**No. 18-1303**

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**IN THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT**

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JUDITH GRAY,

*Plaintiff-Appellant*,

v.

THOMAS A. CUMMINGS; TOWN OF ATHOL, MASSACHUSETTS,

*Defendants-Appellees*.

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On Appeal from the United States District Court for the District of Massachusetts (No. 4:15-cv-10276-TSH)

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# BRIEF FOR *AMICI CURIAE* AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN PSYCHOLOGICAL ASSOCIATION, AND THE JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW IN SUPPORT OF NEITHER PARTY

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## STATEMENT OF INTEREST[1]

The American Psychiatric Association, with more than 37,800 members, is the nation's leading organization of physicians who specialize in psychiatry. Members of the American Psychiatric Association are physicians engaged in treatment, research, and forensic activities, and many members regularly perform roles in the criminal justice system. The American Psychiatric Association has participated as *amicus curiae* in numerous cases in the United States Supreme Court and in the courts of appeals, including *City & County of San Francisco v. Sheehan*, 135 S. Ct. 1765 (2015).

The American Psychological Association is the largest association of psychologists in the United States. A non-profit scientific and professional organization, the American Psychological Association has approximately 115,000 members and affiliates, including the vast majority of psychologists holding doctoral degrees from accredited universities in the United States. Among the American Psychological Association's major purposes are to increase and disseminate knowledge regarding human behavior, to advance psychology as a science and profession, and to foster the application of psychological learning to important human concerns, thereby promoting health, education, and welfare.

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[1] No counsel for a party authored this brief in whole or in part, and no party or party's counsel made a monetary contribution intended to fund its preparation or submission. No person other than amici, their members, and their counsel made a contribution intended to fund the preparation or submission of this brief.

The Judge David L. Bazelon Center for Mental Health Law ("The Center") is a national public interest organization founded in 1972 to advance the rights of individuals with mental disabilities. The Center advocates for laws and policies that provide people with mental illness or intellectual disabilities the opportunities and resources they need to participate fully in their communities. Its litigation and policy advocacy is based largely on the Americans with Disabilities Act's guarantees of non-discrimination and reasonable accommodation. The Center has long worked to promote the diversion of people with mental illness from the criminal justice system and for safer police practices.

Mental health professionals and other advocates for individuals with mental illness, working in cooperation with law-enforcement agencies, have dedicated substantial effort and resources to studying, analyzing, and developing practices to reduce the risks that arise from encounters between law enforcement and individuals with mental illnesses. Many such encounters arise from circumstances, like those present in this case, that involve primarily, if not exclusively, a police encounter with an individual who requires treatment and that should not lead to criminal justice system intervention. There is accordingly a pressing need for police and other law-enforcement personnel to be trained to intervene appropriately and safely during encounters with individuals who may need such treatment – just as they are trained to respond appropriately in other situations

requiring medical treatment. Legal rules governing arrests, including involuntary detention that results from calls for assistance in transporting individuals for medical treatment, should recognize and provide appropriate incentives for law-enforcement authorities to adopt available practices to mitigate risks to both officers and individuals with mental illnesses during arrests. *Amici* believe that such legal rules include the obligation, under the Americans with Disabilities Act of 1990 ("ADA"), to provide reasonable accommodations for individuals with serious mental illness.

## INTRODUCTION

Police regularly come into contact with individuals with mental illness. How those interactions unfold, including whether force is used, is driven in large part by an officer's training. Mental health professionals have partnered with police departments around the country to develop programs to reduce the use of force, improve mental health outcomes for individuals with mental illness involved in such encounters, protect officer safety, and save money. The primary aim of this brief is to describe some of those programs, including the evidence regarding their efficacy, for the benefit of the Court. In particular, because the ADA requires accommodating individuals with disabilities (including mental illness) to the extent such accommodations are reasonable, *amici* submit this brief to describe various resources available to law-enforcement agencies in crafting reasonable

accommodations for individuals with mental illness, including during involuntary detention for medical treatment or civil commitment.

*Amici* have not studied the full record before the district court and take no position on the merits of the summary judgment entered by the court. *Amici* seek to provide pertinent information to assist the Court in its review.

## STATEMENT

### I. The Large and Growing Role of Police in Responding to Mental Health Emergencies

Police must frequently respond to urgent situations involving individuals with mental illness. Research suggests that encounters with individuals with mental illness account for approximately one-tenth of all calls, and law-enforcement officers spend a disproportionate amount of time and resources responding to such calls.[2] In some jurisdictions, police spend more time responding to such calls than they do responding to burglaries or felony assaults.[3]

[2] *See* Melissa Reuland et al., Council of State Gov'ts Justice Center, *Law Enforcement Responses to People with Mental Illnesses: A Guide to Research-Informed Policy and Practice* 6-7 (2009) ("Reuland, *Law Enforcement Responses*"), http://csgjusticecenter.org/wp-content/uploads/2012/12/le-research.pdf; *see also* Martha Williams Deane et al., *Emerging Partnerships Between Mental Health and Law Enforcement*, 50 Psychiatric Services 99-101 (1999) (surveying 194 metropolitan police departments).

