

NEW ERA OF PUBLIC SAFETY

A GUIDE TO FAIR, SAFE, AND EFFECTIVE
COMMUNITY POLICING

5

RESPONDING TO CRISES

Health professionals — not police officers — should respond when people with mental health and developmental disabilities or with substance use disorders are in crisis. Yet officers increasingly respond to calls relating to people in crisis.¹ Indeed, about 10 percent of police encounters are with people experiencing mental health problems, and the percentage of encounters with people with substance use disorders is even higher.² In 2016, one-quarter of all fatal police shootings “involved people with behavioral health or substance use conditions,” according to Mental Health America, a community-based nonprofit organization.³

Many factors contribute to crises relating to mental health and developmental disabilities and substance use disorders, such as inadequate social services and supports; high rates of poverty, income inequality, and housing insecurity; and an ongoing opioid epidemic.⁴ Yet, in recent years, federal, state, and local governments have cut spending on mental health and social services, rendering police officers the nation’s “first responders” not only to accident and attack but also to mental health and other crises.⁵



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This places a great burden on officers, who often respond repeatedly to the same people in crisis, and poses significant enforcement challenges. People in crisis may resist or fail to comply with orders or engage in behavior that officers may interpret as aggressive, threatening, or otherwise problematic.⁶ Inadequate police training and insufficient expertise in crisis response can escalate interactions and result in dangerous, and sometimes deadly, encounters. Indeed, officers who see themselves as warriors against chaos are more likely to escalate crises, while officers who see their roles as guardians of public safety are better able to respond to crises without escalating them or using force.⁷

People with disabilities also experience crises. Under the Americans with Disabilities Act (ADA), a disability is a “physical or mental impairment that substantially limits one or more major life activities.”⁸ This includes substance addictions or a history of substance addiction.⁹

Police interactions with people with disabilities present a host of challenges if officers aren't properly trained. People with disabilities may be unable to interpret or respond to commands or communicate effectively with officers. Training in communication, de-escalation, cultural competency, and implicit bias helps officers recognize and respond to people with disabilities. (For more detail, see Chapters 1 and 2.)

In all cases, society should aim for the least “police-involved” responses to crises. By providing adequate prevention, support, and referral services, communities and departments can divert people with mental health and developmental disabilities from the criminal justice system. Indeed, these crises should be handled by professionals with expertise in mental health, developmental disability, and substance use disorders — not police officers. Officers are not the answer to public health matters.

That said, all departments should work in tandem with mental health and other professionals to develop crisis responses and a network of services to direct people in crisis to appropriate health services. All officers should be trained to identify and respond appropriately to people with mental health or developmental disabilities and to people experiencing substance use disorder crises.

This chapter considers community-based responses to crisis and the appropriate police-based responses to crisis within that structure.

RECOMMENDED BEST PRACTICES

5.1

To limit their role in and respond more appropriately to crises, departments should work with and support communities, government officials, and service providers to:

Develop integrated community-based support services to prevent crises.

5.2

Develop integrated community-based services to respond to crises.

5.3

Establish protocols for interactions with people with mental health or developmental disabilities or who are experiencing substance use disorder crises.

5.4

Train emergency call operators.

5.5

Train all officers in basic techniques to identify and manage crises.

5.6

Pair crisis response teams with mental health and developmental disability co-responders.

5.7

Carefully select crisis response program coordinators and officers.

5.8

Partner with local service providers to coordinate crisis responses.

5.9

Adopt harm-reduction models for people with substance use disorders.

5.10

Track officer responses to crises and assess crisis response programs.

THE HISTORY OF POLICE CRISIS RESPONSES

In 1987, police officers arrived at a public housing project in Memphis, Tennessee, where Joseph DeWayne Robinson¹⁰ was cutting and stabbing himself with a butcher knife.¹¹ Robinson, who had mental health problems, did not respond to police orders and allegedly charged the officers with a knife.

The officers shot and killed Robinson, which sparked community outrage. In response, elected and community leaders turned to the National Alliance on Mental Illness, community mental health professionals, police officers, and others to find a better way to respond to people with mental health or developmental disabilities.¹² They developed an approach known as the Memphis Crisis Intervention Team (CIT) model, which has since been adopted by over 2,700 police departments nationwide.¹³



Elements of the Memphis Crisis Intervention Team (CIT) Model:

- Dispatchers are trained to identify people in mental health or other crisis.
- Officers volunteer to serve as crisis intervention officers and receive specialized training in crisis intervention techniques.
- CIT officers are spread across the city during all shifts.
- CIT officers perform regular patrol duties but are immediately dispatched to scenes of mental health crises.
- CIT officers use de-escalation techniques and verbal tactics to defuse crises.
- CIT officers determine whether to transport people to hospitals or other service providers for further evaluation.
- Receiving facilities refer people to resources, such as community mental health services, social services, and veterans' services.

Sources: Univ. of Memphis CIT Center, Memphis Model, <http://www.cit.memphis.edu/overview.php?page=2>; Randolph Dupont et al., Univ. of Memphis, Crisis Intervention Team Core Elements, 10,15 (2007), <http://cit.memphis.edu/pdf/CoreElements.pdf>.

Crisis response training programs vary by department but share several key elements, including: partnerships with mental health and other service providers; coordination between dispatch and police officers; referrals to and coordination with mental health providers; and continuous evaluation of outcomes.

