ALTERNATIVES TO THE POLICE

RESPONDING TO PEOPLE WITH MENTAL ILLNESS

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JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW

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Policing and Mental Health

The recent killings of George Floyd and many other Black Americans by law enforcement officers have amplified the national discussion about the role of the police in our communities. Calls to "defund" the police have prompted urgent examination of what "public safety" means and brought into sharp relief the cost of having police handle situations better addressed by people with a different skill set and perspective. Many activists and community leaders are urging that resources be redirected from law enforcement to housing, education, and social services to help dismantle institutional racism in the United States. We strongly support a reduced role for the police and additional spending on community-based measures that promote the well-being of all.

We urge communities, when implementing such reforms, to consider the role law enforcement plays in responding to people with mental illness. In far too many communities, police take the lead in responding to people with mental illness in crisis or in need, with tragic consequences, especially for Black people with mental illness. As many as one-quarter of the fatalities from police shootings are people with mental illness.[1] Black people with mental illness are at great risk of dying at the hands of the police.[2]

The shootings of Deborah Danner and Marcus-David Peters illustrate the problem. In both cases, police encountered an individual with mental illness. Instead of calling on mental health personnel to engage Danner and Peters, police took the lead. A different response could have spared both individuals from deadly harm.

Deborah Danner, a 66-year-old Black woman with mental illness, lived in an apartment in New York City. The police went to her building after a report that she was acting erratically, yelling in the hallway of the building and tearing posters off the wall. She was in her apartment when police arrived. Police coaxed her from her bedroom and then rushed forward to grab her. She retreated back to her bedroom, jumped on the bed, pulled a bat from her bedclothes, and then took a batter's stance, wielding the bat. An officer fired two shots, killing her.[3]

Marcus-David Peters, a 24-year-old Black man, was naked and driving wildly in Richmond, Virginia, when he slammed into a line of trees. The police officer who arrived at the scene recognized that Peters was mentally unstable. When Peters, unarmed, ran from his car into traffic, he was knocked down by a car, got back up, and approached the officer, who ordered him to get down on the ground. When Peters did not comply, the officer tased him and shot him twice. Peters died.

At a press conference after Peter's death, Richmond's frustrated police chief complained that his officers are often placed in difficult situations that require them to "wear different hats." Police training cannot adequately prepare them. "I look at what it would take to become a psychologist, psychiatrist, mental-health counselor. Five to eight years of training. Our police department gives our officers 40 hours. Five to eight years, and we get 40 hours," he said. While increasing police training can improve police responses to people with mental illness, the chief is right that training is not the cure. The fundamental problem is having police, rather than mental health personnel, address the situation.[4]

Because of over-policing, people with mental illness, especially those who are Black, have disproportionately suffered both needless death and high rates of incarceration. Approximately 20% of jail inmates and 15% of prison inmates have a serious mental illness,[5] although people with serious mental illness comprise only 4-5% of the population.[6] Two million people with a serious mental illness are booked into jails each year,[7] and the risk of being jailed is particularly high for Black people with mental illness.[8]

A contributing cause of these high figures is the widely acknowledged dysfunction of our public mental health system. Mental health services are limited and available to only a fraction of those who need them. In especially short supply are services with a good track record of success for people with the most significant needs.[9] Black people with mental illness are especially poorly served, and a large percentage of them receive no services at all.[10] As a result, Black people are disproportionately reliant on emergency rooms for mental health care.[11] They

are also at greater risk for being involuntarily committed to a hospital, and are more likely to have a police encounter when experiencing a mental health crisis.[12]

About 1 in 20 police encounters involve individuals with mental illness.[13] Police are deployed in a wide variety of situations involving people with mental illness. Few of these situations threaten public safety. Police respond when families are concerned about a loved one, when people with a mental illness experience a mental breakdown, when homeless individuals with mental illness are lingering where they are not wanted, when people with mental illness fail to obey staff in facilities or schools, and when people with mental illness engage in inappropriate or odd behavior in public because of alcohol or drug use. Police are also deployed to transport people with mental illness to hospitals, typically in handcuffs, when a doctor or judge directs that they receive involuntary care. When police are involved, arrest and incarceration tend to follow and, far too often, the use of deadly force.

