THE CRIMINALIZATION OF HOMELESSNESS AND MENTAL HEALTH CONDITIONS IN THE UNITED STATES

UNIVERSITY OF MIAMI
SCHOOL OF LAW
HUMAN RIGHTS CLINIC

NHLC
NATIONAL HOMELESSNESS LAW CENTER

Acknowledgments

This report was drafted by Abigail Wettstein, a Fellow with the Human Rights Clinic at the University of Miami School of Law, along with Tiana Rose Montague and Nicholas Tricarico, Legal Interns with the Human Rights Clinic, under the supervision of the Clinic's Associate Director, Tamar Ezer. Eric Tars, Senior Policy Director at the National Homelessness Law Center (NHLC), and Siya Hegde, Staff Attorney at NHLC, further provided critical support and guidance. The section of the report focused on New York City's Mental Health Involuntary Removal Directive is adapted from a section, spearheaded by Siya Hegde, of NHLC's and the Human Rights Clinic's Shadow Report for the United States' review by the United Nations Human Rights Committee in 2023.[1] We gratefully acknowledge the foundational work done in that report, which has been incorporated here with appropriate modifications. Additionally, we are grateful to Lili Graham, Litigation Counsel at Disability Rights California; Michelle Kotval, Senior Attorney at Disability Rights California; David Hutt, Deputy Executive Director for Legal Services at the National Disability Rights Network; and Diana Sheinbaum Lerner, Disability and Justice Program Coordinator at Documenta for their valuable review and contributions to the report. Maggie Roberts and Dalgys Estrabao provided the graphic design for this report.

May 2025

[1] Univ. of Miami Sch. of L. Human Rights Clinic & Nat'l Homelessness Law Ctr., *Shadow Report to the U.N. Human Rights Committee on the Criminalization of Homelessness and Mental Health in the U.S.*, for the 5th Periodic Review of the United States under the International Covenant on Civil and Political Rights (ICCPR), 139th Session (Oct. 2023), https://miami.app.box.com/s/ts2gz8qy14gqh674619avty2jdu4z3w7.

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Glossary of Key Terms and Abbreviations

ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act
B-HEARD	New York City Behavioral Health Emergency Assistance Response Division
BTHC	Boston Trauma Healing Collaborative
CAHOOTS	Eugene-Springfield, Oregon Crisis Assistance Helping Out on the Streets program
CALL	St. Petersburg, Florida Community Assistance and Life Liaison program
CARE	California Community Assistance, Recovery and Empowerment
CAT	Convention Against Torture
CAT Committee	UN Committee Against Torture
CCRB	New York City Civilian Complaint Review Board
CERD	UN Committee on the Elimination of Racial Discrimination
CIDT	Cruel, inhuman, and degrading treatment
CMHA	1963 U.S. Community Mental Health Act

CMHCs	Community Mental Health Centers
Community-Based Services	Services provided within a community setting, rather than institutional care, for purposes of supporting individuals in living as independently as possible
Community Health Professionals	Non-police first responders trained in mental health care, de-escalation, and rehabilitation, reducing the risks of force and violence during crisis responses
Criminalization of Homelessness	Laws and policies penalizing unhoused individuals for life-sustaining activities in public when no shelter or housing alternatives are available.
CRPD	Convention on the Rights of Persons with Disabilities
CRPD Committee	UN Committee on the Rights of Persons with Disabilities
Decriminalization	A policy approach that removes criminal penalties for the possession of small amounts of drugs for personal use
Deinstitutionalization	The movement to replace inhumane mental hospitals with community-based care, driven by hopes for new medications and cost-saving
Disability	A physical or mental impairment that substantially limits one or more major life activities, such as walking, speaking, or working
Drug Checking Services	Programs allowing individuals to test drugs for harmful contaminants, enabling safer use and reducing the risks of overdose and poisoning
ESC	Boston Emergency Services Center
FHP	Chicago Flexible Housing Pools

Harm Reduction	A public health approach focusing on reducing the negative physical, social, and legal harms of drug use rather than focusing on the drug use itself
Housing First Approach	A model that prioritizes providing permanent housing with no preconditions or requirements as the foundation for addressing homelessness and mental health issues
HRC	UN Human Rights Committee
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICM	Intensive case management
IDEA	Florida Infectious Disease Elimination Act
IPTF	Minneapolis Indigenous Peoples Task Force
LEAD	Seattle Law Enforcement Diversion Program
Mental Health Crisis	A situation where an individual experiences severe mental distress, potentially posing a risk to their safety or the safety of others, requiring immediate intervention and support
NAMI	National Alliance on Mental Illness
NHLC	National Homelessness Law Center

NIMBYism	**A form of community resistance to local development projects, including PSH, often driven by unfounded concerns about crime or property values**
NYPD	New York Police Department
OCC	San Francisco Office of Coordinated Care
OHCHR	U.N. Office of the High Commissioner for Human Rights
PCG	Policy Coordinating Group
Privatized Incarceration	A system where private entities profit from managing correctional or detention facilities, often linked to think tanks advocating for criminalization policies like those targeting homelessness
PSH	Permanent Supportive Housing
Psychiatric Hospitalization	Inpatient care for individuals experiencing severe mental health crises, often preventable through community-based alternatives like respite centers or mobile crisis response teams
PWID	Persons who inject drugs
SCRT	San Francisco Street Crisis Response Team
Serious Mental Illness	A diagnosable mental disorder that significantly interferes with or limits major life activities
STAR	Denver Support Team Assisted Response program
TAC	Treatment Advocacy Center

TCRC	**Trauma and Community Resilience Center at Boston's Children's Hospital**
Trauma-Informed Care	An approach that acknowledges the impact of past trauma on an individual's current behavior and emphasizes safety, empowerment, and healing in interventions
TRC	San Francisco's Trauma Recovery Center
UDHR	Universal Declaration of Human Rights
UN	United Nations
Unhoused Individuals	Persons experiencing homelessness, including those living on the streets, in shelters, or in temporary accommodations
U.S.	United States of America
VCH	Vancouver Coastal Health
Wrap-Around Services	Supplemental programs including housing support, employment services, and mental health care

Introduction

In recent years, there has been an alarming surge in the implementation of laws and policies across the United States (U.S.) that directly target and criminalize homelessness, impacting at least 771,480 Americans on any given night.[2] This trend includes the Supreme Court's recent reversal in Grants Pass, a case that originally struck down laws penalizing unhoused individuals for sleeping in public when no shelter was available.[3] This decision marks a troubling shift in legal precedent, departing from human rights norms and making it increasingly difficult to rely on constitutional protections to combat the criminalization of poverty and homelessness.[4]

Under this legal landscape, one particularly distressing avenue through which unhoused individuals are being marginalized is the widespread expansion of civil involuntary treatment and commitment. This legal mechanism allows for the confinement of individuals in psychiatric hospitals for mental health "care" purposes. This disturbing trend involves leveraging a person's status of homelessness as evidence of potential danger to themselves or others, thus establishing it as a criterion for involuntary commitment. Moreover, individuals may be subjected to this process even in the absence of any overtly dangerous behavior. This report examines the current policies which enable this criminalization of homelessness and mental health, violations of international human rights standards, and potential evidence-based alternatives to provide mental health support to unhoused individuals.

A human rights-based approach to overlapping homelessness, mental health, and substance use crises is needed now more than ever. Just prior to publication of this report, in July 2025. the Trump Administration issued Executive Order 14321, "Ending Crime and Disorder on America's Streets," which explicitly targets unhoused persons and people with mental health conditions for arrest or involuntary commitment. The order seeks to overturn precedent that limits involuntary commitment and prioritizes funding for cities that adopt "maximally flexible" civil commitment and institutional treatment standards and enforce camping and "loitering" bans.[5] The Trump Administration followed this in August with a Presidential Memorandum implementing that order in the District of Columbia by federalizing local police and bringing in federal law enforcement and the National Guard in order to "get[] rid of the people from underpasses and public spaces all over the city."[6] These actions are giant steps in the wrong direction of disproven and harmful approaches which will make the homelessness, mental health, and substance use crises worse. But often, critics ask, "if you don't want us to arrest or commit people, what should we do instead?' This report seeks to answer those questions using internationally-recognized standards as well as domestically-proven best practices.

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[2] *See* U.S. Dep't of Hous. & Urb. Dev., *The 2023 Annual Homelessness Assessment Report (AHAR) to Congress*, at 12 (Dec. 2023), https://www.huduser.gov/portal/sites/default/files/pdf/2023-AHAR-Part-1.pdf

[3] *City of Grants Pass v. Johnson*, 144 S. Ct. 2202 (2024).

[4] Tamar Ezer & Abigail. Wettstein, *In Punishing Homelessness, the U.S. Abandons Human Rights*, HUMAN RIGHTS AT HOME BLOG (Oct. 2024), https://lawprofessors.typepad.com/human_rights/2024/10/in-punishing-homelessness-theusabandonshumanrights.html#:~:text=Human%20Rights%20Clinic%2C%20University%20of%20Miami%20School%20of%20Law&text=Grants%20Pass%20decision%20and%20reaffirming%20a%20commitment%20to%20housing%20on%20a%20human%20right.

[5] Exec. Order No. 14321, "Ending Crime and Disorder on America's Streets," 90 Fed. Reg. 35817 (Jul. 24, 2025).

[6] Exec. Order No. 14333, "Declaring a Crime Emergency in the District of Columbia," 90 Fed. Reg. 39301 (Aug. 11, 2025); Pres. Memo., "Restoring Law and Order in the District of Columbia," (Aug.11, 2025), https://www.whitehouse.gov/presidential-actions/2025/08/restoring-law-and-order-in-the-district-of-columbia/.

This report is divided into four main sections. The first section provides a historical background of the treatment of mental health conditions generally in the U.S., as well as the overlap between criminalizing mental health and homelessness. The second section then focuses upon current policies across the country that allow for the criminalization of mental health and forced institutionalization, including case studies from California, Florida, and New York. The third section will provide a human rights analysis of these policies, highlighting violations of international human rights standards. The report concludes with a section outlining alternative human rights-based responses to the mental health needs of unhoused individuals. Specifically, this section recommends investing in permanent supportive housing and voluntary community-based treatment options to make crises less likely in the first place, implementing harm reduction models to address substance dependence, and replacing traditional law enforcement with health and social service providers as first responders to mental health crises.

I. Historical Background

A. Historical Treatment of Mental Health

The U.S. has a history of criminalizing individuals with mental health conditions, a practice dating back to the 1700s when many were imprisoned for perceived moral deficiencies deemed "barbaric" and "incurable."[7] The fundamental legal principle that has underpinned this practice is parens patriae, derived from English common law, translating to "parent of the country."[8] This doctrine assigns the government the duty to intervene on behalf of citizens deemed incapable of acting in their best interest.[9] Concurrently, states have used the principle of police power, which mandates comprehensively safeguarding citizens' interests, to support involuntary civil commitment.[10] States have relied on this broad obligation to enact statutes claiming a benefit to society, even if they restrict certain individuals' liberties.[11] Before the establishment of American asylums, individuals with mental illness were often confined to prisons and poorhouses for community safety and did not receive any treatment.[12]

However, between 1817 and 1824, private asylums emerged in northeastern states, followed by public institutions in the South, paving the way for widespread state-run mental health facilities.[13]

While the mid-19th century welcomed this national reform movement seeking to improve the conditions of incarcerated persons with psychosocial disabilities and spurring the establishment of public psychiatric hospitals, [14] it was closely followed by the eugenics movement that emboldened scientific pursuits to forcibly sterilize and selectively breed patients with mental health conditions. [15] Through the first half of the 20th century, more states began investing funds in their own state-run psychiatric facilities. In one example, the New York Lunacy Commission found in 1912 that one-third of New York's budget "was spent locking up and caring for the mentally ill."[16] The state's Office of Mental Hygiene was established in 1926,[17] with its very name suggesting eugenicist undertones of "disinfecting" persons with mental and behavioral health disabilities.

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[7] *Covering Mental Health: 1840s-1890s*, PBS NEWSHOUR CLASSROOM, https://www.journalisminaction.org/case/nellie-bly (last visited Sept. 6, 2023).
[8] Megan Testa & Sara G. West, *Civil Commitment in the United States*, Psychiatry (Edgmont) 30-40 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3392176/.
[9] J. LEHMAN & S. PHELPS, *Parens Patriae*, 2nd Ed. West's Encyclopedia of American Law (2005).
[10] S.G. West & S.H. Friedman, *Entry on civil commitment*, Wiley Encyclopedia of Forensic Science—Behavioral Sciences (2010).
[11] J. LEHMAN & S. PHELPS, *Police power*, 2nd Ed. West's Encyclopedia of American Law (2005).
[12] Stuart Anfag & Paul Appelbaum, *Civil commitment—the American experience*, Psychiatry Relat Sci. (2006), https://pubmed.ncbi.nlm.nih.gov/17294986/.
[13] R. Porter, MADNESS: A BRIEF HISTORY (1st ed. 2002); G.N. Grob, THE MAD AMONG US: A HISTORY OF THE CARE OF AMERICA'S MENTALLY ILL (1994).
[14] *See* Alisa Roth, *The Truth About Deinstitutionalization,* The Atlantic (May 25, 2021), https://www.theatlantic.com/health/archive/2021/05/truth-about-deinstitutionalization/618986/ ("In 1841, a former schoolteacher named Dorothea Dix visited a Massachusetts jail to teach a Bible class. She was appalled to find it filled with people with mental illness, living in horrific conditions; traveling around the country, she found similar conditions in other jails. Residents were kept in 'cages, closets, cellars, stalls, pens!' she later wrote in a letter to the Massachusetts legislature.").
[15] *See The 19th Century Asylum*, Hearing Voices, https://librarycompany.org/hearingvoices-online/section1.html (last visited Sept. 6, 2023) ("The theory of degeneracy and the eugenics movement it precipitated led to the forced sterilization of countless mentally ill patients to prevent the inheritance of insanity.").
[16] Elliott Young, Locking up the mentally ill has a long history, Wash. Post (Jan. 3, 2023, 6:00 AM), https://www.washingtonpost.com/made-by-history/2023/01/03/history-mental-illness-incarceration/.
[17] *Id.*

The majority of individuals admitted to American asylums suffered from conditions such as dementia, seizure disorders, paralysis-related diseases, or advanced neurosyphilis, all of which were untreatable with the available medical practices of the time.[18] Consequently, asylums evolved into long-term residences for chronically ill patients, where care primarily involved restraint, sedation using medications like bromides and chloral hydrate, or experimental treatments like opium, camphor, and cathartics.[19] Unfortunately, these interventions neither cured nor significantly improved patients' conditions, rendering them unable to reintegrate into society. By the 1950s, the population of American asylums had swelled to over 500,000, reaching an all-time high of 559,000 psychiatric inpatients in 1953.[20]

In response to the abuses observed in civil commitment practices, the 20th-century U.S. witnessed a shift in standards for involuntary hospitalization. States revised civil commitment laws to incorporate legal safeguards protecting individuals' liberty rights.[21] These protections included the right to a trial with legal representation prior to psychiatric admission.[22] Stricter commitment standards were implemented, transferring decision-making authority from medical professionals to judges and magistrates.[23]

However, these changes brought about their own set of challenges. Many individuals faced short-term imprisonment while awaiting completion of procedural standards, often due to delays in securing legal representation or scheduling pre-commitment trials. Psychiatrists and mental health advocates criticized these standards as excessive and detrimental to patients. In 1951, the National Institute of Mental Health responded by publishing the "Draft Act Governing Hospitalization of the Mentally Ill," aiming to restore psychiatrists' decision-making authority in civil commitment proceedings, free from lengthy legal procedures.[24]

In a federal effort to deinstitutionalize state hospitals, then-President John F. Kennedy signed the 1963 Community Mental Health Act (CMHA) with the aim to shift the treatment of persons with psychosocial disabilities from state psychiatric facilities to designated local, community-based clinics.[25] Set against the backdrop of the national civil rights movement, his hope was to "liberate the population of confined mentally ill patients through advancements in psychopharmacology and supportive housing."[26] The legislation funded three years of federal grant payments totaling $150 million to the states for the initial staffing and construction of 1,500 community clinics and/or mental health centers.[27]

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[18] Testa & West, *supra* note 6

[19] R. Porter, MADNESS: A BRIEF HISTORY (1st ed. 2002); G.N. Grob, The Mad Among Us: A History of the Care of America's Mentally Ill (1994).

[20] Grob, supra note 17; S.G. West and S.H. Friedman, Entry on civil commitment, Wiley Encyclopedia of Forensic Science—Behavioral Sciences (2010).

[21] Anfag & Appelbaum, *supra* note 12.

[22] *Id.*

[23] Christyne Ferris, *The search for due process in civil commitment hearings: how procedural realities have altered substantive standards,* VAND. L. REV. (2008), https://scholarship.law.vanderbilt.edu/vlr/vol61/iss3/4/.

[24] Anfag & Appelbaum, *supra* note 12.

[25] Vic DiGravio, *The Last Bill JFK Signed – And The Mental Health Work Still Undone,* WBUR (Oct. 23, 2013), https://www.wbur.org/news/2013/10/23/community-mental-health-kennedy (". . . President Kennedy called for society to embrace a new vision for people with mental health disorders and developmental disabilities, one in which the 'cold mercy of custodial care would be replaced by the open warmth of community.'").

[26] Blake Erickson, *Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963*, Am. J. Psychiatry Residents' J. 6, 6 (June 11, 2021), https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp-rj.2021.160404.

[27] *Id*. at 7.

Despite Kennedy's efforts to establish community mental health centers, the legislation ultimately failed to achieve its intended goal of establishing long-term supportive housing solutions for people with psychosocial disabilities. The intended community-based resources "rarely materialized" as initial federal funding was not followed by longer-term commitments,[28] and municipalities utilized zoning measures to prevent the placement of facilities in neighborhoods.[29] Additionally, the model under the CMHA did not adequately address the specific determinants such as "poor socialization and lack of housing, food, and clothing" that many psychiatrists posited were the root causes of the mental health crisis.[30] Paired with the loss of deeply affordable Single Room Occupancy (SRO) housing units, where at least some could find housing, this contributed substantially to the growth of modern homelessness.[31] Thus, persons exiting the larger state facilities often ended up on the streets, and by the 1980s and 90s, federal, state, and local administrations invoked "broken windows" policies that criminalized poor and unhoused persons and forced those with mental disabilities to become "enmeshed in the criminal legal system."[32]

Since the CMHA went into effect, federal courts have issued rulings regarding the legal standards authorizing involuntary commitments. In 1966, a significant legal precedent was established in the case of Lake v. Cameron, heard by a Washington, DC, appeals court.[33] Catherine Lake, a woman with mental illness, had been involuntarily hospitalized at St. Elizabeth's psychiatric hospital for an extended period despite showing no signs of posing a danger to herself or others. Seeking release, Lake petitioned the district court.[34] The ruling emphasized that non-dangerous patients should not be confined if less restrictive alternatives are available.[35] This landmark decision mandated psychiatrists conducting emergency evaluations to recommend the least restrictive treatment options for non-dangerous psychiatric patients, a principle that remains influential in mental healthcare practices today.[36]

The following decade saw a plethora of landmark decisions regarding involuntary commitment. In the 1972 decision of Lessard v. Schmidt, the court sided with the state of Wisconsin's statutory definition of "mental illness"—it held that a person may be institutionalized should "the potential for doing harm be 'great enough to justify such a massive curtailment of liberty.'"[37] While this was a fairly strict standard, the U.S. Supreme Court in the 1975 case of O'Connor v. Donaldson recognized "involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, [to be] a deprivation of liberty which the State cannot accomplish without due process of law."[38]

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[28] Michelle R. Smith, *50 years later, Kennedy's vision for mental health not realized*, SEATTLE TIMES (Oct. 20, 2013, 8:28 PM), https://www.seattletimes.com/nation-world/50-years-later-kennedyrsquos-vision-for-mental-health-not-realized/.

[29] *See generally* Deborah A. Schmedemann, *Zoning for the Mentally Ill: A Legislative Mandate*, 16 HARV. J. LEGIS. 853 (1979) (discussing how local governmental authorities across the United States "reacted defensively" to exclude persons with mental health conditions from their neighborhoods with the use of exclusionary zoning policies).

[30] Blake Erickson, Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963, 16 AM. J. PSYCHIATRY RESIDENTS' J. 6, 7 (2021).

[31] Siya Hegde & Carlton Martin, *With Liberty and Justice for All: The Case for Decriminalizing Homelessness and Mental Health in America*, 21 IND. HEALTH L. REV. 249 (2024).

[32] Young, *supra* note 16; *see also Broken Windows Policing*, GEO. MASON U. CTR. EVIDENCE-BASED CRIME POL'Y (last visited on Sept. 5, 2023), https://cebcp.org/evidence-based-policing/what-works-in-policing/research-evidence-review/broken-windows-policing/ (detailing broken windows policing and its origins).

[33] *Lake v. Cameron*, 364 F.2d 657 (1966).

[34] *Id.*

[35] *Id.*

[36] E. Thackery and G. Cengage, *Involuntary hospitalization*, ENCYCLOPEDIA OF MENTAL DISORDERS (2003).

[37] *Lessard v. Schmidt*, 349 F. Supp. 1078, 1093 (E.D. Wis. 1972).

[38] *O'Connor v. Donaldson*, 422 U.S. 563, 580 (1975).

Once again, however, in 1978, the Supreme Court grappled with the question of the standard of proof required for involuntary hospitalization of psychiatric patients in Addington v. Texas.[39] Frank Addington, a man with a history of psychotic illness, was at the center of the case. His mother sought indefinite commitment for him after he allegedly assaulted her and appeared to be experiencing delusions, such as claiming to be married to a television actress.[40] On appeal, in determining the proper standard of proof, the Supreme Court held that due process required a higher standard than preponderance, as "involuntary commitment . . . can amount to a significant deprivation of liberty that requires due process protection."[41] However, the Court also articulated that the "beyond a reasonable doubt" standard—used in criminal cases—was too stringent and would overly burden the state's ability to provide care for individuals in need.[42] This is because requiring proof beyond a reasonable doubt in civil commitment proceedings would "impose a standard [that] is not susceptible to easy application" in the context of psychiatric diagnoses, which "rest on probabilities rather than certainties."[43] Specifically, the Court was concerned that such a high burden of proof would "erect an unreasonable barrier to needed medical treatment" and frustrate the state's interest in protecting both the individual and the public.[44]

Therefore, the Court ultimately adopted the intermediate "clear and convincing evidence" standard as a balance between individual liberty and the state's interest in providing care and protection.[45] Addington thus built upon the due process principles established in O'Connor v. Donaldson, recognizing that involuntary commitment constitutes a significant deprivation of liberty that requires procedural safeguards, including ensuring that individuals are not committed based on insufficient evidence.[46]

Following the Supreme Court's decision in Addington, the 1990s saw further legal advances in the protection of individuals with psychosocial disabilities as mental health conditions were adopted into the language of the Americans with Disabilities Act (ADA).[47] The ADA not only sought greater protections for individuals from undue confinement but also from unnecessary segregation, mandating that individuals with disabilities should receive services in the most integrated setting possible.[48] This principle was reinforced in Olmstead v. L.C, where the Supreme Court ruled that institutionalization that did not meet the clear and convincing legal standard violated the ADA's mandate for integration, emphasizing the right of individuals with disabilities to participate fully in their communities.[49] Together, these decisions form a critical foundation for human rights discussions on disability, supporting efforts toward equality, integration, and non-discrimination.

[39] *Addington v. Texas*, 441 U.S. 418 (1979).
[40] *Id*.
[41] *Id*. at 425.
[42] *Id*.; Christyne Ferris, *The Search for Due Process in Civil Commitment Hearings: How Procedural Realities Have Altered Substantive Standards*, VAND. L. REV. (2008), https://scholarship.law.vanderbilt.edu/vlr/vol61/iss3/4/.
[43] *Addington*, 441 U.S. at 429.
[44] *Id*. at 430.
[45] *Id*.
[46] *Id*. at 427; O'Connor, 422 U.S. at 580.
[47] Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq. (1990).
[48] *Id*.
[49] *Olmstead v. L.C.*, 527 U.S. 581 (1999).

B. Mental Health Conditions as a Cause and Consequence of Homelessness

The intertwining of mental health and homelessness in the U.S. reveals systemic challenges and misconceptions. While severe psychosocial disabilities disproportionately affect unhoused individuals, the notion that mental health conditions alone cause homelessness is inaccurate and carries with it dangerous implications. This misconception shifts focus away from systemic issues contributing to housing insecurity, instead making homelessness an issue of individual failure to manage a mental health condition. Economic hardships, fractured support systems, and psychological distress perpetuate a cycle of poverty and homelessness. Trauma, substance use disorders, and limited access to treatment further exacerbate psychosocial disabilities among unhoused populations. Addressing these systemic roots requires comprehensive and compassionate approaches.

