 580 (2017); Alice Brennan et al., *Collaboration in Crisis: Carer Perspectives on Police and Mental Health Professional's Responses to Mental Health Crises*, 25 INT'L J. MENTAL HEALTH NURSING 452, 452 (2016); Nev Jones et al., *Youths' and Young Adults' Experiences of Police Involvement During Initiation of Involuntary Psychiatric Holds and Transport*, 73 PSYCHIATRIC SERVS. 912 (2021).

100. Rod K. Brunson & Ronald Weitzer, *Police Relations with Black and White Youths in Different Urban Neighborhoods*, 44 URB. AFFS. REV. 858, 879 (2009).

101. Amanda Geller, Jeffrey Fagan, Tom Tyler & Bruce G. Link, *Aggressive Policing and the Mental Health of Young Urban Men*, 104 AM. J. PUB. HEALTH 2321, 2324–25 (2014).

102. Jordan E. DeVlyder et al., *Psychotic Experiences in the Context of Police Victimization: Data from the Survey of Police–Public Encounters*, 43 SCHIZOPHRENIA BULL. 993, 993 (2017); Jordan E. DeVlyder et al., *Association of Exposure to Police Violence with Prevalence of Mental Health Symptoms Among Urban Residents in the United States*, 1 JAMA NETWORK OPEN art. no. e184945, at 1 (2018).

of encounters with police is likely to be a very salient risk factor across the spectrum of psychotic experience, and may have severe consequences in persons with mental disorders.”<sup>103</sup>

#### D. Strategies to Improve Police Response

Over the past thirty years, strategies to improve how police respond to mental health crises have been developed and implemented in communities across the country, most often following the killing by police of a person experiencing a mental health crisis.<sup>104</sup> A common element of these programs is a partnership between law enforcement and mental health services.

##### 1. The Crisis Intervention Team Model (CIT)

The Crisis Intervention Team model was developed in 1988 following the fatal shooting of a Black man experiencing a mental health crisis by a Memphis police officer.<sup>105</sup> The foundation of the model is partnerships between police, mental health providers and advocates that work together to train officers to safely and compassionately respond to individuals experiencing crisis and to strengthen the crisis response system.<sup>106</sup> CIT training is a forty-hour training for officers that includes content on signs and symptoms of mental illnesses, co-occurring disorders, de-escalation techniques, and local resources.<sup>107</sup> Significant time is devoted to role play scenarios to allow participants to practice CIT skills.<sup>108</sup> The training includes sessions delivered by people with lived experience and their family members, mental health professionals, and law enforcement trainers.<sup>109</sup> According to the model, officers should self-select into the CIT officer specialist role; however, many agencies are now mandating CIT training for all officers.<sup>110</sup>

A growing body of research on CIT supports the effectiveness of the training for improving officer knowledge, attitudes, confidence, and de-escalation decisions, and these effects are strongest when officers volunteer or self-select

---

103. Jeffrey W. Swanson, *Alternative Perspectives on Police Encounters and Psychotic Experiences [Invited Commentary on DeVlyder et al., “Psychotic Experiences in the Context of Police Victimization”]*, 43 SCHIZOPHRENIA BULL. 946, 947 (2017).

104. See, for example, the development of Crisis Intervention Teams, discussed *infra*.

105. Mark R. Munetz & Natalie Bonfine, *Crisis Intervention Team Program Leadership Must Include Psychiatrists*, 24 AM. MED. ASS’N J. ETHICS 154, 154 (2022).

106. Amy C. Watson, Melissa Schaefer Morabito, Jeffrey Draine & Victor Ottati, *Improving Police Response to Persons with Mental Illness: A Multi-Level Conceptualization of CIT*, 31 INT’L J.L. & PSYCHIATRY 359, 362–63 (2008).

