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

[*] Carly Masenthin is a third-year law student at the University of Kansas School of Law. She extends a special thanks to the KU law faculty, advisors, staff, and community for their continuous support and guidance, and to the members of the *Kansas Journal of Law & Public Policy* for their hard work in preparing this article.

1. Meg Wagner, *California Cops Tried to Run over Mentally Ill Homeless Man*, N.Y. DAILY NEWS (Oct. 1, 2016, 2:10 PM), http://www.nydailynews.com/news/national/calif-cops-run-mentally-ill-homeless-man-article-1.2813934.

2. *Id.*

3. Cleve R. Wootson, Jr., *'I'm Going to Hit Him': Dash-Cam Video Shows Officers Tried to Run over a Man Before Shooting Him 14 Times*, WASH. POST (Oct. 3, 2016), https://www.washingtonpost.com/news/post-nation/wp/2016/10/01/im-going-to-hit-him-dashcam-shows-cops-tried-to-run-over-man-before-shooting-him-14-times/?utm_term=.2e0947ce6462.

4. Wagner, *supra* note 1.

5. *Id.*

6. *Id.*

7. *Id.*

8. Wootson, *supra* note 3.

9. *Id.*

jumping onto a street median.[10] Officers chased after Joseph on foot, shooting as they ran.[11] Ultimately, the officers shot Joseph fourteen times, ending his life.[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.[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.[14] Luis had been homeless for about four or five years.[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.[16] No job meant no money for either Luis or his family back home, which sent Luis into a mental and physical breakdown.[17] He even unsuccessfully tried to get deported back to Mexico.[18] His mental state and lack of resources soon left Luis without a home other than the San Francisco streets.[19]

Outreach workers called the police after they witnessed Luis walking down the street, brandishing a knife.[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.[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.[22] Officers claim that Luis lunged at them with his knife; eyewitnesses report the opposite.[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.[24] However, the video shows the officers opened fire and killed Luis within thirty seconds of

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10. *Id.*
11. Wagner, *supra* note 1.
12. *Id.*
13. Jessica Schladebeck, *Sacramento Police Officers Who Shot Joseph Mann 14 Times Cleared of Wrongdoing*, N.Y. DAILY NEWS (Jan. 27, 2017, 2:45 PM), http://www.nydailynews.com/news/national/officers-shot-joseph-mann-14-times-cleared-wrongdoing-article-1.2957596.
14. Julia Carrie Wong, *The Life and Death of Luis Góngora: The Police Killing Nobody Noticed*, GUARDIAN (Aug. 12, 2016), https://www.theguardian.com/society/2016/aug/12/luis-gongora-san-francisco-police-shooting-homelessness.
15. *Id.*
16. *Id.*
17. *Id.*
18. *Id.*
19. *Id.*
20. Wong, *supra* note 14.
21. *Id.*
22. *Id.*
23. *Id.*
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.

exiting their vehicle.[25] 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."[26]

On March 16, 2014, Albuquerque police approached a sleeping James Boyd to arrest him for illegally camping in the Albuquerque foothills.[27] James was homeless and suffered from schizophrenia.[28] The arrest turned into a standoff with nearly twenty officers that lasted several hours.[29] Briefly, the scene appeared to be de-escalating;[30] 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.[31] 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.[32] James was fatally shot by two officers.[33] James's death led to an investigation on excessive force within the Albuquerque police department, and the investigation uncovered a "culture of aggression."[34] The two officers responsible for the shooting were charged with second-degree murder.[35] Their trial ended in a mistrial in October 2016.[36]

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.[37] It is unclear how many of those 256 were homeless.

Police officers' jobs are to fight crime and capture criminals. While society

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25. *Id.*

26. *Id.*

27. Sebastian Murdock, *Police Shoot Homeless Man During Camping Arrest*, HUFFINGTON POST (March 24, 2014, 11:34 AM), http://www.huffingtonpost.com/2014/03/24/james-boyd-killed-by-cops_n_5021117.html.

28. Mary Hudetz, *Ex-Officer Charged with Murder in Homeless Death Testifies*, ASSOCIATED PRESS (Oct. 5, 2016), http://www.bigstory.ap.org/article/27291a071dd4411f92e56a45955945c2/ex-officer-charged-homeless-mans-death-testifies.

