BRIEF OF *AMICI CURIAE* IN SUPPORT OF PETITIONERS

I. INTEREST OF THE *AMICI CURIAE*

The California State Association of Counties ("CSAC"), the League of California Cities ("the League"), the Washington State Association of Municipal Attorneys ("WSAMA"), the Washington Association of Sheriffs and Police Chiefs ("WASPC"), and the Association of Washington Cities ("AWC") respectfully submit this *amicus curiae* brief in support of the Petition for a Writ of Certiorari filed by the City and County of San Francisco, Kimberly Reynolds, and Kathrine Holder in this case.

CSAC is a non-profit corporation with a membership comprised of California's 58 counties. The League is an association of 471 California cities. WSAMA is a non-profit organization of municipal attorneys in Washington State who represent the 281 municipalities throughout the state. WASPC is comprised of executive and top management personnel from law enforcement agencies throughout Washington State. AWC is a private, non-profit corporation that serves all its municipal members through advocacy, education and services.

The cities, counties, and law enforcement agencies represented by these organizations provide a wide array of essential public services to residents of California and Washington, including operating and overseeing the local law enforcement agencies charged with ensuring public safety. They also have substantial experience with and interest in law enforcement encounters with mentally ill individuals, including those who are armed and violent.

CSAC, the League, WSAMA, WASPC, and AWC monitor litigation of concern to municipalities and law enforcement agencies, and identify those cases that have

substantial statewide or nationwide significance. Each organization has identified this case as having such significance, and each respectfully requests that the Court grant the petition for a writ of certiorari for the reasons set forth below.

II. SUMMARY OF REASONS FOR GRANTING THE PETITION

This case presents in an important question regarding the scope of liability under the American with Disabilities Act and the Fourth Amendment when police officers exercise force during encounters with armed and dangerous suspects with a mental illness. The Ninth Circuit Court of Appeals held that law enforcement agencies and their officers may be subject to liability under the ADA or the Fourth Amendment based on an expert's after-the-fact opinion second-guessing the tactics leading up to the encounter even when the use of force is reasonable. In so holding, the Ninth Circuit dramatically expanded liability for those officers and the local governments that employ them. And this unprecedented expansion of liability has serious consequences for those local governments and their police forces.

Since the advent of deinstitutionalization in the 1960s, the number of mentally ill persons living in the community rather than in locked facilities has grown significantly. At the same time, the mental health system has not been able to handle the large influx of mentally ill persons into the community. As a result, many persons with mental illness receive little or no treatment, and police officers have become de facto first responders to mental health crises as their encounters with the mentally ill have skyrocketed.

The wide spectrum of mental illnesses and exigent circumstances present police officers with tremendous challenges on a daily basis. Despite this, injuries during police encounters with the mentally ill mirror the rate and severity of injuries that occur during

encounters with the general population. And law enforcement agencies are developing specialized programs and training so their officers can better handle these encounters.

The Ninth Circuit's decision threatens to change this. Because the decision raises the specter of ADA and 42 U.S.C. § 1983 liability even when police officers use reasonable force and act under established exceptions to the warrant requirement, it will induce paralysis and inaction. When dealing with an armed and dangerous suspect, hesitancy and delay often put officers, innocent bystanders, and suspects at risk of serious injury or death. Imposing liability for moment-to-moment decisions made by officers during encounters with violent, mentally ill persons will also stifle innovation in how best to deal with these encounters, and will deprive local governments of much-needed resources. Currently, there is no evidence-based model for reducing injuries during police encounters with the mentally ill. And law enforcement agencies are attempting to develop best practices through research and study. The Ninth Circuit's decision, by contrast, seeks to establish best practices through litigation and based solely on the testimony of a single expert opining on the specific facts of this case. In doing so, it will lead to the adoption of rigid approaches designed to reduce the risk of liability while stifling innovation. Expanding liability will also deprive law enforcement agencies of resources they need to develop and adopt effective programs for dealing with the mentally ill.

This is not only illogical, it is unfair. Forcing police officers and their agencies to assume responsibility for the failures of our mental health system makes no sense. Officers are not psychiatrists, psychologists, or social workers. And the law does not and should not expect them to be. Ultimately, the burden and consequences of the Ninth

Circuit's decision will fall upon the local government entities – many of them represented by amici curiae – and the residents they serve. Accordingly, amici curiae respectfully request that this Court grant the writ and reverse the judgment.

