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The Structural Harms of Providing Mental Health Services Through the Bipartisan Safer Communities Act

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ABSTRACT

Many have proclaimed that the Bipartisan Safer Communities Act is the most sweeping gun control legislation to be passed in decades. However, the bill is not primarily a gun control bill—instead, much of the Act seeks to improve mental health services in hopes of preventing gun violence. Such a move is not rooted in established evidence, which finds little predictive value in knowing an individual's mental health history. In fact, people with mental health disabilities are more likely to be victims of violent crimes than perpetrators. The Act therefore shifts the debate about gun reform from one about easy access to guns to one about improving mental health services. This is not without consequence.

This paper analyzes the effects of tying mental health to gun violence through legislation. Specifically, it argues that the rhetoric and policy mandates enacted in the Bipartisan Safer Communities Act reproduce internal, interpersonal, and structural stigma against people with mental health disabilities. Investments in community-based services are sorely needed, but tying these reforms to gun violence prevention will increase stigma. This paper acknowledges some provisions' transformative potential while tempering optimism about the scope and nature of these services because they are provided under the auspices of preventing gun violence.

Providing mental health relief through a gun control bill reproduces stigma in three key ways. First, by discursively tying gun ownership to one's mental health history, lawmakers have created a binary between "law-abiding" citi-

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zens and the "mentally ill." The latter category presumptively loses their constitutional rights by virtue of being part of a stigmatized group. Second, because of regional variation in availability and types of services, new crisis intervention lines often work with local law enforcement, creating the potential for incarceration, involuntary hospitalization, or even death. Finally, making educational professionals responsible for "detecting" violent behavior risks contributing to the family policing system and marking racial minorities and students with disabilities as delinquents due to an administrator or teacher's animus. This paper ultimately echoes calls by suicidologists, psychiatric expatients/consumers/survivors, and policymakers to create and improve community-based services free from coercion.

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I. INTRODUCTION

In the wake of a mass shooting in Uvalde, Texas that killed nineteen children and two teachers, Governor Abbott quickly blamed the mental health of the shooter, stating: "[w]e as a state, we as a society need to do a better job with mental health. . . We as a government need to find a way to target that mental health challenge and do

something about it."[1] Media outlets and legislators alike searched for evidence that Salvador Ramos, the Uvalde shooter, had a history of mental illness that his school district ignored.[2] A seventy-seven page Texas House committee report detailed the "missed warning signs" of the shooter's mental illness, including: a fractured home life, unstable housing conditions, poor academic performance, and declining attendance that preceded him dropping out of high school.[3]

After Uvalde, sixty mental health advocacy groups released a joint statement blaming "easy access" to weapons and criticizing attempts to "connect mental illness to mass shootings."[4] The statement noted that mental illness is common worldwide, but gun violence is only this pervasive in the United States.[5] The groups concluded that reforms to youth mental health services are warranted, but that the proposed reforms would not address mass shootings or meaningfully decrease gun violence.[6]

The U.S. House of Representatives responded to community calls for action by passing the "Protecting Our Kids Act," which, among other measures, barred the sale of semiautomatic weapons and required enhanced background checks before someone could purchase a firearm.[7] However, the measure was "doomed to fail" in the Senate, with few Republicans supporting what they viewed as an affront to Second Amendment rights.[8] Therefore, the Senate introduced and passed what was hailed as "the most significant overhaul of the nation's gun laws in decades" aimed at "keeping firearms out of the hands of dangerous people."[9] The Bipartisan Safer Communities Act[10] substantially expanded funding for community-based mental health services, set aside money for crisis intervention programs like mental

1. Mary Kekatos, *As Gov. Abbott places shooting blame on mental health, what has Texas done to address it?*, ABC NEWS (May 27, 2022, 6:10 AM), https://abcnews.go.com/Health/gov-abbott-places-shooting-blame-mental-health-texas/story?id=84993527 [https://perma.cc/RS4F-D4EU].
2. Wynne Davis, *A report detailed the missing warning signs and motives of the Uvalde gunman,* NPR (July 17, 2022, 10:10 PM), https://www.npr.org/2022/07/17/1111945402/uvalde-shooter-warning-signs-report [https://perma.cc/9V2F-CSRD].
3. *Id.*
4. *Statement on Gun Violence Crisis from 60 National Organizations,* THE KENNEDY FORUM (June 6, 2022), https://www.thekennedyforum.org/press-releases/statement-on-gun-violence-crisis-from-60-national-organizations/ [https://perma.cc/BD7A-QM4K].
5. *Id.*
6. *Id.*
7. Matt Murphy, *Uvalde attack: US House passes gun bill doomed to fail in senate*, BBC (June 9, 2022), https://www.bbc.com/news/world-us-canada-61742732 [https://perma.cc/C4FA-P4LG].
8. *Id.*
9. *Id.*
10. Bipartisan Safer Communities Act, Pub. L. No. 117-159 (codified as amended in scattered sections of 42 U.S.C.).

