No. 13-1412

IN THE
Supreme Court of the United States

CITY AND COUNTY OF
SAN FRANCISCO, CALIFORNIA, ET AL.,
Petitioners,
v.

TERESA SHEEHAN,
Respondent.

**On Writ of Certiorari
to the United States Court of Appeals
for the Ninth Circuit**

BRIEF OF AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN PSYCHOLOGICAL ASSOCIATION, DELAWARE, ILLINOIS, NEW MEXICO, OHIO, AND VERMONT PSYCHOLOGICAL ASSOCIATIONS, NATIONAL COUNCIL ON DISABILITY, NATIONAL ALLIANCE ON MENTAL ILLNESS, AND JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICUS CURIAE*[1]

The American Psychiatric Association ("APA"), with more than 36,000 members, is the Nation's leading organization of physicians who specialize in psychiatry. APA has participated in numerous cases in this Court.

The American Psychological Association is the leading association of psychologists in the United States. A non-profit scientific and professional organization, it has approximately 155,000 members and affiliates. Among its major purposes are to increase and disseminate knowledge regarding human behavior, and to foster the application of psychological learning to important human concerns. The American Psychological Association has filed numerous *amicus* briefs in this Court and other state and federal courts around the country. The Delaware, Illinois, New Mexico, Ohio, and Vermont Psychological Associations are the state-level organizations in their respective States with memberships and missions similar to those of the American Psychological Association.

The National Council on Disability is an independent federal agency charged with advising the President, Congress, and other federal agencies on policies and practices that affect people with

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *amici* represent that they authored this brief in its entirety and that none of the parties or their counsel, nor any other person or entity other than *amici*, their members, or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief. Pursuant to Rule 37.3(a), counsel for *amici* also represent that all parties have consented to the filing of this brief by submitting to the Clerk letters granting blanket consent to the filing of *amicus* briefs.

disabilities. Council members are appointed by the President and Congress and are representative of national organizations concerned with individuals with disabilities, providers and administrators of services to individuals with disabilities, individuals engaged in conducting medical or scientific research relating to individuals with disabilities, business concerns, labor organizations, and individuals with disabilities themselves. In furtherance of its duties, the Council systematically gathers and provides decision-makers with information relevant to the implementation of the Americans with Disabilities Act.

NAMI (the National Alliance on Mental Illness) is the nation's largest grassroots mental health organization advocating on behalf of individuals and families affected by mental illness. NAMI has worked for many years with federal, state, and local law enforcement and mental health agencies on crisis intervention team (CIT) programs and strategies to de-escalate mental health crises and reduce adverse outcomes such as deaths and serious injuries. Consequently, NAMI has expertise and a direct interest in the issues under consideration in this case.

The Judge David L. Bazelon Center for Mental Health Law is a national public interest organization founded in 1972 to advance the rights of individuals with mental disabilities. The Center advocates for laws and policies that provide people with mental illness or intellectual disability the opportunities and resources they need to participate fully in their communities. Its litigation and policy advocacy is based on the Americans with Disabilities Act's guarantees of non-discrimination and reasonable accommodation.

The Center has long worked for the diversion of people with mental illness from the criminal justice system and for safer police practices.

Mental health professionals and other advocates for individuals with mental illness have dedicated substantial effort and resources to studying, analyzing, and developing practices to reduce the risks that arise from encounters between law enforcement and persons with mental illnesses. Many such encounters arise from circumstances, like those present in this case, that involve primarily, if not exclusively, the need for *treatment* and that should not lead to criminal justice system intervention. There is accordingly a pressing need for police and other law enforcement personnel to be prepared to intervene to initiate entry into treatment for individuals with acute mental illness – just as they are trained to respond appropriately in other situations requiring medical treatment. Legal rules governing arrests should recognize and provide appropriate incentives for law enforcement authorities to adopt available practices to mitigate risks to individuals with mental illnesses and law enforcement personnel during arrests. *Amici* agree with the court below that such legal rules should include the obligation, under the Americans with Disabilities Act of 1990, to provide reasonable accommodations for individuals with serious mental illness.

INTRODUCTION

The Americans with Disabilities Act of 1990 ("ADA") requires public entities to provide reasonable accommodations for individuals with disabilities, including mental illnesses.[2] In this case, police were called to transport a woman with serious mental illness to a mental health facility for involuntary psychiatric treatment. The Ninth Circuit held that the ADA applied in that circumstance and that – on the view of the facts most favorable to respondent – a jury could find that the police failed to make reasonable accommodations for respondent's serious mental illness.

Encounters between individuals with mental illness and law enforcement officers have become a pervasive feature of police work. On countless occasions, police officers are able to engage successfully with individuals with mental illness and to transport those in need to psychiatric care. We acknowledge the vital role of law enforcement in protecting public safety and the risks that police officers encounter in carrying out their duty. At the same time, stigmatization of individuals with mental illness and failure to implement appropriate practices can lead to tragic loss of life or, as in this case, devastating injury. The purpose of the ADA is to protect individuals like respondent from discrimination, including by requiring reasonable accommodations for mental illnesses. The decision below gives effect to that principle, and this Court, accordingly, should affirm on this issue.

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[2] As used in this brief, "mental illness" refers to illnesses, like Ms. Sheehan's, that qualify as disabilities under the ADA.

STATEMENT

1. A social worker called a nonemergency police line to seek help in transporting Teresa Sheehan, an individual suffering from schizoaffective disorder, from a group home for persons with mental illness to a specialized mental health facility for 72-hour involuntary commitment. JA97-98. Police are asked to respond to calls like this one on a daily basis.

Increasingly, police are the public entities entrusted with responding to individuals with mental illness. In some cities, police spend more time responding to calls involving mental illnesses than they do investigating burglaries or felony assaults.[3] Florida law enforcement officers transport more individuals for involuntary mental illness examinations than they arrest for either aggravated assault or burglary.[4] Although encounters with individuals with mental illness account for less than one-tenth of all calls, law enforcement officers spend a disproportionate amount of time and resources responding to such calls.[5] In large part because of the scarcity of appropriate community-based mental health treatment

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[3] *See* Gary Cordner, U.S. Dep't of Justice, Office of Community Oriented Policing Services, *People with Mental Illness* 1 (May 2006) (discussing Lincoln, Nebraska), http://ric-zai-inc.com/Publications/cops-p103-pub.pdf.

[4] *See* Melissa Reuland & Jason Cheney, Police Executive Research Forum, *Enhancing Success of Police-Based Diversion Programs for People with Mental Illness* 1 (May 2005) ("Reuland & Cheney, *Enhancing Success*"), http://gainscenter.samhsa.gov/pdfs/jail_diversion/PERF2.pdf.

