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A MODEL FOR DEFUNDING: AN EVIDENCE-BASED STATUTE FOR BEHAVIORAL HEALTH CRISIS RESPONSE

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ABSTRACT

Too many Black persons and other persons of color are dying at the hands of law enforcement, leading many to call for the defunding of police. These deaths were directly caused by excessive use of force by police officers but were also driven by upstream and institutional factors that include structural racism, institutional bias, and a historic culture of racialized violence. Public outcry against racial inequities has increased as the authority of police departments has expanded to include not only the authority to respond to and investigate criminal activity but also to respond to calls regarding behavioral health issues and homelessness. Defunding police raises questions about how budget cuts should affect the types of services provided by police departments and what new and improved responses may look like. While advocates may have identified model programs that they hope will be the answer to defunding the police, many community organizers lack the legal training necessary to institutionalize their visions in ways that protect against law enforcement co-option. This Article proposes a model act (the Model Behavioral Health Response Team Act) that can be tailored to meet the needs of local and state policymakers endeavoring to create a new institution to replace the police in responding to mental health, substance use, and housing crises. The institution created by this model act is evidence based, person centered, and community driven. It is informed by empirical evidence on crisis response, federal guidelines, and a case study of political activity resulting from the police killing of a Black man amidst a behavioral health crisis in Greensboro, N.C.

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INTRODUCTION

Public demand to divest public funds from the police and reinvest those resources in broader social services has reached a new apex. These calls to “defund the police” are about more than calls to balance the budgets between police departments¹ and essential

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services like public health—which have seen their budgets steadily decrease.² Rather, they reflect public interest in dismantling institutions that perpetuate racial violence³ and reducing the bureaucratic footprint of policing as an institution.⁴ These calls are demands to meaningfully address and take action to prevent excessive use of force by law enforcement officers that results from unnecessary escalation, implicit bias, or the mismanagement of challenging situations (like behavioral health crises) that require specialized skill sets that law enforcement officers do not have. Importantly, excessive police use of force is disproportionately meted out against Black, Indigenous, and Hispanic persons—a long-standing pattern driven by racism, ethnocentrism,⁵ and authoritarianism⁶ structurally embedded within the institutions that govern, employ,⁷ and represent law enforcement.⁸

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1. See Amna A. Akbar, *An Abolitionist Horizon for (Police) Reform*, 108 CALIF. L. REV. 1781, 1843 (2020) (explaining why calls to defund the police are more than just requests for budget reductions but are instead greater calls for social reform).

2. See Brenden Beck & Adam Goldstein, *Governing Through Police? Housing Market Reliance, Welfare Retrenchment, and Police Budgeting in an Era of Declining Crime*, 96 SOC. FORCES 1183, 1185 (2018) (finding that police budgets have grown and social welfare spending has decreased); David U. Himmelstein & Steffie Woolhandler, *Public Health's Falling Share of US Health Spending*, 106 AM. J. PUB. HEALTH 56, 56–57 (2016) (“Real (inflation-adjusted) per capita public health expenditures peaked at \$281 per capita (2014 dollars) in 2008, falling 9.3% to \$255 in 2014 . . .”).

3. This racial violence is perpetuated, in part, through the racial inequalities found in the act of policing itself, particularly in analyzing the ways that policing institutions engage with the community. See Joe Soss & Vesla Weaver, *Police Are Our Government: Politics, Political Science, and the Policing of Race-Class Subjugated Communities*, 20 ANN. REV. POL. SCI. 565, 565–66 (2017). Many “‘race-class subjugated communities’ are governed through coercion, containment, repression, surveillance, regulation, predation, discipline, and violence.” *Id.* at 565.

4. See Simone Weichselbaum & Nicole Lewis, *Support for Defunding the Police Department Is Growing. Here's Why It's Not a Silver Bullet.*, MARSHALL PROJECT (June 9, 2020, 6:00 AM), <http://www.themarshallproject.org/2020/06/09/support-for-defunding-the-police-department-is-growing-here-s-why-it-s-not-a-silver-bullet> [<http://perma.cc/E2GX-HA2M>] (“Across the country, organizers, celebrities, and former city officials are calling on lawmakers to reimagine the role of police in public safety.”).

5. See Andrea M. Headley & James E. Wright II, *Is Representation Enough? Racial Disparities in Levels of Force and Arrests by Police*, 80 PUB. ADMIN. REV. 1051, 1051–52 (2020) (finding that both Black and white officers are less likely to use force against white persons); James E. Wright II & Andrea M. Headley, *Police Use of Force Interactions: Is Race Relevant or Gender Germane?*, 50 AM. REV. PUB. ADMIN. 851, 851 (2020) (“Findings suggest that there are heightened levels of force used when there is racial and gender incongruence [sic] between the officer and the civilian, particularly White officers interacting with Black civilians.”).

6. See Soss & Weaver, *supra* note 3, at 565–67.

7. Racial inequities are embedded into the policing institutions in how they hire officers, promote officers, and deal with complaints against officers. See, e.g., Andrea M. Headley, *Race, Ethnicity and Social Equity in Policing*, in *ACHIEVING SOCIAL EQUITY: FROM PROBLEMS TO SOLUTIONS* 82, 82–91 (Mary E. Guy & Sean A. McCandless eds., 2020).

8. Police unions are not only involved in negotiating employment contracts for officers but are also active in the political process, in pursuing litigation in the interest of their members, and in contributing to the media discourse. See Catherine L. Fisk & L. Song Richardson, *Police Unions*, 85 GEO. WASH. L. REV. 712, 744 (2017). Police unions have blocked important reforms addressing police misconduct by negotiating great protections for their officers within their employment contracts. See Stephen Rushin & Allison Garnett, *State Labor Law and Federal Police Reform*, 51 GA. L. REV. 1209, 1211, 1223–25 (2017) (explaining how collective bargaining agreements with police unions and its union members make reform more difficult); Stephen Rushin & Atticus

This Article presents a model law to establish a nonpolice response for mental health or substance use related crises (“behavioral health crises”) as a starting point for incrementally divesting policing agencies of their responsibilities. Such divestments would decrease their bureaucratic reach, their interactions with communities of color, and, eventually, their funding. Though it is by no means the only place to begin divestment, this Article and model law focus on behavioral health concerns because, although they do not make up a large percentage of police calls for service, they have been historically⁹—and increasingly—answered by law enforcement¹⁰ and represent a disproportionate number of fatal police encounters.¹¹ The model law proposed in this Article is designed to reduce the number of police encounters with persons experiencing behavioral health crises by diverting emergency calls away from law enforcement to personnel equipped to respond in a humane and evidence-based way. The model law embodies an incremental approach to policy change¹² that can be repurposed to reassign other police responsibilities (and public funding for fulfilling those responsibilities) to more appropriate service providers, one social issue or public service domain at a time.

While legal scholars have not, to date, explicitly rejected the premises or policy agendas of the Defund the Police movement, some scholars have voiced criticism against decreasing police budgets, arguing that police agencies are already *underfunded*¹³ and that further divestment will drive up violent crime rates.¹⁴ Other scholars propose more conservative reforms in lieu of defunding that would support better functioning of police

DeProspo, *Interrogating Police Officers*, 87 GEO. WASH. L. REV. 646, 650, 657 (2019) (explaining how collective bargaining agreements with police unions and their members have hindered the ability to effectively interrogate police officers when issues of police misconduct arise, substantially impacting reform). Police unions have also generated solidarity for the police community, supporting the so-called Blue Lives Matter movement and pitting it as diametrically opposed to the Black Lives Matter movement. See Mark P. Thomas & Steven Tufts, *Blue Solidarity: Police Unions, Race and Authoritarian Populism in North America*, 34 WORK EMPLOY. SOC. 126, 134–37 (2020) (arguing that police union support and creation of the solidarity behind Blue Lives Matter contribute to demonization of the Black Lives Matter movement as a criminal enterprise and subsequently interfere with efforts of police reform); Frank Rudy Cooper, *Cop Fragility and Blue Lives Matter*, 2020 UNIV. ILL. L. REV. 621, 626 (2020) (“Unfortunately, Blue Lives Matter advocates sometimes strike a hysterical tone in their denial that the police should reform. That makes it difficult for them to adopt effective reforms that can heal their relations with racial minority communities.”).

9. See Amy C. Watson & Anjali J. Fulambarker, *The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners*, 8 BEST PRAC. MENTAL HEALTH 71, 72 (2012); Randolph Dupont & Sam Cochran, *Police Response to Mental Health Emergencies—Barriers to Change*, 28 J. AM. ACAD. PSYCHIATRY & L. 338, 338–44 (2000).

10. See Jennifer J. Carroll, Sasha Mital, Jessica Wolff, Rita K. Noonan, Pedro Martinez, Melissa C. Podolsky, John C. Killorin & Traci C. Green, *Knowledge, Preparedness, and Compassion Fatigue Among Law Enforcement Officers Who Respond to Opioid Overdose*, 217 DRUG & ALCOHOL DEPENDENCE 1, 1–2 (2020).

11. DORIS A. FULLER, H. RICHARD LAMB, MICHAEL BIASOTTI & JOHN SNOOK, TREATMENT ADVOC. CTR., OVERLOOKED IN THE UNDERCOUNTED: THE ROLE OF MENTAL ILLNESS IN FATAL LAW ENFORCEMENT ENCOUNTERS 1 (2015), <http://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf> [<http://perma.cc/MX23-YD3W>].

12. See Michael Mintrom & Phillipa Norman, *Policy Entrepreneurship and Policy Change*, 37 POL’Y STUD. J. 649, 654–55 (2009).

13. See Stephen Rushin & Roger Michalski, *Police Funding*, 72 FLA. L. REV. 277, 302, 319–20 (2020).

14. Paul G. Cassell, *Explaining the Recent Homicide Spikes in U.S. Cities: The “Minneapolis Effect” and the Decline in Proactive Policing*, 33 FED. SENT’G REP. 83, 84 (2020).

forces in their current state. Such reforms include increased community oversight of police¹⁵ or restructuring the law to make it easier for police misconduct to be addressed.¹⁶ The structural critiques existing in legal scholarship have largely acknowledged that the law permits racialized police violence and that this violence contributes to societal inequities, economic inequalities, and disproportionate power dynamics.¹⁷ Yet, the more “persistent” legal framework for police reform argues that the institution of policing is socially desirable and essential in ensuring public safety and public order.¹⁸

However, these alternative proposals do not sufficiently address the root problems driving racist and excessive police use of force: the disproportionate social and political power wielded by police agencies and the deeply ingrained racial biases¹⁹ and permissive cultures²⁰ that are inextricably woven into the processes and procedures of policing

15. See Osagie K. Obasogie & Zachary Newman, *Constitutional Interpretation Without Judges: Police Violence, Excessive Force, and Remaking the Fourth Amendment*, 105 VA. L. REV. 425, 447 (2019) (proposing that private citizens should work in tandem with the police in crafting policing standards); Anthony O’Rourke, Rick Su & Guyora Binder, *Disbanding Police Agencies*, 121 COLUM. L. REV. 1327, 1351–52 (2021) (arguing that police agencies should be reformed into more democratic institutions with public oversight).

16. See Cynthia Lee, *Reforming the Law on Police Use of Deadly Force: De-Escalation, Preseizure Conduct, and Imperfect Self-Defense*, 2018 UNIV. ILL. L. REV. 629, 688 (2018) (arguing for the restructuring laws to limit the veil protection of an officer’s “reasonable belief” in discharging a firearm and so as to not allow “force defense” to be raised as limitlessly); Avidan Y. Cover, *Reconstructing the Right Against Excessive Force*, 68 FLA. L. REV. 1773, 1814 (2016) (proposing that qualified immunity in the context of excessive force claims should be governed under the Fourteenth Amendment’s general principles to allow courts to more readily provide equitable relief where it facially is ripe); Osagie K. Obasogie & Zachary Newman, *The Endogenous Fourth Amendment: An Empirical Assessment of How Police Understandings of Excessive Force Become Constitutional Law*, 104 CORNELL L. REV. 1281, 1318 (2019) (arguing the ambiguities in Fourth Amendment doctrine allow police to define what is reasonable in the context of excessive force usage and only by changing this endogenous structure can we promote a model of policing where community stakeholders play an active role in policing and accountability); Jason Mazzone & Stephen Rushin, *State Attorneys General as Agents of Police Reform*, 69 DUKE L.J. 999, 1000 (2020) (suggesting state attorneys general should be granted explicit statutory authority to seek equitable relief against local police departments); Seth W. Stoughton, *How the Fourth Amendment Frustrates the Regulation of Police Violence*, 70 EMORY L.J. 521, 583 (2021) (recommending that state and local officials disentangle state and administrative law from Fourth Amendment doctrine). Some of these works even acknowledge the need to account for the structural drivers of police violence and disparate impact on Black, Indigenous, and People of Color (BIPOC). See, e.g., Devon W. Carbado, *From Stopping Black People to Killing Black People: The Fourth Amendment Pathways to Police Violence*, 105 CALIF. L. REV. 125, 129 (2017) (examining how racial profiling, permitted by the Fourth Amendment, increases the likelihood that Black persons will encounter deadly use of force by police officers).

17. Professor Akbar summarizes this literature as being grounded in arguments for (1) more democratic governance and oversight over policing agencies; (2) greater technocratic inputs into the creation of administrative processes that would better standardize police behavior in ways that align with evidence-based policing; (3) more procedural justice, which reinforces legitimacy and trust in policing agencies leading to greater public compliance; and (4) emphasis on more tools and technologies to assist law enforcement in performing their duties in more equitable ways. Akbar, *supra* note 1, at 1803.

18. *Id.* at 1802.

19. See Kristin Henning, *Boys to Men: The Role of Policing in the Socialization of Black Boys*, in *POLICING THE BLACK MAN: ARREST, PROSECUTION, AND IMPRISONMENT* 57, 58 (Angela J. Davis ed., 2017).

20. See Reade Levinson, *Across the U.S., Police Contracts Shield Officers from Scrutiny and Discipline*, REUTERS (Jan. 13, 2017, 1:18 PM), <http://www.reuters.com/investigates/special-report/usa-police-unions/> [<http://perma.cc/M83J-KY68>]; *Legal Barriers To Challenging Excessive Force by Police*, EQUAL JUST. INITIATIVE (May 18, 2020), <http://eji.org/news/legal-barriers-to-challenging-excessive-force-by-police/> [<http://perma.cc/F9TR-CN5U>].

today. By supporting reforms that maintain the structural status quo (including the problematically broad scope of police responsibilities today), the legal academy relegitimizes policing as an institution and sanctions the atrocities that continue to be conducted at the hands of that institution.

There is a desperate need for strategic reconsideration of the scope of duties assigned to law enforcement. Indeed, legal reforms that seek to alleviate concerns about police use of force through additional training of police officers or oversight of police agencies fail to acknowledge that the range of responsibilities assumed by law enforcement has far exceeded their central organizational purpose of ensuring public safety through the enforcement of the law. Law enforcement has become the proverbial “first responder” as their responsibilities swelled to “fill the gap” in America’s disjointed and, at times, nonexistent systems for healthcare and human services. This leaves law enforcement stretched problematically thin, tasks them with rendering services that officers are not trained to provide, and often places the provision of those essential services in conflict with law enforcement’s primary mission to ensure the public’s safety.

We, the authors, are not alone in noticing the moral and practical shortcomings of responses in opposition to defunding the police.²¹ Of late, more and more legal scholars are writing in support of defunding the police as a viable policy proposal.²² These scholars recognize the folly of using existing legal and institutional structures to address the racism and power dynamics embedded in those systems, as evidenced by the extreme disparity in over-policing and excessive police use of force in American communities.²³ Importantly, many have called for the divestment of public funds from law enforcement agencies while advocating for the development of nonpolice institutions to which responsibilities currently held by law enforcement may be transferred.²⁴ Most notably, Professor Amna A. Akbar has directly confronted those who have dismissed calls to defund the police, elucidating the depth of structural policy reforms contained within those calls²⁵ and challenging legal scholars to “understand how organizers are using law as a tool.”²⁶

We heed Professor Akbar’s call. This Article draws on interviews conducted with advocates across the country—as well as our own work assisting organizers in drafting municipal and county ordinances—in order to explain how law can be used to

21. See generally Akbar, *supra* note 1; Amna A. Akbar, *Toward a Radical Imagination of Law*, 93 N.Y.U. L. REV. 405 (2018); Amna A. Akbar, *Demands for a Democratic Political Economy*, 134 HARV. L. REV. F. 90 (2020); Amna A. Akbar, Sameer M. Ashar & Jocelyn Simonson, *Movement Law*, 73 STAN. L. REV. 821 (2021).

22. See generally Akbar, *supra* note 1; O’Rourke et al., *supra* note 15; V. Noah Gimbel & Craig Muhammad, *Are Police Obsolete? Breaking Cycles of Violence Through Abolition Democracy*, 40 CARDOZO L. REV. 1453 (2019); Jocelyn Simonson, *Police Reform Through a Power Lens*, 130 YALE L.J. 778 (2021); Michelle S. Jacobs, *The Violent State: Black Women’s Invisible Struggle Against Police Violence*, 24 WM. & MARY J. WOMEN & L. 39 (2017); ANDREA J. RITCHIE, *INVISIBLE NO MORE: POLICE VIOLENCE AGAINST BLACK WOMEN AND WOMEN OF COLOR* (2017); K. Sabeel Rahman & Jocelyn Simonson, *The Institutional Design of Community Control*, 108 CALIF. L. REV. 679 (2020); Jordan Blair Woods, *Traffic Without the Police*, 73 STAN. L. REV. 1471 (2021) (proposing a new system of traffic enforcement divorced from policing agencies).

23. See generally Akbar, *supra* note 1.

24. See Akbar, *supra* note 1, at 1830; Gimbel & Muhammad, *supra* note 22, at 1465.

25. Akbar, *supra* note 1, at 1783.

26. *Id.* at 1845.

incrementally reallocate responsibilities from police agencies to other government agencies or service providers.

