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BEHAVIORAL HEALTH AND POLICING: INTERACTIONS AND SOLUTIONS

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BEHAVIORAL HEALTH AND POLICING: INTERACTIONS AND SOLUTIONS

THURSDAY, APRIL 22, 2021

UNITED STATES SENATE,
SUBCOMMITTEE ON CRIMINAL JUSTICE
AND COUNTERTERRORISM,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10 a.m., in Room 226, Dirksen Senate Office Building, Hon. Cory A. Booker, Chair of the Subcommittee, presiding.

Present: Senators Booker [presiding], Whitehouse, Padilla, Ossoff, Cotton, and Cornyn.

Also present: Senators Durbin and Blumenthal.

OPENING STATEMENT OF HON. CORY A. BOOKER, A U.S. SENATOR FROM THE STATE OF NEW JERSEY

Chair BOOKER. I am calling this hearing to order. It is exciting for me that I get to be here with Senator Cotton in our first hearing on the Subcommittee on Criminal Justice and Counterterrorism. I want to welcome Ranking Member Cotton and all the Subcommittee Members and thank the witnesses that are here today, both in person—thank you, Kevin—and the virtual witnesses that we will have as well.

I am going to acknowledge in a moment, after I finish my opening remarks, should Senator Grassley show up, and I see Senator Durbin here. We will offer and make time for both of them to give some remarks after Senator Cotton gives some.

I was asked by one of our Subcommittee Members, Senator Klobuchar, who really wanted to be here today, but she is unfortunately at home attending the funeral services of Daunte Wright, who was shot and killed during a traffic stop. She wanted us to express that she is going to be submitting questions for the record.

Right now across our country and in the Senate, we are having a long overdue, absolutely critical conversation about policing in America. I am very grateful over the last weeks to be in good-faith conversations with colleagues of mine across the aisle about a larger bill to try to advance policing in America.

But today we are here on a far more narrow topic, and the purpose of the hearing is to talk about changes we need to make when it comes to how we as an overall society are going to respond to people dealing with mental health crisis and those who behaviorally have disabilities of behavioral health.

By and large, we as a society have failed to provide these individuals with the support services, compassion, and empathy they need to thrive in our communities and live full lives. We see our streets with people experiencing homelessness, our jails and prisons, and we see unfortunately short and tragic deaths of those who are struggling with mental health crises. I have not met a warden, when I go visit jails or police leaders, who have not spoken with compassion and empathy that they are not the ones that should be dealing with this. There should be a better way to help people live healthy lives.

Today we focus in on what is unfortunately too often our society's first real interaction with people with mental health, and it often goes wrong. We are here to talk about how our great police officers try to deal with this issue. It is about how we have made police officers first responders for mental illness, intellectual development, mental disabilities, substance abuse, and people experiencing homelessness. It is about how officers are deeply frustrated and, as is often the case, overwhelmed because they are expected to play the role of social worker, mental health expert, and medical expert when they do not have the training or the skills often to do so. It is about how, for this reason, these encounters can quickly escalate to violence or turn deadly.

One study of shooting data for 2015 found that people with untreated mental illness were 16 times more likely to be killed during a police encounter. The names, many of which we know, of the people who have died because of their encounters: Daniel Prude, Deborah Danner, Marcus-David Peters, and so many more. Often when these deaths occur, I reach out to the police officers I trust in the police department that I oversaw as a mayor. These are great, tough cops, courageous—fearless, in fact—and I ask them: Should those people with mental illnesses have died in those interactions? They all conclude with me very quickly that there should be a better way. We as a society together should be able to avoid these unnecessary deaths.

Public health issues cannot be fixed with a law enforcement response. We must find a different way. What is needed for people who live with mental illness or addiction is help, services, treatment, access to medication, medical treatment, housing, peer support, and more. We know from our experiences of sound law enforcement officers, people on both sides of the aisle, that this should change in our society. We are better than this.

I mentioned my time as mayor of Newark, and I have to say I was elected with a mandate to lower violent crime. My city was experiencing a surge in crime when I became mayor in 2006, so I spent hours and hours and hours riding along with police officers, often until 4 o'clock in the night. I wanted to know the challenges they faced. I wanted to learn their profession as best I could. I rode with them, and I got to know them. Again, I was humbled by their heroism and their service and their sacrifice. I got to know them and their families. I saw their professionalism. I saw how they were willing to take extraordinary risks, often putting themselves squarely into life-threatening situations, to carry out their duties.

Let me tell you right now the job of being a police officer in America is extraordinarily difficult. What made their work harder

was having to answer calls for service that took them to the person in a mental distress and screaming in their home, to the teenager whose mother called 911 because he was erratic and she had no one else to call, to the person experiencing homelessness, struggling with addiction, lying in the street. We were so frustrated, me and my police leadership, that the calls for service kept people chasing what we called queue, chasing call after call as opposed to doing the strategic work we needed to do to solve violent crimes. Unequipped and under-resourced, I saw my officers spend their nights chasing those calls when they could have been more strategically using our manpower as police. Those people who they responded to could have gotten better help that would have prevented them from having encounters with the police in the future.

I want to note that I received several letters from law enforcement leaders that echoed my own experience across the country in advance of this hearing asking, almost pleading, for Congress to fix the problem. I am going to submit those letters for the record, but I want to read just some of the words.

Chair BOOKER. Sheriff Jerry Clayton of Washtenaw County, Michigan, wrote: "I urge the Subcommittee to support and fund additional community-based services for people with mental health and substance use challenges. Too often people in need of treatment end up in our jails. This is not where they belong. Wherever possible, we should make efforts to find ways to provide community-based care without ever connecting with law enforcement."

Chief Shon Barnes of Madison, Wisconsin, wrote: "In this era of police reform, we must all challenge our Government to provide a better level of service to the community. We can no longer simply rely on police responses to mental wellness and must view this issue from a community health perspective. We have seen far too many times the negative results of police-only responses to mental health calls. No person deserves to be imprisoned or harmed by police simply because they have mental wellness challenges."

Chief RaShall Brackney of Charlottesville, Virginia, wrote: "By simply calling 911, a caller unleashes the full power of a system in which few officers are equipped to navigate. The Senate Judiciary Committee has the opportunity to inform the development of a national framework for responding to individuals in crisis. Included in that framework must be a pathway toward decreasing the presence of law enforcement in the mental health response portfolio and for the allocation of funding and resources which build capacity to support community-led continuum of care options which incorporate lived experiences and racial equity into the system."

In the meeting with local police chiefs 2 weeks ago, my colleague, my friend, and my partner in a lot of work here in the Senate, Senator Cornyn, expressed support for specialized training and more social workers and mental health experts so that police can do their jobs and, "keep the bad guys at bay and protect the community." I believe we can find common ground here. I very purposely made this first hearing about something that I thought there was a wide common ground to do. There are so many issues that we as Democrats and Republicans do a good job of delineating our differences. This is something that should rise, I think, more grace

from all of us. How can we come together, right and left, to try to find a way not to rehash our differences, but champion our shared interests and find commonsense solutions? It is time that we go that extra step to end what for many families with someone that has a mental illness in them has been a constant nightmare, fears of what will happen to their family member.

I am grateful to all the witnesses that are here. I hope today we can narrow in not on our differences but to see if we can find some common ground. That is when we as a country move forward, when we find ways to stand together and work together to the benefit of others. It is the calling of our country to lead with that kind of spirit.

I look forward to hearing from everyone. I look forward to a constructive conversation. With that, I am honored to pass it on to my Ranking Member and someone who I have a lot of respect for, Tom Cotton.

**OPENING STATEMENT OF HON. TOM COTTON,
A U.S. SENATOR FROM THE STATE OF ARKANSAS**

Senator COTTON. Thank you, Senator Booker.

Policing is on the minds of many Americans today. It is on their minds because of the relentless coverage of some high-profile situations, but, unfortunately, that coverage often includes falsehoods which can be incendiary, and if repeated often enough, can do significant damage, something that no mere retraction can correct.

There is another reason that many Americans have policing on their minds today. Last year, our Nation experienced the single largest increase in murders ever recorded, a shocking 25 percent surge nationwide. In big cities, it was even worse. Murders rose in Chicago by 65 percent, in New York City by 58 percent, and in Washington, DC, by 40 percent. Major cities additionally suffered the largest rise in aggravated assaults in three decades.

American families and communities also watched in horror as drug overdose deaths rose to the highest level ever in the tragic history of addiction: 88,000 Americans died in just the last 12 months alone from drug overdoses.

Our country also experienced hundreds of violent riots last year that inflicted billions of dollars in damages and wounded more than 2,000 law enforcement officers.

Policing is a dangerous and difficult profession. It often involves individuals, all of whom are imperfect, making split-second decisions with life-and-death consequences. The vast majority of law enforcement interactions involve no use of force, in fact, are cooperative and cordial between law enforcement and citizens. The vast majority of law enforcement officers are good, brave, selfless individuals putting their lives on the line every day to protect their communities. They face tight budgets, long hours, and sometimes public ridicule, all because they dedicate their lives to protecting others.

Nonetheless, we, of course, have understandable concerns about how police interact with the public, including with poor communities, minority communities, and individuals with mental health challenges. Given the potential consequences if an interaction goes poorly, it is no surprise that Republicans and Democrats alike are

interested in finding ways to improve policing and to improve public safety.

Despite bipartisan interest in this issue, we have seen on occasion unfortunate partisan divides that have gotten sharper in recent years. There is perhaps no more visible example of this partisan divide than calls to defund the police. Activists and politicians can mean different things when they use that term. Some, including some lawmakers in Congress, have literally called for the abolition of all law enforcement, although many of these same lawmakers and advocates spend enormous sums of money on their own phalanx of private security bodyguards. Abolishing law enforcement is, of course, a foolish idea that no serious person would ever want to see enacted.

Others say we should not abolish law enforcement altogether, but that we should simply cut their budgets further and rely more on unarmed social workers or mental health workers to intervene in emergency situations. Of course, we need to involve mental health professionals anytime there is a crisis situation where a person can receive treatment from a mental health professional rather than be subject of our law—our criminal justice system. We do not need to ask police officers to also function as psychiatrists, doctors, and educators or to solve every social problem in our society. They are on our streets to enforce our laws and keep our communities safe.

I suspect that most police departments would be glad to have more and better partnerships with mental health providers, as Chairman Booker outlined in some of the letters he introduced. I expect we will hear more about this in the hearing, and I welcome the opportunity to work with my colleagues in a bipartisan fashion to improve the availability of things like de-escalation training, and training on how to recognize and respond to people facing mental health challenges, and to expand partnerships between law enforcement on the one hand and mental and behavioral health providers on the other hand.

The suggestion that mental health professionals can replace the police rather than supplement and support the police is misguided and dangerous. The simple truth is that when law enforcement stands down, when it responds less to what some people would call small or quality-of-life crimes or when the police are defunded, all we get is more crime and more violence.

Let us be clear. Law enforcement is not the enemy, and we should not try to reduce law enforcement either. Not only can the police prevent additional victims, they can also be the opportunity to connect offenders who suffer from mental illness and addiction with the professionals that can give them the care they need.

Almost every day that a police officer puts on their uniform, they help someone on the worst day of that person's life. Our police see the most heart-wrenching tragedies, the most gruesome gore, the most pernicious evils in our society. They are constantly faced with the worst and are always asked to be at their best.

As violent crime and lawlessness continues to increase, we need more police, more resources, and better training, and, yes, more and better partnerships between our police and our behavioral and mental health professionals.

I thank the witnesses for appearing today, and I look forward to hearing their perspectives on this important issue.

Chair BOOKER. Senator Cotton, I am grateful for those remarks, and I would like—now invite and ask Senator Durbin to give some remarks as well, and I am hoping if Senator Grassley is here, he will do the same.

**OPENING STATEMENT OF HON. RICHARD J. DURBIN,
A U.S. SENATOR FROM THE STATE OF ILLINOIS**

Chair DURBIN. Thank you, Senator Booker. I am honored to be here for your first hearing as Chair of the Subcommittee on Criminal Justice and Counterterrorism. In this room today, we are making history. As you take the gavel, you are the first African-American Chair of a Senate Judiciary Committee. This is not only a historic moment; it is long overdue. I could not think of a better person to Chair this Subcommittee. Our work together on the FIRST STEP Act showed you as a real leader when it came to criminal justice reform, and I know you are showing the same leadership when it comes to police reform.

The topic today is one that is near and dear to me. As Senator Cotton noted, there is an abundance and overwhelming evidence of gun violence in the city of Chicago and many cities across the Nation. As a United States Senator, many groups come to me and say, “Well, what are you going to do about it? You are such a hotshot. You are a leader. You are on the Judiciary Committee.” Many times I throw up my hands and think, “If it depends on passing a law, that is so hard to do politically to get anything done in so many different areas.”

I made a trip a few years ago that has really guided me since to the Cook County Juvenile Facility. This facility houses adolescents under the age of 18 who have been accused of gun crimes, many of them murder, and they stay in this facility in downtown Chicago until their trial. Sometimes that is years. We have created a high school in this facility—classrooms, gyms, cafeterias—for these adolescents waiting for trial as they are accused of gun crimes. I sat down with the teachers and counselors at these facilities and said, “Who are these kids? How did they get into this situation, gang members, gun violence? What is this all about?”

Of course, they said there are many avenues and many paths to that outcome, but they said to me, “There is one overwhelming common theme. Over 90 percent of these kids have been the victims of trauma.” Of course, we think of trauma in the physical sense, but it also is in the mental sense. If you go back to ACEs indicator, adverse childhood experiences, a list created many years ago, and realize what can happen to a little kid as they are growing up that has a direct impact on who they will be, what they will do, you find out there is a long, long list.

The second visit I made—and I will make this very brief—was to a public school in Chicago that was going through a program where they were introducing children in the third grade to meditation. I watched as the teacher—I sat in the classroom as the teacher called for a few minutes, 5 minutes, of just silence and reflection and meditation of the class. As I watched and went out in the hallway later, I said, “There was one little boy in there that just could

not settle down, could not quiet down. What is going on, do you know?" "Well, something terrible has happened at his home." I said to the teacher, "So, what are you going to do about it?" She says, "I teach math in third grade. I am not a psychologist."

The issue that I am raising here this morning at the beginning of this hearing, all the issues you have raised are valid issues, but let us not forget the need for mental health counseling for children, intervention in the lives of children. I do not think these kids are lost forever. They need help. They need a mentor. They need somebody who believes in them and who cares, who can turn them to the right path instead of seeing them end up on the wrong path.

I yield.

Chair BOOKER. Senator Grassley is one of the busier men in the U.S. Senate and moves with the indefatigable determination of the Energizer Bunny, so he is not here right now. I invoked Senator Cornyn's name, and I would love to extend the courtesy to Senator Cornyn if you would like to give any introductory remarks.

**OPENING STATEMENT OF HON. JOHN CORNYN
A U.S. SENATOR FROM THE STATE OF TEXAS**

Senator CORNYN. Thank you for the courtesy and the opportunity. I am glad to be here today, and I appreciate you and Senator Cotton convening this hearing.

I think we have all learned a lot in recent years about law enforcement and the role of mental health in that process. I guess one of the people that made the biggest impression on me a few years back was a journalist named Pete Earley, who chronicled his own family's struggle with a son, an adult son, who was mentally ill, but in the process would commit petty crimes and found himself in a jail cell without any real benefit to him or society because that is the only place they knew to put him.

I have been encouraged by the work that we have been able to do here in the Congress, passing things like my Mental Health and Safe Communities Act, offering grants for those police departments that needed help with things like active shooter response, things like de-escalation training and the like. I have been very much encouraged by the crisis intervention teams that are sprouting up in most major cities around the country, including the major cities in my State, and even the advent of things like mental health courts so that, unlike traditional courts that adjudicate guilt or innocence, they literally monitor people once they are released into the public and make sure that they have the support they need and hopefully to deal with their mental health condition and so they do not repeat those offenses and they get the help they need, hopefully to get better.

I will never forget, about 5 years ago now, I think it was, I was in Dallas at a memorial service where five police officers were killed, and Police Chief David Brown at the time, who has since gone to Chicago, he said to me and everyone else there at the time, "We ask the police to do too much." I think we are making progress to try to provide additional resources and a more effective response. Frankly, I do not think it is an either/or proposition. I do not think the question is: Do you support the police or do you support mental health providers? We need to do both, in my view.

I am glad that this Committee and this Congress has been productive in passing things like the Criminal Justice Reform Act that we all worked together on. I am—Senator Whitehouse and I are working on post-release access to services to make sure that people who do go through the programs to deal with their mental health challenges or with their addictions or lack of job skills, that once they are released from prison that they have the support they need in order to remain a successful and productive member of society and not by going back to the same old neighborhood with the same old bad influences and just get back into their same old bad habits.

Thanks for giving me a chance to say a few words, Mr. Chairman, and thanks for holding this hearing.

Chair BOOKER. Thank you, Mr. Cornyn.

As I learned as a young boy in a small Black church in New Jersey, the choir has now sang, with surprising harmony amongst us all. Now, it is time to get on to the sermon, and that will come from our witnesses, and I am very excited to introduce half of our witnesses, and I will ask my Ranking Member to introduce the other witnesses. If I can find my notes here, forgive me, if I can get my introductions here—thank you very much.

The first witness is Major Martin Bartness. He is the commander of the Baltimore Police Department's Education and Training Section, where he is responsible for the development and delivery of new recruit training and continuing education for approximately 3,000 personnel. Major Bartness also leads the Baltimore Police Department's Crisis Response Program, and he has served as the chief of staff to the police commissioner and commander of the Special Investigations Section. He holds a bachelor of arts degree from Creighton University, a master of arts degree from the University of Nebraska, Omaha, and a master's of criminal justice degree from Boston University.

Then we have Keris Myrick, who is director of the JED Foundation and codirector of the Mental Health Strategic Impact Initiative, and she serves on the board of the National Association of Peer Specialists. Ms. Myrick is—has previously held the position of Director of the Office of Consumer Affairs for the Center for Mental Health Services of the United States Health and Human Services' Substance Abuse and Mental Health Services Administration and the board president of the National Alliance on Mental Illness. Ms. Myrick has a master's of science degree in organizational psychology from the California School of Professional Psychology of Alliant International University. Her master's of business administration degree is from Case Western University and the university's Weatherhead School of Management.

Ebony Martin is the program coordinator and a crisis intervention worker for CAHOOTS. The CAHOOTS program provides mobile crisis response in Eugene and Springfield, Oregon, and has been connecting people experiencing crisis with uniquely trained personnel as an alternative to law enforcement for more than 30 years. In her position, she strives to promote and enhance the crucial role mobile crisis response plays in keeping communities safe.

Kevin Martone is—Kevin, hi—is the executive director of the Technical Assistance Collaborative, a nonprofit organization dedicated to helping our Nation's mental health, addiction, homeless-

ness, and affordable housing systems implement policies and practices that empower people to live healthy, independent lives in the communities they choose. Previously, Mr. Martone served as the mental health commissioner for the great State of New Jersey, president of the National Association of State Mental Health Program Directors, and CEO of a supportive housing agency.

Yes, Ranking Member, please introduce your witnesses.

Senator COTTON. Thank you. I would first like to introduce Terri O'Connor. Ms. O'Connor lives in Philadelphia, where she was born and raised. She is the mother of two children and the grandmother of two. Ms. O'Connor has firsthand experience with the challenges faced by our police. Not only is her son a police officer, but her late husband was also a police officer. In the early years of her marriage, Ms. O'Connor also spent a decade working as a 911 operator herself.

Most recently, and tragically, Ms. O'Connor is also a widow after her husband, Philadelphia Police Corporal James O'Connor, was killed last year as he was serving a high-risk murder warrant on a gang member. His murderer should have been in the jail at the time but for the soft-on-crime policies of the local district attorney who prioritized so-called decarceration and reducing the footprint of the criminal justice system above public safety. Ms. O'Connor, I am so sorry for your loss. Thank you for your testimony today.

Next, I would like to introduce Rafael Mangual. Mr. Mangual is a senior fellow and deputy director of legal policy at the Manhattan Institute as well as a contributing editor to City Journal. He has authored or coauthored a number of reports and articles on issues ranging from urban crime and jail violence to broader matters of criminal and civil justice reform. His work has been featured in a wide array of publications, and he has also appeared on a number of television and radio programs and discussed these issues. He has previously worked in corporate communications for the International Trademark Association. He holds a B.A. in corporate communication from City University of New York's Baruch College and a law degree from DePaul University in Chicago. Last year, he was appointed to serve a 4 year term as a member of the New York State Advisory Committee of the U.S. Commission on Civil Rights. Thank you, Mr. Mangual, for appearing before us today.

Finally, I would like to introduce Sheriff Margaret Mims of Fresno County, California. Sheriff Mims has been a peace officer for more than three decades and was elected sheriff in 2006. Not only was Sheriff Mims the first female deputy sheriff sergeant to supervise field patrols in Fresno County, she was also the first female deputy sheriff there to attain the ranks of lieutenant, captain, or assistant sheriff, or to be elected to the office of sheriff. She is a member of the California Peace Officers Association and the California State Sheriffs Association and is also deeply involved in her community in other ways, including through her service on the board of directors of the Marjaree Mason Center, a local women's shelter, as well as on the board of trustees for the Fresno County Boys and Girls Club. Sheriff Mims is a graduate of Fresno Pacific University and holds a master's degree in public administration from National University. Thank you, Sheriff Mims, for testifying today.

Chairman Booker, I would also like to ask consent to enter into the record a number of other documents, including four peer-reviewed articles regarding policing and behavioral health, three commentary articles published in mainstream media publications, two documents published by the International Association of Chiefs of Police and the Law Enforcement Legal Defense Fund, and a written statement from the Council of State Governments.

Chair BOOKER. Without objection.

[The information appears as a submission for the record.]

Chair BOOKER. I would like to now bring the witnesses on one by one. I think I need to swear folks in, and why don't you stand up, Kevin? The witnesses at home, please stand in your bedroom, living room, wherever you are. Do you affirm—please raise your right hand. Do you affirm that the testimony you are about to give before this Committee will be truthful, wholly truthful, and nothing but the truth, so help you God?

Major BARTNESS. I do.

Mr. MANGUAL. I do.

Ms. MYRICK. I do.

Sheriff MIMS. I do.

Ms. MORGAN. I do.

Ms. O'CONNOR. I do.

Mr. MARTONE. I do.

[Witnesses are sworn in.]

Chair BOOKER. With that, we are going to bring on the first witness, and the first witness will be Major Martin Bartness, the commander, Education and Training Section, at the Baltimore Police Department.

**STATEMENT OF MARTIN A. BARTNESS, COMMANDER,
EDUCATION & TRAINING SECTION, BALTIMORE
POLICE DEPARTMENT, BALTIMORE, MARYLAND**

Major BARTNESS. Good morning, Committee Chairman Booker, Ranking Member Cotton, and distinguished Members of the Subcommittee on Criminal Justice and Counterterrorism. My name is Major Martin Bartness, and I am a 24-year veteran of the Baltimore Police Department, where I currently serve as the commander of education and training and lead the Crisis Response Program. I am also a Bloomberg Fellow at the Johns Hopkins Bloomberg School of Public Health.

While it is my privilege to appear before you today, I wish my presence were not necessary. We have come together, in large measure, because for at least the past decade, law enforcement actions have been associated with the annual death of about 1,100 people nationwide. It is estimated that 25 percent to 50 percent of these deaths involve persons who have been diagnosed with a severe mental illness. In the past 3 weeks alone, more than a dozen people who were mentally ill or in the throes of a breakdown were killed by police.

These tragedies point to the urgent need for law enforcement to partner with behavioral health professionals, community stakeholders, and individuals with lived experience to develop and implement solutions to effectively respond to persons in crisis and meet the complex behavioral health needs of those we serve.

We are in this situation because of public policy decisions made decades ago, when psychiatric institutions were closed and those living with mental illness were returned to their communities without adequate treatment and support. While these institutions were not the answer, States and municipalities failed to provide the supports and treatment needed for people with mental illness to live free from discrimination in their communities.

To this day, in Baltimore and many other places throughout the United States, the behavioral health system's goal of crisis prevention has not been realized. I will share a story to highlight this point.

In June of last year, a 19-year-old man, completely nude and in psychiatric crisis, repeatedly fired a handgun at motorists as he walked the streets of his Baltimore neighborhood. Police responded, safely took the man into custody, recovered the firearm he had been discharging, and drove him to an emergency room for psychiatric treatment. This would have been a great outcome except for within 6 days of his release from the hospital, he had another psychotic episode. This time, when officers answered the 911 call to his home and calmly attempted to de-escalate him, the man pulled a handgun from his pants pocket and pointed it at the officers. In fear for their lives, the officers shot him. He is now paralyzed.

Far too often, police find themselves in positions where the behavioral health system has failed to meet consumers' needs. This is why an estimated 10 percent of total police calls involve mental health situations. Inadequate funding and a system that diffuses responsibility among numerous, uncoordinated entities are at the core of the problem. As a result, people experience crises more frequently, and police are thrust into the role of a last-resort safety net for people in crisis.

Even when police peacefully handle behavioral health calls and link consumers to service providers, these calls can be time-consuming, which is often at odds with the demands of the 911 system and the expectations communities have for timely police response to crime and disorder.

I know we can do better. My testimony today is informed by 10 years of partnering with behavioral health professionals. I have witnessed firsthand how service delivery is improved dramatically when police partner with highly trained clinicians to conduct forensic interviews of sexually abused children; when police partner with victim advocates to coordinate counseling services to survivors of intimate partner violence; when police partner with outreach workers whose credibility within our Nation's most marginalized communities allows them to mediate disputes to disrupt cycles of retaliatory violence; and when police co-respond with licensed clinical social workers to de-escalate a person in crisis.

Through these kinds of successful partnerships between the criminal justice and behavioral health systems, we have demonstrated how it is possible to improve public health outcomes for even the most challenged populations. Moving forward, I hope you will help build upon the promising practices of behavioral health programs like CAHOOTS in Eugene, Oregon; STAR in Denver, Colorado; and GBRICS in Baltimore, Maryland.

I hope you will fund research so that jurisdictions can make evidence-based decisions for allocating scarce resources. I hope you will incentivize law enforcement, behavioral health providers, and academic institutions to collaborate on policy development, training, data analysis, and outcome evaluation. I hope you will heed the calls of behavioral health practitioners and clinicians to fund crisis response services, long-term treatment, and community-based providers at the levels needed to meet the extraordinary demands.

I thank you for the opportunity today to discuss how this Committee can make our communities safer and more responsive to the millions of people who desperately need a robust behavioral health and crisis response system. Your support of law enforcement, behavioral health professionals, and the citizens we serve is greatly appreciated.

Thank you, Mr. Chairman.

[The prepared statement of Major Bartness appears as a submission for the record.]

Chair BOOKER. Thank you so much, Commander. We really appreciate your testimony.

I am really pleased to bring on this next witness. When I was mayor of the City of Newark, the Manhattan Institute was a partner of ours in helping us to establish the first-ever in the State of New Jersey Municipal Office of Prisoner Reentry, and so I am grateful now that one of the Manhattan Institute's senior fellows is here, Mr. Rafael Mangual. I hope I pronounced your name correctly, sir. Would you please give us your testimony?

**STATEMENT OF RAFAEL A. MANGUAL,
SENIOR FELLOW, MANHATTAN INSTITUTE FOR
POLICY RESEARCH, NEW YORK, NEW YORK**

Mr. MANGUAL. You did, and thank you, Chairman Booker and Ranking Member Cotton, as well as Members of the Subcommittee, for the invitation to deliver testimony here today. It is truly an honor and a privilege to address this body on an issue that is among the most important public policy debates of our time, which is police reform.

Unfortunately, it is also one of the most divisive. A lot of the conversation about how to reform policing in the United States seems to be driven by a key misconception, which is that police violence is a likely outcome of an investigative or enforcement interaction. What I would like to do is to start by addressing this misconception and talk a little bit about the potential risks and limits of an approach to reform that primarily seeks to reduce the footprint of police for its own sake.

Right now, 83 percent of Americans—this is according to a recent Pew Research survey—guessed that the typical police officer has fired his gun at least one time on the job, while on duty. In reality, only about one in four actually ever do at any point during their long careers. Police very rarely use force, and when they do, it very rarely results in serious injury. In 2018, police officers in the United States discharged their firearms an estimated 3,043 times. That year, they made more than 10.3 million criminal arrests. If you attributed each of the 3,043 estimated discharges to a unique officer, it would mean that, at most, 0.4 percent of officers purpose-

fully discharged their firearm in 2018. If we assume that every shooting happened during the course of a separate arrest, it would mean that, at most, police applied deadly force with a firearm in just 0.003 percent of arrests.

As to non-deadly force, in 2018, a team of researchers and doctors published a thorough study of police use of force in *The Journal of Trauma and Acute Care Surgery*. That study analyzed over a million calls for service to three mid-sized police departments in Arizona, Louisiana, and North Carolina over a 2-year period. Those calls resulted in more than 114,000 arrests. Police force was used in just 1 of every 128 of them, meaning that more than 99 percent of all arrests and much more than 99 percent of all encounters were effected without any use of force.

That study went on to find that on the people whom police used force against, they sustained no or mild injury more than 98 percent of the time. Only 1.8 percent of suspects sustained moderate or severe injuries, and only one suspect was fatally wounded by police gunfire during the study period.

Nor are uses of force likely when you drill down into particularly dangerous police encounters, including those involving people in crisis. Take my home city of New York, for example. In 2020, the NYPD responded to 161,278 911 calls for persons in crisis. Yet the department recorded just 42 firearm discharges that year, including off-duty shootings, the vast majority of which did not begin with crisis calls.

On average, the NYPD responds to 175,000 calls involving people in crisis annually, and its highly trained emergency service unit officers try to respond, often responding to about 125,000 of those per year, usually in conjunction with beat cops. In the 3-year period between 2018 and 2020, ESU officers recorded just one shooting.

None of this means that there is not room for improvement or that police are perfect. There is, and they are not. Exploring opportunities for reform is a worthwhile endeavor that has to be undertaken soberly, because pulling the wrong policy lever can have disastrous effects, particularly on crime. That is the risk that we should be especially cognizant of now, given the very sharp uptick in shootings and homicides across the country.

Last year, for the first time since 1995, criminologists estimated that the U.S. will have seen more than 20,000 criminal homicides—an increase of about 4,000 additional homicides compared to 2019. That is still a ways off from the nearly 25,000 homicides the country experienced in 1991, but it is important to note that some cities have actually seen their homicide numbers approach and even surpass their 1990s peaks.

I suspect that some of the sincerely held misconceptions about police use of force have shaped some of the overarching goals of the reform movement, which, at the moment, seems to be to minimize the footprint of police, and the criminal justice system more broadly, in any way possible. We have heard calls to defund the police, which, in some cities, have been heeded. We have also heard calls to divert more responsibility, particularly things like traffic enforcement and responding to mental health calls, away from police to unarmed civilians.

On the mental health front, there is some evidence that suggests that we should continue to invest in efforts to augment the police by deploying civilian crisis intervention teams to calls involving people in crisis. In a report released just yesterday, my Manhattan Institute colleague, Charles Lehman, reviews some of that evidence. Among the approaches evaluated in his report is a popular, oft-cited, and promising effort launched in Eugene, Oregon, called CAHOOTS. While effective, CAHOOTS is also a case study in the limits of programs loosely referred to as alternatives to policing. As Lehman notes in his report, CAHOOTS responders are highly specialized. In 2019, they covered just 17 percent of Eugene 911 calls, with 75 percent of those calls being a welfare check or providing transportation, usually to someone homeless or in need. Even in those relatively limited circumstances, CAHOOTS responders still called for backup in roughly 1 in every 67 calls for service in 2019.

While it doubtless provides a useful service now, groups like CAHOOTS are not necessarily a model for how to replace the police. As a complement to policing, it is certainly a useful model for other cities to adopt. When you consider the sheer volume of mental health calls received by the police, not to mention the fact that they are often received in the late-night or early morning hours, it becomes very clear that we simply do not have the capacity to shift this particular responsibility in total.

Another complicating factor is that it is often unclear as to whether a call can be accurately categorized as one that can be safely diverted to civilian responders in mental health crises as opposed to police-based encounters. In other words, there is a study, for example, out of the city of Philadelphia which found recently that some medical or public health activity initially masquerades as crime or other policing work, and some events eventually determined to be police or crime activity can initially appear to be public health related. The study went on to find that about 20 percent of activity in this area actually does not appear predictable from the initial call type as handled by police dispatch, which is important because we need to know that in advance if we are going to successfully divert some of these calls.

I also want to second the comments offered by Major Bartness and say that a real solution to the problems that sometimes arise in police encounters with those suffering from serious mental illness must be built around an effort to provide more and better supervision for those in need so that they can get the care and services that they desperately require in a safe and compassionate setting rather than turning them out onto the street where they are likely to get hurt and/or hurt others.

Again, none of this is to say that improving outcomes in policing is not something that we not should pursue with vigor. It is. While reform is a worthy pursuit, it cannot be allowed to cause us to lose sight of the government's first duty, which is to provide for the public's safety.

Thank you.

[The prepared statement of Mr. Mangual appears as a submission for the record.]

Chair BOOKER. Mr. Mangual, that was really incredible testimony, so good that I am considering sending you a tie as a gift.

I would like to now go to Ms. Keris Myrick. Would you please give us your testimony?

**STATEMENT OF KERIS JAN MYRICK,
CERTIFIED PERSONAL MEDICINE COACH—CPMPC,
INDUSTRIAL-ORGANIZATIONAL PSYCHOLOGY,
LOS ANGELES, CALIFORNIA**

Ms. MYRICK. Good morning, Chairman Booker, Ranking Member Cotton, and Members of the Subcommittee. I appreciate this opportunity to speak with you today about creating behavioral health crisis systems that are safe and work for all. You have heard my bio, but equally important is who I am as a person. I am a daughter, sister, cousin, friend, Army brat, African American, and I am a person who has been given a diagnosis of schizophrenia.

I recall when first diagnosed I believed that no one would want to be my friend, that I was not worthy of help, and, worse, that I was not worthy of love. Initially, I did not even believe that my struggles were due to having a mental illness. This is how I have felt often as a person of color in this country. I rejected any form of help, and due to the embarrassment and stigma of mental illness, I did not even let the people who loved and supported me the most—my parents—into the world that I was experiencing.

My first interaction with the mental health system during a crisis when I was in my 30s, in Los Angeles, went badly, very badly. When I was in emotional distress, my expectation was that an EMT or ambulance would come to help me. I had been told repeatedly that a mental illness is like any other physical illness and should be treated as such. During a time of confusion, paranoia, and extreme emotional distress, the police arrived at my small apartment building where I was the only African-American resident. The officer banged on the door and loudly announced that he was from the police department sent to do a welfare check. As a Black person, so many things ran through my mind: Will the neighbors think that I fit some sort of stereotype about Black people being criminals? Was I safe to open the door given the many horrific outcomes for African Americans and police interactions?

My paranoia was not about my illness. It was about the realities of what it is like to be Black in America. I let the police in, fearing if I did not they would break down my door. Being deemed a danger to myself, I was handcuffed and taken to the police station where I was then handcuffed to a chair while they spoke to an African-American boy about stealing his grandfather's gun that was on the table in a secure gun box. I was trying to understand how it was possible for me to be what everyone said, "sick and needing psychiatric hospitalization," yet to be sitting handcuffed to a chair at a police station seeing for the first time in my life a real gun.

This was my first experience being in such distress and needing mental health support. What I did not need was the police response and being treated like a criminal. I needed health care and support.

I found what "care" was all about: asking for help and getting instead handcuffs and being harmed physically and emotionally. From this, I was unwilling to seek the care I needed, especially when I needed it most. All I can think is I am very fortunate not

to have had the same outcomes as Ms. Mitrice Richardson. A 24-year-old African-American woman known to have bipolar disorder was picked up by the police in the Malibu area of Los Angeles because it was reported she was acting irrationally. Like me, she was taken to a police station. Sadly for Ms. Richardson, she was released from the station in the middle of the night with no car, phone, wallet or money. Her decomposed body was found 11 months later in the area not far from the station.

When someone has a heart attack, stroke, dementia, or even ready to give birth, is this how they are treated? Police are not the default first responders. It is ambulance or EMTs who are the default. Why do we have police responding to mental health emergency situations when others are trained to do so?

Peer support specialists should be part of the mobile crisis response as one of the ways to remove police from the behavioral health crisis response equation. Peer support specialists are trained in evidence-based practices such as wellness recovery action plan, personal medicine coaching, and psychiatric advance directives, and they share their personal story of recovery to support another. Peer support has proven to help people participate in and adhere to treatment, shown reductions in hospitalization, homelessness, an increase in employment and social connection, and for parents and family members, it helps them to feel more confident in their ability to help their loved ones. Peer support is cost-effective and particularly valuable in rural and other areas that have been strapped for resources. We need more fully funded peer respite so people in behavioral health crisis have a safe and supportive place to recover.

These are unprecedented times—a world reeling from the pandemic, racial unrest, economic challenges, and trauma, especially for those who have been so disproportionately impacted. If we want people to engage in their recovery, build resilience, and flourish, we need to create crisis response and systems that look like other health crisis response without police as default first responders.

Recent reports such as The Group for the Advancement of Psychiatry's, "Roadmap to the Ideal Crisis Systems," and the Front End Project's report, "From Harm to Help: Centering Race Equity and Lived Experience in Crisis Response," provide blueprints that could help us get there.

Developing the new 988 phone number for everyone to call specifically for these kinds of crisis situations in lieu of 911 is a start and has created momentum for more comprehensive reforms, including comprehensive police and criminal justice reforms. Yet without the explicit inclusion of peer support throughout, centered on race equity and lived experience, we may not yield the systems that are most effective and the ones that people want, even as the police have said that they want.

This is what we need, and today I ask that we support legislation and robust funding to ensure equity is really equity in behavioral health crisis response. I ask that if we want to move from handcuffs to help, we must work together to ensure the safety of all including the police in creating systems that are humane, compassionate, effective, and help people to flourish and be safe and live to their full potential.

Thank you, Chairman, for this opportunity.

[The prepared statement of Ms. Myrick appears as a submission for the record.]

Chair BOOKER. I am very, very grateful for that powerful testimony.

I would like to now introduce Ms. Margaret Mims—I should really say Sheriff Margaret Mims. I am so grateful that you would take time out of what I know is an intensely busy schedule as a sheriff. We are grateful to have you on. Would you please give us your testimony?

**STATEMENT OF MARGARET MIMS,
SHERIFF, FRESNO COUNTY, CALIFORNIA**

Sheriff MIMS. Thank you, Mr. Chairman, Mr. Ranking Member, and Members of the Committee. I am honored to appear before you to discuss challenges faced by local governments, communities, and families as we work together to respond to those with mental illness. Although there are no simple solutions, we continue to develop and implement initiatives to better serve our communities, including increasing access to mental health treatment, diverting individuals with mental health conditions away from the criminal justice system, and working with mental health professionals on training programs to address those with mental health needs.

Increasing numbers of people with mental illnesses are coming into contact with the criminal justice system. Many times, as first responders, we do not know that a call for service may involve someone with mental illness until we arrive. These calls can be very dynamic and, in some cases, dangerous. In Fresno County we have had two deputy sheriffs killed in the line of duty by mentally unstable individuals who had armed themselves. These calls for service often are repeated as we often respond to the same location or the same individual. All law enforcement agencies in my county book those they arrest into the Fresno County jail. We have three correctional facilities, and our average daily population for March was 2,620 inmates. Of that population, 97 percent are in custody for felony charges; only 3 percent are misdemeanors. For all intents and purposes, we are an all-felony jail. To put this into perspective, this high number of felony cases exists after California passed an initiative in 2014 reducing many felony drug crimes to misdemeanors.

In addition to responding to calls, we are working tirelessly to provide treatment to those inside our correctional facilities. In March of this year, 41 percent of those in our facilities received psychotropic medication for a mental health disorder. Recently, our inmate health care services received accreditation from the National Commission on Correctional Health Care.

As we evaluated our system, we learned that many individuals were not receiving care when they were not in custody. No one should have to be in jail to receive mental health services. The sheriff's office worked with our Department of Behavioral Health to form a strategy to improve the continuum of care when individuals leave our facilities. Rather than release these individuals out the door, we transport them to a safe location. It should be noted many of these individuals are homeless, so they are taken to a shelter at one of our map points that I will discuss in a moment. These efforts

have resulted in strengthening our partnerships, a safer jail release plan, and in the long term the goal is to reduce recidivism.

Moreover, most law enforcement leaders I talk to agree that incidents involving mental health crises require more than just a law enforcement response. However, the lines are rarely bright, and in many cases law enforcement response is required to help save lives. Our law enforcement agencies worked with our Behavioral Health Department who provided us with crisis intervention training, which included de-escalation techniques. We have established a crisis intervention team comprised of mental health professionals and emergency medical services to respond with law enforcement so that both safety and professional services can be available during interactions with individuals in need of care.

We have also activated a Sequential Intercept Mapping initiative. This is a cross-system approach that identifies locations where law enforcement most often comes into contact with those with mental illness. We use the data from this initiative to establish a system that bridges criminal justice and mental health services and minimizes criminal justice involvement for persons with mental illness. Our action plan includes creating a county-wide crisis intervention team, increasing treatment of co-occurring disorders, and creating a sobriety center. We are also focusing on discharge and reentry planning to reduce recidivism in addition to developing diversion tools.

We want to continue to expand these efforts, but enhanced response to mental health crises will require significant increases in training and personnel. Federal support for this would be helpful, as long as it does not displace core law enforcement support programs.

We should be clear that replacing law enforcement—or defunding the police—would result in more harm to the citizens that we serve. “De-policing” has the same effect. The rule of law is a fundamental principle that must be respected. When laws are broken, our citizens expect an effective response—especially when their lives and their homes are threatened.

I began my statements this morning by saying solutions need cooperative relationships. A multidisciplinary approach is needed that includes all stakeholders, mental health professionals, public safety and community-based organizations. I can assure you, Senators, that law enforcement professionals across the Nation want to be a part of the solution and at your service to provide any additional input you may need as policy is developed.

Thank you.

[The prepared statement of Sheriff Mims appears as a submission for the record.]

Chair BOOKER. Sheriff, thank you. I am aware of the enormity and responsibility of your job, so I am grateful for you taking time to share your testimony and remaining for questions as well.

I would now like to bring on someone who has been invoked numerous times. We have heard CAHOOTS mentioned by previous witnesses and others, so I am very excited to hear from Ms. Ebony Morgan. Would you please share your testimony with us.

**STATEMENT OF EBONY C. MORGAN,
OUTREACH MANAGER AND CRISIS INTERVENTION
SPECIALIST, CAHOOTS CRISIS INTERVENTION,
EUGENE, OREGON**

Ms. MORGAN. Good morning, Chairman Booker, Ranking Member Cotton, and Members of the U.S. Senate Committee on the Judiciary. I was asked to come before you today to discuss my experience providing mobile crisis intervention services with the CAHOOTS program of Eugene and Springfield, Oregon.

My name is Ebony Morgan. I am a registered nurse, and I work as the program coordinator of CAHOOTS. CAHOOTS is a mobile crisis response team. We respond in unarmed pairs of a crisis worker and a medical professional to calls for service through police dispatchers via police radios. We coordinate with the police departments, our community partners, to take on the appropriate calls and meet community members where they are at. I am inspired to do this work in very personal ways.

My grandmother, Carolyn, was an extraordinarily kind human being who lived with severe and persistent mental illness. She thrived until her passing under the care of my mother, also a nurse. Growing up watching my mom care for her so diligently taught me that people experiencing a mental health crisis are not to be feared, rejected, judged, or punished. They are to be cared for. Someone in a crisis needs de-escalation, respect, safety, and support. As a society, we often fail to deliver that to the most vulnerable populations.

My father, Charles Morgan, did not get a chance to participate in raising me. He died during an encounter with the police when he was just 25, a young Black man. My family was devastated. I was 5, and my sister had not yet experienced a birthday.

When I graduated from nursing school, I declined an offer to work at our local hospital and double my income. I chose to remain with CAHOOTS, where we are underfunded, because this work matters. As others have also noted today, behavioral health services should not have to be limited by a lack of funding in their efforts to support the community in a way that is proven to be safe and effective.

Mobile crisis responses are worth every effort of implementation. For more than three decades, CAHOOTS has utilized unarmed de-escalation to meet the needs of the community. This frees up local police officers to handle the calls that they are trained to respond to and matches the needs of the community with the appropriate response. If we arrive on a call and find that a law enforcement presence is necessary, we can request them via police radio and work together to come to an outcome.

We can respond independently for welfare checks, suicide prevention, mediation, crisis counseling, substance abuse, and so much more. In 2019, CAHOOTS had some level of involvement in 17 to 20 percent of the total incoming public safety calls for service. No employee has ever lost their life or been seriously injured on the job despite never carrying a weapon, and no clients have died as a result of us showing up to help.

CAHOOTS crisis responders are trained to overcome our own fight-or-flight response. When a scene is escalated, we remain cog-

nizant of safety, show the client that we are there to help, and skillfully de-escalate the situation. In order to de-escalate a client, they must be able to identify that we are not a threat to them, so it helps significantly that we are not.

The honed ability to intervene calmly without giving in to reactivity or impulsivity is imperative. Being unarmed allows us to default to our client-centered training because it is our only way forward. Does the client need to talk? Do they need to go to the hospital? Do they need time to sober at the sobering center? Helping begins when you stop seeing the client as a threat and start evaluating what feels threatening to the client. Cultural competency is imperative to trauma-informed care. Build in anti-racist practices from the start to learn from and avoid perpetuating systemic racism.

Mobile crisis teams can also connect a client to existing community resources, but are not a replacement for them. These can include a 24/7 walk-in crisis center and phone line, low-barrier shelters, permanent supported housing, sobering and detox centers. Each area must be empowered to identify its needs and fund those programs.

As the Nation is recognizing that mental health crises are best responded to by trained mental health professionals, I am extremely hopeful that together we can find a way to provide humans with the appropriate resources for every situation instead of a one-size-fits-all approach to public safety that overburdens a group of people that did not necessarily get specifically trained for these encounters. One size fits all never fits all.

CAHOOTS is one longstanding example of the role that mobile crisis response can play in a community. We operate as an addition to existing structures and, thus, do not replace or change the current public safety systems. Mobile crisis response, however, is a necessary and logical service to provide to communities.

Thank you for making time for me today.

[The prepared statement of Ms. Morgan appears as a submission for the record.]

Chair BOOKER. We are really grateful for that testimony and looking forward to the questions that will come.

I now have the honor to introduce Ms. Terri O'Connor, who is—truly has an extraordinary American family: her son as a law enforcement professional and her late husband as well. We, as Senator Cotton said, give you our deepest condolences. Your family is a family of heroes, and we are very much looking forward to hearing your testimony.

**STATEMENT OF TERRI O'CONNOR, WIFE OF
THE LATE SGT. JAMES O'CONNOR, PHILADELPHIA**

Ms. O'CONNOR. As you heard from my short bio, my husband, Jim, was a Philadelphia police officer. Jim was a corporal in SWAT who was shot and killed in the line of duty on March 13, 2020. Jim's death will never seem real. He served the police department for 23 years. His father was also a police officer, serving for over 40 years. Our son and daughter-in-law are both currently Philadelphia police officers. Our police family extends to numerous other family members, too. This is the one job we all know too well.

I, myself, started out as a police dispatcher. I had firsthand experience of hectic situations and numerous emergencies. My job was to keep a cool voice and calmness to whatever situation needed to be dealt with. Our goal was to have every officer go home at the end of each shift.

Defunding the police is dangerous. Look at what has happened in cities like Seattle and Portland and in so many large cities across the country. Murders are up, and there is a sense, especially among criminals, that there is no law and order on the streets.

The mayor and city council have accepted zero accountability. This brings me to Philadelphia, where we had one of our highest murder rates in decades last year. Five hundred murders were committed in 2020, and more than 2,400 shootings, including 225 women and 195 children. This year, we are already on pace for an even higher murder rate. Four months into the year, and we have over 145 murders, 440 shootings, and 55 of those shooting victims were children.

Philadelphia is a prime example of what happens when police are demoralized and feel the pressure of a no-consequences DA like Larry Krasner along with the narrative that often goes along with the defund the police rhetoric that all cops are bad. My son has told me that while locking criminals up, they laugh and say that they will be out of jail in a day or two. The criminals know there are no real consequences here in Philadelphia.

My husband's four murderers had rap sheets that could go on for days, including multiple violations of probation, drug charges, and gun charges. They all had reduced bail and cases dropped. The man who pulled the actual trigger has five murders under him, including my husband. Those were only the ones they have learned about so far.

One of the other males in the room was wanted for two prior murders. The other males both had previous gun charges. They were holed up in a tiny, rented, one-bedroom apartment, with nine guns lined up and multiple drugs throughout the room. Who do you think should be responsible for going into the room and responding to incidents involving hardened criminals like this? Mental health workers? Maybe a negotiator? This is the job my husband and his coworkers signed up for. There are split-second decisions that needed to be made.

Nobody hates a bad cop more than a good cop, but the movement to defund the police is now about demonizing every officer and taking our country into anarchy by abolishing the police altogether. Every officer is given at least 9 months of training before graduating the academy. They then have continued yearly training. SWAT officers alone have an extra 3 months of training before they can serve warrants, handle a barricaded situation, et cetera.

The morning of March 13th, they used some of their training and used restraint, when fired upon, to return fire, but stop and negotiate through a closed door. The criminals asked them to stop shooting, and the police responded for them to do the same. Four other males could have been killed that day. The police used their training to not make the situation even worse. All our officers could use high-risk training. They sometimes have a split second to make a decision.

During—Defunding the police reduces funding for vitally important training and ongoing professional development that needs to occur to address bad policing tactics. Police brutality usually occurs when overly aggressive policing tactics are implemented in a dramatic fashion or with evil intent. To reduce this type of violence, we should reevaluate policing tactics and make sure our police are trained in the most effective de-escalation skills and techniques possible. Good policing requires a commitment to robust training that must be ongoing. This requires funding.

A recent shooting in Philadelphia reflects the continued need for money and training. Walter Wallace was a knife-wielding, mentally ill man who was shot when he aggressively approached police. Although I do not believe there was enough time for a mental health worker to be called in on this type of job, if a taser was used, he could have been subdued until he was taken to the proper facility. The officers were not equipped with tasers. More than half of Philadelphia officers do not carry the recommended tasers. Funding is an issue.

There are many reforms that we can debate; however, defunding the police is not one of them. To think that criminals are victims of society and the system is totally absurd. There needs to be a respect level for our police officers. We need stricter penalties. We hear too many times that a criminal has a lengthy list of prior arrests, but is out of jail because of reduced bail or convictions overturned and thrown out of jail. Our DA and others need to be held accountable for letting these people out of jail.

I know personally that Jim's murderers should have been locked up. If they had been kept in jail, where they deserved to be, I would not be spending today, April 22d, my 26th wedding anniversary, testifying on his behalf at this congressional hearing. Jim should be here. His life mattered.

Thank you.

[The prepared statement of Ms. O'Connor appears as a submission for the record.]

Chair BOOKER. Ms. O'Connor, that testimony could not have been easy. Thank you for sharing your pain and your purpose, and we honor your husband, his heroism, and his service.

Ms. O'CONNOR. Thank you.

Chair BOOKER. I would now like to bring up a Jersey boy and someone who I have a tremendous amount of respect for, again, the executive director of the Technical Assistance Collaborative, Mr. Kevin Martone.

**STATEMENT OF KEVIN MARTONE,
EXECUTIVE DIRECTOR, TECHNICAL ASSISTANCE
COLLABORATIVE, BOSTON, MASSACHUSETTS**

Mr. MARTONE. Thank you, Senator, Ranking Member Cotton. My name is Kevin Martone, and I will be speaking to you regarding one aspect of police reform: the overutilization of law enforcement to manage mental health emergencies.

I have spent nearly 30 years working in the public mental health system as a provider of direct services, as commissioner for the mental health system in New Jersey, and on various national boards and committees. I am also part of a racially diverse family

and a family member committed to helping a loved one define her life beyond mental illness and navigate the racism that she experiences in her daily life.

In many parts of the United States, 911 is the default mental health crisis line, law enforcement is the default mental health emergency response, and local jails are the default treatment provider. We have criminalized a public health issue and delegated responsibility to law enforcement and the criminal justice system.

There are approximately 240 million calls made to 911 in the United States each year. Estimates are that behavioral health emergencies constitute between 5 to 15 percent, or somewhere between 12 million and 36 million of the calls to the 911 system. Many of these are classified by local dispatchers as “wellness checks,” “disturbances,” “intoxicated persons,” or “mental crises” and do not always require police presence. It is estimated that 80 percent of mental health calls to 911 are resolved without the need for police involvement when diverted to a crisis line. However, law enforcement are often sent.

While a police response may be justified, especially if a weapon is involved, we know that it can also create substantially adverse outcomes for communities of color and individuals with behavioral health disorders and other disabilities.

According to the International Association of Chiefs of Police, “the mere presence of a law enforcement vehicle, an officer in uniform, and/or a weapon . . . has the potential to escalate a situation” when a person is in crisis. All too often, these calls for service result in unnecessary fatalities. People with serious mental health disorders are 16 times more likely than the general public to be killed during a police encounter. Today, in an era when deadly violence—police violence is top of mind, one in four fatalities by police involve people experiencing a mental health emergency.

Half of all people killed by police are people of color, and when combined with mental illness, the difference is nearly tenfold.

The problem is more complex than we have time for today, and I will highlight a few of the factors that have resulted in this. Generally, a series of cascading issues over the past several decades has resulted in two driving factors.

One, a fragmented, underfunded, undervalued, and inaccessible mental health system. This is compounded by poor health insurance coverage, limited funding for services at the Federal, State, and local level, mental health workforce shortages, and geographic challenges and transportation issues that impact services access, especially in rural areas. This has been exacerbated during COVID by increasing demand and reduced provider capacity.

Two, mental health and other systems that do not sufficiently address social determinants of health, such as racism, poverty, and access to affordable housing, employment, and education. People with mental illness, especially those in communities of color, are disproportionately poor, homeless, and unemployed. All of these are correlated with worse outcomes for people with mental illness.

The result is a de facto national policy that it is acceptable for law enforcement to manage mental health emergencies. Most law enforcement officials that I have spoken with would prefer to see people with mental illness served in the mental health system. Peo-

ple with mental illness, their families, and providers agree. The events that we have witnessed in the past year alone—the public health and economic impact of COVID, racial and social unrest, and deadly police encounters for Black and brown people with mental illness—have elevated awareness of the need to treat mental health as the public health issue that it is.

The good news is that there is activity. Recent congressional action has resulted in additional block grant funding for mental health and crisis services, a new Medicaid benefit for mobile crisis services, and funding that can support additional workforce capacity. We have seen important, bipartisan legislation passed recently, including the Crisis Stabilization and Community Reentry Act and the National Suicide Hotline Designation Act that establishes a new 988 suicide prevention and mental health crisis hotline as an alternative to 911.

Solutions exist. In recent years, several communities have established mental health-led or—involved emergency programs, such as CAHOOTS in Oregon and RIGHT Care in Texas. Our system response efforts need to push further upstream to prevent crises from occurring to begin with. Access to evidence-based services like supportive housing, assertive community treatment, specialized peer support, employment supports, children's systems of care, and other approaches exist to serve adults and children in the community, but do not have the capacity and workforce to meet demand in many areas of the country.

In closing, to the extent that law enforcement will likely continue to have some role for the foreseeable future in responding to mental health emergencies, at least in situations when public safety is a concern, law enforcement must own reforms for how it responds to people with mental illness, especially those who are Black—Black and brown. This work should be informed by people who experience mental illness, racial equity and justice groups, and other key stakeholders. If we are to reduce law enforcement response to mental health emergencies, we must commit to addressing mental health reform and build the infrastructure needed to create an accessible mental health system.

Just a note. There are 17,000 police departments in this country—that is a lot—and an underfunded mental health system. If we are to do this one by one, we are never going to get there. We really need a national strategy that funds treatment and services and includes intentional multi-system efforts that include planning and training and design and data collection and research if we are really going to collectively address this issue. One by one is not going to get us there. There needs to be a national strategy.

Thank you.

[The prepared statement of Mr. Martone appears as a submission for the record.]

Chair BOOKER. Mr. Martone, that was incredibly valuable, and I love the point you made about a lot of our solutions should not be about just simply responding to crisis but preventing those crises from happening in the first place. There is a lot of wisdom in that and that last point you made about a larger system to deal with this. Unfortunately, the focus of this hearing today is: What should we be doing in terms of the first response? I do not want

to let that important part of your to be lost on Congress about getting a larger national strategy for mental health awareness. It is fractured. There are so many gaps that swallow up so many folks that then perpetuate the crises that we are seeing. I think that that was worth highlighting.

We are at a point where everybody's testimony is really important for the record and for the strategies I think Congress is going to do in a bipartisan way, the Senate. I do not know if my friend Senator Blumenthal would like to ask some questions first. I will yield to him.

Senator BLUMENTHAL. I really appreciate this opportunity, Mr. Chairman, and I just want to say how important I think this hearing is.

My thanks to Chairman Booker for bringing us together on this critically important topic. I served as United States attorney in Connecticut for 4-1/2 years and then as attorney general in our State for 20 years. I have worked very extensively with law enforcement, and police interactions with people who may have disabilities or mental illness or autism ought to tremendously concern us. I am sure many of my colleagues have said, as I did, that Tuesday's guilty verdict in the *Chauvin* trial provides necessary accountability for the murder of George Floyd last May. It is not true justice, not for George Floyd, not for any other Black or brown American killed by law enforcement in this country. No single verdict in a single case can eliminate the generations of racial injustice, inequality, and inequity faced by Black and brown Americans in policing and across many other aspects of society. There is so much work to do, and Senator Booker has been at the forefront nationally, but also in the Senate among us, reminding us of our obligations to commit ourselves to true justice, equality, and equity. There is a need for real action, real reform, and real change, and I am very proud to work with him on legislation that can achieve that change.

We find ourselves in a moment of reckoning. While Derek Chauvin may have been held accountable for violating his sworn oath to protect and serve, at least three more Black and brown Americans were killed by law enforcement in high-profile incidents just in the last month: Adam Toledo, Daunte Wright, and 20 minutes before the *Chauvin* verdict was announced on Tuesday, Ma'Khia Bryant. Something must change, and we in the United States can make it so.

Let me tell you one reason why I am committed to this most important mission. Last October, one of my constituents from East Hartford, Maureen Sorensen, reached out to my office to share her concerns about her son, Curtis. See, Curtis is 13 years old. He is African American. He is also a person with autism and intellectual disability. Maureen is worried about what would happen if law enforcement were ever to interact with her son. She wrote to me recently, "From the outside, my child appears to look neurotypical," but "there is a delay in processing information, which scares me that an officer will not take the time to understand. Others, without knowing the situation, may see this as being defiant. I do not want him nor any child or adult to be traumatized or lose their life

because law enforcement did not take the time to know how to approach the situation.”

Maureen is an incredible mom. She has a task that is unimaginable for many of us. I have four children. Being a parent is the hardest thing I have ever had to do, and I think it is the most serious task that I or any parent face in life. Maureen is doing her very best to teach Curtis about law enforcement, how to react if he is ever approached by police, or even if he is just asked a question. Quite frankly, she has every right and reason to be concerned. She is doing everything in her power to prepare Curtis for what may be an inevitable encounter with police.

Maureen should not have to prepare Curtis. She should not have to prepare him differently than any other parent would prepare a child. Law enforcement needs to know how to deal with these kinds of situations, how to respond to people like Curtis with autism or other behavioral health diagnoses, how to bring in community mental health services and experts when a police response is necessary but also capable of becoming violent, not only for Curtis but for others who may present with disabilities, difficulties, or illness.

I want to ask a question, and I really appreciate the Chairman indulging me with this time. Major Bartness, I understand that you have been with the Baltimore police for 24 years. What should law enforcement in East Hartford and around the country be doing to ensure that Curtis and people like him are treated appropriately and safely by the police?

Major BARTNESS. Thank you for your question, Senator. I think the kind of training that we are currently developing and delivering in the Baltimore Police Department is moving in the right direction. We have training for CIT officers, which comprised about 30 percent of our patrol ranks, and that training expressly deals with the kinds of topics you recommended: identifying individuals with autism and how to interact with them. We work with a host of behavioral health organizations in creating our training and delivering it, so it is not just law enforcement. We are representing in the classroom what we want to see practiced in the field. We work with the National Alliance on Mental Illness. We work with Behavioral Health System Baltimore. We work with Baltimore Crisis Response Inc.; the Arc, which is an organization that works with individuals with intellectual and developmental disabilities; Disability Rights Maryland. These kinds of partnerships are absolutely essential to ensuring that our officers are prepared to meet the challenges that they are going to have to face on the streets to de-escalate incidents and then make referrals to the appropriate services.

Senator BLUMENTHAL. Thank you, Major Bartness, and thank you, Mr. Chairman. This hearing is so valuable, and I hope that we can build on it in the Judiciary Committee going forward, because it is a key part of what we need to do to reform and improve policing in America. Thanks.