III. BACKGROUND

Police officers "ha[ve] been responding to calls for service that involve the mentally ill throughout the history of the profession." Abigail S. Tucker, et al., *Law Enforcement Response to the Mentally Ill: An Evaluative Review*, 8 Brief Treatment & Crisis Intervention 236, 236 (2008). "All too often, individuals' inadequately treated mental illnesses are manifested in ways that can result in their contact with law enforcements – sometimes with tragic results." Melissa Reuland, et al., *Law Enforcement Responses to People with Mental Illnesses: A Guide to Research-Informed Policy and Practice* 3 (2009).

In recent years, police encounters with the mentally ill have skyrocketed as the number of persons with severe mental illness in the community has grown. In fact, in communities nationwide, local police have become the de facto first responders to incidents involving the mentally ill.

To meet these extraordinary challenges, law enforcement agencies are developing specialized programs designed to respond to persons with mental illness. However, creating a standardized procedure for "police response to the mentally ill is problematic" because the characteristics, propensity for violence, and needs of mentally ill individuals are extremely varied. Tucker, et. al., *supra*, at 245. And importantly, the impact of

existing training programs on the frequency and severity of injury occurring during police encounters with the mentally ill is not clear.

A. Local Law Enforcement Encounters With Mentally Ill Persons Are Increasing.

Over the past decades, the frequency of police encounters with the mentally ill has increased. E. Fuller Torrey, et al., *Justifiable Homicides by Law Enforcement Officers: What Is the Role of Mental Illness* 4 (2013). This increase has been traced to the "deinstitutionalization" process that began in the 1960s, through which mentally ill persons who were formerly confined within locked institutions were released, as well as the limited availability of treatment services for those persons when they began living in the community. *See* Tucker, et al., *supra*, at 237; Reuland, et al., *supra*, at 4; Torrey, et al., *supra*, at 7-8.

1. The number of persons with serious mental illnesses has been steadily increasing, and most do not receive treatment.

The prevalence of mental disorders in the United States has steadily risen over the past decades. Currently, one in four adults—about 61.5 million Americans—experiences mental illness in a given year. National Alliance on Mental Illness ("NAMI"), *Mental Illness Facts and Numbers* 1 (2013) (available at http://www.nami.org/factsheets/mentalillness_factsheet.pdf (last visited June 23, 2014)). One in 17 adults—about 13.6 million Americans—live with a serious mental illness such as schizophrenia, major depression, or bipolar disorder. *Id.* And about 9.2 million adults have co-occurring mental health and addiction disorders. *Id.* Approximately 20 percent of state prisoners and 21 percent of local jail inmates have "a recent history" of a mental-

health condition. *Id.* And about 60 percent of adults with a mental illness and 30 percent of adults with a serious mental illness received no mental health services in the previous year. *Id.* Indeed, "most people with a mental disorder do not receive treatment . . . ." Ronald C. Kessler, et al., *US Prevalence and Treatment of Mental Disorders: 1990-2003,* 352 New Engl. J. Med. 2515, 2522 (2005).

2. Since the 1960s, deinstitutionalization has increased the number of mentally ill persons living in communities throughout the U.S.

The introduction of psychiatric medications in the 1950s and subsequent changes in the treatment of mental illness have dramatically reduced the percentage of mentally ill persons in state and county psychiatric facilities. In 1964, Congress passed the Community Mental Health Centers and Construction Act, Pub. L. 88-164, 77 Stat. 282, which was designed to reduce the number of mentally ill persons institutionalized in state mental hospitals. As a result of the Act, the number of state psychiatric beds per 100,000 persons decreased from 339 in 1955 to 17 in 2005. Reuland, et al., *supra,* at 4.

The passage in 1965 of the Medicaid Act gave states further incentive to move patients out of psychiatric hospitals and into nursing homes and other unlocked facilities by significantly limiting reimbursements to inpatient mental health facilities. *See Connecticut Dept. of Maintenance v. Heckler,* 471 U.S. 524, 533 (1985) (noting that Medicaid program excluded coverage for patients under age of 65 in institution for mental disease "based on the view that long-term care in mental institutions was a state responsibility"). This process of deinstitutionalization resulted in the movement of thousands of persons with severe mental illness from hospitals into the community. Reuland, et al., *supra,* at 4.