In addition to providing a model for a nonpolice behavioral health crisis response, this Article provides guidance to advocates interested in implementing the model law for navigating political roadblocks, particularly those presented by a politically conservative electorate.²⁷ Further, the Article predicts—and addresses through policy design—implementation issues that could arise in efforts to incrementally divest police of responsibilities. The Article provides empirical evidence and political strategy needed to sway both liberal and conservative lawmakers to gradually dismantle policing agencies by reassigning responsibilities to nonpolice institutions. It further adds to the emerging legal scholarship on divestment from law enforcement infrastructures by drawing attention to an important justification for defunding the police—one that has yet to be highlighted in the recent legal scholarship: the routine excessive use of force by law enforcement officers against persons with behavioral health concerns. Indeed, many of these persons are members of the same populations disproportionately subjected to excessive use of force by police because of their race or ethnicity.²⁸

In so doing, the Article addresses necessary bureaucratic concerns about the division of powers between state, county, and municipal governments that will likely arise when proposing policy reforms seeking to reassign responsibilities from one administrative agency (i.e., law enforcement) to another. The Article reviews the costs and benefits of assigning such responsibilities to a private versus public organization and discusses the implications for the creation of institutions needed to justify the defunding of police.

Perhaps this Article's most significant contribution to the legal scholarship on methods for defunding the police is the model law accompanying it, along with political, practical, and legal justifications for the inclusion of each provision. This model statute—the Behavioral Health Response Team (BHRT) Act, attached in Appendix A—offers alternative language to render it suitable for enactment at the municipal, county, or state level and may thereby be customized to fit the needs of various communities seeking methods for the incremental dismantling of their own police institutions. The provisions in the model statute were designed according to several considerations: feedback received from community leaders and members of underrepresented groups in North Carolina; legal considerations encountered in assisting groups advocating for the incremental dismantling of police; our own expertise in mental health and addiction policy history and evidence-based behavioral health treatment; the political process; current understandings of mechanisms of interest group mobilization and policy change; and comments received by national experts in policing, mental health, and addiction policy.

This Article proceeds as follows. Section I describes the empirical literature demonstrating the scope of the problem the model statute seeks to address, focusing on excessive police use of force, race and racism, behavioral health concerns, and how lack of adequate housing increases the risks of victimization. Section II critiques a particular strategy for police reform under the status quo that has not received much attention or

27. *See infra* Part IV.G.

28. *See infra* Section I.

criticism in the legal scholarship: additional training and support for the continuation of police response to behavioral health crises in the form of crisis intervention teams (CIT) and law-enforcement-led co-responder teams.

National advocates for CIT and co-responder programs do not question whether law enforcement officers *should* be responding to behavioral health emergencies; rather, they accept that law enforcement officers *will* be responding to these calls for service and seek to alter *how* officers carry out their response.²⁹ This Article refutes the claim that CIT and co-responder models present a reasonable alternative to police divestment. It further equips policymakers with empirical evidence that demonstrates that these strategies are not only ineffective in decreasing excessive use of force against persons experiencing behavioral health emergencies but also are serving to effectively relegitimize the policing institution as it currently exists.

Section III discusses the case study of Greensboro, North Carolina, presenting the policy proposals adopted and political hurdles faced by advocacy groups in their efforts to defund the local police. Section III offers suggestions for how advocates can overcome these barriers, particularly when proposing incremental police reform efforts in conservative states. Section IV provides specific policy recommendations and a detailed explanation of the provisions of the model statute that may be customized for use by either state or local governments wishing to adopt the recommendations in this Article.

I. THE PROBLEMS POSED BY POLICE RESPONSE TO BEHAVIORAL HEALTH EMERGENCIES

The harms caused by law enforcement's use of force are wide and varied. This Section is not meant to be a systematic review of the literature on police use of force or the harms that result from such encounters. Instead, it is meant to describe the scope of the problem, as well as highlight some of the difficulties that researchers encounter in their efforts to document the amount of harm caused by the excessive use of force by police.

A. *Law Enforcement Use of Force Against Black Persons and Other Persons of Color*

"Use of force"³⁰ by law enforcement officers is a significant public health problem that disproportionately affects Black, Indigenous, and Hispanic persons. Black men and

29. See *Crisis Intervention Team (CIT) Programs*, NAMI, [http://nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-\(CIT\)-Programs](http://nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs) [<http://perma.cc/GQ5R-8LZ5>] (last visited Nov. 1, 2021) ("The lack of mental health crisis services across the U.S. has resulted in law enforcement officers serving as first responders to most crises. A Crisis Intervention Team (CIT) program is an innovative, community-based approach to improve the outcomes of these encounters.").

30. "Use of force" is a term generally used to describe those actions taken by a law enforcement officer in order to mitigate an incident, make an arrest, or protect themselves or others from harm. *Overview of Police Use of Force*, NAT'L INST. JUST. (Mar. 5, 2020), <http://nij.ojp.gov/topics/articles/overview-police-use-force> [<http://perma.cc/A34W-XE2Y>]. Most often, use of force is engaged for purposes of coercion and control of a situation, as is reflected in the definition of this term endorsed by the Bureau of Justice Statistics: "The amount of effort required by law enforcement to gain compliance from an unwilling subject." *Use of Force*, BUREAU JUST. STAT., <http://www.bjs.gov/index.cfm?ty=tp&tid=84> [<http://perma.cc/RR8W-QASY>] (last visited Nov. 1, 2021).

women, American Indian/Alaskan Native men and women, and Hispanic men are all more likely to be killed by law enforcement than their white peers.³¹ Death by a firearm discharged during a law enforcement intervention was among the top twenty most common causes of injury death from 2000 to 2018 in American Indian, Alaskan Native, and Hispanic males aged fifteen to thirty-four years.³² In the same time period, it was the tenth most common cause of injury death among Black individuals of both sexes aged fifteen to twenty-four years.³³ An evaluation of 2,285 instances of death resulting from law enforcement intervention between 2010 and 2014 found that Hispanic and non-Hispanic Black individuals were, respectively, 1.7 and 2.8 times more likely to die as a consequence of law enforcement use of force compared to their white counterparts.³⁴ Should the incidence of law enforcement use of force continue at current rates, about one out of every one thousand Black men alive as of the writing of this Article will ultimately be killed by law enforcement use of force.³⁵ Collectively, this data indicates a widespread pattern of law enforcement use of force that is disproportionately applied more frequently, escalated more quickly, and results in more severe injury and death among Black, Indigenous, and Hispanic populations.

B. *Law Enforcement Use of Force Against Individuals with Behavioral Health Concerns*

Black, Indigenous, and Hispanic persons who experience behavioral health crises are at an even greater risk of being subjected to excessive use of force at the hands of law enforcement. Though no nationally representative datasets exist, current estimates suggest that approximately 1% of all law enforcement dispatches and encounters involve an individual living with one or more mental disorders, excluding substance use.³⁶ For reference, the City of Baltimore, Maryland, reported more than 1.4 million calls for service in 2019, which, according to the 1% estimate, likely represents an average of 1,200 interactions between police and individuals living with mental disorders every month.³⁷ Further, in a nationwide survey of 2,207 senior law enforcement officials

31. Frank Edwards, Michael H. Esposito & Hedwig Lee, *Risk of Police-Involved Death by Race/Ethnicity and Place, United States, 2012–2018*, 108 AM. J. PUB. HEALTH 1241, 1241 (2018) (“Black men’s mortality risk is between 1.9 and 2.4 deaths per 100,000 per year, Latino risk is between 0.8 and 1.2, and White risk is between 0.6 and 0.7.”).

32. See *WISQARS: Leading Causes of Death Reports, 1981-2019*, CDC, <http://wisqars.cdc.gov/fatal-leading> [<http://perma.cc/PE85-XDU6>] (last updated Feb. 20, 2020). To identify these trends, we queried WISQARS three times. Each time, we asked the system to return tables for the period 2000–2018 (most recent data available at time of writing), to show data for all injuries, to return the top twenty causes of death, and to display age groups as every ten years for ages fifteen to sixty-five and older. To generate the statistics we reference, we ran one query for Black individuals of any sex, one for American Indian/Alaskan Native males, and one for Hispanic males.

33. See *id.*

34. James W. Buehler, *Racial/Ethnic Disparities in the Use of Lethal Force by US Police, 2010–2014*, 107 AM. J. PUB. HEALTH 295, 295–96 (2017).

35. See Edwards et al., *supra* note 31, at 1243.

36. James D. Livingston, *Contact Between Police and People with Mental Disorders: A Review of Rates*, 67 PSYCHIATRIC SERVS. 850, 852 (2016).

37. *911 Calls for Service 2019*, OPEN BALTIMORE, <http://data.baltimorecity.gov/datasets/baltimore::911-calls-for-service-2019/about>

conducted in 2011, 81% of respondents reported an increase in the population of people living with mental disorders in their jurisdictions over the length of their careers; 63% of respondents reported a moderate increase in the amount of time on calls for service involving individuals living with mental disorders; and an additional 18% reported a substantial, or larger than moderate, increase in time spent on these calls.³⁸

The public health burden that results from law enforcement interaction and police use of force against individuals with mental or behavioral health concerns can be evaluated in several ways. One method is to assess the prevalence of law enforcement encounters among individuals in this population. An early study sampled 172 people living with schizophrenia or a schizoaffective disorder between 1989 and 1991.³⁹ Each participant was followed for a period of three years.⁴⁰ Researchers who conducted this study noted that these individuals were fourteen times more likely to be victims of a violent crime than to be arrested for allegedly committing one; nevertheless, 48% of participants experienced contact with the police during the study period.⁴¹ A 2012 study examined the nature of police encounters among a population of individuals living with schizophrenia or a related psychosis who were receiving public mental health services.⁴² Over a ten-year period, the majority (65%) of individuals who experienced arrest were detained in connection to crimes against public order,⁴³ suggesting that most of the concerns that law enforcement was dispatched for involved symptoms and sequelae of mental illness—not straightforwardly criminogenic behavior.⁴⁴

Another method for assessing the public health burden of law enforcement interaction with this population is to consider the proportion of injuries resulting from law enforcement intervention sustained by individuals living with mental and behavioral health disorders. An analysis of statewide hospital-discharge data from the State of Illinois for the years 2000–2009 compared 836 individuals treated for injuries sustained during law enforcement intervention with a group of individuals that received treatment for non-law-enforcement-related injuries.⁴⁵ The two comparison groups were matched

[<http://perma.cc/4SGB-M483>] (last visited Nov. 1, 2021). Data published to this website indicate that there were 1,455,168 calls for service in Baltimore in 2019. That number divided by twelve is about 120,000 calls per month, and 1% of 120,000 is 1,200.

38. See Michael C. Biasotti, *Management of the Severely Mentally Ill and Its Effects on Homeland Security* 43 (Sept. 2011) (unpublished Master's thesis, Naval Postgraduate School) (on file with Dudley Knox Library).

39. John S. Brekke, Cathy Prindle, Sung Woo Bae & Jeffrey D. Long, *Risks for Individuals with Schizophrenia Who Are Living in the Community*, 52 *PSYCHIATRIC SERVS.* 1358, 1358 (2001).

40. *Id.*

41. *Id.* at 1362, 1365.

42. Patrick J. McCabe, Paul P. Christopher, Nicholas Druhn, Kristen M. Roy-Bujnowski, Albert J. Grudzinskas Jr. & William H. Fisher, *Arrest Types and Co-Occurring Disorders in Persons with Schizophrenia or Related Psychoses*, 39 *J. BEHAV. HEALTH SERVS. & RSCH.* 271, 271 (2012).

43. *Id.* Crimes against public order are defined differently across jurisdictions, but most frequently encompass drug- and alcohol-related crimes, commercial sex work, public drunkenness, and disorderly conduct. Jessica Tran, *Crimes Against Public Order*, *LEGAL MATCH* (Nov. 4, 2021), <http://www.legalmatch.com/law-library/article/crimes-against-public-order.html> [<http://perma.cc/6W88-VQRY>].

44. See McCabe et al., *supra* note 42, at 271–72.

45. Alfreda Holloway-Beth, Linda Forst, Julia Lippert, Sherry Brandt-Rauf, Sally Freels & Lee Friedman, *Risk Factors Associated with Legal Interventions*, 3 *INJ. EPIDEMIOLOGY* 1, 3–4 (2016).

by eight characteristics, including age, race, gender, and date of admission.⁴⁶ The analysis found that individuals treated for injuries sustained during law enforcement intervention were 1.4 times more likely than the reference group to be living with alcohol use disorder, 1.8 times more likely to be living with another kind of substance use disorder, 2.4 times more likely to be living with depression, 2.8 times more likely to be living with a paralytic condition, and 8.6 times more likely to be living with schizophrenia.⁴⁷ A similar cross-sectional study that incorporated data from a representative sample of the general population in four U.S. cities found that the occurrence of a psychotic episode was associated with experiencing a police encounter and that this relationship displayed a dose-response effect, meaning that a higher number of psychotic episodes experienced by an individual predicted a higher number of police encounters.⁴⁸

In sum, research indicates that the burden of law enforcement interactions and related injuries is disproportionately experienced across populations affected by a spectrum of mental and behavioral health concerns. Further, that burden appears to increase at the individual level as the severity of those behavioral health concerns increases. These findings, in combination with research showing markedly high levels of stigma against mental illness among law enforcement officers,⁴⁹ suggest that disproportionate law enforcement interaction and use of force with individuals living with mental and behavioral disorders is a de facto professional norm in law enforcement that is scaffolded by a complex set of structural, cultural, interpersonal, and individual drivers.

II. LAW ENFORCEMENT PARTNERSHIPS AND POLICE REFORM

A. Crisis Intervention Teams and Co-Responder Models

Interdisciplinary partnerships between law enforcement agencies and specialists working in other human service or healthcare professions have been widely proposed and implemented as collaborative solutions to local problems, such as the opioid

46. *Id.*

47. *Id.* at 4, 6.

48. Jordan E. DeVlyder, Courtney Cogburn, Hans Y. Oh, Deidre Anglin, Melissa Edmondson Smith, Tanya Sharpe, Hyun-Jin Jun, Jason Schiffman, Ellen Lukens & Bruce Link, *Psychotic Experiences in the Context of Police Victimization: Data from the Survey of Police–Public Encounters*, 43 SCHIZOPHRENIA BULL. 993, 995–97 (2017).

49. See Heather Stuart, *Mental Illness Stigma Expressed by Police to Police*, 54 ISR. J. PSYCHIATRY RELATED SCI. 18, 21–22 (2017) (showing that most officers who participated in the study believed that officers “would not seek professional help for a mental illness and would consider treatment as a sign of personal failure”).

overdose epidemic,⁵⁰ mental health crises,⁵¹ and even chronic truancy.⁵² One of the most prolific programs intended to improve the quality of law enforcement responses to behavioral-health-related calls for service is the Crisis Intervention Team (CIT) model, which has already been implemented in nearly 3,000 law enforcement agencies across the United States.⁵³ Recent years have also seen an increase in enthusiasm for co-responder models, in which law enforcement officers respond to crisis calls in tandem with nonpolice partners, such as mental health or substance use professionals.⁵⁴ We discuss these police-centered strategies in turn below.

The CIT model was developed in Memphis, Tennessee, following the shooting death of twenty-seven-year-old Joseph Dewayne Robinson at the hands of the Memphis police.⁵⁵ On September 24, 1987, Robinson's mother called 911 to report that her son—who reportedly had lived experience of chronic mental illness and substance use—was in the area just outside of their home, allegedly cutting himself with a knife and verbally threatening others.⁵⁶ According to the reports made by the four police officers dispatched, Mr. Robinson was stabbing himself in the neck with a butcher's knife when they arrived.⁵⁷ The officers claim Mr. Robinson lunged at them as they approached, after which the officers fired on Mr. Robinson no less than ten times.⁵⁸ Following public outcry over the shooting, the Memphis chapter of the National Alliance on Mental Illness facilitated discussions between law enforcement and the wider community, and the eponymous “Memphis model” for CIT was subsequently launched in 1988.⁵⁹ Since then, CIT (or some variation of it) has been rapidly adopted and is now widespread across the

50. See generally Scott W. Formica, Robert Apsler, Lindsay Wilkins, Sarah Ruiz, Brittni Reilly & Alexander Y. Walley, *Post Opioid Overdose Outreach by Public Health and Public Safety Agencies: Exploration of Emerging Programs in Massachusetts*, 54 INT'L J. DRUG POL'Y 43 (2018) (summarizing findings from interdisciplinary programs in Massachusetts).

51. See *National Model*, UNIV. MEM. CIT CTR., <http://www.cit.memphis.edu/overview.php?page=7> [<http://perma.cc/SW76-8XRF>] (last visited Nov. 1, 2021).

52. See, e.g., Lorraine Mazerolle, Emma Antrobus, Sarah Bennett & Elizabeth Eggins, *Reducing Truancy and Fostering a Willingness To Attend School: Results from a Randomized Trial of a Police-School Partnership Program*, 18 PREVENTION SCI. 469, 469 (2017) (evaluating police-school partnership programs).

53. See UNIV. MEM. CIT CTR., *supra* note 51.

54. See ASHLEY KRIDER & REGINA HUERTER, POL'Y RSCH., INC., KIRBY GAHERTY & ANDREW MOORE, NAT'L LEAGUE OF CITIES, *RESPONDING TO INDIVIDUALS IN BEHAVIORAL HEALTH CRISIS VIA CO-RESPONDER MODELS: THE ROLES OF CITIES, COUNTIES, LAW ENFORCEMENT, AND PROVIDERS 1* (2020), <http://www.theiacp.org/sites/default/files/SJCResponding%20to%20Individuals.pdf> [<http://perma.cc/8QSS-6CWC>].

55. Daniel Connolly, *Memphis Police Crisis Intervention Team Approaches 30 Years, but How Effective Is It?*, COM. APPEAL (Aug. 6, 2017, 6:00 AM), <http://www.commercialappeal.com/story/news/crime/2017/08/06/memphis-police-mental-health-crisis-team-30-years/493740001/> [<http://perma.cc/XTT6-4XSJ>] (reporting on the events that led to the creation of the Memphis CIT).

56. Michael S. Rogers, Dale E. McNiel & Renée L. Binder, *Effectiveness of Police Crisis Intervention Training Programs*, 47 J. AM. ACAD. PSYCHIATRY & L. 414, 415 (2019).

