

COMMUNITY-BASED SERVICES FOR BLACK PEOPLE WITH MENTAL ILLNESS

Advancing An Alternative to Police



This brief was jointly prepared by the Legal Defense Fund (LDF) and the Bazelon Center for Mental Health Law (Bazelon), including by the following LDF and Bazelon staff: for LDF, Lisa Cylar Barrett (Director of Policy), Puneet Cheema (Manager, Justice in Public Safety Project), Katurah Topps (Policy Counsel), Victor Dempsey (Senior Community Organizer), and Sarah Seo (Intern); for Bazelon, Ira A. Burnim (Legal Director), Jennifer Mathis (former Director of Policy and Legal Advocacy), Lewis Bossing (Senior Staff Attorney), Brit Vanneman (Staff Attorney), Logan Miller (Legal Intern), and Kaitlyn Hefter (Legal Intern). The Legal Defense Fund (LDF) is the nation's first and foremost civil rights and racial justice legal organization. Founded in 1940 under the leadership of Thurgood Marshall, LDF was launched at a time when the nation's aspirations for equality and due process of law were stifled by widespread, state-sponsored racial inequality.ⁱ From that era to the present, LDF's mission has been transformative—to achieve racial justice, equality, and an inclusive society, using the power of law, narrative, research, and people to defend and advance the full dignity and citizenship of Black people in America. LDF's litigation, policy advocacy, organizing, and public education programs seek to ensure the fundamental rights of all people, including the right to a fair and just judicial system. As part of that tradition, for more than 80 years LDF has fought to address unconstitutional and racially discriminatory law enforcement conduct,ⁱⁱⁱ and racial bias throughout the criminal legal system.

Since 1972, the Judge David L. Bazelon Center for Mental Health Law has advocated for the civil rights, full inclusion and equality of adults and children with mental disabilities. The Bazelon Center has been pivotal in expanding the civil rights movement to include fighting discrimination against, and segregation of, people with mental disabilities. The Center secured early legal precedents creating basic civil rights for people with mental disabilities—including the rights to a public education, receive services in community-based settings instead of institutions, and make decisions about one's own care. The Center was instrumental in the passage of the Americans with Disabilities Act (ADA) in 1990, and played a key role in the historic case of *Olmstead v. L.C.* (1999), in which the Supreme Court found that needless segregation of people with psychiatric disabilities violates the ADA. Over the past decades, we have worked to expand the reach of *Olmstead* to address not only unnecessary institutionalization in public facilities (psychiatric and carceral), but also to remedy segregation in nursing homes, schools and classrooms, sheltered workshops, and other settings.

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i LDF has been an entirely separate organization from the NAACP since 1957.

ii In 2015, LDF launched its Policing Reform Campaign, now called the Justice in Public Safety Project.

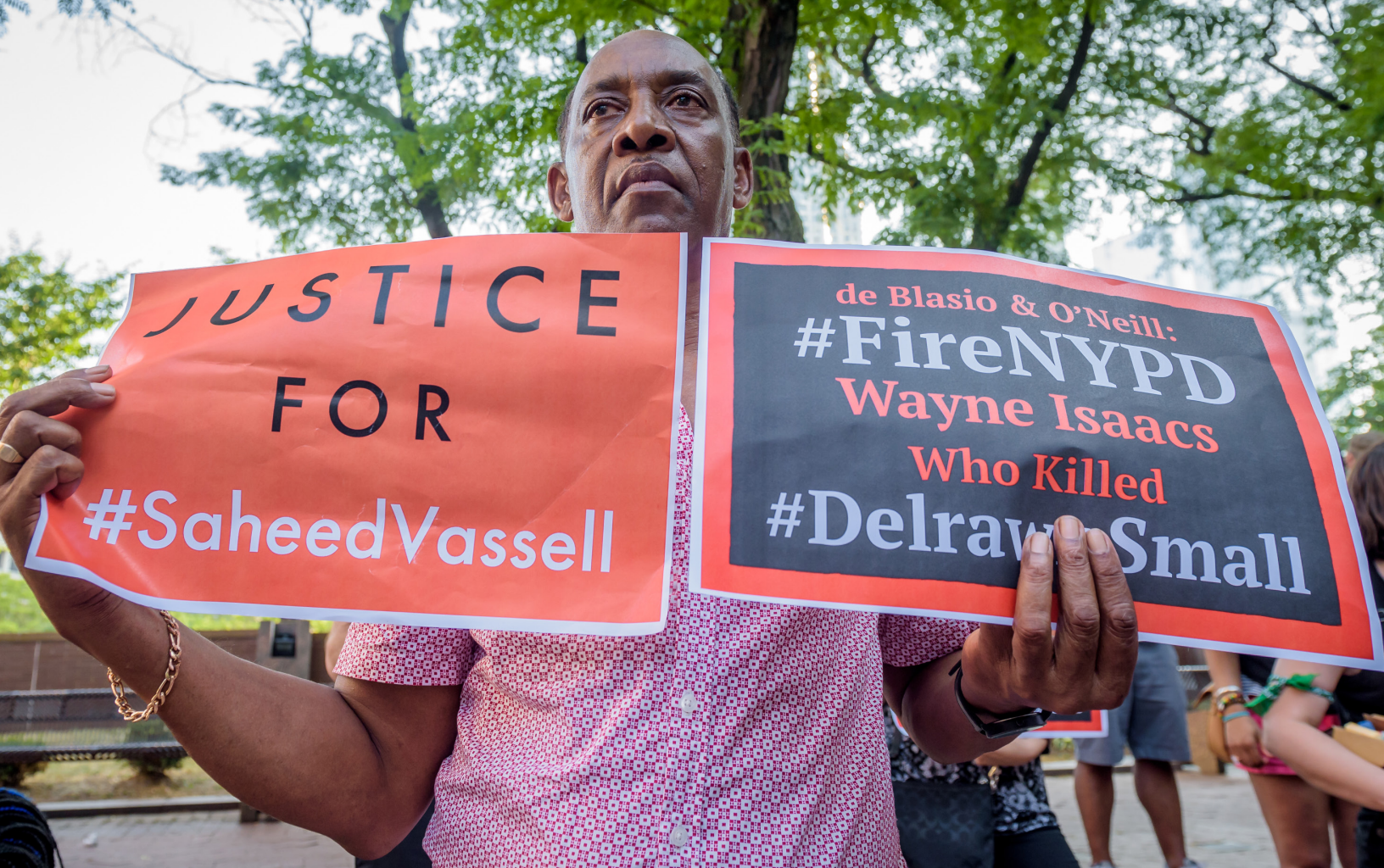
iii *Tennessee v. Garner*, 471 U.S. 1 (1985) (a seminal case that held, for the first time, that police officers cannot shoot "fleeing felons" who do not pose a threat to officers or members of the public); see also *Davis, et al. v. City of New York, et al.*, 902 F. Supp. 2d 405 (S.D.N.Y. 2012).

I. BACKGROUND

Natasha McKenna was a 37-year-old Black mother of a seven-year-old daughter in Alexandria, Virginia.¹ On February 3, 2015, law enforcement officers began to transfer Natasha from her cell in Fairfax County Jail, where Natasha was being detained on suspicion of attacking a police officer, to a facility in Alexandria, where Natasha would have access to the mental health services that she needed.² Natasha was diagnosed with schizophrenia, bipolar disorder, and depression at a young age and clearly displayed signs of her mental illness leading up to and during the week she was detained in Fairfax County jail before her death.³ In fact, officers at the jail initiated Natasha's transfer because of rising concerns over the rapid deterioration of her mental health while she was detained.⁴ After officers handcuffed Natasha in preparation for her transfer, Natasha grew increasingly anxious. Although she was only 5'3" and weighed about 130 pounds,⁵ the Fairfax County Sheriff's Office deployed its emergency response team of five officers dressed in biohazard suits and gas masks to restrain her.⁶ Video footage shows officers forcibly removing Natasha, seemingly nude, out of her cell, wrestling her to the ground, and using a taser on her four times as she sat in a restraint chair.⁷ After withstanding over 100,000 volts of electricity, Natasha's heart stopped beating.⁸ A nearby hospital put Natasha on life support for five days, until hospital staff removed the support and pronounced her dead on February 8, 2015.

Among Natasha's last words to the law enforcement officials who tackled, restrained, and ultimately killed her were, "You promised you wouldn't kill me. I didn't do anything."⁹

On April 4, 2018, Saheed Vassell, a 34-year-old Black man, was walking up and down the block, as he always did, in his neighborhood of Crown Heights in Brooklyn, New York.¹⁰ Saheed had developed and was diagnosed with bipolar disorder following the tragic killing of his best friend at the hands of the NYPD.¹¹ Before his mental illness worsened, Saheed worked as a welder.¹² His bipolar diagnosis inhibited him from maintaining work, but Saheed nonetheless continued to find fascination in collecting and carrying around metal objects reminiscent of his welding days.¹³ On the day of his murder, Saheed was carrying part of a welding torch¹⁴ in the shape of a curved silver pipe.¹⁵ Three 911 calls, however, described a black man pointing something that "looked like a gun."¹⁶ The calls reporting Saheed's "erratic behavior" were likely made by new arrivals in the neighborhood, unfamiliar with Saheed's "frequent, harmless presence on the streets."¹⁷ Three plainclothes officers saw an alert about these calls in their unmarked car and, even though they were not explicitly assigned to the incident, decided to respond.¹⁸ They reached Saheed within two minutes of seeing the alert,¹⁹ followed closely by a marked police car.²⁰ Although all the local police officers



Eric Vassell, father of Saheed Vassell - After two years seeking justice, Delrawn Small's family and community supporters gathered outside the NYPD headquarters at One Police Plaza on July 2, 2018, "to honor his memory and demand that Mayor Bill de Blasio and Commissioner James P. O'Neill fire NYPD officer Wayne Isaacs immediately." Photo By Michael Macor/The San Francisco Chronicle via Getty Images

knew of Saheed, his idiosyncrasies, and his history of mental illness, the officers who responded to the scene were part of a specialty anti-crime unit detached from the community.²¹ The responding officers claimed they saw Saheed assume a “shooting stance” and rapidly shot him ten times²² within less than ten seconds of their arrival.²³ Saheed was pronounced dead after arriving at a nearby medical center.²⁴ Several witnesses recount that the officers did not say anything before opening fire.²⁵

In the early hours of March 23, 2020, Daniel Prude, a 41-year-old Black man, experienced a mental health crisis during his visit to his brother in Rochester, New York.²⁶ During this episode, Daniel ran out of his brother’s home shirtless and shoeless.²⁷ Daniel had experienced a crisis

episode the night before, in response to which he was taken to a nearby hospital for evaluation and released a few hours later.²⁸ This time, several law enforcement officers arrived on the scene to find Daniel completely nude and wandering the streets as snow began to fall.²⁹ The first officer who approached Daniel pointed a taser directly towards him, demanding Daniel lie face first on the street with his hands behind his back.³⁰ Daniel immediately complied.³¹ After several minutes of sitting handcuffed on the cold, wet street with four officers standing at varying distances, Daniel began to verbally express his increasing agitation.³² Video footage shows Daniel spitting something out of his mouth, in the opposite direction from where the officers stood around him.³³ From behind Daniel’s back and without any advance warning, the officers

placed a “spit sock” over Daniel’s face,³⁴ purportedly to decrease the potential spread of the ongoing Coronavirus,³⁵ which Daniel had earlier said he had.³⁶ The mesh hood visibly exacerbated Daniel’s distress and he started to move around on the pavement and speak up even more.³⁷ When Daniel attempted to stand up, three officers pinned him to the ground, with one pressing his knee on Daniel’s back and another pushing his face into the pavement using the weight of his body.³⁸ After two minutes, Daniel stopped breathing.³⁹ He was pronounced brain dead upon arrival to the hospital shortly after.⁴⁰ Daniel’s last words in between gasps of air and prayers were “You’re trying to kill me.”⁴¹

The killings of Natasha McKenna, Saheed Vassell, and Daniel Prude illustrate the all-too-common experiences of Black people with mental illness⁴² who encounter law enforcement officers.⁴³ To protect Black people with mental illness and help them thrive, states and local governments must invest in comprehensive mental health systems to prevent emergencies from occurring, and to respond when emergencies occur.

II. Black People are More Likely to Encounter Law Enforcement and Be Harmed During the Encounter

Black people experience heightened surveillance,⁴⁴ higher rates of stops,⁴⁵ searches,⁴⁶ and arrests by law enforcement,⁴⁷ and are grossly overrepresented amongst those incarcerated in the U.S.⁴⁸ Additionally, Black people are over three times as likely as white Americans to be killed by law enforcement.⁴⁹ In fact, use of force by law enforcement is among the leading causes of death for Black men and boys, making them 2.5 times more likely to be killed by law enforcement officers than white men and boys.⁵⁰ “Over the life course, about 1 in every 1,000 Black men can expect to be killed by police;” a “nontrivial lifetime risk of being killed by police.”⁵¹ Similarly, Black women are 1.4 times more likely to be killed by law enforcement than white women.⁵²

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Anti-Black racial bias—whether unconscious, conscious, or structural—from law enforcement officers and agencies contributes to increased stops and violence for Black people when they encounter law enforcement.⁵³ A false association of Blackness with criminality⁵⁴ has historically been used to control Black bodies and movement.⁵⁵ This dangerous association persists even today, often influencing perceptions by people regardless of race, gender, class, or occupation, including law enforcement. Research has demonstrated that Black people are also perceived to be more “hostile” than white people with the same facial expressions.⁵⁶ These misperceptions likely contribute to aggressive responses from law enforcement officers during encounters with Black people.⁵⁷

Despite decades-long patterns of racial discrimination and law enforcement violence against Black communities, efforts to promote public safety in these communities often rely upon continuing or expanding the use of law enforcement without accounting for the threats and harm law enforcement themselves pose to the communities.⁵⁸ Increased law enforcement presence within Black communities leads to increased exposure and contact with officers. This increased contact with law enforcement can harm Black people not only physically, but also psychologically, through lasting trauma and anxiety even in those they do not arrest.⁵⁹ Studies show that beginning from a young age, men who reported more frequent contact with law enforcement also reported more symptoms of psychological distress, the severity of which positively correlated with the intrusiveness of the encounter and the perceived unfairness of law enforcement in general.⁶⁰ Even those who experience less intrusive kinds of encounters—e.g., being stopped but not physically searched—are at heightened risk of psychological distress.⁶¹

Inundating predominantly Black communities with law enforcement officers⁶² creates a dangerous

self-fulfilling prophecy. High concentrations of law enforcement officers result in overexposure for Black residents to encounters with law enforcement,⁶³ during which officers may be primed to see suspicious activity or criminal conduct where there is none.⁶⁴ Even without a subsequent arrest, law enforcement stops of Black youth have led to a greater likelihood that they engage in criminal activity in the future.⁶⁵ Rather than promoting public safety, an increased law enforcement presence is often counterproductive.⁶⁶

III. People with Mental Illness Are Harmed by Law Enforcement

People with mental illness are also at risk from encounters with law enforcement. The results of such encounters are often deadly,⁶⁷ especially when the person with mental illness is Black, as discussed in Section IV. Nationwide, law enforcement officers are generally the first and only responders to be dispatched when people with mental illness experience a crisis or otherwise need help—or are reported for disturbing or annoying others. The same is true for autistic people, individuals with substance use issues, and individuals with intellectual or developmental disabilities. And far too often, as in the cases of Natasha McKenna, Saheed Vassell, and Daniel Prude, tragic consequences follow.

