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Carceral Systems and Mental Health Crises—Health Care, Not Handcuffs

Rohan Khazanchi, MD, MPH; Destiny Tolliver, MD, MHS

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Individuals with untreated mental illness are 16 times more likely to be killed during a police encounter than other civilians.[1] Unfortunately, these stark disparities exist even for children struggling with acute mental illness, behavioral dysregulation, or chronic developmental disabilities — especially when their mental health conditions intersect with other marginalized identities. From 2003 to 2018, compared with White adolescents, Black and Hispanic adolescents had 6 and 3 times greater risk of firearm-related mortality due to legal intervention, respectively.[2] The high-profile deaths of children such as Ryan Gainer, a 15-year-old Black teen with autism who was killed by a deputy responding to a behavioral health emergency (BHE) call, have motivated clarion calls to reform services for families fighting to support their loved one through a severe mental health crisis.

The Continuum of Disparate Use of Force in BHEs

For minoritized youth experiencing BHEs, police firearm violence is the most severe outcome along a continuum of disparate responses. Watkins and colleagues[3] examine inequities in another sentinel event by assessing how intersections of race and ethnicity, gender, and neighborhood disadvantage shape likelihood of police handcuffing during pediatric BHE evaluations. They studied 6759 BHE encounters in Alameda County, identifying 1.8-times greater odds of handcuffing among Black children compared with White children, 2.6-times greater odds among Black girls compared with White girls, and 1.5-times greater odds of handcuffing in the most disadvantaged neighborhoods. Notably, adjusting for neighborhood deprivation and age only slightly moderated the increased odds of handcuffing among Black children.

Unfortunately, disparate use of force is not limited to community policing; these inequities also shape health care delivery. Studies of pediatric emergency department encounters revealed that Black children were 1.8-times more likely to be physically restrained than White children, with greater disproportionality among Black girls (2.5-times greater odds than White girls) than Black boys (1.7-times greater odds than White boys).[4] In the pediatric inpatient setting, Black race and a primary mental health diagnosis were associated with 1.4-times and 7.1-times greater odds of physical restraint use, respectively.[5] As Watkins and colleagues[3] appropriately note, the harmful outcomes of carceral approaches to child behavioral dysregulation span health care, educational, and criminal-legal settings alike. Moreover, they discuss how disproportionate handcuffing of Black youth can be contextualized further by understanding how adultification bias and intersectionality shape perceptions of Black children as older, less obedient, and less innocent. Excessive and inequitable use of force across law enforcement and health care environments make clear that multisector approaches to reducing carceral responses to BHEs are a crucial next step.

Decoupling Carceral Responses from BHE Prevention and Treatment

By the time sentinel events such as firearm discharge, handcuffing, or physical restraint occur, they reflect upstream structural gaps just as much as they are a response to an unfolding mental health crisis. Thus, structural interventions are necessary. Carceral approaches to BHEs prioritize control and force over rehabilitation and support; a public health and justice-oriented path forward must diverge from this trajectory.

From a research standpoint, expanding hyperlocal research to assess trends within broader and policy-relevant geographies (cities, counties, states) is needed. Linkages across sectors, such as the data pipeline developed by Watkins and colleagues,[3] can improve epidemiologic characterizations and policy evaluations by bringing together public health, health system, policing, and carceral facility data. Cross-sector data linkage and partnerships may provide a roadmap for developing and evaluating future interventions.

Within health care settings, interventions are needed to mitigate the overall and inequitable use of restraints among youth. Dalton and colleagues[6] recently published one promising approach: leveraging Plan-Do-Study-Act cycles and daily deescalation huddles to dramatically reduce physical restraint events. Health systems need not reinvent the wheel; through targeted data collection and intervention, existing institutional quality improvement mechanisms can help improve the care of behaviorally dysregulated youth.

