Investigation of Oklahoma, Oklahoma City, and Oklahoma City Police Department

United States Department of Justice
Civil Rights Division

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SUMMARY OF FINDINGS

The United States Department of Justice finds that the State of Oklahoma, Oklahoma City, and the Oklahoma City Police Department (OKCPD) are violating federal law. Specifically, we have reasonable cause to believe that:

- Oklahoma unnecessarily institutionalizes, or puts at serious risk of unnecessary institutionalization, adults with behavioral health[1] disabilities in the Oklahoma County area, in violation of Title II of the Americans with Disabilities Act (ADA); and

- Oklahoma City and OKCPD engage in a pattern or practice of conduct that discriminates against people with behavioral health disabilities when providing emergency response services, in violation of Title II of the ADA and the pattern or practice provision of the Violent Crime Control and Law Enforcement Act of 1994.

Every year, thousands of people with behavioral health disabilities are admitted to psychiatric hospitals in the Oklahoma County area, and hundreds experience repeat admissions within a year. Many also have long-term stays in nursing or residential care facilities. Most would prefer to live in their communities, surrounded by friends and family, and to have the freedom to make their own choices about their lives. These individuals could live successfully in their communities if they received critical community-based services that are proven to help people with mental illness avoid unnecessary stays in institutional settings. But Oklahoma does not provide sufficient services to prevent unnecessary hospitalization. As a result, many people with behavioral health disabilities never receive treatment until they are in crisis, when they instead end up needlessly hospitalized or in contact with law enforcement.

For many in the Oklahoma County area, OKCPD is the agency they encounter. When a person calls 911 for help with a behavioral health issue, the City defaults to sending police as the sole responders in most cases. These calls for assistance would often be most effectively resolved with a response by behavioral health professionals who can provide appropriate treatment, but the City rarely involves such professionals. And when OKCPD officers respond to situations involving behavioral health, they sometimes fail to help, escalate crises, or even unnecessarily resort to force. People do not get the help they need and then are taken to the hospital to begin the cycle again.

[1] Behavioral health disabilities include mental illness and/or substance use disorders. Such a condition is a disability when it causes an impairment that substantially limits one or more major life activities. *See* 42 U.S.C. § 12102. This population includes people with co-occurring intellectual or developmental disabilities.

Together, the deficiencies in Oklahoma County's behavioral health service system and Oklahoma City's emergency response system lead to an unnecessary cycle of hospitalization and law enforcement contact.

Serena's story illustrates this troubling pattern. Serena was 27 years old when she died. By then, she had struggled for years to access behavioral healthcare in the community, spending a significant amount of time in psychiatric facilities and frequently encountering the police. Her mom describes her as "a really happy person" who "had a lot of life to her." She liked to write and play soccer, she loved animals, and she wanted to be a model.

As a child, Serena spent time in a State-run children's psychiatric hospital, and as an adult she was in and out of hospitals and jail. Serena was frequently homeless, and she struggled to get access to supportive housing and intensive services, such as help taking her medication and attending medical appointments. The lack of services in Oklahoma County meant that she often had to wait a long time to get an appointment with a community provider, and the services she did receive were not intensive enough to help her live successfully in the community. In the two years leading up to her death, Serena had at least five psychiatric inpatient stays. When in crisis, she regularly sought out crisis services but was typically turned away without any treatment to help stabilize her symptoms. In those instances, Serena was given only a piece of paper with an address and phone number for a behavioral health clinic, but was otherwise left to fend for herself. A clinic's intake process can be long, and a paper referral would not address Serena's current crises. Ultimately, Serena did not receive the support she needed to access immediate and long-term behavioral health services.

Serena also had regular contact with OKCPD. She faced arrest for issues such as public drunkenness, property damage, or violations of bond obligations for prior charges. Serena spent much of the last year and a half of her life in jail. She ultimately died by overdose after not receiving behavioral healthcare that would have helped her live successfully in the community and avoid unnecessary encounters with the police.

INVESTIGATION

After receiving a complaint, on November 17, 2022, the Department of Justice opened an investigation of the State of Oklahoma under the ADA[2] and of Oklahoma City and OKCPD under the ADA and the pattern or practice provision of the Violent Crime Control and Law Enforcement Act of 1994.[3] During our investigation, we assessed (1) whether Oklahoma fails to provide sufficient community-based services to adults with behavioral health disabilities in the Oklahoma County area, resulting in unnecessary institutionalization; and (2) whether Oklahoma City and OKCPD's emergency response system discriminates against people with behavioral health disabilities.

Our investigative team consists of career employees from the Special Litigation Section of the Department's Civil Rights Division, as well as consultants with expertise in behavioral health services, police tactics and training, emergency response systems and processes, and data analysis. The team participated in hundreds of interviews with State and City officials, behavioral health and social service providers, and a wide array of stakeholders including advocates, family members, and individuals who have experienced the Oklahoma County behavioral health system and OKCPD. We conducted onsite visits to State- and privately-run facilities for people with behavioral health disabilities in the Oklahoma County area, as well as many community-based providers. We also visited OKCPD patrol divisions, the training facility, and the 911 Communications Center. We reviewed tens of thousands of pages of records and analyzed data that the State, the City, and OKCPD produced to show their respective policies and practices.

We thank the State, City, and OKCPD officials and employees who have cooperated with this investigation. We are also grateful to the many members of the Oklahoma County community who met with us to share their experiences and provided valuable information.

[2] 42 U.S.C. §§ 12133-34; 28 C.F.R. § 35.130(d).

[3] 34 U.S.C. § 12601.

LEGAL FRAMEWORK

"[D]isabilities in no way diminish a person's right to fully participate in all aspects of society."[4] Yet Congress found that "historically, society has tended to isolate and segregate individuals with disabilities,"[5] and discrimination against people with disabilities "persists in critical areas" such as institutionalization and access to public services.[6] Accordingly, the ADA "provide[s] a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."[7] Title II of the ADA protects the rights of people with disabilities to participate in and benefit from a public entity's programs and services. As public entities, the State of Oklahoma and Oklahoma City both must comply with Title II of the ADA.

The ADA's integration mandate requires Oklahoma to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[8] The most integrated setting is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible."[9] In *Olmstead v. L.C.*, the Supreme Court recognized that isolating individuals with disabilities in segregated settings instead of providing them services in their communities is disability discrimination. To prevent this discrimination against adults with behavioral health disabilities in Oklahoma County, Oklahoma must provide them with community-based services whenever (a) those services are appropriate; (b) individuals do not oppose community-based services; and (c) community-based services can be reasonably accommodated.[10] Even where Oklahoma relies on private entities to deliver services, it still bears ultimate responsibility under Title II of the ADA. The ADA's integration mandate applies both to people who are currently segregated and to people who are at serious risk of unnecessary institutionalization.

People with behavioral health disabilities have the right to access public services without discrimination. The ADA requires public entities like Oklahoma City to provide people with disabilities an equal opportunity to participate in or benefit from the City's services, programs, or activities. When providing a service to people with disabilities,

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[4] 42 U.S.C. § 12101(a)(1).

[5] 42 U.S.C. § 12101(a)(2).

[6] 42 U.S.C. § 12101(a)(3).

[7] 42 U.S.C. § 12101(b)(1).

[8] 28 C.F.R. § 35.130(d).

[9] 28 C.F.R. pt. 35, app. B (2011); *see also, e.g.*, *Olmstead v. L.C.*, 527 U.S. 581, 592 (1999) (quoting this definition); *Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1180 (10th Cir. 2003) (same).

[10] *Olmstead*, 527 U.S. at 607.

the City must also ensure that it is as "effective in affording equal opportunity to obtain the same result . . . as that provided to others."[11]

Under the ADA, Oklahoma, Oklahoma City, and OKCPD must reasonably modify their policies, practices, or procedures if doing so is necessary to avoid disability discrimination, unless such modifications would fundamentally alter the nature of their services, programs, or activities.

[11] 28 C.F.R. § 35.130(b)(1)(iii) ("A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability . . . [p]rovide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others."); *Robertson v. Las Animas Cnty. Sheriff's Dep't*, 500 F.3d 1185, 1195 (10th Cir. 2007).

BACKGROUND

A. Oklahoma State and County

Oklahoma is the 28th most populous state in America. Demographically, the state's population identifies as 72.9% white, 12.9% Hispanic, 7.9% Black or African American, 2.6% Asian, 9.5% Native American and Alaskan Native, and 6.8% multiracial. Oklahoma County, with a population of around 796,292 people, is the state's most populous county and home to around 20% of Oklahoma's residents. Almost 30,000 adults in Oklahoma County have a serious mental illness.[12]

Many of these adults depend on the Oklahoma Department of Mental Health and Substance Abuse Services (DMH) for their behavioral healthcare. DMH plans and oversees state and federally funded behavioral health and substance use services throughout the state, including in Oklahoma County. DMH operates Griffin Memorial Hospital in Cleveland County, which serves neighboring Oklahoma County and has 120 beds. DMH also relies on private hospitals and nursing and residential care facilities to serve adults with behavioral health needs in Oklahoma County. The private hospitals include general hospitals with psychiatric inpatient units, such as St. Anthony's and Integris, and private behavioral health hospitals, such as Cedar Ridge and Oakwood Springs. Residential care and nursing facilities within the County include a 77-person residential care facility that receives DMH funds, and at least thirty nursing facilities ranging from 29 to almost 400 beds.

DMH also operates or contracts with thirteen Certified Community Behavioral Health Centers (CCBHCs) to provide ongoing community-based services and supports to adults with behavioral health disabilities. The CCBHCs that serve Oklahoma County are Red Rock Behavioral Health, NorthCare, and Hope Community Services. Along with CCBHCs, DMH contracts with additional community-based providers for specific services, such as peer support or housing.

DMH also oversees Oklahoma's crisis services, which include a non-police crisis line, mobile crisis teams, and crisis receiving and stabilization facilities for people experiencing acute behavioral health symptoms. In Oklahoma County, DMH operates an urgent recovery center (URC) and two crisis centers, Oklahoma County Crisis Intervention Center and Oklahoma Crisis Recovery Unit. Oklahoma County's CCBHCs operate additional URCs, as well as a crisis center on the same grounds as Griffin Memorial Hospital. DMH also oversees the State's 988 Mental Health Lifeline and mobile crisis program.

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[12] Serious mental illness is a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Substance Abuse & Mental Health Servs. Admin., *Mental Health and Substance Use Disorders*, https://www.samhsa.gov/find-help/disorders [https://perma.cc/2ETT-UMAE].

The Oklahoma Health Care Authority (OHCA) administers the State's Medicaid program, commonly known as SoonerCare. The Health Care Authority is also responsible for contracting with and overseeing Managed Care Organizations, which recently started providing behavioral health services for most Medicaid beneficiaries.

B. Oklahoma City and the Police Department

Oklahoma City comprises a significant majority of Oklahoma County by population and land area. With 702,767 people and 620 square miles, Oklahoma City is the 20th most populous and geographically the eighth largest city in the United States. It is also among the nation's fastest growing cities. Demographically, the city's population identifies as 61.4% white, 20.1% Hispanic, 13.7% Black or African American, 4.5% Asian, 3.4% Native American and Alaskan Native, and 11.8% multiracial. The city is home to more than 40,000 veterans and a major military base. Oklahoma City's 2024 "Point in Time" survey identified 1,838 unhoused persons, an increase of 28% from the prior year.

Oklahoma City has a Council-Manager form of government, led by a Mayor, City Council, and City Manager. The City Council consists of a citywide elected Mayor and eight members elected by geographical areas, called Wards. The City Council appoints a Manager to serve as the chief administrative officer overseeing the City's day-to-day operations, 4,800-plus employees, and $1.5 billion budget.