107. *Id.*

108. *Id.*

109. LAURA USHER ET AL., CIT INT’L, CRISIS INTERVENTION TEAM (CIT) PROGRAMS: A BEST PRACTICE GUIDE FOR TRANSFORMING COMMUNITY RESPONSES TO MENTAL HEALTH CRISES (2019), <https://www.citiinternational.org/resources/Best%20Practice%20Guide/CIT%20Guide%20Interactive%20Web%20Version%20Final.pdf> [https://perma.cc/7XM9-RJGN].

110. See Watson et al., *supra* note 106, at 361.

into the CIT role.<sup>111</sup> Research on CIT's effectiveness for reducing uses of force against persons experiencing a mental health crisis or in reducing arrests has not found consistent effects.<sup>112</sup> However, multiple studies support the effectiveness of CIT training and program implementation for increasing linkages to mental health care.<sup>113</sup> This research suggests that though CIT implementation alone may not address all of the concerns outlined herein, it does offer benefits, particularly when coupled with investment in mental health resources.

## 2. Co-Responder Models

The co-responder model typically pairs a clinician with a police officer to provide responses to mental health crisis calls.<sup>114</sup> While more common in Canada, the United Kingdom, and Australia, this model is rapidly gaining popularity in the United States.<sup>115</sup> Systematic reviews of the co-responder literature suggest significant variation on how co-responder teams operate.<sup>116</sup> In some communities, the officer and clinician ride together in a patrol car; in others, they ride separately; and in still others, the officer responds to the scene and the clinician provides telephonic support.<sup>117</sup> There is also variation in terms of when the co-responder team responds. In some communities, the team is dispatched to "hot calls" as the first response; in others, they are a secondary response at the

---

111. Compton et al., *Police Officers' Volunteering for (Rather than Being Assigned to) Crisis Intervention Team (CIT) Training: Evidence for a Beneficial Self-Selection Effect*, 35 BEHAV. SCI. & L. 470, 476–78 (2017).

112. See Amy C. Watson, Michael T. Compton & Jeffrey N. Draine, *The Crisis Intervention Team (CIT) Model: An Evidence-Based Policing Practice?*, 35 BEHAV. SCI. & L. 431, 435 (2017) (discussing different studies analyzing CIT's effectiveness in reducing force against individuals experiencing a mental health crisis).

113. Michael T. Compton et al., *The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest*, 65 PSYCHIATRIC SERVS. 523, 527–28 (2014); Amy C. Watson, Linda K. Owens, Jennifer Wood & Michael T. Compton, *The Impact of Crisis Intervention Team Response, Dispatch Coding, and Location on the Outcomes of Police Encounters with Individuals with Mental Illnesses in Chicago*, 15 POLICING: J. POL'Y & PRACTICE 1948, 1949 (2021); Sheryl Kubiak et al., *Countrywide Implementation of Crisis Intervention Teams: Multiple Methods, Measures and Sustained Outcomes*, 35 BEHAV. SCI. & L. 456, 458 (2017); Jennifer L. S. Teller, Mark R. Munetz, Karen M. Gil & Christian Ritter, *Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls*, 57 PSYCHIATRIC SERVS. 232, 235–36 (2006); Amy C. Watson et al., *Outcomes of Police Contacts with Persons with Mental Illness: The Impact of CIT*, 37 ADMIN. & POL'Y MENTAL HEALTH & MENTAL SERVS. RSCH. 302, 313 (2010).

114. ASHLEY KRIDER & REGINA HUETTER, POL'Y RSCH., INC., RESPONDING TO INDIVIDUALS IN BEHAVIORAL HEALTH CRISIS VIA CO-RESPONDER MODELS 4 (Jan. 2020), <https://www.theiacp.org/sites/default/files/SJCResponding%20to%20Individuals.pdf> [<https://perma.cc/L5FC-T9VB>].

115. Natania Marcus & Vicky Stergiopoulos, *Re-examining Mental Health Crisis Intervention: A Rapid Review Comparing Outcomes Across Police, Co-Responder and Non-Police Models*, 30 HEALTH & SOC. CARE CMTY. 1665, 1668 (2022).

