PEACE OF MIND: IMPROVING CONFLICTS BETWEEN LAW ENFORCEMENT AND THE MENTALLY ILL HOMELESS WHILE EXPLORING SUSTAINABLE COMMUNITY SOLUTIONS FOR CARE

By Carly Masenthin

I. INTRODUCTION

On July 11, 2016, Joseph Mann was wandering around a Sacramento apartment complex, acting erratically.¹ Joseph, homeless and under the influence of methamphetamine,² was doing karate moves and displaying obvious signs of mental distress.³ According to his family, Joseph struggled with mental illness for most of his life but had never acted violently.⁴ When concerned residents of the apartment complex called the police, Joseph threw a thermos at an arriving police cruiser and fled the scene.⁵ The second pair of officers initiated a car chase after Joseph.⁶ Released audio from the officers’ dash camera recorded their frustration at the man fleeing from their grasp.⁷ “F— this guy,” one officer says, “I’m going to hit him.”⁸ His partner’s response: “Okay. Go for it.”⁹ The office tried to ram into Joseph with his car, but Joseph dodged the vehicle twice, the second time he barely avoided being run over by

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¹² Id.

¹³ Id.

¹⁴ Wootson, supra note 3.

¹⁵ Id.

¹⁶ Id.

¹⁷ Id.

¹⁸ Wootson, supra note 3.

¹⁹ Id.
jumping onto a street median.\textsuperscript{10} Officers chased after Joseph on foot, shooting as they ran.\textsuperscript{11} Ultimately, the officers shot Joseph fourteen times, ending his life.\textsuperscript{12} In January 2017, the District Attorney’s Office in Sacramento released a report announcing the two officers acted lawfully when they shot Joseph Mann.\textsuperscript{13}

On April 7, 2016, Luis Góngora finished playing soccer with an old basketball and walked along the streets of San Francisco with a knife in his hand.\textsuperscript{14} Luis had been homeless for about four or five years.\textsuperscript{15} He originally came to America for work so he could send money to his family in Mexico, but when the other Mayan-speaking workers left the restaurant where Luis worked, he lost his job because he could not speak English.\textsuperscript{16} No job meant no money for either Luis or his family back home, which sent Luis into a mental and physical breakdown.\textsuperscript{17} He even unsuccessfully tried to get deported back to Mexico.\textsuperscript{18} His mental state and lack of resources soon left Luis without a home other than the San Francisco streets.\textsuperscript{19}

Outreach workers called the police after they witnessed Luis walking down the street, brandishing a knife.\textsuperscript{20} When police arrived on the scene, they ordered Luis to get down on the ground; according to witnesses, he was already sitting with his back against a building when the police cruisers pulled up.\textsuperscript{21} What happened next is less clear. All that is known is that the officers fired four beanbag rounds and seven rounds of live ammunition into Luis.\textsuperscript{22} Officers claim that Luis lunged at them with his knife; eyewitnesses report the opposite.\textsuperscript{23}

A released surveillance video does not clear up the situation; Luis is not visible in the camera’s lens at the moment the police opened fire.\textsuperscript{24} However, the video shows the officers opened fire and killed Luis within thirty seconds of

\begin{footnotes}
\item 10. Id.
\item 11. Wagner, supra note 1.
\item 12. Id.
\item 15. Id.
\item 16. Id.
\item 17. Id.
\item 18. Id.
\item 19. Id.
\item 20. Wong, supra note 14.
\item 21. Id.
\item 22. Id.
\item 23. Id.
\item 24. Kate Williams & Vivian Ho, SF Police Shooting Unfolded in 30 Seconds, Video Shows, SFGATE (Apr. 8, 2016, 8:00 PM), http://www.sfgate.com/crime/article/Video-shows-San-Francisco-police-shooting-7237146.php.
\end{footnotes}
exiting their vehicle. Jennifer Friedenbach, executive director of San Francisco’s Coalition on Homelessness, criticized the officers for making no effort to de-escalate the situation and instead coming into the situation “with their guns blazing.”