3. Resources for the treatment of mentally ill persons have been significantly reduced in recent years.

Despite the release of thousands of persons with mental illness into the community, "adequate community-based services to pick up the slack were never provided. This vacuum persists to this day, to the extent of complete failure of the mental health system in many jurisdictions." Gary Cordner, *People with Mental Illness*, Problem Oriented Guides for Police, Problem-Specific Guides Series No. 40, May 2006, at 7. And even in communities like Santa Clara County, King County, and the City and County of San Francisco, where substantial public resources have been devoted to mental health services, police frequently must respond to violent mentally ill persons.

Moreover, in recent years, states have made drastic cuts to their mental health budgets. From fiscal years 2009 through 2012, states cut more than $1.6 billion in mental health services. Indeed, California alone cut $764.8 million in mental health services. NAMI, State Mental Health Cuts: The Continuing Crisis at 2 (2011) (available at http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=147763 (last visited June 23, 2014)).

These cuts have resulted in "the loss of services for the most vulnerable residents living with serious mental illnesses." *Id.* at 3. For example, "both inpatient and community services for children and adults living with serious mental illness have been downsized or eliminated. In some states, entire hospitals have been closed; in others, community mental health programs have been eliminated." *Id.*

The drastic cuts to mental health services have exacerbated the problem by further increasing the number of persons in the community with a serious mental illness who do not receive adequate treatment. As a result, "emergency rooms, homeless shelters, and

jails are struggling with the effects of people falling through the cracks due to lack of needed mental health services." *Id.* at 1.

B. Police Have Become The De Facto First Responders For Mental Illness.

The dramatic rise in the number of persons with untreated mental illnesses living in the community has transformed local police into first responders to the mentally ill. Reuland, et al., *supra*, at 3; Torrey, et al., *supra*, at 4. Recognizing that dangerous behavior by mentally ill persons often warrants a law enforcement response, every state has adopted legislation authorizing police to take into custody mentally ill persons who are a danger to themselves or others.[1] Thus, local police have become the "first-line,

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[1] *See* ALA. CODE § 22-52-91 (1975); ALASKA STAT. § 47.30.705 (1984); ARIZ. REV. STAT. § 36-529 (1989); ARK. CODE ANN. § 20-47-210 (1989); CAL. WELF. & INST. CODE § 5150 (West 2014); COLO. REV. STAT. § 27-65-105 (2011); CONN. GEN. STAT. § 17a-503 (2010); DEL. CODE ANN. tit. § 5122 (1953); FLA. STAT. § 394.463 (2006); GA. CODE ANN. § 37-3-41 (1994); HAW. REV. STAT. § 334-59 (2013); IDAHO CODE § 66-326 (2013). 405 ILL. COMP. STAT. 5/3-606 (2010); IND. CODE ANN. § 12-26-4-1 (West 2013); IOWA CODE ANN. § 229.22 (West 2013); KAN. STAT. ANN. §59-2953 (West 1998); KY. REV. STAT. ANN. § 202A.041 (West 1982); LA. REV. STAT. ANN. § 28:53 (2012); ME. REV. STAT. tit. 34, § 3862 (2010); MD. CODE ANN., HEALTH-GEN. § 10-624 (West 2010); MASS. GEN. LAWS ANN. ch. 123 § 12 (West 2010); MICH. COMP. LAWS. ANN. § 330.1427 (West 1995); MINN. STAT. ANN. § 253B.05 (West 2010); MISS. CODE ANN. § 41-21-67 (West 2014); MO. ANN. STAT. § 632.300 (West 1996); MONT. CODE ANN. § 53-21-129 (West 2013); NEB. REV. STAT. ANN. § 71-919 (West 2007); NEV. REV. STAT. ANN. § 433A.160 (West 2007); N.H. REV. STAT. ANN. § 135-C:29 (2014); N.J. STAT. ANN. § 30:4-27.6 (West 2009); N.M. STAT. ANN. § 43-1-10 (West 2013); N.Y. MENTAL HYG. LAW § 9.41 (McKinney 1989); N.C. GEN. STAT. ANN. § 122C-262 (West 1997); N.D. CENT. CODE ANN. § 25-03.1-25 (West 2013); OHIO REV. CODE ANN. § 5122.10 (West 2013); OKA. STAT. ANN. tit. 43A § 5-207 (2012); OR. REV. STAT. ANN. § 426.228 (West 2013); 50 PA. CONS. STAT. ANN. §4405 (West 1966); R.I. FEB. LAWS § 40.1-5-7 (West 1987); S.C. CODE ANN. § 44-178-440 (1994); S.D. CODIFIED LAWS § 27A-10-3 (1991); TENN. CODE ANN. § 33-6-402 (West 2000); TEX. HEALTH & SAFETY CODE ANN. § 573.001 (West 2013); UTAH CODE ANN. § 62A-15-629 (West 1953); VT. STAT. ANN. tit. 18 § 7505 (West 1977); VA. CODE ANN. § 37.1-67.01 (West 2013); WASH. REV. CODE § 71.05.150