Chair BOOKER. Thank you, Senator.

I would like to now call on Senator Whitehouse, who is remote.

Senator WHITEHOUSE. Thank you very much, Chairman Booker. It is good to be with all of you. I appreciate the testimony of everyone.

Ms. O'Connor, my daughter lives in Philadelphia, so I am very glad that your husband's family and your family have been protecting that community through multiple generations, and I just wanted to express my appreciation for their service. It is not at all, as you know, uncommon for police work to be passed on from father to son, and now daughter, and be a very important part of a family's traditions, and I am grateful that you shared your experience with us today.

Senator Cornyn and I have been working for some time on a bill to improve the coordination between law enforcement and behavioral health, mental health, addiction, and recovery. Both of our States have similar situations, although they are different in many, many, many ways.

One of John's sheriffs came to him and said, "You know, John, I am providing more mental health services than I am providing law enforcement services, and that is not what we are trained for." My police chiefs in Rhode Island tell me the same thing. I think the problem reaches across a whole variety of areas.

First of all, at the point of engagement with an individual, to have the crisis intervention teams and to have the crisis intervention centers available so that there can be a timely and appropriate response to support the police response is essential.

Mr. Martone talked about how jails are too often the default collection point for individuals having a behavioral or mental health crisis or an addiction issue. We see that in Rhode Island as well. We also see our emergency rooms as another place where people are brought, and for emergency room doctors trying to deal with regular medical emergencies, this is not appropriate. They need to be in behavioral health treatment, and quickly. The reason that the jails and the emergency rooms are playing that role, in Rhode Island anyway, is not because people are misdirected about where folks should go. It is because there are not the behavioral and mental health services and resources to meet the need.

We need to not only do a lot of crisis intervention support and develop new models for supporting police departments with behavioral health crisis intervention, but we need to make it a lot more robust in terms of the resources for those people.

Someone in the nonpolice-involved mental health crisis who goes to the emergency room in many places, including in Providence, Rhode Island, can spend days waiting in the emergency room for services or a room to become available. The whole question of how much we invest in the necessary infrastructure is a really vital part of this conversation.

I would like to add that I was delighted to hear Senator Cornyn mention mental health courts, because we are working our district court chief judge, Judge LaFazia, who was instrumental in supporting the growth of our veterans court, which stood on the record that the superior court had in a program I started when I was attorney general of having a drug court, and I think the mental health court is a really good idea, but as we look around for how do you resource that, there are not a lot of resources.

Taking the idea of mental health courts to stand on drug courts' and veteran courts' experience I think is another aspect that we have to work on.

I wanted to invite all colleagues to join Senator Cornyn and I in working on that measure. We have worked together successfully before on the reentry measures that were part of the sentencing reform bill, and we hope very much to get a significant piece of legislation put together.

What I would ask the witnesses to do is to share with us what from your experience you think are the best practical models that you have seen, whether in your own State and your own jurisdiction or whether, because this is your field of inquiry, you are aware of really good examples that are taking place in other States and other jurisdictions around the country. I will ask that as a question for the record, if you all do not mind. There will be a week or so after the close of the hearing when Chairman Booker will allow written answers to questions for the record. If you do not mind writing down a brief summary of what you think are the best examples of behavioral health coordination with law enforcement or the best way for engaging with this population and successfully dealing with de-escalation, we would love to know, because the broader the support that we can get from States where there are really good examples, the broader the base for legislation grows in the Senate, and the more likely we can get something big done.

I will close with that real gratitude to all of the witnesses, each of whom made a very special contribution to our understanding and to this hearing, and to the extent you would not mind supplementing that with a list of what you think best practices are out there, I think we would be very grateful as we pull this legislation together.

Senator WHITEHOUSE. Chairman Booker, thank you for this terrific hearing, and I will yield back whatever time I have remaining.

Chair BOOKER. Senator Whitehouse, I am grateful for your comments and the work you are doing with Senator Cornyn. I think there will be a lot of rich contributions from the witnesses in hopes that we can work with you to make that bill something that goes a long way into covering what a lot of our witnesses are saying is urgently needed. We appreciate Senator Whitehouse's leadership.

I want to jump in. If there are no other Democrats on line, then I will just jump in myself. I want to just first jump to Ms. Morgan. There was a little bit of a shadow cast on, I think, the work that CAHOOTS does in some of the testimony, and I am wondering, could you just give us a characterization how many incidents does CAHOOTS respond to each year? In how many of them do responders call police for backup? Can you characterize those moments when—I think it was represented by another witness that one out of every 60 or so times, you guys call for backup. Could you give some light on that data point and also talk to us a little bit about what happens when they call for police?

Ms. MORGAN. Absolutely. The total amount of calls we were dispatched to in 2019, which is our most recent data, wound up to be about 17 percent of the calls, or just over 17,000—17,700. On those calls, we requested police backup about 1.5 percent of the time. It was 311 out of that 17,700. Of those calls that we did call for backup, the 311, we called for Code 3 cover, which is lights and sirens, about 5 percent of the time. It is very—

Chair BOOKER. Could you be more explicit? Code 3 coverage, just explain what that means.

Ms. MORGAN. Code 3 coverage means that in that exact moment we believe there is an imminent threat to someone—ourselves, the clients, a bystander—that we are going to need a police response for immediately. Part of what makes this program work is that we have that access. By carrying the police radios, if a situation either escalates or is a situation that came to us but is appropriate for a law enforcement response, we can request them, and they can come quickly.

What might have us determine that we need a law enforcement response is typically going to be safety related. It is going to be—we are a consent-based program because we do not have the authority of law enforcement to take anybody's rights away, so people can choose to engage with us or not. If they choose not to but are not behaving in a safe way, we cannot just let them be unsafe, and that is where we might end up bringing in law enforcement for that reason.

Chair BOOKER. It is safe to say it is a fraction of the time, 1.7 percent you call for police, and a fraction of that is because of imminent harm or danger to other people?

Ms. MORGAN. Correct.

Chair BOOKER. Got it. Can I—I want to move on from you in the limited time that I have.

Mr. Martone, again, I just find your perspective on this so valuable about the larger crisis in America that we are not doing—do not have a mental health care system that in any way meets the challenges we have. It is a crisis of empathy. It's a crisis of compassion. It's a poverty, really, of our ability to love one another in a substantive way and protect ourselves. Clearly, our lack of doing it is not just a harm to the person struggling with mental health. It is a harm to all of us. It is a self-inflicted wound.

Can I just ask you, I am just trying to figure out ways to build upon your testimony in terms of really good guidance about what we should be doing. When you work with States and local governments, what resources are there that they most frequently request? What are these professionals that are supposed to keep us safe saying to you that they most need?

Mr. MARTONE. Thank you, Senator, for the question. You know, in the crisis space—and I think you heard this from the CAHOOTS program—when calls are diverted to crisis centers, 80 or 90 percent of those calls can be diverted on the phone from the start. Then those that cannot be diverted often then go to a mobile response program like CAHOOTS or many different States have different types of mobile response programs. Then when mobile response programs engage a person, they then can divert a person from more restrictive settings like law enforcement or emergency departments. They can divert people to linkages with outpatient services and things like that.

What we hear in the crisis space is, yes, we may have a program in Eugene or we may have a program in, you know, some State, there is one in a county for a million people, you know? The problem is there is not enough capacity, right? When we think about the capacity for call centers—you know, we have the new 988 Na-

tional hotline that is going to be stood up. We need to make sure that there is enough capacity in those systems to sufficiently handle calls that may be—instead of going to 911, go to 988, or may be triaged from 911 to 988, and we need enough resources so that we can stand up sufficient mobile capacity so that, you know, police can respond right away. Mobile crisis teams, if they cannot respond in a very short period of time, it is going to just default again to the police response. Mobile response programs need to have that capacity.

Then there needs to be sort of that next step beyond mobile, right? There needs to be crisis stabilization programs or drop-offs or a mental health program that can receive that crisis and then begin to serve that person, all that trying to divert a person back upstream and away from the law enforcement system.

Chair BOOKER. I am going to give you—just cogent, quickly as you can, because you are going to be asked this in writing by Senator Whitehouse. You are now the better-looking, more-haired Senator from New Jersey. Three things that you would want to get into the bill, give it to me real quick. Three things.

Mr. MARTONE. I think we need additional Federal Medicaid dollars to match State dollars so that we can provide enhanced capacity to provide these services out there. There is some of that. I think we need more linkages to upstream services. Some of that is State funding, but a lot of it, again, is Medicaid matching dollars. Some of it also, frankly, is rapid rehousing, access to housing. Right? Many of these folks are homeless. We need rapid linkages to housing situations for folks as well because so much of this is tied to that.

Chair BOOKER. That is my experience as well. That is really, really insightful.

I would like to jump to Major Bartness, and, again, thank you for your incredible service and leadership. Building on some of the things we have asked before with CAHOOTS, tell me this: Does responding to calls involving people in crisis or with mental illness divert law enforcement resources? In other words, is this crisis a drain on your ability to focus your Department on other areas where you could help better keep people safe?

Major BARTNESSR. Thank you for the question, Senator. It absolutely is. As I indicated in my testimony and Mr. Martone I believe also indicated, a very significant percentage of 911 calls coming into law enforcement, somewhere around 10 percent, is substantial, and that is time spent away from addressing more traditional matters related to public disorder, crime, and safety. These kinds of calls, to be handled properly, are not disposed of quickly. Police officers—and we are very intentional about this in educating our officers to spend time with consumers on these calls, because we do not want to have to continually come back. We want to do our very best to link them through to community-based services, and so we connect them with the crisis hotline at our crisis response center, and we really endeavor to get these folks the treatment that they need. The reality is, as Mr. Martone has stated, the services are not there to meet the demands of the population.

Chair BOOKER. I really appreciate that.

I want to jump to Ms. Myrick really quick. One thing we have not talked too much about is peer support, peer to peer, and how powerful that could be. Could you just give me really quickly why do you think peer support is so important in behavioral health care and generally what function does it serve?

Ms. MYRICK. Sure. Thank you for the question. Peer support is essential, is all I can say. The first time I met a peer who looked like me, it was the first time I thought, okay, wow, I can really get better, somebody who had been through what I had been through. You know, evidence has shown that peers who have training, who are certified and have training can really support people, especially in crisis, to help identify kind of what is going on. They can slow things down. We have heard from other people giving testimony about how it is important to slow things down in order for people to make their needs known, especially when they are in crisis, and then help get connected to the resources that they need. Peer supporters are trained to do that, and they use also other evidence-based tools and mechanisms to do so.

One of the things that I think is critically important are things like wellness and recovery action plans which could help people to understand what are they doing well and when are things starting to break down in order to prevent a crisis and then develop a plan for what happens if they do enter a crisis and post-crisis. The legal means to do that is through psychiatric advance directives, which peers can also help people do.

I also think that peers who have families to support other families and other parents is also another critically important step so families and parents have a better kind of understanding of how to support their loved one pre, post, and during crisis. You know, having peers on mobile crisis teams, being able to meet people where they are, possibly support them in the field, having them as part of the 988 workforce response also is—988 is the number people can call when they need support, where they can take the time on the call to help with some of the triage and work with people immediately, is another way that peer supporters can be used.

Last, we have heard people need places to go. It might be fine that you can get the crisis team there, but what about where the people go if they need someplace safe to go but may not need hospitalization. Peer support is totally underutilized, totally underfunded, and if there were more peer support respites where people can go and have peer support 24/7 and get that space away from possible crisis that is contributing to their mental health distress is critically important and needs to be part of the mental health crisis response ecosystem.

Chair BOOKER. That is excellent, and it also resonates somewhat the point of Mr. Martone about the power of supportive housing with people that are there.

Senator Cotton, who had to attend to business on the floor of the U.S. Senate, is back. Just so folks know, he is going to give his questioning. Then we are going to go to Senator Padilla, and then I think we are going to end at that point and wrap up the hearing. I appreciate the patience of the witnesses, and I am honored to turn it over to my Ranking Member, Senator Cotton.

Senator COTTON. Thank you, Senator Booker, and thanks to all the witnesses for your patience. As Senator Booker said, we are all at the mercy of the Senate floor schedule, but I know that all of our colleagues on this Subcommittee have taken a great interest in this subject and very much appreciate your appearance here.

Ms. O'Connor, I would like to start with you. What happened to your husband is a tragedy, especially because it was so preventable. If it was not for the criminal leniency efforts in Philadelphia that released dangerous criminals over and over again, we would not have officers like your husband repeatedly facing the same kind of dangerous arrests.

You mentioned in your testimony the extensive training that he received throughout his career, including high-risk training. You also come, as you testified, from a law enforcement family. Do you find that improving training available to officers helps to protect not only the officers but also the suspects they encounter?

Ms. O'CONNOR. I think that the training is necessary. My time as a 911 dispatcher takes me back to the—there is just not enough time. When these calls come out, they need immediate response. I do not know how long it would take to get a mental health worker to show up to a situation. I feel like the police are always going to be the first ones to respond, and then maybe they can go from there and decide—you know, they can get a mental health worker in, but I could not get somebody to come out and, you know, change the lights on the corner for 2 days, or if we needed, you know, a tow truck to come, it could take hours. My concern would be how long it would take to get someone out there.

The police, they need the extra training as much as possible, because they are probably going to be the first ones to deal with the situation at hand immediately, and they can assess from there. The response time is probably—it is not realistic.

Senator COTTON. In your experience in law enforcement, and your husband's and your entire family's, when budgets are tight, and especially when budgets are cut, is training often the first thing that gets cut?

Ms. O'CONNOR. I would say so, yes, definitely. They have to. It is just unfortunate that is the way things are going to happen. Also, right now in Philadelphia and probably across the country, the police officers, they are low. People are retiring and people are not joining the academy right now. All of it, we are in trouble. Our numbers are really too low because of the concerns of not having the support and overall defunding the police. They are who is going to be called first in any situation. If you need help, you are calling the police. They need to have all training possible in many different situations.

Senator COTTON. Thank you, Ms. O'Connor.

I want to turn to Sheriff Mims. You said in your testimony that 97 percent of the inmates in your jail are there on felony charges and have committed pretty serious crimes. A large number of those inmates were also receiving some sort of medication for a mental health disorder while in your jail. Is it fair to say then that a significant number of the serious criminals you encounter also have mental health issues? Would it put mental health workers and pos-

sibly bystanders in danger to have only a nonpolice response to these incidents?

Sheriff MIMS. Yes, Senator, a large number of our calls for service do involve those with mental health services—or mental health illnesses. Of course, the concern is we have some dual diagnosis going on. Not only do they have criminal behavior, they have the mental health behavior, as well as maybe a substance abuse issue. These are calls, for instance, that I testified to that are very dynamic. They unroll very fast. Law enforcement do come into contact very often with those that are mentally ill and have to take enforcement action because of the crimes that they committed.

For example, the two deputies that we lost in the line of duty at the hands of an armed mentally ill person, one was a vehicle stop where that person came right out of the vehicle and shot the deputy as he was approaching the car. The other one was a burglary in progress. We do not know that the person that is involved in this also has a mental illness. They are very dynamic calls. They unfold very quickly. They are very dynamic. We are coming into contact with people who have been in criminal activity that are also mentally ill more and more.

Senator COTTON. Thank you.

As my time is concluding, I would like to return to Ms. O'Connor and just express again my deepest condolences and sympathy for your loss as well as my gratitude for your testimony today. I know that this must have been a hard day to tell your story, but may the memory of your husband and your loving marriage always be a blessing to you and to those who loved him. Thank you.

Ms. O'CONNOR. Thank you.

Chair BOOKER. Thank you, Senator Cotton.

I would like to turn to Senator Padilla, who is on remotely.

Senator PADILLA. Thank you, Mr. Chair.

My first question is for Ms. Myrick, and I want to begin by just thanking you for openly sharing your experience of living with mental illness. You know, it is only by talking about it more that we can improve understanding and awareness of mental health conditions and the impact it has on people's lives, on families' lives, and in so doing help undo the stigma often associated with mental illness that keeps us talking about it individually, as families, and certainly when it comes to passing public policy and investing in better services and supports. I just want to acknowledge that up front, and it means a lot to me, and I commend you for that.

In your testimony you did—have mentioned your personal experience with a police encounter. What I would like to hear more about is how that encounter, in turn, affected your mental health and your general well-being.

Ms. MYRICK. Thank you for the question, and I, you know, speak up and speak out, especially as an African American, because I could not find anybody who was talking about their personal story of living with a diagnosis specifically of schizophrenia. I have to ask permission from my father, "Can I speak out?" Because he is part of this story, too. Without his loving support of him and my mom, who is no longer living, and the rest of my family, you know, truthfully I would not be here.

The impact of that first experience, I was actually wearing a pair of my beloved red—cherry red Doc Marten shoes, and I loved those shoes. It was my first pair of Doc Martens. It takes forever to break those suckers in. They were broken in, and I was wearing them on that day, and they were ripped from my feet as people were struggling with me trying to subdue me to participate in what I did not understand was happening. It was not, again, about my mental illness. It was about seeing people who looked like me in my past treated awfully and having bad outcomes. I did not want to be a victim. I just did not. That is what I was really fighting against.

What that really led to was, number one, I never wore those red shoes again. It took years and years—it took about 15 years before I ever put those shoes back on. They actually do not fit. I have about 20 pairs of Doc Martens, but I did not wear those shoes ever again. I was not willing to—I was not willing to accept treatment, especially when I was not at my best. Every hospitalization after was involuntary and did involve police coming to take me to the hospital, because I thought that is what it was like to go to a psychiatric hospital. I had not seen it done any other way. I did not want to have anything to do with that.

You know, even talking about it, I am sorry, it is like my heart is super-duper racing, because it still brings up a lot of memories and trauma that, on top of having an illness in which you are trying to recover, no one should have to experience.

Senator PADILLA. You hit the exact right word that I was anticipating. It was “traumatic.” It was additional trauma, which does not help someone who is already, you know, working to cope with or overcome a mental health condition. There have got to be smarter ways to do this, and I appreciate you helping to make the points. You are right; in communities of color especially, we do not talk about this enough.

I have a follow-up question for Major Bartness because there is also the flip side to this coin. As I have come to learn in recent years, correct me if I am wrong, but in law enforcement there are more sworn officers who die by suicide every year than lose their lives in the line of duty. Correct me if I am wrong. I just wanted to hear from you for a few minutes about the psychological toll that use of force and other first responder experiences has on law enforcement officers and suggestions and ideas on how to acknowledge that and build that into training and support for sworn officers.

Major BARTNESS. Thank you, Senator Padilla. Secondary trauma in law enforcement is a very serious issue which you have highlighted, and it is incumbent upon police departments to develop very robust employee assistance programs and ensure that those resources, confidential, are available to law enforcement and their family members, because those family members also live with the baggage that our officers bring home. We very intentionally have to create a culture where we recognize that secondary trauma is going to occur and that officers need to talk about it and that there is a very well developed system that they know how to access in real time when they are struggling.

Not every department, obviously, is doing very well with that. So it, too, is a responsibility, that as we assess the State of our profes-

sion at this moment in history, that has to be given attention. Thank you for your attention to it.

Senator PADILLA. Thank you. It is going to be a topic of ongoing conversation.

Thank you, Mr. Chair.

Chair BOOKER. Senator Padilla, I am grateful.

I am going to now adjourn the hearing. QFRs—I am sorry. What is that? Oh, I am sorry. Senator Ossoff, I apologize. I am told you are online.

Senator OSSOFF. All good. No problem, my friend. Thank you, Mr. Chairman, for convening this hearing, and thank you to the panel. I know we have votes, so I will do my best to be concise.

Major Bartness, thank you for being here and thank you for your service. In response to an increase in mental health-related emergency calls during the pandemic, Brookhaven, Georgia, a small city, pioneered a co-responder crisis intervention system. The Mayor of Brookhaven, John Ernst, said that this has helped to de-escalate situations involving individuals suffering from mental illness who may be involved in contact with law enforcement or calls to 911. I would like, Major Bartness, for you to comment on how co-responder programs like the one in Brookhaven, Georgia, might help to de-escalate such interactions and ensure that neither public safety nor the safety and health of those suffering from mental illness is jeopardized when police and law enforcement and emergency services respond to such calls.

Major BARTNESS. Thank you, Senator. I think the co-responder model is outstanding. We have it here in Baltimore. The challenge we have is that it is not large enough. It is operational 7 days a week but only 8 hours a day, and it is one team responsible for the entire city of Baltimore during that 8-hour shift. It is a licensed clinical social worker paired with a highly trained CIT officer, and they respond to some of these most acute calls for service.

What it does allow us to do is what Ms. O'Connor rightly pointed out earlier, and that is, as these calls come in with an officer in the field able to immediately respond, they are able to get there quickly, they do not have to wait an indeterminate amount of time. In order to do that to scale, there has to be more funding for these teams. They are fantastic. They play off each other's skills. They de-escalate, and then they refer to community-based services and case management to get these consumers who need the help.

Senator OSSOFF. Thank you, Major Bartness.

Ms. Myrick, I would like to ask you a couple of questions about necessary investments in mental health services in Georgia and across the country. First of all, to be clear, I have not seen any evidence that people suffering with mental illness are any more likely to commit violent crime than anyone else in the population. In fact, according to the National Alliance on Mental Health, they are not, and, indeed, studies have shown that those suffering from mental illness are, in fact, much more likely to be victims of violent crime.

We also know, at least according to some research, that individuals with untreated mental illness in particular who do come in contact with law enforcement in emergency situations are more likely to be killed in the encounter. I would like to hear from you your view on the importance of increasing our national investment

in mental health care services and what kinds of social services in particular you think are neglected or lacking, generally speaking, across the country.

Ms. MYRICK. Sure, thank you. You know, definitely since the institutionalization of mental health care services and community-based services have never been fully funded, they are woefully underfunded. In order to kind of bring up, I would say, an ecosystem of support for people that move through the continuum of their health and wellness, which includes times when people are in crisis, we need to look at the system as a whole system that also interacts with other social services and systems such as housing, employment, physical health care, mental health care.

Most people with mental health conditions, especially serious mental illness, want everything that anybody else wants. Most importantly, they want to work. Many are told, like myself, to go on disability which impedes sometimes your ability to go to work because of how the system of SSI and SSDI work.

If we had to fund—like if we could fully fund a system, I think the system would include well-trained behavioral health professionals. It would include peer support and family support. Family support for adults with serious mental illness is not fully funded. It is funded for parents who are peers to other parents. It would include things like peer respite as well as family respite. We have not even talked about family respite. Those do not even exist, but families sometimes also need a respite and a place to go where they can get support 24/7 to help support their loved ones.

Other things, I think, that are critically important are mobile crisis teams that do include a behavioral health professional and a peer supporter in order to be in the community and also community supports that are sometimes not even part of the system because sometimes people will not go to the mental health system, but they may go to their church or their barber shop. How do we place people there that can be helpful?

The other things that people need, as Kevin Martone pointed out, most importantly, if you do not have a home, how can you participate in treatment and do that with any kind of consistency? Housing is critical, housing is first for people with both mental health and substance use disorders. I think there need to be better partnerships across jurisdictions, including criminal justice and police systems, in order for mental health, criminal justice, and police to work far better together.

Last—oh, I had another one, and I forgot it. There are so many. I think that will give you your list. Thank you.

Senator OSSOFF. Thank you, Ms. Myrick.

Major Bartness, my time is up. I am going to ask you for the record to respond to a more general inquiry. I have asked this of the FBI Director, I have asked this of nominees for senior positions at DOJ as well as in discussions with leaders in Georgia about the increase in violent crime that we have seen nationally over the last year, particularly during this COVID-19 pandemic, and its causes, how you have responded in Baltimore, what you assess to be the factors driving the increase in crime. We have seen a significant increase in the murder rate in Atlanta. We have seen a higher rate of violent crime in Columbus and in other parts of my State. I

know it is a national dynamic, and so I will be submitting to you for the record, Major Bartness, an opportunity to present your analysis to this Committee of what is causing this increase in violent crime.

Senator OSSOFF. I thank you for being here. I thank all of our witnesses for your testimony.

Mr. Chairman, I yield.

Chair BOOKER. Thank you very much. I agree. I want to give a lot of gratitude to all the witnesses who have been here, who have shared such essentially important testimony. This is a crisis in our country, and this is a great hearing where we have talked about solutions.

I apologize. The floor vote is expiring, so I am going to sprint and run, but I will remind everybody that questions for the record are due in 1 week. The hearing record will be open for 1 week for statements and letters or any other contribution that the incredible witnesses want to make to the constructive work that the U.S. Senate and especially the Judiciary Committee has before it.

Thank you very much, everyone. I appreciate it, and have a good day.

[Whereupon, at 12:04 p.m., the hearing was adjourned.]

[Additional material submitted for the record follows.]

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Statement of Ebony C. Morgan

Program Coordinator

Registered Nurse & Crisis Intervention Worker

Crisis Assistance Helping Out On The Streets

(CAHOOTS)

Before the

Subcommittee on Criminal Justice and Counterterrorism

of the United States Senate Judiciary Committee

Hearing on

“Behavioral Health and Policing: Interactions and Solutions”

Presented

April 22, 2021

Good morning, Chairman Booker, Ranking Member Cotton, and members of the Subcommittee on Criminal Justice and Counter Terrorism of the United States Senate Committee on the Judiciary. I was asked to come before you today to discuss my experience providing mobile crisis intervention services with the Crisis Assistance Helping Out On The Streets (CAHOOTS) program of Eugene and Springfield, Oregon.

My name is Ebony Morgan. I am a registered nurse (RN) and I work as the Program Coordinator of CAHOOTS. CAHOOTS is a mobile crisis response team that responds in unarmed pairs to calls for service through police dispatch that have a behavior health component. We meet community members where they are, de-escalate and assess the nature of their crisis, and help them develop a plan. I am inspired to do this work in very personal ways. I will share two with you today.

My grandmother, Carolyn, was an inexplicably kind human being who lived with Severe and Persistent Mental Illness (SPMI). While she thrived until her passing under the care of my mother, who is also an RN, SPMI requires persistent and structured therapeutic support. Many people do not have access to the same degree of capable, unconditional, live-in, loving dedication.

What my mother showed me in caring so diligently for her own mom while raising me was that mental health crises are not to be feared, rejected, or punished. When human beings are scared, confused, escalated, or perhaps even experiencing delusions or psychosis, they need care. People experiencing a crisis need de-escalation, safety, low-barrier access to supports, and unconditional positive regard. Our nation, at both individual and societal levels, often fails to deliver most, if not all of those things to the most vulnerable populations.

My father, Charles, did not get a chance to participate in raising me. He died during an encounter with the police when he was 25 years old. My family, forever worried for his safety as a young Black man, was devastated. I was 5. My half-sister had not yet experienced a birthday. The same police department that surrounded him at the time of his death is who I now meet with monthly in my work leading the CAHOOTS program because we are community partners. Our agencies work together to provide this service to the community.

When I graduated from nursing school, I declined an offer to work at our local hospital on the unit of my dreams. I chose to remain with CAHOOTS, where we make an hourly rate that's less than 50% what a nurse would make inside of the hospital walls and less than 60% of the entry level police officer wage in Eugene. I did this, and took on a leadership role, because this work matters. Myself and my team should not, however, have to sacrifice our own ability to provide for our families in order to support the members of the community that need it the most in a way that is proven to be safe and effective. No one should.

When considering implementing mobile crisis response teams, it is equally as important as anything else to plan how people will be supported in doing this challenging work. Funding must also include adequate wages for skilled personnel (skills do not always equate to education). The inevitable secondary trauma must be addressed proactively. This can be done with debriefs, time off, healing spaces, clinical supervision, and therapy, as examples. Build in ways to support staff and their self-care so that people can mentally and financially afford to remain in the work after developing the unique skills.

It is also extremely important to include a diverse group of voices in the development of programs to ensure there is more than adequate representation to ensure accessibility and relevance to all members of the community. It is imperative to trauma-informed and client-centered care that assumptions are not made that all community members will benefit from the same thing. It must also be explicitly recognized that systemic racism is ever-present and will inevitably work its way into the development of mobile crisis response teams without incorporating anti-racist practices.

Mobile crisis responses are worth the effort of implementation. For more than three decades, CAHOOTS has utilized unarmed, verbal de-escalation to respond to people in crisis. No employee has ever lost their life or been seriously injured on the job despite never carrying a weapon. This surprises people, so I would like to say for the record today: experiencing a mental health crisis does not automatically make someone a threat.

In Eugene and Springfield, Oregon, when someone calls 9-1-1 or the non-emergency police number for help with a non-violent and non-criminal situation, CAHOOTS may be dispatched instead of police by the same dispatchers via police radio. This is especially true if the

call has a mental health or substance use component. Eugene has had this alternative to police response in place since 1989.

We are part of the public safety response system in our area, providing a unique alternative to police in times of crisis. We operate in unarmed pairs with an EMT and a crisis worker. We respond to calls all over the city in our van offering crisis intervention, support, and resources to community members that need it whether they call for themselves or someone calls on their behalf.

In 2019, CAHOOTS had some level of involvement in 20% (20,746) of the total incoming public safety calls for service in Eugene. An exact diversion rate is difficult to determine, but an analysis done by EPD states the “true divert rate” likely falls between 5-8%. This suggests that there is a significant portion of needs in the community that do not rise to the need of a law enforcement response and would not otherwise get addressed. We cannot know exactly how many early interventions by crisis response result in prevention of an escalated call, but it can be assumed that this happens.

CAHOOTS workers are sometimes referred to as Behavioral Health First Responders. Services offered by the program include:

- | | |
|---------------------------|------------------------------|
| • Crisis Counseling | • Substance Abuse |
| • Suicide Risk Assessment | • Housing Crisis |
| • Suicide Prevention | • Non-emergent Medical Care |
| • Mediation | • Resource Connection |
| • Grief Counseling | • Referrals |
| • Welfare Checks | • Transportation to Services |

CAHOOTS responds in pairs with an EMT and Crisis Worker because medical and mental health are equally important components of overall health. This allows us to provide a more holistic approach and be prepared for the wide variety of situations we will encounter.

The medically trained half of our two-person response team operates within the scope of an EMT Basic, while staff range in level from Basic to Advanced and we also have nurses on our team. Due to the nature of our work, our “medics” are also trained in crisis intervention and support the work of our crisis workers.

We do not require licensure for our crisis workers, but people must have two years of experience supporting people in crisis and be eligible for Qualified Mental Health Associate (QMHA) certification. We have Qualified Mental Health Professionals (QMHP) on our staff that provide clinical supervision. Some team members are licensed as LCSWs.

Some of the pillars of operation for CAHOOTS are:

Client-Centered Approach: We encourage people to identify their own needs and help people figure out how to best meet them. We aim to understand how the world looks from the client's point of view and recognize their autonomy, including their right to choose goals and interventions based on their own identified needs.

Trauma-Informed Care: Trauma-informed care means treating a whole person, considering past trauma and the resulting coping mechanisms when attempting to understand behaviors and treat the patient.

Harm Reduction: We support policies and interventions designed to lessen the negative social and/or physical consequences associated with human behaviors.

De-Escalation: We are an unarmed and consent-dependent response. Consent-dependent means that clients have the choice to engage with us and we cannot force anyone to do anything. Given this, it's crucial that we be extremely skilled in de-escalation. New staff undergo over 500 hours each of field training and more than 30 classroom hours before being considered trained.

Now, as the nation is recognizing that mental health crises are best responded to by trained mental health professionals, I am extremely hopeful that together we can find a way to provide humans with the appropriate resources for every situation, instead of a one-size fits all approach to public safety. One size never fits all.

CAHOOTS mobile crisis was not designed to replace, reform, or repair policing. We are an addition to the current structure of public safety. We fill gaps that police were never designed to handle, including but not limited to mental health crises. CAHOOTS staff are not trained in law enforcement and do not have the same authority as police. Sometimes there is an overlap of

needs and we will respond alongside police or paramedics. This is different from what's typically referred to as a co-response because we are arriving separately and bringing each of our own strategies and protocols to a call, working together to achieve the best possible outcome.

We work very closely with our law-enforcement community partners to provide this service. Our contracts with the cities are through the police departments. We meet with the Eugene Police Department monthly to check-in, share feedback, discuss operations, etc. Sometimes we ask for officers on the radio after we are on a scene if we determine the situation warrants a law enforcement response, and often they will call for us if they arrive and find a scene that is more appropriate for a crisis response. Sometimes we work together. The goal is getting the right resource to the right place and working well together to do that.

A significant piece of what keeps us safe (and what dispatch does) is ensure we are responding to appropriate calls. Certain situations would not be appropriate for CAHOOTS to respond to alone as we do not have lights/sirens, cannot force people to engage with us, and are unarmed. These include violent scenes, criminal situations, requests for law enforcement duties, and emergency medical situations. The tools CAHOOTS uses are very valuable, but we do not pretend they are appropriate for every situation. Mobile crisis response is one piece of a very large, very multi-faceted puzzle.

CAHOOTS staff are trained as crisis responders to overcome our own fight or flight response. In escalated moments, where things may be getting broken, people may be yelling, things may be thrown, we remain cognizant of the safety of ourselves and the client while showing them that we are there to help and skillfully bring the situation to a therapeutic de-escalated resolution. In those energized moments, the ability to remain calm and continually assess the scene without giving into reactivity or impulsivity is imperative. Being unarmed allows us to default to client-centered tools (training) that aim to reduce harm because that is our only way forward. We remain highly aware of scene safety, but rather than assuming the client is a threat to us, we assess what is making the client feel threatened. That is where helping begins.

In de-escalation, the client must be able to identify that the responders are not a threat to them. In order to achieve that, we must actually not be a threat to them. For this reason, CAHOOTS deeply values having the trust of our community. We protect client privacy fiercely, which is why we do not bill insurance for services. We secure our own funding so that

community members can access our services free of charge. We wear a casual uniform and practice body language that clearly portrays our controlled, helpful intentions. Just as panic is contagious because humans are social creatures, a sense of calm can be contagious as well. We control the volume and tone of our voice, our dialogue, and our physical response. Trainees spend more than 500 hours practicing this in the field with a fully trained team.

It is extremely important when trying to support those in crisis that resources be available in the community. Mobile crisis services are significantly strengthened when clients can be connected with next steps. If a crisis requires a resource to resolve, the crisis team can connect a client to an existing service but is not a replacement for that. Necessary community supports could include a 24/7 walk-in crisis center, 24/7 crisis phone line, peer-to-peer programs, low-barrier shelter, permanent supported housing, sobering center, detox facility, mental health emergency room or urgent care, etc. The key here in each community would be assessing the specific needs in that area and allocating funding to support those needs, existing programs or new. This should not be a cookie-cutter design. We must respect the diversity, variety, and different needs of specific communities.

CAHOOTS is one long-standing example of the role mobile crisis response can play in a community. Marginalized communities have been coming up with ways to support themselves for much longer than that. Mobile crisis response is a necessary and logical service to provide to communities. It is an addition to existing structures, thus does not directly address or change any existing public safety systems.

Written Testimony of Keris Jän Myrick, MBA, MS

Co- Director, The Mental Health Strategic Impact Initiative

Board Member, Executive Committee, The National Association of Peer Supporters

Before the Subcommittee on Criminal Justice and Counterterrorism
of the United States Senate Judiciary Committee

Hearing on “Behavioral Health and Policing: Interactions and Solutions”

April 22, 2021

Good morning, Chairman Booker, Ranking Member Cotton and members of the Subcommittee. I appreciate this opportunity to give my insights from my personal lived experience and professional life so that we can have a behavioral health crisis response system that works for people living with behavioral health disorders, their families and community where people desire to live work and play that is centered on race equity, rural and frontier communities.

My name is Keris Myrick and I was previously the president of the board of National Alliance on Mental Illness, and executive for the Substance abuse and Mental health services Administration and an executive with the largest public mental health system in the country – Los Angeles County Department of Mental Health. I am currently on the executive committee and board of the National Association of Peer Supporters and working with the Strategic Impact Initiative on Mental Health.

That is a snapshot of my professional self. Equally important is who I am as a person, I am a daughter, sister, cousin friend, Army brat, African American and person given a diagnosis of schizophrenia.

I recall when given a diagnosis of schizophrenia that I believed that no one would want to be my friend, that I was not worthy of help and worse that I was not worthy of love. I did not initially even believe that my struggles were due to having a mental illness. This is how I have felt often as a person of color in this country. I rejected any form of help and due to embarrassment and stigma of mental illness, I did not let people who loved and supported me the most – my parents - into the world that I was experiencing.

My first interaction with the mental health system during a crisis when I was in my 30's in Los Angeles went badly, very badly. My expectation was that an EMT or ambulance would come to my apartment for a "wellness" check when I was in emotional distress. I had been told repeatedly that a mental illness is like any other physical illness and should be treated as such. During a time of confusion, paranoia and extreme emotional distress, the police arrived at the small apartment building where I was the only African American resident. The officer banged on the door and loudly announced that he was from the police department sent to do a welfare check. As a black person, so many things ran through my mind – will the neighbors think that I fit some sort of stereotype about black people being criminals, was I safe to open the door to the police given the many horrific outcomes for African Americans and police interactions. My paranoia was not about my illness it was about the realities of what it is like to be black in America. I let the police in, fearing if I did not they would knock down my door. Being deemed a danger to self, I was handcuffed and taken to the police station where I was then handcuffed to a chair while they spoke to an African American boy about stealing his grandfather's gun – on the table was a gun in a secure gun box. I was trying to understand how it is possible for me to be what everyone said "sick and needing mental health help" yet to be sitting handcuffed to a chair at a police station seeing for the first time in my life a real gun. This was my first experience being in such distress and needing mental health support. What I didn't need was the police response and being treated like a criminal. I needed health care and support.

I found what “care” was all about – asking for help and getting instead handcuffs and being harmed physically and emotionally. From this, I was unwilling to seek the care I needed when I needed it most. All I can think is I am very fortunate not to have had the outcome of Ms. Mitrice Richardson, a 24-year-old African American woman known to have bipolar disorder was picked up by police in the Malibu/Calabasas area of Los Angeles because it was reported she was acting irrationally. Like me she was taken to a police station – but sadly for Ms. Richardson she was released from the station in the middle of the night with no car, phone, wallet or money. Her decomposed body was found 11 months later in the area not far from the police station.

Over the years, I have worked on advocacy and policy issues proclaiming that mental illness is like any other illness and services and supports should be on parity for both.

When someone has a heart attack, asthma, stroke, dementia or even ready to give birth – is this how they are treated? It is not the police who come (unless they are first on the scene) it is Ambulance, Fire with EMTs. So why do we have police responding to mental health emergency situations when others are trained specifically to assess, provide support onsite, transport if necessary to respite, hospitalization and or refer to other community resources if needed?

Meeting a peer supporter especially one who looked like me, having access to supports in ways that I could enter in – like dipping a toe in the water – is how I and many of others with similar needs describe how peer support has helped them.

Peer Support Specialistsⁱ are trained in evidence-based practices such as seeking safety, wellness recovery action plan, intentional peer support and psychiatric advanced directives and with the addition of sharing their personal story of recovery to support another. We see and evidence has shown that people move from homelessness to being housed, unemployed or on disability to employment and from isolation to connection. Peer support has also provenⁱ to help people participate in and adhere to treatment, and for parents and family members to feel more confident in their ability to help their loved ones. Peer Support is cost effective and particularly valuable in rural and other areas that have been strapped for resources. Peer Support Specialists should be part of mobile crisis response with other behavioral health professionals as one of the ways to remove police from the behavioral health crisis response equation. Peer Respiteⁱⁱⁱ while there is some funding in Medicaid for this cost-effective service, should also be fully funded by Medicaid and commercial insurance to enable people in behavioral health crisis who are not in need of hospitalization yet when in crisis have a safe and supportive place to recover.

These are unprecedented times – a world reeling from the pandemic, racial unrest, economic challenges and trauma especially for those who have been so disproportionately impacted. If we want people to engage in their recovery, build resilience and flourish, we need to create crisis response and systems that look like other health crisis response without police as first responders. We need Federal, State and local systems that can support people when they need help during a mental health emergency. Fortunately there are some blueprints from recent reports that can help us get there such as: The Group for the Advancement of Psychiatry (GAP) report : *“Roadmap to the Ideal Crisis Systems”*^{iv}, and a report of the Front End Project which is the only one that centers those with lived experience and race equity in the vision for crisis response reform: *“From Harm to Help: Centering Race Equity and Lived Experience in Crisis Response”*^v.

Developing the new 988 phone number for everyone to call specifically for these kinds of crisis situations in lieu of 911 is a start. This has created momentum for more comprehensive reforms. Yet, without the explicit inclusion of peer support throughout, centered on race equity and lived experience in the design, implementation and evaluation – we may not yield the systems that are most effective and one’s people with mental health needs, their families, the communities they live in and even as the police have said they want.

This is what we need and today I ask that we support legislation and robust funding to ensure equity is really equity in behavioral health crisis response. I ask that if we are to move from handcuffs to help we must work together to ensure the safety of all including the police in creating systems that are humane, compassionate, effective and help people to flourish to their full potential.

Respectfully Submitted by

Keris Jän Myrick, MBA, MS, CPMC

4.22.2021

ⁱ <https://www.peersupportworks.org/resources/>

ⁱⁱ https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tac/brss_tac_value-of-peers-2017.pdf

ⁱⁱⁱ <https://www.livelearninc.net/peer-respite>

^{iv} https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?dof=375ateTbd56

^v <https://fountainhouse.org/reports/from-harm-to-health>



Senate Subcommittee on Crime and Terrorism
Behavioral Health and Policing: Interactions and Solutions
Dirksen Senate Office Building Room 226

Testimony by Kevin Martone
April 22, 2021

Senator Booker and Members of the Committee:

Thank you for the opportunity to speak with you today about alternatives to policing. I will be speaking to you regarding one aspect of police reform – the overutilization of law enforcement to manage mental health emergencies.

My name is Kevin Martone and I am executive director for the Technical Assistance Collaborative, a national, non-profit agency that provides technical assistance to federal, state and local systems on mental illness, substance use disorders, homelessness and affordable housing. I have spent nearly 30 years working in the public mental health system, as a provider of direct services, as commissioner for the public mental health system in New Jersey, as chairperson for the National Association of State Mental Health Program Directors, and incoming president for the National Association for Rural Mental Health. I am also part of a racially diverse family and a family member committed to helping a loved one define her life beyond mental illness and navigate the racism that she experiences in her daily life.

The Problem

In many parts of the United States, 9-1-1 is the default mental health crisis line, law enforcement is the default mental health emergency response, and local jails are the default treatment provider. We have criminalized a public health issue, and delegated responsibility to law enforcement and the criminal justice system.¹

There are approximately 240 million calls made to 9-1-1 in the U.S. each year.² Estimates are that behavioral health emergencies constitute between five to fifteen percent (i.e. between 12 million to 36 million) of all calls to 9-1-1 systems.³ Many of these are classified by local dispatchers as “wellness checks,” “disturbances,” “intoxicated persons,” or “mental crises” and do not always require police

¹ While the focus of this testimony is on mental health emergencies, consideration should be given to emergencies involving substance use disorders given the co-occurrence of these illnesses.

² National Emergency Number Association.

³ <https://www.nena.org/page/911Statistics#:~:text=An%20estimated%20240%20million%20calls,more%20are%20from%20wireless%20devices>.

³ Balfour, M.E., Hahn Stephenson, A., Winsky, J., & Goldman, M.L. (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors.

presence.⁴ It is estimated that 80% of mental health calls to 9-1-1 are resolved without the need for police involvement when diverted to a crisis line.⁵ However, law enforcement are often sent.

While a police response may be justified, especially if a weapon is involved, unnecessarily dispatching armed officers to calls where their presence is unnecessary is more than just an ineffective use of safety resources;⁶ it can also create substantially adverse outcomes for communities of color, individuals with behavioral health disorders and disabilities, and other groups who have been disproportionately affected by the criminal justice system.⁷

According to the International Association of Chiefs of Police, “the mere presence of a law enforcement vehicle, an officer in uniform, and/or a weapon ... has the potential to escalate a situation” when a person is in crisis.⁸ Police may not understand how a particular disability manifests and may assume that an individual’s reaction—or lack of reaction—to law enforcement is a show of defiance.

All too often, these calls for service result in unnecessary fatalities: People with serious mental health disorders are sixteen times more likely than the general public to be killed during a police encounter.⁹ Today, in an era when deadly police violence is top of mind, one in four fatalities by police involve people experiencing a mental health emergency.

The people with mental health needs involved in these incidents are, much like their counterparts incarcerated in jails and prisons, disproportionately Black and Brown. Police use of force is among the leading causes of death for Black men and boys, who are two and a half times more likely than their white peers to be killed by law enforcement.¹⁰ Half of all people killed by police are people of color,¹¹ and their rate of death at the hands of police during a mental health emergency is even higher than that of the overall population. When combined with mental illness, this difference is nearly ten-fold.¹²

⁴ Center for American Progress. The Community Responder Model How Cities Can Send the Right Responder to Every 911 Call. By Amos Irwin and Betsy Pearl October 2020.

https://cdn.americanprogress.org/content/uploads/2020/10/27134835/Alternatives911-report.pdf?_ga=2.132902987.459527533.1618881407-1494161287.1617639366

⁵ Substance Abuse and Mental Health Services Administration (2020). *National guidelines for behavioral health crisis care – a best practice toolkit*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

⁶ The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness, a National Survey. Treatment Advocacy Center Road-Runners. 2020. A survey of law enforcement agencies in the U.S. estimated the nationwide cost of transporting people with severe mental illness is \$918 million annually.

⁷ Center for American Progress

⁸ IACP Law Enforcement Policy Center, “Responding to Persons Experiencing a Mental Health Crisis” (Alexandria, VA: 2018), available at <https://www.theiacp.org/sites/default/files/2018-08/MentalIllnessBinder2018.pdf>.

⁹ Fuller, A., Lamb, H. R., Biasotti, M., & Snook, J. (2015). “Overlooked in the undercounted: The role of mental illness in fatal law enforcement encounters.” Arlington, VA: Treatment Advocacy Center. Retrieved from: <https://www.treatmentadvocacycenter.org/overlooked-in-the-undercounted>

¹⁰ Frank Edwards, Hedwig Lee, and Michael Esposito, “Risk of being killed by police use of force in the United States by age, race-ethnicity, and sex,” *Proceedings of the National Academy of Sciences of the United States of America* 116 (34) (2019): 16793–16798, available at <https://www.pnas.org/content/116/34/16793>.

¹¹ The Guardian. Black Americans killed by police twice as likely to be unarmed as white people. <https://www.theguardian.com/us-news/2015/jun/01/black-americans-killed-by-police-analysis>

¹² Saleh AZ, Appelbaum PS, Liu X, Scott Stroup T, Wall M. Deaths of people with mental illness during interactions with law enforcement. *Int J Law Psychiatry* 2018;58:110–6 15 Wildeman C, Wang EA. Mass incarceration, public health, and widening inequality in the USA. *Lancet Lond Engl* 2017;389(10077):1464–74



Surveys by the National Alliance on Mental Illness have found that people experiencing a mental health crisis are more likely to encounter police than to get medical attention, resulting in two million people jailed every year.¹³ Balfour and colleagues (Balfour, 2020) describe the transition to correctional settings. The prevalence of mental illness and substance use disorders in jails and prisons are three to four times that of the general population.^{14,15} Once in jail, people with mental illness are incarcerated twice as long, and few receive needed treatment.^{16,17,18} Upon release, with Medicaid benefits interrupted and a criminal record, they are more likely to be unemployed, homeless, and rearrested.^{19,20,21,22}

Why is there overutilization of law enforcement in responding to mental health emergencies?

The problem is more complex than we have time for today, and I will highlight a few of the factors that have resulted in this.

Generally, a series of cascading issues over the past several decades has resulted in two driving factors:

1. A fragmented, underfunded, undervalued, and inaccessible mental health system. This is compounded by poor health insurance coverage, limited funding for services at the federal, state, and local level, mental health workforce shortages, and geographic challenges and transportation issues that impact services access, especially in rural areas.

This has been exacerbated during COVID by increasing demand and reduced provider capacity. The rate of people in the U.S. with mental health concerns such as anxiety, depression, and suicidal thoughts has doubled to more than 40% since March 2020 compared to previous years, according to the CDC – with people of color and low-wealth people among those most affected.^{23,24}

¹³ National Alliance on Mental Illness. <https://www.nami.org/Advocacy/Policy-Priorities/Responding-to-Crises>

¹⁴ Steadman HJ, Osher FC, Robbins PC. Prevalence of serious mental illness among jail inmates. *Psychiatr Serv* Wash DC 2009;60(6):761–5

¹⁵ Glaze LE, James DJ. Mental Health Problems Of Prison And Jail Inmates. Bureau of Justice Statistics. NIMH Statistics [Internet]. 2006; Available from: <https://www.nimh.nih.gov/health/statistics/index.shtml>

¹⁶ The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey. Treatment Advocacy Center & National Sheriffs Association. 2014

¹⁷ Dumont DM, Brockmann B, Dickman S, Alexander N, Rich JD. Public health and the epidemic of incarceration. *Annu Rev Public Health* 2012;33:325–39

¹⁸ The Office of National Drug Control Policy, Washington DC [Internet]. Available from: <https://www.whitehouse.gov/ondcp/>

¹⁹ Greenberg G, Rosenheck R. Jail Incarceration, Homelessness, and Mental Health: A National Study [Internet]. 2008; Available from: ps.psychiatryonline.org

²⁰ Glaze LE, James DJ. Mental Health Problems Of Prison And Jail Inmates. Bureau of Justice Statistics. NIMH Statistics [Internet]. 2006; Available from: <https://www.nimh.nih.gov/health/statistics/index.shtml>

²¹ Peterson R. Re-arrests of Homeless Defendants in New York City [Internet]. 2016; Available from: www.nycja.org/library.php

²² Albertson E, Scannell C, Ashtari N. Eliminating gaps in medicaid coverage during reentry after incarceration. *AJPH* 2020;110(3).

²³ CDC. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm>

²⁴ Commonwealth Fund. Beyond the Case Count: The Wide-Ranging Disparities of COVID-19 in the United States. <https://www.commonwealthfund.org/publications/2020/sep/beyond-case-count-disparities-covid-19-united-states>



2. Mental health and other systems that do not sufficiently address social determinants of health, such as racism, poverty, and access to affordable housing, employment, and education. People with mental illness, especially those in communities of color, are disproportionately poor, homeless, and unemployed. All of these are correlated with worse outcomes for people with mental illness.

The result is a de facto national policy that it is acceptable for law enforcement to manage mental health emergencies. If we are to reduce the overuse of law enforcement response to mental health emergencies, we must commit to addressing mental health reform and build the infrastructure needed to create an accessible mental health system.

Opportunities and Solutions

Most law enforcement officials that I have spoken with would prefer to see people with mental illness served in the mental health system. People with mental illness, their families, and providers agree. The events that we have witnessed in the past year alone – the public health and economic impact of COVID, racial and social unrest, and deadly police encounters for Black and Brown people with mental illness – have elevated awareness of the need to treat mental health as the public health issue that it is.

The good news is that there is activity. Recent congressional action has resulted in additional block grant funding for mental health and crisis services, a new Medicaid benefit for mobile crisis services, and funding that can support additional workforce capacity. We have seen important, bipartisan legislation passed recently, including the *Crisis Stabilization and Community Reentry Act* and the *National Suicide Hotline Designation Act of 2020* that establishes a new 9-8-8 suicide prevention and mental health crisis hotline as an alternative to 9-1-1. We have also seen congress take action in the past on major legislation like the *Mental Health Parity and Addiction Equity Act (MHPAEA)* back in 2008 that puts access to mental health and addiction treatment on par with other health conditions.

In February 2020, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) released its National Guidelines for Behavioral Health Crisis Care outlining a potential framework to establish nationwide capacity to respond to mental health emergencies. The guidelines describe three core components deemed essential to meeting the mental health emergency needs of anyone, anywhere, anytime: 24/7 regional crisis hotlines; 24/7 mobile crisis response; and crisis stabilization programs.

Solutions exist. In recent years, several communities have established emergency mental health systems that include 24/7 crisis hotlines, mobile crisis response teams, and crisis stabilization programs led by mental health system, often in partnership with law enforcement, as alternatives to police led response. Programs that you have heard about, like Eugene, Oregon's CAHOOTS, the Support Team Assisted Response (STAR) program in Denver, the Crisis Response Unit (CRU) in Olympia, Washington, and the Rapid Integrated Group Healthcare Team (RIGHT) Care in Dallas, Texas are creating new ways to respond to mental health emergencies.²⁵ These programs dispatch civilian crisis responders for calls

²⁵ Jessica Porter, "New program diverts some 911 calls from police to a mental health team," Denver 7, July 2, 2020, available at <https://www.thedenverchannel.com/news/local-news/new-program-diverts-some-911-calls-from-police-to-a-mental-health-team>; Angela Ufheil, "The STAR Van Offers an Alternative to Police," 5280, June 17, 2020, available at <https://www.5280.com/2020/06/the-starvan-offers-an-alternative-to-police/>; Urban

related to behavioral health crises, substance use disorders, and other social service needs, and programs include peer responders who have lived experience with the concerns they are responding to, making them uniquely credible and effective in engaging difficult-to-reach individuals.²⁶

Our system response efforts need to push further upstream to prevent crises from occurring to begin with. Access to evidence-based services like supportive housing, Assertive Community Treatment, specialized peer support, employment supports, children's system of care, and other approaches are known to promote recovery and reduce interactions with the crisis system, but do not have the capacity or workforce to meet demand in many areas of the country for adults and children.

In closing, to the extent that law enforcement will likely continue to have some role for the foreseeable future in responding to mental health emergencies, at least in situations when public safety is a concern, law enforcement must own reforms for how it responds to people with mental illness, especially those who are Black and Brown. This work should be informed by people who experience mental illness, racial equity and justice groups, and other key stakeholders. If we are to reduce law enforcement response to mental health emergencies, we must commit to addressing mental health reform and build the infrastructure needed to create an accessible mental health system.

Respectfully submitted,



Kevin Martone, LSW
Executive Director

Enclosure:

From Harm to Health: Centering Racial Equity and Lived Experience in Mental Health Crisis Response. A report prepared by The Front End Project; a collaboration between the Technical Assistance Collaborative (TAC), Fountain House, the Center for Court Innovation (CCI), The W. Haywood Burns Institute, and the Mental Health Strategic Impact Initiative (S2i), with support from the Ford Foundation.
<https://fountainhouse.org/reports/from-harm-to-health>

Strategies Council, "Report on Feasibility and Implementation of a Pilot of Mobile Assistance Community Responders of Oakland (MACRO)" (Oakland, CA: 2020), available at https://urbanstrategies.org/wp-content/uploads/2020/06/USC-MACRO-REPORT-6_10_20.pdf; Christian Hill, "Local crisis unit in cahoots with more police agencies," *The Register-Guard*, December 14, 2018, available at <https://www.registerguard.com/news/20181214/local-crisis-unit-in-cahoots-with-more-police-agencies>.

²⁶ Maya Chiodo, "Caring for Denver Issues First Grants Worth About \$2 Million," *5280*, February 4, 2020, available at <https://www.5280.com/2020/02/caring-for-denverissues-first-grants-worth-about-2-million/>; Denver Police Dept., @DenverPolice, June 11, 2020, 9:05 p.m. ET, Twitter, available at <https://twitter.com/DenverPolice/status/127124711032582147?s=20>; RI International, "Community Support Teams," available at <https://riinternational.com/recovery/community-support-teams/> (last accessed October 2020); City of Olympia, "Crisis Response & Peer Navigators," available at <http://olympiawa.gov/city-services/police-department/Crisis-Response-Peer-Navigator.aspx> (last accessed October 2020).



Written Testimony of Major Martin A. Bartness
Commander
Education & Training Section
Baltimore Police Department

Before the Subcommittee on Criminal Justice and Counterterrorism
of the United States Senate Judiciary Committee

Hearing on “Behavioral Health and Policing: Interactions and Solutions”

April 22, 2021

Good morning Committee Chairman Booker, Ranking Member Cotton, and distinguished members of the Subcommittee on Criminal Justice and Counterterrorism of the Senate Judiciary Committee. My name is Major Martin Bartness, and I am a 24-year member of the Baltimore Police Department, where I currently serve as the Commander of Education & Training and lead the Crisis Response Program. I am also a Bloomberg Fellow at the Johns Hopkins Bloomberg School of Public Health.

While it is my privilege to appear before you today, I wish my presence were not necessary. We have come together, in large measure, because for at least the past decade, law enforcement actions have led to the annual death of about 1,100 people nationwide. The non-profit *Treatment Advocacy Center* estimates that 25% to 50% of these deaths involve persons who have been diagnosed with a severe mental illness.ⁱ In the past three weeks alone, more than a dozen “people who were mentally ill or in the throes of a breakdown” were killed by police.ⁱⁱ These tragedies point to the urgent need for law enforcement to partner with behavioral health professionals, community stakeholders, and individuals with lived experience to develop and implement solutions that most effectively respond to persons in crisis and meet the complex behavioral health needs of those we serve.

We are in this situation because of public policy decisions made decades ago, when psychiatric institutions were closed and those living with mental illness were returned to their communities without adequate treatment and support. While these institutions were not the answer, states and municipalities failed to provide the supports and treatment needed for people with mental illness to live free from discrimination in their communities. To this day, in Baltimore and many other locales across the United States, the behavioral health system’s goal of crisis prevention has not been realized. I will share a story to highlight this point. In June of

last year, a 19-year-old man, completely nude and in psychiatric crisis, repeatedly fired a handgun at motorists as he walked the streets of his Baltimore neighborhood. Police responded, safely took the man into custody, recovered the firearm he had been discharging, and drove him to an emergency room for psychiatric treatment. This would have been a great outcome except for within six days of his release from the hospital, he had another psychotic episode. This time, when officers answered the 911 call to his home and calmly attempted to de-escalate him, the man pulled a handgun from his pants pocket and pointed it at the officers. In fear for their lives, the officers shot him. He is now paralyzed.

Far too often, police find themselves in positions like this, where the behavioral health system has failed to meet consumers' needs. This is why an estimated 10% of total police calls involve mental health situations.ⁱⁱⁱ Inadequate funding and a system that diffuses responsibility among numerous, uncoordinated entities are at the core of the problem. As a result, people experience crises more frequently, and police are thrust into the role of a last-resort safety net for people in crisis. Even when police peacefully handle behavioral health calls and link consumers to service providers, these calls can take a lot of time, which is often at odds with the demands of the 911 system and the expectations communities have for timely police response to crime and disorder.

I know we can do better. My testimony today is informed by 10 years of partnering with behavioral health professionals. I have witnessed firsthand how service delivery is improved dramatically when police partner with highly-trained clinicians to conduct forensic interviews of sexually abused children; when police partner with victim advocates to coordinate counseling services to survivors of intimate partner violence; when police partner with outreach workers whose credibility within our nation's most marginalized communities allows them to interrupt

and mediate disputes to disrupt cycles of retaliatory violence; and when police co-respond with licensed clinical social workers to de-escalate a person in crisis.

Through these kinds of successful partnerships between the criminal justice and behavioral health systems, we have demonstrated how it is possible to improve public health outcomes for even the most challenged populations. Moving forward, I hope you will help build upon the promising practices of behavioral health programs like CAHOOTS in Eugene, Oregon,^{iv} STAR in Denver, Colorado,^v and GBRICS in Baltimore, Maryland.^{vi} I hope you will fund research so that jurisdictions can make evidence-based decisions for allocating scarce resources. I hope you will incentivize law enforcement, behavioral health providers, and academic institutions to collaborate on policy writing, training, data analysis, and outcome evaluation. And I hope you will heed the calls of behavioral health practitioners and clinicians to fund crisis response services, long-term treatment, and community-based providers at the levels needed to meet the extraordinary demands.

I thank you for the opportunity today to discuss how the Committee can make our communities safer and more responsive to the millions of people who desperately need a robust behavioral health and crisis response system. Your support of law enforcement, behavioral health professionals, and the citizens we serve is greatly appreciated.

Thank you, Mr. Chairman.