Each year, the City devotes a substantial portion of its budget to public safety. In 2024, OKCPD was allocated $268 million and 1,581 employees. OKCPD is led by a Chief of Police, five Deputy Chiefs, and twelve Majors. With more than 1,100 uniformed officers and 300 civilians, OKCPD has filled most of its budgeted positions. OKCPD has five bureaus: Administration, Investigations, Operations, Public Safety Support, and Special Operations.

OKCPD provides emergency response services across all 620 square miles of the city through 911 Communications Center dispatch operations and patrol officers interacting directly with people in the community. OKCPD has a Crisis Intervention Team (CIT) made up of about 180 patrol officers. Patrol officers must volunteer and be selected for CIT, and they receive bonus pay for doing so.

FINDINGS

A. Oklahoma relies on segregated settings to serve adults with behavioral health disabilities in Oklahoma County, in violation of Title II of the ADA.

Under Title II of the ADA, Oklahoma is obligated to provide services to adults with behavioral health disabilities in the most integrated setting appropriate to these individuals' needs. But in the Oklahoma County area, Oklahoma provides insufficient community-based services for this group. As a result, adults with behavioral health disabilities experience unnecessary institutionalization, or serious risk of unnecessary institutionalization, in segregated settings such as hospitals and nursing and residential care facilities. Oklahoma could reasonably modify its existing service system to serve people with behavioral health disabilities in the community.

1. Adults with behavioral health disabilities in Oklahoma County are unnecessarily institutionalized, or at serious risk of unnecessary institutionalization, in segregated settings.

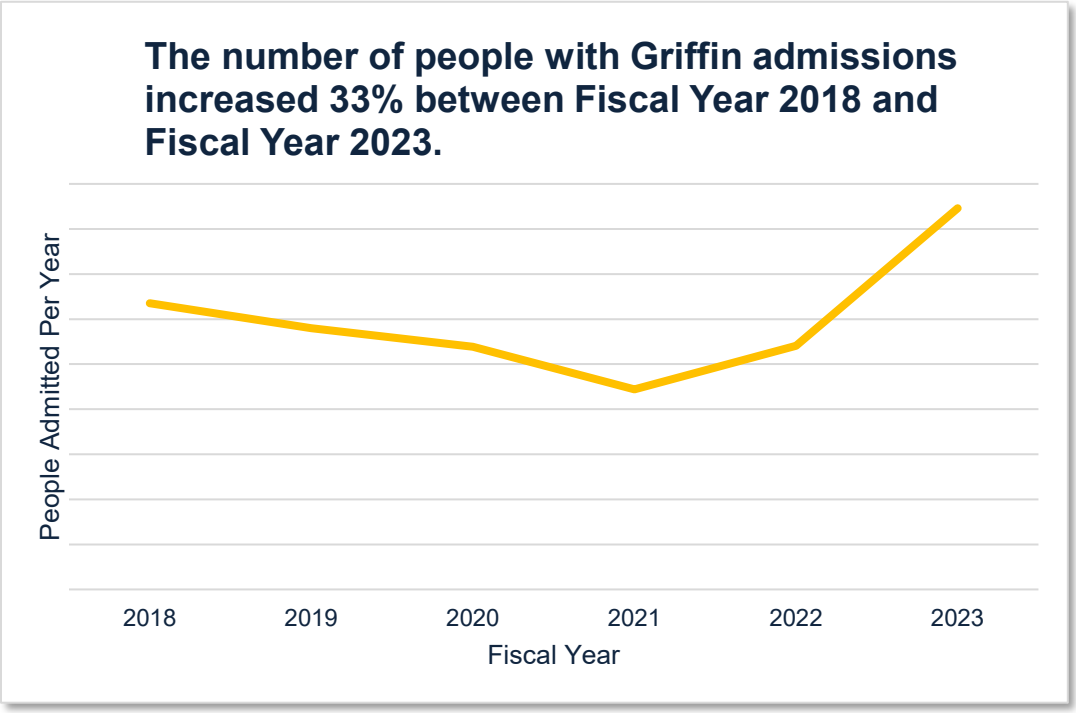
Oklahoma unnecessarily relies on segregated settings, including psychiatric hospitals and nursing and residential care facilities, to serve adults with behavioral health disabilities in Oklahoma County. These individuals may experience long or repeated stays in psychiatric hospitals, and some will then have long-term stays in nursing or residential care facilities instead of returning to the community. Psychiatric institutionalization disrupts people's lives. They may lose contact with their friends, family, and communities, and they may lose their jobs, school, or housing. Long stays in institutional settings may also diminish people's independent living skills, making it more difficult for them to return to and live successfully in the community in the long-run. But for people that are appropriate for and do not oppose community-based services, these institutional stays are avoidable and people can live meaningful and successful lives in the community.

a. Many adults with behavioral health disabilities experience long or repeated stays in psychiatric hospitals.

For residents of Oklahoma County, inpatient psychiatric hospitalization may occur at Griffin Memorial Hospital, the State-run psychiatric hospital that serves a substantial number of people from the Oklahoma County area, or one of the private hospitals in Oklahoma County that accept Medicaid to pay for psychiatric inpatient stays. Psychiatric hospitals and units are segregated institutional settings. The units are locked, and daily schedules are controlled. Patients have little to no privacy, and they may be subject to restraint or seclusion in certain situations.

Admissions to Griffin Memorial Hospital are rising. The number of adults admitted to Griffin exceeds pre-pandemic levels, with over 1,600 adults admitted in Fiscal Year

2023. In addition, more people are experiencing multiple admissions within the same year. For example, more people had five or more admissions within Fiscal Year 2023 than the total number of individuals with five or more within-year admissions for Fiscal Years 2018-2021 combined. While the average length per stay in Fiscal Year 2023 was 14 days, people with three or more admissions spent an average of 45 days in the facility, and people with five or more stays spent an average of 54 days in the facility.



Adults with behavioral health disabilities also have frequent, and sometimes lengthy, stays in private hospitals funded in part through Medicaid. In 2023, over 4,700 adults were hospitalized for behavioral health reasons in private psychiatric hospitals or units. While these stays last around ten days on average, in 2023 over 1,000 people spent two weeks or more in a private psychiatric hospital or unit. And many people also have repeat admissions: Nearly 300 adults were admitted *at least five times* to private psychiatric hospitals between September 2021 and November 2023. On average, this group spent a total of more than 88 days in a hospital setting for psychiatric reasons during this period.

We interviewed and reviewed the records for a sample of adults with behavioral health disabilities who were either in a psychiatric hospital at the time we met them or had recently been hospitalized in the Oklahoma County area. Many had a history of either long or repeated hospitalizations that could have been avoided or reduced with access to appropriate community-based services. Nathaniel was a 39-year-old man when we met him. He likes to cook, watch television, and listen to music. He wants to learn how to be independent and live a "rich life" in the community, but between February 2022 and September 2023, Nathaniel was hospitalized five times. In total, he spent around 500 days in the hospital, including one hospitalization that was almost one year long. Nathaniel has told providers that he struggles to adhere to his medication without structure, which is support that he could receive in the community. Indeed, after a recent hospitalization, he was finally referred to a more intensive community-based program, but it took three months for the services to start, and he was hospitalized again in the meantime.

Nearly 300 adults were admitted to a private psychiatric hospital **at least five times** between September 2021 and November 2023.

Josh is a 36-year-old man who studied biology in college and used to play the violin and viola. Since his early twenties, he has been hospitalized multiple times and has had frequent interaction with police. Josh wants to live with his family, but his family has become less involved throughout his many hospitalizations. When we met Josh five months into his stay at the hospital, he told us "I just don't want to be here anymore." At that point, he would have been appropriate for intensive community-based services that could help him break his cycle of hospitalization and live successfully in the community. But instead of the State supporting Josh in leaving the hospital, he stayed for seven more months.

b. After a hospital stay, some people with behavioral health disabilities experience long-term institutionalization in nursing or residential care facilities.

Instead of receiving services in the community, many people with behavioral health disabilities have long-term stays in a nursing or residential care facility, paid for in part by the State. At the time of our investigation, there were nearly 600 people with behavioral health disabilities living in one of over 30 nursing facilities in Oklahoma County or a large residential care facility called The Harbor. People remain in these facilities for years.

Nursing facilities are segregated institutions that provide onsite medical, nursing, and rehabilitative care to people with mental or physical disabilities or injuries. Residents are typically assigned at least one roommate, providing them with little to no privacy. Nursing facilities also leave little room for residents to exercise independence. There

are staff onsite 24 hours a day and they provide personal care assistance such as housekeeping, laundry, and hygiene services. Daily life is limited and controlled, and some residents feel that their freedom to leave the facility is restricted.

Nursing facility data identify nearly 600 people with significant behavioral health disabilities, such as bipolar affective disorder or schizophrenia, in Oklahoma County's nursing facilities. This is around 20% of all Oklahoma County nursing facility residents. Nine facilities had more than 20 people with significant behavioral health disabilities, and at least two of those are known as "mental health nursing facilities." We interviewed, and reviewed records related to, a sample of people living in Oklahoma County's nursing facilities. Most could be successfully supported in the community with appropriate behavioral health services; some would also need support for their physical healthcare.[13] Yet the people we interviewed had been in a nursing facility for an average of over three years, and few had been engaged in any meaningful discharge planning.

There are **over 500** adults with behavioral health disabilities in Oklahoma County's nursing facilities.

Adults with behavioral health disabilities similarly stay for months and years in The Harbor, a 77-bed residential care facility that serves people with mental illness, substance use disorder, or both. For some individuals, the State funds services at The Harbor through a contract. In addition, the State provides CCBHCs with "flex" funds that can be used to pay for room and board at The Harbor. The Harbor is a large dorm-like facility where daily life for residents is regimented. The facility serves meals at the same time every day, the kitchen is off-limits to residents, there is a curfew, and lights are turned off at the same time every night. Residents' ability to leave the facility may also be restricted. Every resident is asked to notify staff if they plan to leave the facility. Visiting hours are also limited, restricting residents' ability to interact with people who do not have disabilities.

The State has put more resources into residential care over the past several years. It has more than doubled the funding that goes to residential care in Oklahoma County since Fiscal Year 2017. And even as the Griffin population rises, the number of people the State discharged directly to The Harbor in 2023 is more than triple the number discharged in the past six years combined. Interviews with State officials suggest that Oklahoma plans to continue using The Harbor to place people with behavioral health disabilities.

Residents often stay at The Harbor for many years. We reviewed a sample of people who were living in The Harbor. On average, this group had been in the facility for a little under three years. Few had been engaged in plans to leave, and some people who left

[13] Physical healthcare support can also be provided in the community.

The Harbor returned after short stays in the community in part because they did not get the services they needed.

Some people we met in nursing and residential care facilities came from psychiatric hospitals and face challenges in trying to leave these facilities for the community. Leah is an outgoing, 64-year-old woman who previously had a career in the transportation industry and has been living in a facility for six years with one interruption. She once tried to leave the facility for the community. But she found she had lost many independent living skills. She struggled to take her medications correctly and to eat healthy food, needs that could have been supported in the community with appropriate services. She was ultimately hospitalized and then returned to the facility. While Leah would still like to leave the facility for the community, there is no evidence of a plan for her to move.

We spoke to Cora almost one year into her placement in a facility. Prior to this placement, she experienced homelessness before spending six months at a psychiatric hospital despite being ready for discharge after less than two months. After unsuccessfully seeking out community-based options, the hospital discharged her directly into a facility. Cora wants to leave the facility, but she had no documented discharge plan and therefore has little hope of being able to move even though she could live successfully in the community with intensive services and supports.

c. Adults with behavioral health disabilities in segregated settings do not oppose receiving services in the community.