We must end this overreliance on the police, especially in predominantly Black communities, and we must invest in public mental health systems, expanding their capacity to deliver community-based mental health services, housing assistance, substance use treatment, and income support. Schools must take a similar approach, ending their overreliance on law enforcement officers, "school resource officers," and investing instead in professional staff, positive approaches to improving behavior, and better services. Many cities and counties have key elements of a well-functioning public mental health system.[14] Highly effective models exist, including those reflected in settlement agreements with States entered into by the U.S. Department of Justice and the Bazelon Center.[15]

As we build capacity, we must heed the voices of people with mental illness, including those who represent the racial, ethnic, gender, linguistic and other important types of diversity in our communities. Far too often, their voices have been excluded or ignored when changes are formulated, implemented, and evaluated. In addition, more individuals with lived experience must be employed in mental health systems. Their experience and perspective enable them to play a unique and critical role in the service system. Peers develop relationships of trust, support individuals in obtaining the treatment and other help they need, and help prevent and resolve crises.[16]

Examples of successful efforts exist. Some cities have deliberately reduced the role of the police in responding to people with mental illness. In the Eugene, Oregon, CAHOOTS program, a medic and social worker, both unarmed, are dispatched instead of the police to

most situations involving people with mental illness. Police join them in some situations, including if someone is in immediate danger or presents a clear threat to others.[17] 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.[18] Similar programs are underway in Denver, Oakland, and Portland. A greater number of communities are investing in a functional equivalent of CAHOOTS, mental health crisis teams that can be dispatched by 911 or law enforcement.

Solutions for A Better Future

To minimize the police's role in responding to people with mental illness, communities can implement the following three changes.

Re-direct requests for police intervention. Calls to 911 and the police should be screened to see if the person about whom the call is made is known to or appears to have a mental illness. In most cases, such calls should be redirected and handled entirely by a unit within the mental health system. In some cases, it will be appropriate for the police to respond jointly or as backup for the mental health system.[19] Communities should adopt policies and provide training to identify situations that can be handled entirely by the mental health system and situations, such as those involving violence to others, in which the police should also respond. The mental health system, and not police, should be deployed when the individual is suicidal and presents no risk to others.

Capacity for a mental health response. Within the mental health system, there should be a unit that functions much like 911, receiving and responding to calls directly received, calls redirected from 911, and calls from the police. Some calls can be resolved by providing advice, making referrals, or providing transportation. Others will require dispatching mobile mental health staff. Typically, such staff are organized as mobile crisis teams, which respond quickly and de-escalate situations.[20]

In addition, there should be an array of facilities available for crisis care, including respite apartments,[21] apartments for short term stays staffed by mental health personnel including peers,[22] walk-in or drop-off crisis centers (scattered in neighborhoods in urban areas),[23] and inpatient hospital care.[24] Short term detox facilities should be available as well, followed up by offers of treatment for substance use disorders.[25]

Follow-up care. After the immediate issue is resolved, the mental health system must follow-up, checking to make sure the individual has access to needed services on an on-going basis. People who receive crisis care often lack access to on-going mental health services. If the person was regularly receiving services but becomes the subject of a call to the mental health crisis unit, 911, or the police, those services must be reviewed and likely enhanced. Individuals with the most significant mental health needs should have access to housing assistance, intensive case management, peer support services, assertive community treatment, and supported employment.[26]

Conclusion

Policing must be reformed and removed from tasks for which it is ill-suited. Excessive policing and excessive use of force are a threat to people with mental illness, especially Black people with mental illness. We should dramatically reduce the role of the police in the lives of people with mental illness. As the same time, mental health services should be expanded and racial disparities in their delivery eliminated. All services must reflect the voices and concerns of the full diversity of people with mental illness.

References

[1] *See* 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, 112-114 (2018) (estimating that 23% of people killed by police have a psychiatric disability). *See also Overlooked in the Undercounted*, Treatment Advoc. Ctr. (Dec. 2015), https://www.treatmentadvocacycenter.org/overlooked-in-the-undercounted (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*, The 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 Laonga, *Report: Mentally Ill are in Nearly 40 Percent of South Bay Police Shootings,* The Mercury News (last updated 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").

[2] Two circumstances contribute to this result. First, the over-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 1 ("young black men with mental illnesses are in the single most at-risk category in the nation for fatal police violence").