[5] *See* Melissa Reuland et al., Council of State Gov'ts Justice Center, *Law Enforcement Responses to People with Mental Illnesses: A Guide to Research-Informed Policy and Practice* 6-7 (2009) ("Reuland, *Law Enforcement Responses*"), http://csgjusticecenter.org/wp-content/uploads/2012/12/le-research.pdf.

options – discussed further below – police officers expend substantial time responding repeatedly to the same subset of individuals believed to have mental illness.[6]

Law enforcement's role in responding to individuals with mental illness has increased over the last several decades. More people with mental illness are living in the community, as treatment models have shifted from long-term care in state psychiatric hospitals to community-based treatment. The number of people institutionalized long-term in state psychiatric hospitals has decreased dramatically since its peak in 1955.[7] State mental health systems now focus the majority of their spending on community-based mental health services. For example, in 1981, States spent 33% of their mental health expenditures on outpatient services; by 2007, the percentage had increased to 71%.[8] But these shifts tell only part of the story. Community-based mental health services are underfunded and overtaxed, with need greatly outstripping available capacity. As a result, mental

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[6] *See id.* at 7 ("The Los Angeles (Calif.) County Police Department identified 67 people with mental illnesses who had a minimum of five contacts with law enforcement during the first eight months of 2004. This resulted in a total of 536 calls for service during this time period."); Thomas M. Green, *Police as Frontline Mental Health Workers: The Decision to Arrest or Refer to Mental Health Agencies*, 20 Int'l J.L. & Psychiatry 469, 476 (1997) (reporting that Honolulu, Hawaii police officers recognized 94 out of 148 individuals believed to have mental illness "on sight").

[7] *See* Reuland, *Law Enforcement Responses* at 4.

[8] *See* Substance Abuse & Mental Health Services Admin., *Funding and Characteristics of State Mental Health Agencies, 2009*, at 36 (2011), http://store.samhsa.gov/shin/content//SMA11-4655/SMA11-4655.pdf.

health systems are not prepared to address the range of disadvantages – including homelessness and unemployment – that correlate with both mental illness and encounters with police.[9]

The shift toward community-based mental health services has thus been accompanied by a critical shortage of appropriate treatment options for individuals with mental illness, including a lack of outpatient services.[10] One consequence of this shortage of community-based mental health services has been a rise in the number of individuals with mental illness in jails and prisons.[11] Fueled in part by falling state budgets, there is also a lack of appropriately trained mental health professionals, which leads to shortages of care.[12] Discrimination by third-

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[9] *See* Steven K. Hoge et al., American Psychiatric Ass'n Task Force Report, *Outpatient Services for the Mentally Ill Involved in the Criminal Justice System* 11 (Oct. 2009) ("Hoge, *Outpatient Services*"), *available at* http://www.psychiatry.org/learn/library--archives/task-force-reports; *see also* Council of State Gov'ts, *Criminal Justice/Mental Health Consensus Project* 264-65 (June 2002) ("*Consensus Project*") (noting that individuals with mental illness, particularly in the absence of appropriate treatment options, face chronic disability, unemployment, and homelessness), https://www.ncjrs.gov/pdffiles1/nij/grants/197103.pdf.

[10] *See* Hoge, *Outpatient Services* at 11-12.

[11] *See* Timothy Williams, *Jails Have Become Warehouses for the Poor, Ill and Addicted, a Report Says*, N.Y. Times, Feb. 11, 2015, at A19; Ram Subramanian et al., Vera Inst. of Justice, *Incarceration's Front Door: The Misuse of Jails in America* 12-13 (Feb. 2015), http://www.vera.org/sites/default/files/resources/downloads/incarcerations-front-door-report.pdf.

[12] *See Consensus Project* at 280-81; Kathleen C. Thomas et al., *County-Level Estimates of Mental Health Professional Shortage in the United States*, 60 Psychiatric Services 1323 (2009), http://psychiatryonline.org/doi/pdf/10.1176/ps.2009.60.

party payers of medical care in denying or unfairly restricting reimbursement for mental health services has compounded these problems,[13] an issue that has not yet been resolved by the passage of federal and state laws requiring parity for mental health insurance benefits as compared with general medical benefits.[14]

As a consequence of this shortage, calls like the one in this case – which was precipitated by neither a violent act nor a crime, and which asked police officers to respond to a mental health crisis – have grown increasingly common.[15] As this case illustrates, these situations can present serious risks of harm, including death, to individuals with mental illness and to others. Although statistics are hard

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10.1323; Michael A. Hoge et al., *Mental Health and Addiction Workforce Development: Federal Leadership Is Needed To Address the Growing Crisis*, 32 Health Affairs 2005 (2013).

[13] *See* Paul S. Appelbaum, *The 'Quiet' Crisis In Mental Health Services*, 22 Health Affairs 110 (2003), http://content.healthaffairs.org/content/22/5/110.full.pdf+html.

[14] *See* Eric Goplerud, U.S. Dep't of Health & Human Services, Office of Disability, Aging & Long-Term Care Policy, *Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (Nov. 2013), http://aspe.hhs.gov/daltcp/reports/2013/mhpaeAct.pdf; Debra A. Pinals, *Forensic Services, Public Mental Health Policy, and Financing: Charting the Course Ahead*, 42 J. Am. Acad. Psychiatry & L. 7 (2014), http://www.jaapl.org/content/42/1/7.full.pdf.

[15] *See* Fernanda Santos & Erica Goode, *Police Confront Rising Number of Mentally Ill Suspects*, N.Y. Times, Apr. 2, 2014, at A1; Kelli E. Canada et al., *Intervening at the Entry Point: Differences in How CIT Trained and Non-CIT Trained Officers Describe Responding to Mental Health-Related Calls*, 48 Community Mental Health J. 746, 746 (2012).

to come by, there have been numerous incidents of police shootings of individuals with mental illness.[16] In addition to the toll on people with mental illness, these incidents – and the ensuing investigative review and assertions of liability – also take a toll on the police and on the broader community.

2. In response to the call from Ms. Sheehan's social worker, Heath Hodge, San Francisco's automated radio dispatch system called Officer Kathrine Holder, an officer with limited experience responding to civil commitment calls, to the scene. JA33, 98-99. Because of her inexperience,[17] Officer Holder called her street sergeant, Kimberly Reynolds, for assistance. *Id.* Sergeant Reynolds, who had never assisted a social worker effecting a civil commitment order, called her Lieutenant and sought guidance. JA219-20.[18]

The fact that officers responding to Mr. Hodge's call may have lacked adequate training is consistent with studies showing that police officers frequently feel inadequately trained to respond to such situa-

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[16] *See* Kelly Bouchard, *Across Nation, Unsettling Acceptance when Mentally Ill in Crisis Are Killed*, Portland Press Herald, Dec. 9, 2012, http://www.pressherald.com/2012/12/09/shoot-across-nation-a-grim-acceptance-when-mentally-ill-shot-down/.