As such, the criminalization of mental health conditions disproportionately impacts unhoused individuals in the U.S. According to estimates from the U.S. Department of Housing and Urban Development (HUD), about 20 percent of the nation's unsheltered population suffers from a "severe mental [health disability]."[50]

This figure has been corroborated by the U.S.' Substance Abuse and Mental Health Services Administration (SAMHSA), which has also contrasted it with the 5.6 percent of the general population found to have a serious psychosocial disability.[51]

However, psychosocial disabilities are equally a result of homelessness, as they are contributors to it. Individuals grappling with housing instability endure profound psychological and emotional challenges that lead to the development of psychosocial disabilities over time.[52] Factors that fuel a cycle of poverty, such as economic hardships, survival-focused living, fractured familial support systems, and diminished self-esteem equally contribute to psychosocial disabilities. Specifically, income inequality has been found to have a significant association with common mental health conditions, with those persons living in "socially underprivileged and poor city areas [suffering] more often from . . . depression, anxiety, and psychosis than persons living in high-income neighborhoods."[53]

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[50] David Oshinsky, *It's Time to Bring Back Asylums*, Wall St. J. (July 21, 2023, 10:56 AM), https://www.wsj.com/articles/its-time-to-bring-back-the-asylum-ec01fb2.
[51] *Guide Overview: Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness* (SAMHSA Publication No. PEP22-06-02-003, 2023), https://store.samhsa.gov/sites/default/files/pep22-06-02-007.pdf.
[52] Lenni Marcus, Cameron Johnson, & Danna Ramirez, The Complex Link Between Homelessness and Mental Health, MENNINGER CLINIC (2021), https://www.psychologytoday.com/us/blog/mind-matters-menninger/202105/the-complex-link-between-homelessness-and-mental-health.
[53] Derin Marbin, et al., *Perspectives in poverty and mental health*, 10 FRONTIERS PUB. HEALTH 1, 2 (2022), https://doi.org/10.3389/fpubh.2022.975482.

Additionally, the condition of being unhoused only exacerbates individuals' abilities to manage psychosocial disabilities that developed prior to their being unhoused, "especially if there is no solution [for housing] in sight."[54] Acting Executive Director of the Treatment Advocacy Center (TAC), Lisa Dailey, described this concerning cycle: "[Y]ou may be more likely to become homeless because of a mental illness, and if that does happen, the homelessness makes the symptoms and the experience of the mental illness much, much worse."[55] For instance, in comparison to their low-income housed counterparts, unhoused mothers who have endured severe physical and/or sexual abuse throughout their lives experience three times the rate of post-traumatic stress disorder and twice the rate of drug and alcohol dependence.[56]

One reason for the exacerbation of mental health conditions by homelessness lies in extreme sleep deprivation. Unhoused individuals regularly experience disrupted sleep due to safety concerns, exposure to the elements, and limited access to basic comforts.[57] As the Mental Health Foundation notes, "sleep is as essential to our bodies as eating, drinking, and breathing," and a lack of it significantly impacts mental health, leading to increased risks of anxiety, depression, and other mental health conditions.[58]

Despite the increased need for treatment due to the compounding trauma of being unhoused on an existing psychosocial disability, there are great deficiencies in current government support systems for severe psychosocial disabilities. Some systems require individuals to reach a specific state of impoverishment to qualify for benefits, resulting in a paradox where increased income may disqualify individuals from assistance while still leaving them unable to afford essential medication.[59] This lack of access often drives individuals to rely on harmful coping mechanisms, such as substance use or self-harm, which further worsen mental health symptoms and contribute to cycles of homelessness and poverty.[60]

Additionally, variations in cost-of-living expenses across jurisdictions make it difficult to establish consistent eligibility for benefits, as what qualifies as a reasonable income in one region may be insufficient in another.[61] For the approximately 40 percent of unhoused individuals who qualify for programs such as Medicaid, an acute scarcity of mental healthcare providers renders mental healthcare "virtually unattainable" in many parts of the U.S.[62]

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[54] *Fact Sheet: Homelessness & Health: What's the Connection*, NAT'L HEALTH CARE FOR HOMELESS COUNCIL 1 (2019), https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf.

[55] Andrew Fraieli, *The Nuances of Mental Illness and Homelessness*, THE HOMELESS VOICE (2021), https://homelessvoice.org/the-nuances-of-mental-illness-and-homelessness/.

[56] *Homelessness Programs and Resources*, SAMHSA, https://www.samhsa.gov/homelessness-programs-resources.

[57] Eric Ridenour, *Homelessness & the Lack of a Sleep Environment*, AMERISLEEP (Nov. 10, 2023), https://amerisleep.com/blog/homelessness-and-sleep/.

[58] *Sleep Matters Report*, MENTAL HEALTH FOUNDATION (2011), https://www.mentalhealth.org.uk/sites/default/files/2022-06/MHF-Sleep-Matters-Report-MHAW-2011.pdf.

[59] *Id*.

[60] Nat'l L. Ctr. on Homelessness & Poverty, *Housing Not Handcuffs 2021: State Law Supplement*, 16-17 (2021), https://homelesslaw.org/wp-content/uploads/2022/02/2021-HNH-State-Crim-Supplement.pdf.

[61] U.S. Census Bureau, *Poverty Measures*, https://www.census.gov/topics/income-poverty/poverty/guidance/povertymeasures.html#:~:text=The%20official%20poverty%20thresholds%20do,Medicaid%2C%20and%20food%20stamps. While the Supplemental Poverty Measure (SPM), conducted by the Census Bureau, provides a broader view by considering geographic differences, it may also be useful to explore other measures of poverty to gain a more comprehensive understanding of a person's economic situation and their eligibility for support.

[62] Deborah K. Padgett, *Homelessness, Housing Instability and Mental Health: Making the Connections*, 44 BJPSYCH BULL. 197, 199 (Oct. 2020).

Without access to care, untreated mental health conditions often worsen, increasing the risk of homelessness.[63] This correlation is evidenced by data showing that close to 30 percent of individuals discharged from state asylum facilities are rendered either homeless or without a known address within six months of their discharge.[64] Due to the lack of access to consistent treatment and support after discharge from asylum facilities, many patients are left vulnerable to losing stability and ultimately falling into homelessness.

Racial injustices further exacerbate inadequate mental health services and lead to disproportionate homelessness on the basis of race. Lack of access to mental health services disproportionately affects persons of color compared to their white counterparts.[65] More generally, racial disparities in healthcare coverage exacerbate the risk of homelessness for persons of color. Black people are twice as likely as white people to fall in the coverage gap of states that have not expanded Medicaid and are more likely to go without healthcare because of the unaffordable cost, even though they experience higher rates of certain health conditions or diseases.[66] Consequently, the lack of access to health insurance, in turn, affects access to mental health treatment, leaving a significant number of persons of color likely to be uninsured. Not only is there a lack of access to healthcare, but research demonstrates that racial minorities and immigrants are more likely to be diagnosed, and misdiagnosed, with psychotic disorders than white Americans because of clinicians' prejudice and misinterpretation of patient behaviors.[67] The civil legal system can play a role in ameliorating discriminatory effects in healthcare, housing, and government services but has historically been used to subjugate Black people.[68]

[63] *Id*.
[64] Oshinsky, *supra* note 50.
[65] Nat'l Alliance on Mental Illness, *Mental Health Inequities: Racism and Racial Discrimination* (2023), https://www.nami.org/Advocacy/Policy-Priorities/Supporting-Community-Inclusion-and-Non-Discrimination/Mental-Health-Inequities-Racism-and-Racial-Discrimination.
[66] Nat'l Health Care Homeless Council, Health, Homelessness, and Racial Disparities, at 2 (2019).
[67] Robert C. Schwartz, Ph.D., et al., *Racial Disparities in Psychotic Disorder Diagnosis: A Review of Empirical Literature*, 4 WORLD J. PSYCHIATRY 133-140 (2014).
[68] State of California Dep't Just. Off. Att'y Gen., *California Task Force to Study and Develop Reparation Proposals for African Americans: Interim Report* (AB 3121) 390-391 (2022), 2022 - AB3121 Full Interim Report (ca.gov).

II. Criminalization of Mental Health

A. Law Enforcement as First Responders to Mental Health Crises

The U.S., with its inadequate social safety net and lack of community-based mental health resources, has come to rely on the criminal legal system to respond to mental health conditions. Executive Director of the TAC, John Snook, has explained that "the mental health system is largely broken across the country. We've tried to paper over it by funding law enforcement."[69] This has transformed mental health into a law enforcement matter, with people with mental health conditions overrepresented throughout the criminal justice system.[70] When mental health support is not available, rights are violated as discussed below, and crises occur, all too often leading to escalating and disproportionate law enforcement interventions.

Law enforcement officers serve on the frontlines of psychiatric care without the relevant expertise. Nearly one-third of persons found to experience severe mental distress first connect with a mental health treatment resource through law enforcement intervention.[71] Multiple research studies have found that most interactions that police officers have with persons with mental disabilities "do not involve major crimes or violence . . . nor do they often meet the legal criteria of 'emergency apprehension.'"[72]

Additionally, a significant portion of 911 calls, where police serve as initial responders, involve behavioral health issues. A recent examination across eight cities revealed that approximately 21 to 38 percent of these calls pertain to mental health crises, substance use problems, homelessness, and various quality of life issues. These are all issues that must be handled more effectively by professionals with relevant expertise.[73]

Law enforcement officers are inadequately prepared for these situations, typically facing a binary and often arbitrary decision between incarcerating or hospitalizing the individual(s) they are in contact with or leaving them untreated and forcing them to "move along" under threat of future incarceration or hospitalization. Consequently, encounters between police and individuals experiencing mental health crises rarely result in individuals receiving meaningful access to appropriate care. This reality is underscored by the fact that some jails in the U.S., including Los Angeles County Jail, Chicago's Cook County Jail, and New York's Riker's Island Jail Complex, detain more individuals with severe psychosocial disabilities than any specialized treatment facility in the nation.[74]

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[69] Fola Akinnibi, *NYC pilot tries mental health responders instead of police*, BLOOMBERG CITYLAB (Nov. 13, 2020), https://www.bloomberg.com/news/articles/2020-11-13/nyc-pilot-sends-health-workers-in-place-of-police.

[70] *Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters*, TREATMENT ADVOC. CENTER., at 12 (2015), https://www.treatmentadvocacycenter.org/storage/documents/ overlooked-in-the-undercounted.pdf [hereinafter Overlooked in the Undercounted].

[71] Tamar Ezer & Denise Tomasini-Joshi, *First Responders with a Rights-Based Approach to Mental Health Crises*, HEALTH & HUM. RTS. J. (Oct. 10, 2021), https://www.hhrjournal.org/2021/10/first-responders-with-a-rights-based-approach-to-mental-health-crises/#_edn3.

[72] Jennifer D. Wood, et al., *The "Gray Zone" of Police Work During Mental Health Encounters: Findings from an Observational Study in Chicago*, 20 POLICE Q 1, 3 (2017).

[73] Amos Irwin & Betsy Pearl, *The Community Responder Model: How Cities Can Send the Right Responder to Every 911 Call*, CENTER FOR AMERICAN PROGRESS(Oct. 28, 2020), https://www.americanprogress.org/article/community-responder-model/.

[74] Nicholas Turner, *We Need to Think Beyond Police in Mental Health Crises*, VERA (Apr. 6, 2022), https://www.vera.org/news/we-need-to-think-beyond-police-in-mental-health-crises; TREATMENT ADVOC. CTR., SERIOUS MENTAL ILLNESS PREVALENCE IN JAILS AND PRISONS (2016), https://www.treatmentadvocacycenter.org/reports_publications/serious-mental-illness-prevalence-in-jails-and-prisons/.

Moreover, encounters between individuals with mental distress and law enforcement too often result in harm and may even be fatal. Even though research studies demonstrate "people with mental illness are actually more likely to be victims of violence than perpetrators," police acting as first responders often use disproportionate force against people with mental disabilities.[75] According to a TAC study, persons with untreated mental disabilities are 16 times more likely to be killed during a police encounter than other individuals.[76]

In 2021, at least 104 individuals lost their lives following police responses to incidents involving individuals "behaving erratically or experiencing a mental health crisis."[77] Moreover, at least a quarter and perhaps as many as half of all fatal police shootings involve persons with serious mental health conditions.[78] Many leading mental health and human rights organizations such as the National Alliance on Mental Illness (NAMI), have therefore publicly spoken out against the use of police as responders to mental health crises.[79] In fact, the U.N. Office of the High Commissioner for Human Rights (OHCHR) has identified "the intervention of law enforcement officials as first responders in mental health crises" as one of "three key contexts" that "underlie over 85 percent of police-related fatalities."[80]

Moreover, the involvement of law enforcement often has disparate racial impacts.[81] As the Special Rapporteur on Racism has recognized, "the enforcement of minor law enforcement violations . . . take a disproportionately high number of African American homeless persons to the criminal justice system."[82]

Training law enforcement officers to handle mental distress is further insufficient to address these violations. In fact, research has not found more police training on mental health and de-escalation to reduce harmful encounters.[83] This is the case because the fundamental role of police, embedded in policies and culture, is to address criminality, not provide care. Police have limited training in mental health and spend on average 71 hours on firearms training compared to 21 hours on de-escalation.[84] Even when police officers have undergone appropriate training, the presence of armed and uniformed officers can intensify distress for individuals with behavioral health conditions.[85] This distress can be further exacerbated by police threatening unhoused individuals with the removal of their tents, sleeping bags, and other basic survival necessities, as is often the case in "sweeps" of homeless encampments.[86]

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[75] Joanna Laine, *From Criminalization to Humanization: Ending Discrimination Against the Homeless*, 39 HARINGBINGER 1, 3-4 (2015) (citing Margarita Tartakovsky, *Media's Damaging Depictions of Mental Illness*, PYSCH CENTRAL (May 17, 2016), https://psychcentral.com/lib/medias-damaging-depictions-of-mental-illness#1); *see also* Linda A. Teplin, et al., *Crime Victimization in Adults with Severe Mental Illness*, 62 ARCH. GEN. PSYCHIATRY 911, 914 (2005) ("Over one quarter of the SMI sample had been victims of a violent crime . . . in the past year, 11.8 times higher than the [general population] . . .").

[76] TREATMENT ADVOC. CTR., *supra* note 70.

[77] *2021 Police Violence Report*, POLICE VIOLENCE REPORT.ORG, https://policeviolencereport.or.

[78] *Id.* at 3 ("Severe mental illness is an identifiable factor in at least 25% and as many as 50% of all fatal law enforcement encounters, but its role has been rendered virtually invisible by the failure of the government to track or report its presence.").

[79] *Police Use of Force*, NAMI, https://www.nami.org/Advocacy/Policy-Priorities/Stopping-Harmful-Practices/Police-Use-of-Force/.

[80] Rep. of the U.N. High Comm'r Hum. Rts. on Its Forty-Seventh Session, *Promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officers*, ¶ 30, U.N. Doc. A/HRC/47/53 (June 1, 2021).

[81] International Convention on the Elimination of All Forms of Racial Discrimination art. 2(1)(c), *ratified* Oct. 21, 1994, 660 U.N.T.S. 1 [hereinafter ICERD] ("Each State Party shall take effective measures to review governmental, national and local policies, and to amend, rescind or nullify any laws and regulations which have the effect of creating or perpetuating racial discrimination wherever it exists.").

[82] Hum. Rts. Council, *Report of the Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia and Related Intolerance, Doudou Diene, mission to the United States of America*, ¶ 64, U.N. Doc. A/HRC/11/36/Add.3 *at* ¶ 64 (Apr. 28, 2009).

[83] R. Kumar, *Envisioning an America Free from Police Violence and Control*, THE INTERCEPT (Oct. 15, 2017), https://theintercept.com/2017/10/15/alex-vitale-interview-the-end-of-policing/.

[84] M. Pauly, *How Police Officers Are (or Aren't) Trained in Mental Health*, THE ATLANTIC (Oct. 11, 2013), https://www.theatlantic.com/health/archive/2013/10/how-police-officers-are-or-aren-t-trained-in-mentalhealth/280485/; B. Reaves, State and Local Law Enforcement Training Academies, 2013, U.S. Department of Justice (July 2016), https://bjs.ojp.gov/content/pub/pdf/slleta13.pdf.

[85] Nicholas Turner, *We Need to Think Beyond Police in Mental Health Crises*, VERA INSTITUTE OF JUSTICE(Apr. 6, 2022), https://www.vera.org/news/we-need-to-think-beyond-police-in-mental-health-crises.

[86] *See, e.g.* Aishwarya Marwah, et al., *Addressing Homelessness and Mental Health: A Review of the Current Evidence and Future Directions*, 12 INT'L J. ENV'T RSCH. & PUB. Health 5118 (2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC9585118/.

B. Overrepresentation in the Criminal Justice System

Persons with mental health conditions are significantly overrepresented in the criminal justice system.[87] This phenomenon, often termed the "criminalization of the mentally ill," has gained momentum since the 1970s, coinciding with the move away from institutionalization and changes in civil commitment standards toward criteria emphasizing dangerousness.[88] Current estimates evidence that nationwide, mental illness affects between 10 percent to 25 percent of the incarcerated population, but in some states, such as New York, a greater estimate of 44 percent of pre-trial detainees and 37% of prison detainees have a mental health condition.[89] Among these inmates, many are nonviolent offenders, with a significant portion having committed survival-related crimes due to difficulties in social functioning and meeting basic needs resulting from chronic psychosocial disabilities.[90]

Individuals with mental illness are more likely to be arrested compared to those without similar conditions when encountering law enforcement.[91] Furthermore, those with a history of civil commitment are at a heightened risk of arrest compared to individuals with voluntary psychiatric hospital stays.[92]

One reason for law enforcement's preference for taking individuals with mental disorders into criminal custody rather than to hospital emergency rooms is their perception that the justice system offers a more viable path to long-term care.[93] Conversely, their lesser preference for involuntary hospitalization is caused by the fact that the latter can provide immediate but temporary relief for acute mental health crises rather than serving as a step toward sustainable long-term psychiatric care.[94] Ultimately, however, neither civil commitment nor involuntary hospitalization offer long-term care plans as standalone "solutions."

Rikers Island, one of the most notorious jail complexes in the country, exemplifies the disproportionate incarceration of people with mental health conditions. Paradoxically touted as "one of [the] largest psychiatric care providers," half of the Rikers Island population (about 2,780 people) have a mental health diagnosis on an average day.[95]

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[87] Megan J. Wolff, *Fact Sheet: Incarceration and Mental Health*, WEILL CORNELL MED. PSCHIATRY (2017), https://psychiatry.weill.cornell.edu/research-institutes/dewitt-wallace-institute-psychiatry/issues-mental-health-policy/fact-sheet-0 (noting that the "rate of mental disorders in the incarcerated population is 3 to 12 times higher than that of the general community").

[88] V.A. Hiday & H.W. Wales, *Civil commitment and arrests*, 16(5) CURR OPIN PSYCHIATRY 575-580 (2003).

[89] *Mental illness and homelessness*, Nat'l Coalition for the Homeless (2009), http://nationalhomeless.org/factsheets/Mental_Illness.html; V.A. Hiday & H.W. Wales, *Civil commitment and arrests*, 16(5) CURR OPIN PSYCHIATRY 575-580 (2003); *Aashna Lal, New York City's Involuntary Commitment Plan: Fulfilling a Moral Obligation?*, HASTINGS CENTER (Jan. 10, 2023), https://www.thehastingscenter.org/new-york-citys-involuntary-commitment-plan-fulfilling-a-moral-obligation/.

[90] Anfag & Appelbaum, *supra* note 12; E. Silver, et al., *Demythologizing inaccurate perceptions of the insanity defense*, 19(1) LAW HUM BEHAV. 63–70 (1994).

[91] Testa & West, *supra* note 6.

[92] *Id*.

[93] *Id*.

[94] Jennifer D. Oliva, *Perceived Benefits and Harms of Involuntary Civil Commitment for Opioid Use Disorder*, 48 J.L. MED. & ETHICS 205 (2020), https://www.cambridge.org/core/journals/journal-of-law-medicine-and-ethics/article/perceived-benefits-and-harms-of-involuntary-civil-commitment-for-opioid-use-disorder/2E9586FA6087146454FE41848B610F58.

[95] Annie McDonough, *Mental health care on Rikers: New York's largest psychiatric provider*, CITY & STATE (Sept. 30, 2022), https://www.cityandstateny.com/policy/2022/09/mental-health-care-rikers-new-yorks-largest-psychiatric-provider/377870/.

With institutional facilities serving as proxies for criminalization under the guise of corrections facilities, persons with mental health conditions are also less likely to make bail, a reality forcing most of them to languish in jail at a rate "nearly twice as long as [persons] without mental [health conditions]."[96] And given the nexus between the incidence of a psychosocial disability as a systemic consequence of homelessness, it should not come as a surprise that many unsheltered persons with mental disabilities lack the financial support of community members to help bail them out of jail facilities.

Even for those who can afford bail, however, the criminalization of mental health conditions perpetuates homelessness by trapping people in a cycle of poverty. Formerly incarcerated individuals are almost ten times more likely to be homeless than the general public, and even a single period of incarceration makes a person seven times as likely to experience homelessness.[97] The many fines and fees associated with the criminal justice system make it harder for unhoused persons with psychosocial disabilities to pay for food or medication and can lead to their incarceration if they are unable to pay.[98]

Having a criminal record can also prevent people from passing background checks for housing and employment, making it even harder to get off the street and out of poverty. The U.N. Special Rapporteur on extreme poverty and human rights highlighted this in his visit to the U.S., noting that "unpayable fines and the stigma of a criminal conviction . . . virtually prevents subsequent employment and access to most housing."[99] In fact, the U.S. Interagency Council on Homelessness recognizes that "the relationship between homelessness and criminal justice involvement is . . . bi-directional," such that criminalization effectively circulates individuals experiencing homelessness from the street to the criminal justice system and back."[100]

Finally, beyond being an ineffective way of treating mental health conditions, criminalizing mental crises is also costly. More than 2 million people are incarcerated in the U.S. every year and $918 million is spent on transporting these people to various facilities.[101] A study in Santa Barbara, California, for instance, has found the cost of incarceration to be 25% higher than providing supportive services that produce better long-term outcomes for psychosocial disabilities.[102] These services include housing, medical care, substance abuse, and mental health treatment.

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[96] *Opinion Editorial: Treatment, Not Jail, for the Mentally Ill*, N.Y. TIMES (Jan. 31, 2013), https://www.nytimes.com/2013/02/01/opinion/treatment-not-jail-for-the-mentally-ill-in-new-york-city.html#:~:text=Mentally%20ill%20inmates%20also%20stay,willing%20to%20get%20them%20out.

[97] *See* Lucius Couloute, *Nowhere to Go: Homelessness among formerly incarcerated people*, PRISON POL'Y INITIATIVE (Aug. 2018), https://www.prisonpolicy.org/reports/housing.html.

[98] *Justice Department Announces Resources to Assist State and Local Reform of Fine and Fee Practices*, U.S. DEPT OF JUSTICE (Apr. 20, 2023), https://www.justice.gov/opa/pr/justice-department-announces-resources-assist-state-and-local-reform-fine-and-fee-practices.

[99] Hum. Rts. Council, *Report of the Special Rapporteur on Extreme Poverty and Human Rights on His Mission to the United States of America*, ¶ 54, U.N. Doc. A/HRC/38/33/Add.1 (2018).

[100] United States Interagency Council on Homelessness, *Reducing Criminal Justice System Involvement Among People Experiencing Homelessness* (Aug. 2016), https://www.usich.gov/sites/default/files/document/Criminal_Justice_Involvement_08_2016.pdf.

[101] Akinnibi, *supra* note 69; M. Balfour, et al., *Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies*, PSYCHIATRIC SERVS. (Aug. 2020), https://psychiatryonline.org/doi/full/10.1176/appi.ps.202000721.

[102] *Comparing the Costs of Jail Incarceration and Stabilization Services For Homeless Mentally Ill Individuals*, COUNTY OF SANTA BARBARA, https://santabarbara.legistar.com/gateway.aspx?M=F&ID=05bf1da9-a734-43e0-93fd-54ca33867e77.pdf&From=Granicus.

C. Forced Institutionalization

Involuntary commitment laws in the U.S. claim to aim to balance access to psychiatric care and civil liberties. However, concerns arise over potential misuse, particularly in targeting unhoused individuals with psychosocial disabilities, exacerbated by housing unaffordability and intensified policing.