[3] Matt Stevens & Joseph Goldstein, *New York City Agrees to Pay $2 Million to Family of Mentally Ill Woman Killed by Police*, N.Y. Times (Dec. 13, 2018), https://www.nytimes.com/2018/12/13/nyregion/deborah-danner-settlement.html.
Danner wrote a compelling essay on her experience with mental illness, in which she mentioned the possibility of being killed by the police. Deborah Danner, Living with Schizophrenia, N.Y. Times (Jan. 28, 2012), https://www.nytimes.com/interactive/2016/10/19/nyregion/document-Living-With-Schizophrenia-by-Deborah-Danner.html.

[4] Similar stories unfortunately abound.
Osaze Osagie, a 29-year-old Black man, was shot in his home in State College, Pennsylvania, by police performing a mental health "wellness check." Osagie, living in his own apartment and having a rough time, sent texts to his family suggesting he might harm himself. They called 911. The police reported that Osagie had a knife he refused to put down. When he walked toward the officers, they tased and then fatally shot him. King, *supra* note 1.

Theresa Sheehan, a woman of color in her 50's, lived in a San Francisco group home for people with mental illness. When a staff member checked on her one day, she told him to leave her room, threatened him, and said she had a knife. He called the police to have her transported to a hospital. When two police officers entered her room, she grabbed a small bread knife and yelled at them to leave. They retreated but then re-entered the room with guns drawn in an effort to arrest her. Still holding the bread knife, Sheehan yelled at the officers to go away. The officers shot her five times, once after she had fallen to the ground.

Remarkably, Ms. Sheehan survived, but with permanent injuries. City of S.F. v. Sheehan, 135 S. Ct. 1765, 1774 (2015). Her claims for damages pursuant to the Americans with Disabilities Act and Section 504 of the Rehabilitation Act were eventually settled. Alex Emslie, Landmark S.F. Case on Police Force and Mental Illness Settles for $1 Million, KQED (Oct. 14, 2016), https://www.kqed.org/news/11129913/landmark-s-f-case-on-police-force-and-mental-illness-settles-for-1-million.

Kayla Moore, a Black transgender woman with schizophrenia, was suffocated by Berkeley police when she was held down on a futon during a struggle. Angela Ruggiero, *Judge Throws Out Case of East Bay Transgender Woman's In-Custody Death*, E. Bay Times (Mar. 28, 2018, 11:45 AM), https://www.eastbaytimes.com/2018/03/27/judge-throws-out-case-of-transgender-womans-in-custody-death/.

Wayne Jones, a Black man with mental illness, was shot 22 times by police officers in Martinsburg, West Virginia. He was stopped by police for walking in the street instead of on the sidewalk. The encounter escalated. Jones was tased, kicked, and placed in a chokehold. When one of the officers felt a sharp poke on his side and yelled that Jones had a knife, a semicircle of officers fired their guns and killed Jones. Emily Davies, *Family of Man Fatally Shot by Police Reaches $3.5 Million Settlement*, Wash. Post (July 21, 2020, 5:43 PM), https://www.washingtonpost.com/local/legal-issues/family-of-man-fatally-shot-by-police-reaches-35-million-settlement/2020/07/21/da918e9a-cb6c-11ea-bc6a-6841b28d9093_story.html.

"Alfred Olango, a 30-year-old Black man, was killed by police after his sister called 9-1-1 seeking medical assistance. Olango was suffering from a mental breakdown after the loss of a friend. He was behaving erratically and walking through traffic—putting himself at risk. His sister called 9-1-1 seeking medical assistance and told the dispatcher that her brother was mentally ill and unarmed. She called 9-1-1 repeatedly over the 50 minutes it took [El Cajon, California] police to arrive on the scene, telling them that he needed to be taken to a mental health facility. Olango was erratically pacing in the parking lot of a taco shop with his hands in his pockets when the police arrived. Police officers and his sister repeatedly asked him to raise his hands. He eventually pulled an electronic cigarette from his pocket in the direction of the police, at which time one of the police offers discharged his firearm while another discharged his Taser, ending in the fatal shooting of Olango." Erin J. McCauley, *The Cumulative Probability of Arrest by Age 28 Years in the United States by Disability Status, Race/Ethnicity, and Gender*, 107 Am. J. Pub. Health 1977, 1977 (2017).