[17] Mr. Hodge testified that Officer Holder "was not clear about what [he] had called [the police] about, . . . she didn't seem to . . . have a clear understanding of a 5150." JA99.

[18] *Amici* recite these facts, consistent with the applicable summary judgment standard, in the light most favorable to respondent. We recognize that there are at least two sides to the story, and *amici* emphasize that they take no position with regard to what facts a reasonable jury should ultimately find based on all the evidence.

tions.[19] This is so even when, as is true in San Francisco, providing assistance in detaining and transporting individuals with mental illness who are dangerous to self or others or gravely disabled (the standard for civil commitment in California and most States) is a police function.[20] As a result, police officers report that such calls are challenging and difficult to manage.[21] The lack of adequate mental health training for police officers – just one critical tool for responding to individuals in crisis – is particularly problematic because traditional police tactics, such as verbal commands, displays of authority, and threats of physical force, can escalate already-sensitive encounters with individuals with mental illness.[22] That escalation, in turn, can cause individuals, including those with mental illness, to present a more threatening demeanor, which may elicit yet more forceful police responses.[23]

To assist in analyzing and remedying the problems caused by the application of traditional criminal justice system approaches – and in recognition of the role of law enforcement in identifying individuals

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[19] *See* Randy Borum et al., *Police Perspectives on Responding to Mentally Ill People in Crisis: Perceptions of Program Effectiveness*, 16 Behavioral Sci. & L. 393, 394 (1998).

[20] *See* Community Behavioral Health Services, San Francisco Dep't of Health, *Involuntary Detention Training Manual* 47 (Apr. 2010), https://www.sfdph.org/dph/files/CBHSdocs/5150Manual042010.pdf.

[21] *See id.*; *see also* Reuland, *Law Enforcement Responses* at 3.

[22] *See* Canada, 48 Community Mental Health J. at 747.

[23] *See* Robin Shepard Engel et al., *Further Exploration of the Demeanor Hypothesis: The Interaction Effects of Suspects' Characteristics and Demeanor on Police Behavior*, 17 Justice Q. 235 (2000).

with mental illness and diverting them to treatment[24] – mental health professionals and policy makers have developed a framework known as the Sequential Intercept Model.[25] A key premise of the Sequential Intercept Model is that there are untapped improvements in public health and safety – and potential resource savings – that can result from cooperation between law enforcement and mental health professionals.[26] The Sequential Intercept Model focuses on improving outcomes in part through cooperation between law enforcement and mental health professionals. It identifies five points of "intercept" where the collaboration between law enforcement and mental health professionals can be used to identify and divert to treatment individuals with serious mental illnesses.[27] These points of potential intervention range from initial encounters with police, through courts and jails, to prisons and rehabilitative facilities, including points of intervention available to community supervising entities such as probation and parole.[28] Public entities in several

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[24] Such problems can present themselves at all stages of the criminal justice system. *See*, *e.g.*, *Brown v. Plata*, 131 S. Ct. 1910 (2011) (concluding that mental health services in California prisons fell below constitutional standards).

[25] *See generally* Mark R. Munetz & Patricia A. Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness*, 57 Psychiatric Services 544 (2006), http://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2006.57.4.544.

[26] *See id.* at 547-48.

[27] *See* Joseph P. Morrissey & Gary S. Cuddeback, *Jail Diversion*, *in Clinical Handbook of Schizophrenia* 524, 526-28 (Kim T. Mueser & Dilip V. Jeste eds., 2008).

[28] *See id.*; *see also* National Alliance on Mental Illness, *The Sequential Intercept Model*, http://www2.nami.org/Template.

States have used the Sequential Intercept Model to develop interventions for individuals with mental illnesses at various stages of the criminal justice process, but a more systematic approach would foster more comprehensive interventions.[29] These interventions include strategies for screening and assessment to enhance identification of behavioral health conditions, development of closer coordination with community service providers, and development of policies, protocols, and memoranda of agreement to enhance the capacity to meet the needs of individuals with mental illness and direct them toward treatment when appropriate and safe.

Because entrance into the criminal justice system starts with a police encounter, the initial point of contact between police and an individual with mental illness is the best opportunity to identify serious mental illnesses and to ensure that an individual with such a disability can be diverted into treatment.[30] Intervention at the earliest stage is also most critical in part because it is most cost-effective.[31]

When a social worker seeks assistance from law enforcement to bring an individual with mental illness into custody for temporary civil commitment, there is often no imminent threat to public safety. Such a call for assistance is equivalent to a call for medical help, seeking emergency treatment for what is a psychiatric problem. When officers with

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cfm?Section=CIT&Template=/ContentManagement/ContentDisplay.cfm&ContentID=79159 (last visited Feb. 12, 2015).

[29] *See id.*

[30] *See* Munetz & Griffin, 57 Psychiatric Services at 548.

[31] *See id.*

inadequate training, including because of an absence of policies and procedures to guide them, respond to such a call, an opportunity for "intercept" is lost. When such an encounter leads to incarceration, what began as a call for more intensive treatment ends with the individual being denied effective treatment interventions and instead being punished. Furthermore, responding to such a situation using traditional police tactics may put all parties, including the police officers, in danger. In particular, hundreds of individuals with mental illness are shot and killed by police officers every year.[32] In this case, police were dispatched to transport Ms. Sheehan safely to a medical facility where she could receive treatment. This point of contact between the police and Ms. Sheehan therefore represented not merely a lost point of intercept but rather a step backward. Ms. Sheehan did not need an intercept; she had committed no crime. She needed emergency medical care.

3. When the police arrived at Ms. Sheehan's group home, she was in her own room; she did not engage in any unlawful behavior; until approached by her social worker, she had not threatened anyone; and there was no indication that she was suicidal. JA168.

This fact pattern – no crime, no immediate threat – represents a significant percentage of all police

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[32] *See* Bouchard, *supra* ("[A] review of available reports indicates that at least half of the estimated 375 to 500 people shot and killed by police each year in this country have mental health problems.").

encounters with individuals with mental illness.[33] Police injuries during encounters with such individuals may be no more frequent than injuries during encounters with others, and, when they do occur, rarely require medical attention.[34] The National League of Cities and other local-government organizations ("NLC"), as *amici* in support of petitioners, argue that "[a]ny encounter with an armed suspect who suffers from a serious mental illness presents a significant risk of suicide as well as an elevated risk of violence to others." NLC Br. 21. Presumably any encounter with an armed suspect presents such risks; most individuals with mental illness, however, are not violent, and most violence is not associated with mental illnesses.[35] Both law enforcement officers and the public nevertheless tend to overestimate the connection between mental illnesses and violence toward others.[36]

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[33] *See* Green, 20 Int'l J.L. & Psychiatry at 475, 477 (reporting that, for the Honolulu police department, 45.3% of calls involve no crime, and 27.7% involve only disorderly conduct).

