The Judge David L.
BAZELON CENTER
for Mental Health Law
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VIA FIRST CLASS AND ELECTRONIC MAIL

March 12, 2015

President's Task Force on 21st Century Policing
Office of Community Oriented Policing Services
U.S. Department of Justice
145 N Street, N.E. 11th Floor
Washington, DC 20530
Via Email To: Comment@taskforceonpolicing.us

Dear Co-Chairs Ramsey and Robinson, and Members of the Task Force:

The Judge David L. Bazelon Center for Mental Health Law is a national public interest organization, founded in 1972 to advance the rights of individuals with mental illness or an intellectual disability. Among other priorities, we seek implementation and enforcement of the Americans with Disabilities Act's guarantees of non-discrimination and reasonable accommodation. The Center has long worked for the diversion of people with mental illness from the criminal justice system and for safer police practices. We applaud your work promoting better policing practices and fostering collaboration between law enforcement and communities. We would welcome the opportunity to talk to you about the resources law enforcement and other public agencies require to ensure safe and non-discriminatory policing for people with mental illness.

Law enforcement's role in responding to individuals with mental illness has increased over the last several decades, as more people with such disabilities are living and receiving services in the community. Community mental health systems lack the resources they need and, as a result, many individuals with mental illness are homeless or unemployed, circumstances that correlate with encounters with police.[1] Individuals with mental illness have higher rates of arrest than the general population, and the rate of arrest among public mental health service recipients is "roughly 4.5 times higher than those observed in the general population."[2]

It is especially concerning that people with mental illness are disproportionately injured or killed in encounters with the police.[3] Moreover,

[1] Steven K. Hoge, et al., *Outpatient Services for the Mentally Ill Involved in the Criminal Justice System*, American Psychiatric Association Task Force Report (Oct. 2009) at 11-12, *available at* www.law.uchicago.edu/files/file/outpatient-crimjustice.pdf.
[2] William H. Fisher, et al., *Risk of Arrest Among Public Mental Health Services Recipients and the General Public*, 62 *Psychiatric Services* 62 (Jan. 2011) at 67, *available at* psychiatryonline.org/doi/abs/10.1176/ps.62.1.pss6201_0067.
[3] Rachael Bale & Alex Emslie, *More Than Half of Those Killed by San Francisco Police are Mentally Ill*, KQED News (Sept. 30, 2014), *available at* ww2.kqed.org/news/2014/09/30/half-of-those-killed-by-san-francisco-police-are-mentally-ill; Kelley Bouchard, *Across Nation*,

25% of inmates in local prisons and jails have a mental illness;[4] and 17% of inmates have a *serious* mental illness.[5]

These are grim statistics. But the situation is not hopeless. Police departments across the country are implementing modifications to traditional policing practices that can increase the safety of officers and of people with mental illness during police encounters.[6] To be truly successful, though, strategies such as enhanced police training and mobile crisis teams must be coupled with community-based mental health and addiction services—those that help individuals with mental illness avoid police encounters in the first place and those that help reduce the risk of recidivism upon release from police custody or incarceration. We were pleased to see that the Task Force's interim report contained several recommendations for increasing the use of some of the successful practices we discuss below, but we urge the commission to make more specific recommendations on several points.[7]

1. Strategies to Protect Officers and Better Serve Individuals with Mental Illness During Police Encounters

Police are increasingly responding to calls relating to individuals in mental health crisis who have committed no violent act or crime.[8] With proper training, the risk to both officers and the individual in crisis can be greatly reduced. Among the modifications officers can make to their practices when interacting with people in mental health crisis is the use of **Crisis Intervention Teams** (CITs) and of the skills officers learn in "CIT training." CITs consist of officers with specialized training in de-escalation techniques, who safely and effectively respond to situations involving people in mental health crisis.[9] Officers who are not part of a CIT can receive CIT training on these same techniques. CIT training gives officers the knowledge they need to connect

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Unsettling Acceptance when Mentally Ill in Crisis are Killed, Portland Press Herald (Dec. 9, 2012), *available at* www.pressherald.com/2012/12/09/shoot-across-nation-a-grim-acceptance-when-mentally-ill-shot-down/; Tux Turkel, *When Police Pull the Trigger in Crisis, the Mentally Ill Often are the Ones Being Shot*, Portland Press Herald (Dec. 8, 2012), *available at* www.pressherald.com/2012/12/08/shoot-maine-misfiring-on-deadly-force/.