29. *Id.*

30. *Id.*

31. *See id.*

32. *See id.*

33. *See id.*

34. *Id.*

35. *Id.*

36. *Murder Case Against Former New Mexico Police Officers Ends in Mistrial*, L.A. TIMES (Oct. 11, 2016), http://www.latimes.com/nation/nationnow/la-na-new-mexico-police-mistrial-20161011-snap-story.html.

37. *2015 Washington Post Database of Police Shootings*, WASH. POST, https://www.washingtonpost.com/graphics/national/police-shootings/ (last visited Sept. 22, 2017).

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).[38] 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.[39] The close link between mental illness and homelessness can be partially attributed to the deinstitutionalization movement[40] 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.[41] 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.

39. James B. Arey et al., *Crisis Intervention Teams: An Evolution of Leadership in Community and Policing*, 10 POLICING 143, 144 (2015).

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]

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42. Fred E. Markowitz, *Mental Illness, Crime, and Violence: Risk, Context, and Social Control*, 16 AGGRESSION & VIOLENT BEHAV. 36, 37 (2011).

43. *See* Lamb, *supra* note 41, at 899.

44. *Id.* at 903.

45. *Id.* at 904.

46. *See* Markowitz, *supra* note 42.

47. Michael J. Lynch & Lyndsay N. Boggess, *A Radical Grounding for Social Disorganization Theory: A Political Economic Investigation of the Causes of Poverty, Inequality and Crime in Urban Areas*, 6 RADICAL CRIMINOLOGY 11, 18 (2016).

48. *Id.* at 19.

49. *Id.*

50. *Id.*

51. Amy C. Watson et al., *Improving Police Response to Persons with Mental Illness: A Multi-Level Conceptualization of CIT*, INT'L J.L. & PSYCHIATRY 359, 365 (2008).

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.[54] 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.[55] Today, police are often the sole resource relied on to respond to situations involving individuals in mental crises.[56] 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.[57] Officers increasingly have to make those calls due to passage of laws that "criminalize" homelessness.[58] These laws effectively force officers to either fine or arrest the homeless for actions like camping, panhandling, loitering, and sleeping in public spaces.[59] 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.[60]

In 2015, the homeless were 6.5 times more likely to be killed by police than the general population.[61] 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[62] 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.[63] Three important factors played into the fall of the publicly funded mental hospital.[64] 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

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.*

58. NAT'L LAW CTR. ON HOMELESSNESS & POVERTY, NO SAFE PLACE: THE CRIMINALIZATION OF HOMELESSNESS IN U.S. CITIES 8 (2014), https://www.nlchp.org/documents/No_Safe_Place [hereinafter NO SAFE PLACE].

59. *See generally id.*

60. *See* Markowitz, *supra* note 42, at 39.

61. Wong, *supra* note 14.

62. *See infra* Part IV.

63. Markowitz, *supra* note 42, at 37.

64. *Id.*

level.[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.[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.[67] This was accompanied by substantial budget cuts to community mental health services at the state and federal level.[68]

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

Hospital psychiatric units and emergency rooms bear the brunt of the burden caused by the decrease of beds in state funded mental hospitals.[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,[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.[75] Specialized psychiatric hospitals that do still exist continuously decrease the time admitted patients can stay as the number of beds decreases.[76] In the 1960s, the average stay in a psychiatric hospital was six months.[77] By the early 2000s, the average stay had decreased to ten days.[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.[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

65. *Id.* Unfortunately, as this paper will demonstrate, that idea did not become reality.
66. *Id.*
67. *Id.*
68. *Id.*
69. Fred E. Markowitz, *Psychiatric Hospital Capacity, Homelessness, and Crime and Arrest Rates*, 44 CRIMINOLOGY 45, 46 (2006).
70. Markowitz, *supra* note 42, at 37.
71. *Id.*
72. *Id.*
73. *See id.*
74. *See id.*
75. *See id.*
76. *See id.*
77. *Id.*
78. *Id.*
79. *See id.*

lives.[80]

Not only do psychiatric hospitals provide medical care, they also serve as a method of supervision.[81] Psychiatric hospitals provide a controlled environment for those who cannot care for themselves or whose behavior could turn threatening or violent.[82] Reduced availability of public psychiatric institutions led to an increase of mentally ill who lack consistent support.[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.[84]

