COMMUNITY-BASED SERVICES FOR BLACK PEOPLE WITH MENTAL ILLNESS

Advancing An Alternative to Police
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, 2015.⁹

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.”¹⁰

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.¹¹ Saheed had developed and was diagnosed with bipolar disorder following the tragic killing of his best friend at the hands of the NYPD.¹² Before his mental illness worsened, Saheed worked as a welder.¹³ 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.¹⁴ On the day of his murder, Saheed was carrying part of a welding torch¹⁵ in the shape of a curved silver pipe.¹⁶ Three 911 calls, however, described a black man pointing something that “looked like a gun.”¹⁷ 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.”¹⁸ 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.¹⁹ They reached Saheed within two minutes of seeing the alert,²⁰ followed closely by a marked police car.²¹ Although all the local police officers

---

¹ Legal Defense Fund & Bazelon Center for Mental Health Law.
² Bazelon Center for Mental Health Law.
³ Bazelon Center for Mental Health Law.
⁴ Bazelon Center for Mental Health Law.
⁵ Bazelon Center for Mental Health Law.
⁶ Bazelon Center for Mental Health Law.
⁷ Bazelon Center for Mental Health Law.
⁸ Bazelon Center for Mental Health Law.
⁹ Bazelon Center for Mental Health Law.
¹⁰ Bazelon Center for Mental Health Law.
¹¹ Bazelon Center for Mental Health Law.
¹² Bazelon Center for Mental Health Law.
¹³ Bazelon Center for Mental Health Law.
¹⁴ Bazelon Center for Mental Health Law.
¹⁵ Bazelon Center for Mental Health Law.
¹⁶ Bazelon Center for Mental Health Law.
¹⁷ Bazelon Center for Mental Health Law.
¹⁸ Bazelon Center for Mental Health Law.
¹⁹ Bazelon Center for Mental Health Law.
²⁰ Bazelon Center for Mental Health Law.
²¹ Bazelon Center for Mental Health Law.

© Copyright 2023 Washington D.C. Legal Defense Fund and Judge David L. Bazelon Center for Mental Health Law. Reproduction is permitted for non-commercial educational and advocacy purposes only, provided that attribution is included as follows: Legal Defense Fund & Bazelon Center for Mental Health Law, Community-Based Services for Black People with Mental Illness: Advancing An Alternative to Police Washington, DC 2023.
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 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
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.59

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

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. The risk of death at the hands of law enforcement is even higher when the individual is Black. 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. 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.

Despite this risk, law enforcement is generally the default and only response to calls from or involving people with mental illness. 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, 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. Other calls may involve situations when individuals at large.

4-5% of the U.S. population

15% of the U.S. prison population

20% of the U.S. jail population

One study found that Black people with mental illness were more likely to be incarcerated than any other racial group.
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” model—should be limited to only the rarest exceptions because of the potentially dire consequences. Even when co-responder models dispatch officers who have undergone crisis intervention training (CIT), 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. One study of the Chicago Police Department, however, showed a marginal increase in use of force by CIT-trained officers over their non-CIT counterparts. 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. One factor, studies have suggested, is that officer involvement may retraumatize individuals due to their previous traumatic interactions with law enforcement.

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 communities. The services that work best for people with serious conditions are in very short supply. 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. 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.

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.

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, but also of racially biased and discriminatory treatment by mental health professionals. 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
defiant disorder (ODD) or conduct disorder (CD)) rather than with ADHD. 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. 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.

Beyond the education system, Black people face the challenges of cross-cultural communication and language differences in the healthcare system, which leads to fear and mistrust of the system itself. 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. 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. Only 3% of American Psychological Association members are Black, leading some mental health advocates to worry that the majority of mental health care practitioners lack the cultural competency to adequately treat Black patients. When Black patients do receive care, they often receive inadequate services and experience worse outcomes. For example, Black people are less likely to receive appropriate care for depression, leading to longer and more severe episodes. They may also be more likely to experience coerced treatment, in the form of involuntary commitment. In Alameda County, California, where Black people make up 11 percent of the population, 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”; 36% of people detained at one facility—“more than three times their overall representation in Alameda County”—were Black; and “[f]rom January 2018 to June 2020, more than 45% of individuals institutionalized in County psychiatric facilities three or more times were Black.” And yet, two-thirds of Black people in need of mental health services do not receive any care.