Nearly all individuals whose records we reviewed would prefer living in their own homes and communities with appropriate supports rather than in a hospital or other segregated setting. Adults who have experienced life in a facility describe it as a "dead end" and like being "stuck" or in "jail." One man said of the hospital: "I just don't want to be here anymore." A nursing facility resident, Vicky, wants to live in the community so that she can "take classes," "work," "make her own money," and be "part of society." Forty-four-year-old Abigail also expressed a strong desire to leave her nursing facility and return to the community: "I want out of here. I don't want to be here my whole life. I'm young." Emily told us that she and her husband "feel lucky" if their son, who has a behavioral health disability, "makes it home from the facilities," while Sarah said that her own facility stay "felt like a prison. I was scared of everyone there." Discussing her son Tom's stay at a residential care facility, Lisa recalled: "He told me, 'I just want to come home, mother.' He never liked being there." And Anita, whose sister passed away at a young age after a lifetime of struggle to receive appropriate community-based services for her behavioral health conditions, recalls how her sister "never seemed happy" when in the hospital: "[E]ven in her right

> **"I want out of here.** I don't want to be here my whole life. I'm young."
>
> *Abigail*

mind, she'd never speak positively about them or indicate she was getting better thanks to her stay there."

In contrast, the people we met who had access to community services felt empowered, hopeful, and positive about their behavioral health recovery. As Jeremiah shared, "I got case management today which was so extremely helpful. It almost brought me to tears. It was nice, I felt so good about myself in the process when making phone calls with the case manager. I felt good about myself, I felt able." Miles appreciates receiving services in the community because there are "more people who can help," making him better equipped to reach informed decisions about his care. He says, "In the community I can get different opinions and resources." These experiences reflect that, with appropriate supports, Oklahomans with mental illness strongly prefer to live in their own homes, not in an institution.

d. Adults with behavioral health disabilities can be served in the community with appropriate community-based services.

With appropriate community-based services, most adults with behavioral health disabilities segregated in Oklahoma County facilities could live successfully in the community and avoid long or repeated institutional placements. Records of many people we met in hospitals reflect that they needed support such as help obtaining and keeping housing, help remembering to take their medications and attend healthcare appointments, and connection to therapy and other resources. This support can be provided in the community, but we found many people who tried and were unable to access such support. For example, Xavier repeatedly tried to obtain access to therapy and other supports necessary to manage his behavioral health disabilities through a CCBHC in hopes of reestablishing contact and visitation with his seven-year-old son. Despite these efforts, he was hospitalized at least 13 times since the beginning of 2020. Olivia was similarly unsuccessful in her efforts to find housing and medication management in the community, sharing that community behavioral health providers "just give you a big booklet and tell you to call numbers." As a result, she has been hospitalized five times since January 2021. With appropriate supports, people like Xavier and Olivia could have spent less time in a hospital or avoided these hospital stays altogether.

Staff at nursing and residential care facilities told us that they believe their residents could live independently if more intensive supports were available for them. For instance, a nursing facility social worker explained that residents remain institutionalized, not due to their medical needs, but because the system is "woefully underdeveloped." As she put it, "intact" provider networks would enable many residents to viably transition to community settings. Jean's three years as a nursing facility resident illustrate the challenges these residents face. At only 48 years old, Jean feels that she is too young to spend the rest of her life in a facility. Jean enjoys writing and hopes to publish a book. She wishes she could live close to her friends in the community, but she remains institutionalized because she has nowhere else to go for assistance with managing her medications and reliable access to counseling.

Many residents with behavioral health disabilities live in these facilities because they lack housing and the supportive services needed to maintain that housing in the community. One of these residents, Aiyanna, was admitted to a facility after years of struggling with her behavioral health disabilities and chronic homelessness. Because her providers have been unable to find appropriate community housing for her, she has remained in a facility even though she wants to and could live in her own apartment with necessary supports. Similarly, Vicky has relied on facilities for housing due to an unstable housing situation and lack of reliable access to needed services in the community. A lover of drawing and coloring, Vicky is eager to live in her own apartment and have a job filing papers in an office because she has "colored enough" throughout her time in her facility. Nonetheless, Vicky remains institutionalized with no access to housing and no one to talk to about her options for transitioning to a community-based placement.

Community-based services enable people with behavioral health disabilities, including even those with the most significant disabilities, to live successfully in the community. One homeless services provider described a client who, following a decade of repeated hospitalizations and a "perpetual crisis state," no longer required hospitalization after receiving intensive services in the community and assistance with housing. A provider of services for justice-involved individuals who routinely assists with behavioral health conditions summed it up: "People can do just fine in the community when they have the access to the services needed to help them function and be healthy."

2. Oklahoma provides insufficient community-based behavioral health alternatives to hospitals and residential care and nursing facilities.

> The community-based system for people with behavioral health disabilities is **"radically unavailable."**
>
> *Homeless Services Provider*

Community-based services such as Program of Assertive Community Treatment, permanent supported housing, case management, peer support, supported employment, and crisis services are effective alternatives to stays in hospitals and nursing and residential care facilities. Oklahoma offers these services through Medicaid or State funds, but there is not enough supply to prevent unnecessary institutionalization in Oklahoma County. As a homeless services provider put it, the community-based system for people with behavioral health disabilities is "radically unavailable." As a result, the only option left for many people is hospitalization, which may lead to longer-term institutionalization at nursing or residential care facilities.

The lack of community-based services also contributes to high rates of behavioral health-related calls to 911. In 2023, OKCPD logged at least 18,614 behavioral health calls for police response. Many of the crises leading to those calls could have been prevented with access to appropriate community-based behavioral health services. And

for many adults with behavioral health disabilities in Oklahoma County, the County jail has become the default behavioral health provider.

a. Oklahoma fails to provide sufficient intensive services to prevent unnecessary institutionalization.

Intensive community-based services successfully support people with behavioral health disabilities in the community, prevent hospitalizations, and serve as alternatives to institutional care. But in Oklahoma County, the organizations that provide these services are "overloaded" with clients. The CCBHC intake process is long and cumbersome, impeding access to services for many people. Those who do connect with CCBHCs often receive only basic services below the level of intensity that many people with behavioral health disabilities need to avoid hospitalization. Providers also lack the capacity for intensive outreach and engagement activities that would keep people in treatment, so people often lose contact with community service providers and are eventually institutionalized. Building capacity in the community-based programs outlined below would prevent these unnecessary institutionalizations and keep people in the community.

Often described as a "hospital without walls,"[14] **Program of Assertive Community Treatment (PACT)** is an intensive and individualized community-based service designed for people with significant behavioral health needs. For example, PACT often helps people who have multiple psychiatric admissions to hospitals or emergency rooms, lack safe and stable housing, or have been arrested or incarcerated. PACT services could include therapy, substance use treatment, employment services, assistance with activities of daily living, housing support services, case management, peer support, and medication management. Services are provided by a team of practitioners in locations convenient to the person, such as at home or work. Crisis services are also available 24 hours a day, 7 days a week, although PACT teams often anticipate and prevent crises from happening.[15]

When implemented properly, PACT reduces psychiatric hospitalizations and criminal justice involvement, improves housing stability, supports people in living independently and working, and promotes behavioral health recovery. Across the country, PACT has successfully supported people in the community who spent years in institutions. In

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[14] Ross Ellenhorn, *Assertive Community Treatment: A "Living-Systems" Alternative to Hospital and Residential Care*, 45 PSYCHIATRIC ANNALS 120, 120 (2015), https://www.ellenhorn.com/pdf/assertive-community-treatment.pdf [https://perma.cc/4B3M-CP2F].

[15] *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DHHS PUB. NO. SMA-08-4344, ASSERTIVE COMMUNITY TREATMENT: BUILDING YOUR PROGRAM 5-7, 9 (2008), https://store.samhsa.gov/sites/default/files/sma08-4344-buildingyourprogram.pdf [https://perma.cc/RGJ5-8SUK].

Oklahoma County, PACT would be an effective alternative for many people with behavioral health disabilities in institutional settings.

Katie was a 22-year-old woman when we met her at a behavioral health hospital. She has a history of hospitalization; she told us that she feels like she "can't stay out of the hospital" and lets the hospital staff down every time she is admitted, but without additional support, she struggles to keep up with appointments. PACT services are designed specifically for people like Katie, who with more intensive supports and individualized care can be successfully supported in the community. A PACT team could even support Katie in pursuing her goal of becoming a mechanical engineer.

Oklahoma funds PACT through Medicaid and State funds. There is only one full PACT team in Oklahoma County. A second provider previously offered full PACT team services until July 2023, when it transitioned to a different service model, in part, because it lacked the resources necessary to maintain the low staffing ratios required by the PACT model. The State can now only provide true PACT services to around 130 people in Oklahoma County. This is simply not enough PACT in Oklahoma County to serve the more than 800 people with behavioral health disabilities in the area who may be institutionalized at any given time.

Those people who have received PACT in Oklahoma County had fewer rehospitalizations and fewer arrests than before entering the program. But as one homeless services provider put it, only the "lucky ones" get PACT. A hospital provider told us he would be more confident that people could live successfully in the community if PACT were more widely available. But his experience was that the PACT waitlist is generally full, and that it had been several months since he got anyone off the waitlist.

Permanent Supported Housing combines long-term, safe, and affordable housing with supportive services that help people live successfully with maximum independence just like people without disabilities. It typically includes a lease for an apartment or house in the person's name, with the tenant paying no more than 30% of their income toward rent and basic utilities. Supportive services are tailored to a person's needs and often include helping to locate and lease the housing. Supportive services are voluntary and not a condition of tenancy. Permanent supported housing reduces emergency

room visits, hospitalizations, and incarceration because it provides residential stability that promotes behavioral health recovery.[16]

Oklahoma says it "maintains a strong commitment to both the provision of housing and housing support services and advocacy for increased housing options for people with mental illness and/or addiction disorders," and it includes permanent supported housing in its housing continuum.[17] However, State employees, providers, and community members universally report there is a critical, unmet need for supported housing in Oklahoma, and in Oklahoma County specifically. As one State employee put it, "by simple math we need more."

The State reports that it has fewer than 30 State-funded designated permanent supported housing units in Oklahoma County, in addition to federally funded supported housing.[18] It also contracts with a community provider to assist people discharging from State-run facilities to locate housing and connect with supportive services; this program serves around 30 to 40 people each year. Each of the CCBHCs also have housing teams to assist people with mental illness in finding a home and providing supportive services. Some community providers operate permanent supported housing using other funds. The State also provides CCBHCs with "flex funds" for people to use for rent. Still, the capacity for permanent supported housing is insufficient.

Housing is a common barrier for people seeking to live successfully in the community. A sizeable portion of Oklahoma County's homeless population has significant behavioral health needs, and many are also in and out of jail. According to a homeless services provider, this group is "just surviving" because they lack access to ongoing supportive services. Providers tell us they "see a lot of crises driven by lack of resources," so people with mental illness who are unhoused experience avoidable police contact or stays in crisis centers or hospitals.

Some adults with behavioral health disabilities remain in a hospital setting for longer than necessary while trying to find housing. Others are discharged to homeless shelters because of the lack of available permanent supported housing. Without stable housing, people may be rehospitalized because it is difficult for people to focus on

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[16] *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DHHS PUB. NO. SMA-10-4509, PERMANENT SUPPORTIVE HOUSING: BUILDING YOUR PROGRAM 1-6, 15 (2010), https://store.samhsa.gov/sites/default/files/buildingyourprogram-psh.pdf [https://perma.cc/M7CE-TQG6].

[17] Okla. Dep't of Mental Health & Substance Abuse Servs., *Housing*, https://oklahoma.gov/odmhsas/recovery/housing.html [https://perma.cc/Y8GV-576K].

