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Changing the Route:

Seeking Compassionate Alternatives to Police Transport in Involuntary Civil Commitment

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Executive Summary

Across the United States, communities are developing innovative strategies to reduce the presence of law enforcement when responding to a person experiencing a mental health crisis. This momentum brings with it opportunities to examine alternatives to law enforcement involvement in specific areas of behavioral health services, such as transportation in the involuntary civil commitment (IVC) process. IVC is a civil legal process that determines whether a person meets the legal criteria to be involuntarily ordered to an inpatient psychiatric treatment, or a supervised outpatient treatment, program.* Often, law enforcement is called upon to transport the patient throughout this process. Transportation needs may include but are not limited to, initial transportation to an emergency facility for evaluation by medical providers, transportation to an inpatient facility, and transportation to and from several court hearings. Frequently, law enforcement transportation involves restraining (e.g., handcuffing) a patient and transporting them in the back of a squad car while being escorted by a uniformed officer.

Not only does law enforcement involvement blur the lines between treatment and criminalization of mental illness, people with serious mental illness are also overrepresented in law enforcement use-of-force encounters and law enforcement-related injuries. People with serious mental illness are over eleven times more likely to experience law enforcement use-of-force and over ten times more likely to be injured in law enforcement interactions compared to other individuals.[1] Racial biases and prejudices further

* In many states, individuals may also be committed due to substance use disorder or their status as a "sexually violent predator." For the purpose of this report, we focus only on commitments due to mental illness.

exacerbate these outcomes, as Black people are already disproportionately more likely than white people to experience force at the hands of law enforcement.[2] Notably, law enforcement officers widely express that they do not feel well-equipped to handle mental health crises, nor do they believe they should be handling IVC transports.[3] Nevertheless, law enforcement remains the default transportation provider for individuals subject to IVC across the country, even though forty-three states allow for alternatives to law enforcement transportation by statute (see Section 3 for a table of statutes). However, even in states where alternatives are permitted, law enforcement remains the default transporter due to lack of available alternatives. As such, policy change is instrumental for normalizing non-law enforcement transportation in the IVC process.

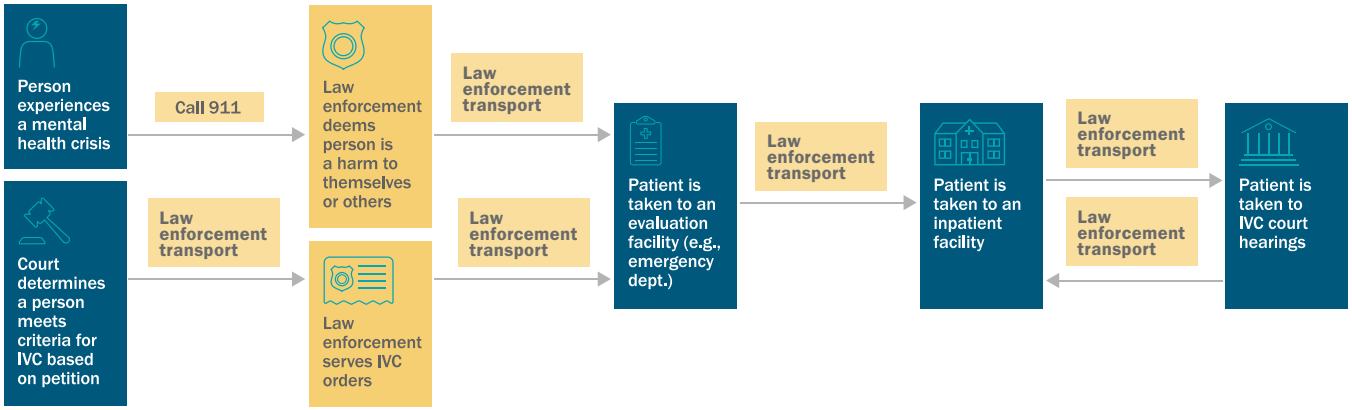
This brief examines statutory requirements for law enforcement custody and transportation under IVC, when alternative transport is permitted, and opportunities to reduce the role of law enforcement in involuntary commitment when possible. While there likely is not a one-size-fits-all approach to this issue given the number of touchpoints that exist between law enforcement and IVC patients, this brief recommends the following:

1. State policymakers should ensure state statutes allow for non-law enforcement transportation for all IVC pathways when appropriate.
2. States should provide adequate funding and technical assistance to ensure communities can implement non-law enforcement transportation.
3. States and localities should implement creative crisis interventions designed to minimize the need for law enforcement transportation.
4. States and law enforcement agencies should review policies and procedures so that when law enforcement transportation is necessary, it is conducted in the least harmful way possible. For example, when law enforcement transportation is necessary, the officer should be dressed in plain clothes, transportation should be with an unmarked car, and the officer should be of the same gender as the patient.
5. To effectively monitor IVC processes, states should require data collection on the entirety of the IVC process, including transportation.

Law Enforcement and the Involuntary Civil Commitment Process

Involuntary civil commitment (IVC) is a civil legal process through which individuals are examined by qualified clinicians to assess whether they meet the criteria for involuntary treatment at an inpatient facility, or supervised outpatient program, in order to prevent harm to themselves or others.[4] Following this evaluation, the patient attends a court hearing where a judge or other decisionmaker determines if and for how long the patient will be under a commitment order. IVC statutes vary considerably by state, but a typical commitment standard requires that an individual, as a result of a mental illness, has been deemed a danger to themselves or others, or that they are unable to provide for their basic needs.[5] For example, a depressed individual might become seriously suicidal, but refuse care due to the irrational thinking that accompanies suicidality. The person may warrant IVC if the suicidality becomes life-threatening.

While law enforcement transportation may be requested at several points in the IVC process, there are two main situations in which a law enforcement officer could be called upon to transport the individual at the onset of the commitment process: 1) in response to an acute crisis or 2) as directed by a petition or involuntary commitment order.[6]



Responding to an Acute Crisis

Law enforcement may be the first to respond when someone is suffering from an apparent mental health crisis. Whether responding to a person who is acting erratically in public, a family member who is concerned for the mental health and safety of a loved one, or a neighbor who initiates a welfare check, 911 or 988 are often the first calls for assistance. If a responding officer believes an individual should be taken into custody and evaluated under the state's IVC statute, the officer

usually has the authority to transport the person for an emergency evaluation.[7]

A similar process may unfold in a hospital or medical provider's office (although the definition of medical provider varies from state to state). If a medical provider, upon examining a patient, determines that the patient is in crisis and may be a threat to themselves or others, the provider may request the person be taken into custody for further examination or be transported to a psychiatric facility. Often, a law enforcement officer will transport the patient to an inpatient facility from the emergency department.

Responding to Direction from a Commitment Order

Law enforcement involvement may also be initiated under a custody or detention order from a court in response to a petition for involuntary commitment. This type of law enforcement transportation can be initiated for a variety of reasons.

First, in many states, anyone with knowledge of a person in crisis can petition a judge, magistrate, or designated court officer to have the person evaluated for IVC.[8] If the court or magistrate determines that there is probable cause that the person meets the criteria for IVC, the order often requires law enforcement to serve the custody order and transport the individual for emergency evaluation.[9] Additionally, some states allow for immediate confinement or emergency custody without a court order when there is reason to believe the individual poses an imminent danger to themselves or others.[10] In these cases, the court can order the individual to be immediately taken into custody by law enforcement and detained, typically in a healthcare facility, pending a hearing on the IVC petition.[11]

Once at the evaluation facility, a medical provider, psychologist or other designated examiner may determine whether the patient meets the criteria for inpatient involuntary commitment. Upon this decision, a law enforcement officer may be called to transport the patient to an inpatient facility certified to accept IVCs for a second evaluation, even if it is several hours away.[12] Often, an officer is required to wait with the patient until a physician or designated examiner conducts another examination to determine if the patient appears to meet the IVC criteria pending a court hearing.[13] One survey found that the average wait for law enforcement officers when transporting someone to a hospital is three hours.[14]