116. Stephen Puntis et al., *A Systematic Review of Co-Responder Models of Police Mental Health 'Street' Triage*, 18 BMC PSYCHIATRY, Aug. 15, 2018, at 9–10, <https://bmcpsy psychiatry.biomedcentral.com/articles/10.1186/s12888-018-1836-2> [<https://perma.cc/U4WL-QMCF>].

117. KRIDER & HUETTER, *supra* note 114, at 4.

request of a patrol officer; and in others they primarily conduct follow up visits.<sup>118</sup> Research to date suggests that stakeholders find the co-responder model acceptable and preferable to police alone response.<sup>119</sup> There is also evidence that the model may reduce unnecessary emergency department transports and increase service use following the initial contact, reduce short term incarceration risk, and reduce use of force in situations involving suicidal persons.<sup>120</sup>

### 3. Non-Police or Police-Alternative Mobile Crisis Responses

In the wake of the George Floyd murder, demands to reduce the footprint of police have led to many communities experimenting with response models that do not include police officers.<sup>121</sup> These programs are referred to as non-police or police-alternative responses. Like the co-responder model, there is significant variation in such programs; however, most programs are loosely based on the Crisis Helping Out on the Streets (CAHOOTS) model that has been operating in Eugene, Oregon since the late 1980s.<sup>122</sup> Operating out of the Whitebird Clinic, CAHOOTS teams include a bachelor's degree level crisis worker and an EMT or nurse medic that carry police radios and are dispatched via the Eugene emergency communications center.<sup>123</sup> The teams respond to behavioral health and social vulnerability-related calls for service.<sup>124</sup> While there has not been an external evaluation published, the Eugene Police Department analysis of program data suggests five to eight percent of calls for service that would have otherwise been handled by police are diverted to the CAHOOTS team.<sup>125</sup> Of the 18,106 calls dispatched directly to the CAHOOTS team in 2021, only two percent

---

118. See e.g., Josh Wood, *The US Police Department that Decided to Hire Social Workers*, GUARDIAN (Sept. 19, 2020), <https://www.theguardian.com/us-news/2020/sep/19/alexandria-kentucky-police-social-workers> [<https://perma.cc/7ELN-SG9Y>] (reporting that in Lexington, Kentucky, social workers are dispatched to follow-up on calls after police have responded).

119. G. K. Shapiro et al., *Co-responding Police-Mental Health Programs: A Review*, 42 ADMIN. & POL'Y MENTAL HEALTH & MENTAL HEALTH SERVS. RSCH. 606, 614 (2015).

120. Puntis et al., *supra* note 116, at 7; Shapiro et al., *supra* note 119, at 607–08; Katie Bailey et al., *Evaluation of a Police–Mental Health Co-Response Team Relative to Traditional Police Response in Indianapolis*, 73 PSYCHIATRIC SERVS. 366, 372 (2022); Etienne Blais & David Brisebois, *Improving Police Responses to Suicide-Related Emergencies: New Evidence on the Effectiveness of Co-Response Police-Mental Health Programs*, 51 AM. ASS'N SUICIDOLOGY 1095, 1101–03 (2021).

121. Taleed El-Sabawi & Jennifer J. Carroll, *A Model for Defunding: An Evidence-Based Statute for Behavioral Health Crisis Response*, 94 TEMP. L. REV. 1, 61 (2021).

122. See, e.g., *Support Team Assisted Response (STAR)*, WELLPPOWER, <https://www.wellpower.org/star-program> [<https://perma.cc/A2BU-JWYT>] (last visited Oct 5, 2022) (outlining Denver's STAR program).