People with mental illness are grossly overrepresented among those in jail and prison.⁶⁸ Their interactions with law enforcement officers often end in arrest and incarceration, even when they do not engage in actual criminal behavior. Although people with a serious mental illness comprise only 4-5% of the U.S. population,⁶⁹ they make up about 15 and 20% of the prison and jail population, respectively.⁷⁰ Contrary to a misguided and unfortunate public perception, people with mental illness, or serious mental illness, are not more violent than the population

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at large.⁷¹ Moreover, people with mental illness do not engage in criminal behavior more than people without mental illness.⁷² Nonetheless, two million people with a serious mental illness are booked into jails each year,⁷³ and the risk of confinement is particularly high for Black people with mental illness.⁷⁴ Indeed, one study found that Black people with mental illness were more likely to be incarcerated than any other racial group.⁷⁵

As the stories of Natasha McKenna, Saheed Vassell, and Daniel Prude illustrate, there is a real risk that police will use deadly force when they interact with individuals with mental illness. Of the over 7,500 people shot and killed by law enforcement officers since 2015, one in five fatalities were of people who were experiencing a mental health crisis.⁷⁶ The risk of death at the hands of law enforcement is even higher when the individual is Black.⁷⁷ Black people account for less than 13 percent of the population, yet police officers fatally shoot Black people at more than twice the rate as they do White Americans.⁷⁸ A recent study shows that Black men with mental illness are shot and killed by law enforcement officers at significantly higher rates than white men who exhibit similar behaviors.⁷⁹

Despite this risk, law enforcement is generally the default and only response to calls from or involving people with mental illness.⁸⁰ The vast majority of these calls, however, would be much safer and more effectively handled if trained mental health workers—including people with lived experience with mental illness working as “peers”—responded to the crisis instead of law enforcement or, only in the rarest exceptions, with law enforcement as a backup. About ten percent of calls to 911 involve people with mental illness,⁸¹ yet few of these situations actually threaten public safety. Such calls may involve situations where families are concerned for a loved one experiencing a mental health crisis, but who is not posing any kind of threat.⁸² Other calls may involve situations when individuals

ONE STUDY FOUND
THAT BLACK PEOPLE
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RACIAL GROUP.

Image credit: TONL

with mental illness display behavior considered “erratic” in public, or when a person’s unusual but nonthreatening behavior is induced by alcohol or drug use.⁸³ Law enforcement officials also respond to situations when individuals with a mental illness are suicidal or otherwise experiencing a crisis, when unhoused individuals with mental illness linger in public spaces, and when individuals with mental illness fail to obey staff in facilities or schools. Law enforcement officers are also used to transport people to hospitals, typically in handcuffs, when a doctor or judge directs that they be institutionalized.

Since the risk of harm to the individual is so great, and the actual threat to public safety is usually small, mental health advocates stress that law enforcement response to people with mental illness should be avoided whenever possible.⁸⁴ Contact

trained officers over their non-CIT counterparts.⁸⁹ While co-responder models have had some success in increasing access to behavioral health services more than traditional police responses, there is not enough evidence to conclude that overall, co-responder programs positively impact encounters for people experiencing mental health crises.⁹⁰ One factor, studies have suggested, is that officer involvement may retraumatize individuals due to their previous traumatic interactions with law enforcement.⁹¹

The overall failure of our public mental health systems largely explains why law enforcement continues to be the first responder to people experiencing mental health crises, and often the only responder. Publicly funded mental health service agencies have limited funding, and what services exist are inequitably distributed across

Studies have shown that equipping officers with CIT has produced **no net effect on outcomes of arrest or officer use of force.**

between law enforcement and people experiencing mental health crises—even when officers respond alongside mental health workers in the “co-responder” model⁸⁵—should be limited to only the rarest exceptions because of the potentially dire consequences.⁸⁶ Even when co-responder models dispatch officers who have undergone crisis intervention training (CIT),⁸⁷ completing such training should not exempt officers from this limitation. Studies have shown that equipping officers with CIT has produced no net effect on outcomes of arrest or officer use of force.⁸⁸ One study of the Chicago Police Department, however, showed a marginal increase in use of force by CIT-

communities.⁹² The services that work best for people with serious conditions are in very short supply.⁹³ Programs created or funded through federal and state legislation, intended to provide community-based services and avoid the harmful and unnecessary placement of people with mental illness in institutions to receive care, have never been sufficiently funded to meet the needs of people with mental illness, especially those with the most serious conditions.⁹⁴ The dearth of appropriate care, combined with the rise of mass incarceration and the lack of adequate federal support for affordable housing (and the concurrent increase in homelessness), has exposed people with mental

illness to disproportionately high rates of arrest and incarceration. The lack of community services also results in many people with mental illness being unnecessarily institutionalized, in violation of the Americans with Disabilities Act and the U.S. Supreme Court’s *Olmstead* decision.⁹⁵

When law enforcement officers respond, this not only fails to protect people with mental illness, but also exacerbates the crisis they are experiencing. Law enforcement officers are not adequately equipped to respond to people going through mental health crises. Experiencing a mental health crisis can significantly compromise a person’s ability to think and behave rationally, making it much more difficult for even close family and friends, let alone law enforcement officers, to calm the person down. The threat of force inherent in police encounters, especially when weapons are drawn, aggravates an already-sensitive situation and distresses the person in crisis even further. This unhealthy dynamic contributes to the disproportionate incarceration, institutionalization, and trauma experienced by people with mental illness at the hands of law enforcement, and is counterproductive to promoting the wellness and safety of people with mental illness.⁹⁶

IV. Black People with Mental Illness Face Discrimination in the Mental Health System

Black people with mental illness are not only at great risk of arrest, incarceration, and fatal harm by law enforcement,⁹⁷ but also of racially biased and discriminatory treatment by mental health professionals.⁹⁸ This process begins for Black people in their youth and continues through adulthood. For example, when Black youth show indications of attention deficit/hyperactivity disorder (ADHD), medical professionals, perhaps due to unconscious biases, are more likely to misdiagnose them with disruptive behavior disorders (e.g., oppositional

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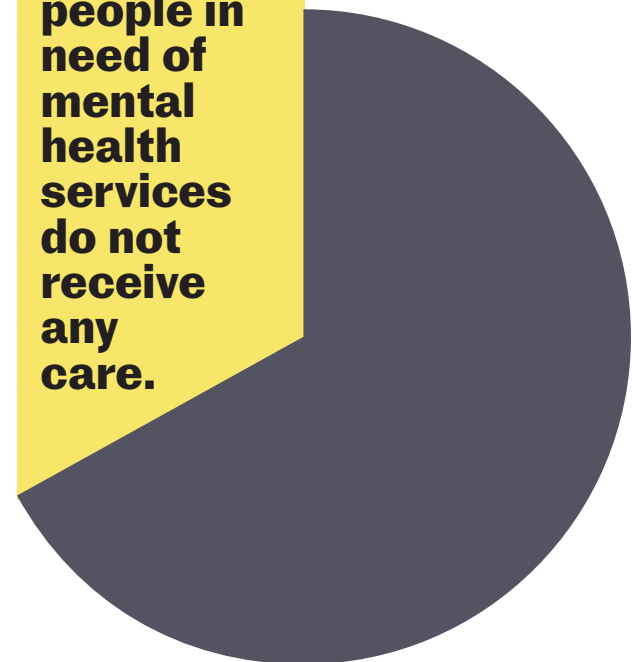
defiant disorder (ODD) or conduct disorder (CD)) rather than with ADHD.⁹⁹ The over-diagnosis of disruptive behavior disorders deprives Black youth of the proper behavioral interventions, educational accommodations, and medication provided to children with an ADHD diagnosis. Moreover, medical professionals are less supportive of children with ODD or CD, who are seen as less treatable or even untreatable.¹⁰⁰ The bias in diagnosis may perpetuate other biases by, for example, influencing how educators and school administrators perceive Black children and contributing to disparities in disciplinary practices and involvement in the juvenile corrections system.¹⁰¹

Beyond the education system, Black people face the challenges of cross-cultural communication and language differences in the healthcare system,¹⁰² which leads to fear and mistrust of the system itself.¹⁰³ One study found that physicians were more verbally dominant and less patient-centered

when communicating with Black patients than with white patients, two factors that contribute to poorer health outcomes.¹⁰⁴ Nurses, too, have demonstrated implicit biases against Black people by recommending significantly less pain medication for Black patients than white patients, upon viewing pictures of both patients exhibiting genuine expressions of pain.¹⁰⁵ Only 3% of American Psychological Association members are Black,¹⁰⁶ leading some mental health advocates to worry that the majority of mental health care practitioners lack the cultural competency to adequately treat Black patients.¹⁰⁷ When Black patients do receive care, they often receive inadequate services and experience worse outcomes.¹⁰⁸ For example, Black people are less likely to receive appropriate care for depression, leading to longer and more severe episodes.¹⁰⁹ They may also be more likely to experience coerced treatment, in the form of involuntary commitment.¹¹⁰ In Alameda County, California, where Black people make up 11 percent of the population,¹¹¹ a lawsuit alleged that “[d]uring a recent two-year period, over 2,300 people were detained at the County’s psychiatric facilities more than three times, the majority of whom were Black” and “some individuals were detained more than 100 times”;¹¹² 36% of people detained at one facility—“more than three times their overall representation in Alameda County”—were Black;¹¹³ and “[f]rom January 2018 to June 2020, more than 45% of individuals institutionalized in County psychiatric facilities three or more times were Black.”¹¹⁴ And yet, two-thirds of Black people in need of mental health services do not receive any care at all.¹¹⁵

The existence of bias in the responses of both the police and medical professionals to Black people with mental illness is supported by research regarding how Black people are perceived in general.¹¹⁶ Decades of research demonstrate that most people have implicit biases against Black people.¹¹⁷ People have a tendency to unconsciously associate Black people with criminality¹¹⁸ and

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THE OVER-DIAGNOSIS OF DISRUPTIVE BEHAVIOR DISORDERS DEPRIVES BLACK YOUTH OF THE PROPER BEHAVIORAL INTERVENTIONS, EDUCATIONAL ACCOMMODATIONS, AND MEDICATION PROVIDED TO CHILDREN WITH AN ADHD DIAGNOSIS.

BLACK MEN AND PEOPLE WITH MENTAL ILLNESS ARE AT GREATER RISK OF BEING PERCEIVED AS NON-COMPLIANT, AND THUS, DISRESPECTFUL, TO OFFICERS.

often perceive identical ambiguous behaviors as more “aggressive” when committed by Black people as compared to white people.¹¹⁹ Further, law enforcement officers have a view of acceptable behavior—of what is obedient or compliant—that often leads them to react harshly to people they think are not according them the level of deference they believe they deserve.¹²⁰ Black men and people with mental illness are at greater risk of being perceived as noncompliant, and thus, disrespectful, to officers.¹²¹ Taken together, these two biases help explain how contact with the police for minor behavior can become fatal for so many Black people with a mental illness.¹²²

Walter Wallace Jr.’s experience with Philadelphia police officers illustrates the risk that Black people with mental illness face when encountering law enforcement. In the midst of a mental health crisis on October 26, 2020, Walter Wallace Jr., a 27-year-old Black man, walked outside of his parents’ front door in Philadelphia, Pennsylvania holding a kitchen knife by his side.¹²³ Walter did not make any threatening motions or actions towards anyone,¹²⁴ even when two police officers pointed their guns at Walter and yelled for him to drop the kitchen knife.¹²⁵ A number of factors signaled that Walter was experiencing a mental health episode: several calls to 911 from Walter’s family earlier that day seeking emergency medical assistance for Walter’s condition;¹²⁶ shouts from bystanders familiar with Walter’s history with bipolar disorder, warning officers that Walter was “mental;”¹²⁷ and Walter’s almost trance-like state as he casually walked away from and around the officers, ignoring their repeated commands.¹²⁸ But Walter’s seeming indifference towards the two white police officers and nonthreatening grasp of a kitchen knife resulted in both officers quickly shooting Walter seven times each,¹²⁹ hitting him in the shoulder and chest.¹³⁰ Walter’s mother, who just seconds before was pleading for the officers not to shoot her son,¹³¹ ran towards his bleeding body, screaming, “You

killed my son.”¹³² Walter was pronounced dead shortly after arriving at a nearby hospital.¹³³ It was only three weeks after his wedding day.¹³⁴

Walter Wallace Jr. did not attack, threaten, nor engage with the police officers who shot and killed him. The officers were not even the emergency responders Walter’s family requested in their calls to 911—Walter’s brother, who made the last of several calls that day, specifically requested medical assistance and an ambulance for Walter because of his history of mental illness.¹³⁵ Tragically, police arrived at the Wallace family home before the ambulance.¹³⁶ The Wallaces knew that Walter needed help from medical professionals who would be better equipped to de-escalate their loved one. Had medical assistance intervened instead of law enforcement, Walter could still be alive today.

Assertive Community Treatment (ACT), housing, assistance securing and maintaining employment, and substance use treatment.¹³⁸ Schools must take a similar approach, ending their reliance on law enforcement and school resource officers, and increasing their investment in professional staff and improved services.¹³⁹ Providers of all these services must take steps to ensure that staff understand the cultural norms and socio-economic challenges of the communities they serve, and the traumas experienced by members of those communities. These steps should include training received from community members themselves.

When there is a physical health emergency, typically the health care system responds, with a medic, ambulance, or both. When people experience a mental health crisis, there should also be a

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V. New Solutions are Needed to Better Support Black People with Mental Illness, and All People with Mental Illness

As demonstrated above, the practice of law enforcement responding to calls involving people with mental illness does not provide people with mental illness the needed support and often results in physical harm, sometimes fatal. We must therefore develop better solutions to serve those with mental illness, and protect their rights.¹³⁷ To do so, we must expand the capacity of states, counties, and cities to deliver culturally competent community-based mental health services, including

healthcare-centered response, with the mental health system taking the lead.

As we develop alternatives to a police response, we must look at the historic and current harmful impact of police involvement, and heed the voices of those communities that have borne the brunt of such harms—Black people, people with mental illness, and those at the intersection. Far too often, their voices have been excluded or ignored. Peers with lived experience, including those with lived experience with mental illness, should play a major role in planning and implementing the alternatives developed. Peers with lived experience are a valuable resource. They have a keen understanding



of the needs and concerns of people receiving services, and they are able to develop relationships of trust, help individuals see the benefits of treatment, and help prevent and respond to crises.¹⁴⁰

Some communities have already taken steps to reduce the role of the police in responding to people with mental illness. In the Eugene, Oregon CAHOOTS¹⁴¹ program, a medic and social worker, both unarmed, are dispatched to most situations involving people with mental illness, instead of the police. Police join them in rare situations, including if someone is in immediate danger or presents a clear threat to others.¹⁴² The program reports that each year it saves the city \$8.5 million in public safety costs and \$14 million in ambulance and emergency room costs.¹⁴³ Other communities are

of law enforcement have common elements: they are implemented by skilled unarmed personnel from a variety of backgrounds able to address the needs of people with mental illness, including – clinical training in mental health or social work, nursing, peers with lived experience with mental illness, and specially-trained emergency medical technicians (EMTs). Psychiatrists are available “on call” through telehealth as virtual back-up to responders. Mobile crisis teams are trained to successfully de-escalate situations, diverting people from arrest and incarceration, or hospitalization. When the crisis is resolved, they strive to connect people with the services they need for long term stability.¹⁴⁹

These types of alternative responses should be supplemented by a sufficient array of facilities that are available for crisis care, including short-stay

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implementing similar programs.¹⁴⁴ For example, San Francisco has adapted the CAHOOTS model so that it includes a peer responder on the team.¹⁴⁵

An even greater number of communities are investing in mental health crisis teams.¹⁴⁶ New federal funding is available for such teams,¹⁴⁷ which can be dispatched by 911 or law enforcement as well as by the mental health system. Mental health crisis teams include a clinician and often a peer.¹⁴⁸

The alternative programs that communities have implemented to better support people with mental illness and to address the disproportionate harm people with mental illness experience at the hands

apartments staffed by mental health professionals and peers,¹⁵⁰ walk-in urgent care centers and “drop-off” centers (in urban areas, scattered so that they are readily accessible to people in all neighborhoods),¹⁵¹ and hospital beds for those who need inpatient care.¹⁵² Short-term detox facilities should be available as well, with offers of treatment for substance use disorders upon and following discharge.¹⁵³

Some proponents of changing responses to people with mental illness have focused on improving law enforcement encounters through training or pairing police with mental health professionals¹⁵⁴ (frequently called “co-responder models”). These

are not solutions to the problems caused by unnecessary police contact with people with mental illness. Meta-analyses of currently implemented training programs and co-responder models across the country have not found either reform to have significant positive impacts on police encounters with people with mental illness.¹⁵⁵ These programs will not remedy the trauma and safety issues experienced during even the best-intentioned law enforcement interactions. Better police training will not provide the expert medical and peer support that people with mental illness or in crisis need. Police responses by their very nature present a threat of violence or incarceration.¹⁵⁶ And a police response is unnecessary in the vast majority of calls involving people with mental illness.¹⁵⁷ Moreover, as noted in Section III above, research on the effects of CIT programs across the country demonstrates no significant effect on officer use of force in encounters of people with mental illness.¹⁵⁸ Mental health systems should provide services to prevent people from experiencing crises, and when crises occur, they should provide the services needed to stabilize the situation, and connect people to long-term services. Not only is this safer and more effective, but it also advances civil rights and avoids incarceration, institutionalization, and coercion.