IV. CUTS IN FEDERAL HOUSING FUNDING

Since 2001, more than 12.8% of the nation's low-income housing has been lost.[85] This is the culmination of a forty-year trend of funding decreases for federally subsidized housing.[86] Approximately 10,000 units of federally subsidized housing has been lost each year since the 1970s.[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.[88] The goal was to reduce national deficits by a total of $1.2 trillion over the course of the ten years.[89] Non-defense appropriations include a variety of government functions such as housing assistance and public health.[90] In 2010, the funding for non-defense programs was $596 billion; in 2016, it was cut to $493 billion.[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.[92] Many mentally ill homeless frequently filter in and out of police stations.[93] Public Housing Authorities, which administer federal

80. *Id.*
81. *See* Markowitz, *supra* note 69, at 47.
82. *See id.*
83. *See id.*
84. *See id.* at 48.
85. NO SAFE PLACE, *supra* note 58, at 7.
86. *Id.*
87. *Id.* at 14.
88. DAVID REICH, CTR. ON BUDGET & POL'Y PRIORITIES, SEQUESTRATION AND ITS IMPACT ON NON-DEFENSE APPROPRIATIONS 2 (2015), http://www.cbpp.org/research/federal-budget/sequestration-and-its-impact-on-non-defense-appropriations.
89. *Id.*
90. *Id.*
91. *See id.* at 4.
92. NO SAFE PLACE, *supra* note 58, at 32.
93. *See infra* Part VII.

housing programs at a local level, have broad discretion to determine whether an individual with a criminal record can receive assistance.[94] Many Public Housing Authorities deny housing assistance to anyone who has a criminal record, even for minor offenses.[95]

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.[96] 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.[97] Police rigorously enforced city ordinances against trespassing, begging, sleeping in parks, and panhandling.[98] The public displayed widespread support for these policies by electing city officials who campaigned on public order platforms and by ballot initiatives.[99] Under the Giuliani administration, New York City led the trend of adopting aggressive policing measures to reduce visible signs of social disorder.[100] 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.[101] 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."[102] 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."[103]

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94. NO SAFE PLACE, *supra* note 58, at 33.

95. *Id.*

96. *See* Markowitz, *supra* note 69, at 51.

97. ALEX S. VITALE, CITY OF DISORDER: HOW THE QUALITY OF LIFE CAMPAIGN TRANSFORMED NEW YORK POLITICS 10 (2008).

98. *Id.* at 11.

99. *Id.*

100. *Id.*

101. ANDREA MCARDLE & TANYA ERZEN, ZERO TOLERANCE: QUALITY OF LIFE AND THE NEW POLICE BRUTALITY IN NEW YORK CITY 5 (2001).

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.[104] Thirty-four percent of cities impose citywide bans on camping in public, while 57% ban camping in particularized public places.[105] Citywide bans have increased by 60% since 2011.[106] Particularized camping in public places bans have increased by 16% since 2011.[107] 33% of cities ban loitering in public places throughout the entire city; 65% ban loitering in particularized public places.[108] Citywide bans on loitering have increased by 35% since 2011.[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.[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.[111] The National Law Center on Homelessness and Poverty points to several key studies to evidence this point.[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.[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%.[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.[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.[116] Eighty-

104. NO SAFE PLACE, *supra* note 58, at 22.
105. *Id.* at 7.
106. *Id.* at 8.
107. *Id.*
108. *Id.* at 21.
109. *Id.* at 9.
110. *Id.*
111. *Id.*
112. *Id.* at 10.
113. *Id.* at 9.
114. *Id.*
115. *Id.*
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.[117] In 2005, Utah created a 10-year plan to end chronic homelessness in the state.[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%.[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.

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.[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.[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."[122]

Certain severe mental disorders have been linked to an increased risk of violence and arrest.[123] Increased risk of violent behavior and arrest holds even "after controlling for comparable risk factors, such as sex, age, race, and socioeconomic status."[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.[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.[126] In every situation, police officers are trained to maintain their authority.[127] A tense situation between a mentally ill "offender" and the police can be the breeding ground for

117. *Id.*
118. *Id.*
119. *Id.*
120. *See* Markowitz, *supra* note 69, at 49.
121. *See id.* at 51.
122. *See id.* at 49.
123. *See id.* at 50.
124. *See id.* at 50–51.
125. *See id.*
126. *See id.* at 49.
127. *See id.*

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.[128] In 1989, the landmark case *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."[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."[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."[131] Approaching the reasonableness determination from this perspective accounts for law enforcement officers' need to make "split second judgments" in tense, uncertain circumstances.[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."[133]

