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Decoupling Crisis Response from Policing — A Step Toward Equitable Psychiatric Emergency Services

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As young psychiatrists of color, we bear witness to the failings of the U.S. mental health emergency response system. We reluctantly counsel our patients to trust this system, though we're fully aware that it may harm them rather than ensure their safety. Our fears intensify when we undertake emergency planning with Black patients, whose ensnarement in systems of social control has been reinforced by centuries of racism in policing in particular and White supremacy more broadly. Obtaining care in a mental health crisis should be as routine and assistive as calling an ambulance for other health crises. Yet for too long, calling 911 for psychiatric aid has been fraught with the possibility of lethal consequences.

Though sirens announcing the arrival of professional help are commonplace today, emergency medical services providing prehospital care were atypical before the late 1960s. Instead, police officers and morticians responded to most medical emergencies in the United States by transporting patients to the hospital in a police car or hearse, with minimal or no equipment on board for treatment.[1,2] In 1966, the National Academy of Sciences outlined the morbidity and mortality stemming from undeveloped infrastructure and training for emergency response and implored policymakers to enact legislation providing for national emergency services.[3] Although inadequate prehospital care led to avoidable deaths for all populations, Black and other minority communities had disproportionately worse outcomes. Racist policies and practices contributed to this disparity.

In Pittsburgh, for example, city ordinance required police to transport patients to the nearest hospital. However, calls for help from Pittsburgh's Hill District and other predominantly Black neighborhoods were often ignored.[1] Police negligence and racist hostility toward Black residents prompted Black community leaders, including James McCoy, Jr., president of Freedom House Enterprise Corporation, an offshoot of the Pittsburgh branch of the National Association for the Advancement of Colored People (NAACP), to partner with physicians and city officials to develop the Freedom House Ambulance Service in 1967.[1]

With physician guidance from Nancy Caroline — appropriately dubbed the "mother of paramedics" — and cardiopulmonary resuscitation (CPR) pioneer Peter Safar, Freedom House provided state-of-the-art first-responder training to young, purportedly "unemployable," Black community members, who were not only successfully hired, trained, and paid, but often performed at higher levels than their professional peers. They were among the first to provide 24-hour service, deploy electrocardiography machines and medications on scene, and treat cardiac arrest in the field with CPR and intubation. Law enforcement, recognizing these paramedics' expertise, eventually requested Freedom House response for emergency cases in predominantly White neighborhoods as well.[1] Ultimately, Freedom House Ambulance Service pioneered a new standard of care: emergency medical response provided by professionals specifically trained to handle medical emergencies outside the hospital.[1,4,5] Tragically, more than 50 years later, this standard of care is still not applied to emergency mental health response in the United States.

THE CRIMINALIZATION OF RACE AND MENTAL ILLNESS

Police responses to psychiatric crises harm patients far too often, especially in minority communities, where a long history of institutional

racism informs warranted distrust of law enforcement.[6,7] Structural violence — including discrimination and criminalization — disproportionately harms marginalized minorities, particularly targeting many immigrant, LGBTQIA+, and Black people.[8-10] Recurring incidents corroborate studies demonstrating that police-based interventions not only fail to meet the psychiatric needs of vulnerable patients, but also dramatically increase the risks of arrests and fatal encounters.[11,12]

Basic training for U.S. police officers takes 21 weeks, on average,[13] and rarely includes training on bias, de-escalation of tense situations, recognition of psychiatric symptoms, or mental health first aid techniques. But even when officers undergo training in these areas, research demonstrates that it is not effective.[14,15] In the United States, a police encounter with a civilian is 16 times as likely to result in that person's death if they have an untreated mental illness as if they do not.[12] Structural racism exacerbates this risk, placing Black men with mental illness at significant risk for dying from U.S. police violence.[12] And each killing reinforces the link between Black racial identity and violent fates, worsening the mental health of Black Americans.[16,17]