123. *Id.*; WHITE BIRD CLINIC, CRISIS ASSISTANCE HELPING OUT ON THE STREETS (CAHOOTS) MEDIA GUIDE 1–2 (2020), <https://whitebirdclinic.org/wp-content/uploads/2020/06/CAHOOTS-Media-Guide-20200624.pdf> [<https://perma.cc/TA36-RP9F>]. CAHOOTS also assists the police department in Springfield, Oregon. *Id.*

124. *Id.* at 2. Such calls include welfare checks (indicated in 32.5 percent of diverted calls), transportation to social or medical services (indicated in 34.8 percent of diverted calls), and public assistance (indicated in 66.3 percent of diverted calls).

125. *Id.*

required police back-up, indicating that non-police teams can be deployed safely.<sup>126</sup>

Loosely based on CAHOOTs, Denver STAR pairs a master's level clinician with a paramedic or EMT to respond to low-risk calls where individuals are not in imminent risk such as situations involving trespass, welfare checks, or mental health crises<sup>127</sup> In the first year of the program, STAR responded to 1,396 calls with no arrests, injuries or calls for police backup. The only peer reviewed study of a community responder team to date examined the first six months of the STAR program.<sup>128</sup> During the study period, STAR responded to 748 incidents, two thirds were direct dispatches and one third were at the request of police.<sup>129</sup> Examining arrest data for the police precincts for the six months before and six months after implementation, the authors found a thirty-four percent reduction in reports of low-level crimes such as trespassing, public disorder, and resisting arrest.<sup>130</sup>

In sum, efforts to improve responses to mental health crises in the community include developing partnerships between law enforcement and mental health services, providing training to officers, adding clinicians to police teams, and developing response options that do not include police officers. While arguments can be made that each reform is an improvement on traditional police response, and that in some instances, police involvement is necessary due to safety or criminal concerns, strong arguments can be made for the need to reduce the footprint of police officers, particularly in Black communities and other communities of color. The development of a non-police response for at least a subset of mental health or social welfare-related calls is warranted.<sup>131</sup>

#### IV

#### EFFORTS TO REBALANCE THE POLICE ROLE

The murder of George Floyd, Walter Wallace, Daniel Prude, and so many other people of color experiencing mental health crises, combined with renewed attention to mental health spurred by the COVID-19 pandemic, has brought new demands for and opportunities to shift primary responsibility for mental health crisis response away from police. These opportunities exist at the local, state, and federal level, and include the allocation of resources and the leveraging of the ADA.

---

126. *Id.*

127. *Id.*

128. Thomas S. Dee & James Pine, *A Community Response Approach to Mental Health and Substance Abuse Crises Reduced Crime*, 8 SCI. ADVANCES, no. 23, 2022, at 6–8.

129. *Id.*

130. *Id.*

131. See El-Sabawi & Carroll, *supra* note 121, at 8. See also April Shaw & Taleed El-Sabawi, *To Promote Health Equity, States Must Restrict Police Intervention in Mobile Crisis Response*, BILL OF HEALTH (Mar. 31, 2022), <http://blog.petrieflom.law.harvard.edu/2022/03/31/to-promote-health-equity-states-must-restrict-police-intervention-in-mobile-crisis-response/> [<https://perma.cc/CCS8-PVM2>] (detailing, for example, how police are more likely to use fatal force against unarmed Black men displaying signs of mental illness than against unarmed white men).

### A. State Reform Efforts

Several states have moved to pass legislation requiring the development of mental health system resources that reduce reliance on police for mental health crisis response. The Illinois Community Emergency Services and Support Act (CESSA) requires the Illinois Department of Human Services Division of Mental Health to develop twenty-four hour, seven day a week mobile crisis team capacity throughout the State.<sup>132</sup> It prohibits law enforcement response to behavioral health crises unless (1) the individual in crisis is suspected of having committed a crime or (2) presents a threat of physical injury to self or others.<sup>133</sup> The Act does permit law enforcement actors to position themselves nearby—at the request of responders—so as to intervene if needed, though the Act encourages officers to remain out of sight of the individual in crisis.<sup>134</sup> The Act also makes clear that the fact that someone is experiencing a behavioral health emergency is not enough to assume that the person is a danger to themselves or others or to require police transport to appropriate services.<sup>135</sup> The shift to mobile crisis team response will be facilitated by the transfer of mental health-related calls from 911 call centers to 988 call centers that will have the ability to activate local mobile crisis teams. The law requires full implementation by July 1, 2023.<sup>136</sup>