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. Decades of research demonstrate that most people have implicit biases against Black people. People have a tendency to unconsciously associate Black people with criminality and
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. 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. Black men and people with mental illness are at greater risk of being perceived as noncompliant, and thus, disrespectful, to officers. 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.

Walter Wallace Jr.’s experience with Philadelphia police 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. Walter did not make any threatening motions or actions towards anyone, even when two police officers pointed their guns at Walter and yelled for him to drop the kitchen knife. 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; shouts from bystanders familiar with Walter’s history with bipolar disorder, warning officers that Walter was “mentally,” and Walter’s almost trance-like state as he casually walked away from and around the officers, ignoring their repeated commands. 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, hitting him in the shoulder and chest. Walter’s mother, who just seconds before was pleading for the officers not to shoot her son, ran towards his bleeding body, screaming, “You killed my son.” Walter was pronounced dead shortly after arriving at a nearby hospital. It was only three weeks after his wedding day.

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. Tragically, police arrived at the Wallace family home before the ambulance. 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.

Peers with lived experience ... should play a major role in planning and implementing the alternatives developed.

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.

To do so, we must expand the capacity of states, counties, and cities to deliver culturally competent community-based mental health services, including Assertive Community Treatment (ACT), housing, assistance securing and maintaining employment, and substance use treatment. 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. 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 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 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 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 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

When people experience a mental health crisis, there should be a healthcare-centered response, with the mental health system taking the lead.

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 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 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. 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. A police response is unnecessary in the vast majority of calls involving people with mental illness. 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. 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. 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. 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. 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.

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:
BLACK PEOPLE, PEOPLE WITH MENTAL ILLNESS, AND THOSE AT THE INTERSECTION.
long-term housing, intensive case management, peer support services, ACT, and supported employment.\(^{49}\) 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.\(^{46}\)

- Permanently authorize flexibilities in Medicaid funding for tele-mental health services as permitted related to COVID-19;\(^{44}\) 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.\(^{46}\)

- Fund call centers within the mental health system to which calls for help involving people with mental illness can be routed.\(^ {47}\)

- 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.\(^ {48}\)

- 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.\(^ {49}\)

- Robustly promote and fund services that prevent encounters with law enforcement, including ACT, mobile crisis services, peer services, supported housing, and supported employment.\(^ {50}\)

- 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.\(^ {51}\)

- 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).\(^ {52}\)

- Allow federal Medicaid dollars to be used to support housing for people with mental illness.\(^ {73}\)

- Improve Medicaid rules regarding reimbursement for peer services, including removing the requirement that peer services be delivered under the supervision of a clinician.\(^ {54}\)

- 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.\(^ {75}\)

- 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.\(^ {55}\) The services should be culturally competent and acknowledge the trauma Black people have experienced, and incorporate a trauma-informed approach.\(^ {77}\)

- 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 warmline numbers) that can resolve most calls for help,\(^ {56}\) mobile crisis teams to respond quickly when needed, de-escalate situations, and connect people to services,\(^ {79}\) and an array of facilities when people need somewhere to go for crisis resolution and stabilization.\(^ {50}\)

- Create a continuum of alternative responders to calls for help, from street outreach teams,\(^ {18}\) to CAHOOTS-type teams, to mental health crisis teams to handle the wide variety of calls involving people with mental illness.\(^ {57}\)

- 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.\(^ {43}\)

- 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.\(^ {54}\)

- 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.\(^ {56}\)

- 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.\(^ {46}\)

- 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,\(^ {47}\) investing in professional development, and identifying and removing barriers to entry for Black people and others.\(^ {46}\)
Invest in peer-led services such as peer crisis respite centers, peer “bridger” services that help people transition from hospitals, jails, and prisons to the community, and peer-run hotlines and warmlines for people who need help.