Today, every state has in place laws requiring some form of civil court hearing before a person can be involuntarily committed that requires the government to show that they are an imminent threat to themselves or others.[103] The stated aim of these statutes is to ensure that individuals in need of both mental health services and supervision receive appropriate psychiatric care.[104] Outpatient commitment, a commonly utilized form of civil commitment where a judge orders a person with a severe psychosocial disability "to adhere to an outpatient treatment plan designed to prevent relapse and dangerous deterioration," is contingent upon several criteria.[105] Firstly, the individual must be diagnosed with a mental disorder. Secondly, they must demonstrate a clear need for treatment and have a history of poor insight into their need for care, leading to periods of nonadherence to treatment. This lack of insight suggests that they would be unlikely to consistently seek psychiatric care voluntarily. Thirdly, there must be evidence indicating that the individual is at risk of deteriorating into a state that could pose a danger to themselves or others if they fail to adhere to treatment.[106] If these criteria are met, the individual can be mandated to undergo outpatient psychiatric treatment, although they may not be compelled to take prescribed medications.[107]

For some, the advantage of outpatient commitment lies in the monitoring and requirement of adherence to outpatient mental health visits. Individuals subject to civil commitment in the outpatient mental health system are more easily hospitalized involuntarily at earlier stages of psychiatric decline, as they are under the careful supervision of the community mental health system. Families also often find it more accessible to obtain necessary care for mentally ill relatives who are under outpatient commitment.[108] Additionally, outpatient commitment results in fewer arrests of individuals with mental illness.[109] Moreover, studies have shown that outpatient commitment is effective in improving patients' psychiatric outcomes, reducing hospitalization rates and lengths of inpatient stays, as well as increasing participation in community psychiatric treatment.[110]

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[103] *See* Samantha M. Caspar and Artem M. Joukov, *Worse than Punishment: How the Involuntary Commitment of Persons with Mental Illness Violates the United States Constitution*, 47 HASTINGS CONST. L.Q. 499, 508 (2020), https://repository.uchastings.edu/hastings_constitutional_law_quaterly/vol47/iss4/3) (citing Brian Stettin, et al., Mental Health Commitment Laws: A Survey of the States, TREATMENT ADVOC. CTR. (2014), https://www.treatmentadvocacycenter.org/mental-health-commitment-laws). The Trump Administration's Executive Order 14321 seeks to overturn precedent that limits involuntary commitment. Exec. Order No. 14321, "Ending Crime and Disorder on America's Streets," 90 Fed. Reg. 35817 (Jul. 24, 2025).

[104] S.G. West & S.H. Friedman, *Entry on civil commitment*, Wiley Encyclopedia of Forensic Science—Behavioral Sciences (2010).

[105] *Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment*, AMERICAN PSYCHIATRIC ASSOCIATION (2020), https://www.psychiatry.org/getattachment/d50db97b-59aa-4dd4-a0ec-d09b4e19112e/Position-Involuntary-Outpatient-Commitment.pdf.

[106] Anfag & Appelbaum, *supra* note 12.

[107] *Id*.

[108] D.A. Copeland & M.V. Heilemann, *Getting "to the point:" The experience of mothers getting assistance for their adult children who are violent and mentally ill*, 57(3) NURS RES. 136–143 (2008).

[109] Silver, et al., *supra* note 90.

[110] S. P. Segal &CP.M. Burgess, *The utility of extended outpatient civil commitment*, 29(6) INT J LAW PSYCHIATRY 525-534 (2006); S. P. Segal & P.M. Burgess, *Extended outpatient civil commitment and treatment utilization*, 43(2-3) SOC WORK HEALTH CARE 37-51 (2006).

However, all of the above advantages do not necessarily apply when an individual receiving outpatient treatment does not have a stable and permanent place to live. A concerning trend is emerging of states reducing protections specifically to make it easier to involuntarily commit unhoused persons with mental health conditions through the "grave disability" or "need-for-treatment" standards. Under the "grave disability" standard, involuntary commitment is justified based on the perceived risk of "danger of physical harm" arising from an individual's inability to meet basic survival needs such as food, clothing, shelter, or personal safety.[111]"Need-for-treatment laws render involuntary commitment available to an individual who suffers from a mental health disability, even if the individual manages to meet basic survival needs and exhibits no violent or suicidal tendencies."[112]As housing becomes increasingly unaffordable and urban-control bylaws result in intensified policing of unhoused populations, individuals are frequently subjected to detention in both jails and psychiatric facilities based on hasty, ad hoc judgments by law enforcement or other field personnel. According to the Prison Policy Initiative, 22,000 people are involuntarily committed across various institutional facilities "and many without any determined release date."[113]

For unhoused individuals, adhering to strict, court-mandated outpatient treatment requirements can be extremely challenging, especially when the foundational need for stable housing is not addressed.[114] Without permanent housing, individuals may struggle to maintain the routines or stability necessary for successful treatment, and the penalty for non-compliance may include incarceration.[115]

In some communities, this approach, though framed as an opportunity for care, often functions more as a pretext for incarceration rather than an actual solution to the underlying issues.[116] Without ensuring that individuals have access to housing, these policies do little to support their success in treatment, perpetuating a cycle where homelessness and mental health conditions are criminalized rather than addressed through comprehensive, supportive measures.[117]

1. The Cicero Institute's Template Legislation

One organization that has advocated for lowering standards for involuntary commitment is the Cicero Institute. At the forefront of the criminalization of homelessness initiative, the Cicero Institute is a "think-tank" founded and chaired by Joe Lonsdale, a venture capitalist who advocates for, and whose venture capital board advisors financially benefit from, privatizing incarceration.[118] The Cicero Institute has developed template legislation to adopt stricter requirements for arresting or involuntarily committing unhoused people with mental health conditions in a non-evidence-based effort to improve public safety.[119]

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[111] *Id.; see, e.g.* ALASKA STAT. § 47.30.915(9)(A) (2019). Utah also has a standard similar to the "grave disability" standard and provides that an individual may be involuntarily committed if he or she is in "substantial danger," which is defined, in part, as the individual is at serious risk of "serious bodily injury because the individual is incapable of providing the basic necessities of life, including food, clothing, or shelter." UTAH CODE ANN. § 62A-15-602(17).

[112] Segal & Burgess, *supra* note 110.

[113] Derecka Purnell, Becoming Abolitionists: Police, Protests, and the Pursuit of Freedom, at 216 (2021).

[114] Nat'l Homelessness L. Ctr., *Housing Not Handcuffs 2021: State Law Supplement* 13 (2021), https://homelesslaw.org (discussing the barriers unhoused individuals face in accessing treatment without stable housing).

[115] *Id.*

[116] *Id.*

[117] *Id.*

[118] Justin Miller, *Abbot's Border Splurge*, TEXAS OBSERVER(Mar. 3, 2025), https://www.texasobserver.org/abbott-operation-lone-star-contractors-bonanza/; *see also*, Invisible People, *Private Prisons for Homeless Criminalization* (Nov. 7, 2020), https://invisiblepeople.tv/private-prisons-for-homeless-criminalization/.

[119] Christopher Jones & Devon Kurtz, *Issue Brief: Involuntary Civil Commitment*, CICERO INSTITUTE (Jan. 11, 2024), https://ciceroinstitute.org/research/involuntary-civil-commitment/.

Although this legislation lowers barriers that may make it more difficult to commit individuals who need mental health treatment, it also enables the involuntary commitment of those who may not actually have a psychosocial disability at all. The Cicero Institute template legislation includes a portion that would allow any person to seek a petition for a 72-hour psychiatric hold if the court finds that the person "(a) Poses a serious threat to himself or others; (b) Is incapable of caring for himself; or (c) Has a mental state that will deteriorate to a dangerous level without medical intervention." After those 72 hours, the person would be discharged, possibly with an outpatient treatment plan (but not housing), and the penalty for non-compliance with that plan is up to one month in jail or a $5,000 fine.[120]

Therefore, under this legislation, a policeman, for example, could put an individual into a psychiatric hold purely for behavior that they believe aligns with a potential psychosocial disability. This legislation also opens the door for factors such as homelessness to be used alone as the criteria for assessing a mental health crisis. Since the language of the drafted legislation does not specify what qualifies as a person being "incapable of caring for himself," factors such as being unhoused could meet the threshold and allow for involuntary commitment.

While at least eight states—Florida, Georgia, Kentucky, Missouri, Oklahoma, Tennessee, Texas, and Utah —have adopted some version of the Cicero template, all except Kentucky removed the language reducing standards for involuntary commitment.[121] Additionally, other states, such as California, described further below, have introduced alternative models decreasing protections for homeless persons who undergo involuntary commitment.

2. The California CARE Act

Not explicitly based on the Cicero template, but adopting a similarly concerning approach is the recently enacted California Community Assistance, Recovery and Empowerment (CARE) Act—to more easily place unhoused persons with mental health conditions into involuntary commitments.[122] The CARE Act specifically authorizes law enforcement to initiate the commitment process, requiring only a showing that a person is likely to result in "grave disability or serious harm" absent a CARE plan, and can be done in abstentia, without even providing individuals an opportunity to make a case for themselves.[123]

In practical terms, if a police officer, behavioral health provider, or family member observes someone exhibiting erratic behavior and suspects a mental health crisis, they can file a petition for referral to a CARE Court, even in the absence of any criminal activity.[124] Following this referral, the individual undergoes a "clinical evaluation" to diagnose conditions such as schizophrenia spectrum or other psychotic disorders.[125] If diagnosed, the individual is assigned legal representation and enrolled in a CARE plan, which includes counseling and court-ordered medication for stabilization.[126]

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[120] Reducing Street Homelessness Act of 2022, CICERO INST. (2022), https://ciceroinstitute.org/wp-content/uploads/2021/11/Reducing-Street-Homelessness-Act-Model-Bill.090821.pdf.

[121] *Emergent Threats: Homelessness & Criminalization*, HOUSING NOT HANDCUFFS https://housingnothandcuffs.org/emergent-threats-homelessness-criminalization/.

[122] Jay Caspian King, *California's Fight Against Homelessness Has Turned Desperate and Dangerous*, N.Y. TIMES (June 27, 2022), https://www.nytimes.com/2022/06/27/opinion/california-homeless-mental-illness.html.

[123] S.B. 1338, ch. 319, §§ 5972, 5977, subdiv. (a), 2021-2022 Leg., (Cal. 2022).

[124] CARE Court FAQ, CALIFORNIA HEALTH and HUMAN SERVICES AGENCY, https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARECourt_FAQ.pdf.

[125] *Id.*

[126] *Id.*

State Senator Tom Umberg, one of the bill's authors, explained that the initiative targets approximately "7,000 to 12,000 individuals in California" with "schizophrenia or schizophrenia-like conditions," who are challenging to engage, stabilize, and reintegrate into society.[127]

Rather than requiring proof of an imminent threat, this vague, prospective "likely to" standard invites arbitrary speculation by courts, based on biased considerations of poverty. After this showing, individuals are subject to numerous court hearings and medical examinations. Throughout approximately a year, participants in a CARE program undergo various assessments to ensure compliance with its requirements.[128] Those who meet these standards satisfactorily are eligible to "graduate" from CARE Court. While earlier versions of the bill discussed a potential plan to facilitate access to temporary or permanent supportive housing for individuals, there is presently no definitive commitment regarding the provision of such housing.[129]

If participants drop out of CARE Court or fail to comply with their therapy and medication program, they could ultimately be placed into a conservatorship.[130] Conservatorship for noncompliance can result in locked placements and forcible psychotropic medication for an extended—and potentially unlimited—duration. Moreover, conservatorship may grant the state the authority to make significant decisions in the lives of the individuals under commitment, ranging from their residence and financial matters to their social interactions and activities.[131]

Therefore, once an individual is targeted for CARE Act intervention (based on vague inconsistent criteria and a very low eligibility threshold), potential missteps carry the inherent risk of a dramatic loss of their liberty. Susan Mizner, the director of the A.C.L.U.'s Disability Rights Program, said: "There is a reason this is called the greatest deprivation of civil liberties aside from the death penalty. People in prison at least get to have visitors and decide whether they take medication."[132]

The sustainability of the CARE Act could be challenged by California's limited availability of psychiatric beds. With the state already grappling to accommodate the existing population of unhoused persons with mental health conditions, the CARE Act would introduce at least an additional 7,000 to 12,000 individuals into the system.[133] It remains uncertain what specific measures the government will implement to address this hurdle.

A report on Reparations in California also details the pervasive effects of racial discrimination in the healthcare system over centuries, including the weaponizing of a mental health diagnosis to force sterilization and treatment of Black Californians, meaning this process will likely have racially disparate impacts.[134] Troublingly, while the CARE Act provides much for the loss of liberty of individuals, it does nothing to provide the one thing that unhoused persons with psychosocial disabilities need most: supportive housing where any humane treatment plans would be more likely to be successful than court-sanctioned involuntary commitments.

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[127] King, *supra* note 122.
[128] CARE Court FAQ, *supra* note 124.
[129] King, *supra* note 122.
[130] S.B. 1338, ch. 319, §§ 5979(a)(2)-(3), 2021-2022 Leg., (Cal. 2022).
[131] King, *supra* note 122.
[132] *Id*.
[133] *Id*.
[134] *See* CAL. DEP'T JUST. – OFF. ATT'Y GEN., *California Task Force to Study and Develop Reparation Proposals for African Americans: Interim Report* (A.B. 3121) (June 2022), https://oag.ca.gov/ab3121/report (citing *Chapter 12: Mental and Physical Harm and Neglect* at 422-23, fn. 408; *Chapter 11: An Unjust Legal System* at 390-91; *Chapter 12: Mental and Physical Harm and Neglect* at 406-436); *see also* Robert C. Schwartz, Ph.D., et al., *Racial disparities in psychotic disorder diagnosis: A review of empirical literature*, 4 WORLD J. PSYCHIATRY 133-140 (2014).

3. The Florida Baker Act

State policies continue to make it easier to involuntarily commit people as well. Dating back to the 1970s in Florida, the Baker Act allows for involuntary commitment for those who pose a danger to themselves or others so that they may receive emergency evaluation and psychiatric care.[135] Specifically, a person may be taken to a facility for involuntary examination:

> "[I]f there is reason to believe that the person has a mental illness and because of his or her mental illness . . . the person has refused voluntary examination . . . , is unable to determine for himself or herself whether examination is necessary . . . , and there is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future . . ."[136]

People can be committed against their will after a judge, police officer, or doctor finds the person is ill enough to require a 72-hour in-hospital psychiatric evaluation.[137] In 2014, Florida issued 181,471 Baker Act commitments.[138] Over the past decade, the number of people statewide who are subjected to the Baker Act has increased by 64 percent.[139]

Although the act was intended to provide short-term involuntary help during crises, the Act has been used extensively statewide and often affects the same individuals repeatedly. A statewide report by the Baker Act Reporting Center showed that in 2013 alone, 31 individuals in Florida were Baker Acted 16 or more times each.[140] Additionally, looking back over 10 years of data, from 2004 to 2013, nearly 350 individuals were involuntarily committed 36 times or more per person.[141]

Essentially, a revolving door phenomenon is created. Unhoused individuals are released to the street from involuntary commitment, left only with a few pills clutched in their hands or a written prescription for psychiatric medication. Others may be released to families unwilling or unable to secure continuing care for them. Without the support of outside services, it's all too easy for a patient to stop taking the medications provided at the Baker Act facility. Therefore, within a very short time, the person is back in the facility.[142]

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[135] § 394.451-394.47891, Fla. Stat. (1971).
[136] § 394.463, Fla. Stat. (1971).
[137] *Id.*
[138] *Id.*
[139] *Id.*
[140] Times-Union Editorial, *Florida's Baker Act is overused, inefficient and inadequate*, THE FLORIDA TIMES-UNION (Nov. 6, 2015, 1:09 PM), https://www.jacksonville.com/story/opinion/editorials/2015/11/06/floridas-baker-act-overused-inefficient-and-inadequate/15687219007/.
[141] *Id.*
[142] Carrie Siedman, *Our mental health system's revolving door*, SARASOTA HERALD-TRIBUNE (Aug. 23, 2018, 6:00 AM), https://www.heraldtribune.com/story/news/local/sarasota/2018/08/23/seidman-our-mental-health-systems-revolving-door/10980976007/.

The use of the Baker Act on children and older persons is especially abused and misused. Of the 64% increase in Baker Act commitments over the past decade, 17 percent were for patients younger than 18, and 7.5 percent were for people 65 and older.[143] Baker Act hospitalizations of children are sometimes used as stop-gap measures for school systems or parents unable or unwilling to care for difficult children.[144] Sometimes those children are agonizingly young.[145] At the other end of the age spectrum, the Baker Act can be used to inappropriately commit older persons who may act out due to dementia or other illnesses.[146] Patient advocates say older persons are often shuttled from place to place in efforts to find somewhere that can contend with all their needs.[147]

4. New York City's Mental Health Involuntary Removal Directive

Shortly after New York City Police Department (NYPD) officers murdered 66-year-old Eleanor Bumpers—a Black woman who was experiencing a mental health crisis amid an eviction—in 1984, the city instituted policy changes around how to handle so-called "emotionally disturbed people."[148] In one reform measure, NYPD officers were ordered "to isolate and contain suspects in mental distress and to establish a 'zone of safety' around them."[149] Mayor Ed Koch of New York City authorized the practice of involuntary commitments of persons with mental health conditions in 1987, contributing to a renewed era of institutionalization that disproportionately and purposefully targeted unhoused persons with psychosocial disabilities.[150]

The legacies of this and related government-sanctioned practices hold especially true in the city today as the current mayoral administration's issuance of various criminalization agendas has escalated police violence against unhoused persons.

In an alleged attempt to curb New York City's homelessness crisis, which has reached record-high levels since the 1930s' Great Depression,[151] Mayor Eric Adams promulgated a directive interpreting and expanding Article 9 of the state's Mental Hygiene Law as it concerns the standard for involuntary removal. This November 2022 Mental Health Involuntary Removals directive (the Directive) explicitly authorizes a police officer "to take into custody, for the purpose of a psychiatric evaluation, an individual who appears to be mentally ill and is conducting themselves in a manner likely to result in serious harm to self or others."[152] Concerningly, as its provisions apply to persons with mental health conditions, including those who have not committed an overtly dangerous act, it has enabled the forced removal and hospitalization of those who may not pose a risk of harm to themselves or others.

[143] Times-Union Editorial, *Florida's Baker Act is overused, inefficient and inadequate*, THE FLORIDA TIMES-UNION (Nov. 6, 2015, 1:09 PM), https://www.jacksonville.com/story/opinion/editorials/2015/11/06/floridas-baker-act-overused-inefficient-and-inadequate/15687219007/.
[144] *Id.*
[145] Annette Christy, et al., *The Baker Act Fiscal Year 2021-2022 Report*, BAKER ACT REPORTING CENTER, https://www.usf.edu/cbcs/baker-act/documents/ba_usf_annual_report_2021_2022.pdf.
[146] Adam Walser, *Dementia patient spends 50th anniversary in a mental hospital after Baker Act detention*, ABC ACTION NEWS WFTS TAMPA BAY (Feb. 8, 2024, 4:48 AM), https://www.abcactionnews.com/news/local-news/i-team-investigates/dementia-patient-spends-50th-anniversary-in-a-mental-hospital-after-baker-act-detention#:~:text=Florida's%20Baker%20Act%20allows%20people,classified%20as%20a%20mental%20illness.
[147] Times-Union Editorial, *supra* note 141.
[148] *See* Alan Feuer, *Fatal Police Shooting in Bronx Echoes One from 32 Years Ago*, N.Y. TIMES (Oct. 19, 2016), https://www.nytimes.com/2016/10/20/nyregion/fatal-police-shooting-in-bronx-echoes-one-from-32-years-ago.html.
[149] *Id.*
[150] *See* Oshinsky, *supra* note 48.
[151] *Basic Facts About Homelessness: New York City*, COAL. FOR HOMELESS (Aug. 2023), https://www.coalitionforthehomeless.org/basic-facts-about-homelessness-new-york-city/#:~:text=The%20Basic %20Facts%3A-,In%20recent%20years%2C%20homelessness%20in%20New%20York%20City%20has%20reached,City's%20main%20municipal%20shelter%20system.
[152] *Mental Health Involuntary Removals*, N.Y.C. 1, 1 (Nov. 28, 2022), https://www.nyc.gov/assets/home/downloads/pdf/press-releases/2022/Mental-Health-Involuntary-Removals.pdf [hereinafter Removals Directive].

Since taking effect, the Directive has been challenged at the federal trial court level by civil rights lawyers for violations of the U.S. Constitution, and federal, state, and local laws.[153] These violations include disability discrimination against unhoused persons with disabilities under the ADA and New York City Human Rights Law, and the use of excessive force, unlawful seizure, and warrantless entry under the Fourth and Fourteenth Amendments to the U.S. Constitution.[154] The 93-page Amended Complaint describes individuals with actual or perceived psychosocial disabilities who endured forced detention and physical and/or emotional injury while being involuntarily transported to a hospital against their will, and despite presenting no risk of harm to themselves or anyone else.[155] As of October 4th, 2024, the U.S. Department of Justice filed a statement of interest in this case, urging the Southern District of NY to assess how NYC's emergency response system solely targets people with mental health conditions for police intervention, whereas people with physical health emergencies receive care immediately from a trained health professional.[156]

One individual plaintiff of the active lawsuit—a 41-year-old unhoused Black man by the name of Oritseweyimi Omoanukhe Ayu (Mr. Ayu), diagnosed with bipolar and schizoaffective disorders—has been involuntarily detained and hospitalized by NYPD officers on multiple occasions.[157]

On one occasion in March 2022, when Mr. Ayu expressed frustration with the long wait time for his psychiatry appointment (his conduct limited to banging on the clinic's door), approximately seven NYPD officers arrived on scene. Despite him verbalizing to them his intent to voluntarily leave the clinic site and exhibiting no violent tendencies, the officers deemed him to be an "emotionally disturbed person" and proceeded with threats of arrest and forced detention if he failed to go to the hospital. Fearful of both possibilities, Mr. Ayu relented and was transported to a hospital, where he received no treatment and was explicitly told by a hospital employee to "tell [the NYPD] not to bring [him] back."[158] He was also not charged with any crime.

In a more recent account, which took place in February 2023, 39-year-old Neil Amitabh (Mr. Amitabh), an unhoused New Yorker of West Indian descent, was physically harmed by an NYPD officer who slammed him into the wall of a subway station upon his initial refusal to leave the station.[159] Despite the absence of a mental health diagnosis, Mr. Amitabh was handcuffed by multiple officers who perceived him to be a person with psychosocial disabilities and was forced to "stand in a corner of the station . . . facing the wall" before he was involuntarily transported to a psychiatric ward by ambulance.[160]

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[153] Second Amended Class Action Complaint, *Greene v. City of New York*, No. 21-cv-05762 (S.D.N.Y. Apr. 20, 2023), ECF No. 155 (detailing a class action suit on behalf of six individuals and four similarly situated organizations against the New York City Police Department and Mayor Eric Adams regarding the City's involuntary removal policy) [hereinafter Greene v. City of New York].

[154] *Id*. at ¶¶ 396-501.

[155] *Id*.

[156] New York Lawyers for the Public Interest, *Statement of Interest of the United States of America, Baerga v. City of New York*, at 1 (Nov. 2, 2024), https://www.nylpi.org/wp-content/uploads/2024/10/DOJ-Statement-of-Interest-Baerga-v.-City-of-NYC_NYLPI.pdf.

[157] *Id*. at ¶¶ 245-279.

[158] *Id*. at ¶ 256..

[159] *Id*. at ¶¶ 280-315.

[160] *Id*. at ¶ 289.

