Dying at the Intersections: Police-Involved Killings of Black People With Mental Illness

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On March 23, 2020, Daniel Prude, a 41-year-old Black man wandered the snowy streets of Rochester, New York, naked and confused after abruptly leaving his brother Joe's home. Joe called 911 twice that day seeking care for Daniel; the first call resulted in contact with medical professionals who discharged him, seemingly without appropriate treatment. The second resulted in contact with officers who restrained him, seemingly without appropriate regard for his life (1). Months passed before the Prude family was allowed to view bodycam footage of Daniel, naked, handcuffed, and hooded by officers. The footage showed him pinned to the ground, vomiting, and repeating "In Jesus Christ I pray, Amen," before he eventually stopped breathing (2).

In the 1980s, legal scholar and critical race theorist Kimberlé Crenshaw challenged "single-axis" frameworks for considering oppression and argued that such conceptual limitations erased the lived experiences of Black women, neglected by mainstream antiracist and feminist frameworks (3). She proposed, instead, the concept of *intersectionality* to account for the ways in which individuals can be "multiply-burdened" by a unique interplay of various sources of oppression that are greater than the sum of their parts (3).

Daniel Prude's homicide (2) is one of too many examples of the long-standing lethality of police encounters for Black people in the United States (4). It also specifically highlights the compounding risk of having mental illness *and* being Black, which increases the likelihood of interactions with mental health and legal systems that are replete with an interplay of structural racism and mental health stigma. Further, Prude's story and its relative absence in mainstream media outlets underscore that narratives of marginalization and violence marked by intersectionality tend to be erased from the public eye. As discourse on crisis intervention gains momentum in the United States, it is imperative to acknowledge that current data and existing approaches fall short, particularly as they pertain to even considering—let alone addressing—structural inequities that are the root cause of these unjust, tragic outcomes, especially for those who live at the intersection of compounding axes of oppression.

Dearth of Data Erases Black Intersectional Deaths, Stunts Evidence-Based Interventions

The Centers for Disease Control and Prevention (CDC) estimates that fatalities from lethal use of force by law enforcement officers (LEOs) constitute at least 4% of homicides in the United States annually (4), but no comprehensive national database exists to accurately measure or document these deaths. In fact, existing reporting systems use data from the U.S. Federal Bureau of Investigation Uniform Crime Reporting Program, which likely underestimates LEO-related killings, because participation in these registries is voluntary, and police involvement in homicides may be omitted from death certificates (4). Although the CDC's National Violent Death Reporting System inputs data from multiple sources and has estimated double the number of LEO-related deaths than does the FBI's report, it does not collect data in all states. And even though some existing repositories include information about victims' race or mental health status, these data often rely on LEOs' subjective assessments of victims, calling their accuracy into question. Related analyses pertain to either race or mental health status but rarely the compounding effect of racial marginalization *and* mental illness on the likelihood of experiencing LEO use of force.

More comprehensive data are needed to fully understand the impact of both racism and mental illness on outcomes of LEO encounters, yet the existing data clearly identify mental illness and racial marginalization as independent risk factors for LEO-involved killings. Estimates suggest that at least 25% of fatal police encounters involve persons with mental illness, and 76% of individuals killed in police encounters have had previous mental health treatment (4). Of all LEO encounters, Black peoples' fatality rate is 2.8 times that of their White counterparts, despite Black victims being less likely to be armed (4).

Crisis Intervention Team Training and Limitations of Existing Interventions

Crisis intervention team (CIT) training is a curriculum for LEOs, typically taught by mental health professionals, and is

a frequently proposed intervention to decrease lethal outcomes in mental health–related police encounters (5). Despite its 2,700 programs nationwide and decades of operation, only sparse data are available to support CIT's effectiveness in reducing lethal outcomes (5). Research findings indicate an increase in referrals to mental health services and reduction in officers' *self-perceived* likelihood of using force in hypothetical mental health encounters after undergoing CIT. No data, however, show actual positive benefits of CIT on reducing use-of-force outcomes or lethality, and the scope of CIT program implementation is inconsistent. Further, the CIT curriculum lacks content specifically addressing the impact of race and racism on potential use of force among LEOs and on mental health professionals' and LEOs' detection of mental illness or threat assessment. No specific CIT content is dedicated to structural racism as it pertains to access to mental health services or patient risk for encountering carceral system inequities. Although CIT may result in increased mental health referrals, insufficient data exist on referral rates or patterns by race. These factors pose additional challenges for researchers and policy makers seeking to characterize CIT's impact on LEOs' use of force and mental health outcomes among patients and whether these impacts are racially equitable. Furthermore, given that mental health professionals are not free of racism and overestimate risk for violence among Black patients (6), these interventions will continue to fail patients who are victimized by both the carceral and mental health systems.