Lastly, outside of hospital walls, carceral systems cannot and should not serve as de facto BHE response systems. Indeed, in *Bread for the City v. District of Columbia*, the American Civil Liberties Union has argued that reliance on police creates a disparity between responses to physical and mental health emergencies, thereby discriminating against people with mental health conditions and developmental disabilities. The Department of Justice seemingly concurred in February 2024, noting that existing civil rights laws such as the Americans with Disabilities Act "may require dispatching a different type of response to mental health emergencies when appropriate, such as mobile crisis teams staffed with behavioral health professionals, to avoid discrimination on the basis of disability."[7]

Alternatives to carceral BHE response systems exist and have demonstrable benefits. For example, the Crisis Assistance Helping Out On The Streets (CAHOOTS) program has been funded in Eugene, Oregon since 1989.[8] Unlike police transport, which requires uniforms, sirens, and handcuffs that can exacerbate distress for individuals in crisis, CAHOOTS teams can voluntarily drive a person in crisis to a clinic or hospital. Of almost 24 000 CAHOOTS responses in 2019, only 311 calls (~ 1%) required police backup.[8] More recently, CAHOOTS services have expanded to include emergency case management for people experiencing homelessness and greater integration with schools, shelters, and community behavioral health professionals. CAHOOTS has saved millions of taxpayer dollars by preventing and diverting emergency calls.[8]

In short, for patienst with no immediate safety concerns, a crisis intervention team composed solely of mental health professionals can be a more compassionate, community-centered, and cost-effective response. To this end, Congress should pass the 9-8-8 Implementation Act, which would include federal funding and guidance for states to implement crisis response infrastructure which relies on trained mental health specialists instead of armed law enforcement.

End Indiscriminate Youth Shackling in Health Care Settings

To be clear, there are circumstances when interventions such as physical restraints may be a medically necessary last resort to mitigate a patient's risk of elopement, harm to others, or self-harm. However, in accordance with the American Medical Association Code of Ethics, all patients — and especially children — should "never be restrained punitively, for convenience, or as an alternative to reasonable staffing."[9] This commitment must be upheld in prehospital and hospital settings.

Indiscriminate shackling undermines clinician autonomy, exacerbates moral injury for the clinical team, and contributes to suboptimal care by prioritizing carceral policies over medical necessities. Yet, in prehospital and hospital settings — and in violation of international human rights standards such as the *United Nations Rules for the Protection of Juveniles Deprived of their Liberty* (the "Havana Rules"), which note that physical restraints "can only be used in exceptional cases, where all other control methods have been exhausted and failed"[10] — detained youth are often mandatorily shackled or handcuffed while seeking care. For children who pose no immediate safety or elopement risks, shackling is unnecessarily humiliating, stigmatizing, traumatizing, and is inconsistent with the purported rehabilitative goals of the juvenile justice system. Patient, staff, and

law enforcement or correctional officer safety can be ensured through other means during health care encounters, including use of existing protocols for behaviorally dysregulated patients for individualized security risk assessments, strategic room allocation near staff, huddles with bedside and behavioral health teams, and, when medically necessary, use of soft physical restraints or pharmacotherapy.[6]

Conclusions

In sum, efforts to measure and ameliorate the harms of carceral BHE responses across community and health care settings must disrupt cycles of control and punishment that risk exacerbating behavioral health inequities. Mental health crises require health care, not handcuffs; existing research offers insight into how clinicians, care delivery systems, law enforcement, and policymakers can reorient their efforts toward restorative and rehabilitative goals.

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Corresponding Author: Rohan Khazanchi, MD, MPH, Boston Children's Hospital, 300 Longwood St, Boston, MA 02115 (rohan.khazanchi@childrens.havard.edu).

Author Affiliations: Harvard Internal Medicine-Pediatrics Residency Program at Brigham and Women's Hospital, Boston Children's Hospital, and Boston Medical Center, Boston, Massachusetts (Khazanchi); François-Xavier Bagnoud Center for Health and Human Rights at Harvard University, Boston, Massachusetts (Khazanchi); Department of Pediatrics, Boston University Chobanian & Avedisian School of Medicine, Boston, Massachusetts (Tolliver).

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