[3] *See* Gary Cordner, U.S. Dep't of Justice, Office of Community Oriented Policing Services, *People with Mental Illness* 1 (May 2006) (discussing Lincoln, Nebraska), http://ric-zai-inc.com/Publications/cops-p103-pub.pdf; Melissa Reuland & Jason Cheney, Police Executive Research Forum, *Enhancing Success of Police-Based Diversion Programs for People with Mental Illness* 1 (May 2005) ("Reuland

In large part because of the scarcity of community-based mental health treatment options, officers spend substantial time responding to calls involving a small number of individuals.[4]

Law enforcement's role in responding to calls involving individuals with mental illness has increased over the last several decades. More people with mental illness are living in the community, as treatment models – and mental health funding – have shifted from long-term care in state psychiatric hospitals to community-based treatment. *See Olmstead v. L.C.*, 527 U.S. 581 (1999) (holding that the ADA bars public entities from needlessly institutionalizing individuals with mental disabilities). The number of people institutionalized in state psychiatric hospitals has decreased dramatically since its peak in 1955.[5] Similarly, whereas in 1981, 33% of states' mental health expenditures were on outpatient services, by FY 2008, it was 72%.[6]

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& Cheney, *Enhancing Success*"), www.evawintl.org/library/DocumentLibraryHandler.ashx?id=495.

[4] Reuland, *Law Enforcement Responses* at 7 (noting that the LAPD "identified 67 people with mental illnesses who had a minimum of five contacts with law enforcement during the first eight months of 2004" resulting in "536 calls for service"); Thomas M. Green, *Police as Frontline Mental Health Workers: The Decision to Arrest or Refer to Mental Health Agencies*, 20 Int'l J.L. & Psychiatry 469, 476 (1997) (reporting that Honolulu police officers recognized 94 out of 148 individuals with mental illness "on sight").

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

[6] *See* Substance Abuse & Mental Health Services Admin., *Funding and Characteristics of State Mental Health Agencies, 2010*, at 60, 61, 67,

Community-based mental health services, however, are underfunded and overtaxed. And mental health systems and related public institutions are not adequately prepared to address the range of negative outcomes – including homelessness and unemployment – that correlate with both mental illness and encounters with police.[7] Outpatient services and other treatment options are in short supply, as are appropriately trained mental health professionals.[8] One consequence has been a rise in the number of incarcerated individuals with mental illness.[9]

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https://www.aahd.us/wp-content/uploads/2012/12/FundingStateMentalHealthAgencies2010.pdf.

[7] *See* Steven K. Hoge et al., American Psychiatric Ass'n Task Force Report, *Outpatient Services for the Mentally Ill Involved in the Criminal Justice System* 5 (Oct. 2009) ("Hoge, *Outpatient Services*") (noting that individuals with mental illness, particularly in the absence of appropriate treatment options, face chronic disability, unemployment, and homelessness), https://www.psychiatry.org/psychiatrists/search-directories-databases/library-and-archive/task-force-reports; *see also* Council of State Gov'ts, *Criminal Justice/Mental Health Consensus Project* 264-65 (June 2002) ("*Consensus Project*"), https://www.ncjrs.gov/pdffiles1/nij/grants/197103.pdf.

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

[9] *See* Timothy Williams, *Jails Have Become Warehouses for the Poor, Ill and Addicted, a Report Says*, N.Y. Times, Feb. 11, 2015, at A19; Ram Subramanian et al., Vera Inst. of Just., *Incarceration's Front Door: The Misuse of Jails in America* 12-13 (Feb. 2015), https://storage.googleapis.com/vera-web-assets/downloads/Publications/incarcerations-front-door-the-misuse-of-jails-in-america/legacy_downloads/incarcerations-front-door-report_02.pdf; *see Consensus Project* at 280-81; Kathleen C. Thomas et al., *County-Level Estimates of Mental Health Professional Shortage in the United States*, 60 Psychiatric Services 1323 (2009), http://psychiatryonline.org/doi/pdf/10.1176/ps.2009.60.10.1323; Michael A. Hoge et al., *Mental Health and Addiction Workforce Development: Federal*

A second consequence of this shortage is that calls like the one in this case – precipitated by neither a violent act nor a crime – are increasingly common. Particularly where police lack adequate training in dealing with individuals with mental illness, these situations can present serious risks of harm, including death. Although statistics are scarce, there have been numerous incidents of police shootings of individuals with mental illness.[10] Such incidents take a toll not only on those individuals but also on the broader community and, of course, on officers, who must endure the emotional consequences of the shooting as well as burdens of any ensuing investigative review or assertions of liability.