[4] *The New Asylums Frequently Asked Questions*, PBS Frontline, *available at* www.pbs.org/wgbh/pages/frontline/shows/asylums/etc/faqs.html. The most recent Bureau of Justice Statistics study estimated that the United States inmate population with mental illness (defined as a clinical diagnosis or treatment by mental health professional) was higher: 56% of inmates in state prisons and 45% of inmates in federal prisons. *See* Doris James & Lauren Glaze, *Mental Health Problems of Prison and Jail Inmates*, U.S. Dep't of Justice (Sept. 2006) at 1, *available at* www.bjs.gov/content/pub/pdf/mhppji.pdf.

[5] Alex M. Blandford & Fred C. Ocher, *A Checklist for Implementing Evidence-Based Practices and Programs for Justice-Involved Adults with Behavioral Health Disorders*, SAMHSA Gains Center for Behavior Health and Justice Transformation (Aug. 2012) at 1, *available at* gainscenter.samhsa.gov/cms-assets/documents/73659-994452.ebpchecklistfinal.pdf. For a definition of "serious mental illness," *see* Federal Register Vol. 58 No. 96 at 29422-29425 (May 20, 1993).

[6] Title II of the Americans with Disabilities Act requires that state and local governments make reasonable modifications to their programs for individuals with disabilities. *See* 28 C.F.R. § 35.130(b)(7); *cf.* 42 U.S.C. § 12182(b)(2)(A)(ii) (defining discrimination for purposes of Title III of the ADA to include the "failure to make reasonable modifications").

[7] Although our comments are focused on individuals with mental illness, individuals with intellectual disabilities face similar challenges. *See, e.g.*, "Suspects with developmental disabilities & the criminal justice system," The ARC of New Jersey, *available at* www.arcunion.org/resources/pdfs/ithddadwarenessforofficers.pdf (noting that between 2-10% of offenders and at least 25,000 individuals in prison have intellectual disabilities).

[8] Fernanda Santos & Erica Goode, *Police Confront Rising Number of Mentally Ill Suspects*, New York Times (Apr. 2, 2014), *available at* www.nytimes.com/2014/04/02/us/police-shootings-of-mentally-ill-suspects-are-on-the-upswing.html.

[9] Randolph Dupont, *et al*., *Crisis Intervention Team Core Elements*, The University of Memphis School of Urban Affairs and Public Policy, Department of Criminology and Criminal Justice CIT Center, (2007) at 3, 5, *available at* www.cit.memphis.edu/information_files/CoreElements.pdf.

people in crisis with the public mental health system, rather than channeling them into the criminal justice system.[10]

The results of properly-implemented CITs and CIT training for officers are dramatic: increased officer safety, improved outcomes for people with mental illness, increased confidence for responding officers, and cost savings. CIT-trained officers in Memphis—where the first CIT was developed in 1988—are "more likely to indicate that they [are] well prepared in situations involving people with mental illnesses," view their non-CIT trained colleagues as less capable of successfully responding to such situations, and are "more likely to rate the mental health system as being helpful."[11] In Georgia and Indiana, CIT-trained officers demonstrated greater knowledge of mental illness and how to appropriately respond to symptoms of mental illness; as a result, they used less-aggressive policing techniques with people with mental illness and had "improved rapport-building skills, de-escalation abilities, and communication between officers and . . . [individuals with mental illness] and their family members, as well as better outcomes . . . in terms of referrals to mental health services."[12] The use of CITs and CIT training for officers is also associated with less use of "high-intensity police units" such as SWAT teams, and there is a "lower rate of officer injuries" among police departments with CITs and officers who have undergone CIT training.[13] According to the National Alliance on Mental Illness (NAMI), which provides CIT training to many police officers around the country, the introduction of CIT-trained officers has resulted in an 80% reduction in officer injuries when responding to situations involving a person in mental health crisis.[14]

By teaching officers how to better interact with people with mental health illness and avoid channeling them into the criminal justice system, CIT training also results in lower arrest rates and thus reduces burdens on criminal justice systems. The Memphis CIT program has shown significant savings for that city's criminal justice system by shifting costs to the mental health system, where such costs belong and public resources are more efficiently invested.[15] Research on the Louisville, Kentucky CIT program shows that an annual investment of $150,000 in CIT training for police officers has saved over $1 million per year for both the criminal justice and mental health systems, mostly in deferred hospitalizations and reduced inpatient referrals from jail.[16]

Although there are over 400 CITs[17] in forty-six states,[18] most states do not require the forty-hour training that is considered standard for police officer CIT training.[19] A review of thirty-seven states shows that most require eight or fewer hours of CIT training, and Hawaii and others have