Named in honor of a Black high school teacher that was killed by police while experiencing a mental health crisis in 2018, the Marcus David Peters Act of 2020 in Virginia was designed to ensure that a behavioral health crisis gets a behavioral health response.<sup>137</sup> The Act mandates the development of a crisis continuum and interconnections between 911 and behavioral health services.<sup>138</sup> The Act anticipates that the majority of mental health-related 911 calls will be diverted to the 988 system and requires the development of local protocols for mobile crisis response to behavioral health crises whenever possible. Additional components of the Act include the MARCUS alert system, which provides mental health information and emergency contact information for response to an emergency or crisis, formal agreements between regional behavioral health crisis hubs and law enforcement, and the requirement that law enforcement agencies have specialized responses to behavioral health calls.<sup>139</sup>

---

132. Community Emergency Services and Support Act, 2021 Ill. Legis. Serv. 102-580 (West).

133. *Id.*

134. 50 ILL. COMP. STAT. ANN. 754/30 (2022).

135. *Id.*

136. 50 ILL. COMP. STAT. ANN. 754/65 (2022).

137. *The Marcus-David Peters Act*, VA. DEPT' OF BEHAV. HEALTH & DEV. SERV., <https://dbhds.virginia.gov/human-resource-development-and-management/health-equity/mdpa/> [<https://perma.cc/36CE-KV3V>] (last visited Jan. 13, 2023).

138. H.B. 5043, 161st Leg., 1st Spec. Sess. (Va. 2020).

139. Stephanie Hepburn, *Virginia Develops Statewide 911 Call Matrix to Divert Mental Health and Substance Use Crises*, #CRISIS-TALK (May 17, 2022), <https://talk.crisisnow.com/virginia-develops-statewide-911-call-matrix-to-divert-mental-health-and-substance-use-crises/> [<https://perma.cc/4ZCS-BRNL>].

Several key challenges will need to be addressed for successful implementation of these state legislative efforts. Triage protocols must be developed to identify 911 calls that can be transferred to non-law enforcement response resources. Such protocols will need to be tailored based on local conditions, including the response capacity, training, and make-up of local mobile crisis teams. Further, the existing mobile crisis workforce may not be sufficient to respond to the expanded demand and may not be prepared to take on calls previously handled by police. Thus, attention to workforce preparation and capacity expansion will be needed.

## B. Federal Efforts to Support Mental Health Crisis Response Reforms

While decisions to reform emergency response to mental health emergencies often occur at state and local levels, recognition of the frequency of police encounters involving people with mental illnesses and the negative impacts on individuals, families, and systems has led to significant federal policy attention and investment over the past two decades. This federal response has included grant funding ear-marked at improving police response, the enactment of federal laws that offer greater protections to persons with mental disabilities, and the increased enforcement of federal laws.

### 1. Funding

Much of the work across the country to expand the availability of non-law enforcement crisis services has been facilitated by federal resources supporting the implementation of the National Suicide Hotline Designation Act.<sup>140</sup> The Act amended the Communications Act of 1934 to designate 988 as the universal telephone number to reach the National Suicide Prevention Lifeline.<sup>141</sup> While the legislation allows states to assess cell phone bill surcharges to support 988 call centers and crisis-related services, by the July 2022 launch only four states had done so.<sup>142</sup> The American Rescue Plan provided \$105 million to states and territories via SAMHSA to support the transition to 988 and support call center infrastructure.<sup>143</sup> Additional ARPA funding is being provided to states to create or enhance existing mobile crisis services.<sup>144</sup> Multiple bills have been introduced in Congress that would provide additional resources to build crisis systems and

---

140. National Suicide Hotline Designation Act of 2020, Pub. L. No. 116-172, 134 Stat. 832.

141. ARLENE HAHN STEPHENSON, STATES' EXPERIENCES IN LEGISLATING 988 AND CRISIS SERVICES SYSTEMS 5 (2022).

142. *Id.* at 6.