## II. Leading Frameworks for Police Mental Health Training

When a social worker or, as here, a healthcare provider, seeks assistance from law enforcement to bring an individual with mental illness into custody for temporary civil commitment, there is often no imminent threat to public safety. Such a call is for medical help. Officers with inadequate training who respond to

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*Leadership Is Needed To Address the Growing Crisis*, 32 Health Affairs 2005 (2013).

[10] *See* Kelly Bouchard, *Across Nation, Unsettling Acceptance when Mentally Ill in Crisis Are Killed*, Portland Press Herald, Dec. 10, 2012, http://www.pressherald.com/2012/12/09/shoot-across-nation-a-grim-acceptance-when-mentally-ill-shot-down; Wesley Lowery et al., *Distraught People, Deadly Results*, Washington Post, June 30, 2015, https://www.washingtonpost.com/sf/investigative/2015/06/30/distraught-people-deadly-results/?utm_term=.25f7b31bee6e (one-quarter of people shot to death by police nationwide in the first half of 2015 were experiencing a mental health crisis).

such a call using traditional police tactics may put all parties, including the officer or officers, in danger.

Studies show that police officers frequently feel inadequately trained to respond to calls involving individuals with mental illness, even though providing assistance in detaining and transporting individuals with mental illness who pose a likelihood of serious harm to self or others (the standard for civil commitment in Massachusetts) is generally a police function.[11] Officers report that such calls are challenging and difficult to manage.[12] Furthermore, traditional police tactics, such as verbal commands, displays of authority, and threats of physical force, can escalate already-sensitive encounters.[13] That escalation, in turn, can cause an individual with mental illness to act or appear more threatening, which may elicit yet more forceful police responses.[14]

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

[12] *See* Reuland, *Law Enforcement Responses* at 3.

[13] *See* Kelli E. Canada et al., *Intervening at the Entry Point: Differences in How CIT Trained and Non-CIT Trained Officers Describe Responding to Mental Health-Related Calls*, 48 Community Mental Health J. 746, 747 (2012) (author manuscript available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3670143/).

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

Training for law enforcement is critical in part because of the pervasive misunderstanding that many officers (like the public generally) have about mental illness. Police injuries during encounters with individuals with mental illness are no more frequent than injuries during encounters with others,[15] yet law-enforcement officers and the public nevertheless tend to overestimate the connection between mental illnesses and violence toward others.[16] Most individuals with mental illness are not violent, and most violence is not associated

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[15] *See* Amy N. Kerr et al., *Police Encounters, Mental Illness and Injury: An Exploratory Investigation*, 10 J. Police Crisis Negot. 116 (2010) (finding rate of police injury in encounters with people with mental illness roughly equal to that for the population at large) (author manuscript available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2991059/).

[16] *See* Amy C. Watson et al., *Police Officers' Attitudes Toward and Decisions About Persons With Mental Illness*, 55 Psychiatric Services 49, 53 (2004) (finding exaggerated police perceptions of violence among individuals with schizophrenia), http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.55.1.49; Jeffrey W. Swanson et al., *Mental Illness and Reduction of Gun Violence and Suicide: Bringing Epidemiologic Research to Policy* 2 (2014) ("Swanson, *Bringing Epidemiologic Research to Policy*") ("[T]he assumption of dangerousness is a key element of th[e] negative stereotype [toward persons with serious mental illnesses such as schizophrenia]."), http://www.annalsofepidemiology.org/article/S1047-2797(14)00147-1/pdf (to be published in Annals of Epidemiology); Colleen L. Barry et al., *After Newtown – Public Opinion on Gun Policy and Mental Illness*, 368 New Eng. J. Med. 1077, 1080 (2013) (finding that 45.6% of respondents believe individuals with mental illness are "by far" more dangerous than others), http://www.nejm.org/doi/pdf/10.1056/NEJMp1300512.

with mental illnesses.[17] Indeed, the fact pattern in this case – no crime and no immediate threat at the beginning of the encounter – characterizes a significant percentage of all police encounters with individuals with mental illness.[18]

Working with police departments nationwide, mental health professionals have developed training programs and specialized units designed to respond to mental health emergencies in ways that focus on de-escalation and diversion from jail. For example, Crisis-Intervention Team ("CIT") programs involve 40 hours of training, for both officers and dispatchers.[19] CIT programs also involve the development of relationships with community mental health centers, which provide emergency assessments and treatment, if necessary. The training component – provided by psychiatrists, other mental health professionals, and advocates for individuals with mental illness – focuses on de-escalation techniques, role-playing, and awareness of mental health issues.[20] That training also increases

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[17] *See* Swanson, *Bringing Epidemiologic Research to Policy* 2-3 ("[V]iolence is a complex societal problem that is caused, more often than not, by other things besides mental illness.").