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

128. *See* Lamb et al., *supra* note 54, at 1267.
129. Graham v. Connor, 409 U.S. 386, 388 (1989).
130. *Id.* at 396.
131. *Id.*
132. *Id.* at 397.
133. *Id.*

were aware Abdi had schizophrenia and a violent history.[134] They approached him slowly and explained they needed to take him "to see a doctor."[135] Abdi became extremely aggravated; he cursed at the officers, drew a knife, and swung it over his head.[136] The officers unsuccessfully attempted to persuade Abdi to drop his weapon and then pepper-sprayed him.[137] One officer attempted to arrest Abdi, but Abdi swung the knife at him.[138] In response, an officer shot and killed Abdi.[139]

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.[140] 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.[141] Mental illness can cause people to act dangerously;[142] 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.

134. *See generally* Abdi v. Karnes, 556 F. Supp. 2d 804 (S.D. Ohio 2008).

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.[143] The program was the result of local efforts between mental health professionals, advocates, and the Memphis police department.[144] 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.[145] 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.[146] The program provides 40 hours of both classroom and experiential training in the de-escalation of mental health crises.[147] CIT training directs officers to gather important information from family members and health care providers before encountering the person in crisis.[148] 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.[149] De-escalation training teaches officers to expect verbal outbursts and to "speak softly and keep a distance from the person."[150] 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.[151] 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.[152]

CIT founder Sam Cochran emphasizes the importance of a community-based approach: "CIT is more than just training; it is a community program."[153] CIT International, the organization created to facilitate police department training, states its mission is to "create and sustain more effective interactions

143. *See* Michael T. Compton et al., *A Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs*, 36 J. AM. PSYCHIATRY L. 1, 47 (2008).

144. *See id.*

145. *See id.*

146. Josh Sanburn, *Alfred Olango Shooting Raises Troubling Questions About Police and Mental Illness*, TIME (Sept. 29, 2016), http://time.com/4512253/el-cajon-police-shooting-alfred-olango-mental-illness/.

147. Compton et al., *supra* note 143, at 47.

148. Abdi v. Karnes, 556 F. Supp. 2d 804, 806 (S.D. Ohio 2008).

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.

153. Henry J. Steadman & David Morrissette, *Police Responses to Persons with Mental Illness: Going Beyond CIT Training*, 67 LAW & PSYCHIATRY 1054, 1054 (2016).

among law enforcement, mental health providers, individuals with mental illness, their families and communities and also to reduce the stigma of mental illness."[154] Partnerships among law enforcement, advocacy, and mental health providers are listed as the first of CIT's ten core elements.[155]

To operate effectively, CIT programs rely heavily on "a strong community partnership and vibrant crisis system that understands the role and needs of law enforcement" and encourages officers to access crisis facilities.[156] Specialized response sites are critical to the successful operation of CIT programs; sites are typically open 24 hours a day and allow officers to bring individuals in who are in need of a psychiatric evaluation.[157] For example, the Memphis police department agreed on a "no refusal" policy with the University of Memphis Medical Center's psychiatric department; this allows police to drop off individuals at any time for psychiatric care.[158] If there are not reasonably accessible non-jail options or treatment centers available in the community, a CIT program is not likely to achieve its full potential.[159]

CIT success is largely based on officer attitude.[160] Since their creation, approximately 2,700 police departments in the United States have implemented CIT programs.[161] The decision to accept a CIT program, and motivation to volunteer, will likely be based on the influence of fellow officer support.[162] Officer support for CIT and officer attitude toward the mentally ill is influenced by the broader social views of their communities.[163] Characteristics of the community in which police departments are responding can influence the nature and frequency of mental disturbance calls as well as the resources available to officers.[164] Generally, programs that have a large network in which police officers work with mental health organizations are more successful.[165] Officers can only refer mentally ill individuals to community mental health resources if those resources exist.[166] Police officers that work in disorganized communities can be cynical about the effectiveness of social reform programs, and may be more likely to rely on stereotypes about persons with mental illness.[167] These

154. *About Us*, INT'L CRISIS INTERVENTION TEAM, http://www.citinternational.org/About (last visited Oct. 15, 2016).

155. RANDOLPH DUPONT ET AL., CRISIS INTERVENTION TEAM CORE ELEMENTS 5 (2007), http://citinternational.org/resources/Pictures/CoreElements.pdf.