143. *As Part of President Biden's Mental Health Strategy, HHS Awards Nearly \$105 Million to States and Territories to Strengthen Crisis Call Center Services in Advance of July Transition to 988*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Apr. 19, 2022), <https://www.samhsa.gov/newsroom/press-announcements/20220419/hhs-awards-105-million-states-territories-strengthen-crisis-call-center-services> [https://perma.cc/DGA5-87EC].

144. *Cooperative Agreements for Innovative Community Crisis Response Partnerships*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/grants/grant-announcements/sm-22-016> [https://perma.cc/U4Z5-M9YJ] (last updated June 17, 2022).



mobile crisis capacity, including legislation that would require private insurers to cover mobile crisis services.<sup>145</sup>

The Mentally Ill Offender Treatment and Crime Reduction Act of 2004, including its re-authorization in 2008 and amendment in the 21<sup>st</sup> Century CURES Act of 2016, funds the Bureau of Just Assistance (BJA) Justice and Mental Health Collaboration Program (JMHP), which provides grant funds to communities to support mental health and criminal justice system collaborations to improve the criminal justice system's ability to serve people with mental illnesses.<sup>146</sup> The policing component of this work has focused on collaborations and training to improve the ability of police to safely resolve encounters with people experiencing mental health crises.<sup>147</sup>

More recently, BJA and the Community Oriented Policing Services (COPS) office have funded resources supporting communities in developing co-responder teams that pair a clinician with an officer to respond to mental health crisis calls.<sup>148</sup> It is only following the murder of George Floyd that BJA has included police alternative or non-police mobile crisis response teams as eligible for funding with the JMHP grant mechanism.<sup>149</sup> It is not surprising or even inappropriate that agencies such as BJA and the COPS Office have focused their funding efforts on improving the criminal justice system response to people with serious mental illnesses. Yet, what is notable is the historical lack of parallel attention from federal mental health agencies on expanding the capacity of the mental health system to provide mental health crisis response and serve people with mental illnesses that are justice-system involved.

## 2. Federal Enforcement Efforts

The Civil Rights Act of 1957 created the Civil Rights Division of the Department of Justice (DOJ), which was tasked with enforcing federal statutes that prohibit discrimination based on protected categories, including disability.<sup>150</sup> The Disability Rights Section of the DOJ enforces the ADA, Section 504 of the Rehabilitation Act, and other federal laws governing protections for persons with

---

145. See e.g., Behavioral Health Crisis Services Expansion Act, H.R. 1902, 117th Cong. (2021) (proposing a bill “[t]o empower communities to establish a continuum of care for individuals experiencing mental or behavioral health crisis, and for other purposes”); CAHOOTS Act, H.R. 764, 117th Cong. (2021) (proposing a bill “[t]o amend title XIX of the Social Security Act to encourage State Medicaid programs to provide community-based mobile crisis intervention services, and for other purposes”).

146. *Justice and Mental Health Collaboration Program (JMHP), Overview*, BUREAU OF JUST. ASSISTANCE (May 12, 2022), <https://bja.ojp.gov/program/justice-and-mental-health-collaboration-program-jmhcp/overview> [https://perma.cc/ZNH8-2GLB].

147. *Id.*

148. *BJA FY 2022 Connect and Protect: Law Enforcement Behavioral Health Response Program*, BUREAU OF JUST. ASSISTANCE (Apr. 1, 2022), <https://bja.ojp.gov/funding/opportunities/o-bja-2022-171076> [https://perma.cc/9NED-6WCF].