Continued reliance on police as mental health first responders in Black and other minority communities leads directly to unnecessary injuries and deaths and increases the stigma against seeking treatment by fostering distrust of health care institutions, thereby limiting access to necessary mental health services.[6] Black patients receive poorer care than White patients throughout medicine,[18] and policing Black patients directly worsens psychiatric outcomes.[18,19] Policing of mental illness and substance use disorders, especially in Black communities, perpetrates structural violence manifesting as police brutality and incarceration under the guise of aid. Prioritizing policing over investment in Black and minority communities perpetuates this violence and contributes to racialized residential segregation, zero-tolerance policies criminalizing Black schoolchildren,[20] and underresourced community health programs.[6,7,21] Furthermore, extrajudicial killings of unarmed Black children and adults by police traumatize Black Americans, inflicting lasting generational damage.[7]

These long-standing systems of racialized power and control eventually led to the demise of the Freedom House Ambulance Service, despite its celebrated successes. Both physician and city leadership refused to durably and fairly partner with the Freedom House Enterprise organization and the communities they served, which resulted in promotion of less-skilled White medics to leadership positions over their Black colleagues. In addition, predominantly White unions in fire and police departments lobbied against Freedom House's contracting for city services while simultaneously usurping Freedom House protocols and responsibilities — actions that eventually led to a complete loss of funding and to dissolution of the service.[1]

HUMANITY IN CRISIS

Every day, we bear witness to the pain and suffering that systemic racism inflicts on our patients and our communities, the outcome all too often being social or physical death.[9,22] These systemic injustices demand that we as physicians examine our complicit role in systems of care that put our patients in harm's way.[23] Knowing that we might suffer the same fate, how can we ask our patients to reach out to police for psychiatric aid that may lead to inappropriate treatment, restraint, humiliation, injury, and death?

In October 2020, 27-year-old Walter Wallace, Jr., was killed in Philadelphia after his mother had initially called for an ambulance. But police responded first, shooting him more than a dozen times. Wallace had bipolar disorder and was being treated with lithium by a psychiatrist. He and his wife were about to celebrate the birth of a baby girl. Videos can be seen of his mother screaming and rushing to his body as he falls to the ground.[24]

Police in Rochester, New York, responded to a January 29, 2021, call from a family concerned about the suicidality of their 9-year-old daughter. Body-camera footage shows her crying for her father as she is pushed to the ground and handcuffed, then screaming as police pepper-spray her in the face. One officer says, "You're acting like a child." "I am a child!" the girl responds. The police union said no rules were broken.[25]

In 2019, Daniel Prude, an unarmed, 41-year-old Black man with mental illness, died after officers in Rochester placed a hood over his head, pinned his naked body to the frozen ground, and pressed his chest into the pavement. They were responding to a 911 call from Prude's brother seeking help because Prude had voiced thoughts of suicide and hyperreligiosity and was wandering naked in

the snow. After videos of his death circulated online, several police officers involved were suspended or fired after initially reporting that Prude died of an overdose while in police custody. Government officials have announced that the involved officers did not violate policing guidelines or ethical standards and will not be charged.[26]

In 2016, in San Diego, Alfred Olango, a 38-year-old refugee from Uganda, was in distress after his best friend's death by suicide a few days earlier. Olango's sister called for a psychiatric response team, but since it was unavailable, police responded instead and shot him several times, killing him. Olango was holding a vaping device.[27]

There are publicly available video and audio recordings of Stacy Kenny, a 33-year-old, White, trans woman, calling 911 in Springfield, Missouri, and begging an emergency operator to explain why she had been pulled over. Police officers proceed to smash the windows of her red Nissan, Taser her twice, punch her in the face more than a dozen times, and try to pull her out by her hair. After fatally shooting her, an officer is heard saying: "We are all okay. Bad guy down." Kenny was unarmed and had previously been diagnosed with schizophrenia. After her death, her family received a $4.55 million settlement from the city.[28]

