

New Federal Guidance for Alternatives to Police for People with Behavioral Health or Other Disabilities

In guidance and public findings issued last year, the United States Departments of Justice (DOJ) and Health and Human Services (HHS) have made clear that federal law requires that people with behavioral health and other disabilities receive a health response—not a law enforcement response—in circumstances where others would receive a health response.¹ This means that when someone experiences a mental health crisis, a health-focused team of workers with mental health expertise should be deployed instead of the police, just as an ambulance would be dispatched to help someone experiencing a physical health emergency. Any failure to do so violates the civil rights of people with disabilities.

The new federal guidance can be a useful tool for communities to implement a comprehensive community-based mental health system that can and will reduce violence against people with behavioral health disabilities, especially in Black, Indigenous, and People of Color (BIPOC) communities, which disproportionately experience the most negative impacts of policing.² However, in implementing the guidance, states and localities must be careful to avoid an overly expansive view of when police involvement is appropriate. The guidance states that dispatching a co-responder team may be a “reasonable modification” in situations “where a police response is called for,” but without further clarification emergency response systems may continue to over-rely on police, thus falling short of the guidance’s potential.³ The Bazelon Center for Mental Health Law and the Vera Institute of Justice urge the federal government to further explain and assert the need to expand non-police approaches and use data to reduce overreliance on law enforcement responses in these situations, and to back this up with

¹ U.S. Department of Justice and U.S. Department of Health & Human Services, *Guidance for Emergency Responses to People with Behavioral Health or Other Disabilities*, (Washington, DC: U.S. DOJ and U.S. HHS, May 2023), https://www.justice.gov/d9/2023-05/Sec.%2014%28a%29%20-%20DOJ%20and%20HHS%20Guidance%20on%20Emergency%20Responses%20to%20Individuals%20with%20Behavioral%20Health%20or%20Other%20Disabilities_FINAL.pdf,

[hereinafter DOJ-HHS, *Guidance for Emergency Responses*]. As used in the guidance, the term “behavioral health” encompasses both mental health and substance use.

² Vera Institute of Justice, “Arrest Trends,” <https://arresttrends.vera.org/arrests>; Vera Institute of Justice, “Incarceration Trends,” <https://trends.vera.org/#/incarceration-rates>; Washington Post, “Fatal Force: Police Shootings Database,” database (Washington, DC: Washington Post, accessed September 20, 2023), <https://www.washingtonpost.com/graphics/investigations/police-shootings-database/>; and Legal Defense Fund and Bazelon Center for Mental Health Law, *Advancing an Alternative to Police: Community-Based Services for Black People with Mental Illness*, (Washington, DC: LDF and Bazelon Center, 2022), <https://www.bazelon.org/wp-content/uploads/2022/07/2022.07.06-LDF-Bazelon-Brief-re-Alternative-to-Policing-Black-People-with-Mental-Illness.pdf>, passim, [hereinafter LDF-Bazelon, *Advancing an Alternative*].

³ DOJ-HHS, *Guidance for Emergency Responses*, 2023, 4.

increased and sustained investments in non-police crisis services that will help communities make changes consistent with federal law.

DOJ Findings Show the Risks of Unnecessary Police Encounters

The DOJ issued findings in June 2023 that the Minneapolis Police Department and the City of Minneapolis engage in a pattern or practice of conduct that violates the U.S. Constitution and federal law.⁴ The DOJ report comes in the wake of the murder of George Floyd and includes findings that Minneapolis’s police and emergency response systems discriminate against people with behavioral health disabilities.⁵ The DOJ found that Minneapolis unnecessarily deploys police in response to calls for help involving people with disabilities, a practice that is “often harmful and ineffective” and violates the Americans with Disabilities Act (ADA).⁶ People with disabilities, including those who are BIPOC, in Minneapolis experience significant harms from these unnecessary police encounters.⁷ As the report explains, the inappropriate deployment of police to these calls not only violates the law but can also cause or exacerbate trauma and increase stigma for people with disabilities.