On March 16, 2014, Albuquerque police approached a sleeping James Boyd to arrest him for illegally camping in the Albuquerque foothills. James was homeless and suffered from schizophrenia. The arrest turned into a standoff with nearly twenty officers that lasted several hours. Briefly, the scene appeared to be de-escalating. James was gathering his belongings to leave the foothills with the officers when, for unknown reasons, one of the officers detonated a smoke bomb near James. The smoke bomb was meant to frighten James, and it surely did; he responded to the loud noise by pulling out two knives in the face of rifles, handguns, hundreds of rounds of ammunition, a Taser, and a K-9 unit. James was fatally shot by two officers. James’s death led to an investigation on excessive force within the Albuquerque police department, and the investigation uncovered a “culture of aggression.” The two officers responsible for the shooting were charged with second-degree murder. Their trial ended in a mistrial in October 2016.

Each of these situations took place in separate cities, under differing circumstances, and involved police departments as unique as their communities. Unfortunately, these stories are just three of many. Despite efforts for reform, the relationship in the United States between some of the most recognized members of the community—police officers—and some of the most hidden or ignored—mentally ill, homeless individuals—continues to grow more volatile. Of the 995 people fatally shot by the police in 2015, 256 either showed signs of mental illness or were confirmed to be mentally ill. It is unclear how many of those 256 were homeless.

Police officers’ jobs are to fight crime and capture criminals. While society
may favor hard-hitting police tactics for pursuing individuals in the midst of criminal activity, these tactics do not translate to de-escalating situations involving mentally ill individuals. Acts committed while in the throes of a mental health break are inherently the opposite of intentional acts committed by competent persons in efforts to execute crimes. Most often, a display of authority and power only furthers a developing mental health crisis, and officer intervention can cause more harm than good. But, who else does one call when they witness someone acting erratically, in need of medical attention? For better or worse, society has shifted the care of mentally ill individuals from government institutions to law enforcement. Despite this, until recently, law enforcement offices across the country failed to implement meaningful change in training on this new class of individuals under their care.

Several police departments have implemented strategies to improve the relations between officers and homeless mentally ill, such as Crisis Intervention Teams (CIT). CITs consist of police officers who have undergone training on de-escalation techniques in mental health crises. CITs have been largely successful in aiding individuals during a mental health crisis, but they do not fully address the particularized concerns present for the mentally ill homeless. For example, without a stable environment to return to after a mental health crisis, the homeless often end up in the same position they were in before the crisis. Several police departments, such as Houston, have developed a Homeless Outreach Team within the department’s CIT to focus on issues that are particular to homeless mentally ill. In addition to assisting in mental health crises, these teams assist the homeless in finding housing, obtaining legal documents, and reporting community violence. This article advocates for the implementation of thorough police training on mental illnesses and de-escalation techniques. This article also advocates for community resources that provide stable housing for the homeless, which in turn will cut down on taxes associated with jail bookings and emergency mental health care.

II. BACKGROUND

There is a strong link between mental illness and homelessness. Approximately 46% of homeless individuals live with a severe mental illness. The close link between mental illness and homelessness can be partially attributed to the deinstitutionalization movement and society’s failure to implement a system to replace the care and shelter that state mental institutions provided for most of the twentieth century. Reduced hospital capacity has led to a large number of mentally ill living in urban areas with little to no supervision.

38. See infra Section IV.A.
40. See infra Part III.
41. See generally H. Richard Lamb, Deinstitutionalization and the Homeless Mentally Ill, 35 HOSP. & COMMUNITY PSYCHIATRY 899 (1984) (discussing how deinstitutionalization without an adequate replacement system has led to homelessness).
or support.42

A variety of issues can lead mentally ill individuals to homelessness.43 They may wander from community to community hoping that a new geographical location will erase the problems of their past and symptoms of mental illness.44 They also may not want to see themselves as mentally ill, and thus refuse to seek medical attention.45 Perhaps most unfortunate, they may not have access to a strong community support system, they may not have families that have the resources to care for them, or they may not have families that are willing to care for persons whose behavior can be unpredictable and even threatening at times.46

Social disorganization theory, a “major structural explanation for crime,”47 can also provide a psychological-economic explanation for why so many mentally ill become homeless. Social disorganization theory posits that “lower economic status” and “residential instability” contribute to disruption of the strong community ties that are necessary for crime control and general neighborhood safety.48 “Socially organized” communities are more capable of establishing “effective networks of informal social control,” most likely due to communication stemming from stronger bonds within the community.49 Socially disorganized communities “tend to inhibit” these kinds of bonds from forming, which “limits the capacity of a neighborhood” to control and monitor behavior, and “contributes to higher rates of crime.”50