around-the-clock, emergency responders, mediators, referral agents, counselors, youth mentors, crime prevention actors, and much more." Reuland, et al., *supra*, at 3. And "calls to the police about crimes and disorder involving people with mental illness [have] increased." Cordner, *supra*, at 8. Indeed, the frequency of police encounters with mentally ill persons are quite "high." Tucker, et al., *supra*, at 238. For example, 28 California counties reported more than 597,000 detentions of persons determined to be a danger to themselves, a danger to others, or gravely disabled from July 2000 through July 2007. Tim A. Bruckner, Jangho Yoon, Timothy T. Brown & Neal Adams, *Involuntary Civil Commitments After the Implementation of California's Mental Health Services Act*, 61 Psychiatric Services 1006, 1007-08 (2010) (analyzing California Dept. of Mental Health data (available at http://ps.psychiatryonline.org/data/Journals/PSS/3916/10ps1006.pdf (last visited June 20, 2014)).

In responding to these calls, police must deal with a wide range of mental illnesses, ranging from schizophrenia to major depression to bipolar disorder to panic and post-traumatic stress disorders. Cordner, *supra*, at 238. Further, "the people with mental illness the police encounter are likely to have substance abuse problems." *Id.* at 7; *see also* Peter H. Silverstone, et al., *A Novel Approach to Training Police Officers to Interact with Individuals Who May Have a Psychiatric Disorder*, 41 J. Am. Acad. Psychiatry & L. 344, 344 (2013) ("Individuals with various psychiatric problems, including addictions, depression, and schizophrenia, have an increased probability of coming into contact with police.").

(2011); W. VA. CODE ANN. § 9-6-5 (West 1984); WIS. STAT. ANN. § 51.20 (West 1987); WYO. STAT. ANN. §25-10-109 (West 2013).

It cannot be denied that police "do respond to calls for service that involve people with mental illnesses whose violent behavior is at issue." Reuland, M., et al., *supra*, at 6. Some of those people may be "at risk of harming themselves," *id.* at 6, and the incidents of "suicide-by-cop" – where a mentally ill person essentially commits suicide by violently attacking police officers – appear to be increasing, Torrey, et al., *supra*, at 7. Other evidence further suggests that "responding to a call involving a person with mental illness may be among the most dangerous" duties of police officers. Amy Kerr, et al., *Police Encounters, Mental Illness and Injury: An Exploratory Investigation*, 10 J Police Crisis Negot. 116, 117 (2010).

C. Although Law Enforcement Agencies Are Developing Specialized Programs For Dealing With The Mentally Ill, Those Efforts Are Constrained by Limited Resources, Especially In Jurisdictions With Small Police Forces.

To address the challenges created by persons with mental illness, many law enforcement agencies have collaborated "with mental health providers and advocates to design specialized responses to people with mental illnesses." Reuland, et al., *supra*, at 9. Two primary response models have been developed. The first model, known as the Crisis Intervention Team (CIT) model, was pioneered by the City of Memphis and "trains officers to provide crisis intervention services and act as liaisons to the formal mental health system . . . ." *Id.* It is currently the most popular model among law enforcement agencies. Michael T. Compton, et al., *A Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs*, 36 J. Am. Acad. Psychiatry & L. 47, 47 (2008). The second model, known as the "co-responder model," "partners mental health professionals with law enforcement at the scene to provide consultation on mental-health related issues and assist individuals in accessing treatments and supports." Reuland, et

al., *supra*, at 9. This model may include "police-based mental health responses, in which the police department hires mental health consultants to assist with mental health crisis calls, and mental-health based specialized responses, which are typified by mobile crisis units." Compton, et al., *supra*, at 47.