Expand supported employment services using the Individual Placement and Support (IPS) model. 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.

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.

Address the social determinants of health, which helps prevent mental health crises.

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. 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.

Address the social determinants of health, which helps prevent mental health crises.

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. 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.

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.


4 Id.  


8 Id.


11 Benjaimn Mueller, Jan Ransom, & Luis Ferré-Sadurní, Locals Know He Was Mentally Ill. The Officers Who Shot Him Did Not., N.Y. TIMES (Apr. 5, 2018) [hereinafter Locals Know], https://www.nytimes.com/2018/04/05/nyregion/brooklyn-police-shooting-sahed-vasell.html?action=click&module=RelatedCoverage&gateway=Article&region=Footer (noting that Saheed was known as the “idiosynratic fixture on the block”).

12 TheGrio Staff, INMATE KILLED SHACKLED after he was haunted by fatal police shooting of his best friend, Grio (Apr. 9, 2018), https://thegrio.com/2018/04/09/nyudp-killed-sahed-vasell-after-he-was-haunted-by-fatal-police-shooting-of-his-best-friend/.


16 Locals Know, supra note 10.

17 Id.


19 Id.

20 Id.

21 Id.

22 Mueller, supra note 14.

23 Locals Know, supra note 10.

24 Mueller, supra note 12.

25 Mueller & Schweber, supra note 12.

26 Locals Know, supra note 10.


28 Id.


32 Id.

33 Id.


35 Id.


38 Romine et al., supra note 30.

39 Id.

40 Id.  

41 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. 2019), https://www.apa.org/pi/psychiatry/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 use other terms in the context of advocacy or self-identification. 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 MIND (Mad, Mentally Ill, Neurodivergent, and Disabled) College Student Experiences, REDDIT (Oct. 15, 2021), https://www.reddit.com/r/SampleSize/comments/4u0hug/academic_queer_mind_mad_mentally_ill/.

42 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.

43 Devon W. Carbard & 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.”).

44 Drew DeSilver et al., Ten things we know about race and policing in the U.S., PUB. RSH. 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 to witness as they’ve been unfairly stopped by police because of their race or ethnicity.”).

45 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 than whites and Latinos more. But they’re less likely to have possession of contraband than whites, L.A. TIMES (Oct. 3, 2019, 3:52 PM PT), https://www.latimes.com/local/lanow/la-me-lapd-searches-blacks-and-latinos-more-theyre-less-likely-to-have-contraband-than-whites, L.A. TIMES (Oct. 3, 2019, 3:52 PM PT), https://www.latimes.com/local/lanow/la-me-lapd-searches-201909065-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. REV., U.S. DIP’T OF JUST., INVESTIGATION OF THE
Delinquency maintain social control and “undermine the impact of the abolition of slavery”); Cheryl Nelson Butler, Sex and 39 white men and boys per 100,000 are killed by police, respectively).

SeeingBlackRaceCrimeandVisualProcessing.pdf [hereinafter Seeing Black]; Brian Keith Payne, https://kb.osu.edu/bitstream/handle/1811/73475/OSJCL_V12N1_115.pdf. (noting that police killings are the sixth leading cause of death in Black men; 100 Black men and boys people are 3.23 time more likely to be killed by police than white people); J

S

H

57

53

https://www.hup.harvard.edu/catalog.php?isbn=9780674238145 (“Chronicling the emergence of deeply embedded
derate for Black people and white people is 2,306 and 450 per 100,000, respectively).

https://www.prisonpolicy.org/research/race_and_ethnicity/ (last visited June 21, 2022) (noting that the incarceration

rate for Black men-2/ (noting that police killings are the sixth leading cause of death in Black men; 100 Black men and boys

people are 3.23 time more likely to be killed by police than white people); J

E

L

ELINQ

5

4

https://kb.osu.edu/bitstream/handle/1811/73475/OSJCL_V12N1_115.pdf. (noting that police killings are the sixth leading cause of death in Black men; 100 Black men and boys people are 3.23 time more likely to be killed by police than white people); J