ⁱ Maciag M. 2016 May. The Daily Crisis Cops Aren't Trained to Handle. *Governing*. Accessed April 19, 2021 at <https://www.governing.com/archive/gov-mental-health-crisis-training-police.html>

ⁱⁱ Eligon J and Hubler S. 2021 April 17. Throughout trial over George Floyd's death, killings by police mount. The New York Times. Accessed April 19, 2021 at <https://www.nytimes.com/2021/04/17/us/police-shootings-killings.html?referringSource=articleShare>

ⁱⁱⁱ Maciag M. 2016 May. The Daily Crisis Cops Aren't Trained to Handle. *Governing*. Accessed April 19, 2021 at <https://www.governing.com/archive/gov-mental-health-crisis-training-police.html>

^{iv} What Is CAHOOTS? <https://whitebirdclinic.org/what-is-cahoots/>

^v Hauck G. 2021 February 6. Denver successfully sent mental health professionals, not police, to hundreds of calls. USA Today. Accessed April 20, 2021 at <https://www.usatoday.com/story/news/nation/2021/02/06/denver-sent-mental-health-help-not-police-hundreds-calls/4421364001/>

^{vi} Greater Baltimore Region Integrated Crisis System (GBRICS) Partnership. <https://www.bhsbaltimore.org/learn/gbrics-partnership/>

**Statement to the U.S. Senate Committee on the Judiciary
Subcommittee on Criminal Justice and Counterterrorism**

Hearing on Behavioral Health and Policing

Thursday, April 22, 2021

Washington, DC

Contextualizing Criticisms of Policing and Understanding the Limits of “Alternatives”

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About the Author

Rafael A. Mangual is a senior fellow and deputy director of legal policy at the Manhattan Institute for Policy Research**—a 501(c)(3) public policy think tank—and a contributing editor of *City Journal*, a quarterly magazine published by the Manhattan Institute (MI). He has authored and coauthored a number of MI reports and op-eds on issues ranging from urban crime and jail violence to broader matters of criminal justice reform. His work has been featured and mentioned in a wide array of publications, including *The New York Times*, *Wall Street Journal*, and the *Washington Post*. Mangual has also made a number of national and local television and radio appearances on outlets such as Fox News, C-SPAN, and NPR. He holds a B.A. in corporate communications from the City University of New York’s Baruch College and a J.D. from DePaul University’s College of Law in Chicago, IL.

***The Manhattan Institute for Policy Research does not take institutional positions on legislation, rules, or regulations. Although my comments draw upon my research and writing about criminal justice issues as an Institute scholar, my statement to the Subcommittee is solely my own, not my employer’s.*

Statement

I'd like to thank the Subcommittee for the invitation to deliver testimony. It is an honor and a privilege to address this body on an issue that is among the most important public policy debates of our time. Unfortunately, it's also among the most divisive.

Much of the conversation about how to reform policing in the United States seems to be driven by a key misperception: that police violence is a likely outcome of an investigative or enforcement interaction—particularly when those interactions involve people of color. For example, in a report released by the Manhattan Institute earlier this month, political scientist Eric Kaufmann found that 8 in 10 African American survey respondents “believe that young Black men are more likely to be shot to death by the police than to die in a traffic accident”; and “among a highly educated sample of liberal Whites, more than 6 in 10 agreed.”¹ A 2016 *Morning Consult* poll found that twice as many Black respondents reported worrying about those they know becoming victims of police brutality than of gun violence, generally.²

But these beliefs are completely at odds with the data on police use of force. A recent study published in the *Proceedings of the National Academy of Sciences (PNAS)* shows that young Black men (between the ages of 25-29) are killed by police “at a rate between 2.8 and 4.1 per 100,000,” which is far lower than the rate at which they die in traffic accidents.³ That same *PNAS* study put the odds of dying at the hands of police at 1 in 1,000 for black men. Contrast that with the odds for *all* Americans (i.e., of *any* race) of being killed by gun assault, which, according to the National Safety Council, are *dramatically* higher at 1 in 298.⁴ Given that Black men are more than *10 times more likely* than their White counterparts to be the victim of a homicide, it's quite clear that their risk of death at the hands of police is *far* lower than their risk of being killed by gun violence, generally.

And while 83% of respondents to a Pew Research survey guessed that the typical police officer has fired his gun at least once on the job, only about 1 in 4 (27%) actually do.⁵

In reality, police very rarely use force; and when they do, it very rarely results in serious injury.

In 2018, police officers in the U.S. discharged their firearms an estimated 3,043 times.⁶ That year, they made more than 10.3 million criminal arrests.⁷ Attributing each of the 3,043 estimated

¹ Eric Kaufmann, [The Social Construction of Racism in the United States](#), MANH. INST. FOR POL'Y RES. (Apr. 2021).

² Eli Yokley, [Poll: Voters More Worried by Violence Against Police Than Police Brutality](#), MORNING CONSULT (Jul. 11, 2016) (see crosstabs).

³ Edwards, Lee, and Esposito, [Risk of being killed by police use of force in the United States by age, race-ethnicity, and sex](#), PNAS (2019); see also, Alex Berezow, [Most Dangerous Drivers Ranked By State, Age, Race, And Sex](#), AMERICAN COUNCIL ON SCIENCE AND HEALTH (Aug. 10, 2018) (showing that the traffic death rate for Blacks is about 13 per 100,000).

⁴ [Lifetime odds of death for selected causes, United States](#), 2018, NSC.org.

⁵ Rich Morin and Andrew Mercer, [A closer look at police officers who have fired their weapon on duty](#), FACTTANK, PEW RES. CENTR. (Feb. 8, 2017).

⁶ Rafael A. Mangual, [Police Use of Force and the Practical Limits of Popular Reform Proposals: A Response to Rizer and Mooney](#), FEDERALIST SOCIETY REVIEW, Vol. 21 at p. 129 (2020).

⁷ [Crime in the United States, 2018: Table 29 \(Estimated Number of Arrests\)](#), FEDERAL BUREAU OF INVESTIGATION.

firearm discharges by police in 2018 to a unique officer would mean that, at most, 0.4% of officers purposely discharged a firearm in 2018; and assuming that every shooting happened during the course of a separate arrest would mean that, at most, police applied deadly force with a firearm in just 0.003% of arrests.⁸

As to non-deadly force, in 2018, a research team of doctors and a criminologist published a thorough study of police use of force in *The Journal of Trauma and Acute Care Surgery*.⁹ The study analyzed over a million calls for service to three midsized police departments in Arizona, Louisiana, and North Carolina over a two-year period. Those calls resulted in more than 114,000 arrests. Physical force was used in 1 of every 128 of them, meaning that more than 99% of arrests were effected without any use of force.¹⁰ The study went on to find, based on expert medical examinations of suspects' medical records, that 98% of suspects on whom police used physical force "sustained no or mild injury," and 1.8% of suspects sustained moderate or severe injuries (only one suspect was fatally wounded by police gun fire during the study period).¹¹

Nor are uses of force likely when you drill down into particularly dangerous police encounters or encounters involving those in crisis. Take my home city of New York for example. In 2020, the NYPD made 20,935 arrests of suspects who possessed weapons.¹² They also responded to 161,278 911 calls for persons in crisis.¹³ Yet, the Department recorded just 42 firearm discharges in 2020, including off-duty shootings.¹⁴ It would seem that, by and large, police are generally pretty skilled at dealing with dangerous and/or unstable subjects without relying on brute force.

Of course, none of this means that there isn't room for improvement, or that police are perfect. There is, and they're not. Exploring opportunities for reform is a worthwhile endeavor; but it's one that must be undertaken soberly, because pulling the wrong policy lever can have disastrous effects, particularly on crime. That's a risk we should be especially cognizant of now, given the sharp uptick in shootings and homicides across the country.

Last year, for the first time since 1995, criminologists have estimated, based on preliminary figures, that the U.S. saw at least 20,000 criminal homicides—an increase of about 4,000 additional homicides compared to 2019.¹⁵ While that's still a ways off from the nearly 25,000 homicides the country experienced in 1991,¹⁶ some cities have seen their homicide numbers approach and even surpass their 1990s peaks. In 2020, Cleveland, OH had its highest murder

⁸ Mangual, *supra* note 5.

⁹ William P. Bozeman et al., [Injuries associated with police use of force](#), 84 J. TRAUMA & ACUTE CARE SURGERY 466 (Mar. 2018).

¹⁰ *Id.*

¹¹ *Id.*

¹² See, [NYPD Force Dashboard](#) (start date, Wednesday, Jan. 1, 2020; end date, Thursday, Dec. 31, 2020).

¹³ *Id.*

¹⁴ See, [Use of Force Data Tables](#), NYPD (see quarterly incidents by force category).

¹⁵ German Lopez, [2020's historic surge in murders, explained](#), Vox (Mar. 25, 2021).

¹⁶ Alexia Cooper & Erica L. Smith, [Homicide Trends in the United States, 1980-2008](#), BUREAU OF JUSTICE STATISTICS (Nov. 2011).

tally since 1982;¹⁷ Minneapolis, MN had more murders than every year since 1995;¹⁸ Cincinnati, OH and Louisville, KY both set new homicide records.¹⁹

That uptick, it should be noted, was not evenly distributed. It was heavily concentrated in minority neighborhoods already struggling with elevated levels of crime. While many conversations about policing in America tend to focus heavily on racial disparities in various enforcement statistics, we should also remember that while people of color may bear a disproportionate share of the costs attributable to policing, the burden of serious violent crime increases is one that also falls disproportionately on the shoulders of people of color. In New York City, going back to at least 2008, a minimum of 95% of all shooting victims were either Black or Hispanic; 2020, which saw shootings spike 97%, was no exception.²⁰

It has been well-documented that policing can produce real societal benefits in the way of reduced crime. There are a number of strong studies done throughout the country over the course of many years that find additional policing to have significant crime-reduction effects. In laymen's terms, what those studies bear out is that, generally speaking, more police means less crime.²¹ And just as people of color—particularly Black men—are disproportionately impacted by crime increases, they disproportionately benefit from crime declines. Between 1991–2014, the U.S. experienced a sharp decline in homicides. A 2019 analysis of that decline showed that, during that period, “the decline of homicide-specific mortality led to increases in [life expectancy] of... 0.14 years [] for white males,” versus “1.00 years [] for African American males.”²² To contextualize that datapoint, that same study's lead author wrote in his 2018 book that, “[T]he impact of the decline in homicide on the life expectancy of black men is roughly equivalent to the impact of eliminating obesity altogether.”²³

¹⁷ Adam Ferrise, *‘It’s like war numbers’: Cleveland endures worst homicide rate in recent history in 2020*, CLEVELAND.COM (Jan. 1, 2021).

¹⁸ Libor Jany, *Minneapolis violent crimes soared in 2020 amid pandemic, protests*, MINNEAPOLIS STAR TRIBUNE (Feb. 6, 2021).

¹⁹ See, Jennifer Edwards Baker, *Cincinnati police updates council on 2020 crime stats, record-high homicides*, FOX19 (Jan. 20, 2021); and Kachmar, Aulbach, and Bullington, *170-plus killings and few answers: Louisville besieged by record homicides and gun violence*, COURIER JOURNAL (Jan. 5, 2021).

²⁰ See, *Crime and Enforcement Activity Reports*, NYPD (Each of the reports from 2008-2020 break down the percentages of shooting victims by race).

²¹ A robust body of research suggests that replenishing departments can and will have significant crime-reduction effects. Some examples: Economists Jonathan Klick and Alexander Tabarrok found a strong causal connection between police presence and crime, showing that the latter declined when the former was boosted. (See, *Using Terror Alert Levels to Estimate the Effect of Police on Crime*, J.OF LAW & ECON. 48, no. 1 at p. 267–79 (Apr. 2005)). In another study, Klick, along with criminologist John MacDonald and law professor Ben Grunwald, found that an increase in police patrols around the University of Pennsylvania “decreased crime in adjacent city blocks by 43%–73%.” (See, *The Effect of Private Police on Crime: Evidence from a Geographic Regression Discontinuity Design*, J. OF THE ROYAL STAT. SOC. 179, no. 3 at p. 831–46 (Jun. 2016)). Criminologist Aaron Chalfin, along with law professor Justin McCrary, found “reduced victim costs of \$1.63 for each additional dollar spent on police in 2010, implying that U.S. cities are under-policed.” (See, *Are U.S. Cities Underpoliced? Theory and Evidence*, REV. OF ECON. AND STAT. 100, no. 1 at p. 167–86 (Mar. 2018)).

²² Patrick Sharkey and Michael Friedson, *The Impact of the Homicide Decline on Life Expectancy of African American Males*, DEMOGRAPHY (Mar. 5, 2019).

²³ Patrick Sharkey, *Uneasy Peace: The Great Crime Decline, the Renewal of City Life, and the Next War on Violence*, W. W. Norton & Company (2018).

Crime declines are often cited as examples of policing's success by police executives, rank and file officers, and other defenders of the institution. One question that might be worth considering, given the rhetorical posture of the current debate about American policing is whether an institution whose stated purpose (as stated by both those at its helm and its lower ranks) is to produce outcomes that the evidence tells us disproportionately benefits minorities can be fairly categorized as systemically racist toward those very minority groups. The answer to the question isn't simple. Black and Hispanic communities do bear disproportionately the costs of policing, including false-positive police interventions, a phenomenon partly but probably not wholly attributable to underlying variations in violent crime levels. But at a minimum, if we're assessing the racial impact of policing, it's important to look at both sides of the ledger—that is, not only at the costs but also the benefits.

I suspect that sincerely held misperceptions about police have shaped the overarching goal of the reform movement, which, at the moment, seems to be to minimize the footprint of police (and the criminal justice system more broadly) in any way possible. We have heard calls to “defund” the police—which, in some cities, have been heeded. We have also heard calls to divert more responsibilities—particularly things like traffic enforcement, and responding to mental health calls—away from police to unarmed civilians. The assumption is that this will reduce the scope of interactions that might result in tragedy. But, even if that's true in the case of traffic enforcement, for example, it will also reduce the scope of interactions that might lead to the discovery of more serious criminal activity. In 1995, the National Institute of Justice published a study entitled, *The Kansas City Gun Experiment*, which analyzed enforcement and deployment decisions targeted in hot spots for gun violence. Among the key findings, it was noted that, in the targeted beats, “Traffic stops were the most productive method of finding guns, with an average of 1 gun found in every 28 traffic stops.”²⁴ What needs to be carefully considered is the reality that many “lower-level” interactions can and often do lead to the discovery of contraband, the closure of open warrants, and the recovery of illegal firearms. Zeroing out those encounters, therefore, will not be cost-free.

On the mental health front, there is some evidence to suggest that we should continue to invest in efforts to augment the police by deploying civilian crisis intervention teams to calls involving people in crisis. In a report released just yesterday, my Manhattan Institute colleague, Charles F. Lehman reviews some of that evidence.²⁵ Among the approaches evaluated in that report is a popular, oft-cited, and promising effort launched in Eugene, OR, called CAHOOTS (Crisis Assistance Helping Out On The Streets). While effective, CAHOOTS is also a case study in the limits of programs loosely referred to as alternatives to policing. As Lehman notes in his report:

CAHOOTS responders are highly specialized. In 2019, they covered just 17% of Eugene 911 calls, with 75% of those calls being a welfare check, providing transportation to someone (usually homeless or in need), or assisting the police already on the beat. Even in those relatively limited circumstances, CAHOOTS responders still called for backup in roughly one in every 67 calls for service in 2019.

²⁴ Sherman, Shaw, and Rogan, *The Kansas City Gun Experiment*, NAT'L INST. OF JUST., Research Brief (Jan. 1995).

²⁵ Charles Fain Lehman, *Policing Without the Police? A Review of the Evidence*, MANH. INST. FOR POL'Y RES., Report (May, 2021).

It is hard to see that model scaling up to cover the other 83% of 911 calls to the Eugene PD. Doing so would involve not only dramatically scaling up CAHOOTS's \$2.1 million budget but also identifying a large population of trained CIT professionals and, most significantly, asking those professionals to handle situations that grow increasingly risky as responsibility expands. In other words, though it doubtless provides a useful service now, groups like CAHOOTS are not a model for how to replace the police. But as a complement to policing, it may be a useful model for other cities to adopt.²⁶

When you consider the sheer volume of mental health calls received by police (not to mention the fact that they're often received in the late-night or early-morning hours), it becomes clear that we simply don't have the capacity to shift this particular responsibility in total. Another complicating factor is that it is often unclear as to whether a call can be accurately categorized as one that can be safely diverted to civilian responders trained in mental health crises as opposed to police based on either 911 calls or dispatcher information. One study of such calls for service in the city of Philadelphia recently found "that some medical or public health activity initially masquerades as crime or other policing work and some events eventually determined to be police/crime activity can initially appear to be public health related."²⁷ The study went on to note that "[a]bout 20% of activity in this area does not appear predictable from the initial call type as handled by police dispatch."²⁸

None of this is to say that improving outcomes in policing isn't something we should pursue with vigor. It is. I have outlined a number of reforms that would be worth pursuing in the short and long-run;²⁹ and I will talk about some of those in my oral testimony. But, while reform is a worthy pursuit, it cannot be allowed to cause us to lose sight of the government's first duty, which is to provide for the public's safety. As serious violent crime across American cities continues to rise in the first months of this year, that mission should be viewed as more critical than ever.

Thank you.

****Note to the Subcommittee: This statement reflects an earnest attempt to balance the competing goals of thoroughness and concision. As such, it is quite possible that the Subcommittee may desire more information on the points laid out above. Should further questions arise, please do not hesitate to contact me, as I would be more than happy to supplement what I've submitted.*

²⁶ See, *Id.* at p. 7 (internal citations omitted).

²⁷ Jerry H. Ratcliffe, [Policing and public health calls for service in Philadelphia](#), CRIME SCIENCE, Vol. 10, Art. No. 5 (2021).

²⁸ *Id.*

²⁹ See, e.g., Rafael A. Mangual, [MI Responds: Five Ideas for a More Sensible Approach to Police Reform](#), MANH. INST. FOR POL'Y RES. (Jun. 12, 2020).

Statement of Terri O'Connor

My name is Terri O'Connor. As you just heard from my short bio, my husband, Jim, was a Philadelphia Police Officer. Jim was a Corporal in Swat who was shot and killed in the line of duty on March 13, 2020. Jim's death will never seem real, he served the police department for 23 years. His father was also a Philadelphia Police Officer, serving for over 40 years. Our son, and daughter-in-law, are both currently, Philadelphia police officers. Our police family extends to numerous other family members, too. This is the one job we all know too well. I, myself, started out as a police dispatcher. I had first-hand experience of hectic situations, and numerous emergencies. My job was to keep a cool voice and calmness to whatever situation needed to be dealt with. Our goal was to have every officer go home at the end of each shift.

Defunding the police is dangerous. Look at what has happened in cities like Seattle and Portland -- and in so many large cities across the country -- murders are up and there is a sense especially among criminals that there is no law and order on the streets. The mayor and city council have accepted zero accountability. This brings me to Philadelphia, where we had one of our highest murder rates in decades last year. 500 murders were committed in 2020, and more than 2,400 shootings including 225 women and 195 children. This year, we're already on pace for an even higher murder rate. Four months in the year and we have over 145 murders, 440 shootings, and 55 of those shooting victims were children. Philadelphia is a prime example of what happens when police are demoralized and feel the pressure of a no consequences DA like Larry Krasner along with the narrative that often goes along with the defund the police rhetoric that all cops are bad. My son has told me that while locking criminals up, they laugh and say that they'll be out of jail in a day or two. The criminals know there are no real consequences here in Philadelphia.

My husband's four murderers had rap sheets that could go on for days. Including multiple violations of probation, drug chargers, and gun charges. They all had reduced bail, and cases dropped. The man who pulled the actual trigger has five murders under him, including my husband. And those were the ones they've only learned about so far. One of the other males in the room was wanted for 2 prior murders. The other males both had previous gun charges. They were holed up in a tiny, rented, one bedroom apartment, with nine guns lined up, and multiple drugs throughout the room. Who do you think should be responsible for going into the room and responding to incidents involving hardened criminals like this? Mental health workers, maybe a negotiator? This is the job my husband, and his coworkers signed up for. There are split second decisions that need to be made.

Nobody hates a bad cop more than a good cop, but the movement to defund the police is now about demonizing every officer and taking our country into anarchy by abolishing

the police altogether. Every officer is giving at least 9 months of training before entering the academy. They then have continued yearly training. Swat officers alone, have an extra three months of training before they can serve warrants, handle a barricaded situation, etc. The morning of March 13th, they used some of their training and used restraint, when fired upon, to return fire, but stop and negotiate through a closed door. The criminals asked them to stop shooting, and the police responded for them to do the same. Four other males could have been killed that day. The police used their training to not make the situation even worse. All our officers could use high risk training. They sometimes have a split second to make a decision.

Defunding the police reduces funding for vitally important training and ongoing professional development that needs to occur to address bad policing tactics. Police brutality usually occurs when overly aggressive policing tactics are implemented in dramatic fashion, or with evil intent. To reduce this type of violence, we should reevaluate policing tactics and make sure our police are trained in the most effective de-escalation skills and techniques possible. Good policing requires a commitment to robust training that must be ongoing. This requires funding.

A recent shooting in Philadelphia reflects the continued need for money and training. Walter Wallace, was a knife-wielding, mentally ill man, was shot when he aggressively approached police. Although, I do not believe there was enough time for a mental health worker to be called in on this type of job, if a taser was used, he could have been subdued until he was taken to the proper facility. But the officers were not equipped with tasers. More than half of Philadelphia officers don't carry the recommended tasers. Funding is an issue. There are many reforms that we can debate, however, defunding the police is not one of them.

To think that criminals are victims of society and the system is totally absurd. There needs to be a respect level for our police officers. We need stricter penalties. We hear too many times that a criminal has a lengthy list or prior arrests, but is out of jail because of reduced bail, or convictions overturned and thrown out of jail. Our DA, and others need to be held accountable for letting these people out of jail.

I know, personally, that Jim's murderers still should have been locked up. If they had been kept in jail, where they deserved to be, I wouldn't be spending today, April 22, my 26th Wedding Anniversary, testifying on his behalf at this congressional hearing. Jim should be here, his life mattered.

Senate Hearing

4/22/21

“Behavioral Health and Policing: Interactions and Solutions”

Sheriff Margaret Mims

Fresno County, California

Thank you, Mr. Chairman, Mr. Ranking Member and members of the subcommittee. I am honored to appear before you to discuss challenges faced by local governments, communities and families as we work together to respond to those with mental illness. Although there are no simple solutions, we continue to develop and implement initiatives to better serve our communities, including increasing access to mental health treatment; diverting individuals with mental health conditions away from the criminal justice system; and working with mental health professions on training programs to address those with mental health needs.

Increasing numbers of people with mental illnesses are coming into contact with the criminal justice system. Many times, as first responders we do not know that a call for service may involve someone with mental illness until we arrive. These calls can be very dynamic and, in some cases, dangerous. In Fresno County we have had two deputy sheriffs killed in the line of duty by mentally unstable

individuals who had armed themselves. These calls for service often are repeated as we often respond to the same location or the same individual.

All law enforcement agencies in my county book those they arrest into the Fresno County jail. We have three correctional facilities. Our average daily population (ADP) for March 2021 was 2620 inmates. Of that population 97% had been booked on felony charges, only 3% are misdemeanants. For all intents and purposes we are an all felony jail. To put this in perspective this high number of felony cases exist AFTER California passed an initiative in 2014 reducing many felony drug crimes to misdemeanors.

In addition to responding to calls, we are working tirelessly to provide treatment to those inside our correctional facilities. In March 2021, 41% of those in our facilities received psychotropic medication for a mental health disorder.

As we evaluated the system, we learned that many individuals are not receiving care when they are not in custody. A correctional facility is not the best environment to give proper services to those with mental health challenges. No one should have to be in jail to receive mental health services. We worked to form a strategy to improve the continuum of care when individuals leave our facilities. Rather than release these individuals out of the door, we transport

them to a safe location. It should be noted many of these individuals are homeless, so they are taken to a shelter at one of our map points that I will discuss in a moment. These efforts have resulted in strengthening our partnerships, a safer jail release plan and in the long term the goal is to reduce recidivism.

Moreover, most law enforcement leaders I talk to agree that incidents involving mental health crises require more than just a law enforcement response. However, the lines are rarely bright, and in many cases law enforcement response is required to help save lives. Our law enforcement agencies worked with our Department of Behavioral Health who provided us with Crisis Intervention Training. We have established a Crisis Intervention Team comprised of mental health professionals and Emergency Medical Services to respond with law enforcement so that both safety and professional services can be available during interactions with individuals in need of care.

We have also activated a Sequential Intercept Mapping initiative. This is a cross system approach that identifies locations where law enforcement most often comes into contact with those with mental illness. We use the data from this initiative to establish a system that bridges criminal justice and mental health

services and minimizes criminal justice involvement for persons with mental illness. Our action plan includes:

- Creating a county-wide Crisis Intervention Team;
- Increasing treatment of co-occurring disorders; and
- Creating a sobriety center.

We are also focusing on discharge and reentry planning to reduce recidivism, in addition to developing diversion tools.

We want to continue and expand these efforts, but enhanced response to mental health crises will require significant increases in training and personnel. Federal support for this would be helpful, as long as it does not displace core law enforcement support programs.

We should be clear that replacing law enforcement - or defunding the police - would result in more harm to the citizens that we serve. "De-policing" has the same effect. The rule of law is a fundamental principle that must be respected. When laws are broken our citizens expect an effective response - especially when their lives and their homes are threatened.

I began my statements this morning by saying any solutions need cooperative relationships. A multi-disciplinary approach is needed that includes

all stakeholders, mental health professionals, public safety and community-based organizations. I can assure you Senators that law enforcement professionals across the Nation want to be a part of the solution and at your service to provide any additional input you may need as policy is developed.

Thank you.

**Senate Judiciary Committee Hearing
“Behavioral Health and Policing: Interactions and Solutions”
Questions for the Record
for Ebony Morgan, Outreach Manager and Crisis Intervention Specialist, CAHOOTS
Crisis Intervention
Submitted April 29, 2021**

QUESTIONS FROM SENATOR WHITEHOUSE

1. This hearing highlighted the difficulties that arise when police officers are called upon to respond to mental health, substance use, and other behavioral health crises, and alternative approaches to these situations.
 - a. Based on your experience, what are the most promising models to handle these situations?
 - b. What are the biggest obstacles these programs face?
 - c. How can the federal government encourage and support these programs?
 - d. How have cities and states created sustainable funding for these programs? What can the federal government do to help other jurisdictions do the same?

2. Even when jurisdictions have alternate responder programs, police may still respond to situations where people are experiencing mental health or substance use crises or have disabilities (whether because of inaccurate dispatching, to support behavioral health professionals, or because a serious crime is in progress).
 - a. What should police departments do to better prepare their officers to respond safely and effectively to these situations?
 - b. How can the federal government support these efforts—i.e., by providing funding, developing best practices, etc.?

3. Reforming how law enforcement responds to mental and behavioral health crises also requires working with other stakeholders at the state and local levels, such as health departments and behavioral health providers.
 - a. Are there any jurisdictions successfully coordinating various state and local stakeholders? If so, which ones?
 - b. What suggestions do you have to better coordinate funding, training, and resources among stakeholders?

**Subcommittee on Criminal Justice and Counterterrorism
Behavioral Health and Policing: Interactions and Solutions
Submitted April 29, 2021**

QUESTIONS FROM SENATOR BOOKER

Questions for Ebony Morgan

1. Can you provide the percentage of 911 calls that are diverted from the 911 system in Eugene, Oregon to CAHOOTS on an annual basis?
 - a. How many of these calls require law enforcement assistance?
 - b. Why is it that CAHOOTS workers are able to handle situations involving people in crisis without using force?
 - c. Why does a response from a behavioral health professionals better serve the needs of people with mental illness than a law enforcement officer?
 - d. Do you think that the CAHOOTS model could be duplicated and scaled in other cities?

Senate Judiciary Committee Hearing
“Behavioral Health and Policing: Interactions and Solutions”
Questions for the Record
for Maj. Martin Bartness, Baltimore Police Department
Submitted April 29, 2021

QUESTIONS FROM SENATOR WHITEHOUSE

1. This hearing highlighted the difficulties that arise when police officers are called upon to respond to mental health, substance use, and other behavioral health crises, and alternative approaches to these situations.
 - a. Based on your experience, what are the most promising models to handle these situations?
 A crisis response system needs to have different levels of response available to meet the varying acuity levels of crises. A hotline (988) with counselors can handle a segment of crisis calls that do not require an in-person response or an immediate in-person response. The next level of response is mobile crisis teams staffed with clinicians who can respond to crises where there isn't a threat to public safety. When there is a threat to public safety (e.g., weapons present), law enforcement paired with a mental health clinician (co-responder model) or the emerging multi-disciplinary team model—consisting of a paramedic, mental health clinician, and law enforcement officer—can respond to the most acute cases.
 - b. What are the biggest obstacles these programs face?
 Lack of funding to fully staff different levels of response to meet consumer demand.
 - c. How can the federal government encourage and support these programs?
 Fund multiple levels of response to meet consumer demand.
 - d. How have cities and states created sustainable funding for these programs? What can the federal government do to help other jurisdictions do the same?
 The Greater Baltimore Regional Integrated Crisis System (GBRICS) partnership is investing \$45 million over five years to transform the behavioral health crisis response system in Baltimore City, Baltimore County, Carroll County, and Howard County. GBRICs will expand the capacity of mobile crisis teams and community-based providers. This kind of funding is essential.
2. Even when jurisdictions have alternate responder programs, police may still respond to situations where people are experiencing mental health or substance use crises or have disabilities (whether because of inaccurate dispatching, to support behavioral health professionals, or because a serious crime is in progress).

- a. What should police departments do to better prepare their officers to respond safely and effectively to these situations?

The implementation of behavioral health training and crisis response teams can better prepare officers when responding to these situations. BPD offers a crisis intervention team (CIT) training to officers. This is 40 hours of specialized training for patrol officers to serve as primary responders to behavioral health-related calls for service to which a police response is necessary. The Crisis Response Team is a specialized unit comprised of certified officers and licensed mental health professionals who respond in pairs to persons in crisis and highly complex and/or emotionally heightened situations.

- b. How can the federal government support these efforts—i.e., by providing funding, developing best practices, etc.?

As previously stated, funding is key, but so is high-quality policy and training that requires police departments to adopt best practices. Research is demonstrating what works but too many jurisdictions are slow to adopt these practices for a variety of reasons.

- 3. Reforming how law enforcement responds to mental and behavioral health crises also requires working with other stakeholders at the state and local levels, such as health departments and behavioral health providers.

- a. Are there any jurisdictions successfully coordinating various state and local stakeholders? If so, which ones?
- b. What suggestions do you have to better coordinate funding, training, and resources among stakeholders?

**Subcommittee on Criminal Justice and Counterterrorism
Behavioral Health and Policing: Interactions and Solutions
Submitted April 29, 2021**

QUESTIONS FROM SENATOR BOOKER

Questions for Major Bartness

1. The Washington Post database¹ recording fatal shootings by law enforcement from 2015-2021 shows that 23% of them involved people with mental illness. Why do you think this number is so high?

There are multiple reasons why such a large percentage of police-involved shootings involve people with mental illness. First, people in psychiatric crisis can be very difficult to communicate with and may fail to comply with commands. When someone in psychiatric crisis is also armed with a deadly weapon, officers may reasonably fear their lives, or the lives of others, are in imminent danger. Second, many police departments have not yet adopted use of force policies, practices, and training that prioritize the standards of reasonableness, necessity, and proportionality, and require officers to attempt de-escalation techniques such as time, distance, cover, and utilization of resources. Third, few jurisdictions have sufficiently funded the behavioral health system to meet the demands of America's drug dependency and rates of mental illness. People who need treatment are therefore untreated, homeless, and acting in ways that cause people to fear for their safety.

2. Cities across the country are beginning to increase their behavioral health services in order to reduce the burdens on law enforcement officers who spend large amounts of their time responding to calls for service involving people in distress.
 - a. Can you describe the steps that the Baltimore Police Department is taking to work with behavioral health service providers and how shifting to a model in which they become first responders to crisis will serve individuals with behavioral health or substance use issues?

The Baltimore Police Department (BPD) works collaboratively with the Collaborative Planning and Implementation Committee (CPIC), a partnership of over 50 local, state, and community-based behavioral health providers and advocates to develop and implement policy and training and to collect and analyze data to improve response delivery. More specifically, BPD partners with Baltimore Health Systems Baltimore (BHSB) and Baltimore Crisis Response, Inc. (BCRI) to improve the city's response to crisis calls for service. To provide the least police-involved response possible to citizens' behavioral health needs, the city is developing a 911 diversion program that sends low-acuity behavioral health related calls to a crisis hotline rather

¹ WASH. POST., [Police shootings database 2015-2021 - Washington Post](#).

than to police officers. Additionally, BPD, BHSB, and BCRI have created a Crisis Response Team comprised of officers and clinicians who co-respond to acute behavioral crises and serve high-risk petitions for emergency psychiatric evaluation.

- b. Can you describe the 911 call diversion program that the City of Baltimore is creating and the effect you see this having on your officers?

Since June 2021, Baltimore's 911 call center has piloted a process to divert certain low-acuity, mental health-related emergency calls for service to a 24-hour behavioral health and crisis hotline staffed by trained counselors. The process has served as a first step in the city's goal of providing the least police-involved response to behavioral health emergencies and responding to individuals experiencing a behavioral health crisis in a manner that respects their civil rights, contributes to their overall health and welfare, ensures appropriate crisis response techniques, promotes a connection to the behavioral health system, and decreases inappropriate criminal justice involvement for individuals with behavioral health disabilities or experiencing a crisis.

In addition to refining the operations of the diversion program, the stakeholders (BPD, Baltimore City Fire Department (BCFD), BCRI, BHSB, and the CPIC) examined the city's 911 call-intake and dispatch system, gaining firsthand insight to the needs of callers experiencing behavioral health emergencies. This program was designed with significant input from CPIC and was purposely limited in scope, with the intention to expand after pilot testing and an increase in resources.

The 988 Crisis Hotline is designed to resolve non-emergency calls through community-based referrals or response by a mobile crisis team, but a responding clinician may return a call to the 911 center if an emergent need requires a BPD or BCFD response. Calls that require a first responder are diverted to BPD (including the deployment of a Crisis Intervention Team officer or Crisis Response Team), BCFD, or both for a co-response. At the discretion of the 911 Specialist, the 988 Hotline can be notified in parallel with the dispatch of BCFD and/or BPD resources. All of these efforts combined have contributed to a steady increase in the total number of hours saved by BPD, allowing police officers time to focus more attention on other areas of public service.

3. Does responding to calls involving people in crisis or with mental illness divert law enforcement resources from public safety issues that actually require a response by an armed officer? How so?

Yes, responding to calls for people in crisis or with mental illness diverts law enforcement resources from addressing other public safety issues to which only armed police officers ought to respond. This is why the law enforcement profession has advocated for and adopted several 911 diversion practices in recent years: online crime

reporting for incidents such as theft, destruction of property, identify theft, and automobile accidents without injury; 988 Crisis Hotlines, and co-responder models. Effective policing also requires officers to have sufficient time to proactively patrol hot spots, problem solve, walk foot patrol, and talk to the community. All of an officer's time cannot be consumed in call response if communities are going to be safe and citizens are going to have confidence in police to meet their needs.

- a. Would officers prefer to spend time investigating crimes rather than responding to calls involving people in crisis or with mental illness?

In general, I believe police officers would rather investigate crimes rather than respond to people in crisis or living with mental illness. However, when someone's behavior requires police to respond, officers are eager to do so to protect the public and to safely take the person in crisis into custody.

Senate Subcommittee on Criminal Justice & Counterterrorism Hearing
Entitled, *"Behavioral Health and Policing: Interactions and Solutions"*
Questions for the Record Submitted
April 29, 2021

**QUESTIONS FOR RAFAEL MANGUAL FROM
RANKING MEMBER COTTON**

1. You mentioned in your testimony a report issued the day before this hearing by one of your colleagues at the Manhattan Institute, regarding policing and crisis intervention teams. Please provide the Subcommittee with a copy of that report.
 - A PDF of the requested report can be downloaded here: <https://www.manhattan-institute.org/policing-without-police-review-evidence>. I would direct you to pg. 7, which reports the data I referenced to the Subcommittee.

2. Based on your research on this issue, what recommendations do you have for policymakers who are looking to improve policing and to improve police interactions with people who face mental health challenges?
 - My first recommendation would be to continue to invest in efforts to identify viable and scalable de-escalation training programs with an understanding that (1) not every encounter with an individual facing a mental health challenge can be successfully de-escalated without the use of force, and (2) sometimes the use of force to restrain an individual earlier on in an encounter may, under some circumstances, reduce the likelihood of more serious force being used later on in the encounter.
 - Secondly, I would recommend that communities continue to *supplement* police efforts with mental health responder models like CAHOOTS, understanding that police efforts simply cannot be supplanted in this space.
 - Finally, I would recommend a serious inquiry into the impact of the move in many jurisdictions across the country to drastically raise the transaction costs of involuntary commitment, with an eye toward exploring whether (and, if so, how) to expand the scope and intensity of supervision for populations struggling with mental health challenges. Here I would direct you to the work of my colleague Stephen Eide, who has written on and researched this topic extensively.



Housing and services strategies that work for people.

September 22, 2023

Senator Durbin, Chair
United States Senate Committee on the Judiciary
Email: record@judiciary-dem.senate.gov

Re: August 26, 2022 questions from Subcommittee on Criminal Justice and Counterterrorism hearing entitled "Behavioral Health and Policing: Interactions and Solutions" on Thursday, April 22, 2021

Dear Senator Durbin,

Thank you for the questions submitted by Senators Booker and Whitehouse in response to the testimony that I provided at the Senate Committee on the Judiciary, Subcommittee on Criminal Justice and Counterterrorism, hearing entitled "Behavioral Health and Policing: Interactions and Solutions" on Thursday, April 22, 2021. Please accept my response to the questions from Senator Booker and Senator Whitehouse into the record in addition to my original testimony.

If I can be of further assistance to the Committee regarding the behavioral health system and related issues, please do not hesitate to contact me.

Sincerely,

A handwritten signature in blue ink, appearing to read "K Martone".

Kevin Martone, LSW
Executive Director

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**Subcommittee on Criminal Justice and Counterterrorism
Behavioral Health and Policing: Interactions and Solutions
Submitted April 29, 2021
Received August 26, 2022**

QUESTIONS FROM SENATOR BOOKER

1. What are the basic components of a behavioral health system, and the critical services that a city, town, or county would need to have in place to provide basic services to people with mental illness, or those who are in crisis, or people with substance disorders?
 - a. What function does each of these components serve?

Background

Mental illnesses and substance use disorders, commonly known together as behavioral health conditions, affect roughly 25% of the U.S. population and are among the most common causes of disability.¹ Neuropsychiatric disorders are the leading cause of disability in the United States, accounting for 18.7% of all years of life lost to disability and premature mortality.^{2,3} Recent data suggests that roughly 56% of young adults and 40% of adults in the U.S. have reported symptoms of anxiety or depression during the COVID pandemic.⁴

The severity, chronicity, and recovery from these health conditions varies widely across the population, and is also influenced by a number of other factors, including, but not limited to, social determinants of health such as economic stability, access to affordable housing, education, and employment, and the impact of racism and other forms of discrimination on health equity.

Estimating the full costs of untreated mental illness and the criminalization of people with mental illness are difficult. The National Alliance on Mental Illness estimates that untreated mental illness already costs us up to \$300 billion annually due to lost productivity and associated costs due to absenteeism, employee turnover and increases in medical and disability expenses.⁵

¹ National Institute of Mental Health. <https://www.nimh.nih.gov/health/statistics/mental-illness>

² US Burden of Disease Collaborators. The state of US health, 1990-2010: burden of diseases, injuries, and risk factors. JAMA, 310(6): 591-608, 2013.

³ Neuropsychiatric disorders include behavioral health conditions, but also encompass a broader range of disorders (e.g. seizures, migraine headaches).

⁴ Twenge JM, Joiner TE. U.S. Census Bureau-assessed prevalence of anxiety and depressive symptoms in 2019 and during the 2020 COVID-19 pandemic. *Depress Anxiety*. 2020 Oct;37(10):954-956. doi: 10.1002/da.23077. Epub 2020 Jul 15. PMID: 32667081; PMCID: PMC7405486.

⁵ National Alliance on Mental Illness. <https://www.nami.org/Press-Media/In-The-News/2021/2020-devastated-US-mental-health-%E2%80%94-healing-must-be-a-priority?feed=In-the-news#;:~:text=The%20National%20Alliance%20on%20Mental,in%20medical%20and%20disability%20expenses.>



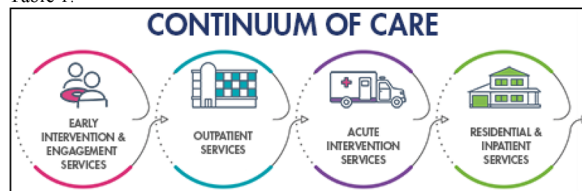
Estimates of the added impact of the coronavirus pandemic on mental health in the United States could reach approximately \$1.6 trillion.⁶

Accordingly, behavioral health is a public health issue that requires multidimensional approaches to the prevention, early intervention, treatment, and recovery from behavioral health conditions, as well as, interbudgetary strategies to more appropriately allocate and align resources.

Basic Components of a Behavioral Health System

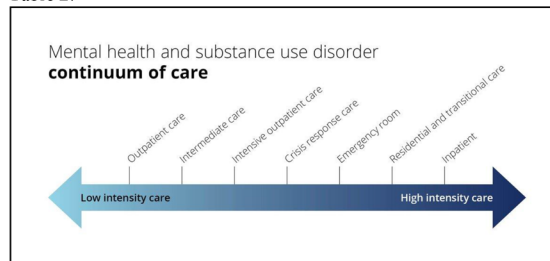
A well-functioning behavioral health system should be built on a public health framework (as opposed to a public safety approach) that includes prevention, early intervention, treatment, and recovery supports. A range of evidence-based, best, and promising treatment and support services must be available in communities to meet the diverse needs of people who are at risk for or are experiencing behavioral health conditions. The following two graphics demonstrate examples of the basic components of services that should be available to people in all communities, including urban, suburban, rural, and frontier areas.

Table 1:



Source: [Alaska Division of Behavioral Health](#)

Table 2:



Source: [UCare](#)

⁶ Cutler DM, Summers LH. The COVID-19 Pandemic and the \$16 Trillion Virus. JAMA. 2020;324(15):1495–1496. doi:10.1001/jama.2020.19759

Functions of Core Services

Using Table 1 as a framework, the core functions of these basic components are described below.

Early Intervention and Engagement Services: Mental illnesses and substance use disorders can emerge at any time across the age span, and prevention and early intervention services should be basic components of all systems.⁷ These services are designed to prevent the development of behavioral health conditions, identify early warning signals, and provide early interventions that can prevent or reduce the severity of behavioral health conditions. Early intervention and engagement services can begin as early as infancy and carry through older adulthood, and may be delivered through programs and services in pediatric and primary care settings, schools (i.e. primary, secondary, and post-secondary), employment, and behavioral health providers.

Outpatient Services: Community-based outpatient services include a broad range of face-to-face and tele-health treatment and service delivery options designed to provide ongoing treatment and recovery supports for mental illnesses and/or substance use disorders. These may include traditional appointments for medication management and individual and group psychotherapy. They also include program-based services designed to support individuals with more complex needs. These programs may include permanent supportive housing (PSH), Assertive Community Treatment (ACT), intensive case management, and supported employment. Services should be person-centered, range in intensity, and be provided daily, weekly, or monthly depending on a person and/or family's needs. Provider types may include Community Mental Health Centers (CMHCs), Certified Community Behavioral Health Clinics (CCBHCs), Federally Qualified Healthcare Centers (FQHCs), private practitioners, and organizations run by persons with lived experience.

Active Intervention Services: Active intervention services are those designed to identify, respond to, and resolve emerging or active behavioral health emergencies. These "safety net" services typically include a range of: 1) behavioral health crisis call centers (e.g. the new national 988 Suicide & Crisis Lifeline); 2) behavioral health mobile response teams; and 3) crisis stabilization services, designed to ensure safety, resolve a crisis, and promote recovery. Crisis respite and crisis residential services are also important components that can help provide extended support to help resolve a crisis.

Ideally, acute intervention services are the responsibility of the behavioral health system and led by designated behavioral health providers, but will likely include coordination with other first responders, such as law enforcement, EMS, and Fire, depending on the nature of the call, clinical assessment, and any public safety concerns. Additional information regarding crisis services is discussed below.

While the availability of 24/7/365 crisis services must be a safety net component of the behavioral health system, it is critical to ensure access to preventative, early intervention, and "upstream" services that can help prevent behavioral health emergencies that require acute intervention services.

Residential and Inpatient Services: Residential and psychiatric inpatient services are designed to meet the needs of people with mental illnesses and substance use disorders with more complex, chronic conditions, as well as, acute care needs due to a behavioral health emergency. Most people who experience behavioral health conditions do not need these intensive, more supervised and restrictive services with access to upstream, community-based options, but the need for capacity to exist as a safety net function is an important component of a comprehensive system. These services are the most intensive and costly, and tend to be designed for short term use.

Access to Social Determinants of Health

Access to Social Determinants of Health (SDOH) are also critically important functions necessary to support people with behavioral health conditions, and are non-medical factors that influence behavioral health outcomes. Addressing social determinants of health is a primary approach to achieving health equity.⁸ Among these include access to affordable housing, education and employment, as well as, programs and services that address racism and discrimination and food security.

All people need access to safe, decent affordable housing. However, a significant number of people with mental illness and substance use disorders experience homelessness or live in segregated settings.^{9,10} Most people with mental illness and substance use disorders can benefit from, and prefer, to live in integrated housing in their communities.¹¹ While supervised residential treatment settings described above may have a short term role in treatment and recovery, most people with behavioral health conditions do not need to live in supervised housing. Access to housing is not a behavioral health system issue; it is an issue that is the result of a shortage of affordable housing that exists nationally.¹² Unfortunately, a significant number of people with behavioral health conditions experience poverty and are unable to afford housing. In fact, for people with serious mental illness living on Supplemental Security Income (SSI), there is not a single housing market in the United States where a person on SSI can afford housing at the HUD established Fair Market Rent (FMR).¹³

Many people with behavioral health conditions are unemployed/under-employed, but are interested in working and furthering their education. Supported employment and supported education are important services that should be basic components of a behavioral health system.

Funding Behavioral Health Services

Federal, state, and local government agencies, as well as, health insurers have roles in ensuring equitable access to behavioral health services and related SDOH and other supports. Because the

⁸ Centers for Disease Control and Prevention. <https://www.cdc.gov/nchhstp/socialdeterminants/faq.html>

⁹ National League of Cities. [Mental Illness, Substance Use, and Homelessness: Advancing coordinated solutions through local leadership.](#)

¹⁰ Mental Health America. [Position Statement 25: Community Inclusion after Olmstead.](#)

¹¹ Tsai J, Bond GR, Salyers MP, Godfrey JL, Davis KE. Housing preferences and choices among adults with mental illness and substance use disorders: a qualitative study. *Community Ment Health J.* 2010 Aug;46(4):381-8. doi: 10.1007/s10597-009-9268-6. Epub 2009 Nov 7. PMID: 19898935; PMCID: PMC2891397.

¹² Martone, K. [The Impact of Failed Housing Policy on the Public Behavioral Health System.](#) *Psychiatric Services.* March 2014 Vol. 65 No. 3

¹³ Technical Assistance Collaborative. [Priced Out: The Housing Crisis for People with Disabilities](#)

basic behavioral health components do not always fit neatly into a single payer, treatment and services are often paid for through braided or blended funding strategies.¹⁴ Other supports are paid for by non-behavioral health agencies (e.g. housing assistance through HUD or state housing agencies; employment assistance Vocational Rehabilitation agencies) and should be coordinated with behavioral health funds.

However, chronic underfunding and the patchwork of paying for services results in barriers to access, workforce shortages, and red tape that interfere with a person's ability to engage in and remain in services. In addition, the [2008 Mental Health Parity and Addiction Equity Act](#) (MHPAEA) was passed by congress to create more equitable access to behavioral health treatment and services, but, over ten years later, there is continued and increased disparities between behavioral health care and physical health care coverage, indicating possible evidence of noncompliant insurance practices.¹⁵

2. After a 911 call is made involving a person in crisis, or with mental health disabilities, or with a substance use disorder, if the person dispatched was a mental health professional rather than a law enforcement officer, how would the outcome differ?
 - a. Why is the difference significant?

In many communities, 911 and police are the default response for behavioral health emergencies due to a lack of behavioral health crisis services, and 911 will dispatch police, even if a response is unnecessary. Depending on the capacity of the behavioral health system, the skills of police, and level of coordination between law enforcement and behavioral health providers, the outcomes can vary significantly. When 911 is called for a behavioral health emergency, the range of outcomes when police are dispatched may include use of force, arrest and incarceration, drop-off at the emergency department/hospital, or transportation to an outpatient behavioral health provider.

The less involved behavioral health professionals are, the more likely that the disposition by law enforcement will be a more restrictive, forceful, and clinically unnecessary intervention. Compared to the general population, individuals with mental illness are three times more likely to interact with police and are more likely to be arrested.¹⁶ People with untreated mental illness are sixteen times more likely to be killed during a police encounter than other civilians approached or stopped by law enforcement.¹⁷ Numbering fewer than 1 in 50 U.S. adults,

¹⁴ Urban Institute. [Examples of braiding and blending to support community health: a compendium of resources](#). October 2018.

¹⁵ Davenport, S., Gray, T., and Melek, S. [Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement](#). November 2019.

¹⁶ Magee, L.A., Fortenberry, J.D., Rosenman, M. *et al.* Two-year prevalence rates of mental health and substance use disorder diagnoses among repeat arrestees. *Health Justice* 9, 2 (2021). <https://doi.org/10.1186/s40352-020-00126-2>

¹⁷ Treatment Advocacy Center. [Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters](#). December 2015

individuals with untreated severe mental illness are involved in at least 1 in 4 and as many as half of all fatal police shootings.¹⁸

It is also widely known that people with mental illness are overrepresented in the criminal justice system and disproportionately Black.¹⁹ Nationally, approximately 20% of inmates in jails and 15% of inmates in state prisons are now estimated to have a serious mental illness.²⁰ There is evidence that people who are Black are less likely to be identified as having a mental health problem,²¹ and they are less likely to receive access to treatment once incarcerated.²²

The potential outcomes of a behavioral health led response instead of, or in coordination with law enforcement, are significant. In better-developed behavioral health systems, the 988 national crisis hotline or a similar crisis hotline and warm lines exist, the call is fielded by a behavioral health specialist, and the response is triaged based on the individual situation and need. In places where 988 and crisis hotlines are used, the majority of crises are deescalated on the phone with referrals or warm handoffs made to the appropriate provider. Approximately 98% of answered 988/Lifeline calls do not require an emergency response,²³ and it is estimated that 80% of mental health calls to 911 are resolved without the need for police involvement when diverted to a crisis line.²⁴ The ability of crisis lines to de-escalate calls enable police resources to be directed to legitimate policing activities, and reduces the likelihood of negative police encounters that involve use of force, arrests and incarceration, and costly and unnecessary emergency department and inpatient hospital stays.

Behavioral health led mobile crisis response teams (MCRTs) may be dispatched by 988 or 911 to engage an individual if, based on assessment, there is minimal public safety risk. MCRTs add another level of diversion or deflection from law enforcement and associated outcomes. Many MCRT encounters result in a de-escalation, a voluntary transport to the hospital or a crisis stabilization program, or referral and follow-up to outpatient services. Referral and follow-up are critical services not typically provided by law enforcement that can help mitigate a crisis and prevent it from escalating further. The CAHOOT team in Eugene, Oregon, for example, handles about 60 calls per day and request police assistance less than once a day. For 911 calls, the CAHOOTS team diverts an estimated 5–8 percent of calls to 911 that would otherwise have been dispatched to police officers, estimating over 6,000 avoided police calls.²⁵

¹⁸ Treatment Advocacy Center.

¹⁹ NAMI. [Racial Disparities in Mental Health and Criminal Justice](#).

²⁰ Treatment Advocacy Center. [Serious Mental Illness Prevalence in Jails and Prisons](#). September 2016.

²¹ US Department of Justice, Bureau of Justice Statistics. Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12. June 2017.

²² Kaba F, Solimo A, Graves J, Glowa-Kollisch S, Vise A, MacDonald R, Waters A, Rosner Z, Dickey N, Angell S, Venters H. Disparities in Mental Health Referral and Diagnosis in the New York City Jail Mental Health Service. *Am J Public Health*. 2015 Sep;105(9):1911-6. doi: 10.2105/AJPH.2015.302699. Epub 2015 Jul 16. PMID: 26180985; PMCID: PMC4539829.

²³ Vibrant Emotional Health. [FAQ for Understanding 988 and How It Can Help with Behavioral Health Crises](#).

²⁴ Substance Abuse and Mental Health Services Administration (2020). *National guidelines for behavioral health crisis care – a best practice toolkit*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

²⁵ Congressional Budget Office. Estimated budgetary effects of the American Rescue Plan Act [Internet]. Washington (DC): CBO; 2021. Table 9, Estimated budgetary effects of Title 9 (Committee on Finance) of the amendment in the nature of a substitute to H.R. 1319 (KIN21174) as posted on the Senate Budget Committee's

Unfortunately, a comprehensive and coordinated set of services does not exist locally in most communities, particularly in rural and remote areas. Furthermore, the lack of “upstream” services often results in preventable behavioral health emergencies that lead to encounters with law enforcement, arrest and incarceration, unnecessary emergency department and inpatient hospital use, suicide, and other negative outcomes such as loss of employment and homelessness.

QUESTIONS FROM SENATOR WHITEHOUSE

1. This hearing highlighted the difficulties that arise when police officers are called upon to respond to mental health, substance use, and other behavioral health crises, and alternative approaches to these situations.
 - a. Based on your experience, what are the most promising models to handle these situations?
 - b. What are the biggest obstacles these programs face?
 - c. How can the federal government encourage and support these programs?
 - d. How have cities and states created sustainable funding for these programs? What can the federal government do to help other jurisdictions do the same?

In many communities throughout the United States, the default system in place to respond to behavioral health emergencies is 911 and law enforcement dispatch. As discussed above, the default system often leads to negative outcomes for people with behavioral health conditions who are experiencing a behavioral health emergency, as well as, the misappropriation of police and criminal justice system resources.

Access to a comprehensive set of behavioral health crisis services are essential to effective response for people experiencing behavioral health emergencies. Based on my nearly thirty years in behavioral health as a direct clinician, agency administrator, state mental health commissioner, national consultant, and family member of a person living with mental illness, the following are promising models that federal, state and local systems should support and ensure access to.

Crisis Hotline and Warm Lines

As discussed above, crisis hotlines and warmlines staffed by trained mental health professionals and para-professionals (e.g. trained peer support workers) perform a critical first line intervention for people who may be experiencing a behavioral health crisis, and are effective at de-escalating the crisis, providing immediate support, and reducing the need for mobile crisis or law enforcement response. Generally, crisis lines are designed to take calls from, or regarding, individuals who may be experiencing a behavioral health crisis, whereas warmlines are used as an important early intervention support function to help prevent a crisis.²⁶

website on March 4, 2021 (see Subtitle J, section 9813 in tab labeled “Title 9”); [cited 2021 Apr 26]. Available for download from: https://www.cbo.gov/system/files/2021-03/Reconciliation_Detailed_Tables.xlsx Google Scholar

²⁶ American Psychiatric Association. [Warm Lines: Providing Help Before a Crisis Develops](#).

Signed into law on October, 17, 2020 and effective July 2022, the national 988 Suicide & Crisis Lifeline provides an easy to remember number to call that can provide immediate support, link with local mobile crisis providers, refer to treatment services, and triage to 911 and law enforcement if needed. Congress has provided financial assistance to support states in this transition through various federal agencies (e.g. SAMHSA), and the authorizing legislation enabled states to establish fees on telecommunication companies to support development and operation of local 988 call centers. Several states are actively working to identify resources through legislation and state appropriations. Colorado, Nevada, Washington, and Virginia, for example, have passed fees on telecom to support 988 operations and service.

Many systems also have their own state, regional, or local crisis lines that are operated by 988 centers or other providers. As state and local systems work to develop their crisis hotline systems, they will need to ensure that crisis lines, as well as 911, work together to manage and triage calls, minimize police and provider confusion, ensure coordination, and make calling for help easier for potential callers.

Mobile Crisis Response Teams

It is important to understand that there is not a universal mobile response model that is applicable across all jurisdictions in the United States. Among the reasons for this include population density and geography (i.e. urban/suburban/rural/frontier), behavioral health system capacity, funding streams, and system structure. Nevertheless, leading mobile crisis response team (MCRT) models are run by community behavioral health organizations, led and staffed by behavioral health professionals and para-professionals (e.g. peer support specialists) that respond and provide needed assessment, intervention, and disposition, including transportation when possible. Since linkage to ongoing, upstream community-based services may not be immediate, MCRTs should have capacity to provide short-term, interim crisis case management to help bridge any time between the crisis and needed services. In some jurisdictions, especially in rural communities, MCRTs are part of the local police department and dispatched as a co-response with police or alone depending on the nature of the call.

If a decision has been made that there is not a public safety risk based on the initial evaluation by 988, another crisis line, or 911, the response must be driven by the individual's need, and not based on what or who is available. When needed, a MCRT should be dispatched by 988 or other crisis hotlines, or 911. MCRTs need to have the capacity to respond quickly to a location; otherwise, the crisis could escalate necessitating police response. There may be times when there is a potential safety risk or medical concern that warrants a co-response by police and/or EMS. If the situation warrants it, EMS and police should assist if there is a potential medical need or safety risk. These first responder dispatches could be requested by the MCRT, or sent as a co-response to the location to provide support and help ensure safety.

Well known MCRT programs and model examples include: CAHOOTS in Eugene, Oregon; RIGHT Care in Dallas, Texas; the STAR program in Denver, Colorado; Community Bridges teams in Arizona; and New Jersey's Mobile Response and Stabilization Services program and Connecticut's Mobile Crisis Intervention Services program for children and youth.



While more calls will be handled by behavioral health systems as crisis systems develop nationally, it is likely that many calls will continue to go to 911 resulting in police dispatches, even if unnecessary. CIT trained officers will still be an important response when an MCRT is unavailable, or in coordination with an MCRT response.²⁷

Behavioral health led MCRTs face various obstacles. Lack of funding for design, start-up, infrastructure and technology, staffing, and ongoing training is a major barrier. MCRTs need 24/7/365 capacity to respond to one or more emergencies simultaneously, but funding is often insufficient to meet demand, not well coordinated, and vulnerable to budget cuts. In order for MCRTs, as well as other crisis services, to be viable and sustainable, they cannot rely solely on a fee-for-service model of reimbursement or variations in annual budget cycles. MCRTs should be considered essential services with mandatory funding support. Medicaid does not pay for all types of services, and other federal, state, and local funds should be braided with Medicaid to pay for ongoing services and infrastructure (e.g. technology; vehicles, training, planning). Unfortunately, many non-Medicaid commercial insurers do not pay for crisis services utilized by their members. Because MCRTs need to respond to individuals who may have health insurance through Medicaid, non-Medicaid commercial insurers, Medicare, or be uninsured, multiple sources must have a role in supporting MCRT capacity. However, in most systems where MCRTs exist, a patchwork of funding exists and typically does not include Medicare or commercial insurers.

In addition, significant challenges with recruitment and retention have resulted in severe workforce shortages in behavioral health. This is due to a combination of near-poverty level salaries, lack of training and supervision, and burnout. Funding for livable salaries, as well as, training and supervision need to be built in to grants and/or insurance rates.

In some communities, resistance by police to coordinate with MCRTs is an issue due to the belief that behavioral health emergencies are public safety issues requiring a public safety response. Lack of coordination and collaboration between MCRTs, law enforcement, and other systems providers are barriers to successful implementation and operations. Also, poor communication and marketing publicly about behavioral health resources, including alternatives to 911 (i.e. 988 and other crisis hotlines/warmlines) results in far too many behavioral health calls going to 911 and police dispatch that could be handled by MCRTs.

The federal government should encourage and support these programs in various ways. The U.S. Department of Health and Human Services (HHS) should continue to inform policy and best practices in mobile response. SAMHSA and key partners, such as the National Association of State Mental Health Program Directors and others, are working together on these issues. Identifying best practices, minimum core standards, roles, coordination, identification of key outcome measures are important for state and local communities to use in the development of policy, standards, funding, and overall design, implementation, and sustainable operations. The federal government can support training and technical assistance in best practices, and consideration should be given to the development of a national training and technical assistance

center that can provide training and TA to state behavioral health and Medicaid agencies, behavioral health providers, local police departments, and others.

States and cities have developed some funding strategies for these programs. Medicaid is a potential sustainable funding source to pay for crisis services that leverages state and federal funding. Several states do use Medicaid to pay for some crisis services, and the American Rescue Plan created a new mobile crisis team state plan option through Medicaid to pay for services. Many states are in the process of designing their state plans for approval by CMS, and Congress should continue to explore incentives for states to expand and sustain crisis and upstream services through, for example, additional enhanced match and broadening coverable services. While most non-Medicaid commercial insurers do not pay for crisis services utilized by their members, Washington and Massachusetts have recently required commercial health insurers to contribute to crisis services which will be helpful in sustaining crisis capacity for non-Medicaid members who utilize crisis services.

2. Even when jurisdictions have alternate responder programs, police may still respond to situations where people are experiencing mental health or substance use crises or have disabilities (whether because of inaccurate dispatching, to support behavioral health professionals, or because a serious crime is in progress).
 - a. What should police departments do to better prepare their officers to respond safely and effectively to these situations?
 - b. How can the federal government support these efforts—i.e., by providing funding, developing best practices, etc.?