More and more law enforcement agencies have been creating these specialized programs for dealing with persons with mental illnesses. Reuland, et al., *supra*, at 9; Tucker, et al., *supra*, at 245. But they are still the exception rather than the rule. "Few law enforcement agencies or their training programs will have the internal capacity or expertise to teach the entire range of topics that first responders require when working with people with mental illnesses." Melissa Reuland & Matt Schwarzfeld, *Improving Responses to People with Mental Illnesses: Strategies for Effective Law Enforcement Training* at 9 (2008). Moreover, "[n]ot all communities will have an adequate pool of local experts who can provide aspects of this training to officers" or "the funds to coordinate a training initiative, including expenses related to contracting with trainers." *Id.*

This is particularly true for smaller law enforcement agencies where neither model may be feasible or effective. *See* Cordner, *supra*, at 26-27. Mental health service providers may not be available in the smaller jurisdictions protected by those agencies. *Id.* at 27. Indeed, "sufficient social work/mental health resources are rarely available to provide prompt mobile response to a majority of incidents." *Id.* at 38, Thus, "a standardized procedure or 'model' for police response to the mentally is problematic." Tucker, et al., *supra*, at 245. And even in jurisdictions that have adopted these

specialized response models, "the types of training vary widely in nature, design, duration, and timing . . . ." Silverstone, et al., *supra*, at 344.

D. The Impact Of These Specialized Programs On The Rate And Severity Of Injuries During Police Encounters With The Mentally Ill Is, At Best, Unclear.

The impact of these specialized law enforcement programs for responding to persons with mental illness on the use of force and injuries is "unclear." Kerr, et al., *supra*, at 120. "[N]o published studies have examined [CIT's] impact on injuries." *Id.* And "there has been very little research about the best training approaches." Silverstone, et al., *supra*, at 344. Thus, "there are no currently accepted models that appear to have reproducibly positive outcomes." *Id.* at 345. Indeed, consistent with studies suggesting that "specific training on de-escalation techniques may not decrease the number of severity of physical interactions between individuals with mental illness and health care providers," *Id.* at 344, at least one study suggests that "CIT training appears to have no effect on injuries in police encounters with people with mental illness," Kerr, et al., *supra*, at 129.

This may reflect the fact that the rate of occurrence of injuries in police encounters with people with mental illness "is similar to their rate of occurrence in police encounters with members of the general population." *Id.* And "the type of injuries [experienced in encounters police encounters with mentally ill persons] mirror those experienced in the general population." *Id.* Indeed, "the criminal justice literature overwhelmingly suggests that *situational factors* are the most predictive of the outcomes of these encounters *rather than characteristics of the individual*. *Id.* at 119 (emphasis added). Thus, the specialized police programs designed to improve police encounters

with the mentally ill – which are beneficial for other reasons – may not reduce the risk of injury during those encounters.[2]

IV. REASONS FOR GRANTING THE PETITION

In this case, the Ninth Circuit Court of Appeals extended liability under the ADA to local governments whose police officers who use force deemed reasonable under the Fourth Amendment. That court also held that officers may be personally liable under 42 U.S.C. § 1983 for the use of reasonable force so long as an expert is willing to question the tactical decisions leading up to the moment that force is used. Under the Ninth Circuit's decision, police officers and law enforcement agencies may therefore incur substantial legal costs and liability even when officers act reasonably to protect themselves, innocent bystanders, or the mentally ill suspect.

If allowed to stand, this decision will jeopardize the safety of police officers, innocent bystanders, and suspects and harm the mentally ill persons it purportedly protects. These serious consequences amplify the inherent unfairness of imposing liability on police officers and law enforcement agencies when officers act to protect the public in exigent situations involving persons with mental illnesses. In those situations, the reasonableness standard governing the use of force under the Fourth Amendment is more than sufficient to protect the public, including the mentally ill, from the use of unnecessary force.

For these reasons as well as the reasons articulated in the Petition for a Writ of Certiorari, the writ should be granted and the judgment reversed.

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[2] For example, studies suggest that "the CIT model may be an effective component in connecting individuals with mental illnesses who come to the attention of police officers with appropriate psychiatric services." Compton, et al., *supra,* at 52.

A. Holding Law Enforcement Agencies And Officers Liable Where The Use Of Force Was Reasonable Puts Officers And The Public At Risk.

Armed and violent individuals are dangerous. And when dealing with those dangerous individuals, police officers must often make split-second decisions in order to protect themselves, innocent bystanders, or the suspect. *See Graham v. Connor*, 490 U.S. 386, 397 (1989) ("police officers are often forced to make split-second judgments – in circumstances that are tense, uncertain, and rapidly evolving. . ."). In these exigent circumstances, hesitancy and delay often have serious consequences. This is true regardless of whether the suspect has a mental illness.