57. See *id.*

58. Charles L. Scott, *Jail Diversion: A Practical Primer*, in DECRIMINALIZING MENTAL ILLNESS 106, 107 (Kathrine Warburton & Stephen M. Stahl eds., 2021), <http://services.cambridge.org/us/academic/subjects/medicine/mental-health-psychiatry-and-clinical-psychology/decriminalizing-mental-illness?format=PB&isbn=9781108826952> [<http://perma.cc/JZU8-DDUX>].

59. Rogers et al., *supra* note 56, at 415–17.

United States. For illustration, by the time the first scholarly manuscript fully describing a generalized programmatic framework for CIT emerged in the peer-reviewed literature in 2008, CIT programs were already in operation at an estimated 400 U.S. law enforcement agencies.⁶⁰ By 2019, the CIT Center at the University of Memphis boasted a roster of more than 2,700 CIT programs across the United States.⁶¹

The core components of the CIT model, as defined by the CIT Center at the University of Memphis, include (1) a forty-hour comprehensive training for officers wishing to participate in the program; (2) the establishment of a fully staffed CIT leadership team (consisting of trained CIT law enforcement officers, trained dispatch personnel, a CIT law enforcement coordinator, a mental health coordinator, an advocacy coordinator, and a multijurisdictional program coordinator); and (3) an established partnership with a specialized mental health emergency care facility capable of receiving referrals from the CIT program.⁶² Officer training—the backbone of the CIT model—generally includes education about mental illness, the causes, signs, and symptoms of mental illness, and information on involuntary commitment criteria, communication skills, and de-escalation strategies.⁶³

Despite the enormous number of programs in operation in the thirty years following CIT's conception, little evidence exists to show that the CIT approach is effective at reducing incidents of police use of force (or even simply reducing incidents of *excessive* police use of force) during behavioral-health-related calls.⁶⁴ One challenge in assessing the efficacy of the CIT approach is that the stated goals of CIT programs vary from place to place: some communities employ the model to improve community safety, others to enhance officer safety, still others to facilitate linkage to care and diversion from booking and jail.⁶⁵ This variation in implementation priorities makes it difficult—if not practically impossible—to conduct rigorous, controlled trials to test the effects of CIT programs.⁶⁶ Further, the task of evaluating the public health impacts of CIT efforts is far from straightforward.⁶⁷ Such an evaluation exercise would require a substantial deviation from (or addition to) the data collection and evaluation activities in which law enforcement agencies already engage.⁶⁸ The data collected at current is often limited to variables not

60. Amy C. Watson, Melissa Schaefer Morabito, Jeffrey Draine & Victor Ottati, *Improving Police Response to Persons with Mental Illness: A Multi-Level Conceptualization of CIT*, 31 INT'L J. L. & PSYCHIATRY 359, 361 (2008) [hereinafter Watson et al., *Improving Police Response*].

61. Rogers et al., *supra* note 56, at 417; UNIV. MEM. CIT CTR., *supra* note 51.

62. See RANDOLPH DUPONT, SAM COCHRAN & SARAH PILLSBURY, CRISIS INTERVENTION TEAM CORE ELEMENTS 4 (2007).

63. Watson et al., *Improving Police Response*, *supra* note 60, at 363.

64. Eddie Kane, Emily Evans & Farhad Shokraneh, *Effectiveness of Current Policing-Related Mental Health Interventions: A Systematic Review*, 28 CRIM. BEHAV. & MENTAL HEALTH 108, 108 (2018) (systematically reviewing studies on policing-related mental health interventions).

65. Michael T. Compton, Masuma Bahora, Amy C. Watson & Janet R. Oliva, *A Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs*, 36 J. AM. ACAD. PSYCHIATRY & L. 47, 53 (2008) [hereinafter Compton et al., *Comprehensive Review*].

66. Kane et al., *supra* note 64.

67. See Watson et al., *Improving Police Response*, *supra* note 60, at 359–60.

68. See *id.* at 360.

directly impacted by behavioral health responses such as arrest rates, crime statistics, and response times.⁶⁹

As a result, the vast majority of research on CIT programs has been limited to the evaluation of officer-level outcomes, including law enforcement officers' abilities to identify someone living with a mental illness and officers' reported confidence in responding to calls involving an individual with a mental illness.⁷⁰ Indeed, there is ample evidence that CIT training is effective in increasing officer knowledge and confidence.⁷¹ In rare cases, studies have gone further and assessed officers' perceptions of possible scenarios in the field, but those scenarios are, by definition, hypothetical and a better reflection of officer knowledge than they are of officer behavior or actual use of force.⁷² Today, the evidence base for CIT still lacks meaningful assessments of the events that unfold in the field as law enforcement officers respond to CIT-related calls for service.⁷³ Likewise, no satisfactory evidence exists that would support the assertion that changes in an individual officer's knowledge or confidence as a result of CIT training are associated with measurable changes in call dispositions or patterns of police use of force in the field.⁷⁴ In other words, though ample research exists to demonstrate that individual law enforcement officers gain a great deal personally from CIT training, whether their behaviors on the job subsequently change due to that personal growth is largely unknown.⁷⁵

At current, the evidence that behavioral health response training—including but not limited to CIT approaches—fundamentally changes officer behavior in the field is not strong. A 2017 study that evaluated more than 2,000 officer reports spanning more than five years of police activity in a single county in Michigan found that the disposition of a call for service (i.e., whether someone was arrested, transported, etc.) was predicted not by officer training but by how the call was dispatched.⁷⁶ Specifically, CIT calls that were dispatched as “mental disturbance” were significantly more likely to result in a subject being transported to a mental health facility than CIT calls dispatched as “citizen

69. See *id.* at 362.

70. Compton et al., *Comprehensive Review*, *supra* note 65, at 49; Watson et al., *Improving Police Response*, *supra* note 60, at 362.

71. Marisa D. Booty, Rebecca G. Williams & Cassandra K. Crifasi, *Evaluation of a Crisis Intervention Team Pilot Program: Results from Baltimore, MD*, 56 CMTY. MENTAL HEALTH J. 251, 253–55 (2020); Kelli E. Canada, Beth Angell & Amy C. Watson, *Intervening at the Entry Point: Differences in How CIT Trained and Non-CIT Trained Officers Describe Responding to Mental Health-Related Calls*, 48 CMTY. MENTAL HEALTH J. 746, 748 (2012).

72. See Michael T. Compton, Berivan N. Demir Neubert, Beth Broussard, Joanne A. McGriff, Rhiannon Morgan & Janet R. Oliva, *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, 737 (2011) [hereinafter Compton, *Use of Force*].

73. See Watson et al., *Improving Police Response*, *supra* note 60, at 359.

74. See Compton et al., *Comprehensive Review*, *supra* note 65, at 53.

75. Amy C. Watson, Michael T. Compton & Jeffrey N. Draine, *The Crisis Intervention Team (CIT) Model: An Evidence-Based Policing Practice?*, 35 BEHAV. SCIS. & L. 431, 438 (2017) [hereinafter Watson et al., *CIT Model*]; Amy C. Watson & Michael T. Compton, *What Research on Crisis Intervention Teams Tells Us and What We Need To Ask*, 47 J. AM. ACAD. PSYCHIATRY & L. 422, 423–24 (2019).

76. See Christian Ritter, Jennifer L. S. Teller, Kristen Marcussen, Mark R. Munetz & Brent Teasdale, *Crisis Intervention Team Officer Dispatch, Assessment, and Disposition: Interactions with Individuals with Severe Mental Illness*, 34 INT'L J. L. & PSYCHIATRY 30, 31–32 (2011).

assist,” “disturbance,” “suspicious person,” or “assault.”⁷⁷ Further, CIT calls dispatched as “suspected suicide” were significantly more likely than CIT calls dispatched as “mental disturbance” to result in transportation to a mental health facility.⁷⁸ Thus, while CIT programs have been demonstrated to increase transportation to mental health facilities,⁷⁹ there is compelling evidence that those transportation decisions may not be clinically appropriate. Indeed, it is the first impression of the dispatcher, rather than the enhanced assessment skills that CIT officers have allegedly gained through behavioral health crisis identification and response training, that seems to be the primary factor influencing the choices made by CIT officers on the scene.⁸⁰

Research assessing other types of specialized mental or public health response training for law enforcement officers also suggests that officer training does not directly influence officer behavior in the field. A recent study conducted across several precincts within the Chicago Police Department found that a training in transparency and procedural justice—akin to CIT training in its focus on community perspective but without a behavioral health component—produced a mere 10% reduction in citizen complaints and 6.4% reduction in police use of force incidents.⁸¹ These findings were significant, but the overall impact of training on officer behavior was extremely modest. A different study, which surveyed more than 2,800 police officers in twenty states about their training and experience responding to calls for opioid overdose emergencies, found that officer training and self-reported attitudes about substance use and public health responses to the overdose epidemic were not significantly associated with the actions officers took on calls.⁸² Indeed, the fact that officer deviation from agency protocol is looked down upon in police culture was considered an explanatory hypothesis for this finding by this research team.⁸³ In the words of one co-author of the study who is a career law enforcement professional, “[police chiefs] don’t care what their officers think, they care what they *do*.”⁸⁴

Importantly, two studies have identified perverse outcomes of CIT implementation. One study comparing use of force among officers who had received CIT training versus those who had not in the Chicago Police Department found no statistically significant

77. *Id.* at 30.

78. *Id.*

79. Sheryl Kubiak, Erin Comartin, Edita Milanovic, Deborah Bybee, Elizabeth Tillander, Celeste Rabaut, Heidi Bisson, Lisa M. Dunn, Michael J. Bouchard, Todd Hill & Steven Schneider, *Countywide Implementation of Crisis Intervention Teams: Multiple Methods, Measures and Sustained Outcomes*, 35 BEHAV. SCIS. & L. 456, 459 (2017).

80. See Ritter et al., *supra* note 76, at 37.

81. See Hilary Hurd Anyaso, *Police Training Reduced Complaints and Use of Force Against Civilians*, NW. NOW (Apr. 20, 2020), <http://news.northwestern.edu/stories/2020/04/police-training-reduced-complaints-and-use-of-force-against-civilians/> [<http://perma.cc/QDU5-BTC3>].

82. See Carroll et al., *supra* note 10, at 3.

83. Karen Frewin & Keith Tuffin, *Police Status, Conformity and Internal Pressure: A Discursive Analysis of Police Culture*, 9 DISCOURSE & SOC’Y 173, 173–85 (1998); STEVE MCCARTNEY & RICK PARENT, ETHICS IN LAW ENFORCEMENT ch. 8.1 (2015), <http://opentextbc.ca/ethicsinlawenforcement/front-matter/accessibility-statement/> [<http://perma.cc/E23J-GPB3>].

84. Personal Communication with Jack Killoran (Sept. 2018).

difference in the frequency or severity of use of force between these two groups; however, the CIT officers displayed a marginal *increase* in use of force over their non-CIT counterparts.⁸⁵ A similar study of all 4,211 use of force incidents documented between 2008 and 2011 by the Portland Police Bureau (in Portland, Oregon)—in which all sworn officers had received CIT training—found that individuals perceived to be living with a mental or behavioral disorder by the responding officer were *more likely* to be subject to use of force and *more likely* to be perceived by responding officers as violently resisting.⁸⁶

Beyond these isolated instances, however, the overwhelming consensus that has emerged from systematic reviews of scientific evidence is that insufficient evidence exists to conclude that CIT programs change officer behavior in the field, alter use of force patterns, or increase officer or civilian safety during calls for service.⁸⁷ Thus, after more than thirty years of implementation, no local jurisdiction has conclusively demonstrated that the CIT model consistently reduces the risks faced by people living with mental and behavioral disorders when interacting with the police.

Co-responder models are a newer trend in policing. Though some co-responder programs have been around for several decades (such as the twenty-four-hour Crisis Unit deployed in Chapel Hill, North Carolina, founded in 1973⁸⁸), interest in implementing and studying such programs has become more widespread in the last decade.⁸⁹ These programs generally consist of dispatching a specially trained team that includes law enforcement officers in tandem with at least one mental health professional or some other type of social or behavioral health support specialist to respond to behavioral health crises.⁹⁰ Some programs, as in Chapel Hill, deploy teams including at least one law enforcement officer to respond to crisis calls.⁹¹ Others dispatch law enforcement as first responders and subsequently engage non-law enforcement partners to follow up with community members.⁹² In 2016, for example, the police department in Lexington, Kentucky, hired two licensed social workers to follow up with individuals in crisis after

85. Melissa S. Morabito, Amy N. Kerr, Amy Watson, Jeffrey Draine, Victor Ottati & Beth Angell, *Crisis Intervention Teams and People with Mental Illness: Exploring the Factors that Influence the Use of Force*, 58 CRIME & DELINQ. 57, 71–72 (2012).

86. Melissa S. Morabito, Kelly Socia, Amanda Wik & William H. Fisher, *The Nature and Extent of Police Use of Force in Encounters with People with Behavioral Health Disorders*, 50 INT'L J. L. & PSYCHIATRY 31, 31 (2017).

87. Kane et al., *supra* note 64, at 116; Sema A. Taheri, *Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? A Systematic Review and Meta-Analysis*, 27 CRIM. JUST. POL'Y REV. 76, 90 (2016).

88. *Crisis Unit, TOWN OF CHAPEL HILL*, <http://www.townofchapelhill.org/government/departments-services/police/divisions/specialty-units/crisis-unit> [<http://perma.cc/8UC9-DBH6>] (last visited Nov. 1, 2021).

89. See Stephen Puntis, Devon Perfect, Abirami Kirubarajan, Sorcha Bolton, Fay Davies, Aimee Hayes, Eli Harriss & Andrew Molodynski, *A Systematic Review of Co-Responder Models of Police Mental Health 'Street' Triage*, 18 BMC PSYCHIATRY 256, 256–57 (2018), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC6094921/pdf/12888_2018_Article_1836.pdf [<http://perma.cc/EY2B-DKWQ>].

90. KRIDER ET AL., *supra* note 54, at 4.

91. See *id.*; TOWN OF CHAPEL HILL, *supra* note 88.

92. KRIDER ET AL., *supra* note 54, at 4–5.

police concluded their first response.⁹³ Though co-responder models differ from the CIT model by prioritizing interdisciplinary response, CIT training has been presented by some proponents of co-responder models as an appropriate foundation for officers serving on co-responder teams⁹⁴—despite the lack of evidence that CIT training meaningfully affects officer behaviors in the field.⁹⁵

Little evidence exists to support the use of co-responder models or to suggest that co-responder models will produce better outcomes than the classic, police-only CIT approach; indeed, the research that does exist indicates that co-response may be just as problematic.⁹⁶ A 2018 systematic review found insufficient evidence to conclude that any positive benefits associated with co-responder models (such as reductions in arrest) could be attributed to the co-response approach, suggesting that shifting public opinion about behavioral crisis response could be the driver of these changes, not police procedure.⁹⁷ The review found evidence that co-responder programs are more successful at providing timely linkage with behavioral health services compared to traditional police response.⁹⁸ At the same time, many studies included in the review found that individuals who received a co-responder intervention reported previous traumatic interactions with law enforcement,⁹⁹ suggesting that co-responder models may retraumatize persons experiencing behavioral health crises, even if their risk of arrest is reduced.

Emerging data from the study of police-led, post-overdose outreach programs reflects similar problems with police involvement. These programs typically involve a co-responder team with at least one law enforcement representative conducting proactive outreach to survivors of overdose within two to three days after the overdose emergency.¹⁰⁰ A 2019 survey of these programs in Massachusetts found that 57% of these programs check for warrants against the overdose survivor before conducting outreach and that 11% arrest the overdose survivor on the authority of that warrant in lieu of offering needed behavioral health supports.¹⁰¹ Qualitative research from this study further suggests that increased law enforcement involvement in post-overdose co-response directly contributes to increased likelihood of arrest and increased likelihood of coercive responses to substance use,¹⁰² and that officer-involved outreach teams are

93. Josh Wood, *The US Police Department that Decided To Hire Social Workers*, GUARDIAN (Sept. 19, 2020, 5:00 AM), <http://www.theguardian.com/us-news/2020/sep/19/alexandria-kentucky-police-social-workers> [<http://perma.cc/7KZ2-236Y>].

94. KRIDER ET AL., *supra* note 54, at 4.

95. Kane et al., *supra* note 64, at 116.

96. Puntis et al., *supra* note 89, at 10.

97. *Id.* at 1.

98. *Id.*

99. *Id.*

100. See Formica et al., *supra* note 50, at 44.

101. Scott W. Formica, Katherine M. Waye, Allyn O. Benintendi, Shapei Yan, Sarah M. Bagley, Leo Beletsky, Jennifer J. Carroll, Ziming Xuan, David Rosenbloom, Robert Apsler, Traci C. Green, Allie Hunter & Alexander Y. Walley, *Characteristics of Post-Overdose Public Health-Public Safety Outreach in Massachusetts*, 219 DRUG & ALCOHOL DEPENDENCE 1, 4 (2021) [hereinafter Formica et al., *Characteristics of Post-Overdose*].

102. Marco Tori, Emily Cummins, Leo Beletsky, Samantha F. Schoenberger, Audrey M. Lambert, Shapei Yan, Jennifer Carroll, Scott W. Formica, Traci C. Green, Robert Apsler, Ziming Xuan & Alexander Y.

often supportive of involuntary civil commitment for substance use disorder¹⁰³ (a potentially harmful response to substance use that is contradicted by current scientific evidence¹⁰⁴).

Policing experts have voiced similar skepticism about the appropriateness of law enforcement involvement through co-responder models. When asked about the Lexington model (described above), Jerry Ratcliffe, who teaches criminal justice studies at Temple University, emphasized the lack of evidence for this police-led co-response approach.¹⁰⁵ Alex Vitale, a sociologist at Brooklyn College, has further warned against “turn[ing] police departments into hubs for social work” by noting that police-led co-response could be detrimental to undocumented persons and persons on probation or parole who may have a valid reason to distrust social workers hired by police departments.¹⁰⁶ In sum, despite the wide implementation of the co-responder model and the even wider implementation of the CIT model, systematic research has failed to produce evidence that these approaches can successfully mitigate the risks of arrest, abuse, or other trauma at the hands of police. Research has also failed to produce evidence that these law-enforcement-led strategies improve outcomes compared to traditional police response or that they are remarkably more effective at meeting community needs without excessive violence compared to nonpolice alternatives.