S

H

57

53

https://www.hup.harvard.edu/catalog.php?isbn=9780674238145 (“Chronicling the emergence of deeply embedded
derate for Black people and white people is 2,306 and 450 per 100,000, respectively).

https://www.prisonpolicy.org/research/race_and_ethnicity/ (last visited June 21, 2022) (noting that the incarceration
these individuals, they could be provided housing and effective community-based mental health services. See Alex Jones & Orlandi, Opioid Overdoses, and Repeat: How Police and Jails are Related to Opioid Overdose Problems, PRISON POL’Y INITIATIVE (Aug. 2019), https://www.prisonpolicy.org/reports/opioidoverdose.htm (finding that investment in community-based mental health 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. FREQ. USERS OF PUB. SERVICES: ENDING THE INSTITUTIONAL CIRCLE OF LIFE (2009), https://www.csh.org/wp-content/uploads/2011/12/Report_FRUBooklets.pdf (calculating that investment in supportive housing saves $2,953 and $7,231 in incarceration costs per person placed in that housing).


(10) See The Washington Post Police Shootings Database, WASH. POST (hereinafter DATABASE), https://www.washingtonpost.com/graphics/investigations/police-shootings-database/ (last verified June 27, 2022). See also Jere Lowery et al., Distracted People, Deadly Results, WASH. POST (June 30, 2015), https://www.washingtonpost.com/sf/investigative/2015/06/30/distracted-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., Risk Factors, and Short-Term Outcomes of Interventions for Patients with Mental Illness in Police Custody, 26, 29 (2012).

(11) See also supra Part I (discussing the fatal shooting of Ricardo Muñoz, where his mother called emergency services for assistance with Ricardo’s mental health episode, but main police officer on scene did not have any training or knowledge on how to respond to any of 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 any active signs of threat during his mental health crisis, even in the presence of the officers who responded to the scene).

(12) See Bellafante, supra note 17 and accompanying text.


(14) Two circumstances contribute to this result. First, the disproportionate policing of Black people and communities, and second, the higher 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 URB. L. 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 in contrast to those without a mental illness).

(15) See 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”).


(17) Rogers et al., supra note 65.

(18) 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 diagnosis); LODESTAR, L.A. POLICE DEP’T DISCERN MENTAL ILLNESS PROJECT, FINAL REPORT 24 (May 28, 2002), https://www.lapdnews.org/media/publications/lapd_executive_summary_consent_decree_mental_illness_proj_eect_2002.pdf (estimating that 23% of calls to the Los Angeles Police Department involve mental health); see also Alexander Black et al., The Treatment of People with Mental Illness in the Criminal Justice System: The Example of Hudson County, New Jersey, 2017 LEGIT. REV. FOR PUB. AFF’RS. AT HAMILTON COLL. 9 (June 2019), https://digitalcommons.hamilton.edu/cgi/viewcontent.cgi?article=1005&amp;context=student_scholarship

(19) Crellin, supra note 12, 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, hospitalization, and jails.”); id. at 1 (“A disproportionate percentage of people with mental illness and co-occurring substance use disorders and prisons, segregated from society to appropriate community-based services and supports.”); id. at 5 (“Psychiatric crisis services are often nonexistent or insufficient to deal with an individual’s mental health crisis or 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.”).

(20) See supra note 124 and accompanying text (stating that police officers are Black and in a Mental Health Crisis, 911 Can Be a Death Sentence, INTERCEPT (Sept. 29, 2017, 7:00 AM), https://theircept.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 Bay police shootings, MERCURY NEWS (May 14, 2018, 9:03 AM), https://www.mercerynews.com/2018/05/11/report-mentally-ill-are-in-nearly-40percent-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.”).