"35-year-old Paul Castaway was shot and killed by police [in Denver] after his mother called 9-1-1. Castaway, who had a history of schizophrenia and alcoholism, was holding a knife to his own throat when he was fatally shot by police." *Id.*

"In Oklahoma this past April, 17-year-old Isaiah Lewis, also naked and in a mental health crisis, was shot and killed by police. This past June, Taun Hall called 911 for support with her 23-year-old-son, Miles, who had a mental illness. Police shot and killed him." King *supra* note 1.

[5] Marcus Berzofsky & Jennifer Bronson, *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-2012* 1, Bureau of Just. Stat. (June 2017), https://www.bjs.gov/content/pub/pdf/imhprpji112.pdf; *How Many Individuals with Serious Mental Illness are in Jails and Prisons?*, Treatment Advoc. Ctr. (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.
"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. *Serious Mental Illness and Serious Emotional Disturbance*, Substance Abuse and Mental Health Servs. Admin. (last updated Jan. 23, 2020), https://www.samhsa.gov/dbhis-collections/smi.

[6] *Mental Illness*, Nat'l Inst. of Mental Health (last updated Feb. 2019), https://www.nimh.nih.gov/health/statistics/mental-illness.shtml. *See also* Kevin Martone et al., *Olmstead at 20: Using the Vision of Olmstead to Decriminalize Mental Illness* 3 (Sept. 2019), http://www.tacinc.org/media/90942/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").

Contrary to a misguided and unfortunate public perception, people with mental illness, or serious mental illness, are not more violent than the population at large. *See* Heather Stuart, *Violence and Mental Illness: An Overview*, 2 World Psychiatry 121, 123 (2003) ("members 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 14, 2020), 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").

Moreover, people with mental illness do not engage in criminal behavior more than people without mental illness. "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." Martone, *supra* note 7, at 3-4.

[7] Mary Giliberti, *Treatment, Not Jail: It's Time to Step Up*, Nat'l All. on Mental Illness (May 5, 2015), https://www.nami.org/Blogs/From-the-CEO/May-2015/Treatment,-Not-Jail-It%E2%80%99s-Time-to-Step-Up. 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 rooms, and hospital beds, at great cost to the taxpayers.

Studies show that for less than what is now being spent on 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 Frequent Users of Public Services: Ending the Institutional Circuit*, Corp. for Supportive Hous. 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).

[8] *Black and African American Communities and Mental Health*, Mental Health Am. (last visited July 14, 2020), https://www.mhanational.org/issues/black-and-african-american-communities-and-mental-health.

[9] *See* Martone, *supra* note 7, 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.*

("Unfortunately, throughout the United States, inadequate community-based treatment options exist for individuals with mental illness. Consequently, too many people with mental illness end up in crisis, landing them in much more restrictive settings than needed, including 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, and Mark J. Murphy, *Diversion, Not Discrimination*, Judge David L. Bazelon Ctr. for Mental Health L. 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"); *Diversion to What? Evidence-Based Mental Health Services That Prevent Needless Incarceration,* Judge David L. Bazelon Ctr. for Mental Health L. 2 (Sept. 2019), https://secureservercdn.net/198.71.233.254/d25.2ac.myftpupload.com/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").

[10] *See* U.S. Dep't of Health and Human Servs., *Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General* (2001) (finding that racial and ethnic minorities have less access to mental health services than do white people, are less likely to receive needed care and are more likely to receive poor quality care when treated); Michelle Dalencour et al., *The Role of Faith-Based Organizations in the Depression Care of African Americans and Hispanics in Los Angeles*, 68 Psychiatric Servs. 368, 368 (2017) (finding that only 30% of Black people who need mental health care receive any services); Ronald C. Kessler et al., *U.S. Prevalence and Treatment of Mental Disorders: 1990-2003*, 352 N. Eng. J. Med. 2515, 2519 (2005) (finding that among people with psychiatric disabilities, Black people are half as likely as white people to receive any kind of mental health treatment even after adjusting for the disorder's severity); *Mental Health Disparities: African Americans*, Am. Psychiatric Ass'n 2 (2017), www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-African-Americans.pdf ("Only one-in-three African Americans who need mental health care receives it"). *See also* Benjamin Le Cook et al., *Trends in Racial-Ethnic Disparities in Access to Mental Health Care, 2004-2012*, 68 Psychiatric Servs. 9, 9 (2017) ("disparities in mental health care remain wider than in most other areas of health care services").