While no officer informed him as to why he was being hospitalized, he was discharged from the hospital within twenty-four hours without having received any mental health treatment or medical treatment for his injured hip.[161] Furthermore, upon his return to the subway station, Mr. Amitabh found his personal belongings, including his wallet with identification cards, phone, clothing, and a pair of headphones, to have been removed.[162] Since this and other related incidents that date as far back as 2020, Mr. Amitabh remains extremely fearful about future police encounters. Moreover, as his account in the lawsuit complaint details, he also "has had negative and scary experiences in shelters, and it is out of fear that he at times sleeps in public spaces where he feels safer."[163]

The criminalization of mental health in New York City has had disparate impacts based on race. Over 3.38 million New York City residents reportedly suffer from at least one serious mental health condition.[164]

However, despite having seven times fewer incidences of serious psychosocial disabilities than non-Black residents, Black New Yorkers experience a higher hospitalization rate.[165] In addition to this racial disparity, the city's highest-poverty neighborhoods have over twice as many psychiatric hospitalizations per capita in comparison to its lowest-poverty neighborhoods,[166] evidencing the ways that the Directive criminalizes mental health and homelessness by perpetuating pre-existing racial and socio-economic biases against low-income, historically marginalized persons of color. In doing so, it has reverted to historic broken windows policing and practices where unhoused persons were conceived of as signs of "disorder" and subjects of criminalization.[167]

> "Unnecessary institutionalization is discrimination."
> Attorney Elena Landriscina, Special Litigation Unit of the Legal Aid Society[168]

It appears that New York City, most notably the NYPD, has not been adequately tracking arrest reports or data around voluntary and involuntary transport of unhoused persons with mental health conditions pursuant to this directive. Nor has it reported the number of New Yorkers who have been hospitalized under the directive's "basic living needs" standard.[169]

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[161] *Id.* at ¶¶ 292-294.
[162] *Id.* at ¶ 295.
[163] *Id.* at ¶ 315.
[164] Transcript of the Minutes of the New York City Council Hearing, Joint Committee on Mental Health, Disabilities, and Addiction, Committee on Hospitals, Committee on Public Safety, and Committee on Fire and Emergency Management, p. 19, ll. 21-23 (Feb. 6, 2023) (That is over 3.38 million New Yorkers that might be suffering from schizophrenia, severe depression, bipolar disorder.") [hereinafter City Council Transcript].
[165] *Id.* at p. 21, ll. 23-25; *see also id*. at p. 22, ll. 1-4.
[166] *Id*. at p. 13, ll. 24-25; *see also id*. at p. 14, ll. 2-3.
[167] *See generally* Tony Sparks, *Reproducing Disorder*, 45 SOC. JUST. 51 (2018) (examining the impact of policing tactics on the lives of unhoused persons with mental disabilities, illustrating how such tactics "reproduce the disorderly bodies they aim to remove").
[168] City Council Transcript, *supra* note 164, at p. 202, l. 10.
[169] The Office of Mental Health ("OMH") has interpreted sections 9.41 and 9.58 of the Mental Hygiene Law, amended by the Mental Health Involuntary Removals directive, to "authorize the removal of a person who appears to be mentally ill and displays an inability to meet basic living needs, even when no recent dangerous at has been observed." *See Removals Directive*, *supra* note 152, at 1.

However, there is ample data around the number of mental health crisis calls made to the NYPD over the past several years. In 2022 alone, over 176,311 mental health calls were made to the NYPD, though approximately 1 percent (or just over 1,700) of these calls resulted in the arrest of an individual presumed to have a psychosocial disability.[170] Since 2015, at least nineteen (19) individuals —sixteen (16) of them identifying as Black or other persons of color—have been killed by the NYPD while experiencing a mental health crisis.[171] Countless more than undergone mistreatment by police officers, serious injuries, arrests, imprisonments, and forced hospitalizations. In fact, since 2017 alone, the New York City Civilian Complaint Review Board (CCRB) has reported nearly 2,700 allegations of police misconduct against individuals who they involuntarily hospitalized.[172]

In one tragic example, two NYPD officers murdered 32-year-old African American, Kawaski Trawick (Mr. Trawick), on April 14, 2019, at the supportive housing facility where Mr. Trawick was receiving "care for his [mental] health."[173] While neither officer attempted to administer aid to him in his living quarters, they "tased him and shot him within 112 seconds . . . [leaving] him to die."[174] A subsequent CCRB investigation confirmed police abuse charges against both officers, with Public Advocate Jumaane Williams stating that the case had amplified "the city's need to replace cops with medical professionals on [emergency] 911 calls dealing with mentally ill people."[175]

> "From [my son's] story, it's clear New York City HealthCare System and the NYPD does not see Black people as humans."
> Ellen Trawick, Mother of Kawaski Trawick[176]

Relatedly and just as devastatingly, 26-year-old African American Eudes Pierre (Mr. Pierre), an Uber Eats driver months away from being a college graduate, was shot ten times and killed by NYPD officers during an apparent mental health episode in December 2021.[177] In responding to a mental health crisis call "of a man [allegedly] armed with a gun and a knife," police followed Mr. Pierre "into a nearby subway station, where [they] unsuccessfully tried to tase him."[178] After one officer "eventually fired seven rounds at Pierre when he exited the station," killing him in the process, Mr. Pierre was found not to have been in possession of a gun. Following an investigation by the New York State Attorney General, the shooting was considered justified as Mr. Pierre was brandishing a knife in a manner

[170] City Council Transcript, *supra* note 164, at p. 70, ll. 11-13.
[171] Greene v. City of New York, *supra* note 153, ¶ 83.
[172] City Council Transcript, *supra* note 164, at p. 130, ll. 2-6.
[173] City Council Transcript, *supra* note 164, at p. 182, ll. 8-9.
[174] City Council Transcript, *supra* note 164, at p. 182, ll. 13-16.
[175] *Bronx Cops in Kawaski Trawick Killing Guilty of Misconduct, CCRB Finds*, THE CITY (June 10, 2021, 6:38 PM), https://www.thecity.nyc/2021/6/10/22528600/bronx-cops-in-kawaski-trawick-killing-guilty-of-misconduct-ccrb.
[176] City Council Transcript, *supra* note 164, at p. 182, ll. 17-19.
[177] Graham Rayman & Leonard Greene, *Attorney General clears NYPD cops in death of Brooklyn man Eudes Pierre, who charged them with knife*, N.Y. DAILY NEWS (Mar. 31, 2023, 11:21 PM), https://www.nydailynews.com/2023/03/31/ny-attorney-general-clears-nypd-cops-in-death-of-brooklyn-man-eudes-pierre-who-charged-them-with-knife/.
[178] Kirstyn Brendlen & Ben Brachfeld, *Family of Eudes Pierre files suit against cops, city for wrongful death as Eastern Parkway co-named in his honor*, BROOKLYN PAPER (Oct. 20, 2022), https://www.brooklynpaper.com/family-eudes-pierre-file-suit-co-name/.

"enough for the officers to feel like their lives were in danger."[179] This was despite his death being deemed a "suicide by cop" after a suicide note was recovered at his family's home and multiple 9-1-1 calls were traced from his own cell phone.[180] It was also despite a petition of over 16,000 signatories calling for New York City's adoption of the "Eudes Pierre Law," to require mental health professionals to be dispatched to all emergency mental health crisis calls as first responders.[181]

Private attacks on unhoused persons with mental health conditions are encouraged by the criminalization and violent treatment at the hands of law enforcement. On May 1, 2023, Jordan Neely, an unhoused Black man struggling with mental health, was strangled to death on a publicly viral video in a New York City subway car by a former Marine soldier, David Penny.[182] Right-wing media has praised Penny as a "Good Samaritan" and encouraged others to take similar vigilante actions.[183] President Trump and Vice President Vance even invited Penny to attend a football game in their private suite,[184] and right-wing Congressmembers have proposed to award him the Congressional Medal of Honor.[185]

Rather than investing in safe, stable housing with support services for unhoused persons with psychosocial disabilities, the City funneled over $11 billion dollars toward NYPD spending in its Fiscal Year 2023 budget.[186] As the third-highest funded agency in the City and the highest police budget in the nation, the NYPD's budget currently comprises 5.3 percent (or $5.44 billion) of the City's total 2024 Fiscal budget.[187] This has made criminalization policies like the Directive a significantly larger budgetary priority than critical mental health support, public education, and community solutions to housing.

[179] Rayman & Greene, *supra* note 177.
[180] Brendlen & Brachfeld, *supra* note 178.
[181] Rayman & Greene, *supra* note 177; *see also* Herbert Dubique, *The Eudes Pierre Law 'A Cry for Help'*, CHANGE (Dec. 24, 2021), https://www.change.org/p/nyc-council-member-the-eudes-pierre-law.
[182] Claire Thornton, *Who was Jordan Neely, the New York subway victim? A 'young man in real crisis,' advocates say*, U.S.A TODAY (May 7, 2023, 10:43 AM), https://www.usatoday.com/story/news/nation/2023/05/07/who-was-jordan-neely/70190944007/.
[183] Bailee Hill, *Indictment of Marine veteran Daniel Penny 'defies logic,' says local NY official: 'Something rotten'*, FOX NEWS (June 15, 2023, 10:05 AM), https://www.foxnews.com/media/indictment-marine-veteran-daniel-penny-defies-logic-ny-official-something-rotten.
[184] Alys Davies, *Daniel Penny is guest of Trump and Vance at football game*, BBC NEWS (Dec. 14, 2024), https://www.bbc.com/news/articles/cy09k15l21ro.
[185] *Steube wants to award man acquitted in NYC subway killing with Congressional Gold Medal*, SARASOTA HERALD TRIBUNE (Dec. 12, 2024), https://steube.house.gov/in-the-news/steube-wants-to-award-man-acquitted-in-nyc-subway-killing-with-congressional-gold-medal/.
[186] *See* Press Release, NYCLU Statement on the FY23 NYC Budget (June 14, 2022), https://www.nyclu.org/en/press-releases/nyclu-statement-fy23-nyc-budget.
[187] Owen Kotowski, *Report on the Fiscal 2024 Preliminary Plan and the Fiscal 2023 Mayor's Management Report for the New York Police Department* 1, 1 (N.Y.C. Council Fin. Div., Briefing Paper, 2023), https://council.nyc.gov/budget/wp-content/uploads/sites/54/2023/03/NYPD-1.pdf.

III. Human Rights Analysis

Criminalizing mental distress contravenes basic human rights outlined in international law, including the rights to liberty and freedom from arbitrary arrest and detention, security of person and freedom from torture and cruel, inhuman, and degrading treatment (CIDT), health, life, and equality and nondiscrimination.[188]

The analysis concerning the various rights violations in this section will draw upon the following key international human rights instruments: the Universal Declaration of Human Rights (UDHR) which is referred to by the United Nations (UN) as the "standard of achievements for all peoples and all nations."[189] The UDHR is the foundational document for the international human rights system. Although a declaration (and not a treaty), it maintains important normative status, and at least portions of the UDHR are binding customary law.[190] This report further looks to three human rights treaties the U.S. has ratified: the International Covenant on Civil and Political Rights (ICCPR), the Convention Against Torture (CAT), and the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD).[191] Finally, this report includes the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of Persons with Disabilities (CRPD), which the U.S. has signed but not ratified.[192] Treaties which have been ratified are legally binding on states whereas treaties that have only been signed create an obligation for states to avoid acts that contradict the object and purpose of the treaty.[193]

[188] Universal Declaration of Human Rights, G.A. Res. 217A (III) (1948), art. 3, 5, 7, 9, 25(1) [hereinafter UDHR]; International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI) (1966), art. 6, 7, 9, 26 [hereinafter ICCPR]; International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) (1966), art. 12 [hereinafter ICESCR]; Convention on the Rights of Persons with Disabilities, G.A. Res. A/RES/61/106 (2006), art. 5, 10, 14, 15, 25 [hereinafter CRPD]; Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. Res. 39/45 (1984), art. 2, 16(1) [hereinafter CAT].
[189] United Nations, *Universal Declaration of Human Rights*, https://www.un.org/en/about-us/universal-declaration-of-human-rights.
[190] Hurst Hannum, *The Status of the Universal Declaration of Human Rights in National and International Law*, 25 GA. J. INT'L & COMP. L. 287, 289 (1996).
[191] ICCPR, *supra* note 188; CAT, *supra* note 188; ICERD, *supra* note 81.
[192] ICESCR, *supra* note 188; CRPD, *supra* note 188.
[193] United Nations Dept. of Econ. And Soc. Affairs, *Chapter Four: Becoming a Party to the Convention and the Optional Protocol – Joining the Convention*, (last visited Dec. 23, 2023), https://www.un.org/development/desa/disabilities/resources/handbook-for-parliamentarians-on-the-convention-on-the-rights-of-persons-with-disabilities/chapter-four-becoming-a-party-to-the-convention-and-the-optional-protocol.html.

A. Right to Liberty and Freedom from Arbitrary Arrest and Detention

The criminalization of mental health conditions directly violates the right to liberty, as well as the right to freedom from arbitrary arrest and detention, as enshrined in international human rights law. The involvement of law enforcement and judicial systems in addressing mental health conditions—such as through involuntary hospitalization or incarceration—constitutes a deprivation of liberty and, in many cases, arbitrary detention, particularly when such actions are undertaken without proper legal justification or alternatives for community-based care.

The right to liberty is guaranteed under the UDHR, the ICCPR, and the CRPD. Article 3 of the UDHR and Article 9 of the ICCPR affirm that "everyone has the right to . . . liberty," and that "no one shall be subjected to arbitrary arrest or detention."[194] The CRPD further reinforces these protections by stipulating, in Article 14, that "the existence of a disability shall in no case justify a deprivation of liberty."[195]

In interpreting Article 9 of the ICCPR, the U.N. Human Rights Committee (HRC) has emphasized that involuntary hospitalization and involuntary transportation constitute deprivations of liberty, as they occur without free consent.[196]

The HRC has also highlighted the harm inherent in any deprivation of liberty, noting that "involuntary hospitalization may amount to a violation of human dignity," and stressing the specific harms related to such situations.[197] States are urged to "provide less intrusive alternatives to confinement, including community-based services," in order to better protect individuals' rights.[198]

In line with these interpretations, the CRPD unequivocally condemns the institutionalization of persons with disabilities without their consent. The Special Rapporteur on the Rights of Persons with Disabilities asserts that "the institutionalization of persons with disabilities without their free and informed consent constitutes a violation of their right to personal liberty and to live independently."[199] Moreover, she emphasizes "the lack of adequate community-based services cannot justify the deprivation of liberty of persons with disabilities."[200] Involuntary admission to mental health facilities, especially when based solely on an alleged mental disorder, violates their rights to liberty and informed consent as outlined in Articles 14 and 25 of the CRPD.[201]

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[194] UDHR, *supra* note 188, art. 3; ICCPR, *supra* note 188, art. 9.
[195] CRPD, *supra* note 188, art. 14.
[196] U.N. Hum. Rts. Comm., General Comment No. 35, ICCPR Art. 9 (Liberty and security of person), ¶ 6, U.N. Doc. CCPR/C/GC/35 (Dec. 16, 2014) [hereinafter General Comment No. 35].
[197] *Id.*; *see also* Hum. Rts. Council, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶ 34, U.N. Doc. A/HRC/44/48 (2020) (emphasizing the need to address "the broader human rights and social harms produced by medicalization, such as social exclusion, forced treatment, loss of custody and children and loss of autonomy") [hereinafter *Special Rapporteur on Physical and Mental Health*].
[198] General Comment No. 35, *supra* note 196.
[199] Special Rapporteur on the Rights of Persons with Disabilities, *Report on the Right of Persons with Disabilities to Liberty and Security*, ¶ 48, U.N. Doc. A/HRC/40/54 (Dec. 11, 2018).
[200] *Id.*
[201] *Id.* at ¶ 49.

CRPD Article 12 further strengthens this position by requiring "that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, . . . [are] proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body."[202] A recent report from the OHCHR reinforces this principle, stating that CRPD Article 12 ensures that "persons with psychosocial disabilities should not be arbitrarily deprived of their liberty on the basis of their impairment."[203] Additionally, CRPD's Article 19 asserts the right of persons with disabilities to live independently and be included in the community, challenging the legitimacy of institutionalization without free consent.[204]

In practice, the criminalization of mental health conditions frequently leads to the arbitrary arrest and detention of individuals, particularly those from marginalized and low-income communities. For example, ordinances like Denver's anti-camping law, which targets homeless individuals—many of whom have mental health conditions—by criminalizing their mere existence in public spaces, result in thousands of arrests and citations.[205] Such measures amount to arbitrary deprivation of liberty, as these individuals are punished not for criminal behavior but for their status as unhoused with a psychosocial disability.

B. Right to Security of person and freedom from torture and CIDT

The criminalization of mental health conditions in the United States further violates the right to security of person and the prohibition on torture and CIDT under international human rights law.[206] By subjecting individuals with mental health conditions to punitive measures, coercive treatment, and criminal justice interventions, the U.S. breaches its human rights obligations, exposing vulnerable individuals to treatment that violates their dignity and safety.

The right to personal security and freedom from torture and CIDT is safeguarded by several international human rights instruments. Article 3 of the UDHR establishes that "everyone has the right to . . . security of person."[207] This broad protection includes the right to be free from physical or psychological harm by state agents, particularly in contexts of deprivation of liberty or mental health interventions. Similarly, Article 9 of the ICCPR affirms the right to security of person, emphasizing that no one shall be subjected to arbitrary arrest or detention.[208]

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[202] CRPD, *supra* note 188, art. 12(4).
[203] U.N. High Comm'r for Human Rights, *Report on Mental Health and Human Rights*, ¶ 9, U.N. Doc. A/HRC/34/32 (2017) [hereinafter *Mental Health and Human Rights*].
[204] CRPD, *supra* note 188, art. 19.
[205] Nat'l L. Ctr. on Homelessness & Poverty, *Housing Not Handcuffs: Ending the Criminalization of Homelessness in U.S. Cities*, at 42 (2019), https://homelesslaw.org/wp-content/uploads/2019/12/HOUSING-NOT-HANDCUFFS-2019-FINAL.pdf.
[206] Please note that the U.S. is currently out of step with international human rights law in light of the *Grants Pass* decision, which held that punishing sleeping outdoors does not violate the 8th Amendment's prohibition on "cruel and unusual punishment" even when no shelter is available. Tamar Ezer & Abigail Wettstein, *In Punishing Homelessness, the U.S. Abandons Human Rights*, HUMAN RIGHTS BLOG (Oct. 2024), https://lawprofessors.typepad.com/human_rights/2024/10/in-punishing-homelessness-the-us-abandons-human-rights.html.
[207] UDHR, *supra* note 188, art. 3.
[208] ICCPR, *supra* note 188, art. 9.

The prohibition on torture and CIDT is set forth in Article 7 of the ICCPR, which explicitly prohibits such treatment under any circumstances, as well as in Article 5 of the UDHR and the CAT.[209] The CAT further elaborates on state obligations to prevent torture and CIDT and to hold accountable any public authorities engaging in such practices.[210]

Human rights bodies have interpreted these provisions to address the intersection of disability, mental health, and criminal justice. The HRC has emphasized that Article 9 of the ICCPR encompasses not only protection from arbitrary detention but also protection from threats to personal security arising from state actions, including instances of "involuntary medical treatment and hospitalization."[211] In its 2014 review of the U.S., the HRC expressed concern "about the criminalization of people for being homeless or for having a mental disability," and emphasized that such practices may amount to "cruel, inhuman or degrading treatment," particularly in the way law enforcement is used to address these social issues.[212] Similarly, the U.N. Committee Against Torture (CAT Committee) in its review of the U.S. has expressed concern "at the frequent use of police officers as first responders in mental health crises, which has resulted in excessive use of force" and may violate "the prohibition against cruel, inhuman or degrading treatment or punishment."[213]

Additionally, the CRPD introduces specific protections for persons with disabilities. Article 14 affirms their "right to . . . security of person on an equal basis with others," while Article 17 guarantees "the right to respect for his or her physical and mental integrity on an equal basis with others."[214] Furthermore, Article 15 of the CRPD directly prohibits torture and CIDT, ensuring that no person with a disability is subjected to "torture or to cruel, inhuman or degrading treatment or punishment."[215] In this context, the CRPD explicitly prohibits coercive treatment, forced institutionalization, or involuntary medical interventions "without the free consent of the person concerned."[216] The U.N. Committee on the Rights of Persons with Disabilities (CRPD Committee) has been clear that these actions, when imposed on persons with disabilities, are inherently discriminatory, violate their right to personal security, and "may also amount to torture or cruel, inhuman or degrading treatment."[217]

The U.S. approach to psychosocial disabilities, which often involves police responses and coercive legal interventions, directly undermines the rights to security of person and freedom from torture and CIDT. Police are frequently used as first responders to mental health crises, resulting in the use of force, detention, and involuntary hospitalization.[218] These actions compromise the personal security of individuals with mental health conditions, subjecting them to harmful interventions rather than appropriate care. When states fail to provide adequate social support, such as housing or healthcare, and instead rely on coercive treatment, they breach their obligation to protect the personal security and dignity of individuals under the ICCPR, CAT, and CRPD.

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[209] ICCPR, *supra* note 186, art. 7; UDHR, *supra* note 188, art. 5; CAT, *supra* note 188, art. 16.

[210] U.N. Comm. Against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment, *Concluding Observations on the Combined Third and Fifth Periodic Reports of the United States of America*, ¶ 26, U.N. Doc. CAT/C/USA/CO/3-5 (Dec. 19, 2014) [hereinafter *Concluding Observations on the Third and Fifth Periodic Reports*].

[211] General Comment No. 35, *supra* note 196, ¶¶ 3, 19.

[212] U.N. Human Rights Committee, *Concluding Observations on the Fourth Periodic Report of the United States of America*, U.N. Doc. CCPR/C/USA/CO/4 (Apr. 23, 2014) [hereinafter *Concluding Observations on the Fourth Periodic Report*].

[213] *Concluding Observations on the Third and Fifth Periodic Reports*, *supra* note 210, ¶¶26-27.

[214] CRPD, *supra* note 188, art. 14, 17.

[215] *Id*. at art. 15.

[216] *Id*.

[217] U.N. Committee on the Rights of Persons with Disabilities, General Comment No. 1 (2014), Article 12: Equal Recognition before the Law, ¶¶ 42-43, U.N. Doc. CRPD/C/GC/1 (Apr. 11, 2014).

[218] Ezer & Tomasini-Joshi, *supra* note 71.

C. Right to Health

The criminalization of mental health conditions violates the right to the highest attainable standard of health by preventing individuals from accessing appropriate care and, instead, subjecting them to harmful interventions that exacerbate their conditions. By using law enforcement as a front-line response to mental health crises, rather than providing adequate medical support, the state fails to uphold its obligation to ensure the right to health, which includes both mental and physical well-being.

The right to health is enshrined in the UDHR and ICESCR and expounded upon in several other treaties including the CRPD and ICERD. Article 25 of the UDHR declares that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including . . . medical care and necessary social services."[219] The ICESCR further requires member states to guarantee the right to "the highest attainable standard of physical and mental health" in Article 12.[220] Under this provision, states must ensure access to healthcare services, preventive measures, and the "underlying determinants of health, such as . . . adequate food, nutrition, and housing."[221] The CRPD also plays a pivotal role in protecting the health rights of individuals with psychosocial disabilities.

Article 25 of the CRPD emphasizes the obligation of states to provide persons with disabilities with the health services they need "without discrimination on the basis of disability."[222] These protections are further reinforced by other international treaties such as the ICERD, which calls for equal access to "the enjoyment of . . . the right to public health, medical care, social security, and social services" without discrimination.[223]

Human rights bodies have consistently interpreted these international obligations as requiring states to prioritize voluntary, community-based care over coercive or institutionalized approaches. The U.N. High Commissioner for Human Rights has condemned practices such as forced treatment and institutionalization, stating "forced treatment and institutionalization are not adequate responses to mental health issues and violate the human rights of persons with mental disabilities."[224] In 2018, the High Commissioner called for the elimination of practices such as "forced medication, forced electroconvulsive treatment, forced institutionalization and segregation," which violate individuals' autonomy and undermine their health.[225]

[219] UDHR, *supra* note 188, art. 25.
[220] ICESCR, *supra* note 188, art. 12.
[221] *Id*.
[222] CRPD, *supra* note 188, art. 25.
[223] ICERD, *supra* note 81, art. 5(e).
[224] *Mental Health and Human Rights*, *supra* note 203.
[225] Rep. U.N. High Comm'r Hum. Rts., 39th Sess, Sept. 10-28, 2018, U.N. Doc. A/HRC/39/36 (July 24, 2018).

The Special Rapporteur on the right to health has also criticized the overmedicalization of mental health issues, warning that it "presents challenges to the promotion and protection of the right to health."[226] The Special Rapporteur emphasized that medicalization often obscures the social context of mental health problems, "fueling misrecognition of legitimate sources of distress (health determinants, collective trauma)."[227] This approach, which focuses on individual-level interventions rather than addressing the underlying social causes of mental distress, can lead to alienation and entrench discrimination against marginalized groups. The Special Rapporteur further warned that "medicalization risks legitimizing coercive practices that violate human rights and may further entrench discrimination against groups already in a marginalized situation throughout their lifetimes and across generations."[228]

In the U.S., the criminalization of mental health conditions starkly violates the right to health by substituting law enforcement for healthcare. Studies have shown that police spend an average of 71 hours on firearms training compared to only 21 hours on de-escalation training, a clear indication that their role is to "address criminality, not to provide care."[229] This approach perpetuates harmful cycles of arrest, detention, and forced treatment rather than providing individuals with the medical support they need, denying them of their right to the highest attainable standard of health under the UDHR, ICESCR, CRPD, and ICERD. To comply with its obligations under international law, the U.S. must invest in mental health services that respect individuals' autonomy, dignity, and well-being, and move away from coercive and punitive responses to psychosocial disabilities.