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[10] *Id*. at 5
[11] Michael T. Compton, et al., *A Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs*, The Journal of the American Academy of Psychiatry and the Law (2008) at 49, *available at* www.jaapl.org/content/36/1/47.short.
[12] *Id*. at 50.
[13] *Id*. at 52.
[14] Megan Pauly, *How Police Officers Are (or Aren't) Trained in Mental Health*, The Atlantic (Oct. 11, 2013), *available at* www.theatlantic.com/health/archive/2013/10/how-police-officers-are-or-aren-t-trained-in-mental-health/280485/.
[15] *Id*. at 52.
[16] Peggy El-Mallakh, et al., *Costs and Savings Associated with Implementation of a Police Crisis Intervention Team*, Southern Medical Journal (2014), *available at* sma.org/southern-medical-journal/abstract/2014/0600/costs-and-savings-associated-with-implementation-of-a-police-crisis-intervention-team/.
[17] *A Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs*, *supra* note 11 at 48.
[18] *Crisis Intervention Team Map*, The University of Memphis School of Urban Affairs and Public Policy, Department of Criminology and Criminal Justice CIT Center, *available at* cit.memphis.edu/CitMap/.
[19] *How Police Officers Are (or Aren't) Trained in Mental Health*, *supra* note 14.

no mental health training requirement despite having a registered CIT program.[20] Police departments report that it is primarily a lack of funding that prevents them from investing more in CIT training.[21]

CITs and CIT training are not the only methods proven to improve outcomes in encounters between people with mental illness and law enforcement. **Mobile Crisis Teams** ("MCTs") arrange for one or more highly-trained mental health treatment providers—psychiatric nurses, social workers, or paraprofessionals—to accompany an officer responding to a mental health crisis. MCTs are on-call and can be deployed as needed to help officers assess a situation, or meet with individuals without a law enforcement presence. MCTs use a variety of interventions to de-escalate crises and connect people with the public mental health system.[22] Depending on the jurisdiction, MCTs can be called by police dispatchers or even social workers or family members, and they often facilitate rapid treatment and transportation to hospitals or other mental health providers.[23] The results can be dramatic: a survey of mobile crisis teams in DeKalb County, Georgia found that their use prevents hospitalization 55% of the time compared to only 28% for typical police interventions.[24] The same study found that mobile crisis teams cost 23% less than traditional police involvement and hospitalizations.[25]

Both mental health professionals and the United States Department of Justice have embraced the use of CITs and MCTs. Based on research and experience, the American Psychiatric Association and the American Psychological Association have declared that CITs improve "officers' familiarity and comfort with the mental health system" and mobile crisis teams are "effective at de-escalating police interactions with individuals with mental illness," leading to better outcomes for individuals with mental illness.[26] A 2012 settlement the DOJ reached with Portland, Oregon required substantial investments in CITs and mobile crisis services.[27] The City agreed to invest additional resources in its existing officer CIT training by requiring that all officers receive a minimum of forty hours of training before assuming independent patrol or call-response duties; it also agreed to create a Memphis-style CIT, with an initial size of 60-80 volunteer officers, depending on demand for CIT services.[28] In addition, the city committed to expanding its mobile crisis services so that each precinct had a Mobile Crisis Team consisting of an officer and a mental health professional.[29]

Some funding from the federal government is available for these services. The Bureau of Justice Assistance, a component of the Office of Justice Programs at the U.S. Department of Justice that administers the Justice and Mental Health Collaboration Program (JMHCP), provides funding to

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[20] *Id*.
[21] *Id*.
[22] *Mobile Crisis Teams*, New York City Dep't of Health and Mental Hygiene, *available at* www.nyc.gov/html/doh/html/mental/mobile-crisis.shtml.
[23] *Id*.; H. Richard Lamb, et al., *The Police and Mental Health*, Psychiatric Services 1266 (2002) at 1269, *available at* www.popcenter.org/problems/mental_illness/PDFs/Lamb_etal_2002.pdf.
[24] Roger Scott, *Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction*, 51 Psychiatric Services 9 (Sept. 2000) at 1153-6, *available at* ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.51.9.1153.
[25] *Id*.
[26] *See* Brief of American Psychiatric Association, American Psychological Association, *et al*. at 30, 32, *City and County of San Francisco, California v. Teresa Sheehan*, No. 13-1412 (S. Ct. Feb. 17, 2015), *available at* www.americanbar.org/content/dam/aba/publications/supreme_court_preview/BriefsV5/13-1412_amicus_resp_apa.authcheckdam.pdf.
[27] *See* Settlement Agreement, *United States v. City of Portland*, Civil Action No. 12-2265 (D. Or. Dec. 17, 2012).
[28] *Id*. at 37-38.
[29] *Id*. at 40.

projects designed to "increasing public safety through innovative cross-system collaboration for individuals with mental illness who come into contact with the criminal justice system."[30] This grant program has been used to fund CIT training and to develop and maintain statewide implementation efforts.[31] Medicaid funding, at least 50% of which is federal, can be used to pay for the activities of the mental health professionals who participate on MCTs, although a national survey identified only 12 states using Medicaid to cover mobile crisis services.[32] The Administration has also allocated money to mental health first aid programs through the "Now is the Time Initiative."[33] There are several states that also directly fund CIT training.[34]

Nevertheless, CIT training and MCTs are in short supply. Funding for these fundamentally necessary trainings and services should be expanded.