Training for police on behavioral health should be mandatory for all officers. This should be part of basic training provided at the academy, as well as, made available periodically for all officers. Topics should include an understanding of mental illness and the types of symptoms that people may experience and behaviors they may display, particularly if they are experiencing a crisis, the impact of trauma, and how racial and other disparities affect mental health conditions, access to services, and responses. Training on substance use disorders and other conditions, such as intellectual and developmental disabilities, is important since these alone or co-occurring with mental illness can complicate the situation. Advanced Crisis Intervention Team (CIT) training should also be made available so that police departments can also have officers with more advanced training respond to behavioral health emergencies when needed. CIT is well known model with specific training and protocols.²⁸

Advance coordination and collaboration with local behavioral health, social service, and homeless providers, not just hospital emergency departments, is important for police departments to engage in. Officers will be more capable of making an appropriate intervention and disposition the more aware they are of the behavioral health provider system and capabilities. Police should be aware of 988 and local crisis and warmlines, mobile crisis response teams, and a range of community-based alternatives. A drop-off at a crisis stabilization program or walk-in

²⁸ CIT International. <https://www.citinternational.org/What-is-CIT>

behavioral health urgent care may be more appropriate than the local emergency department, and officers should know about these resources in advance and have pre-established protocols for working with them.

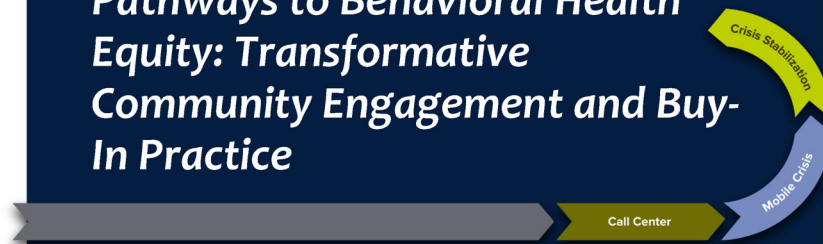
The federal government can support these efforts in various ways. Funding made available to states and local jurisdictions for police training, as well as, cross system capacity building, training, and coordination are important. This includes funding opportunities for cross system partners to come together for ongoing planning and implementation. Sustainable funding is important due to the complexity of these cross system issues, as well as, the need to ensure continued coordination due to staff turnover in systems. These funds are often hard to come by and not generally covered by Medicaid or other insurers, but are critical to successful crisis response. Funding for performance monitoring and evaluation of outcomes should be built in.

3. Reforming how law enforcement responds to mental and behavioral health crises also requires working with other stakeholders at the state and local levels, such as health departments and behavioral health providers.
 - a. Are there any jurisdictions successfully coordinating various state and local stakeholders? If so, which ones?
 - b. What suggestions do you have to better coordinate funding, training, and resources among stakeholders?

Attached is a report prepared by the Technical Assistance Collaborative (TAC) and Meadows Mental Health Policy Institute (MMHPI), *Pathways to Behavioral Health Equity: Transformative Community Engagement and Buy-In Practice*. The report identifies the importance of community stakeholder engagement. In addition to engaging state health departments and behavioral health providers, the report identifies the importance of engaging individuals served in these systems, identifies examples of jurisdictions who are doing good work in this area, and shares recommendations for coordination of funding, training, and other resources at the federal, state, and local level.



Pathways to Behavioral Health Equity: Transformative Community Engagement and Buy- In Practice



MEADOWS
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This brief was developed by the Technical Assistance Collaborative, Inc. (TAC) and the Meadows Mental Health Policy Institute (MMHPI) for a time-limited collaborative of philanthropic organizations initially consisting of The Pew Charitable Trusts, Ballmer Group, Blue Meridian Partners, Peg's Foundation, the MacArthur Foundation, and the Charles Koch Institute, a part of the Stand Together community. These organizations came together in a joint learning process to explore the potential for lasting change and innovation in behavioral health emergency response. The collaborative's goal is to develop a common understanding of the key steps necessary to advance an effective, equitable system in which people with mental health and substance-use-related emergencies have access to a continuum of targeted crisis response services. This brief was developed to support the collaborative's learning process; it does not represent the formal position of TAC, MMHPI, the collaborative, or its individual members. The brief is being shared informally as a resource to the field.

Executive Summary

This is a pivotal moment for behavioral health crisis response systems. Our current crisis response system is flawed, is rooted in racism, continues to perpetuate the oppression of disenfranchised communities, and is marked by negative outcomes for communities of color. The current reality has resulted in distrust from impacted communities. To address inequities and improve outcomes, the current behavioral health crisis system must be redesigned and trust reestablished through an authentic community engagement and buy-in process. To date, authentic community engagement has not been a consistently established process in behavioral health crisis response systems. However, there are adjacent areas which do have an established history of authentic community engagement and buy-in that can be considered for application to this system. There is a significant opportunity for philanthropic organizations to contribute to these efforts in ways that federal, state, and local governments cannot. This brief discusses the current behavioral health crisis landscape and offers opportunities for philanthropic organizations to consider related to effective and authentic community engagement and buy-in.

I. Introduction

In 2020, the COVID-19 pandemic, coupled with increasing awareness of structural racial inequity in the United States ignited by the killing of George Floyd at the hands of law enforcement, has exposed deep-seated inequities in behavioral health care systems. Currently, behavioral health crisis systems often produce avoidable adverse outcomes for racially marginalized, historically disenfranchised (LGBTQ2S+¹ and disabled), rural, and under-resourced communities. These negative outcomes are often a consequence of utilizing law enforcement as the default response to behavioral health crises, especially in regions that lack an appropriate crisis system. This results in an overreliance on hospital emergency rooms and jails, rather than the appropriate community health-based response. In fact, jails and prisons have become the largest de facto behavioral health treatment providers in the United States.² In 2018, people with mental illness accounted for 25 percent of all fatalities at the hands of police, with many of those deaths occurring during a response to a mental health emergency.³ In order to address inequities and improve outcomes in the existing behavioral health response system overall, the behavioral health crisis system must be redesigned — an undertaking which will require both the full participation of crisis services recipients and a fundamental shift in how stakeholders and communities are defined and engaged.

To anchor a reimagining of behavioral health crisis systems, this brief proposes three key principles, each explored further below:

- To create trustworthy and effective solutions, it is both urgent and necessary to redesign behavioral health crisis systems in strong collaboration with impacted communities, the health care system, housing, social services, and law enforcement systems.
- An active, sustained commitment to authentic community engagement and buy-in is an essential component of all successful redesign efforts.
- The current state of the system presents a unique opportunity for philanthropy to advance behavioral health equity through strategic investments, especially in strategies that federal, state and local governments are often unable to fund.

Currently, there are no prominent documented efforts to establish this process related to behavioral health crisis response. However, there are adjacent areas with a greater history of authentic community engagement and buy-in that may lend themselves for consideration for application, and some of those efforts are discussed below.

Developing a Common Language

Developing a common language sets the stage to build context, operationalize terminology, and level the “knowledge playing field” so there is a shared understanding as system redesign occurs. The United Nations Office for the Coordination of Humanitarian Affairs defines community engagement as “a two-way dialogue between crisis-affected communities, and humanitarian organizations.”⁴ This definition emphasizes that effective community engagement enables people to meet their needs by building on innate community assets, such as knowledge, culture, and resiliency. For the purposes of this brief, “community” refers to individuals and their families who are underserved or not served well by current behavioral health crisis systems, including people with lived experience (PWLE), their families, and residents of impacted areas. Although “community” members are often stakeholders as well — those who are interested in or affected by a process, intervention, or initiative — for clarity in the context of this brief we limit the term stakeholders to those within organizational and power structures such as law enforcement, call centers, emergency medical services (EMS) providers, mobile crisis team providers, and faith-based leaders. Thus, community engagement would refer to the sharing of power and

decision-making between the two stakeholder groups — communities and organizational and power structures. Shared decision-making, which is critical to achieving successful community engagement, occurs when the system's agents and the intended recipients of crisis services co-create solutions with equal power and influence.⁵

Shared decision-making also entails developing an understanding of each stakeholder's unique needs and characteristics while centering the preferences and solutions raised by communities most affected. Alongside community engagement, buy-in is an important component of maximizing the impact of an intervention. Buy-in is the commitment of a community, individual, or organization to support and take part in an intervention.⁶ Buy-in is more than acceptance of a shared vision and plan; it is a willingness and ability to act, compromise, and dedicate resources to achieve a common goal. Authentic community engagement goes a step further to ensure ongoing meaningful collaboration between community and providers, beyond the initial buy-in phase, so that redesign efforts are successful and continuously assessed by those who utilize those services.

Identifying the Right Participants

It is imperative to recognize which stakeholders respect the community, care about the issue, and are actively working to change behavioral health care systems. Each of these stakeholders is essential to every part of the crisis response process, from the initial needs assessment to the ongoing evaluation. Stakeholders should also be involved in the communications process, as they know their preferences for receiving information and understand how to convey the information equitably with their communities.

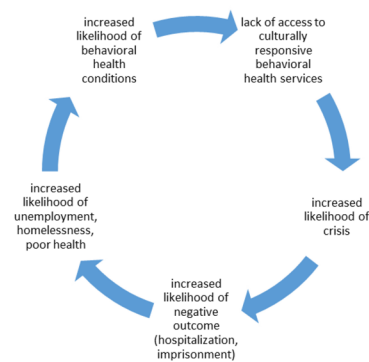
Community includes not only leaders, but also individuals and families whose voices are often not considered and who are directly impacted by the issue at hand. A growing body of evidence shows that people actively involved in their health and health care have better outcomes, reducing costs in the long term.⁷ This evidence supports the need for increased involvement of people with lived experience and their families in the development of an effective crisis response system. This is particularly important given that for decades, people with mental illnesses were deemed incapable of constructive participation in decisions regarding their needs. The inclusion of stakeholder voice in every aspect of redesigning crisis response will positively improve that system process. Stakeholders know their needs best and should have access to a platform to communicate those needs. As we consider reimagining the crisis response system, it is essential to consider stakeholder and community feedback to center the conversation on the identified needs and desires of those who are directly receiving crisis services, which are often reinforcing broader inequities.

II. Opportunities for Change

Effective Practices within the Crisis Continuum and Knowledge Gaps

Sequential Intercept Modeling (SIM) is a useful tool to illustrate how people with behavioral health crisis needs meet and flow through the criminal justice system due to a lack of crisis services. As a conceptual model, SIM can inform community-based responses to shift from ineffective and costly criminal justice interventions to more effective and humane behavioral health and human services interventions. Rebecca Boss, a Senior Consultant with the Technical Assistance Collaborative (TAC), developed the Community Intervention Opportunity Cycle, which illustrates the compounding impacts due to lack of access to culturally responsive behavioral health crisis services. This model, illustrated below, emphasizes community engagement and buy-in with people with lived experience (PWLE) and their families as essential components in disrupting the sequelae of inadequate access to culturally responsive behavioral health services.

Figure 1: Community Intervention Opportunity Cycle



Rebecca Boss, 2021: Technical Assistance Collaborative

In efforts to improve access to culturally responsive behavioral health services, the U.S. Substance Abuse and Mental Health Services Administration's (SAMHSA) National Best Practices identify three core components (crisis call centers, mobile crisis teams, and crisis receiving centers) to ensure access to behavioral health crisis care anytime, anywhere. This care should be accessible to anyone, regardless of race, ethnicity, or location. However, as noted above, disparities in access and service delivery caused by racism, insufficient services in rural areas, culturally insensitive practices, and funding barriers have resulted in an inequitable system; adoption of SAMHSA's three core components will not in itself create a more equitable system.^{8 9} An equitable system is one

in which every individual has the same opportunity to be healthy, successful, and have their needs met. National, state, and local momentum currently exists to reimagine crisis services due to the [impending deadline](#) for 988 implementation, [American Rescue Plan Act](#) investments in mobile crisis services, and other [enhanced federal funding for crisis response](#). However, planning efforts are uneven across the country, and some key stakeholders are unaware of, or otherwise not engaged in, these efforts.¹⁰ Without authentic community engagement and buy-in, a unique opportunity to transform crisis response will render the same patchwork of services rather than a comprehensive and transformed system. At the same time, these federal efforts, as well as multiple forums focused on transformed crisis response, provide opportunities for authentic community engagement that can disrupt the cycle presented in the diagram and reduce inequities that are embedded in our traditional responses. The next sections highlight examples and research on community engagement strategies that can lead to accomplishment of this goal, through providing a framework for true community engagement.

Community Spotlights

Community Spotlight: Texas

The Meadows Mental Health Policy Institute has worked alongside communities throughout Texas, including Dallas, Bexar, Travis, Abilene, Galveston, and El Paso counties, to transform their responses to mental health emergencies. The programmatic approach has been through the development of multi-disciplinary response teams (MDRTs)¹¹, and planning, implementing, and evaluating the success of this approach has depended on the engagement of a broad range of stakeholders. These stakeholders have historically been traditional parties such as law enforcement, mental health providers, local philanthropic organizations, health systems, and housing agencies, with an increasing reliance on the perspectives and views of persons with lived experience and their families. Techniques for gathering information include individual interviews, focus groups with multiple parties, analysis of archival materials, and quantitative analysis relying on statewide and local data bases. Findings and recommendations are vetted by stakeholders for accuracy and “fit” with the community. This approach, combining local expertise with the Institute’s expertise, engages stakeholders deeply in the role of key informants and consultants.

This work demonstrates attempts at authentic community engagement; however, the methods employed reflects more of a consultation approach through the use of interviews, focus groups, and quantitative data to surface findings and recommendations. System agents, excluding PWLE, translated the findings and recommendations into policy, programmatic, and systemic interventions. Authentic community engagement and buy-in would include collaboration with shared decision making throughout the entire process, thereby reducing the possibility of misinterpretations, and strengthening implementation and continuous quality improvement.

Community Spotlight: Washington, D.C.

The need for the Washington D.C. Department of Behavioral Health’s (DBH) Homeless Outreach Program (HOP) was identified through community engagement and reinforced by intentional input from key stakeholders. Though some stakeholders changed during the process, the core group consisted of DBH, homeless services providers, law enforcement, individuals who were experiencing homelessness and who had acute behavioral health conditions, advocacy groups, and community members. Monthly cross-sectional meetings with law enforcement, fire and emergency services, community members, and individuals with lived expertise were held to allow for input into the formation, strategy, and ongoing evaluation of the program. HOP employed peer support staff, a psychiatrist, social workers, and behavioral health specialists who worked with providers and law

enforcement “homeless liaisons” in order to target individuals and connect them to intensive wraparound supports and behavioral health services. HOP provided comprehensive outreach and crisis response to individuals experiencing homelessness throughout the District and ensured short-term case management support until a person could be strongly connected to ongoing behavioral health providers.

Twice over the course of eight years, the program merged with existing programs to support sustainability, and in the course of these adaptations the purview and scope of services shifted. The monthly meetings and ongoing evaluation became more sporadic as the program shifted, and turnover in essential staffing led to low attendance at these meetings. In 2019, HOP was absorbed into the Community Response Team. Key stakeholders were engaged during the initial stages by top government officials (Executive Director, Mayor, Chief of Police etc.) and several stakeholders (law enforcement, Public Safety Answering Points, peer support staff) were engaged but the ongoing community engagement moved to a less formal process consisting of staff member outreach and community meetings for consultation. These shifts made the interventions less effective as PWLE and communities most impacted became less involved in the strategy, design, and evaluation of services; this result highlights the need to ensure sustainable engagement with PWLE to maintain the efficacy of interventions.

Community Spotlight: Ohio Community Collective Impact Model for Change

Through grant funding under the federal 21st Century CURES Act, the Ohio Department of Mental Health and Addiction Services (OhioMHAS) awarded funding to two cohorts of Ohio communities to participate in the [Community Collective Impact Model for Change](#) (CCIM4C) initiative, a two-year program to reduce opioid-related deaths and increase access to treatment in the state of Ohio. During the initiative, 18 communities across the state utilized a data-driven, strategic planning process with a focus on community trauma, using the [Tool for Health and Resilience in Vulnerable Environments](#) (THRIVE) and the [Adverse Community Experiences and Resilience](#) (ACE/R) framework, and an emphasis on working collectively across the continuum of care, using a collective impact model, to address the opioid crisis and social determinants of health in their local communities. Eleven communities were involved in the first cohort (2017-2019) and seven communities are currently involved in the second cohort (2019-2021).

The initiative had two overall goals:

- Reduction in opioid use disorder (OUD) deaths as a result of increased collaboration between prevention, treatment, and recovery supports
- Increased access to OUD treatment, including medications for opioid use disorder (MOUD)

To achieve these goals, each community designated a backbone organization (e.g. county behavioral health authority or community-based coalition) that identified the scope of the problem and available interventions already in place in the area, brought together a wide range of stakeholders in multiple sectors, and developed a strategic plan across the continuum of care to mount a more comprehensive response. These local teams are supported by an overarching leadership team. In addition to a strategic plan across the continuum of care, the teams are tasked with developing a strategic plan that goes beyond the typical responses to the opioid crisis, addressing the complex social problems that fuel this public health emergency, such as childhood trauma, poverty, unstable housing, economic opportunity, and social isolation.

A key driver of the CCIM4C Initiative was that each community created a local ecosystem that reflected the community context. These local ecosystems ensured that participating communities were able engage a wide range of organizations to move forward on the opioid epidemic with a common agenda.

For future improvements, it is important to note that CCIM4C lacked engagement with PWLE and their families. The majority of respondents [evaluating the Model's effectiveness](#) were project directors (54%), member partners (15%), coordinators (8%), executive directors (8%), evaluators (5%), and other (10%). Most respondents (88%) were female and a large majority of respondents (95%) reported their race as white.¹² Although communities participating in the CCIM4C model made progress in creating a common agenda and working across the continuum of care to address the opioid crisis, the primary actors included local government, behavioral health providers, and other system agents. Including PWLE and beneficiaries of services would strengthen the model's efficacy and impact.

III. Principles, Barriers, and Models

This section highlights principles, barriers, and models for authentic community engagement and buy-in. As mentioned earlier, the upcoming implementation of g88 presents a significant opportunity to reimagine a more humanizing and effective crisis response system co-designed by impacted communities. For g88 to be successful and to assure integration with g11, it will require broad buy-in and support and high levels of trust with historically disenfranchised communities and both traditional and non-traditional stakeholders. To do this, behavioral health, health, law enforcement, and other partners must include individuals and communities who will be the beneficiaries of crisis services in every step of the crisis response process, including preliminary conversations, decision-making, implementation, and evaluation.

Seven Core Principles for Community Engagement

In 2009, a group of practitioners and scholars in the fields of public engagement, conflict resolution, and collaboration developed a set of seven useful principles, which they suggested could be applied to a range of projects.¹³ For the purposes of this brief, the principles have been adapted for relevancy to behavioral health crisis community engagement efforts. In the Kettering Foundation's annual newsletter, David Mathews explored the task of obtaining a better understanding of the decision-making process: how resources are recognized and committed, how actions are organized, and how a community learns from its efforts.¹⁴

1. **Preparation.** Through adequate and inclusive planning, ensure that the crisis system design, organization, and convening of the process fulfills a clearly defined purpose and the needs of the people served.
2. **Inclusion and demographic diversity across all processes in crisis system design.** Equitably incorporate diverse populations, voices of people with lived experience, ideas, and information to lay the groundwork for quality and equitable outcomes and democratic legitimacy.¹⁵
3. **Collaboration and shared purpose.** Support and encourage participants, government and community institutions, and other stakeholders identified by the communities served to work together to advance system transformation, implementation, and sustainability.
4. **Openness and learning.** Help all involved listen to each other, explore new ideas unrestrained by predetermined outcomes, learn and apply information in ways that generate new options, and rigorously evaluate community engagement activities throughout the entire process for effectiveness.
5. **Transparency and trust.** Be clear and open about the process, and provide a public record of the organizers, sponsors, outcomes, and range of views and ideas expressed. In most cases, this will require intensive work to repair trust in the crisis system and those who have perpetuated the system.
6. **Impact and action.** Ensure each participatory effort has real potential to make a difference, and that participants are aware of that potential.
7. **Sustained engagement and participatory culture.** Systems implementing or redesigning crisis response systems should promote a culture of participation within programs and institutions that support ongoing community engagement of all communities served. A special focus should be placed to reach under-resourced communities, rural, and historically disenfranchised populations.

Appendix A illustrates a more detailed application of these principles to behavioral health crisis community engagement efforts, including relevant community examples.

Barriers to Community Engagement within the Crisis Continuum

There are many barriers to the implementation, scalability, and sustainability of effective crisis intervention practices. Trust, or its absence, however, is a cornerstone. Without sustained, intentional efforts to develop trust and create strong relationships throughout the engagement process, the impact of community engagement will be diluted. A growing challenge in community engagement and buy-in is the widely documented waning of trust in institutions, government, and behavioral health care and crisis response systems.¹⁶ Institutional mistrust poses serious challenges to those seeking to engage communities in effective dialogue, decision-making, and participation processes related to health care and crisis response systems, and exacerbates preexisting barriers such as the following:

- **Insufficient funding.** Competition for resources, real or perceived, exists when some stakeholders' gain is seen as others' loss. This situation can lead to territorialism, duplication of services, inefficient use of resources, diffuse accountability, and fragmented funding. A competitive environment can also foster passive-aggressive collaboration between groups that fear losing resources. Funding and its allocation present a primary challenge to more widespread adoption of crisis services. Despite significant investments in crisis services, there is continued concern related to financing a comprehensive system of care.¹⁷⁻¹⁸ Funding is needed for strong community partnerships to assist with diversion from less appropriate settings, increase awareness of crisis services, and establish linkages to community services.¹⁹
- **Bias and unresolved conflict.** Perceptions of biases in people or organizations leading the process or in the information provided can undermine collaboration and implementation. The crisis system is ripe with unresolved conflict as individuals have endured a system that did not meet their needs, and often, caused detrimental harm. There are current tensions around the role of law enforcement within behavioral health response; however, many communities without effective response services continue to rely on law enforcement as primary responders to behavioral health crises. This further exacerbates tensions between the community, law enforcement, and trust in behavioral health systems. Unresolved prior conflicts can further fuel bias due to legacy considerations, such as past involvement with the behavioral health system that did not meet people's needs, or stakeholder tension from prior negative interactions.
- **Polarization.** Political polarization of health care, particularly behavioral health and crisis response systems, and the reliance on preconceived notions guiding processes, creates tension between individuals and can impede cross-system collaboration.
- **Hyper-professionalization and elitism.** While there is significant focus on ensuring individuals with lived experience are involved in the crisis workforce, the distance between professionals and the recipients of services has increased as governance of systems and processes, activities, and service delivery has become increasingly specialized, complex, and detached from its implementation in communities. The barrier is magnified by the tendency among funders, providers, regulators, and others with technical or clinical expertise to assume that they understand the problem and solutions better than individual communities.
- **Time constraints.** To fully support buy-in, communities must commit to the process, which can take time. Without the support of leaders to allow for this time and facilitate buy-in, changes will not happen. There are continuous changes within the crisis system; ARPA enhancements to mobile crisis go into effect April 2022 and the deadline for 988 is July 2022.²⁰⁻²¹ The rapid pace and drive to stand up a crisis system prior to these deadlines can directly conflict with the ability of localities to participate in authentic community engagement.
- **Poor coordination.** While 988 planning has set the stage for cross-sector collaboration with planning workgroups, unclear or inconsistent communications between stakeholders, especially between systems of care, providers, interest groups, and the communities most affected, hinders effective collaboration and sustainable change.
- **Lack of leadership.** The scaling of innovations is often undermined by the low priority accorded to mental health by policymakers, the challenge of changing poorly organized services (e.g., over-

centralized care), and poor management or leadership of systems.²² While there is currently significant national momentum to prioritize crisis services, to create effective crisis systems, there needs to be leadership that understands the nuances of community needs and the tensions that may create barriers to effective systems.

- **Incongruent values.** Providers, funders, governmental organizations, people with lived experience (PWLE), historically disenfranchised people, and rural communities all view issues through the lens of their experiences and values, which often affects both their perception of the problem and their opinions on potential innovations. In crisis response, tension exists in primary focus of response being rooted in public safety versus public health which creates incongruent values and these differences in values manifest in different approaches to shifting the paradigm.
- **Diffuse accountability.** Crisis response has long been a scattered array of services rather than a coordinated system with various entities serving as primary responders. These poorly defined responsibilities and authority across the systems can, at times, cause stakeholder blaming and retraumatization. The reasons that such barriers exist, and the responsibility for creating solutions, are often neither well understood nor agreed upon.
- **Lack of recognition.** Individuals respond well to recognition and are often driven to contribute by acknowledgment that their expertise is valuable and legitimate. Often, the strengths and assets of PWLE, historically marginalized, and rural communities are overlooked or not appropriately recognized, which can create distrust and negatively affects system implementation and sustainability.

Popular Models to Support Community Engagement and Buy-in

The Collective Impact Model

Many states and localities, including [Denver](#), [North Carolina](#), and [Ohio](#), have utilized the Collective Impact model to address public health issues, such as the opioid crisis.²³ This model recognizes the complex nature of issues and creates a structured form of collaboration in which a network of key stakeholders works to advance equity through learning, aligning, and integrating actions to create system-level change. It involves identifying a common agenda, creating shared measurements, mutually reinforcing activities, and engaging in continuous communication. The model also requires a backbone support agency with unique and dedicated staff to support the process.²⁴

- **Strengths:** Implementation teams report success in bringing together executive-level leaders across the community to develop a shared consciousness, improve cross-system coordination, and align funding.
- **Weaknesses:** The model does not adequately address equity, nor does it prioritize engaging people most affected by the issue. This results in strategies uninformed by essential community knowledge of root causes, and solutions that do not meet the needs of the most impacted communities. Additionally, the model is not as effective in rural areas due to contextual distance.²⁵

The Active Community Engagement Continuum

The Active Community Engagement (ACE) continuum allows for analyzing community engagement and the role it plays in lasting behavior change.²⁶ It provides a framework to empower communities through three phases of community engagement: consultative, cooperative, and collaborative. Five characteristics are used to empower communities through those phases: pre-program assessment; access to information; inclusion of communities in decision-making; developing capacity to advocate to institutions; and governing structures and accountability of government to the public.²⁷

- **Strengths:** The model offers a spectrum of approaches that provide an accessible and concise roadmap to measure the success of community engagement efforts. It is particularly useful in establishing

benchmarks and milestones of success upon launch of a community planning initiative, and it is applicable to both simple and complex efforts.

- **Weaknesses:** There is limited research on the model's effectiveness in systems redesign and in the development and adoption of innovations by diverse stakeholders. The model does not provide examples of communities involved in the evaluation and continuous quality improvement processes.

Human-Centered Design

Human-Centered Design (HCD) has become popular in the health and human services sector due to its efficacy and accessibility. HCD prioritizes empathy to deeply understand the needs and behaviors of beneficiaries. This framework involves fast-paced data collection through interviews, journey mapping, and observations that are synthesized to design prototypes that are tested and scaled.

- **Strengths:** HCD is a highly creative and agile approach to problem-solving that results in new solutions that are client-centered. The original model did not utilize an equity lens, but in practice, many in-field adaptations have incorporated equity considerations.
- **Weaknesses:** HCD relies heavily on the commitment of those facilitating the process to engage people with lived experiences and historically disenfranchised communities as equal partners in the co-creation process. The model is effective when PWLE are included in conversations about their needs, experiences, and behaviors as well as in conversations about designing and implementing innovative solutions. The degree to which PWLE are involved in this process rests solely on the individual facilitators.

These models have features that facilitate community engagement and buy-in; however, none of the models offer a comprehensive framework grounded in the seven core principles described previously, nor do they necessarily address common barriers to community engagement and buy-in. Therefore, we propose an innovative framework in the next section that leverages the strengths of the aforementioned models while overcoming common barriers.

Develop a Comprehensive Community Engagement and Buy-in Framework for Behavioral Health Crisis Innovations

As outlined previously, there is a need for a comprehensive and transdisciplinary approach to community engagement and buy-in that addresses critical elements of systems redesign while centering the experiences of PWLE and their families. Current community engagement and buy-in approaches for PWLE and under-resourced communities are inadequate. When considering community engagement, the dominant strategies include community meetings, focus groups, surveys, and tokenizing representation on planning committees. Typically, government actors extract information by these methods and then take that information to more traditional stakeholders to develop programming. Even collaboration with cross-systems stakeholders can be fraught with tension and territorialism. Some communities utilize social innovation and other creative problem-solving processes, such as Human-Centered Design, to address behavioral health crisis inequities. However, these programs are often utilized in a way that does not engage communities, share decision-making power with PWLE, recognize the disparate racial impact of current responses, or address the complexity of behavioral health systems. A truly comprehensive framework should integrate the best features of the following models, frameworks, and models:

1. **Collective Impact Model:** This model creates space for diverse stakeholders to collaborate in a structured way through a common agenda, shared measurements, mutually reinforcing activities,

continuous communication, and backbone support. This framework also facilitates the successful scaling of the most effective components of a program.

2. **Team Science:** This framework is an evidence-based approach that augments community engagement and buy-in and the translation of effective measures into policy and practice by focusing on institutional infrastructure, team-building, interpersonal dynamics, trust, shared vision, and rewards. This model also facilitates multiple stakeholder groups to work together towards the identification and implementation of complex interventions.
3. **Community-Centered Integrative Practice:** This approach focuses on culturally responsive ways of approaching, engaging, and empowering diverse communities and stakeholders while respecting their identities, positions, indigenous wisdom, values, and histories.
4. **Equity-Centered Community Design:** This community engagement and buy-in process utilizes design thinking, equity, and humility-building while integrating history and healing practices and addressing power dynamics to develop effective solutions with both impacted communities and traditional stakeholders.
5. **Innovation Dynamics:** This is a framework to consider complex social problems and identify the social norms that reinforce those problems. Innovation Dynamics utilizes six lenses — actors, history, limits, future, configuration, and parthood — to surface stakeholder motivations and behaviors and strengthen buy-in.
6. **Transdisciplinary Science:** Complex interventions require work across many disciplines and sectors, and need community knowledge to unearth innovative and viable solutions. An integrated, transdisciplinary, and relational approach addresses historical shortcomings in a way unlike the fragmented approaches that are overly clinical, discipline-specific, and ignore community knowledge and other cultural assets.
7. **Continuous Quality Improvement Framework:** This framework fosters curiosity and rapid iteration to “fail fast to succeed sooner.” This data-driven, iterative approach encourages stakeholders to look for ways to improve interventions through a culture of continuous refinement and adaptation. Improvement cycles occur more often than traditional evaluation approaches and thereby accelerate the process of achieving better outcomes.

To fully develop a framework based on these elements, additional resources are needed, especially to make it accessible and useful to non-professionals. A training curriculum, facilitator guide, coaching materials, branding, and marketing would be needed for ease of learning and dissemination.

Federal, State, and Local Government Roles: Supporting Community-Based Crisis System Collaborations and Integrated Crisis Systems

Federal, state, and local governments must play a role in fostering and advancing community crisis system collaborations, but many such efforts reflect the strengths and weaknesses of the models discussed above. The idea of a reimagined approach to community engagement and buy-in rests on the notion that crisis system and services design, implementation, oversight, and improvements must be centered in advocacy, voice, leadership, and the needs articulated by service users and policy and practice drivers. The absence of adequate federal or state guidance can lead to a gap between local, community-centered planning and successful implementation. Arizona provides a good example of state guidance. Arizona's contracts with health plans contain the following requirement, “... work in partnership with Contractors [indicating other health plans] in its service area to meet, agree upon, and reduce to writing, a memorandum of understanding detailing and/or joint collaborative protocols with the following: [list of state agencies, justice partners, and tribal entities]... each collaborative protocol, at a minimum, shall include... mechanisms for resolving problems...” This is forcing the health plans to work with others across a system. Of note, in other sections of the contract, health plans are required to engage and utilize PWLE and their families in the leadership and operations of the health plan.

Government often establishes an intent for inclusion of PWLE choice of by creating requirements for some level of participation. SAMHSA established a requirement for the Mental Health Block Grant to create a state mental health planning council that includes PWLE and their families. HRSA requires that the boards of Federally Qualified Health Centers have 51-percent representation of patients served by the health center. These health center patient board members must, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender. However, these examples, and even the contractual requirements highlighted in Arizona, risk a tokenizing approach unless carefully evaluated and monitored for effectiveness.

See Appendix B for a detailed overview of how federal, state, and local governments have negatively and positively influenced the development of community crisis collaborations. The overview includes current barriers, current initiatives, and examples of efforts to support community collaborations, as well as opportunities for federal, state, and local government to offer effective support.

IV. Opportunities for Philanthropy

Advancing Equity-Based Decision-Making to Guide Strategic Investments

Currently, both private and governmental efforts have resulted in limited authentic community engagement. Philanthropic investments can play a critical role in fully engaging communities and stakeholders, including people with lived experience (PWLE), in the design, implementation, and evaluation of a reimagined crisis response system.

The COVID-19 pandemic and the latest manifestations of the movement for racial justice serve as a reminder that racism is a key driver of inequity in the United States, as racially marginalized communities continue to be disproportionately impacted by the pandemic. Racism also drives behavioral health inequities resulting in:

- Lack of access to culturally relevant care
- Poorer quality of care
- Misdiagnosis (both under- and over-diagnosing)
- Criminalization of behavioral health and substance use disorders
- Higher economic burden to impacted families and the system

There is much more emphasis today on employing the voices of PWLE in formal governmental processes. However, the evolution of behavioral health systems has not eliminated and in some cases has exacerbated disparate racial impact. Studies point to the continuous over-diagnosis of schizophrenia and under-diagnosis of mood disorders in the Black community.²⁸ Additionally, there is an overrepresentation of white clinicians serving an increasingly racially diverse patient population, further exacerbating implicit bias and inequities in the design, development, implementation, and evaluation of services.²⁹ As noted above, overreliance on jail and hospital emergency departments as default responses to mental health emergencies exacerbates the longstanding issue of overrepresentation of Black and Latinx groups in the criminal justice system; while arrests and jail populations have declined during COVID³⁰, racial disparities within the overall reduction in arrests were significant.³¹

To advance effective community engagement and behavioral health equity in this rapidly changing environment, philanthropic investments should be guided by these values³²:

- Invest in focused strategies that address barriers identified by racially marginalized and underserved communities and amplify solutions co-designed by those communities.
- Invest in strategies that shift from a victim or needs analysis in an attempt to “fix” disenfranchised communities to a systems change approach that recognizes the role of systems in perpetuating inequities.
- Invest in strategies that seek to heal the long history of behavioral health inequity and in approaches that shift resources and power back to people and communities of color while utilizing cultural assets, community knowledge, and resiliency that are often underfunded and devalued.

The Weissberg Foundation, a small family foundation based in Arlington Virginia, provides an excellent example of the aforementioned strategies in practice. Trustee Nina Weissberg was inspired after participating in a six-month learning series organized by Washington Regional Association of Grantmakers titled “Putting Racism on the Table.”

This resulted in the Weissberg Foundation engaging in the following programmatic activities to ensure more racially equitable grantmaking³³:

- **"Reparative" grantmaking:** Prioritizing funding people of color-led organizations, which have been and continue to be egregiously underfunded by philanthropy, that are explicitly striving to advance racial equity through advocacy, organizing, civic engagement and/or other power-building strategies.
- **"Partly-participatory" grantmaking:** Sharing grantmaking decision-making power by engaging community reviewers throughout our proposal review process, including co-creation of our application assessment rubric; compensating them fairly; and building a pipeline to their board.
- **Going beyond the "no" with declined grant applicants:** Inviting 2-way feedback conversations with declined grant applicants and providing acknowledgment grants to those that get to a certain stage in the grant review process to signal appreciation for their efforts.
- **Tending to the ABCs:** Going beyond funding by ramping up our strategies around Amplification, Building capacity and Collaboration in ways that help grantee partners meet their larger vision for racial equity.

It is recommended that philanthropic organizations develop an equity-based decision-making framework designed to guide strategic investments to support behavioral health crisis innovations that advance behavioral health equity. The purpose of such a framework is to ensure that philanthropic investments catalyze behavioral health innovations, system processes, and policies that proactively eliminate racial, LGBTQ2S+, disability, and rural inequities while maximizing benefit and minimizing harm to affected communities. A noteworthy example developed by the [National Innovation Service for Equitable COVID-19 Homelessness Response](#) illustrates the utility of an equity-based decision making framework.

Community Spotlights of Effective Community Engagement and Buy-in Strategies within Adjacent Systems

Community Spotlight: King County Regional Homelessness Authority (Seattle, WA)

King County and the City of Seattle declared homelessness a state of emergency in 2015. January 2017, the nationally mandated one-night count of people who are homeless found 11,643 people experiencing homelessness. County and city governments, providers, United Way of King County, and local philanthropy worked hard to improve system capacity amidst a growing housing affordability crisis. However, system efforts were consistently undermined due to diffuse authority, separate funding and contracting processes, and funder autonomy slowing down programmatic changes to meet rapidly changing community needs resulting in increasing numbers of unsheltered residents. Reports and collaborative efforts such as [One Table](#) and the [Regional Affordable Housing Task Force](#) pointed to the fractured nature of homeless services and the need for unification efforts.

In 2018, the City of Seattle and King County collaborated with [National Innovation Services](#) (NIS) to launch a community engagement and buy-in process to design a stronger regional response to the homelessness system. PWLE and communities most impacted by homelessness were seen as important stakeholders throughout the planning, research, design, governance, and implementation process. The goal of the design process was to produce a holistic and integrated system versus applying a band-aid approach to structural failures. NIS's mission was to help the community develop a homelessness system that was inoculated against inequity.

The NIS led community-engagement and redesign process led to an Inter Local agreement in December 2019 approved by the King County Council, Regional Policy committee, and Seattle City Council in the creation of a

new King County Regional Homelessness Authority (KCRHA) to oversee a coordinated and unified response to homelessness. This formal agreement marked an unprecedented collaboration between Seattle, King County, King County's cities, people with lived experience of homelessness, and philanthropy and business to improve coordination of services, funding, and governance in addressing the crisis of homelessness.

KCRHA's theory of change has been grounded in the belief that "if we create a homeless crisis response system that centers customer voice, then we will be able to focus on meeting needs and eliminating inequities, in order to end homelessness for all." KCRHA utilized an equity-based decision-making framework to ensure that the homeless service system's processes and policies are designed to proactively eliminate racial inequities and advance equity. This decision-making structure was mandated by the Inter Local Agreement and Charter whom PWLE played a major role in drafting. KCRHA's guiding principles reinforce accountability across all of its activities, decision-making processes, governance, and strategic planning to its customers. The KCRHA launched in early 2021. The CEO hired to run KCRHA, Marc Dones, is a person with lived experience. Staff of the authority reflects communities overrepresented in the homelessness system with many having lived experience of homelessness.

KCRHA demonstrated its commitment to elevating the voices of those with lived experience of homelessness by joining with several philanthropies in funding the Lived Experience Coalition (LEC). The LEC was founded completely by people who have experienced homelessness with the stated mission "of working beyond oppressive structures by unifying our voices, speaking truth to power, and working together to dismantle multisystem barriers impacting people who are experiencing homelessness and involvement in the criminal justice system, face unmet behavioral health needs, and/or fleeing violence or emotional /psychological victimization. The LEC has over 250 members who are actively engaged in advocating for systems change through the following key activities:

- Working with system stakeholders to end homelessness
- Advocating for equitable and people-centered system change
- Building community to support unsheltered neighbors
- Providing leadership development and employment training for people with lived expertise.

Support provided by KCRHA and philanthropy allowed the LEC to provide members with \$30/hour stipends to remove barriers to engagement, leadership development and coaching, and staff support for members serving on various committees and workgroups. Philanthropy, government, providers, and the business community have partnered with the LEC in their efforts to develop innovative, equitable, and win-win solutions that work.

Philanthropy played a major role in supporting the LEC's advocacy efforts for systems change and is an excellent example of how philanthropy can lead with values that shift resources and power back to people and communities of color by recognizing their cultural assets, community knowledge, and resiliency that are often underfunded and devalued. In fact, the LEC played a major role in assisting philanthropy in designing the King County Partners Group known as We Are In. Philanthropic organizations partnered with PWLE, civic leaders, housing and advocacy groups, business, providers, and faith-based communities to coordinate and align non-governmental efforts through an intermediary body that works closely with the KCRHA to address ongoing and emergent needs in regional homelessness. The We Are In board consists of 50% of PWLE with the remaining seats filled by philanthropy, business, and civic leaders.

This community's engagement and buy-in strategies not only embodied the Seven Core Principles of community engagement but also embodied an approach that utilized the best features of Collective Impact, Equity-Centered Community Design, and Transdisciplinary Science while being responsive to and honoring the identities, positions, indigenous wisdom, values, and histories of all stakeholders, especially those most impacted by homelessness.

Community Spotlight: Project Peace (Tacoma, WA)

The practice of authentic community engagement and buy-in can help drive racial equity and systemic change efforts while healing historical mistrust between stakeholders if done correctly. It is essential that community engagement directly inform strategic planning and policymaking efforts. One example where deep community engagement and buy-in strategies have been effectively utilized to inform institutional and structural changes is in the City of Tacoma.

In 2015, Project PEACE (Partnering for Equity and Community Engagement) arose from a group of African American faith-based leaders who feared that racial unrest could happen in Tacoma due to increasing tension between law enforcement and racially marginalized communities. The mission of Project PEACE was to do the difficult work of healing and building trust between marginalized communities and law enforcement. The project aims included:

- Acknowledge the historical harm between racially marginalized communities and law enforcement.
- Cultivate a deeper understanding of those harms and begin the healing process through intergroup dialogue between communities most affected and law enforcement.
- Transform community safety by making concrete changes in collaboration with communities most affected and law enforcement.

In order to accomplish the aforementioned aims, a Project PEACE Executive Committee (PPEC) was formed. PPEC included historically disenfranchised community members, law enforcement, grassroots leaders, city officials, and youth and young adults. PPEC oversees Project PEACE to assure relationships between law enforcement and communities of color are built and improved, information relevant to Project PEACE actions are shared with the larger community, and opportunities are created for law enforcement and communities to engage in healing, dialogues, and shared learning opportunities.



Image 1: Project PEACE participants. Photo: City of Tacoma Office of Equity and Human Rights

PPEC gathered community input through six community listening sessions in which over 800 people participated, followed by the creation of a [report](#) that laid out goals for the future. The listening sessions lasted 3.5 hours and included food and beverage. The majority of the listening sessions were conducted in small dialogue groups, with each group having two trained facilitators and a recorder taking notes. The groups all included law enforcement and community members sitting in a circle. The first portion of the session focused on race and racism so

participants can develop a shared language around structural and institutional racism. This initial segment is followed by a short lesson on the history of racism in the United States (adapted from the larger Undoing Institutional Racism workshop by the People's Institute for Survival and Beyond). Both of these listening session components served to educate and build awareness about racial equity, priming participants to make connections between individual experiences and structural issues in the remainder of the listening session. Back in small groups, participants then dived into two conversations. First: what did you learn about police growing up, and what has been your experience with Tacoma Police Department? Then: what advice or guidance would you suggest that the police department pay attention to?

Following each event, participants were asked to take an online survey:

- When asked to rate their opinion of Tacoma Police Department before and after the engagement, 34% (statistically significant change) became more positive or hopeful, and 3% (statistically insignificant change) became more negative.
- When asked to rate their understanding of the challenges that exist between the police and residents, 38.6% (statistically significant change) became more positive, and 5.4 (statistically insignificant change) became more negative.
- When asked if they thought Project PEACE community conversations will improve relations between the Tacoma Police and residents, responses were mostly agreed. The majority of the sample identified as people of color. There were no significant differences as a function of race, age, or gender, although the race difference remained for the youngest group.

Following a successful series of Project PEACE conversations, the PPEC in partnership with the Tacoma Police Department expanded the initiative and achieved the following outcomes:

- Established a Citizen Police Advisory Committee and developed a Community Trauma Response Team.
- Launched a community co-designed Undoing Institutional Racism/Implicit Bias/De-escalation Training for law enforcement.
- Launched an annual survey to track and analyze the level of trust that citizens, especially racially marginalized and historically disenfranchised communities, have with the Tacoma Police Department.
- Made significant progress in diversifying the workforce of Tacoma Police Department.
- Increased non-enforcement contacts with community members in neighborhoods, business districts, schools, and community centers.
- Established ongoing Project PEACE gatherings with youth young people in the community.

Project Peace received recognition as a best practice from President Obama's 21st Century Policing Task Force and the National Civic League highlighted Project PEACE as a promising practice. Inspired by Project PEACE, the City of Tacoma has expanded the work of Project PEACE and in October 2020 passed [Resolution 40622 – Heal the Heart of Tacoma](#). This initiative is aimed at creating systemic change that strengthens and heals communities, provide the foundation necessary to achieve greater equity in service delivery, and increase trust in local institutions. Heal the Heart is community-led, and invites local organizations to bring their expertise to the table to transform Tacoma into an anti-racist city.

Much can be learned from Project PEACE to ensure 988 is well publicized and well received by supporting the engagement of historically disenfranchised communities, especially, communities of color and rural communities, to inform the implementation of 988 and to foster trust in it as a crisis response that is different than 911. Project PEACE was exceptional in its approach to building trust by weaving Healing-Centered Engagement to create a more humanizing milieu that strengthened stakeholder relations. Project PEACE assumed very stakeholder has

some trauma that they are carrying whether it is PWLE or law enforcement. By creating an intentional space for stakeholders to be vulnerable and human by prioritizing the emotional climate and wellbeing of stakeholders to foster healthy relationships and group dynamics, the City of Tacoma was able to cultivate a safe and supportive environment that led to trust, broad buy-in, and systemic change.

Create a National Community Action Hub

Effective community engagement and buy-in practice is essential to designing behavioral health crisis response systems that work. However, most local governments and communities lack the capacity and skills to facilitate this kind of engagement. Supporting communities in developing, scaling, and sustaining effective solutions while advancing research, knowledge development, policy reform, and implementation is possible. A National Community Action Hub could make this a reality. Given that community engagement varies across the United States and that there is currently no federal guidance on effective practices, investments to create a National Community Action Hub could support both behavioral health crisis services and cross-sector collaboration.

The National Community Action Hub can serve as a home for technical assistance, training, and coaching provided to communities in employing the Comprehensive Community Engagement and Buy-in Framework for Behavioral Health Crisis Innovations outlined above. A National Community Action Hub can also evaluate the efficacy and reach of community-led initiatives, ultimately contributing to the literature on what is most effective in various communities.

History of the National Hub Model

The Action Hub model was developed by Dr. Heather Mosher at the Institute for Community Research (ICR) in 2015 in response to the need for an effective, system-level mechanism for receiving continuous input from young people with the lived experience of homelessness. Additionally, input was needed for the development of youth leadership and youth-adult partnership in policy advocacy and research towards ending youth homelessness in Connecticut. Funded by the Melville Charitable Trust, the initial concept of the Youth Action Hub was developed by ICR in partnership with the Center for Children's Advocacy. During its first year, the Hub conducted a statewide study on young people's access to housing services, and presented these findings and recommendations to policymakers. Hub members were also active partners on committees and task groups, helping translate data and evidence into changes in practice and policy.

The Action Hub Model

The Action Hub model is designed to change unequal power dynamics within decision-making groups working to end disparities. The model intends to create a system where PWLE are equal partners in the design, implementation, and evaluation of services they receive, as well as in the development of comprehensive policy and innovative practices to end racial and social disparities. The model uses supportive employment and participatory action research to grow community leaders who have been disproportionately impacted. Participatory action research embodies equitable participation of community members in all phases of research and uses research collaboratively to enact social transformation. The Hub model provides stable part-time employment and on-the-job training for a diverse group of PWLE.

Action Hub Model Background and Purpose

Within the work to end homelessness in Connecticut, youth who have experienced homelessness and housing instability are leaders, researchers, and policy advocates through the Youth Action Hub of the Institute for

Community Research. Similar efforts are needed to engage adults with lived experience with behavioral health systems to build the political and civic will to advance behavioral health equity. An Action Hub model can be developed with both youth and older adults and can offer meaningful leadership and partnership with people with lived experience in statewide or local efforts to improve behavioral health systems. Creating decision-making processes that include PWLE as equal partners can help ensure that behavioral health systems, policies, and programs are shaped by the most impacted populations and their specific needs.

V. Conclusion

This moment represents a tremendous opportunity for philanthropy to take bold action to influence real, sustainable change in the behavioral health crisis system. This reimagined system must be co-designed with stakeholders and community members to maximize the potential impact of the system, including improved outcomes, reduced disparities and inequities, and greater system efficiency. We outlined two evidence-based strategies, community engagement and buy-in practices, that share decision-making power with people with lived experience and their families. We also provided a framework that can be operationalized for the co-creation/co-design process. This new system will overcome structural and systemic barriers in the existing behavioral health crisis system and move impacted communities towards more equitable outcomes.

Appendix A: Seven Principles and Considerations for Behavioral Health Crisis Response System Transformation

Adapted from the “Core Principles for Public Engagement” outlined in the National Coalition for Dialogue and Deliberation’s [Resource Guide on Public Engagement](#) [PDF].

1: Preparation

Through adequate and inclusive planning, ensure that the crisis system design, organization, and convening of the process serve both a clearly defined purpose and the needs of the people served.

Considerations

- The introduction and national rollout of 988 presents an opportunity to ensure that the correct participants are at the table for each step of the planning process.

Initiatives

- American Rescue Plan Act (ARPA) planning grants to implement Medicaid mobile crisis programs are allotted based on the ability to utilize those funds to conduct a statewide needs assessment, which includes evaluation of equity strategies.
- Intentionally define the strategy, purpose, and include communities in the design of the enhanced mobile crisis program.

2: Inclusion and Demographic Diversity across System Design

Equitably incorporate diverse populations, voices of people with lived experience (PWLE), ideas, and information to lay the groundwork for high-quality and equitable outcomes and democratic legitimacy.

Considerations

- Many programs already exist that were specifically created with the vision of inclusion and diversity; learn from these community-led and peer-run organizations.

Initiatives

- [People USA](#) is a 100% peer run organization providing wraparound crisis services to individuals through a forensic mobile crisis team, crisis stabilization units, and [Rose Houses](#), a voluntary short-term crisis respite that provides a home-like alternative to psychiatric units.
- [R.E.A.L.](#) is a peer-run organization formed in order to promote wellness and recovery that achieved a 44% decrease in participants needing to go to the hospital.³⁴

Minnesota mobile teams are required to ask about psychiatric advanced directives, and to utilize them when clinically appropriate. These directives allow individuals to legally state their wishes in the event that they are unable to make decisions during a behavioral health crisis.

3: Collaboration and Shared Purpose

Support and encourage participants, government and community institutions, and stakeholders identified by the communities served to work together to advance system transformation, implementation, and sustainability.

Considerations

- Identifying preconceived notations of state and PWLE
- Impact of historical trauma
- Compassion fatigue of workforce

Initiatives

- The [Newark Community Street Team](#) utilizes individuals who reside in the neighborhoods, including those who have been incarcerated or previously engaged in drug sales, to provide targeted outreach and mentorship to at-risk youth as a method to prevent crime.³⁵
- [New York City](#) and [Washington DC](#) support city-community partnership to create community-driven interventions to decrease gun violence through the use of violence interrupters. As a result of the intervention in New York, crime dropped and the city invested further in the program to enhance sustainability of the success.³⁶

4: Openness and Learning

Help all involved listen to each other, explore new ideas unrestrained by predetermined outcomes, learn and apply information in ways that generate new options, and rigorously evaluate community engagement activities throughout the entire process for effectiveness.

Considerations

- Finding the win-win and developing a shared mission and goals that all stakeholders can agree on.
- Spending time to understand each stakeholder's motivations, fears, and other concerns.
- Stakeholders spending time getting to know each other personally.

Initiatives

- [Restorative justice](#) is a technique that focuses on community healing through bringing together those most impacted by a crime with the offender. It is also the name of a conflict resolution and community-building organization for preventing and resolving conflicts from bullying to auto theft to assault.
- [Restorative Response Baltimore](#) utilizes a "community conferencing" empowerment-focused model, where a trained facilitator brings both parties together for a structured dialogue that ultimately results in shared conflict resolution, a written agreement, and high compliance with those agreements.

5: Transparency and Trust

Be clear and open about the process, and provide a public record of the organizers, sponsors, outcomes, and range of views and ideas expressed. In most cases, this will require intensive work to repair trust in the crisis system and those who have perpetuated the system.

Considerations

- Historic and current mistreatment had created distrust of the "system" by communities of color and rural communities
- Repairing trust between state/local government, law enforcement, and communities of color will take intentional effort
- Requires acknowledgement of the harm that has historically been done by the government and collaborating with the community to move forward
- Tapping into networks can support community engagement and assist in reestablishing trust

Initiatives

- Partnerships with trusted community leaders, such as faith based organizations, has proven an effective strategy to facilitate these discussions.
- Shift law enforcement focus from community-based strategies, moving to more community designed and led approaches, such as [credible messengers](#).
- [Salvation and Social Justice](#) is a faith-rooted organization that works across the faith community to organize individuals impacted by systemic inequities to engage legislators, state representatives, and government agencies in order to be part of the solution moving forward.
- System accountability enhances trust. Approaches such as ABLE ([Active Bystander for Law Enforcement](#)) which serves to promote a culture of accountability within law enforcement through the prevention of misconduct and encouragement of colleague intervention to prevent harm.

6: Impact and Action

Ensure participatory efforts have real potential to make a difference, and participants are aware of that potential.

Considerations

- PWLE highlighted feeling part of a broader impact and system-wide changes when they felt their input was utilized by other stakeholders and when they saw tangible action from engagement in work groups and community forums with leadership.³⁷

Initiatives

- Many states are currently setting their standards for mobile crisis services under ARPA and have the opportunity to ensure participatory effort shapes both data collection and system creation.

7. Sustained Engagement and Participatory Culture

Systems implementing or redesigning crisis response systems should promote a culture of participation within programs and institutions that supports ongoing community engagement of all communities served. A special focus should be on reaching under-resourced communities and historically marginalized populations.

Considerations

- Historically, the identified [best practices](#) for evaluation of crisis programming involve in-system data collection and occasional satisfaction surveys of individuals who utilized services.

- Systems should broaden the scope of ongoing evaluation and participation of historically marginalized populations.
- Metrics should focus on evaluating change in impact of those underserved due to health disparities, remote access issues, and inadequate cultural response.

Initiatives

- The inclusion of PWLE on advisory committees to guide practice and support with ongoing evaluation of crisis systems (call centers, mobile crisis and crisis stabilization units).
- Texas created the [Behavioral Health Advisory Committee](#), which includes multiple stakeholders with lived expertise, family members, faith-based organizations, and state representatives, to guide their behavioral health strategy.
- Georgia and Arizona have "Autism advisory committees" to evaluate services, including crisis services, to individuals living with autism to enhance effective interventions.

Appendix B: Federal, State, and Local Government Roles in Supporting Community-Based Crisis System Collaborations and Integrated Crisis Systems

Federal Government

Current Barriers

Collaboration across health and human services, and collaboration with people receiving those services, have been virtually nonexistent at the federal level, with the limited exception of cross-system collaboration efforts deep within a single federal agency. In these cases, plans are developed often with minimal financial support to achieve the goals (e.g., National Strategy for Suicide Prevention³⁸). While some federal agencies have used funding strategies to incentivize cross-system collaborations (see below), there is not a consistent mechanism which supports ongoing coordination.

Positive Examples

A noteworthy example of federal investments shaping state and local system collaboration is the [Justice and Mental Health Collaboration Program](#), which supports individuals involved in behavioral health and justice systems. While it is difficult to point to an example of federal interagency collaboration with crisis systems, there are examples of the federal government fostering collaboration addressing other broader needs. The U.S. Department of Health and Human Services (HHS) Administration for Children and Families (ACF) and Substance Abuse Mental Health Services Administration (SAMHSA) have fostered the development of the Systems of Care (SOC) approach, which, at its core, is designed to involve children, youth, and families in child welfare such that they are at the center of advocacy and the decision-making process related to policy development and implementation. HHS and SAMHSA support organizations that exemplify this concept, including the Federation of Families, an organization developed and led by families and youth to serve as the nation's choice for families of children who experience emotional, behavioral, mental health, and/or substance use challenges. Additionally, SAMHSA recently awarded funding to support the first National Family Support Technical Assistance Center. While these examples are not crisis-related, they highlight federal initiatives that promote the power and importance of having people with lived experiences at the center of the decision-making process as well as cross-agency collaboration. Components that are essential for a reimagined crisis system based upon authentic community engagement and buy-in.

Current Initiatives

The federal government recently implemented infrastructure to address the coordination of behavioral health and crisis services. HHS Secretary Xavier Becerra has been vocal about addressing the needs of individuals and families with behavioral health challenges. On May 18, 2021, the Secretary announced the creation of the Behavioral Health Coordinating Council, which is tasked with coordinating all federal government resources to address inequities and gaps within the mental health and substance use disorder system. Additionally, with the anticipated launch of the national 988 crisis line in July 2022, SAMHSA has added personnel to enhance its crisis systems and services expertise and developed coordination across federal agencies to support funding, leadership, and policy direction.³⁹ SAMHSA has conveyed its intention to work with other state agencies, such as

emergency services (e.g., 911), and to develop policy directions and learning collaboratives for states and local governments. It is unknown if these policy directions and learning collaboratives will ensure that those with lived experience are part of these efforts.

Opportunities

The newly formed Behavioral Health Coordinating Council, initiated by HHS, could recommend the following:

- The utilization of federal funding to support state and local communities in creating and advancing crisis system collaboratives that align with the concepts brought forward in this brief regarding a reimagined community crisis collaboration driving policy and practices with individuals and families with lived experience.
- The funding of community technical assistance support to foster reimagined community crisis collaboration that is led and provided by individuals and families with lived experience.

Philanthropy could enable support for the development of a reimagined and collaborative community crisis system through advocacy and messaging to the federal government. When financing of crisis systems and services is explored in several months, the research should consider how federal funding can support the development of a reimagined crisis system.

State Government

Current Barriers

Like the federal government, most state governments have patchwork crisis systems, a situation which does not support systematic community collaboration. With a few exceptions, states have multiple state and local agencies that are involved with crisis services. However, very few prioritize collaboration that will advance crisis systems. For example, some states have a mental health department separate from other entities (e.g., Medicaid), which are in turn separate from agencies that address the needs of other populations (e.g., individuals involved with child welfare or justice systems). The funding of these agencies is fragmented and often has divergent policy direction that does not encourage community collaboration or cross-system partnerships.

Positive Examples

Many states like Arizona set the expectation for coordination between state agencies, justice partners, and tribal entities. States can support standardization of collaboration through the inclusion of that expectation in their provider and MCO contracts. This requires the health plans to work with others across a system. Additionally, Arizona health plans are required to engage and utilize individuals and family members with lived experience in the leadership and operations of the health plan.

Current Initiatives

Several states have enacted legislation pertaining to the implementation of 988, and many bills have introduced topics related to the study or expansion of crisis systems and services overall, beyond 988 itself. Some of this legislation requires the engagement of individuals with lived experience in the evaluation and planning processes.⁴⁰ The state of Washington's HB1477 outlines a Crisis Response Improvement Strategy Committee that must include at least four representatives with lived experience.⁴¹

The State of Colorado has been in the process of creating a Behavioral Health Administration (BHA) to bring together a fragmented system to achieve better outcomes for all Coloradans.⁴² The BHA does not place all behavioral health agencies under one umbrella; rather it encourages all Colorado state agencies to collaborate in

the development of shared policies and approaches, including a standardized way to collect and analyze data. Part of the BHA design involves an Advisory Council that includes people representing rural communities, children and youth, criminal justice, local government, Tribal Nations, consumers, families, providers and health care payers, and others. The Advisory Council is intended to provide a space to raise questions and concerns and bring innovative ideas to the broader BHA.

Opportunities

State governments could explore ways to enhance coordination between state agencies that are involved in crisis systems or services, such as through an existing or new cabinet-level position that oversees and integrates behavioral health services across the state, inclusive of crisis services. Further, states could develop practices that encourage the development of sustainable and effective collaboration and place individuals and families with lived experience at the center of the process.

Philanthropy could fund projects that prioritize community collaboration and cross-system partnerships that use community-based data points to measure effectiveness.

Local Government

Current Barriers

Local initiatives are limited without state guidance and funding, as are state initiatives without federal guidance and funding. Missing connections between the three levels of government has resulted in little to no comprehensive, collaborative engagement strategies. This does not mean that there are not “pockets of excellence” within a disjointed system, but it does mean that those efforts are not as efficient as they could be if authentic community engagement and cross-system collaboration were taking place. The [Council of State Governments](#) has identified 10 communities of best practice in behavioral health and law enforcement partnerships for crisis response, all at the local level, however there is no consistency in how — or how much — the community is engaged in the process.