[34] *See* Amy N. Kerr et al., *Police Encounters, Mental Illness and Injury: An Exploratory Investigation*, 10 J. Police Crisis Negotiation 116 (2010) (finding rate of police injury in encounters with people with mental illness roughly equal to that for the population at large).

[35] *See* Jeffrey W. Swanson et al., *Mental Illness and Reduction of Gun Violence and Suicide: Bringing Epidemiologic Research to Policy* 2-3 (2014) ("In short, violence is a complex societal problem that is caused, more often than not, by other things besides mental illness."), http://www.annalsofepidemiology.org/article/S1047-2797(14)00147-1/pdf (to be published in Annals of Epidemiology).

[36] *See* Amy C. Watson et al., *Police Officers' Attitudes Toward and Decisions About Persons With Mental Illness*, 55 Psychiatric Services 49, 53 (Jan. 2004) (finding exaggerated police percep-

4. In 2011, in response to a series of officer-involved shootings of persons with mental illnesses, San Francisco announced municipal funding of a Crisis Intervention Team ("CIT"), a special mental health training program for police.[37] CIT units are one way for police departments to serve as an intercept point. As described below, CIT units receive 40 hours of specialized training in responding to mental health crises, including de-escalation techniques and appropriate local treatment facilities.

Despite the existence of such specialized teams, the officers did not request assistance from a CIT or less-than-lethal-force unit until after they entered Ms. Sheehan's room. JA28-29, 61; Pet. Br. 7, 9-10. And, although the non-lethal-use-of-force team had just arrived at the group home, the officers forced re-entry into Ms. Sheehan's room before that team had a chance to assist. JA41.

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tions of violence among individuals with schizophrenia), http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.55.1.49; Swanson, *Bringing Epidemiologic Research to Policy* at 2 ("[T]he assumption of dangerousness is a key element of th[e] negative stereotype [toward persons with serious mental illnesses such as schizophrenia]."); Colleen L. Barry et al., *After Newtown – Public Opinion on Gun Policy and Mental Illness*, 368 New Eng. J. Med. 1077, 1080 (2013) (finding that 45.6% of respondents believe individuals with mental illness are "by far" more dangerous than others), http://www.nejm.org/doi/pdf/10.1056/NEJMp1300512.

[37] *See* Shoshana Walter, *SF Police to Train Crisis Team for Mentally Ill*, The Bay Citizen, Feb. 10, 2011, https://www.baycitizen.org/news/policing/sf-police-train-crisis-team-mentally-ill/ (last visited Feb. 12, 2015); *see also* City & County of San Francisco Police Dep't, Police Commission Minutes of Regular Meeting, Feb. 9, 2011 (adopting resolution unanimously), http://www.sf-police.org/Modules/ShowDocument.aspx?documentid=25386 (last visited Feb. 12, 2015).

CIT units are the most developed and most prevalent means for police to work with mental health professionals to identify individuals with serious mental illness and to ensure that they are diverted into treatment where appropriate.[38] They are, however, just one potential method for enhancing crisis response for individuals with mental illness. Other models for such collaboration include mental health-based mobile-crisis teams ("MCTs"), co-responder services involving mental health professionals employed by police departments, and partnerships with local mental health emergency rooms; many of these approaches have led to promising and effective practices by police departments to accommodate individuals with mental illness.

CIT programs, for example, involve an intensive 40 hours of training that includes both classroom and experiential role-playing components, for both officers and dispatchers.[39] CIT programs also involve the development of relationships with community mental health centers, which provide emergency

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[38] *See* Michael T. Compton et al., *A Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs*, 36 J. Am. Acad. Psychiatry & L. 47, 47 (2008), http://www.jaapl.org/content/36/1/47.full.pdf+html.

The CIT model developed out of a pioneering partnership between Dr. Randolph Dupont, a psychiatrist at the University of Tennessee, Memphis, and Major Sam Cochran of the Memphis Police Department. The program was developed in response to a fatal police shooting of a man with a history of mental illness and substance abuse. *See* Janet R. Oliva & Michael T. Compton, *A Statewide Crisis Intervention Team (CIT) Initiative: Evolution of the Georgia CIT Program*, 36 J. Am. Acad. Psychiatry & L. 38, 39 (2008), http://www.jaapl.org/content/36/1/38.full.pdf+html.

[39] *See* Compton, 36 J. Am. Acad. Psychiatry & L. at 47.

assessments and treatment, if necessary. The training component – which is provided by psychiatrists, other mental health professionals, and advocates for individuals with mental illness – focuses on de-escalation techniques and awareness of mental health issues.[40] That training also serves to increase officer knowledge of local mental health services and thereby increase the chances that individuals with serious mental illness will be referred to and receive appropriate mental health care and, as a result, avoid harm.[41] In particular, CIT officers receive specialized training designed to allow them to assess threats caused by mental illnesses differently – and in greater accord with scientific evidence – than do officers without such training, who may respond based on stereotypes about mental illnesses.[42] Once trained, CIT-eligible police officers form specialized teams of first responders that can be dispatched to calls believed to involve individuals with mental illnesses. Because of its flexibility and the fact that it gives police departments the tools they need to be effective first responders without requiring immediate aid from mental health professionals, "CIT is considered by many to be the most rapidly expanding and promising partnership between law enforcement and mental health professionals."[43] There are currently hundreds of CIT programs in the United States, including statewide programs in Connecticut,

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[40] *See* Oliva & Compton, 36 J. Am. Acad. Psychiatry & L. at 39.

[41] *See id.*

[42] *See* Canada, 48 Community Mental Health J. at 750.

[43] Compton, 36 J. Am. Acad. Psychiatry & L. at 47-48.

Georgia, Iowa, New Mexico, North Carolina, Ohio, Oregon, Tennessee, Texas, and Washington.[44]

Other criminal justice-mental health partnerships, like MCT units, provide community crisis management services based on alternative models. These programs may be particularly helpful for smaller police departments, which may lack sufficient personnel to create dedicated CIT teams. MCT programs involve training teams of mental health professionals – including nurses, social workers, psychiatrists, psychologists, addiction specialists, and peer counselors – to become co-responders alongside traditional first responders.[45] MCTs can be called by dispatchers or, in some jurisdictions, by social workers or family members directly.[46] MCTs can facilitate rapid treatment, hospital admission, and referrals to other mental health providers.[47] MCTs and related programs have been implemented in, among other places, New York City; Birmingham, Alabama; Long Beach, California; San Diego County, California; Anne Arundel County, Maryland; and

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[44] *See id.* at 48.