Mauris DeSilva, originally from Sri Lanka, emigrated to the United States, where he obtained his doctorate in biomedical engineering, held professorships at multiple universities, and eventually became a principal investigator as a neuroscientist with the U.S. Navy. In 2019, he was shot and killed by police in Austin, Texas, who responded to a 911 call by a bystander reporting a man having a mental breakdown and holding a knife to his own neck. A few months later, the same officer shot and killed Michael Brent Ramos, an unarmed Black and Latinx man.[29]

MOVING TOWARD EQUITABLE EMERGENCY SERVICES

We believe that unarmed clinicians must lead crisis response teams, since no amount of training for police in de-escalation and bias can reverse a history of racism. Moreover, involving lethally armed agents in all psychiatric emergencies criminalizes crisis encounters and deviates from the clinical standard of care.[30,31] Shifting the obligation of mental health emergency response from law enforcement to clinical teams would advance parity and outcomes for all patients, and particularly for Black patients.[32] Assigning this responsibility to clinical teams aligns with standards set by the Substance Abuse and Mental Health Services Administration (SAMHSA), which recommends that crisis models use licensed clinicians dispatched by a call center capable of triaging acuteness and severity, with a focus on linkage to treatment.[30,31,33] The recent federal mandate for a 988 nationwide hotline for mental health crisis assistance by July 2022 offers a timely opportunity to turn crisis response into a community health initiative — one that prioritizes rendering of aid and treatment over provision of transportation and threat control.

Elected officials, regulatory agencies, professional medical societies, mental health specialty organizations, and community advocates must collaborate to develop the funding mechanisms and infrastructure necessary for a viable and integrated mental health emergency response system. One example that has garnered national attention is Crisis Assistance Helping Out On The Streets (CAHOOTS), which has been implemented in Eugene, Oregon. CAHOOTS not only provides 24/7 mobile crisis intervention and first aid, but it also assists with conflict resolution and mediation, grief and loss, substance use disorders (including acute intoxication and linkage to ongoing treatment), housing crises, connection to social services and treatment referrals, and transportation to services. CAHOOTS teams consist of a licensed mental health clinician paired with a nurse or emergency medical technician. In 2019, these teams responded to nearly 24,000 calls — about 17% of all 911-dispatch calls — and requested police backup in less than 1% of cases. The local community and police department have welcomed CAHOOTS, which saves Oregon taxpayers an average of $8.5 million in police and emergency department expenditures every year by effectively triaging emergency care needs to clinical response teams.[34]

To replicate these successful outcomes, Pittsburgh,[35] New York City,[36] San Francisco,[37] and other U.S. cities have modeled pilot programs on CAHOOTS, using clinician teams as primary responders and reserving police for backup in the uncommon event that their assistance is indicated. Some state legislatures, as well as the U.S. House and Senate, have introduced bipartisan legislation to expand these efforts.[36,38] Though these advances are promising, elected representatives can also prioritize evidence-based mechanisms for sustainable financing of model implementation.[31,39] Without such financing, many

underresourced districts will not have the political or financial capital to develop the requisite infrastructure. To make crisis services available to all communities, physicians must collaborate with social workers, psychologists, nurses, public health officials, and other stakeholders, since this endeavor will require our collective efforts.

More than 50 years later, many of the same forces that drove the formation and demise of the Freedom House Ambulance Service persist,[6] as racist systems of social control rooted in White supremacy continue to result in poor health outcomes for Black and other marginalized groups. Broad discrimination against patients with mental health conditions leads to a constant struggle for equality with other areas of medicine. These two inequities coalesce to chronically imperil Black patients with mental illness, whose intersection of identities and conditions places them at great risk from police and other structural violence. Decoupling mental health treatment from policing will advance equity in both domains for these patients, for Black communities seeking services, and broadly for patients with mental illness, regardless of their race.

Galvanized by the ineffective and often hostile and harmful police responses to both marginalized communities and mental health crises, we call on the medical profession to uphold our duty to our most vulnerable patients. The failures of the current mental health emergency response system reverberate as a clarion call for a national effort to bring this pursuit to fruition. The lives of our patients, communities, families, and friends — and even our own lives — may depend on it.

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