[18] A recent report shows that Oklahoma City has been successful in maximizing federal housing benefits. The area has nearly 950 federally funded permanent supported housing units. U.S. DEP'T OF HOUS. & URB. DEV., CONTINUUM OF CARE REPORT: OKLAHOMA CITY (June 24, 2024), https://files.hudexchange.info/reports/published/CoC_Dash_CoC_OK-502-2023_OK_2023.pdf [https://perma.cc/C7A3-QKYR].

behavioral health recovery without safe and stable housing and access to services to meet basic needs. Micah, a 42-year-old mother of two young children, has experienced regular hospitalizations and interactions with law enforcement due to her mental illness. She has repeatedly tried to access housing through different CCBHCs, but she is still on a waiting list. Her brother Darius says Micah "has been trying to get housing" because her "toughest problem is the place to live. She would do so much better if she had housing assistance." Imani, who we met while she was staying at a homeless shelter after discharging from Griffin, told us it "would be nice to have a building where we could shower. It would help me keep up my hygiene and get a job."

Oklahoma City is attempting to fill the housing gap by funding programs for housing and homelessness itself, but there does not appear to be a significant focus on permanent supported housing in particular nor is there sufficient coordination with DMH to ensure the necessary supportive services are included. And even as the State is interested in expanding the availability of housing units for people with behavioral health disabilities, it is not clear that providers presently have the capacity to provide the intensive services that are necessary to make this housing truly supported.

Case Management provides support to people with behavioral health needs in gaining access to appropriate community resources. The goal of case management is to promote recovery, maintain community tenure, and assist people in achieving self-sufficiency.[19]

Oklahoma funds case management through State and Medicaid funds. For people receiving PACT, intensive case management is an included service. Those not receiving PACT may receive standard case management or targeted case management. Standard case management is generally a clinic-based service that assists people with accessing additional services and supports. Targeted case management in Oklahoma is reserved for people transitioning from institutions to the community, or people who have a demonstrated need through frequent hospitalization or crises. It is intended to be more intensive in directly assisting people with their needs, but provided over a shorter period than standard case management.

Case management services are limited in Oklahoma County and not sufficiently intensive to prevent unnecessary hospitalization. One provider explained that "more intensive case management is needed for most participants." Indeed, the State's own data suggest that less than half the people with serious mental illness in Oklahoma County receive any case management. Those that do receive case management receive very little of the service per year.

Case management in Oklahoma County is also not proactive enough to keep people engaged in services, leading them to disconnect from services and ultimately to be

[19] Okla. Dep't of Mental Health & Substance Abuse Servs., *Behavioral Health Case Management*, https://oklahoma.gov/odmhsas/recovery/bhcm.html [https://perma.cc/NH38-ZL5F].

institutionalized. Some people with mental illness can succeed with basic case management. Others need the additional support of a case manager who actively follows up and uses affirmative engagement strategies, instead of solely relying on the person to maintain services, find resources, and follow their treatment plan on their own.[20]

Elijah, who we met during his fifth hospitalization in a six-month period, has a case manager but he told us "she doesn't come by until she thinks something is wrong." Theo works with a CCBHC, but the sole focus is on providing medication even though Theo has had frequent hospitalizations and is likely eligible for more intensive services. His family reports that he has experienced a lot of case manager turnover, and his current case manager "basically doesn't ever reach out," instead telling the family to reach out to him if it needed anything. Theo's father told us, "My biggest worry [is] who is going to care for him [when I'm gone]."

Peer Recovery Support Services are provided by people who have lived experience with mental illness, are in recovery, and are certified to work with others in similar situations. Through shared experience, peers can help people become and stay engaged in community treatment and can prevent crises and hospitalization.[21] Peer recovery support can be especially helpful for people transitioning out of institutional settings.[22] After four trips to a crisis center, Jeremiah finally spoke to a peer support specialist. He said "that hit me in the gut. This is my kind of people. It set me on my path today."

Oklahoma funds peer support services through Medicaid and State funds. In Oklahoma County, CCBHCs and other community providers provide peer support, but some advocates and community members report that peer support is unavailable or not routinely offered. Indeed, the State's own data suggests that only a fraction of people

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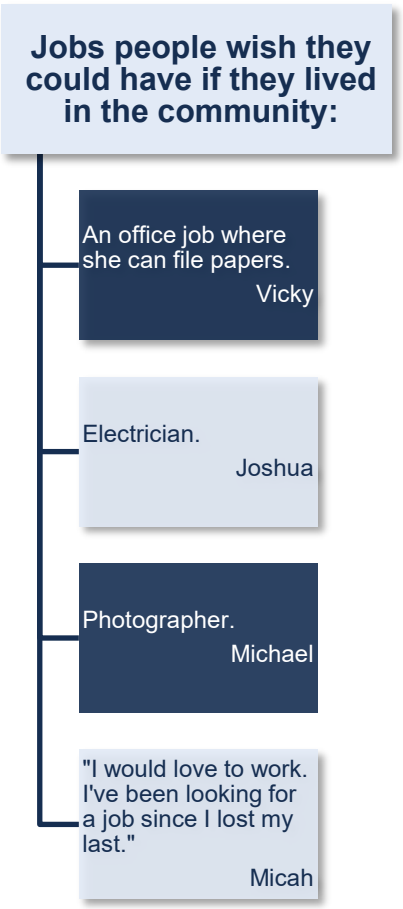
[20] Recognizing the importance of connecting individuals who experience frequent crises and hospitalization to intensive services, DMH recently created an internal Care Coordination Team. The team consists of an access specialist and four care coordinators who assist CCBHCs in connecting with about 5,000 people statewide on a "Most in Need List." The team tracks outcomes by asking who the CCBHCs have contacted and whether they have engaged those people in services but appears to do minimal outreach or direct services provision itself. DMH's efforts to identify those in clear need of services is positive, but the effort appears to have fallen short given the lack of available and ongoing intensive services.

[21] SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., VALUE OF PEERS 4-5, 12-13, 23-24 (2017), https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf [https://perma.cc/ZQY4-7LX2].

[22] CTRS. FOR MEDICARE & MEDICAID SERVS., SMD NO. 18--011, OPPORTUNITIES TO DESIGN INNOVATIVE SERVICE DELIVERY SYSTEMS FOR ADULTS WITH A SERIOUS MENTAL ILLNESS OR CHILDREN WITH A SERIOUS EMOTIONAL DISTURBANCE 15 (Nov. 13, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf [https://perma.cc/RX75-HKUH].

with serious mental illness receive peer support and those that do, on average, do not have frequent contact with their peer support specialist. Kelsey, a married, 28-year-old mother of three children, has experienced several behavioral health-related hospitalizations. She would "definitely" be interested in peer support; she is "constantly seeking out people who understand" because they "get it" and have "been through similar experiences."



Individual Placement and Support (IPS) helps people with serious mental illness attain integrated, paid, competitive employment, and provides supports to help them succeed in the job. It is based on the understanding that everyone with mental illness can work in the right type of job and environment for them. Everyone interested in working is eligible for the service.[23] IPS leads to reduced hospitalization, increased confidence, less social isolation, and increased motivation to engage in treatment.

Oklahoma funds IPS through State funds. All three Oklahoma County CCBHCs have IPS programs, although they are not always fully staffed. Compared to the over 800 people in institutional settings at any one time, only around 200 people received employment services through Oklahoma County CCBHCs in 2023. But it is not clear how many received evidence-based IPS services even within this group.

We found that many people who are institutionalized want to work. Gerald, who has been hospitalized at least three times, likes to work but "no one has ever helped [him] with jobs." And Jack, who we met in the hospital, wants to get back on his feet, finish his high school degree, and get a job when he is discharged.

b. Oklahoma's existing crisis system fails to prevent unnecessary institutionalization.

Serious mental illness is frequently episodic, with symptoms that can change over time. With an effective crisis response system, people can often manage behavioral health

[23] SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DHHS PUB. NO. SMA-08-4364, SUPPORTED EMPLOYMENT: BUILDING YOUR PROGRAM 3, 7 (2009), https://store.samhsa.gov/sites/default/files/sma08-4364-buildingyourprogram.pdf [https://perma.cc/DY5H-WSPJ].

crises without hospitalization. Critical components of an effective crisis system include a regional crisis call center, mobile crisis team services, and crisis receiving and stabilization services. Crisis services allow for "seamless transitions" to longer-term behavioral health care and should be available 24 hours a day, 7 days a week. Crisis services also decrease psychiatric emergency department visits, psychiatric hospitalizations, encounters with law enforcement, arrest rates, and incarceration.[24]

Oklahoma acknowledges the vital importance and effectiveness of crisis services, and it has made laudable efforts to build its crisis system over the past several years. This system includes crisis hotlines (most notably, implementation of the 988 Mental Health Lifeline), mobile crisis teams, urgent recovery centers (URCs), and crisis centers. Even so, many of these services are not sufficiently available to prevent unnecessary hospitalization. Moreover, these services often do not operate in a manner that prevents unnecessary institutionalization or connects people with ongoing services.

Mobile Crisis Teams are two-person teams that include access to a clinician and offer 24/7 "community-based intervention to individuals in need wherever they are."[25] Effective mobile crisis teams should seek to deescalate and stabilize the person in crisis, connect the person with a community provider for follow-up services, and can transport the person to an inpatient facility if necessary. When in place, these teams can help resolve crisis situations in the community, and reduce psychiatric hospitalizations, encounters with law enforcement, and incarceration.

Oklahoma funds mobile crisis services through Medicaid and State funds. It also contracts with Solari, a third-party agency, to operate the 988 Mental Health Lifeline, a national behavioral health crisis number with a regional call center in Oklahoma County that can dispatch a mobile crisis team.[26] There are four teams serving all of Oklahoma County. The teams are supposed to be available 24 hours a day, 7 days a week, and they are typically staffed by a case manager and a peer support specialist, with a licensed clinician available via telehealth.

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[24] SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISIS CARE 10-12, 39 (2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf [https://perma.cc/L7N2-MNUY].

[25] *Id.* at 18.

[26] Each CCBHC also has a dedicated crisis hotline that can dispatch the CCBHC's mobile crisis team to its own consumers.

Mobile crisis services in Oklahoma County have grown in recent years, but the number of teams is still insufficient for this major population center. As a result, community members shared that it is difficult to access a mobile crisis team when they need it, and mobile crisis teams are often not available. Even when a mobile crisis team is dispatched, the wait is long—the State's data show that almost 30% of mobile crisis teams experience delays in reaching a person.

> Almost 30% of mobile crisis teams experience delays in reaching a person.

The lack of available mobile crisis teams can lead to unnecessary hospitalizations. Xavier goes to the hospital every time he experiences a behavioral health crisis. He says, "I get isolated, don't eat, don't want to leave the house," so he finds a hospital with a bed. If Xavier had consistent and reliable access to a mobile crisis team, he could receive the support he needs in the community without having to stay in the hospital. Instead, he has been hospitalized over ten times in the past four years.