2. Strategies to Reduce Encounters Between Police and People with Mental Illness: Expanding Community-Based Mental Health Services

CITs and MCTs are important, but they seek to improve outcomes when a crisis occurs. We must devote resources to expanding community mental health services that prevent mental health crises from occurring in the first place and provide appropriate—non-forensic—responses when they do, including diversion from the criminal justice system.

There is a broad consensus in the mental health community about how to achieve these goals. Mental health crisis services including MCTs based in and operated by the mental health system (vs. law enforcement agencies), Assertive Community Treatment ("ACT"), and supportive housing are key evidence-based approaches to preventing mental health crises and responding safely and appropriately when they do occur.

Mental health crisis services include mental health MCTs,[35] crisis walk-in centers, crisis respite apartments, and crisis hotlines, and can help prevent police encounters from occurring in the first place. Crisis walk-in centers allow individuals who are having a mental health crisis to receive an immediate assessment and diagnosis for treatment as well as planning and referrals for ongoing treatment.[36] Crisis respite facilities provide temporary living space and supports during a mental health crisis; they are often staffed with peers who have lived

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[30] See *Justice and Mental Health Collaboration Program (JMHCP)*, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance (2015), *available at* https://www.bja.gov/ProgramDetails.aspx?Program_ID=66. The Bureau of Justice Assistance is also funding a report summarizing how some states have utilized JMHCP funds to increase usage of CIT and mobile crisis teams. *See* Melissa Reuland, Laura Draper, and Blake Norton, *Statewide Law Enforcement/ Mental Health Efforts: Strategies to Support and Sustain Local Initiative*, Council of State Governments Justice Center (Dec., 2012) *available at* https://www.bja.gov/Publications/CSG_StatewideLEMH.pdf.

[31] *See* Reuland, et al., supra note 30, at fn.11.

[32] *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*, Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) at 16 (listing Arizona, Connecticut, Delaware, Florida, Hawaii, Mississippi, North Carolina, New Jersey, New Mexico, Oklahoma, Vermont, and Wisconsin as states in which Medicaid funding is available), *available at* store.samhsa.gov/shin/content/SMA14-4848/SMA14-4848.pdf.

[33] *"Now is the Time" Project AWARE State Educational Agency Grants*, SAMHSA (2014), *available at* www.samhsa.gov/grants/grant-announcements/sm-14-018.

[34] *Id.* at 6-9. *See also Crisis Intervention Team Grant Program Guidelines and Application Instructions for Projects Starting June 1, 2009*, The Commonwealth of Virginia, Department of Criminal Justice Services (2009), *available at* www.dcjs.virginia.gov/cple/grants/cit/citguidelines.pdf.

[35] *See Mobile Crisis Teams*, *supra* notes 22 and 23 and the corresponding text. MCTs that are operated by and within the mental health system do not include law enforcement officers.

[36] *See*, *e.g.*, *Walk-In Crisis and Psychiatric Aftercare*, North Carolina Dep't of Health and Human Services, *available at* www.ncdhhs.gov/mhddsas/services/crisisservices/walkincrisis.htm.

experience with mental illness.[37] Crisis hotlines provide support services and referrals via telephone and text message.[38] Mental health MCTs travel to the person in crisis. In most instances, they both allay the crisis and arrange for needed treatment.

Assertive Community Treatment (ACT) teams are comprised of mental health specialists—psychiatrists, nurses, social workers, and others—working in a coordinated fashion to help people with serious mental illness live independently and avoid crises.[39] ACT teams are mobile, provide services in the home and in other community settings where people spend time, and are available twenty-four hours a day, seven days a week.[40] ACT teams help people access mental health care, maintain stable housing, secure and maintain employment, become part of a community, manage physical health, and develop other recovery skills.[41]

Supportive housing, another critical service that reduces homelessness and improves mental health outcomes,[42] provides an individual with rental assistance to move in to their own apartment or home while making available a wide range of "wraparound" services that support recovery, engagement in community life and successful tenancy.[43] ACT teams or similar support staff work with residents in supportive housing to provide a flexible array of services.[44] There are no preconditions to participating in supportive housing (such as treatment compliance), the housing is permanent and affordable, and residents have the rights and responsibilities of tenants.[45]

These approaches work.[46] A recent survey of evidence of the effectiveness of mental health

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[37] *The Key Assistance Report Focus on Peer-Run Crisis Respite Services*, National Mental Health Consumers' Self-Help Clearinghouse, *available at* www.mhselfhelp.org/storage/publications/key-assistance-reports/KAR%20Focus%20on%20Peer-Run%20Crisis%20Respites%201.pdf.