156. Nick Margiotta, *The Five-Legged Stool: A Model for CIT Program Success*, POLICE CHIEF, http://www.policechiefmagazine.org/the-five-legged-stool-a-model-for-cit-program-success/ (last visited Sept. 19, 2017).

157. Compton et al., *supra* note 143, at 54.

158. Watson, *supra* note 51, at 361.

159. Compton et al., *supra* note 143, at 53.

160. *Id.*

161. Sanburn, *supra* note 146.

162. *Id.*

163. Watson et al., *supra* note 51, at 365.

164. *Id.* at 364.

165. *Id.* at 361.

166. *Id.* at 364.

167. *Id.*

officers may be less likely to support or volunteer for a CIT program.[168]

As CIT programs gain traction around the nation, their proven benefits may persuade even the most skeptical police department. The National Alliance on Mental Illness (NAMI), a major advocate for CIT programs, lists three key benefits of CIT: improving officer safety, maintaining community safety, and saving public money.[169] According to NAMI, since the induction of the original CIT model in Memphis, officer injuries during mental disturbance response calls decreased by 80%.[170] Officers in CIT programs report that the program minimizes time spent responding to mental disturbance calls, effectively meets the needs of the mentally ill, and maintains community safety.[171] NAMI also states that pre-booking jail programs, like CIT, reduce the number of re-arrests of mentally ill individuals by 53%, saving tax dollars.[172]

While CIT programs show success in improving police interactions with mentally ill, they may not be enough to fully address the issues specific to the mentally ill homeless. After a psychotic crisis, a mentally ill person with a home or stable environment to return to is in a better position to treat their illness than one who is homeless. Release from police custody or emergency treatment and return to life on the streets propagates the "revolving door" phenomenon.

2. Homeless Outreach Teams

Several cities have partnered with police forces to create programs targeted to address the specific needs of homeless mentally ill. In Houston, the police department's CIT program is a successful example of a model that reaches out specifically to the homeless. Launched in 2011,[173] the Houston police department's Homeless Outreach Team is a subdivision of their CIT program. The team is relatively small—it consists of one sergeant, four officers, and three county mental health case managers.[174] Despite its size, the team has received both national and international recognition for its collaborative effort and innovative approach to addressing homelessness issues using policing strategies.[175] The team helps the homeless find housing, obtain social security cards, passports, and birth certificates; it provides shelter referrals, medical equipment, medical treatment, mental health treatment and bus fare; and helps to secure employment.[176] The team is connected with several advocacy organizations throughout the city, including Goodwill and the Salvation

168. *Id.*

169. *What is CIT?*, NAT'L ALL. ON MENTAL ILLNESS, http://www.nami.org/Law-Enforcement-and-Mental-Health/What-Is-CIT#_edn2 (last visited Aug. 30, 2017).

170. *Id.*

171. *Id.*

172. *Id.*

173. NO SAFE PLACE, *supra* note 58, at 10.

174. George T. Buenik, *Houston's Homeless Outreach Team*, POLICE CHIEF, Sept. 2015, at 45, http://www.policechiefmagazine.org/wp-content/uploads/Police-community_relations_September2015.pdf.

175. *Id.*

176. *Homeless Outreach Team*, HOUSTON POLICE DEP'T MENTAL HEALTH DIV. (Jan. 6, 2014), http://www.houstoncit.org/test/.

Army.[177] It provides assistance and expertise to other Houston patrol officers who do not typically interact with the homeless mentally ill.[178]

The program has been largely successful in strengthening a positive relationship between police and the homeless. Team members have developed personal relationships with many people living on the street and regularly check up on them.[179] In turn, homeless people feel comfortable telling the team when they have been victims of a crime, which assists the officers in developing information on leads in criminal cases around the areas in which the homeless reside.[180] The Houston model provides a working example of how CIT programs can expand to better address the specific needs of homeless mentally ill individuals. The Houston team attributes their success to their collaboration with local mental health professionals and advocacy groups.[181] In areas where those resources are scarce, it may be difficult for CIT programs to effectively deal with the specialized needs of the homeless mentally ill.