A. Specific Steps to Implement Alternatives to Harmful Police Response

Developing alternatives to a law enforcement response requires action in three areas.

1. Re-direct requests for police intervention.

Calls to 911 and the police should be screened to determine whether the person about whom the call is made is known to or appears to have a mental illness or is experiencing a mental health crisis. Such calls should be redirected to experts and peers in the mental health system and handled by a unit

within the mental health system that operates much like 911, making urgent responses when required.

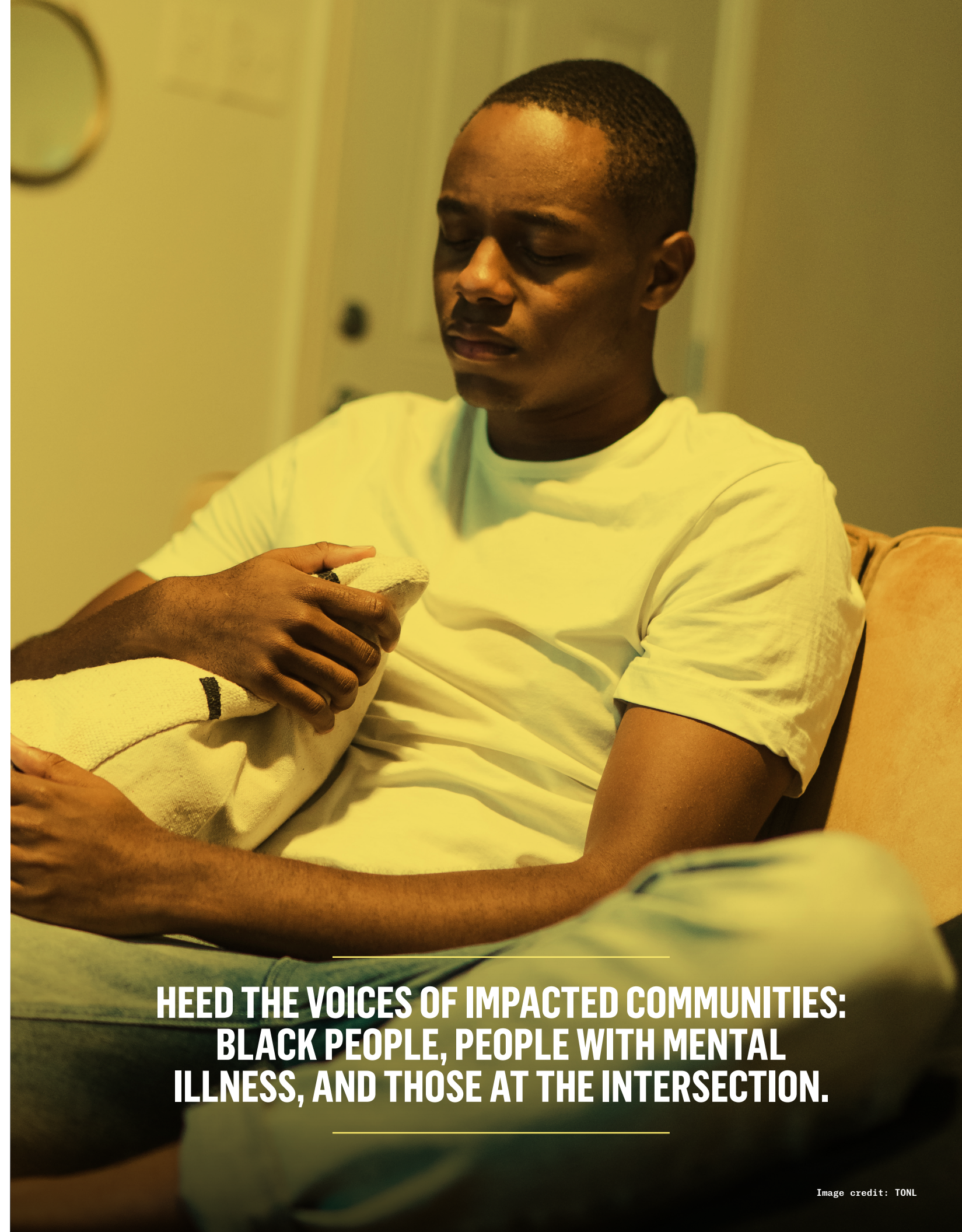
The mental health system should have policies identifying the small number of cases where it may be appropriate for the mental health system to respond jointly with the police or have the police on the scene as backup.¹⁵⁹ Communities should collect and analyze data and provide training to call-takers and police staff, identifying those situations that can and should be handled entirely by the mental health system.¹⁶⁰ The police should not respond, jointly or as backup, when the call involves an individual who is suicidal and presents no risk to others.

2. Develop the services needed for a non-police response.

Each community should have the services needed to respond to calls involving an individual with mental illness or experiencing a mental health crisis. Such calls, including calls to 911, should be routed to the mental health system, where trained call-takers can resolve many calls by providing advice, making referrals, and/or providing transportation to a community-based provider. Other calls will require dispatching a mobile support team that can quickly respond and resolve the situation—like the CAHOOTS team (discussed above) or a mental health crisis team.¹⁶¹ There should also be an array of walk-in, drop-off, and other facilities for crisis resolution and stabilization, scattered throughout the community. Many of these activities, including mobile crisis teams, can be funded through Medicaid, with the federal government picking up a sizeable share of the cost.¹⁶²

3. On-going community-based services.

After the immediate issue is resolved, the mental health system should follow up to ensure the individuals gain access to voluntary community-based services on an on-going basis. Many people with serious mental illness will need access to



**HEED THE VOICES OF IMPACTED COMMUNITIES:
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ILLNESS, AND THOSE AT THE INTERSECTION.**

long-term housing, intensive case management, peer support services, ACT, and supported employment.¹⁶³ People with lived experience working as peers can be involved in—and lead—the delivery of all of these services.

If the person was regularly receiving services before the episode, the mental health system should review and improve the services it is providing, in order to help the person avoid similar issues in the future.

B. Advocating for Solutions

To protect Black people and others with mental illness, it is critical that we expand culturally competent community-based mental health services. The services needed include clinical services, such as ACT and mental health crisis services, but also non-clinical services, such as supportive housing, peer support, and supported employment.

Below is a list of actions that government authorities should take to better support Black people and others with mental illness.

Actions that Congress, the U.S. Department of Health and Human Services, and State and Local Governments Should Take

Congress should:

- Enact legislation to fund community-based mental health services including supportive housing. Congress should pass, and the President should sign, legislation that provides states and localities with the resources they need to provide these critical services and supports and require that they be culturally competent.¹⁶⁴
- Permanently authorize flexibilities in Medicaid funding for tele-mental health services as permitted related to COVID-19,¹⁶⁵ while also

requiring that in-person services and hybrid in-person and virtual services are available for people who want them. This will ensure that services are accessible by whatever means people with mental illness find most effective.¹⁶⁶

- Fund call centers within the mental health system to which calls for help involving people with mental illness can be routed.¹⁶⁷
- Provide strong financial incentives, including through federal grant programs, for communities to use the mental health system, rather than law enforcement, to respond to calls involving people with mental illness.¹⁶⁸
- Invest in programs that help expand the behavioral health workforce, including peer support/services, and provide incentives to individuals from Black and Brown communities to join the behavioral health workforce.¹⁶⁹

The U.S. Department of Health and Human Services (HHS) should:

- Robustly promote and fund services that prevent encounters with law enforcement, including ACT, mobile crisis services, peer services, supported housing, and supported employment.¹⁷⁰
- Support programs that address underlying problems—sometimes called “social determinants of health”—that may prompt mental health crises for people with mental illness, such as supportive housing and supported employment programs.¹⁷¹
- Provide significant funding to efforts that ensure mental health services are culturally competent, including the efforts of the National Network to Eliminate Disparities In Behavioral Health (NNED).¹⁷²

- Allow federal Medicaid dollars to be used to support housing for people with mental illness.¹⁷³
- Improve Medicaid rules regarding reimbursement for peer services, including removing the requirement that peer services be delivered under the supervision of a clinician.¹⁷⁴
- Clarify Medicaid rules regarding reimbursement for mental health services provided to students at school, which could help build significant additional service capacity in school districts that enroll large numbers of Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries.¹⁷⁵

States and local governments should:

- Ensure that there is a robust array of voluntary, community-based services that reduce the occurrence of mental health crises, provide an effective response when they occur, and provide on-going treatment and support after the crisis is resolved.¹⁷⁶ The services should be culturally competent and acknowledge the trauma Black people have experienced, and incorporate a trauma-informed approach.¹⁷⁷
- Ensure that every community has each of the necessary components of a community-based behavioral health crisis response system, and that this system is a meaningful alternative to a law enforcement response. This includes call centers (reachable through 911, 988, or other hotline or warmlines) that can resolve most calls for help,¹⁷⁸ mobile crisis teams to respond quickly when needed, de-escalate situations, and connect people to services,¹⁷⁹ and an array of facilities when people need somewhere to go for crisis resolution and stabilization.¹⁸⁰

- Create a continuum of alternative responders to calls for help, from street outreach teams,¹⁸¹ to CAHOOTS-type teams, to mental health crisis teams to handle the wide variety of calls involving people with mental illness.¹⁸²
- Conduct public education campaigns to inform people about the availability of alternatives to calling 911 and law enforcement, and of community-based mental health services. Such campaigns should effectively reach Black communities—including by acknowledging trauma, featuring Black service providers, and reducing stigma about mental health services.¹⁸³
- Collect and analyze data, adopt policies, and provide training to 911, 988, and police staff about situations involving people with mental illness that can and should be handled entirely by the behavioral health system, and situations to which the police should also respond.¹⁸⁴
- Ensure that law enforcement officers refer people with mental illness whom they encounter while on duty to appropriate community-based resources, and arrange for safe transportation if needed.¹⁸⁵
- Ensure that affected communities are involved in the design, implementation, and evaluation of all alternatives to a law enforcement response to people with mental illness, such as advisory councils and working groups.¹⁸⁶
- Expand the mental health workforce, including peer services, by among other things, taking advantage of federal Community Mental Health Services and Substance Abuse Prevention and Treatment block grants and Certified Community Behavioral Health Center (CCBHC) funds,¹⁸⁷ investing in professional development, and identifying and removing barriers to entry for Black people and others.¹⁸⁸

- Invest in peer-led services such as peer crisis respite centers,¹⁸⁹ peer “bridger” services that help people transition from hospitals, jails, and prisons to the community,¹⁹⁰ and peer-run hotlines and warmlines for people who need help.¹⁹¹
- Expand supported employment services using the Individual Placement and Support (IPS) model.¹⁹² Peer specialists should be part of the IPS teams.
- Take steps to diversify the mental health workforce to reflect the racial, ethnic, cultural, sexual orientation, and gender identity diversity of the communities served. Peer workers should reflect the lived experiences of people in the communities they serve, including Black communities.¹⁹³
- Take advantage of COVID-19-related flexibilities in Medicaid to suspend premiums, co-pays, and other cost sharing; suspend the need for prior authorizations or re-authorizations for mental health services; make advanced and/or incentive payments to community mental health providers; and increase payment rates for services.¹⁹⁴

- Address the social determinants of health, which helps prevent mental health crises.¹⁹⁵
- States and local governments should invest in programs that, among other things, help people secure and maintain housing and find and maintain employment.
- Use federal COVID-19 relief funds to support mental health services in schools.¹⁹⁶ Schools can use these funds to recruit, retain, and train more school-based mental health professionals, such as social workers and counselors; provide more individualized and small group instruction and tutoring; provide high-quality afterschool and summer programs; and invest in other strategies for supporting student mental health.¹⁹⁷

V1. CONCLUSION

It is past time that we address the incarceration, institutionalization, and police violence that Black people with mental illness, and all people with mental illness, face in law enforcement encounters when community-based mental health services are available to respond to their needs. It is too late to avoid the tragic deaths of Natasha McKenna, Saheed Vassell, Daniel Prude, Walter Wallace, Jr., and the other Black people with mental illness who have lost their lives during encounters with law enforcement. But it is not too late for stakeholders to demand action and for our policymakers to respond with effective solutions.

We urgently call upon national and local stakeholders to center community based, trauma informed approaches that integrate peers, language

diversity, cultural competency, and cross disability accessibility. Effective alternative responses to crises are needed. Robust longer-term services, including peer services, Assertive Community Treatment (ACT), supported employment, and supported housing, delivered equitably and without bias, are also critical. Black communities must be centered and participate in decision-making about the systems that will serve them. These systems must be a meaningful alternative to a police response.

Implementing a comprehensive community-based mental health system can and will stop violence against Black people with mental illness. We urgently call on our cities, states, and the federal government to implement these systems now.

WE URGENTLY CALL ON OUR CITIES, STATES, AND THE FEDERAL GOVERNMENT TO IMPLEMENT A COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH SYSTEM NOW.

¹ Justin Jouvenal, *Va. Inmate had been restrained, fitted with anti-spitting mask before death*, WASH. POST LOC. (Feb. 19, 2015), https://www.washingtonpost.com/local/crime/woman-was-restrained-masked-before-death-at-jail/2015/02/19/cf7c731c-b786-11e4-aa05-1ce812b3fdd2_story.html; Editorial Board, *A death in the Fairfax jail renews questions about transparency*, WASH. POST OP. (Feb. 12, 2015), https://www.washingtonpost.com/opinions/a-death-in-the-fairfax-jail-renews-questions/2015/02/12/363e8034-b252-11e4-886b-c22184f27c35_story.html.

² *Say Their Names Green Library Exhibit, Natasha McKenna*, STAN. LIBR., <https://exhibits.stanford.edu/saytheirnames/feature/natasha-mckenna> (last visited June 17, 2022).

³ Justin Jouvenal, *Prosecutor will not pursue charges in death of mentally ill inmate in Va.*, WASH. POST LOC. (Sept. 8, 2015), https://www.washingtonpost.com/local/crime/prosecutor-will-not-pursue-charges-in-death-of-mentally-ill-inmate-in-va/2015/09/08/ff2ecf7a-564f-11e5-b8c9-944725fd3b9_story.html.