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

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

[20] *See* Janet R. Oliva & Michael T. Compton*, A Statewide Crisis Intervention Team (CIT) Initiative: Evolution of the Georgia CIT Program*, 36 J.

officers' knowledge of local mental health services and thereby increases the chances that individuals with serious mental illness will receive appropriate care and avoid harm.[21] CIT-trained officers receive specialized training in assessing threats caused by mental illnesses, training that accords with scientific evidence and thus reduces the risk of responses based on stereotypes.[22] CIT-trained officers can be first responders for calls believed to involve individuals with mental illnesses.

The empirical literature on the effects of implementation of CITs shows beneficial effects in certain dimensions; other studies show no statistically significant effects on other metrics. A 2017 commentary by leading researchers found evidence that CIT contributes to improvements in knowledge and attitudes with respect to mental illness and some evidence of reduced use of force in encounters with individuals with mental illness, leading the authors to conclude that there are positive effects from CIT on officer-level outcomes.[23] One 2016

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Am. Acad. Psychiatry & Law 38, 41 (2008), http://www.jaapl.org/content/36/1/38.full.pdf+html.

[21] *See id.* at 39.

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

[23] *See* Amy C. Watson et al., *The Crisis Intervention Team (CIT) Model: An Evidence-Based Policing Practice?*, 35 Behavioral Sci. L. 431 (2017); *see also* Michael T. Compton, *et al.*, *Police Officers' Volunteering for (Rather than Being Assigned to) Crisis Intervention Team (CIT) Training: Evidence for a Beneficial Self-Selection Effect*, 35 Behavioral Sci. L. 470 (2017).

review article found, however, that there was no statistically significant evidence that CITs have a beneficial effect on either arrests of individuals with mental illness or on police officer safety.[24] That said, leading researchers have observed that "CIT is considered by many to be the most rapidly expanding and promising partnership between law enforcement and mental health professionals."[25] And additional data continues to emerge as practices are further studied and refined, including from the thousands of extant CIT programs in states across the country.[26]

CITs are, furthermore, just one method for improving law enforcement's response to situations involving individuals with mental illness. Another is mobile-crisis teams ("MCTs"), which provide community crisis-management services generally managed through behavioral health services as opposed to police. These programs may be particularly helpful for police departments that lack sufficient personnel to create dedicated CIT teams. MCT programs involve training teams of mental health professionals to respond to community mental health crises, allowing those professionals to provide a joint response alongside

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[24] *See* Sema A. Taheri, *Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? A Systematic Review and Meta-Analysis*, 27 Crim. Just. Pol. Rev. 76 (2016).

[25] Compton, 36 J. Am. Acad. Psychiatry & Law at 47-48.

[26] *See id.* at 48; *see also* Michael T. Compton, et al., *The Police-Based Crisis Intervention Team (CIT) Model: I. Effects on Officers' Knowledge, Attitudes, and Skills*, 65 Psychiatric Services 517, 518 (2014) (estimating that there are more than 2,700 CIT programs in the United States).

traditional first responders.[27] MCTs can be called by dispatchers or, in some jurisdictions, by social workers or family members.[28] MCTs can facilitate rapid treatment, hospital admission, and referrals to other mental health providers.[29] Jurisdictions that have implemented MCTs and related programs include Massachusetts, New York City, Birmingham, Long Beach, San Diego County, and Anne Arundel County, Maryland.[30] Although these programs vary in how they structure funding for the mental health professionals who act as responders, they all promote referral away from arrest and toward treatment by placing mental health professionals at the scene as soon as possible.[31]

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[27] *See* N.Y.C. Dep't of Health & Mental Hygiene, *Mobile Crisis Teams*, https://www1.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-mobile-crisis-teams.page (last visited Aug. 22, 2018).

[28] *See id.* (providing direct 888-number); Maryland Coalition of Families for Children's Mental Health, *Listening and Learning from Families: Crisis Services and the Experiences of Families Caring for Children and Youth with Mental Health Needs* 11 (Dec. 2013) ("If available, mobile crisis was a service that was pursued quite frequently."), http://www.mdcoalition.org/LiteratureRetrieve.aspx?ID=142917&A=SearchResult&SearchID=7715782&ObjectID=142917&ObjectType=6.

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

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

[31] *See Consensus Project* at 46.