The insufficiency of mobile crisis also leads to avoidable interactions with the police, who may be called to respond if a mobile crisis team is not available. Rachel tried to call 988 for her brother when he was having a behavioral health crisis, but she was only given the option of a police response and was told that a non-police response was not available. Eventually her brother's situation escalated so someone else called the police, who arrested him and took him to jail. Rachel says, "A big problem with that whole situation was that I was relying on 988 to help and it was not helpful. If anything, it was harmful—on top of them not helping, it wasted time and allowed someone else to call 911 in the meantime." OKCPD itself reports that 988 frequently transfers calls to the 911 Center that are not appropriate for a police response.[27]

When mobile crisis teams do respond, they seem to focus primarily on assessing whether a person in crisis needs treatment in a facility such as a hospital (and then transporting them there), rather than resolving the crisis in the community and connecting the person to ongoing services, as the State's mobile crisis services are intended to do. Facilitating access to facility-based treatment takes less time than resolving the crisis where it occurs, but it undermines the efficacy of the mobile crisis team and leads to avoidable hospitalization. As a result, people in crisis sometimes receive almost no help from mobile crisis. For example, Michelle requested mobile

[27] The State provides tablets to people with higher behavioral health needs to help them access CCBHCs when necessary. It also provides tablets to law enforcement agencies, including OKCPD, as a resource to connect with a provider during behavioral health-related calls. Although this may be helpful in some circumstances, tablets are not a substitute for in-person mobile crisis teams, particularly in populated areas. And though it is important for law enforcement to have a resource for behavioral-health related calls, the State should not rely on law enforcement as a first response for people in crisis at the expense of building up crisis services that could prevent law enforcement interactions.

crisis help for her daughter Ariel three separate times; on each occasion, the mobile crisis team either called the police or determined that Ariel did not meet criteria for facility-based treatment. But the mobile crisis team provided no additional assistance once they determined she was not appropriate for inpatient care and did not connect her to ongoing services. Once, after Michelle and Ariel waited for more than two hours for a team to arrive, the mobile crisis team did nothing except call the police. Although Ariel continues to need crisis support, her mother has not used 988 since, saying "I can call the police myself."

Crisis Receiving and Stabilization Facilities provide short-term observation and crisis stabilization services in a home-like, non-hospital environment. They should be staffed at all times, accept all walk-ins regardless of acuity,[28] and offer screening, assessments, and treatment aimed at stabilization onsite. In Oklahoma, these crisis stabilization services include urgent recovery centers (URCs) and crisis centers. Oklahoma funds these services through Medicaid and State funds.

In Oklahoma County, the State and two CCBHCs operate three URCs that collectively have between 40 and 50 chairs. URCs "offer services aimed at the assessment and immediate stabilization" of crises related to mental illness, substance use, or emotional distress.[29] They are intended to be voluntary facilities where people stay for up to 23 hours and 59 minutes, although this is not a hard limit. People may walk in, police or mobile crisis teams may drop them off, or they can be referred by emergency departments or hospitals.

The State also operates two crisis centers in Oklahoma County that collectively have 32 beds.[30] Crisis centers are overnight facilities where people stay for an average of six days. Although stays may be voluntary or involuntary, most people in the Oklahoma County crisis centers are admitted involuntarily.

The Oklahoma County community has benefitted from access to these crisis stabilization services. But insufficient intensive community-based behavioral health services, such as PACT and permanent supported housing, increase demand for Oklahoma County's URCs and crisis centers. As one first responder noted, "as soon as we create a program [to handle behavioral health crises], it saturates [i.e., fills up]." This

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[28] When used in healthcare settings, "acuity" refers to an individual's level of illness severity or their severity of needs. *See* DEP'T OF HOUS. & URB. DEV., COVID-19 HOMELESS SYSTEM RESPONSE: PRIMER ON SERVING PEOPLE WITH HIGH-ACUITY NEEDS 1 (Oct. 2020), https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Primer-on-Serving-People-with-High-Acuity-Needs.pdf [https://perma.cc/QCY2-9WPP].

[29] OKLA. ADMIN. CODE § 450:23-3-21 (2014).

[30] One of the Oklahoma County CCBHCs operates a 56-bed crisis center in neighboring Cleveland County on the same campus as Griffin Memorial Hospital. It serves people from counties across the state, including Oklahoma County.

focus on crisis services at the expense of more intensive ongoing services is reflected in the experiences of many people we spoke to who regularly use crisis services, but do not have access to ongoing care before or after a crisis. As a result of this pressure on the crisis system, people continue to rely on hospital-based treatment for behavioral health crises.

Moreover, the State's emphasis on evaluation for inpatient treatment means these crisis stabilization services are less effective at preventing unnecessary institutionalization. While State and national guidelines describe stabilization and ongoing service connection as key features of 23-hour crisis receiving facilities like URCs,[31] in Oklahoma County, assessment for inpatient care in crisis centers has become the primary function of the State-run URC. The State-run crisis centers thus are effectively operating like short-term hospital inpatient units and its URC as a "mental health emergency room" to assess whether people in crisis meet the State's inpatient criteria for its crisis centers—danger to self or others.

As with the mobile crisis teams, the crisis centers' focus on assessment and triage for further hospitalization misses opportunities to resolve crises in the community and connect people to appropriate ongoing services and can lead to unnecessary institutionalization. For example, Olivia visited a URC three times in a month requesting shelter and assistance with accessing behavioral health services. Each time, she was assessed not to meet criteria for inpatient care and was discharged with a referral to the same CCBHC and no additional support. Three months later, Olivia was hospitalized.

3. Oklahoma can reasonably modify its existing service system to meet the needs of Oklahomans in the community.

Oklahoma can reasonably modify its behavioral health system to avoid unnecessary institutionalization of people with behavioral health disabilities.[32] Such modifications would allow people with behavioral health disabilities to live in their own homes and communities instead of entering segregated settings to access care. Moreover, these modifications are consistent with the priority areas identified in Oklahoma's Olmstead plan, updated in November 2024. Incorporating these modifications will ensure the plan effectively reduces unnecessary institutionalization.

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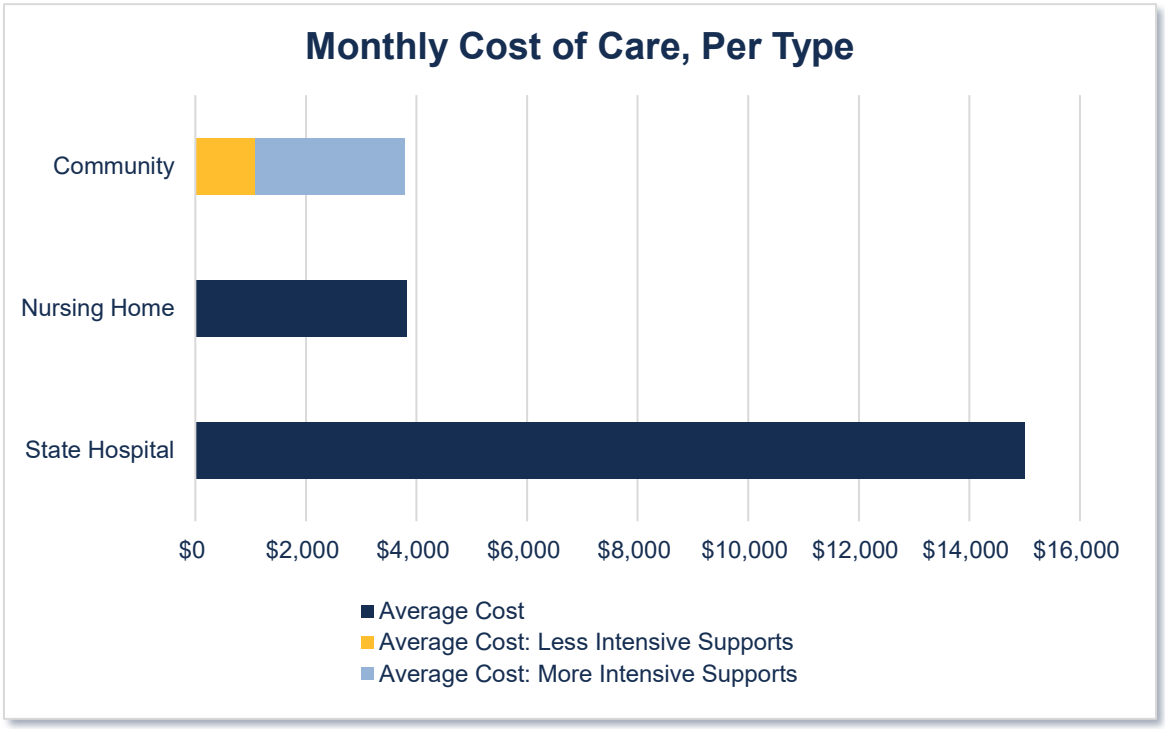
[31] Federal guidance on emergency response for people with behavioral health disabilities also identifies crisis apartments and crisis respite among the array of key services necessary to prevent unnecessary hospitalization. *See* DEP'T OF JUST. & DEP'T OF HEALTH & HUMAN SERVS., GUIDANCE FOR EMERGENCY RESPONSES TO PEOPLE WITH BEHAVIORAL HEALTH OR OTHER DISABILITIES (May 2023), https://www.justice.gov/d9/2023-05/Sec.%2014%28a%29%20-%20DOJ%20and%20HHS%20Guidance%20on%20Emergency%20Responses%20to%20Individuals%20with%20Behavioral%20Health%20or%20Other%20Disabilities_FINAL.pdf [https://perma.cc/4FU9-Q8TX].

[32] *See* 28 C.F.R. § 35.130(b)(7)(i); *Olmstead*, 527 U.S. at 607.

Oklahoma already offers some people in Oklahoma County community-based alternatives to institutionalization, including PACT, permanent supported housing, case management, peer support, supported employment, and crisis services. In addition, many of these services, including PACT, case management, peer support, and crisis services, are included in Oklahoma's Medicaid State Plan, which commits the State to provide the covered services with reasonable promptness statewide to everyone who is eligible and needs them.[33] But as discussed above, these services are either unavailable in sufficient quantity to meet the need or not provided at the appropriate intensity to prevent unnecessary institutionalization. Ensuring these services are sufficiently available at an intensity appropriate to support people in the community is a necessary and reasonable modification of the State's existing behavioral health system. Moreover, as discussed further below, the State can improve its existing collaboration with Oklahoma City to ensure the behavioral health and emergency response systems work together to prevent unnecessary institutionalization.



Providing behavioral health services in the community is likely to be less expensive than delivering those services in institutional settings and will likely prevent the need for many hospitalizations. For example, the State estimates the monthly cost of care for a nursing facility resident to be around $3,840 to $4,529. Moreover, the State spends approximately $15,000 for a month-long stay at Griffin. By contrast, based on current

[33] *See* 42 U.S.C. § 1396a(a)(1), (8); 42 C.F.R. §§ 431.50, 435.930.

service limitations and rates, community-based services for adults with behavioral health disabilities would likely cost between $1,103 and $3,790 per person per month, depending on individual needs.

Further, the State has already achieved significant savings through previous attempts to develop community-based services. Between 2014 and 2017, the State implemented a federal grant to increase the availability of supported housing for homeless veterans with behavioral health-related disabilities. This led to savings of at least three million dollars by reducing veterans' reliance on hospitals, emergency rooms, and ambulances for the services they needed. Such savings reflect the cost-effectiveness of community-based care and can enable the State to reasonably modify its behavioral health system.

The State can use savings from existing programs to bolster the scope and availability of community-based services. For example, in 2020, the federal government authorized Oklahoma to use Medicaid funds to pay for stays in certain freestanding psychiatric hospitals. The goal was to reduce preventable readmissions to hospitals and residential settings and improve the availability of crisis stabilization services and access to community-based services. Although the State has put some of the savings made possible by Medicaid toward expanding the crisis system, we have not seen evidence that these savings have been put toward more intensive ongoing services. With expanded Medicaid coverage, the State can use money saved to boost the network of community-based services as anticipated under this existing waiver.

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In sum, Oklahoma provides insufficient community-based services for adults with behavioral health disabilities in Oklahoma County who could be appropriately served in their homes and communities. As a result, Oklahoma unnecessarily relies on institutional settings to treat adults with behavioral health disabilities and law enforcement to respond to behavioral health crises. Oklahoma can reasonably modify its existing services to ensure people with behavioral health disabilities in Oklahoma County receive appropriate services and supports in the community and avoid unnecessary institutionalization.