For the mentally ill, access to treatment is grounded in social and community networks. These networks may be absent from communities that are “disorganized,” and have consequentially higher levels of crime, violence, poverty, and homelessness.51 In these types of communities, individuals exhibiting signs of mental illness are often not encouraged to seek help because they have fewer ties to formal and informal social networks, like clubs or church groups.52 As a result, mental health treatment is delayed or never administered; this can lead to escalation of the illness. Escalation can lead to homelessness, and both of those factors heighten the likelihood of police intervention. Escalation too often leads to police intervention.53

43. See Lamb, supra note 41, at 899.
44. Id. at 903.
45. Id. at 904.
46. See Markowitz, supra note 42.
48. Id. at 19.
49. Id.
50. Id.
52. Id.
53. Id.
The increasing number of mentally ill homeless forced law enforcement agencies to take on a greater role in psychiatric crisis management. Two principles support this increased role: the duty of police to protect the safety and welfare of all community members, and the state’s role in protecting citizens with disabilities who cannot protect themselves. Today, police are often the sole resource relied on to respond to situations involving individuals in mental crises. This places police in a unique position. Police become “gatekeepers,” who determine whether an individual with mental illness would benefit more from mental health treatment or the penal system. Officers increasingly have to make those calls due to passage of laws that “criminalize” homelessness. These laws effectively force officers to either fine or arrest the homeless for actions like camping, panhandling, loitering, and sleeping in public spaces. These laws foster a tense relationship between the homeless and police officers. Particularly in the case of the mentally ill homeless, interactions with police officers can be jarring and lead to violence – even death.

In 2015, the homeless were 6.5 times more likely to be killed by police than the general population. Police training through programs such as Crisis Intervention Teams and Homeless Outreach Teams is a crucial component to correcting this problem. However, cuts to funding for Federal Housing Programs are making it more difficult for Crisis Intervention and Homeless Outreach teams to direct mentally ill homeless to a stable environment.

Understanding the history of deinstitutionalization in conjunction with the rise of criminalization laws and loss in Federal Housing is crucial to promoting the creation and success of Crisis Intervention and Homeless Outreach Teams within police departments.

III. DEINSTITUTIONALIZATION

Until the 1960s, a large number of mentally ill individuals were housed and treated in state psychiatric hospitals. Three important factors played into the fall of the publicly funded mental hospital. First, the development of psychiatric medications for even the most debilitating mental illnesses fostered the idea that mental illnesses could be managed at the familial and individual

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54. See Richard Lamb et al., The Police and Mental Health, 53 PSYCHIATRIC SERVICES 1266, 1266 (2002).
55. Id.
56. See id.
57. See id.
59. See generally id.
60. See Markowitz, supra note 42, at 39.
62. See infra Part IV.
63. Markowitz, supra note 42, at 37.
64. Id.
level.\textsuperscript{65} Second, a more liberal ideological shift occurred amongst mental health advocates that advocated against involuntary confinement and led states to adopt stricter legal standards for involuntary psychiatric commitment.\textsuperscript{66} Third, a major change in fiscal policy shifted the costs of mental health care from states to the federal government at the birth of programs such as Medicaid, Medicare, and Social Security Disability Income.\textsuperscript{57} This was accompanied by substantial budget cuts to community mental health services at the state and federal level.\textsuperscript{68}

Over the last few decades, the capacity for inpatient services at public psychiatric hospitals has dramatically decreased.\textsuperscript{69} In 1960, there were about 563,000 beds available in state psychiatric hospitals and about 535,400 residents.\textsuperscript{70} By 1990, the number of available beds had significantly decreased to about 98,800 with about 92,000 residents in state psychiatric hospitals.\textsuperscript{71} By 2005, the number further decreased to about 17 beds in public psychiatric hospitals available per 100,000 persons.\textsuperscript{72}

Hospital psychiatric units and emergency rooms bear the brunt of the burden caused by the decrease of beds in state funded mental hospitals.\textsuperscript{73} While an insolvent person can receive treatment for mental illness in emergency rooms and psychiatric units of hospitals and bill Medicaid for doing so,\textsuperscript{74} these types of solutions are only available for the short term. Emergency hospital visits are not designed to provide the type of long term, supervised health care that many individuals with mental illness need to successfully manage their illness.\textsuperscript{75} Specialized psychiatric hospitals that do still exist continuously decrease the time admitted patients can stay as the number of beds decreases.\textsuperscript{76} In the 1960s, the average stay in a psychiatric hospital was six months.\textsuperscript{77} By the early 2000s, the average stay had decreased to ten days.\textsuperscript{78} The increased admissions rate of existing psychiatric treatment facilities from the early-to-mid 2000s indicates that mental health patients are often stabilized and released, only to return due to lack of resources and adequate follow-up treatment in the community.\textsuperscript{79} This pattern is coined by some scholars as “the revolving door” phenomenon; it suggests that those in need of mental health care frequently come in and out of psychiatric facilities and have no sustainable means of treatment in their daily