New Guidance Is Long Overdue

In May 2023 DOJ and HHS issued guidance for state, tribal, and local officials on responding to and interacting with people with behavioral health disabilities. The guidance describes practices for responding to crises experienced by people with mental health and substance use conditions and other disabilities, including intellectual, developmental, vision, and hearing disabilities.⁸ The agencies were required to issue the guidance by President Biden’s 2022 Executive Order on advancing effective and accountable policing.

As the guidance explains, as many as 10 percent of police calls involve people with mental illness, who account for 20 to 25 percent of individuals killed by law enforcement.⁹ Although representing only 22 percent of the population, persons with disabilities may account for 30 to 50 percent of incidents of police use of force.¹⁰

⁴ U.S. Department of Justice Civil Rights Division and U.S. Attorney’s Office District of Minnesota Civil Division, *Investigation of the City of Minneapolis and the Minneapolis Police Department*, (Washington, DC and Minneapolis, MN: DOJ and U.S. Attorney’s Office, 2023), https://www.justice.gov/d9/2023-06/minneapolis_findings_report.pdf.

⁵ *Ibid.*, 1.

⁶ *Ibid.*, 57.

⁷ *Ibid.*, 9.

⁸ DOJ-HHS, *Guidance for Emergency Responses*, 2023.

⁹ *Ibid.*, 2.

¹⁰ *Ibid.*, 2.

BIPOC people with disabilities are disproportionately harmed in these encounters with the police.¹¹ Black men with behavioral health disabilities are killed by law enforcement officers at significantly higher rates than white men who exhibit similar behaviors.¹² The widely reported killings of Black people with mental health needs, like Natasha McKenna, Saheed Vassell, and Daniel Prude, illustrate an all-too-common experience during encounters with law enforcement officers.¹³

As in Minneapolis, the DOJ’s finding in Kentucky that the Louisville/Jefferson County Metro Government and the Louisville Metro Police Department violate the Constitution and the ADA provides chilling details of police officers treating people with disabilities with “contempt and callous disregard,” leading to physical harm and trauma that likely worsened their mental health symptoms.¹⁴

A Different Response Is Urgently Needed

Vera and the Bazelon Center agree with the new guidance that “jurisdictions should not assume that the proper response to a crisis is always to send law enforcement.”¹⁵ Law

¹¹ See, for example, Susan Mizner, ACLU, “Police ‘Command and Control’ Culture Is Often Lethal—Especially for People with Disabilities,” ACLU, May 10, 2018, <https://www.aclu.org/news/criminal-law-reform/police-command-and-control-culture-often-lethal?redirect=blog%2Fcriminal-law-reform%2Freframing-police-practices%2Fpolice-command-and-control-culture-often-lethal> (“[A]t least 25 percent of all police killings are people in a mental health crisis. And as with police killings in general, those killed by police while in mental health crises are disproportionately people of color.”); Erin J. McCauley, “The Cumulative Probability of Arrest by Age 28 Years in the United States by Disability Status, Race/Ethnicity, and Gender,” *American Journal of Public Health* 107, no. 12 (2017), 1977–1981, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5678390/> (people with disabilities in cohort have higher probability of arrest than those without disabilities, with Black people with disabilities experiencing highest cumulative probability of arrest, followed by Hispanic and white people with disabilities). For the purpose of this analysis, researchers rely on the race and ethnicity categorization in the administrative data analyzed.

¹² Washington Post, “Fatal Force: Police Shootings Database,” database (Washington, DC: Washington Post, accessed September 20, 2023); see also Marilyn D. Thomas, Nicholas P. Jewell, and Amani M. Allen, “Black and Unarmed: Statistical Interaction between Age, Perceived Mental Illness, and Geographic Region among Males Fatally Shot by Police Using Case-Only Design,” *Annals of Epidemiology* 53, no. 42 (2021), <https://doi.org/10.1016/j.annepidem.2020.08.014>.