D. Right to Life

The criminalization of mental health conditions violates the right to life by placing individuals in dangerous situations where their safety and survival are compromised, and by denying them access to essential services necessary for their well-being. Article 3 of the UDHR states that "everyone has the right to life."[230] Similarly, Article 6 of the ICCPR provides that every human being has the "inherent right to life" and that "no one shall be arbitrarily deprived of his life."[231] In line with these protections, Article 10 of the CRPD affirms that persons with disabilities also have the inherent right to life.[232] These provisions place a positive obligation on states to not only refrain from taking life arbitrarily but also to ensure conditions that allow individuals to live with dignity.

The HRC has elaborated that the right to life must be understood broadly to include the right to live with dignity. In its General Comment No. 36, the HRC emphasized that states are required to address "general conditions in society that may give rise to direct threats to life or prevent individuals from enjoying their right to life with dignity."[233] These conditions include access to healthcare, food, housing, and other basic services essential to survival.[234] The HRC also noted that states must take measures to reduce homelessness and provide adequate social housing to fulfill their obligation to protect life.[235]

[226] *Special Rapporteur on Physical and Mental Health*, *supra* note 197, ¶ 29.
[227] *Id*.
[228] *Id*.
[229] Ezer & Tomasini-Joshi, *supra* note 71.
[230] UDHR, *supra* note 188, art. 3.
[231] ICCPR, *supra* note 188, art. 6.
[232] CRPD, *supra* note 188, art. 10.
[233] Human Rights Committee, *General Comment No. 36 on Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life*, ¶26 U.N. Doc. CCPR/C/GC/36 (Oct. 30, 2018) [hereinafter General Comment No. 36].
[234] *Id*.
[235] *Id*.

The HRC's delineation of the right to life specifically recognizes the connection between poverty, homelessness, and the right to life. In its review of state practices in the U.S., the HRC expressed concern with laws that "criminalize people for being homeless and punish them for life-sustaining activities in public spaces, such as sleeping or eating," which directly threaten the lives of unhoused individuals.[236] These laws are considered a violation of the right to life because they deprive individuals of access to necessities, placing their survival at risk.[237]

The HRC has further urged states to "ensure access without delay to essential goods and services, such as food, water, shelter, and healthcare, especially for individuals belonging to marginalized groups," and to implement measures to protect vulnerable individuals from life-threatening conditions.[238] This includes establishing and maintaining robust social housing programs, access to healthcare, and other social safety nets.[239]

In the U.S., the criminalization of mental health conditions, particularly in cases where individuals are homeless or in crisis, violates the right to life by exposing them to environments that threaten their survival. A specific example of this is found in the City of Miami's Ordinance 13907, which criminalizes food sharing and restricts access to food for homeless individuals.[240]

Another example is City of Miami Beach Code §70-45, which criminalizes sleeping in public spaces without providing alternatives for shelter.[241] Such ordinances contravene the right to life by denying individuals the ability to engage in life-sustaining activities. People with psychosocial disabilities, who are overrepresented in the homeless population, are particularly vulnerable under these laws. The criminalization of activities necessary for survival—such as seeking shelter, food, and medical care —effectively negates the right to life for these individuals.

Furthermore, the state's failure to provide adequate mental health services contributes to the conditions that place individuals' lives at risk. Institutionalizing or imprisoning individuals with psychosocial disabilities, rather than offering community-based support, compounds the problem by isolating individuals from the healthcare services they need. Without access to adequate mental healthcare, individuals are more likely to experience deteriorating health, homelessness, and even death, in direct violation of their right to life. To fulfill its international human rights obligations under the UDHR, ICCPR, CRPD, and other relevant treaties, the U.S. must ensure that individuals with psychosocial disabilities have access to care, housing, and essential services that allow them to live with dignity and free from the threat of deprivation of life.

[236] *Concluding Observations on the Fourth Periodic Report*, *supra* note 212, ¶19.
[237] General Comment No. 36, *supra* note 233.
[238] *Id*.
[239] *Id*.
[240] City of Miami, Florida, *Ordinance No. 13907* (1998).
[241] City of Miami Beach, Florida, *Code §70-45* (2002).

E. Right to Equality and Non-Discrimination

The criminalization of mental health conditions violates the human right to equality and non-discrimination under international law by inherently penalizing individuals for their disabled status, as well as disproportionately impacting racial minorities. The right to equality and non-discrimination is guaranteed in multiple international instruments, including the UDHR, ICCPR, CRPD, as well as by the Committee on the Elimination of Racial Discrimination (CERD). Article 1 of the UDHR broadly guarantees that "all human beings are born free and equal in dignity and rights."[242] Likewise, all individuals "are equal before the law and are entitled without any discrimination to equal protection of the law,"[243] and "everyone is entitled to all the rights and freedoms set forth [in the UDHR] . . . without distinction of any kind."[244] The ICCPR specifies a similar prohibition against "any discrimination and guarantee[s] to all persons equal and effective protection against discrimination on any ground."[245]

The CRPD provides protections against the differential treatment of individuals based on mental health conditions or psychosocial disabilities. Article 5 of the CRPD mandates that member states "shall prohibit all discrimination on the basis of disability and guarantees to persons with disabilities equal and effective legal protection against discrimination on all grounds."[246] Article 1 of the CRPD further defines disabilities to include long-term mental or intellectual conditions "which in interaction with various barriers may hinder . . . [a person's] full and effective participation in society on an equal basis with others."[247] In interpreting Article 5's prohibition on discrimination, the CRPD Committee has stated that the "denial of reasonable accommodation constitutes discrimination," underscoring the necessity for states to provide reasonable accommodations to eliminate barriers to inclusion.[248]

Additionally, ICERD provides explicit protections against discrimination based on racial classifications. Article 5 provides that "everyone, without distinction as to race, colour, national or ethnic origin, [shall enjoy] equality before the law, notably in the enjoyment of . . . the right to housing."[249] CERD has clarified that the Convention protects individuals from both "purposive or intentional discrimination and discrimination in effect."[250] Thus, ICERD member states have an affirmative obligation to "adopt regulations ensuring" that both public and private actors "avoid causing disparate or disproportionate impact on the social groups protected by the Convention."[251] A recent CERD General Recommendation specified that "[t]he right to equality and freedom from racial discrimination includes prevention and protection against

[242] UDHR, *supra* note 188, art. 1.
[243] *Id*. at art. 7.
[244] *Id*. at art. 2.
[245] ICCPR, *supra* note 188, art. 26.
[246] CRPD, *supra* note 188, art. 5(1).
[247] *Id*. at art. 1.
[248] CRPD Comm., General Comment No. 6, ¶ 3, U.N. Doc. CRPD/C/GC/6 (2018); but see Hum. Rts. Comm., General Comment No. 18: Non-discrimination, ¶ 13, U.N. Doc. HRI/GEN/1/Rev.1 at 26 (Nov. 10, 1989) (clarifying that "not every differentiation [based on mental disability] will constitute discrimination, if the criteria for such differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate under the Covenant").
[249] ICERD, *supra* note 81, art. 5(e)(iii).
[250] Comm. on the Elimination of Racial Discrimination, General Recommendation No. 32: The Meaning and Scope of Special Measures in the International Convention on the Elimination of All Forms of Racial Discrimination, ¶ 7, U.N. Doc. CERD/C/GC/32 (2009).
[251] Comm. on the Elimination of Racial Discrimination, General Recommendation No. 36: Preventing and Combating Racial Profiling by Law Enforcement Officials, ¶ 64, U.N. Doc. CERD/C/GC/36 (2020).

involuntary admission and treatment and seclusion and restraint of persons protected by ICERD in mental health services and the general community."[252] Accordingly, "[s]tate parties should refrain from . . . over-policing communities, racial profiling, increased surveillance and other form of policing activity with a negative impact on mental health and well-being of individuals and their families.[253]

Domestically, the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[254] The ADA defines "disability" as a "physical or mental impairment that substantially limits one or more major life activities."[255] Regulations issued by the Attorney General likewise mandate that "[n]o qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity."[256] Further, in Olmstead v. L.C., the U.S. Supreme Court ruled that Title II of the ADA and associated regulations which address the provision of public services provision of the ADA and associated regulations mandate that states provide community-based services in the most integrated setting possible to disabled individuals when (1) such services are deemed appropriate by treatment professionals; (2) the affected individual gives consent; and (3) such services can be reasonably accommodated accounting for the resources of the public entity and the needs of others who are receiving disability services.[257] The state is not, however, required to fundamentally alter the services provided. This ruling has been instrumental in shifting the approach towards disability services, making community integration the standard.

In effect, the U.S. practice of criminalizing homelessness and mental health disproportionately impacts individuals with psychosocial disabilities and racial minorities. For example, a study of the Los Angeles County Jail System revealed that individuals with mental illness are disproportionately charged with misdemeanor offenses, despite the Los Angeles Sheriff's Department's stated policy that their jails "do not generally retain inmates on misdemeanor charges."[258] Additionally, an investigation of nine police departments across the U.S. determined that police interactions with individuals experiencing serious mental illness were 12 times more likely to result in the use of force than interactions with other individuals.[259] In addition to differentiations based solely on mental disability, historic trends show that "[m]entally ill racial minority members are overrepresented in [U.S.] prisons."[260]

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[252] Comm. on the Elimination of Racial Discrimination, General Recommendation No. 37: Racial Discrimination in the Enjoyment of the Right to Health, ¶ 31, U.N. Doc. CERD/C/GC/37 (2024).
[253] *Id*. at ¶ 51.
[254] 42 U.S.C. § 12132.
[255] *Id*. § 12102(1) (emphasis added).
[256] 28 C.F.R. § 35.130(a) (2016).
[257] 527 U.S. at 607.
[258] Oona Appel, et al., *Differential Incarceration by Race-Ethnicity and Mental Health Service Status in the Los Angeles County Jail System*, 71 PSYCHIATRIC SERVS. 8 (2020), https://psychiatryonline.org/doi/epdf/10.1176/appi.ps.201900429.
[259] A. Lanixonu & P.A. Goff, *Measuring Disparities in Police Use of Force and Injury Among Persons with Serious Mental Illness*, 21 BMC PSYCHIATRY 500 (2021), https://mcpsychiatry.biomedcentral.com/articles/10.1186/s12888-021-03510-w#.
[260] P. Grekin, et al., *Racial Differences in the Criminalization of the Mentally Ill*, 22 BULL. AM. ACAD. PSYCHIATRY & L. 411 (1994), https://jaapl.org/content/jaapl/22/3/411.full.pdf.

The criminalization of homelessness and mental health conditions also exacerbates racial disparities, violating the right to equality and non-discrimination.[261] Laws targeting life-sustaining activities are predominantly enforced against unhoused persons and against Black, Indigenous, and other persons of color.[262] One study in Austin, Texas showed that Black unhoused persons were almost ten times more likely than white persons to receive a camping citation.[263] As the U.N. Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance recognized, "the enforcement of minor law enforcement violations . . . take a disproportionately high number of African American homeless persons to the criminal justice system."[264]

The U.N. Special Rapporteur on contemporary forms of slavery has also raised concerns about the disparate impact of criminalization on persons of color and called for states to "decriminalize conduct associated with homelessness."[265] In its recent review, the CERD called upon the U.S. government to "abolish laws and policies that criminalize homelessness," "redirect funding from criminal justice responses to adequate housing and shelter programs, in particular for persons belonging to racial and ethnic minorities most affected by homelessness,"[266] and "affirmatively further[] fair housing and protection against discriminatory effects."[267]

V. Human Rights-Based Approaches to Mental Health

This section seeks to address the intersection of homelessness and mental health through human rights-based approaches centered around treatment and support, rather than punishment. Specifically, it focuses on several distinct, yet interrelated approaches: permanent supportive housing, community-based mental health services, harm reduction, and interdisciplinary crisis responders. These approaches have proven effective in various localities across the U.S. and globally. As discussed in the sections above, they not only represent best practices in care delivery but also advance fundamental human rights to liberty, health, life, equality, and housing.

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[261] ICERD, *supra* note 81, art. 2(1)(c) ("Each State Party shall take effective measures to review governmental, national and local policies, and to amend, rescind or nullify any laws and regulations which have the effect of creating or perpetuating racial discrimination wherever it exists."); ICCPR, *supra* note 188, arts. 2, 26 ("All persons are equal before the law and are entitled without any discrimination to the equal protection of the law.").

[262] Nat'l Ctr. for Homelessness & Poverty, *Racism, Homelessness, and the Criminal and Juvenile Legal Systems*, at 1, 3 (2020), https://jaapl.org/content/jaapl/22/3/411.full.pdf.

[263] *Id.* at 3.

[264] Hum. Rts. Council, *Report of the Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia and Related Intolerance*, Doudou Diène, Mission to the United States of America, ¶ 64, U.N. Doc. A/HRC/11/36/Add.3 (Apr. 28, 2009).

[265] Hum. Rts. Council, *Report of the Special Rapporteur on Contemporary Forms of Slavery*, Tomoya Obokata, Homelessness as a Cause and Consequence of Contemporary Slavery, ¶ 65, U.N. Doc. A/HRC/54/30 (July 12, 2023).

[266] Comm. on the Elimination of Racial Discrimination, *Concluding Observations on the Combined Tenth to Twelfth Reports of the United States of America*, ¶ 40, U.N. Doc. CERD/C/[Country Code]/CO/10-12 (2022).

[267] National Homelessness Law Center, *Criminalization of Homelessness is Racially Discriminatory*, (Aug. 30, 2022), https://homelesslaw.org/criminilzation-of-homelessness-is-racially-discriminatory/.

An evidence-based, trauma-informed framework underpins each of these models, recognizing how past experiences shape individuals' responses to care and ensuring that services promote dignity, safety, and healing. Trauma is both a cause and consequence of homelessness, with many individuals experiencing childhood abuse, domestic violence, systemic discrimination, or the psychological toll of life on the streets.[268] A trauma-informed approach recognizes these impacts and integrates this knowledge into service design and delivery.[269] A trauma-informed care system has six principles: safety, trustworthiness, peer support, collaboration, empowerment, and humility.[270] At its core, it aims to avoid re-traumatization and foster environments where people feel physically, emotionally, and psychologically safe. Dignity is upheld by ensuring that individuals are treated with respect, free from stigma or coercion, and that services are designed to be survivor-centered rather than punitive. Additionally, trauma-informed approaches restore agency and control by providing clear communication about what to expect from services, enabling choice in decision-making, and ensuring voluntary engagement.[271] This framework is essential for homelessness and mental health interventions. Those with traumatic pasts often undergo heightened stress responses, which can make traditional services lacking a trauma-informed lens ineffective or even harmful. Involuntary hospitalization and punitive policing further worsen trauma by creating cycles of distrust and reluctance to care.[272] By integrating trauma-informed techniques and human rights principles, programs like Permanent Supportive Housing (PSH), Community-Based Mental Health Services, Harm Reduction, and Interdisciplinary Crisis Responders can build trust, support long-term stability, and fulfill states' obligations to uphold the rights and dignity of all individuals, including those who are unhoused. It is, moreover, critical that these interventions are implemented with fidelity to their core evidence-based models, ensuring quality and impact.[273]

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[268] E. Bassuk, et al., *The Prevalence of Mental Illness in Homeless Populations: A Systematic Review and Meta-Analysis*, JAMA PSYCHIATRY (2020), https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2817602.

[269] U.S. Dep't of Health & Hum. Servs., Substance Abuse and Mental Health Servs. Admin. (SAMHSA), *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach* 9 (July 2014), https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf; Ctr. for Health Care Strategies, *What Is Trauma-Informed Care?*, https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care.

[270] Tex. Health & Hum. Servs., *Six Principles of Trauma-Informed Care* 1–8 (2020), https://www.hhs.texas.gov/sites/default/files/documents/six-principles-trauma-informed-care.pdf.

[271] Inter-Agency Standing Committee (IASC), *Definition & Principles of a Victim/Survivor-Centered Approach* 2–3 (2023), https://interagencystandingcommittee.org/sites/default/files/migrated/2023-06/IASC%20Definition%20%26%20Principles%20of%20a%20Victim_Survivor%20Centered%20Approach.pdf; Caroline Bettinger- López & Tamar Ezer, *Improving Law Enforcement Responses to Gender-Based Violence: Domestic and International Perspectives in The Rowman and Littlefield Handbook of Policing, Communication, and Society* 307 (Howie Giles, Edward Maguire, Shawn Hill eds. 2021), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3697459; Ctr. for Health Care Strategies, What Is Trauma-Informed Care?

[272] U.N. Special Rapporteur on the Right to Health, *Report on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, U.N. Doc. A/HRC/35/21, ¶ 48 (2017), https://www.ohchr.org/en/documents/thematic-reports/ahrc3521-report-special-rapporteur-right-everyone-enjoyment-highest.

[273] Substance Abuse & Mental Health Servs. Admin., *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* 9–11 (2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf. SAMSHA and other national leaders have developed fidelity assessment tools to guide implementation of these programs. *See, e.g*, Substance Abuse & Mental Health Servs. Admin., *Evaluating Your Program Using the Permanent Supportive Housing Fidelity Scale* (2010), https://library.samhsa.gov/sites/default/files/evaluatingyourprogram-psh.pdf; Substance Abuse & Mental Health Servs. Admin., *Evaluating Your Program Using the Assertive Community Treatment Fidelity Scale* (2008), https://library.samhsa.gov/sites/default/files/sma08-4344-evaluatingyourprogram.pdf; Ana Stefancic, et al., *The Pathways Housing First Fidelity Scale for Individuals With Psychiatric Disabilities*, 16(4) AM. J. PSYCH. REHABIL. 240–61 (Dec. 3, 2013), https://www.tandfonline.com/doi/full/10.1080/15487768.2013.847741?scroll=top&needAccess=true.

A. Permanent Supportive Housing

> "People with mental disabilities can successfully live in the community like everyone else. . . . Supportive housing makes this possible."
> Bazelon Center for Mental Health Law[274]

Permanent Supportive Housing (PSH) combines affordable housing with comprehensive voluntary services, creating a stable foundation for recovery and wellness while respecting individual autonomy.[275] A trauma-informed approach is central to PSH, recognizing that many individuals facing housing instability have experienced significant trauma.[276] By prioritizing individual safety, dignity, and agency, PSH ensures that services are focused on the survivor to reduce the risk of re-traumatization and cultivate long-term stability.[277] Participants receive immediate, permanent housing through standard leases, with costs typically capped at 30% of income,[278] along with tailored services, including mental health care, substance use treatment, and education and employment support.[279] Unlike many other housing programs, PSH provides immediate access to permanent housing without requiring compliance with treatment or sobriety as preconditions, and temporary absences do not result in the loss of housing eligibility.[280] As the Bazelon Center explains, this approach recognizes that "stable housing can act as a motivator for people to seek services and supports and to engage in and sustain treatment,"[281] PSH thus addresses both housing instability and healthcare needs simultaneously, advancing the rights to housing and health,[282] while promoting dignity, equality, and community integration.

PSH directly addresses the gaps left by deinstitutionalization.[283] The deinstitutionalization movement aimed to improve conditions for people with severe mental illness through community-based care.[284]

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[274] Bazelon Ctr. for Mental Health Law, *Supportive Housing Fact Sheet* 5 (n.d.), https://www.bazelon.org/wp-content/uploads/2017/04/supportive-housing-fact-sheet.pdf.
[275] Corianne Payton Scally, et al., *Building and Launching Tiny Homes as Permanent Supportive Housing: Outcomes Study for Housing First Village in Bozeman, Montana*, URBAN INST. (Dec. 2021), https://www.urban.org/sites/default/files/publication/102715/implementing-tiny-homes-as-permanent-supportive-housing.pdf.
[276] Substance Abuse & Mental Health Servs. Admin. (SAMHSA), *Training Frontline Staff: Permanent Supportive Housing* 12 (2013), https://library.samhsa.gov/sites/default/files/trainingfrontlinestaff-psh.pdf.
[277] Tex. Health & Hum. Servs., *supra* note 270.
[278] U.S. Dep't of Hous. & Urban Dev., *Housing First: A Review of the Evidence*, https://archives.huduser.gov/portal/periodicals/em/spring-summer-23/highlight2.html.
[279] Nat'l Acads. of Scis., Eng'g & Med., *Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness* 9–12 (2018), https://doi.org/10.17226/25133.
[280] Bazelon Ctr. for Mental Health Law, *Supportive Housing Fact Sheet* 1 (n.d.), https://www.bazelon.org/wp-content/uploads/2017/04/supportive-housing-fact-sheet.pdf.
[281] *Id*. at 3.
[282] ICESCR, *supra* note 188, arts. 11 & 12; UDHR, *supra* note 188, art. 25(1).
[283] Daniel Yohanna, *Deinstitutionalization of People with Mental Illness: Causes and Consequences*, 15(10) AMA J. ETHICS 890 (2013), https://doi.org/10.1001/virtualmentor.2013.15.10.mhst1-1310.
[284] Daniel Yohanna, *Deinstitutionalization of People with Mental Illness*, 15 AMA J. ETHICS at 886 (2013).

As Daniel Yohanna notes, "three forces drove the movement of people with severe mental illness from hospitals into the community: the belief that mental hospitals were cruel and inhumane; the hope that new antipsychotic medications offered a cure; and the desire to save money."[285] However, this transition left many individuals without the necessary housing and support to thrive outside institutional settings, resulting in cycles of homelessness, untreated mental health conditions, and re-hospitalization.[286] Without stable housing and support, unhoused individuals or those with inadequate housing often experience re-traumatization, worsening their mental health conditions. PSH addresses these gaps by combining stable, trauma-informed housing with integrated services such as mental health treatment, case management, and peer support. By focusing on the trauma-informed principles of safety, trust, and empowerment, PSH enables individuals to maintain stability and avoid hospitalization or incarceration.[287] As a result, PSH not only upholds the dignity and rights of individuals but also demonstrates cost-effectiveness and long-term success in improving mental health outcomes and reducing homelessness.[288]

An example of PSH in action is Houston's The Way Home initiative, a collaborative effort launched in 2012 to address chronic homelessness by uniting local governments, nonprofits, and housing authorities.[289] Led by the Coalition for the Homeless of Houston/Harris County, which serves as the program's lead agency, The Way Home has brought together over 100 partner organizations, including health and social service providers, to implement a collaborative, trauma-informed strategy aimed at ending homelessness through coordinated care and sustainable solutions.[290] As the lead agency, the Coalition coordinates resources and develops adaptable strategies to meet Houston's changing needs.[291] This method prioritizes secure, supportive housing for people experiencing chronic homelessness and provides essential services tailored to individual needs to promote long-term stability.[292] Since its beginning, The Way Home has provided housing and supportive services to over 32,000 individuals and achieved a housing retention rate of nearly 90%.[293] This high retention rate highlights the initiative's success in helping participants sustain long-term housing and avoid the cycle of homelessness, incarceration, and institutional care.[294] Thus, PSH can stabilize lives and promote dignity, human rights, and community integration.[295]

Additionally, many PSH settings offer employment programs that provide individualized, on-site and off-site employment support. These initiatives foster empowerment, choice, and self-sufficiency amongst participants by aligning with each resident's personal goals and strengths. These programs promote trust and collaboration by providing employment services that are person-centered and trauma-sensitive.[296]

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[285] *Id*.
[286] *Id*. at 887-89.
[287] *Id*. at 890.
[288] Dennis P. Culhane, et al., *Cost-Effectiveness of Supported Housing for Homeless Persons with Mental Illness*, 60 AM. J. PUB. HEALTH 1613, 1613–17 (2002), https://www.researchgate.net/publication/10575684_Cost-effectiveness_of_Supported_Housing_for_Homeless_Persons_With_Mental_Illness.
[289] The Way Home, *The Way Home Houston*, https://www.thewayhomehouston.org/about-us#WhatWeDo.
[290] *Id*.
[291] Coalition for the Homeless of Houston/Harris County, *Who We Are*, https://www.cfthhouston.org/about-us#WhoWeAre.
[292] Coalition for the Homeless of Houston/Harris County, *CCHP Explained: Bridge to Permanent Supportive Housing*, https://www.cfthhouston.org/cchp-explained-bridge-to-permanent-supportive-housing.
[293] The Way Home, *supra* note 289.
[294] *Id*.
[295] Coalition for the Homeless of Houston/Harris County, *What We Do*, https://www.cfthhouston.org/about-us - WhatWeDo.
[296] U.S. Dep't of Hous. & Urban Dev., *Employment Supports: What Permanent Supportive Housing Providers Need to Know* (n.d.), https://files.hudexchange.info/public/resources/documents/Housing-and-Employment-Works-Employment-Supports-What-Permanent-Supportive-Housing-Providers-Need-to-Know.pdf.

