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Before I begin, it's important to recognize that mental disability is a socially constructed concept, and that there is significant violence associated with the punitive way in which our society responds to mental health crises.

That being said, I would like to remember Kayla Moore. Kayla Moore was an African American Transgender woman who was killed in her own apartment by Berkeley police responding to a mental health crisis call. When officers arrived at the scene, Kayla was experiencing a schizophrenic episode. She was not making rational sense, but she was not violent or belligerent. Before leaving, officers ran Kayla's birth name, Xavier Moore, through the criminal database and discovered a warrant. Berkeley police then forcibly entered Kayla's apartment to issue the arrest. A struggle ensued, and Officers used what is called a "WRAP" device to restrain Kayla. Kayla was a large woman. Wrap devices are not supposed to be used on people who are overweight because it requires the subject to lay on their stomach with their arms and legs tied behind their back. From the police report, we learned that there was also 7 officers on top of Kayla to "secure" the device. Kayla suffocated and the officers did nothing to resuscitate her. In addition, it was later discovered that the arrest warrant was not even valid for Kayla.

The Kayla Moore case illustrates why police are unfit to be first responders. Police are trained to control and contain situations with the use of force. When police approach mental health crisis with this mentality, it is very dangerous for the person in crisis, who may be unable to respond to police orders like "hands up". Police perceive noncompliance as a threat and because of this, people living with mental disability are 16 times more likely to be killed and have a 67% higher probability of being arrested in police encounters.

Seeking to prevent further victimization of people living with mental health disabilities, the Justice for Kayla Moore Coalition issued a set of demands. The core demand of the coalition is that police should not be first responders for MHC situations. 35% of police calls for service in Berkeley are mental-health related. In San Francisco, that figure is as high as 70-80%. So, it makes sense that 35% of BPD's funding be redirected to community-based alternatives. The Big Question is: to what organization or promising alternative do we want to direct these funds?

The demands of the Kayla Moore coalition inspired my research question, which was essentially: what alternatives exist and how have they been structured? My work was centered in the Bay Area.

A little bit of context is necessary on this issue; *Why is there an urgency to reduce police contact with mentally disabled people now?* Increased contact between the police and people living with mental disability is a result of large scale policy changes that began in the 50s. In regards to the graph, the Red Line is the Mental Hospital incarceration rate per 100,000; the Blue line is the prison incarceration rate per 100,000 people; the yellow line is the total incarceration

rate per 100,000 people. What this graph depicts is the re-institutionalization of people living with mental disabilities.

Deinstitutionalization actually began here in CA under then governor Reagan and continued nationally during his presidency. The closure of mental asylums was for humanitarian and civil rights reasons. People were being involuntarily held under abusive conditions. Reagan promised the transfer of care from institutions to the community, but these initiatives were never adequately funded. People recently deinstitutionalized were left to fend for themselves. With the institution of mandatory minimum sentences, three-strikes laws, anti-vagrancy laws; low level offenders were being incarcerated at alarming rates. Hence the present era of mass incarceration wherein people with mental health disabilities are disproportionately represented in the justice system. The majority of inmates (over 65%) have a clinical diagnoses of mental disorder, those with serious mental illness are significantly over-represented (14.5% of male and 31% of female inmates have a serious mental illness compared to 5.7% of the general population).

In regards to my methodology, I began by Compiling a Literature Review on police-based and community-based approaches for crisis response. I also engaged in participatory research. I have organized with Berkeley Copwatch & the Justice for Kayla Moore Coalition for the past three years. This summer, I attended government and community events related to Mental Health Crisis response. I also completed first responder trainings for crisis response. Interviews were another central component of my research. I sought out organizations that do not rely on the police as first responders, and I focused on interviewing the people who actually perform mental health crisis intervention. Many community-based first responders are peer workers, meaning that they have personal experience with mental health crisis. Their perspective and experience was particularly pertinent to my research.

My preliminary research revealed that scholarly work has focused on police-based mental health crisis response. Crisis Intervention Training (CIT) is the most widely adopted Police-Based Intervention Program. I often heard the program referred to as an “evidence-based practice” at hearings on police reform measures and at conferences that discussed “best-practices” for law enforcement. The thing about CIT is that the content and structure of the program are determined at the department level, meaning that there is no standardization or oversight as to what is included in each program. For example, Berkeley’s CIT training is a an 8 hour course that is mandatory for all officers; SFPD’s CIT training is voluntary for officers, is 40 hours, and is organized and funded by a coalition of non-profit groups. Therefore, CIT is NOT an evidence based practice because the results from the studies on CIT are not generalizable.