Despite this, the Ninth Circuit has adopted a decision that induces hesitancy and delay by police officers when they deal with armed and violent persons with mental illnesses. The decision creates the specter of liability for discretionary decisions made by police officers during those encounters, even when the use of force is reasonable under the Fourth Amendment. Thus, as a practical matter, the Ninth Circuit's decision exposes those officers and their agencies to liability for *any* use of force in *any* confrontation with armed and violent persons with mental illnesses. In so doing, the decision encourages police officers to hesitate before using force or to eschew contact with mentally ill suspects in order to minimize the risk of liability.

This is exacerbated by the Ninth Circuit's decision to impose liability for failure to accommodate under the ADA and to reject qualified immunity. Police officers are not mental health professionals. And they often receive little or no information about the mental condition of an armed and violent suspect before they must confront that suspect. Moreover, standardized procedures for dealing with the wide spectrum of mentally ill suspects and exigent circumstances have proven to be neither practical nor effective. *See*

Silverstone, et al., *supra*, at 345; Tucker, et al., *supra*, at 245; Cordner, *supra*, at 26-27. Despite providing minimal guidance on the appropriate course of action under the ADA or the Fourth Amendment, the Ninth Circuit now requires police officers to predict the behavior of unpredictable suspects under unpredictable circumstances. Left with no good options, police officers may be paralyzed into inaction.

This paralysis jeopardizes public safety. When confronted with armed and violent persons, officers often experience perceptual and memory distortions such as tunnel vision, time dilation, and auditory blunting. J. Peter Blair, *Reasonableness and Reaction Time*, 14 Police Q. 323, 328 (2011). As a result, even well-trained officers generally cannot react and fire their weapons before a suspect can use deadly force against the officers or innocent bystanders – even when the officer has his gun aimed at the suspect. *Id.* at 335-336. Consistent with these findings, this Court has long held that "judges should be cautious about second-guessing a police officer's assessment, made on the scene, of the danger presented by a particular situation." *Ryburn v. Huff*, 132 S.Ct. 987, 991-2 (2012). Thus, the Ninth Circuit's decision places the health and safety of police officers and the public they have sworn to protect at serious risk.

Indeed, under the Ninth Circuit's decision, police officers are better off avoiding or delaying encounters with armed and violent persons with mental illnesses rather than attempting to neutralize the threat they pose to the public. This may not only jeopardize the safety of innocent bystanders, it will likely increase the risk of harm to the mentally ill suspect. Many police encounters with the mentally ill involve threats of suicide. Delays in engaging those persons under the auspices of offering an accommodation may increase the likelihood that they will harm themselves.

The risk of harm to police officers and the public will only increase as the number of police encounters with mentally ill suspects continues to rise. Thus, law enforcement agencies should not, as the plaintiff's expert in this case opined, supplant the judgment of police officers in the field with a proscribed approach to encounters with violent, mentally ill persons in order to reasonably accommodate them To protect public safety, officers must be able to take any necessary actions, including actions that may further agitate the mentally ill individual, without fear of liability based on 20/20 hindsight. This Court should therefore grant the writ in order to decide this important and recurring issue.

B. Holding Police Officers And Their Agencies Liable For The Use of Reasonable Force Will Stifle Innovative Approaches To Dealing With The Mentally Ill And Deprive Local Governments Of Much-Needed Resources.

Recognizing that officers often function as "armed social workers," law enforcement agencies have developed specialized programs that train officers to recognize the signs of mental illnesses and identify strategies for addressing situations involving mentally ill persons. Torrey, et al., *supra,* at 9. But current research on the effectiveness of these programs is limited, and "the best methods for educating the police force remain uncertain." Silverstone, et al., *supra,* at 344. Indeed, "there are no currently accepted models that appear to have reproducibly positive outcomes." *Id.* at 345. Moreover, studies suggest that these specialized programs, although beneficial for other reasons, may have no effect on injuries in police encounters with persons with mental illnesses. *See, e.g.*, Kerr, et al., *supra,* at 129.

Despite this, the Ninth Circuit held that police officers and their agencies may be held liable for the reasonable use of force when they fail to take "reasonable" steps to de-escalate encounters with persons with mental illness under both the ADA and the Fourth

Amendment. *Sheehan* at 1216-1217. Specifically, the Ninth Circuit suggests that the officers "should have respected her comfort zone, engaged in non-threatening communications and used the passage of time to defuse the situation rather than precipitating a deadly confrontation." *Id.* at 1233. In doing so, the Ninth Circuit appears to imply that there is a one-size-fits-all approach that will reduce the risk of injury during police encounters with mentally ill persons who are armed and violent.