[45] *See* N.Y.C. Dep't of Health & Mental Hygiene, *Mobile Crisis Teams*, http://www.nyc.gov/html/doh/html/mental/mobile-crisis.shtml (last visited Feb. 12, 2015).

[46] *See id.* (providing direct 800-number); Maryland Coalition of Families for Children's Mental Health, *Listening and Learning from Families: Crisis Services and the Experiences of Families Caring for Children and Youth with Mental Health Needs* 11 (Dec. 2013) ("If available, mobile crisis was a service that was pursued quite frequently."), http://www.mdcoalition.org/images/stories/publications/listening%20and%20learning%20from%20families_final.pdf.

[47] *See* H. Richard Lamb et al., *The Police and Mental Health*, 53 Psychiatric Services 1266, 1269 (2002), http://www.popcenter.org/problems/mental_illness/PDFs/Lamb_etal_2002.pdf.

statewide in Massachusetts.[48] Although these programs vary in how they structure funding for the mental health professionals who act as responders, they all facilitate referral away from arrest and jail and toward treatment by placing mental health professionals at the scene as soon as possible.[49]

Other programs, like "mental health first-aid" training for police, take a hybrid approach by providing basic mental health training to a broader segment of police officers. Such training focuses on increasing understanding of mental illnesses, decreasing mental health stigma, and promoting

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[48] *See Consensus Project* at 46; Massachusetts Dep't of Mental Health, *Pre-Arrest Law Enforcement Based Jail Diversion Programs* (2015) ("MDMH, *Jail Diversion Program – 2015*"), http://www.mass.gov/eohhs/docs/dmh/forensic/jdp-fact-sheet.pdf.

[49] *See Consensus Project* at 46. One particular step that police departments can take to better accommodate individuals with mental illness, particularly in conjunction with a more comprehensive training program, is to implement screening checklists. For example, many state and local jails employ "brief jail mental health screening" checklists to identify mental health risks among inmates. Those checklists have proven effective in improving treatment of mental illness in jails, where, according to one estimate, as many as 56% of inmates suffer some form of mental illness. *See* Christian Mason et al., *Responding to Persons with Mental Illness: Can Screening Checklists Aid Law Enforcement?*, FBI Law Enforcement Bulletin (Feb. 2014), http://leb.fbi.gov/2014/february/responding-to-persons-with-mental-illness-can-screening-checklists-aid-law-enforcement (last visited Feb. 12, 2015). Those same checklists show promise in assisting first-responding police officers to identify whether mental illness may play a role in a situation calling for police response. *See id.* The use of mental health checklists can increase public and officer safety and help officers on the scene determine the best approach to resolve tense situations and prevent injury or the need for arrest. *See id.*

early access to help by people with mental illness.[50] These programs complement and enhance the effectiveness of more programmatic mental health first-response strategies, like the CIT and MCT programs discussed above.

5. In this case, police were called for the purpose of bringing respondent in for treatment; in other circumstances, police officers may face questions about whether an individual who has been arrested for a non-violent crime – vagrancy, disturbing the peace, public intoxication – may be exhibiting symptoms of severe mental illnesses such that treatment, rather than criminal justice system intervention, is called for. Training and development of linkages to appropriate community mental health resources can assist officers in such situations. For example, in Baltimore, Maryland, Baltimore Crisis Response, Inc. provides free mental health crisis beds for individuals who do not meet the criteria for involuntary commitment but who nevertheless need treatment and are unable to receive it elsewhere.[51] In San Antonio, Texas, community resources were developed for a specialized drop-off center that police can use to give individuals with mental health or substance abuse needs access to treatment providers in an

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[50] *See* Massachusetts Dep't of Mental Health Forensic Services, *Pre-Arrest Law Enforcement-Based Jail Diversion Program Report, July 1, 2011 to January 1, 2014*, at 8 (2014) ("MDMHFS, *Jail Diversion Program – 2014*"), http://www.mass.gov/eohhs/docs/dmh/forensic/jail-diversion-program-2014.pdf; *see generally* Mental Health First Aid, http://www.mentalhealthfirstaid.org/cs/ (last visited Feb. 12, 2015).

[51] *See Consensus Project* at 55; *see also* Llewellyn J. Cornelius et al., *Reach out and I'll Be There: Mental Health Crisis Intervention and Mobile Outreach Services to Urban African Americans*, 28 Health & Soc. Work 74 (2003).

efficient manner.[52] Police officers who are aware of such programs can avoid jailing individuals who are homeless for minor violations caused by symptoms of mental illness. In 2011, the Department of Justice reached a settlement agreement with the State of Delaware under the ADA providing, among other things, MCTs and crisis walk-in centers, which are 24-hour "community-based psychiatric and counseling services to people experiencing a mental health crisis," with specific accommodations made for police referrals or drop-offs.[53]

The programs described above have not provided any panacea to the deep problems caused by insufficient mental health services and the responsibilities borne by police officers in responding to mental health crises. All such programs, to be most effective, require continuing training, review for best practices, funding, and oversight. And no one program will solve the problem of mental illness in the criminal justice system or work for all police departments. Given the diversity of community sizes, infrastructures, and resources, law enforcement agencies should have flexibility to implement programs and services that work in their areas. Nevertheless, the literature reflects that these programs have demonstrated positive effects on public health, the use of force, arrest rates for individuals

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[52] *See* Jenny Gold, *Mental Health Cops Help Reweave Social Safety Net In San Antonio*, Nat'l Pub. Radio, Aug. 19, 2014, http://www.npr.org/blogs/health/2014/08/19/338895262/mental-health-cops-help-reweave-social-safety-net-in-san-antonio.

[53] *See* Settlement Agreement at 5, § II.C.2.c, *United States v. Delaware*, No. 11-591-LPS (D. Del. filed July 6, 2011), http://www.ada.gov/delaware.htm; Order Entering Settlement Agreement, *United States v. Delaware*, No. 11-591-LPS (D. Del. July 15, 2011).

with mental illness, officer safety, police department budgets, and officer attitudes toward individuals with mental illness. As funding for such programs has grown, so too has the number of models for criminal justice-mental health collaborations.[54]

SUMMARY OF ARGUMENT

I. The Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12101 *et seq.*, requires police officers to provide reasonable accommodations for individuals with mental illnesses at the time of arrest. None of the parties asks this Court to conclude otherwise. Encounters with individuals with mental illnesses, many of which involve either no criminal conduct or only nuisance crimes that may reflect the individuals' illnesses, are an every-day part of law enforcement. Preserving the ADA's protection in those encounters is close to the heart of the statute's non-discrimination mandate.