HUD supports these measures by facilitating paths to employment for people exiting homelessness and cultivating alliances with workforce boards and local employers to create training and apprenticeship opportunities.[297] For people with serious psychosocial disabilities, PSH programs frequently incorporate employment and social engagement approaches to support residents' stability, autonomy, and overall quality of life.[298] A fundamental model for this is the Clubhouse Model, first implemented at Fountain House, which creates an inclusive, community-centered environment by organizing a "work-ordered day."[299] Here, members and staff work on daily tasks essential for clubhouse operations, fostering a sense of shared purpose and community belonging.[300] Members engage in activities such as culinary work, community outreach, and administrative tasks, which build self-confidence, develop practical skills, and reinforce social connections through work-based interactions.[301] Research shows that this trauma-informed method can reduce rates of psychiatric hospitalization and enhance quality of life and community integration.[302]

The effectiveness of PSH is well-documented.[303] Studies consistently show that providing immediate, permanent housing results in greater long-term stability than traditional housing programs.[304] The impact extends beyond housing stability–research has shown significant reductions in hospitalization and incarceration rates.[305] A five-year University of Pennsylvania study found that for individuals in supportive housing, emergency shelter use decreased by 60 percent and incarceration rates fell by 85 percent compared to similar individuals without supportive housing.[306] Supportive housing is significantly more cost-effective, costing half as much as a shelter, a quarter of the cost of prison, and only a tenth of the expense of a state psychiatric hospital bed for individuals with mental disabilities.[307] These savings are achieved through multiple avenues, including lower costs by renting available apartments or houses on the open market. Additionally, savings result from reducing participants' reliance on costly resources like day programs, shelters, inpatient psychiatric care, public hospitals, and correctional facilities, which can each cost tens of thousands of dollars per person annually.[308]

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[297] U.S. Dep't of Hous. & Urban Dev., *Strengthening Pathways to Employment for People Exiting Homelessness*, HUD EXCHANGE (Mar. 29, 2023), https://www.hudexchange.info/news/strengthening-pathways-to-employment-for-people-exiting-homelessness/.
[298] *Id*.
[299] Fountain House, *What is a Clubhouse?*, .
[300] *Id*.
[301] *Id*.
[302] Fountain House, *The Clubhouse Model in Action: Designing Communities for People with Serious Mental Illness*, BETTER CARE PLAYBOOK (2024), https://bettercareplaybook.org/_blog/2024/26/clubhouse-model-action-fountain-house-designing-communities-people-serious-mental; William H. McKay, et al., *A Systematic Review of Evidence for the Clubhouse Model of Psychosocial Rehabilitation*, 48 ADMIN. & POL'Y MENTAL HEALTH & MENTAL HEALTH SERVS. RES. 250, 251 (2016) (the Club House Model helps people avoid psychiatric hospitalization, improvise the quality of life, and promotes social integration, while calling for randomized control trials and long-term follow-up).
[303] Substance Abuse & Mental Health Servs. Admin., *Evaluating Your Program Using the Permanent Supportive Housing Fidelity Scale* 4–5 (2010).
[304] Bazelon Ctr. for Mental Health Law, *Supportive Housing*, https://www.bazelon.org/supportive-housing/.
[305] *Id*.
[306] Bazelon Ctr. for Mental Health Law, *Amicus Brief of the Bazelon Center for Mental Health Law in Support of Respondents, Grants Pass v. Johnson* (Apr. 3, 2024), https://www.bazelon.org/wp-content/uploads/2024/04/Amicus-brief-Grants-Pass-v-Johnson-4-3-2024.pdf.
[307] Bazelon Ctr. for Mental Health Law, *supra* note 304.
[308] *Id*.

The impact of PSH is further demonstrated by Finland's national implementation of the Housing First model, which prioritizes providing permanent housing as the initial step to addressing homelessness.[309] In 2007, Finland committed to this approach, integrating stable housing with comprehensive support services.[310] Finland's national strategy, backed by multi-stakeholder collaboration among government agencies, municipalities, NGOs, and private organizations, has led to noteworthy outcomes. Between 2008 and 2015, long-term homelessness in Finland declined by 33%, and overall homelessness rates dropped significantly despite rising trends across Europe.[311] In particular, the Housing Finance and Development Centre played a key role by converting shelters into permanent housing and funding the construction of over 2,200 new units for long-term homeless individuals.[312] This approach has not only reduced homelessness but also generated significant cost savings. Finland's PSH model saves an estimated EUR 9,600 to EUR 15,000 per person annually due to decreased reliance on emergency services, hospital visits, and incarceration costs.[313] Additionally, the program's resilience was apparent during the COVID-19 pandemic, as Finland's existing support system enabled it to sustain housing for previously homeless individuals with minimal disruption.[314]

In the U.S., despite PSH's proven effectiveness, significant challenges remain in scaling it up to meet current needs.[315] A critical barrier is the lack of consistent, long-term funding, as PSH programs often rely on a patchwork of federal, state, and local funds, which can be unpredictable and insufficient to meet the growing demand.[316] Additionally, community resistance, often known as NIMBYism-- "Not in My Backyard", frequently blocks or delays PSH developments.[317] The lack of affordable housing leaves many individuals with mental illness either without stable housing or at a high risk of homelessness.[318]

To overcome the current barriers to PSH expansion, there is an urgent need for increased federal and state investment. Policymakers should establish dedicated funding streams that are both consistent and long-term.[319] According to the National Low-Income Housing Coalition, the reliance on short-term and fragmented funding sources has resulted in waiting lists that stretch for years, preventing vulnerable populations from accessing stable housing.[320] A comprehensive funding strategy, which includes increasing the supply of affordable housing and incentivizing private developers to participate in supportive housing projects, is critical for meeting the demand.[321]

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[309] Ctr. for Pub. Impact, *Eradicating Homelessness in Finland: The Housing First Programme*, https://centreforpublicimpact.org/public-impact-fundamentals/eradicating-homelessness-in-finland-the-housing-first-programme. The Trump Administration's Executive Order 14321 explicityly ends support for Housing First policies. Exec. Order No. 14321, "Ending Crime and Disorder on America's Streets," 90 Fed. Reg. 35817 (Jul. 24, 2025).

[310] Ctr. for Pub. Impact, Eradicating Homelessness in Finland: The Housing First Programme, https://centreforpublicimpact.org/public-impact-fundamentals/eradicating-homelessness-in-finland-the-housing-first-programme.

[311] Timo Tiihonen, *Finland's Zero Homeless Strategy – Lessons from a Success Story*, OECD ECOSCOPE (Dec. 13, 2021), https://oecdecoscope.blog/2021/12/13/finlands-zero-homeless-strategy-lessons-from-a-success-story.

[312] Lilly Dietz, *A Look at Finland's Housing First Initiative*, PULITZER CTR. (Aug. 18, 2022), https://pulitzercenter.org/stories/look-finlands-housing-first-initiative.

[313] *Id*.

[314] *Id*.

[315] Nat'l Low Income Hous. Coal., *The Gap: A Shortage of Affordable Homes*, https://nlihc.org/gap.

[316] *Id*.

[317] Michael Peterson, *The Sad Irony of "Not In My Backyard" (NIMBY)*, DAILY ECON. (Mar. 13, 2024), https://thedailyeconomy.org/article/the-sad-irony-of-not-in-my-backyard-nimby/.

[318] Nat'l Low Income Hous. Coal., *supra* note 315.

[319] U.S. Interagency Council on Homelessness, *Federal Homelessness Prevention Framework* (Jan. 2024), https://www.usich.gov/sites/default/files/document/Federal%20Homelessness%20Prevention%20Framework_2.pdf.

[320] Nat'l Low Income Hous. Coal., *supra* note 315.

[321] U.S. Interagency Council on Homelessness, *supra* note 319, at 12

Additionally, removing local barriers to PSH development is critical for its success. NIMBYism often blocks or delays housing projects due to unfounded fears about crime or property values.[322] Public education and community outreach initiatives are necessary to dispel misconceptions about PSH and highlight its benefits in stabilizing communities and reducing reliance on emergency services and incarceration.[323] Strengthening zoning laws to support the development of supportive housing can also help bypass local resistance.[324] By framing PSH within the context of both domestic legal frameworks like the ADA and international human rights standards, policymakers can advocate for housing as a right rather than a privilege,[325] reinforcing PSH as a sustainable, humane solution to chronic homelessness and mental health conditions.

B. Community-Based Mental Health Services

Mental health care works best when people can access it in their communities. This empowering approach upholds fundamental human rights by treating people with dignity and connecting them to their support networks.[326] Instead of isolating people in institutions or treating mental health conditions as crimes, community-based care focuses on meeting people where they are, providing vital support while respecting their independence and helping them stay engaged in community life.[327] Trauma-informed care strengthens these services by recognizing that many individuals seeking care have experienced significant past trauma. By fostering safety, trust, and empowerment, community-based programs ensure that people receive support that acknowledges their experiences and encourages healing.[328]

Communities support mental health in many ways, offering different levels of care to match what people need. Someone facing serious challenges might work closely with an Assertive Community Treatment (ACT) team that visits them at home.[329] Others might drop by their local mental health center when they need someone to talk to.[330] These centers understand how past trauma affects current mental health, and they focus on treating people with respect while helping them stay independent.[331]

Some argue that serious psychosocial disabilities require institutional care, but the evidence demonstrates otherwise.[332] A trauma-informed approach focuses on safety, trust, and empowerment, all of which are better fostered in community-based settings than in institutions.[333]

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[322] Peterson, *supra* note 317.

[323] U.S. Interagency Council on Homelessness, *supra* note 319, at 13-17.

[324] Samantha Batko & Kathryn Reynolds, *Homelessness Is Solvable—But Only with Sufficient Investment in Housing*, URBAN INST. (Jan. 24, 2023), https://www.urban.org/urban-wire/homelessness-solvable-only-sufficient-investment-housing.

[325] Nat'l Low Income Hous. Coal., *2020 Advocates' Guide: A Primer on Federal Affordable Housing & Community Development Programs* (2020), https://nlihc.org/sites/default/files/AG-2020/2020_Advocates-Guide.pdf.

[326] World Health Org., *Mental Health: Promoting and Protecting Human Rights*, https://www.who.int/news-room/questions-and-answers/item/mental-health-promoting-and-protecting-human-rights.

[327] Brandon A. Kohrt, et al., *The Role of Communities in Mental Health Care in Low- and Middle-Income Countries: A Meta-Review of Components and Competencies*, 15 INT'L J. ENVTL. RES. & PUB. HEALTH 1279 (2018), https://doi.org/10.3390/ijerph15061279.

[328] Substance Abuse & Mental Health Servs. Admin., *Expanding the Use of Mobile Mental Health and Substance Use Disorder Treatment and Crisis Intervention Teams* (2023), https://library.samhsa.gov/sites/default/files/pep23-06-05-005.pdf.

[329] Title IV-E Prevention Services Clearinghouse, *Housing First*, U.S. Dep't of Health & Hum. Servs., https://preventionservices.acf.hhs.gov/programs/754/show.

[330] Mem'l Healthcare Sys., *Rebels Drop-In Center*, https://www.mhs.net/services/mental-health/conditions-treatments-and-services/rebels-drop-in-center.

[331] *Id*.

[332] Ryan K. McBain, et al., *Evaluation of the Housing for Health Permanent Supportive Housing Program* (RAND Corp. 2017), https://www.rand.org/pubs/research_briefs/RBA889-1.html.

[333] Lene Lauge Berring, et al., *Implementing Trauma-Informed Care—Settings, Definitions, Interventions, Measures, and Implementation across Settings: A Scoping Review*, 12 HEALTHCARE 908 (2024), https://doi.org/10.3390/healthcare12090908.

When communities invest properly in local mental health services, people experience greater autonomy and do better than they would in institutions.[334] They are more likely to stick with their treatment plan, build meaningful relationships, and feel satisfied with their lives. Real success depends on proper funding and strong programs - but when communities make this investment, people thrive while staying connected to their neighborhoods and support networks.[335]

Having a stable home makes mental health support work better, and mental health support helps people keep their housing. We see this powerful connection when apartment buildings offer more than a place to live. Residents can walk down the hall to meet with their counselor, join a support group, or check in with a case manager who knows them well.[336] This combination of housing and accessible care creates a supportive environment where individuals feel seen, heard, and valued, empowering people to build stable, healthier lives in their communities.[337] When people have both stable housing and mental health support where they live, they are less likely to end up in crisis, reducing stress and reinforcing their ability to maintain independence and self-sufficiency.[338] This approach is supported by CRPD Committee General Comment 5, which specifies that states have an affirmative obligation to guarantee the equal right of persons with disabilities to live independently and participate in their community."[339]

Cascadia Health tracked this impact, finding that people stayed healthier when they had a home plus easy access to mental health care, addiction treatment, and regular medical check-ups.[340] Their emergency room visits dropped by 18%, and they spent 23% less time in the hospital - showing how the proper support can help people avoid medical emergencies.[341]

Community-based mental health services can take various forms. Below we highlight five core modalities of providing community-based mental health care: intensive care management, assertive community treatment, community health centers, drop-in centers, and peer support.

[334] McBain, et al., *supra* note 332.
[335] *Id*.
[336] Nat'l All. to End Homelessness, *Housing First*, https://endhomelessness.org/resources/toolkits-and-training-materials/housing-first/.
[337] Nat'l Conf. of State Legislatures, *Addressing Health Outcomes Through Supportive Housing* (Jan. 3, 2023), https://www.ncsl.org/health/addressing-health-outcomes-through-supportive-housing.
[338] Cascadia Health, *Integrated Health Care: What It Is, Why It Matters, and How It Works* 2 (n.d.), https://cascadiahealth.org/wp-content/uploads/2020/05/IntegratedCare-handout_web_FINAL.pdf.
[339] U.N. Comm. on the Rights of Persons with Disabilities, *General Comment No. 5 (2017), Article 19: Living Independently and Being Included in the Community*, ¶ 46, U.N. Doc. CRPD/C/GC/5 (Oct. 27, 2017) (States are expressly required "to repeal or reform policies, laws and practices that prevent persons with disabilities from . . . choosing their place of residence . . . or accessing such general mainstream facilities and services as their independence would require.")
[340] Cascadia Health, *supra* note 338.
[341] *Id*.

1. Intensive Case Management

People with psychosocial disabilities often struggle to navigate healthcare systems alone. That is where Intensive Case Management (ICM) comes in. ICM connects each person with their own case manager, someone who knows the system and can help clear the path forward while prioritizing safety, trust, and client empowerment in decision-making.[342] This targeted support works well for people who need regular guidance but can manage without 24/7 assistance, and it costs less to provide. Each case manager works closely with 10 to 15 people, giving them time to build meaningful relationships and offer genuine, personalized support.[343] In alignment with trauma-informed principles of trust, collaboration, and empowerment, strong connections between case managers and their clients drive the success of ICM programs.[344] Rather than surrounding someone with an entire 24/7 team like ACT, ICM provides one dedicated guide through the healthcare maze.[345] This individualized approach fosters a sense of safety and consistency, which is critical for individuals with trauma histories. The case manager becomes a trusted partner, helping tackle everything from finding housing to making it to medical appointments[346] By embedding trauma-informed principles into ICM, case managers can effectively address the root causes of instability, including unrecognized trauma and distrust in services, leading to better engagement and long-term outcomes.[347]

The evidence for ICM is compelling in improving lives and reducing healthcare costs. When people participate in these programs, they are far less likely to need hospital stays for mental health crises. One study found hospital admissions dropped by 38%.[348] ICM also helps people find and keep stable housing, with remarkable results. After two years, 62% of ICM participants had stable homes, compared to just 31% of those receiving standard care.[349] ICM programs are making a real difference in cities across the country. San Francisco's experience shows just how powerful these programs can be.[350] The city's Community Behavioral Health Services has transformed many lives through its Full-Service Partnership program. [351] A five-year study demonstrated improvements for participants.[352] Hospital visits dropped sharply. Emergency calls decreased. More people found stable homes.[353] The program helped 47% of participants find stable housing in the first year, more than double its initial 20% target.[354] Thus, many people who might otherwise end up in institutions can thrive with ICM support. This is done by matching the level of help to each person's needs.[355] This balanced approach offers more support than occasional check-ins but less than round-the-clock care.

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[342] U.S. Dep't of Hous. & Urban Dev., *COVID-19 Homeless System Response: Case Management Ratios* (2020), https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Case-Management-Ratios.pdf.

[343] Claudia Davidson, *Vital Role of Case Management for Individuals Experiencing Homelessness*, 4:1 IN FOCUS: A QUARTERLY RESEARCH REVIEW OF THE NATIONAL HCH COUNCIL (Nat'l Health Care for the Homeless Council Apr. 2016), https://nhchc.org/wp-content/uploads/2019/08/in-focus-case-management-hrsa-approved-final-version.pdf.

[344] Substance Abuse & Mental Health Servs. Admin., *Practical Guide for Implementing a Trauma-Informed Approach*, SAMHSA Pub. No. PEP23-06-05-005 (2023), https://library.samhsa.gov/sites/default/files/pep23-06-05-005.pdf.

[345] Berring, et al., *supra* note 333, at 112, 118–20.

[346] Elizabeth K. Hopper, Ellen L. Bassuk & Jeffrey Olivet, *Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings*, 3 OPEN HEALTH SERVS. & POL'Y J. 80 (2010), https://benthamopen.com/contents/pdf/TOHSPJ/TOHSPJ-3-80.pdf.

[347] Kristen D. Seay, et al., *Interventions Addressing Housing and Housing-Related Risk Factors for Victims and Survivors of Human Trafficking: A Systematic Review, 25 Trauma, Violence, & Abuse* 466 (2024), https://doi.org/10.1177/1524838019843197.

[348] Catherine Hudon, et al., *Effectiveness of Case Management Interventions for Frequent Users of Healthcare Services: A Scoping Review*, 6 BMJ OPEN e012353 (2016), https://bmjopen.bmj.com/content/6/9/e012353.

[349] Lars F. Westman, et al., *Effect of Permanent Supportive Housing on Unhealthful Drinking Among Homeless Adults With Mental Illness*, 313 JAMA 2438 (2015), https://jamanetwork.com/journals/jama/fullarticle/2174029.

[350] Cal. Behav. Health Planning Council, *Full Service Partnerships*, https://bhsoac.ca.gov/initiatives/full-service-partnerships/.

[351] *Id*.

[352] San Francisco Dep't of Pub. Health, Five Year Report on *Full Service Partnerships* (2010), https://www.sfdph.org/dph/files/CBHSdocs/MHSA-docs/FiveYearReportFSP2010.pdf.

[353] *Id*.

[354] *Id*.

[355] Ann-Kathrin Klaehn, et al., *Cost-Effectiveness of Case Management: A Systematic Review*, AM. J. MANAGED CARE (Nov. 19, 2014), https://www.ajmc.com/view/cost-effectiveness-of-case-management-a-systematic-review.

While case management programs need upfront funding, they often pay for themselves through smarter, more efficient care. The research backs this; a central review of 29 studies found that six programs saved money while providing better care than usual services.[356] Seven more programs proved highly cost-effective, spending less than $50,000 for each year of improved life quality they provided.[357] Beyond financial benefits, these programs promote stability, autonomy, and well-being by ensuring individuals receive coordinated, trauma-informed support.[358] Overall, these programs create lasting value. People live better lives, need fewer hospital stays, and experience a greater sense of control over their care, all while reducing overall healthcare costs.[359]

2. Assertive Community Treatment

People with serious psychosocial disabilities often struggle to navigate fragmented care systems, which can exacerbate stress and feelings of helplessness.[360] Assertive Community Treatment (ACT) transforms this experience by bringing comprehensive psychiatric care and rehabilitation directly to them for consistent and person-centered support.[361] Teams meet people where they are, both literally and figuratively, delivering intensive support in community settings that build trust and engagement.[362] This approach not only improves health outcomes but honors each person's dignity and right to live independently in their community, aligning with trauma-informed principles of empowerment and choice.[363] ACT brings mental health care directly to people through dedicated teams available around the clock. Each team includes a range of specialists, from psychiatrists and nurses to social workers and substance use experts, who work closely with a small group of clients.[364]

Because ACT teams work closely with clients over time, they develop a deep understanding of each individual's needs, incorporating trauma-informed strategies, including trust-building and person-centered planning.[365] Teams maintain small caseloads to ensure personalized care, with each staff member supporting just 10 clients.[366] For more extensive programs serving 100 clients, teams expand to include additional specialists; a psychiatrist, two nurses, and pairs of experts in substance use and vocational support.[367] This community-based approach eliminates the need for clients to juggle multiple appointments across different locations. Instead, support comes to them where they live and work.[368]

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[356] *Id.*
[357] *Id.*
[358] B.C. Ministry of Health, *Intensive Case Management Team Model of Care: Standards and Guidelines* (2014), https://www.health.gov.bc.ca/library/publications/year/2014/icmt-standards.pdf.
[359] Klaehn, et al., *supra* note 355.
[360] AAMC Rsch. Inst., *Exploring Barriers to Mental Health Care in the United States* (2023), https://www.aamcresearchinstitute.org/our-work/issue-brief/exploring-barriers-mental-health-care-us.
[361] Office of Inspector Gen., U.S. Dep't of Health & Hum. Servs., *State and Local Use of SAMHSA Grant Funding for Mobile Crisis Services* (Mar. 2024), https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000228.asp.
[362] Cleveland Clinic, *Assertive Community Treatment (ACT)*, https://my.clevelandclinic.org/health/treatments/assertive-community-treatment-act.
[363] Substance Abuse & Mental Health Servs. Admin., *Trauma-Informed Care in Behavioral Health Services*, Treatment Improvement Protocol (TIP) Series 57, HHS Pub. No. (SMA) 14-4816, at 9–10 (2014), https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4816.pdf.
[364] Cleveland Clinic, *supra* note 362.
[365] N.Y. State Off. of Mental Health, *Assertive Community Treatment (ACT) Program Guidelines: Adult and Young Adult* (2025), https://www.omh.ny.gov/omhweb/act/program-guidelines-2025.pdf.
[366] Dartmouth Psychiatric Research Ctr., *Dartmouth Assertive Community Treatment Scale (DACTS)* (Jan. 2017), https://www.dartmouth.edu/~prc/pubs/dacts.pdf.
[367] *Id.*
[368] *Id.* at 4

ACT has proven its effectiveness, particularly in reducing hospitalization.[369] When studied during court-ordered treatment, people receiving ACT care spent just 21 days in the hospital, an 18-day reduction from the 39 days they averaged before entering the program, reflecting significant improvement in outcomes.[370] Beyond reducing hospital stays, ACT helps people maintain stable housing at higher rates than traditional outpatient services and also results in fewer overall hospitalizations.[371] These outcomes demonstrate how intensive community-based support can transform lives while reducing reliance on institutional care such as traditional outpatient treatment. [372]

Cities across America are proving ACT's real-world impact. New York's Pathway Home program helps people build new lives in their communities after psychiatric hospitalization.[373] The program's success is evident. 93% of participants make it to their first behavioral health appointment within a month of leaving the hospital,[374] and most maintain stable housing through ongoing community support.[375] Minnesota's experience reinforces these promising results.[376]

Their ACT programs reduce hospital stays and help people thrive in their communities.[377] By 2019, an impressive 91.9% of Minnesotans receiving mental health services, including ACT participants, were living independently in private homes.[378] This rate significantly exceeded the national average of 83.7%, showing how intensive community support can help people build stable, independent lives.[379]

The intensive support provided by ACT has spurred discussion of personal autonomy, with healthcare professionals and policymakers critically examining how to balance comprehensive care with individual choice.[380] At its core, ACT's success depends on respecting each person's right to make their own choices. Teams build trust by working together with participants, not by imposing decisions. This partnership approach helps people maintain their independence while receiving the comprehensive support they need – support that might otherwise only be available in institutional settings.[381]

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[369] Gary R. Bond & Robert E. Drake, *The Critical Ingredients of Assertive Community Treatment*, 14 WORLD PSYCHIATRY 240 (2015), https://doi.org/10.1002/wps.20234.

[370] Mark R. Munetz, et al., *Association Between Hospitalization and Delivery of Assisted Outpatient Treatment With and Without Assertive Community Treatment*, 70 PSYCHIATRIC SERVS. 833, 833–35 (2019), https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201800375.

[371] *Id*.

[372] Tim Aubry, et al., *A Randomized Controlled Trial of the Effectiveness of Housing First in a Small Canadian City*, 19 BMC PUB. HEALTH 1154, 8–11 (2019), https://doi.org/10.1186/s12889-019-7492-8, (finding that participants receiving Housing First services with ACT were nearly three times as likely to be stably housed compared to those receiving treatment as usual (TAU), with 79.6% of ACT participants housed continuously for six months or more compared to 55.5% of TAU participants).

[373] Coordinated Behavioral Care, *Pathway Home*, https://cbcare.org/network/specialized-programs/pathway-home/.

[374] Jorge R. Petit, *Stopping the Hospital Revolving Door: A Pathway Home to Stable Community Life*, BEHAV. HEALTH NEWS (Spring 2019), https://behavioralhealthnews.org/stopping-the-hospital-revolving-door-a-pathway-home-to-stable-community-life/.