[38] *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*, SAMHSA (2014) at 11-12, *available at* store.samhsa.gov/shin/content/SMA14-4848/SMA14-4848.pdf

[39] *A Way Forward: Diverting People with Mental Illness from Inhumane and Expensive Jails into Community-Based Treatment that Works*, ACLU of Southern California and the Bazelon Center for Mental Health Law (2014) at 4, *available at* https://www.aclusocal.org/wp-content/uploads/2014/07/JAILS-REPORT.pdf.

[40] *Id*.

[41] *Id*. The Substance Abuse and Mental Health Services Administration provides an Evidence-Based Practices Kit on ACT teams. *See* store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345.

[42] *A Way Forward*, *supra* note 39 at 4.

[43] *Id*. *See also Housing First*, Pathways to Housing, *available at* pathwaystohousing.org/our-model/.

[44] *A Way Forward*, *supra* note 39 at 4.

[45] *Supportive Housing: The Most Effective and Integrated Housing for People with Mental Disabilities*, The Bazelon Center for Mental Health Law, *available at* www.bazelon.org/LinkClick.aspx?fileticket=eRwzUzZdIXs%3d&tabid=126. The Substance Abuse and Mental Health Services Administration provides an Evidence-Based Practices Kit on supportive housing. *See* store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510.

[46] Another key service is supported employment, which helps people with mental illness find and keep employment, and provide supports as needed, including skills training, benefits counseling, and job coaching. *See generally* www.centerforebp.case.edu/practices/se and www.psych.iupui.edu/Users/gbond/pdfs/114%202004%20Bond%20SE%20rev%20psr%20j.pdf. Higher rates of unemployment among people with serious mental illness impact the disproportionate arrest and incarceration rates among this population, making supported employment another key approach to improving mental health outcomes and preventing unnecessary police interactions. *See Employment Status of the Civilian Population by Sex, Age, and Disability Status, Not Seasonally Adjusted*, United States Dep't of Labor Bureau of Labor Statistics (2015), *available at* www.bls.gov/news.release/empsit.t06.htm (showing that the February 2015 unemployment rate for individuals with disabilities is 11.9%, versus 5.9% for people without disabilities); Eric Gould, et al., *Crime Rates and Local Labor Market Opportunities in the United States: 1979-1997*, The Review of Economics and Standards (1997), *available at* www.mitpressjournals.org/doi/abs/10.1162/003465302317331919; *see also* Steven Raphael and Rudolf Winter-Ebmer, *Identifying the Effect of Unemployment on Crime*, Journal of Law and Economics (2001),

crisis services found that crisis walk-in centers, peer-run crisis respites, and crisis hotlines provide effective care, with greater consumer satisfaction than hospital care.[47] ACT programs have decreased participants' days spent in jail over the course of a year by as much as 83%.[48] Supportive housing reduces shelter use, hospitalizations, duration of hospital stays, and incarceration.[49] Pathways to Housing,[50] a well-studied and widely-emulated provider of ACT and supportive housing, has reduced prison episodes by 50%, shelter use by 88%, hospitalization episodes by 71%, and crisis response episodes by 71% percent among its participants.[51]

The Department of Justice has incorporated these services into a series of settlements with cities and states in its cases enforcing the United States Supreme Court's landmark decision in *Olmstead v. L.C.*,[52] in which the Court affirmed that the needless institutionalization of people with disabilities is a form of discrimination prohibited by the Americans with Disabilities Act. In a 2010 DOJ settlement with Delaware, the state agreed to create mental health MCTs that could "reach someone anywhere in the state within one hour," ACT teams, and supportive housing vouchers.[53] In a 2010 DOJ settlement with Georgia, the state agreed to create ACT teams, mental health MCTs, and supportive housing.[54] And in a 2012 settlement with North Carolina, the state agreed to create additional supportive housing slots, ACT teams, and crisis services including mental health MCTs, walk-in crisis clinics, and a twenty-four hour crisis telephone line.[55] In a 2014 settlement with New Hampshire, the state agreed to create a crisis system that included mental health MCTs and crisis apartments with peer staff and clinical staff, as well as expand ACT and supportive housing services.[56]

Not only do these community-based services work, they save money. In one year, Georgia experienced a net cost savings of $1.1 million in reduced hospitalizations, fewer arrests and