Still other programs, like "mental health first aid" training, provide basic mental health training to a broader segment of police officers. Such training focuses on increasing understanding of mental illnesses, decreasing stigma, and promoting early access to help for individuals with mental illness.[32] In some jurisdictions, enhanced training has borrowed from CIT and mental health first aid concepts. These programs complement the CIT and MCT programs discussed above.

Another step that police departments can take to better accommodate individuals with mental illness, particularly in conjunction with a more comprehensive training program, is to implement screening checklists. Many state and local jails employ such checklists to identify mental health risks among inmates. Those checklists have proven effective in improving treatment of mental illness in jails, where, according to one estimate, as many as 26% of inmates reported serious mental illness.[33] Those same checklists show promise in assisting

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[32] *See* Massachusetts Dep't of Mental Health Forensic Services, *Pre-Arrest Law Enforcement-Based Jail Diversion Program Report, July 1, 2011 to January 1, 2014*, at 8 (2014) ("MDMHFS, *Jail Diversion Program – 2014*"), http://www.mass.gov/eohhs/docs/dmh/forensic/jail-diversion-program-2014.pdf; *see generally* Mental Health First Aid, http://www.mentalhealthfirstaid.org/cs/ (last visited Aug. 22, 2018).

[33] Jennifer Bronson & Marcus Berzofsky, U.S. Dep't of Justice, Office of Justice Programs, *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12* (June 2017), https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf.

first responders to identify signs of mental illness. The use of checklists can increase public and officer safety and help officers determine the best approach to resolve tense situations and prevent injury or the need for arrest.[34]

Police officers often must make a judgment whether an individual who has been arrested for a non-violent crime – vagrancy, disturbing the peace, public intoxication – is exhibiting symptoms of mental illness, such that treatment, rather than criminal justice system intervention, is called for. Training and development of linkages to appropriate community mental health resources can assist. For example, Baltimore Crisis Response, Inc. provides free mental health crisis beds for individuals who do not meet the criteria for involuntary commitment but who nevertheless need treatment and cannot receive it elsewhere.[35] In San Antonio, Texas, community resources were developed for a specialized drop-off center that police can use to give individuals with mental health or substance abuse needs efficient access to treatment providers.[36] Such programs allow officers to avoid

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[34] *See* Christian Mason et al., *Responding to Persons with Mental Illness: Can Screening Checklists Aid Law Enforcement?*, FBI Law Enforcement Bulletin (Feb. 2014), http://leb.fbi.gov/2014/february/responding-to-persons-with-mental-illness-can-screening-checklists-aid-law-enforcement.

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

[36] *See* Jenny Gold, *Mental Health Cops Help Reweave Social Safety Net In San Antonio*, Nat'l Pub. Radio, Aug. 19, 2014, http://www.npr.org/blogs/health/

jailing homeless individuals for minor violations caused by symptoms of mental illness. ADA settlements entered as a result of Department of Justice investigations have recognized the importance of mental health crisis services in avoiding ADA violations. For example, in 2011, the Department of Justice reached a settlement with Delaware over litigation under the ADA that provided, among other things, for Delaware to establish MCTs and crisis walk-in centers, 24-hour "community-based psychiatric and counseling services to people experiencing a mental health crisis," with specific accommodations for police referrals or drop-offs.[37]

## SUMMARY OF ARGUMENT

The Americans with Disabilities Act of 1990, 42 U.S.C. §12101 *et seq.*, should be interpreted to require police officers to provide reasonable accommodations for individuals with mental illnesses when taking such individuals into custody. Encounters with such individuals, many of which involve either no criminal conduct or only nuisance crimes that may reflect the individuals'

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2014/08/19/338895262/mental-health-cops-help-reweave-social-safety-net-in-san-antonio.

[37] *See* Settlement Agreement at 3-4, § II.C.2.c, *United States v. Delaware*, No. 11-591-LPS (D. Del. filed July 6, 2011), http://www.ada.gov/delaware.htm; Order Entering Settlement Agreement, *United States v. Delaware*, No. 11-591-LPS (D. Del. July 15, 2011).

illnesses, are an everyday part of law enforcement. *Amici* believe it is important to affirm that the ADA provides protection in those encounters.

Though some may associate the term "arrest" with criminal activity, an arrest includes any involuntary detention – including where the police take an individual into custody so that the person can receive necessary mental health services. *See*, *e.g.*, *Sheehan v. City & Cty. of San Francisco*, 743 F.3d 1211, 1232 (9th Cir. 2014) (holding that the ADA applies to arrests, where police were called to transport an individual to a mental health facility), *rev'd in part on other grounds*, 135 S. Ct. 1765 (2015) (declining to address ADA question). In this case, the police detained the plaintiff to transport her to a treatment facility, not because she was suspected of a crime. In these circumstances and others where criminal justice system intervention may be unwarranted, use of de-escalation tactics and other reasonable accommodations make it is less likely that a detained individual will become violent and thus more likely that the person can be taken for necessary treatment rather than entering the criminal justice system. In this brief, amici use the word "arrest" to refer to any time that a person is taken into custody involuntarily, including non-criminal matters such as detention for purposes of civil commitment.