(21) See supra note 124 and accompanying text (stating that police officers are Black and in a Mental Health Crisis, 911 Can Be a Death Sentence, INTERCEPT (Sept. 29, 2017, 7:00 AM), https://theircept.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 Bay police shootings, MERCURY NEWS (May 14, 2018, 9:03 AM), https://www.mercerynews.com/2018/05/11/report-mentally-ill-are-in-nearly-40percent-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.”).

(22) Two circumstances contribute to this result. First, the disproportionate policing of Black people and communities, and second, the higher 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 URB. L. 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 in contrast to those without a mental illness).

(23) See 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”).


(25) Rogers et al., supra note 65.

(26) 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 diagnosis); LODESTAR, L.A. POLICE DEP’T DISCERN MENTAL ILLNESS PROJECT, FINAL REPORT 24 (May 28, 2002), https://www.lapdnews.org/media/publications/lapd_executive_summary_consent_decree_mental_illness_proj_eect_2002.pdf (estimating that 23% of calls to the Los Angeles Police Department involve mental health); see also Alexander Black et al., The Treatment of People with Mental Illness in the Criminal Justice System: The Example of Hudson County, New Jersey, 2017 LEGIT. REV. FOR PUB. AFF’RS. AT HAMILTON COLL. 9 (June 2019), https://digitalcommons.hamilton.edu/cgi/viewcontent.cgi?article=1005&amp;context=student_scholarship

(27) Community-Based Services for Black People with Mental Illness: Advancing An Alternative to Police
Mental Retardation (Feb. 5, 1963), which set out to deinstitutionalize and reduce the number of people in psychiatric hospitals. The act also aimed to provide funding for community-based services, such as rehabilitation programs and support for individuals returning to a community setting after institutional care.

The deinstitutionalization movement was not without its challenges, however. The transition to community-based care was slow and uneven, with many individuals falling through the cracks of the existing mental health system. This was due in part to a lack of state oversight and funding, as well as resistance from those who benefited from the institutional system.

Despite these challenges, the movement towards community-based care has been a positive step forward. It has allowed more people to receive the care they need in a setting that is more aligned with their individual needs and preferences. While there is still much work to be done to ensure equitable access to mental health care, the movement towards community-based care is a significant step in the right direction.

**References**

1. Mental Retardation (Feb. 5, 1963), which set out to deinstitutionalize and reduce the number of people in psychiatric hospitals. The act also aimed to provide funding for community-based services, such as rehabilitation programs and support for individuals returning to a community setting after institutional care.

2. The transition to community-based care was slow and uneven, with many individuals falling through the cracks of the existing mental health system. This was due in part to a lack of state oversight and funding, as well as resistance from those who benefited from the institutional system.

3. Despite these challenges, the movement towards community-based care has been a positive step forward. It has allowed more people to receive the care they need in a setting that is more aligned with their individual needs and preferences. While there is still much work to be done to ensure equitable access to mental health care, the movement towards community-based care is a significant step in the right direction.
30

Community-Based Services for Black People with Mental Illness: Advancing An Alternative to Police


122 Inappropriate and unnecessary contact between Black people with mental illness and law enforcement officers also violates our nation’s violence 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/eos/file/883295/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 and biased policing against Black residents with mental health disabilities. Id. at 74-85. The BPD also failed to make reasonable modifications to its policies for interactions with 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-00991-KW), 2017 WL 13185156, https://www.justice.gov/usao-md钊/file/2952656/download; CONSENT DECREE & MONITORING TEAM, SEVENTH SEMIANNUAL REPORT (Feb. 15, 2022), https://static1.squarespace.com/static/39dbf8644e54a7c708738cc21ef62055d1a35527404a7e2164946189934571h-7SemianualReport.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., Apr. (Aug. 5, 2022), https://www.justice.gov/opa/speech/attorney-general-merrick-b Garland-delivers-remarks-announcing-pattern-or-practice (announcing the Justice Department’s investigation into the Phoenix Police Department).