Positive Examples

The Tucson, Arizona police department created a Mental Health Support Team (MHST) in January 2014 in response to several high-profile incidents throughout the country, including one in Pima County, where Tucson resides.⁴³ The MHST serves primarily as a follow-up unit, acting as an entry point into mental health treatment and aiming to prevent incidents through early intervention. The MHST also is the sole clearinghouse for mental health court orders, allowing the police more capacity for other duties. This team, as well as the broader police department, work with mobile crisis teams from the area’s local mental health authorities and crisis observation centers to provide officers a quick place to drop off people experiencing a behavioral health crisis rather than taking them to jail.⁴⁴ Notably, the MHST is now training other city employees who are likely to encounter people experiencing a mental health crisis, including employees of Parks and Recreation and Sun Tran. This is an example of effective cross-system collaboration at the local level.

Current Initiatives

Despite the fact that Washington, DC operates a 24/7 mobile crisis team throughout the city, there were still numerous calls to 911 for behavioral health related concerns, which resulted in detrimental impacts to individuals and created strain on the law enforcement workforce. An interagency task force collaboration between law

enforcement, public safety, behavioral health, and other city entities identified an unmet need. Through this interactive process, the behavioral health system collaborated with 911 to divert behavioral health calls away from law enforcement onto the existing mobile crisis team. A new pilot program sends unarmed teams of behavioral health experts and peers when feasible to avoid sending armed officers.⁴⁵ Notably, the program includes both clinicians and people with lived experience.

The Alaska Native Tribal Health Consortium is a nonprofit Tribal health organization “designed to meet the unique health needs of Alaska Native and American Indian people living in Alaska.”⁴⁶ The Consortium provides comprehensive medical services, wellness programs, disease research and prevention, as well as rural provider training and other services. Now, the Consortium is training “lay people” — people without specialized training or knowledge — to support health needs, which could be expanded to include behavioral health needs. This program provides a unique opportunity to engage communities in improving their wellbeing.

Opportunities

The Tucson model supports the idea that local law enforcement can collaborate with local behavioral health agencies to reduce the number of people with mental illness who are incarcerated. This model has been scaled in communities across the U.S., and it can have continued success should there be an explicit focus on racial equity and the inclusion of people with lived experience in the design, implementation, and evaluation of the program.

The Bexar County Sheriff’s office utilizes a Specialized Multidisciplinary Alternative Response Team (SMART) to respond to calls where a person is in crisis. Members of SMART include a licensed mental health professional, a peer support specialist, a qualified mental health specialist, a specially trained mental health law enforcement officer, and a paramedic. Dispatch plays a vital role in SMART’s deployment, and personnel are trained to deploy SMART only to nonviolent mental health calls where their impact can be greatest.

Philanthropy can help support research that will identify core data points that would be indicators of effectiveness in authentic community engagement that can be broadly used for improvement.

Endnotes

¹ Lesbian, gay, bisexual, transgender/transsexual, queer/questioning, two-spirit, and other marginalized sexual/gender identities

² Stringer, H. (2019). *Improving mental health for inmates*. *Monitor on Psychology*, 50(3). <https://bit.ly/31hPPkc>

³ Rogers, M. S., McNeil, D. E., & Binder, R. L. (2019). Effectiveness of police Crisis Intervention Training programs. *Journal of the American Academy of Psychiatry and the Law*, 47(4): 414-421

⁴ The United Nations Office for the Coordination of Humanitarian Affairs (2015). *What is community engagement?* [PDF]. <https://bit.ly/3HpFPVq>

⁵ Hart, R. (2008). *Ladder of participation* [PDF]. <https://bit.ly/3quVmOd>

⁶ Advancing Health Equity (n.d.). *Securing buy-in*. <https://bit.ly/3JsgdsF>

⁷ James, J. (2013). *Patient engagement*. *Health Affairs* Policy Brief, February 14, 2013. <https://doi.org/10.1377/hpb20130214.898775>

⁸ Shim, R., & Starks, S. (2021). COVID-19, structural racism, and mental health inequities: Policy implications for an emerging syndemic. *Psychiatric Services*, 72(10): 1193-1198.

⁹ The Front End Project [Fountain House, Haywood Burns Institute, Technical Assistance Collaborative, Center for Court Innovation, Mental Health Strategic Impact Initiative] (2021). *From harm to health: Centering racial equity and lived experience in mental health crisis response*. <https://bit.ly/3EDB1er>

¹⁰ National Alliance on Mental Illness (2021). *NAMI 988 crisis response research* [PDF]. Paris, France: Ipsos. <https://bit.ly/33rjgko>

¹¹ *Multi-disciplinary response teams* [PDF] consist of a paramedic, a licensed mental health professional, and a law enforcement officer. In Dallas, this program is known as RIGHT Care (the Rapid Integrated Group Healthcare Team). RIGHT Care is an integrated, health-driven approach based on best-practice responses to medical emergencies, and is based on the community paramedicine approach. RIGHT Care relies on multi-disciplinary teams of a paramedic, a licensed master's level mental health professional with at least five years of experience in mental health emergency care, and a tenured law enforcement officer with advanced crisis and mental health peace officer training. The team operates on the principles of community paramedicine: functioning as a single integrated unit, relying on shared knowledge and experience, and responding as a team. Other communities have looked at additional features that may add value. For example, in addition to developing a core three-component team approach like Dallas (paramedic, mental health specialist, police), the Austin 911 system has developed the capacity to use telehealth to augment the paramedic response with a virtual mental health clinician in situations where there is no public safety risk (similar to the *CAHOOTS* [PDF] model). In Bexar County, a peer support specialist with lived experience has been added to the team. In Abilene, telehealth is used to provide access to a mental health clinician in the 911 dispatch center. These additional components are necessary to meet the specific needs of the communities they serve.

¹² Collins, D. A., Raffle, H., Burggraf, C., Shamblen, S., Schweinhart, A., & Courser, M. (2019). Local project director and key staff perceptions of Ohio's CCIM4C Initiative [PDF]. Athens, OH: Voinovich School of Leadership and Public Affairs at Ohio University. <https://bit.ly/3GpayBS>

¹³ National Coalition for Dialogue and Deliberation (2010). *Resource guide on public engagement* (second version) [PDF]. Boiling Springs, PA: National Coalition for Dialogue and Deliberation. <https://bit.ly/3rfynpb>

¹⁴ Mathews, D. (2008). Looking back / looking ahead at communities [PDF]. *Connections: The Kettering Foundation's Annual Newsletter*, 2008. <https://bit.ly/3FoolWC>

¹⁵ Democratic legitimacy refers to a governmental structure's ability to persuade constituents that it is just, fair, and impartial, that it has value, and that it should exist. The value of proximity has become tremendously important as governing structures have sought to find new ways to share power with historically disenfranchised and racially marginalized groups who are often underrepresented politically. Enhancing the proximity of affected communities with their government structures embodies the practice of social equality — a key feature of democracy.

¹⁶ Shore, D. (2006). *The trust crisis in healthcare: Causes, consequences, and cures*. Oxford, U.K.: Oxford University Press.

¹⁷ Cooney, V. (2021, March 3). [Funding change to crisis stabilization services could improve access to care, lawmakers say. Minnesota Legislature.](https://bit.ly/34TgN37) <https://bit.ly/34TgN37>

¹⁸ Curi, M. (2022, January 12). [Call centers on "shoestring budget" for suicide prevention line. Bloomberg Law.](https://bit.ly/3K9oaU3) <https://bit.ly/3K9oaU3>

¹⁹ Pietras, S., & Wishon, A. (2021). [Crisis services and the behavioral health workforce issue brief](https://bit.ly/3HlcjQw). Washington, D.C.: Office of the Assistant Secretary for Planning and Evaluation. <https://bit.ly/3HlcjQw>

²⁰ U.S. Federal Communications Commission (n.d.) Fact sheet: 988 and suicide prevention hotline [PDF]. Retrieved September 27, 2021 from <https://www.fcc.gov/sites/default/files/988-fact-sheet.pdf>

²¹ [American Rescue Plan Act of 2021](https://bit.ly/3njZ7Ur), H.R. 1319, 117th Cong., 2021. <https://bit.ly/3njZ7Ur>.

²² Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., & Bolton, B. (2018). [The Lancet Commission on Global Mental Health and Sustainable Development](https://bit.ly/32viAuo). *The Lancet*, 392(10157), 1553–1598. <https://bit.ly/32viAuo>

²³ Kania, J., & Kramer, M. (2011). [Collective impact](https://doi.org/10.48558/5900-KN19). *Stanford Social Innovation Review*, 9(1), 36–41. <https://doi.org/10.48558/5900-KN19>

²⁴ Kania, J., Williams, J., Schmitz, P., Brady, S., Kramer, M., & Juster, J. S. (2021). [Centering equity in collective impact](https://doi.org/10.48558/RN5M-CA77). *Stanford Social Innovation Review*, 20(1), 38–45. <https://doi.org/10.48558/RN5M-CA77>

²⁵ Wolff, T., Minkler, M., Wolfe, S., Berkowitz, B., Bowen, L., Butterfoss, F. D.,... & Lee, K. (2017). [Collaborating for equity and justice: Moving beyond collective impact](https://bit.ly/3JyKKFv). *Non-Profit Quarterly*, 9. <https://bit.ly/3JyKKFv>

²⁶ McCloskey, D. J., McDonald, M. A., Cook, J., Heurtin-Roberts, S., Updegrave, S., Sampson, D.,... & Eder, M. (2011). [Chapter 1: Community engagement: Definitions and organizing concepts from the literature](https://bit.ly/3JyT3Bb) [PDF]. In Clinical and Translational Science Awards Consortium Community Engagement Day Function Committee Task Force on the Principles of Community Engagement, *Principles of community engagement (Second edition)* (pp. 1-42). Washington, D.C.: U.S. Department of Health and Human Services. <https://bit.ly/3JyT3Bb>

²⁷ McCloskey, D. J., McDonald, M. A., Cook, J., Heurtin-Roberts, S., Updegrave, S., Sampson, D.,... & Eder, M. (2011). [Chapter 1: Community engagement: Definitions and organizing concepts from the literature](https://bit.ly/3JyT3Bb) [PDF]. In Clinical and Translational Science Awards Consortium Community Engagement Day Function Committee Task Force on the Principles of Community Engagement, *Principles of community engagement (Second edition)* (pp. 1-42). Washington, D.C.: U.S. Department of Health and Human Services. <https://bit.ly/3JyT3Bb>

²⁸ Schwarz, R., & Blankenship, D. (2014). [Racial disparities in psychotic disorder diagnosis: A review of empirical literature](https://doi.org/10.5498/wjp.v4.i4.133). *World Journal of Psychiatry*, 4(4): 133–140. doi: 10.5498/wjp.v4.i4.133

- ²⁹ Edgoose, J., Quiogue, M., & Sidhar, K. (2019). How to identify, understand, and unlearn implicit bias in patient care. *Family Practice Manager Journal*, 26(4): 29-33.
- ³⁰ Safety and Justice Challenge (n.d.). [The impact of COVID-19 on crime, arrests, and jail populations: An expansion on the preliminary assessment](https://bit.ly/3znlcpR) [PDF]. Washington, D.C.: The JFA Institute. <https://bit.ly/3znlcpR>
- ³¹ Li, W. (2020, June 2). [Police arrested fewer people during Coronavirus shutdowns — even fewer were white](https://bit.ly/31kTnSy). The Marshall Project. <https://bit.ly/31kTnSy>
- ³² Le, H. (2020). [Moving power to advance racial equity](https://bit.ly/3Kayz1Y) [PDF]. *Responsive Philanthropy*, 2020(1). <https://bit.ly/3Kayz1Y>
- ³³ Le, H. (2020). [Moving power to advance racial equity](https://bit.ly/3Kayz1Y) [PDF]. *Responsive Philanthropy*, 2020(1). <https://bit.ly/3Kayz1Y>
- ³⁴ U.S. Substance Abuse and Mental Health Services Administration, Pre-Arrest Diversion Expert Panel (2018). [Tailoring crisis response and pre-arrest diversion models for rural communities](https://bit.ly/34nzv7) [PDF]. Washington, D.C.: U.S. Substance Abuse and Mental Health Services Administration. <https://bit.ly/34nzv7>
- ³⁵ The Front End Project [Fountain House, Haywood Burns Institute, Technical Assistance Collaborative, Center for Court Innovation, Mental Health Strategic Impact Initiative] (2021). [From harm to health: Centering racial equity and lived experience in mental health crisis response](https://bit.ly/3EDB1er). New York, NY: Fountain House. <https://bit.ly/3EDB1er>
- ³⁶ Kanno-Youngs, Z., Calvert, S., & Gay, M. (2017, January 4). [New York City major crimes fall to lowest recorded level](https://on.wsj.com/3sRZrNV). *Wall Street Journal*. <https://on.wsj.com/3sRZrNV>
- ³⁷ D, Contee and stakeholder group. (Personal communication) December 14, 2021
- ³⁸ Action Alliance (n.d.). National Strategy for Suicide Prevention. Retrieved January 3, 2022 from <https://bit.ly/3qKeVAN>
- ³⁹ National Association of State Mental Health Program Directors Crisis Now Learning Community, *Presentation by SAMHSA – SAMHSA Updates* <https://talk.crisisnow.com/videos/>
- ⁴⁰ National Alliance for Mental Illness 988 State Bill Tracking: <https://bit.ly/32DTeul>
- ⁴¹ Implementing the national 988 system to enhance and expand behavioral health crisis response and suicide prevention services, Washington H.B. 1477. <https://bit.ly/3cMglnK>
- ⁴² Colorado Department of Human Services (n.d.). [Behavioral health reform](https://cdhs.colorado.gov/behavioral-health-reform). Retrieved January 3, 2022 from <https://cdhs.colorado.gov/behavioral-health-reform>
- ⁴³ City of Tucson (n.d.). Tucson Police Mental Health Support Team. Retrieved January 3, 2022 from <https://bit.ly/3eKUyOb>
- ⁴⁴ Casanova, S. (2021, April 30). Tucson solutions: Police visit patients, offer rides to mental health treatment. Tucson.com. <https://bit.ly/3HC0g1x>
- ⁴⁵ Weiner, R. (2021, May 17). D.C. to divert some mental health calls away from police. The Washington Post. <https://wapo.st/3pMVCaO>
- ⁴⁶ Alaska Native Tribal Health Consortium. (n.d.) Overview. Retrieved January 3, 2022 from <https://anthc.org/who-we-are/overview/>

**Senate Subcommittee on Criminal Justice &
Counterterrorism Hearing Entitled, “*Behavioral
Health and Policing: Interactions and Solutions*”**

**Questions for the
Record Submitted
April 29, 2021**

**QUESTIONS FOR SHERIFF
MARGARET MIMS FROM
RANKING MEMBER COTTON**

1. There’s been some research on the deterrence effect of a visible police presence. The idea is that more patrols, especially in crime-prone areas, can reduce crime simply through the regular presence of officers and the accompanying increase in perceived certainty that committing a crime will result in arrest. There is also evidence that increasing police presence results in more trust between officers and the community, leading to better and more communication between victims and law enforcement when crime occurs. Has that been your experience?

Yes this has been my experience. Our resources are finite and we must deploy our deputies in areas where we know we regularly receive a higher number of calls for service. Important though is that deputies identify opportunities for positive community engagement. When officers are out in the community it builds trust and the public sees officers as a support with the understanding that law enforcement will actively enforce the rule of law. This community engagement strengthens the value of a co-

response model for crisis response, in that individuals have an expectation that law enforcement officers as first responders are there to help them in partnership with the mental health responders.

2. You mentioned in your testimony your “Sequential Intercept Mapping” initiative, which helps get mental health treatment where it’s most needed. Can you explain how that initiative helps to focus your resources and the resources of your mental health partners?

The Sequential Intercept Mapping (SIM) initiative was spearheaded by the Department of Behavioral Health (DBH) in 2017 and again in 2022. This was facilitated by external experts from Policy Research Associates. Each process convened multiple stakeholders across sectors for a two-day event during which the participants collaboratively diagram in detail how individuals flow from the community to the criminal justice system with a stated purpose of identifying key intercepts for diversion and treatment. The structured process provided a valuable forum to recognize strengths and build on those while transparently and collaboratively highlighting gaps and barriers. The processes resulted in the creation of shared priorities and action plans. Following the 2017 SIM the county greatly expanding the Crisis Intervention Team response model, particularly in the urban areas of the county, as well as significant expansion of behavioral health services for persons involved in or at-risk of justice involvement. In May of 2022 the SIM resulted in a plan to focus on expansion of resources in rural areas of the county and a plan to

support the development of a Sobering Center. For both SIM events, a positive outcome was a strengthening of connections and relationships among all stakeholders including law enforcement. By identifying these intercepts we can focus our resources more effectively.

3. Can you tell us more about your experiences with crisis intervention teams?

The Fresno County Sheriff's Office works closely with the Fresno County Department of Behavioral Health in responding to persons experiencing behavioral health crisis in the community. Law Enforcement Officers can access a mental health clinician to co-respond in-person to assist in the community. The partnership is a support to officers not only for support in serving community members with complex needs, but through the experience working alongside clinicians our model also strengthens skills of officers in responding when a clinician is not available.

4. Based on your experience as a law enforcement officer, what recommendations do you have for policymakers who are looking to improve policing and to improve police interactions with people who face mental health challenges?

I and our County Department of Behavioral Health believe policymakers would benefit from understanding that there is not a one-size fits all approach to community crisis response. We see value in building out an array of

options, including emphasizing the importance of co-response and law enforcement response models as well as alternatives to law enforcement response when appropriate to ensure the safety of the public and other professionals serving persons with mental health challenges in the community. This includes more than just our first responders in our communities, it also includes partnerships that must be established to those who are incarcerated in our local jails. For example, a few years ago I worked with our DBH to evaluate whether those who receive mental health services in our jail receive services when they are not in custody. The result was that these individuals did not get services when they were not in jail because they just were not connected to the system when they were not in custody. We have worked to change that with a more robust continuum of care model.

**Senate Judiciary Committee Hearing
“Behavioral Health and Policing: Interactions and Solutions”
Questions for the Record
for Keris Myrick, Vice President of Partnerships, Inseparable
(former Director, JED Foundation)
Submitted April 29, 2021**

QUESTIONS FROM SENATOR WHITEHOUSE

RESPONSES KERIS MYRICK:

QUESTION 1:

1. This hearing highlighted the difficulties that arise when police officers are called upon to respond to mental health, substance use, and other behavioral health crises, and alternative approaches to these situations.
 - a. Based on your experience, what are the most promising models to handle these situations?
 - b. What are the biggest obstacles these programs face?
 - c. How can the federal government encourage and support these programs?
 - d. How have cities and states created sustainable funding for these programs? What can the federal government do to help other jurisdictions do the same?

RESPONSES:

- a. The most promising models for response to people experiencing behavioral health crisis are ones in which law enforcement is not involved. Rather than law enforcement, people with lived experience of behavioral health conditions who have experienced crisis and navigating their way to recovery along with training to support others can and do serve as ‘first responders’ either as a team of Peers (Peer Support Specialist/ Peer Recovery Coaches) and or alongside other licensed professionals such as nurses, social workers and psychiatrists – this can be either as mobile crisis teams or street outreach teams. Other models included Peer Respite for those in crisis who are not in need of emergent medical services and imbedding Peers supports in sobering centers as well.
- b. The first obstacle is that of stigma – the belief that Peers in settings such as ERs, Psychiatric units of hospitals and on mobile teams will get hurt, not be well enough to tolerate the work (type of work) or do not have a medicalized understanding of behavioral health conditions therefore will be more of a burden than help. This is not what the research has shown and these stigmatizing beliefs deter the use and or

expansion of a well-trained, needed and for the person receiving crisis services – desired workforce. The other barrier is funding – how to maximize the use of federal, state, block grant dollars as well as how commercial insurance will pay for the use of peer services in mobile teams, peer respite and peers in hospital or ER settings. Further, financing is usually based on the person served (do they have insurance what kind and what does it pay for) which can restrict the crisis continuum of care services and options to build out alternative and effective responsive services that do not include law enforcement.

- c. SAMHSA released an advisory in June 2022 – [Peer Support in Crisis Care](#) that lays provides excellent guidance on the need , best practices for implementation and the evidence for the use of peers in behavioral crisis along the continuum of care¹. This is an example of what the federal government can do as a start to provide guidance and technical assistance to field about the role of peer supports in crisis response to reduce or eliminate the use of law enforcement as default responders. To support funding crisis continuum of services to reduce the use of law enforcement – the federal government can provide guidance to states about the following:
 - a. the need and importance of requiring all funder participation from private to public behavioral health funders to contribute to crisis systems services that serves people who are covered or affected by their funding.
 - b. CMS can provide clear guidance and definitions of what Medicaid and other funders can reimburse within a crisis continuum of care such as urgent care centers, crisis centers, residential crisis services, mobile crisis, intensive community crisis intervention and to ensure that rates adequately cover those services.

The goal is to make sure that at any point within the crisis continuum – when a person needs help and after a crisis subsides – they do not fall through the cracks or have to rely on 911 law enforcement response because there is “no there, there” to support them due to regulatory and or financing barriers.

d. / e.

¹ Substance Abuse and Mental Health Services Administration (SAMHSA). *Peer Support Services in Crisis Care*. Advisory. SAMHSA Publication No. PEP22-06-04-001 Published June 2022

Noting that financing is not my area of expertise, I want to refer to the GAP Report²: As a participant in the Group for the Advancement of Psychiatry in developing the report “the ideal crisis system”, I learned more about financing and the examples of states with sustainable funding programs and roles of the government from the report are two examples extracted from the report and listed below

Federal Example: “CCBHC Expansion Legislation Introduced”

“In light of the program’s success, as of January 2021, Congress has extended the original 8-state Medicaid demonstration to two additional states and allocated yearly funds for CCBHC expansion grants since 2018. Thirty-three states now have at least one CCBHC. The bipartisan Excellence in Mental Health and Addiction Treatment Act (S. 824/H.R. 1767) would renew the CCBHC Medicaid demonstration program and expand it to new states. By renewing and expanding the demonstration, Congress could expand behavioral health capacity and alleviate the pressure on our nation’s jails and emergency rooms. This legislation will also ensure sustainability for CCBHC grantees beyond their 2-year grant terms by supporting more states in implementing the model as part of Medicaid.” (page 45)

State Example: “All-Payer Example - Kent County, Michigan”

“The Kent County crisis collaborative under the auspice of the population health consortium has developed a business plan for a crisis center, call center, behavioral health urgent care, and mobile crisis that includes all Medicaid Health Plans and commercial plans (including Medicare Advantage) as potential partners. The three largest health plans have been invited to the table and have agreed to participate in the funding collaboration. In Michigan, the Medicaid health plans are responsible for mild to moderate behavioral health but not crisis, even though 60% of Medicaid recipients who have behavioral health crisis are in the mild to moderate group. However, the Medicaid health plans can benefit directly from supporting ED diversion and are interested in partnering with community leaders because of the high-level collaboration that has been created.” (page 46)

QUESTION 2:

² Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry. (2021). *Roadmap to the ideal crisis system: Essential elements, measurable standards and best practices for behavioral health crisis response*. <https://www.thenationalcouncil.org/resources/roadmap-to-the-ideal-crisis-system/>

2. Even when jurisdictions have alternate responder programs, police may still respond to situations where people are experiencing mental health or substance use crises or have disabilities (whether because of inaccurate dispatching, to support behavioral health professionals, or because a serious crime is in progress).
 - a. What should police departments do to better prepare their officers to respond safely and effectively to these situations?
 - b. How can the federal government support these efforts—i.e., by providing funding, developing best practices, etc.?

RESPONSES FOR 2 A and B:

Though ideally under any circumstance when someone calls 911 for mental health crisis response, law enforcement should not be the default and or only responder but rather there is a connection to 988 and or other community mobile and or crisis services. There are instances when safety of the person or others are at risk and law enforcement may need to be present to support a safe resolution. There also may be times when calls are dispatched incorrectly from the call centers (or there are no other available responders available in time sensitive crisis situations) when law enforcement are the only available. Also, there may be bias that may occur for example if it is stated that a black male in mental health distress needs crisis support. Evidence shows that police may be called to respond more often than other crisis responses services for similar circumstances that do not involve Black men and disproportionately those calls in the harm or death to Black men.

Training for law enforcement exists such as Crisis Intervention Training and other community-based trainings from the National Alliance on Mental Illness (NAMI), Mental Health First Aid and Psychological First Aid trainings to name a few that may be available to police officers, first responders and 911 call center operators. However, there are no standards, oversight and research that support mandating such training and or providing evidence that such training can reduce harmful outcomes or increase better outcomes when law enforcement is involved. There are mixed outcomes for co-responder models (such as CIT trained officers with Social worker or licensed behavioral health professionals), yet there is continued use of such models.

At a minimum ensuring all officers, police departments and 91 call centers are aware of 988 can be a short term first step. Creating an easy way to transfer between 911 and 988 can also reduce time lags which may be what drives law enforcement swift response (they operate in seconds not minutes or hours) and reluctance perhaps to call 988. Currently there is no easy way to transfer from one system to another (911 to 988) however, with interagency collaboration this is something that can and should be explored

I also think the best place to start is for an independent body with funding do a landscape analysis of the various training available, the costs, barriers to implementing training and how many officers and call agents have been trained alongside their outcomes. It is hard to understand the complexity and develop a strategic way forward without a deep dive from an independent body to inform a strategy. The landscape analysis can include recommendations for core competency in training, funding needed

to implement the training and oversight to monitor outcomes and hold officers and call agents accountable with incentives and or sanctions for expected outcomes.

QUESTION 3

3. Reforming how law enforcement responds to mental and behavioral health crises also requires working with other stakeholders at the state and local levels, such as health departments and behavioral health providers.
 - a. Are there any jurisdictions successfully coordinating various state and local stakeholders? If so, which ones?
 - b. What suggestions do you have to better coordinate funding, training, and resources among stakeholders?

RESPONSES to QUESTION 3:

- a. I will refer to the GAP *Ideal Crisis System* report³ again for examples of states and localities that have coordinated state and local stakeholders:

The Tucson Model: A Collaborative Approach to Behavioral Health Crisis and Public Safety: Margaret Balfour, MD (Page 184)

“Pima County also plays an important role as a leader and convener. As the operator of the jail and a primary funder of the safety net hospital emergency department, the County has long had an interest in improving care for individuals with behavioral health needs. The County created a dedicated Behavioral Health Department in 2010 to oversee its role in civil commitment evaluations and jail programs. As part of the MacArthur Foundation Safety + Justice Challenge, Pima County has developed data sharing agreements which it uses to identify opportunities for community-based alternatives to incarceration and collaborates closely with the RBHA, law enforcement and various service providers on a variety of self and grant funded programs.”

A community case study: Building a crisis center from the ground up. Johnson County (Iowa City), Iowa: Michael Flaum, MD (page 187)

³ Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry. (2021). *Roadmap to the ideal crisis system: Essential elements, measurable standards and best practices for behavioral health crisis response*. <https://www.thenationalcouncil.org/resources/roadmap-to-the-ideal-crisis-system/>

“Iowa has a long history of local control for its mental health services. Indeed, up until a recent legislative change, each of Iowa’s 99 counties had its own funding streams, and many decisions about services were made at the county level. In the county in which Iowa City is located - Johnson County - a “System of Care” (SOC) group had been established in the early 2000s at the suggestion of a consultant who had been brought in to advise about how our community could improve behavioral health services. This proved to be a critical step in much of what would happen since. The group consisted of representatives from a variety of agencies and entities that share a common population – including each of the hospitals (in addition to UICH, there is a VA hospital and one small private hospital), the primary substance use service provider, the local homeless shelter (which provides a variety of housing services), multiple law enforcement agencies (county sheriff and the police of several surrounding municipalities as well as University police), community support service providers, family and consumer advocacy groups and others. The group met monthly. All those who came did so voluntarily on their own time and expense.”

High Level Collaboration to Establish a Crisis Continuum for Adults: The Healthy Minds Policy Initiative Tulsa, Oklahoma (page 192-193)

“Between 2016-2018, careful strategic planning and consensus building resulted in a report by the Urban Institute. The funder of this work, The Anne and Henry Zarrow Foundation, obtained consultation to help establish an ongoing infrastructure to develop and oversee initiatives to advance the plan. What emerged is the Healthy Minds Policy Initiative (HMPI), a dedicated team of mental health policy experts who work with state and local leadership to build capacity and develop policies to improve mental health services in Tulsa and the state. A key focus for Tulsa has been building on the work of multiple collaborations to further develop existing crisis services in the Tulsa area and identifying strategies to address gaps that limit capacity for effective crisis response for all.

After years of careful strategic planning, consensus building and implementation planning, local and state mental health professionals and community leaders from the Mayor’s office, Tulsa Police Department, universities, philanthropy and non-profits are well-underway to developing a robust and comprehensive crisis response system for behavioral health disorders”

These examples I think miss only the meaningful inclusion of people with lived experience throughout the process. Further without getting more information it is not clear how the collaborations and or results have changed or improved outcomes for underserved or un-served minoritized populations where the greatest disparities occur especially as it pertains to law enforcement involvement and poor outcomes in crisis care. When creating stakeholder groups that are national, state or local, there must be attention paid to the intentional, meaningful involvement throughout the stakeholder process of people (service recipients) that are directly impacted. Using guidance such as Harts Ladder of Consumer

Engagement⁴ (see attached adaptation) can support participation and inclusion of people with lived experience and people of color throughout the process. Federal, State and local bodies can require such involvement within grant or contract requirements to incentive the inclusion of consumers, peers and people of color.

To support stakeholder groups that may not normally come together, have difference of opinions and or professions with cultures of practice that differ from one another, I think this is where the field of organizational psychology and or human centered design can play a pivotal role. The organizational psychology practitioners train in systems design, group development, facilitation and change management. Human Centered Design practitioners are expert in systems design work from all users' perspectives. Using funding from philanthropy matched with federal, state and local dollars can help support the work needed in bringing diverse experienced stakeholders together using expert facilitation and trainers in the work of system design theories (and pragmatic evidence-based practices) to reform our old way of using law enforcement to a new way of creating a humanistic, safe and recovery practiced crisis response continuum of care.

⁴ Hart, R. (1992). *Children's Participation from Tokenism to Citizenship*. Florence: UNICEF Innocenti Research Centre

The Lived Experience-Engaged Ladder
Keris Jân Myrick, MBA MS

A lived experience engaged organization and or project is one where people with lived experience contribute to the success of the organization/project in meaningful ways. A fully lived experience organization and or project has a vibrant partnership between clinicians, administrators, peers and people with lived experience (service recipients) in order to identify and meet the needs of people they serve, innovate to meet emerging needs, and reduce barriers to success.

The Lived Experience-Engaged Ladder is built on the concepts first outlined in Hart's Ladder of Participation (1992) where UNICEF sought to better define how they were involving the people they were seeking to serve in the design, implementation, and evaluation of all of its programs.¹

This tool is intended to encourage organizations and or projects to go through a self-assessment and act intentionally to more fully integrate people with the experience of living with their own behavioral health condition or as a parent of a child under the age of 18 living with a behavioral health condition as well as people of color and other historically marginalized groups into the development, implementation, and evaluation of their organization's or project's program policies and procedures.

By involving people with the lived experience in all aspects of the organization's life, the system is better able to offer high quality and effective programs, policies, and procedures that meet the needs of those they are seeking to serve.

While it may help point the way, the Lived Experience-Engaged Organization Ladder is not intended to define a career ladder for peer support staff or those with lived experience receiving services. It is designed as a self-assessment tool for organizations, programs and or projects to rethink how they include consumers in all aspects of the organization so that the organization can be effective in meetings its mission.

The Lived Experience Engaged Ladder:



¹ adapted from Hart, R. (1992). *Children's Participation from Tokenism to Citizenship*. Florence: UNICEF Innocenti Research Centre

The Lived Experience-Engaged Ladder
Keris Jän Myrick, MBA MS

The Lived Experience-Engaged Assessment

Every organization/project will have a mixture of things they do that might be best described by different rungs on the ladder. For example, an organization/project may be able to describe themselves on rung eight and still be doing things at rung one. There is nothing wrong with having a mixture of ways people with lived experience are engaged in the organization/project. Not every person with lived experience or peer will have the experience to contribute at rung seven and may be more comfortable developing those skills through volunteer activities at rung two. However, a review of where your organization or project primarily and consistently lands on the ladder can point out areas for growth and lead to strategically improving your success as a lived experience engagement.

Step One: Take a moment think about your project and project partners, work together and place check marks next to the corresponding rung on the ladder as follows as it pertains to your Learning Lab Project:

- ✓✓✓ We do this consistently
- ✓✓ We can point to a few instances where we have done this
- ✓ We have done this on a rare occasion
- No check mark means we have never done this

Step Two: Jot down an example that illustrates your check marks in each area

Levels	Check Marks	Illustration
Lived Experience Contributing at all Levels		
Lived Experience in Leadership		
Lived Experience Initiated Partnerships		
Lived Experience Input and Influence, No Leadership		
Separate but Equal		
Input, No Influence		
Job Tokenism		
Tokenism		
Marketing Capital and Entertainment		

Step Three: Now take a moment and consider where most of your check marks are placed. Do you see any patterns? Are most of your check marks in the green, yellow or orange zones? What does it mean?

Step Four: What specific strategies could you implement to improve the lived experience engagement orientation of your organization/project?

**Subcommittee on Criminal Justice and Counterterrorism
Behavioral Health and Policing: Interactions and Solutions
Submitted April 29, 2021**

QUESTIONS FROM SENATOR BOOKER

Questions for Keris Myrick

1. In most instances, when people with mental illness need assistance, what is the consequence of a police response?
 - a. How would a response from a mental health professional better serve the needs of people with mental illness than a law enforcement officer in moments of crisis?
2. Why is peer support so important in behavioral health care? What function does it serve?

RESPONSE from Keris Myrick-

Question 1 –

Police response is not what one would expect or want when experiencing any kind of health emergency including a mental health emergency. Police are not nor should they be trained primarily as health professionals. Police are trained to enforce the law (hence the name of the use of the name law enforcement as synonymous with Police officer) and to protect the public and themselves. Police response can result in emotional and physical harm including death to people with mental health conditions when they need emergency or crisis assistance. Further these harms result in trauma which can result in people refusing to reach out for assistance, in the future, access treatment or deteriorating trust of the mental health system, providers and or even their loved ones who may have called 911 for help.

The Washington Post [Database](#) on Police Officer Shootings indicate that 1 in 5 people with a mental illness are fatally shot by on-duty police. It is important to also point out the disparities of outcomes for people who have a mental illness who are also Black and Brown. A [recent study](#) found that when police are responding to a mental health emergency call, unarmed Black men are more likely to be shot and killed (1).

QUESTION 1A-

Mental health professionals such as social workers, psychiatric nurses, psychiatrists, Peer Supporters/Recovery coaches can and do respond to people experiencing mental health crisis. They are trained to work with people and support people during all aspects of their recovery journey. Trained mental health professionals can work in teams such as mobile crisis teams, or in home like settings such as Peer Respite where people who themselves have been through similar mental health crisis are trained to provide a welcoming, safe and trusting environment in which one can heal and move forward toward on their recovery journey. Mobile crisis teams made up of mental health professionals including Peers can many times resolve a crisis in the field reducing the need to transport to costlier and more intensive

emergency room or psychiatric hospitals. While police may in general only transport to EDs and locked psychiatric wards.

From my personal experience and those of my peers who report similar encounters, what is desired when we are in emotional distress and in need of emergent care is to be met with someone who is caring, can slow things down, meet us where we are, build trust and create a sense of safety as we navigate through these struggles. This type of response is part of providing person centered humanistic care which is technically what mental health professionals as trained to do as opposed to police. [The Harm to Health Report](#): Centering Race Equity and Lived Experience in Mental Health Crisis Response provides a ‘north star vision’ to move from our now too often used public safety response to a public health response to eliminate trauma, handcuffs, harm and death and advance prevention, earlier intervention, advance use of peer support services and increase access to an array of mental health and other services that help people when they are at their most vulnerable to heal (3).

SAMHSA released an advisory [Peer Support Services in Crisis Care](#) in June 2022 that also provides information about, the role, evidence and support of Peer Support as an important part of crisis response systems. This advisory can aid legislators, policy makers, systems of care, CBOS (federal, national ,state and local folks) to not only understand the importance of the peer support and service role, but also how to deploy across the continuum of care including crisis services.

Foot notes:

1. Marilyn D. Thomas, Nicholas P. Jewell, Amani M. Allen, Black and unarmed: statistical interaction between age, perceived mental illness, and geographic region among males fatally shot by police using case-only design, *Annals of Epidemiology*, Volume 53, 2021, Pages 42-49.e3, ISSN 1047-2797, <https://doi.org/10.1016/j.annepidem.2020.08.014>.
2. Fatal Force: Washington Post Database. <https://www.washingtonpost.com/graphics/investigations/police-shootings-database/> Retrieved 8.7.2022
3. From Harm to Health: Centering Race Equity and Lived Experience in Mental Health Crisis Response. <https://fountainhouse.org/reports/from-harm-to-health> . Retrieved 8.7.2022
4. Substance Abuse and Mental Health Services Administration (SAMHSA). *Peer Support Services in Crisis Care*. Advisory. SAMHSA Publication No. PEP22-06-04-001 Published June 2022



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April 21, 2021

U.S. Senator Cory A. Booker
Via E-Mail

Re: Support of Behavioral Health and Policing Alternative Programs

Dear Senator Booker,

My name is Chief Shon F. Barnes with the Madison Police Department located in the capital city of Madison, Wisconsin. I am writing in support of alternative programs and community services to behavioral health issues.

As a 21-year veteran in policing, I have seen firsthand the effectiveness of community partnerships when dealing with mental wellness challenges. In this era of police reform, we must all challenge our government to provide a better level of service to our community. We can no longer simply rely on police responses to mental wellness and must view this issue from a community health perspective. We have seen far too many times, the negative results of "police only" responses to mental health calls. No person deserves to be imprisoned or harmed by police simply because they have mental wellness challenges.

Please consider my letter in support of community services and programs to handle mental health and substance abuse issues. We must do all we can to reduce dangerous interactions between the police and the community we are sworn to service and protect.

Respectfully,

Shon F. Barnes
 Chief of Police

**Testimony of Ayesha Delany-Brumsey, PhD
Division Director, Behavioral Health, Council of State Governments Justice Center**

**Committee on the Judiciary
Subcommittee on Criminal Justice and Counterterrorism
U.S. Senate**

Hearing on “Behavioral Health and Policing: Interactions and Solutions”

April 22, 2021

Chairman Booker, Ranking Member Cotton, and members of the Subcommittee, thank you for the opportunity to submit testimony for the record in support of the subcommittee’s hearing on Behavioral Health and Policing: Interactions and Solutions.

As you may know, the Council of State Governments (CSG) Justice Center has a long history of working with Republicans and Democrats to foster dialogue, provide policymakers with research-driven solutions, build momentum for policy change, and provide expert assistance. We serve governors, state legislators, judges, local officials, and members of Congress across the political spectrum. The CSG Justice Center combines the power of a membership organization with the expertise of a policy and research team focused on assisting others to attain measurable results.

This hearing comes at a pivotal moment in our nation’s history. In the wake of George Floyd’s killing by former Minneapolis police officer David Chauvin, there continues to be a national conversation on how to change law enforcement culture and how to hold police accountable. The CSG Justice Center and our colleagues in law enforcement recognize that there is hard work that must be done to ensure that officers and their agencies are held accountable for adhering to high standards of conduct and of rebuilding trust and legitimacy within the communities they serve.¹

CSG Justice Center staff have decades of experience working closely with law enforcement agencies and their partners across the country to develop collaborative solutions to challenges at the intersection of law enforcement and behavioral health. Since 2009, the CSG Justice Center

¹ Statements from law enforcement organizations have included:
<https://www.sheriffs.org/Incoming-NSA-President-Sheriff-David-Mahoney-Makes-Statement-George-Floyd-Death>;
<https://ndaa.org/wp-content/uploads/NDAA-Statement-on-Killing-of-George-Floyd-FINAL-1.pdf>;
<http://www.mymcpnews.com/wp-content/uploads/MCCA-Open-Letter.pdf>;
<https://mcsheriffs.com/mcsa-statement-regarding-the-death-of-george-floyd/>;
<https://www.theiacp.org/news/blog-post/the-challenge-before-us>;
<https://lawenforcementactionpartnership.org/wp-content/uploads/2020/06/LEAP-National-Policing-Recommendations-7.pdf>

has been the lead training and technical assistance provider for the U.S. Department of Justice's Bureau of Justice Assistance's (BJA's) Justice and Mental Health Collaboration Program (JMHC). In this role, we have supported over 140 law enforcement grantees to work in partnership with other systems—health, homeless services, and more—to improve their responses to people with mental health and substance use conditions. This includes helping communities launch co-responder programs where law enforcement and health workers respond together to people experiencing a mental health crisis, among other initiatives. Last year, with the support of BJA, we launched a national technical assistance center to offer free, practical training and education to communities looking to safely connect people who have behavioral health conditions or intellectual and developmental disabilities to community-based supports and services in lieu of arrest and incarceration.

Building Alternative Response Models

Law enforcement officers are too often called upon to serve as our first (and frequently only) responders to address socioeconomic and health needs, including mental health crises, substance use, and homelessness. The actual day-to-day job of law enforcement can be very different than officers imagine it to be when they apply, and many departments struggle to effectively recruit, train, and equip their police forces for the reality of the work.

At best, these are challenging situations for officers to respond to, which may result in less-than-optimal outcomes for those in need of help.² At worst, these interactions can lead to injury or tragic loss of life: of the more than 6,220 people fatally shot by on-duty officers since 2015, approximately 23 percent were people with a mental illness.³

Conversations with our partners underscore that there is significant agreement between law enforcement and community activists that the status quo is not working for officers or the communities they serve. Both concur that the ideal response to these social challenges is not increased enforcement, but rather allocation of more significant investments in community supports and solutions that connect people to needed services. Given this agreement, now is the time to rethink how we can respond to these social service needs in ways that meaningfully engage other systems, such as health, housing, and social services. Ideally, these responses would be led by the health and social service systems, not law enforcement, and law enforcement may not need to be involved at all.

Communities know what resources they need to ensure their own safety. Therefore, community-based organizations and community members should be supported to work in

² The Council of State Governments Justice Center, *Police-Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Responses for People who have Mental Health Needs* (New York: The Council of State Governments Justice Center, 2019),

<https://csgjusticecenter.org/wp-content/uploads/2020/02/Police-Mental-Health-Collaborations-Framework.pdf>.

³ "Fatal Force: Police shootings database," *The Washington Post*, accessed April 22, 2021,

<https://www.washingtonpost.com/graphics/investigations/police-shootings-database/>.

partnership with local and state governments to design and operate alternative responses that meet the short-term acute needs of people in crisis, as well as support longer-term well-being. Community-based organizations are already the backbone of public safety in our communities,⁴ and the supports they are able to provide are key to fostering neighborhood cohesion, increasing trust among residents and between residents and government, reducing violence, and improving health. Further, community members will be able to offer guidance about the resources they know are needed to support public safety in their community, and their engagement will boost public trust and confidence in the initiatives they help design.⁵

Recommendations

Backed by our organizational experience in law enforcement and mental health and our decade-long partnership with the federal government, we are honored to offer Congress the following recommendations as it seeks to address the complex issues which are the subject of this hearing:

Recommendation 1: Congress should appropriate funds to support initiatives that promote innovative cross-system collaborations between law enforcement and health or social service systems to improve responses to people with mental illness. This includes supporting the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA)

For people who have serious mental illnesses overrepresented in the criminal justice system, MIOTCRA promotes public safety and community health by facilitating collaboration among the criminal justice, juvenile justice, mental health treatment, and substance use treatment systems to ensure those with mental illnesses receive the treatment and help they need.

The Justice and Mental Health Collaboration Program (JMHCPC) — authorized under MIOTCRA — ensures our criminal justice and mental health systems have the funds they need to serve some of our nation’s most vulnerable individuals. State and local governments can use the grants for a broad range of activities, including: including mental health courts, specialized first response options for people in crisis, in-facility treatment for mental illnesses and substance use, and interventions for youth who are involved or at risk for involvement in the juvenile justice system.

The program was reauthorized as part of the 21st Century Cures Act, which incorporated two bills: The Comprehensive Justice and Mental Health Act and the Mental Health and Safe Communities Act. The provisions in the Cures Act made improvements to MIOTCRA that would support state and local efforts to identify people with mental health conditions at each

⁴ Patrick Sharkey, Gerard Torrats-Espinosa, and Delaram Takyar, “Community and the Crime Decline: The Causal Effect of Local Nonprofits on Violent Crime,” *American Sociological Review*, 82, no. 6 (2017): 1214–1240.

⁵ Policing Project NYU Law School, *Beyond the Conversation: Ensuring Meaningful Police-Community Engagement* (New York: Policing Project NYU Law School, 2018), <https://static1.squarespace.com/static/58a33e881b631bc60d4f8b31/t/5b29056a758d460f539bc079/1529415022872/Policing+Project+Beyond+the+Conversation.pdf>.

point in the criminal justice system in order to appropriately connect them with mental health services; increase focus on corrections-based programs, such as transitional services that reduce recidivism rates and screening practices that identify inmates with mental health conditions; support the development of curricula for police academies and orientations; and develop programs to train federal law enforcement officers in how to respond appropriately to incidents involving a person with a mental health condition. It also expands treatment and transitional services for people reentering society from prison and jail with mental illnesses, substance use problems, or chronic homelessness.

Using JMHCP funding, jurisdictions across the country have been able to launch and expand innovative programs that support public safety while connecting people to needed community-based treatment and supports. One example of this is the work that Douglas County, Kansas has done to launch a systems-wide approach to jail diversion, including implementing crisis intervention training (CIT), co-responder teams, pre-arrest diversion, jail screening and assessment, and a behavioral health campus that provided crisis services, problem-solving beds, and housing. Through these efforts, and more, the county reported that they had a 56 percent reduction in jail books for people with serious mental illnesses from 2014 to 2018. Today they are continuing their work with the goal of eliminating the disparity between the percentage of people in jail with a serious mental illness and the percentage of people in the community with a serious mental illness.

Similarly, leveraging JMHCP funding, as well as other sources of support, allowed Houston, Texas to launch a 911 Call Diversion Program. This program, operated in partnership between the Houston Police Department and the Harris Center for Mental Health, aimed to divert 911 calls away from law enforcement response and to mental health treatment. In 2019, the program was able to divert 2,333 calls by connecting callers to mental health professionals rather than dispatching law enforcement to the scene.

Recommendation 2: Congress should appropriate funds to support initiatives that promote adoption of best practices and improved responses to people in crisis. This includes supporting the National Criminal Justice and Mental Health Training and Technical Assistance Center.

The 21st Century Cures Act, signed into law in 2016, established a National Criminal Justice and Mental Health Training and Technical Assistance Center through the Department of Justice to provide broad, national-level training and technical assistance on issues related to mental health, crisis intervention, criminal justice systems, and law enforcement. Congress appropriated \$2.5 million for a national training initiative in FY18 and in FY20, but this initiative has not been funded since that time. Funds may be used to, among other purposes, provide law enforcement officers with training on how to work with people with mental illness; provide training and technical assistance to mental health providers and criminal justice agencies on diversion, incarceration, and reentry programs for people with mental illness; develop suicide prevention and crisis intervention training for criminal justice agencies; and disseminate best practices, policy standards, and research findings relating to the provision of mental health services.

Since launching, the program has been able to support the establishment of the [Law Enforcement Mental Health Collaboration Support Center](#) which offers free training and resources to any community who requests help to improve their law enforcement response to people with mental health conditions, substance use conditions, or intellectual and developmental disabilities.

Any jurisdiction that is interested in receiving assistance can request support through the center and will receive a response within three days. Support ranges from telephone coaching to site visits, to connections to peers to learn from the innovations of other jurisdictions. Indeed, the center supports the Law Enforcement Mental Health Learning Sites, which are nine departments across the country that embody best practices in law enforcement response to people in crisis. In 2020, these sites supported 194 agencies from across 48 states to adopt best practices.

In addition to direct consultation, the center also provides access to tools such as the [Police-Mental Health Collaboration \(PMHC\) Self-Assessment Tool](#) that law enforcement agencies and their behavioral health partners can use to help them connect people with behavioral health conditions to treatment and services in lieu of arrest. Finally, to support the adoption of best practices broadly, the center publishes policy guidance through briefs and webinars.

We want to thank the members of the subcommittee who have taken a leadership role in supporting bipartisan initiatives such as JMHCP and the National Criminal Justice and Mental Health Training and Technical Assistance Center.

We are at a moment in time where the nation is seeking meaningful responses and reforms to our justice system that promote both public safety and racial equity. While the guilty verdict of Mr. Chauvin is a first step toward healing, we must continue to support state and local officials committed to tackling racial inequities, offering second chances, and achieving safety and justice. Our fervent hope is that this moment serves as a turning point toward a more just justice system. The Justice Center stands ready to assist Congress as it works on these critical issues. Thank you for considering this testimony and for your vital work to ensure the safety of our communities.



IACP LAW ENFORCEMENT POLICY CENTER

Responding to Persons Experiencing a Mental Health Crisis

Concepts and Issues Paper

Updated: August 2018

I. INTRODUCTION

A. PURPOSE OF DOCUMENT

This paper was designed to accompany the *Model Policy on Responding to Persons Experiencing a Mental Health Crisis* developed by the IACP Law Enforcement Policy Center. This paper provides essential background material and supporting documentation to provide greater understanding of the developmental philosophy and implementation requirements for the model policy. This material will be of value to law enforcement executives in their efforts to tailor the model policy to the requirements and circumstances of their community and their law enforcement agency.

B. BACKGROUND

Law enforcement agencies across the globe are increasingly required to respond to and intervene on behalf of persons experiencing a mental health crisis. For the purposes of this document, the term person in crisis (PIC) will be used to describe individuals who are affected by mental illness or are experiencing a mental health crisis. Many individuals affected by mental illness are currently housed in jails, prisons, and juvenile detention centers, rather than mental health treatment facilities. Individuals who are unable to obtain effective mental health treatment through the limited available resources are likely to behave in ways that bring them into contact with law enforcement. In far too many communities, the local detention center or jail is inappropriately utilized as the only location to which law enforcement can bring those who are behaving erratically due to a mental health crisis.

In addition, there is an increased likelihood that PIC will be arrested for low-level crimes such as, but not limited to, petty theft, aggressive panhandling, public urination, littering, and trespassing; offenses that often characterize the behavior of homeless people affected by untreated mental health disorders. Unless enhanced enforcement of these types of crimes is accompanied by increased access to treatment and support services, PIC who commit these "nuisance" offenses will likely become trapped in a repetitive cycle of arrest, short jail stays, and return to the streets without treatment, only to commit more minor illegal acts that result in their re-arrest.

A more effective approach involves redirecting societal resources from containment to treatment of PIC whose behaviors are seen as atypical or aberrant. In a number of jurisdictions, law enforcement agencies have partnered with justice system, mental health, and other community agencies to develop more compassionate and cost-effective approaches that emphasize providing community-based treatment instead of arrest and incarceration for both adult and juvenile PIC. Ideally, the only PIC who should come into contact with law enforcement are those who are victims of crimes, suspected of committing crimes, or who are a danger to themselves or others. Those who do not fall into the category of potentially dangerous behavior are more appropriately handled by mental health provider response and referral. Also, if mental health services and other social support systems are functioning optimally, a much smaller proportion of PIC will likely engage in criminal, threatening, or suicidal behavior that becomes the focus of a law enforcement response.

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Officers should assess the behavior and intention of PIC, while performing enforcement and investigative functions. PIC and their families rely on first responders, particularly law enforcement officers, to behave in an effective manner, treating the PIC with compassion and respect. Law enforcement officers who face these complex situations must be as prepared as possible so that they can respond in ways that ensure their safety, the public's safety, and the safety of the PIC. It is critical for the officer responding to a mental health call to possess the proper knowledge and training to adequately assess the situation and engage community resources in the best interests of the PIC, the officer, and the community.

To this end, it is helpful for officers to understand the symptomatic behavior of PIC. In this way, officers are in a better position to formulate appropriate strategies for gaining the individual's compliance and determining whether medical or other assistance is required, whether detention is appropriate or required, and, whether a suspect is in a suitable state to be questioned. However, a law enforcement officer should not attempt to diagnose PIC. Mental illness is often difficult for even the trained professional to diagnose under controlled circumstances; for an officer who confronts such an individual in an enforcement setting with other aggravating factors in play, the task would be even more complex and uncontrolled. However, officers can and should be able to recognize behavior that is characteristic of mental illness and particularly that which is potentially destructive and/or dangerous.

II. POLICY RECOMMENDATIONS

A. Symptoms of Mental Illness

Mental health problems are health conditions involving changes in thinking, mood, and/or behavior and are associated with distress or impaired functioning. When these conditions are more severe, they are called mental illnesses. Mental illness is an impairment of an individual's normal cognitive, emotional, or behavioral functioning, caused by physiological or psychosocial factors. A person may be affected by mental illness or experiencing a mental health crisis if they display an inability to think rationally (e.g., delusions or hallucinations); to exercise adequate control over behavior or impulses (e.g., aggressive, suicidal, homicidal, sexual); and/or to take reasonable care of their welfare with regard to basic provisions for clothing, food, shelter, or safety. Some types of mental illness include anxiety disorders, attention-deficit/hyperactivity disorder, depressive and other mood disorders, eating disorders, and schizophrenia. The following are some of the more commonly encountered forms of mental illness.

Schizophrenia. Schizophrenia tends to appear earlier in men than in women, showing up in their late teens or early 20s, as compared to their 20s or early 30s in women. Schizophrenia often begins with an episode of psychotic symptoms like the individual hearing voices (i.e., hallucinations) or irrationally believing that others are trying to control or harm them (i.e., delusions). The delusions—thoughts that are fixed, bizarre, and have no basis in reality—may occur along with hallucinations and disorganized speech and behavior, leaving the individual frightened, anxious, and confused. A person with schizophrenia may exhibit grandiose delusions, such as “I am Christ,” or persecutory delusions such as “Everyone is out to get me.” Delusional persons may also have generalized fears or beliefs such as unrealistic fears that they are being constantly watched; that their conversations or even their thoughts are being overheard, recorded, or monitored; or, that they are being talked about, followed, or otherwise persecuted, harassed, or controlled.

Hallucinations are usually present with schizophrenia. Hearing or seeing things is most common, but hallucinations can involve any of the five senses. For example, the individual may hear voices commanding them to act in a particular way, may feel their skin “crawl,” smell strange odors, or see “devils” or “ghosts.” While hallucinations are usually symptomatic of schizophrenia, they may also be caused by controlled substances or alcohol.

Bipolar Disorder. Bipolar disorder, formerly called manic-depressive illness, is a type of mood disorder characterized by recurrent episodes of highs (mania) and lows (depression) in mood. These episodes involve extreme changes in mood, energy, and behavior. Manic symptoms include extreme irritable, euphoric, or elevated mood; an inflated sense of self-importance (grandiosity); increased high-risk behaviors; distractibility; increased energy; and a perceived decreased need for sleep. Depressive episodes of bipolar disorder involve a period of a pervasive sense of sadness and/or loss of interest or pleasure in most activities that interferes with the ability to work or function. This is a severe condition that can impact a person's thoughts, sense of self-worth, sleep, appetite, energy, and concentration. It is frequently associated with thoughts of suicide. Individuals affected by bipolar disorder may demonstrate alternating cycles of a mood disturbance with repeated episodes of depression, mania, or a mixture of both.

Major Depressive Disorder. Like the periods of depression in bipolar disorder, major depressive disorder involves a pervasive sadness and/or loss of interest or pleasure in most activities. The disorder interferes with the ability to work, study, sleep, eat, and enjoy once pleasurable activities. The condition can impact a person's

thoughts, sense of self-worth, sleep, appetite, energy, and concentration. Suicidal thoughts may be prominent. The condition can occur as a single debilitating episode or as recurring episodes. It differs from bipolar disorder in that it is unipolar—the person suffers only from periods of depression.

Post-traumatic Stress Disorder (PTSD). Post-traumatic Stress Disorder affects about 7.7 million adult Americans.¹ PTSD occurs after an individual experiences an event such as military combat, a sexual or physical assault, automobile accidents, or a natural disaster. First responders can be traumatized by exposure to calls such as collecting human remains or through repeated exposure to details of child abuse. With PTSD, individuals struggle with re-experiencing the original trauma either through nightmares or disturbing, intrusive thoughts throughout the day that may make them feel detached, numb, irritable, or aggressive. Attempts to avoid thinking about the trauma may be present including amnesia for all or part of the event. Persistent negative thoughts or feelings (e.g., survival guilt) may continue beyond the trauma. Ordinary events may serve as reminders of the trauma and may cause flashbacks, hyperarousal, or panic. Some people recover a few months after the event, while others experience lasting or chronic PTSD.

Personality Disorders. Personality disorders are conditions marked by enduring maladaptive personality traits and characteristics. No psychotic symptoms (i.e., hallucinations and delusions) are present. Two of these conditions are frequently encountered by law enforcement: Borderline Personality Disorder and Antisocial Personality Disorder. However, while Antisocial Personality Disorder usually does not present in a way that rises to the level of distress or emotional crisis that is the topic of this paper.

Borderline Personality Disorder. Borderline Personality Disorder causes uncertainty about the person's identity or view of themselves. As a result, interests and values can change rapidly, and behavior may be fickle and unstable. Individuals affected by the disorder tend to view things in terms of extremes, such as either all good or all bad. Their views of other people can change quickly. A person who is looked up to one day may be looked down on the next. These suddenly shifting feelings often lead to intense and unstable relationships, extreme fear of being abandoned, intolerance for being alone, recurring feelings of emptiness and boredom, and frequent displays of inappropriate anger and impulsiveness, such as with substance abuse or sexual relationships. Recurring suicidal behaviors or threats or self-harming behavior, such as cutting, frequently occur.

¹ National Institutes of Health, "Post-Traumatic Stress Disorder," fact sheet, <http://report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=58&key=P#P>.

B. Other Causes of Atypical Behavior

Officers should not confuse mental illness with seemingly atypical behavior that is the product of other types of disabilities. This includes intellectual disability or other developmental disabilities (I/DDs) that may manifest similarly to mental illness. There are important differences between individuals affected by I/DDs and those affected by mental illness. To officers, it is often not possible to differentiate I/DDs from mental illness, especially from a brief interaction with a person with a suspected disability. Instead of trying to diagnose individuals, officers should focus instead on addressing immediate safety concerns and then addressing the person's need. For example, someone with a disability may need to feel safe, extra time to calm down, medical assistance, transportation assistance, and/or access to mental health services.²

Developmental disabilities (DD) refers to long-term disabilities attributable to a physical, mental, or combination of impairments that result in functional limitations in major life activities, such as understanding and expressing language, learning, moving, self-direction, self-care, independent living, and economic self-sufficiency. The disability must have originated before the age of 22 and is likely to continue throughout the individual's life. "Developmental disability" is an umbrella term that encompasses intellectual disability, but also covers some physical disabilities. Some DDs might consist only of physical or sensory impairments, such as blindness from birth. Other DDs involve both physical impairments and diminished intellectual functioning stemming from genetic or other causes, such as Down syndrome.

Examples of DDs include the following:

Intellectual Disability (ID). Intellectual disability is characterized by limited or diminished intellectual functioning and difficulty with adaptive behaviors, such as managing money, schedules and routines, or social interactions. Unlike ID, individuals affected by mental illness may not be impaired intellectually. ID is a type of DD, with onset during an individual's early years of development and continues across the lifespan, whereas mental illness may develop during any period of an individual's life and can be cyclical, episodic, short-term, or long-term. People affected mental illness may benefit from various therapies and/or psychotropic medications. However, people with an ID may benefit from different forms of therapy, such as behavioral therapy, but generally will not benefit from the use of psychotropic medications unless they are also affected by mental illness. Individuals

² For more information on responding to individuals with I/DDs, see the IACP *Model Policy and Concepts & Issues Paper on Interactions with Individuals with Intellectual and Developmental Disabilities* available at http://www.theiacp.org/model-policy/model_policy/developmentally-disabled/.

who have both an ID and are affected by mental illness are referred to as having a “dual diagnosis.”

Cerebral Palsy. Cerebral palsy is a type of DD.

Persons with cerebral palsy often have limitations in motor and speech functions, which may impact their ability to move and communicate. People with cerebral palsy might or might not also have a co-occurring intellectual disability, so officers should not assume the person automatically has ID. People with cerebral palsy may use mobility devices, such as wheelchairs, scooters, walking sticks, walkers, and/or canes, and may also use communication devices, such as iPads, type-to-text technologies, and picture boards. Some people with cerebral palsy may be mistakenly perceived as drunk or otherwise under the influence of drugs, due to slurred speech and involuntary motor movements.

Autism Spectrum Disorders. Autism is a type of DD that affects language, communication, social skills, sensory systems, and behavior. Due to differences in sensory perception and processing, people with autism may be easily distressed by changes in their environment or routine; may experience pain at lesser or greater intensity; and may react unpredictably to touch or other forms of stimuli, such as flashing lights or sirens. People with autism may engage in repetitive behavior and may also exhibit atypical body movements, such as hand flapping or rocking. These behaviors may be mistakenly perceived as the product of being under the influence of drugs.