But there are currently no accepted, evidence-based models for reducing injury during police encounters with mentally ill persons. *See* Silverstone, et al., *supra*, at 345; Kerr, et al., *supra*, at 129. And the wide spectrum of mental illnesses that police encounter combined with the wide range of crisis situations that may arise make a standardized approach ineffective and impractical. *See* Tucker, et al., *supra*, at 245. As a result, the Ninth Circuit's decision will likely result in the adoption of "best practices" based on litigation risk, rather than empirical evidence. And those best practices will likely include rigid approaches designed to avoid liability rather than reduce injury and improve outcomes.

At the same time, the decision will discourage innovative approaches to police encounters with the mentally ill. Because the use of untested or unproven approaches may subject law enforcement agencies to liability under the Ninth Circuit's holding, those agencies will be reluctant to try new approaches for dealing with the mentally ill. Yet, those approaches may be the key to improving outcomes.

Even more troubling, the Ninth Circuit's decision, by creating new grounds for liability in cases involving the use of force, will deprive local governments of funds they need to develop and adopt specialized programs for dealing with the mentally ill. Cities

and counties already "spend large sums of money to defend themselves against lawsuits when the officer is ultimately exonerated and the shooting is ruled justifiable." Blair, et al., *supra*, at 325. Exposing those cities and counties to liability when the use of force is reasonable will only increase the amount of money that they must devote to defending lawsuits, rather than treating persons with mental illness.

The harm to jurisdictions with small police forces is especially pernicious. Many of those jurisdictions lack the capacity, expertise and funds to train their police officers and do not have access to the mental health resources needed to deal effectively with the mentally ill. Reuland and Schwarzfeld, *supra*, at 9. Moreover, many of the widely accepted approaches to dealing with the mentally ill like CIT may not be suitable or effective for small jurisdictions. Cordner, *supra*, at 26-27. These jurisdictions have the greatest need for innovative approaches to dealing with the mentally ill and resources to implement those approaches. Thus, the Ninth Circuit's decision will have a disproportionate impact on the jurisdictions that can least afford it.

The proper approach to police encounters with mentally ill persons who are armed and violent should not be determined through litigation. By subjecting police officers and their agencies to liability when the use of force is reasonable, the Ninth Circuit's decision does just that. Because of the decision's deleterious impact on police agencies, this Court should grant the writ and reverse the judgment.

C. The Ninth Circuit's Decision Unfairly Shifts Responsibility For Treating Mentally Ill Persons To Local Law Enforcement.

Successful treatment of the mentally ill depends on many factors, including adherence to mental health and substance abuse treatment regimens; effective case management; the availability of inpatient and outpatient treatment; provision of

structured housing; and support from family and community members. When police officers are called to a crisis situation involving an armed and violent suspect with a mental illness, that suspect is usually untreated or the treatment has failed. Police often have limited information about the suspect's mental illness and current state of deterioration, and often have limited options for handling the situation. *See* Tucker, et al., *supra*, at 241. Moreover, in instances where injuries occur, the use of force that gave rise to those injuries is often justified based on an objective assessment of the circumstances. Blair, et al., *supra*, at 325.

The primary job of police officers is to safeguard the public and keep the peace. That is what officers are hired and trained to do. They are not mental health professionals nor can we expect them to be. And they only receive limited training on dealing with the mentally ill. Torrey, et al., *supra*, at 8. Yet, police officers have been forced to play the role of social worker, psychiatrist, and psychologist. *Id*. Forcing police officers to shoulder the burden of the mental health system in the rare instances when injuries occur, as the Ninth Circuit has done, is simply unfair.

It is especially unfair in crisis situations involving armed and violent suspects with mental illnesses. Those suspects may suffer from a wide spectrum of psychiatric ailments, ranging from schizophrenia to psychosis to major depression to substance abuse. Cordner, *supra*, at 1. Moreover, police officers typically have limited information about the suspect's mental condition. And even if officers do know about the suspect's mental illness, they still may not know what the best approach will be. There is no standardized approach for dealing with mentally ill suspects, *see* Silverstone, et al., *supra*, at 345 ("there are no currently accepted models that appear to have reproducibly

positive outcomes"), 354 ("there is little documentation describing in detail what methods should be developed to produce consistent, high-quality, effective training.") , and there is little or no evidence that any approach will actually reduce the risk of injury, *id.* at 345; Kerr, et al., *supra*, at 129. Thus, as other circuits have held, to expect officers to accommodate a suspect's mental illness in a crisis situation that requires split-second decisions is not reasonable. *See Tucker v. Tennessee*, 539 F.3d 526, 536 (6th Cir. 2006), *cert. denied*, 558 U.S. 816 (2009); *Hainze v. Richards*, 207 F.3d 798, 801-2 (5th Cir.), *cert. denied*, 531 U.S. 959 (2000). Indeed, a true assessment of a suspect's mental health needs can only occur after the suspect is no longer armed and dangerous and has been taken into custody. Accordingly, holding police officers liable for their reasonable use of force simply makes no sense and makes a difficult job virtually impossible.