⁴ *Id.*

⁵ Tom Jackman, *The death of Natasha McKenna in the Fairfax jail: The rest of the story*, WASH. POST LOC. (Apr. 13, 2015, 12:44 PM EDT), <https://www.washingtonpost.com/news/local/wp/2015/04/13/the-death-of-natasha-mckenna-in-the-fairfax-jail-the-rest-of-the-story/>.

⁶ Jess Bidgood, *Virginia Sheriff Releases Video of Effort to Subdue Inmate Who Died*, N.Y. TIMES (Sept. 10, 2015), <https://www.nytimes.com/2015/09/11/us/virginia-sheriff-releases-video-of-effort-to-subdue-inmate-who-died.html>.

⁷ New York Daily News, *Police release video in Natasha McKenna death*, YOUTUBE (Sept. 10, 2015), <https://www.youtube.com/watch?v=Segr3t00ayQ&t=27s>.

⁸ Tom Jackman & Justin Jouvenal, *Fairfax jail inmate in Taser death was shackled*, WASH. POST LOC. (Apr. 11, 2015), https://www.washingtonpost.com/local/crime/fairfax-jail-inmate-who-died-was-fully-restrained-when-tasered-four-times/2015/04/11/ede0957c-decd-11e4-be40-566e2653afe5_story.html?noredirect=on&utm_term=.397c0d9c21bb.

⁹ Justin Jouvenal, *Inmate who died after jail encounter with Fairfax deputies: 'You promised you wouldn't kill me.'* WASH. POST LOC. (Sept. 10, 2015), https://www.washingtonpost.com/local/crime/video-of-encounter-that-preceded-inmates-death-at-fairfax-jail-is-released/2015/09/10/0e7b6104-57e1-11e5-8bb1-b488d231bba2_story.html.

¹⁰ Benjamin Mueller, Jan Ransom, & Luis Ferré-Sadurní, *Locals Knew He Was Mentally Ill. The Officers Who Shot Him Did Not.*, N.Y. TIMES (Apr. 5, 2018) [hereinafter *Locals Knew*], <https://www.nytimes.com/2018/04/05/nyregion/brooklyn-police-shooting-saheed-vassell.html?action=click&module=RelatedCoverage&pgtype=Article®ion=Footer> (noting that Saheed was known as the “idiosyncratic fixture on the block”).

¹¹ TheGrio Staff, *NYPD killed Saheed Vassell after he was haunted by fatal police shooting of his best friend*, GRIO (Apr. 9, 2018), <https://thegrio.com/2018/04/09/nypd-killed-saheed-vassell-after-he-was-haunted-by-fatal-police-shooting-of-his-best-friend/>.

¹² Benjamin Mueller & Nate Schweber, *Police Fatally Shoot a Brooklyn Man, Saying They Thought He Had a Gun*, N.Y. TIMES (Apr. 4, 2018), <https://www.nytimes.com/2018/04/04/nyregion/police-shooting-brooklyn-crown-heights.html>.

¹³ Akintunde Ahmad, *Saheed Vassell and the forgotten victims of police brutality*, COLUM. JOURNALISM REV. (July 1, 2020), <https://www.cjr.org/watchdog/saheed-vassell-police-brutality-victims.php>.

¹⁴ Benjamin Mueller, *Police Release First Footage of Officers Shooting Man in Brooklyn*, N.Y. TIMES (Apr. 10, 2018), <https://www.nytimes.com/2018/04/10/nyregion/nypd-video-saheed-vassell-shooting.html>.

¹⁵ *Locals Knew*, *supra* note 10.

¹⁶ *Id.*

¹⁷ Ginia Bellafante, *A Fear Born of Brooklyn Gentrification*, N.Y. TIMES (Apr. 9, 2018), <https://www.nytimes.com/2018/04/09/nyregion/brooklyn-gentrification-fear-police-shooting.html>.

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ Mueller, *supra* note 14.

²¹ *Locals Knew*, *supra* note 10.

²² *Id.*

²³ Mueller, *supra* note 14.

²⁴ Mueller & Schweber, *supra* note 12.

²⁵ *Locals Knew*, *supra* note 10.

²⁶ Michael Gold & Troy Closson, *What We Know About Daniel Prude's Case and Death*, N.Y. TIMES (Apr. 16, 2021), <https://www.nytimes.com/article/what-happened-daniel-prude.html>.

²⁷ *Id.*

²⁸ Sarah Maslin Nir, *Rochester Officers Will Not Be Charged in Killing of Daniel Prude*, N.Y. TIMES (Mar. 6, 2021), <https://www.nytimes.com/2021/02/23/nyregion/daniel-prude-rochester-police.html>.

²⁹ Gold & Closson, *supra* note 26.

³⁰ Taylor Romine, Benjamin Norbitz, & Madeline Holcombe, *7 Rochester police officers suspended over Daniel Prude's death, mayor says*, CNN (Sept. 4, 2020, 3:21 AM ET), <https://www.cnn.com/2020/09/03/us/rochester-police-daniel-prude-death/index.html>.

³¹ *Id.*

³² *Id.*

³³ Michael V. Pettigano, *Daniel Prude video: Rochester police body cam footage (10-min. version)*, DEMOCRAT & CHRON. (Sept. 5, 2020, 12:49 PM), <https://www.democratandchronicle.com/videos/news/2020/09/04/daniel-prude-death-rochester-police-body-cam-video-10-minute-version/5710351002/> (showing spitting at 2:56).

³⁴ *Id.*

³⁵ Ali Watkins, *What Are 'Spit Hoods,' and Why Do the Police Use Them?*, N.Y. TIMES (Sept. 8, 2020), <https://www.nytimes.com/2020/09/03/nyregion/spit-hoods-police.html>.

³⁶ Gold & Closson, *supra* note 26.

³⁷ Romine et al., *supra* note 30.

³⁸ *Id.*

³⁹ Gold & Closson, *supra* note 26.

⁴⁰ Romine et al., *supra* note 30.

⁴¹ *Id.*

⁴² This paper uses the term “mental illness” to describe people who have “health conditions involving changes in emotion, thinking or behavior (or a combination of these).” *What is Mental Illness?*, AM. PSYCH. ASS'N (Aug. 2018), <https://psychiatry.org/patients-families/what-is-mental-illness>. “Mental illnesses are associated with distress and/or problems functioning in social, work or family activities.” *Id.* There are other terms that people use to describe these conditions. For example, most people with mental illness are protected by the Americans with Disabilities Act (ADA); for that reason, this paper sometimes uses the term “mental health disabilities.” *See infra* notes 95, 110. However, many people with mental illness do not use either of these labels to describe themselves. Some people refer to having “lived experience” with mental health conditions. Others use different terms to describe themselves and others with such issues. *See, e.g.,* u/MadQueerResearcher, *Queer MMIND (Mad, Mentally Ill, Neurodivergent, and Disabled) College Student Experiences*, REDDIT (Oct. 15, 2021), https://www.reddit.com/r/SampleSize/comments/q8ouhg/academic_queer_mmind_mad_mentally_ill/.

⁴³ This paper uses the terms “law enforcement” and “police” interchangeably to represent the array of law enforcement officers and agencies that disproportionately harm black people and people with mental illness, and especially those at the intersection of both identities.

⁴⁴ Devon W. Carbado & Patrick Rock, *What Exposes African Americans to Police Violence?*, 51 HARV. C.R.-C.L. L. REV. 159, 166 (2016) (noting that Black people are disproportionately exposed to law enforcement); Rashida Richardson et al., *Dirty Data, Bad Predictions: How Civil Rights Violations Impact Police Data, Predictive Policing Systems, and Justice*, 94 N.Y.U. L. REV. 192, 209 n.68 (2019) (“The areas that are subject to heightened [Chicago Police Department] presence...are concentrated in the South and West sides of Chicago, which are predominantly non-white and heavily low income neighborhoods.”).

⁴⁵ Drew DeSilver et al., *10 things we know about race and policing in the U.S.*, PEW RSCH. CTR. (June 3, 2020), <https://www.pewresearch.org/fact-tank/2020/06/03/10-things-we-know-about-race-and-policing-in-the-u-s/> (“Black adults are about five times as likely as whites to say they’ve been unfairly stopped by police because of their race or ethnicity.”).

⁴⁶ Data from the Los Angeles Police Department shows that a “black person in a vehicle was more than four times as likely to be searched by police as a white person,” even though white people were more likely to be found with illegal items. Ben Poston & Cindy Chang, *LAPD searches blacks and Latinos more. But they're less likely to have contraband than whites*, L.A. TIMES (Oct. 8, 2019, 3:52 PM PT), <https://www.latimes.com/local/lanow/la-me-lapd-searches-20190605-story.html>. The DOJ’s investigation of the Ferguson Police Department revealed that “African Americans are more than twice as likely as white drivers to be searched during vehicle stops,” but “are found in possession of contraband 26% less often than white drivers.” C.R. DIV., U.S. DEP’T OF JUST., INVESTIGATION OF THE

releases/attachments/2015/03/04/ferguson_police_department_report.pdf.

⁴⁷ See Emma Pierson et al., *A Large-Scale Analysis of Racial Disparities in Police Stops Across the United States*, 4 NATURE HUM. BEHAV. 736, 737 (2020), <https://www.nature.com/articles/s41562-020-0858-1.pdf> (“...[A]mong state patrol stops, the annual per-capita stop rate for black drivers was 0.10 compared to 0.07 for white drivers; and among municipal police stops, the annual per-capita stop rate for black drivers was 0.20 compared to 0.14 for white drivers.”); see also *Table of Arrest rates by offense and race in 2019 (all ages)*, U.S. DEP’T OF JUST., OFF. OF JUV. JUST. & DELINQ. PREVENTION, https://www.ojjdp.gov/ojstatbb/crime/ucr.asp?table_in=2&selYrs=2019&rdoGroups=1&rdoData=r (last visited June 21, 2022) (reporting that the arrest rate for Black people and white people is 5,723.3 and 2,750.4 per 100,000, respectively); *U.S. Incarceration Rates by Race and Ethnicity, 2010*, PRISON POL’Y INITIATIVE, https://www.prisonpolicy.org/research/race_and_ethnicity/ (last visited June 21, 2022) (noting that the incarceration rate for Black people and white people is 2,306 and 450 per 100,000, respectively).

⁴⁸ Peter Wagner & Wendy Sawyer, *States of Incarceration: The Global Context 2018*, PRISON POL’Y INITIATIVE (June 2018), <https://www.prisonpolicy.org/global/2018.html>.

⁴⁹ Gabriel L. Schwartz & Jacqueline L. Jahn, *Mapping fatal police violence across U.S. metropolitan areas: Overall rates and racial/ethnic inequities, 2013-2017*, PLOS ONE 15(6): e0229686 (2020), <https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0229686&type=printable> (finding that Black people are 3.23 times more likely to be killed by police than white people); JUDGE DAVID L. BAZELON CTR. FOR MENTAL HEALTH L., “DEFUNDING THE POLICE” AND PEOPLE WITH MENTAL ILLNESS (Aug. 2020), <http://www.bazelon.org/wp-content/uploads/2020/08/Defunding-the-Police-and-People-with-MI-81020.pdf>.

⁵⁰ Morgan Sherburne, *Police: Sixth-leading cause of death for young black men*, UNIV. OF MICH. INST. FOR SOC. RSCH. (June 1, 2020), <https://isr.umich.edu/news-events/news-releases/police-sixth-leading-cause-of-death-for-young-black-men-2/> (noting that police killings are the sixth leading cause of death in Black men; 100 Black men and boys and 39 white men and boys per 100,000 are killed by police, respectively).

⁵¹ Frank Edwards et al., *Risk of Being Killed by Police Use of Force in the United States by Age, Race—Ethnicity, and Sex*, 116 PNAS 16793, 16793 (2019), <https://www.pnas.org/content/pnas/116/34/16793.full.pdf>.

⁵² *Id.*

⁵³ See generally Dr. Jennifer L. Eberhardt et al., *Seeing Black: Race, Crime, and Visual Processing*, 87 J. OF PERSONALITY & SOC. PSYCH. 876 (2004), <https://web.stanford.edu/~eberhard/downloads/2004-SeeingBlackRaceCrimeandVisualProcessing.pdf> [hereinafter *Seeing Black*]; Brian Keith Payne, *Prejudice and Perception: The Role of Automatic and Controlled Processes in Misperceiving a Weapon*, 81 J. OF PERSONALITY & SOC. PSYCH. 181 (2001) (finding that exposure to Black faces facilitated the categorization of crime-relevant objects), <http://web.missouri.edu/~segerti/capstone/PayneBias.pdf>.

⁵⁴ Natsu T. Saito, *Tales of Color and Colonialism: Racial Realism and Settler Colonial Theory*, 10 FLA. A&M U. L. REV. 1, 56 (2014) (explaining that white American political leaders advanced the criminalization of Black people to maintain social control and “undermine the impact of the abolition of slavery”); Cheryl Nelson Butler, *Blackness as Delinquency*, 90 WASH. U.L. REV. 1335, 1364 (noting that the eugenics movement promoted the idea that black people were more prone to delinquency and criminal activity).

⁵⁵ Summary of *The Condemnation of Blackness: Race, Crime, and the Making of Modern Urban America, With a New Preface* by Khalil Gibran Muhammad (2019), HARV. UNIV. PRESS, <https://www.hup.harvard.edu/catalog.php?isbn=9780674238145> (“Chronicling the emergence of deeply embedded notions of black people as a dangerous race of criminals by explicit contrast to working-class whites and European immigrants, Khalil Gibran Muhammad reveals the influence such ideas have had on urban development and social policies.”).

⁵⁶ L. Song Richardson & Phillip Atiba Goff, *Interrogating Racial Violence*, 12 OHIO ST. J. CRIM. L. 115, 121 (2014), https://kb.osu.edu/bitstream/handle/1811/73475/OSJCL_V12N1_115.pdf.

⁵⁷ For more on the effects of implicit bias on policing, see generally *id.*; see also L. Song Richardson, *Police Racial Violence: Lessons from Social Psychology*, 83 FORDHAM L. REV. 2961 (2015).

⁵⁸ Amanda Geller et al., *Aggressive Policing and the Mental Health of Young Urban Men*, 104 AM. J. OF PUB. HEALTH 2321, 2321 (2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4232139/pdf/AJPH.2014.302046.pdf> (finding that individuals who reported more police contact also reported more symptoms of trauma and anxiety, exacerbated by the number of stops they encountered and the intrusiveness of the encounters).

⁵⁹ Abigail A. Sewell, Kevin A. Jefferson, & Hedwig Lee, *Living under Surveillance: Gender, Psychological Distress, and Stop-Question-and-Frisk Policing in New York City*, 151 SOC. SCI. & MED. 1, 1 (2016).

⁶⁰ Ana Sandoiu, *Police Violence: Physical and Mental Health Impacts on Black Americans*, MED. NEWS TODAY (June 22, 2020), <https://www.medicalnewstoday.com/articles/police-violence-physical-and-mental-health-impacts-on-black-americans>.

⁶¹ Geller et al., *supra* note 58.

⁶² Jeffrey Fagan, *No Runs, Few Hits, and Many Errors: Street Stops, Bias, and Proactive Policing*, 68 UCLA L. REV. 1584, 1632 (2022), https://scholarship.law.columbia.edu/cgi/viewcontent.cgi?article=4295&context=faculty_scholarship (“As concentrations of Black residents increase, officer allocations also increase.”).

⁶³ *Id.* at 1664 (finding that the higher allocation of police in Black neighborhoods indicates an overexposure risk for Black residents).

⁶⁴ *Id.* at 1636, 1666.

⁶⁵ Juan Del Toro et al., *The Criminogenic and Psychological Effects of Police Stops on Adolescent Black and Latino Boys*, 116 PNAS 8261, 8266 (2019), <https://www.pnas.org/doi/epdf/10.1073/pnas.1808976116> (citing qualitative research).