\textsuperscript{65} Id. Unfortunately, as this paper will demonstrate, that idea did not become reality.
\textsuperscript{66} Id.
\textsuperscript{67} Id.
\textsuperscript{68} Id.
\textsuperscript{70} Markowitz, supra note 42, at 37.
\textsuperscript{71} Id.
\textsuperscript{72} Id.
\textsuperscript{73} See id.
\textsuperscript{74} See id.
\textsuperscript{75} See id.
\textsuperscript{76} See id.
\textsuperscript{77} Id.
\textsuperscript{78} Id.
\textsuperscript{79} See id.
lives.\textsuperscript{80} Not only do psychiatric hospitals provide medical care, they also serve as a method of supervision.\textsuperscript{81} Psychiatric hospitals provide a controlled environment for those who cannot care for themselves or whose behavior could turn threatening or violent.\textsuperscript{82} Reduced availability of public psychiatric institutions led to an increase of mentally ill who lack consistent support.\textsuperscript{83} Lack of support in dealing with a mental illness leads to job loss and disintegration of relationships, community ties, and a sense of self. All too often, this instability leads mentally ill individuals to the streets. As a result, deinstitutionalization contributed significantly to the increased risk of homelessness for the mentally ill.\textsuperscript{84}

\section*{IV. Cuts in Federal Housing Funding}

Since 2001, more than 12.8\% of the nation’s low-income housing has been lost.\textsuperscript{85} This is the culmination of a forty-year trend of funding decreases for federally subsidized housing.\textsuperscript{86} Approximately 10,000 units of federally subsidized housing has been lost each year since the 1970s.\textsuperscript{87} These cuts can be partially attributed to the growing national debt. In 2011, Congress approved the Budget Control Act, which set binding caps on non-defense appropriations from the years 2012 through 2021.\textsuperscript{88} The goal was to reduce national deficits by a total of $1.2 trillion over the course of the ten years.\textsuperscript{89} Non-defense appropriations include a variety of government functions such as housing assistance and public health.\textsuperscript{90} In 2010, the funding for non-defense programs was $596 billion; in 2016, it was cut to $493 billion.\textsuperscript{91}

It has never been easy for the homeless, much less mentally ill homeless, to find sustainable housing. Lack of financial and general life stability makes finding a stable place to live close to impossible. But another problem for the mentally ill homeless is that federal housing applications require the disclosure of a criminal record.\textsuperscript{92} Many mentally ill homeless frequently filter in and out of police stations.\textsuperscript{93} Public Housing Authorities, which administer federal

\begin{itemize}
\item \textsuperscript{80} Id.
\item \textsuperscript{81} See Markowitz, supra note 69, at 47.
\item \textsuperscript{82} See id.
\item \textsuperscript{83} See id.
\item \textsuperscript{84} See id. at 48.
\item \textsuperscript{85} NO SAFE PLACE, supra note 58, at 7.
\item \textsuperscript{86} Id.
\item \textsuperscript{87} Id. at 14.
\item \textsuperscript{89} Id.
\item \textsuperscript{90} Id.
\item \textsuperscript{91} See id. at 4.
\item \textsuperscript{92} NO SAFE PLACE, supra note 58, at 32.
\item \textsuperscript{93} See infra Part VII.
\end{itemize}
housing programs at a local level, have broad discretion to determine whether an individual with a criminal record can receive assistance. Many Public Housing Authorities deny housing assistance to anyone who has a criminal record, even for minor offenses.

Severe cuts in funding and restrictions on accessibility of federal housing have stifled even the possibility of progress in an already difficult area of stability for mentally ill homeless individuals.