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available at www.jstor.org/stable/10.1086/320275; Deborah R. Becker, et. al, *Converting Day Treatment Centers to Supported Employment Programs in Rhode Island*, 52 Psychiatric Services 3 (Mar. 2001) at 351, *available at* www.hawaii.edu/hivandaids/Converting_Day_Treatment_Centers_to_Supported_Employment_Programs_in_Rhode_Island.pdf (finding that a Rhode Island supported employment program resulted in employment rates as high as 56.7%, compared to 19.5% for individuals in a day treatment program). By helping people with mental health disabilities obtain jobs, states and localities help reduce homelessness and give people a productive way to fill their day. The Substance Abuse and Mental Health Services Administration provides an Evidence-Based Practices Kit on supported employment. *See* store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365.

[47] *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*, *supra* note 32, at 8-14.

[48] J. Steven Lamberti et al., *Forensic Assertive Community Treatment: Preventing Incarceration of Adults with Severe Mental Illness*, 55 Psychiatric Services 11 (Nov. 2004) at 1285-1293, 1289, *available at* ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.55.11.1285.

[49] Dennis P. Culhane et al., *Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing*, 13 Housing Policy Debate 107 (2002) at 137-138, *available at* repository.upenn.edu/cgi/viewcontent.cgi?article=1067&context=spp_papers.

[50] More information available at pathwaystohousing.org.

[51] *Evaluation of Pathways to Housing PA*, Fairmont Ventures, Inc. (Jan. 2011), *available at* pathwaystohousing.org/pa/wp- content/themes/pathways/assets/uploads/PTHPA-ProgramEvaluation.pdf; *see also* Ronda Eisenberg & Sam Tsemberis, *Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals*, 51 Psychiatric Services 4 (Apr. 2000) at 487, *available at* ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.51.4.487.

[52] 527 U.S. 582 (1999).

[53] Settlement Agreement, *United States v. Delaware*, Civil Action No. 11-591 (D. Del. July 6, 2011), *available at* www.ada.gov/olmstead/olmstead_cases_list2.htm.

[54] Settlement Agreement at 12-13, 18-19, 29, *United States v. Georgia*, Civil Action No. 10-249 (N.D. Ga. Oct. 19, 2010), *available at* www.ada.gov/olmstead/olmstead_cases_list2.htm.

[55] Settlement Agreement at 4, 9, 11, *United States v. North Carolina*, Civil Action No. 12-557 (E.D.N.C. Aug. 13, 2012), *available at* www.ada.gov/olmstead/olmstead_cases_list2.htm.

[56] Settlement Agreement, *United States v. New Hampshire*, Civil Action No. 12-53 (D. N.H. Feb. 12, 2014), *available at* www.ada.gov/olmstead/olmstead_cases_list2.htm.

decreased jail time among ACT recipients.[57] Numerous studies have shown that expanding supportive housing saves states significant money by reducing shelter use, hospitalizations, duration of hospital stays, and incarceration.[58] A survey of community crisis services such as mobile crisis services and crisis respites found that these services produced cost savings.[59]

In addition, Medicaid funding is available to cover the costs of these services for individuals who are Medicaid eligible.[60] This is a growing group, especially among adults with serious mental illness, because states that have adopted the Medicaid expansion may cover all of these services at largely federal expense for numerous people who were previously uninsured and ineligible for Medicaid.[61]

Despite the substantial benefits of these services and the Medicaid financing available to pay for them, these services are largely unavailable to those who need them. In 2012, state mental health authorities reported that only 2% of individuals served received ACT services and only 2.6% received supportive housing services.[62]

These services need to be expanded, and we urge the Task Force to recommend that additional federal funding be allocated to support these services.

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[57] *Forensic Assertive Community Treatment: First Year in Review*, Georgia Rehabilitation Outreach, Inc., July 1, 2004 - June 30, 2005 3 (2006), *available at* www.supporthousing.org/FACTrept1.pdf.

[58] *See, e.g.*, Dennis P. Culhane, *et al*., *Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing*, 13 Housing Policy Debate 107 (2002), *available at* repository.upenn.edu/cgi/viewcontent.cgi?article=1067&context=spp_papers (supportive housing participants used an average of $16,282 less in services per year, and the cost of providing supportive housing was approximately the same as the cost of having individuals remain homeless); Fairmount Ventures, Inc., *Evaluation of Pathways to Housing PA*, *supra* note 51 (supportive housing reduced participants' shelter episodes by 88%, hospitalization episodes by 71%, crisis response center episodes by 71%, and prison system episodes by 50%, and cost approximately $28,000 annually per person, compared to $56,600 for programs housing chronically homeless people and $41,000 for residential drug and alcohol programs for homeless people with mental illnesses); Robert Bernstein, *Fourth Report of the Court Monitor on Progress Toward Compliance with the Settlement Agreement:* U.S. v. State of Delaware (Sept. 2013), *available at* www.dhss.delaware.gov/dhss/dsamh/files/usdoj_courtmonitorreport4_2013_09_24.pdf (net annual savings per person between $96,000 and $276,000 when state psychiatric hospital residents, many with protracted stays, moved to supportive housing; hospital readmission rate for this high-risk group was about half of that of all individuals with serious mental illness in the state).