[375] NYC Health + Hosps., *NYC Health + Hospitals Launches a Support Program for Individuals with Mental Health Needs* (Sept. 3, 2019), https://www.nychealthandhospitals.org/pressrelease/nyc-health-hospitals-launches-a-support-program-for-individuals-with-mental-health-needs/.

[376] Minn. Dep't of Hum. Servs., *Assertive Community Treatment (ACT)* (Sept. 2021), https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_058151.

[377] *Id*.

[378] Substance Abuse and Mental Health Servs. Admin., *Minnesota 2019 Mental Health National Outcome Measures (NOMS)*: SAMHSA UNIFORM REPORTING SYSTEM (2019), https://www.samhsa.gov/data/sites/default/files/reports/rpt27953/Minnesota%202019%20URS%20Output%20Tables/Minnesota%202019%20URS%20Output%20Tables.pdf.

[379] *Id*.

[380] Canadian Homelessness Rsch. Network, *Ethical Concerns with Assertive Community Treatment (ACT) (2012)*, https://homelesshub.ca/resource/ethical-concerns-assertive-community-treatment-act/.

[381] *Id.*

ACT's intensive support model may seem expensive initially, but the investment pays off surprisingly.[382] ACT dramatically reduces costly crisis services by helping people stay well in their communities.[383] The numbers present a clear and powerful story. ACT participants spend 37% fewer days in the hospital compared to standard care, demonstrating the program's effectiveness in promoting stability and reducing reliance on crisis services.[384] This shift from hospital-based care drives a 26% reduction in overall mental health costs.[385] Instead of cycling through hospitals, emergency rooms, and the justice system, people get consistent support that helps prevent crises before they start.

However, the success of ACT and similar community-based programs is significantly undermined by the ongoing criminalization of homelessness and mental health.[386] Criminalization policies, including forced displacement, institutionalization, and frequent police encounters, disrupt the continuity of care and make it harder for outreach teams to build trusting relationships.[387] When individuals are pushed into inaccessible areas or are detained, sustained support and engagement opportunities are lost.[388] Moreover, while ACT and related services are focused on harm reduction, their effectiveness is constrained when they cannot be paired with access to housing.[389] Without the ability to offer stable housing alongside treatment, outreach teams are left addressing symptoms while systemic drivers of instability remain unresolved.[390]

3. Community Mental Health Centers

Within neighborhoods, Community Mental Health Centers (CMHCs) offer accessible, professional care in familiar, community-based settings.[391] People can walk into a familiar local building rather than travel to distant institutions, making it easier to seek support in a nearby, trusted environment, reducing barriers such as transportation challenges and stigma.[392] This community-based approach provides more than just convenient access; it creates a welcoming environment where treatment naturally reflects local cultural values and is trauma-informed, respecting individual dignity and choice.[393]

CMHCs form the backbone of local mental health care and meet diverse needs, with individual therapy provided at 92.5% of centers and group therapy at 86.5%.[394] Centers serve different populations; 37.7% help children struggling with serious emotional challenges, 29.8% support older adults, 19.7% assist veterans, and many provide crucial support for unhoused persons.[395] Additionally, 53.2% provide substance use treatment.[396] Bringing multiple services under one roof, CMHCs make it easier for people to get comprehensive care close to home. This accessibility makes a difference, as reflected in the number of people served. As of 2020, CMHCs comprised 20.8% of U.S. mental health facilities and served 3.7 million people, delivering 78.5% of their care through outpatient services.[397] Studies consistently show that when people can easily reach these centers, they start and stick with treatment.[398]

[382] Craig M. Coldwell & William S. Bender, *The Effectiveness of Assertive Community Treatment for Homeless Populations With Severe Mental Illness: A Meta-Analysis*, 164 AM. J. PSYCHIATRY 393, 396 (2007), https://doi.org/10.1176/appi.ajp.164.3.393.
[383] *Id.*
[384] *Id.*
[385] *Id.*
[386] Nat'l Homelessness L. Ctr. & Univ. of Miami Sch. of L. Hum. Rts. Clinic, *Criminalization of Homelessness and Mental Health in the United States: A Report to the United Nations Human Rights Committee* 10–12 (Sept. 2023), https://homelesslaw.org/wp-content/uploads/2023/09/ICCPR-Report-2023.pdf.
[387] *Id.*
[388] Nat'l Health Care for the Homeless Council, *Impact of Encampment Sweeps on People Experiencing Homelessness* 3 (Dec. 2022), https://nhchc.org/wp-content/uploads/2022/12/NHCHC-encampment-sweeps-issue-brief-12-22.pdf.
[389] Sam Tsemberis, et al., *Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis*, 94 AM. J. PUB. HEALTH 651 (2004), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448313/.
[390] *Id.*
[391] Thriving Mind S. Fla., *Community Mental Health Centers*, https://thrivingmind.org/community-mental-health-centers.
[392] Karen A. Urbanoski, et al., *The Role of Community Mental Health Centers in Reducing Barriers to Care: A Trauma-Informed Approach*, 28 J. CMTY. MENTAL HEALTH 145, 150–53 (2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC10462245.
[393] Thriving Mind S. Fla., *supra* note 391.
[394] Substance Abuse & Mental Health Servs. Admin., *2020 National Mental Health Services Survey (N-MHSS)* (2021), https://www.samhsa.gov/data/report/national-mental-health-services-survey-n-mhss-2020-data-mental-health-treatment-facilities.
[395] *Id.*
[396] *Id.*
[397] *Id.*
[398] Mental Health Am., *Access to Care Data 2023* (2023), https://www.mhanational.org/issues/2023/mental-health-america-access-care-data; see also *Telehealth and In-Person Mental Health Service Utilization and Spending in the United States, 2019–2022*, 4 JAMA HEALTH F. 6 (2023), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2808748.

Moreover, when CMHCs operate in a community, fewer people end up in emergency rooms for mental health crises.[399] This is a crucial shift, given that mental health-related Emergency Department visits currently affect nearly 53 of every 1,000 adults nationwide.[400] By providing early intervention and consistent care, these centers help people avoid both costly emergency visits and psychiatric hospitalizations, significantly reducing the financial burden that mental health crises placed on emergency departments in 2017.[401] Perhaps most importantly, people receiving care through CMHCs show better life outcomes than those treated in traditional psychiatric settings.[402] They are more likely to find and keep jobs, maintain stable housing, and build meaningful social connections—especially when centers offer integrated support for housing and employment needs.[403]

CMHCs have further proven effective in supporting people living with serious psychosocial disabilities. Their supported employment programs help people with severe mental illness not only find jobs but also keep them, creating the stability needed to build independent lives in their communities.[404] These centers have also proven skilled at coordinating complex care needs. Clients receiving comprehensive support through integrated care teams show better daily functioning and spend less time in hospitals.[405]

CMHCs are transforming mental health care nationwide, with several states leading in this area.[406] Connecticut's network of 24 centers illustrates this impact; in 2020 alone, they supported many of the state's 63,742 mental health clients.[407] The state's success extends to specialized care, where community providers have used Trauma-Focused Cognitive Behavioral Therapy to help over 12,000 children heal from trauma, with participants showing marked improvements in daily functioning and reduced symptoms[408] Colorado's approach demonstrates how CMHCs can bridge the divide between mental and physical health care. By integrating these services under one roof through the State Innovation Model, Colorado's centers achieved remarkable results; each participant saved an average of $91.12 in monthly healthcare costs by 2017, adding up to $18.4 million in annual savings.[409] Beyond the financial benefits, clients experienced significant improvements in managing depression and controlling diabetes, proving that treating the whole person leads to better outcomes across all aspects of health.[410]

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[399] Nat'l Ctr. for Health Statistics, *Emergency Department Visits Among Adults With Mental Health Disorders: United States, 2017–2019*, NCHS DATA BRIEF No. 426 (2021), https://www.cdc.gov/nchs/data/databriefs/db426.pdf.

[400] *Id*.

[401] Zeynal Karaca & Brian J. Moore, *Costs of Emergency Department Visits for Mental and Substance Use Disorders in the United States, 2017*, HCUP Statistical Brief No. 257 (2020), https://hcup-us.ahrq.gov/reports/statbriefs/sb257-ED-Costs-Mental-Substance-Use-Disorders-2017.jsp; s*ee also Patterns of US Mental Health–Related Emergency Department Visits During the COVID-19 Pandemic*, 6 JAMA NETW. OPEN e2312345 (2023), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807138.

[402] Jorge R. Petit, *Recovery Reimagined: Integrating Housing and Employment Support*, BEHAV. HEALTH NEWS (Jan. 22, 2024), https://behavioralhealthnews.org/recovery-reimagined-integrating-housing-and-employment-support/.

[403] *Id*.

[404] Emi Patmisari, et al., *Supported Employment Interventions with People Who Have Severe Mental Illness: Systematic Mixed-Methods Umbrella Review*, 19 PLOS ONE e0304527 (2024), https://doi.org/10.1371/journal.pone.0304527.

[405] Caroline van Genk, et al., *Current Insights of Community Mental Healthcare for People With Severe Mental Illness: A Scoping Review*, 14 FRONT. PSYCHIATRY 1156235 (2023), https://doi.org/10.3389/fpsyt.2023.1156235.

[406] McBain, et al., *supra* note 332.

[407] Substance Abuse & Mental Health Servs. Admin., *supra* note 394.

[408] Child Health & Dev. Inst. of Conn., *Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)*, https://www.chdi.org/our-work/evidence-based-practices/treatments/tf-cbt.

[409] Colo. Health Inst., *Making the Case: A Societal Cost-Benefit Analysis of Community Behavioral Health Care Services in Colorado* (Oct. 2021), https://www.coloradohealthinstitute.org/sites/default/files/2021-10/Colorado-CMHC-Cost-Benefit-Analysis-Report.pdf.

[410] Colo. Behavioral Healthcare Council, *An Innovative Model for Integrated Care: A Guide for Community Mental Health Centers Interested in Adopting Integrated Care* (2021), https://www.cbhc.org/resources.

Despite their proven impact, many CMHCs need help to keep their doors open, especially in communities that need them most.[411] Investing in these centers makes strong economic sense, and Colorado's experience shows why. When the state studied the returns on CMHC funding, they found every dollar invested yielded more than four dollars back to the community. These savings added to $2.9 billion yearly as people stayed healthier, avoided legal troubles, and remained productive at work.[412]

4. Drop-in Centers

Drop-in centers embody human rights in action by providing open, unconditional access to support and immediate necessities, including food, clothing, hygiene facilities, mental health services, case management, and peer support.[413] No appointments, insurance cards, or filling out forms are required.[414] People can simply walk in and connect with the care they need.[415] Drop-in centers are trauma-informed by developing an environment where dignity comes first and everyone matters regardless of their situation. Individuals can also access services at their own pace.[416] Instead of pushing for immediate treatment, staff take time to build relationships, letting trust grow organically.[417] This flexible approach is effective for engaging those who are hesitant to seek help through traditional channels.[418] For example, unhoused youth are twice as likely to use drop-in centers compared to shelters.[419] These centers are more frequently utilized than other outreach methods for accessing medical, substance use, and mental health services.[420] Additionally, when drop-in centers link visitors to housing-first programs and other structured support, many obtain stable housing[421]

Drop-in centers in Portland, Boston, and Washington offer support for unhoused individuals. Portland's Transition Projects serve over 10,000 people annually, providing essential services such as showers and secure mail services.[422] In 2023, the organization helped more than 600 individuals transition into affordable housing.[423] Boston's CASPAR Emergency Services Center (ESC) operates 24 hours daily, offering a safe space for unhoused persons with substance use challenges.[424] The center provides rest areas, medical care, meals, and access to staff who can assist when individuals seek further support.[425] The ER is for Emergencies program in Washington State addresses high emergency room utilization by connecting frequent visitors to coordinated care and long-term support services. The program led to an 11% reduction in hospital emergency room visits with high-need individuals.[426] By offering continuous, low-barrier support, these centers help stabilize individuals in crisis while reducing reliance on costly, and often unnecessary, trips to the emergency room.[427]

[411] Colo. Health Inst., *supra* note 409.
[412] *Id.*
[413] *Id.*
[414] Thriving Mind S. Fla., *Drop-In & Self-Help Centers*, https://thrivingmind.org/network-services/drop-in-self-help-centers.
[415] *Id.*
[416] *Id.*
[417] *Id.*
[418] *Id.*
[419] Eric R. Pedersen, et al., *Facilitators and Barriers of Drop-In Center Use Among Homeless Youth*, 59 J. ADOLESC. HEALTH 144, 144–53 (2016), https://doi.org/10.1016/j.jadohealth.2016.03.035; U.S. Interagency Council on Homelessness & Substance Abuse & Mental Health Servs. Admin., *The Role of Outreach and Engagement in Ending Homelessness: Lessons Learned from SAMHSA's Expert Panel* (Aug. 2016), https://www.usich.gov/sites/default/files/document/Outreach_and_Engagement_Fact_Sheet_SAMHSA_USICH.pdf.
[420] Pedersen, et al., *supra* note 419.
[421] *Id.*
[422] The People Concern, *The People Concern: Empowering the Most Vulnerable Among Us*, https://www.tprojects.org/.
[423] The People Concern, *Resource Center Services*, https://www.tprojects.org/resource-center.
[424] Bay Cove Hum. Servs., *CASPAR (Cambridge and Somerville Programs for Addiction Recovery)*, https://baycovehumanservices.org/caspar.
[425] *Id.*
[426] Collective Med., *ED Optimization: Avoid Unnecessary Utilization, Reduce Costs, and Transform Patient Care* (Sept. 2019), https://marketing.collectivemedical.com/whitepaper-ED-optimization.
[427] *Id.*

Drop-in centers play an essential role in empowering unhoused individuals by providing accessible support without unnecessary barriers. When people can access support on their own terms, they are more likely to take those first crucial steps toward change.[428] NAMI's research confirms this; building trust and removing barriers-- core principles of drop-in centers-- motivate more people to seek mental health treatment.[429] The Behavioral Health Initiative similarly discovered that these welcoming spaces often become bridges to long-term care and stable housing.[430] Far from enabling homelessness, drop-in centers open doors that many thought were closed to them.

While these centers need steady funding to keep their doors open, they save money.[431] When people have a welcoming place to go during the day, they are far less likely to end up in emergency rooms or hospital beds. The impact is striking; emergency room visits dropped by 25%, and psychiatric hospitalizations plummeted by half.[432] For each person served, that adds up to $850 saved every year.[433] Moreover, every dollar invested in these centers returns $3.43 to the community through reduced healthcare costs and helping more people find jobs.[434] Helping people with dignity does not just support human rights, but it makes good economic sense.

5. Peer Support

Peer support is a community-based approach that connects people with mental health conditions or experiences of homelessness to trained peers who have lived through similar struggles. These peers, often called peer navigators, peer specialists, or recovery coaches, use their lived experience of homelessness and mental health conditions to offer emotional support, guidance, and practical assistance, helping others access resources, navigate services, and build trust in care systems.[435] Sharing their experiences with those in need creates trust and a sense of belonging that traditional services sometimes overlook.[436]Peer support programs are trauma-informed and relationship-centered, led by people who have faced systemic marginalization themselves.[437] They center the voices of those in recovery rather than imposing rigid treatment plans.[438]

Peer support covers many areas. This can include mental health services, housing programs, and substance use recovery. The setting can occur in drop-in centers, public spaces with street outreach teams, or housing programs such as PSH.[439] Peers meet individuals where they are, both physically and emotionally.[440] This model makes mental health and housing services more accessible by allowing people to receive care on their own terms.[441] Peer support thus promotes the right to health and housing, helping people rebuild stability and independence.

[428] Fla. Hous. Coal., *Low-Barrier Housing: Housing First Without Preconditions*, https://flhousing.org/low-barrier-housing/.
[429] Nat'l All. on Mental Illness, *A New Standard for Mental Health Care: Engagement* (July 2016), https://www.nami.org/Support-Education/Publications-Reports/A-New-Standard-for-Mental-Health-Care-Engagement.
[430] Amir Chapel, *Summary Literature Review: Drop-in Centers and Clubhouses* (Dec. 22, 2016), https://isr.unm.edu/centers/center-for-applied-research-and-analysis/behavioral-health-initiative-reports/summarized-literature-reviews/drop-in-centers-and-clubhouses.pdf.
[431] Fla. Hous. Coal., *supra* note 428.
[432] Mental Health Am., *Evidence for Peer Support* 5 (2018), https://mhanational.org/sites/default/files/Evidence%20for%20Peer%20Support%20May%202018.pdf.
[433] Harrison Clarke, et al., *Cost-Effectiveness of a Mental Health Drop-In Centre for Young People With Long-Term Physical Conditions*, 22 BMC HEALTH SERVS. RES. 518 (2022), https://doi.org/10.1186/s12913-022-07901-x.
[434] *Id*.
[435] Homeless & Hous. Res. Ctr., *Expanding Peer Support Roles in Homeless Services Delivery: A Toolkit for Service Providers* 1–3 (July 2023), https://hhrctraining.org/knowledge-resources.
[436] *Id*. at 3.
[437] Homeless & Hous. Res. Ctr., *Expanding Peer Support Roles in Homeless Services Delivery: A Toolkit for Service Providers* 1–2 (2024), https://hhrctraining.org/system/files/paragraphs/download-file/file/2023-08/HHRC_Peer_Support_Toolkit-508.pdf.
[438] *Id*. at 9.
[439] *Id*. at 2.
[440] *Id*. at 9.
[441] *Id*.

In the U.S., peer support has gained traction as a core component of homelessness and mental health services. Programs such as Pathways to Housing DC, SHARE! Collaborative Housing, and Skid Row Housing Trust combine peer workers into their service models.[442] These programs ensure that people with lived experience play a central role in outreach, housing support, and recovery coaching.

Peer support programs improve service engagement, housing retention, and mental health outcomes for unhoused individuals, bridging gaps in traditional care models. Peer interventions can reduce the likelihood of returning to homelessness by providing structured support for individuals managing substance use disorders and mental health conditions.[443] In a peer-supported housing program, 98% of participants remained housed after 12 months.[444] Further, 84% of individuals who had experienced homelessness identified peer support as a critical factor in their ability to secure and maintain stable housing.[445]

Additionally, peer support improves mental health outcomes. Those receiving peer-led support showed lower levels of depression, improved mental health treatment, and stronger social connections.[446] Peer support thus reduces psychiatric-based hospitalizations and emergency visits, leading to overall cost savings. For example, peer support programs like Optum Pierce's Peer Bridger initiative achieved a 79.2% reduction in hospital admissions within a year, resulting in total savings of $550,215.[447]

However, despite the documented benefits, peer support workers also face barriers. This includes low wages, unclear job roles, and inadequate training. Additionally, since many peer workers navigate their own recovery while supporting others, they face the risk of burnout.[448] Strengthening the infrastructure for peer support for workers and increasing the accessibility of these services is critical to ensuring the long-term success of these programs.

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[442] Homeless & Hous. Res. Ctr., *COVID-19 Homeless System Response: Peer Support* 1–2 (2024), https://hhrctraining.org/knowledge-resources.

[443] Homeless & Hous. Res. Ctr., *supra* note 437, at 22.

[444] Joanna Astrid Miler, et al., *Provision of Peer Support at the Intersection of Homelessness and Problem Substance Use Services: A Systematic 'State of the Art' Review*, 20 BMC PUB. HEALTH 641 (2020), https://doi.org/10.1186/s12889-020-8407-4.

[445] European Fed'n of Nat'l Orgs. Working with the Homeless, *Peer Support: A Tool for Recovery in Homelessness Services* (2020), https://www.feantsa.org/public/user/Resources/policy_papers/peer_support_policy_paper.pdf.

[446] *Id*.

[447] *Id*. at 5.

[448] Jessica Mangan, et al., *Peer and Lay Health Work for People Experiencing Homelessness: A Scoping Review*, 4 PLOS GLOB. PUB. HEALTH e0003332 (2024), https://doi.org/10.1371/journal.pgph.0003332.

C. Harm Reduction

Harm reduction refers to programs aimed at reducing drug-related harms, rather than focusing on the drug use itself. Programs encompass a broad range of evidence-based public health and social services designed to mitigate the physical, legal, and social impacts associated with drug use.[449] As outlined by the UN Special Rapporteur on the Right to Health, harm reduction services include needle and syringe exchanges, opioid agonist therapy, overdose prevention and reversal programs, housing and employment strategies, and narcotics education.[450] Needle and syringe programs provide access to and disposal of sterile injection equipment to minimize the negative health impacts of unsanitary drug use.[451] Opioid agonist therapy involves providing therapeutic drugs such as methadone and buprenorphine for the management of opioid dependence.[452] Overdose prevention and reversal programs equip individuals who are likely to experience drug overdoses with naloxone, a "life-saving" medication that can reverse opioid overdoses.[453] Housing and employment programs seek to mitigate poverty and homelessness—both key determinants of drug abuse—through expanded legal and social services. Narcotics education provides people with information regarding the chemical composition of narcotics to facilitate more informed decision-making.[454]

Further, sobering centers are short-term facilities where individuals who are intoxicated and nonviolent can safely recover without involuntary commitment or incarceration.[455] Rather than addressing individual drug abuse in a vacuum, harm reduction approaches further target the fundamental causes of risk, including mental illness, discrimination, and marginalization.[456] Moreover, harm reduction refers to not just programs, but also a philosophy that is non-judgmental and respects the human dignity and rights of each individual.[457] Harm reduction is also trauma-informed, recognizing that some people may attempt to manage trauma symptoms through substance use.[458] Harm reduction seeks to meet people "where they are at" without coercion, discrimination, or preconditions.[459] Harm reduction is thus intrinsically human rights-oriented. By connecting people to essential and life-saving health services and addressing disproportionate incarceration, it supports the human rights to life, health, equality, and liberty.[460]

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[449] Harm Reduction Int'l, *What is harm reduction?*, ?, https://www.hri.global/what-is-harm-reduction. The Trump Administration's Executive Order 14321 defunds harm reduction programs, claiming they "only facilitate illegal drug use and its attendant harm," despite research to the contrary as discussed below. Exec. Order No. 14321, "Ending Crime and Disorder on America's Streets," 90 Fed. Reg. 35817 (Jul. 24, 2025).

[450] Hum. Rts. Council, *Report of the Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Drug use, harm reduction and the right to health*, ¶¶ 57-67, U.N. Doc. A/HRC/56/52 (2024) [hereinafter *Drug use, harm reduction and the right to health*].

[451] *Id*. at ¶ 61.

[452] *Id*. at ¶ 62.

[453] *Id*. at ¶65.

[454] *Id*. at ¶ 64.

[455] California Health Care Foundation, *Sobering Centers Explained: An Innovative Solution for Care of Acute Intoxication* (July 2021), https://www.chcf.org/wp-content/uploads/2021/07/SoberingCentersExplainedInnovativeSolutionAcuteIntoxication.pdf.

[456] UN Office on Drugs and Crimes, *World Drug Report 2024: Contemporary Issues on Drugs*, https://www.unodc.org/documents/data-and-analysis/WDR_2024/WDR24_Contemporary_issues.pdf.

[457] Harm Reduction Int'l, *What is harm reduction?* https://www.hri.global/what-is-harm-reduction.

[458] Nat'l Ass'n of Cty. and City Health Officials, *Harm Reduction as a Trauma-Informed Approach to Substance Use: A Guide for Primary Care Providers* (Apr. 4, 2023), https://www.naccho.org/uploads/full-width-images/L2HR-Academic-Detailing-Aid-2.pdf.

[459] *What is harm reduction?*, *supra* note 457; Mignon, Sylvia I., *Substance Abuse Treatment: Options, Challenges, and Effectiveness*, at 27 (2015) ("[H]arm reduction is a nonjudgmental approach that meets substance abusers where they are at.").

[460] UDHR, *supra* note 188, art. 1, 2, 3, 7, 25; ICCPR, *supra* note 188, art. 6, 9, 26; CRPD, *supra* note 186, art. 5.