⁶⁶ *Id.*; Brenden Beck, *We Analyzed 29 Years of Police Spending in Hundreds of Cities: Here’s what we learned*, SLATE (Apr. 14, 2022, 4:42 PM), <https://slate.com/news-and-politics/2022/04/increased-police-spending-leads-to-more-misdemeanor-arrests.html> (citing study of hundreds of U.S. cities and towns over 29 years, finding that “[w]hen cities decreased the size of their police departments, they saw fewer misdemeanor arrests and when they increased them, they saw more.”).

⁶⁷ Michael S. Rogers, MD et al., *Effectiveness of Police Crisis Intervention Training Programs*, 47 J. AM. ACAD. PSYCHIATRY L. 414, 414 (2019), <http://jaapl.org/content/jaapl/47/4/414.full.pdf> (noting that between 2015-2018, approximately 25 percent of the roughly 1,000 people killed during a law enforcement encounter involved a person with mental illness).

⁶⁸ See KEVIN MARTONE ET AL., TECH. ASSISTANCE COLLABORATIVE, *OLMSTEAD AT 20: USING THE VISION OF OLMSTEAD TO DECRIMINALIZE MENTAL ILLNESS* 3 (Sept. 2019), https://www.tacinc.org/wp-content/uploads/2020/02/olmstead-at-twenty_09-04-2018.pdf (“[There is a] vastly disproportionate number of people with mental illness in the U.S. criminal justice system.”).

⁶⁹ *Mental Illness*, NAT’L INST. OF MENTAL HEALTH (last updated Jan. 2022), <https://www.nimh.nih.gov/health/statistics/mental-illness>. “Serious mental illness” is a term of art that refers to individuals who have particular diagnoses and whose functioning is significantly impaired due to their illness. See *Living Well with Serious Mental Illness*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/serious-mental-illness> (last updated Mar. 31, 2022).

⁷⁰ JENNIFER BRONSON, PH.D. & MARCUS BERZOFKY, BUREAU OF JUST. STAT., INDICATORS OF MENTAL HEALTH PROBLEMS REPORTED BY PRISONERS AND JAIL INMATES, 2011-2012, (June 2017), <https://bjs.ojp.gov/content/pub/pdf/imhprj1112.pdf>; TREATMENT ADVOC. CTR., HOW MANY INDIVIDUALS WITH SERIOUS MENTAL ILLNESS ARE IN JAILS AND PRISONS? (last updated Nov. 2014), <https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/how%20many%20individuals%20with%20serious%20mental%20illness%20are%20in%20jails%20and%20prisons%20final.pdf>.

⁷¹ See Heather Stuart, *Violence and Mental Illness: An Overview*, 2 WORLD PSYCHIATRY 121, 123 (2003) (“[M]embers of the public undoubtedly exaggerate both the strength of the relationship between major mental disorders and violence, as well as their own personal risk ... It is far more likely that people with a serious mental illness will be the victim of violence”); *Mental Health Myths and Facts*, MENTALHEALTH.GOV (last visited July 1, 2022), <https://www.mentalhealth.gov/basics/mental-health-myths-facts> (“The vast majority of people with mental health problems are no more likely to be violent than anyone else. Most people with mental illness are not violent and only 3%-5% of violent acts can be attributed to individuals living with a serious mental illness. In fact, people with severe mental illnesses are ... more likely to be victims of violent crime than the general population”).

⁷² MARTONE ET AL., *supra* note 68, at 3-4 (“Mental illness itself is not predictive of criminal behavior, and research suggests that crime rates for people with mental illness are similar to those of the general population.... As with the general population, there are people with mental illness who might commit criminal acts irrespective of their mental illness.... The risk factors that predict crime among people with serious mental illness are the same risk factors that predict crime among people without serious mental illness.”).

⁷³ Mary Giliberti, *It’s Outrageous: Jails and Prisons Are No Place to Treat Mental Illness; Just Ask Paton Blough*, HUFF. POST BLOG (May 21, 2016) https://www.huffpost.com/entry/its-outrageous-jails-and-prisons-are-no-place-to-treat-mental-illness_b_7334026. The people with mental illness who are being arrested and jailed are also cycling in and out of emergency rooms and psychiatric hospital units. In many communities, there is a discrete and identifiable group of poor and poorly served people with mental illness, often homeless, who cycle in and out of jail, emergency

these individuals, they could be provided housing and effective community-based mental health services. See Alexi Jones & Wendy Sawyer, *Arrest, Release, and Repeat: How Police and Jails are Misused to Respond to Social Problems*, PRISON POL'Y INITIATIVE (Aug. 2019), <https://www.prisonpolicy.org/reports/repeatarrests.html> (finding that investment in community-based mental health and substance use treatment “is estimated to yield a \$12 return for every \$1 spent, as it reduces future crime, costly incarceration, and lowers health care expenses”). See also CORP. FOR SUPPORTIVE HOUS., FREQUENT USERS OF PUBLIC SERVICES: ENDING THE INSTITUTIONAL CIRCUIT 6 (2009), https://www.csh.org/wp-content/uploads/2011/12/Report_FUFBooklet.pdf (calculating that investment in supportive housing saves between \$2,953 and \$7,231 in incarceration costs per person placed in that housing).

⁷⁴ *Black and African American Communities and Mental Health*, MENTAL HEALTH AM. (last visited July 1, 2022) [hereinafter *Black Communities*], <https://www.mhanational.org/issues/black-and-african-american-communities-and-mental-health>.

⁷⁵ William B. Hawthorne et al., *Incarceration Among Adults Who Are in the Public Mental Health System: Rates, Risk Factors, and Short-Term Outcomes*, 63 PSYCHIATRIC SERVS. 26, 29 (2012).

⁷⁶ See *The Washington Post Police Shootings Database*, WASH. POST [hereinafter DATABASE], <https://www.washingtonpost.com/graphics/investigations/police-shootings-database/> (last visited June 27, 2022).

See also Wesley Lowery et al., *Distraught People, Deadly Results*, WASH. POST (June 30, 2015), <https://www.washingtonpost.com/sf/investigative/2015/06/30/distraught-people-deadly-results/> (finding that 27% of people killed by police in the first half of 2015 were in crisis); Amam Z. Saleh et al., *Deaths of People with Mental Illness During Interactions with Law Enforcement*, 58 INT'L J. OF L. AND PSYCHIATRY 110, 112-14 (2018) (estimating that 23% of people killed by police have a psychiatric disability); DORIS A. FULLER ET AL., TREATMENT ADVOC. CTR., OVERLOOKED IN THE UNDERCOUNTED: THE ROLE OF MENTAL ILLNESS IN FATAL LAW ENFORCEMENT ENCOUNTERS (Dec. 2015),

<https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf> (estimating the risk of death as sixteen times greater than for people without mental illness); Shaun King, *If You Are Black and in a Mental Health Crisis, 911 Can Be a Death Sentence*, INTERCEPT (Sept. 29, 2019, 7:00 AM),

<https://theintercept.com/2019/09/29/police-shootings-mental-health/> (“Studies show that as many as 50 percent of people killed by American police had registered disabilities and that a huge percentage of those were people with mental illnesses”); Robert Salonga, *Report: Mentally ill are in nearly 40 percent of South Bay police shootings*, MERCURY NEWS (May 14, 2018, 9:03 AM), <https://www.mercurynews.com/2018/05/11/report-mentally-ill-are-in-nearly-40-percent-of-south-bay-police-shootings/> (“[A] new civil grand jury report reveals that nearly 40 percent of officer shootings in Santa Clara County involve someone who is mentally ill.”).

⁷⁷ Two circumstances contribute to this result. First, the disproportionate policing of Black people and communities, and second, the high percentage of people killed by police shootings who have a mental illness. See Camille A. Nelson, *Frontlines: Policing at the Nexus of Race and Mental Health*, 43 FORDHAM URBAN L. REV. 615, 621 (2016) (finding that Black people report higher rates of serious psychological stress than White people, and “people who exhibit mental health challenges are more likely to attract heightened police scrutiny and reasonable suspicion; they are less likely to respond to police in ways that comport with police behavioral expectations and may, thereby, prompt unfortunate police escalation.”); King, *supra* note 76 (“[Y]oung black men with mental illnesses are in the single most at-risk category in the nation for fatal police violence”).

⁷⁸ See DATABASE, *supra* note 76.

⁷⁹ M.D. Thomas, N.P. Jewell, & A.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*, 53 ANNALS OF EPIDEMIOLOGY 42, 42 (2021).

⁸⁰ Rogers et al., *supra* note 67.

⁸¹ See Martha Williams Deane et al., *Emerging Partnerships Between Mental Health and Law Enforcement*, 50 PSYCHIATRIC SERVS. 99, 100 (1999) (estimating that 7% of all police contacts involve someone with a psychiatric disability); LODESTAR, L.A. POLICE DEP'T CONSENT DECREE MENTAL ILLNESS PROJECT, FINAL REPORT 24 (May 28, 2002),

https://www.prisonlegalnews.org/media/publications/lapd_executive_summary_consent_decree_mental_illness_project_2002.pdf (estimating that 2-3% of calls to the Los Angeles Police Department involve mental health); Jennifer L.S. Teller et al., *Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls*, 57 PSYCHIATRIC SERVS. 232, 234 (2006) (finding that 6.55% of calls to the Akron, Ohio Police Department involve mental health). But see Alexander Black et al., *The Treatment of People with Mental Illness in the Criminal Justice System: The Example of Oneida County, New York*, LEVITT CTR. FOR PUB. AFFS. AT HAMILTON COLL. 9 (June 2019), https://digitalcommons.hamilton.edu/cgi/viewcontent.cgi?article=1005&context=student_scholarship

(estimating that ten percent of police calls involve mental health). These encounters can be especially time-consuming. See LAURA DRAPER, MELISSA REULAND, & MATTHEW SCHWARZFELD, COUNCIL OF STATE GOV'TS JUST. CTR., LAW ENFORCEMENT RESPONSES TO PEOPLE WITH MENTAL ILLNESSES: A GUIDE TO RESEARCH-INFORMED POLICY AND PRACTICE 7 (2009), <https://csgjusticecenter.org/wp-content/uploads/2020/02/le-research.pdf> (finding that the Los Angeles Police Department spends 28,000 hours each month on calls that involve someone in psychiatric distress).

⁸² See Brett Sholtis, *During a Mental Health Crisis, A Family's Call to 911 Turns Tragic*, NPR (Oct. 29, 2020, 5:00 AM ET), <https://www.npr.org/sections/health-shots/2020/10/29/928239761/during-a-mental-health-crisis-a-family-call-to-911-turns-tragic> (discussing the fatal shooting of Ricardo Muñoz, where his mother called emergency services for assistance with Ricardo's mental health episode, but maintained that “Ricardo was never a threat to them”); see also *supra* Part I (discussing the fatal shooting of Daniel Prude, where his brother called for emergency assistance although Daniel was wandering an empty street); see also *infra* note 124 and accompanying text (stating that Walter Wallace Jr. did not show active signs of threat during his mental health crisis, even in the presence of the officers who responded to the scene).

⁸³ See Bellafante, *supra* note 17 and accompanying text.

⁸⁴ *Position Statement 59: Responding To Behavioral Health Crises*, MENTAL HEALTH AM., https://www.mhanational.org/issues/position-statement-59-responding-behavioral-health-crises#_ednref2.

⁸⁵ Taled El-Sabawi & Jennifer J. Carroll, *A Model for Defunding: An Evidence-Based Statute for Behavioral Health Crisis Response*, 94 TEMPLE L. REV. 1, 13 (2021).

⁸⁶ Lauren Young, *Decriminalizing Disability*, 52 MD. B.J. 62, 62 (2019).

⁸⁷ El-Sabawi & Carroll, *supra* note 85, at 17.

⁸⁸ Sema A. Taheri, *Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? A Systematic Review and Meta-Analysis*, 27 CRIM. JUSTICE POL'Y REV. 76, 90 (2016).

⁸⁹ El-Sabawi & Carroll, *supra* note 85, at 16.

⁹⁰ *Id.*

⁹¹ *Id.* at 17.

⁹² Margarita Alegría, PhD. et al., *A New Agenda for Optimizing Investments in Community Mental Health and Reducing Disparities*, 179 AM. J. PSYCHIATRY 6, 402 (2022) (citing inadequate funding as one of the underlying reasons of the racial disparity in effective and accessible public mental health care).

⁹³ See MARTONE ET AL., *supra* note 68, at 5 (“Throughout the country, communities lack the capacity to provide intensive community-based mental health services, including Assertive Community Treatment, mobile crisis services, intensive case management, peer outreach and support, and supported housing, all of which have been proven successful in reducing arrest and incarceration as well as other forms of institutionalization. For people with mental illness and co-occurring substance use disorders, there is not enough medication-assisted treatment, detoxification services, or peer outreach and support, among other treatment options.”); *id.* (“Consequently, too many people with mental illness end up in crisis, landing them in ... emergency rooms, hospitals, and jails.”); *id.* at 3 (“a disproportionate number of people with mental illness are incarcerated in jails and prisons, segregated from society for offenses that could well have been prevented had they had access to appropriate community-based services and supports.”); *id.* at 5 (“Psychiatric crisis services are often nonexistent or insufficient to respond to, divert, or refer individuals back into the mental health system, leaving law enforcement professionals with the dilemma of having to arrest a person because no treatment diversion option exists.”); ROBERT BERNSTEIN, IRA BURNIM, & MARK J. MURPHY, JUDGE DAVID L. BAZELON CTR. FOR MENTAL HEALTH L., DIVERSION, NOT DISCRIMINATION: HOW IMPLEMENTING THE AMERICANS WITH DISABILITIES ACT CAN HELP REDUCE THE NUMBER OF PEOPLE WITH MENTAL ILLNESS IN JAILS 24 (July 2017), <http://www.bazelon.org/wp-content/uploads/2018/07/MacArthur-White-Paper-re-Diversion-and-ADA.pdf> (“Public mental health systems are underfunded. While most overwhelmingly embrace the core principles of deinstitutionalization and community mental health ... services such as Assertive Community Treatment and supported housing are in short supply and are reserved for frequent users of psychiatric hospitals.... Often, this tendency results in mental health systems placing too little priority on people with mental illness who are—or who are at high risk of becoming—justice-involved”); JUDGE DAVID L. BAZELON CTR. FOR MENTAL HEALTH L., DIVERSION TO WHAT? EVIDENCE-BASED MENTAL HEALTH SERVICES THAT PREVENT NEEDLESS INCARCERATION 2 (Sept. 2019) [hereinafter DIVERSION TO WHAT], http://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf (“Investing in community-based mental health services. provides numerous benefits, including a reduction in law enforcement intervention and incarceration.”).