B. *Law Enforcement Is the Wrong Tool for This Job*

If specialized training for law enforcement and law-enforcement-led co-response teams have not been effective at improving the outcomes of behavioral-health-related calls for service, why are these collaborations still presented as “invaluable” tools?¹⁰⁷ One answer is that state and local governments have consistently prioritized the financial support of law enforcement over other budgetary initiatives that could mitigate some of the very problems to which CIT programs are ostensibly designed to respond.¹⁰⁸ Put another way, shunting more and more resources into police department budgets is a politically safe move for state and local leadership that buttresses the ideological inertia that law enforcement agencies are the dominant form of first response that communities want or need.¹⁰⁹

Walley, *Warrant Checking Practices by Post-Overdose Outreach Programs in Massachusetts: A Mixed-Methods Study*, 100 INT’L J. DRUG POL’Y (forthcoming 2022).

103. See Formica et al., *Characteristics of Post-Overdose*, *supra* note 101, at 6.

104. D. Werb, A. Kamarulzaman, M.C. Meacham, C. Rafful, B. Fisher, S.A. Strathdee & E. Wood, *The Effectiveness of Compulsory Drug Treatment: A Systematic Review*, 28 INT’L J. DRUG POL’Y 1, 7 (2016), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4752879/pdf/nihms751135.pdf> [<http://perma.cc/6TKV-CFJU>].

105. Wood, *supra* note 93.

106. *Id.*

107. See *Crisis Intervention Teams (CIT): An Invaluable Community Resource*, NAMI SW. WASH., <http://namiswwa.org/crisis-intervention-teams-cit-an-invaluable-community-resource/> [<http://perma.cc/7G3C-827Z>] (last visited Nov. 1, 2021).

108. See Rogers et al., *supra* note 56, at 417.

109. See Noah Smith, *Spending So Much on Police Has Real Downsides*, BLOOMBERG OP. (June 4, 2020, 8:00 AM), <http://www.bloomberg.com/opinion/articles/2020-06-04/police-budgets-reflect-political-power-not-need-to-control-crime> [<http://perma.cc/P2M3-AS9G>].

Another explanation is that policymakers in state and local government have historically failed at the necessary task of imagining a different (i.e., nonpolice) kind of first response in their communities. Illustrative of this rationale are the numerous historical attempts to reform, adapt, or repurpose law enforcement agencies towards community-oriented response efforts, and how those attempts have subsequently failed throughout the last century. The Police/Community Relations movement in the 1950s and team policing in the 1970s were both meant to improve alignment between law enforcement activity and community values. Yet each effort failed to generate meaningful impact and ultimately petered out due in large part to a widespread perception among law enforcement professionals that the missions of these auxiliary programs deviated from the goals of “real policing.”¹¹⁰ This ability of law enforcement logics to overpower community-oriented training and protocols is even visible in the ongoing opioid overdose epidemic. Today, police officers who work in urban areas most affected by the overdose epidemic consistently associate mental health crises with substance use and substance use with criminal behavior. As a consequence, the dominant ideological frame that these officers impose upon behavioral-health-related calls for service is one of surveillance and control, not de-escalation, assistance, and referral.¹¹¹

The biggest problem with CIT programs and similar law-enforcement-led behavioral health response initiatives is not the failure of those programs to produce meaningful outcomes (which, in fact, they do fail to produce). Rather, the biggest problem is the way these programs forestall the development and consideration of fundamentally new approaches to providing first response to calls for service from the community. In other words, advocates for law-enforcement-led programs and partnerships take for granted the presumption that law enforcement officers *should* be involved in first response for behavioral health crises at all.¹¹² Yet, as discussed in this Article, the overwhelming evidence indicates that this is not the case.

Law enforcement officers should not be included in first response to emergent behavioral health emergencies for a number of reasons. In addition to the abovementioned data, six additional arguments for excluding law enforcement personnel from first response for behavioral-health-related calls for service are outlined below.

First, per the 2008 census of state and local law enforcement agencies (which, at the time of writing, is the most recent data available), nearly half of the 18,000 state and local law enforcement agencies in the United States employ fewer than ten sworn officers; another quarter of those agencies employ between ten and twenty-five.¹¹³ The human resources available to these agencies are not sufficient to justify some or all of those sworn officers pursuing unique and specialized skills that are already possessed by other local health and human services professionals.

Second, the response to calls for service related to behavioral health crises consumes an extraordinary amount of law enforcement resources—as much as 87% more

110. Watson et al., *Improving Police Response*, *supra* note 60, at 361.

111. See Jade Boyd, Susan Boyd & Thomas Kerr, *Visual and Narrative Representations of Mental Health and Addiction by Law Enforcement*, 26 INT’L J. DRUG POL’Y 636, 642–43 (2015).

112. Cf. NAMI, *supra* note 29.

113. BRIAN A. REAVES, DEP’T OF JUST., CENSUS OF STATE AND LOCAL LAW ENFORCEMENT AGENCIES, 2008, at 1–2 (2011), <http://www.bjs.gov/content/pub/pdf/cslllea08.pdf> [<http://perma.cc/LY6C-GSPG>].

resources than most other kinds of calls.¹¹⁴ This disparity indicates an extreme mismatch between the services that law enforcement officers are equipped to provide and the services that are needed to respond to these incidents of community need.

Third, law enforcement agencies that attempt to implement community partnerships are met with consistent and intractable challenges in those efforts, which reduce the return to the community on these law-enforcement-centered investments. Programs like CIT, for example, can be challenging to adopt with fidelity because “they involve making large scale changes to almost every facet of police operations—from training and scheduling to dispatch and patrol as well as forging partnerships with the mental health community.”¹¹⁵ The investments required from both law enforcement and health systems to implement such a change can be expensive,¹¹⁶ and the benefits, as discussed above, are at best extremely modest.

Fourth, the lack of diversity in law enforcement is, itself, a reason why law enforcement officers are ill-equipped to respond to emergent behavioral health crises. In San Francisco, California, where women represent only 15% of all sworn officers,¹¹⁷ a department policy that officers could only search same-sex suspects resulted in many more male suspects being searched than female suspects.¹¹⁸ Thus, public impressions—and subsequently public complaints—alleged that officers unfairly targeted (mostly male) gang members in their patrol activities.¹¹⁹ If lack of diversity inhibits equitable policing, it must also inhibit equitable responses to behavioral health emergencies.

Fifth, law enforcement involvement is a well-known exacerbator of behavioral health concerns. Among individuals with a history of substance use, for example, law enforcement interaction is known to be positively associated with the initiation of substance injection.¹²⁰ Incarceration is known to be positively associated with both fatal and nonfatal overdose, and the growing evidence base is congruent with the hypothesis that this relationship is causal (meaning that incarceration most likely causes new overdose events directly, not simply that people more likely to overdose are also more

114. Yanick Charette, Anne G. Crocker & Isabelle Billette, *Police Encounters Involving Citizens with Mental Illness: Use of Resources and Outcomes*, 65 PSYCHIATRIC SERVS. 511, 511–12 (2014).

115. Watson et al., *Improving Police Response*, *supra* note 60, at 361.

116. DAVE MCCLURE, ELLEN PADDOCK, RAYANNE HAWKINS & MAYOOKHA MITRA-MAJUMDAR, PAY FOR SUCCESS AND THE CRISIS INTERVENTION TEAM MODEL 1 (2017), http://www.urban.org/sites/default/files/publication/94741/pay-for-success-and-the-crisis-intervention-team-model_1.pdf [<http://perma.cc/MUM5-VVWK>].

117. S.F. DEP'T ON THE STATUS OF WOMEN, PATHWAYS TO PROMOTION: A GENDER ANALYSIS OF THE SAN FRANCISCO POLICE DEPARTMENT 1 (2019), http://sfgov.org/dosw/sites/default/files/Gender%20Analysis%20SFPD%20REPORT%20Final_122019.pdf [<http://perma.cc/4LWT-GGZG>].

118. See Madeleine Novich, Anne Li Kringen & Geoffrey Hunt, “They Can’t Search Her”: How Gender Imbalances in the Police Force Contribute to Perceptions of Procedural Unfairness, 13 FEMINIST CRIMINOLOGY 260, 261 (2018).

119. *Id.* at 278.

120. J. S. Melo, R.S. Garfein, K. Hayashi, M.J. Milloy, K. DeBeck, S. Sun, S. Jain, S.A. Strathdee & D. Werb, *Do Law Enforcement Interactions Reduce the Initiation of Injection Drug Use? An Investigation in Three North American Settings*, 182 DRUG & ALCOHOL DEPENDENCE 67, 68 (2018).

likely to become incarcerated at some point).¹²¹ Moreover, officers who are concerned about appearing racist—individuals who might otherwise be identified as most qualified to participate in a novel community partnership for their interest in the subject—are significantly more likely to voice increased support for unreasonable use of force and disapproval of restrictions on use of force tactics.¹²² On a broader level, a recent study involving a sample of nearly 40,000 Black respondents in the United States found that every police killing of an unarmed Black person that respondents were exposed to in the past three months significantly predicted an average increase of 0.14 additional poor mental health days per individual.¹²³ Excessive police use of force against a Black individual injures every Black person in that community.

Sixth, and most importantly, research has repeatedly shown that individuals experiencing noncriminal, behavioral health crises *do not want a police response*. A qualitative study exploring mental health consumers' perceptions of formal crisis services found that these individuals overwhelmingly preferred that a clinician be the one to intervene; some participants voiced their acceptance of collaborative interventions, but no one wanted a police response.¹²⁴ Similarly, a survey of more than 200 homeless individuals—nearly 80% of whom reported living with a mental illness—found that nearly half of respondents had interacted with police in the past month.¹²⁵ Many of these individuals were handcuffed by police but experienced no other law enforcement use of force; yet the physical restraint of cuffs alone was enough to leave participants feeling disrespected and led to a deep erosion in their trust in law enforcement—an effect that was still measurable years after the handcuffing incident occurred.¹²⁶

For all these reasons, sworn officers employed by state and local law enforcement agencies constitute an extremely poor choice when selecting first responders for emergent behavioral health crises. They lack the training, the institutional support, the infrastructure, the culture, the freedom, and the public image to respond to such calls for service effectively. Though community partnerships with law enforcement may have flourished in a political environment that favored allocating public funds into police coffers, it is clear that providing a meaningful, safe, and effective response to behavioral crises via law enforcement response requires law enforcement to be something that they are not. Therefore, first responders to behavioral-health-related calls for service should

121. Sasha Mital, Jessica Wolff & Jennifer Carroll, *The Relationship Between Incarceration History and Overdose in North America: A Scoping Review of the Evidence*, 213 *DRUG & ALCOHOL DEPENDENCE* 1, 9 (2020).

122. See Rick Trinkner, Erin Kerrison & Phillip Atiba Goff, *The Force of Fear: Police Stereotype Threat, Self-Legitimacy, and Support for Excessive Force*, 43 *L. & HUM. BEHAV.* 421, 423 (2019).

123. Jacob Bor, Atheendar S. Venkataramani, David R. Williams & Alexander C. Tsai, *Police Killings and Their Spillover Effects on the Mental Health of Black Americans: A Population-Based, Quasi-Experimental Study*, 392 *LANCET* 302, 306 (2018).

124. Kara Boscarato, Stuart Lee, Jon Kroschel, Yitzchak Hollander, Alice Brennan & Narelle Warren, *Consumer Experience of Formal Crisis-Response Services and Preferred Methods of Crisis Intervention*, 23 *INT'L J. MENTAL HEALTH NURSING* 287, 294 (2014).

125. Yasmeen I. Krameddine & Peter H. Silverstone, *Police Use of Handcuffs in the Homeless Population Leads to Long-Term Negative Attitudes Within this Group*, 44 *INT'L J. L. & PSYCHIATRY* 81, 81 (2016).

126. See *id.* at 85–86.

not be law enforcement. First responders should consist of a different set of service professionals entirely.

C. *The CAHOOTS Model*

A behavioral health response program operated out of Eugene, Oregon, offers a viable model for a nonpolice first response service for emergent behavioral health crises—one that was used to inform the model legislation included in this Article and that other community advocates could emulate in their own communities. Since 1989, emergency dispatchers in Eugene have had the option of diverting calls for service stemming from an emergent behavioral health or chronic housing crisis away from police and towards a program called the Crisis Assistance Helping Out On The Streets, or CAHOOTS.¹²⁷ CAHOOTS is not a law enforcement agency; it is a third-party, nonprofit organization contracted by local law enforcement to respond to calls involving nonviolent crises in lieu of a law enforcement response.¹²⁸ CAHOOTS team members do not carry weapons.¹²⁹ Instead, they are armed with trauma-informed, de-escalation, and harm-reduction strategies that allow them to address the emergent needs of civilians in crisis while maximizing the safety of everyone involved.¹³⁰ While CAHOOTS staff may be called to assist law enforcement already on scene, CAHOOTS is most often dispatched by 911 operators without law enforcement assistance.¹³¹ According to CAHOOTS, police presence was required during only 250 calls out of the approximately 24,000 calls responded to in 2019—about 1% of the calls.¹³²

CAHOOTS responds to a variety of calls in which an armed law enforcement response is neither necessary nor desired, including welfare checks (indicated in 32.5% of diverted calls), transportation to social or medical services (indicated in 34.8% of diverted calls), and public assistance (indicated in 66.3% of diverted calls).¹³³ CAHOOTS assists persons in need of nonemergency medical care and behavioral health services (including services to assist with mental health and substance use issues, episodes of psychosis, suicide threats, acute intoxication, and overdose).¹³⁴ CAHOOTS provides transportation to social services, substance use treatment facilities, and healthcare providers.¹³⁵ Over 60% of the persons CAHOOTS has served are homeless, and 30% are persons living with severe and persistent mental illness.¹³⁶

127. See WHITE BIRD CLINIC, CRISIS ASSISTANCE HELPING OUT ON THE STREETS (CAHOOTS) MEDIA GUIDE 1–2 (2020) [hereinafter WHITE BIRD CLINIC, CAHOOTS MEDIA GUIDE], <http://whitebirdclinic.org/wp-content/uploads/2020/06/CAHOOTS-Media-Guide-20200624.pdf> [<http://perma.cc/YMA2-F3DX>]. CAHOOTS also assists the police department in Springfield, Oregon. *Id.*

128. *See id.*

129. *Id.* at 1.

130. *Id.*

131. *See id.* at 2.

132. *Id.*

133. *Id.* at 4. For reference, calls were categorized into more than one category, if appropriate. *Id.* In other words, these were not exclusive categories—a call could, for example, be both a welfare check and involve transportation for medical services. *See id.*

134. *See id.* at 1, 3.

135. *Id.* at 3.

136. *Id.*

A CAHOOTS mobile team, which is dispatched to these calls for service, is comprised of two persons: a medic (such as a nurse, paramedic, EMT-Intermediate, or EMT-Basic) and a crisis worker who has training and experience in behavioral health services (including substance use).¹³⁷ When the mobile crisis team responds to a call, it provides immediate stabilization by addressing any emergent medical or psychological concerns.¹³⁸ The team then identifies how the person in need may be assisted through the provision of information, referral to services, advocacy to resolve a particular issue, or, if the situation warrants, transportation to a facility that can provide a higher level of care.¹³⁹

The CAHOOTS model was years in the making—a luxury that many community advocates responding to police violence today do not have.¹⁴⁰ Public support for the program grew organically thanks to the positive reputation of the nonprofit White Bird Clinic, where the CAHOOTS program is housed.¹⁴¹ The White Bird Clinic is a long-standing community institution in Eugene, operating since 1969¹⁴² as a 24-7 socio-medical station supporting individuals presenting with adverse drug experiences in a “safe and supportive way.”¹⁴³ As the White Bird Clinic tells it, “[w]ord quickly spread that this was a place with caring and helpful people who didn’t ask for money and who didn’t judge or lecture.”¹⁴⁴

Though the unique history of CAHOOTS cannot be easily reproduced elsewhere, community advocates can inform their current efforts by applying two major lessons learned through the implementation of the CAHOOTS program. First, over its fifty years in the greater Eugene community, the White Bird Clinic has worked hard to earn the trust of the community it serves.¹⁴⁵ Therefore, community advocates seeking to build non-law enforcement institutions to respond to behavioral-health-related calls for service may want to seek community partners who are already building positive relationships with the community—especially those members of the community who are experiencing behavioral health or housing needs. This could include the staff of existing

137. *Id.* at 1. Crisis workers also receive over five hundred hours in training from CAHOOTS. *Id.* at 2.

138. *Id.* at 1.

139. *Id.*

140. See Hicham Raache, *Norman Police Officials Plan To Make Crisis Intervention Team Training Mandatory for All Officers*, KFOR (Dec. 18, 2020, 11:18 PM), <http://kfor.com/news/local/norman-police-officials-plan-to-make-crisis-intervention-team-training-mandatory-for-all-officers/> [<http://perma.cc/9ZV6-JQPL>]; Ted Roelofs, *Detroit Police Working To De-Escalate Confrontations with the Mentally Ill*, BRIDGE MICH. (Dec. 14, 2020), <http://www.bridgemi.com/talent-education/detroit-police-working-de-escalate-confrontations-mentally-ill> [<http://perma.cc/7SZ5-PNXH>] (describing incidents in which CIT programs were implemented rapidly following the death of a loyal civilian at the hands of police, possibly forestalling any opportunity to discuss and weigh the benefits of alternative proposals).

141. See Rob Waters, *Enlisting Mental Health Workers, Not Cops, in Mobile Crisis Response*, 40 HEALTH AFFS. 864, 865–66 (2021), <http://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2021.00678> [<http://perma.cc/4C5G-LMPW>].

142. WHITE BIRD CLINIC, CAHOOTS MEDIA GUIDE, *supra* note 127, at 7.

143. *About Us*, WHITE BIRD CLINIC, <http://whitebirdclinic.org/about/> [<http://perma.cc/Q6UG-454Z>] (last visited Nov. 1, 2021) (outlining the history of the White Bird Clinic).