The role of law enforcement does not end once a patient has been involuntarily committed to an inpatient facility. Law enforcement may also be contacted to transport the patient to and from follow-up court hearings required during the IVC process.[15] Further, if the patient leaves the inpatient facility against medical advice, law enforcement may also be asked to return the patient to the inpatient setting.[16]

It is important to note that in some states, a custody order is analogous to an arrest warrant. As such, an officer is allowed to use forcible entry when they are taking a patient into custody. They are also allowed to use "reasonable force" to restrain the patient when they are being taken into custody. "Reasonable force" is at the discretion of the responding officer.[17]

Why Law Enforcement Transportation During IVC is Problematic

Law enforcement involvement can lead to excessive use of force, injury, and death

People with serious mental illness are over eleven times more likely to experience law enforcement use-of-force and over ten times more likely to be injured in law enforcement interactions compared to other individuals.[18] Further, several studies suggest that people with evidence of mental illness are overrepresented amongst those killed in civilian-police interactions.[19] These outcomes are further exacerbated among people of color. For example, Black people are already disproportionately more likely than white people to experience force at the hands of law enforcement.[20] Black patients are also more likely than white patients to be brought to the emergency department by police transport.[21] Once at the emergency department, Black patients are more likely to be restrained in emergency settings than white patients, even after controlling for other demographic and clinical factors.[22] While it is true that law enforcement officers are being called upon to intervene in particularly risky circumstances, one study found that some persons with mental illness were killed at home by police and were not brandishing a firearm.[23] This suggests that more effective de-escalation methods and/or a reduction in law enforcement intervention, when appropriate, might reduce the incidence of fatal outcomes.

"I had an adolescent patient who came into the Emergency Department voluntarily seeking care because she was suicidal and very cooperative. The parents were with her and were willing to take her wherever necessary to get treatment. The only hospital bed available was over an hour away and that hospital said they would only take her if she was under involuntary commitment to guarantee she would come for admission without any reluctance. I told them the parents were willing to drive her there but the hospital refused. The parents were devastated knowing she would have to go the hospital with law enforcement. Seeing that young girl shackled for the transport was heart-breaking."

— *Psychiatrist in an Emergency Department*

Law enforcement transportation can be confusing and traumatizing for the patient

Because law enforcement officers sometimes lack the specialized training to recognize and de-escalate a mental health crisis, law enforcement response can lead to more harm in these situations.[24] Negative policing interactions are associated with incidences of post-traumatic stress disorder.[25] It is not surprising that a person experiencing a mental health crisis may be further traumatized through escalated law enforcement interactions, especially where excessive use of force is involved and especially if they have a history of negative interactions with law enforcement. In one study of youth and young adults who had experienced law enforcement involvement in the IVC process, a majority of participants reported distressing experiences; from experiencing the intervention as disciplinary rather than therapeutic to perceived aggression and callousness from police officers, and poor communication.[26] Further, handcuffing a person experiencing a mental health crisis and transporting them in the back of a squad car can blur the lines between providing care for a mental health crisis and criminalizing mental illness. Some patients even reported that they believed they were being arrested during the IVC process.[27]

> "I have felt very helpless as a provider in situations with patients who did require involuntarily commitment. I recall one patient who was a confused elderly woman who needed hospitalization but was refusing admission. When the sheriff came to pick her up she looked bewildered and struggled when they put her in handcuffs. Her family tried to calm her down but they were very upset themselves. I felt really terrible about it."
>
> — *Nurse Practitioner*

Some law enforcement officers do not feel equipped to handle mental health crises, nor do they feel that IVC transportation is a good use of their resources

A 2017 survey of law enforcement offices revealed that many officers do not believe they should have such a prominent role in caring for and transporting individuals with serious mental illness.[28] This nationwide survey revealed an awareness on the part of law enforcement officers that their involvement in mental health crises contributes to the stigma and criminalization of mental illness, as well as trauma for the patient. Additionally, many expressed concerns that their law enforcement training was not adequate or appropriate for handling mental health crises. This sentiment is also echoed by law enforcement organizations. For example, in 2022 the North Carolina Sheriff's Association advocated that, "[r]esponsibility for transportation for initial evaluation of an individual who is the subject of an IVC be shifted from law enforcement officers to mental health professionals of the local management entity."[29] Further, law enforcement officers are wary of the strain IVC transportation places on their agencies' already limited resources. Based on a 2017 nationwide survey, it was estimated that law enforcement agencies spent approximately $918 million nationwide transporting people with severe mental illness.[30]

Why is CIT not enough?