We need to reject the privileged assumption that the state (thru law enforcement) can solve all our community members’ problems. We need to acknowledge that the presence of law enforcement is both dangerous and traumatizing for those victimized by racist, sexist, and ableist policing. My research sought to address the gap in scholarly literature regarding Community-Based dispatches that do NOT rely on the police as first responders.

Alarm over the disproportionate number of mentally disabled incarcerated prompted the creation of “alternatives” *by* the system, *within* the system that would supposedly divert individuals *from* the system. Sequential intercept model is used by justice system reformers to visualize how people with mental illness can be “diverted” at various “intercept points” within the system. For example, offenders living with mental disability can be “diverted” to the “specialty court” rather than being sent straight to jail. This model, however, is a paradox.

What we should be focusing on is intercept zero. Adequate community resources could prevent crises from occurring in the first place. I heard this over and over again from the people I

interviewed. We spend money criminalizing the crisis without considering the underlying issues that make crises a recurring issue. This is precisely how our society perpetrates industrial complexes. We call on the same industries that created the problem to design the solution (hence funding CIT rather than community services). We need basic resources, not an expansion of the prison system.

The other critical oversight of the sequential intercept model is that it does NOT recognize an alternative to law enforcement as first responders! Community-Based Dispatch is the only way to truly divert people living with mental disability from entering the justice system to begin with. Successful Crisis intervention depends on accessible and robust community services that are similarly independent from the justice system. Focus of my research this summer is specifically on Community-Based Dispatches that exist in the Bay Area.

I want to highlight the work of CONCRN, which is an organization that operates in the Tenderloin district of SF. CONCRN is staffed by volunteers that live in the district. “Compassionate responders” is the term they use to refer to those that intervene in crises. A substantial portion of their work is outreach. Playing sports, music, talking; providing basic resources: extra blankets, toothbrushes, things like that. CONCRN members practice community in a way that is inclusive of un-housed members. In terms of dispatch, CONCRN offers a phone app (iphone and android), as well as a call-in hotline. The person who issues the crisis report provides location and other relevant information, and a core group of responders are then altered on their cell phones and ideally whoever is in the area can respond. The most encouraging thing about CONCRN’s approach is that the core responders are committed to not calling the police. In interviews, they described numerous examples of successfully de-escalating crisis situations that involved an armed subject without calling the police. CONCRN’s model illustrates that it is well within the realm of possibility to deliver community-based crisis intervention.

“Safety from below” is an adaption of Howard Zinn’s “History from Below,” which denotes a subversion of oppressive state authority in favor of a collective alternative created by and for the people. By calling on police to resolve medical crises, we invite a militant intrusion into our community to uphold a definition of “safety” that safeguards normalcy rather than well-being. Fortunately, there is a new narrative emerging, a sort of “Safety from Below” that is defined by community education and engagement. Education initiatives break down the stigma associated with mental illness and re-define crises as a community concern, rather than as criminal behavior. Community engagement is crucial; the best preventative measure for crises is a robust network of supportive relationships.

Organizations doing crisis intervention can facilitate this type of network by collaborating more in service provision. Organizations are presently operating in silos. Centralizing an alternative dispatch would be an effective way to collaborate. Different organizations I interviewed trained first responders for specific types of crises: STAND, an organization out of Contra Costa, dispatches supportive first responders for sexual assault cases; MHASF dispatches peers to help people struggling with collecting behaviors in non-acute crisis situations. If an alternative dispatch for crises was centralized, a single number could be used to reach the appropriate first responders for a variety of crisis situations. There is no need to continue re-inventing the wheel.

In closing, I will address the obstacles and opportunities for community-based crisis intervention. In terms of obstacles, “its not us, it’s the system” is something I would hear all the time in interviews. For ex, mandatory reporting laws require licensed practitioners to call the police if clients express intent to harm themselves or others. This systemic reliance on the police

is particularly dangerous for marginalized populations. Its important to recognize that hospitals are also institutions of the carceral state. Patients have been known to go into a hospital in crisis, and leave in handcuffs after a warrant for their arrest was discovered by police stationed in the ER. The reality is that police act as gate-keepers for basic services. Police presence deters people from seeking the help they need. The unfortunate fact is that 9-1-1 is the only 24/7 emergency dispatch in most areas.

Finally, opportunities: we are all capable of performing compassionate crisis intervention. Collective change requires individual initiative. We can empower alternative dispatches by calling on them in crisis situations. But we also need to educate ourselves on basic de-escalation techniques so that we can provide our community members with the support they need when crises occur.