144. *Id.*

145. WHITE BIRD CLINIC, CAHOOTS MEDIA GUIDE, *supra* note 127, at 6.

day or drop-in centers, harm reduction agencies, peer support specialists, recovery groups, mutual support groups for behavioral health concerns, or drug user unions.¹⁴⁶

Second, the trust that the CAHOOTS first-response program developed ensured the program's success only after that program was coupled with an existing human services network serving the wider community (i.e., beyond the White Bird Clinic as a single point of service).¹⁴⁷ Indeed, if local mental, social, and healthcare service offerings are limited or operating with insufficient capacity to meet local needs, non-law enforcement response efforts will have little to offer residents who require ongoing assistance once emergent concerns are resolved. If a robust network of social services providers is not established locally, programs modeled after CAHOOTS may decrease the harms associated with unnecessary law enforcement interaction, but they will not have the lasting impact CAHOOTS has had in Eugene. Insufficient healthcare and social services capacity are not problems that first responders of any kind can resolve.

In addition to their success in providing appropriate and effective services to local residents in crisis, CAHOOTS further estimates that their program has saved taxpayers of Lane County, Oregon (where Eugene is located), an average of \$8.5 million per year in public safety costs alone.¹⁴⁸ This is due in part to CAHOOTS' responding to and ultimately resolving 17% of the Eugene Police Department's overall call volume.¹⁴⁹ Because CAHOOTS also responds to nonemergency medical issues, the program saves taxpayers an additional \$14 million in ambulance transport fees and emergency department treatment costs annually.¹⁵⁰

It is relevant to community advocates working to establish similar programs that CAHOOTS provides consulting and strategic guidance to communities seeking to implement a model like CAHOOTS.¹⁵¹ CAHOOTS staff will even assist advocates in writing grant proposals to cover the costs of their initial planning and implementation fees.¹⁵² As consultants, CAHOOTS representatives have made themselves available to assist in training mental health crisis counselors by traveling to interested communities and conducting field training, providing training manuals, guiding best practices development, and helping in the interviewing and hiring processes.¹⁵³ As of the writing of this Article, CAHOOTS has been assisting the cities of Olympia, Washington, and Denver, Colorado, in implementing their own mobile crisis response programs.¹⁵⁴

146. Drug user unions are peer-led organizations that fight for the health and rights of people who use drugs. See Livia Gershon, *Drug Users Are Forming Unions To Protect Their Rights and Safety*, HUFFINGTON POST (Dec. 19, 2017, 5:46 AM), http://www.huffpost.com/entry/drug-user-unions_n_5a257c26e4b03350e0b86c00 [<http://perma.cc/N7JE-AUC7>]; *Other Orgs.*, INPUD, <http://www.inpud.net/en/links> [<http://perma.cc/Z7QY-BKL9>] (last visited Nov. 1, 2021) (listing regional drug user unions).

147. See WHITE BIRD CLINIC, CAHOOTS MEDIA GUIDE, *supra* note 127, at 6.

148. *Id.* at 1.

149. *Id.*

150. *Id.* at 5.

151. *Id.* at 6.

152. *See id.*

153. *See id.*

154. *Id.*

III. THE POLICY STORY BEHIND THE MODEL BHRT ACT

A. *The Tragic Death of Marcus Deon Smith*

As laid out in Section II, the untimely and unnecessary death of Marcus Deon Smith at the hands of law enforcement as he was experiencing an emergent behavioral health crisis served as the focusing event of local efforts to defund the police in Greensboro, North Carolina. Recall that, on September 8, 2018, the Greensboro Police Department encountered a thirty-eight-year-old Black man, later identified as Mr. Smith, running in and out of traffic in downtown Greensboro, North Carolina, after his mother called 911 to report his crisis.¹⁵⁵ Police officers were the first public servants to appear at the scene.¹⁵⁶

Mr. Smith was approached by officers and subsequently asked for their help.¹⁵⁷ “Please sir, please help me, sir,” Mr. Smith begged the officers.¹⁵⁸ “They’re gonna kill me. . . . I want to go to the hospital.”¹⁵⁹

“Boss man,” an officer responded, “you need to chill out.”¹⁶⁰

The officers put Mr. Smith into the back of a squad car.¹⁶¹ This confinement further agitated Mr. Smith, who began banging on the squad car’s window.¹⁶²

“He’s just buggin’ out on somethin’,” an officer said.¹⁶³

The officers then decided¹⁶⁴ that they should hog-tie, or “RIPP Hobble,”¹⁶⁵ Mr. Smith, using a restraint that the Department of Justice has identified as capable of

155. See Complaint at 5, *Smith v. City of Greensboro*, 2020 WL 1452114 (M.D.N.C. Apr. 10, 2019) (No. 1:19-cv-386).

156. See *Man Who Collapsed in Police Custody Dies*, GREENSBORO 101 (Sept. 8, 2018, 5:31 AM), <http://greensboro101.com/press-release-subject-collapses-in-police-custody/> [<http://perma.cc/MGN8-8ZJD>] (detailing the circumstances surrounding Mr. Smith’s death).

157. See William C. Anderson, ‘*Please Help Me, Sir*’, APPEAL (Apr. 9, 2019), <http://theappeal.org/please-help-me-sir/> [<http://perma.cc/DK27-5A9Q>] (transcribing the audio from the body camera footage taken from officers at the scene of Mr. Smith’s death).

158. *Id.*

159. *Id.*

160. *Id.*

161. *See id.*

162. *Id.*

163. *Id.*

164. Ian McDowell, *Hogtying, Homicide and Humanity: DOJ Document Warns About Restraint that Killed Marcus Deon Smith*, YES! WEEKLY (Dec. 11, 2018) [hereinafter McDowell, *Hogtying, Homicide and Humanity*],

http://www.yesweekly.com/news/hogtying-homicide-and-humanity-doj-document-warns-about-restraint-that-killed-marcus-deon-smith/article_68589c92-6a97-5ce5-b562-c25f9e6a1abd.html

[<http://perma.cc/Q7TM-FMA6>] (reporting on Department of Justice warnings against the use of “hogtying” by police officers). The paramedic that had arrived at the scene approximately five minutes later did also state that Mr. Smith would have to be restrained before transport; however, the paramedic did not specify the method of restraint that should be used. *See id.*

165. RIPP is the name of the manufacturer that makes the hobble device that is commonly used by officers to restrain individuals. Joelle R. DeVane & Bill DeVane, *About RIPP™ Restraints*, RIPP™ RESTRAINTS INT’L INC., <http://www.rippinternational.com/about-ripp-restraints.html> [<http://perma.cc/X6W5-UH44>] (last visited Nov. 1, 2021) (providing manufacturer information on RIPP restraints); *see also* Ian McDowell, ‘*NEVER Hog-Tie a Prisoner: Instructions on Device Warn Against Fatal Restraint*’, YES! WEEKLY (Feb. 18, 2019)

interfering with an individual's ability to breathe.¹⁶⁶ Even the manufacturers of the device used to hog-tie¹⁶⁷ Mr. Smith clearly state that it should never be used to hog-tie a prisoner.¹⁶⁸

Nevertheless, police officers pulled (or pushed) Mr. Smith out of the car.¹⁶⁹

"I ain't resisting," Mr. Smith pled.¹⁷⁰

Officers hog-tied him anyway.¹⁷¹

After the restraint was in place, the officers realized that Mr. Smith was no longer breathing.¹⁷² Mr. Smith died after being transported to the hospital by Emergency Medical Services (EMS).¹⁷³

Mr. Smith's official cause of death was cardiopulmonary arrest caused primarily by positional asphyxia, a known consequence of hog-tying.¹⁷⁴ The City of Greensboro took the official position that the officers involved followed all police procedures and did not

[hereinafter McDowell, *Never Hog-Tie a Prisoner*], http://www.yesweekly.com/news/never-hog-tie-a-prisoner-instructions-on-device-warn-against-fatal-restraint/article_62feb4f9-77c2-574f-b56e-cc5b002ee414.html [<http://perma.cc/HKC4-BL7N>] (presenting a warranty manual for RIPP restraints, which warns against the use of RIPP restraints to hogtie prisoners).

166. See NAT'L INST. OF JUST., U.S. DEP'T OF JUST., NATIONAL LAW ENFORCEMENT TECHNOLOGY CENTER BULLETIN: POSITIONAL ASPHYXIA—SUDDEN DEATH 1–2 (1995), <http://www.ncjrs.gov/pdffiles/posasph.pdf> [<http://perma.cc/XL5S-XQY9>] ("When occurring while confined by restraints, cocaine-induced excited delirium (an acute mental disorder characterized by impaired thinking, disorientation, visual hallucinations, and illusions) may increase a subject's susceptibility to sudden death by effecting an increase of the heart rate to a critical level.").

167. Hog-tying refers to placing a person on their stomach, handcuffing them, restraining their legs, and then connecting the restraints of the legs and the arms together, resulting in their elevation. See *Gutierrez v. City of San Antonio*, 139 F.3d 441, 444 (5th Cir. 1998); *Vizbaras v. Prieber*, 761 F.2d 1013, 1015 (4th Cir. 1985). This technique is often referred to by law enforcement as a "hobble," in part, because of the negative connotation associated with the phrase "hog-tying." AELE L. Enf't Legal Ctr., *Restraint and Asphyxia Part One – Restraint Ties*, AELE MONTHLY L.J. 101, 103 (2008), <http://www.aele.org/law/2008ALL12/2008-12MLJ101.pdf> [<http://perma.cc/8PSX-9FJE>].

168. McDowell, *Never Hog-Tie a Prisoner*, *supra* note 165.

169. See McDowell, *Hogtying, Homicide and Humanity*, *supra* note 164.

170. *Id.*

171. *Id.*

172. *Id.*

173. Richard Barron, *Greensboro Releases Video in Police Custody Death*, NEWS & REC. (Dec. 1, 2018), http://greensboro.com/news/crime/greensboro-releases-video-in-police-custody-death/article_aba680b1-430b-5d26-84bc-0ba235aef016.html [<http://perma.cc/4B5B-DTHJ>] (reviewing findings from police body camera footage).

174. NAT'L INST. OF JUST., U.S. DEP'T OF JUST., *supra* note 166, at 2; see also S.N. Kunz, S. Þórðardóttir & R. Rúnarsdóttir, *Restraint-Related Asphyxia on the Basis of a Drug-Induced Excited Delirium*, 288 FORENSIC SCI. INT'L e5, e5, e8 (2018) ("Cases of intoxication in combination with extreme agitation, physical exertion and restraint are mainly associated with restraint-related deaths (RRD) in the context of police use of force."). The official cause of death was cardiopulmonary arrest brought on by the prone restraint, the presence of drugs in his system and his preexisting cardiovascular disease. Jordan Green, *Medical Examiner's Investigation into the Death of Marcus Deon Smith*, SCRIBD, <http://www.scribd.com/document/394567666/Medical-examiner-s-investigation-into-the-death-of-Marcus-Deon-Smith> [<http://perma.cc/S23C-A3GB>] (last visited Nov. 1, 2021) (presenting a copy of the medical examiner's report on the death of Marcus Deon Smith).

violate any policies in their treatment of Mr. Smith.¹⁷⁵ The district attorney determined that the police officers did not commit criminal negligence.¹⁷⁶ In sum, public officials condoned the actions of the police officers, indicating that they had behaved as they were trained and expected to act. The medical examiner ruled Mr. Smith's death a homicide.¹⁷⁷

Notably, this was not Mr. Smith's first encounter with the police or EMS.¹⁷⁸ Mr. Smith was known to have been living with comorbid behavioral health issues and a preexisting heart condition.¹⁷⁹ Though acting erratically in his encounter with police officers, Mr. Smith did not constitute a danger to the public.¹⁸⁰ He did not need armed police officers to respond to his cries for help—police officers who felt empowered to use dangerous methods of restraint¹⁸¹ that injured, dehumanized, and ultimately killed

175. *News Release: City's Response to Press Conference Regarding Marcus Smith*, GREENSBORO 101 (Nov. 14, 2018, 5:11 PM), <http://web.archive.org/web/20200211185930/https://greensboro101.com/news-release-citys-response-to-press-conference-regarding-marcus-smith/> [<http://perma.cc/2QGK-WPFD>] (re-printing Greensboro city government's press conference condoning the actions of the police officers involved in Marcus Deon Smith's death). The City made this statement despite the Greensboro Police Department Directives Manual chapter 11.1.4, stating that a hobble restraint should only be used if the subject can be restrained sitting up or laying on their side. GREENSBORO POLICE DEP'T, GREENSBORO POLICE DEPARTMENTAL DIRECTIVES ch. 11.1.4 (2008), <http://www.greensboro-nc.gov/Home/ShowDocument?id=25639> [<http://perma.cc/5X3R-XTWY>]. The police department chief's response to this point when questioned was that Mr. Smith was not actively being transported. See McDowell, *Never Hog-Tie a Prisoner*, *supra* note 165.

176. Jordan Green, *Doug Henderson Letter re Marcus Smith*, SCRIBD (Jan. 4, 2019), <http://www.scribd.com/document/396822043/Doug-Henderson-Letter-Re-Marcus-Smith> [<http://perma.cc/G38C-66ZA>] (presenting a copy of the Greensboro city attorney's official comment on the culpability of law enforcement in Marcus Deon Smith's death).

177. *Id.*

178. Telephone Interview with Marcus Hyde, Former Organizer, Homeless Union of Greensboro (Aug. 6, 2020). During a previous incident that started much the same earlier in 2018, EMS and police arrived to help Marcus Smith during a momentary mental health crisis, and transported him to the hospital, where he was cared for and released back to the street. *Id.* While this did not address all of the underlying reasons why he was having a mental health crisis while experiencing homelessness, it shows that there is a continuum of ways that public health and safety systems can be designed to respond to public health issues. *Id.*

179. *Id.*

180. See #JusticeforMarcusSmith, HOMELESS UNION: #JUSTICEFORMARCUSMITH, <http://www.homelessunion.org/justiceformarcussmith> [<http://perma.cc/JJZ8-3UCZ>] (last visited Nov. 1, 2021).

181. While this Article focuses on proposing policies to decrease police encounters resulting in the use of these potentially deadly restraints during initial encounters or pre-arrests, it is important to note that persons that are incarcerated are also at risk of dying at the hands of officers seeking to restrain them. See, e.g., Jordan Green, *Placed in Prone Restraint by His Jailers, He Said, 'I Can't Breathe.' The Cause of Death Was Asphyxia.*, TRIAD CITY BEAT (July 9, 2020), <http://triad-city-beat.com/prone-restraint-i-cant-breathe-asphyxia/> [<http://perma.cc/HV88-6UVE>] (detailing the death of John Neville, who died from the use of a prone restraint while incarcerated); see also Eric Mark, *Corrections Officers Left LCCF Just Before Mackey Suit Settlement*, CITIZEN'S VOICE (Aug. 5, 2020), http://www.citizensvoice.com/news/crime-emergencies/corrections-officers-left-lccf-just-before-mackey-suit-settlement/article_8a9ccb78-65aa-5092-a084-cdfa35519024.html [<http://perma.cc/3R3E-FLE4>] (highlighting the death of Shaheen McKay, who also died from restraints while incarcerated). The *New York Times* has identified at least seventy additional cases where individuals have died from an inability to breathe due to police restraint. See Mike Baker, Jennifer Valentino-DeVries, Manny Fernandez & Michael LaForgia, *Three Words. 70 Cases. The Tragic History of 'I Can't Breathe.'*, N.Y. TIMES (June 29, 2020), <http://www.nytimes.com/interactive/2020/06/28/us/i-cant-breathe-police-arrest.html> [<http://perma.cc/5JKE-KLYG>].

Mr. Smith. He needed help from someone who understood his lived experience and who could de-escalate his behavioral health crisis humanely. He needed a person-centered behavioral health crisis response team.

In response to the death of Mr. Smith, community organizers in Greensboro, North Carolina, began pressuring members of Greensboro City Council to establish a non-law enforcement service capable of responding to the scene of behavioral health emergencies in lieu of the police.¹⁸² With no model statute in hand to provide a concrete policy proposal for implementing such a request, advocates found themselves not in a legal battle but a narrative battle. The struggle focused on whether local police were the problem behind deaths, like those of Mr. Smith, or whether police constituted a central component of the solution—albeit one they argued was underfunded and underequipped.¹⁸³ In the end, community advocates were unsuccessful in controlling the policy narrative. Greensboro City Council rejected proposals that would have excluded law enforcement from behavioral-health-related calls for service,¹⁸⁴ instead choosing a strategy that consists of “dually dispatch[ing]” both police and mental health workers to a scene when a 911 operator “identif[ied] a call where they [we]re needed.”¹⁸⁵

Persons who were party to the policy discussions noted that the prevailing narratives leveraged to oppose advocates’ proposal to implement the CAHOOTS model were based upon several key suppositions: (1) the idea that law enforcement officers are *needed* to protect the safety of other health and human service professionals on the scene (a belief widely held among law enforcement officers across the United States),¹⁸⁶ and (2) the belief that co-responders, which included police officers, would be sufficiently effective at fostering desired outcomes. Section II of this Article provides ample evidence to refute both of these claims.

Despite the lack of evidence justifying law enforcement involvement in or co-response to behavioral health calls (as described in Section II), the Greensboro City Council chose to pursue a policy that allowed law enforcement agencies to maintain their authority over behavioral health response, their legitimacy as a universal responder to all calls for service, and all of their funding dollars associated with responding to those calls. Importantly, the program chosen for implementation by the City of Greensboro included

182. *Hyde Interview*, *supra* note 178.

183. See Richard Barron, *Marcus Smith Supporters Mark the Anniversary of His Death with Vigil; Family ‘Still Lost, Still Confused with Unanswered Questions’*, NEWS & REC. (Sept. 8, 2019), http://greensboro.com/news/local_news/marcus-smith-supporters-mark-the-anniversary-of-his-death-with-vigil-family-still-lost-still/article_30f91206-73a1-5ced-8b27-e9b89ea5cdd2.html [<http://perma.cc/5JZK-ELUV>].