Crisis intervention team (CIT) training provides instruction for law enforcement officers to identify and de-escalate mental health crises. This training model has been implemented in nearly 3,000 law enforcement agencies across the United States, albeit inconsistently given the fragmentation that exists across the law enforcement system in the U.S.[31] CIT intends to help law enforcement officers identify when a person is experiencing a mental health crisis and de-escalate the situation until a mental health professional arrives.[32] However, there is little evidence to suggest that CIT training reduces use of force incidents or trauma.[33] Additionally, there is no guarantee that all officers on a force receive CIT training or that a CIT-trained officer will always be available for dispatch. While it is important for officers to be trained to recognize the signs of a mental health crisis and in de-escalation, CIT training alone does not negate the potential risks of law enforcement transportation in the IVC process.[34] Officer training should be considered necessary, but is in no means sufficient, to minimizing negative outcomes for individuals subjected to IVC.

Why are police social workers not enough?

The Police Social Workers (PSW) model refers to social workers who are hired by law enforcement agencies and embedded in the department to perform social work and behavioral health functions.[35] PSWs conduct case management with clients after a police interaction, organize social service agencies around community needs, and can also act as co-responders alongside officers in mental health crisis calls.[36] Evaluation has shown that PSWs are better able to recognize a mental health crisis and de-escalate situations compared to CITs.[37] As such PSWs may be an effective model for providing transportation during the IVC process. However, the presence of law enforcement during the response and the association of the social workers with the law enforcement agency may lead to mistrust in the community.[38] This model also continues to blur the lines between incarceration and mental health treatment in ways that may be harmful to patients.

Reform Opportunities in the States

For this report, the Wilson Center team conducted a comprehensive survey of current statutory provisions for IVC custody and transportation during IVC through January 1, 2024. "Involuntary commitment laws" were defined as statutes concerning the length, duration, criteria, and regulation of involuntary psychiatric evaluations for hospitalizations. The researchers (three law students, a graduate student research assistant, a lawyer, and a psychiatrist) developed a research protocol that reliably identified the target statutes. The search terms included mentally ill, civil commitment, and mental illness procedures. Using Westlaw, and Lexis when needed, the team searched for laws in all 50 states and the District of Columbia. The team used state legislature websites to obtain text of the current law.

As seen in Table 1, despite heavy reliance on law enforcement transportation across the United States,[39] only seven states bar non-law enforcement transportation in any circumstance during the IVC process: Alabama, Georgia, Indiana, Maryland, Missouri, Montana, and Wyoming.[40] In the other forty-three states, non-law enforcement may transport an individual involved in the IVC process in at least some circumstances. However, even in these states, law enforcement often serves as the default transporter due to a lack of available alternatives. For instance, in many states, localities can develop their own IVC transportation plans or authorize alternative transporters, but this requires technical assistance and funding.

Table 1. Summary of Availability of Alternatives to Law Enforcement Transportation in the States.