B. Federal Assistance Programs

1. 21st Century Cures Act

In December 2016, Congress passed and President Obama signed into law the 21st Century Cures Act (Act).[182] The Act marks a significant step in mental health legislation. The Act purports to modernize mental-health reforms, improve mental health services for children, and increase the amount of training received by those who work with the mentally ill.[183] The Act allocates $4.8 billion in funding to the National Institutes of Health.[184] It requires $15 million in annual funding (through 2022) to go to training firefighters, police officers, and other first responders how to best handle mental health crises.[185] The Act also re-instates the Mentally Ill Offender Treatment and Crime Reduction Act, which provides extra funding to programs that have shown success in diverting mentally ill persons from the criminal justice system toward "alternatives to incarceration."[186] These alternatives can include clinical or home-based

177. *Id.*

178. Buenik, *supra* note 174.

179. *Id.*

180. *Id.*

181. *Id.*

182. Ken Newton, *Washington Gives New Look at Mental Health*, NEWS-PRESS NOW (Dec. 22, 2016), http://www.newspressnow.com/news/local_news/washington-gives-new-look-at-mental-health/article_009567fe-499a-5184-bea4-12d69af4a4e9.html; *see also* Mike DeBonis, *Congress Passes 21st Century Cures Act, Boosting Research and Easing Drug Approvals*, WASH. POST (Dec. 7, 2016), https://www.washingtonpost.com/news/powerpost/wp/2016/12/07/ congress-passes-21st-century-cures-act-boosting-research-and-easing-drug-approvals/?utm_term=.974f9759b69f.

183. Newton, *supra* note 182.

184. DeBonis, *supra* note 182.

185. Newton, *supra* note 182.

186. Richard Frank, *What the 21st Century Cures Act Means for Behavioral Health*, HARV. HEALTH PUBLICATIONS (Jan. 19, 2017, 9:30 AM), https://www.health.harvard.edu/blog/21st-century-cures-act-means-behavioral-health-2017011910982.

services, treatment and recovery services, job training, and GED preparation.[187] Funding is also expected to go toward programs that assist mentally ill people with re-integrating into a community after serving jail time.[188] Also, the Act funds prison initiatives to better serve its mentally ill inhabitants.[189]

In Minnesota, The Department of Corrections partnered with the Minnesota chapter of the National Alliance on Mental Illness to train prison guards in crisis intervention training.[190] By January 2016, the Minnesota Department of Correction had approximately 350 CIT-trained staff.[191] This effort created better resources for care for mentally ill individuals in prison. The 21st Century Cures Act is a monumental piece of legislation for the future of mental health care. The Act signifies the federal government's recognition of the wide-spread issues regarding law enforcement and the mentally ill. The Act blends mental health awareness with federal funding and Department of Justice training and addresses many problems of mentally ill individuals. By supporting efforts to move the mentally ill away from the justice system, the Act provides resources to the mentally ill homeless to prevent more of these individuals from entering the revolving door between the streets and law enforcement.

2. Continuum of Care Program

The U.S. Department of Housing and Urban Development facilitates the Continuum of Care (CoC) program. The CoC program was created to promote community-based care facilities and give support to the homeless, provide the homeless with connections to mainstream technology and resources, and to allow each community to tailor the program to particular community needs and nuances.[192] The program's goal is to provide federal funding to "rehouse homeless individuals and families while minimizing trauma and dislocation . . . promote access to an effect utilization of mainstream programs. . .and optimize self-sufficiency among individuals and families experiencing homelessness."[193] The CoC program has five components: permanent housing, transitional housing, supportive services only, homeless management information, and homeless prevention.[194] Nonprofits and state and local governments can apply for funds to execute one or more of the program's components.[195] Eligible costs vary with each program component, but may include acquisition of real property, rehabilitation of structures, construction of new structures, leasing

187. JUSTICE CTR., COUNCIL OF STATE GOV'TS, THE MENTALLY ILL OFFENDER TREATMENT AND CRIME REDUCTION ACT 2 (Feb. 2016), https://csgjusticecenter.org/wp-content/uploads/2014/08/MIOTCRA_Fact_Sheet.pdf.

188. Frank, *supra* note 186.

189. JUSTICE CTR., COUNCIL OF STATE GOV'TS, *supra* note 187, at 1.

190. *Id.* at 2.

191. *Id.*

192. *See Continuum of Care (CoC) Program Eligibility Requirements,* U.S. DEP'T OF HOUSING & URBAN DEV., https://www.hudexchange.info/programs/coc/coc-program-eligibility-requirements/ (last visited Sept. 22, 2017).