184. See Richard Barron, *Other Cities Have Mental-Health Response Teams. Now, Greensboro Does, Too.*, NEWS & REC. (Dec. 17, 2019) [hereinafter Barron, *Other Cities*], http://greensboro.com/news/local_news/other-cities-have-mental-health-response-teams-now-greensboro-does-too/article_a7c9753a-9a76-5be4-b42c-4246a33cf974.html [<http://perma.cc/3939-CCXV>] (detailing the CIT program enacted by Greensboro City Council in response to Marcus Deon Smith’s homicide at the hands of police).

185. *Statement from Greensboro Mayor Nancy Vaughan*, GREENSBORO, N.C.: CITY NEWS (June 7, 2020, 9:01 AM), <http://www.greensboro-nc.gov/Home/Components/News/News/14807/36> [<http://perma.cc/E4G7-XYYP>].

186. In a study of more than 2,800 officers working in twenty states, 95% agreed with the statement that it is important for law enforcement to be at the scene of an overdose in order to protect the safety of medical personnel. See Carroll et al., *supra* note 10, at 3.

no mechanism that would have prevented Mr. Smith from being killed by law enforcement officers.¹⁸⁷

The goal of the Model BHRT Act, and the strategies for pursuing this or similar policy adoptions, is to ensure that the historical cycle of law enforcement's interfering with necessary efforts to divert responsibilities and resources away from law enforcement agencies does not continue. This cycle is intractable, but not insurmountable. Community advocacy groups generally do not have extensive lobbying budgets, and if they are organized as public charities, they are prohibited from substantial lobbying.¹⁸⁸ They may, therefore, feel that they are at a great disadvantage in influencing policy outcomes, especially when advocates go up against politically powerful interests, like police unions.¹⁸⁹ Despite the popular belief that money buys votes, the empirical evidence suggests that even grassroots advocacy groups can influence policy outcomes.¹⁹⁰

B. Pressuring Policymakers To Act

Political science research on legislative behavior has shown that advocacy groups can positively influence the policymaking process by providing legislators with assistance or support in the form of a legislative subsidy.¹⁹¹ A legislative subsidy can take many forms; however, they all share the characteristic of saving legislators time and resources by providing subject-matter expertise to which the legislator did not previously have access.¹⁹²

One type of legislative subsidy is model legislation. Model legislation provides an immense time-saving subsidy to legislators and their staffers—busy professionals who no longer have to invest the time and effort to research and draft a policy proposal when

187. See Barron, *Other Cities*, *supra* note 184. Pursuant to the reform initially enacted in Greensboro, North Carolina, trained counselors would respond to “many” calls “in tandem” with specially-trained police officers. Richard Barron, *Because of Smith Tragedy, Greensboro Police Changes How It Handles Mental-Health Calls*, NEWS & REC. (Nov. 17, 2020), http://greensboro.com/because-of-smith-tragedy-greensboro-police-changes-how-it-handles-mental-health-call/s/article_afa32876-2844-11eb-a46d-2394779cc51e.html [<http://perma.cc/PA45-XJ56>]. Mr. Smith was killed during his initial interaction with police, so such a program would not have prevented Mr. Smith's death.

188. Jon S. Vernick, *Lobbying and Advocacy for the Public's Health: What Are the Limits for Nonprofit Organizations?*, 89 AM. J. PUB. HEALTH 1425, 1426 (1999), <http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.89.9.1425> [<http://perma.cc/JD3T-5XNZ>].

189. See generally David Unger, *Which Side Are We on: Can Labor Support #BlackLivesMatter and Police Unions?*, 29 NEW LAB. F. 28 (2020), http://journals.sagepub.com/doi/full/10.1177/1095796020950309?casa_token=h23qVCnTYy0AAAAA:1pQz1F_BFTcRb8oyZADFIPLMFxRXd0BN3E_JjA0WOi3qDJTPnAdZVWMDyIir7eWXFdcnV3_N9b4P [<http://perma.cc/F2KC-VTAR>] (reviewing the power of police unions in lobbying local governments).

190. See generally Taled El-Sabawi, *What Motivates Legislators To Act: Problem Definition & the Opioid Epidemic, a Case Study*, 15 IND. HEALTH L. REV. 189 (2018), <http://journals.iupui.edu/index.php/ihlr/article/view/22880/22242> [<http://perma.cc/QX75-YKZ2>] (reviewing how pressure groups influence legislative behavior).

191. See Richard L. Hall & Alan V. Deardorff, *Lobbying as Legislative Subsidy*, 100 AM. POL. SCI. REV. 69, 69 (2006) (explaining that “legislative subsidy” refers to the specialized information that organized interest groups can provide to legislators, so that legislators do not have to expend costs in acquiring this information themselves).

192. *Id.*

a functional proposal is already in hand.¹⁹³ Additionally, studies have shown that when advocacy groups draft model legislation, the existence of that model legislation increases the likelihood that they will control the narrative and institutionalize that narrative into law.¹⁹⁴ Further, the possibility that a model policy proposal will be adopted increases dramatically if advocacy groups form a coalition in support of the proposal and include high-ranking members of state, county, or local government in that coalition.¹⁹⁵ Once model legislation has been enacted in one jurisdiction, advocacy groups can use the prior enactment to persuade policymakers in other jurisdictions to do the same.

The Model BHRT Act developed, and attached hereto as Appendix A, aligns with best practices in behavioral health crisis management as outlined by the U.S. Substance Abuse and Mental Health Services Administration's (SAMHSA) behavioral health crisis guidelines.¹⁹⁶ The Act proposes new services modeled on the CAHOOTS program but has been adapted to reflect input obtained through interviews with local advocacy groups representing the populations that the BHRT teams would serve in Greensboro, North Carolina. The Model BHRT Act also includes protective mechanisms that help insulate the program from co-option by law enforcement agencies or providers. Section IV, below, reviews the provisions in the Act and explains why the various clauses are included. Section IV also provides additional recommendations on factors advocates must consider in approaching state or local legislators.

IV. THE BHRT ACT AND POLICY RECOMMENDATIONS

The Act, printed in Appendix A, can be referred to as the Model Behavioral Health Response Team Act, the BHRT Act, or the Act. The Act is divided into eleven sections, each discussed in detail below. While model laws are typically drafted for enactment by state legislatures, the BHRT Act has been written to be adopted at the state or local level, with bracketed language included to allow for customization.

193. See Kristin N. Garrett & Joshua M. Jansa, *Interest Group Influence in Policy Diffusion Networks*, 15 STATE POL. & POL'Y Q. 387, 392 (2015) (finding that model legislation can influence the spread, or diffusion, of policy).

194. For example, in a fifty-state comparison of statutory definitions of mental health disorders to be covered under insurance parity laws, researchers found that in states where the National Alliance on Mental Illness (NAMI) assisted legislators in drafting the bills, the laws were much more likely to mandate coverage only for mental health disorders that were defined as biologically based disorders. Marcia C. Peck & Richard M. Scheffler, *An Analysis of the Definitions of Mental Illness Used in State Parity Laws*, 53 PSYCHIATRIC SERVS. 1089, 1091 (2002). This "biologically based" distinction between some disorders versus others was not grounded in the scientific literature. *Id.* at 1090–91. However, its use furthered NAMI's goals of institutionalizing the narrative that mental illness was a biologically-based disorder and should be treated like other brain disorders, like Alzheimer's. *Id.*

195. See generally FRANK R. BAUMGARTNER, JEFFREY M. BERRY, MARIE HOJNACKI, DAVID C. KIMBALL & BETH L. LEECH, *LOBBYING AND POLICY CHANGE: WHO WINS, WHO LOSES, AND WHY* (2009).

196. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISIS CARE: BEST PRACTICE TOOLKIT (2020), <http://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf> [<http://perma.cc/S2VN-VHCH>].

A. BHRT Act Section II: The Purpose

Its purpose, stated in BHRT Act Section II, is to develop and implement non-law enforcement administered crisis call centers (CCCs) and behavioral health crisis response teams (BHRTs). The Act includes the appropriate language in brackets to aid groups in their customization efforts.

B. BHRT Act Section III: Definitions

Section III of the Act defines phrases commonly used throughout the model legislation. While most of the definitions used are straightforward, there are a few that warrant further discussion. First, the term behavioral health consumer means anyone who has received mental health or substance use treatment services in the past, has a mental health or substance use disorder diagnosis, or has experienced a mental health or substance use disorder. Second, peer specialist is defined as “any individual certified or qualified as a peer specialist or as a recovery specialist by the appropriate agency or organization.”¹⁹⁷ A behavioral health consumer should not be a peer specialist, as defined in this Act.¹⁹⁸

The behavioral health consumer is meant to provide the viewpoint of a person who is not a professional—someone who is not credentialed or trained—but rather has lived experience and can bring that experience to bear in emergent crises. For years, the dominant approach in training recovery or peer counselors who would assist in twelve-step recovery treatment was to engage persons who had, themselves, already gone through the twelve steps.¹⁹⁹ These individuals would become peer specialists or recovery coaches, serving as staff or volunteers in the same programs they completed.²⁰⁰ While it may be advantageous to have treatment providers who have lived experience themselves,²⁰¹ the peer specialist role has since evolved into a professional or credentialed role in many states.²⁰² Now, even national professional organizations exist

197. See *infra* Appendix A, BHRT Act § III(d).

198. See *infra* Appendix A, BHRT Act § III(a).

199. Twelve-step programs are programs that are based on guidelines created by founders of Alcoholics Anonymous that heavily utilize peer support groups. See *The Purpose of the 12 Steps*, ADDICTION CTR., <http://www.addictioncenter.com/treatment/12-step-programs/> [<http://perma.cc/LG35-SM3B>] (last updated Aug. 12, 2020) (providing history of Alcoholics Anonymous and its role in developing the twelve-step methodology).

200. See *Who Is a Peer Support Specialist?*, N.C.’S CERTIFIED PEER SUPPORT SPECIALIST PROGRAM, <http://pss.unc.edu/#:~:text=The%20North%20Carolina%20Certified%20Peer,health%20or%20substance%20use%20disorder> [<http://perma.cc/P6PW-4TWL>] (last visited Nov. 1, 2021) (describing the requirements for becoming a peer support specialist in North Carolina).

201. See, e.g., Louise Byrne, Promoting Lived Experience Perspective: Discussion Paper Prepared for the Queensland Mental Health Commission (Feb. 16, 2017) (unpublished discussion paper on file with author) (explaining that “lived experience provided services, particularly peer roles, contribute to an improved sense of hope, empowerment and social inclusion for those accessing services”).

202. In 1999, Georgia was able to secure payments from Medicaid for a certified peer specialist, encouraging other states to follow suit. LYN LEGERE, SERA DAVIDOW & W. MASS PEER NETWORK, *THE PROVIDER’S HANDBOOK ON DEVELOPING & IMPLEMENTING PEER ROLES* 7 (2014), http://www.psresources.info/images/stories/A_Providers_Handbook_on_Developing_Implementing_Peer_Roles.pdf [<http://perma.cc/HDN9-6US2>]; see also N.C. GEN. STAT. § 90-21.22A (2019) (setting forth the statutory requirements to become a credentialed peer support specialist in North Carolina).

to certify peer specialists.²⁰³ Peer specialist groups may have sought credentialing to establish minimum standards, ensure a certain level of quality, and enable peer specialists to receive appropriate payment for their services rendered through Medicaid and other insurance programs.²⁰⁴ However, these facts do not detract from the reality that peer specialists constitute an established professional group that identifies as such, distinct from individuals who identify solely as persons who have had behavioral health issues or persons who have consumed behavioral healthcare. In acknowledgment of this history, the Act uses the term “consumer” over “peer,” in part to prioritize persons who have lived experience with mental health and substance use conditions that may have necessitated the navigation of the behavioral healthcare system. Such persons are best situated to explain how to navigate the system and understand firsthand that the choice to seek treatment is, in and of itself, a choice that only the person experiencing a crisis can make.

Occasionally, some advocacy groups and scholars have presented dislike for the word “consumer”; however, such aversion was rooted in the belief that the term consumer indicated that persons with behavioral health conditions do not have the right to behavioral healthcare and that such healthcare is instead a commodity that should be bought and sold in the marketplace. We are sensitive to these criticisms. Nevertheless, the term is useful for its implicit reference to its historical use by mental health advocates in the 1970s.

In the 1970s, advocates sought to decenter the “patient” narrative, which depicted psychiatrists and psychologists as professionals capable of making decisions on behalf of their patients and “patients” as individuals who should be placed under that professional control.²⁰⁵ The term “consumer” was embraced by these groups to discursively wrench back some of the power that mental health institutions have traditionally leveraged to force people into residential treatment or onto psychiatric medication.²⁰⁶ In this context, the term consumer was meant to communicate that persons with diagnosed mental illness or other mental health issues retain the agency to choose for themselves what type of treatment they will seek and even whether they want to seek treatment at all.²⁰⁷

203. See, e.g., *MHA Peer Programs*, MENTAL HEALTH AM., <http://www.mhanational.org/mha-peer-programs> [<http://perma.cc/H5PD-EGR6>] (last visited Nov. 1, 2021) (describing the process for national certification as a certified peer support counselor).

204. See generally *SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CRITERIA FOR THE DEMONSTRATION PROGRAM TO IMPROVE COMMUNITY MENTAL HEALTH CENTERS AND TO ESTABLISH CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS* (2016), http://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf [<http://perma.cc/U57P-UAEY>] (summarizing requirements for federal payment and reimbursement of peer support specialist costs).

205. See Athena Helen McLean, *From Ex-Patient Alternatives to Consumer Options: Consequences of Consumerism for Psychiatric Consumers and the Ex-Patient Movement*, 30 INT’L J. HEALTH SERVS. 821, 822–23 (2000) (tracing the evolution of the anti-psychiatry movement in the United States).

206. See *id.* at 821. See generally ELYN R. SAKS, *THE CENTER CANNOT HOLD: MY JOURNEY THROUGH MADNESS* (2007) (chronicling Professor Saks’s experiences with coercive practices in mental health treatment in the United States).

207. See McLean, *supra* note 205, at 821.

In an effort to emphasize that the purpose of the BHRT program is not to make it easier to institutionalize persons who have behavioral health conditions, the BHRT Act uses the term “consumer.” It should also be noted that using the term consumer instead of peer further underscores the need to include a person on the Advisory Board with lived experience in the behavioral healthcare system whose primary role is not as a professional but as a directly impacted person.

Additionally, Section III(e) of the Act defines sexual minorities but does not define racial or ethnic minorities, immigrant communities, or persons with disabilities. If possible, policymakers should reference definitions of these vulnerable groups as found in their respective state antidiscrimination laws.

Finally, we recommend using person-first language²⁰⁸ whenever possible. We understand that there are critiques of the use of person-first language²⁰⁹ and that there are more contemporary ways to reference persons from minority groups, but the acceptance of these new terminologies is not as widespread.²¹⁰ The use of person-first language is rooted in the discourse of monumental lobbying efforts by groups of persons with disabilities to highlight that they are people first and not defined by their disabilities.²¹¹

C. BHRT Act Section IV: Authorization

To facilitate the local government’s implementation of the proposed BHRT program, the Act includes a section that expressly authorizes the local government to establish and operate a CCC and a BHRT program that is not administered or staffed by law enforcement. Such authorization language may be necessary due to the division of powers in the state of enactment, a topic that will be discussed further in this Part.

In order to further protect the BHRT from co-option, the Act makes use of an Advisory Board. BHRT Act Section IV(b) establishes the Advisory Board, “which should be comprised of at least 51% behavioral health consumers, persons who have experienced or are experiencing houselessness, members of local immigrant communities, sexual minorities, persons with disabilities, and racial or ethnic minorities.” The way in which the Advisory Board is structured allows for

208. The Office of Disability Rights describes person-first language as follows:

“People First Language” (PFL) puts the person before the disability, and describes what a person has, not who a person is. PFL uses phrases such as “person with a disability,” “individuals with disabilities,” and “children with disabilities,” as opposed to phrases that identify people based solely on their disability, such as “the disabled.”

People First Language: Usage Guidelines, DC.GOV: OFF. DISABILITY RTS., <http://odr.dc.gov/page/people-first-language> [<http://perma.cc/QD4S-7F9S>] (last visited Nov. 1, 2021).

209. See generally Morton Ann Gernsbacher, *Editorial Perspective: The Use of Person-First Language in Scholarly Writing May Accentuate Stigma*, 58 J. CHILD PSYCHOL. & PSYCHIATRY 859 (2017) (arguing that person-first language increases stigma).

210. For example, Pew Research Center has found that many Hispanics prefer to be called Hispanics versus Latinx. See Luis Noe-Bustamante, Lauren Mora & Mark Hugo Lopez, *About One-in-Four U.S. Hispanics Have Heard of Latinx, but Just 3% Use It*, PEW RSCH. CTR. (Aug. 11, 2020), <http://www.pewresearch.org/hispanic/2020/08/11/about-one-in-four-u-s-hispanics-have-heard-of-latinx-but-just-3-use-it/> [<http://perma.cc/HZ6Y-5L4R>].

211. Dana S. Dunn & Erin E. Andrews, *Person-First and Identity-First Language: Developing Psychologists’ Cultural Competence Using Disability Language*, 70 AM. PSYCH. 255, 256 (2015) (advocating for the use of person-first language by psychologists when speaking about persons with disabilities).

representatives of provider groups; however, it attempts to maintain control of the Board by vulnerable community members by requiring that a simple majority of Board seats at any given time be held by those groups identified in Section IV(b).²¹² If possible, at least one person from each of the aforementioned populations, as well as one person who has been formerly incarcerated, should be selected. Ideally, 75% of the Board would be representatives from vulnerable populations, but the Act uses 51% as a minimum threshold. Legislators should tailor the membership of the Board to reflect the demographics of the local community.

We arrived at the categories of groups included in the Act through discussions with the community of grassroots activists in Greensboro, North Carolina. The list of vulnerable populations was developed based on input received from multiple advocacy groups in Greensboro, North Carolina, which included a coalition of groups for police reform, “Greensboro Rising,”²¹³ the Homeless Union of Greensboro, the NC Survivors Union (the local drug users union), Guilford for All (a local progressive coalition), representatives from Greensboro immigrant community, and representatives from the Greensboro Democratic Party leadership.