Despite this backdrop, the Ninth Circuit established a new rule that subjects police officers and their agencies to liability under the ADA and Fourth Amendment even when the use of force is objectively reasonable. As a result, law enforcement agencies and officers may now be held liable for the use of force *whenever an injury occurs*. This decision by the Ninth Circuit to transfer of responsibility for the well-being of the mentally ill to law enforcement is inherently unfair and misplaced.

D. Existing Fourth Amendment Limitations On The Use Of Force Are Sufficient To Ensure That Mental Disabilities Are Reasonably Accommodated In Exigent Circumstances And To Protect Suspects From Unreasonable Search And Seizure.

Under the Fourth Amendment, an officer may only use any force that is reasonable to make an arrest. *Graham*, 490 U.S. at 396. The reasonableness of a particular use of force "must be judged from the perspective of a reasonable officer on the scene, rather than with the 20/20 vision of hindsight." *Id*. And "[t]he calculus of

reasonableness must embody allowance for the fact that police officers are often forced to make split-second judgments—in circumstances that are tense, uncertain, and rapidly evolving—about the amount of force that is necessary in a particular situation." *Id.* at 396-97.

This standard ensures that police officers may only use force that is objectively reasonable under the circumstances. But when those circumstances justify deadly force, officers have no duty to use non-deadly alternatives.[3] And as this Court recently held, officers need not halt their use of deadly force until the threat is over. *See Plumhoff v. Rickard*, 134 S.Ct. 2012, 2022 (2014) ("if lethal force is justified, officers are taught to keep shooting until the threat is over"). Any other standard would require officers to exercise "superhuman judgment:"

> In the heat of battle with lives potentially in the balance, an officer would not be able to rely on training and common sense to decide what would best accomplish his mission. Instead, he would need to ascertain the least intrusive alternative (an inherently subjective determination) and choose that option and that option only. Imposing such a requirement would inevitably induce tentativeness by officers, and thus deter police from protecting the public and themselves. It would also entangle the courts in endless second-guessing of police decisions made under stress and subject to the exigencies of the moment.

Scott v. Henrich, 39 F.3d 912, 915 (9th Cir. 1994).

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[3] Officers do not have a duty to retreat under California law. Cal. Penal Code § 835a (Peace officers need not retreat or desist from their efforts by reason of the resistance or threatened resistance of the person being arrested); *accord State v. Allery*, 682 P.2d 312, 316 (Wash. 1984) (Washington law does not require retreat when "one is feloniously assaulted in a place where she has a right to be"). An en banc panel of the Ninth Circuit has also "reject[ed] the premise" that "in an armed standoff, once a suspect is seized by virtue of being surrounded and ordered to surrender, the passage of time may operate to liberate that suspect, re-kindle the arrest warrant requirement, and require police to assess with each passing minute whether the circumstances remain exigent." *Fisher v. City of San Jose*, 558 F.3d 1069, 1076 (9th Cir. 2009) (en banc).

Thus, the existing standard governing the use of force under the Fourth Amendment already establishes what is objectively reasonable for a police officer to do during a confrontation with an armed and violent suspect who is mentally ill. Neither the ADA – which only requires reasonable accommodation – nor the Fourth Amendment – which only prohibits an unreasonable search or seizure – should require more.

The Department of Justice has already reached this conclusion. In regulations promulgated under the ADA, the Department does not require a public entity to permit an individual to participate in or benefit from its services, programs, or activities if the individual poses a "direct threat" to the health or safety of others. 28 C.F.R. §§ 35.139(a) and 104. This interpretation should be accorded deference especially where, as here, the ADA is silent. *Bragdon v.* Abbott, 524 U.S. 624, 646 (1998). The Ninth Circuit should have done so here and found no duty to "reasonably accommodate" in this case. Because it did not, this Court should grant certiorari and reverse the judgment.

V. CONCLUSION

Based on the foregoing, this Court should grant the petition.