In resolving whether an individual with mental illness was provided a reasonable accommodation when being taken into custody – and whether an

individual is "qualified" within the meaning of the ADA – courts should take into account the entire encounter between the individual and law enforcement. When police are called to detain and transport an individual for involuntary hospitalization, there is an opportunity to provide reasonable accommodations. And where the alleged failure to make such reasonable accommodations – for example, to employ trained personnel using established protocols or to utilize de-escalation techniques – is the partial cause of threatening or violent behavior in an individual suffering from serious mental illness, that individual should not be deprived of the statute's protection.

The obligation to provide *reasonable* accommodations for individuals with mental illness in such encounters imposes no unfair burden on public entities. Established approaches to training police officers and implementing programs and procedures designed to reduce the risk both to individuals being taken into custody and to officers have been reported to improve law-enforcement outcomes without imposing significant additional costs.

## ARGUMENT

### I. The ADA Requires Reasonable Accommodations for Individuals with Mental Illness at the Point of Arrest

Although this Court has not resolved the question, *see Buchanan v. Maine*, 469 F.3d 158, 177 (1st Cir. 2006) (recognizing the issue), this Court should start from the premise that the ADA applies to arrests and requires reasonable

accommodations in that context, *see* United States Department of Justice, Civil Rights Division, "Examples and Resources to Support Criminal Justice Entities in Compliance with Title II of the Americans with Disabilities Act."[38] ("DOJ, Examples and Resources") (statement by the Justice Department – the agency charged with interpreting and enforcing Title II of the ADA – that Title II of the ADA applies to "[l]aw enforcement street interactions" including "arrests").

At least three courts of appeals have held Title II of the ADA applies in this circumstance. *See Haberle v. Troxell*, 885 F.3d 170, 178 (3d Cir. 2018) ("As a threshold matter, we consider whether the ADA applies when police officers make an arrest. Although the question is debatable, we think the answer is generally yes."); *Sheehan*, 743 F.3d at 1232 ("We agree with the majority of circuits to have addressed the question that Title II applies to arrests."); *Roberts v. City of Omaha*, 723 F.3d 966, 973 (8th Cir. 2013) ("[Plaintiff] is correct in noting the ADA and the Rehabilitation Act apply to law enforcement officers taking disabled suspects into custody."). Only the Fifth Circuit has held to the contrary. *See Hainze v. Richards*, 207 F.3d 795 (5th Cir. 2000).[39] Other circuits (like this one) have

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[38] https://www.ada.gov/cjta.html (last visited Aug. 27, 2018).

[39] In *Tucker v. Tennessee*, 539 F.3d 526, 536 (6th Cir. 2008), the court of appeals stated that it would be "unreasonable" to require "officers presented with exigent or unexpected circumstances" to provide "certain accommodations . . . in light of the overriding public safety concerns." This simply suggests that exigency should be considered in the reasonableness calculus; the court did not rule out the

addressed similar claims without resolving the question. *See*, *e.g.*, *Roell v. Hamilton County*, 870 F.3d 471, 489 (6th Cir. 2017).

The view of the Third, Eighth, and Ninth Circuits – and of the Department of Justice – is correct. Title II of the ADA, which covers public services, provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. The Justice Department's implementing regulations provide that "[a] public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability," unless such modifications would fundamentally change the government activity. 28 C.F.R. § 35.130(b)(7)(i); *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").

For purposes of the ADA, a "service[ ], program[ ], or activit[y] of a public entity," 42 U.S.C. § 12132, includes taking an individual into custody. To begin with, the Supreme Court has explained that " 'public entity' " includes " 'any State or local government' " and " 'any department, agency, . . . or other instrumentality

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possibility that certain circumstances involving arrest would not involve such exigency or that other accommodations would be reasonable even in exigent circumstances.

of a State,'" *United States v. Georgia*, 546 U.S. 151, 154 (2006) (omission in original) (quoting 42 U.S.C. § 12131(1)). Indeed, the Court has construed the ADA to apply to prisons, holding that such institutions "fall squarely within the statutory definition of 'public entity.'" *Pennsylvania Dep't of Corr. v. Yeskey*, 524 U.S. 206, 210 (1998). In so holding, the Court noted that prisons provide inmates with "'benefits' of 'programs, services, or activities,' as those terms are ordinarily understood." *Id.* And, as the Third Circuit has noted, "police officers may violate the ADA when making an arrest by failing to provide reasonable accommodations for a qualified arrestee's disability, thus subjecting him to discrimination." *Haberle*, 885 F.3d at 180.