The minimum number of members on the Advisory Board is set at seven people, each with a term of two years. Advocacy groups will want to consider whether they would like to add term limits for board members in order to reduce opportunities for highly capable individuals to exert disproportionate control over the program. We have also suggested an application process for vetting and appointing Advisory Board members; however, we encourage advocacy groups to tailor this application process to coincide with the local politics and government structure. The responsibilities of the Advisory Board are outlined in Sections V and VII(b) of the Act.

D. BHRT Act Section V: Implementation Procedure

BHRT Act Section V requires that the appropriate governmental department work with the Advisory Board to create a CCC and BHRT program plan within six months of the enactment of the Act. This program plan must include the following: (1) protocols and procedures for establishing a designated non-law enforcement crisis response phone number for the public to call; (2) procedures for call routing to BHRTs; (3) a plan to market the crisis phone number and CCC/BHRT program to the community; (4) protocols and procedures for the BHRT; (5) staffing requirements for CCC and BHRT; and (6) a minimum standardized set of data to be collected from the CCC and BHRT program, including, but not limited to, demographic information of program participants, the general nature of the calls received, and the services provided.

Government officials, in collaboration with the Advisory Board, should procure the recommendations of CAHOOTS, particularly as applied to call routing procedures, staffing requirements, and protocols. The history of CIT programs²¹⁴ offers a cautionary tale. Programs not implemented with fidelity to their model are greatly hindered in their

212. See generally *infra* Appendix A.

213. See *Our Demands to the City of Greensboro*, GREENSBORO RISING, <http://greensbororising.wordpress.com/> [<http://perma.cc/2PNP-G6BT>] (last visited Nov. 1, 2021) (presenting the ten demands Greensboro Rising made of local policymakers).

214. See *supra* Section II.

ability to produce meaningful or desired outcomes. Though the precise details of this program will not be appropriate for every community, CAHOOTS is a time-tested and evidence-based approach to implementing a BHRT program.²¹⁵ While adaptation of some kind will always be necessary, the technical assistance that CAHOOTS can provide to communities implementing BHRT programs for the first time should not be undervalued. If funding is an issue, and local governments cannot allocate funds to cover costs associated with consultation from the CAHOOTS program, advocacy groups or government officials should discuss their limitations with CAHOOTS or other technical support agencies and consider seeking funds through private or federal block grants. CAHOOTS provides grant-writing assistance so that cities can get the funding they need to offset CAHOOTS consultation and start-up costs.²¹⁶

Section V(c) of the Act requires that the CCC and BHRT report data gathered, as defined by Section V(a)(vi), to the Advisory Board each quarter. BHRT Act Section V(c) also requires the CCC and BHRT to make the data available to the public. Public oversight will help ensure that program effectiveness and benefit are analyzed in the future, with the hopes that the data gathered will allow for modifications and improvements to the program. To protect the privacy of the persons served by the CCC and BHRT program, the Act requires that services be rendered to persons without asking for identifying information²¹⁷ and that all publicly posted data be appropriately de-identified.

E. BHRT Act Section VI: Program Requirements

BHRT Act Section VI outlines a list of program requirements. Section VI(a) of the Act requires that the BHRT program be the primary, if not sole, first responder to crises that do not require an armed law enforcement response. This includes crises involving homelessness, intoxication, disorientation, substance use, mental illness, and wellness checks. Doing so differentiates the BHRT from co-responder models or CIT, which are consistently dispatched with law enforcement. Section VI(b) of the Act requires that the BHRT provide immediate stabilization in case of urgent medical need or psychological crisis, assessment, information, referrals, advocacy, and, if requested by the affected individual, transportation to a facility that can provide a higher level of care. Again, emphasis is placed on facilitating access to treatment, if desired, rather than forced institutionalization.

Section VI(c) of the Act mandates that each BHRT has not only an EMS personnel and a trained mental health crisis counselor but also a behavioral health consumer. To increase the likelihood that the BHRT response team will be consumer centered, the Act departs from the CAHOOTS model in its requirement that the BHRT has a behavioral health consumer on the mobile crisis response team. The primary role of the behavioral health consumer is to (1) ensure that the person in crisis is treated in a supportive and empowering way and is given agency over themselves, and (2) to ensure to those in crisis and to those immediately involved that the BHRT is not simply another coercive mental health team looking to involuntarily commit or force a person into treatment. Behavioral

215. See *supra* Part II.C for an outline of the evidence base supporting CAHOOTS efficacy.

216. Telephone Interview with Tim Black, Dir. of Consulting, CAHOOTS (July 24, 2020).

217. See *infra* Appendix A, BHRT Act § VI(e).

health consumers can use their lived experience in aiding a person in crisis and in offering traditional “peer support” by “encouragement, empathy, hope, consideration, respect and empowerment from the vantage point of experiential understanding.”²¹⁸

As previously discussed, the history of behavioral health treatment in the United States is fraught with examples of patient coercion and disenfranchisement, often including widespread institutional failure to link consumers to evidence-based treatment. Sections VI(d)–(h) of the Act include some additional safeguards that help ensure the provision of nonjudgmental, person-centered, evidence-based care. Those Sections require that the BHRT provide information and access to more than one behavioral health treatment type if requested, including information on how to access medication for opioid use disorders when indicated, as stigma against this evidence-based form of care often creates an artificial barrier to treatment.²¹⁹ To help further protect against unnecessary institutionalization, Section VI of the Act mandates that the BHRT refer persons in need to the least restrictive treatment setting available if transportation is required.

F. BHRT Act Section VII: Funding

BHRT Act Section VII(a) authorizes the governing body to appropriate funding for the CCC and BHRT program. Section VII(b) of the Act establishes an additional power of the Advisory Board: the power to approve how the budget is allocated for the BHRT and CCC programs. On the issue of funding, the Act is purposefully vague and nonspecific, due in part to the variance in city, county, and state budgets across the country. Advocates should lobby the state government to fund such initiatives or, if there is a political window of opportunity for action, pressure local government officials to shift some of the police budget to fund the BHRT. Indeed, a primary goal in developing this Model BHRT Act was to create a feasible and successful alternative that could fill a need for services potentially created by defunding police. While future research needs to be conducted to validate their findings, CAHOOTS has reported a significant multimillion-dollar savings to the City of Eugene.²²⁰ This evidence can be used to convince fiscally conservative politicians that the BHRT will have a similar cost-saving function.

G. Potential Implementation Issues & Recommendations

The BHRT Act is purposefully silent on the organizational structure of the BHRT program and whether the BHRT would be (1) a part of the local government or (2) a private, nonprofit entity that is contracted with the local government. The Act does not designate a particular structure because there are significant differences in how states allocate power to local governments and variances in local politics that will need to be accounted for. In this Part, we review factors that advocacy groups should consider in determining how to structure the BHRT program.

218. See LEGERE ET AL., *supra* note 202, at 6.

219. Nat'l Acad. of Scis., *Barriers to Broader Use of Medications To Treat Opioid Use Disorder*, NAT'L CTR. FOR BIOTECHNOLOGY INFO. (Mar. 30, 2019), <http://www.ncbi.nlm.nih.gov/books/NBK541389/> [<http://perma.cc/Z52N-LAZ7>].

220. See WHITE BIRD CLINIC, CAHOOTS MEDIA GUIDE, *supra* note 127, at 1, 5.

1. BHRT as a Local Government Entity

One benefit of establishing the BHRT as a government program is that greater effort would be required (possibly up to and including the passing of new legislation) to end the program. In the United States, governmental departments or agencies are rarely disassembled, instead becoming longstanding fixtures.²²¹ Moreover, it would decrease the likelihood that the BHRT program would be abandoned if political party control of the local government changed.²²² State public employees also tend to have greater protections against layoffs,²²³ a feature which would decrease the likelihood that the staffing of the BHRT would become subject to the whims of fluctuating local budgets. If, however, the decision is made to place the BHRT within the local government, that decision must be accompanied by careful consideration of whether the BHRT should be placed in the municipal or county government.

In many states, county governments oversee the provision of mental health and substance use treatment, as funded by state budget allocations through county mental health and substance use treatment boards.²²⁴ These county boards are often dominated by behavioral healthcare provider groups²²⁵ that are, collectively, a substantial and powerful political lobby.²²⁶ As with all lobbying groups, these provider groups often engage in the political process in large part to protect their financial interests.²²⁷ And, while some of these behavioral healthcare providers may be nonprofit entities, the market behavior of nonprofit providers is often indistinguishable from for-profit providers.²²⁸ Undoubtedly, treatment providers can offer valuable resources to persons who choose to enter into care, but many provider groups have been historically, and even contemporaneously, associated with coercive treatment,²²⁹ involuntary commitment, and disenfranchisement of persons who use substances or persons living with mental

221. See, e.g., S. E. Condrey, *Organizational and Personnel Impacts on Local Government Consolidation: Athens-Clarke County, Georgia*, 16 J. URB. AFFS. 371, 376 (1994) (discussing the entrenchment of local governments).

222. See Richard Winters, *Party Control and Policy Change*, 20 AM. J. POL. SCI. 597, 597 (1976).

223. See Matisa Hollister, *Employment Stability in the U.S. Labor Market: Rhetoric Versus Reality*, 37 ANN. REV. SOCIO. 305, 310–11 (2011).

224. Michael F. Hogan, *Perspective: Public-Sector Mental Health Care: New Challenges*, 18 HEALTH AFFS. 106, 107–08 (1999); see also Wade H. Silverman, *A Statewide Assessment of Mental Health Governing Board Training Needs*, 8 J. CMTY. PSYCH. 302, 302 (1980) (noting that these boards can be advisory boards or governing boards). Boards allow the community to be represented in decisions but may not have much administrative power. See Silverman, *supra*. Governing boards have more power and authority. *Id.* at 306.

225. In this Article, the term “behavioral healthcare provider groups” refers to coalitions, interest groups, and groups of providers.

226. See, e.g., Larry R. Faulkner, David L. Cutler & Morris H. Middleton, *A Participatory Planning Process for the Evaluation of Community Mental Health Centers*, 18 CMTY. MENTAL HEALTH J. 169, 177 (1982) (providing an example of how community mental health centers can lobby state government).

227. See Marie Hojnacki & David C. Kimball, *Organized Interests and the Decision of Whom To Lobby in Congress*, 92 AM. POL. SCI. REV. 775, 777 (1998).

228. Mark Duggan, *Hospital Market Structure and the Behavior of Not-For-Profit Hospitals*, 33 RAND J. ECON. 433, 433 (2002) (finding that not-for-profit hospitals, in general, behave like for-profit hospitals).

229. See Stefanie Klag, Frances O’Callaghan & Peter Creed, *The Use of Legal Coercion in the Treatment of Substance Abusers: An Overview and Critical Analysis of Thirty Years of Research*, 40 SUBSTANCE USE & MISUSE J. 1777, 1779 (2005).

illness.²³⁰ Further, Black people, Indigenous people, and other people of color are more likely than their white peers to receive coercive treatment at the hands of behavioral healthcare treatment providers.²³¹ Therefore, county officials may insist on involving behavioral healthcare provider groups in the planning and implementation of BHRT. In such cases, care should be taken to insulate the Act from self-serving modifications proposed by provider groups. Perhaps most importantly, provider groups should not be permitted to insinuate themselves into the new institutions that the Act creates; otherwise, as with co-option by law enforcement, communities run the risk of substituting one form of coercive restraint for another.

Regardless of the influence of provider groups, advocacy groups may decide that county-level adoption of the Act, and its absorption within the county government, is best because it expands access to services provided by the BHRT to the entire population of the county, and because in many states EMS is administered by the county government.²³² Housing the emergency call center and BHRT within EMS has both political and practical advantages. In many states, EMS has the authority to dispatch emergency response services, often overseeing the 911 call system in place of law enforcement oversight.²³³ Therefore, many EMS agencies already have the practical expertise needed to manage a crisis call system and can even integrate the CCC into the existing infrastructure, decreasing redundancy in staffing and expenditures. Further, by maintaining a single emergency call line (911), the implementation of BHRT will feel seamless to members of the public, who do not need to learn new emergency call numbers or remember to distinguish between different service systems when calling for help. The drawbacks to housing the entire BHRT within EMS can be institutional bias that arises should EMS be administered by the same county or municipal department that oversees public safety.²³⁴ Existing EMS personnel may also bring with them their

230. See Arthur Robin Williams, Shelly Cohen & Elizabeth B. Ford, *Statutory Definitions of Mental Illness for Involuntary Hospitalization as Related to Substance Use Disorders*, 65 *PSYCHIATRIC SERVS.* 634, 634–35 (2014); see also PEMINA YELLOW BIRD, *WILD INDIANS: NATIVE PERSPECTIVES ON THE HIAWATHA ASYLUM FOR INSANE INDIANS* 3–4 (2017), <http://power2u.org/wp-content/uploads/2017/01/NativePerspectivesPeminaYellowBird.pdf> [<http://perma.cc/K5CV-ZRU9>].

231. See Marguerite J. Ro, Carolina Casares, Henrie M. Treadwell & Kisha Braithwaite, *Access to Mental Health Care and Substance Abuse Treatment for Men of Color in the U.S.: Findings from the National Healthcare Disparities Report*, 12 *CHALLENGE* 65, 71 (2006).

232. EMS administration does vary state by state and even county by county, as does the definition of what an EMS is and whether it is fire department based or hospital based. See *COMM. ON THE FUTURE OF EMERGENCY CARE IN THE U.S. HEALTH SYS., INST. OF MED. OF THE NAT'L ACADS., EMERGENCY MEDICAL SERVICES: AT THE CROSSROADS* 60 (2007), <http://www.nap.edu/read/11629/chapter/4#58> [<http://perma.cc/52M6-BK66>].

233. MARYN CONSULTING INC., *NAT'L HIGHWAY TRAFFIC SAFETY ADMIN. OFF. OF EMERGENCY MED. SERVS. (EMS), EMERGENCY COMMUNICATIONS CENTERS AND THE ROLE OF COMMUNICATIONS TECHNOLOGIES IN REDUCING MORTALITY RATES IN THE RURAL U.S.* 9, 20–39 (2015), <http://www.ems.gov/pdf/advancing-ems-systems/Reports-and-Resources/ECC-Role-of-Communications-Tech-nologies.pdf> [<http://perma.cc/Q88K-DXA2>] (revised Jan. 15, 2016).

234. See Nat'l Highway Traffic Safety Admin., *Integration of Health Services*, *EMERGENCY MEDICAL SERVICES: AGENDA FOR THE FUTURE*, <http://one.nhtsa.gov/people/injury/ems/agenda/emsman.html#SERVICES> [<http://perma.cc/YP2W-GR5C>] (last visited Nov. 1, 2021).

preferential biases for police escorts and insist that law enforcement officers remain first responders that secure the scene and establish safety.²³⁵

Additionally, human or social services agencies tend to operate at the county level. However, it is not advised to house BHRT programs within county social services agencies. Social services agencies make reports to parole officers, drug court representatives, and other authorities in community supervision, and persons with behavioral health or housing problems may have had prior negative encounters with such agencies.²³⁶ Moreover, county social services agencies have historically treated vulnerable communities paternalistically; rather than empowering them, such agencies leave the populations they serve feeling marginalized.²³⁷ Many of these interactions have evidenced racial biases and have led to poorer outcomes for communities of color.²³⁸ Many jurisdictions have taken steps to remedy this sordid past and rebuild relationships with communities;²³⁹ however, much work still needs to be done. Ultimately, placing a BHRT program within an institution with a contentious and racialized relationship with the larger community risks that the BHRT will take on the characteristics of its parent institution.

If implementation and administration of the BHRT program at the county level are not politically or practically feasible, advocates can look to municipal governments to administer and implement the program. While, in many jurisdictions, advocacy groups may have a choice as to which level of government to approach, advocacy groups in some states may be limited based on the statutory authority each level of government has to act. States differ in how much power they allocate to their county and municipal governments.²⁴⁰ Generally, states are said to follow either “home rule” or “Dillon’s rule” in how they divide powers between state and local governments.²⁴¹ Home rule authorizes local governments to act in all instances not expressly prohibited by state or local law.²⁴² States that follow Dillon’s rule, on the other hand, only authorize local governments to act if the state legislature has explicitly granted the authority, or the authority is implied or reasonably necessary to exercise express powers granted by the state.²⁴³ Not all states

235. See Connor O’Halloran, Troy Kolar, Robert Tieche & Matthew Ozanich, *Why We Work Together*, EMS WORLD (May 16, 2018), <http://www.emsworld.com/article/220457/why-we-work-together> [<http://perma.cc/H8YT-NFYU>].

236. See Sarah Maiter, Sally Palmer & Shehenaz Manji, *Strengthening Social Worker-Client Relationships in Child Protective Services*, 5 QUALITATIVE SOC. WORK 167, 179–81 (2006).

237. See *id.* at 169.

238. See Lisa A. Flores, *Between Abundance and Marginalization: The Imperative of Racial Rhetorical Criticism*, 16 REV. COMM’N. 4, 8 (2016).

239. See Charlotte Carr, Becca Warner, Greg Jordan-Detamore & Owen O’Malley, *Engaging Marginalized Communities in the Wake of COVID-19*, MEDIUM (July 13, 2020), <http://medium.com/the-guide-to-remote-community-engagement/engaging-marginalized-communities-in-the-wake-of-covid-19-9385a7edd543> [<http://perma.cc/EJ4S-V94B>].

240. See Frayda S. Bluestein, *Do North Carolina Local Governments Need Home Rule?*, 84 N.C. L. REV. 1983, 1984, 1985 n.10 (2006).

241. *Id.* at 1985.

242. Bluestein, *supra* note 240, at 1985. See generally WILLIAM L. WHITE, *SLAYING THE DRAGON: THE HISTORY OF ADDICTION TREATMENT AND RECOVERY IN AMERICA* (1998).