⁹⁴ Among others, the Community Mental Health Services Act of 1963, Pub. L. 88-164, intended to provide federal support for community-based services that would help people with mental illness avoid the “cold mercy of custodial

Mental Retardation (Feb. 5, 1963), <https://www.jfklibrary.org/asset-viewer/archives/JFKWHA/1963/JFKWHA-161-007/JFKWHA-161-007>. However, because of construction and funding barriers, states only built half of the community service centers envisioned in the Act. See Blake Erickson, M.D., M.A., *Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963*, 16 AM. J. OF PSYCH. RESIDENTS' J. 6, 6 (June 2021), <https://psychiatryonline.org/doi/epdf/10.1176/appi.ajp-rj.2021.160404> (citing GERALD N. GROB, FROM ASYLUM TO COMMUNITY: MENTAL HEALTH POLICY IN MODERN AMERICA (1991)). “Those without homes often ended up on the streets, with many entering an institutional circuit of acute care hospitals, jails, prisons, and forensic facilities.” *Id.* See also *Reflecting on JFK’s Legacy of Community-Based Care*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Mar. 18, 2021), <https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/jfks-legacy-community-based-care> (“[W]e have to acknowledge that the execution of the vision was flawed, that fragmented implementation of the promise it held out allowed too many people to fall through the cracks. Too many people failed to receive the help they needed. Too many became homeless or were bypassed by our society.”) (quoting Rep. Patrick Kennedy). Similar state initiatives have faced similar challenges. See, e.g., Sigrid Bathen, *Real Change Proves Elusive In Mental Health System*, CAPITOL WEEKLY (Nov. 10, 2021), <https://capitolweekly.net/real-change-proves-elusive-in-mental-health-care-legislation/> (“[California’s 2004 Mental Health Services Act] has provided billions in funding for mental-health programs, but has also been criticized for its complex regulatory structure and lack of state oversight. Counties have also been accused of ‘hoarding’ MHSA funds that should be going to mental-health programs, or using it for other purposes.”).

⁹⁵ *Olmstead v. L.C.*, 527 U.S. 581 (1999) (holding that unnecessary segregation is discrimination actionable under Americans with Disabilities Act). In *Olmstead*, the Supreme Court noted Congress’s finding that “society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.” *Id.* at 588. The Court also noted Congress’s intent that the ADA “provide a clear and national mandate for the elimination of discrimination against individuals with disabilities.” *Id.* at 589.

⁹⁶ Kristen M. Folkerts, Isra Merchant, & Chenxi Yang, *A Tri-Country Analysis of the Effects of White Supremacy in Mental Health Practice and Proposed Policy Alternatives*, 19 COLUM. SOCIAL WORK REV. 86, 97 (2022) (citing a study revealing that 25-40% of Americans with mental health illnesses face incarceration in their lifetimes).

⁹⁷ See Abigail Adams, *Black, Disabled and at Risk: The Overlooked Problem of Police Violence Against Americans with Disabilities*, TIME (June 25, 2020, 8:56 AM), <https://time.com/5857438/police-violence-black-disabled/> (“The combination of disability and skin color amounts to a double bind”); Jeffrey Swanson et al., *Racial Disparities in Involuntary Outpatient Commitment: Are They Real?*, 28 HEALTH AFFS. 816, 821 (2009) (“Rates of outpatient commitment per 10,000 were higher for blacks than for whites at every level”); *supra* text accompanying note 75.

⁹⁸ See generally Elizabeth N. Chapman, MD et al., *Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*, 28 J. GEN. INTERN. MED. 1504 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3797360/pdf/11606_2013_Article_2441.pdf (discussing research suggesting that implicit biases may shape physician behavior and result in discriminatory treatment); see also Alan Nelson, M.D., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, 94 J. NAT’L MED. ASS’N 666, 667 (2002), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2594273/pdf/jnma00325-0024.pdf> (“Bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health careindirect evidence from several lines of research support this statement”); see generally Ana I. Balsa & Thomas G. McGuire, *Prejudice, Clinical Uncertainty and Stereotyping As Sources of Health Disparities*, 22 J. HEALTH ECON. 89 (2003), <https://www.sciencedirect.com/science/article/abs/pii/S016762960200098X?via%3Dihub>; Ana I. Balsa et al., *Testing for Statistical Discrimination in Health Care*, 40 HEALTH SERVS. RSCH. 227, 227 (2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361135/pdf/hesr_00351.pdf (“In the case of depression, we find evidence that race affects decisions through differences in communication patters between doctors and minority patients.”).

⁹⁹ Matthew C. Fadus et al., *Unconscious Bias and the Diagnosis of Disruptive Behavior Disorders and ADHD in African American and Hispanic Youth*, 44 ACAD. PSYCHIATRY 95, 98-99 (2019), <https://link.springer.com/content/pdf/10.1007/s40596-019-01127-6.pdf>.

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² See Jude Mary Cénat, *How to provide anti-racist mental health care*, 7 LANCET PSYCHIATRY 929, 929 (2020), <https://www.thelancet.com/action/showPdf?pii=S2215-0366%2820%2930309-6> (“[R]acial discrimination, racial

profiling, microaggressions, and racism exist within physical and mental health-care institutions and services in western countries. These widespread and chronic factors are associated with lack of training of mental health professionals on racial issues and disparities.”); Vickie Mays et al., *Perceived Discrimination in Health Care and Mental Health/Substance Abuse Treatment Among Blacks, Latinos, and Whites*, 55 MED. CARE 173, 180 (2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5233585/pdf/nihms807350.pdf> (finding that experiences of discrimination in mental health or substance abuse visits contributes to early treatment discontinuation for Black people, which could be a factor in poorer mental health outcomes).

¹⁰³ See MARTIN SUMMERS, MADNESS IN THE CITY OF MAGNIFICENT INTENTIONS: A HISTORY OF RACE AND MENTAL ILLNESS IN THE NATION’S CAPITAL (2019) (tracing our country’s history of institutionalization in Black communities and explaining how Black communities and patients approached institutions with caution, fearing unequal treatment and care and the possibility of violence, abuse, and long-term confinement).

¹⁰⁴ Rachel L. Johnson, MD, PhD et al., *Patient Race/Ethnicity and Quality of Patient-Physician Communication During Medical Visits*, 94 AM. J. OF PUB. HEALTH 2084, 2087 (2004), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448596/pdf/0942084.pdf>.

¹⁰⁵ Chapman et al., *supra* note 98.

¹⁰⁶ *Demographics of U.S. Psychology Workforce [interactive data tool]*, AM. PSYCH. ASS’N (2020), <https://www.apa.org/workforce/data-tools/demographics>.

¹⁰⁷ *Black Communities*, *supra* note 74.

¹⁰⁸ Mays et al., *supra* note 102.

¹⁰⁹ See generally Mary S. Garner & Dorcas E. Kunkel, *Quality Improvement of Pastoral Care For Major Depression in the Community of an African American Religious Organization*, 41 ISSUES MENTAL HEALTH NURSING 568 (2020) (explaining that, because Black Americans are less likely to receive appropriate diagnosis and culturally competent care for depression, their depression tends to become chronic and more severe).

¹¹⁰ See, e.g., First Amended Complaint at ¶ 2, *Disability Rights California v. County of Alameda*, 2021 WL 212900 (N.D. Cal. Feb. 22, 2021) (No. 5:20-cv-05256-CRB) (“During a recent two-year period, over 2,300 people were detained at the County’s psychiatric facilities more than three times, the majority of whom were Black.”); Press Release, Dep’t of Justice, Justice Department Finds that Alameda County, California, Violates the Americans with Disabilities Act and the U.S. Constitution (Apr. 22, 2021), <https://www.justice.gov/opa/pr/justice-department-finds-alameda-county-california-violates-americans-disabilities-act-and-us> (finding that Alameda County failed to provide services to its constituents with mental health disabilities and unnecessarily institutionalized them at various psychiatric facilities instead of providing appropriate community-based services).

¹¹¹ First Amended Complaint, *supra* note 110, at ¶ 57.

¹¹² *Id.* at ¶ 2.

¹¹³ *Id.* at ¶ 74.

¹¹⁴ *Id.* at ¶ 84.

¹¹⁵ AM. PSYCHIATRIC ASS’N, MENTAL HEALTH DISPARITIES: AFRICAN AMERICANS (2019), <https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-African-Americans.pdf>; Tahmi Perzichilli, *The Historical Roots of Racial Disparities in the Mental Health System*, COUNSELING TODAY (May 7, 2020), <https://ct.counseling.org/2020/05/the-historical-roots-of-racial-disparities-in-the-mental-health-system/> (listing barriers for BIPOC individuals seeking mental health care, including racism and discrimination, greater vulnerability to being uninsured, access and communication barriers, and fear and mistrust of treatment); see also Sirry M. Alang, *Mental health care among blacks in America: Confronting racism and constructing solutions*, 54 HEALTH SERVS. RSCH. 346, 352 (2019), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6407345/pdf/HESR-54-346.pdf> (finding that racism causes mistrust in mental health service systems and that Black people usually receive lower quality mental health care than white people).

¹¹⁶ Richardson & Goff, *supra* note 56, at 121.

¹¹⁷ Richardson, *supra* note 57.

¹¹⁸ *Id.*

¹¹⁹ Richardson & Goff, *supra* note 56.

¹²⁰ Robert E. Worden et al., *On the Meaning and Measurement of Suspects’ Demeanor Toward the Police: A Comment on “Demeanor and Arrest,”* 33 J. RSCH. CRIME & DELINQ. 324, 325 (1996) (noting that the proposition that police officers respond punitively to those they believe are not according them deference “emerged from some of the earliest systematic inquiry into police behavior”). Research also shows significantly high levels of stigma against mental illness among law enforcement officers. See El-Sabawi & Carroll, *supra* note 85, at 11. One study reported that a majority of surveyed police officers viewed being treated for a mental illness as a “sign of personal

18, 20 (2017).

¹²¹ Richardson & Goff, *supra* note 56, at 137.

¹²² Inappropriate and unnecessary contact between Black people with mental illness and law enforcement officers also violates our nation's Constitution and its civil rights laws. *See, e.g.*, C.R. DIV., U.S. DEP'T OF JUST., INVESTIGATION OF THE BALTIMORE CITY POLICE DEPARTMENT 3, 8 (Aug. 10, 2016), <https://www.justice.gov/crt/file/883296/download>. Following the killing of Freddie Gray in 2014, the Department of Justice conducted a comprehensive investigation of the Baltimore Police Department's (BPD's) policies and practices. *Id.* at 10. Among other things, the Department found that the BPD engaged in a pattern or practice of use of excessive force against Baltimore's residents, including Black residents with mental health disabilities. *Id.* at 74-85. The BPD also failed to make reasonable modifications to its policies for interactions for people with mental health disabilities, in violation of the Americans with Disabilities Act (ADA). *Id.* at 80-85. At the same time, the BPD also engaged in racially discriminatory stops, searches, arrests, and use of force, in violation of the Constitution and Title VI of the Civil Rights Act. *Id.* at 47-72. The Department, the BPD, and the City of Baltimore resolved the Department's findings through a Consent Decree, which is still being implemented by the parties under court supervision. Consent Decree, *United States v. Police Dep't of Baltimore City*, 282 F. Supp. 3d 897 (2017) (No. 17-cv-00099-JKB), 2017 WL 4481156, <https://www.justice.gov/opa/file/925056/download>; CONSENT DECREE MONITORING TEAM, SEVENTH SEMI-ANNUAL REPORT (Feb. 15, 2022), <https://static1.squarespace.com/static/59db8644e45a7c08738ca2f1/t/620c205fdfa1535274047ae2/1644961899345/7th+Semiannual+Report.pdf>. The Department continues to investigate police departments across the country for potential violations of the Constitution, Title VI, and the ADA. *See, e.g.*, Attorney General Merrick B. Garland Delivers Remarks Announcing a Pattern or Practice Investigation into the City of Phoenix and the Phoenix Police Department, U.S. DEP'T OF JUST., (Aug. 5, 2021), <https://www.justice.gov/opa/speech/attorney-general-merrick-b-garland-delivers-remarks-announcing-pattern-or-practice> (announcing the Justice Department's investigation into whether the Phoenix Police Department uses unconstitutional excessive force, engages in discriminatory policing practices, and "respond[s] to people with disabilities in a manner that violates the Americans with Disabilities Act").

¹²³ Mallika Kallingal & Brynn Gingras, *The Family of a Philadelphia man is suing two police officers who fatally shot him last year*, CNN (Apr. 2, 2021, 5:11 AM ET), <https://www.cnn.com/2021/04/02/us/walter-wallace-jr-lawsuit-vs-police/index.html>.

¹²⁴ *Id.*

¹²⁵ NBC10 Philadelphia, *VIDEO: Body-Worn Camera Footage From Walter Wallace Jr. Shooting*, YOUTUBE (Nov. 4, 2020) [hereinafter NBC Video], <https://www.youtube.com/watch?v=USiOvzp-PP4>.

¹²⁶ Scott Calvert, *Philadelphia Police Shooting: Who Was Walter Wallace Jr., and What Happened?*, WALL ST. J. (Oct. 28, 2020, 6:33 PM ET), <https://www.wsj.com/articles/philadelphia-police-shooting-who-is-walter-wallace-jr-and-what-happened-11603906148>.

¹²⁷ Doha Madani, *Philadelphia police release 911 calls, body camera video in fatal shooting of Walter Wallace*, NBC NEWS (Nov. 4, 2020, 10:18 PM EST), <https://www.nbcnews.com/news/nbcblk/philadelphia-police-release-911-calls-body-camera-video-fatal-shooting-n1246461>.

¹²⁸ NBC Video, *supra* note 125.

¹²⁹ Vanessa Romo, *Philadelphia Police Release 'Traumatic' Bodycam Video of Walter Wallace Jr. Shooting*, NPR (Nov. 4, 2020, 11:28 PM ET), <https://www.npr.org/2020/11/04/931598467/philadelphia-police-release-traumatic-bodycam-video-of-walter-wallace-jr-shooting>.

¹³⁰ Claudia Lauer, *Philadelphia victim's family sought ambulance, not police*, AP NEWS (Oct. 27, 2020), <https://apnews.com/article/us-news-arrests-shootings-philadelphia-racial-injustice-f1d460e37c7d407f52743f06cbfe8e23>.

¹³¹ Madani, *supra* note 127.

¹³² *Id.*

¹³³ *Id.*

¹³⁴ Calvert, *supra* note 126.

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *See supra* note 122.

¹³⁸ The community mental health services in which substantial investment is needed is described in DIVERSION TO WHAT, *supra* note 93, at 2. *See also* MARTONE ET AL., *supra* note 68, at 3 (noting that "many states have implemented policies, programs, and new housing options" that effectively serve people with mental illness in the community and "[w]hile progress has been slow, ...many more people with mental illness [are] living in integrated,

community-based settings"). Among these, Assertive Community Treatment (ACT) is "an individualized package of services and supports effective in meeting the needs of people with serious mental illness living in the community," delivered by a multi-disciplinary team that provides case management, assessments, psychiatric services, substance use disorder services, housing assistance, and supported employment. DIVERSION TO WHAT, *supra* note 93, at 3. "The team is on call 24 hours a day to address the individual's needs and any crises that may occur." *Id.*

¹³⁹ *See, e.g.*, JUDGE DAVID L. BAZELON CTR. FOR MENTAL HEALTH L., REPLACING SCHOOL POLICE WITH SERVICES THAT WORK (Aug. 2021), <https://secureservercdn.net/198.71.233.111/d25.2ac.myftpupload.com/wp-content/uploads/2021/08/Replacing-Police-in-Schools-1.pdf>.

¹⁴⁰ *Peer Support: Research and Reports*, MENTAL HEALTH AM. (last visited July 1, 2022), <https://www.mhanational.org/peer-support-research-and-reports>; NAT'L LEAGUE OF CITIES, CITY & COUNTY LEADERSHIP TO REDUCE THE USE OF JAILS: ENGAGING PEERS IN JAIL USE REDUCTION STRATEGIES, https://www.nlc.org/wp-content/uploads/2020/10/Peers_Support_Brief_v3.pdf (last visited July 1, 2022).

¹⁴¹ CAHOOTS stands for Crisis Assistance Helping Out On The Streets. *What is CAHOOTS?*, WHITE BIRD CLINIC (Oct. 29, 2020) [hereinafter WHITE BIRD CLINIC], <https://whitebirdclinic.org/what-is-cahoots/>.