Specialized CIT officers receive training beyond the basic crisis intervention training that all officers receive, which usually involves 40 hours of training over five days¹⁴ on topics including implicit bias, cultural awareness and responsiveness, empathy, procedural justice, effective social interactions, tactical skills, verbal intervention and de-escalation, and negotiation. These skills apply not only to mental health crises but also to interactions with people with developmental disabilities, substance use disorders, and other issues that require a police response, such as homelessness, intimate partner violence, human trafficking, and child abuse.

Evaluations conclude that CIT programs are effective in: “developing positive perceptions and increased confidence among police officers; providing very efficient crisis response times; increasing jail diversion among those with a mental illness; improving the likelihood of treatment continuity with community-based providers; and impacting psychiatric symptomatology for those suffering from a serious mental illness, as well as substance [use] disorders[.]” while reducing officer injury rates.¹⁵

Studies also show that CIT programs reduce the use of force in encounters with people in mental health crises.¹⁶ In addition, officers report feeling more comfortable interacting with people with mental health disabilities, and mental health service providers report more positive views of police.¹⁷

The Final Report of the President’s Task Force on 21st Century Policing (the President’s Task Force Report) underscores the need for police crisis intervention training and calls on the federal government to fund it.¹⁸ Legislation that would do so was introduced in the U.S. House of Representatives in 2017 but has not yet been passed into law.¹⁹

While this type of legislation aims to improve police responses to crises, community-based support services can help prevent crises — and are ultimately more appropriate than police-based responses. Communities, departments, and elected officials should therefore prioritize strengthening social services so people in crisis can get the care and treatment they need and to reduce reliance on officers. This approach will channel people in crisis into the appropriate system (i.e., the public health system) and allow officers to focus on law enforcement matters, such as investigating serious crime.



BEST PRACTICES IN RESPONDING TO CRISES

Police departments should work with community stakeholders, social service providers, mental health and developmental disabilities professionals, and others to develop holistic, nonpunitive responses to people in crisis. With their participation, collaboration, and input, departments can coordinate responses with community-based social service networks.

The scope and depth of community involvement in the crisis response process is regularly cited as a significant predictor of its success.²⁰ A strong commitment to addressing these challenges can reduce the use of force, increase community and officer safety, and improve outcomes for people in mental health and other crises.

Communities, police departments, service providers, and local and state governments should work together to provide a comprehensive continuum of crisis prevention and response services to people with mental health disabilities.²¹ These services should be designed “to stabilize individuals in psychological distress and engage them in the most appropriate course of treatment.”²² Both service types (those focusing on prevention and treatment) offer alternatives to police-based responses and lessen involvement with the criminal justice system.

Ideally, communities should have adequate community-based services that people can access to prevent crises. To limit their role in and respond more accurately to crises, departments should work with and support communities, government officials, and service providers to:

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RECOMMENDATION 5.1 DEVELOP INTEGRATED COMMUNITY-BASED SUPPORT SERVICES TO PREVENT CRISES.

When supporting people with mental health or developmental disabilities, government officials and department leaders should be mindful of their obligations under Olmstead v. L.C., which requires states to provide integrated community-based services for people with disabilities so they have the option to live in the community.²³ In other words, they should not fix one problem (inadequate services) if it creates or exacerbates another (services and supports, such as involuntary institutions, that segregate people with mental health and developmental disabilities from the larger community).

Community-based services provide individualized treatment in the community so people don't have to go to facilities to access care. The assertive community treatment (ACT) model, for example, sends teams of clinicians, psychiatrists, social workers, and employment and housing specialists to people to provide various support services.²⁴ Employment specialists help people search and apply for jobs, access training and transportation, and succeed on the job.²⁵ Case managers identify needs, coordinate services, and help people manage logistics, such as transportation to appointments for services.²⁶ And “peers” — people who draw on their own experiences with mental health crises who are certified to support others in crisis²⁷ — are also involved.

Department leaders should support community members and service providers to identify needed services. A stronger, more comprehensive network of community-based services will help people with mental health and developmental disabilities manage their health issues so that they do not result in crisis — or bring them in contact with police officers and the criminal justice system at large.

Communities are best situated to know what services they need. Departments also have valuable insights based on the calls they receive and respond to. For this reason, departments should work with communities to advocate for increased and improved community-based services to address the needs identified. Funding for community-based support programs is available from the U.S. Centers for Medicare & Medicaid Services and other federal agencies, state and local governments, and philanthropic foundations.²⁸

RECOMMENDATION 5.2 DEVELOP INTEGRATED COMMUNITY-BASED SERVICES TO RESPOND TO CRISES.

Department leaders should support community members, government officials, and service providers in working together to create a range of services to support people in crisis.²⁹ There are a variety of community-based crisis response services, including:³⁰



Crisis hotlines. These hotlines help people cope with crises and access medical and community support services.³¹ They provide immediate, around-the-clock support and should be toll-free and staffed by licensed clinical professionals.³²

Walk-in centers. These centers offer community-based psychiatric and counseling services, reducing arrest as a response to crisis. They should be open 24 hours a day, seven days a week, and staffed by licensed clinical professionals.³³

Mobile crisis teams. MCTs provide services and treatment to de-escalate crises for people at home or in community settings.³⁴ They are staffed by mental health professionals, community health workers, and peers,³⁵ who are able to empathize with and gain the trust of people in crisis. They are also cost-effective; one study compared the effectiveness and efficiency of an MCT program to regular police intervention and found, on average, a 23 percent lower cost per case.³⁶

Peer crisis support services.