243. *City of Clinton v. Cedar Rapids & Mo. River R.R. Co.*, 24 Iowa 455, 480 (1868), *superseded by constitutional amendment*, IOWA CONST. art. III, § 38A, *as recognized in* *Berent v. City of Iowa City*, 738

fit neatly within these designations. In North Carolina, for example, there exists a line of cases that reject Dillon's rule but instead adopt an even more restrictive standard.²⁴⁴

If advocates live in a state that follows Dillon's rule, or an equally restrictive law, then county and municipal governments may be limited in their authority to implement a BHRT program. Most likely, this will affect municipal adoption more so than county adoption, because counties in most jurisdictions have at least one department (such as EMS) with the authority to regulate and provide for the health of the citizens and therefore capable of housing the BHRT. Municipal governments—like that of Greensboro, North Carolina—may be limited in their ability to enact policies outside of their specifically authorized powers. In Greensboro, for example, the only departments that run through the city manager's office amenable to housing a BHRT program are the 911 call center (funded by the county), fire, police, and human relations.²⁴⁵ All these departments are suboptimal choices given the implementation concerns discussed above. Moreover, at the municipal level, fire, police, and the 911 call center may be placed under the same city manager, forming a "public safety" arm of the municipal government,²⁴⁶ rendering these departments potentially problematic choices for housing BHRT.

Practically speaking, it may make sense to place the BHRT program within the public safety arm, given local circumstances. However, advocates should be wary of such shared management schemes, which may put the BHRT at greater risk of being co-opted and tucked under or within the police department or another law enforcement agency. If care is not exercised in protecting the autonomy of the BHRT, it could become yet another law enforcement-led response.

2. BHRT as a Nonprofit Government Contractor

CAHOOTS, the program on which the BHRT Act is modeled, is managed by the police department and is located underneath the public safety arm of the municipal government.²⁴⁷ CAHOOTS itself, however, is a private, nonprofit entity that operates via a third-party contract provided by law enforcement.²⁴⁸ Structuring the BHRT as a private, nonprofit entity, like CAHOOTS, also has its advantages. If advocates find that they are getting more local support for the adoption of the Act as a municipal ordinance, then

N.W.2d 193 (Iowa 2007). It should be noted that Dillon's Rule is a rule of strict construction, so any doubts as to whether a local government has the requisite authority will be resolved against the local government. Bluestein, *supra* note 240, at 2011.

244. See Frayda Bluestein, *Is North Carolina a Dillon's Rule State?*, COATES' CANONS: N.C. LOC. GOV'T L. (Oct. 24, 2012), <http://canons.sog.unc.edu/> [<http://perma.cc/FB4M-EDTZ>]; see also David W. Owens, *Local Government Authority To Implement Smart Growth Programs: Dillon's Rule, Legislative Reform, and the Current State of Affairs in North Carolina*, 35 WAKE FOREST L. REV. 671, 694–99 (2000).

245. See *City Manager's Office*, GREENSBORO, N.C., <http://www.greensboro-nc.gov/government/city-manager-s-office> [<http://perma.cc/5X96-EQR2>] (last visited Nov. 1, 2021) (click "Organizational Chart").

246. See DURHAM COUNTY N.C., PUBLIC SAFETY (2017–2018), <http://www.dconc.gov/home/showdocument?id=21668> [<http://perma.cc/GH2Z-3N8K>].

247. See *CAHOOTS & the Police Departments: What Is CAHOOTS?*, WHITE BIRD CLINIC (Oct. 29, 2020), <http://whitebirdclinic.org/what-is-cahoots/> [<http://perma.cc/NHV2-YKFK>] (explaining that CAHOOTS team members are not law enforcement officers and do not carry weapons; instead, CAHOOTS staff are specifically trained to ensure nonviolent resolutions).

248. *Black Interview*, *supra* note 216.

perhaps the creation of a private, nonprofit entity that contracts with law enforcement agencies or public safety departments may be best. As a private, nonprofit entity, the BHRT will be more insulated from fluctuating local politics, a feature that staff at CAHOOTS have cited as a benefit.²⁴⁹ Such arrangements appear to operate best in cities with more progressive police departments or in cities with predominantly progressive voters that will hold city officials accountable—like that of Eugene, Oregon, where CAHOOTS is located.²⁵⁰ CAHOOTS' longstanding success²⁵¹ suggests that this model is workable if the political circumstances permit.

Finally, advocates who choose to opt for the implementation of the Act through the use of a private, nonprofit entity contracted with the local government should first ensure that a private, nonprofit organization exists that is equipped to take on the duties of a BHRT. Advocacy groups are strongly encouraged to explore the types and capacities of services available in their state and identify gaps that could undermine the implementation of a BHRT program. When assessing available services, local advocates are well-advised to hold focus groups of persons who have lived experiences in the state and local service delivery systems. Only by hearing the stories of affected persons will advocacy groups be able to identify issues with care continuity, racial bias, and access that are not readily identifiable by the service providers or even siloed groups. Advocacy groups can then use this knowledge to tailor the BHRT to truly fit the needs of their community.

In sum, advocates looking to propose the BHRT Act will have to consider whether the BHRT program should (1) be part of the county or municipal government or (2) be provided by a private, nonprofit entity that is contracted with the local government. The BHRT Act has been written to allow for customization based on the factors mentioned above.

CONCLUSION

The deaths of Marcus Deon Smith (Greensboro, 2018) and Joseph Dewayne Robinson (Memphis, 1987) bear eerie similarities. Both were Black men with histories of substance use and chronic mental illness. Both were experiencing a mental health crisis at the time of their deaths. Both were met by law enforcement in the midst of their crises, and those officers responded to both men in their time of greatest need with excessive use of force intended to overpower violent and willful resistance. Both men unnecessarily lost their lives as a result of these lethal and inappropriate law enforcement actions. In the subsequent administrative review of both killings, the officers' deadly choices in the field were deemed to be procedurally sound.

249. *Id.*

250. See CAHOOTS, WHITE BIRD CLINIC, <https://whitebirdclinic.org/cahoots/> [<http://perma.cc/BJP4-ARXZ>] (last visited Nov. 1, 2021) (explaining that the power of CAHOOTS lies within community relationships).

251. See Anna V. Smith, *There's Already an Alternative to Calling the Police*, HIGH COUNTRY NEWS (June 11, 2020), <http://www.hcn.org/issues/52.7/public-health-theres-already-an-alternative-to-calling-the-police> [<http://perma.cc/Z7RU-YDCG>] (highlighting the thirty-one-year-old program as a “model in de-escalating situations that could end with law enforcement violence”).

That these killings took place more than thirty years apart is a powerful testament to the profound intractability of a law enforcement culture that tolerates—if not enables—anti-Black racism, other racisms, and stigma against behavioral health concerns, often with deadly consequences. In the wake of so many violent, unnecessary, and preventable deaths (including the deaths of Eric Garner, Michael Brown, Tamir Rice, Walter Scott, Alton Sterling, Freddie Gray, Sandra Bland, Philando Castile, Corey Jones, Antronie Scott, Joseph Mann, Stephon Clark, Donnelle Thompson, Jamarion Robinson, Deborah Danner, Jordan Edwards, Mikel McIntyre, James Lacy, Damon Grimes, Charleena Lyles, Marcus-David Peters, Charles Roundtree Jr., Jemel Roberson, Sterling Higgins, Pamela Turner, Elijah McClain, Atatiana Jefferson, Michael Dean, Darius Tarver, William Green, Cornelius Frederick, David McAtee, Breonna Taylor, George Floyd, and many, many others), social support for defunding the police has swelled such that nearly one in three Americans today is in favor of reducing financial support for law enforcement agencies,²⁵² and commensurately reducing their scope of work.

This Article has argued, based on the current science of law-enforcement-inflicted injury on vulnerable populations, that removing law enforcement's mandate to respond to calls related to behavioral health and housing crises is reasonable and appropriate.²⁵³ Yet, without adequate funding and statutory mandates to establish humane behavioral health services and response teams to take up that mandate, dismantling existing law enforcement infrastructures will simply create a vacuum that will most certainly be filled by different yet equally inappropriate systems already at hand. This truth is evidenced in the way jails have filled the existing gaps in mental health services across the country.²⁵⁴

The co-opting of public health policy proposals by law enforcement is not a new phenomenon. Law enforcement professionals have successfully framed themselves as authorities on numerous public health issues over which they have no real expertise, including substance use, overdose, linkage to substance use treatment, and the management of mental health crises. When policymakers in Greensboro, North Carolina, enacted their policy solutions to the police actions that caused Marcus Deon Smith's death, public health responses were co-opted into the criminal justice system.

The BHRT Act seeks to interrupt that cycle by requiring that the crisis response team empowered by the Act contains *at least one nonprofessional, behavioral health consumer* and by creating *an Advisory Board* with oversight powers comprised of at least 51% nonprofessionals with lived experience. Rather than responding to individuals in crisis with coercion and violence, this program would seek to connect participants to housing, mental health counseling, harm reduction services, and other forms of support throughout the community.

252. See Nathaniel Rakich, *How Americans Feel About 'Defunding the Police'*, FIVETHIRTYEIGHT (June 19, 2020, 5:58 AM), <http://fivethirtyeight.com/features/americans-like-the-ideas-behind-defunding-the-police-more-than-the-slogan-itself/> [<http://perma.cc/Z8JQ-EKRY>].

253. See *supra* Part II.B.

254. See E. FULLER TORREY, AARON D. KENNARD, DON ESLINGER, RICHARD LAMB & JAMES PAVLE, MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES I (2010), http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf [<http://perma.cc/28HQ-D9GR>].

No single program can address structural issues that create and reinforce behavioral health concerns and social vulnerability. A BHRT program cannot address larger issues like the chronic underfunding of behavioral health services or the severe lack of affordable housing in many areas. Likewise, a BHRT program cannot end racism or eliminate the profound disparities across racial and ethnic divides in this country. What well-designed BHRTs can do, however, is ensure that people struggling with homelessness, people who use substances, and people with emergent behavioral health concerns are treated with dignity and respect, ending systemic cycles of stigma and harm in first response.

Above all, our proposal emphasizes the care that must be taken in creating new institutions to replace the old ones that we dismantle. It reminds us all that these new institutions must reflect the values and needs of the people that it serves. We must be intentional about creating institutions that will not replicate the racist and oppressive systems of the past, which have reinforced pervasive stigma, racism, and marginalization. Instead, we must fundamentally reimagine what public safety can look like, creating systems that are useful, dignifying, and equitable for all people who need care.

APPENDIX A

THE MODEL BEHAVIORAL HEALTH RESPONSE TEAM ACT

By Taled El-Sabawi, M.S., J.D., Ph.D.
Jennifer J. Carroll, Ph.D., M.P.H.

SECTION I. SHORT TITLE.

This Act can be referred to as the Model Behavioral Health Response Team Act, the BHRT Act, or the Act.

SECTION II. PURPOSE.

Consistent with the National Guidelines on Behavioral Crisis Intervention⁺ and as outlined in this Act, it is the intent of the [City Council, County Board of Commissioners, State Legislature] to authorize the [City Manager's Office, County Commissioners' Office, the State Department of Health] to develop and implement [local, county-wide, regional] nonpolice administered crisis call center[s] (CCC[s]) and behavioral health mobile crisis response teams (BHRTs) to respond to calls regarding crises that arise due to mental health, substance use, or homelessness.

SECTION III. DEFINITIONS.

For the purposes of this Act, unless the context explicitly indicates otherwise, the words and phrases listed below have the meanings given to them in this Section.

(a) Behavioral health consumer.—“behavioral health consumer” means anyone who has received mental health or substance use treatment services in the past, anyone who has a mental health or substance use disorder diagnosis, or anyone who has experienced a mental health or substance use disorder. A behavioral health consumer should not be a peer specialist, as defined in this Act.

(b) Mental health disorder.—“mental health disorder” means any mental illness, not including substance use disorders, as diagnosed according to the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), or subsequent editions.

(c) Substance use disorder.—“substance use disorder” means substance use disorders as described in the DSM-5, or subsequent editions.

(d) Peer specialist.—“peer specialist” means any individual certified or qualified as a peer specialist or as a recovery specialist by the appropriate agency or organization.

(e) Treatment.—“treatment” means the treatment for substance use disorder or mental health disorder with a licensed or certified professional. This can include an individualized assessment, diagnosis, counseling, the prescription of medication,

⁺ SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISIS CARE: BEST PRACTICE TOOLKIT (2020), <http://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf> [<http://perma.cc/9AF5-J7RN>].

recovery support services, hospitalization, non-hospital residential services, and withdrawal management.

(f) Treatment provider.—“treatment provider” means any substance use disorder or mental health disorder treatment professional, facility, or program that is [licensed, certified, approved] by [the state] to provide treatment.

(g) Emergency medical services personnel.—“Emergency medical services personnel” means individuals who are licensed or certified to provide ambulance or paramedic services, including pre-hospital treatment, medical stabilization, and transportation to more comprehensive care.

(h) Harm reduction services.—“Harm reduction services” means public health services designed to empower individuals to mitigate the potential harms of risk-associated behaviors. Such services include, but are not limited to: distribution of sterile syringes; distribution of other sterile injection equipment (tourniquets, alcohol swabs, sterile water, sterile cottons, sterile cookers, etc.); distribution of naloxone and training in overdose response; collection of used syringes and other biohazard waste; rapid testing for Human Immunodeficiency Virus (HIV), Hepatitis C Virus, and other infectious diseases; wound care; referral to social services; referral to healthcare services; referral to treatment for substance use disorders; and other forms of mutual aid.

(i) Sexual minorities.—“Sexual minorities” means individuals who identify as lesbian, gay, bisexual, transgender, nonheterosexual, nonbinary, third gender, or intersex.

(j) Trained mental health crisis counselor.—“Trained mental health crisis counselor” is any mental health professional with experience or training in crisis intervention theory and therapeutic practices.

SECTION IV. AUTHORIZATION.

(a) In general.—The [City Manager’s Office, County Commissioners’ Office, the State Department of Health] is directed to establish a CCC that is not administered or staffed by law enforcement and a BHRT program subject to the provisions of this Act.

(b) The establishment of the CCC and BHRT program shall occur in partnership with a consumer-led advisory board that is comprised of at least 51% behavioral health consumers, persons who have experienced or are experiencing houselessness, members of local immigrant communities, sexual minorities, persons with disabilities, and racial or ethnic minorities (together, “Advisory Board”). If possible, at least one person from each of the aforementioned populations should be selected. Members of the community interested in serving on the Advisory Board should submit an application to the [City Manager’s Office or County Commissioners’ Office]. [City Council Members or Commissioners] will review the applications and appoint a minimum of seven (7) applicants to the Advisory Board. Each Advisory Board member will serve a two-year term. The Advisory Board will have the authority to carry out the responsibilities listed in Section V and VII(b) of this Act.

SECTION V. IMPLEMENTATION PROCEDURE.

(a) Within six (6) months of the effective date of this Act, the [City Manager's Office, County Commissioners' Office, the State Department of Health] and Advisory Board shall create a CCC and BHRT program plan ("program plan") that includes:

- (i) protocols and procedures for establishing a designated nonpolice crisis response phone number for the public to call;
- (ii) procedures for call routing to BHRTs;
- (iii) a plan to market the crisis phone number and CCC/BHRT program to the community;
- (iv) protocols and procedures for the BHRT;
- (v) staffing requirements for CCC and BHRT; and
- (vi) a standardized set of minimum data to be collected from the CCC and BHRT program, including, but not limited to, demographic information on program participants, the general nature of the calls received, and the services provided.

(b) The program plan must be approved by 51% of the Advisory Board and must meet the requirements set forth in Section VI of this Act.

(c) Once in operation, the CCC and BHRT must report the data, as defined by Section V(a)(vi), to the Advisory Board each quarter and shall make the data available to the public.

SECTION VI. PROGRAM REQUIREMENTS.

(a) The BHRT shall be the sole first responder to calls dispatched from the CCC involving crises that do not require law enforcement response, including homelessness, intoxication, disorientation, substance use, mental illness, and wellness checks.

(b) The BHRT shall provide immediate stabilization in case of urgent medical need or psychological crisis, assessment, information, referrals, advocacy, and, if requested by the affected individual, transportation to the next step in treatment.

(c) Each unique BHRT responding to calls will consist of at least three members: (1) at least one emergency medical services personnel, (2) a trained mental health crisis counselor, and (3) a behavioral health consumer.

(d) When responding to calls, the BHRT must carry overdose reversal medication.

(e) All services provided by CCC and BHRT must remain confidential and comply with any state and federal statutes governing the confidentiality of health information, including the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 100 Stat. 2548, and related rules and regulations. An individual in crisis shall not be required to provide their name or identifying information in order to be served by the CCC or BHRT.

(f) The BHRT must provide the individual in crisis with information on how to access local harm reduction services, substance use treatment, mental health services, housing assistance resources, healthcare services, and any other social services that the BHRT deems appropriate.

(g) If an individual with a substance use crisis requests or agrees to be provided with information on treatment options, the BHRT must provide the individual with

information on how to access various types of treatment, including outpatient treatment and medication for treatment of substance use disorders.

(h) In accordance with the U.S. Substance Abuse and Mental Health Services Administration's (SAMHSA) National Guidelines for Crisis Care, the BHRT will follow the principle of least restrictive setting for follow-up care.

SECTION VII. FUNDING.

(a) In general.—The [City Council, County Board of Commissioners, State Legislature] may appropriate funds to [City Manager's Office, County Commissioners' Office, the State Department of Health] for the purpose of funding services provided as part of the CCC and BHRT program subject to Section IV of this Act ("Authorization").

(b) Guidelines and requirements.—The [City Manager's Office, County Commissioners' Office, the State Department of Health], with majority approval of the Advisory Board, will set requirements for the distribution of funds for the expenses related to the CCC and BHRT programs.

SECTION VIII. RULES AND REGULATIONS.

[State or local] agencies and officials shall promulgate rules and regulations necessary to implement their responsibilities under this Act.

SECTION X. SEVERABILITY.

If any provision of this Act or application thereof to any individual or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act that can be given effect without the invalid provisions or applications, and to this end, the provisions of this Act are severable.

SECTION XI. EFFECTIVE DATE.

This Act shall be effective on ____.