Harm reduction approaches, either packaged together or in isolation, have been successfully implemented within various U.S. municipalities. One prominent case study is the Law Enforcement Assisted Diversion (LEAD) pilot program established in Seattle, Washington. This program provides alternatives to the criminal justice system for people whose unlawful behavior stems from unmanaged substance abuse, mental health crises, or extreme poverty.[461] The specific practices and protocols are adapted to local needs by a Policy Coordinating Group (PCG) comprised of senior law enforcement officers, prosecutors and public defenders, project managers, business representatives, elected officials, civil rights leaders, and community advocates.[462] Generally, LEAD cases involve individualized support after an assessment of substance-use frequency and treatment, time spent in housing, quality of life, psychological symptoms, interpersonal relationships, and health status.[463] By equipping law enforcement with credible, rehabilitation-centered alternatives in the pre-booking phase, Seattle's LEAD participants averaged 1.4 fewer jail bookings per year, spent 41 fewer days in jail per year on average, and had 88% lower odds of incarceration than non-participants.[464] Research also shows that Seattle's LEAD program decreases criminal recidivism rates compared to exposure to the criminal justice system.[465]

The state of Florida likewise implemented the Infectious Diseases Elimination Act (IDEA) in 2019, which aims to enable counties to protect vulnerable populations from the spread of HIV, Hepatitis C, and other blood-borne diseases associated with homelessness and drug use.[466] Miami-Dade County's IDEA Exchange program, operating in partnership with the University of Miami Miller School of Medicine, hosts three fixed and five mobile sites and exchanges up to 10,000 syringes throughout the county each week.[467] Beyond these one-to-one syringe swaps, IDEA Exchanges provide additional services aimed at mitigating the harmful health impacts of homelessness and drug use including safe injection packs, naloxone packs, harm reduction packs with first aid supplies and condoms, anonymous HIV and Hepatitis C testing, and linkage to rehabilitation and treatment.[468] Florida's pilot IDEA Exchanges, initially conceived in 2016, were a resounding success.[469] A 2018 study of Miami-Dade County's IDEA Exchange program found that 73% of syringes disposed of by persons who inject drugs (PWIDs) were disposed of at syringe exchange centers or public exchange containers, a drastic increase from just 3.2% in 2009 before its implementation.[470] The program's integrated model of care has successfully established trust amongst local PWIDs, which has been credited as a critical component of the comprehensive testing and surveillance that helped avert an HIV outbreak in Miami in 2018.[471]

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[461] Washington State Health Care Authority, *Law Enforcement Assisted Diversion (LEAD) Grant Program* (2025), https://www.hca.wa.gov/assets/program/fact-sheet-lead.pdf.
[462] *Id*.
[463] Nat'l Institute of Justice, *Program Profile: Law Enforcement Assisted Diversion (LEAD) Program (Seattle, Washington)*,https://crimesolutions.ojp.gov/ratedprograms/law-enforcement-assisted-diversion-lead-program-seattle-washington#1-0.
[464] Susan E. Collins, et al., *Seattle's law enforcement assisted diversion (LEAD): program effects on criminal justice and legal system utilization and costs*, 15 JOU. OF EXPERIMENTAL CRIMINOLOGY 201 (2019).
[465] *Id*. at 49-56.
[466] Florida Health, *IDEA Opens the Door for Syringe Exchange Programs in Florida Counties to Fight HIV*, https://www.floridahealth.gov/programs-and-services/idea/index.html.
[467] Miller School of Medicine Infectious Diseases Division, *SUD/Syringe Exchange: Infectious Diseases Elimination Act (IDEA Exchange)*, https://med.miami.edu/departments/medicine/divisions/infectious-diseases/community-outreach/sud-syringe-exchange.
[468] IDEA Exchange Florida, *Services*, https://ideaexchangeflorida.org/services/.
[469] Marissa Conrad, *How a Needle Exchange is Saving Lives in Miami-Dade*, THE MIAMI FOUNDATION, https://miamifoundation.org/blog/how-a-needle-exchange-is-saving-lives-in-miami-dade/.
[470] Harry Levine, et al., *Syringe disposal among people who inject drugs before and after the implementation of a syringe services program*, 202 DRUG AND ALCOHOL DEPENDENCE 13-17 (2019).
[471] Hansel Tookes, et al., *Rapid Identification and Investigation of an HIV Risk Network Among People Who inject Drugs—Miami, Fl, 2018*, 24 AIDS AND BEHAVIOR 246-256 (2020).

Similarly, Vancouver has implemented a comprehensive public health and addiction program designed to promote prevention and treatment rather than criminalization. Through collaboration with Vancouver Coastal Health (VCH), individuals are provided needle distribution and other harm reduction supplies, overdose outreach teams and prevention sites, drug checking, and social wellness services.[472] Additionally, as of January 31, 2023, British Columbia no longer arrests individuals for possessing small amounts of certain narcotics for personal use; these individuals are instead connected to treatment, recovery, and systems of support.[473] Since decriminalization, early data suggests that British Colombia has seen a decrease in small-quantity drug arrests and seizures without a relevant increase in trafficking-related offenses.[474]

Beyond North America, other international harm reduction efforts serve as archetypes for domestic policymaking. One such case study is Portugal's National Plan for the Reduction of Addictive Behaviors and Dependencies. This law decriminalizes up to 10 days' worth of narcotics intended for individual use; these individuals who are detected by law enforcement sit before a local panel typically comprised of one lawyer along with a physician, psychologist, social worker, or other professional with expertise in drug addiction.[475] These panels determine whether the individual is suffering from an addiction, craft a targeted treatment plan, and may utilize their discretion to suspend civil or criminal penalties if the individual agrees to this targeted assistance.[476] Since the policy's enactment in 2001, Portugal has experienced dramatically beneficial results: overdose deaths have decreased by over 80%, incarceration for drug offenses has decreased by over 40%, and the rate of people who use drugs accounting for new HIV/AIDS diagnoses fell from 52% to 6%.[477]

In 2012, largely in response to the growing rates of HIV/AIDS among people who use drugs, Kenya also implemented harm reduction policies that shifted their approach to addressing drug use by injection from a criminal justice issue to a public health issue.[478] This program provided individuals with various drug abuse resources including needle and syringe programs, opioid agonist therapy, and naloxone distribution.[479] In the nine years after the program's inception, Kenya provided needle and syringe services to over 21,000 individuals and opioid agonist services to over 9,500 individuals.[480] Kenya currently has more than 10 public opioid agonist therapy programs and 35 drop-in centers providing needle-syringe exchanges and take-home naloxone.[481]

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[472] Vancouver Coastal Health, *Harm reduction*, https://www.vch.ca/en/health-topics/harm-reduction.

[473] British Columbia Ministry of Mental Health and Addictions, *Decriminalization Early Outcomes Dashboard* (July 2023), https://www2.gov.bc.ca/assets/gov/overdose-awareness/q1_data_report_to_health_canada__july_2023.pdf.

[474] *Id*.

[475] Rebecca A. Clay, *How Portugal is solving its opioid problem*, AMERICAN PSYCHOLOGICAL ASSOCIATION, Monitor on Psychology (2018), https://www.apa.org/monitor/2018/10/portugal-opioid.

[476] *Id*.

[477] Drug Policy Alliance, *Drug Decriminalization in Portugal: Learning from a Health and Human-Centered Approach* (2018), https://drugpolicy.org/wp-content/uploads/2023/08/dpa-drug-decriminalization-portugal-health-human-centered-approach_0.pdf.

[478] *Drug use, harm reduction and the right to health*, *supra* note 450, ¶ 69.

[479] Harm Reduction Int'l, *Harm Reduction Financing in Kenya*, (Mar. 2021), https://hri.global/wp-content/uploads/2022/10/HRI_VOCAL_Briefing_Harm_Reduction_Financing_in_Kenya-1.pdf.

[480] *Id*.

[481] *Drug use, harm reduction and the right to health*, *supra* note 450, ¶ 69.

To achieve these ends, increased investment and reform activity is needed at all levels. Effective harm reduction models should secure public funding through federal, state, or local pathways rather than solely relying on philanthropic donations, as these public funding models are likely to produce more reliable and sustainable services for impacted populations.[482] Harm reduction models should also prioritize trauma-informed care that recognizes and responds to past traumas often associated with drug use and resists re-traumatization during treatment.[483] Such models should also recognize and mitigate vicarious trauma and staff burnout through education and clinical supervision, as both provider participation and client support can become compromised when staff become triggered by adverse client responses and re-traumatization behaviors.[484] Further, reviews of existing harm reduction programs, such as the IDEA Exchange program in Miami-Dade County, suggest that utilizing mobile service units coordinated locally to target underserved communities will position such programs to serve a broader range of impacted individuals and to mitigate geographic and income-based disparities in care.[485] Finally, while the harm reduction approach has proven effective at moderating the negative personal and societal impacts of drug use, harm reduction can be further augmented with other wrap-around supportive services.[486] One such supplemental service is medication-assisted treatment programs, which combine mental health treatment, behavioral therapy, and targeted medications to treat substance use disorders that often co-occur with mental illness.[487] A more comprehensive harm reduction approach looks not only to mitigate the immediate impacts of an individual's drug use, but also to target the underlying structural determinants and social assumptions of drug use and addiction.

[482] Nat'l Governors Ass'n Publications, *Supporting And Sustaining Access to Harm Reduction Services For People Who Use Drugs* (Aug.11, 2022), https://www.nga.org/publications/supporting-and-sustaining-access-to-harm-reduction-services-for-people-who-use-drugs/.
[483] Nat'l Ass'n of Cty. and City Health Officials, *supra* note 458.
[484] Canadian Centre on Substance Abuse, *Trauma-informed Care*, at 3, https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Trauma-informed-Care-Toolkit-2014-en.pdf.
[485] Siddarth Iyenger, et al., *Baseline differences in characteristics and risk behaviors among people who inject drugs by syringe exchange program modality: an analysis of the Miami IDEA syringe exchange program*, 16 HARM REDUCTION JOURNAL 7 (2019).
[486] Jessica L. Taylor, et al., *Integrating Harm Reduction into Outpatient Opioid Use Disorder Treatment Setting*, 36(12) J. GEN. INTERN. MED. 3810-19 (2021).
[487] Stacy Mosel, *Medications for Addiction Treatment*, AMERICAN ADDICTION CENTERS (Feb. 28, 2025), https://americanaddictioncenters.org/addiction-medications.

D. Interdisciplinary Crisis Responders

Interdisciplinary crisis response teams provide another important human rights-based approach to mental health and homelessness. These programs seek to address severe mental distress and crisis by deploying mobile response teams composed of a paramedic, mental health professional, and, at times, a social worker and peer counselor. While several variations of interdisciplinary crisis response programs have been implemented, including clinical approaches, co-responder programs or mixed approaches, and police response training campaigns, treatment-based response teams without traditional law enforcement most directly support human rights. Crisis interventions are largely centered around the principles of communication and dialogue, presence, flexibility, continuity, peer involvement, and responses to basic needs.[488] They rely on de-escalation and harm reduction techniques to provide immediate stabilization, referral, advocacy, and if needed, transportation to treatment.[489] These responses are a trauma-informed alternative to the criminal justice system and forced institutionalization, both of which can exacerbate negative mental health outcomes by triggering prior traumas that may have caused an individual's mental health crisis in the first place.[490] They thus work to resolve mental health crises within communities while ensuring that those in need of a higher level of care are connected to additional services.[491]

A growing consensus has gathered around both the clinical effectiveness and financial efficiency of interdisciplinary crisis responders, particularly in reducing higher costs services such as hospitalizations and incarceration.[492]Further, by providing immediate care and extended rehabilitative services to individuals experiencing mental health crises, these programs support the human rights to life, health, liberty, and freedom from arbitrary arrest and detention.[493]

Treatment-centered response teams provide several tangible benefits compared to traditional law enforcement approaches. Research suggests that they effectively promote de-escalation and reintegration by reducing the risks of force and violence that are more likely to ensue when police respond to mental health crises.[494] Studies show that persons with serious mental illness are 11.6 times more likely to experience the use of force and 10.7 times more likely to suffer bodily injuries during interactions with law enforcement than persons without serious mental illness.[495] Further, between 25-50% of fatal police encounters involve individuals suffering from serious mental illness.[496] The introduction of community health professionals—trained in de-escalation, treatment, and services rather than criminal punishment—within first response teams offers to mitigate these heightened rates of violence in mental crisis interventions. Notably, there have also been no known major injuries of any clinical or civilian first responders in the implementation of these policies throughout the U.S., and these interactions only require further police intervention in roughly 1% of cases.[497]

[488] Stastny, P., et al., *Crisis Response as a Human Rights Flashpoint: Critical Elements of Community Support for Individuals Experiencing Significant Emotional Distress*, 22:1 HEALTH AND HUM. RIGHTS JOU. 105, 110-14 (2020).

[489] White Bird Clinic, *What is Cahoots*? (June 29, 2020), https://whitebirdclinic.org/what-is-cahoots/.

[490] Adams, C., et al., *Trauma-Informed Crisis Intervention*, JOURNAL OF PROFESSIONAL COUNSELING: PRACTICE, THEORY & RESEARCH (2022), https://doi.org/10.1080/15566382.2022.2148810.

[491] University of Cincinnati Center for Police Research and Policy, *Assessing the Impact of Mobile Crisis Teams: A Review of Research*, https://www.theiacp.org/sites/default/files/IDD/Review%20of%20Mobile%20Crisis%20Team%20Evaluations.pdf.

[492] Daniel Tsai, *Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services*, U.S. Dep't of Health and Human Services Center for Medicaid and Chip Services at 2-3 (Dec. 28, 2021), https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf.

[493] UDHR, *supra* note 188, art. 3, 25; ICCPR, *supra* note 188, art. 9, 12; CRPD, *supra* note 188, art. 14; ICESCR, *supra* note 188, art. 12.

[494] Mental Health Alliance, *Responding to Behavioral Health Crises*, https://mhanational.org/issues/responding-behavioral-health-crises.

[495] Laniyonu, A., & Goff., P, *Measuring disparities in police use of force and injury among persons with serious mental illness*, BMC PSYCHIATRY 21:500 (2021).

[496] Overlooked in the Undercounted, *supra* note 70.

[497] The Marshall Project, *Sending Unarmed Responders Instead of Police: What We've Learned* (July 25, 2024), https://www.themarshallproject.org/2024/07/25/police-mental-health-alternative-911.

Interdisciplinary crisis response teams can also be supplemented by other federal, state, and local initiatives aimed at mitigating the adverse impacts of mental health crises amongst vulnerable populations. For instance, community respite centers, which provide voluntary mental health treatment services and short-term residential support as an alternative to psychiatric hospitalization, can supplement the work of mobile response teams by helping to prevent mental health crises before an emergency intervention is required.[498] Studies also show that these clinical and support-based crisis intervention programs reduce unnecessary hospitalizations and police interactions, saving costs for both law enforcement and healthcare providers while providing vulnerable populations with necessary services.[499]

Successful interdisciplinary crisis response team programs have been implemented in municipalities across the U.S., largely starting in 1989 with the Crisis Assistance Helping Out on the Streets (CAHOOTS) program in Oregon's Eugene-Springfield Metro area. CAHOOTS is a mobile crisis intervention plan that dispatches a qualified healthcare professional (nurse or EMT) alongside an experienced mental health crisis worker skilled in counseling and de-escalation, to respond to 911 calls for mental health crises.[500] The teams respond without law enforcement, with less than 2% of responses requiring police backup.[501] These response teams provide immediate stabilization, assessment, and treatment through a range of services including crisis counseling, suicide prevention and intervention, conflict resolution and mediation, substance abuse support, housing resources, and other medical and social services.[502] This program has improved criminal outcomes and alleviated burdens on police departments; in 2021, CAHOOTS teams responded to 16,479 dispatch calls, representing nearly 12 percent of such calls.[503] CAHOOTS has been reported to save the city $2.2 million in police officer wages each year.[504] Further, the program has saved Eugene an estimated $8.5 million annually in public safety spending, in addition to $14 million in annual savings for emergency medical costs.[505] This program has served as an archetype for related local crisis response programs across the country.

In recent years, local government bodies and advocates in other major cities across the U.S. have also implemented similar human rights-based response programs. In 2021, New York City launched the Behavioral Health Emergency Assistance Response Division (B-HEARD), a health-centered pilot program that dispatches teams with a paramedic, alongside a qualified mental health professional, to respond to mental health emergency calls in impacted neighborhoods; law enforcement officers only intervene in situations involving a weapon or other imminent risk of bodily harm.[506] B-HEARD teams are jointly trained to manage a range of health crises including suicide, substance abuse, serious mental illness, and health problems.[507] These teams provide both on-site and follow-up services, connecting individuals to support systems.[508] From July 2023 to June 2024, B-HEARD teams responded to almost 15,000 mental health calls, representing more than 73% of the eligible mental health calls in the pilot neighborhoods.[509] B-HEARD response teams also reduce unnecessary emergency medical expenses, as patients have required hospitalizations in approximately 54% of cases compared to 87% of cases with traditional law enforcement responses.[510]

[498] *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*, *supra* note 273, at 25.
[499] Herbert Bengelsdorf, et al., *The cost effectiveness of crisis intervention. Admission diversion savings can offset the high cost of service*, 181(12) J. NERV. MENT. DIS. 757-62 (1993).
[500] Eugene Police Department, *CAHOOTS*, https://www.eugene-or.gov/4508/CAHOOTS.
[501] Kim Krisberg, *More communities shifting mental health crisis response away from police*, THE NATION'S HEALTH 53:9 (Nov./Dec. 2023).
[502] White Bird Clinic, *CAHOOTS (Crisis Assistance Helping Out on the Streets)*, https://whitebirdclinic.org/cahoots/.
[503] The Journal, *Responding to a mental health crisis without badges or guns* (Dec. 19, 2022), https://klcjournal.com/mental-health-cahoots/#:~:text=In%202021%2C%20dispatch%20received%20137%2C527, 2019%2C%20311%20required%20police%20backup.
[504] National League of Cities, *Eugene, OR: Community Response Model*, https://www.nlc.org/resource/reimagining-public-safety-impact-updates/eugene-or-community-response-model/#:~:text=According%20to%20EPD%2C%20 CAHOOTS%20saves,with%20CAHOOTS%20for%20was%20%24820%2C586.
[505] Akinnibi, *supra* note 69.
[506] New York City Mayor's Office of Community Mental Health, *Re-imagining New York City's mental health emergency response*, https://mentalhealth.cityofnewyork.us/b-heard.
[507] *Id*.
[508] New York City Mayor's Office of Community Mental Health, *B-HEARD: 911 Mental Health Emergency Health-Centered Response Pilot Project*, https://mentalhealth.cityofnewyork.us/wp-content/uploads/2022/04/B-HEARD-One-Pager-FINAL-4.14.2022.pdf.
[509] New York City Mayor's Office of Community Mental Health, *Re-imagining New York City's mental health emergency response: Data Overview*, https://mentalhealth.cityofnewyork.us/bheard-data.
[510] New York City Mayor's Office of Community Mental Health, *Transforming NYC's Response to Mental Health Emergencies: Fiscal 2022*, https://mentalhealth.cityofnewyork.us/wp-content/uploads/2022/10/FINAL-DATA-BRIEF-B-HEARD-FY22-TOTAL.pdf.

In Denver, Colorado, the Support Team Assisted Response (STAR) partnership between Denver Police and local mental health institutions dispatches mobile teams with a paramedic and a qualified behavioral health professional to respond to mental health crises without a significant safety risk.[511] Since their inception in June 2020, STAR teams have responded to almost 7,500 calls with no reported arrests or tickets issued during those responses.[512] In cases where STAR teams are dispatched, police are only called for backup 7% of the time.[513] Similarly, in 2020, San Francisco established the Street Crisis Response Team (SCRT), which dispatches three-person response teams including a paramedic, a mental health professional, and a peer counselor to respond to mental health crises.[514] These teams provide "rapid, trauma-informed care" to individuals suffering from behavioral crises, as well as linkages to shelters, drug and alcohol abuse programs, mental health clinics, and other support systems.[515] Since its implementation, San Francisco's SCRT program has responded to over 49,513 calls, including 1,449 in its most recent data collection from October 2024.[516] SCRT teams resolve crises on scene in 53% of cases, and patients require hospitalization in just 20% of cases.[517]

Finally, the Community Assistance and Life Liaison (CALL) pilot program in St. Petersburg, Florida, dispatches mobile response teams with a clinical professional alongside a social worker as first responders to non-crime-related calls including mental health crises, wellness checks, homelessness complaints, and substance abuse.[518] CALL teams have responded to approximately 57% of nonviolent, noncriminal calls, with the majority of the responses being for mental health crises.[519]

These case studies reveal that effective responses to mental health crises should consist of interdisciplinary teams with trained healthcare professionals, centered around treatment and de-escalation. Crisis response teams should be trained in trauma-informed care to provide responsive health services while minimizing the chances of re-traumatization during observation and stabilization.[520] To further support the human rights of patients, crisis response teams should also connect patients with other service providers for long-term supportive care. In a survey of Denver's STAR program patients, for example, the most common long-term needs identified were basic services such as housing, mental health services, food and clothing, transportation, and physical health services.[521] San Francisco's SCRT program connects individuals treated by crisis response teams for follow-up with the city's Office of Coordinate Care (OCC) to assess patients and determine appropriate trauma-informed, community-based support services.[522] Furthermore, mobile supportive services, such as street medicine and street care teams, can be effective mechanisms to meet the needs of impacted individuals before mental health crises arise. For example, in Miami, Florida, local organizations such as Dade County Street Response and Miami Street Medicine work to provide physical and mental health services to unhoused and underserved communities at increased risk of experiencing mental health crises.[523] Thus, comprehensive, human rights-based responses to mental health needs consist of interdisciplinary teams. who provide care and connect impacted individuals to wrap-around services without traditional law enforcement intervention.

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[511] City of Denver, *Support Team Assisted Response (STAR) Program*, https://denvergov.org/Government/Agencies-Departments-Offices/Agencies-Departments-Offices-Directory/Public-Health-Environment/Community-Behavioral-Health/Behavioral-Health-Strategies/Support-Team-Assisted-Response-STAR-Program?lang_update=638652130741667790.

[512] WellPower, *Support Team Assisted Response (STAR)*, https://www.wellpower.org/star-program/.

[513] Sarah Gillespie, et al., *Evaluating Alternative Crisis Response in Denver's Support Team Assisted Response (STAR) Program: Interim Findings*, URBAN INSTITUTE (Sept. 2024), https://denvergov.org/files/assets/public/v/1/public-health-and-environment/documents/cbh/star/evaluating _alternative_crisis_response_in_denvers_support_team_assisted_response_program-interim_findings.pdf.

[514] Justice Center, *San Francisco Street Crisis Response Team* (SCRT – San Francisco, CA, https://csgjusticecenter.org/publications/expanding-first-response/program-highlights/san-francisco-ca/.

[515] City & County of San Francisco Street Crisis Response Team, July 2024 SCRT Report, https://www.sf.gov/sites/default/files/2024-09/July%202024%20SCRT%20Report.pdf.

[516] City & County of San Francisco Street Crisis Response Team, October 2024 SCRT Report, https://www.sf.gov/sites/default/files/2024-12/October%202024%20SCRT%20Report.pdf.

[517] *Id*.

[518] City of St. Petersburg Police Department, *Community Assistance and Life Liaison*, https://police.stpete.org/call/index.html#gsc.tab=0; University of South Florida Center for Justice, Research & Policy, *CALL Program Evaluation*, https://www.usf.edu/arts-sciences/centers/cjrp/research/call-program-eval.aspx.

[519] Kailey Tracy, *St. Pete community leaders reflect on first two years of CALL program*, FOX 13 TAMPA BAY, https://www.fox13news.com/news/st-pete-community-leaders-reflect-on-first-two-years-of-call-program.

[520] Adams, et al., *supra* note 490.

[521] Gillespie, et al., *supra* note 513.

[522] City & County of San Francisco Street Crisis Response Team, October 2024 SCRT Report, *supra* note 516.

[523] Miami Street Medicine, *Why Street Medicine*, https://www.miamistreetmedicine.org/.

Conclusion

The criminalization of mental health conditions and homelessness in the U.S. perpetuates cycles of poverty and social exclusion, infringing on international human rights standards. Relying on coercive institutionalization, punitive measures, and law enforcement as first responders undermines the dignity and well-being of individuals with psychosocial disabilities and violates their fundamental rights to liberty, security, health, life, and non-discrimination. These policies further disproportionately affect marginalized communities, particularly racial minorities, exacerbating systemic inequalities. The U.S. must shift towards human rights and evidence-based approaches to effectively address mental health concerns and ensure all individuals are treated with dignity and respect, regardless of their status.

To that end, this report has explored several evidence-based, trauma-informed approaches that better promote the human rights of unhoused individuals experiencing mental health crises. PSH offers stable, long-term housing with voluntary, wrap-around support services, allowing individuals to recover in dignity without the threat of institutionalization. CBMHS, including ACT, ICM, and peer-led services, delivers mental healthcare in community settings rather than restrictive facilities. Both of these approaches improve mental health outcomes and long-term stability, decreasing homelessness. Harm Reduction utilizes public health and social service programs to mitigate the adverse psychological and physiological effects of drug use, respecting the dignity of persons who use drugs. Interdisciplinary Crisis Responders deploy teams with medical professionals and other workers trained in de-escalation and stabilization to respond to individuals experiencing mental health crises rather than traditional law enforcement. Impacted individuals are thus connected to immediate treatment and long-term rehabilitative services. These approaches, which have been successfully implemented both domestically and internationally, protect the rights to health, life, equality, and liberty and serve as promising alternatives to criminalization.