V. Rise of Criminalization Laws

Deinstitutionalization and cuts in federal housing funding caused an influx of mentally ill homeless on the streets, particularly in large cities. State and local governments perceive that large numbers of homeless people harm social order and contribute to social disorganization. A high level of social disorganization often leads to an increase in community-based fear, which “reduces social cohesion” amongst neighborhoods and can foster the growth of more severe crimes. In response to a rise in homelessness, local governments across U.S. cities enacted laws that limited public exposure to the homeless, which limited places the homeless could take refuge. The early nineties saw an increase in the adoption of rigorous police policies in Denver, Miami, Houston, San Francisco, Seattle, and other major cities. Police rigorously enforced city ordinances against trespassing, begging, sleeping in parks, and panhandling. The public displayed widespread support for these policies by electing city officials who campaigned on public order platforms and by ballot initiatives. Under the Giuliani administration, New York City led the trend of adopting aggressive policing measures to reduce visible signs of social disorder. New York’s “Quality of Life” campaign was adopted in the mid-nineties and advocated a zero-tolerance, active policing stance to maintain public order. New York City dramatically expanded its Police Department, and police officers became the first responders to “complaints about the declining quality of community life, including homelessness.” Society began associating behaviors such as “aggressive panhandling. . .street prostitution. . .[and] public drunkenness” with homeless people, which “established a new way of thinking about homeless people as causes of disorder, thereby facilitating the criminalization of a whole range of socially marginal people.”

94. NO SAFE PLACE, supra note 58, at 33.
95. Id.
96. See Markowitz, supra note 69, at 51.
98. Id. at 11.
99. Id.
100. Id.
102. Vitale, supra note 97, at 11.
103. Id. at 12.
A recent study from the National Law Center on Homelessness and Poverty found that 53% of cities have laws that prohibit sitting or lying down in public; this is a 43% increase since 2011.\textsuperscript{104} Thirty-four percent of cities impose citywide bans on camping in public, while 57% ban camping in particularized public places.\textsuperscript{105} Citywide bans have increased by 60% since 2011.\textsuperscript{106} This is a 16% increase since 2011.\textsuperscript{107} 33% of cities ban loitering in public places throughout the entire city; 65% ban loitering in particularized public places.\textsuperscript{108} Citywide bans on loitering have increased by 35% since 2011.\textsuperscript{109} These statistics reveal the struggle of the homeless. These laws make it functionally illegal to be homeless. Rather than address the issues central to why people are homeless, these laws either force the homeless to relocate outside the city or force police officers to arrest them for sleeping and finding food.

Criminalization is an expensive and ineffective way of addressing the issue of homelessness in major cities.\textsuperscript{110} It does virtually nothing to address the underlying reasons for homelessness, and ultimately costs taxpayers more money in the long run through its cycle of arrests, bookings, and court proceedings for which the homeless defendant cannot pay.\textsuperscript{111} The National Law Center on Homelessness and Poverty points to several key studies to evidence this point.\textsuperscript{112} In a 2013 report on homelessness, Utah found that the annual cost of jail stays and emergency room visits per year for a single homeless person cost taxpayers around $16,000, whereas the annual cost to provide an apartment and social worker to these individuals totaled about $11,000.\textsuperscript{113} A 2013 study in New Mexico discovered that, by making the investment to provide homeless with housing, the city reduced spending associated with homeless-related jail costs by 64%.\textsuperscript{114} A 2014 Central Florida economic impact report found that taxpayers would save approximately $150 million over the next decade by simply providing the “chronically” homeless with sustainable housing and case managers.\textsuperscript{115}

Several cities recognize the economic black hole created by laws criminalizing common activities of the homeless. These cities have adopted new programs to improve the quality of life for both the chronically homeless and the taxpayers. For example, Miami-Dade County implemented a 1% tax on all food and beverage sales in establishments licensed to sell alcohol.\textsuperscript{116} Eighty-

\footnotesize{\textsuperscript{104} NO SAFE PLACE, supra note 58, at 22.  
\textsuperscript{105} Id. at 7.  
\textsuperscript{106} Id. at 8.  
\textsuperscript{107} Id.  
\textsuperscript{108} Id. at 21.  
\textsuperscript{109} Id. at 9.  
\textsuperscript{110} Id.  
\textsuperscript{111} Id.  
\textsuperscript{112} Id. at 10.  
\textsuperscript{113} Id. at 10.  
\textsuperscript{114} Id.  
\textsuperscript{115} Id.  
\textsuperscript{116} Id. at 10.}
five percent of the tax revenue is dedicated to the county’s Homeless Trust, created to assist and monitor agencies that provide outreach and housing to the county’s homeless population.\textsuperscript{117} In 2005, Utah created a 10-year plan to end chronic homelessness in the state.\textsuperscript{118} The plan’s “housing first” model sets aside permanent housing units for the homeless; since its inception, it has reduced chronic homelessness by approximately 75%.\textsuperscript{119}

While these programs point toward promising, sustainable solutions for the homeless population, they do not address the daily confrontations between police and homeless mentally ill. Police are still the front line of responding to crises or enforcing criminalization laws. Police can often be the best resource for directing homeless, particularly those with mental illnesses, to resources and treatment. However, they cannot effectively do so without first gaining a broader understanding of mental illness and how to interact with an individual in a mental health crisis.