149. *Id.*

150. *Id.*

disabilities.<sup>151</sup> For example, in 2010, the DOJ used its enforcement power to intervene in a private suit; the DOJ filed a Statement of Interest clarifying that the ADA required police officers to provide reasonable accommodations to persons with mental illness disabilities during “on-the-street encounters” and arrest.<sup>152</sup>

In 1994, Congress passed the Violent Crime Control and Law Enforcement Act, 42 U.S.C 14141, which gave the DOJ authority to investigate patterns and practices of law enforcement agencies that may be violating people’s federal rights. The Special Litigation Division, a subsection of the Civil Rights Division of the DOJ, which oversees these investigations, can also investigate patterns of discrimination pursuant to the Omnibus Crime Control and Safe Streets Act of 1968 and Title VI of the Civil Rights Act of 1964 for law enforcement agencies receiving federal funds.<sup>153</sup> Pursuant to this authority, the DOJ has investigated and found numerous police departments to have engaged in a pattern or practice of violating Constitutional or federal rights.<sup>154</sup> Several of the resulting consent decrees and or settlement agreements have addressed reforms related to police response to people with mental illnesses and or those experiencing mental health crisis.<sup>155</sup> For example, the DOJ settlement agreement with the City of Portland, following a finding of a pattern and practice of excessive use of force against people experiencing mental health crises, addresses police training and protocols related to mental health crisis response and requires the city to engage with community mental health organizations to design a better system of care and reduce the involvement of burden on law enforcement.<sup>156</sup>

### 3. Individual Rights of Action Pursuant to Federal Law

In addition to the DOJ having authority to enforce the ADA, individuals have private rights of actions pursuant to the ADA. Additionally, Section 1983 of Title 42 of the United States Code gives individuals the right to file lawsuits for civil rights violations against local government employees—or others acting “under color of state law”—including police officers.<sup>157</sup> However, qualified

---

151. Exec. Order No. 12,250, 45 Fed. Reg. 72995 (Nov. 2, 1980).

152. *Sage v. City of Winooski*, Case No. 2:16-cv-116, 2017 WL 1100882, at \*7 (D. Vt. 2017).

153. *Conduct of Law Enforcement Agencies*, U.S. DEP’T OF JUST., <https://www.justice.gov/crt/conduct-law-enforcement-agencies> [<https://perma.cc/3DAS-5XMK>] (last updated July 28, 2022).

154. *See Special Litigation Section Cases and Matters*, U.S. DEP’T OF JUST., <https://www.justice.gov/crt/special-litigation-section-cases-and-matters/download> [<https://perma.cc/PT2X-BAK8>] (last visited Oct. 5, 2022) (summarizing findings of constitutional violations in various states and territories).

155. *See generally* U.S. DEP’T OF JUST., *THE CIVIL RIGHTS DIVISION’S PATTERN AND PRACTICE POLICE REFORM WORK: 1994-PRESENT* (2017).

156. Proposed Settlement Agreement at 59, *United States v. City of Portland*, Case No. 3:12-cv-02265-SI (D. Ore. 2013).

157. 42 U.S.C. § 1983.

immunity may still be raised by police officers as a defense in Section 1983 cases.<sup>158</sup>

The Supreme Court has not explicitly addressed whether the ADA requires police to provide reasonable accommodations during arrests. In *City & County of San Francisco California v. Sheehan*, the Supreme Court reviewed a case involving a claim that the ADA applied to arrests, but rather than rule on the ADA claim, the Court focused its analysis on whether the Ninth Circuit erred in denying the police officer's qualified immunity defense.<sup>159</sup> The ADA has also been the basis of lawsuits addressing police response to people with mental illnesses. In August of 2008, San Francisco police officers were called to a group home to transfer Theresa Sheehan to a psychiatric hospital after Sheehan refused to provide group home staff with entry into her private room.<sup>160</sup> Sheehan reportedly said, "Get out of here! You don't have a warrant! I have a knife, and I'll kill you if I have to."<sup>161</sup> Group home staff reported being concerned because Sheehan had stopped taking her medications and was deteriorating.<sup>162</sup> This led the counseling supervisor to certify that Sheehan required emergency short term hospitalization.<sup>163</sup> Though the San Francisco Police Department's training and standards instructed police officers to call a negotiator to attempt to negotiate a surrender when someone barricades themselves inside a room, police officers entered the room twice, pepper-spraying and shooting Sheehan five times at close range.<sup>164</sup> The Court held that the police officers were entitled to qualified immunity, overruling the Ninth Circuit's holding that qualified immunity was barred because the officers intentionally or recklessly "provoked" the violent confrontation.<sup>165</sup>