B. Oklahoma City and the Oklahoma City Police Department discriminate against people with behavioral health disabilities when providing emergency response services.

The ADA prohibits Oklahoma City from excluding people with behavioral health disabilities from participating in, or denying them the benefits of, the City's services, programs, or activities.[34] This includes the City's emergency response system. People with behavioral health disabilities have the right to participate in and benefit from the City's emergency response system to an extent that is equal to that afforded others and effective in affording equal opportunity to obtain the same result.[35] The City and OKCPD must make reasonable modifications to their normal policies, practices, and procedures when necessary to avoid discriminating on the basis of disability, unless they can show that making such modifications would fundamentally alter the nature of the service, program, or activity offered.[36] And under the federal law enforcement misconduct statute, cities may not engage in a pattern or practice of law enforcement conduct that deprives people of their rights protected by the U.S. Constitution or federal law.[37]

When a person seeks help for a behavioral health emergency, the 911 Center and OKCPD are often the first point of contact. The Oklahoma City 911 Communications Center is a division within OKCPD's Operations Bureau. Its purpose is to provide people "a proper service response and a timely dispatch."[38] It is the largest 911 call center in Oklahoma by volume and handles all emergency calls for Oklahoma City—about one million calls annually.

The City responds to the majority of 911 behavioral health calls by sending only police officers when a behavioral health response would more effectively resolve the call. This occurs even when there is no public safety issue identified in the call. A police response can be, in turn, intimidating or traumatizing, ineffective, and harmful. OKCPD officers sometimes use tactics that can escalate encounters with people in crisis. This

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[34] *See* 42 U.S.C. § 12132.

[35] 28 C.F.R. § 35.130(b)(1)(ii), (iii).

[36] *See* 28 C.F.R. § 35.130(b)(7).

[37] *See* 34 U.S.C. § 12601; *see also* 42 U.S.C. § 12101 *et seq*. A pattern or practice exists where violations are repeated rather than isolated. *Int'l Bhd. of Teamsters v. United States*, 431 U.S. 324, 336 n.16 (1977). A pattern or practice does not require the existence of an official policy or custom. *United States v. Colorado City*, 935 F.3d 804, 810 (9th Cir. 2019).

[38] OKLAHOMA CITY, LEADING FOR RESULTS, POLICE DEPARTMENT STRATEGIC BUSINESS PLAN 21 (July 1, 2021), https://www.okc.gov/home/showpublisheddocument/26859/637800772082100000 [https://perma.cc/JS49-M8NU].

conduct deprives people with behavioral health disabilities of an equal opportunity to benefit from the City's emergency response services.

To be sure, many people in need of behavioral health help ultimately call 911 or encounter police in part due to shortcomings in the State's community behavioral health system. When people with behavioral health disabilities use the City's emergency response system, which many inevitably will, the City must provide a non-discriminatory response. Providing a non-discriminatory response—one that is equal to and as effective as an emergency response provided to people without behavioral health disabilities—is reasonable and would not fundamentally alter the nature of the City's emergency response system. Many City employees, including OKCPD call takers and officers, demonstrated professionalism in their work. We saw examples of exemplary conduct. But the City and OKCPD's policies and practices leave room for too many instances in which people with behavioral health disabilities received a response that was deficient and unlawful.

To evaluate the City and OKCPD's compliance with the ADA, with the assistance of experts, we reviewed documentation for hundreds of randomly selected 911 calls and police incidents involving behavioral health. We also reviewed every incident in a recent 14-month period where officers reported using force and OKCPD identified a behavioral health component.[39] We reviewed audio recordings of 911 calls, officer body-worn camera recordings, call taker and dispatcher notes, officer reports, use-of-force reporting and reviews, and data. We interviewed City and OKCPD staff and officials, spoke with people familiar with the City's emergency response system, and heard from people who themselves have used the City's emergency response services for a behavioral health need. In conducting our review, we focused on overall patterns of conduct, rather than individual incidents, although we also describe individual incidents that illustrate those patterns here. Our findings are based on available information, including individual incident data provided by OKCPD for various types of calls between June 2022 and January 2024.

During our investigation, the City and OKCPD made some important changes related to providing an effective, non-discriminatory behavioral health response to many calls that police currently handle.[40] OKCPD issued new policies about the 911 Center's and

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[39] We reach no conclusions as to whether OKCPD officers exhibit a pattern or practice of using excessive force in violation of the Fourth Amendment.

[40] In a report issued earlier this year, the City detailed its efforts to provide effective and appropriate responses to people with behavioral health disabilities. OKLAHOMA CITY, TRANSFORMATIONAL PROGRESS: OKLAHOMA CITY'S MENTAL HEALTH SERVICES: CHALLENGES, INNOVATION, AND SOLUTIONS (July 1, 2024), https://www.okc.gov/home/showpublisheddocument/43000/638551865059570000 [https://perma.cc/WD4T-GWBA]. Of particular note, this report includes an addendum in which the City describes its progress toward implementing the *Guidelines for Emergency Responses to People with Behavioral Health or Other Disabilities* published by the Department of Justice and the Department of

patrol officers' use of behavioral health resources, such as calling mobile crisis teams to the scene, when appropriate. OKCPD has created quality assurance programs to evaluate and improve its response to people with behavioral health disabilities. Preliminary data suggests that the City is increasing its use of existing behavioral health resources and reducing its use of police to respond to people with behavioral health disabilities. The City has plans to develop non-police emergency response teams that include behavioral health professionals. It intends to dispatch these teams to certain behavioral health calls either alone or jointly with OKCPD patrol officers. And it has plans to place a behavioral health clinician within the 911 Center to assist with dispatching an appropriate response to behavioral health calls. We applaud these efforts, but they remain in their infancy. Further, as proposed, the City's planned behavioral health response would have too few teams and cover too few hours to meet the need, still leaving police to handle most calls alone. We also have concerns about whether these efforts are being sufficiently coordinated with the State and the broader crisis system. The violations we identify in each jurisdiction are interrelated and close coordination between the jurisdictions in resolving these violations will be important.

1. Oklahoma City's emergency response system needlessly sends police as the sole responder to most behavioral health calls.

In 2023, the 911 Center logged at least 18,614 behavioral health calls for police response.[41] During the same year, the 911 Center transferred only 703 calls to be resolved by behavioral health professionals. Once officers are on the scene, they can call behavioral health professionals to assist or even take over a response, although there is presently limited capacity. But during a recent six-month period, OKCPD officers reported making use of a mobile crisis team at the scene in only 140 behavioral health calls. OKCPD's new Mental Health Response Protocol Guide states, "police officers do not need to be the primary contact with persons in crisis or affected by a

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Health and Human Services in 2023. OKLAHOMA CITY, TRANSFORMATIONAL PROGRESS: ADDENDUM A: BEHAVIORAL HEALTH EMERGENCY RESPONSE - A SELF-EVALUATION OF OKLAHOMA CITY'S COMPLIANCE WITH FEDERAL GUIDELINES (July 1, 2024) https://www.okc.gov/home/showpublisheddocument/42978/638550934804565361 [https://perma.cc/6C26-REU9]. As that evaluation indicates, the City has only begun to implement many of those guidelines, but we applaud the City's adoption of these guidelines.

[41] The number of calls involving individuals with behavioral health disabilities is even larger than the number of calls specifically identified as "behavioral health related" by OKCPD. This is in part because the 911 Center codes behavioral health calls involving an alleged crime with the code associated with that crime, such as "Trespassing," or with other noncriminal codes such as "Check Welfare," "Citizen Assist," "Suspicious Activity," or "Transient/Homeless." Even these noncriminal calls receive a response solely from police in almost all cases.

mental health disorder in all cases[.]"[42] Despite this recognition, OKCPD officers are frequently the primary responders to such calls.

We analyzed a random sample of incidents that OKCPD identified as behavioral health-related between June 2022 and May 2023. Most of those which received a police response involved no reported threat of violence or the presence of a weapon. The majority could have been handled either by behavioral health responders alone or by behavioral health professionals in coordination with law enforcement to address a public safety need, such as crowd or traffic control. But for the vast majority of behavioral health calls, OKCPD was the default—and usually sole—responder irrespective of whether police were needed on the scene. For instance, OKCPD dispatched only police to: a call about a woman who was screaming about her missing baby, even though the call taker knew that she was having delusions and there was no missing child; a call from a person who reported that her aunt, who was diagnosed with paranoid schizophrenia, had been having episodes for two months and "thinking she's seeing bugs and stuff;" and a call about a 10-year-old boy at school who wrote a note saying he was going to kill himself when he got home. OKCPD involved no behavioral health professionals when dispatching officers to respond to a man who had called multiple times that day, reporting that he had been attacked, was having a manic episode, has bipolar disorder, and had not taken his medications that day, and complaining that previously dispatched Crisis Intervention Team (CIT) officers had not helped him.

OKCPD dispatches police to 911 calls where the caller clearly describes a nonviolent behavioral health issue. For example, a 911 caller reported that a young man had come into his business asking for help with his "mind." The caller was clear that the man was not a threat: "He's being real gentle. . . . He's being peaceful and everything but he just said his 'mind' and he didn't know what to do. . . ." The caller did not request police, he simply wanted to get help for the man. At the time of the call, the man had left the business and was waiting outside in the parking lot. Although the man posed no threat, had committed no crime, and had simply asked someone for help, the 911 Center sent police to respond.

At times, police may need to respond to behavioral health calls due to certain safety needs. But a coordinated joint response with behavioral health professionals can help resolve the crisis effectively while connecting people with further services. We did not identify any calls in our sample where call takers requested a joint response of police and behavioral health professionals, even though many calls were appropriate for such a response. In one example, police responded alone to a call from a shelter requesting a CIT officer because a client was standing in a median, saying he was suicidal. The

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[42] OKLAHOMA CITY POLICE DEPARTMENT, MENTAL HEALTH RESPONSE PROTOCOL GUIDE 4 (Apr. 9, 2024) https://www.okc.gov/home/showpublisheddocument/41556/638495538473770000 [https://perma.cc/BC52-8HN7].

man had tried to fight shelter staff when they attempted to speak with him and stated he had a machete. After police arrived, the man was calm and standing with his head down under a tree in a median wide enough to park at least two police cars. Surrounded by four officers, he explained that he was "tired of hurting" and wanted help getting in touch with the mother of his son. Officers concluded that he did not meet "criteria" for protective custody.[43] Instead, they debated whether to run his name for warrants, ultimately doing so and arresting the man for a warrant for property destruction. A mobile crisis team could have been dispatched alongside police and taken over the interaction once safe to do so, saving the officers valuable time—one officer complained about this taking them "off the streets"—and helping the man address his mental health needs.

Dispatching police to behavioral health calls without a public safety need contrasts with OKCPD's handling of calls involving physical health emergencies. By policy and in practice, calls involving a physical health emergency with no public safety need are transferred directly to specialized dispatchers who send trained emergency medical professionals. Police are dispatched alongside emergency medical professionals only if the call taker determines that police are needed to ensure safety.

When dispatched to behavioral health calls, officers rarely seek assistance from behavioral health professionals, though OKCPD policy encourages officers to call a mobile crisis team when safe.[44] In our random sample of hundreds of behavioral health calls identified by OKCPD, we found only four instances (less than 2%) where there was evidence that after arriving on the scene an officer called for in-person response from behavioral health professionals. Officers failed to call for assistance from behavioral health professionals on the scene even when there was an obvious reason to do so and there was no urgency to resolve the encounter.