\section*{VI. Interaction Between Police and Homeless Individuals}

Diminishing avenues for sustainable treatment and the increase in laws criminalizing common activities of the homeless have led to a rise in confrontations between police and mentally ill homeless.\textsuperscript{120} In addition to “public order” types of offenses, such as loitering, sleeping in public, or vagrancy, mentally ill homeless are at a higher risk of arrest for crimes associated with violence.\textsuperscript{121} Erratic or violent behaviors associated with mental illness that could be treated in psychiatric hospitals are now “more likely to be treated as criminal behavior.”\textsuperscript{122}

Certain severe mental disorders have been linked to an increased risk of violence and arrest.\textsuperscript{123} Increased risk of violent behavior and arrest holds even “after controlling for comparable risk factors, such as sex, age, race, and socioeconomic status.”\textsuperscript{124} Those suffering from psychological crisis are more likely to misinterpret the words and actions of others as threatening, which can lead to aggressive behavior.\textsuperscript{125} Even if police officers are able to recognize mental illness in homeless persons, criminalization laws or lack of resources forces police officers to arrest anyway in order to de-escalate a situation that could lead to harm to the mentally ill individual or others.\textsuperscript{126} In every situation, police officers are trained to maintain their authority.\textsuperscript{127} A tense situation between a mentally ill “offender” and the police can be the breeding ground for

\begin{itemize}
\item \textsuperscript{117} Id.
\item \textsuperscript{118} Id.
\item \textsuperscript{119} Id.
\item \textsuperscript{120} See Markowitz, supra note 69, at 49.
\item \textsuperscript{121} See id. at 51.
\item \textsuperscript{122} See id. at 49.
\item \textsuperscript{123} See id. at 50.
\item \textsuperscript{124} See id. at 50–51.
\item \textsuperscript{125} See id.
\item \textsuperscript{126} See id. at 49.
\item \textsuperscript{127} See id.
\end{itemize}
the more hostile, even fatal, outcomes described in Part I.

Legally, officers have wide discretion to use force against those they perceive to be threatening.\textsuperscript{128} In 1989, the landmark case \textit{Graham v. Connor} established that an “objective reasonableness” standard governed citizens’ claims of excessive force by law enforcement officials relating to arrests, investigatory stops, or “other ‘seizures’ of the person.”\textsuperscript{129} Courts evaluate the “reasonableness” of an officer’s use of force from the perspective of a reasonable law enforcement officer confronted with the same situation, not by the “20/20 vision of hindsight.”\textsuperscript{130} The test is an objective determination of whether the officers’ actions were reasonable “in light of the facts and circumstances confronting them, without regard to their underlying intent or motivation.”\textsuperscript{131} Approaching the reasonableness determination from this perspective accounts for law enforcement officers’ need to make “split second judgments” in tense, uncertain circumstances.\textsuperscript{132}

This test gives a great amount of discretion to police officers. Mentally ill individuals, particularly those on the streets, are inherently at a risk of being taken advantage of or abused. Mental illness may leave them unable to effectively take care of themselves. Erratic or violent behavior characteristic of certain mental illnesses can aggravate others or cause them to feel threatened. Police officers who are not trained to recognize or de-escalate mental crises may not understand the individual’s actions are not completely voluntary. Although it may be “objectively reasonable” for an officer to use excessive force, a mentally ill person having an episode arguably bears a different level of culpability than a criminal intentionally provoking the police. Society accepts that a fully competent criminal who chooses to threaten an officer should face the consequences. An officer may have to use lethal force to stop a threat to themselves or a fellow officer. However, it seems unjust to attribute the same level of culpability, or the same level of threat, to a mentally ill person who is having a psychotic episode. For example, a mentally ill person who brandishes a knife at an officer might do so because he is having a psychotic episode and he does not realize the officer is trying to help him. Justice requires a more subjective, thorough inquiry into the level of force considered reasonable in these cases. However, the Court flatly rejected this type of subjective analysis: “an officer’s evil intentions will not make a Fourth Amendment violation out of an objectively reasonable use of force; nor will an officer’s good intentions make an objectively unreasonable use of force constitutional.”\textsuperscript{133}