The judgment whether a public entity has provided a reasonable accommodation – and whether an individual is "qualified" within the meaning of the ADA – should take into account the entire encounter between law enforcement and an individual with a mental illness. When police are called to detain and transport an individual for involuntary hospitalization, there is an opportunity to provide reasonable accommodations. And where the alleged failure to make such reasonable accommodations – for example, to provide appropriate training or to employ trained personnel using established protocols – is the partial cause of threatening or violent behavior in an individual suffering from severe mental illness, that individual should not be deprived of the statute's protection.

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[54] *See* MDMH, *Jail Diversion Program – 2015*, at 2.

II. The obligation to provide *reasonable* accommodations for individuals with mental illness at the time of arrest imposes no unfair burden on public entities. Established approaches to training police officers and implementing programs and procedures designed to reduce the risk to individuals subject to arrest and to law enforcement have been reported to improve law enforcement outcomes without imposing significant additional costs on public authorities.

ARGUMENT

I. THE ADA REQUIRES REASONABLE ACCOMMODATIONS FOR MENTAL ILLNESSES AT THE POINT OF ARREST

A. ADA's Application to Arrests Is Not Disputed

The Ninth Circuit determined that "Title II [of the ADA] applies to arrests." Pet. App. 43. We do not understand any party or *amicus* before this Court to disagree with that proposition,[55] and it is correct.

The ADA is a broadly worded non-discrimination statute. *See PGA Tour, Inc. v. Martin*, 532 U.S. 661, 675 (2001) ("[o]ne of the Act's most impressive strengths has been identified as its comprehensive character" making it "a milestone on the path to a more decent, tolerant, progressive society") (internal quotation marks omitted). Title II of the Act, which covers public services, provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be

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[55] *See* Pet. Br. 20-21; U.S. Br. 7 ("By its plain terms, the provision therefore extends to arrests."); NLC Br. 21-23 (arguing only that accommodation was not reasonable on these facts); *cf.* Int'l Mun. Lawyers Ass'n Br. 21 (arguing for municipal liability for failure to train).

denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. "Discrimination includes a failure to reasonably accommodate a person's disability." Pet. App. 41. Binding regulations adopted by the Department of Justice broadly require that "[a] public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability," unless such modifications would fundamentally change the government activity. 28 C.F.R. § 35.130(b)(7); *cf.* 42 U.S.C. § 12182(b)(2)(A)(ii) (defining discrimination for purposes of Title III of the ADA to include the "failure to make reasonable modifications").

Bringing an individual into custody constitutes a "service[], program[], or activit[y] of a public entity." 42 U.S.C. § 12132; *see also United States v. Georgia*, 546 U.S. 151, 154 (2006) ("'public entity'" includes "'any State or local government'" and "'any department, agency, . . . or other instrumentality of a State'") (quoting 42 U.S.C. § 12131(1)) (alteration in original). Moreover, the manner in which an arresting officer treats an arrestee or suspect falls comfortably within the broad meaning of "benefit." This Court has previously construed the ADA to apply to prisons, holding that such institutions "fall squarely within the statutory definition of 'public entity.'" *Pennsylvania Dep't of Corr. v. Yeskey*, 524 U.S. 206, 210 (1998). In so holding, the Court noted that prisons provide inmates with "'benefits' of 'programs, services, or activities,' as those terms are ordinarily understood." *Id.* That law enforcement provides "benefits" within the meaning of the ADA in the context of effectuating an arrest follows from *Yeskey*.

It is especially clear in the context of this case that petitioners were providing a "benefit" to respondent when they sought to take her into custody for involuntary hospitalization. The statute under which petitioners sought to take respondent into custody authorizes temporary civil commitment when "a[ny] person, as a result of a mental disorder, is a danger to others, or to himself or herself, or gravely disabled." Cal. Welf. & Inst. Code § 5150(a). Among the reasons for civil commitment under this statute – and one of the reasons invoked by respondent's social worker – is to provide aid to an individual who cannot care for herself as a result of a mental illness. *See*, *e.g.*, *Addington v. Texas*, 441 U.S. 418, 426 (1979) (characterizing civil commitment as an adjunct to "providing care" to individuals with mental illness).

Accordingly, this Court should start from the uncontested premise that the ADA applies to arrests and requires reasonable accommodations in that context.

B. At Least in the Context of Involuntary Civil Commitment, the Question of Reasonable Accommodation Addresses the Entire Encounter Between Law Enforcement and an Individual with Mental Illness

Respondent was, moreover, a "qualified individual" within the meaning of Title II of the ADA. In the circumstances of this case – like many others – respondent was subject to arrest not because of any immediate danger she posed to the public but because of concern that she was gravely disabled and might pose such a danger if untreated. There was – at least on the view of the facts most favorable to respondent – no reason that petitioners could not have provided a reasonable accommodation for

respondent's mental illness when they arrived to transport her to a medical facility.

Petitioners argue that, because of "the danger Sheehan posed to the[] officers . . . at the time the officers re-opened her door," she was not "qualified" to receive any reasonable accommodation. Pet. Br. 17; *see id.* at 19-23. But that argument improperly narrows the focus of the reasonable-accommodation inquiry, as the Ninth Circuit properly recognized.

In a case involving involuntary civil detention and transportation of an individual who poses no immediate threat, the reasonable-accommodation inquiry should examine the entire course of the encounter between law enforcement and the individual with a disability. Application of ordinary police arrest procedures in such a case would often be inappropriate, and the failure to employ techniques appropriate to dealing with an individual with a known mental illness may be unreasonable. To the extent a public entity fails to employ such techniques, such failure may constitute precisely the sort of discrimination against individuals with disability that the ADA was intended to address.

Applying petitioners' narrow focus would improperly deprive qualified individuals of the statute's protection. As noted above, research shows that ordinary police techniques, including threats of physical force, can render encounters with individuals with mental illness more dangerous to those individuals and to the arresting officer.[56] Unnecessarily subjecting individuals with mental illness to such risks is a clear example of a failure to provide a reasonable accommodation and therefore discrimination

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[56] *See* Canada, 48 Community Mental Health J. at 747.

within the meaning of the ADA. And an individual should not lose the protection of the statute because a failure to provide reasonable accommodation triggers the very reaction that the reasonable accommodation was designed to prevent.