Following the rollout of new policies and training, some data indicate that OKCPD's use of behavioral health resources is increasing. This appears to be particularly so with

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[43] Oklahoma law provides that law enforcement will take a person with mental illness into protective custody if they believe the person poses a substantial risk of immediate harm to themselves or others, has made serious and immediate threats of violence or physical harm to another person, or is in a condition of severe deterioration that risks severe injury without immediate intervention, based on their own observations or based on a written statement of another person. OKLA. STAT. tit. 43A § 5-207(A)-(C) (1988); OKLA. STAT. tit. 43A § 1-103.13 (1953). The officer may then either contact a behavioral health professional from the field via tablet, call for a mobile crisis team to respond to the person's location, or transport the individual to a facility for a behavioral health assessment to determine whether the person should be further involuntarily detained. OKLA. STAT. tit. 43A § 5-207(D); OKLA. STAT. tit. 43A § 1-110 (1988).

[44] Many officers also have access to tablets that provide "real-time, on-the-spot assessments and counseling from mental health professionals." There was just one incident in our sample where it appeared that an officer used a tablet to involve a behavioral health professional.

respect to officers' use of 988 in the field. City and police department leaders have expressed their belief that call takers and officers are generally using behavioral health resources consistent with the new policies. The City has also announced plans to develop new programs to provide a behavioral health-led response to behavioral health calls, with an expectation of continued improvement in this area.

Still, the City's overall use of behavioral health professionals to respond to or help resolve nonviolent behavioral health calls appears to have remained low compared to the number of calls that are appropriate for such a response.[45] According to data provided by OKCPD, from the introduction of 988 in July 2022 through February 2024, the number of calls transferred to 988 from the 911 Center never exceeded 101 in any month. Other sources indicate that in October 2024, Oklahoma County law enforcement (both 911 call takers and officers from multiple agencies, including OKCPD) contacted 988 for behavioral health help in 245 calls. City employees and its consultant have described preliminary data analyses suggesting the number of calls appropriate for a behavioral health resource could be around 1,100 calls per month. This is consistent with our experts' review of a sample of OKCPD behavioral health calls. Others familiar with the emergency response system also acknowledged during our investigation that the City sends police to the vast majority of calls that lack any law enforcement or public safety purpose. In 63% of behavioral health calls in 2023, police concluded there was no need to take the person into custody or provide any transport. Nevertheless, the City relies on a police response to many behavioral health calls that can be appropriately handled by behavioral health professionals.

2. Sending OKCPD officers to respond to people with behavioral health disabilities is harmful, ineffective, and unnecessary.

The City's unnecessary use of armed OKCPD officers to respond to people with behavioral health disabilities is often ineffective and even harmful. The stated purpose of OKCPD's 911 Communications program is to provide a "proper service response."[46] But the City and its staff have acknowledged, and our review showed, that sending only police is not the proper response to many behavioral health-related calls. Our review also demonstrated that when police respond, OKCPD officers at times fail to make

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[45] The City recently reported publicly that the number of behavioral health calls dispatched to police decreased from 1,292 in October 2023 to 549 in October 2024—a significant reduction. It attributed this decrease to the public's use of 988 instead of 911 for behavioral health crisis calls. But 988 data does not reflect a corresponding increase in calls to that service and the City did not publish additional information. Therefore, we cannot conclude that the calls not dispatched to police are receiving a behavioral health response. However, if this data proves to reflect a continuing trend resulting in improved behavioral health response, it would suggest that the steps the City is taking to reform its emergency response system are beginning to work.

[46] OKLAHOMA CITY, LEADING FOR RESULTS, POLICE DEPARTMENT STRATEGIC BUSINESS PLAN 21 (July 1, 2021), https://www.okc.gov/home/showpublisheddocument/26859/637800772082100000 [https://perma.cc/JS49-M8NU].

reasonable modifications in their interactions. In many of the incidents we reviewed, officers knew or should have known the person had a disability and could have safely made reasonable modifications to resolve the encounter peacefully. These modifications include calling for assistance from behavioral health professionals, giving the person more time and space to comply with commands, using active listening, communicating clearly, speaking in a calm tone, and using other well-established deescalation techniques. Instead, we saw officers escalate encounters or use unreasonable tactics, which sometimes led to using unnecessary and avoidable force. This occurred in incidents where the person was not threatening anyone's safety, had not committed a crime, and needed help. The City and OKCPD's failure to make reasonable modifications denies people with behavioral health disabilities an equal opportunity to access and benefit from its emergency response system.

In some cases involving mental health crises, a police response itself can escalate a situation or cause trauma, increase stigma, or create anxiety.[47] As one OKCPD official said, "Sometimes seeing an officer, seeing the uniform can be a trigger." Unnecessary police responses can also result in avoidable hospitalization, criminal charges, arrest, and incarceration. And for many people with mental illness, confinement in jail can make behavioral health symptoms worse. One person told officers that he would "rather kill himself than go back to jail." Yet, people with behavioral health needs regularly end up at the local jail because officers are not sure what else to do with them, as one jail official explained.

At times, we saw officers act with hostility toward people with behavioral health needs. In one such incident, a mother reported that her 17-year-old daughter was having a behavioral health crisis and waiting outside of a CVS while the mother sat in the parking lot inside the car. The mother explained, "She's mentally ill, she's not well . . . she's diagnosed with major depressive disorder [and] major disruptive disorder." The mother started crying as she explained the situation: "I have been calling Cedar Ridge[48] for the past two weeks and they don't have any beds." A mobile crisis team could have handled this call, but the call taker only dispatched a police officer.[49] Upon arrival, the officer, who was a member of the CIT, stated that this was the third time in three weeks that he had been out to see this girl. He then blamed her for the dispute that gave rise to the call, lectured her that she was "entitled" and "being the victim," and responded to her behavioral health needs with sarcasm. Faced with no other alternatives, the mother

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[47] SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISIS CARE: BEST PRACTICE TOOLKIT EXECUTIVE SUMMARY 8-10 (2020) https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf [https://perma.cc/4QNM-565A].

[48] Cedar Ridge is a private behavioral health hospital in Oklahoma County.

[49] Based on the detailed explanation by the caller, the call taker correctly determined that this was a "priority 3" call, with "danger of life/prop[erty] NOT inv[olved]."

asked the officer to take the girl to the hospital, and the officer handcuffed the girl and transported her in a locked squad car.

Police are not behavioral health professionals and thus unable to provide urgent mental health care. We saw officers attempt to take the place of behavioral health professionals but use inappropriate and coercive tactics. In one case, for example, three officers were dispatched to a man threatening suicide with a knife whose wife reported that he was diagnosed with schizophrenia and was not taking his medication. The man was peaceful with the officers upon arrival and made no threats to their or others' safety. During a long discussion about the man's medications, officers questioned how many pills he had taken and when he last filled them. One officer poured the pills into his own hand to count them, and later officers asked that the man take a dose in their presence. The man then took the medication. Their conduct was inappropriate and potentially dangerous—police are not behavioral health clinicians with expertise in psychiatric diagnosis, medication, or dosage. The officers clearly knew the man needed help, yet they did not offer any other assistance with obtaining behavioral health services. A mobile crisis team, with officers present to address safety needs, could have avoided such an inappropriate intervention and helped connect the man with further services.

> "That's really messed up, [people are] in here just for psych treatment, and [the] only police role should be to transport, but they run their names and find warrants and take them to jail."
>
> *Local Hospital Nurse Technician*

A criminal justice approach to behavioral health calls may discourage people from seeking help or create other harms. For example, we observed officers treating people as possible criminals, such as automatically running checks for warrants, when responding to requests for behavioral health help even when there was no indication the person had committed a crime. One man who reported having bipolar disorder and autism told us that he called 911 asking for help getting to a psychiatric facility. When an OKCPD officer eventually arrived, they ran the man's name for warrants and located a warrant for an alleged crime of "unauthorized use of a vehicle" committed by the man's brother under the man's name. The man was arrested and spent more than three weeks in jail before the mistaken identity was resolved. The 911 Center could have instead transferred the call to behavioral health staff whose focus would be on helping the man get treatment like he wanted. A nurse technician at a local hospital complained that the police run warrant checks when the facility requests a transport: "That's really messed up, [people are] in here just for psych treatment, and [the] only police role should be to transport, but they run their names and find warrants and take them to jail." Making warrant checks a routine practice when responding to calls that involve no alleged crime can discourage people from seeking help with behavioral

health symptoms. In 2023, 48% of the arrests resulting from known behavioral health calls were for outstanding warrants.

Officers also escalated encounters with people showing symptoms of behavioral health disabilities when they could have safely and reasonably used well-known deescalation tactics, such as approaching the person slowly, clearly identifying oneself, and giving time to comply. But we saw officers sometimes give the person just seconds to comply, leading to avoidable uses of force. In one case, an officer straddled a naked woman who posed no risk within 15 seconds of encountering her alone in a parking lot. The officer was dispatched to the scene after a 911 caller reported a naked person outside in winter who may have been on drugs. When the officer arrived, the woman was wearing only a knit cap pulled down over her face and was kneeling on the pavement, bowing her head in repetition. The officer approached the woman from behind, and without identifying himself, demanded, "Hey, you," while poking her in the back. The woman responded that she needed to finish bowing. "No, we're not going to do that," the officer said. He then roughly grabbed the woman's arm, wrestled her to the ground, and sat on her while pushing her face (still covered in a hat) toward the pavement. The woman lay face down on one of her arms, and, when she did not release it on command, the officer struck the back of her head with his elbow and punched her in the head several times. The officer could have modified his conduct by approaching slowly, identifying himself clearly, allowing the woman to finish "the number of bows" that she said she "needed" to do, and seeking the help of a behavioral health professional. Instead, the officer handcuffed and arrested the woman, then allowed her to remain naked for almost 40 minutes, some of that time exposing her to public view.

In other instances, OKCPD officers used appropriate deescalation tactics, but after a short period of time, abruptly and unnecessarily escalated the incident by using force. We saw officers abandon deescalation tactics to use force even when responding to calls requesting behavioral health support and calls involving youth. In one incident, a mother called 911 to report that her teenage son had mental health problems and wanted to die. She thought he had crashed his car before returning home with bloody hands, but reported he had no weapons. Two officers responded, and a CIT-trained officer saw the teen standing in his kitchen, unarmed, with his hands up. The CIT officer entered the house and talked with the teen for more than 15 minutes, doing an excellent job building rapport, and at one point telling him, "I'm not a mental health professional . . . if you're having some issues, I can get you somebody who wants to help you." Instead of calling for a mobile crisis team, the other officer sought authority to take the teen into protective custody for an evaluation. Once approved, he said, "Time to go," and both officers immediately crossed the kitchen to corner the teen. As they grabbed his arms, the CIT officer said, "I'm not going to hurt you, I promise." The teen said, "You're scaring me," and held his arms rigid. Seconds after grabbing him, the CIT officer fired a Taser into his chest, causing the teen to wet himself. The teen was not a threat. The officers knew he needed behavioral health help, and they could have reasonably called a mobile crisis team to assist while continuing to talk calmly with him. But neither the call taker nor the officers asked for those resources, and instead escalated the situation by cornering and grabbing the teen.

We also saw officers use restraints on people who needed a behavioral health response, sometimes resorting to using them quickly and in inappropriate circumstances. For example, officers used a "Violent Prisoner Transport Restraint" on a 15-year-old girl who ran from officers because she thought they were trying to kill her. The 911 call was for child neglect. The girl's mother had not been seen in more than 24 hours, and the girl, who said she was feeling suicidal, was living alone with her three-year-old sister. Officers took the girl to the hospital with her hands cuffed, her feet bound, and her chest strapped against the seat of the patrol car so she could not move.

OKCPD has made some laudable efforts to enhance oversight of officers' interactions with people with behavioral health disabilities. But problems with supervision have contributed to officers' failure to modify their conduct. Each time an officer reports using force, supervisors review whether the force was justified and whether officers used appropriate deescalation. In our review, however, OKCPD's chain of command rarely made use of this as an opportunity to help officers improve their conduct. Instead, OKCPD nearly universally validated uses of force against people in crisis and approved the officer's deescalation, even when officers behaved aggressively and failed to make reasonable modifications. We also note that we observed several *unreported* uses of force in our random sample—suggesting there are some uses of force that escape review altogether.