¹⁴² 'CAHOOTS': How Social Workers and Police Share Responsibilities in Eugene, Oregon, NPR (June 10, 2020), <https://www.npr.org/2020/06/10/874339977/cahoots-how-social-workers-and-police-share-responsibilities-in-eugene-oregon>. A joint response by both CAHOOTS staff and police happens infrequently. Anna V. Smith, *There's Already an Alternative to Calling the Police*, MOTHER JONES (June 13, 2020), <https://www.motherjones.com/environment/2020/06/theres-already-an-alternative-to-calling-the-police/>.

¹⁴³ Scottie Andrew, *This Town of 170,000 Replaced Some Cops with Medics and Mental Health Workers. It's Worked for Over 30 Years*, CNN (July 5, 2020, 10:10 PM), <https://www.cnn.com/2020/07/05/us/cahoots-replace-police-mental-health-trnd/index.html>.

¹⁴⁴ *See, e.g.*, *Support Team Assisted Response (STAR) Program*, CITY OF DENVER [hereinafter STAR PROGRAM], <https://www.denvergov.org/Government/Agencies-Departments-Offices/Agencies-Departments-Offices-Directory/Public-Health-Environment/Community-Behavioral-Health/Behavioral-Health-Strategies/Support-Team-Assisted-Response-STAR-Program> (last visited July 1, 2022); Tess Riski, *Portland Street Response Expands City-Wide, With 24/7 Service Still On Hold*, WILLAMETTE WEEK (Mar. 28, 2022, 5:28 PM PDT), <https://www.wweek.com/news/city/2022/03/28/portland-street-response-expands-citywide-with-247-service-still-on-hold/>.

¹⁴⁵ *See What is the Street Crisis Response Team?*, CITY & CNTY. S.F., <https://sf.gov/street-crisis-response-team> (last visited July 1, 2022). "San Francisco's new, unarmed, non-police teams are scheduled, at first, to take over the police calls for code 800 – a broad, catch-all category the police describe as a 'report of a mentally disturbed person.' The police here got nearly 17,000 of those code 800s last year, according to SFPD data, and nearly 22,000 overall from persons in mental or behavioral crisis. The vast majority of them were non-violent. Of those code 800 calls, the police data show, only 132 of them reported 'a potential for violence or a weapon.'" S.F. DEP'T PUB. HEALTH, STREET CRISIS RESPONSE TEAM ISSUE BRIEF (Feb. 2021), https://www.sfdph.org/dph/files/IWG/SCRT_IWG_Issue_Brief_FINAL.pdf. There are several different mental health crisis response models with varying degrees of law enforcement involvement, including none at all. A few community-based mental health programs in California importantly conduct all of their services without any law enforcement involvement. For a more in-depth description of the various mental health crisis response teams, see MIMI E. KIM ET AL., INTERRUPTING CRIMINALIZATION, DEFUND THE POLICE - INVEST IN COMMUNITY CARE: A GUIDE TO ALTERNATIVE MENTAL HEALTH RESPONSES (May 2021), <https://static1.squarespace.com/static/5ee39ec764dbd7179cf1243c/t/60ca7e7399f1b5306c8226c3/1623883385572/Crisis+Response+Guide.pdf>.

¹⁴⁶ *See GBRICS Partnership (Greater Baltimore Regional Integrated Crisis System): Transforming Behavioral Health Crisis Services*, BEHAV. HEALTH SYS. BALT. [hereinafter *GBRICS Partnership*], <https://www.bhsbaltimore.org/learn/gbrics-partnership/> (last visited July 1, 2022) (describing Baltimore region's plans to "[e]xpand capacity of mobile crisis teams (non-law enforcement) so that they are available 24/7 across the region," with the goal of "[r]educ[ing] unnecessary emergency department use and police interaction for people in behavioral health crisis").

¹⁴⁷ *See* Letter from Daniel Tsai, Deputy Admin. & Director, Ctrs. for Medicare & Medicaid Servs., to U.S. Dep't of Health & Human Servs. (Dec. 28, 2021) [hereinafter CMS Letter], <https://www.medicare.gov/federal-policy-guidance/downloads/sho21008.pdf>.

¹⁴⁸ DIVERSION TO WHAT, *supra* note 93, at 7-8. The federal government has endorsed the clinician-peer worker model as a "best practice." *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., NAT'L GUIDELINES FOR

<https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>.

¹⁴⁹ See, e.g. Eric Westervelt, *Removing Cops From Behavioral Health Crisis Calls: “We Need To Change the Model,”* NPR (Oct. 19, 2020), <https://www.npr.org/2020/10/19/924146486/removing-cops-from-behavioral-crisis-calls-we-need-to-change-the-model> (stating that the goal of San Francisco’s Street Crisis Response Team program is to “better guide people to long-term supportive services, and to end the in-and-out emergency rooms and homeless shelter cycle”).

¹⁵⁰ See NAT’L ALL. ON MENTAL ILLNESS, CRISIS SERVICES FACT SHEET 2 (Mar. 2015), <https://www.nami.org/NAMI/media/NAMI-Media/Images/FactSheets/Crisis-Service-FS.pdf> (“Crisis respite centers and apartments provide 24-hour observation and support by crisis workers or trained volunteers until a person is stabilized and connected with other supports”); DIVERSION TO WHAT, *supra* note 93, at 7-8 (describing “community crisis apartments where individuals can stay for a short period as an alternative to hospitalization, incarceration, or stays in costly and hospital-like crisis facilities” that provide support from clinicians and peers); DANIEL FISHER ET AL., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., PEER-RUN RESPITES: AN EFFECTIVE CRISIS ALTERNATIVE, <https://www.nasmhpd.org/sites/default/files/Peer%20Run%20Respite%20slides.revised.pdf> (last visited July 1, 2022).

¹⁵¹ “Crisis drop-off centers that are open 24 hours a day and have a ‘no refusal’ policy enable law enforcement to divert persons with mental illness away from the criminal justice system.” MARTONE ET AL., *supra* note 68, at 10-11.

¹⁵² Most psychiatric crises can be addressed without resort to hospitalization, however. See, e.g., TREATMENT ADVOC. CTR., PSYCHIATRIC BED SUPPLY NEED PER CAPITA 1 (Sep. 2016), <https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/bed-supply-need-per-capita.pdf> (“[M]ost people with a diagnosed mental illness never require hospitalization, and many with the most serious conditions can be successfully treated in the community”); Margie Balfour, M.D., Ph.D., Chief of Quality & Clinical Innovation, Connections Health Sols., Presentation to the Ohio Mental Health Admin.: The Ideal Crisis System: Strategies for Mental Health and Law Enforcement Collaboration to Prevent Justice Involvement 21 (Nov. 18, 2019),

<https://mha.ohio.gov/static/Portals/0/assets/SchoolsAndCommunities/CommunityAndHousing/Community-Planning/Crisis%20Services/Ideal-Crisis-System.pdf?ver=2019-11-18-104750-667> (noting that in southern Arizona’s behavioral health crisis system, 80% of crisis calls were resolved by phone; of the rest, 71% were resolved in the field by mobile crisis teams, and 68% of the remaining individuals were stabilized in care centers and returned to their communities without hospitalization).

¹⁵³ A widely respected example of such a center is the Houston Recovery Center. *Harris County Confidential Jail Diversion Programs*, HOUS. RECOVERY CTR., <https://houstonrecoverycenter.org/harris-county-confidential-jail-diversion-programs/> (last visited July 1, 2022).

¹⁵⁴ Exec. Order No. 14,074, 87 Fed. Reg. 32945 (May 25, 2022), <https://www.whitehouse.gov/briefing-room/presidential-actions/2022/05/25/executive-order-on-advancing-effective-accountable-policing-and-criminal-justice-practices-to-enhance-public-trust-and-public-safety/>. The Executive Order requires the Attorney General and the Secretary of Health and Human Services to lead a study of co-responder and alternative responder models and issue guidance on best practices for responding to calls for and from people experiencing mental health crises. *Id.* at § 14(a)-(b). Studies show, however, that co-responder models are ineffective. See generally Taheri, *supra* note 88. While it is important to consider alternatives, focusing on the co-responder model will continue to result in criminalization and physical violence against people with mental illness, especially those who are Black. Alternative responder models like the community response program piloted in Denver, CO, on the other hand, are proven to reduce the criminalization of people experiencing mental health crises and reduce the actual level of crime in the community altogether. See Thomas S. Dee & Jaymes Pyne, *A community response approach to mental health and substance abuse crises reduced crime*, 8 SCI. ADV. 1, 6 (2022), <https://www.science.org/doi/pdf/10.1126/sciadv.abm2106>.

¹⁵⁵ See generally Taheri, *supra* note 88; El-Sabawi & Carroll, *supra* note 85.

¹⁵⁶ In addition, the training models that exist have produced mixed results. For example, some studies of Crisis Intervention Training (CIT) for police, a popular approach, have indicated that it does not change the outcomes from police interventions. El-Sabawi & Carroll, *supra* note 85, at 13 (“Despite the enormous number of programs in operation in the thirty years following CIT’s conception, little evidence exists to show that the CIT approach is effective at reducing incidents of police use of force (or even simply reducing incidents of excessive police use of force) during behavioral-health-related calls.”).

¹⁵⁷ See *supra* notes 81-83 and accompanying text.

¹⁵⁸ Taheri, *supra* note 88, at 90.

¹⁵⁹ There are different ways to implement a joint response. A pre-existing team of police and mental health personnel can be dispatched, or the police and mental health system can separately deploy personnel who coordinate and converge on the scene. Communities have implemented a variety of co-responder models. ASHLEY KRIDER ET AL., POL’Y RSCH., INC. & NAT’L LEAGUE OF CITIES, RESPONDING TO INDIVIDUALS IN BEHAVIORAL HEALTH CRISIS VIA CO-RESPONDER MODELS: THE ROLES OF CITIES, COUNTIES, LAW ENFORCEMENT, PROVIDERS (Jan. 2020), <https://www.theiacp.org/sites/default/files/SJCResponding%20to%20Individuals.pdf>.

¹⁶⁰ See, e.g., S. Rebecca Neusteter, Ph.D., Exec. Dir., Univ. Chi. Health Lab, Presentation to the National Association of Counties: Understanding Law Enforcement Response 5-19, (Jan. 27, 2021) [hereinafter Neusteter Presentation], https://www.naco.org/sites/default/files/event_attachments/Coordinating%20a%20System%20Response%20to%20911%20Dispatch.pdf.

¹⁶¹ DIVERSION TO WHAT, *supra* note 93, at 7-8.

¹⁶² See CMS Letter, *supra* note 147 (discussing enhanced federal Medicaid financing for qualifying mobile crisis services); Richard G. Frank & Vikki Wachino, *Building A Sustainable Behavioral Health Crisis Continuum*, BROOKINGS (Jan. 6, 2022), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2022/01/06/building-a-sustainable-behavioral-health-crisis-continuum/> (“The new Medicaid mobile crisis incentive is modeled on the CAHOOTS (Crisis Assistance Helping Out on the Streets) mobile crisis intervention program in Eugene Oregon.”).

¹⁶³ See MARTONE ET AL., *supra* note 68, at 5 (noting these services “have been proven successful in reducing arrest and incarceration as well as other forms of institutionalization”); Bernstein, Burnim, & Murphy, *supra* note 93, at 18 (noting these services’ success in preventing needless institutionalization and pointing out that their availability increases jurisdictions’ compliance with the Americans with Disabilities Act); DIVERSION TO WHAT, *supra* note 93, at 7-8 (describing these services and the evidence of their success in preventing incarceration).

¹⁶⁴ In November 2021, the House of Representatives passed the Build Back Better Act, which included \$150 billion in federal financial resources for Medicaid reimbursement for services like ACT, crisis services, supported employment, and peer support services. Emily Cochrane & Jonathan Weisman, *House Narrowly Passes Biden’s Social Safety Net and Climate Bill*, N.Y. TIMES (Nov. 21, 2021), <https://www.nytimes.com/2021/11/19/us/politics/house-passes-reconciliation-bill.html>; Elise Aguilar, *The Build Back Better Act: \$150 Billion for Medicaid HCBS Funding and Other Important Programs*, AM. NETWORK CMTY. OPTIONS & RES. (Nov. 2, 2021), <https://www.ancor.org/newsroom/news/build-back-better-act-150-billion-medicaid-hcbs-funding-and-other-important-programs>. The Build Back Better Act also allocated another \$150 billion in federal housing resources, including Department of Housing and Urban Development (HUD) housing vouchers that can be used by people with mental illness so that they can afford safe and stable housing. Will Fischer, *Housing Investments in Build Back Better Would Address Pressing Unmet Needs*, CTR. BUDGET & POL’Y PRIORITIES (Feb. 10, 2022), <https://www.cbpp.org/research/housing/housing-investments-in-build-back-better-would-address-pressing-unmet-needs#:~:text=The%20House%2Dpassed%20Build%20Back%20Better%20bill%20would%20provide%20more,expansion%20is%20fully%20phased%20in.>

¹⁶⁵ CTR. CONNECTED HEALTH POL’Y, COVID-19 TELEHEALTH COVERAGE POLICIES (Mar. 2021), https://www.cchpca.org/2021/11/Spring2021_COVIDPolicies-1.pdf. This recommendation also applies to state lawmakers, as well as to private insurance regulators.

¹⁶⁶ This recommendation also applies to state lawmakers, as well as to private insurance regulators.

¹⁶⁷ This summer will see the roll-out of 988, the new three-digit number for calls to the national network of call centers affiliated with the National Suicide Prevention Lifeline. Designating 988 for the National Suicide Prevention Lifeline, 47 CFR § 52.200 (2020). 988 is intended to be a new “mental health 911” for calls involving mental health crises including but not limited to threats of self-harm. National Suicide Hotline Designation Act of 2020, Pub. L. 116-172 (2020). As currently constituted, the 988 network is inadequate to meet the needs of all those who are expected to call 988, or to serve as an effective resource to the 911 system. JUDGE DAVID L. BAZELON CTR. FOR MENTAL HEALTH L., A NEW DAY OR MORE OF THE SAME? OUR HOPES AND FEARS FOR 988 (AND 911) (June 2022) [hereinafter HOPES AND FEARS FOR 988], <https://secureservercdn.net/198.71.233.111/d25.2ac.myftpupload.com/wp-content/uploads/2022/06/A-New-Day-or-More-of-the-Same-Our-Hopes-Fears-for-988-and-911.pdf>. Congress has enacted legislation permitting states to place fees on mobile phone networks to pay for staffing and training for 988, see *id.*, but more federal support has been proposed and is needed.

¹⁶⁸ For example, under the Mental Health Justice and Parity Act of 2022, introduced in the House of Representatives by Congresswoman Katie Porter, the Department of Health and Human Services (HHS) would provide grants to

Health Justice and Parity Act of 2022, H.R. 7254, 117th Cong. (introduced Mar. 28, 2022). These alternative responders would be trained in the principles of de-escalation and antiracism, and grantees could receive additional funds if they demonstrate a notable reduction in incarceration or death of people with mental illness, or a notable increase in referrals of people with mental illness to voluntary community-based services. *Id.* Federal funding for other initiatives, such as the 988 network, *see* HOPES AND FEARS FOR 988, *supra* note 167, was included in the Bipartisan Safer Communities Act of 2022, enacted by Congress and signed by President Biden in June 2022. *See* President Joseph R. Biden, Remarks at the Signing of S.2938, the Bipartisan Safer Communities Act (June 25, 2022), <https://www.whitehouse.gov/briefing-room/speeches-remarks/2022/06/25/remarks-by-president-biden-at-signing-of-s-2938-the-bipartisan-safer-communities-act/>.