[59] *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*, *supra* note 32, at 14-15.

[60] *Take Advantage of New Opportunities to Expand Medicaid Under the Affordable Care Act*, The Bazelon Center for Mental Health Law (July 2012), *available at* www.bazelon.org/LinkClick.aspx?fileticket=cwAuDZLEmQI%3D&tabid.

[61] The Medicaid Expansion gives states an enhanced reimbursement rate (100% until 2016, after which a minimum 90%) for all newly eligible individuals, anyone whose annual income is less than 139% of the federal poverty level. States must create Medicaid expansion plans that cover, at a minimum, the mandatory traditional Medicaid services and the essential health benefits. States can also chose to align these expansion plans with the state's traditional Medicaid plan, simplifying administration. Regardless of what states cover in their Medicaid expansion plans, individuals with serious mental illness are among those considered "medically frail" and thus can choose to receive traditional Medicaid services. The state will still receive the increased reimbursement rate for the newly eligible. *See When Opportunity Knocks: How The Affordable Care Act Can Help States Develop Supported Housing for People with Mental Illness*, The Bazelon Center for Mental Health Law (2014), *available at* www.bazelon.org/portals/0/Where%20We%20Stand/Community%20Integration/Olmstead/When%20Opportunity%20Knocks.%20Bazelon%20Center%20for%20Mental%20Health%20Law.pdf.

[62] *2012 CMHS Uniform Reporting System Output Tables*, Substance Abuse and Mental Health Service Administration, (2012), *available at* www.samhsa.gov/dataoutcomes/urs/urs2012.aspx.

3. Strategies for Justice-Involved Individuals: Diverting Individuals with Mental Illness from Jail and Reducing Recidivism

For individuals who are swept up in the criminal justice system as a result of mental illness, appropriate services are needed that focus on diverting them from jail and supporting them in the community after release (if they are incarcerated), to prevent cycling in and out of jail and prison.[63]

The same services that help prevent involvement with the criminal justice system in the first place, like MCTs, ACT teams, and supportive housing, are key components of effective diversion programs. They also help individuals with mental illness avoid committing new offenses.

Miami-Dade County mounted a major effort to divert people with mental illness from detention in its jail. Among other approaches, the County invested more in ACT and supportive housing services. As a result, misdemeanor recidivism has been reduced from 75% to 20%.[64] The same program has reduced felony recidivism to just 6%.[65] A study of a San Francisco diversion program showed an 84% percent drop in the likelihood of re-arrest for program graduates.[66]

The Nathaniel Project in New York City, which relies on ACT and supportive housing, has demonstrated a "70% reduction in arrests over a two-year period among program participants."[67] Chicago's Thresholds' Justice Program, which offers ACT and supportive housing, has shown an "89% reduction in arrest, an 86% reduction in jail time, and a 76% reduction in hospitalizations."[68] In King County, Washington, a Forensic ACT program serving adults with serious mental illness who have extensive criminal histories has demonstrated a 45% reduction in jail and prison bookings among participants, who have "significantly decreased their amount of time institutionalized" in jails, prisons, and hospitals.[69]

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[63] Diverting people from incarceration and reducing recidivism through community-based services can also lead to substantial savings for states and local governments. Localities with limited budgets spend disproportionate funds jailing individuals with mental illness. The Los Angeles County Jails, the Rikers Island Correctional Facility in New York City, and the Cook County Jail in Chicago have become the three largest psychiatric institutions in the nation. *See A Way Forward*, supra note 39 at 6. In Los Angeles County, for example, it costs $38,000 per year to jail an inmate without a mental illness, but it costs $48,500 to house an inmate with a mental illness; the average length of stay in jail is just eighteen days for a person without a mental illness compared to forty-three days for a person with a mental illness. *See id*. at 8. Just to cover psychiatric medications for inmates, Los Angeles County spends $10 million per year—and because the recipients are inmates, Medicaid dollars are not available to cover these costs. *See id.* at 3, 8.

[64] *Id*. at 7.

[65] *Id*.

[66] *Id*.

[67] *Id*. at 5.

[68] *Id*.

[69] *Id*.