In contrast with these harms, a behavioral health-led response would be more likely to effectively resolve the emergency; reduce the risk of arrest, institutionalization, and traumatic police interactions; and increase the likelihood a person will receive and accept behavioral health services. When operating in line with evidence-based practices, mobile crisis teams can divert people in crisis from psychiatric hospitalization and are better than hospitals at connecting people in crisis to ongoing services in the community.[50] Instead, people with behavioral health disabilities have avoidable encounters with OKCPD officers that are ineffective, harmful, and lead to crisis escalation and unnecessary use of force. Unnecessary police responses also tie up police resources that could be better spent on more pressing public safety needs.

Many City staff emphasized that it would be better for everyone if behavioral health professionals responded to behavioral health calls when law enforcement is not needed. They also explained that calls that do involve a public safety component could often be more effectively and appropriately resolved with a coordinated joint response by law enforcement and a mobile crisis team. We reviewed a call about a man screaming that he wanted to die. While responding, the officer acknowledged the person's repeated encounters with law enforcement and remarked, "We wear too many hats; we do not need the police for certain problems." As a 2021 report commissioned by the City stated, after interviews of OKCPD employees and community members

[50] SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISIS CARE 19 (2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf [https://perma.cc/L7N2-MNUY].

alike, “There was clear consensus in every room that an alternative response structure was critical for OKC.”

3. Call taking and dispatch practices contribute to Oklahoma City’s discriminatory emergency response system.

OKCPD’s practice of dispatching a police-only response to most behavioral health calls, even when those calls do not involve safety concerns, occurs in part because of 911 Center practices. This is so despite recent efforts by OKCPD to encourage call takers to use behavioral health resources. Over the course of 2023, OKCPD rolled out policies and trainings for call takers about handling behavioral health calls. These policies direct that call takers should assign a behavioral health call code and dispatch police where the behavior is criminal in nature but crisis is “the pressing issue” or where a person poses “an immediate danger” to self or others, and should transfer behavioral health calls to 988 or other appropriate resources where the call involves noncriminal behavior, there is no “immediate danger” to self or others, and there is no need for medical attention. The 911 Center also recently launched a program to evaluate and improve upon how call takers handle 911 calls, with a significant component focused on behavioral health calls.

Despite OKCPD’s significant improvements to policies and training, gaps remain that can lead to dispatching police alone when a behavioral health-led response or a coordinated joint response would be more effective. Notably, policies provide little direction to call takers as to when to request a mobile crisis team to respond jointly with police, and call takers rarely do. Failure to initiate a joint response can delay or prevent a mobile crisis team from responding, which officers already know can take significant time.

In addition, existing call taker training gives minimal guidance on how to interpret key components of the new policies, such as what would be considered an “immediate danger” or when a crisis is “the pressing issue” over an alleged crime. Call takers have a list of guiding questions and receive training on common behavioral health symptoms and the importance of asking about safety, but there appear to be minimal scenarios and other guidance provided to help call takers evaluate specific calls. We observed a pattern of call takers failing to ask appropriate questions about behavioral health needs and scene safety, including the presence of weapons.[51] Without adequate information about safety, it is impossible for a call taker to make an accurate determination about whether there is an “immediate danger.” In the absence of sufficient information about danger, call takers may default to a police response instead of a behavioral health

[51] The 911 Center’s new quality assurance program, piloted this year, is progress toward helping to ensure that call takers follow current policies.

response,[52] and officers may not have all the information about behavioral health issues when arriving at the scene.

4. The City and OKCPD can make reasonable modifications to avoid discrimination in providing an emergency response to people with behavioral health disabilities.

The City and OKCPD can reasonably modify their emergency response system to avoid discrimination against people with behavioral health disabilities. The City recognizes that it is appropriate and effective to use a behavioral health-led response to resolve many of the calls that currently receive a police response and identifies this as a policy goal. OKCPD has made some changes to policies and training, and the City has plans to develop two behavioral health crisis response programs and place a behavioral health professional within the 911 Center to help identify the appropriate response for behavioral health calls. The City and OKCPD can fully build out the mobile crisis response programs and 911 Center clinician role that they have begun to develop and use evidence-based practices for communicating with callers, providing them with a behavioral health-led response where appropriate, and preventing unnecessary institutionalization and criminal justice involvement. The City can improve training, accountability, and oversight practices to ensure that its policies consistently result in an emergency response to people with behavioral health disabilities that is equal to that afforded to others without disabilities. As discussed above, when appropriate, officers can call for assistance from behavioral health professionals, give a person in crisis more time and space to comply with commands, use active listening, or clearly communicate with people in crisis. OKCPD must also hold supervisors accountable for ensuring officers follow policies and training. And, as above, both the State and the City can improve existing collaboration to ensure the behavioral health and emergency response systems work together to prevent unnecessary police response to behavioral health calls.

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In sum, Oklahoma City and OKCPD unnecessarily send law enforcement to respond to behavioral health calls. Many of these calls could receive a behavioral health-led response that would be more likely to effectively resolve the emergency, prevent unnecessary hospitalization, and connect people with needed community-based behavioral health services. Instead, people with behavioral health disabilities have avoidable encounters with OKCPD officers that are ineffective, harmful, and lead to crisis escalation and avoidable use of force. As a result, many become incarcerated or

[52] 911 Center officials also shared call taker concerns that many people refuse to be transferred to 988 and that 988 inappropriately sends calls to 911. It is unclear whether and to what extent OKCPD has identified this as an ongoing concern for the State or Solari. While we observed some examples of callers refusing transfer to 988 and callers who had already spoken to 988 in our random sample, we found that call takers far more frequently failed to offer to transfer calls to 988 when appropriate.

unnecessarily hospitalized; when they return to the community, they continue to experience a pattern of behavioral health crisis and avoidable law enforcement contact.

RECOMMENDED REMEDIAL MEASURES

A. State of Oklahoma

Remedial measures needed to ensure that Oklahoma serves adults in Oklahoma County with behavioral health disabilities in the most integrated setting appropriate for their needs include:

Availability of community-based services. Oklahoma should ensure availability of services such as PACT, mobile crisis, permanent supported housing, case management, peer support services, and IPS, with the intensity necessary to successfully support people in the community. The services should be provided consistent with the evidence-based models. After implementing these critical services, the State should assess the need for additional crisis stabilization services and ensure that the services provided are operating as intended to prevent unnecessary institutionalization. They should also encompass a full array of crisis services, such as crisis apartments or crisis respite, to ensure people experiencing crisis can receive needed help in the community whenever possible.

Proactive outreach and engagement in the community to avoid unnecessary institutionalization. The State should develop proactive outreach strategies to engage and connect people to ongoing services while addressing barriers to treatment, including through peer support and supported employment. This outreach should focus on people who are at high risk of crisis and hospitalization, including unhoused populations and those who have frequent interactions with crisis services or law enforcement.

Strong connections to community-based services from institutions to prevent unnecessary readmissions. To prevent unnecessary readmissions to hospitals or other facilities, the State should ensure that discharge planning identifies appropriate community-based services and arranges for a prompt connection to those services. Given that many people need enhanced support following an institutional stay, the services should be flexible and frequent enough to help the person successfully transition to the community. Community-based providers should play a critical role in transition planning from institutional stays.

B. Oklahoma City and OKCPD

Remedial measures needed to ensure that Oklahoma City does not discriminate against individuals with behavioral health disabilities in its emergency response system include:

Develop behavioral health mobile response teams consistent with evidence-based practices and deploy behavioral health professional-led responses where appropriate. The City has identified the need for behavioral health-led response teams that it can deploy to a range of calls where police are not needed, or where a coordinated joint response between behavioral health staff and law enforcement would be most effective. The City should develop these teams consistent with evidence-based practices and with sufficient capacity to respond when needed.

Ensure policies and training for handling behavioral health 911 calls are clear and effective. 911 Center policies and training must provide sufficient clarity and guidance to support call takers to identify and dispatch the appropriate response, including asking sufficient questions and recording sufficient detail about the call, and helping callers understand when police are not necessary and when a behavioral health response will be most effective. The City and OKCPD must ensure compliance with their policies by continuing to implement the new 911 quality assurance program and ensuring this and other supervision and accountability systems are effective.

Ensure OKCPD officers make reasonable modifications when responding to people with behavioral health disabilities. OKCPD must ensure effectiveness of its policies and training so that officers consistently request and wait for a mobile crisis team in appropriate situations. OKCPD's practices with respect to when officers use force against people with disabilities must change, and its force and deescalation review process must be improved to ensure both that officers are making reasonable modifications when safe to do so and that first-line supervisors are thoroughly and objectively evaluating officer actions. OKCPD must also ensure that both officers and supervisors are held accountable when they fail to do so. OKCPD has taken some steps to enhance oversight and improve practices by recently implementing a new mental health quality assurance program. This program, if implemented well, could have a positive impact.

C. Oklahoma City and the State of Oklahoma

Addressing these violations most effectively and efficiently will require Oklahoma City and the State of Oklahoma to coordinate closely with each other. While we heard of a variety of meetings and opportunities for communication between these entities, in addition to certain ways in which the two are working together, we saw many areas in which this coordination remained ineffective or absent altogether.

The City is of the view that there is insufficient capacity to respond to crisis events through the State's 988 and mobile crisis system, and as described above, we reached a similar conclusion. It is the State's responsibility under the ADA to provide sufficient community-based crisis services when necessary to prevent avoidable institutionalization. It is the City's responsibility to provide a behavioral health response when necessary to prevent discrimination in its provision of emergency response services. Neither entity may fully absolve itself of these obligations by relying solely on the other without a clear understanding of who will take responsibility for what. Coordination between the two is critical.

There are disconnects between the 911 Center and 988 in terms of what types of calls each should be handling, despite there being regular meetings and conversations held between the two entities. More than a year and a half after the implementation of 988, 911 Center management had not seen Solari's actual policies but identified several areas of confusion. 911 Center management also explained its understanding of certain Solari rules that did not align with Solari's view of its services, particularly with respect to what calls 988 would accept.

There also appears to be a lack of coordinated planning within the City with respect to the two teams it is developing, and with the State with respect to the integration of the City teams with the existing 988 and mobile crisis system. The City and OKCPD should share specific information and data with area behavioral health service providers, the State, and Solari to jointly identify and address challenges that arise and to ensure that policies that affect the interaction between these entities are consistent and understood.

Enhanced coordination between the City and the State will also help ensure that the public has a clear understanding of how to obtain a behavioral health response and who is accountable for that response.

CONCLUSION

We find that Oklahoma fails to provide services to adults with behavioral health disabilities in the Oklahoma County area in the most integrated setting appropriate to their needs. Due to insufficient community-based services, Oklahoma relies unnecessarily on psychiatric hospitals and residential care and nursing facilities to serve adults with behavioral health disabilities who could be appropriately served in their own homes and communities. We further find and have reasonable cause to believe that Oklahoma City and OKCPD engage in a pattern or practice of conduct that deprives people with behavioral health disabilities of their rights under federal law, by failing to make reasonable modifications to and denying them an equal opportunity to benefit from the emergency response system. Oklahoma City and OKCPD's unlawful practices harm community members and undermine public safety.

We look forward to working cooperatively with Oklahoma and Oklahoma City to reach a resolution of our findings. We are required to advise you that if we cannot reach a resolution, the United States may take appropriate action, including bringing a lawsuit, to ensure compliance with the ADA. Please also note that this Report is a public document. It will be posted on the Civil Rights Division's website.