¹³ See, for example, LDF-Bazelon, *Advancing an Alternative*, 2022.

¹⁴ U.S. Department of Justice and U.S. Attorney’s Office Western District of Kentucky Civil Division, *Investigation of the Louisville Metro Police Department and Louisville Metro Government* (Louisville, KY: U.S. DOJ and U.S. Attorney Office, 2023), 62, <https://www.justice.gov/crt/case-document/file/1572951/download>. See also Department of Justice, “Justice Department Finds Civil Rights Violations by the Louisville Metro Police Department and Louisville/Jefferson County Metro Government,” March 8, 2023, <https://www.justice.gov/opa/pr/justice-department-finds-civil-rights-violations-louisville-metro-police-department-and>.

¹⁵ DOJ-HHS, *Guidance for Emergency Responses*, 2023, 4.

enforcement and 911 dispatch should divert calls to unarmed, properly trained behavioral health responders “whenever appropriate.”¹⁶ As the guidance explains:

Equal opportunity requires that people with behavioral health disabilities receive a health response in circumstances where others would receive a health response—for example, if call centers would dispatch an ambulance or a medic rather than law enforcement to respond to a person experiencing a heart attack or diabetic crisis, equal opportunity would entail dispatching a health response in similar circumstances involving a person with a behavioral health disability.¹⁷

In other words, sending police in response to a mental health crisis where there is no immediate safety risk to the public is discriminatory and violates civil rights laws.

Tools for Responding to Behavioral Health Calls

The guidance identifies a number of tools that should be available in all communities so that they can connect people in need of help to the most appropriate response as quickly as possible.¹⁸ This includes:

- transferring 911 calls involving people with behavioral health disabilities to local behavioral health hotlines and warmlines—confidential, free phone or text services offering mental health support—including as appropriate those affiliated with the new 988 Suicide and Crisis Lifeline;¹⁹
- investing in mobile crisis teams, such as those consisting of a mental health clinician and a person with lived or living experience working as a peer; and
- making mobile crisis teams available 24/7 and ensuring they respond in real-time to the location of the person in crisis, engage the person, assess their needs, intervene to de-escalate the situation, and connect the person to the services they need for long-term stability.

¹⁶ *Ibid.*, 5.

¹⁷ *Ibid.*, 3–4.

¹⁸ *Ibid.*

¹⁹ See U.S. Substance Abuse Mental Health Services Administration (SAMHSA), “988 Suicide & Crisis Lifeline,” <https://988lifeline.org>, (last visited Sep. 25, 2023). Many people with mental health issues do not use the 988 Lifeline, however, because in certain situations, 988 call takers may dispatch law enforcement officers to the caller’s location, whether or not that was the caller’s intention. See, for example, Bazelon Center for Mental Health Law, *A New Day or More of the Same? Our Hopes & Fears for 988 (and 911)*, (Washington, DC: Bazelon Center, 2022), 7, note 56, <https://secureservercdn.net/198.71.233.111/d25.2ac.myftpupload.com/wp-content/uploads/2022/06/A-New-Day-or-More-of-the-Same-Our-Hopes-Fears-for-988-and-911.pdf>.

Most behavioral health crises can be effectively addressed and resolved on site or in the community.²⁰ When it is necessary to take someone somewhere for crisis care, the guidance identifies models that have been shown to be effective, such as staffed crisis apartments and peer-led crisis respite centers.²¹ People with co-occurring substance use conditions may need short-term detox facilities, with offers of further support like outpatient medication.²²

Importantly, the guidance also recommends that crisis workers link individuals with disabilities to longer-term services that have been shown to help people avoid crises, including supported housing, assertive community treatment (ACT), intensive case management, peer support services, and supported employment.²³

Both short-term and long-term services must be trauma-informed and culturally and linguistically appropriate. These services can be paid for through Medicaid, and in an increasing number of places, peer support specialists work in and lead them.²⁴