C. Persons in Crisis

Without regard to whether a person is affected by mental illness, they may react in inappropriate ways or display bizarre behavior if experiencing a mental health crisis. “Mental health crisis,” for purposes of this discussion, relates to an event or experience in which an individual’s normal coping mechanisms have become overwhelmed, causing them to have an extreme emotional, physical, mental or behavioral response. A person may experience a mental health crisis during times of stress and in response to real or perceived threats and/or loss of control. Symptoms may include emotional reactions such as fear, anger, or excessive giddiness; psychological impairments such as an inability to focus, confusion, nightmares, and potentially even psychosis; physical reactions like vomiting or stomach issues, headaches, dizziness, excessive tiredness, or insomnia; and/or behavioral reactions, including the trigger of a “freeze, fight, or flight” response. Any individual can experience a crisis reaction regardless of previous history of mental illness.

D. Law Enforcement Response to PIC

The dynamics and circumstances of response to a call involving a PIC will be determined to some degree by the manner in which the contact is initiated. Family members of a PIC are frequently the initiators of law enforcement contact, often when the affected person has created a family disturbance. Such family disturbances can be the source of complex and challenging dilemmas for officers. Family members usually call asking for assistance in the hopes of gaining access to treatment for their family member. These situations can have a high potential for noncompliance and resistance from the PIC to law enforcement, which may lead to misunderstandings and dissatisfaction, particularly when the situation results in a use of force and/or an arrest. A PIC may also seek out assistance from law enforcement themselves, particularly when there is a degree of familiarity between the officer and person based on prior contacts.

Possible points of contact between law enforcement and a PIC are on city streets and in other public places. Members of the public may contact law enforcement if they witness a PIC behaving in a way that is perceived as bizarre or disruptive. While the intention may be to act as a Good Samaritan, some members of the public may simply be uncomfortable in the presence of a PIC, which leads them to call for assistance from law enforcement.

In both enforcement and investigative capacities, officers often encounter PIC among the homeless population inhabiting public places on a full-time or part-time basis. A large proportion of these individuals are affected by mental illness.³ Other homeless persons may have milder forms of mental illness that often allow them to move between living on the street and the homes of relatives and friends, shelters, care homes, or other living arrangements. Among these are also persons who are affected by a combination of mental illness, alcoholism, drug abuse, head injury, and degenerative or incapacitating diseases.

E. Assessing Risk

Due to the unpredictable nature of some PIC, officers must be particularly conscious of their own safety and that of bystanders when dealing with individuals in crisis. Promotion of a more thoughtful approach to calls involving PIC does not reduce the emphasis on officer safety. Assessment of the individual and the situation must be ongoing throughout the contact, beginning with the receipt of basic information about the individual and continuing until the contact is over. The more the officer can obtain health-related information about the individual

³ National Alliance on Mental Illness, “Mental Health by the Numbers,” <https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers>.

(e.g., do they have a diagnosed condition, are they taking medication, is there an established relationship with a mental health provider), the better prepared the officer is to make responsive decisions. If the initial contact is made through a dispatched call for service, some basic information can be obtained from communications personnel. The same type of information should be obtained if possible from other sources, whether that is a concerned citizen, another officer, the court, jail personnel, or family member.

When situationally appropriate and time allows, responding officers should seek helpful information, as available. Such information can include, but is not limited to, the characteristics and specific behavior of the PIC, relationship of the complainant to the PIC (if any), whether a crime is involved, the availability of weapons to the PIC, prior law enforcement contact with the PIC, and the nature of any previous mental health dispositions.

Once equipped with this type of information, the responding officer can better determine an appropriate response. Unless a crime of violence has been committed and/or a dangerous weapon is involved, officers should normally respond to the incident or approach a PIC in a low-profile manner while still remaining tactically sound. Emergency lights and sirens should be used only when urgent response is critical, and these devices should be turned off as soon as possible upon arrival. Emergency equipment can have a disturbing and altogether negative impact on a PIC and may potentially heighten the person's anxiety, further hindering the officers' efforts to calm the situation. When circumstances allow, contacts with PIC should be slowed down. Officers should try to establish themselves as helpers, rather than enforcers; the uniform, duty weapon, and badge imply that a uniformed officer is capable of using force and is authorized to engage in enforcement activities, so it need not be emphasized. When it is situationally appropriate, officers should try to understand the person's issues and concerns, and focus on developing rapport, before attempting to gain compliance. By reassuring the PIC that they are there to help keep them safe, officers will help to foster a relationship that can increase their ability to use influence rather than force to gain compliance.

Where there is reason to believe that the individual is in a crisis situation, such as threatening suicide or involved in a hostage and/or barricade situation, officers should request any specialized crisis intervention assistance available while taking initial steps necessary to moderate or defuse the situation. This may include summoning officers with special training in crisis negotiations, such as Crisis Intervention Team (CIT) trained officers, or crisis negotiators.

At the scene of an incident involving a PIC, officers should first take time, if possible, to assess the situation and gather necessary information, avoiding hasty and potentially counterproductive decisions and actions. Such calls usually have a better outcome if time is used to an officer's advantage. While circumstances may preclude such inquiries, where time permits, family members or friends of the individual can often lend some insight into the person's background and specifics about their behavior. Friends or acquaintances may be able to provide some information regarding the person's present behavior. Pinpointing the cause of the behavior, as perceived by the individual, can provide officers with a basis for discussion and possible moderation of the person's distress and behavior. It can also help the officer decide if the problem is the result of a disability.

Also important is information on the person's present or past use of psychiatric medication. Many persons who are affected by mental illness fail to use medication that has been prescribed for their diagnosed mental illnesses. This is common, for example, among persons affected by schizophrenia and bipolar disorder. Many people affected by schizophrenia receive treatment on an outpatient basis and gain a degree of self-control and remission of symptoms as long as that treatment is continued. However, without medical supervision, many are incapable or unwilling to maintain the prescribed treatment regimen on their own, either due to a lack of insight into their illness, an inability to afford or access medication, or a substantial discomfort from the medication's side effects. As such, they often revert to their previous pattern of symptomatic behavior.

In addition, some persons affected by mental illness attempt to alleviate their anxieties and related mental illness symptoms through self-medication with alcohol, controlled substances, or a combination of these. The use of these drugs tends to exacerbate existing mental conditions, compounds the difficulty in diagnosing and treating these individuals, and causes additional difficulty for officers in their attempts to gain control of the individual's behavior.

Before approaching the PIC, officers should attempt to control the immediate surroundings and establish a perimeter. PICs are generally adversely influenced by distractions including noise and crowds. Crowds of curious bystanders generally, and antagonistic or rowdy persons, in particular, can excite and unduly agitate a PIC, particularly those who are threatening suicide or violence. Therefore, where such crowds or bystanders are on hand they should be controlled and preferably removed so officers may better communicate with the PIC. Family members who create disruption or who contribute to the confusion of the PICs are no exception. However, witnesses and those who

can provide information or assistance that is helpful in resolving the situation should be asked to remain nearby.

Once the immediate surroundings are under control, attention should be directed toward determining whether the individual represents a danger to himself, herself, or others. The presence of a dangerous weapon is an obvious indication that violence is possible, but there are other behavioral characteristics that an officer can use to help determine whether the PIC is prone to dangerous conduct toward self or others.

Statements of the PIC. Any threatening statements made by the PIC should be given serious consideration and should not be dismissed simply as the ramblings of a confused or troubled individual. This is particularly the case where the capacity or capability to engage in dangerous conduct exists. Such statements may range from subtle innuendo to direct threats. Comments that suggest intent to commit a dangerous act do not have to be taken at face value. When taken in conjunction with other information, such threats can paint a more complete picture of the potential for violence. In as much as a direct threat is not required to conclude a person is dangerous to themselves or others, the officer should assess in totality whether the PIC poses a serious threat of substantial harm to themselves or others.

Personal History. It is not uncommon for law enforcement officers to have some familiarity with a PIC based on prior contacts. Under such circumstances, officers are in a better situation to assess the individual's propensity for violence as well as the predictability of the individual's behavior. Where the PIC is unknown to the officers, friends, family, or others may be able to provide some insight into the individual's behavior and capacity for dangerous behavior. With or without such information, officers should be cautioned that PIC may be unpredictable. Even the familiar and often compliant PIC can sometimes react in a dangerous manner without perceived provocation.

Observed Actions. The PIC's actions while officers are on the scene, as well as those that were observed prior to the officers' arrival, are relevant to a determination of the individual's propensity for violence. Acts or threats of violence should be taken seriously. Failure to act in a dangerous manner prior to an officer's arrival does not guarantee that there is no danger, but it does tend to diminish the potential.

Officers should make mental notes of the precise actions and behaviors taken by the individual so that these can be entered into their report. Descriptions of the exact actions of a PIC are particularly important when justification is required for arrest or evaluation and possible commitment to a mental health facility. Use of generalized terms such as "bizarre" or "crazy" to describe the nature

of an individual's actions are not sufficient and should be substantiated with concrete illustrations of actual behavior. Verbatim quotes are very helpful when providing a description of the PIC's comments, either when taking an individual into custody for a mental health evaluation or during an arrest that may lead to later questions regarding the arrestee's mental state at the time of the crime.

Degree of Control. The amount of control that an individual demonstrates is significant, particularly the amount of physical control over emotions of rage, anger, fright, or agitation. Signs of a lack of control include extreme agitation, inability to sit still or communicate effectively, wide eyes, and rambling thoughts and speech. In addition, clutching oneself or other objects to maintain control, begging to be left alone, or offering frantic assurances that one is all right may also suggest that the individual is close to losing control. It may also be pertinent to note whether the PIC is actively losing control during the contact as this could be a sign of acute mental illness and/or a decompensation of the PIC's ability to remain oriented to place and time.

Volatility of the Environment. The general environment surrounding the event should also be taken into consideration. This potentially covers a broad range of issues in addition to those involving crowds, noise, and confusion already mentioned. For example, if a criminal offense is involved and an arrest is required, attempts to restrain the individual can be the source of agitation and confrontation between the officers and the PIC if not handled wisely and skillfully. In open public spaces where attention is being drawn, the individual may be more easily distracted and/or agitated as opposed to isolated or private settings.

F. Approaching and Interacting with PIC

When officers are preparing to approach a PIC, they should take several factors into consideration. First, officers should always be aware of their personal safety when interacting with a PIC. A backup officer should be summoned to provide assistance. This is particularly necessary prior to efforts to take the person into custody.

Officers should also recognize that they are not in a position personally to solve the problems of a PIC. However, it is entirely possible that this same person will again come into contact with law enforcement in a similar or related context, so officers should remember that their actions may have a long-term impact on the perceptions of that person toward law enforcement. A negatively remembered contact will also invariably create difficulty for the same or other officers in future interactions with that individual. In a worst-case scenario, failure to interact responsibly and fairly with the individual may lay the groundwork for a later, more serious confrontation with

law enforcement and the community involving potential physical injury or loss of life.

When approaching a PIC, officers should attempt to slow things down and build rapport by speaking in a calm and relaxed manner. It is important for officers to be prepared for physical contact, but critical that they do not come off as aggressive in their posture or stance as this could escalate the PIC's emotional state or level of agitation. Officers should avoid closely approaching the PIC until a degree of rapport has been developed, if this is at all possible. When speaking with the individual, officers should attempt to exhibit a caring attitude without becoming authoritarian, overbearing, condescending, or intimidating. While the PIC might not be in command of their behavior at all times, they do not necessarily lack intellectual abilities or insight, and may be provoked by demeaning, condescending, arrogant, or contemptuous attitudes of others. Officers should attempt to constructively help the person in a calm, non-judgmental manner and should maintain command presence by demonstrating some understanding and empathy for the individual's problems or concerns, while avoiding a tough or threatening manner.

Officers should engage in active listening (e.g., reflection of feelings, restating, paraphrasing, and supportive statements) by asking the person to express their concerns. This verbal tactic is a control strategy that helps de-escalate or defuse an agitated, fearful, or angry individual. The officer can enhance the person's willingness to engage by frequent communication of the officer's understanding of the person's concerns. In addition, avoiding issues and topics that may agitate the individual is recommended along with efforts to guide the conversation toward subjects that help bring the individual back to reality. Officers should reassure the individual that they are there to help and that an appropriate resolution of the problem can be reached. All attempts should be used to reassuringly communicate with the person first by allowing them to vent in order to determine the possible source of agitation or conflict. Efforts should be made to relate the officer's concern for the individual's feelings and an appreciation for the problems and concerns that the individual describes, no matter how trivial or bizarre they may appear. The emphasis here is to develop a rapport with the individual that will provide reassurance that the officer is not there simply in an authoritarian role but to assist them. In attempts to assist, however, officers should always strive to be truthful with a PIC. If the person becomes aware that officers are being deceitful, they may withdraw from contact in distrust and may become hypersensitive or retaliate in anger.

The individual should not be threatened with arrest or other enforcement action, as this will only add to their fright and stress and may potentially spark aggression. However, should arrest or detention be necessary, the officer should inform the person of what is about to occur, ask for their cooperation, and proceed with taking them into custody.

G. Taking Custody of PIC or Making Referrals to Mental Health Professionals

Based on the overall circumstances of the situation, applicable state law, and agency policy, an officer may take one of several courses of action when interacting with a PIC. The options for assisting such individuals generally fall into four response categories:

Counsel and/or Refer. When a criminal or other offense is not involved and there are not sufficient grounds for taking the person into custody for their own protection, the protection of others, or for other reasons (e.g., grave disability) as specified by law, it is often best to make mental health referrals and provide some basic guidance for the individual. For the PIC who resides in a public place, referrals to community mental health facilities may go unheeded. Individuals in this situation might be unable to recognize their mental health conditions and have even less ability or interest in acting upon referral recommendations. If the agency keeps track of calls involving PIC or works with liaisons in the mental health community, notifications should be made to these individuals. Some PIC go through periods of relative lucidity during which they may be able to recognize their needs and act upon an officer's suggestions, particularly if the location and telephone number of local mental health facilities has been provided to them in writing.

In cases where PIC have friends, family, and other support systems in the community, information on mental health facilities may also be provided directly to these individuals. With this information, they may be in a better position to seek assistance for their friend, acquaintance, or relative who is affected by mental illness.

In cases where the individual is extremely agitated, it is generally inadvisable to leave them unattended. In many such cases, when left alone in a highly emotional state, the PIC may resort to the same behavior that was the basis for law enforcement intervention in the first place. In such cases, officers may, if permitted by agency policy, provide transportation for the individual to a group home, respite care, or other facility that can provide shelter, counseling, or related mental health services or, to the home of a friend, family member, or acquaintance who may be willing to provide assistance.

Professional Assistance. Because it is not possible for officers to diagnose mental illness or understand the degree to which some persons may need professional care in order to avoid violence to themselves or others, use of a trained mental health professional is often a preferred option. Some agencies are fortunate to have a mental health professional, such as a counselor or crisis intervention specialist, on staff who may be employed in this capacity. Agencies may also have contract community mental health providers who can assist. In any of these cases, officers may, based on the nature of the situation, request assistance by either direct intervention at the scene of the incident, by telephone consultation with a mental health professional, or by transporting the individual to a centralized location where assessment and other treatment can be obtained.

Refusal to submit to voluntary examinations or professional assistance can be expected in many instances, since PIC may lack an understanding that they are ill. However, it is entirely acceptable for officers to explain that such refusal may leave the officer with no other option than to seek alternative remedies, such as arrest where justified or detention for an involuntary examination in a mental health facility where legal grounds exist. Some PIC, recognizing that they are not fully in control of their actions and/or thoughts, and who may be aware of stories of confinement related by other mentally ill acquaintances, fear mental health professionals and examinations. Officers can dispel some of that fear by explaining that an examination does not mean incarceration or confinement in a mental health facility—but it may provide them with much-needed assistance and possibly allow them to avoid future confrontations with others, including law enforcement. Officers need to be mindful that they are assisting a vulnerable population, and act in accordance with that responsibility.

Involuntary Examination. Some laws provide the legal criteria and limitations for involuntary commitment of individuals for mental health examinations. While laws and statutes vary, they generally provide for a brief involuntary examination when the person is a danger to self or others, is gravely disabled by mental impairment, and/or is so impaired as to not understand the need for mental health treatment. Officers must refer to specific jurisdictional statutes for details in regarding these provisions and should be aware of the rights of those who are detained for mental health examinations and any special requirements expected of the officer in such situations. If the criteria for involuntary mental health examination has been satisfied, and a misdemeanor or other less serious violations have also been committed, officers may, depending upon agency policy, choose the course of involuntary commitment

in lieu of or in addition to lodging criminal charges and may ask for notification from the facility at the time of discharge from the commitment, if permitted by law in the jurisdiction.

The issue of involuntary examination may be problematic for officers and others involved. Many mental health institutions have limited resources including bed space, which can sometimes result in the PIC being treated for a short period of time and then released back into the community, where law enforcement may make contact with that person again. This cycle can be frustrating for officers.

At the same time, failure to take action when there are sufficient grounds to believe that a PIC may be a danger to themselves or others can have serious consequences. In such situations, officers may place themselves and/or their agency in jeopardy of civil liability should a serious incident develop as the result of their inaction. Jurisdictions that have developed a coordinated law enforcement-mental health partnership to respond to PIC are in a far better position to respond to these and other related issues.

Arrest. As noted in the foregoing, arrest may be used solely or in combination with involuntary commitment. However, when a felony or other serious offense is involved, officers should normally make the arrest and rely on supervisory and other command-level personnel to determine whether an involuntary mental health examination is warranted.

Before taking a person into custody under arrest or for involuntary mental examination, officers should consider summoning a supervisor. Taking custody of a PIC can be a difficult undertaking. Once a decision has been made to take a PIC into custody, it should be done as soon as possible to avoid prolonging a potentially violent situation. Officers should immediately remove any objects that can be used as a dangerous weapon and restrain the person if necessary. While the use of restraints can, with some individuals, aggravate their aggression, officers should take these and related security measures necessary to protect the PIC's safety and the safety of others with whom the PIC will come in contact.

In cases where the arrest of a PIC is warranted, the officers should effectively communicate to the PIC in an attempt to reduce any additional stress.

III. CONCLUSION

All law enforcement officers should be familiar with the potential signs and symptoms of a PIC. However, it must be stressed that officers are not required to diagnose mental illness; instead, they should be able to recognize that an individual is in crisis and respond in an informed manner. The procedures suggested herein should be utilized when responding to a call involving a PIC, in an effort to provide appropriate care for the individual and ensure safety for all involved parties.

Each incident involving a PIC is different and therefore requires officers to have proper understanding and training to successfully assess the needs of the PIC and determine the best course of action. This often includes the use of tactics designed to slow down the encounter and provide an opportunity for officers to communicate with the PIC. Ideally, officers should aim to provide PIC with the resources they need, to include referrals to appropriate services or medical and/or psychiatric treatment, where necessary. However, in some instances, arrest and/or involuntary mental examination is the best resolution.

Increasingly, there are calls from the public for law enforcement to be well-trained in working with non-traditional populations, to include PIC. While the work of law enforcement officers is inherently unpredictable, training and education in responding to PIC provides officers with the tools to offer optimal assistance. Such a response works to improve trust and continue to bridge the gap between community and law enforcement.

Every effort has been made to ensure that this document incorporates the most current information and contemporary professional judgment on this issue. Readers outside of the United States should note that, while this document promotes procedures reflective of a democratic society, its legal basis follows United States Supreme Court rulings and other federal laws and statutes.

Law enforcement administrators should be cautioned that no "model" policy can meet all the needs of any given law enforcement agency. Each law enforcement agency operates in a unique environment of court rulings, state laws, local ordinances, regulations, judicial and administrative decisions and collective bargaining agreements that must be considered, and should therefore consult its legal advisor before implementing any policy.

This document is not intended to be a national standard.

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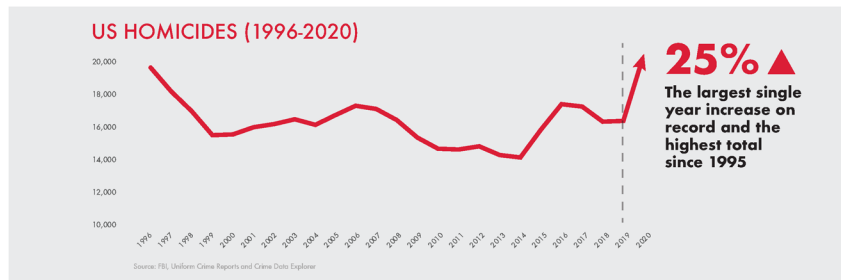


MAR. 2021

Less Policing = More Murders

Law enforcement pulled back after the May/June 2020 anti-police protests and violence soared.

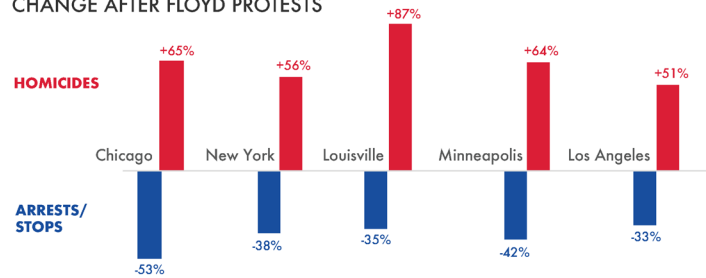
In 2020, the United States recorded over **20,000** murders — **4,000** more victims than 2019.



Why? Less proactive policing

Murder surged as police reduced their activity including stops, searches, and arrests.

CHANGE AFTER FLOYD PROTESTS

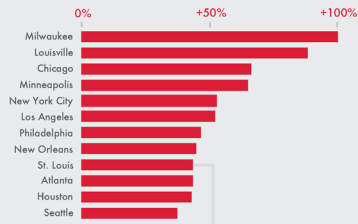


Source: City Police Agencies (June 2019-Feb 2020 vs. June 2020 - February 2021); *NYPD June-Dec 2019 vs. June-Dec 2020; *Louisville reflects vehicle stops, other agencies show arrests.

Since June 2020, local leaders and activists' increasing attacks **demoralized, debilitated,** and, in some cases, **defunded** law enforcement. As police stepped back, violence surged.

Urban areas are hardest hit by growing bloodshed with 35% rise in homicide across America's largest 60 cities. Meanwhile, aggravated assaults (which includes non-fatal shootings) increased by 10.5% – the largest jump in three decades.

CHANGE IN HOMICIDES SINCE FLOYD PROTESTS



St. Louis is America's Murder Capital and 3 times more dangerous than Mexico and Central America. In 2020, St. Louis' death toll hit a 50-year high with 87 out of every 100,000 residents being murdered.

PORTLAND

After the city of Portland slashed its police budget by \$12 million and eliminated three police units, the police withdrew while shootings climbed 173% and murders rose 255% in nine months.



Source: City Police Agencies (June 2019-Feb. 2020 vs. June 2020- February 2021); FBI; St. Louis Post-Dispatch; Insight Crime; Portland Police Bureau.

The hostile work environment for law enforcement makes them risk-averse, reactive, disempowered and discouraged. Increasingly, police are disengaging from the hardest, and riskiest, but most necessary types of police work.

If the Thin Blue Line retreats, violence charges in.

This has happened before

CHICAGO - 2016



After an ACLU lawsuit curtailed Chicago police's ability to make stops and searches, the Windy City's killings jumped 58% as street stops fell 82% in 2016.

BALTIMORE - 2015



In 2015, Baltimore City prosecutor Marilyn Mosby's hostility toward police demoralized officers and deterred proactive policing. The next year, arrests fell 28% while murders rose 55%.

Source: Chicago Data Portal, Public Safety Dashboard, 2015 - 2016; Open Data Baltimore Hub, Baltimore Police Department Crime Map, May 2014 - April 2016

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ARTICLES

Contact Between Police and People With Mental Disorders: A Review of Rates

James D. Livingston, M.A., Ph.D.

Objective: There is widespread belief that people with mental disorders are overrepresented in police encounters. The prevalence of such interactions is used as evidence of extensive problems in our health care and social support systems. The goal of this study was to estimate the rates of police arrests among people with mental disorders, police involvement in pathways to mental health care, and police calls for service involving persons with mental disorders.

Methods: A systematic review was performed with seven multidisciplinary databases. Additional studies were identified by reviewing the reference lists of all included records and by using the "related articles" and "cited articles" tools in the Web of Science database. Studies were included if they were published in peer-reviewed journals, reported primary research findings, and were written in English.

Results: Eighty-five unique studies covering 329,461 cases met inclusion criteria. Data reported in 21 studies indicated that one in four people with mental disorders have histories of police arrest. Data from 48 studies indicated that about one in ten individuals have police involved in their pathway to mental health care. Data reported in 13 studies indicated that one in 100 police dispatches and encounters involve people with mental disorders.

Conclusions: These estimates illuminate the magnitude of the issue and supply an empirically based reference point to scholars and practitioners in this area. The findings are useful for understanding how local trends regarding police involvement in the lives of people with mental disorders compare with rates in the broader research literature.

Psychiatric Services 2016, 67:850–857. doi: 10.1176/appi.ps.201500312

Contemporary health care systems, social programs, and policing models have been designed in such a way that contact between people with mental disorders and the police is inevitable. Attending to mental health crises, working with witnesses and victims of crime, searching for those who have absconded from inpatient and residential care, and identifying people who have mental health needs and connecting them to services are the foreseeable duties for today's police officer (1,2). In addition, officers are called on to intervene in criminal acts—from public disturbances to more serious incidents involving threatened or actual violence—perpetrated by people exhibiting a variety of mental health problems, such as dementia, intoxication, intellectual disability, or serious mental illnesses (3).

To many police, interacting on a routine basis with people who have mental disorders is problematic (2). Police chiefs have asserted that officers should not be the mental health response agency of first resort and that mental health situations consume too much time of frontline officers, diverting precious resources from core law enforcement activities (4). For example, police officers routinely express concern about the amount of time spent waiting in hospital emergency rooms in combination with the prospect that individuals with mental disorders may not be admitted to inpatient care (1). Research has shown that contacts involving people with mental disorders place great demands on police resources

(5). Police officers express frustration with deficiencies in the health and social service systems that severely constrain their ability to resolve situations involving people with mental disorders in a timely and appropriate manner. Serious concerns have also been raised by people with mental disorders about police interventions, particularly those that involve the use of force (6,7).

Media and academic discourses suggest that these encounters are a common and growing phenomenon, or "crisis" (8), but how truly common are these interactions? Although published reviews have examined the prevalence of mental disorders in various criminal justice populations and settings, such as correctional institutions (9,10), there has been no synthesis of rates within the context of policing. This study took stock of general trends within the extant knowledge by examining the rates of interaction between police and people with mental disorders. Published data on the following three rates were synthesized: police arrests among people with mental disorders, police involvement in pathways to mental health care, and police calls for service involving persons with mental disorders.

METHODS

A systematic search was conducted in PubMed, PsycINFO, Web of Science, JSTOR, Criminal Justice Abstracts,

Sociological Abstracts, and the National Criminal Justice Reference Service. The search was first performed in September 2009 to scope the literature as part of a larger study focused on gathering self-reported data from people with mental illnesses about their encounters with the police. After the primary data were analyzed and published, the search was updated in June 2015 and more carefully analyzed for patterns. Combinations of the following terms were searched: (police* OR law enforce*) AND (bipolar* OR mania* OR mental ill* OR mental disorder OR schizophreni* OR psycho*). Searches with large numbers of records (>250) were narrowed by adding the interact* term. Additional studies were located by reviewing the reference lists of all included records and by using the related articles and cited articles tools in the Web of Science database.

Studies were included if they were published in peer-reviewed journals, reported primary research findings, and were written in English. No restrictions were placed on publication year or methodological design. Studies were excluded if they reported data in such a way that an exact numerator and denominator, used for calculating rates, could not be ascertained. In addition to studies that met general eligibility criteria, studies on arrest rates were included if they provided data on histories of arrest over the lifetime or over extended periods among persons with mental disorders and were excluded if they used only police-involved samples or examined arrest rates over a brief period (fewer than five years). Studies of rates of police involvement in care pathways were included if they reported data on the proportion of people who interacted with police on their way to inpatient or outpatient mental health services, including emergency or compulsory psychiatric care, and were excluded if they used only police-involved samples. Studies of police calls for service were included if they provided data on the proportion of police dispatches or encounters that involved people with mental disorders and were excluded if they focused only on use-of-force incidents, used only samples detained in police custody, or focused only on calls to police-mental health crisis teams. [The excluded studies are listed in a table in an online supplement to this article.]

For every included study, data about selected variables were extracted and entered into Excel and SPSS. Data were extracted by a research assistant and then verified by the author. Student's *t* tests, Spearman rank correlation, and analyses of variance were performed to assess differences in average rates across study characteristics. Because of the possibility that studies with exceptionally large samples—exceeding the combined samples of the remaining studies—would distort the findings, those studies were removed from calculations of the overall rates described in the text.

RESULTS

Data from smaller studies—those with fewer than 500 individual cases—were combined for summary in Tables 1–3. Rates that include all studies are reported in the tables. In total, 85

unique studies with 329,461 cases involving contact between the police and people with mental disorders were included and synthesized. Cases covered individuals and events.

Police Arrests of People With Mental Disorders

Arrest rates can provide an approximation of formal interactions between police and the community. In relation to police arrest histories, the search uncovered 22 studies that included 126,852 individuals with mental disorders (311–31) (Table 1). After removal of one study with a relatively large sample (*N*=73,579) (19), the overall results indicated that 25% of persons with mental disorders (13,304 of 53,273 individuals) have been arrested by police at some point in their lifetime.

All studies (*k*=22 studies) were from the United States, and most (*k*=14, *N*=96,037) reported data prior to 2000. On average, arrest rates were higher in studies with smaller (<500) samples (*k*=11, *N*=2,286, *M*=49%) than those with larger (≥500) samples (*k*=11, *N*=124,566, *M*=26%; *t*=4.15, *df*=20, *p*<.001). Arrest rates determined by self-report (*k*=9, *N*=76,867, *M*=51%) were, on average, higher than those ascertained through official criminal justice records (*k*=11, *N*=49,517, *M*=33%; *t*=2.16, *df*=18, *p*<.05). Average arrest rates did not differ significantly between studies that established mental disorders through official records (*k*=13, *N*=50,577, *M*=39%) or structured interviews (*k*=7, *N*=75,679, *M*=45%). Average arrest rates for samples drawn exclusively from institutional settings (*k*=6, *N*=2,126, *M*=61%), such as hospitals and residential care, were higher than those from non-institutional (*k*=10, *N*=78,750, *M*=38%) or combined (*k*=6, *N*=45,796, *M*=24%) samples (*F*=7.70, *df*=2 and 21, *p*<.01). Finally, average arrest rates were similar for studies focused on serious mental illnesses (*k*=12, *N*=121,467, *M*=40%), such as schizophrenia or bipolar disorder, or a broader range of disorders (*k*=10, *N*=5,385, *M*=41%).

Although formal subgroup analysis could not be performed on the data set, the included studies suggest that a number of factors were associated with an increased rate of police contact by means of arrest among persons with mental disorders, including male gender (11,13,14,18,30), black race (13,24), bipolar disorder and manic symptoms (11,13), involuntary hospitalizations (17,21), substance use problems (11,13,17–20,28,30), unemployment and low socioeconomic status (18,30), and homelessness (20,25,26,30).

Police Involvement in Pathways to Mental Health Care

In regard to police involvement in care, the search uncovered 49 studies including 615,360 individuals accessing mental health services (24,32–79) (Table 2). After removal of one study with a relatively large sample (*N*=552,137) (35), the overall results indicate that 12% of persons with mental disorders (7,563 of 63,223 individuals) had the police involved in their pathway to mental health services.

Most studies (*k*=43, *N*=609,327) were from Western countries, predominantly the United States (*k*=18, *N*=561,327), the United Kingdom (*k*=11, *N*=17,920), and Australia (*k*=11, *N*=18,981). Rates reported in the United States

TABLE 1. Police arrests among persons with mental disorders in 22 studies

Study	With disorder and history of arrest	With disorder	Rate of police arrest (%)	99% CI
McCabe et al., 2012 (3)	1,538	13,816	11	10.31–11.69
Christopher et al., 2012 (11)	134	1,044	13	10.32–15.68
Harry and Steadman, 1988 (16)	81	568	14	10.25–17.75
Swartz and Lurigio, 2007 (19)	13,295	73,579	18	17.64–18.36
Cuellar et al., 2007 (13)	1,563	6,624	24	22.65–25.35
Cocozza et al., 1978 (12)	510	1,938	26	23.43–28.57
Fisher et al., 2006 (14)	3,856	13,816	28	27.02–28.98
Fisher et al., 2011 (15)	3,523	10,742	33	31.83–34.17
Holcomb and Ahr, 1988 (17)	232	611	38	32.94–43.06
Muntaner et al., 1998 (18)	442	1,155	38	34.52–41.68
Theriot and Segal, 2005 (20)	303	673	45	40.06–49.94
11 smaller studies ^a	1,122	2,286	49	46.31–51.69
Total	26,599	126,852	21	20.71–21.29
Total, excluding (19)	13,304	53,273	25	24.52–25.48

^a Bloom et al., 1981 (21); Brekke et al., 2001 (22); Calsyn et al., 2005 (23); Compton et al., 2006 (24); Gelberg et al., 1988 (25); Lamb and Lamb, 1990 (26); Lamb et al., 1995 (31); Link et al., 1992 (27); McFarland et al., 1989 (28); Sosowsky, 1978 (29); White et al., 2006 (30)

($k=18$, $N=561,329$, $M=29\%$) were higher than those reported elsewhere ($k=31$, $N=54,031$, $M=18\%$; $t=2.37$, $df=47$, $p<.05$). Most studies ($k=29$, $N=33,640$) reported data prior to 2000. Average rates of police involvement were higher in studies with smaller (<500) samples ($k=31$, $N=6,225$, $M=26\%$) than those with larger (≥ 500) samples ($k=18$, $N=609,134$, $M=15\%$; $t=2.44$, $df=47$, $p<.05$). Average rates of police involvement were similar for institutional services, such as hospitals and residential care ($k=37$, $N=43,302$, $M=22\%$), noninstitutional services ($k=3$, $N=837$, $M=28\%$), or combined services ($k=6$, $N=997$, $M=18\%$).

The included studies pointed to numerous factors that were associated with higher rates of police involvement in pathways to mental health care, most of which have been studied at the individual level. These factors include male gender (33,41,43,58,70,77), black race (49,65), substance use problems (37,43,45,52,58,69,77), aggressive and violent behavior (37,45,49,67,69,77), psychosis and related symptoms (58,73,77), severe psychiatric impairment (37,49,67), unemployment (43,49), and involuntary service use (35,46,69).

Police Calls for Service Involving People With Mental Disorders

The search uncovered 15 studies that together included 3,624,990 police calls for service and encounters (80–94) (Table 3). After removal of two studies with relatively large samples ($N=2,868,889$) (89,93), the overall results indicate that 1% of police calls for service (8,459 of 756,101 calls) involved people with mental disorders. Three studies relied on a similar data set with overlapping, but different, time periods. As such, two of the studies (83,84) were removed, and an overall rate was recalculated, confirming that 1% of police calls for service (4,693 of 414,311) involved people with mental disorders.

Proportions of police calls involving people with mental disorders were similar for studies from the United States ($k=10$, $N=2,919,397$, $M=6\%$) or Canada ($k=5$, $N=705,593$,

$M=8\%$). Most studies ($k=9$, $N=3,582,022$) reported data after 2000. Studies with smaller samples tended to have larger rates ($r_s=-.86$, $df=15$, $p<.001$). Average rates were statistically similar between studies that collected data through administrative databases ($k=7$, $N=3,574,482$, $M=4\%$), police officer surveys ($k=4$, $N=42,899$, $M=6\%$), and researcher field observations ($k=4$, $N=7,609$, $M=8\%$). Average rates of mental health-related calls for service were elevated when mental disorders were determined through fieldworker

observations ($k=3$, $N=4,368$, $M=9\%$) and police officer perceptions ($k=6$, $N=398,237$, $M=8\%$) compared with other methods, such as dispatcher coding ($k=2$, $N=2,868,889$, $M=1\%$), researcher-generated data algorithms ($k=3$, $N=350,255$, $M=2\%$), and combined methods ($k=1$, $N=3,241$, $M=4\%$); however, the small number of studies within each method type precluded statistical comparisons. Average rates in studies focused on crime-related incidents only ($k=6$, $N=8,523$, $M=10\%$) tended to be larger than rates reported in studies that captured a broader range of interactions between police and citizens ($k=9$, $N=3,616,467$, $M=3\%$; $t=2.93$, $df=13$, $p<.05$).

The included studies pointed toward some contextual variables that were associated with rates of police calls for service involving people with mental disorders. Two studies indicated that neighborhood characteristics, such as a high concentration of mental health and social services, a low proportion of black citizens, and a high proportion of renters, were associated with an increase of mental health-related calls to police (89,94). Another study indicated that increased rates are associated with characteristics of local police services, such as the implementation of a crisis intervention team program (93).

DISCUSSION

This review synthesized rates reported in 85 unique studies of contact between police and people with mental disorders. The estimates varied considerably depending on the type of rate. Overall, the findings suggest that typically one in four people with mental disorders have histories of police arrest, which is substantially higher than estimated rates among general adult populations in Canada (95) and the United Kingdom (96) but in line with rates in the United States (97,98). This review also found that about one in ten individuals encountered police in their pathway to mental health care, and one in 100 police dispatches and encounters

involve people with mental disorders. Such results shed empirical light on claims made by journalists, politicians, police personnel, and scholars about the frequency with which the police and people with mental disorders interact.

As is the case with most reviews of this nature, the included studies reported a wide range of rates, varying across the populations studied and the methods employed. This body of research predominantly consists of samples drawn from the United States, with some indication that U.S. police officers, compared with those in other countries, may play a greater role in connecting people to mental health services. When viewed optimistically, this might suggest that U.S. police officers are more actively involved, compared with their counterparts in other countries, in facilitating precharge diversion processes aimed at preventing people with mental disorders from further involvement with the criminal justice system. Conversely, this finding may also signal serious problems associated with the criminalization of people with mental disorders in the United States, whereby criminal justice processes, agents, and institutions are used to manage mental health issues. Another source of variation in rates was the diverse methods used for establishing the presence of an arrest history and a mental disorder, such as self-report versus official records, although these findings were mixed across the three types of rates examined in this review. Methodological quality of the studies was not formally appraised and controlled in this review, but the rates varied across different methodological characteristics, such as the size of the samples and the various ways in which mental disorder was operationalized.

One problem that has plagued research in this area is how to establish valid and reliable indicators of mental disorder in the context of police contacts. Scholars have developed rigorous field observation methods to reduce biases inherent in police-generated data (90,94). A limitation of this approach is that it is resource-intensive and difficult to perform on a large scale. Sophisticated data algorithms also have been produced to identify persons with mental disorders within administrative police databases (80,81,83,84). Although this method can be carried out on large data sets

and is relatively easy to replicate, it is dependent on the reporting practices of dispatchers and police officers and, as such, likely underestimates the number of encounters that actually involve people with mental disorders. Triangulating data and methods, as was done in this review, enhances the validity of such rates, but the underreporting of mental disorders remains an issue. A number of factors influence whether mental disorders will be discovered by, or reported to, the police, including relevance to the encounter, concealability, the skills of police personnel, and the fact that people who more often interact with the police, such as men and persons from racial-ethnic minority groups, may be the least motivated to disclose mental health issues (99). It would be prudent for researchers and decision makers to be mindful of these methodological issues when comparing the rates of different jurisdictions and when drawing conclusions about the nature and magnitude of the phenomenon.

Rates of contact between the police and people with mental illness tell us more about the patterned social arrangements in society than the criminality of individuals with mental disorders. Numerous studies expose the powerful social forces and diverse situations that bring these two groups together. Police interactions involving people with mental illnesses are often casual in nature, unrelated to offending behavior, and resolved through informal means

TABLE 2. Police involvement in care pathway among persons with mental disorders in 49 studies

Study	With disorders		Rate of police involvement (%)	99% CI
	Police involvement in mental health care pathway	Sought or accessed mental health care		
Evans and Boothroyd, 2002 (37)	53	1,779	3	1.96–4.04
Lim, 1983 (44)	46	1,280	4	2.59–5.41
Malla et al., 1987 (46)	231	5,729	4	3.33–4.67
Hitch and Clegg, 1980 (40)	46	1,131	4	2.50–5.50
Meadows et al., 1994 (47)	306	6,127	5	4.28–5.72
Hatfield, 2008 (39)	810	14,514	6	5.49–6.51
Kimhi et al., 1996 (41)	144	1,861	8	6.36–9.62
Bruffaerts et al., 2006 (33)	306	3,708	8	6.85–9.15
Bruffaerts et al., 2004 (32)	93	1,050	8	5.84–10.16
Kneebone et al., 1995 (42)	634	6,967	9	8.12–9.88
Brunero et al., 2007 (34)	130	869	15	11.88–18.12
Fry and Brunero, 2004 (38)	194	1,076	18	14.98–21.02
Durham et al., 1984 (36)	650	3,570	18	16.34–19.66
Maharaj et al., 2011 (45)	269	1,462	18	15.41–20.59
Lee et al., 2008 (43)	460	2,334	20	17.87–22.13
Watson et al., 1993 (49)	186	763	24	20.02–27.98
Christy et al., 2010 (35)	248,639	552,137	45	44.83–45.17
Wang et al., 2015 (48)	1,433	2,777	52	49.56–54.44
31 smaller studies ^a	1,572	6,225	25	23.59–26.41
Total	256,202	615,360	42	41.84–42.16
Total, excluding (35)	7,563	63,223	12	11.67–12.33

^a Archie et al., 2010 (50); Bhugra et al., 1999 (51); Broussard et al., 2010 (52); Burnett et al., 1999 (53); Burns et al., 2011 (54); Chong et al., 2005 (55); Cole et al., 1995 (56); Commander et al., 1999 (57); Compton et al., 2006 (24); Dhosse and Ghani, 1998 (58); Friedman et al., 1981 (59); Garety and Rigg, 2001 (60); Gater and Goldberg, 1991 (61); Gater et al., 2005 (62); Gillig et al., 1990 (63); Kilic et al., 1994 (64); Lawlor et al., 2012 (65); Lund et al., 2010 (66); McNeil et al., 1991 (67); Moodley and Perkins, 1991 (68); Reinish and Ciccone, 1995 (69); Sales, 1991 (70); Sim et al., 1990 (71); Steadman et al., 1986 (72); Steel et al., 2006 (73); Swanson et al., 2008 (79); Termingh and Oosthuizen, 2008 (74); Thienhaus et al., 1995 (75); Way et al., 1992 (76); Way et al., 1993 (77); Zohar et al., 1987 (78)

TABLE 3. Police calls for service involving people with mental disorders in 15 studies

Study	Police calls for service		Rate of calls involving mental disorders (%)	99% CI
	Involving people with mental disorders	All calls		
Crocker et al., 2009 (81)	1,491	354,981	0	.57–.43
Teller et al., 2006 (93)	10,004	1,527,281	1	.98–1.02
Hartford et al., 2005 (83)	2,949	229,858	1	.95–1.05
Hoch et al., 2009 (84)	817	111,912	1	.92–1.08
Kessell et al., 2009 (89)	28,197	1,341,608	2	1.97–2.03
Kaminski et al., 2004 (88)	49	2,060	2	1.21–2.79
Charette et al., 2011 (80)	272	8,485	3	2.52–3.48
Engel and Silver, 2001 (82)	103	3,241	3	2.23–3.77
Teplin, 1985 (94)	85	2,122	4	2.90–5.10
Panzarella and Alicea, 1997 (91)	1,879	35,000	5	4.70–5.30
Ruiz and Miller, 2004 (92)	376	5,220	7	6.09–7.91
Novak and Engel, 2005 (90)	49	617	8	5.19–10.81
Johnson, 2011 (86)	62	619	10	6.89–13.11
Kalinich and Senese, 1987 (87)	256	1,629	16	13.66–18.34
1 smaller study ^a	71	357	20	14.55–25.45
Total	46,660	3,624,990	1	.99–1.01
Total, excluding (89,93)	8,459	756,101	1	.97–1.03
Total, excluding (83,84,89,93)	4,693	414,331	1	.96–1.04

^a Holley and Arboleda-Florez, 1988 (85)

(80,93,100). The criminalization of illicit substances, the coercive underpinnings of mental health policies and services, and the intersecting functions of our mental health and criminal justice institutions are all implicated in these trends (101,102). Consistent with other reviews (103), this study revealed that rates of contact between police and people with mental disorders were correlated with a number of individual, organizational, and contextual factors, including homelessness, substance use problems, gender and race, and social disorganization. In addition to methodological differences, these characteristics are likely major sources of variation in rates between studies and jurisdictions. Interestingly, one study indicated that building the capacity for police services to respond appropriately to people with mental disorders, such as through training or specialized response teams, may increase the rate of mental health-related calls for services; however, the drivers of such changes (reporting practices versus greater reliance on police services) are not well understood and warrant greater research attention. What is clear is that reducing the rates revealed in this study will require that improvements be made to the undesirable social context in which people with mental disorders find themselves: terrible situations requiring routine and recurrent intervention by the police.

A number of methodological limitations must be noted. First, it is likely that a sizeable number of studies reporting on arrest histories among people with mental disorders were not captured by the literature search because they focused on other substantive issues and their titles, abstracts, or keywords did not contain necessary terms (that is, police[®] OR law enforce[®]). Second, the literature search was first performed in 2009 and then replicated in 2015; consequently, it was not possible to determine and report on the total number of studies screened and assessed for eligibility. Third,

methodological quality of the included studies was not formally appraised, and variability in quality was not controlled. Fourth, an initial search of the gray literature revealed few unpublished documents reporting primary data and satisfying other inclusion criteria. As such, the review was restricted to published research, which may pose a threat to the validity of the findings on account of publication bias.

The gross estimates of rates presented in this study will be of interest to researchers and police personnel who focus their efforts on understanding and improving such interactions; however, the study did not engage with

a number of central questions. For instance, are these interactions increasing in frequency? Is the nature of these encounters changing? Are repeated contacts becoming more common? In what ways do interactions with police differ for people with or without mental disorders? How are rates affected by the implementation of specific strategies, including police training and specialized response models, aimed at improving encounters between police officers and people with mental disorders? What role does the presence of a mental disorder, as opposed to other factors, actually play in these interactions? Such questions have important implications for policy makers, police leadership, and health care planners and are worthy of additional research.

CONCLUSIONS

Numerous coroner inquests and public inquiries after tragic events have created a heightened awareness of issues surrounding police encounters with people who have mental disorders. A prevailing sentiment is that many of these interactions are undesirable, unnecessary, and avoidable. By providing estimates regarding the rates of contact between police and people with mental disorders, this study illuminates the magnitude of the issue and supplies an empirically supported reference point to scholars and practitioners in this area.

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REFERENCES

- Godfredson JW, Thomas SDM, Ogloff JRP, et al: Police perceptions of their encounters with individuals experiencing mental illness: a Victorian survey. *Australian and New Zealand Journal of Criminology* 44:180–195, 2011
- Martin T, Thomas SDM: Police officers' views of absconding from mental health units in Victoria, Australia. *International Journal of Mental Health Nursing* 23:145–153, 2014
- McCabe PJ, Christopher PP, Druhn N, et al: Arrest types and co-occurring disorders in persons with schizophrenia or related psychoses. *Journal of Behavioral Health Services and Research* 39:271–284, 2012
- Police should not be 'front-line on mental health,' chiefs say. *Globe and Mail*, 2013. Available at www.theglobeandmail.com/news/national/police-should-not-be-front-line-on-mental-health-say-chiefs/article13898687
- Charette Y, Crocker AG, Billette I: Police encounters involving citizens with mental illness: use of resources and outcomes. *Psychiatric Services* 65:511–516, 2014
- Watson AC, Angell B, Morabito MS, et al: Defying negative expectations: dimensions of fair and respectful treatment by police officers as perceived by people with mental illness. *Administration and Policy in Mental Health and Mental Health Services Research* 35:449–457, 2008
- Brink J, Livingston JD, Desmarais SL, et al: A Study of How People With Mental Illness Perceive and Interact With the Police. *Calgary, Alberta, Mental Health Commission of Canada*, 2011
- Boyd J, Kerr T: Policing 'Vancouver's mental health crisis': a critical discourse analysis. *Critical Public Health*, 2015; doi 10.1080/09581596.2015.1007923
- Fazel S, Danesh J: Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys. *Lancet* 359:545–550, 2002
- Prins SJ: Prevalence of mental illnesses in US state prisons: a systematic review. *Psychiatric Services* 65:862–872, 2014
- Christopher PP, McCabe PJ, Fisher WH: Prevalence of involvement in the criminal justice system during severe mania and associated symptomatology. *Psychiatric Services* 63:33–39, 2012
- Cocozza JJ, Melick ME, Steadman HJ: Trends in violent crime among ex-mental patients. *Criminology* 16:317–334, 1978
- Cuellar AE, Snowden LM, Ewing T: Criminal records of persons served in the public mental health system. *Psychiatric Services* 58:114–120, 2007
- Fisher WH, Roy-Bujnowski KM, Grudzinskas AJ Jr, et al: Patterns and prevalence of arrest in a statewide cohort of mental health care consumers. *Psychiatric Services* 57:1623–1628, 2006
- Fisher WH, Simon L, Roy-Bujnowski K, et al: Risk of arrest among public mental health services recipients and the general public. *Psychiatric Services* 62:67–72, 2011
- Harry B, Steadman HJ: Arrest rates of patients treated at a community mental health center. *Hospital and Community Psychiatry* 39:862–866, 1988
- Holcomb WR, Ahr PR: Arrest rates among young adult psychiatric patients treated in inpatient and outpatient settings. *Psychiatric Services* 39:52–57, 1988
- Muntaner C, Wolyniec P, McGrath J, et al: Arrest among psychotic inpatients: assessing the relationship to diagnosis, gender, number of admissions, and social class. *Social Psychiatry and Psychiatric Epidemiology* 33:274–282, 1998
- Swartz JA, Lurigio AJ: Serious mental illness and arrest: the generalized mediating effect of substance use. *Crime and Delinquency* 53:581–604, 2007
- Theriot MT, Segal SP: Involvement with the criminal justice system among new clients at outpatient mental health agencies. *Psychiatric Services* 56:179–185, 2005
- Bloom JD, Shore JH, Arvidson B: Local variations in arrests of psychiatric patients. *Bulletin of the American Academy of Psychiatry and the Law* 9:203–209, 1981
- Brekke JS, Prindle C, Bae SW, et al: Risks for individuals with schizophrenia who are living in the community. *Psychiatric Services* 52:1358–1366, 2001
- Calsyn RJ, Yonker RD, Lemming MR, et al: Impact of assertive community treatment and client characteristics on criminal justice outcomes in dual disorder homeless individuals. *Criminal Behaviour and Mental Health* 15:236–248, 2005
- Compton MT, Esterberg ML, Druss BG, et al: A descriptive study of pathways to care among hospitalized urban African American first-episode schizophrenia-spectrum patients. *Social Psychiatry and Psychiatric Epidemiology* 41:566–573, 2006
- Gelberg L, Linn LS, Leske BD: Mental health, alcohol and drug use, and criminal history among homeless adults. *American Journal of Psychiatry* 145:191–196, 1988
- Lamb HR, Lamb DM: Factors contributing to homelessness among the chronically and severely mentally ill. *Hospital and Community Psychiatry* 41:301–305, 1990
- Link B, Andrews H, Cullen FT: The violent and illegal behavior of mental patients reconsidered. *American Sociological Review* 57: 275–292, 1992
- McFarland BH, Faulkner LR, Bloom JD, et al: Chronic mental illness and the criminal justice system. *Hospital and Community Psychiatry* 40:718–723, 1989
- Sosowsky L: Crime and violence among mental patients reconsidered in view of the new legal relationship between the state and the mentally ill. *American Journal of Psychiatry* 135:33–42, 1978
- White MC, Chafetz L, Collins-Bride G, et al: History of arrest, incarceration and victimization in community-based severely mentally ill. *Journal of Community Health* 31:123–135, 2006
- Lamb HR, Shaner R, Elliott DM, et al: Outcome for psychiatric emergency patients seen by an outreach police-mental health team. *Psychiatric Services* 46:1267–1271, 1995
- Bruffaerts R, Sabbe M, Demyttenaere K: Attenders of a university hospital psychiatric emergency service in Belgium: general characteristics and gender differences. *Social Psychiatry and Psychiatric Epidemiology* 39:146–153, 2004
- Bruffaerts R, Sabbe M, Demyttenaere K: Who visits the psychiatric emergency room for the first time? *Social Psychiatry and Psychiatric Epidemiology* 41:580–586, 2006
- Brunero S, Fairbrother G, Lee S, et al: Clinical characteristics of people with mental health problems who frequently attend an Australian emergency department. *Australian Health Review* 31: 462–470, 2007
- Christy A, Handelsman JB, Hanson A, et al: Who initiates emergency commitments? *Community Mental Health Journal* 46: 188–191, 2010
- Durham ML, Carr HD, Pierce GL: Police involvement and influence in involuntary civil commitment. *Psychiatric Services* 35: 580–584, 1984
- Evans ME, Boothroyd RA: A comparison of youth referred to psychiatric emergency services: police versus other sources. *Journal of the American Academy of Psychiatry and the Law* Online 30: 74–80, 2002
- Fry M, Brunero S: The characteristics and outcomes of mental health patients presenting to an emergency department over a twelve month period. *Australasian Emergency Nursing Journal* 7: 21–25, 2004
- Hatfield B: Powers to detain under mental health legislation in England and the role of the Approved Social Worker: an analysis of patterns and trends under the 1983 Mental Health Act in six local authorities. *British Journal of Social Work* 38:1553–1571, 2008
- Hitch PJ, Clegg P: Modes of referral of overseas immigrant and native-born first admissions to psychiatric hospital. *Social Science and Medicine* 14A:369–374, 1980

41. Kimhi R, Zohar M, Barak Y, et al: Police referrals to an urban psychiatric emergency room in Israel. *Journal of Forensic Psychiatry and Psychology* 7:641–646, 1996
42. Kneebone P, Rogers J, Hafner RJ: Characteristics of police referrals to a psychiatric emergency unit in Australia. *Psychiatric Services* 46:620–622, 1995
43. Lee S, Brunero S, Fairbrother G, et al: Profiling police presentations of mental health consumers to an emergency department. *International Journal of Mental Health Nursing* 17:311–316, 2008
44. Lim MH: A psychiatric emergency clinic: a study of attendances over six months. *British Journal of Psychiatry* 143:460–466, 1983
45. Maharaj R, Gillies D, Andrew S, et al: Characteristics of patients referred by police to a psychiatric hospital. *Journal of Psychiatric and Mental Health Nursing* 18:205–212, 2011
46. Malla A, Norman RM, Helmes E: Factors associated with involuntary admission to psychiatric facilities in Newfoundland. *Canadian Medical Association Journal* 136:1166–1171, 1987
47. Meadows G, Calder G, Van den Bos H: Police referrals to a psychiatric hospital: indicators for referral and psychiatric outcome. *Australian and New Zealand Journal of Psychiatry* 28:259–268, 1994
48. Wang JP, Wu CY, Chiu CC, et al: Police referrals at the psychiatric emergency service in Taiwan. *PLoS One* 7:436–444, 2015
49. Watson MA, Segal SP, Newhill CE: Police referral to psychiatric emergency services and its effect on disposition decisions. *Hospital and Community Psychiatry* 44:1085–1090, 1993
50. Archie S, Akhtar-Danesh N, Norman R, et al: Ethnic diversity and pathways to care for a first episode of psychosis in Ontario. *Schizophrenia Bulletin* 36:688–701, 2010
51. Bhugra D, Corridan B, Rudge S, et al: Early manifestations, personality traits and pathways into care for Asian and white first-onset cases of schizophrenia. *Social Psychiatry and Psychiatric Epidemiology* 34:595–599, 1999
52. Broussard B, McGriff JA, Demir Neubert BN, et al: Characteristics of patients referred to psychiatric emergency services by crisis intervention team police officers. *Community Mental Health Journal* 46:579–584, 2010
53. Burnett R, Mallett R, Bhugra D, et al: The first contact of patients with schizophrenia with psychiatric services: social factors and pathways to care in a multi-ethnic population. *Psychological Medicine* 29:475–483, 1999
54. Burns JK, Jhazbhay K, Kidd M, et al: Causal attributions, pathway to care and clinical features of first-episode psychosis: a South African perspective. *International Journal of Social Psychiatry* 57: 538–545, 2011
55. Chong SA, Mythily, Lum A, et al: Determinants of duration of untreated psychosis and the pathway to care in Singapore. *International Journal of Social Psychiatry* 51:55–62, 2005
56. Cole E, Leavey G, King M, et al: Pathways to care for patients with a first episode of psychosis: a comparison of ethnic groups. *British Journal of Psychiatry* 167:770–776, 1995
57. Commander MJ, Cochrane R, Sashidharan SP, et al: Mental health care for Asian, black and white patients with non-affective psychoses: pathways to the psychiatric hospital, in-patient and after-care. *Social Psychiatry and Psychiatric Epidemiology* 34: 484–491, 1999
58. Dhossche DM, Ghani SO: Who brings patients to the psychiatric emergency room? Psychosocial and psychiatric correlates. *General Hospital Psychiatry* 20:235–240, 1998
59. Friedman S, Feinsilver DL, Davis GW, et al: Decision to admit in an inner-city psychiatric emergency room: beyond diagnosis—the psychosocial factors. *Psychiatric Quarterly* 53:259–274, 1981
60. Garety PA, Rigg A: Early psychosis in the inner city: a survey to inform service planning. *Social Psychiatry and Psychiatric Epidemiology* 36:537–544, 2001
61. Gater R, Goldberg D: Pathways to psychiatric care in South Manchester. *British Journal of Psychiatry* 159:90–96, 1991
62. Gater R, Jordanova V, Maric N, et al: Pathways to psychiatric care in Eastern Europe. *British Journal of Psychiatry* 186:529–535, 2005
63. Gillig P, Dumaine M, Hillard JR: Whom do mobile crisis services serve? *Hospital and Community Psychiatry* 41:804–805, 1990
64. Kiliç C, Rezaki M, Ustün TB, et al: Pathways to psychiatric care in Ankara. *Social Psychiatry and Psychiatric Epidemiology* 29: 131–136, 1994
65. Lawlor C, Johnson S, Cole L, et al: Ethnic variations in pathways to acute care and compulsory detention for women experiencing a mental health crisis. *International Journal of Social Psychiatry* 58:3–15, 2012
66. Lund C, Oosthuizen P, Flisher AJ, et al: Pathways to inpatient mental health care among people with schizophrenia spectrum disorders in South Africa. *Psychiatric Services* 61:235–240, 2010
67. McNeil DE, Hatcher C, Zeiner H, et al: Characteristics of persons referred by police to the psychiatric emergency room. *Hospital and Community Psychiatry* 42:425–427, 1991
68. Moodley P, Perkins RE: Routes to psychiatric inpatient care in an Inner London Borough. *Social Psychiatry and Psychiatric Epidemiology* 26:47–51, 1991
69. Reinish LW, Ciccone JR: Involuntary hospitalization and police referrals to a psychiatric emergency department. *Bulletin of the American Academy of Psychiatry and the Law* 23:289–298, 1995
70. Sales GN: A comparison of referrals by police and other sources to a psychiatric emergency service. *Hospital and Community Psychiatry* 42:950–952, 1991
71. Sim LP, Lim LC, Lee SL, et al: A study of police referrals to Woodbridge Hospital. *Singapore Medical Journal* 31:131–134, 1990
72. Steadman HJ, Morrissey JP, Braff J, et al: Psychiatric evaluations of police referrals in a general hospital emergency room. *International Journal of Law and Psychiatry* 8:39–47, 1986
73. Steel Z, McDonald R, Silove D, et al: Pathways to the first contact with specialist mental health care. *Australian and New Zealand Journal of Psychiatry* 40:347–354, 2006
74. Temmingh HS, Oosthuizen PP: Pathways to care and treatment delays in first and multi episode psychosis: findings from a developing country. *Social Psychiatry and Psychiatric Epidemiology* 43:727–735, 2008
75. Thienhaus OJ, Ford J, Hillard JR: Factors related to patients' decisions to visit the psychiatric emergency service. *Psychiatric Services* 46:1227–1228, 1995
76. Way BB, Evans ME, Banks SM: Factors predicting referral to inpatient or outpatient treatment from psychiatric emergency services. *Psychiatric Services* 43:703–708, 1992
77. Way BB, Evans ME, Banks SM: An analysis of police referrals to 10 psychiatric emergency rooms. *Bulletin of the American Academy of Psychiatry and the Law* 21:389–397, 1993
78. Zohar M, Hadas Z, Modan B: Factors affecting the decision to admit mental patients in a community hospital. *Journal of Nervous and Mental Disease* 175:301–305, 1987
79. Swanson J, Swartz M, Elbogen E, et al: Psychiatric advance directives and reduction of coercive crisis interventions. *Journal of Mental Health* 17:255–267, 2008
80. Charette Y, Crocker AG, Billette I: The judicious judicial dispositions juggle: characteristics of police interventions involving people with a mental illness. *Canadian Journal of Psychiatry* 56: 677–685, 2011
81. Crocker AG, Hartford K, Heslop L: Gender differences in police encounters among persons with and without serious mental illness. *Psychiatric Services* 60:86–93, 2009
82. Engel RS, Silver E: Policing mentally disordered suspects: a reexamination of the criminalization hypothesis. *Criminology* 39: 225–252, 2001
83. Hartford K, Heslop L, Stitt L, et al: Design of an algorithm to identify persons with mental illness in a police administrative database. *International Journal of Law and Psychiatry* 28:1–11, 2005

84. Hoch J, Hartford K, Heslop L, et al: Mental illness and police interactions in a mid-sized Canadian city: what the data do and do not say. *Canadian Journal of Community Mental Health* 28: 49-66, 2009
85. Holley HL, Arboleda-Florez J: Criminalization of the mentally ill: part I. police perceptions. *Canadian Journal of Psychiatry* 33: 81-86, 1988
86. Johnson R: Suspect mental disorder and police use of force. *Criminal Justice and Behavior* 38:127-145, 2011
87. Kalinich DB, Senese JD: Police discretion and the mentally disordered in Chicago: a reconsideration. *Policy Studies* 10:185-191, 1987
88. Kaminski R, DiGiovanni C, Downs R: The use of force between the police and persons with impaired judgment. *Police Quarterly* 7:311-338, 2004
89. Kessell ER, Alvidrez J, McConnell WA, et al: Effect of racial and ethnic composition of neighborhoods in San Francisco on rates of mental health-related 911 calls. *Psychiatric Services* 60:1376-1378, 2009
90. Novak KJ, Engel RS: Disentangling the influence of suspects' demeanor and mental disorder on arrest. *Policing* 28:493-512, 2005
91. Panzarella R, Alicea JO: Police tactics in incidents with mentally disturbed persons. *Policing* 20:326-338, 1997
92. Ruiz J, Miller C: An exploratory study of Pennsylvania police officers' perceptions of dangerousness and their ability to manage persons with mental illness. *Police Quarterly* 7:359-371, 2004
93. Teller JLS, Munetz MR, Gil KM, et al: Crisis intervention team training for police officers responding to mental disturbance calls. *Psychiatric Services* 57:232-237, 2006
94. Teplin LA: The criminality of the mentally ill: a dangerous misconception. *American Journal of Psychiatry* 142:593-599, 1985
95. Basic Facts About Federal Corrections: 2001 ed. Ottawa, Correctional Service Canada, 2001
96. Annual Report and Accounts 2008/09. London, National Policing Improvement Agency, 2009. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/248237/0738.pdf
97. Survey of State Criminal History Information Systems, 2012. Washington, DC, US Department of Justice, Bureau of Justice Statistics, 2014
98. Rodriguez MN, Emsellem M: 65 Million "Need Not Apply": The Case for Reforming Criminal Background Checks for Employment. New York, National Employment Law Project, March 2011. Available at www.nelp.org/content/uploads/2015/03/65_Million_Need_Not_Apply.pdf
99. Clement S, Schauman O, Graham T, et al: What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine* 45:11-27, 2015
100. Livingston JD, Desmarais SL, Verdun-Jones S, et al: Perceptions and experiences of people with mental illness regarding their interactions with police. *International Journal of Law and Psychiatry* 37:334-340, 2014
101. Lamb HR, Weinberger LE, Gross BH: Mentally ill persons in the criminal justice system: some perspectives. *Psychiatric Quarterly* 75:107-126, 2004
102. Lurigio AJ: People with serious mental illness in the criminal justice system: causes, consequences, and correctives. *Prison Journal* 91:66-86, 2011
103. Roy L, Crocker AG, Nicholls TL, et al: Criminal behavior and victimization among homeless individuals with severe mental illness: a systematic review. *Psychiatric Services* 65:739-750, 2014



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The potential for violence in arrests of persons with mental illness

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Abstract

Purpose – The purpose of this paper is to determine whether police use of force and suspect resistance are more likely to occur in arrest encounters involving suspects with mental health problems.