193. *Id.*

194. *Id.*

195. *Id.*

costs, rental assistance costs, supportive services costs, operating costs, costs related to contributing client data or maintaining data, and project administration.[196] The CoC program focuses on the resources mentally ill homeless need once they exit the criminal justice system. The program's five components also serve to prevent the homeless mentally ill from re-entering the criminal justice system.

3. Federal Surplus Property Program

The Mckinney-Vento Homeless Assistance Act of 1987 contains the Title V program, which allows state and local government, non-profits, and other eligible organizations to convert "unutilized, underutilized, excess, or surplus" federal property into shelters for the homeless.[197] Leases are free and extend from one to twenty years.[198] Every week, the Department of Housing and Urban Development posts available properties in the Federal Register; organizations or governments then have sixty days to notify the U.S. Department of Housing and Human Services that they intend to apply for the property.[199] Upon receipt of the "statement of interest," the Department of Housing and Human Services provides an application for the interested entity, which must be returned in ninety days.[200]

C. Community Care in Kansas

Volunteer efforts at local missionaries and charities throughout the country shoulder the most responsibility, next to law enforcement, for caring for mentally ill homeless. Shelters provide stability and community resources to homeless individuals in a variety of ways, from providing consistent meals to recommending medical providers, therapy, and career counseling. In its major cities, Kansas is a leader in community care.

In Topeka, Kansas, the capitol city serves as a shining example of successful sustainable community solutions thanks to its Rescue Mission. The Topeka Rescue Mission has cared for the homeless since 1953, when it provided shelter and food for the homeless out of a single room.[201] The Mission has increased exponentially since its founding by developing its shelters and a new distribution center.[202] The Mission reports that, on average, it shelters 250 individuals a day.[203] In 2016, the Mission sheltered around 2,000 people.[204]

In 2011, the Mission created Operation Street Reach to serve individuals

196. *Id.*

197. *Title V - Federal Surplus Property for Use to Assist the Homeless*, U.S. DEP'T OF HOUSING & URBAN DEV., https://www.hudexchange.info/programs/title-v/ (last visited Sept. 22, 2017).

198. *Id.*

199. *Id.*

200. *Id.*

201. *About Us*, TOPEKA RESCUE MISSION, http://trmonline.org/about-us/ (last visited Aug. 27, 2017).

202. *Id.*

203. *Id.*

204. *Id.*

who are not able to travel to shelters.[205] This program locates the homeless and provides them with food, water, clothing, and toiletries.[206] The program partners with Topeka agencies and churches to help individuals find housing and jobs.[207] Perhaps most importantly, the program's partnerships provide substance abuse treatment and physical and mental health services.[208]

The Kansas City Rescue Mission offers similar services.[209] The Mission has different services and programs for homeless men and women; however, the programs are essentially the same.[210] Both provide long-term counseling and access to resources to help individuals find jobs, permanent housing, health care, and educational opportunities. Individuals are provided with case managers and counselors.[211]

The Kansas City Rescue Mission notably offers both a Recovery and Transitional Program for those it shelters.[212] The Recovery Program is a six-month residential program that offers life skills classes, GED preparation, high school courses, addiction recovery services, counseling, and religious education.[213] Once an individual completes the Recovery Program, she is eligible to join the Transitional Living Program. In this setting, she is sheltered for up to two years by the Rescue Mission while she completes schooling, seeks jobs, builds a career, and saves for permanent housing.[214] Those with disabilities are assigned a Kansas City Rescue Mission Case Worker for additional help in obtaining benefits and permanent housing.[215]

The Uplift organization in Kansas City, Missouri helps to address all the above needs with individuals who are not able to travel to shelters—and the need is great. In just the first quarter of 2017, the outreach center served approximately 7,000 homeless in the metropolitan area.[216] Uplift partners with local elementary schools, secondary schools, and university students to provide food and supplies to the homeless.[217] Every Monday and Wednesday evening, Uplift vans travel across the city to deliver hot meals and supplies to the homeless population in the Kansas City area.[218]

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205. *Id.*

206. *Street Reach*, TOPEKA RESCUE MISSION, http://trmonline.org/divisions/street-reach/ (last visited Aug. 27, 2017).

207. *Id.*

208. *Id.*

209. KAN. CITY RESCUE MISSION, http://kcrm.org (last visited Aug. 27, 2017).

210. *Id.*

211. *Id.*

212. *Men's Ministries*, KAN. CITY RESCUE MISSION, http://kcrm.org/kcrm-ministries/mens-ministries/ (last visited Aug. 27, 2017).