Amicus NLC argues (at 14-15) that knowing of respondent's mental illness gave the officers no additional ability to predict whether Ms. Sheehan would react violently under the circumstances. That contention is hard to understand on the record of this case – the officers had time to consult with the social worker on the scene and develop an approach that would respond to Ms. Sheehan's psychiatric needs without escalating the situation. In any event, whether, in any given case, circumstances call for any particular accommodation will necessarily depend on the facts. Where there is evidence that a public entity failed to follow established procedures for effectuating involuntary civil commitment, a jury might reasonably conclude that police officers have not provided the accommodations required by the ADA.

Petitioners argue (at 18, 28) that they had no obligation to provide reasonable accommodations for Ms. Sheehan's mental illness because she posed a "direct threat" to their safety. For the reasons explained above, however, petitioners' argument rests on improperly restricting the focus of the reasonable-accommodation inquiry. The obligation to provide reasonable accommodations arose once police were called to transport an individual with a serious mental illness to a facility for treatment, before she represented a direct threat. Moreover, even when a "direct threat" is present, the obligation to provide a "reasonable accommodation" exists as long as police

could allay the threat through reasonable accommodations. *See* 28 C.F.R. § 35.139(b) ("In determining whether an individual poses a direct threat to the health or safety of others, a public entity must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain . . . whether reasonable modifications of policies, practices, or procedures or the provision of auxiliary aids or services will mitigate the risk.").[57] Research and the experience of mental health professionals indicate that there are reasonable accommodations police departments can employ during encounters with individuals with mental illness and that those accommodations can mitigate the risk caused by mental illnesses. To the extent any threat Ms. Sheehan posed could have been mitigated through better training or direct involvement of mental health professionals, Ms. Sheehan did not pose a "direct threat" under Department of Justice regulations.[58]

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[57] *See also* U.S. Dep't of Justice, Office on the Americans with Disabilities Act, *The Americans with Disabilities Act: Title II Technical Assistance Manual Covering State and Local Government Programs and Services* § II.2-8000 (1992) ("A 'direct threat' is a significant risk to the health or safety of others that cannot be eliminated or reduced to an acceptable level by the public entity's modification of its policies, practices, or procedures, or by the provision of auxiliary aids or services."), http://www.ada.gov/taman2.html#II-2.8000; 42 U.S.C. § 12182(b)(3) (defining "direct threat" as "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services").

[58] The United States takes a similar position. *See* U.S. Br. 17 n.4 ("Safety concerns also may obviate the need to provide an accommodation in *other* circumstances.") (emphasis added).

The Court should accordingly rule that respondent was a qualified individual entitled to reasonable accommodation under the ADA.

II. REQUIRING POLICE TO ACCOMMODATE INDIVIDUALS WITH MENTAL ILLNESS IS PRACTICABLE

Applying the ADA to arrests of individuals known to be suffering from mental illness is of surpassing importance precisely because encounters between law enforcement and individuals with mental illness are such an integral part of police work. *See supra* pp. 4-8. Requiring state and local governments to provide reasonable accommodations for individuals with mental illness does not impose an unfair burden. What is called for, after all, is *reasonable* accommodation.

Furthermore, imposition of such a duty under the ADA should not mean that law enforcement personnel will be subject to second-guessing when they make reasonable judgments that lead to bad outcomes. *Amici* do not question that police officers face real challenges and, in some cases, real risks in their interactions with individuals with severe mental illnesses (although such risks are often perceived to be greater than they really are). *See supra* pp. 13-14. At the same time, the ADA requires public entities to provide appropriate training and to follow appropriate police practices in their interactions with individuals with mental illnesses, just as they must accommodate other disabilities. Effective partnerships between law enforcement and mental health professionals have been implemented in hundreds of cities nationwide. The evidence is convincing that such programs, when properly funded and managed, improve police interactions with individuals with

mental illness without adding costs or posing risks to officer safety.

A. Programs Such as CIT Improve Police Response to Situations Involving Individuals with Mental Illness

There is clear evidence that CIT program development, with its emphasis on training and community partnerships, increases officers' familiarity and comfort with the mental health system. Other programs have also been shown to have similar effects. As a result, requiring police departments to train their officers and implement programs designed to provide reasonable accommodations would serve the ADA's goals of reducing disparate treatment of individuals with disabilities.

Although a one-size-fits-all model is not workable given differences among jurisdictions, CIT programs have provided an effective model for many cities. The best available evidence of CIT's effectiveness comes from police officers who have received CIT training. One study – which surveyed police officers in Birmingham, Alabama; Knoxville, Tennessee; and Memphis, Tennessee – found that CIT-trained officers were more likely to report that: (a) they were well-prepared to handle individuals with mental health in crisis; (b) the mental health system in general was helpful; and (c) emergency rooms were useful resources.[59] Evidence suggests that most police officers believe that understanding mental illnesses is important to their work, and many of those would welcome an opportunity to learn more

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[59] *See* Borum, 16 Behavioral Sciences & L. at 401-04.

about how best to work with individuals with mental illness.[60]

These findings are consistent with research showing that CIT-trained officers understand mental illnesses better and are less likely to stigmatize individuals with mental illness. CIT-trained officers assess threats caused by individuals with mental illness differently than do officers without the benefit of CIT training by exhibiting a greater understanding of how mental illnesses can cause individuals to act in ways that might otherwise appear threatening.[61] As a result, CIT-trained officers are more likely to consider alternatives to arrest and jailing and to avoid the use of force. For example, CIT-trained officers are less likely to respond to descriptions of people with schizophrenia with stigmatizing views.[62] CIT-trained officers are also better able to identify mental illnesses and are more knowledgeable about local treatment options for individuals with mental illness.[63] Evidence also suggests that CIT-trained

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[60] *See* Heidi S. Vermette et al., *Mental Health Training for Law Enforcement Professionals*, 33 J. Am. Acad. Psychiatry & L. 42, 44-45 (2005), http://www.jaapl.org/content/33/1/42.full.pdf+html.

[61] *See* Canada, 48 Community Mental Health J. at 750.

[62] *See* Compton, 36 J. Am. Acad. Psychiatry & L. at 49 & n.12 (citing Christian Ritter et al., *The Quality of Life of People with Mental Illness: Consequences of Pre-Arrest and Post-Arrest Diversion Programs*, Presented at Second National CIT Conference, Orlando, Fla. (Sept. 2006)).