123 BPD also engaged in racially discriminatory stops, searches, arrests, and use of force, in violation 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., Apr. (Aug. 5, 2022), https://www.justice.gov/opa/speech/attorney-general-merrick-b Garland-delivers-remarks-announcing-pattern-or-practice (announcing the Justice Department’s investigation into the Phoenix Police Department). Inappropriate and unnecessary contact between Black people with mental illness and law enforcement officers also violates our nation’s violence 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/eos/file/883295/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 and biased policing against Black residents with mental health disabilities. Id. at 74-85. The BPD also failed to make reasonable modifications to its policies for interactions with 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-00991-KW), 2017 WL 13185156, https://www.justice.gov/usao-md钊/file/2952656/download; CONSENT DECREE & MONITORING TEAM, SEVENTH SEMIANNUAL REPORT (Feb. 15, 2022), https://static1.squarespace.com/static/39dbf8644e54a7c708738cc21ef62055d1a35527404a7e2164946189934571h-7SemianualReport.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., Apr. (Aug. 5, 2022), https://www.justice.gov/opa/speech/attorney-general-merrick-b Garland-delivers-remarks-announcing-pattern-or-practice (announcing the Justice Department’s investigation into the Phoenix Police Department).


127 NBC Video, supra note 125.


130 Madani, supra note 127.

131 Id.

132 Calvert, supra note 126.

133 Id.

134 Id.

135 See supra note 122.

136 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, assessment and treatment activities, case management, therapy, medication, and crisis management, as well as 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. See, e.g., JUDGE DAVID L. BAZELJ, CIR., FOR MENTAL HEALTH, L., REPLACING SCHOOL POLICE (Aug. 2021), https://www.nclie.org/wp-content/uploads/2021/08/Replacing-Police-in-Schools-1.pdf.


139 Id.


There are different ways to implement a joint response. A pre-existing team of police and mental health practitioners 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 KRIER ET AL., POLY RICH., 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.theaicp.org/sites/default/files/SICoResponding%20Individuals.pdf.


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

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/speaking-of-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.”)

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, BURNIN, & 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).


While there is an enhanced focus as a result of the Build Back Better Act and other federal policy changes, the number of mobile crisis interventions is unlikely to increase because few local jurisdictions have the capacity to deploy this number of crisis workers.

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

The number of crisis center 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. In addition to the traditional treatments of suicide, the National Suicide Prevention Lifeline now provides crisis intervention services 24 hours a day (except holidays) at (800)273-TALK. It is now a 24/7/365 service, available to anyone in the United States. In 2020, the National Suicide Prevention Lifeline received over 1.5 million calls.

The number of crisis center 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. In addition to the traditional treatments of suicide, the National Suicide Prevention Lifeline now provides crisis intervention services 24 hours a day (except holidays) at (800)273-TALK. It is now a 24/7/365 service, available to anyone in the United States. In 2020, the National Suicide Prevention Lifeline received over 1.5 million calls.


See e.g., ALFRED WURSTWERTZ, 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, (noting 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 of cycle”).

See NAT’L. ON MENTAL HEALTH CRISIS SERVICES FACT SHEET (2 Mar. 2015), https://www.nami.org/NAMI-Media/NAMI-Media-Images/FactSheets/Crisis-Service-FS.pdf (“Crisis center and police volunteers are trained to de-escalate crisis situations, and provide support by crisis workers until a person is stabilized and connected with other responders”); 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 SERVICES ADMIN., PER-RUN RESPONDEES: AN EFFECTIVE CRISIS ALTERNATIVE, https://namsphd.org/sites/default/files/Peer%20Run%20Respon%20ides.pdf (last visited July 1, 2022).

“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.