Design/methodology/approach – The study uses data from interviews with 942 individuals recently arrested by officers in more than a dozen different police departments in Maricopa County, Arizona in 2010. Both logistic and ordinal regression analyses are used to predict two models of suspect resistance (resistance in the current arrest, resistance in a previous police contact) and three models of police use of force (any force in the current arrest, ordinal measure of force in the current arrest, and any force in a previous contact).

Findings – The results provide empirical support for a link between mental illness and increased resistance against the police. With regard to arrestee mental illness and use of force, the results are mostly consistent with prior research suggesting a null relationship, with an important caveat involving greater use of higher level, weapon force.

Research limitations/implications – The study suffers from the traditional limitations associated with self-report data, and the generalizability of the findings beyond arrest encounters in Maricopa County is not known. The explanatory power of the multivariate models was relatively weak, suggesting a good degree of unexplained variance.

Practical implications – The non-significant relationship between arrestee mental illness and use of force is consistent with efforts by police to improve their response in these complex encounters. The significant weapon-force finding may suggest that police respond to the affronts of mentally ill suspects differently than affronts from other suspects. The non-significance of key extra-legal factors suggests that police decisions to use force were not influenced by arrestee race/ethnicity, age, or social standing.

Originality/value – Unlike previous studies, the current research uses self-reported measures of mental health problems. The current study also examines arrests from more than a dozen different police departments.

Keywords Resistance, Mental illness, Criminalization, Use of force

Paper type Research paper



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Introduction

Handling encounters involving persons with mental illness (PMIs) has become an increasingly important part of routine police work (Deane *et al.*, 1999; Borum *et al.*, 1998). Despite the increasing frequency of these contacts, there is a long history of poor police response to PMIs highlighted by the potential for those encounters to end in violence (Lurigio *et al.*, 2008). For example, data indicate that PMIs are four times more likely to be fatally shot by police than citizens without mental illness; alternatively, though police line-of-duty deaths are rare, those deaths are five times more likely to be committed by an assailant with a mental illness (Treatment Advocacy Center, 2005;

see also Lurigio *et al.*, 2008). Police-citizen encounters that end in violence are highly controversial and can have long-term devastating consequences (Fyfe, 1988; Klinger, 2004) – consequences that are aggravated when PMIs are involved.

Despite the potential for violence in these interactions, there have been few studies examining the dynamics of police encounters with PMIs, particularly the critical interactions where force is used. In fact, only three studies to date have explored police use of force in encounters with PMIs (Kaminski *et al.*, 2004; Johnson, 2011; Terrill and Mastrofski, 2002). Notably, results from all three studies found no association between suspect mental illness and likelihood of police use of force. Unfortunately, the use of force/suspect mental illness question has not been investigated in more than a decade and additional research is needed to explore key features of these encounters. In particular, research is needed to investigate the relationship between mental illness and increased likelihood of resistance (a proxy for violence), as well as the role mental illness plays in police officer decisions to use force. This knowledge gap is especially troubling when considering the debate over the “criminalization” of mental illness (Abramson, 1972; Engel and Silver, 2001) and efforts to improve police handling of encounters involving PMIs (e.g. Crisis Intervention Teams (CIT); Dupont and Cochran, 2000).

The current study examines this issue using data from interviews with 942 individuals recently arrested by officers in more than a dozen different police departments in Maricopa County, Arizona in 2010. The study seeks to address the following research questions:

RQ1. Is there a relationship between suspect mental health problems and likelihood of resistance against police during arrest encounters?

RQ2. Is there a relationship between suspect mental health problems and likelihood of police use of force during arrest encounters?

Importantly, the analyses focus on the current arrest that resulted in their participation in the study, as well as a previous encounter with police during the past year ($n = 662$). Overall, the paper seeks to clarify the relationships between mental health problems, resistance, and police use of force, and to improve our understanding of these increasingly frequent, complex police-citizen encounters.

Prior research

PMIs, the police, and criminalization

Currently, there are more individuals with mental illness in jail or prison than all the state run psychiatric institutions in the USA combined (Council of State Governments, 2007; Sigurdson, 2000). This has not always been the case, however. At the height of the institutionalization movement there were over 500,000 individuals living in inpatient psychiatric facilities (Torrey, 1997). After 1955 this trend began to change drastically. Within 30 years, the number of persons in mental institutions had decreased by 80 percent to just over 100,000 (Mechanic and Rochefort, 1990), and by 2005, that number had dropped to 52,000 (Lurigio *et al.*, 2008). Although deinstitutionalization successfully emptied psychiatric asylums, the movement's second component fell far short, as tax dollars for the development of community mental health treatment never materialized (Bachrach, 1978; Gilligan, 2001).

The movement of so many PMIs from psychiatric institutions to the community without proper treatment or care inevitably led to increased contact with the police

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(Bonovitz and Bonovitz, 1981; Torrey, 1997). Early research by police sociologists painted a clear picture of how police managed PMIs (and other marginalized populations) with peacekeeping as a central feature. Bittner (1967b) noted that police attempt to provide "psychiatric first aid" to divert those with mental illness from the criminal justice system. Moreover, Bittner (1967a) asserted that officers assigned to handle marginalized citizens on skid row developed specific techniques to reduce risk of violence and successfully manage their beats, while also protecting this vulnerable population (see also Muir, 1977; Van Maanen, 1978).

Alternatively, some scholars have suggested that police interactions with PMIs have become increasingly "criminalized." Abramson (1972) described a process whereby the untreated individuals with mental illness come into contact with the police and are arrested. In jail, they become treatment compliant and are subsequently released to the community; but the cycle starts again once these individuals are released to the community. Abramson (1972) referred to this process as the "criminalization of the mentally ill," and his pioneering work received empirical support (e.g. Lurigio, 2000; Sosowsky, 1978; Teplin, 1983). For example, Teplin's (1984) was among the first to empirically examine how police resolve encounters with PMIs. She reported that the probability of being arrested was almost 20 percent greater for PMIs. Teplin and Pruett (1992) later referred to the police as "street level psychiatrists," noting that they often preferred to deal with PMIs informally. However, when informal resolutions were not possible, officers were often left with arrest (or "mercy bookings") as the only practical alternative (Teplin, 1983; Wells and Schafer, 2006).

More recent studies have questioned the criminalization hypothesis and the extent to which PMIs are at greater risk of arrest. For instance, Engel and Silver (2001) used data from two large, multi-city policing projects and found that despite higher levels of non-compliance with police, PMIs were significantly less likely to be arrested. Novak and Engel (2005) examined police-public contacts in Cincinnati and reported similar findings (see also Fisher *et al.*, 2006; Peterson *et al.*, 2010).

The changing context for police encounters with PMIs

As part of an effort to reduce the flow of PMIs into the criminal justice system (e.g. reduce criminalization), police departments across the country have sought to better prepare their officers to handle such encounters (Lurigio *et al.*, 2008). The most popular of these programs is the CIT, developed in Memphis in the late 1980s. As part of the program, officers receive 40 hours of training led by mental health specialists, and calls for service involving individuals with mental health problems are dispatched to CIT officers (Cochran *et al.*, 2000). Dupont and Cochran (2000) found that the CIT program in Memphis reduced injuries to both police and citizens while successfully diverting PMIs into treatment. The program, which has been identified as a "model program" by the National Alliance for the Mentally Ill and the US Department of Justice, has been replicated in numerous jurisdictions across the USA (Lurigio *et al.*, 2008).

At the same time, however, many police departments have adopted new strategies that emphasize public order and minor quality of life offenses, and as a consequence, have led to increased formal interactions between police and PMIs (e.g. Broken Windows; zero tolerance strategies; Lurigio *et al.*, 2008). For example, in 2006 the LAPD implemented the Safer Cities Initiative (SCI) to address crime and disorder in the skid row section of Los Angeles. The SCI focussed on low-level crime with aggressive saturation patrol, resulting in large numbers of citations and arrests (Berk and MacDonald, 2010; White, 2010).

The potential for violence in police encounters with PMIs

The increased formality of police contacts with the mentally ill via zero tolerance (and similar) strategies raises concerns about an enhanced risk for violence, either through suspect resistance, police use of force, or both. Though police use of force is a statistically rare event, occurring in about 1.4 percent of all police-citizen encounters (Bureau of Justice Statistics, 2011), the volume of encounters in a year (approximately 40 million) translates into an estimated 560,000 use of force incidents per year, or more than 1,500 events per day. Moreover, use of force by police is much more common in arrest encounters, as research indicates about one in five arrests involves the use of some level of police force (Hickman *et al.*, 2008).

Over the past four decades, an abundance of research has focussed on identifying factors that influence police officer decisions to use force, and much of that research has focussed on characteristics of the participants in the encounter, especially the suspect[1]. Most relevant for the current study is the research examining police encounters with individuals who are impaired (intoxicated, under the influence of drugs, or mentally ill). Several studies have shown that police use of force is more likely in encounters with suspects who are impaired, but much of this work has not specified the type of impairment (Crawford and Burns, 1998; Engel *et al.*, 2000; Garner and Maxwell, 2000; Garner *et al.*, 2002; Terrill and Mastrofski, 2002)[2]. A few studies have shown that use of force rates vary by citizen drug and alcohol impairment. For example, Garner *et al.* (1996) found that alcohol impairment was associated with higher rates of use of force, but drug impairment was not (see also Bayley and Garofalo, 1989; Friedrich, 1980). Kaminski *et al.* (2004, p. 329) found the exact opposite, however.

Only three studies to date have examined whether police use of force is more frequent in encounters with suspects who have a mental illness. Using data on 619 police encounters in two Oregon cities from 1995, Johnson (2011) examined whether suspects with mental illness were more likely than non-disordered suspects to experience police use of force. Johnson (2011, p. 141) examined two measures of force, any force used and serious force only, and found, "no evidence to suggest that mentally disordered individuals receive harsher treatment at the hands of officers than do non-disordered persons." Terrill and Mastrofski (2002) examined 3,116 police-citizen encounters in two cities (from 1996 to 1997) and found that a number of factors were associated with increased coercive behavior by police, including suspect sex, race/ethnicity, class, age, and drug/alcohol impairment. However, suspect mental illness was not among those factors. Kaminski *et al.* (2004) examined use of force in more than 2,000 arrests made by officers in one department (in 2000-2001) and found that a combined measure of impairment (drug, alcohol, and mental illness) was positively associated with use of force. However, the relationship was explained almost entirely by drug impairment, and the authors concluded, "that impairment by mental illness does not appear to increase the likelihood of use of force" (Kaminski *et al.*, 2004, p. 330). The picture emerging from these three studies suggests a null relationship between suspect mental illness and police use of force. However, each of the aforementioned studies examined police encounters from 2001 or earlier. Given the ongoing developments in police strategies over the last decade (see above, e.g. CIT, zero tolerance) and the continuing debate over criminalization, additional research is needed to more sufficiently explore questions surrounding police encounters with PMIs, most notably the potential for those interactions to end in violence.

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Methods and data

The current study seeks to address these questions through an examination of 942 arrests made by officers in more than a dozen different police departments in Maricopa County, Arizona from June 1, 2010 through December 31, 2010. Data were collected through interviews of arrestees as part of the Arizona Arrestee Reporting Information Network (AARIN). The AARIN project in Maricopa County was originally established in 1987 under the auspices of the Drug Use Forecasting program, and later the Arrestee Drug Abuse Program (ADAM); both sponsored by the National Institute of Justice (NIJ) to monitor drug use trends, treatment needs, and at-risk behavior among recently booked arrestees. Though ADAM operations were suspended by NIJ in January 2004, Maricopa County re-established (and re-named) the program in 2007 through local funds.

The AARIN project employs the same rigorous methodology as its predecessor (ADAM), which centers on a systematic sampling protocol with quarterly data collection from countywide jail facilities (and target quotas at each facility). More specifically, each quarter interviews are conducted (and urine specimens are collected) during a two-week period at the 4th Avenue County Jail and during a one-week period at the Mesa and Glendale Police Department lockups. During data collection periods, interviews are conducted with arrestees who are randomly selected based on booking time using a stock (i.e. arrested during non-data collection hours) and flow (i.e. arrested during data collection hours) selection process. Over the study period for this paper, more than 90 percent of approached adult arrestees agreed to participate in the study; and 90 percent of those who were interviewed also provided a urine specimen ($n = 942$)[3].

The mental health variables

The core AARIN survey instrument gathers a range of self-report data on background and demographics, prior criminal history, current charge information, drug use patterns, substance abuse dependence and treatment, and mental health. The variables used to assess mental health warrant some discussion. These questions, which were derived from the Dual Diagnosis addendum developed and used for ADAM (Alemagno *et al.*, 2004), focus on whether the respondent has received professional help for an emotional, psychiatric, or mental health problem, if they have been told they have a problem by a professional, or if they have been treated, prescribed medication, or hospitalized for a mental health condition[4]. Importantly, prior research has shown that brief, self-reported screening for mental health problems is a valid proxy for clinical assessments (Berwick *et al.*, 1991).

In the current study, the mental health variables were captured for both the past 30 days and the past 12 months. Arrestees who indicated that, in the last 30 days, they had been treated, prescribed medication or hospitalized for a psychiatric problem, or were told by a mental health professional that they have a problem, were coded as having a current mental health problem. If an arrestee reported affirmative to any of the above within the last year, he or she was coded as having a mental health problem in the past 12 months. The authors acknowledge that the past 30-day measure does not focus specifically on arrestees' mental health condition during the current arrest. This broader measure was employed because the authors believe that the increased formality of the indicators being queried (e.g. being medicated, or hospitalized) captures a more accurate prevalence rate of mental illness[5].

This study departs from previous work in this area through its use of arrestee self-reports for capturing mental illness. Prior research has relied on either police

officer observations (Kaminski *et al.*, 2004; Johnson, 2011), or trained research observers (Terrill and Mastrofski, 2002) to capture this information, and both of these approaches have limitations. For example, Teplin and Pruett (1992) noted that police officers often are not properly trained to identify mental illness, or to differentiate mental illness from other forms of impairment. Moreover, both trained observers and police may fail to identify internalizing disorders, or those that are not immediately observable during the encounter. As a result, the current study uses arrestee self-reports of mental health problems. Though the limits of self-report are well known, research indicates that, in jail-based interviews, arrestees have generally been truthful in their responses with regard to a range of sensitive topics such as drug use, criminal history, and immigration status (e.g. Katz *et al.*, 1997).

The key outcomes: suspect resistance and police use of force

The current study also employs a Police-Contact Addendum that captures arrestee resistance and police use of force levels. The suspect resistance items include a series of questions about the arrestee's behavior during the encounter, including arguing, cursing, disobeying, threatening, resisting or attempting escape, hitting or fighting, and use of a weapon[6]. The authors created an aggregate resistance measure by combining responses to all of the questions into one measure (any resistance, no or yes). The officer use of force items asked the arrestee to indicate whether the officer pushed, grabbed, hit, kicked, or used weapons (chemical spray, baton, TASER, firearm, other) during the incident (or threatened to do any of these). The authors created an aggregate use of force measure (any force used, no or yes) and an ordinal measure with three outcomes: no force, non-weapon force (officer, pushed, grabbed, hit, kicked), and weapon force (baton, chemical, TASER, firearm, or other weapon).

The survey asks respondents both about the current arrest ($n = 942$) and a prior police contact within the last year ($n = 662$; 280 arrestees reported no prior contact). The authors examine both the current arrest and a previous encounter because this multiple timeframe approach captures a larger universe of police-citizen encounters, and allows for a more comprehensive investigation of the relationships between these key variables. With regard to analysis, logistic and ordinal regression using robust standard errors are employed to identify predictors of five outcomes: two suspect resistance measures (resistance during current arrest and resistance during a prior encounter) and three police use of force measures (any force during current arrest, ordinal measure of force during current arrest, and any force during a prior encounter)[7]. The authors were able to document arresting agency for the current arrest, and as a consequence, the robust standard error models for current arrest outcomes are clustered by the arresting agency.

Results

Descriptive findings

Table I displays the background characteristics of the arrestee sample. Three quarters of the sample is male, and nearly half was white (46 percent). Almost two-thirds graduated from high school or obtained their GED, and 50 percent had at least part-time employment at the time of their arrest. In total, 41 percent had a prior arrest within the last year, and almost half were currently detained on a felony charge (48 percent). Approximately 8 percent reported a mental health problem within the last 30 days, and 15 percent indicated a problem within the last year. Table I also shows that 13 percent of arrestees reported that they resisted against police during the

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410	Sex	
	Female	24.20
	Male	75.80
	Race/ethnicity	
	African-American	17.73
	White	46.17
	Hispanic	28.56
	Other	7.54
	Age (mean)	31.53
	High school graduate	66.45
	Employment status	
	Employed	50.00
	Illegal income	8.52
	Arrest charges	
	Felony	47.57
	Violent offense	21.23
	Prior arrests (past 12 months)	40.87
	Homeless	7.75
	Mental health problem	
	Past 30 days	7.64
	Last 12 months	15.40
Table I. Characteristics of arrestee sample	Resistance to arrest	
	Current resistance	13.48
	Past year resistance	15.39
	Police use of force	
	Current force	21.23
	Past year force	15.71
	<i>n</i>	942

current arrest, and 15 percent indicated resistance in a previous encounter. In total, 21 percent stated that police used force against them in the current arrest, and 16 percent had force used against them in a previous encounter.

Table II shows the sample by arresting agency. For example, the first column illustrates that 41 percent of the sample was arrested by department one. Table II also shows the portion of arrestees – by agency – that reported current mental health problems, as well as resisting and experiencing police use of force during the current encounter. The percentage of arrestees reporting a mental health problem is fairly consistent across agencies, generally from 3 to 11 percent. There is wider variation in reports of suspect resistance, ranging from 5 percent to more than 20 percent. Reports of police use of force are also disparate, ranging from 0 to nearly 30 percent. The variation in these measures underscores the importance of clustering by agency in the regression models.

Multivariate analysis

Table III displays the regression models for suspect resistance during the current and prior encounters. When controlling for other relevant factors, individuals with a current mental health problem were nearly three times more likely ($\text{Exp}(b) = 2.89$) to resist during the current arrest. The relationship between mental health problems and increased resistance is also evident in the prior contact model ($\text{Exp}(b) = 2.11$). In simple

	<i>n</i>	% arrested	% current MH problem	% current resistance	% current use of force	Violence in arrests of PMI
Department 1	385	40.87	8.83	13.51	25.45	411
Department 2	97	10.30	3.09	8.25	12.37	
Department 3	84	8.92	11.90	10.71	20.24	
Department 4	74	7.86	9.46	14.86	27.03	
Department 5	68	7.22	2.94	16.18	22.06	
Department 6	63	6.69	3.17	4.76	12.70	
Department 7	31	3.29	6.45	29.03	29.03	
Department 8	31	3.29	6.45	16.13	9.68	
Department 9	21	2.23	9.50	14.29	0.00	
Department 10	18	1.91	11.11	22.22	22.22	
Department 11	10	1.06	0.00	20.00	0.00	
Department 12	60	6.37	10.00	16.67	23.33	
	<i>n</i> = 942		<i>n</i> = 72	<i>n</i> = 127	<i>n</i> = 200	Table II. Sample characteristics by arresting agency

	Current arrest ^a		Past 12-month contact	
	<i>b</i> (SE)	Exp(<i>b</i>)	<i>b</i> (SE)	Exp(<i>b</i>)
Mental health problem				
Current	1.06 (0.202)	2.89***	—	—
Last 12 months	—	—	0.750 (0.271)	2.11**
Sex (males reference)	−0.217 (0.330)	0.8	−0.276 (0.295)	0.76
Race or ethnicity				
White (referent)	—	—	—	—
Black or African-American	0.264 (0.217)	1.30	0.554 (0.309)	1.74
Hispanic or Latino	−0.069 (0.382)	0.94	0.420 (0.300)	1.52
Other	0.288 (0.190)	1.33	1.04 (0.397)	2.81**
Age 25 and under	0.600 (0.099)	1.82***	0.058 (0.237)	1.06
Level of education				
Did not graduate high school (referent)	—	—	—	—
High school graduate	−0.208 (0.233)	0.81	−0.025 (0.253)	0.98
Employment status				
Not employed (referent)	—	—	—	—
Legal employment	−0.024 (0.153)	0.98	−0.164 (0.261)	0.85
Illegal income	0.487 (0.393)	1.63	1.09 (0.330)	2.99***
Substance use				
Current alcohol	0.280 (0.214)	1.32	0.340 (0.240)	1.40
Current drug (any)	0.328 (0.222)	1.39	−0.241 (0.241)	0.79
Arrest charges				
Felony	0.170 (0.223)	1.19	0.135 (0.231)	1.14
Violent offense	−0.509 (0.228)	0.60*	0.471 (0.264)	1.60
Prior arrests (12 months)	0.981 (0.212)	2.67***	0.453 (0.243)	1.57
Homeless	0.061 (0.236)	1.06	−0.281 (0.403)	0.76
<i>n</i>	942		662	
McFadden's R^2	0.096		0.11	
Model χ^2	71.29***		39.39***	
Notes: ^a Model is clustered by arresting agency. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$				
			Table III. Predicting resistance to arrest	

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terms, arrestees with mental health problems were much more likely to resist against police, compared to other arrestees. Other predictors of resistance during the current arrest include younger age ($\text{Exp}(b) = 1.82$), prior arrests in the past year ($\text{Exp}(b) = 2.67$), and violent offense in the current arrest (negatively associated with resistance, $\text{Exp}(b) = 0.60$). Obtaining illegal income ($\text{Exp}(b) = 2.99$) and "other" arrestee race/ethnicity ($\text{Exp}(b) = 2.81$) were also significant in the prior contact model.

Table IV shows the regression models predicting police use of force. It is important to note that the dependent variable for the models in Table III – suspect resistance – now becomes a covariate in the models in Table IV. The first current arrest model (with the dichotomous use of force outcome) shows that, when controlling for other factors, arrestees with mental health problems are no more likely than other arrestees to experience police use of force. There are a number of other variables that are significant predictors of any police use of force, including suspect resistance ($\text{Exp}(b) = 1.67$), testing positive for alcohol and drugs ($\text{Exp}(b) = 1.55$ and 1.51 , respectively), felony and violent charges in the current offense ($\text{Exp}(b) = 2.02$ and 1.96 , respectively), and prior arrests ($\text{Exp}(b) = 1.85$). Additionally, there are several variables of note that are not significant. These include extra-legal factors such as sex, race/ethnicity, age, and social status variables (education and employment), which have been identified as predictors of police use of force in prior research (e.g. Terrill and Mastrofski, 2002).

In the current arrest model with an ordinal level measure of force (none, physical, weapon), results indicate that arrestees with mental health problems are at greater risk of experiencing use of force by police ($\text{Exp}(b) = 1.74$), even when controlling for resistance and other relevant factors. The significance of the mental health variable is tied to incidents where police use weapon force (e.g. baton, TASER). Even though police use of weapons is uncommon (reported in 11.5 percent of all arrests), when officers do use this level of force it is significantly more likely to be against arrestees with mental health problems. In addition, many of the variables significant in the previous model remain significant here, including suspect resistance ($\text{Exp}(b) = 1.59$), testing positive for alcohol and drugs ($\text{Exp}(b) = 1.52$ and 1.50 , respectively), felony and violent charges in the current offense ($\text{Exp}(b) = 2.05$ and 2.14 , respectively), and prior arrests ($\text{Exp}(b) = 1.85$). The notable extra-legal factors also remain non-significant (race/ethnicity, sex, age, employment, and education). The final model examines police use of force in a prior encounter, and the arrestee mental health problem variable is not significant.

Discussion

The link between mental health problems and increased resistance

Arrestee mental health problems were a strong predictor of resistance against police, even when controlling for other risk factors such as substance abuse and prior criminal history. There are several aspects of this finding, however, that mitigate the conclusions that can be drawn regarding mental health problems and increased violence toward police. First, the current study focusses on a very specific and small percentage of the population of PMIs. This sample is defined by two important characteristics:

- (1) they engaged in behavior that drew the attention of police; and
- (2) the incident ended with their arrest.

There is a much larger population of individuals who live with mental illness but who likely never come to the attention of the police. Moreover, it is unknown how many

	Current arrest ^a <i>b</i> (SE)	Exp(<i>b</i>)	Current arrest ^a (ordinal) <i>b</i> (SE)	Exp(<i>b</i>)	Past year contact <i>b</i> (SE)	Exp(<i>b</i>)
Resistance to arrest	0.512 (0.229)	1.67*	0.463 (0.227)	1.59*	0.539 (0.259)	1.71*
Mental health problem						
Current	0.581 (0.308)	1.79	0.554 (0.248)	1.74*	0.154 (0.259)	1.17
Last 12 months	–	–	–	–	–0.639 (0.261)	0.33*
Sex (males reference)	–0.164 (0.158)	0.85	–0.252 (0.132)	0.78		
Race or ethnicity						
White (reference)	–	–	–	–	–	–
Black or African-American	–0.094 (0.210)	0.91	–0.014 (0.214)	0.99	0.119 (0.260)	1.13
Hispanic or Latino	0.082 (0.227)	1.09	0.092 (0.208)	1.10	–0.055 (0.251)	0.95
Other	–0.065 (0.225)	0.94	–0.021 (0.197)	0.98	0.342 (0.380)	1.41
Age 25 and under	0.049 (0.131)	1.05	0.035 (0.123)	1.04	0.311 (0.199)	1.36
Level of education						
Did not graduate high school (reference)	–	–	–	–	–	–
High school graduate	0.106 (0.236)	1.11	0.106 (0.234)	1.11	0.193 (0.212)	1.21
Employment status						
Not employed (reference)	–	–	–	–	–	–
Legal employment	0.234 (0.163)	1.26	0.203 (0.144)	1.23	–0.217 (0.220)	0.81
Illegal income	0.392 (0.233)	1.48	0.461 (0.205)	1.58*	–0.051 (0.333)	0.95
Substance use						
Current alcohol	0.438 (0.110)	1.55***	0.417 (0.097)	1.52***	–0.182 (0.200)	0.83
Current drug (any)	0.410 (0.172)	1.51*	0.404 (0.168)	1.50*	0.302 (0.206)	1.35
Arrest charges						
Felony	0.705 (0.225)	2.02***	0.720 (0.251)	2.05***	0.405 (0.202)	1.50*
Violent offense	0.674 (0.129)	1.96***	0.763 (0.152)	2.14***	–0.005 (0.255)	0.99
Prior arrests (12 months)	0.599 (0.107)	1.85***	0.616 (0.109)	1.85***	0.417 (0.206)	1.52*
Homeless	0.304 (0.201)	1.16	0.147 (0.222)	1.15	0.296 (0.321)	1.35
<i>n</i>	942		942		662	
McFadden's R^2	0.091		0.076		0.078	
Model χ^2	89.018***		95.09***		32.26**	

Notes: ^aModel clustered by arresting agency. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

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Table IV.
Predicting use of force
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times individuals with mental illness interacted with police and the officer resolved the encounter through other means (informally or drop-off at a psychiatric care facility). Second, a comparison of current charge type shows that arrestees with mental health problems were no more likely than other arrestees to be charged with violent (25.0 and 20.9 percent) or felony offenses (52.8 and 47.0 percent). Third, the authors took a closer look at the level of resistance offered by suspects and developed two resistance categories: low (verbal, fleeing, passive) and high (physical aggression and weapon, threatened or used)[8]. Though arrestees with mental health problems were more likely than other arrestees to engage in high-level resistance, the overall rate is still quite low (6.9 v. 1.4 percent), as most arrestees with mental health problems engaged in either low-level resistance (22.2 percent), or no resistance at all (70.8 percent).

Police use of force in arrests of PMIs

The findings regarding mental health problems and use of force were mixed. On the one hand, when use of force was measured generally (no, yes), arrestees with mental health problems were no more likely than other arrestees to experience force. This finding held for both the current arrest and a prior encounter. However, when a more specific, ordinal measure capturing different levels of force was used, arrestee mental health problems emerged as significant, specifically in cases where officers resorted to higher levels of force (when controlling for resistance level and other factors). These findings have a number of implications.

First, the non-significance of arrestee mental illness for use of force generally, and for lower level force, is consistent with the few prior studies that have examined this question (Johnson, 2011; Kaminski *et al.*, 2004; Terrill and Mastrofski, 2002). Moreover, several early police scholars highlighted the importance of empathy and tolerance when interacting with individuals suffering from mental illness, and the findings here are consistent with that line of research (Bittner, 1967a; Muir, 1977). Second, the findings may also reflect police efforts to improve their response during encounters with mentally ill citizens. For example, CIT training has been offered to police in Maricopa County, Arizona since the early 2000s, and thousands of officers have participated in this training. CIT training has been shown to effectively reduce violence (Dupont and Cochran, 2000), and the results from the current study may indicate that those effects are now being realized in Maricopa County.

The significant relationship between mental health problems and higher levels of force, however, is not consistent with this evidence. Drawing again on the work of early police scholars, the seemingly incongruous findings regarding weapon force and mental health problem may be explained by Van Maanen's (1978) police typology of citizens. Van Maanen (1978) noted that when a citizen commits an affront against police, the officer goes through a process to determine the appropriate remedy to that affront, and that process hinges on two important questions: did the person know what he was doing? And could the person have acted differently? Van Maanen (1978) focussed specifically on the group of people for whom the answer to both of these questions is "yes" (he referred to them as "assholes"). But the category of individuals more relevant for the current discussion are those for whom the answer to both of these questions is "no." Citizens who have mental health problems fall into this category. Van Maanen (1978, p. 325) noted that for these individuals, the police consider the affront "to lie beyond the responsibility of the actor [...] the moral indignation felt by police is tempered by the understanding that the person is not aware nor could be easily made aware of the rule-breaking nature of his actions." This framework is consistent with

the first set of use of force findings from the current study – as arrestees with mental health problems who engaged in low-level resistance were no more likely to experience use of force by police.

But the association between arrestee mental illness and higher degrees of force suggests that there may be another level to this dynamic. In Van Maanen's (1978) terms, what if the individual with a mental health problem escalates his or her behavior beyond those low-level affronts? Are there limits to what an officer will write off as "tolerable?" Simply put, there may be a threshold effect for affronts committed by suspects with mental health problems. Officers may be willing to accept certain types of disruptive behaviors and affronts from persons with mental health problems – affronts they will not tolerate from others – but once their tolerance level has been reached, they also will be more likely to escalate their own coercive responses to end the encounter quickly and forcefully. In effect, when dealing with PMIs, police may have greater tolerance for low-level affronts and less tolerance for high-level affronts. This potential relationship should be explored further as it represents a double-edged sword for the police and for PMIs.

Other arrestee attributes

Consistent with prior research, the current study highlights a number of important predictors of police use of force including suspect resistance, violent and felony charges, prior arrest histories, and substance use (Garner *et al.*, 1996; Paoline and Terrill, 2007). Alternatively, prior research has identified a link between a number of extra-legal factors and police use of force. For example, Terrill and Mastrofski (2002, p. 215) found that "male, nonwhite, poor, and younger suspects were all treated more forcefully, irrespective of their behavior." The persistence of elevated rates of use of force by police against minorities, the young and the disenfranchised has been a disturbing trend, suggesting that decisions by police to draw on this most important aspect of their authority continue to be influenced by skin color and social standing. However, the current study found that race/ethnicity, sex, age, educational level, and employment status (legal) were all unrelated to use of force by police. The non-significance of these extra-legal factors may signify positive developments in this critically important area of police field behavior.

The current study suffers from several limitations. First, though the authors argue that arrestee self-report is a valid method for capturing mental health problems, Klinger (2008) has questioned the use of arrestee interviews to capture information on use of force by police, suggesting a tendency to over-report such behavior. Second, this study examines only those incidents that resulted in arrest in Maricopa County, Arizona. The extent to which the findings here can be generalized to non-arrest incidents and to other jurisdictions remains unknown. Third, the mental health items employed here do not reflect a clinical diagnosis, nor do the items necessarily capture the arrestee's mental health status at the time of arrest. Rather, the measures document more formal, generalized indications of mental illness. Last, the authors acknowledge that the explanatory power of the multivariate models reported in Tables III and IV is low, indicating that there is a good deal of unexplained variance.

Nevertheless, the current study offers insights on the dynamics of formal arrest encounters of suspects who are mentally ill. These encounters differ from arrests of non-mentally ill suspects in distinctive ways, including a greater likelihood of suspect resistance and, although rare, greater use of weapon force by police. This last finding may suggest that police respond to the affronts by PMIs differently than affronts

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from other suspects. Given the consequences surrounding poor police responses in encounters with PMIs, as well as the concerns over use of force, future research should continue to explore these questions.

Notes

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1. Prior research has identified three sets of variables that influence police use of force: environmental or community level variables, organizational variables, and situational attributes. For discussion of this literature, see: Fyfe (1988), Terrill and Mastrofski (2002), and White and Klinger (2012).
2. The vast majority of research described here relied on either officer perceptions of impairment (drug, alcohol, mental), or the perceptions of trained research observers.
3. Arrestees who had been in custody longer than 48 hours were ineligible for participation in AARIN because of time limitations associated with urinalysis testing. The urinalysis tested for four different drugs: marijuana, cocaine, opiates, and methamphetamine. The test is calibrated to detect drugs ingested within 72 hours of the interview and to keep false positives to no more than two per 100 (Visser, 1991). As a reliability check, all specimens that test positive with EMIT methods are retested using Gas Chromatography with Mass Spectrum detection.
4. These same criteria have been used in the Survey of Inmates in State and Federal Correctional Facilities, the Survey of Inmates in Local Jails, and the Survey of Adults on Probation, as reported by the Bureau of Justice Statistics special report on mental health (Ditton, 1999).
5. The overall goal of the paper is to examine the dynamics of police encounters with arrestees who suffer from mental health problems. Our broader, past 30-day measure is intended to capture more accurate indicators of mental health problems through a reporting of clinical interventions. The prevalence rates of these clinical interventions during a more immediate timeframe would likely be very low (e.g. questions such as "have you been hospitalized or medicated in the hours before your arrest?").
6. The addendum is similar in design and format to the Bureau of Justice Statistics' Police-Public Contact Survey. As an example, the survey asks: "Did you argue with or disobey the officer for any reason? Curse at, insult or call the officer an offensive name? Say something threatening to the officer? Resist being handcuffed or arrested? Resist being searched, or having your vehicle searched? Try to escape by hiding, running, or engaging in a vehicle chase? Grab, push, hit, or physically fight with the officer? Use a weapon to threaten the officer? Use a weapon to assault the officer?"
7. The authors attempted to create an ordinal measure of suspect resistance for the current arrest, but there was insufficient variation in the variable to create this more nuanced measure. The authors were faced with the same problem when examining resistance and use of force reported in the prior police encounter. As a result, the dichotomous, composite measures are employed for these models.
8. Recall that there was not enough variation in the resistance outcome measure to support an ordinal-level regression.

References

- Abramson, M.F. (1972), "The criminalization of mentally disordered behavior: possible side-effect of a new mental health law", *Hospital and Community Psychiatry*, Vol. 23 No. 4, pp. 13-17.
- Alemagno, S.A., Shaffer-King, E., Tonkin, P. and Hammel, R. (2004), *Characteristics of Arrestees at Risk for Co-existing Substance Abuse and Mental Disorder*, Institute for Health and Social Policy, University of Akron, Akron, OH.
- Bachrach, L.L. (1978), "A conceptual approach to deinstitutionalization", *Hospital and Community Psychiatry*, Vol. 29 No. 9, pp. 573-578.

- Bayley, D.H. and Garofalo, J. (1989), "The management of violence by police patrol officers", *Criminology*, Vol. 27 No. 1, pp. 1-26.
- Berk, R. and MacDonald, J. (2010), "Policing the homeless: an evaluation of efforts to reduce homeless-related crime", *Criminology & Public Policy*, Vol. 9 No. 4, pp. 813-840.
- Berwick, D.M., Murphy, J.M., Goldman, P.A., Ware, J.E., Barsky, A.J. and Weinstein, M.C. (1991), "Performance of a five-item mental health screening test", *Medical Care*, Vol. 29 No. 2, pp. 169-176.
- Bittner, E. (1967a), "The police on skid row: a study of peace keeping", *American Sociological Review*, Vol. 32 No. 5, pp. 699-715.
- Bittner, E. (1967b), "Police discretion in emergency apprehension of mentally ill persons", *Social Problems*, Vol. 14 No. 3, pp. 278-292.
- Bonovitz, J.C. and Bonovitz, J.S. (1981), "Diversion of the mentally ill into the criminal justice system: the police intervention perspective", *American Journal of Psychiatry*, Vol. 138 No. 7, pp. 973-976.
- Borum, R., Williams, M., Deane, M.A., Steadman, H.J. and Morrissey, J. (1998), "Police perspectives on responding to mentally ill people in crisis: perceptions of program effectiveness", *Behavioral Sciences and the Law*, Vol. 16 No. 4, pp. 393-405.
- Bureau of Justice Statistics (2011), *Contacts Between Police and the Public, 2008*, Bureau of Justice Statistics, Washington, DC.
- Cochran, S., Deane, M.W. and Borum, R. (2000), "Improving police response to mentally ill people", *Psychiatric Services*, Vol. 51 No. 10, pp. 1315-1316.
- Council of State Governments (2007), *People With Mental Illness in the Criminal Justice System: About the Problem*, Criminal Justice/Mental Health Consensus Project, New York, NY, <http://consensusproject.org/search?q=fact+sheets> (accessed on July 1, 2011).
- Crawford, C. and Burns, R. (1998), "Predictors of the police use of force: the application of a continuum perspective in Phoenix", *Police Quarterly*, Vol. 1 No. 4, pp. 41-63.
- Deane, M.W., Steadman, H.J., Borum, R., Veysey, B.M. and Morrissey, J.P. (1999), "Emerging partnerships between mental health and law enforcement", *Psychiatric Services*, Vol. 50 No. 1, pp. 99-101.
- Ditton, P.M. (1999), *Mental Health and Treatment of Inmates and Probationers*, US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, Washington, DC.
- Dupont, R. and Cochran, S. (2000), "Police response to mental health emergencies – barriers to change", *Journal of the American Academy of Psychiatry and the Law*, Vol. 28 No. 3, pp. 338-344.
- Engel, R.S. and Silver, E. (2001), "Policing mentally disordered suspects: a reexamination of the criminalization hypothesis", *Criminology*, Vol. 39 No. 2, pp. 225-252.
- Engel, R.S., Sobol, J.J. and Wordon, R.E. (2000), "Further exploration of the demeanor hypothesis: the interaction effects of suspects' characteristics and demeanor on police behavior", *Justice Quarterly*, Vol. 17 No. 2, pp. 235-258.
- Fisher, W.H., Silver, E. and Wolff, N. (2006), "Beyond criminalization: toward a criminologically informed framework for mental health policy and services research", *Administration and Policy in Mental Health and Mental Health Services Research*, Vol. 33 No. 5, pp. 544-557.
- Friedrich, R.J. (1980), "Police use of force: individuals, situations and organizations", *Annals of the American Academy of Political and Social Science*, Vol. 452 No. 1, pp. 82-97.
- Fyfe, J.J. (1988), "Police use of deadly force: research and reform", *Justice Quarterly*, Vol. 5 No. 2, pp. 165-205.
- Garner, J.H. and Maxwell, C.D. (2000), "What are the lessons of the police arrest studies?", *Journal of Aggression, Maltreatment & Trauma*, Vol. 4 No. 1, pp. 83-114.

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37,2

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- Garner, J.H., Maxwell, C.D. and Heraux, C.G. (2002), "Characteristics associated with the prevalence and severity of force used by the police", *Justice Quarterly*, Vol. 19 No. 4, pp. 705-746.
- Garner, J.H., Schade, T., Hepburn, J. and Buchanan, J. (1996), *Measuring the Continuum of Force Used by and Against the Police*, National Institute of Justice, Washington, DC.
- Gilligan, J. (2001), "The last mental hospital", *Psychiatric Quarterly*, Vol. 72 No. 1, pp. 45-61.
- Hickman, M.J., Piquero, A.R. and Garner, J.H. (2008), "A national estimate of police use of nonlethal force", *Criminology and Public Policy*, Vol. 7 No. 4, pp. 563-604.
- Johnson, R.R. (2011), "Suspect mental disorder and police use of force", *Criminal Justice and Behavior*, Vol. 38 No. 2, pp. 127-144.
- Kaminski, R.J., DiGiovanni, C. and Downs, R. (2004), "The use of force between the police and persons with impaired judgment", *Police Quarterly*, Vol. 7 No. 3, pp. 311-338.
- Katz, C.M., Webb, V.J., Gartin, P.R. and Marshall, C.E. (1997), "The validity of self-reported marijuana and cocaine use", *Journal of Criminal Justice*, Vol. 25 No. 1, pp. 31-41.
- Klinger, D.A. (2004), "Environment and organization: reviving a perspective on the police", *The Annals of the American Academy of Political and Social Science*, Vol. 593 No. 1, pp. 119-136.
- Klinger, D.A. (2008), "On the importance of sound measures of forceful police actions", *Criminology & Public Policy*, Vol. 7 No. 4, pp. 605-617.
- Lurigio, A., Smith, A. and Harris, A. (2008), "The challenge of responding to people with mental illness: police officer training and special programmes", *The Police Journal*, Vol. 81 No. 4, pp. 295-322.
- Lurigio, A.J. (2000), "Persons with serious mental illness in the criminal justice system: background, prevalence, and principles of care", *Criminal Justice Policy Review*, Vol. 11 No. 4, pp. 312-328.
- Mechanic, D. and Rochefort, D.A. (1990), "Deinstitutionalization: an appraisal of reform", *Annual Review of Sociology*, Vol. 16 No. 1, pp. 301-327.
- Muir, W.K. (1977), *Police: Streetcorner Politicians*, University of Chicago Press, Chicago, IL.
- Novak, K.J. and Engel, R.S. (2005), "Disentangling the influence of suspects' demeanor and mental disorder on arrest", *Policing: An International Journal of Police Strategies & Management*, Vol. 28 No. 3, pp. 493-512.
- Paoline, E.A. and Terrill, W. (2007), "Police education, experience, and the use of force", *Criminal Justice and Behavior*, Vol. 34 No. 2, pp. 179-196.
- Peterson, J., Skeem, J.L., Hart, E., Vidal, S. and Keith, F. (2010), "Analyzing offense patterns as a function of mental illness to test the criminalization hypothesis", *Psychiatric Services*, Vol. 61 No. 12, pp. 1217-1222.
- Sigurdson, C. (2000), "Mad, the bad and the abandoned: the mentally ill in prisons and jails", *Corrections Today*, Vol. 62 No. 7, pp. 70-78.
- Sosowsky, L. (1978), "Crime and violence among mental patients reconsidered in view of the new legal relationship between the state and the mentally ill", *American Journal of Psychiatry*, Vol. 135 No. 1, pp. 33-42.
- Teplin, L.A. (1983), "The criminalization of the mentally ill: speculation in search of data", *Psychological Bulletin*, Vol. 94 No. 1, pp. 56-67.
- Teplin, L.A. (1984), "Criminalizing mental disorder: the comparative arrest rate of the mentally ill", *American Psychologist*, Vol. 39 No. 7, pp. 794-803.
- Teplin, L.A. and Pruett, N.S. (1992), "Police as streetcorner psychiatrists: managing the mentally ill", *International Journal of Law and Psychiatry*, Vol. 15 No. 2, pp. 139-156.
- Terrill, W. and Mastrofski, S.D. (2002), "Situational and officer-based determinants of police coercion", *Justice Quarterly*, Vol. 19 No. 2, pp. 215-248.

- Torrey, E.F. (1997), *Out of the Shadows: Confronting America's Mental Illness Crisis*, John Wiley and Sons, New York, NY.
- Treatment Advocacy Center (2005), *Law Enforcement and People With Severe Mental Illnesses*, Treatment Advocacy Center, Arlington, VA.
- Van Maanen, J. (1978), "The Asshole", in Manning, P. and Van Maanen, J. (Eds), *Policing: A View From the Street*, Goodyear, Santa Monica, CA, pp. 221-238.
- Visher, C. (1991), *A Comparison of Urinalysis Technologies for Drug Testing in Criminal Justice*, National Institute of Justice, Washington, DC.
- Wells, W. and Schafer, J.A. (2006), "Officer perceptions of police responses to persons with a mental illness", *Policing: An International Journal of Police Strategies & Management*, Vol. 29 No. 4, pp. 578-601.
- White, M.D. (2010), "Jim Longstreet, Mike Marshall, and the lost art of policing skid row", *Criminology & Public Policy*, Vol. 9 No. 4, pp. 883-896.
- White, M.D. and Klinger, D.A. (2012), "Contagious fire? An empirical assessment of the problem of multi-shooter, multi-shot deadly force incidents in police work", *Crime and Delinquency*, Vol. 58 No. 2, pp. 196-221.

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Can't Replace Policing with Social Services That Don't Do What They're Supposed to

By Stephen Eide

June 21, 2020

Black Lives Matter and other activists are calling on cities across the nation to #DefundthePolice. So what would they have us replace law enforcement with? Many are calling for diverting resources from police to social-service systems, including mental-health care.

The problem is that these arguments studiously ignore the dysfunctional state of the systems we have. Indeed, it's because of chronic policy failure in areas such as mental health that the police and other public-safety agencies so often find themselves dealing with problems that shouldn't be their responsibility.

Consider the case of Rashid Brimmage, a 31-year-old homeless New Yorker with a serious mental illness, who has been arrested a whopping 103 times over the last 15 years.

This month, he allegedly shoved to the ground a 92-year-old woman near the corner of Third Avenue and East 16th Street in Manhattan. Surveillance video of the incident shows her striking her head against a fire hydrant and Brimmage proceeding along without even breaking his stride. The alleged assault was random and completely unprovoked.

Would more spending on mental health have kept Brimmage out of jail and his victim from having been put "in a state where [she's] fearful to walk the streets alone," as The Post has reported?

Probably not. We know this, because we tried it, via Mayor Bill de Blasio's high-profile ThriveNYC initiative and other equally expensive and misbegotten programs in the Big Apple.

If states and cities are "laboratories of democracy," New York should be seen as an experiment in whether vast spending on social services fixes social problems. The budgets of Gotham's Department of Health and Mental Hygiene and the New York state Office of Mental Health are the envy of social workers in poorer red states. And yet the results are utterly underwhelming.

Even if they haven't been assaulted by the mentally ill, many Gothamites have shared subway cars with symptomatic street people and grown inured to headline-grabbing atrocities. Before Brimmage, there was Randy Santos, the perp behind the Chinatown stabbing spree last fall.

Before Santos, there was David Aleer-Chol, a mentally ill homeless man busted in 2018 for sending a senior citizen to the hospital after assaulting him near Bryant Park with a bike lock. And then there was Marcus Gomez, a resident of the Creedmoor Psychiatric Center arrested on charges that he repeatedly stabbed his grandmother's home-health aide the same year.

The data back up New Yorkers' impressions of a broken mental-health system. As of last year, about 17 percent of the city's jail inmates have a serious mental illness, as do more than 13,000 of the homeless. Both metrics have been on the rise during the ThriveNYC era.

Launched in 2015, Hizzoner's Thrive initiative has faced withering criticism for its lack of accountability and opacity. Its core flaw, though, is its neglect of cases like Brimmage.

The program dedicates only a token share of its \$222 million annual budget to the seriously mentally ill, instead focusing mainly on problems such as mild depression and anxiety. Even after a recent reboot, Thrive is expected to dedicate about a quarter of its budget to serious mental illness.

Shoveling more money into the mental-health system without addressing its manifold deficiencies amounts to a call for "revenue before reform." Progressives might as well cut the police budget and send taxpayers a rebate.

Helping the hardest cases always takes more than money.

In the case of mental health, the hardest cases are found largely in shelters and jails and on the streets. That's where we should target our resources, using interventions targeted to the seriously mentally ill. People with mild depression and anxiety don't need court-ordered treatment programs, such as Kendra's Law, and inpatient psychiatric hospitalization. But people with schizophrenia sometimes do.

Advocates believe that stripping funds from the police and transferring them to social services takes an enlightened, "upstream" approach to policymaking. But that same prevention-oriented rationale justified ThriveNYC's focus on mild mental illness instead of serious mental illness. Far too often, going upstream to prevent social problems isn't enlightened — but simply an excuse to dodge responsibility for our most pressing social challenges.

#DefundthePolice would have us hamstring a vital public service — only to swell the budgets of failed programs already gorged with taxpayer cash.

This piece originally appeared at the New York Post, available online at <https://nypost.com/2020/06/21/you-cant-replace-law-enforcement-with-social-services/>.

Stephen Eide is a senior fellow at the Manhattan Institute and contributing editor of City Journal.



"The National Voice of the Field of Deflection"

April 28, 2021

The Honorable Cory Booker
Chairman
Subcommittee on Criminal Justice and
Counterterrorism
Committee on the Judiciary
United States Senate
717 Hart Senate Office Building
Washington, DC 20510

The Honorable Tom Cotton
Ranking Member
Subcommittee on Criminal Justice and
Counterterrorism
Committee on the Judiciary
United States Senate
326 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Booker and Ranking Member Cotton:

The subcommittee's hearing of April 22, 2021 on "Behavioral Health and Policing: Interactions and Solutions" included compelling remarks from both of you, several of your colleagues, and testimony from experts from around the country. The Police, Treatment, and Community Collaborative (PTACC) is honored to contribute to the record of that hearing. PTACC is the national voice of the field of deflection, pre-arrest diversion, and co-responder deflection – the range of community-centered partnerships among police, treatment, and community designed to keep individuals with mental health and/or substance use disorder out of the criminal justice system.

PTACC is a rapidly growing movement of more than 45 national organizations from law enforcement, behavioral health (substance-use and mental health), community, advocacy, recovery, research, and policy. Our mission is to widen community behavioral health, housing, and social service options available to people through deflection during encounters with law enforcement and EMS (co-responder deflection). PTACC's work for the last many years "reframes the relationship" between police and community, and as such, creates a public health response to what have traditionally been solely public safety responses to addiction and mental health.

This reframed response is why the topics raised at the April 22 hearing are so critical – and cross partisan lines that divide Americans. Indeed, as you both articulated in the hearing, we as a society must better prepare for and handle the 60.5 million encounters between law enforcement and citizens with mental/behavioral health and/or substance use so we see it through the lens of a person in need of help. PTACC calls this "flipping the script" on police and community interactions. This is critical because in these cases, police find themselves in roles such as social worker and counselor, and others – for which they are neither properly trained nor equipped, which if responded to instead with a treatment partner, would provide a different ending to the story.

An example of "flipping the script" that comes from the work of PTACC and deflection is the thousands and thousands of lives every year that are saved when police carry and deploy naloxone. This intervention in homes, businesses, and on the street mitigates



"The National Voice of the Field of Deflection"

the worst effects of drug use incidents and prevents them from spiraling into death. Still, beyond this, our public health and justice systems have failed to provide at scale an adequate response and sufficient infrastructure to respond to many cases involving those with mental health or substance use disorder crises, including the community-based programs of treatment and services necessary for them to live productive lives. Through the continued expansion of deflection, this script could be flipped too.

Most police know that they are in many cases ill equipped to respond in all the ways these individuals need; but we ask them to do so as our 24/7 first line of response. Police know that those with these conditions need community-based resources and care, ideally without ever having to interact with the police or the justice system. We believe that deflection, and the pathways it creates to community-based treatment, housing, and services, provides for the people and families in jurisdictions everywhere the best route away from the justice system, thereby reducing the size, scope, and scale of the system itself. In addition, because deflection works without arrest, it disrupts the cycle of human and financial costs associated with justice system involvement, advancing true collaboration at the community level. Further, deflection allows police to concentrate on what they are best equipped to do and allows citizens facing the challenges of addiction and mental health to remain in their communities with their families and supportive networks receiving the treatment and services they need to be better.

The members of the growing PTACC movement have been at the forefront of the field of deflection, and continue to grow the entire field, which now counts an estimated 1,000 deflection sites.

Mr. Chairman and Mr. Ranking Member, on behalf of PTACC I thank you for your endorsement of these important issues and offer our support, guidance, and networks as a resource as you move forward with legislative action.

Sincerely,

Jac Charlier
Executive Director
jcharlier@tasc.org

Copies to:
Senator Dick Durbin, Chair, Senate Committee on the Judiciary
Senator Chuck Grassley, Ranking Member, Senate Committee on the Judiciary
Members of the Senate Subcommittee on Criminal Justice and Counterterrorism
Members of the Senate Committee on the Judiciary

SHORT CONTRIBUTION

Open Access

Policing and public health calls for service in Philadelphia

Jerry H. Ratcliffe*



Abstract

This contribution outlines various spatial and temporal aspects of medical or public-health related calls for service from the public to police in Philadelphia in 2019. These incidents comprise about 8% of the police department's workload that originates from the public. Calls appear to be highly concentrated in a few areas, and specifically the Center City and Kensington neighborhoods. They are also more likely to occur late afternoon and evening. The article shows that some medical or public health activity initially masquerades as crime or other policing work and some events eventually determined to be police/crime activity can initially appear to be public health related. About 20% of activity in this area does not appear predictable from the initial call type as handled by police dispatch.

Keywords: Philadelphia, Police, Public health, Medical, Calls for service, CAD

Introduction

Researchers have long recognized that the police role stretches beyond crime enforcement to social order and peacekeeping (Bittner, 1967; Goldstein, 1979). Public health issues are also 'inseparable' from policing (Wood, 2020). Police regularly encounter vulnerable groups, including people struggling with mental illness, domestic and sexual violence, challenges related to sex work and drug addiction, alcohol abuse, and human trafficking (Dijk & Crofts 2017). These conditions can present together in multiple ways that challenge police officers to address the complexity of co-morbidity issues, often within a 'vacuum' of support from other organizations (Wood et al., 2021). Given numerous cities are discussing police involvement in public health-related incidents, this brief contribution describes a year's worth of public health related calls to police in one city, as evidenced through police administrative records.

To examine a typical period, a pre- COVID-19 year was selected. In 2019, Philadelphia, Pennsylvania, was the 6th largest city in the United States with a population of 1.58

million comprising 34.2% White, 40.1% Black, and 15.2% Hispanic. It had a median household income of just under \$46,000, and a quarter of the city lived in poverty.¹ Among over 15,000 violent crimes and 50,000 property offenses, the city recorded 356 homicides (a rate of 22.5 per 100,000 and 4.5 times higher than the national rate).

Medical/public health related incidents

The Philadelphia Police Department's (PPD) computer-aided dispatch (CAD) database contains over 3.3 million entries for 2019, of which just over 1 million (1.07 million) were unique calls for service from the public to which at least one of the city's 6584 sworn officers² was dispatched. Call classification (also called 'slotting' or 'recoding', Gillooly, 2020) involves interpreting the call information and assigning a relevant organizational category, type or code. As Neusteter, Mapolski, Khogali, and O'Toole (2019: 9) note "A handful of codes is likely insufficient to cover all eventualities", and PPD has over 130 CAD codes, ranging from assaults to vandalism. Selecting

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¹ <https://www.census.gov/quickfacts/philadelphiacitypennsylvania>.

² <https://ucr.fbi.gov/crime-in-the-u.s/2019/crime-in-the-u.s.-2019/tables/table-1>.



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Table 1 General CAD event categories with frequencies and equivalent officer shift activity time

Event type	Frequency	Percent	Officer shifts	Percent
Community	108,158	10.2	11,016	7.2
Crime	425,337	39.9	83,458	54.7
Medical/public health	79,211	7.4	13,097	8.6
Proactive	80,804	7.6	7,525	4.9
Quality	251,990	23.7	20,850	13.7
Traffic	119,944	11.3	16,690	10.9
Total	1,065,444	100	152,636	100

Note that percentages do not sum exactly to 100 due to rounding. A shift was estimated at 7.5 h (8 h minus a 30-min refreshment break)

one of these codes reflects the initial 'best guess' classification of an event by the dispatcher and does not necessarily indicate the final disposition after police attend the incident.

Table 1 summarizes the 1.07 million dispatched events. Rather than list over 80 CAD codes,³ they are grouped here into general categories such as calls to help the *community* manage non-crime problems, active *crime* events or reports of recent crime, *medical*-type activities or calls related to public health, *proactive* work generated by the public to suspicious activity, *quality* of life incidents that may run contrary to the usual and tranquil flow of neighborhood life, and *traffic* activity.⁴ What appear (at least initially at the point of dispatch) to be crime and quality of life incidents comprise nearly two-thirds of dispatched calls from the public.

The number of calls is rarely indicative of how long officers spend on each activity. This can be calculated by taking the time spent on each call (from when the call was dispatched to the officer until the officer closes out the event) and multiplying by the number of patrol officers who attended the incident. While at the initial dispatch level what appear to be medical/public health events comprise 7.4% of calls, the nearly 80,000 calls

take up the equivalent of over 13,000 total personnel shifts (7.5 h per shift). This represents 8.6% of all committed time by police to calls from the public (Table 1).