There are also indications that the ADA will be useful in leveraging the development of mental health service capacity and to reduce the reliance on police. For example, in May of 2022, the DOJ announced an investigation under the ADA that will "examine whether Kentucky unnecessarily segregates people with serious mental illness in psychiatric hospitals and places them at risk of law enforcement encounters by failing to provide integrated community-based mental health services needed to avoid these results."<sup>166</sup>

---

158. *Pierson v. Ray*, 386 U.S. 547, 555–56 (1967).

159. *City of San Francisco v. Sheehan*, 575 U.S. 600, 603 (2015).

160. *Id.* Group home staff reported being concerned because Sheehan had stopped taking her medications and was deteriorating. This led the counseling supervisor to certify that Sheehan required emergency short term hospitalization. *Id.*

161. *Id.*

162. *Id.*

163. *Id.*

164. John E. Oliver, *Law Enforcement Intervention in Mental Health Crises: The Legal Standards for Officer Conduct After the Supreme Court's Decision in Sheehan v. City and County of San Francisco*, 34 DEVS. MENTAL HEALTH L., July 2015, at 3–4.

165. *Id.*

166. *Justice Department Launches Civil Rights Investigation into Kentucky's Mental Health Service System*, U.S. DEP'T OF JUST. (May 24, 2022), <https://www.justice.gov/opa/pr/justice-department-launches-civil-rights-investigation-kentucky-s-mental-health-service-0> [<https://perma.cc/JKS5-HB4Q>].

## V

## CONCLUSION

The historic reliance on police to respond to people experiencing mental health crises in the community emerged due to a confluence of factors largely rooted in society's neglect of people with serious mental illnesses and racism. The fact that it took fifty-plus years for dissatisfaction with this arrangement to reach a boiling point and promote meaningful action speaks to the entrenchment of stigma and racism in our social structures. There will continue to be a role for police in mental health crisis response when significant safety or criminal concerns are present. Agencies must ensure their officers are prepared to respond safely and effectively. However, instead of focusing primarily on making police and the criminal legal system better at responding to people with mental illnesses, it is time to shift attention and resources to building the capacity of the mental health system to address the needs of people with mental illnesses and those experiencing mental health crises. Marvin Swartz suggests:

As the field struggles with addressing systemic racism, a tangible first step is to commit to minimize law enforcement involvement in mental health crises and involuntary commitment. When law enforcement officers are the first responders in a large proportion of mental health crises, something has badly gone awry. To be concrete: a key performance measure for state and local mental health authorities should be the proportion of mental health crises that rely on law enforcement.<sup>167</sup>

Tools to leverage this shift are being utilized at both the state and federal level, providing an opportunity for significant improvements in mental health crisis response. There is, however, a risk that we will develop non-police responses that primarily benefit white communities while continuing to send police to Black and brown communities based on deeply entrenched biases. It is critical that we monitor these efforts to ensure they benefit communities of color at least as much as they benefit white communities. Otherwise, we will increase rather than decrease racial inequities.

---

167. Marvin S. Swartz, *The Urgency of Racial Justice and Reducing Law Enforcement Involvement in Involuntary Civil Commitment*, 71 *PSYCHIATRIC SERVS.* 1211, 1211 (2020).