Community-based services should include peers who have lived experiences with crisis. In Tennessee, certified peer specialists work on MCTs, and Maine staffs central crisis lines at designated mental health centers with peers as well as mental health professionals.³⁷ Other states operate “warm lines” staffed by peers who respond to situations that threaten to become emergencies.³⁸

Crisis stabilization units. These in-patient facilities provide direct care to de-escalate crises, stabilize people, and reduce reliance on hospitals.³⁹ The Tennessee Department of Mental Health & Substance Abuse Services operates seven such units across the state, in addition to walk-in sites and detoxification units.⁴⁰



RECOMMENDATION 5.3 ESTABLISH PROTOCOLS FOR INTERACTIONS WITH PEOPLE WITH MENTAL HEALTH OR DEVELOPMENTAL DISABILITIES OR WHO ARE EXPERIENCING SUBSTANCE USE DISORDER CRISES.

Crisis response plans should include policies that address interactions with people in crises.⁴¹ Ideally, they should provide specific examples and necessary skills for handling encounters without force or arrest.⁴²

Community members, especially those with mental health and developmental disabilities, should participate in the development of these policies and procedures and in the development and delivery of training.⁴³

Departments should provide specialized training that addresses sensitivity, awareness, and effective communication. Officers should have the skills to interact with

people with disabilities so that encounters do not escalate or result in the use or misuse of force. People with developmental disabilities, for example, may not make eye contact or communicate verbally, and they may make sudden movements. Officers who mistake this behavior for noncompliance might escalate the encounter.⁴⁴ And unexpected or sudden actions by people with disabilities could be misconstrued as suspicious activity.

The ADA requires police officers to be able to communicate effectively with people with disabilities.⁴⁵ American Sign Language (ASL) is the primary language for people who are Deaf and hard of hearing, but it may also be the preferred and most effective way to communicate with people who are nonverbal. By working with disability experts and people with developmental disabilities, departments can create protocols for interactions with people with disabilities. This should involve hiring people who speak ASL who can serve as interpreters. Officers should never serve as interpreters for people who are Deaf or hard of hearing during questioning or interrogations.

The Importance of Training Emergency Call Operators:

In 2015, a Chicago police officer shot and killed Quintonio LeGrier and his neighbor, Bettie Jones, when responding to a call about a domestic disturbance. The officers who arrived on the scene did not know that LeGrier was experiencing a mental health crisis and therefore did not use crisis response techniques.

Jones answered the door as LeGrier was coming down the stairs with a baseball bat; officers shot both of them. LeGrier had called the police three times to complain about being threatened before his father called 911 to report a domestic disturbance with his son. The dispatcher did not identify any of the calls as a crisis, hung up on LeGrier the first time he called, and did not dispatch CIT officers to the scene.

Source: Jeremy Gorner & Annie Sweeney, Quintonio LeGrier Called 911 Three times Before a Chicago Cop Shot Him, Chi. Tribune (Jan. 26, 2016), <https://www.chicagotribune.com/news/local/breaking/ct-met-quintonio-legrier-police-shooting-trial-20180621-story.html>.

RECOMMENDATION 5.4 TRAIN EMERGENCY CALL OPERATORS.

Training should cover how to identify when people are in crisis so that officers are prepared to use crisis response tactics upon arrival. In departments with CITs, operators should be trained to dispatch CIT officers⁴⁶ and should prepare officers to use crisis response tactics. Call operators should have a script with specific questions so they can get needed information, including whether callers have weapons and whether they have mental health or developmental disabilities or substance use disorders.

RECOMMENDATION 5.5 TRAIN ALL OFFICERS IN BASIC TECHNIQUES TO IDENTIFY AND MANAGE CRISES.

All officers (even those in departments that have CITs) should receive basic crisis response training, including sensitivity training to recognize people with disabilities and understand their unique needs.⁴⁷ Basic crisis response training should be 40 hours, and departments should require additional (and continual) in-service training. The Houston Police Department, for example, requires all officers to take eight-hour refresher courses every two years after they have received 40 hours of basic training.⁴⁸

As noted above, training should be mandatory, and it should cover topics including implicit bias, cultural awareness and responsiveness, empathy, procedural justice, effective social interactions, tactical skills, verbal intervention and de-escalation, and negotiation.⁴⁹ These skills strengthen officers' ability to recognize when people are in crisis, defuse crises, and refer people to needed services. The President's Task Force Report recommends that state Peace Officer and Standards Training boards (which set training requirements for law enforcement in regions across the country) include CIT training in basic recruit and in-service training requirements.⁵⁰

RECOMMENDATION 5.6

PAIR CRISIS RESPONSE TEAMS WITH MENTAL HEALTH AND DEVELOPMENTAL DISABILITY CO-RESPONDERS.

Under the Memphis CIT (crisis intervention team) model, officers volunteer to receive advanced training and are available for rapid response to mental health crises.⁵¹ They lead de-escalation efforts at the scene and assess the need to connect people with mental health services.⁵² The Chicago Police Department, for example, offers two 40-hour advanced trainings to help officers safely and effectively respond to youth and veterans in crisis.⁵³

While these officers are better equipped to respond to people in crisis, they do not have the advanced skills and expertise that mental health professionals and/or community-based service providers do. Thus, CIT officers should be dispatched with qualified professionals from community-based services to respond to and manage crisis situations.⁵⁴ These "co-responders" can be located within departments or be called to crises.⁵⁵

By involving professionals, departments can avoid defaulting to arrest and jail, even when people have apparently violated the law (so long as they pose no immediate threat to public safety).⁵⁶ Often, people who are acting erratically or causing a public disturbance but not committing an act of violence are placed under custodial arrest and/or issued a summons. If the summons turns into a warrant for failure to appear or pay fines, they can end up in jail for a minor initial offense and become ensnared in the criminal justice system.