Even officers who attempt to handle mental health crises with minimal force are placed into difficult positions. In \textit{Abdi v. Karnes}, Ohio officers executing an Order to Detain had experience with mentally ill individuals and

\textsuperscript{128} See Lamb et al., \textit{supra} note 54, at 1267.
\textsuperscript{130} Id. at 396.
\textsuperscript{131} Id.
\textsuperscript{132} Id. at 397.
\textsuperscript{133} Id.
were aware Abdi had schizophrenia and a violent history. They approached him slowly and explained they needed to take him “to see a doctor.” Abdi became extremely aggravated; he cursed at the officers, drew a knife, and swung it over his head. The officers unsuccessfully attempted to persuade Abdi to drop his weapon and then pepper-sprayed him. One officer attempted to arrest Abdi, but Abdi swung the knife at him. In response, an officer shot and killed Abdi.

Abdi illustrates that lack of officer training is not the only problem to consider when attempting to remedy police interactions with the mentally ill; the mental illness itself can thwart the plans of the most well-intentioned officers. Due to Abdi’s death, the facts in his case came solely from the officers’ testimony. There is no independent confirmation that the officers executed the Order with the least amount of force necessary. However, mental illness can lead to violence against officers. In fact, police officers may see it as their duty to arrest someone exhibiting violent behavior, despite their mental illness, to remove a potential danger to civilians or other officers in the area. Mental illness can cause people to act dangerously; this does not in any way mean they deserve to be treated akin to criminals, but it is an immediate threat to an officer or other individual attempting to aid them. These situations are not cut-and-dry.

The combination of deinstitutionalization and cuts in federal housing has placed the burden of mental health intervention in the hands of local law enforcement. To better the relationship between mentally ill homeless and police, officers must gain a more comprehensive understanding of mental health disorders. However, this is not simply a “police problem,” but rather a societal problem. Many of these negative outcomes, including the one in Abdi, likely could be avoided if a better, more efficient system is in place to house and counsel those coping with mental illnesses. To truly solve issues stemming from police interactions with mentally ill people, federal, state, and local governments must adopt legislation to fund sustainable housing and care solutions.

135. Id. at 808.
136. See id.
137. See id. at 809.
138. See id.
139. See id.
140. Id. at 809. The district court denied Defendant’s Motion for Summary Judgment on the issue of causation. See id. at 819.
141. See Markowitz, supra note 42, at 39.
142. Id.
VII. CURRENT PROMISING SOLUTIONS

A. Improvements in Police Training

1. Crisis Intervention Teams

In 1988, the first Crisis Intervention Team (CIT) was formed in Memphis, Tennessee in the wake of a police shooting of mentally ill person. The program was the result of local efforts between mental health professionals, advocates, and the Memphis police department. The CIT model is a police-based program in which officers are trained on how to interact with mentally ill individuals in order to improve police response and safety of all parties. The program is intended to give officers the tools to recognize mental illness so they can diffuse situations by providing proper help rather than applying force or arrest. The program provides 40 hours of both classroom and experiential training in the de-escalation of mental health crises. CIT training directs officers to gather important information from family members and health care providers before encountering the person in crisis. The training includes information on: signs of mental illness, existing mental health treatment, criteria and procedures for commitment to mental health institutions, visits to treatments providers, and de-escalation techniques. De-escalation training teaches officers to expect verbal outbursts and to “speak softly and keep a distance from the person.” Officers who complete the training serve as specialized responders to mental health calls and work to direct individuals with mental illness to treatment instead of jail. Trained officers often serve as “team leaders” when responding to mental health crises with untrained officers and are designated to speak to the person in crisis.

CIT founder Sam Cochran emphasizes the importance of a community-based approach: “CIT is more than just training; it is a community program.” CIT International, the organization created to facilitate police department training, states its mission is to “create and sustain more effective interactions...”

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144. See id.
145. See id.
147. Compton et al., supra note 143, at 47.
149. Watson et al., supra note 51, at 363.
150. Abdi, 556 F. Supp. 2d at 806.
151. Compton et al., supra note 143, at 47.
152. Abdi, 556 F. Supp. 2d at 806.