For more detail, in Fig. 1 box size indicates the time spent on each CAD code type in 2019, based on initial classification assigned by the dispatcher and weighted for the number of officers in attendance. The *crime* category dominates (54.7% of time committed, see Table 1), mainly consisting of domestic incidents, people with weapons, and robberies and thefts in progress. In discussions with CAD supervisors and PPD personnel, four CAD codes were associated with a public health nexus (see footnote 4). A category for reports of people in one of the city's rivers (144 such incidents in 2019), a 'sick assist' call for general assistance, a welfare check (*check on well-being*), and a large catch-all category for 'hospital case'. In 2019, Philadelphia did not disaggregate mental health type calls at the CAD entry level (though CAD free-text notes not available to the author might reflect this).

Spatio-temporal patterns

As with criminal activity, and a characteristic not unique to Philadelphia (Kozlarski, in press), health-related policing calls are concentrated in space and time. In Philadelphia, public health calls concentrate in the Center City (A in Fig. 2) and Kensington (B) neighborhoods of the city. Both are focal areas for the homeless populations, with the latter recently referred to as "the largest open-air heroin market on the East Coast of the United States" (Johnson et al., 2020: 3). Health-related policing calls are up to four times more frequent in the afternoon and evening compared to the early hours of the morning (Fig. 3) with on average 15 calls per hour on Friday afternoons and early evening.

From initial call to final disposition

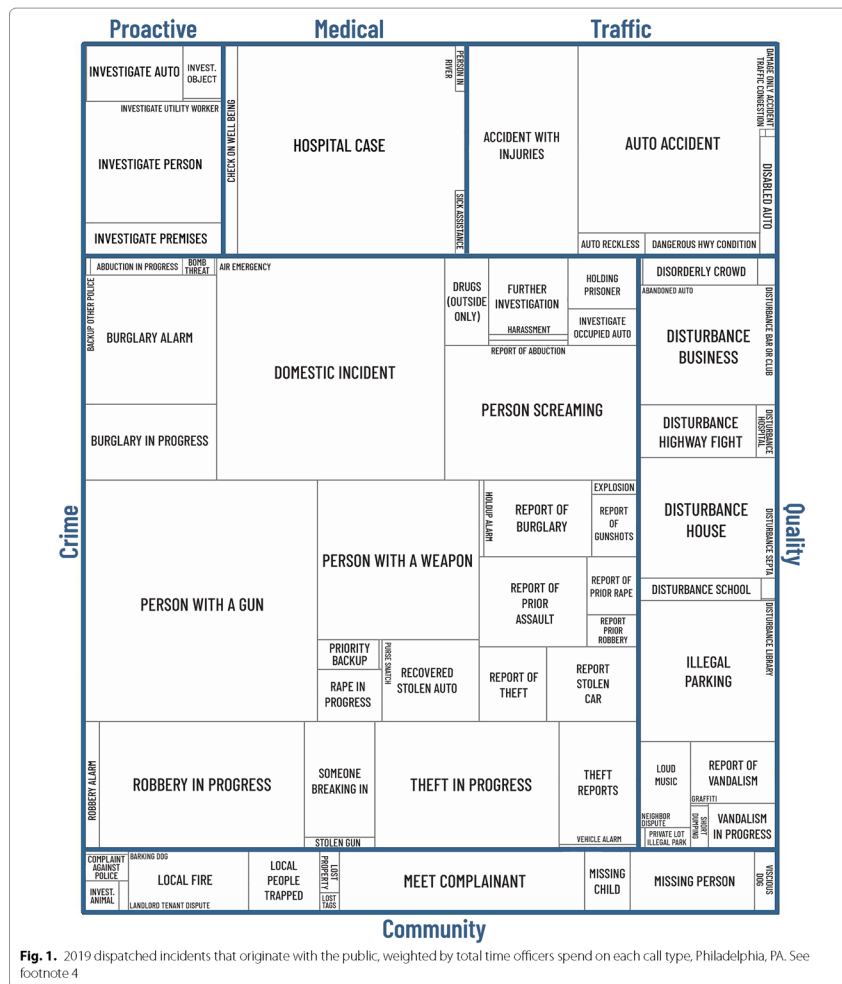
Given the limitations of the dispatch process, once the officer arrives on scene, the event's final disposition may be different than suggested by the initial CAD classification (Simpson, in press). This is evident in Fig. 4. The nearly 80% of health-related calls to police that go on to result in a health-related outcome are shown in grey. Blue lines reflect the 11.6% of calls that originate as a health-related CAD event but result in a crime or other policing outcome, and red lines indicate the 8.8% of events that originate as non-health related, but on investigation by police result in a health-type disposition.

Conclusion

This brief contribution seeks to inform the current discussion around the public health role of the police. In Philadelphia, at least in a relatively normal (i.e.

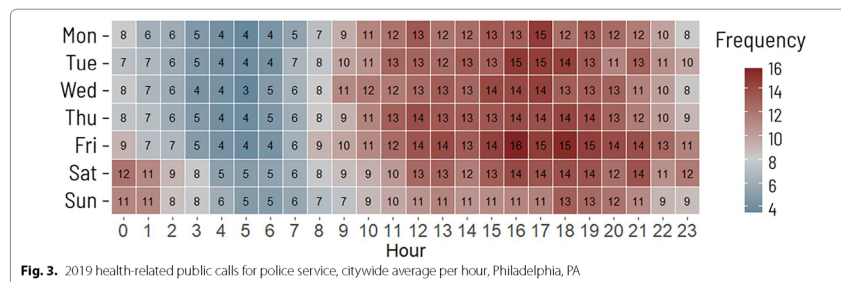
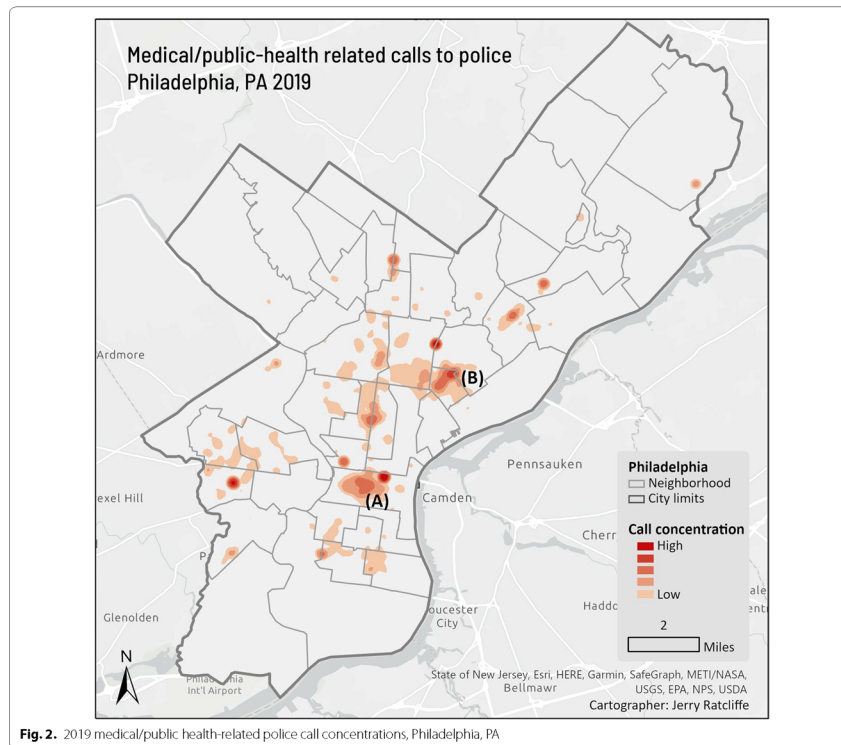
³ While PPD has over 130 CAD codes, many do not originate with the public or require dispatching a police officer. These CAD events are excluded from this analysis.

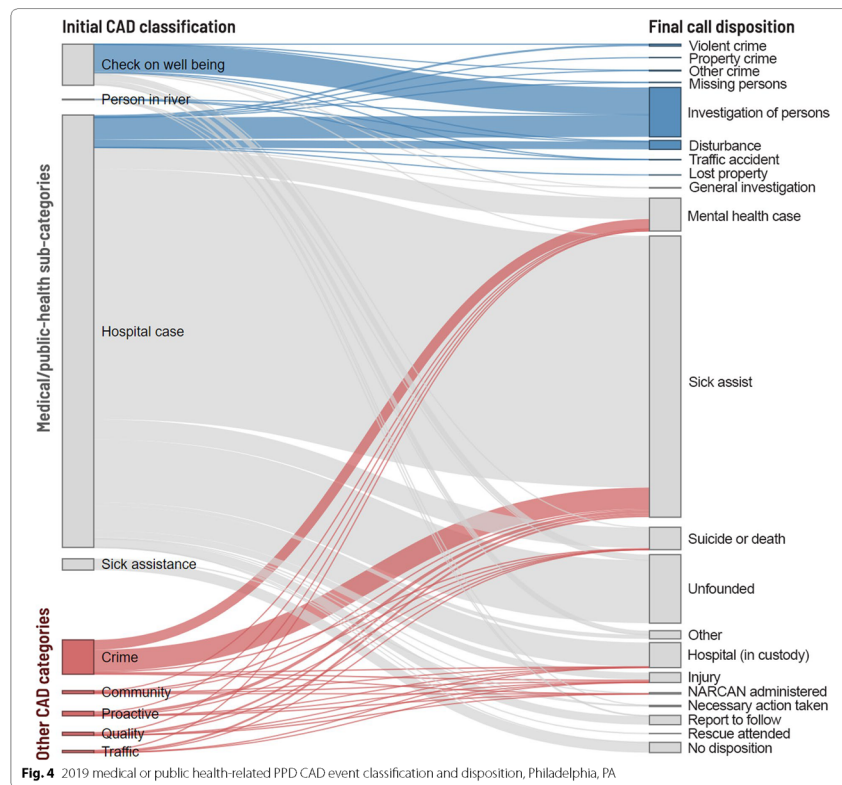
⁴ These general categories are not used by PPD. They only assign and dispatch the 130 or more CAD codes. The overview categories are used here to illustrate broad classifications of event types and are for descriptive summary purposes only. CAD events were classified after consultation and subsequent refinement from a CAD supervisor and staff in PPD offices for research, planning and personnel, though it is acknowledged that CAD events can be classified in different ways. Police-initiated activity (not reflected here) can also result in medical/health outcomes; however, this contribution focuses on calls that originate when the public call police.



non-COVID-19) year, calls to the police that start or result in some form of medical/public health connection comprise about 8% of the police activity that originates

from the public. Many of these incidents reflect policing's social service role, and could be dealt with by other agencies, though the final call disposition is not easily





predicted from the initial CAD classification. Sometimes the only way to determine if a police response is needed is to send a police response.

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References

1. Bittner, E. (1967). The police on skid-row: a study of peace keeping. *American Sociological Review*, 32(5), 699–715.

- Dijk, A. V., & Crofts, N. (2017). Law enforcement and public health as an emerging field. *Policing and Society*, 27(3), 261–275.
- Gillooly, J. W. (2020). How 911 callers and call-takers impact police encounters with the public: The case of the Henry Louis Gates Jr. arrest. *Criminology and Public Policy*, 19(3), 787–804.
- Goldstein, H. (1979). Improving policing: A problem-oriented approach. *Crime and Delinquency*, 25(2), 236–258.
- Johnson, N. J., Roman, C. G., Mendlein, A. K., Harding, C., Francis, M., & Hendrick, L. (2020). Exploring the influence of drug trafficking gangs on overdose deaths in the largest narcotics market in the eastern United States. *Social Sciences*, 9(11), 1–21.
- Kozlarski, J. (in press). Examining the spatial concentration of mental health calls for police service in a small city. *Policing: A Journal of Policy and Practice*.
- Neusteter, S. R., Mapolski, M., Khogali, M., & O'Toole, M. (2019). *The 911 Call Processing System: A Review of the Literature as it Relates to Policing*. New York: Vera Institute of Justice. www.vera.org/publications/911-call-processing-system-review-of-policing-literature.
- Simpson, R. (in press). Calling the police: Dispatchers as important interpreters and manufacturers of calls for service data. *Policing: A Journal of Policy and Practice*.
- Wood, J. D. (2020). Private policing and public health: a neglected relationship. *Journal of Contemporary Criminal Justice*, 36(1), 19–38.
- Wood, J. D., Watson, A. C., & Barber, C. W. J. (2021). What can we expect of police in the face of deficient mental health systems? Qualitative insights from Chicago police officers. *Journal of Psychiatric and Mental Health Nursing*, 28, 28–42.

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Police De-escalation and its Discontents

By Stephen Eide

October 21, 2020

Long before George Floyd's death this past May, police reform debates have centered around de-escalation. The interest has stemmed, mainly, from high profile police shootings of mentally ill individuals. Reformers hope to prevent such incidents by giving cops special training to de-escalate crisis situations.

De-escalation's not universally popular. Defund the police advocates would prefer diverting resources to social services. Academic researchers have cast doubt on whether de-escalation reduces shootings. City budget deficits pose the greatest threat to de-escalation. Getting de-escalation right costs money, and the COVID-19 pandemic has pounded governments' finances. With signs emerging of diminished commitment to de-escalation, now's a good time to rethink the case for it.

The goal of de-escalation programs is best described as reducing the number of fatal police shootings of mentally ill individuals *that could be prevented with de-escalation*. We don't know how many shootings fit that bill. The Washington Post has tracked all fatal police shootings since 2015 and coded them based on "signs of mental illness." It also codes them based on whether the victim was armed and/or attacking the officer. If one defines shootings that de-escalation could have prevented as those in which the victim was mentally ill, unarmed, and not attacking the officer, the count appears to be around 5-10 incidents per year.

De-escalation trained officers have shot to death mentally ill individuals. De-escalation-trained officers have themselves been shot to death by mentally ill individuals. Some departments have seen the number of police shootings of mentally ill individuals increase after adopting de-escalation. On September 13th in Lancaster, Penn., a mentally disturbed man was shot to death after charging at a cop with a knife. We should discuss how to prevent tragedies such as the incident in Lancaster. But de-escalation is the wrong answer to that question.

Now, surely some police shootings of victims who were technically "armed," but containable, could have been prevented. Examples include the June 2014 death of Jason Harrison in Dallas and the October 2016 death of Deborah Danner in the Bronx. One 2018 analysis found that half of all police shootings of mentally ill people happen at home, where the containment potential should be the greatest. "No one wants Rambo answering a mental health call" says Pete

Earley, the author and prominent advocate. But if there's only a small handful of true "Rambo"-style incidents each year, de-escalation's benefit will be hard to quantify. Further complications, from a program evaluation standpoint, include that de-escalation is often brought online amidst other mental health reforms and the extremely decentralized nature of American policing. There are around 18,000 public safety agencies nationwide. De-escalation programs can vary widely in quality, based not only on the nature of the training itself but who gets it. Certain officers are going to be better at de-escalation than others. A de-escalation training program that's given to every cop in a department is not likely to be a very high-quality program. And yet, half of all departments in the nation employ ten or fewer cops; over 80 percent employ fewer than 50. To maximize the availability of de-escalation trained cops, small departments may have no choice but to train everyone.

If we don't know whether de-escalation works, why do it? Progressive critics offer two alternatives to reducing police shootings of mentally ill individuals. Invest more in "upstream" social services or respond to mental illness-related calls for service with emergency personnel who are not armed cops.

An effective mental healthcare system would, in theory, eliminate all mental illness-related police shootings. Mental health reform is the right answer to how to prevent cops from shooting to death mentally ill individuals who are attacking them with knives. But before investing more money, we should ask why the current mental healthcare system's not more effective. The police reform debate is supposed to be about accountability. The 200-250 police shootings of people with mental illness every year, plus the hundreds of thousands mentally ill people in jails and prisons stand as abundant evidence of system failure. Yet who's ever forced to resign their office when a city's jail population sees an increase in the number of schizophrenic inmates? Which nonprofit loses its contract when a psychotic man is shot to death for attacking a cop with a knife? Many mental health service providers have little interest in working the type of person who would attack a cop with a knife. A system that's geared mainly towards reducing incarceration and homelessness among the mentally ill, and would accept the consequences of failure, would merit increased investment at a very large scale. But that is not the mental healthcare system we have.

Now let's consider de-escalation critics' second recommendation, about replacing police as first responders with other emergency personnel. This recommendation is more sensible. Erratic yet innocuous behavior can be sometimes mistaken for dangerous behavior, and with fatal consequences. Perhaps responding to mental health crisis calls with unarmed social services personnel or, simply cops with community knowledge, would reduce the risk of thinking harmless mentally ill people are threats. Governments could direct 911 to dispatchers decide whether to send out cops or social workers, or a mix of both, or set up a separate hotline for mental health crisis calls.

We don't know how effective any of that would be, though. It may well be true that the majority of mental health crisis calls don't need police to arrive as first responders. But it's likely also true that the minority that do are those that hold the greatest potential for fatal outcomes. Earlier this month, a Manhattan, Kansas man was shot dead by police after mental health responders failed to de-escalate a crisis situation after hours of effort. Not all mental health crisis calls are coded as such by the dispatcher. Sometimes, all that's known by the first cops on the scene is there's been a report about a potential firearm or someone armed with a knife. If governments set up alternative dispatch systems, will everyone call the mental health crisis number instead of 911? (In the recent Lancaster Penn. incident, one of the victim's relatives did call a local non-emergency help line while another relative called 911.)

We should not accept mental illness-related shootings as inevitable and should debate solutions. We should also acknowledge that all solutions will have evidentiary problems. Good programs shouldn't be conflated with weak programs. To do de-escalation right, oversight and funding are necessary. State or regional authorities need to exercise some oversight over programs' quality. Many de-escalation proponents emphasize the importance of a community-orientation, which points in the direction of local control. But localism can't get in the way of program integrity. A community should not be allowed to decide on a superficial de-escalation program. Sending a handful of cops to a daylong mental health first aid course shouldn't count as de-escalation. Ideally, the training should consist of a full 40 hour week course for cops with at least a few years of patrol experience. Special teams should be selected for dispatch purposes based on officers' interest and dedication.

The training itself doesn't necessarily need to cost very much. Some highly-regarded de-escalation training programs use mainly volunteer instructors. But a de-escalation program with integrity allows patrol officers to spend two hours resolving a single call if that's how long it takes. In the 2019 documentary *Ernie & Joe: Crisis Cops*, de-escalation officers in San Antonio do check-in visits with people months after assisting them on a 911 crisis call. Communities should reconcile themselves to longer response times to non-mental health crisis calls if that allows for more resources to dedicate to de-escalation. Slashing a police budget to make a political point, even if it does not directly affect de-escalation training proper, could do deep harm, indirectly, by preventing officers from dedicating the time they need to use the training.

De-escalation's about owning the idea that police work is social work. We must reject the idea promulgated by an unholy alliance of progressives and pro-cop traditionalists that police should only focus on "serious" crime. The mental health reform debate *needs* the involvement of people from criminal justice. Because that's who deals with the hardest cases: beat cops in midtown Manhattan, staff at jails and prisons, judges and district attorneys. Instead of taking the attitude of "step aside, cops, real social workers will take it from here," de-escalation engages the police

in the mental health reform debate. Mental health reform should be left to the experts, but cops are the experts. Recognizing that helps to define the challenge and point towards solutions.

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Effectiveness of Police Crisis Intervention Training Programs

Michael S. Rogers, MD, Dale E. McNiel, PhD, and Renée L. Binder, MD

Approximately 1,000 people in the United States were fatally shot by police officers during 2018, and people with mental illness were involved in approximately 25 percent of those fatalities. Crisis Intervention Team (CIT) training is a specialized police curriculum that aims to reduce the risk of serious injury or death during an emergency interaction between persons with mental illness and police officers. CIT has been implemented widely both nationally and internationally. Given the increasing resources devoted to CIT, efforts to analyze its effectiveness and outcomes relative to other approaches are important. Studies of CIT and similar interventions are found within both the mental health and the criminal justice arenas, which use very different terminologies, approaches, and outcome studies, rendering unified analyses challenging. This article describes the CIT model and reviews several recent systematic analyses of studies concerning the effects of CIT. Studies generally support that CIT has beneficial officer-level outcomes, such as officer satisfaction and self-perception of a reduction in use of force. CIT also likely leads to prebooking diversion from jails to psychiatric facilities. There is little evidence in the peer-reviewed literature, however, that shows CIT's benefits on objective measures of arrests, officer injury, citizen injury, or use of force.

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Approximately 1,000 people in the United States were fatally shot by police officers during 2018, and people with mental illness (PMI) were involved in approximately 25 percent of those fatalities.¹ This rate has remained roughly constant between 2015 and 2018.² Police are often the first responders to PMI in acute distress, and sometimes they are the only responders.³ Over the last two decades, a diversion program known as the Crisis Intervention Team (CIT) model for police interactions in crisis situations involving persons in the community with mental, emotional, or developmental challenges has become one of the dominant paradigms in the United States for police-PMI interaction. According to Watson *et al.*,⁴ the original, primary goal of CIT was to reduce officer and citizen injuries. There is controversy in the research literature about the extent to which adoption of CIT has reduced the risk of serious injury or death for persons with mental illness

during an emergency interaction with police officers. This article describes the history of the CIT model and reviews the research literature on the extent to which it is achieving its goals, including reducing injury to officers and citizens.

Methods

Search keywords were collected by polling experts on the topic and reviewing key articles that had relatively high impact factors or that were highlighted by expert consultation. A literature search was conducted using the U.S. National Library of Medicine's MEDLINE database, Google Scholar, the Excerpta Medica dataBASE (EMBASE), The Cochrane Library, the Web of Science, ProQuest Dissertations and Theses, PsycINFO, Sociological Abstracts, OpenGrey, and the New York Academy of Medicine's Gray Literature Report. Search terms included CIT, crisis intervention, police, mental health, LEO, psychiatric, emergency, crisis, mobile, and logical combinations. Inclusion criteria included papers relating to police interventions for PMI and reports of objective measures or surveys. Priority was given to those papers reporting or analyzing experimental or quasi-experimental design with either intervention and control, matched-cohort or case-control stud-

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ies, or those with pretest and posttest data collection. Priority was given to papers published since 1989 (i.e., the deployment of the first CIT) and those written in English. Non-peer-reviewed material, such as theses, were generally excluded from substantive results. After de-duplication, the search identified 198 core CIT-related articles. Of these, two recent systematic analyses were identified as significant.^{5,6}

Origins

CIT began in response to an incident that occurred in Memphis, TN. Police encountered 27-year-old Joseph Dewayne Robinson in the street outside his mother's house as they responded to a 911 emergency dispatch called in by Mr. Robinson's mother on September 24, 1987.^{7,8} Mr. Robinson's mother had called police dispatch to report that her son, who had a reported history of mental illness and substance abuse, had been using cocaine and was cutting himself and threatening people. According to the police officers, Mr. Robinson did not respond to verbal requests and "lunged" at the officers, who shot him multiple times.

In response to this incident, community organizers, civil administrators, the Universities of Memphis and Tennessee, and the Memphis Police Department came together to organize the Memphis Police Department's Crisis Intervention Team. Its recommendations became the Memphis model of CIT, with a goal to reduce lethality during police encounters with people with mental/substance abuse disorders (i.e., PMI) and to divert such people, when appropriate, away from the criminal justice system and into the civil treatment system. Press reports in 1999 noted that in Memphis during the years prior to 1987, on average seven people with a history of mental illness had been fatally shot per annum by police officers, whereas by 1999 there had been only two such police-involved deaths of people with mental illness.⁸

The local Memphis city's chapter of the National Alliance on Mental Illness (NAMI) facilitated police-community discussions, education, and outreach in 1988. Today the national NAMI organization advocates for CIT programs and provides education and volunteer resources to establish and operate such programs throughout the United States. From a small beginning, the CIT approach has spread nationally and internationally.⁹ The

Memphis model of CIT formulated in 1988 and incrementally updated provides a template for CIT deployment.

The CIT Model

Codifying specific police responses to PMI is an example of problem-oriented policing,¹⁰ which is an approach to reducing the probability of the use of force through research, interventions, and outcome analysis. Following Hails and Borum¹¹ (after work by Deane *et al.*¹²), police responses to emergencies involving PMI nationally and internationally generally fall within a tripartite typology:

Police-based specialized police response: Sworn officers obtain special training to interact with PMI. The officers function as first responders to emergency dispatch calls in the community and coordinate with local community mental health resources. CIT falls within this category.

Police-based specialized mental health response: Non-sworn police department employees with mental health training provide on-site or remote consultation and advice to sworn officers in the field. This often involves a centralized resource center and was formerly a prevalent model.¹³

Mental-health-based specialized mental health response: Police departments coordinate with independent mental health systems and workers to cooperate on emergency response in the field, with mental health workers as primary agents. Mobile crisis units fall within this category, as do neighborhood-based care coordination and street triage.¹⁴

The Memphis model CIT program as enumerated within the CIT Core Elements specifies several components.¹⁵ The first component is training for self-selected police officers comprising 40 hours of instruction from community mental health workers, PMI and their families and advocates, and police officers familiar with CIT. The University of Memphis provides a sample curriculum suitable for a recommended 40 hours of training. Many local implementations exist, sponsored or funded by state agencies or through federal agencies such as the Substance Abuse and Mental Health Services Administration.

The second component involves training and special coding for dispatch operators to enable them to

recognize community reports with a high probability of PMI involvement and to route CIT officers there preferentially. This is significant because research indicates that the characteristics of the call for service initiating the contact is a strong determinant of the probability of future use of force.¹⁶

The third component, a centralized drop-off mental health facility with an automatic acceptance policy to minimize police officer transfer time, was identified in 2000 by Steadman *et al.*¹⁷ as an important element of a successful CIT deployment. Larger metropolitan areas have deployed multiple facilities within geographically dispersed areas. Rural settings present specific challenges.¹⁸

The goals of CIT are variably defined between different stakeholders. On its website, the University of Memphis describes CIT as a prearrest jail diversion for those in a mental illness crisis. It adds that the goal of CIT is to provide a system of services that is friendly to individuals with mental illness, their family members, and the police officers.¹⁹ On its website, the Memphis Police Department describes CIT as a community partnership working with mental health consumers and family members.²⁰ It adds that the goals of CIT include setting a standard of excellence for its officers regarding treatment of PMI and joining both the police and the community together for the common goals of safety, understanding, and service to people with mental illness and their families.²⁰ NAMI describes CIT as a model for community policing that brings together law enforcement, mental health providers, hospital emergency departments, and individuals with mental illness and their families.²¹ It adds that the goal of CIT is to improve responses to people in crisis.

The University of Memphis states that outcomes for CIT programs include being able to effectively divert persons in mental health crisis away from jail and into appropriate mental health settings and to be a potent agent for overcoming the negative stereotypes and stigma associated with mental illness.²² On its website, the Memphis Police Department states an outcome for CIT is that CIT-trained officers can offer a more humane and calm approach.²⁰ On its website, NAMI states concrete claims for CIT, stating that it improves officer safety, keeps law enforcement officers' focus on crime, and reduces community spending.²¹

CIT's Success

During the Obama Administration, the U.S. Department of Justice's Community-Oriented Policing Services (COPS) published information on local policing practices and numbers. According to the President's Task Force on 21st-Century Policing,²³ at the end of 2015 there were 17,985 police agencies within the United States. The Bureau of Justice said in 2013 that there were 15,388 police agencies.²⁴ Various federal or interstate initiatives, such as the U.S. Department of Justice's Police-Mental Health Collaboration²⁵ or the Justice Center's Law Enforcement/Mental Health liaison services,²⁶ attempt to provide centralized resources for training and referral.

The fragmented and overlapping U.S. law enforcement system presents challenges in terms of oversight and monitoring, and this extends to gathering statistics. Although the police power rests with the individual states and there are some state-wide police forces, most U.S. police officers work within small, local departments with limited resources.²⁷ Half of all agencies have fewer than ten officers, and nearly 75 percent have fewer than 25 officers. Testimony recorded in the President's Task Force Report on 21st-Century Policing describes significant difficulties providing training and equipment for such small departments, as well as challenges with local municipal boundaries and traditions that prevent many agencies from combining forces with neighbors. Small departments can have significant difficulties deploying or consistently operating a CIT model that closely follows the core elements of the Memphis approach.

According to Deane *et al.*,¹² in the 1990s, only 45 percent of 174 responding police departments reported any specialized response to PMI, and of those, a distinct minority ($n = 6$, or 3%) reported using the CIT model. Since then, CIT uptake has been rapid. In a 2008 comprehensive qualitative analysis of CIT, Compton *et al.*²⁸ noted that there were approximately 400 CIT programs operating across the United States. In 2019, the University of Memphis CIT Center reports 2,700 CIT programs within the United States.²² This national figure of 2,700 CIT programs, while representing only around 15 to 17 percent of the total number of police agencies, probably underestimates the absolute number of people interacting with CIT-trained officers because of CIT's relative ease of adoption within larger, ur-

ban agencies (compared with smaller, rural, or more dispersed agencies). The form of CIT deployment is also variable, and some may conform more or less closely to the elements of the Memphis model.

CIT's spread is not limited only to the United States. Two of the founders of the Memphis model CIT in 1988 (i.e., Major Sam Cochrane (Retired) of the Memphis Police Department and Dr. Randolph DuPont of the University of Memphis) are on the Board of Directors of CIT International, an advocacy and training group. CIT International and the University of Memphis CIT posts "Crisis Intervention Team Core Elements"¹⁵ on their websites. This document provides a template for establishing and operating a CIT in the Memphis model. Despite very different policing regimes globally, international uptake within common-law countries has progressed. CIT programs are now found in Canada, the United Kingdom, and Australia.

CIT's Effects and Reception

Given the broad uptake of CIT deployment nationally and internationally, the evaluation of CIT's effects and benefits is important. As many researchers have noted, this is a difficult question to answer, but it important in terms of resource allocation and social justice. Most of the studies on CIT involve analysis of the planning,²⁹ deployment, and procedural functioning of the CIT process itself, including the selection,³⁰ training,³¹ operations,³² and measurement³³ or self-report³⁴ of CIT-trained officers.

Concerns have been raised previously about evidence-based outcomes measurements for the CIT approach. The 2008 review by Compton *et al.*²⁸ limited itself to a narrative synthesis because of a paucity of eligible studies as well as heterogeneity of methodology and data. This review produced a critical response by Geller,³⁵ likening being in favor of educating officers of police departments about mental illness and mental health services with being in favor of motherhood and apple pie. The concern over an uncritical CIT adoption universally is multifactorial. There is concern about the lack of evidence of efficacy for specific goals and concern over the opportunity cost of pursuing this model to the exclusion of others. In addition, there have been concerns regarding the possibility that a jail diversion program such as CIT may shift cost burdens from police budgets (generally relatively politically favored) to community mental health budgets (potentially less relatively

politically favored). This relative favoring of one budgetary initiative over others may explain some of the growth of CIT in preference to other alternatives, such as specialized mental health-based response or street triage.

Several recent reviews and a meta-analysis have attempted to summarize the results of research on the effects of CIT with certain specific, quantifiable goals. Whereas published studies of CIT within small, relatively homogeneous regions that adhere closely to the Memphis model's parameters are often positive, larger-scale multi-site analyses are mixed. The core element of CIT involves 40 hours of training, usually for officers who are voluntary and self-selected.³⁶ Other agencies have adopted a universal training approach where training is recommended or even mandatory for all officers. Sometimes cash bonus payments are offered as incentives for officers to participate and maintain certification as being CIT-specialized. Other elements may not be available or configured differently, such as CIT-oriented dispatchers (and coding) and integrated community resources, such as a no-refusal, rapid drop-off behavioral health center. Fidelity to some or all of these core elements may be fundamental to enabling quantifiable and replicable CIT outcomes between different deployments.³⁷

Outcomes

Much research has shown an improvement in attitudes and a reduction of stigma in police officers who received mental health training.^{38,39} There is good evidence for benefit in officer-level outcomes, such as officer satisfaction and self-perception of a reduction in the use of force.⁴⁰⁻⁴² A survey of police officers indicated that CIT-trained officers perceived themselves as less likely to escalate to the use of force in a hypothetical mental health crisis encounter.⁴³

There is also evidence for CIT's effect on prebooking jail diversion. One study, which involved 180 officers (roughly 50% CIT-trained) from multiple departments and reported on 1,063 incidents, demonstrated a CIT effect of increased verbal negotiation as the highest level of force used, with referral to mental health units more likely and arrest less likely.⁴⁴ The same study noted, however, that there was no measurable difference in the use of force between officers with CIT training and those without it. Other studies have also found a lack of evidence for a reduction in injuries associated with CIT in-

involvement.⁴⁵ One reasonable hypothesis is that environmental effects may overwhelm the detection of possible favorable effects of CIT in terms of reducing the lethality of encounters between police officers and PMI.

It has been challenging for researchers to operationalize and then evaluate the relative efficacy of different models of CIT compared to similar specialized interventions. A recent systematic literature review by Kane *et al.*⁶ considered several interventions: CIT; an approach called "liaison and diversion," which has a primary goal of diversion where specialist mental health-trained staff are located at police custody sites or courts; and an approach called "street triage," which has a primary goal of timely access to mental health services involving mobile crisis units and specialized mental health-trained staff deployed locally according to individualized protocols. Kane *et al.*⁶ found no clear evidence from the studies reviewed of superiority for one approach over the others in terms of benefit for various criminal justice outcomes, such as the number of arrests or days spent in detention, or for primary health outcomes, such as identification of mental illness at an earlier stage.⁴⁶ Each of the structured programs produced some beneficial effects compared with control groups within the relevant studies. The reported effects were variable between programs, however, and the significant outcome heterogeneity made quantitative comparisons challenging. CIT was assessed to be the best program in terms of reducing re-offending and improving mental health outcomes. This was postulated to be related to the fact that CIT was the only intervention that offered an integrated service combining the initial call and response triage with specialized trained police officers and mental health professional intervention.

The difficulty of establishing clear evidence for CIT's efficacy in reducing officer and citizen injuries is illustrated by a 2016 systematic review and meta-analysis of research on CIT at multiple sites by Taheri.⁵ The difficulties in terms of heterogeneity and lack of intention-to-treat analyses encountered by the earlier study by Compton *et al.*²⁸ persisted. It remains challenging to identify agreement between studies about exactly what constitutes a mental health crisis call. Individual programs demonstrate differences in terminology and thresholds to identify an encounter as a mental health crisis.

The lack of high-quality CIT outcome studies suitable for data analysis was illustrated by Taheri's challenge in identifying suitable candidates.⁵ Out of 820 records for potential incorporation in the analysis, only eight met criteria suitable for evaluating quantifiable outcomes for arrests, police officer injury, or use of force. The meta-analysis goal of measuring officer injury outcomes could not be achieved due to the absence of a standardized measurement across the studies satisfying inclusion criteria. None of the analyzed studies showed a positive benefit of CIT on use-of-force outcomes. Analysis of pooled studies found that CIT officers were significantly less likely to arrest PMI compared with a control group of non-CIT officers. This result was based on self-reporting by study participants, however, whereas analysis of the official arrest statistics did not show a consistent effect of CIT for either an increase or decrease in the arrest frequency for PMI.

Discussion

Despite a lack of evidence for effectiveness in terms of its original goal of reducing lethality during police encounters with people with mental health and substance use disorders, CIT has been shown to have some measurable positive effects, mainly in the area of officer-level outcomes. These include increased officer satisfaction and self-perception of a reduction in the use of force. CIT programs have also been promoted to increase diversion to psychiatric services rather than jails and to decrease costs. Studies of specific CIT programs have found some positive but mixed outcomes or trends toward statistical significance in terms of increased diversion to psychiatric services overall.⁴⁷ This may lead to cost reductions. For example, one study of the cost effects of CIT in a city with around 600,000 inhabitants found modest cost reductions mainly through a reduction of hospitalization days and inpatient referrals from jail. This was despite a significant outlay for emergency psychiatric evaluations.^{48,49}

CIT may influence the prevalence and frequency of early-stage, outpatient psychiatric referrals. Such emergency services triage may result in an overall reduction in psychiatric health care costs due to a reduction in significantly more expensive inpatient or hospital services. This may represent an analog of preventive health care, where money spent earlier can produce greater benefit than money spent later in a disease process. The variability, effectiveness, and

vertical coordination of the psychiatric services available to PMI referred after CIT intervention is difficult to quantify. There are bound to be significant location- and insurance-specific factors that affect whether such individuals respond to treatment or resume behaviors likely to result in repeat CIT interactions. These unknown variables may also account for the difficulty in demonstrating many consistent, measurable health outcomes of CIT.

Another factor to consider is that, with the thousands of CIT programs deployed, there may be a publication bias leading to a reduction in the likelihood of publication or dissemination of studies identifying a null effect or adverse cost increases or shifts associated with a specific CIT program.

Another important goal of CIT programs is to improve officer and citizen safety. This outcome is harder to demonstrate. After 20 years of CIT training programs and the recent increase in dissemination, large-scale studies of the quantifiable benefits of CIT as applied to the reduction of lethality and effect on overall arrest rates remain limited.⁵⁰ Some studies have demonstrated little significant difference between CIT-trained officers and untrained officers in terms of the characteristics of PMI diverted to psychiatric emergency services.⁵¹ Studies have not shown consistent reduction in the risk of mortality or death during emergency police interactions.

These studies, however, are limited by variability in how CIT is implemented across the heterogeneous U.S. police systems and the reality that state and federal databases tend to undercount officer-involved shooting fatalities by wide margins of 30 to 50 percent.^{52,53} This data imprecision could limit sensitivity for detecting improvement associated with CIT. Police use of deadly force itself is relatively rare,⁵⁴ and this low base rate, coupled with relatively underpowered studies, creates an elevated risk of Type II error (i.e., false negative error).

There also may be larger trends at work in U.S. society whose effects obscure or counteract those of CIT, including: the effects of race⁵⁵ on officer-involved shootings, where African Americans are nearly three times more likely to be killed by police than white Americans;⁵⁶ officer characteristics;⁵⁷ increased militarization of policing;⁵⁸ and gun ownership patterns.⁵⁹ One study concluded that there were two significant neighborhood characteristics important in officers' decisions to use force. One factor was the actual threat level in a neighborhood, as mea-

sured by the number of active resistance incidents by residents. The other factor was the officers' perceived level of threat, as measured by the percentage of non-white residents.⁶⁰ The high comorbidity of substance use in PMI⁶¹ means that many people involved in emergency police interactions may be intoxicated.⁶² Intoxication is an additional risk factor for violence and a strong predictor of force use during police interactions.^{63,64} This is probably due to increases in aggressiveness and perceived threat of violence.^{65,66} Police officers perform dangerous jobs within a society distinguished by relatively high homicide rates, high levels of gun ownership, and concomitant gun homicide.⁶⁷⁻⁶⁹ The individual characteristics of the encounter are often cited by officers as the primary element informing the decision to use force.^{70,71} This decision to use deadly or injurious force during an encounter may be largely a function of the incidence of high-risk encounters and may remain relatively insensitive to preencounter training such as CIT.⁷²

Another concern about the use of CIT programs relates to cost effectiveness and opportunity costs, i.e., not spending money on alternatives. These alternatives could include increased use of mental health-based specialized response or street triage,⁷³ increased funding for comprehensive or assertive community outreach programs, or an increase in the number of beds at inpatient acute or long-term residential facilities. Alternatives could also include increased focus and intervention on the social determinants of mental health or additional resources devoted to preventive mental health.^{74,75} In their recent systematic literature review, Kane *et al.*⁶ concluded that, in general, diversion programs resulted in lower criminal justice costs and greater health-funded intervention costs. Even if CIT may reduce overall costs to the criminal justice system, this needs to be measured against potential costs shifted to the community mental health systems associated with successful diversion to treatment.⁷⁶ Further research is warranted to measure the quantifiable outcomes of CIT, and to consider the opportunity costs versus the benefits of continuing to expand CIT programs.

References

1. Saleh AZ, Appelbaum PS, Liu X, *et al*: Deaths of people with mental illness during interactions with law enforcement. *Int J L & Psychiatry* 58:110–16, 2018

2. Fatal Force: 2018 police shootings database. Washington Post. Available at: <https://www.washingtonpost.com/graphics/2018/national/police-shootings-2018>. Accessed February 6, 2019
3. Lamb HR, Weinberger LE, DeCuir WJ: The police and mental health. *Psychiatr Serv* 53:1266–71, 2002
4. Watson AC, Morabito MS, Draine J, *et al*: Improving police response to persons with mental illness: a multi-level conceptualization of CIT. *Int J L & Psychiatry* 31:359–68, 2008
5. Taheri SA: Do crisis intervention teams reduce arrests and improve officer safety? A systematic review and meta-analysis. *Crim Just Pol'y Rev* 27:76–96, 2016
6. Kane E, Evans E, Shokraneh F: Effectiveness of current policing-related mental health interventions: a systematic review. *Crim Behav Ment Health* 28:108–19, 2018
7. Watson AC, Fulambarker AJ: The crisis intervention team model of police response to mental health crises: a primer for mental health practitioners. *Best Pract Ment Health* 8:71, 2012
8. Sweeney K: Sheriff Says Existing Policy Is Functional, Appropriate. The Florida Times Union. Available at: <https://www.questia.com/newspaper/1G1-57527308/no-crisis-here-untrained-memphis-police-used-to-kill>. January 10, 1999. Accessed December 29, 2017
9. Kane E, Evans E, Shokraneh F: Effectiveness of current policing-related mental health interventions in England and Wales and Crisis Intervention Teams as a future potential model: a systematic review. *Syst Rev* 6:85, 2017
10. Prenzler T, Porter L, Alpert GP: Reducing police use of force: case studies and prospects. *Aggress Violent Behav* 18:343–56, 2013
11. Hails J, Borum R: Police training and specialized approaches to respond to people with mental illnesses. *Crime & Delinq* 49:52–61, 2003
12. Deane MW, Steadman HJ, Borum R, *et al*: Emerging partnerships between mental health and law enforcement. *Psychiatr Serv* 50:99–101, 1999
13. Pogrebin MR: Police responses for mental health assistance. *Psychiatr Q* 58:66–73, 1986
14. Reveruzzi B, Pilling S: UCL: Street Triage Final Report (March 2016). Mental Health Crisis Care Concordat. Available at: <http://www.crisiscareconcordat.org.uk/inspiration/ucl-street-triage-final-report-march-2016>. Accessed February 7, 2018
15. Dupont R, Cochran S, Pillsbury S: CIT International - Memphis Model Core Elements. Available at: <http://www.citinternational.org/memphis-model-core-elements>. Accessed February 10, 2019
16. MacDonald JM, Manz PW, Alpert GP, *et al*: Police use of force: examining the relationship between calls for service and the balance of police force and suspect resistance. *J Crim Just* 31:119–27, 2003
17. Steadman HJ, Deane MW, Borum R, Morrissey JP: Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatr Serv* 51:645–49, 2000
18. Compton MT, Broussard B, Hankerson-Dyson D, *et al*: System- and policy-level challenges to full implementation of the crisis intervention team (CIT) model. *J Police Crisis Negot Int J* 10: 72–85, 2010
19. The University of Memphis: About CIT. Available at: <http://www.cit.memphis.edu/aboutcit.php>. Accessed February 10, 2019
20. The City of Memphis: Crisis Intervention Team. Available at: https://memphistn.gov/government/police_department/crisis_intervention_team. Accessed February 10, 2019
21. National Alliance on Mental Illness: What is CIT? Available at: <https://www.nami.org/law-enforcement-and-mental-health/what-is-cit>. Accessed February 1, 2019
22. The University of Memphis: Overview of CIT. CIT Center. Available at: <http://www.cit.memphis.edu/overview.php>. Accessed February 12, 2019
23. President's Task Force on 21st Century Policing: Final Report of the President's Task Force on 21st Century Policing. Washington, DC: Office of Community Oriented Policing Services, 2015. Available at: https://cops.usdoj.gov/pdf/taskforce/taskforce_finalreport.pdf. Accessed September 25, 2016
24. Reaves B: Bureau of Justice statistics - local police departments, 2013: personnel, policies, and practices. Available at: <https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5279>. Accessed February 14, 2019
25. Bureau of Justice Assistance: Police mental health collaboration. Available at: <https://pmhctoolkit.bja.gov/learning>. Accessed February 15, 2019
26. Council of State Governments, Justice Center: Law enforcement/mental health learning sites FAQ. 2018. Available at: <https://csgjusticecenter.org/law-enforcement/le-mh-learning-sites-faq>. Accessed February 15, 2019
27. Brandt S: Police in America. Thousand Oaks, California: Sage Publishing, 2017
28. Compton MT, Bahora M, Watson AC, *et al*: A comprehensive review of extant research on crisis intervention team (CIT) programs. *J Am Acad Psychiatry Law* 36:47–55, 2008
29. Thomas S, Watson A: A focus for mental health training for police. *J Criminology Res Pol'y & Prac* 3:93–104, 2017
30. Compton MT, Broussard B, Hankerson-Dyson D, *et al*: Do empathy and psychological mindedness affect police officers' decision to enter crisis intervention team training. *Psychiatr Serv* 62: 632–38, 2011
31. Cuddeback GS, Kurtz RA, Wilson AB, *et al*: Segmented versus traditional crisis intervention team training. *J Am Acad Psychiatry Law* 44:338–43, 2016
32. Helfgott JB, Hickman MJ, Labossiere AP: A descriptive evaluation of the Seattle Police Department's crisis response team officer/mental health professional partnership pilot program. *Int J L & Psychiatry* 44:109–22, 2016
33. Broussard B, Krishan S, Hankerson-Dyson D, *et al*: Development and initial reliability and validity of four self-report measures used in research on interactions between police officers and individuals with mental illnesses. *Psychiatry Res* 189:458–62, 2011
34. Canada KE, Angell B, Watson AC: Intervening at the entry point: differences in how CIT-trained and non-CIT trained officers describe responding to mental health-related calls. *Community Ment Health J* 48:746–55, 2012
35. Geller JL: Commentary: Is CIT today's lobotomy? *J Am Acad Psychiatry Law* 36:56–58, 2008
36. T. Compton M, Bakeman R, Broussard B, *et al*: Police officers' volunteering for (rather than being assigned to) crisis intervention team (CIT) training: evidence for a beneficial self-selection effect. *Behav Sci & L* 35:470–79, 2017
37. Steadman HJ, Morrisette D: Police responses to persons with mental illness: going beyond CIT training. *Psychiatr Serv* 67: 1054–56, 2016
38. Godschalx SM: Effect of a mental health educational program upon police officers. *Res Nurs Health* 7:111–17, 1984
39. Compton MT, Esterberg ML, McGee R, *et al*: Brief reports: crisis intervention team training: changes in knowledge, attitudes, and stigma related to schizophrenia. *Psychiatr Serv* 57:1199–202, 2006
40. Ellis HA: Effects of a crisis intervention team (CIT) training program upon police officers before and after crisis intervention team training. *Arch Psychiatr Nurs* 28:10–16, 2014

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41. Bonfine N, Ritter C, Munetz MR: Police officer perceptions of the impact of crisis intervention team (CIT) programs. *Int J L & Psychiatry* 37:341–50, 2014
42. Morabito MS, Kerr AN, Watson A, *et al*: Crisis intervention teams and people with mental illness: exploring the factors that influence the use of force. *Crime & Delinq* 58:57–77, 2012
43. Compton MT, Demir Neubert BN, Broussard B, *et al*: Use of force preferences and perceived effectiveness of actions among crisis intervention team (CIT) police officers and non-CIT officers in an escalating psychiatric crisis involving a subject with schizophrenia. *Schizophr Bull* 37:737–45, 2011
44. Compton MT, Bakeman R, Broussard B, *et al*: The police-based crisis intervention team (CIT) model: II. Effects on level of force and resolution, referral, and arrest. *Psychiatr Serv* 65:523–29, 2014
45. Kerr AN, Morabito M, Watson AC: Police encounters, mental illness and injury: an exploratory investigation. *J Police Crisis Negot Int J* 10:116–32, 2010
46. Earl F, Cockledge K, Rheeder B, *et al*: Neighbourhood outreach: a novel approach to liaison and diversion. *J Forensic Psychiatry Psychol* 26:573–85, 2015
47. Watson AC, Ottati VC, Morabito M, *et al*: Outcomes of police contacts with persons with mental illness: the impact of CIT. *Adm Policy Ment Health Ment Health Serv Res* 37:302–17, 2010
48. El-Mallakh PL, Kiran K, El-Mallakh RS: Costs and savings associated with implementation of a police crisis intervention team. *South Med J* 107:391–95, 2014
49. El-Mallakh RS, Spratt D, Butler C, *et al*: Evaluation of consequences of implementation of police crisis intervention team in Louisville. *J Ky Med Assoc* 106:435–37, 2008
50. Cross AB, Mulvey EP, Schubert CA, *et al*: An agenda for advancing research on crisis intervention teams for mental health emergencies. *Psychiatr Serv* 65:530–36, 2014
51. Broussard B, McGriff JA, Demir Neubert BN, *et al*: Characteristics of patients referred to psychiatric emergency services by crisis intervention team police officers. *Community Ment Health J* 46: 579–84, 2010
52. Krieger N, Chen JT, Waterman PD, *et al*: Police killings and police deaths are public health data and can be counted. *PLoS Med* 12:e1001915, 2015
53. Williams HE, Bowman SW, Jung JT: The limitations of government databases for analyzing fatal officer-involved shootings in the United States. *Crim Just Pol'y Rev* 30:201–22, 2016
54. Klahm CF IV, Frank J, Liederbach J: Understanding police use of force: rethinking the link between conceptualization and measurement. *Police Int J* 37:558–78, 2014
55. Kochel TR, Wilson DB, Mastrofski SD: Effect of suspect race on officers' arrest decisions. *Criminology* 49:473–512, 2011
56. Bor J, Venkataramani AS, Williams DR, *et al*: Police killings and their spillover effects on the mental health of black Americans: a population-based, quasi-experimental study. *Lancet* 392:302–10, 2018
57. Lersch KM, Mieczkowski T: Violent police behavior: past, present, and future research directions. *Aggress Violent Behav* 10: 552–68, 2005
58. Bove V, Gavrilova E: Police officer on the frontline or a soldier? The effect of police militarization on crime. *Am Econ J Econ Policy* 9:1–18, 2017
59. Wintemute GJ: The epidemiology of firearm violence in the twenty-first century United States. *Annu Rev Public Health* 36: 5–19, 2015
60. Lersch KM, Bazley T, Mieczkowski T, *et al*: Police use of force and neighbourhood characteristics: an examination of structural disadvantage, crime, and resistance. *Police Soc* 18:282–300, 2008
61. Drake RE, Mueser KT, Brunette MF: Management of persons with co-occurring severe mental illness and substance use disorder: program implications. *World Psychiatry* 6:131–36, 2007
62. Kaminski RJ, Digiovanni C, Downs R: The use of force between the police and persons with impaired judgment. *Police Q* 7:311–38, 2004
63. Van Dorn R, Volavka J, Johnson N: Mental disorder and violence: is there a relationship beyond substance use? *Soc Psychiatry Psychiatr Epidemiol* 47:487–503, 2012
64. Parker RN, Auerhahn K: Alcohol, drugs, and violence. *Annu Rev Sociol* 24:291–311, 1998
65. Hoaken PNS, Stewart SH: Drugs of abuse and the elicitation of human aggressive behavior. *Addict Behav* 28:1533–54, 2003
66. Skeem J, Bibau L: How does violence potential relate to crisis intervention team responses to emergencies? *Psychiatr Serv* 59: 201–4, 2008
67. Covington MW, Huff-Corzine L, Corzine J: Bartered police: risk factors for violence against law enforcement officers. *Violence Vict* 29:34–52, 2014
68. Grinshteyn E, Hemenway D: Violent death rates: the U.S. compared with other high-income OECD countries. *Am J Med* 129: 266–73, 2016
69. Felson RB, Berg MT, Rogers ML: Bring a gun to a gunfight: armed adversaries and violence across nations. *Soc Sci Res* 47:79–90, 2014
70. Morabito MS, Socia K, Wik A, *et al*: The nature and extent of police use of force in encounters with people with behavioral health disorders. *Int J L & Psychiatry* 50:31–37, 2017
71. Garner JH, Maxwell CD, Haux CG: Characteristics associated with the prevalence and severity of force used by the police. *Just Q* 19:705–46, 2002
72. Bierie DM, Detar PJ, Craun SW: Firearm violence directed at police. *Crime & Delinq* 62:501–24, 2016
73. Horspool K, Drabble SJ, O'Gathain A: Implementing street triage: a qualitative study of collaboration between police and mental health services. *BMC Psychiatry* 16:313, 2016
74. Allen J, Balfour R, Bell R, *et al*: Social determinants of mental health. *Int Rev Psychiatry* 26:392–407, 2014
75. Wood J, Beierschmitt L: Beyond police crisis intervention: moving "upstream" to manage cases and places of behavioral health vulnerability. *Int J L & Psychiatry* 37:439–47, 2014
76. Cowell AJ, Broner N, Dupont R: The cost-effectiveness of criminal justice diversion programs for people with serious mental illness co-occurring with substance abuse: four case studies. *J Contemp Crim Just* 20:292–314, 2004



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MARK A. PTASZEK
UNDERSHERIFF

April 20, 2021

The Honorable Cory Booker, Chair
U.S. Senate Judiciary Subcommittee on Criminal Justice and Counterterrorism

The Honorable Tom Cotton, Ranking Member
U.S. Senate Judiciary Subcommittee on Criminal Justice and Counterterrorism

Dear Chairman Booker, Ranking Member Cotton, and Subcommittee Members,

I urge this Subcommittee to support and fund additional community-based services for people with mental health and substance use challenges. Too often, across this country people in need of treatment end up in our jails. This is not where they belong. Mental health and addiction issues should not be part of the criminal legal system. Therefore, whenever possible we should make efforts to find ways to provide community-based care without ever connecting with law enforcement. This is consistent with our philosophical and operational beliefs around Deflection, Diversion, Rehabilitation and Restorative Justice, where we particularly focus on keeping those with mental health and substance abuse disorders out of the criminal legal system. When we engage in discussions about when and how police should respond the highest priority should always be the sanctity of all human life.

We are supportive of, whenever possible without endangering the public or law enforcement officers, that people in crisis be responded to by funded, trained, culturally competent mental health and social work professionals. This should not be an issue of defunding the police. The focus should be on how to provide the best possible service and care to vulnerable people. I strongly advocate for and support funding for a continuum of response options. During situations involving individuals experiencing a behavioral health crisis that has no direct nexus to criminal activity or behaviors that put others in harm's way, Emergency Response Centers should have the capacity to send alternative responders that do not involve law enforcement.

Too often, however, calls for service involve ambiguous or multi-layered situations. In those cases, there should be some sort of co-response. Again, we urge support for those programs. Realistically, there still may be many situations where law enforcement will be the proper and safest initial response to a situation which later turns out to involve mental health/ substance abuse issue and trained treatment responders should be called in. We therefore urge you to support and fund enhanced training for law enforcement to recognize and respond appropriately and safely in situations where they are first on scene. We urge increased support for mental health and substance abuse treatment beds as well as trained personnel, and alternate and innovative programs to better serve our communities. We can and should do better in how we respond and care for people in need of treatment not incarceration.

Sincerely,

Sheriff Jerry L. Clayton

Public Safety – Quality Service – Strong Communities



City of Charlottesville Police
Department



April 19, 2021

The Honorable Cory Booker
Chair
U.S. Senate Judiciary Subcommittee on Criminal Justice and Counterterrorism

The Honorable Tom Cotton
Ranking Member
U.S. Senate Judiciary Subcommittee on Criminal Justice and Counterterrorism

Dear Chairman Booker, Ranking Member Cotton, and Subcommittee Members,

The Senate Judiciary Committee, Subcommittee on Criminal Justice and Counterterrorism is poised to consider the intersectionality of policing and behavioral health. During a recent convening of thought leaders grappling with institutional systems of supremacy, which fuel disparate police responses in communities of color, William Snowden of the Vera Institute of Justice, referred to law enforcement systems as the "catch basin" for societal ills.

Many localities have ordinances, or statutes which leverage a mandated police response for individuals experiencing a mental health emergency. By simplify dialing 911, a caller unleashes the full of power of a system in which few officers are equipped to navigate, and the recipient is powerless to advocate against.

Police officers are not mental health experts; yet, they are being tasked with responding, triaging, and providing diagnostic assessments similarly to highly-trained, clinical mental health providers. This approach has resulted in our jails and prisons becoming the default "catch basin" for those living with serious mental illness or experiencing a crisis.

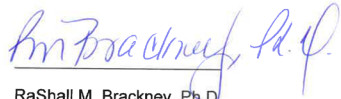
The Senate Judiciary Committee has the opportunity to inform the development of a national framework for responding to individuals in crisis. Included in that framework, must be a pathway toward decreasing the presence of law enforcement in the mental health response portfolio. And for the allocation of funding, and resources which build

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capacity to support community-led, continuum of care options which incorporates lived experiences and racial equity into the system.

Our societal failure to support our most vulnerable populations has led to the criminalization of those experiencing a mental health crises. We can no longer afford to utilize the criminal-legal system as a de facto provider for mental health services. Decriminalizing mental health and decoupling law enforcement as the primary crises responders must be a legislative priority.

Respectfully submitted,

A handwritten signature in blue ink, reading "RaShall M. Brackney, Ph.D.", is written over a horizontal line.

RaShall M. Brackney, Ph.D.
Chief of Police
Charlottesville Police Department



Fewer than 1 in 5 support 'defund the police' movement, USA TODAY/Ipsos Poll finds

By Sarah Elbeshbishi & Mabinty Quarshie

March 7, 2021

Support to redistribute police department funding has decreased among Americans since August after a summer of protests had erupted across the country against racial injustice and police brutality, a recent Ipsos/USA TODAY poll found.

The call to redistribute police budgets stemmed from Black Lives Matter activists and protesters who called to "defund the police" after the deaths of unarmed Black Americans at the hands of police, such as George Floyd and Breonna Taylor.

While some believe defunding the police is a call to get rid of law enforcement completely, many activists behind the slogan intended to make a more nuanced argument for police budgets to be steered toward community social programs so officers were less often required to take on roles better suited to social workers.

Only 18% of respondents supported the movement known as "defund the police," and 58% said they opposed it. Though white Americans (67%) and Republicans (84%) were much more likely to oppose the movement, only 28% of Black Americans and 34% of Democrats were in favor of it.

"Don't defund the police department. We need them here to keep law and order," said Kevin Hayworth, 66, of Garner, Iowa, who is white. "We need our police department just as they are."

And the responses were even more negative when Americans were asked if they thought the police should be abolished or eliminated, with 67% overall saying they were opposed, including a majority of Black Americans and Democrats.

But respondents were less opposed to the idea of redirecting police funds to social services, though a 57% majority was still against the idea. Forty-three percent of Americans supported the idea. Those numbers represented a slight decline from August, after the peak of the protests, when 53% were opposed and 47% were in favor of redirecting police spending.

Respondent Valda Pugh, 67, a retiree from Louisville, Kentucky, believes that when the call to defund the police began, people didn't fully understand the concept. "When it first surfaced, I think people had the wrong definition of what that meant. We still obviously need a police force. We need them in full force."

Steve Laskowitz, 73, of Boca Raton, Florida, agreed.

"I think it's misguided," said Laskowitz, who was among those surveyed. "I don't think anybody wants to defund the police. I think we might want to restructure how the police budget is spent, better training, better analysis of the people who become police and more efforts towards community involvement."

Support for the effort to redirect police spending was clearly divided along political and racial lines.

Eighty-four percent of Republicans polled support fully funding police budgets, while only 33% of Democrats would like to keep police budgets at their current levels. The survey found that 67% of Democrats support redistributing portions of police budgets to social programs, compared with only 16% of Republicans.

"I don't like that concept, and I thought the minute it came out 'defund' was a horrible word. 'Reallocate' would be the correct word," said Mary DeLucco, a Democrat from Portland, Oregon. "Police are already defunded. ... We're already understaffed in Oregon for police issues. We had five shootings yesterday, and cops are having a hard time to get to those locations. They're just not enough of them."

Support for the redistribution of money was also divided by the race of voters. Sixty-three percent of Black voters support distributing portions of police funds to social programs, while 35% of white voters do. Most white voters surveyed supported fully funding the police: 65% say police budgets should remain the same compared, with 37% of Black voters.

Pugh, who is Black, also told USA TODAY that money shouldn't be taken away from police but "can just reallocate some of that to do more training."

Philip Hamel, 47, of Agawam, Massachusetts, who is white, called defunding the police a "recipe for full-scale trouble."

"And if they try that we may have a prospect that people may stand up and say: 'No way, ma'am. We're taking up arms and forming a militia.' If it does, I hate to prophesize it, we may have civil (war) No. 2, but this time crazy socialist versus true-blooded Americans," Hamel said.

The poll was conducted March 1-2 from an online sample of 1,165 Americans. Rather than a margin of error, Ipsos measured its "credibility interval," which it put at plus or minus 3.3 percentage points.

This piece originally appeared in USA Today, available online at <https://www.usatoday.com/story/news/politics/2021/03/07/usa-today-ipsos-poll-just-18-support-defund-police-movement/4599232001/>.