RECOMMENDATION 5.7

CAREFULLY SELECT CRISIS RESPONSE PROGRAM COORDINATORS AND OFFICERS.

When creating crisis response programs, department leaders should carefully select officers to serve as program coordinators and responders from a pool of volunteers.⁵⁷ Not all officers are well suited for this specialized task. Leaders should select those who are skilled at interacting with people and who are committed to and genuinely interested in helping people in crisis.⁵⁸ Being a crisis response program coordinator or officer can be a source of esteem if it is promoted as such.

RECOMMENDATION 5.8

PARTNER WITH LOCAL SERVICE PROVIDERS TO COORDINATE CRISIS RESPONSES.

Central to proper crisis responses is the ability to connect people with the community-based services that can help address and treat the underlying circumstances and conditions that lead to crisis. Departments should create a network of mental health and social service providers to work with in order to help connect people to services and to help develop departmental crisis response policies and training.⁵⁹ This includes hiring experts in mental health and developmental disabilities and substance use disorders, and especially people who have lived experiences, to coordinate crisis responses.⁶⁰



RECOMMENDATION 5.9

ADOPT HARM-REDUCTION MODELS FOR PEOPLE WITH SUBSTANCE USE DISORDERS.

Police officers frequently interact with people with substance use disorders (whether alcohol or drugs) and often express frustration with the “revolving door” that some individuals (many of whom also have mental health problems) find themselves in. Indeed, some people are “arrested, detained, and released — only to be arrested again.”⁶¹ To reduce their involvement with the criminal justice system, these individuals need social supports and mental health services — not involvement with the police.⁶²

For this reason, departments are turning to deflection programs and other models of harm-reduction policing. Deflection programs refer people to treatment (when possible) instead of arresting them. In 2018, the Tucson Police Department in Arizona partnered with a local service provider to create a program that gives people with substance use disorders the option to enter treatment.⁶³ The program trains officers to explain what treatment involves (because not everyone opts for it). Officers then call service providers and either drive people to providers or wait until they are picked up.

In other programs, officers become “partners” in treatment; in the Tucson program, officers’ involvement is over when the call ends. As a result, this program moves people with substance use disorders into the public health system, allowing officers to spend more time addressing serious crime and protecting and preserving public safety.



As the rate of opioid addiction climbs, officers are increasingly responding to drug overdoses. In 2016, the U.S. Department of Justice issued a memorandum recognizing the power of naloxone (popularly known as Narcan) to reverse overdoses and save lives. The memorandum encourages departments to administer naloxone⁶⁴ and offers guidance to departments seeking to create naloxone programs. Nearly 2,500 law enforcement agencies are known to carry naloxone.⁶⁵ Departments should implement these types of programs according to guidelines put forth by the White House Office of National Drug Control Policy to ensure safe implementation and administration.⁶⁶

RECOMMENDATION 5.10 TRACK OFFICER RESPONSES TO CRISES AND ASSESS CRISIS RESPONSE PROGRAMS.

To assess the incidence of crises and the efficacy of crisis response practices, departments should track data,⁶⁷ including the number of encounters with people in crisis and the nature of the encounter (e.g., mental health crisis, suicide attempt, drug overdose, disability, etc.). Departments should also track officers' responses and the outcomes of their responses, which supports internal analysis and promotes transparency. These data help all involved — officers, clinicians, and service providers — create and refine a systemwide approach to mental health crises.

Department leaders and officers should use data and draw on the experiences of community members with mental health problems who have interacted with police to assess the efficacy of crisis response programs, and they should work with community members and service providers to do so. As the President's Task Force Report recommends, community members should hold officers accountable and work with them to continually improve and adapt programs to changing needs and problems.⁶⁸

Departments should also conduct post-training assessments of officers who respond to crises, as well as the outcomes of those responses, to ensure that programs are effective and that training addresses community challenges (e.g., an opioid crisis). To identify shortcomings and improve trainings, assessments should be done in partnership with community members, and especially with people from affected communities, and with mental health and other professional service providers.⁶⁹

I NEED A HOME

THEN A JOB

Chapter 5

¹ See, e.g., Mental Health America, Position Statement 59: Responding to Behavioral Health Crises (indicating that since 1960, police contact with people experiencing behavioral health crises has increased), <http://www.mentalhealthamerica.net/issues/position-statement-59-responding-behavioral-health-crises> (last visited Dec. 22, 2018); Police Exec. Res. Forum, Critical Issues in Policing Series: An Integrated Approach to De-Escalation and Minimizing Use of Force 9 (2012) [hereinafter PERF Critical Issues] (quoting Sheriff Doug Gillespie of the Las Vegas Metropolitan Police Department to explain that, because funding for mental health services decreased, a significant portion of the jail population is under psychiatric care), https://www.policeforum.org/assets/docs/Critical_Issues_Series/an%20integrated%20approach%20to%20de-escalation%20and%20minimizing%20use%20of%20force%202012.pdf.

² Mental Health America, *supra* note 1 (“Approximately 10% of all police contacts involve persons with serious mental illness.”); Jennifer D. Wood, PhD, et al., The “Gray Zone” of Police Work During Mental Health Encounters: Findings from an Observational Study in Chicago (noting that 7 to 10 percent of all police encounters involve people affected by mental illness), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5342894/>; Doris A. Fuller et al., Treatment Advocacy Ctr., Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters (Dec. 2015), <https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf>.