213. *Id.*

214. *Id.*

215. *Id.*

216. *News*, Uplift Newsletter (Uplift Org., Kansas City, Mo.), Spring 2017, at 2, http://www.uplift.org/wp-content/uploads/2017/05/Uplift_News_Sprin17_web.pdf.

217. *Id.* at 3; *News*, Uplift Newsletter (Uplift Org., Kansas City, Mo.), Winter 2017, at 3, http://www.uplift.org/wp-content/uploads/2017/05/Uplift_News_Winter17_web.pdf.

218. *News*, Uplift Newsletter (Uplift Org., Kansas City, Mo.), Spring 2017, at 4,

Kansas City, Missouri is home to another notable outreach center for the homeless—ReStart. ReStart offers a full range of services for homeless men, women, youth, and families. ReStart offers therapy, substance abuse counseling, and housing and employment specialists.[219] ReStart employs past and current residents at its outreach centers.[220] It partners with a variety of agencies across the Kansas City metropolitan area to connect individuals with mental health screenings, therapy, and referrals.[221] Its partnerships offer a variety of services, including, but not limited to: sexual assault and domestic violence counseling, health education workshops, education for adults and referrals for children of homeless individuals to school districts for enrollment purposes, job search and placement coordination, life skills training, monthly budgeting classes, and health benefits.[222]

Community-based centers for care lessen the need for police intervention. Without the growth of local, sustainable care shelters and programs, the often-contentious interactions between law enforcement and the mentally ill homeless are likely unavoidable. The efforts of some departments to train officers in crisis intervention techniques have proven successful, but there is still work to be done. Law enforcement training paired with community care will reduce the risks associated with homelessness and mental illness, while also greatly reducing the amount of taxes spent on emergency room or jail-bookings that provide little to no sustainable solutions for care.

VIII. CONCLUSION

Mental illness fosters instability. Deinstitutionalization deprived the mentally ill of stable environments and forced many to seek shelter in the only place they could find—the streets. Cuts in federal housing funding placed an added barrier between the mentally ill homeless and sustainable shelter. The rise in the homeless population led to a backlash from communities seeking to ban disorderly behaviors, such as loitering, panhandling, and public camping. As a result, police exerted control over these behaviors through arrest and other measures. For better or worse, police are now the first responders to mental health crises; they decide whether an individual receives medical help or jail time. Increased interactions between police and the homeless mentally ill has bred violence. Without sustainable solutions to help the mentally ill homeless rehabilitate their lives, police find themselves encountering the same individuals repeatedly.

In order to better the relationship between both police officers and the mentally ill homeless and the community and the mentally ill homeless, more training and resources are needed. Police officers need to be trained to recognize

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http://www.uplift.org/wp-content/uploads/2017/05/Uplift_News_Sprin17_web.pdf.

219. *Supportive Services*, RESTART, http://restartinc.org/programs/supportive-services/ (last visited Aug. 27, 2017).

220. *Id.*

221. *Id.*

222. *Id.*

and de-escalate mental health crises. CIT training should be mandatory for all officers to reflect the growing officer response to mental health crises. Each police department in an area with a substantial homeless population should implement the use of a Homeless Outreach Team, if they have the resources to do so.

There should be a different standard for measuring what is "reasonable" force for mentally ill individuals than for those acting intentionally and with cognizance. Perhaps a subjective test, considering the illness of the individual and the symptoms it produces, in combination with an objective view into the officer's perception of a threat, would be more beneficial to mentally ill individuals. This would incite police officers to take more caution in using force, particularly lethal force, with mentally ill individuals.

Communities need to build and facilitate sustainable solutions to mental health issues in homeless individuals. Sustainable solutions will help alleviate the burden placed upon law enforcement officials and will save taxpayer dollars by preventing continuous bookings or emergency-treatment situations. The solutions discussed in Part VII are all promising initiatives that bring hope to an otherwise bleak landscape for both law enforcement and the homeless mentally ill. However, in order for these programs to truly reduce the amount of mentally ill individuals without homes or access to treatment, a combination of the above programs in a single area is crucial. Police officers need to be better trained in order to safely handle a mental health crisis, and stable, sustainable avenues for treatment and housing need to be available for rehabilitation and care. A combination of police training with sustainable solutions for care can bring peace of mind and environment to communities struggling with providing alternatives to life on the streets for the mentally ill homeless.

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