²⁰ See, for example, National Association of State Mental Health Program Directors (NASHMPD), *Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies*, (Alexandria, VA: NASHMPD, 2020), 6–11, <https://www.nasmhpd.org/sites/default/files/2020paper11.pdf>. See also Margie Balfour, *What if . . . Access to Care was the Priority? Lessons from the Southern Arizona Crisis System* (Phoenix, AZ: Connections Health Solutions, last visited Sep. 25, 2023), https://www.neomed.edu/wp-content/uploads/CJCCOE_01-Margie-Balfour-What-if-access-to-care-was-a-priority.pdf.

²¹ DOJ-HHS, *Guidance for Emergency Responses*, 2023, 3, 14–15.

²² See Bazelon Center for Mental Health Law, *“Defunding the Police” and People with Mental Illness* (Washington, DC: Bazelon Center, 2020), 4, note 25, <https://www.bazelon.org/wp-content/uploads/2020/08/Defunding-the-Police-and-People-with-MI-81020.pdf>. A respected example of such a center is the Houston Recovery Center. Houston Recovery Center, “Harris County Confidential Jail Diversion Programs,” <https://houstonrecoverycenter.org/harris-county-confidential-jail-diversion-%20programs/> (last visited Sep. 25, 2023).

²³ DOJ-HHS, *Guidance for Emergency Responses*, 2023,

²⁴ See, for example, Olivia Randi, “American Rescue Plan Act Allows States to Expand Mobile Crisis Intervention Service for Children and Youth Through Medicaid,” National Academy For State Health Policy, October 2, 2021, <https://nashp.org/american-rescue-plan-act-allows-states-to-expand-mobile-crisis-intervention-services-for-children-and-youth-through-medicaid/> (Section 9813 of the ARPA creates a new state Medicaid option which provides funding for mobile crisis intervention services that meet federally established requirements); Behavioral Health News, “Spotlight on Excellence – An Interview with Steve Miccio, CEO of People USA,” Behavioral Health News, November 24, 2021, <https://behavioralhealthnews.org/interview-with-steve-miccio-ceo-of-people-usa/> (leader of peer support provider agency describes “building a funding tool under Medicaid” to make crisis services “more sustainable”). Some Medicaid rules may inhibit the effectiveness of peer support work, however, and should be changed. See Letter from Dennis G. Smith, Director, Centers for Medicare and Medicaid Services, to State Medicaid Directors, August 15, 2007, <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf> (stating that supervision of peer support workers is a “core component” of peer services, and must be provided by a “competent mental health professional”).

The Need for the Least Police Involved Response Appropriate

Communities must prioritize a health response to behavioral health crisis calls, not a “co-responder” model, whereby police respond alongside behavioral health workers. The recent DOJ and HHS guidance states that co-responses and specially trained officer responses may be “reasonable modifications” for situations “where a police response is called for,” but while accommodating such modifications, the federal government must clearly communicate and operate with the understanding that situations that involve people with behavioral health disabilities rarely require police involvement.²⁵ As noted in the Substance Abuse and Mental Health Services Administration’s (SAMHSA) crisis care guidelines, the mere presence of police can escalate crisis situations.²⁶ Studies of approaches relying on officer training have shown no net effect on outcomes of arrest or officer use of force, and no significant positive impacts on police encounters with people with behavioral health disabilities, other than a few anecdotal reports of positive participant experiences.²⁷ The evidence is mixed with respect to co-responder models, but there is little concrete evidence that these models reduce the risk of physical harm to people with disabilities.²⁸ Moreover, the co-responder model is premised on the assumption that most behavioral health-related calls pose a high safety risk, but this is not borne out by communities across the country that have implemented unarmed teams.²⁹

²⁵ DOJ-HHS, *Guidance for Emergency Responses*, 2023, 4.