³ Mental Health America, *supra* note 1 (citing Wash. Post, “Fatal Force,” (2016), <https://www.washingtonpost.com/graphics/national/police-shootings-2016/>) (indicating that, since 1960, police contact with people experiencing behavioral health crises has increased), <http://www.mentalhealthamerica.net/issues/position-statement-59-responding-behavioral-health-crises> (last visited Dec. 22, 2018); see also Fuller et al., *supra* note 2, at 5.

⁴ Kevin M. Simon, MD, et al., Addressing Poverty and Mental Illness, *Psychiatric Times* (June 29, 2018) (“Poverty in adulthood is linked to depressive disorders, anxiety disorders, psychological distress, and suicide.”) (citing Leventhal T, Brooks-Gunn J., Moving to Opportunity: An Experimental Study of Neighborhood Effects on Mental Health. *Am J Public Health*. 93:1576-1582 (2003)), <https://www.psychiatristimes.com/special-reports/addressing-poverty-and-mental-illness>; Pickett KE, Wilkinson, R.G. Child Wellbeing and Income Inequality in Rich Societies: Ecological Cross Sectional Study. *BMJ*. 335:1080 (2007); see Paolo del Vecchio, Substance Abuse and Mental Health Servs. Admin., Increasing Community Capacity to Respond to Mental Health Crises (May 22, 2014), <https://web.archive.org/web/20160130004608/http://blog.samhsa.gov/2014/05/22/increasing-community-capacity-to-respond-to-mental-health-crises/>; Organization for Economic Co-operation and Development, Poverty Rate; Substance Abuse and Mental Health Services Administration, Community Conversations About Mental Health: Information Brief, HHS Publication No. SMA-13-4763 13, 16 (2013), <https://store.samhsa.gov/system/files/sma13-4763.pdf>.

⁵ PERF Critical Issues, *supra* note 1, at 16 (quoting Ron Honberg).

⁶ See Liza Lucas, Changing the Way Police Respond to Mental Illness, CNN (Sept. 28, 2016) (“Traditional training teaches police to control situations by demanding compliance, and the unpredictable nature of a person with a psychiatric condition can be misinterpreted as a threat and quickly escalate to violence. CIT training is meant to prevent that.”), <http://www.cnn.com/2015/07/06/health/police-mental-health-training/index.html>; Kurt Vorndran et al., Police Complaints Bd., Enhancing Police Response to People with Mental Illness in the District of Columbia: Incorporating the Crisis Intervention Team (CIT) Community Policing Model 10 (2006) (“In instances where police know or suspect that a person is mentally ill, they often respond based on commonly held misconceptions.”), <https://policecomplaints.dc.gov/sites/default/files/dc/sites/police%20complaints/publication/attachments/Enhancing%20Police%20Response%20to%20People%20with%20Mental%20Illness.pdf>.

⁷ PERF Critical Issues, *supra* note 1, at 20; see also Lucas, *supra* note 6; Vorndran et al., *supra* note 6, at 10.

⁸ Americans With Disabilities Act of 1990, 42 U.S.C.A. § 12101 (West 2018).

⁹ See U.S. Dep’t of Justice, Civil Rights Division, Disability Rights Section, Questions and Answers: The Americans With Disabilities Act and Hiring Police Officers (Mar. 25, 1997), <https://www.ada.gov/copsq7a.pdf>.

¹⁰ Univ. of Memphis CIT Ctr., The CIT Program: Background [hereinafter Memphis CIT Background], <http://cit.memphis.edu/overview.php?page=1> (last visited Feb. 25, 2019); see also Daniel Connolly, Memphis Police Crisis Intervention Team Approaches 30 Years, But How Effective Is It?, *Commercial Appeal* (Aug. 6, 2017), <https://www.commercialappeal.com/story/news/crime/2017/08/06/memphis-police-mental-health-crisis-team-30-years/493740001/>.

¹¹ Connolly, *supra* note 10.

¹² Memphis CIT Ctr., *supra* note 10; see also Yolanda Jones, Memphis Police Crisis Intervention Team Works to Defuse Mental Health Calls, *Commercial Appeal* (Mar. 5, 2016), <http://archive.commercialappeal.com/news/memphis-police-crisis-intervention-team-works-to-defuse-mental-health-calls--2c9bba98-fe28-1e3b-e053-371108951.html/>.

¹³ Univ. of Memphis CIT Ctr., The CIT Program: National Model, <http://www.cit.memphis.edu/overview.php?page=7> (last visited Feb. 25, 2019); How Memphis Has Changed the Way Police Respond to Mental Health Crises, PBS News Hour (Nov 7, 2015 3:17 PM EST), <https://www.pbs.org/newshour/show/memphis-changed-way-police-respond-mental-health-crises>.

¹⁴ Mark G. Peters & Philip K. Eure, N.Y.C. Dep’t of Investigation, Putting Training into Practice: A Review of NYPD’s Approach to Handling Interactions With People in Mental Crisis 8 (2017) (“The training also emphasizes de-escalation strategies through role-playing scenarios involving people in crisis (in clinical or informal settings) in order to increase officers’ capacity to successfully resolve encounters.”), http://www1.nyc.gov/assets/oignypd/downloads/pdf/Reports/CIT_Report_01192017.pdf.

¹⁵ Randolph Dupont, et al., Univ. of Memphis, Crisis Intervention Team Core Elements 17 (2007), <http://cit.memphis.edu/pdf/CoreElements.pdf>.