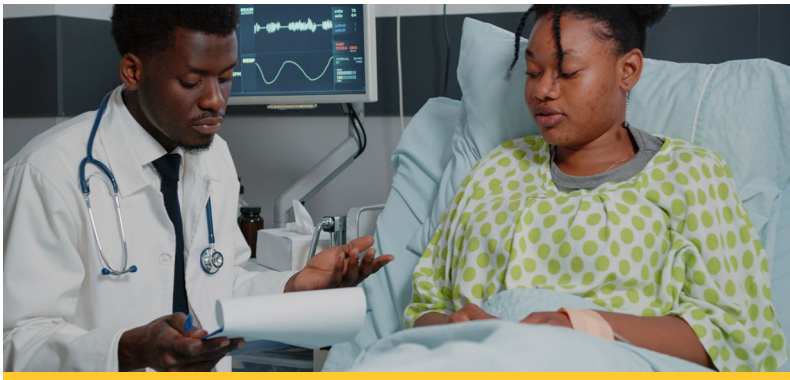
Alternatives to Police Transportation	
Permitted	
Generally	CA, MA, NJ, ND, OR [41]
In limited circumstances	AK, DC, IA, OK, UT, VT [42]
At discretion of court	AZ, CO, CT, ID, KS, ME, MN, MS, NM, OH, SC, TX, UT, VA, WI [43]
At discretion of law enforcement	DE, KY, LA, MN, NV, OR [44]
At discretion of individual certifying admission	NY, RI, SD [45]
If law enforcement is not available	NE [46]
If local communities establish an alternative	AR, CO, FL, IL, MI, NC, TN, TX, WA, WV [47]
For emergency crisis holds	CO, HI, LA, NH, OH, PA, TN, WI [48]
Not Permitted	
AL, GA, IN, MD, MO, MT, WY[49]	

Table 2. Categories of Alternative Transporter in the States.

Types of Other Permissible Transport	
Authorized transporter	**State**
Health care professional	AK, CA, CO, DC, ID, MN, NJ, NC, OH, OR, PA, RI, SC, TN, TX, UT, VT, WA, WI [50]
Other government agency personnel	KY, NV, PA, VA [51]
Ambulance service or private transportation provider	AZ, DE, FL, HI, IL, IA, KY, LA, MI, MN, NV, NJ, NY, TN, TX, UT, VA, WI [52]
Family or friend	AR, KS, LA, NC, OR, PA, SC, TN, TX, VA, WI [53]
Crisis teams	AR, CA, FL, NY, SC [54]
Other authorized persons6	AZ, CA, CT, DE, HI, KS, LA, MA, ME, MN, MS, NE, NM, NC, ND, OR, SD, TN, TX, VA, WV, WI [55]

Seven states completely bar the use of alternatives to law enforcement transportation while, on the opposite end of the spectrum, five states broadly permit alternatives without imposing some conditions. Overall, as seen in Table 1, current state statutes are generally permissive of implementing non-law enforcement transport. For example, ten states require that local communities develop and seek approval for their local transportation plans. This relatively low barrier to change would likely not require statutory changes, although financing and implementing new custody and transportation plans might be complex. Because most states have defaulted to the use of law enforcement for custody and transportation, those agencies are budgeted and staffed accordingly. There could be considerable resistance to reducing the budget and staffing of law enforcement to fund a new custody and transportation plan or to increasing budgets for these functions elsewhere without commensurate cuts to law enforcement. In contrast, fifteen states indicate alternatives to law enforcement transport may only be implemented at the discretion of the court. In these states permission from the courts likely would not require a statutory change, but similarly raise the specter of a local budget impasse.

As seen in Table 2 a variety of other permissible transportation modes may be authorized, including health care professionals, government agency personnel, ambulance services, families or friends, crisis teams, or other categories of authorized persons.



> I have had patients who have had to literally wait days in the emergency room for the sheriff to come to transport them under involuntary commitment. The sheriff's department gets busy and transporting our patients is a low priority for them. Hence the long waits."
>
> — *Psychiatrist in the Emergency Department*

Recommendations

1. **States should allow non-law enforcement transportation for all IVC pathways when appropriate.** Policymakers should ensure that state statutes allow for alternative methods of transportation for IVC patients outside of law enforcement. When needed for safe transport, trained mental health personnel should be the first line of response, even if law enforcement is needed to assist such as in a co-response model. When determined to be safe, alternatives may include family, friends, medical providers, mental health professionals, ambulance services, and/or other authorized providers.

Won't removing law enforcement from IVC transportation put the other transporters at risk?