The ordinary meaning of the statutory language supports the conclusion that when police take an individual with mental illness into custody, even for involuntary commitment, they are generally providing a "benefit" to that individual. For example, the statute under which the officer here took plaintiff into custody authorizes temporary civil commitment when a qualified mental health provider determines that failure to hospitalize "would create a likelihood of serious harm by reason of mental illness." Mass. Gen. Laws Ann. ch. 123, § 12(a) (West 2010). Hence, taking a person into custody provides the "benefit" of avoiding serious harm. *Cf. Addington v. Texas*, 441 U.S. 418, 426 (1979) (characterizing

civil commitment as an adjunct to "providing care" to individuals with mental illness).

Applying the ADA to arrests of individuals with mental illness is important precisely because encounters between such individuals and law enforcement are such a pervasive part of police work. Requiring reasonable accommodations for individuals with mental illness does not impose an unfair burden. What is called for, after all, is reasonable accommodation, and courts have recognized that "the exigent circumstances" that may give rise to arrest "inform the reasonable-accommodation analysis." *Roell*, 870 F.3d at 489 (discussing precedent).

## II. Requiring Police To Accommodate Individuals with Mental Illness Is Practicable

Imposition of a duty under the ADA does not mean subjecting law enforcement personnel to second-guessing when they make reasonable judgments that lead to bad outcomes. *Amici* recognize that police officers face real challenges and, in some cases, real risks in their interactions with individuals with serious mental illnesses (although such risks are often perceived to be greater than they really are). *See supra* pp. 9-10. At the same time, the ADA requires public entities to provide training so that officers can follow appropriate police practices in their interactions with individuals with mental illness, just as they must accommodate other disabilities. The availability of effective techniques to de-escalate confrontations with individuals experiencing a mental health crisis may likewise

inform the inquiry into whether a particular use of force was reasonable. Effective partnerships between law enforcement and mental health professionals have been implemented in cities nationwide. The evidence is convincing that such programs, when properly operated, improve police interactions with individuals with mental illness without adding costs or posing risks to officer safety.

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

There is clear evidence that CIT program development, with its emphasis on training and community partnerships, increases officers' familiarity and comfort with the mental health system.[40] Furthermore, systematic partnerships between law enforcement and mental health professionals have brought substantial benefits to police officers and departments.[41] Requiring police departments to train officers and implement programs designed to provide reasonable accommodations would serve the ADA's goal of reducing disparate treatment of individuals with disabilities.

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[40] *See supra* note 23.

[41] *See* Compton, 36 J. Am. Acad. Psychiatry & L. at 52 (citing Randolph Dupont & Sam Cochran, *Police Response to Mental Health Emergencies—Barriers to Change*, 28 J. Am. Acad. Psychiatry & L. 338 (2000)); Deborah L. Bower & W. Gene Pettit, *The Albuquerque Police Department's Crisis Intervention Team: A Report Card*, 70 FBI Law Enforcement Bull. 1, 2 (Feb. 2001) (finding 58% decrease in SWAT team usage), http://leb.fbi.gov/2001-pdfs/leb-february-2001; *supra* note 23.

Although a one-size-fits-all model is not workable given differences among jurisdictions, CIT programs have provided an effective model for many cities. CIT-trained officers are more likely to consider alternatives to arrest and jailing and more likely to avoid the use of force when responding to calls involving an individual with mental illness.[42] Law enforcement agencies that have implemented CIT programs have reported that the training results in fewer police shootings, assaults, batteries, and "problematic use of force issues."[43] One study – which surveyed police officers in Birmingham, Knoxville, and Memphis – found that CIT-trained officers were more likely to report that: (a) they were well-prepared to handle individuals in a mental health crisis; (b) the mental health system in general was helpful; and (c) emergency rooms were useful resources.[44] Evidence suggests that most police officers believe that understanding mental illnesses is important to their work.[45]

These findings are consistent with research showing that CIT-trained officers understand mental illnesses better and are less likely to stigmatize

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

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

[44] *See* Borum, 16 Behavioral Sciences & Law at 401-04.

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

individuals with mental illness. CIT-trained officers assess threats caused by individuals with mental illness differently than officers without such training, exhibiting greater understanding of how mental illnesses can cause individuals to act in ways that might otherwise appear threatening.[46] In studies, CIT-trained officers are less likely to respond to descriptions of people with schizophrenia with stigmatizing views.[47] CIT-trained officers are also better able to identify mental illnesses and are more knowledgeable about local treatment options.[48] And CIT-trained officers are more likely to understand that taking the time to de-escalate situations with talking and other non-threatening behaviors is the key to success when dealing with individuals with mental illness.[49] CIT-trained officers report that "taking their time is necessary in safely and effectively responding to calls

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[46] *See supra* note 23.