- ¹⁶ See, e.g., Deborah L. Bower & W. Gene Pettit, The Albuquerque Police Department's Crisis Intervention Team: A Report Card, FBI Law Enforcement Bull. 2 (Feb. 2001) (finding that the Albuquerque CIT program improved outcomes, and that injuries to members of the public occurred in slightly more than 1 percent of CIT contact calls, 58 percent of which involved mental health crises), http://www.au.af.mil/au/awc/awcgate/fbi/crisis_interven.pdf; Michael T. Compton et al., Use of Force Preferences and Perceived Effectiveness of Actions Among Crisis Intervention Team (CIT) Police Officers and Non-CIT Officers in an Escalating Psychiatric Crisis Involving a Subject With Schizophrenia, 37 Schizophrenia Bull. 737, 742 (Nov. 2009) (finding that "CIT-trained officers chose less escalation (i.e., opting for less force at the third scenario) than non-CIT-trained officers" during psychiatric crises), https://www.researchgate.net/publication/40027064_Use_of_Force_Preferences_and_Perceived_Effectiveness_of_Actions_Among_Crisis_Intervention_Team_CIT_Police_Officers_and_Non-CIT_Officers_in_an_Escalating_Psychiatric_Crisis_Involving_a_Subject_With_Sch; Fuller et al., *supra* note 2, at 10 ("De-escalation techniques such as those used in CIT have been documented to produce 'positive outcomes for police, offenders, and the community[.]'").
- ¹⁷ The President's Task Force on 21st Century Policing, Final Report of the President's Task Force on 21st Century Policing 56 (2015) [hereinafter President's Task Force Report], https://cops.usdoj.gov/pdf/taskforce/taskforce_finalreport.pdf.
- ¹⁸ *Id.* at 44, 56.
- ¹⁹ Preventing Tragedies Between Police and Communities Act of 2017, H.R. 3060, 115th Cong. (2017), <https://www.congress.gov/bill/115th-congress/house-bill/3060/text>.
- ²⁰ See Dupont, et al., *supra* note 15, at 6, 8.
- ²¹ U.S. Dep't of Health and Human Servs., Substance Abuse and Mental Health Services Administration, Community Conversations About Mental Health: Information Brief, HHS Publication No. SMA-13-4763 ii (2013), <https://store.samhsa.gov/system/files/sma13-4763.pdf>; U.S. Dep't of Health and Human Servs., Substance Abuse and Mental Health Services Administration, "Crisis Response": An Alternative, 22 SAMSHA News no. 4 (Fall 2014) [hereinafter SAMHSA, "Crisis Response"], available at https://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_4/crisis_response_an_alternative/.
- ²² Substance Abuse and Mental Health Services Administration, SAMHSA, "Crisis Response," *supra* note 21.
- ²³ See *Olmstead v. L.C.*, 527 U.S. 581 (1999) (holding that people with disabilities have a right to services in the most integrated setting appropriate).
- ²⁴ Nat'l Alliance on Mental Illness, Psychosocial Treatment, <https://www.nami.org/Learn-More/Treatment/Psychosocial-Treatments> (last visited Feb. 24, 2019).
- ²⁵ *Id.* Settlement Agreement, United States v. Delaware, No. 11-cv-591 (D. Del. Jul. 6, 2011) [hereinafter Delaware Settlement Agreement], https://www.justice.gov/sites/default/files/crt/legacy/2011/07/06/DE_settlement_7-6-11.pdf.
- ²⁶ Nat'l Alliance on Mental Illness, Psychosocial Treatment, *supra* note 24.
- ²⁷ Mental Health America, *supra* note 1 (indicating that, since 1960, police contact with people experiencing behavioral health crises has increased).
- ²⁸ See U.S. Dep't of Health and Human Servs., Substance Abuse and Mental Health Services Administration, Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies (2014), <https://store.samhsa.gov/system/files/sma14-4848.pdf> [hereinafter SAMHSA Crisis Services]; see also Florida Philanthropic Network, \$6 Million Project to Address Student Isolation in Broward (Apr. 16, 2018) ("creat[ing] a fresh new approach to address the social, emotional and academic needs of isolated, struggling middle school students"), <https://www.fpnetwork.org/funding-area/mental-healthcrisis-services>.
- ²⁹ Nat'l Alliance on Mental Illness, Getting Treatment During a Crisis, <https://www.nami.org/Learn-More/Treatment/Getting-Treatment-During-a-Crisis> (last visited Feb. 25, 2019).
- ³⁰ SAMHSA Crisis Services, *supra* note 28, at 8.
- ³¹ SAMHSA Crisis Services, *supra* note 28, at 11.
- ³² Delaware Settlement Agreement, *supra* note 25, at §§(II) (C) (2) (a) (i-ii).
- ³³ Nat'l Alliance on Mental Illness, Getting Treatment During a Crisis, <https://www.nami.org/Learn-More/Treatment/Getting-Treatment-During-a-Crisis> (last visited Feb. 25, 2019); see e.g., Tenn. Dep't of Mental Health and Substance Abuse Services, Crisis Walk-In Centers, <https://www.tn.gov/behavioral-health/need-help/crisis-services/mental-health-crisis-services/crisis-walk-in-centers.html> (last visited Feb. 25, 2019).
- ³⁴ Delaware Settlement Agreement, *supra* note 25, at §§(II) (C) (2) (b) (i-iii).
- ³⁵ Mental Health America, *supra* note 1.
- ³⁶ SAMHSA Crisis Services, *supra* note 28, at 15.
- ³⁷ SAMHSA Crisis Services, *supra* note 28, at 23.
- ³⁸ SAMHSA Crisis Services, *supra* note 28, at 12, 23.
- ³⁹ Verlatta Saxon, Dhruvodi Mukherjee, & Deborah Thomas, Behavioral Health Crisis Stabilization Centers: A New Normal, 23(3) J. Mental Health & Clinical Psychol. 23, 24 (2018), <http://www.mentalhealthjournal.org/articles/behavioral-health-crisis-stabilization-centers-a-new-normal.pdf>.
- ⁴⁰ SAMHSA Crisis Services, *supra* note 28, at 22.
- ⁴¹ See Peters & Eure, *supra* note 14, at 9; Dupont, et al., *supra* note 15, at 10 ("Policies and procedures are a necessary component of CIT. They provide a set of guidelines that direct the actions of both law enforcement and mental health officials.").
- ⁴² Peters & Eure, *supra* note 14, at 8-9, 33.