This has not been the experience of certain communities that have implemented mobile crisis units that respond to behavioral health crises instead of law enforcement. For example, Crisis Assistance Helping Out On The Streets (CAHOOTS) is a mobile crisis intervention unit in Eugene and Springfield, Oregon that has operated since 1989. The crisis team is dispatched through the police-fire-ambulance communications center in Eugene through the non-emergency number. Dispatchers are trained to recognize non-violent situations with a behavioral health component and route those calls to CAHOOTS. Every CAHOOTS team deployed is unarmed and consists of an EMT and a crisis worker who has several years of experience in the mental health field.[56]

In 2021, CAHOOTS was dispatched to 18,106 public-initiated calls for service and arrived on seen 89% of the time.* Of these calls, there were 14,212 instances where CAHOOTS was the sole unit that arrived on the scene. Notably, there were only 301 calls where CAHOOTS called for law enforcement backup, indicating that calls are largely being appropriately diverted and that responders feel equipped to handle the situation without law enforcement when they arrive on the scene.[57]

Another mobile crisis unit, Durham, North Carolina's Holistic Empathetic Assistance Response Teams (HEART), specifically surveyed their responders on their perceived safety when responding without law enforcement. While HEART is still relatively new, the program responded to 5,055 service encounters—an average of 18 calls per day—between June 28, 2022, and March 31, 2023.[58] Like CAHOOTS, findings from this period suggest that calls are being effectively diverted to the appropriate team. Importantly, survey results indicate that HEART staff overwhelmingly feel safe when responding to a call. According to HEART's data dashboard, since June 2022, HEART staff report feeling safe at 99% of encounters and have only needed to call for law enforcement backup at 0.01% of encounters.[59]

While CAHOOTS and HEART do not currently provide transportation for IVC patients, these results provide encouraging evidence that non-law enforcement mobile crisis units are equipped to triage and assess safety when responding to a behavioral health crisis and possess the de-escalation and behavioral health expertise to provide safe, less traumatic transportation.

*According to CAHOOTS, a discrepancy in calls and arrival on scene is common for this type of response. It is often caused by the call being canceled after dispatch. Due to the delay between a call being received, dispatched, and resources arriving on scene, a caller may call back and report the subject of the call is no longer on scene.

2. **State policymakers should provide adequate funding and technical assistance to ensure communities can implement non-law enforcement transportation options.**

Funding mechanisms for alternative transportation options for IVC will vary based on state, county, and municipal budgets, making it difficult to provide sample language for funding. Policymakers should allocate sustainable funding to alternative methods of transportation in the IVC process. If politically feasible, some communities may find success in shifting some of the law enforcement budget to an alternative transportation model given that alternative transportation models should reduce strain on law enforcement resources.[60]

Case Study: Virginia's investment in non-law enforcement transportation

In 2009, the Virginia General Assembly passed legislation allowing individuals under commitment orders to be transported by non-law enforcement entities.[61] However, a decade later, it was clear that law enforcement was still conducting most of the IVC transportation in the state.[62] Recognizing the need for a widely available alternative transportation provider, Virginia contracted with the private security company, GS4 (now Allied Universal) to provide transportation for IVC patients across the state.[63] This program uses secure, unmarked vehicles with specially trained drivers who are unarmed and wearing plain clothes.[64] Staff are not allowed to restrain patients and thus are only called to transport non-aggressive patients.[65]

In 2022, the funding to Allied Universal increased to $6.5 million with the goal of providing 50% of the state's IVC transportation needs. However, due to the shortage of psychiatric inpatient beds in the state, the Allied transporters have to stay with the patient in an emergency facility until an inpatient bed becomes available. Further, these long wait times may lead a patient, who was previously not aggressive, to become agitated.[66] Since Allied transporters do not use restraints, it has been difficult for them to maintain custody if someone becomes dysregulated and transporters are unable to de-escalate the situation.[67] Given this time commitment, Virginia's Department of Behavioral Health and Developmental Services estimates it would cost $16 million for Allied Universal to provide the targeted 50% of transports.[68]

3. **States and localities should implement creative crisis interventions designed to minimize the need for transportation.**

Many individuals transported by law enforcement to a facility for evaluation are ultimately not eligible for IVC. States and localities can implement in-field examinations, either by a clinician co-responder or a non-law enforcement mobile crisis team, to prevent unnecessary law enforcement transportation in the first place. Additionally, in rural areas, states and localities should explore the possibility of conducting telehealth in-field examinations, given potential staffing difficulties in areas with health care provider shortages. Finally, states may consider allowing for IVC court hearings to be held virtually from a hospital, thus eliminating the need for transportation to the courthouse.