¹⁶⁹ *See, e.g., Fact Sheet: President Biden to Announce Strategy to Address Our National Mental Health Crisis, As Part of Unity Agenda in his First State of the Union*, WHITE HOUSE (Mar. 1, 2022) (announcing President’s FY2023 budget request for mental health workforce capacity-building programs), <https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/>. Existing programs such as the National Health Service Corps, Nurse Corps, Behavioral Health Workforce Education and Training Program, Substance Use Disorder Treatment and Recovery Loan Repayment Program, and the Minority Fellowship Program, provide training, access to scholarships and loan repayment to mental health clinicians committed to practicing in underserved communities.

¹⁷⁰ *Assertive Community Treatment Grants*, SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN. (Mar. 2021), <https://www.samhsa.gov/grants/grant-announcements/sm-18-013>.

¹⁷¹ *See, e.g.,* DIVERSION TO WHAT, *supra* note 93 (calling on communities to implement supported housing and supported employment programs).

¹⁷² *See About*, NAT’L NETWORK TO ELIMINATE DISPARITIES IN BEHAV. HEALTH (NNED), <https://nned.net/about/> (last visited July 1, 2022) (stating that NNED supports community-based organizations in learning about and implementing training and other efforts to increase behavioral health equity).

¹⁷³ *See, e.g.,* Lucy Tompkins, *If Housing Is a Health Care Issue, Should Medicaid Pay the Rent?*, N.Y. Times (June 14, 2022), <https://www.nytimes.com/2022/06/14/headway/medicaid-housing-rent-health.html>; Jennifer Mathis, *Housing is Mental Health Care: A Call for Medicaid Demonstration Waivers Covering Housing*, PSYCHIATRY ONLINE (Dec. 18, 2020), <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000252> (stating that Medicaid should “approve demonstrations covering housing for people with serious mental illnesses. If these demonstrations show that providing Medicaid financing for housing improves mental health outcomes and reduces use of more costly services, those results should spur a conversation about modifying Medicaid to allow reimbursement for housing in appropriate circumstances”). Studies show that providing permanent, scattered-site supported housing to people with mental illness fosters better outcomes, in terms of reduced emergency room and hospital utilization, reduced engagement with law enforcement, and increased measures of social interaction and community engagement. *See, e.g.,* JUDGE DAVID L. BAZELON CTR. FOR MENTAL HEALTH L., SUPPORTIVE HOUSING: THE MOST EFFECTIVE AND INTEGRATED HOUSING FOR PEOPLE WITH MENTAL DISABILITIES (Apr. 2017), http://www.advancingstates.org/sites/nasquad/files/hcbs/files/155/7711/Supportive_Housing.pdf; *Position Statement 38: Supportive Housing and Housing First*, MENTAL HEALTH AM. (Sep. 18, 2018), https://www.mhanational.org/issues/position-statement-38-supportive-housing-and-housing-first#_ednref13; Tim Aubry et al., *A randomized controlled trial of the effectiveness of Housing First in a small Canadian City*, 19 BMC PUB. HEALTH 1154 (2019), <https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/s12889-019-7492-8.pdf>. Providers of mental health services report that it is easier to engage people with mental illness in considering other services, and in active participation in service planning and recovery. *See, e.g.,* *What We Do: Housing First Teams, PATHWAYS TO HOUSING DC* [hereinafter PATHWAYS], <https://pathwaystohousingdc.org/what-we-do/housing-first/> (“After receiving housing first, every client is matched with a support team[,] . . . which works together to provide a client-centered, comprehensive community-based treatment and support services around the clock. . . . Using this model, we have been able to maintain a housing retention rate of at least 91% with clients who have traditionally been viewed as ‘treatment resistant,’ and ‘not ready for housing’”) (last visited July 1, 2022).

¹⁷⁴ *See* Letter from Dennis G. Smith, Dir., Ctrs. for Medicare & Medicaid Servs., to U.S. Dep’t of Health & Hum. Servs. (Aug. 15, 2007), <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf> (stating that supervision of peer support workers is a “core component” of peer services, and must be provided by a “competent mental health professional”). Although consulting with clinicians such as psychologists or social workers may be beneficial to people working as peers, it should not be a requirement for reimbursement of all peer support services. The lived experience of peers, and their ability to share these experiences with other people with

mental illness, are intrinsically valuable, and there are other approaches to ensuring that peer services are effective, including those in which networks of peers share their experiences among themselves, that should be considered. *See, e.g.,* *People USA’s Rose Houses*, PEOPLE USA, <https://people-usa.org/program/rose-houses/> (last visited July 1, 2022) (“Rose Houses are short-term crisis respites that are home-like alternatives to hospital psychiatric ERs and inpatient units. They are 100% operated by peers who have their own lived experiences with behavioral health challenges, crisis, and moving toward wellness.”); *Online and Phone Supports*, WILDFLOWER ALL. [hereinafter Wildflower Phone Supports], <https://wildfloweralliance.org/online-support-groups/> (last visited July 1, 2022) (hosting peer-led suicide-related support groups both online and by phone); *The Living Room: Forever Hope*, THRESHOLDS, <https://www.thresholds.org/programs-services/peer-services/the-living-room> (last visited July 1, 2022) (“The Living Room . . . is an entirely peer-led crisis respite center, an alternative to psychiatric hospitalization. . . . [The] Living Room is a calm, peaceful, and inviting space with plenty of natural light. . . . Staff at The Living Room help guests through a screening and assessment process in a natural, comfortable setting.”); *What is the Evidence for Peer Recovery Support Services?*, RECOVERY RSCH. INST., <https://www.recoveryanswers.org/research-post/what-is-the-evidence-for-peer-recovery-support-services/> (last visited July 1, 2022) (citing Reif et al., *Peer recovery support for individuals with substance use disorders: assessing the evidence*, 65 PSYCHIATRIC SERV. 853 (2014)); DIVERSION TO WHAT, *supra* note 93, at 11.

¹⁷⁵ *See, e.g.,* Phyllis Jordan, Anne Dwyer, Bella DiMarco & Margaux Johnson-Green, *How Medicaid Can Help Schools Sustain Support for Students’ Mental Health*, GEO. UNIV. HEALTH POLY INST. CTR. FOR CHILDREN & FAMILIES (May 2022), <https://ccf.georgetown.edu/2022/05/17/how-medicaid-can-help-schools-sustain-support-for-students-mental-health/>.

¹⁷⁶ DIVERSION TO WHAT, *supra* note 93, *passim*. These services include intensive case management, peer support services, Assertive Community Treatment (ACT, which should serve as a crisis response resource for its clients), supported employment, and supported housing. *Id.* For children and youth, available services should be wrapped around the child and family, through a plan developed by a multi-disciplinary team partnering with the child and family. *See, e.g.,* Letter from Vanita Gupta, Principal Deputy Assistant Att’y Gen., C.R. Div., U.S. Dep’t of Just., to Honorable Earl Ray Tomblin, Governor, W. Va. 9 (June 1, 2015), https://www.ada.gov/olmstead/documents/west_va_findings_ltr.pdf; CINDY MANN & PAMELA S. HYDE, CTR. FOR MEDICAID & CHIP SERVS. & SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., JOINT CMCS & SAMHSA INFORMATIONAL BULLETIN: COVERAGE OF BEHAVIORAL HEALTH SERVICES FOR CHILDREN, YOUTH, AND YOUNG ADULTS WITH SIGNIFICANT MENTAL HEALTH CONDITIONS 3-6 (2013), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf>. Services should be adapted to make them effective for all communities, including Black communities. RAHN K. BAILEY, M.D., AM. PSYCHIATRIC ASS’N, BEST PRACTICE HIGHLIGHTS: AFRICAN AMERICANS/BLACKS, <https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Treating-Diverse-Populations/Best-Practices-AfricanAmerican-Patients.pdf> (last visited June 14, 2022).

¹⁷⁷ *See, e.g.,* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., TREATMENT IMPROVEMENT PROTOCOL 57, TRAUMA-INFORMED CARE IN BEHAVIORAL HEALTH SERVICES (2014). So delivered, participation in these services can help people with mental illness avoid crises which may prompt involvement with law enforcement. *See, e.g.,* *Addressing Law Enforcement Violence as a Public Health Issue*, AM. PUB. HEALTH ASS’N (Nov. 13, 2018), <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence>.

¹⁷⁸ *See, e.g.,* HOPES AND FEARS FOR 988, *supra* note 167, at 10-11. Effective call centers resolve requests for help by providing advice, making referrals, and/or providing transportation to a community-based service provider. *Id.*

¹⁷⁹ DIVERSION TO WHAT, *supra* note 93, at 7.

¹⁸⁰ HOPES AND FEARS FOR 988, *supra* note 167, at 11. These include respite apartments or “living room” model care centers. *Id.* All of the components of the behavioral health crisis response system should be coordinated so that provider capacity and an individual’s progress through the system are tracked and outcomes monitored. *See, e.g.,* TOOLKIT, *supra* note 148.

¹⁸¹ *See, e.g.,* PATHWAYS, *supra* note 173.

¹⁸² *See, e.g.,* WHITE BIRD CLINIC, *supra* note 141 (describing implementation of the CAHOOTS program in the Eugene-Springfield metro area of Oregon); STAR PROGRAM, *supra* note 144.

¹⁸³ *See, e.g.,* Natasha Hinds Fitzsimmins, Lenore Bromley, & Liben Gebremikael, *City of Toronto Launches Black Mental Health Campaign Ahead of Black History Month*, CITY OF TORONTO (Jan. 30, 2020), <https://www.toronto.ca/news/city-of-toronto-launches-black-mental-health-campaign-ahead-of-black-history-month/>; *see generally* *Identity and Cultural Dimensions: Black/African American*, NAT’L ALL. ON MENTAL ILLNESS,

2022).

¹⁸⁴ See, e.g., HOPES AND FEARS FOR 988, *supra* note 167, at 12; NAT'L SUICIDE PREVENTION LIFELINE, POLICY FOR HELPING CALLERS AT IMMINENT RISK OF SUICIDE 1 (Dec. 2010), <https://www.madinamerica.com/wp-content/uploads/2020/11/SAMHSA-Lifeline-Policy-for-Helping-Callers-at-Imminent-Risk-of-Suicide.pdf> (finding that in a 2007 study of four Lifeline centers, deployment of emergency rescue services varied from 0.5% of calls at one center to 8.5% of calls at another center). 988 and 911 service providers, and law enforcement agencies, should audit those instances when police are dispatched to better understand whether involving the police was appropriate. See, e.g., Neusteter Presentation, *supra* note 160.

¹⁸⁵ See *Delivering Behavioral Health: Police-Mental Health Collaboration (PMHC) Toolkit*, U.S. DEP'T OF JUST., BUREAU OF JUST. ASSISTANCE, <https://bja.ojp.gov/program/pmhc/behavioral-health#:~:text=Non%2DCrisis%20Diversi%20%20E%20%80%93%20In%20non,support%20and%20services%20as%20appropriate> (last visited Jun. 14, 2022).

¹⁸⁶ See, e.g., *GBRICS Partnership*, *supra* note 146 (describing 21-member stakeholder group providing guidance to behavioral health crisis reform effort; members are required to participate in committees including to promote community engagement). This may mean providing stipends or childcare to community members so that they can participate in meetings.

¹⁸⁷ See, e.g., *Community Mental Health Services Block Grant*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Apr. 2020), <https://www.samhsa.gov/grants/block-grants/mhbg>; *Substance Abuse Prevention and Treatment Block Grant*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Apr. 2022), <https://www.samhsa.gov/grants/block-grants/sabg>; *What is a CCBHC?*, NAT'L COUNCIL FOR MENTAL WELLBEING, <https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-overview/> (last visited June 30, 2022).

¹⁸⁸ See, e.g., *Peers*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Apr. 2022), <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers>.

¹⁸⁹ See, e.g., *PEER RESPITES: ACTION & EVALUATION*, <https://www.peerrespice.com/> (last visited June 14, 2022).

¹⁹⁰ See, e.g., *Expanding the Peer Bridger Program*, WASH. MENTAL HEALTH SUMMIT, <https://www.wamhsummit.org/peer-bridger-program> (last visited July 1, 2022).

¹⁹¹ See, e.g., *Wildflower Phone Supports*, *supra* note 174; NAT'L ALL. ON MENTAL ILLNESS, NAMI NATIONAL WARMLINE DIRECTORY (Apr. 2021), <https://www.nami.org/NAMI/media/NAMI-Media/BlogImageArchive/2020/NAMI-National-HelpLine-WarmLine-Directory-3-11-20.pdf>; WARMLINES, <https://warmline.org/> (last visited May 31, 2022).

¹⁹² See, e.g., *Individualized Placement and Support (IPS) Supported Employment for People Experiencing Homelessness*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (June 2022), <https://soarworks.samhsa.gov/article/individual-placement-and-support-ips-supported-employment-for-people-experiencing>.

¹⁹³ See, e.g., *SUPPORT, TECH. ASSISTANCE & RES. CTR., CULTURAL COMPETENCY IN MENTAL HEALTH PEER-RUN PROGRAMS AND SELF-HELP GROUPS: A TOOL TO ASSESS AND ENHANCE YOUR SERVICES 8* (2010), <https://power2u.org/wp-content/uploads/2017/09/CulturalCompetencyInMentalHealthPeer-runProgramsSelf-helpGroups.pdf> (advising providers of peer support services to look at “cultural composition of your peer staff, volunteers or leadership”).

¹⁹⁴ See, e.g., *DIVERSION TO WHAT*, *supra* note 93; LAUREN WOOD & LAUREN BLOCK, NAT'L GOVERNORS ASS'N SUPPORTING STATE BEHAVIORAL HEALTH SYSTEMS DURING COVID-19 RECOVERY AND RESPONSE (Nov. 2020), <https://www.nga.org/wp-content/uploads/2020/11/Supporting-State-Behavioral-Health-Systems-During-COVID-19-Response-and-Recovery.pdf>.

¹⁹⁵ See, e.g., JESSICA ALLEN ET AL., WORLD HEALTH ORG., SOCIAL DETERMINANTS OF MENTAL HEALTH (2014), https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf.

¹⁹⁶ The American Rescue Plan Act (ARPA) allocated \$122 billion to support school districts through the Elementary and Secondary School Emergency Relief (ESSER) program. See, e.g., U.S. DEP'T OF EDUC., FACT SHEET: AMERICAN RESCUE PLAN ACT OF 2021 ELEMENTARY AND SECONDARY SCHOOL EMERGENCY RELIEF FUND (Mar. 2021), https://oese.ed.gov/files/2021/03/FINAL_ARP-ESSER-FACT-SHEET.pdf. Schools who obtain ESSER funds from their states must commit them to specific projects on designated deadlines through September 2024, but then have another 18 months from their “obligation” deadline to spend the funds. Letter from Roberto J. Rodríguez, Assistant Sec'y, Off. of Planning, Evaluation & Pol'y Dep't, U.S. Dep't of Educ., to Daniel Domenech, Exec. Dir., School Superintendents Ass'n (May 13, 2022), [https://aasa.org/uploadedFiles/AASA_Blog_The_Total_Child\(1\)/AASA%20Response%20Letter%205_13_22.pdf](https://aasa.org/uploadedFiles/AASA_Blog_The_Total_Child(1)/AASA%20Response%20Letter%205_13_22.pdf).

¹⁹⁷ U.S. DEP'T OF EDUC., FREQUENTLY ASKED QUESTIONS: ELEMENTARY AND SECONDARY SCHOOL EMERGENCY RELIEF PROGRAMS & GOVERNOR'S EMERGENCY EDUCATION RELIEF PROGRAMS 29-30 (May 2021), https://oese.ed.gov/files/2021/05/ESSER.GEER_FAQs_5.26.21_745AM_FINALb0cd6833f6f46e03ba2d97d30aff953260028045f9ef3b18ea602db4b32b1d99.pdf.

**WE WILL NOT STAND BY AND WATCH
THIS LIST OF INNOCENT VICTIMS GROW.**