²⁶ Substance Abuse and Mental Health Services Administration, *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit* (Washington, DC: SAMHSA, 2020), 33, 68, <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>.

²⁷ Taleed El-Sabawi and Jennifer J. Carroll, “A Model for Defunding: An Evidence-Based Statute for Behavioral Health Crisis Response,” *Temple Law Review* 94, no. 1(2021), 13, https://www.templelawreview.org/lawreview/assets/uploads/2021/12/1.-CarrollEl-Sabawi_FOR-PRINT.pdf; Sema A. Taheri, “Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? A Systematic Review and Meta-Analysis,” *Criminal Justice Policy Review* 27, no.1 (2016), 76, 90, http://www.gocit.org/uploads/3/0/5/5/30557023/sept_19_event_meta-analysis_crisis_intervention_training_for_police.pdf.

²⁸ See, for example, Natania Marcus and Vicky Stergiopoulos, “Re-Examining Mental Health Crisis Intervention: A Rapid Review Comparing Outcomes Across Police, Co-Responder and Non-Police Models,” *Health and Social Care in the Community* 30, no.5 (2022), 1665, 1670–1672, <https://onlinelibrary.wiley.com/doi/10.1111/hsc.13731> (finding that there is “little concrete evidence that co-response models avert injury,” unclear evidence on whether co-response models reduce arrest rates, and mixed evidence on whether co-response models correlate to decreased emergency department transports and hospital admissions); but see *id.* at 1673 (service user perceptions of the services they received were more positive for co-response models than for police-only models).

²⁹ Rachel Bromberg, “Busting Myths About Safety and Community Responder Teams,” Council of State Governments Justice Center, October 7, 2021, <https://csgjusticecenter.org/2021/10/07/busting-myths-about-safety-and-community-responder-teams/>.

Since the risk of harm to the individual is so great, and the actual threat to public safety is usually small, mental health advocates stress that law enforcement involvement in responses to behavioral health-related calls should be avoided whenever possible.³⁰ Contact between law enforcement and people experiencing mental health crises—even when officers respond alongside mental health workers in the “co-responder” model³¹—should be limited to only the rarest exceptions because of the risk of potentially dire consequences.³²

Likewise, the federal government must continue building on its meaningful investments in behavioral health approaches—such as SAMHSA grant awards for mobile crisis teams—to assist cities in moving from pilot programs or services with limited hours of operation to widespread, scaled programs. The DOJ Minneapolis report highlights that, among other factors, the limited number of calls the Behavioral Crisis Response (BCR) unit responded to during the investigation period “compromised BCR’s ability to achieve its emergency crisis response mission and continued the City’s reliance upon MPD for many first responses.”³³ As an increasing number of communities across the country pursue these non-police programs, they need access to more grants to plan and grow them.

It is past time that we address the incarceration, institutionalization, and police violence that BIPOC people with behavioral health disabilities—and all people with disabilities—face in law enforcement encounters when community-based mental health services are not available to respond to their needs. The new federal guidance is an important step forward, and at all levels of government, we urge greater investment in and clarity around the prioritization and implementation of unarmed crisis responses over police-led approaches.

³⁰ See, for example, Mental Health America, “Position Statement 59: Responding To Behavioral Health Crises,” accessed November 16, 2023, <https://mhanational.org/issues/position-statement-59-responding-behavioral-health-crises>; LDF-Bazelon, *Advancing an Alternative*, 2022, 4.

³¹ El-Sabawi & Carroll, “A Model for Defunding,” 2021, 13.

³² Lauren Young, “Decriminalizing Disability,” *Maryland Bar Journal* (Spring 2019), 62, https://issuu.com/marylandstatebarassociation/docs/spring_2019_maryland_bar_journal_ma/64.

³³ Department of Justice, “Investigation of the City of Minneapolis and the Minneapolis Police Department,” June 16, 2023, 63, https://www.justice.gov/d9/2023-06/minneapolis_findings_report.pdf.