4. **When law enforcement transportation is necessary, the officer should be dressed in plain clothes and transportation should be with an unmarked car.**
To minimize trauma for the patient, IVC transporters should dress in plain clothes and avoid transporting patients in marked law enforcement vehicles. Every effort should be made to accompany the patient with a person of their gender. Policymakers can ensure that this non-threatening presentation is the default for IVC transportation.

5. **Require data collection on the entirety of the IVC process, including transportation.**
Consistent and reliable data is key to evaluating and continuing to improve the IVC process. Policymakers should ensure that data is collected at each stage of the IVC transportation process and that the data will be reported to and overseen by an advisory board. Areas for data collection can include: how IVC was initiated, how the patient was transported, who transported the patient, use and rationale for restraints, patient demographic information, and patient outcomes (e.g., if the patient ultimately committed, if force was used, if the patient was harmed in transit, if the patient was connected to services, etc.). To protect patient privacy, data should be collected without asking for identifying information. Finally, data and reports should be made available to the public regularly and all publicly posted data should be appropriately deidentified.[69]

Case Study: North Carolina: State Statute vs. On-the-Ground Implementation

North Carolina is an example of a state that, in statute, provides options for alternatives to law enforcement transportation yet still relies heavily on law enforcement to transport IVC patients. Specifically, the North Carolina General Statutes leave IVC transportation up to cities and counties. While transportation can be provided by a friend, family member, or the individual's health care provider when the patient is not considered dangerous, most counties name law enforcement as the default transportation entity.[70] However, the state's most recent state budget earmarked $10 million over two years for pilot programs that explore alternatives to law enforcement response and IVC transportation.[71]

Key takeaways from North Carolina:

1

Without overarching state policy that specifies and mandates alternatives to law enforcement transportation for IVC, it will be difficult to change the norm of law enforcement being the default transportation entity. States have an opportunity to name a different option, like health care professionals, as the default transporter.

2

If IVC transportation must be left up to local government, state funding can play a key role in incentivizing counties and municipalities to move away from law enforcement transportation for IVC.

Why are co-response teams not enough?

In a co-response model, a behavioral health crisis team arrives on the scene with law enforcement when someone is experiencing a mental health crisis. Unlike the PSW model, the co-responding mental health team can be independent from the law enforcement agency. Co-response teams have been shown to reduce use of force incidents against people experiencing a mental health crisis.[72] Co-response models have also been shown to be more effective than law-enforcement response models at connecting the person in crisis to behavioral health resources and for those patients to follow-through with treatment recommendations.[73] However, many studies found that individuals who received a co-responder intervention reported previous traumatic interactions with law enforcement, suggesting that co-responder models may retraumatize persons experiencing behavioral health crises, even if their risk of arrest is reduced.[74] Additionally, co-response models vary greatly across communities based on the populations they serve, funding levels, type of response, hours of response, and staff resources. Lengthy response times, lack of clarity on the role of the co-response team in the community, and establishing partnerships between clinicians and law enforcement (without a single entity "owning" the program), all put the sustainability of co-response models at risk.[75]

Case Study: OK RIDE CARE shows that alternatives to law enforcement transportation in IVC are possible

As of April 2021, Oklahoma law enforcement officers are only required to securely transport of individuals experiencing mental health crises to the nearest facility within a 30-mile radius of the law enforcement headquarters.[76] In response, the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) launched OK RIDE CARE. OK RIDE CARE contracts with local transportation vendors to provide transportation for children and adults requiring psychiatric care.[77]

OK RIDE CARE strives to provide safe, secure, and trauma-informed care by requiring its transporters providers to be trained in client rights, a therapeutic options curriculum approved by the ODMHSAS, CPR/first aid, HIPAA, and patient confidentiality.[78] Additionally, all transporters use unmarked vehicles.