⁴³ See Dupont, et al., *supra* note 15, at 10 (“Due to the large number of stakeholders in CIT, it is important that these guidelines be designed by all those affected.”); Mecklenburg Cty., N.C. Health Dep’t, Crisis Intervention Team (“Consumer and family advocates are integrally involved in the design and implementation of local CIT programs.”), <https://www.mecknc.gov/healthdepartment/communityhealthservices/tjp/pages/cit.aspx?redirect=charmack> (last visited Dec. 23, 2018).

⁴⁴ See e.g., David Lohr, Police Allegedly Beat Pearl Pearson for Disobeying Orders He Could Not Hear, *Huffington Post* (Jan. 15, 2014), https://www.huffingtonpost.com/2014/01/15/pearl-pearson-police-brutality_n_4603445.html; see also Vanderbilt Kennedy Center for Excellence in Developmental Disability, Healthcare for Adults with Intellectual and Developmental Disabilities Toolkit for Primary Care Providers: Communicating Effectively, <https://vk.mc.vanderbilt.edu/etoolkit/general-issues/communicating-effectively/> (last visited Feb. 25, 2019); Nat’l Inst. on Deafness and Other Communication Disorders, Autism Spectrum Disorder: Communication Problems in Children, <https://www.nidcd.nih.gov/health/autism-spectrum-disorder-communication-problems-children> (Mar. 23, 2018).

⁴⁵ Americans With Disabilities Act of 1990, 42 U.S.C. §§ 12131-12165 (2018); U.S. Dep’t of Justice, Civil Rts. Div., Disability Rights Section, ADA Requirements Effective Communication (Jan. 31, 2014), <https://www.ada.gov/effective-comm.htm>.

⁴⁶ See Dupont, et al., *supra* note 15, at 10 (“All dispatchers should be trained to appropriately elicit sufficient information to identify a mental health related crisis.”); Peters & Eure, *supra* note 14, at 31 (“A look at successful CIT programs around the country demonstrates that exposing dispatchers and call takers to CIT training is essential to the implementation of a successful CIT program.”); Vorndran et al., *supra* note 6, at 17 (“A crucial component of the CIT model is dispatch operations. To ensure that calls involving mental health issues are properly identified and that CIT officers are dispatched to those calls, dispatchers and 911 call takers receive specialized training on how to perform their duties in support of the CIT program.”); Carmen Best, Chief of Police, Seattle Police Dep’t Manual, 16.110 – Crisis Intervention, *Seattle.gov* (Aug. 16, 2018) (noting that CIT-trained officers should be dispatched to calls that appear to involve a subject in behavioral crisis), <https://www.seattle.gov/police-manual/title-16---patrol-operations/16110---crisis-intervention>.

⁴⁷ Civil Rights Coalition on Police Reform, A Uniform Statement of Action to Promote Reform and Stop Police Abuse (Aug. 18, 2014), <https://lawyerscommittee.org/wp-content/uploads/2015/08/Civil-Rights-Coalition-on-Police-Reform-Resource-Packet.pdf>.

⁴⁸ PERF Critical Issues, *supra* note 1 at 15.

⁴⁹ President’s Task Force Report, *supra* note 17, at 10-11, 56-57 (asserting that “mitigating implicit bias should be a part of training at all levels of a law enforcement organization” and recommending that law enforcement departments “adopt procedural justice as the guiding principle for internal and external policies”).

⁵⁰ President’s Task Force Report, *supra* note 17, at 3-4.

⁵¹ Dupont, et al., *supra* note 15, at 12 (“Officers within a patrol division should voluntarily apply for CIT positions ... [E]ach of the CIT Officers maintains their role as a patrol officer and gains new duties and skills through the CIT training, serving as the designated responder and lead officer in mental health crisis events.”).

⁵² See Dupont, et al., *supra* note 15, at 14 (“Police officers receive intensive training to effectively respond to citizens experiencing a behavioral crisis. ... Officers are encouraged to maintain these skills throughout the course, while incorporating new de-escalation techniques to more effectively approach a crisis situation.”); Vorndran et al., *supra* note 6, at 14 (“The CIT model ... consists of a select group of police officers who, although continuing to serve as regular patrol officers in a district or precinct, are certified to provide highly specialized mental health crisis intervention.”); Charles Dempsey, Beating Mental Illness: Crisis Intervention Team Training and Law Enforcement Response Trends, 26 S. Cal. Interdisc. L.J. 323, 324 (2017) (stating that one of the primary goals of CIT models is to “redirect individuals with mental illness from the judicial system to the health care system.”), <https://gould.usc.edu/why/students/orgs/lij/assets/docs/26-2-Dempsey.pdf>.