Without effective programs like those described above, reported rates of recidivism for individuals with serious mental illness are alarmingly high—from 54% among individuals with severe mental illness in Philadelphia,[70] to 80% in California,[71] to 95% in Los Angeles.[72]

In addition to the right set of services, both diversion efforts and efforts to prevent recidivism require collaboration between the mental health and the criminal justice systems. For example, mental health service providers must have notice of individuals with mental illness being released from jails and prisons. In addition, the two systems must collaborate to ensure that inmates who are being released have ready access to Veterans benefits, Medicaid, and Social Security disability benefits upon release.[73]

4. Conclusion

The shortage of training and effective community-based services is a fundamental problem in our law enforcement and public mental health systems, and it can lead to tragic consequences. There are concrete steps that can be taken to improve the situation. As we initially mentioned, we think that the Task Force's interim report included some excellent recommendations, but we urge the Task Force to include the following specific recommendations in its final report to the President:

Crisis Point Practices and Services:

We support Recommendation 5.6 of the Task Force's interim report that Crisis Intervention Team (CIT) training should be made a part of both basic recruit and in-service officer training. We also support the Task Force's recommendation that Congress provide additional funding to ensure that there is sufficient capacity.

We also support Recommendation 4.3 and agree that "multidisciplinary, community team approaches for planning, implementing, and responding to crisis situations with complex causal factors" is a fundamentally important practice. In the mental health context, this includes ensuring that Mobile Crisis Teams are available to respond to individuals in mental health crises.

We would add to this recommendation that:

1. The federal government should provide clear guidance and technical assistance to states about how to use Medicaid funding for Mobile Crisis Teams.

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[70] *Study finds higher rates of jail recidivism among people with co-occurring severe mental illness and substance use disorders*, Case Western Reserve University (2012), *available at* www.centerforebp.case.edu/stories/study-finds-higher-rates-of-jail-recidivism-among-people-with-co-occurring-severe-mental-illness-and-substance-use-disorders.

[71] *Council on Mentally Ill Offenders*, California Department of Corrections and Rehabilitation, *available at* www.cdcr.ca.gov/COMIO/Legislation.html.

[72] *A Way Forward*, *supra* note 39 at 7.

[73] Alex Blandford & Fred Osher, *Guidelines for Successful Transition of People with Behavioral Health Disorders from Jail and Prison*, SAMHSA's GAINS Center for Behavioral Health and Justice Transformation and the Council of State Governments Justice Center (Nov. 2013) at 3, *available at* csgjusticecenter.org/wp-content/uploads/2013/12/Guidelines-for-sucessful-transition-summary.pdf.

2. States should ensure that there are both law enforcement-based and mental health system-based Mobile Crisis Teams available on a statewide basis and in sufficient numbers to respond to mental health crises.

Strategies to Reduce Encounters Between Police and People with Mental Illness:

We appreciate that the Task Force made the Overreaching Recommendation 0.2 that "[t]he President should promote programs that take a comprehensive and inclusive look at community based initiatives that address the core issues of poverty, education, health, and safety [. . .] the justice system alone cannot solve many of the underlying conditions that give rise to crime. It will be through partnerships across sectors and at every level of government that we will find the effective and legitimate long-term solutions to ensuring public safety." This is especially true for people with mental illness, many of whom do not have access to the services they need to avoid encounters with the police.

We urge the Task Force to add to its final report the recommendation that states expand access to services proven to decrease encounters with law enforcement including mental health crisis services, ACT teams, and supportive housing.

Strategies for Justice-Involved Individuals:

The same services that are so successful upstream are also an important part of appropriate downstream diversion and are necessary to prevent recidivism. We urge the Task Force to add these additional recommendations to its final report:

1. States should ensure that there are diversion programs that include mental health crisis services, ACT teams and supportive housing.

2. In order to prevent recidivism, states must also provide these services as part of reentry programs for individuals who are transitioning back into the community after incarceration. As the Interim Report notes at Recommendation 4.6, law enforcement agencies should involve their communities in re-entry programs for adults leaving prisons and jails. This reentry period is crucial and all agencies involved in this process should enter into memorandums of understanding that address how inmates who are being released can apply for services, the response time for determinations, and how to ensure ready access to Veterans benefits, Medicaid, and Social Security disability income upon release from prison or jail.

3. The federal government and Congress must work to ensure there is sufficient funding for States to implement the recommendations above.

Only by adequately funding and expanding community mental health services can we dramatically improve outcomes for both police officers and people with mental illness. We urge the Task Force to consider the information we have provided as it finalizes its recommendations to the President. Thank you for taking the time to review our recommendations, and please contact us if we can provide more information.

Sincerely,

Robert Bernstein, Ph.D.
President and CEO