[11] *See* Lonnie R. Snowden et al., *Disproportionate Use of Psychiatric Emergency Services by African Americans*, 60 Psychiatric Servs. 1664, 1664 (2009) ("African Americans appear in emergency rooms for mental health problems in numbers well out of proportion to their representation in the U.S. population at large").

[12] *See* Snowden, supra note 11, at 1665 ("[A]frican Americans are overrepresented among persons subject to involuntary commitment and among persons admitted for inpatient psychiatric hospitalization"); 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"); McCauley, *supra* note 5, at 1980 (finding that Black people with disabilities have a significantly higher probability of being arrested than other groups); 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").

[13] *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, *Los Angeles Police Department Consent Decree Mental Illness Project: Final Report* (May 28, 2002), http://assets.lapdonline.org/assets/pdf/consent_decree_mental_ill_finalrpt.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. (June 2019) at 9, 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, *Law Enforcement Responses to People with Mental Illnesses: A Guide to Research-Informed Policy and Practice* 7 (2009) (finding that the Los Angeles Police Department spends 28,000 hours each month on calls that involve someone in psychiatric distress).

[14] *Diversion to What? Evidence-Based Mental Health Services That Prevent Needless Incarceration*, *supra* note 10, at 2. *See also* Martone, *supra* note 7, 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, the increased attention *Olmstead* has brought to individuals with mental illness … has resulted in many more people with mental illness living in integrated, community-based settings").

[15] United States v. New Hampshire, No. 1:12-cv-53-SM (D. N.H. Feb. 2, 2014) (settlement agreement); United States v. Delaware, No. 11-cv-591 (D. Del. July 15, 2011) (settlement agreement).

[16] *Peer Support: Research and Reports*, Mental Health Am. (last visited July 23, 2020), https://www.mhanational.org/peer-support-research-and-reports; *City & County Leadership to Reduce the Use of Jails: Engaging Peers in Jail Use Reduction Strategies*, Nat'l League of Cities & Pol'y Rsch. Inst. (last visited July 23, 2020), https://www.nlc.org/sites/default/files/users/user60554/Peers_Support_Brief_v3.pdf.

[17] *'CAHOOTS': How Social Workers and Police Share Responsibilities in Eugene, Oregon*, Nat'l Pub. Radio (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/.

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

[19] There are different ways to implement a joint response. A pre-existing team comprised 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., *Responding to Individuals in Behavioral Health Crisis Via Co-Responder*

Models: The Roles of Cities, Counties, Law Enforcement, Providers, Nat'l League of Cities (Jan. 2020), https://www.nlc.org/sites/default/files/users/user60554/RespondingtoBHCrisisviaCRModels.pdf.

[20] *Diversion to What? Evidence-Based Mental Health Services That Prevent Needless Incarceration*, *supra* note 10, at 7-8.

[21] Daniel Fisher et al., *Peer-Run Respites: An Effective Crisis Alternative* (last visited July 23, 2020), https://www.nasmhpd.org/sites/default/files/Peer%20Run%20Respite%20slides.revised.pdf.

[22] *See* Nat'l All. on Mental Illness, *Crisis Services* (March 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? Evidence-Based Mental Health Services That Prevent Needless Incarceration*, *supra* note 10, 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); United States v. New Hampshire, No. 1:12-cv-53-SM (D. N.H. Feb. 2, 2014) (settlement agreement) (providing for crisis apartments).

[23] "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, *supra* note 7, at 10-11.

[24] Most psychiatric crises can be addressed without resort to hospitalization.

[25] A widely respected example of such a center is the Houston Recovery Center. *Harris County Confidential Jail Diversion Programs*, Hous. Recovery Ctr. (last visited July 23, 2020), https://houstonrecoverycenter.org/harris-county-confidential-jail-diversion-programs/.

[26] *See* Martone, *supra* note 7, at 5 (noting these services "have been proven successful in reducing arrest and incarceration as well as other forms of institutionalization"); Bernstein, Burnim, and Murphy, *supra* note 10, 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? Evidence-Based Mental Health Services That Prevent Needless Incarceration*, *supra* note 10, at 7-8 (describing these services and the evidence of their success in preventing incarceration).