Most psychiatric crises can be addressed without resort to hospitalization, however. See e.g., TREATMENT ADVOC. CTR., PSYCHIATRIC BED SUPPLY NEED PER CAPITA I (Sep. 2016), https://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 Solts, 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://nra.ohio.gov/static/Portals/0/Assets/SchoolsAndCommunities/CommunityAndHousing/Community- Planning/Crisis%20Services/Ideal-Crisis-System.pdf?v=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 referred to mental health crisis teams, and 69% of the remaining individuals were stabilized in care centers and returned to their communities without hospitalization).

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


...rations that exist have produced mixed results. For example, some studies of Crisis Intervention Teams (CIT) and mobile crisis teams, and 68% of the remaining individuals were stabilized in care centers and returned to their communities without hospitalization.

...is fully phased in.

In addition, the training models that exist have produced mixed results. For example, some studies of Crisis Intervention Teams (CIT) shows, by contrast, 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.”).

See supra notes 81-83 and accompanying text.
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://peopleusa.org/programs-people/rose-houses (last visited July 1, 2022) (“Rose Houses are short-term crisis respite 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, WILDFLOWE[1], https://wildflowerphone.org/ (last visited July 1, 2022) (hosting peer-led suicide-related support groups both online and by phone); The Living Room: Forever Hope, https://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 RES. INST., https://www.recoverystatements.org/recovery-work/trends-and-news/360 (last visited July 1, 2022) (citing Reif et al., Peer recovery support for individuals with substance use disorders: assessing the evidence, 65 PSYCHIATR. SERV. 853 (2014)); DIVERSION TO WHAT, supra note 93; at 7.

122. 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 POL’Y INST. COLL. FOR CHILDREN & FAMILIES (May 2023), https://ccf.georgetown.edu/2022/05/17/how-medicaid-can-help-schools-sustain-support-for-students-mental-health/

123. See, e.g., DISSERTATION TO WHAT, supra note 93, passim. These services include intensive case management, peer support services, Assertive Community Treatment (ACT, which should 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 At’y Gen., C.R. Div., U.S. Dep’t of Just., to Honorable Earl Ray Tomblin, Governor, W. Va. (June 1, 2015), https://ada.gov/olmstead/documents/wa.va FINDINGS.pdf; CINDY MANN & PAMELA S. HYDE, CTR. FOR MEDICAL & CHIP SERVS. & SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., JOIN CMCS & SAMHSA INFORMATIONAL BULLETIN: COVERAGE OF BEHAVIORAL HEALTH SERVICES FOR CHILDREN, YOUTH, AND YOUNG ADULTS WITH SIGNIFICANT MENTAL HEALTH NEEDS (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. RAIN K. BAILEY, M.D., AM. PSYCHIATRIC ASS’N, BEST PRACTICE HIGHLIGHTS: AFRICAN AMERICANS/BLACKS, https://www.psychiatry.org/File2/Library/Psychiatrists/Cultural-Compentence/Treating-Diversity/Populations-Best-Practices/AfricanAmerican-Patients.pdf (last visited June 14, 2022).


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

126. DIVERSION TO WHAT, supra note 93, at 7. 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 patients can chart their individual’s progress through the system are tracked and outcomes monitored. See, e.g., TOOLKIT, supra note 148.

127. See, e.g., PATHWAYS, supra note 173.

128. 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.


35

Community-Based Services for Black People with Mental Illness: Advancing An Alternative to Police
2022).
185 See, e.g., HOPES AND FEARS FOR 988, supra note 167, at 12; NAT’L SUICIDE PREVENTION LIFELINE, POLICY FOR HELPING CALLERS AT IMMEDIATE RISK OF SUICIDE 1 (Dec. 2010), https://www.samhsa.gov/wp-content/uploads/2020/11/SAMHSA-Lifeline-Policy-for-Helping-Callers-at-Immediate-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.


187 See, e.g., GBRFCS’ 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.


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

194 See, e.g., SUPPORT, TECH. ASSISTANCE & RES. CTR., CULTURAL COMPETENCY IN MENTAL HEALTH PEER-RUN PROGRAMS AND SELF-HELP GROUPS: A TOOLKIT TO ASSESS AND IMPROVE 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”).


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