⁵³ William Harms, Police Need to Work More with Mental Health Professionals, 23 Univ. of Chi. Sch. of Social Serv. Admin. Mag. (Summer 2016), https://ssa.uchicago.edu/ssa_magazine/police-need-work-more-mental-health-professionals.

⁵⁴ Civil Rights Coalition, *supra* note 47.

⁵⁵ See, e.g., Melissa Reuland, Police Exec. Res. Forum, A Guide to Implementing Police-Based Diversion Programs for People with Mental Illness 10–11 (Jan. 2004), <http://www.pacenterofexcellence.pitt.edu/documents/A%20Guide%20to%20Implementing%20Police-Based%20Diversion%20Programs.pdf>; see also Henry J. Steadman et al., Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies, 51 *Psychiatry Servs.* 645 (2000) (finding that a “specialized” response to mental health crises, partnering police with mental health professionals, was effective in reducing arrests), [https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.51.5.645?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&Council of State Gov’ts, Criminal Justice/Mental Health Consensus Project 41](https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.51.5.645?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&Council%20of%20State%20Gov%27ts%20Criminal%20Justice%20Mental%20Health%20Consensus%20Project%2041) (June 2002) (“Some law enforcement agencies hire licensed mental health workers as secondary responders. These civilians serve in units that are either located in the police department — where civilian workers are under the chief’s supervision — or reside outside the department because staffing is shared with other county or city mental health providers. These civilian workers may either ride along with officers in special teams or respond when called by an officer after the scene has been secured for various crisis calls, including those involving people with mental illness.”), <https://www.ncjrs.gov/pdffiles1/nij/grants/197103.pdf>; U.S. Dep’t of Justice, Police Mental Health Collaboration, Co-Responder Team, <https://pmhctoolkit.bja.gov/learning/types-of-pmhc-programs/co-responder-team> (last visited Dec. 23, 2018).

⁵⁶ See Best, *supra* note 46 (utilizing an intercept continuum that balances criminal charges with mental health interventions at different levels of crisis and provides for referral to a crisis solutions center in certain instances when resolving behavioral crisis-related misdemeanor property crimes).

⁵⁷ See, e.g., N.C. Dep't. of Health and Human Servs., Mental Health, Developmental Disabilities and Substance Abuse Servs. Div., Attachment D: Lessons Learned 24 ("While all officers should be informed about CIT, officers shouldn't be required to go through CIT training. Officers that are ordered to go through CIT training may resent it, resist the training, and may lack commitment to being a CIT officer."), https://files.nc.gov/ncdhhs/documents/files/cit-lessonslearned3_6-09.pdf.

⁵⁸ *Id.* ("You want experienced street-level officers (and their immediate supervisors) who want to help persons with mental illness, and who already possess good interpersonal skills that CIT training can enhance.").

⁵⁹ Civil Rights Coalition, *supra* note 47.

⁶⁰ See Civil Rights Coalition, *supra* note 47.

⁶¹ Marc Krupanski, Open Society Foundations, Police & Harm Reduction 3 (2018), <https://www.opensocietyfoundations.org/sites/default/files/police-harm-reduction-20180720.pdf>.

⁶² *Id.*

⁶³ Caitlin Schmidt, New Tucson Police Program Will Refer Opioid Addicts to Treatment, Not Jail, *Ariz. Daily Star*, (June 30, 2018), https://tucson.com/news/local/new-tucson-police-program-will-refer-opioid-addicts-to-treatment/article_01b5576b-b401-5a2f-9c1a-8d8efd8a9a0d.html.

⁶⁴ Memorandum from Office of the Att'y Gen. to Heads of Department Components 3 (Sept. 21, 2016), <https://www.justice.gov/opioidawareness/file/896776/download>; see also U.S. Dep't of Justice, Bureau of Justice Assistance, Nat'l Training and Tech. Assistance Ctr., Law Enforcement Naloxone Toolkit, <https://bjatta.bja.ojp.gov/tools/naloxone/Naloxone-Background> (last visited Dec. 24, 2018).

⁶⁵ North Carolina Harm Reduction Coalition, Law Enforcement Departments Carrying Naloxone, <http://www.nchrc.org/law-enforcement/us-law-enforcement-who-carry-naloxone/> (last visited Feb. 25, 2019); Peter Jamison, D.C. Mayor Announces Large New Investment in Opioid Overdose Antidote, *Wash. Post* (Jan. 18, 2019), https://www.washingtonpost.com/local/dc-politics/dc-police-officers-to-carry-opioid-overdose-antidote-naloxone/2019/01/18/b76de64a-1b44-11e9-8813-cb9dec761e73_story.html?utm_term=.79ae522dde94.

⁶⁶ U.S. Office of Nat'l Drug Control Policy, Fentanyl Safety Recommendations for First Responders, <https://www.whitehouse.gov/ondcp/key-issues/fentanyl/> (last visited Dec. 23, 2018).

⁶⁷ Peters & Eure, *supra* note 14, at 9 ("CIT stresses data collection, evaluation, and research to 'help measure [the program's] impact, continuous outcomes, and efficiency.'").

⁶⁸ See President's Task Force Report, *supra* note 17, at 44.

⁶⁹ Dupont, et al., *supra* note 15, at 17 ("Evaluation and research can help measure the impact, continuous outcomes, and efficiency of a community's CIT program. More specifically, it may help to identify whether the program is achieving its objectives and should be an ongoing part of CIT.").



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