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

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

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

involving mental illness."[50] This additional time helps officers put individuals with mental illness at ease and manage unpredictable situations.[51] Finally, evidence suggests that MCT units are effective at de-escalating police interactions with individuals with mental illness, with arrest rates for MCTs at roughly one-third the level for traditional police response.[52]

### B. Partnerships with Mental Health Professionals Save Money and Improve Mental Health Outcomes

Many programs achieve the benefits described above without imposing additional costs on the criminal justice system. One study that undertook to quantify the cost impact of CIT implementation found that, for a medium-sized city (Louisville), the savings exceeded $1 million annually.[53] Another study found that Memphis's path-breaking CIT program yielded cost savings to the criminal

[50] Canada, 48 Community Mental Health J. at 752; *see also* DOJ, Examples and Resources (citing training for law enforcement officers in "responding to a person in mental health crisis" as an example of compliance with the ADA's obligation to provide reasonable accommodation).

[51] *See* Sonya Hanafi et al., *Incorporating Crisis Intervention Team (CIT) Knowledge and Skills into the Daily Work of Police Officers: A Focus Group Study*, 44 Community Mental Health J. 427, 431-32 (2008).

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

[53] *See* Peggy L. El-Mallakh et al., *Costs and Savings Associated with Implementation of a Police Crisis Intervention Team*, 107 S. Med. J. 391, 393 (2014).

justice system.[54] Yet another study showed that MCTs decrease even costs due to hospitalization.[55] In short, the evidence suggests that specialized programmatic responses to police encounters with individuals with mental illness are associated with at least modest savings for public entities.

There is also evidence that such specialized programs improve mental health outcomes months after a police encounter. The Massachusetts Department of Mental Health Forensic Services has reported that MCT, CIT, co-response, and related programs "help people with mental illness access appropriate treatment, help them live their lives with fewer symptoms, and can provide incentives to stay in treatment thereby minimizing or ending the costly cycling through crisis care."[56] This conclusion is supported by empirical evidence.[57]

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[54] *See* Compton, 36 J. Am. Acad. Psychiatry & Law at 51-52 (citing Alexander J. Cowell et al., *The Cost-Effectiveness of Criminal Justice Diversion Programs for People With Serious Mental Illness Co-Occurring With Substance Abuse: Four Case Studies*, 20 J. Contemp. Crim. Just. 292 (2004)) (noting some increase in hospitalization costs but overall savings to criminal justice system).

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

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

[57] *See* Compton, 36 J. Am. Acad. Psychiatry & Law at 52 (noting that CIT programs can materially improve psychiatric symptoms three months after diversion).

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The programs described above have not provided a panacea for the problems caused by insufficient mental health services and the responsibilities borne by police officers in responding to mental health crises. All such programs, to be most effective, require continuing training, review for best practices, funding, and oversight. And no one program will solve the problem of mental illness in the criminal justice system or work for all police departments. Given the diversity of community sizes, infrastructures, and resources, law enforcement agencies have flexibility to implement programs and services that work in their areas. Nevertheless, the literature reflects that these programs have demonstrated positive effects. As funding for such programs has grown, so too has the number of models for criminal justice-mental health collaborations.[58]

In short, criminal justice-mental health collaboration provides tangible benefits to individuals with mental illness, police officers, police departments, and communities at large. Applying the ADA to claims involving arrests – and requiring that arresting officers provide reasonable accommodations to individuals with mental illness – thus would benefit not only the detainees themselves, but everyone involved in these encounters.

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

## CONCLUSION

In resolving this appeal, the Court should affirm that the ADA applies to the arrest of individuals with mental illness, that the determination of whether a reasonable accommodation was provided should take into account the entire encounter between the individual and law enforcement, and that this determination should be informed by the availability of effective techniques to de-escalate confrontations with individuals experiencing a mental health crisis.

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## CERTIFICATE OF COMPLIANCE WITH RULE 32

Pursuant to Federal Rule of Appellate Procedure 32(g), the undersigned certifies that this brief complies with the applicable type-volume limitation. This brief was prepared in 14-point Times New Roman and complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5), as well as the type-style requirements of Federal Rule of Appellate Procedure 32(a)(6).

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September 6, 2018

**CERTIFICATE OF SERVICE**

I hereby certify that, on September 6, 2018, I electronically filed the foregoing document with the United States Court of Appeals for the First Circuit by using the CM/ECF. I certify that the following parties or their counsel of record are registered as ECF Filers and that they will be served by the CM/ECF system:

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