How Effective is OK RIDE CARE?

In FY22, OK RIDE CARE performed 10,078 transports. Of those transports, 1,685 were juveniles and 8,393 were adults.[79] Due to the success of the program, OK RIDE CARE expanded in the summer of 2023.[80] However, some locations report the program is under-utilized, largely because residents do not know about it.[81] Additionally, because this program is rather recent, robust evaluation data is not yet available. More data should be collected to truly understand the reach of the program and its ability to improve patient outcomes.

How is OK RIDE CARE used for IVC?

If a patient requires transportation to a facility that is more than 30 miles away, OK RIDE CARE provides that transportation 24/7.[82] Request for OK RIDE CARE is initiated by the treatment facility. OK RIDE CARE is then responsible for transporting the client and ensuring the client and their belongings are safely in the hands of the receiving facility before departing.[83] OK RIDE CARE can be used to provide transportation both to a facility for an initial intake and between facilities when a patient is transferred.[84] Finally, OK RIDE CARE can provide transportation both between medical facilities and to an initial evaluation facility if a mobile crisis unit or law enforcement agency requires assistance transporting an individual.

OK RIDE CARE provides an example of a state-funded, IVC transportation system that is meant to improve patient outcomes and reduce the burden on law enforcement. While an ideal program would remove the distance requirement for non-law enforcement transportation, OK RIDE Care demonstrates that a well-coordinated alternative to law enforcement transportation for IVC is feasible.

Conclusions

Relying on law enforcement for routine transportation in the IVC process is far too often traumatic and unsafe for the patients involved, as well as an inappropriate use of law enforcement resources. Policy change can be a key tool to minimize the use of law enforcement to transport IVC patients. Policymakers can allow for non-law enforcement entities to transport patients in the IVC process, whether that be friends/family members, EMS, or ideally, mental health professionals, as well as allocating funding for diversion and alternative transportation models.

Several challenges require thoughtful consideration when building a better response system. Given the number of touchpoints that exist between law enforcement and IVC patients, there likely is not a one-size-fits-all solution to this issue. Ideally, communities can establish a diversion program, where calls for responding to a person experiencing a mental health crisis can be routed to a mobile crisis unit staffed by mental health professionals, as seen in the CAHOOTS and part of the HEART models. In this model, law enforcement is rarely engaged and only as partners if a situation is considered unsafe by

Through intentional policy efforts, communities can build a safer, more effective, trauma-informed system for persons under commitment.

the mobile crisis unit. If funding is not available for a mobile crisis unit, police social workers or co-response models may be a more viable option for the community. However, these models do not negate the necessity of better training for law enforcement since, regardless of the protections in place, a law enforcement officer may still be the first person to encounter a person in crisis. Therefore, law enforcement officers should be trained to recognize the signs of a mental health crisis, to safely de-escalate a crisis, and to contact a mental-health response team (if available).

Further, while many established models provide alternatives to law enforcement response in the community, few provide transportation for IVC patients between medical facilities and court hearings. Mobile crisis units in particular seem hesitant to be tied to the IVC process for fear of fostering mistrust in the community. Both of these issues may be resolved by contracting with trauma-informed, specifically trained transportation services, as seen in the OK RIDE CARE model.

Finally, any conversation about IVC would be incomplete without acknowledging the deep societal stigma that surrounds people with mental illness. Dangerousness as a preeminent criterion for IVC has led society to view those with mental illness as just that - dangerous. While it is true that some mental health crises are particularly risky, this mindset has seriously undermined a more humane view of the need for IVC and how persons in need of IVC are transported. Policy changes toward a non-law enforcement dominant IVC model can be an important step in fostering a more humane and patient-centric culture around IVC.

As reviewed, existing state statutes offer many opportunities to reduce the widespread use of law enforcement custody and transportation in the IVC process and reduce the risk of traumatizing experiences for persons in mental health crises. Through intentional policy efforts, communities can build a safer, more effective, trauma-informed system for persons under commitment.

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