[63] *See* William Wells & Joseph A. Schafer, *Officer Perceptions of Police Responses to Persons with a Mental Illness*, 29 Policing 578 (2006); *see also* Michael T. Compton et al., *The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest*, 65 Psychiatric Services 523, 528 (2014).

officers are less likely to employ force when responding to a call involving a person with mental illness.[64]

Research also shows that CIT training is effective at least in part because it persuades officers that taking the time to de-escalate situations with talking and other non-threatening behaviors is the key to success when responding to individuals with mental illness. In particular, CIT-trained officers report that "taking their time is necessary in safely and effectively responding to calls involving mental illness."[65] This additional time helps officers put individuals with mental illness at ease and manage unpredictable situations, and thereby reduce the risk of injury.[66] Other models have also proven effective. Evidence suggests that MCT units are effective at de-escalating police interactions with individuals with mental illness.[67]

Amicus NLC argues (at 16-19) that rigorous empirical evidence demonstrating that CIT training reduces officer injuries or use of force is lacking. That is fair enough; as *amicus* also concedes (at 18), however, research by forensic psychiatrists and psychologists has found positive impacts in attitudinal

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[64] *See* Canada, 48 Community Mental Health J. at 754; Compton, 65 Psychiatric Services at 525-26.

[65] Canada, 48 Community Mental Health J. at 752.

[66] *See* Sonya Hanafi et al., *Incorporating Crisis Intervention Team (CIT) Knowledge and Skills into the Daily Work of Police Officers: A Focus Group Study*, 44 Community Mental Health J. 427 (2008).

[67] *See* Lamb, 53 Psychiatric Services at 1268 (reporting an arrest rate for MCTs one-third that of traditional police response).

studies.[68] And there is a sound clinical basis for the conclusion that certain types of police techniques may exacerbate the risk of harm to an individual who is being brought into custody.[69] Public authorities across the country have adopted policies that reflect this understanding.[70] It would be a mistake to ignore the consensus of mental health and law enforcement professionals in dealing with individuals with mental illness; that consensus is supported by the extant empirical evidence.

B. Partnerships with Mental Health Professionals Promote Officer Safety and Save Money

Systematic partnerships between law enforcement and mental health professionals, such as CIT, have also been shown to bring substantial benefits to police officers and departments. For example, the best evidence suggests that CIT programs promote rather than compromise officer safety.[71] CIT programs are also associated with less frequent use of SWAT teams when responding to calls involving individuals with mental illness.[72] Many law enforcement agencies

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[68] *See also* Borum, 16 Behavioral Sciences & L. at 401-04; Compton, 36 J. Am. Acad. Psychiatry & L. at 49 (collecting sources).

[69] *See* Canada, 48 Community Mental Health J. at 747.

[70] *See id.* (noting that more than 400 jurisdictions have adopted CIT programs).

[71] *See* Compton, 36 J. Am. Acad. Psychiatry & L. at 52 (citing Randolph Dupont & Sam Cochran, *Police Response to Mental Health Emergencies—Barriers to Change*, 28 J. Am. Acad. Psychiatry & L. 338 (2000)).

[72] *See id.*; Deborah L. Bower & W. Gene Pettit, *The Albuquerque Police Department's Crisis Intervention Team: A Report Card*, 70 FBI Law Enforcement Bull. 1, 2 (Feb. 2001) (finding

that have implemented CIT programs have reported that the training results in fewer police shootings, assaults, batteries, and "problematic use of force issues."[73]

Many programs achieve the benefits described above without imposing additional costs on the criminal justice system. For example, CIT training leads to lower arrest rates.[74] One study undertook to quantify the cost savings of CIT implementation and found that, for a medium-sized city (Louisville, Kentucky), the cost savings exceeded $1 million annually.[75] Another study found that Memphis, Tennessee's path-breaking CIT program yielded cost savings to the criminal justice system as a result of the program, although with some increased hospitalization expenses.[76] Another study showed that MCTs decrease even costs due to hospitalization.[77]

58% decrease in SWAT team usage), http://leb.fbi.gov/2001-pdfs/leb-february-2001.

[73] Reuland & Cheney, *Enhancing Success* at 7.

[74] *See* Compton, 36 J. Am. Acad. Psychiatry & L. at 51; Canada, 48 Community Mental Health J. at 750 (reporting officer belief that CIT reduces arrests).

[75] *See* Peggy L. El-Mallakh et al., *Costs and Savings Associated with Implementation of a Police Crisis Intervention Team*, 107 S. Med. J. 391 (2014).

[76] *See* Compton, 36 J. Am. Acad. Psychiatry & L. at 51-52 (citing Alexander J. Cowell et al., *The Cost-Effectiveness of Criminal Justice Diversion Programs for People With Serious Mental Illness Co-Occurring With Substance Abuse*, 20 J. Contemp. Crim. Justice 292 (2004) ("Cowell, *Cost-Effectiveness*")).

[77] *See* Herbert Bengelsdorf et al., *The Cost Effectiveness of Crisis Intervention*, 181 J. Nervous & Mental Disease 757, 762 (1993) (finding savings of almost $1,000 per patient whose hospital admission is made unnecessary by timely and effective diversion), http://www.researchgate.net/publication/14945620_

In short, the evidence suggests that specialized programmatic responses to police encounters with individuals with mental illness are associated with at least modest savings for public entities.

Although more research is needed, there is some evidence that such specialized programs can improve mental health outcomes months after a police encounter. The Massachusetts Department of Mental Health Forensic Services has reported that MCT, CIT, co-response, and related programs "help people with mental illness access appropriate treatment, help them live their lives with fewer symptoms, and can provide incentives to stay in treatment thereby minimizing or ending the costly cycling through crisis care."[78] This conclusion is supported by empirical evidence.[79]

As noted above, these gains from police training and specialized response programs depend on good management and secure funding to retain their effectiveness. Even after they are implemented and operational, CIT and related programs face myriad challenges: insufficient dispatcher training, limited availability of emergency psychiatric receiving services, and the difficulty of maintaining CIT readiness in rural areas.[80] Best practices suggest that departments

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The_cost_effectiveness_of_crisis_intervention._Admission_diversion_savings_can_offset_the_high_cost_of_service.

[78] MDMHFS, *Jail Diversion Program – 2014*, at 4.

[79] *See* Compton, 36 J. Am. Acad. Psychiatry & L. at 52 (noting that CIT programs can materially improve psychiatric symptoms three months after diversion) (citing Cowell, *Cost-Effectiveness*).

[80] *See* Michael T. Compton et al., *System- and Policy-Level Challenges to Full Implementation of the Crisis Intervention Team (CIT) Model*, 10 J. Police Crisis Negotiation 72 (2010)

should attempt to standardize training curricula, create a schedule for periodic review of curricula and program materials, and provide continuing education opportunities for officers who previously completed CIT training.[81]

In sum, the models of criminal justice-mental health collaboration described above provide tangible benefits to individuals with mental illness, police officers, police departments, and communities at large.

CONCLUSION

The judgment of the court of appeals should be affirmed.

(author manuscript available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2990634/pdf/nihms195775.pdf).

[81] *See* Compton, 36 J. Am. Acad. Psychiatry & L. at 52.

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