Finally, addressing the excessive use of force by LEOs against Black persons with mental illness requires a historically informed, structurally competent approach. In its earliest forms, the police force was explicitly charged with controlling enslaved Black people and maintaining racial hierarchy (7). The police force has a legacy of indiscriminate violence against Black people with little accountability (7), a pattern perpetuated by persistently low rates of LEO sanctioning or legal charges after LEO-related deaths (4). The gravity and persistence of this pattern calls into question the viability of CIT to counter centuries of programming around community harassment and officer predisposition to use of force, particularly in Black communities.

Centering the Intersections: Recommended Approaches

Reimagining interventions to prevent LEO-related deaths—specifically for Black persons with mental illness—will require fundamental paradigm shifts in both the mental health and legal systems. Superimposing "race-neutral" reforms onto inherently racist systems will predictably fail to address the root causes of inequity. Mental health professionals will remain blind to their differential treatment of Black patients. Policy makers and administrators will remain ignorant of the disparate impacts of their laws and procedures on treatment accessibility for Black people with mental illness. An intersectional approach that acknowledges the "interlocking nature of co-occurring social categories" (8) (in this case being Black and living with mental illness) and that centers and safeguards those most affected by compounding variables of oppression will be required for the protection of all.

For evidence-based interventions to succeed, universal participation and consistent data gathering are imperative, both to measure baseline data and to track efficacy of future interventions. Databases will require measures of more than race as a proxy for racism. Instead, an explicit focus on racism will elaborate *mechanisms* by which its effects occur, allowing for targeted antidotes (8). Given the politically charged interests of law enforcement agencies and the imperative for transparency in LEO-related deaths, data collection should be managed and assessed by independent evaluators to ensure the impartiality and integrity of public health data.

Programs that have been most effective in reducing violence and fatality in responding to mental health crises largely remove police involvement. One example is the CAHOOTS (Crisis Assistance Helping Out On The Streets) program in Eugene, Oregon (1), an approach led by mental health professionals that eradicates firearms, the most common inflictor of death in LEO killings, from crisis responses involving LEOs (4). Because mental health professionals and health care systems are not free of racism (6), programs led and developed by the mental health workforce will require an actively antiracist approach to succeed, informing everything from leadership and demographic characteristics of response teams to pedagogies guiding mission, vision, and outcome measures.

Finally, while the development of new infrastructure for mental health response is under way, a concurrent harm reduction approach must increase public awareness of nonpolice alternatives to call for help during mental health crises, particularly for Black families. Without these alternatives, in addition to their loss, families are left feeling complicit in their loved one's death. Joe Prude's reflection on his brother's homicide underscores the urgent need for alternatives: "I placed the phone call for my brother to get help, not for my brother to get lynched" (1).

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Technology in Mental Health Column: Submissions Welcome

A Technology in Mental Health, a *Psychiatric Services* column edited by Dror Ben-Zeev, Ph.D., focuses on technology-based or technology-assisted approaches in the assessment, treatment, monitoring, or prevention of mental health problems (e.g., mHealth or eHealth, decision support tools, wearable devices, social media, and training programs). Given the rapid pace of technology development, multiple stakeholders—policy makers, administrators, clinicians, and consumers of mental health services—stand to benefit from learning about novel approaches as they emerge.

The column is an ideal venue to expose readers to innovative technologies and innovative strategies for using existing technology to improve mental health outcomes in a timely manner. Submissions may include (but are not limited to) informed opinion pieces, conceptual papers, analyses of the state of the field, policy papers relevant to the use of technology, and first-person accounts from users of technology in mental health (i.e., patients, providers, and administrators). Empirical efforts (e.g., deployment in the context of real-world care, proof-of-principle studies) will be considered only if the findings are used to inform a "bigger picture" discussion that has broader implications for the field. Authors are encouraged to explore, debate, and demonstrate how to capitalize on and build new technologies that will redefine the field by generating new science and practice.

Submissions should include a 100-word abstract. Up to 10 references are permitted. The total word count (including abstract, text, and references) should not exceed 2,400 words—or 2,000 with a small table or figure. Tables, figures, and multimedia material may be submitted as an online-only supplement to the column. Please submit online at ScholarOne Manuscripts (https://mc.manuscriptcentral.com/appi-ps).