health and drug courts, made background checks prior to gun purchases more expansive, and enhanced criminal penalties for gun trafficking.[11] Senate Minority Leader Mitch McConnell (R-KY) called the bill: "a commonsense package of popular steps that will help make these horrifying incidents less likely while fully upholding the Second Amendment rights of law-abiding citizens."[12] Similarly, President Biden called the passage of the law a decisive act by both parties: "How many times have you heard that? Just do something. For God's sake, just do something."[13] The President added: "[w]ell, today, we did. . . ."[14]

The Bipartisan Safer Communities Act was indeed an example of congressional action, which may itself warrant celebration. Nonetheless, optimism regarding the bill should be tempered. While the Act creates more resources for people with mental health disabilities in their communities, it links mental health and the problem of mental health service provision to gun violence discursively through its legislative history, which will likely have substantive effects on the bill's enactment. This Paper evaluates the provisions of the Act and suggests that linking mental health to gun violence via legislation contributes to multiple forms of stigma surrounding mental illness. Moreover, because of regional variation in the availability of community-based services, the Act may expose disabled people to coercive and punitive treatment methods. While providing people the services they need in their communities is laudable, the provisions in the Act increase state surveillance and intervention in the lives of people with mental health disabilities based on an erroneous belief that they are more likely to commit violent crimes.

Section II begins by assessing the evidence (or lack thereof) connecting mental health to mass shootings and violent crime more generally. Section II.B suggests that attempts to manufacture correlations between gun violence and mental illness contribute to an increase in stigma. Section III evaluates the legislative history of the Act and some of the provisions relating to mental health. Section III.A demonstrates that the Bipartisan Safer Communities Act shifted narratives about gun violence away from a focus on gun access, instead scapegoating mental illness. Senators supporting the bill reinforced the narrative that people with mental illnesses are not "law-abiding

11. Emily Cochrane and Zolan Kanno-Youngs, *Biden Signs Gun Bill Into Law, Ending Years of Stalemate,* N.Y. TIMES, (June 25, 2022), https://www.nytimes.com/2022/06/25/us/politics/gun-control-bill-biden.html [https://perma.cc/3QXB-JGR9].
12. Kelsey Snell, *Senators reach final bipartisan agreement on a gun safety bill*, NPR (June 22, 2022, 12:18 PM), https://www.npr.org/2022/06/21/1106466279/senators-reach-final-bipartisan-agreement-on-a-gun-safety-bill [https://perma.cc/4SVA-FPF2].
13. Cochrane & Kanno-Youngs, *supra* note 11.
14. *Id.*

citizens" and supported laws prohibiting gun ownership by the "mentally ill." Section III.B discusses the Act's funding for community-based mental health services and evaluates the evidence in support of community-based interventions. Section III.C describes the school-based mental health programs funded by the Act. Part IV assesses and criticizes provisions that may increase people with mental health disabilities' vulnerability to coercive state intervention. Section IV.A argues that regional variation in the rollout of the 9-8-8 crisis line without adequate services in place will increase dangerous encounters with law enforcement. Section IV.B underscores the structural harms associated with making educational professionals responsible for "detecting" potential offenders. This Article concludes that while the Bipartisan Safer Communities Act has transformative potential, many of its provisions risk exposing vulnerable populations to violence or coercive treatment methods. Policymakers implementing the Act should invest in community-based care that is non-coercive and therapeutic.

II. STIGMA IN CHARACTERIZATIONS OF MENTAL ILLNESS AND GUN CONTROL

Section II.A assesses whether the scientific literature demonstrates a link between mental health, mass shooting, and violent crime more generally. Empirical evidence overwhelmingly indicates that although people with serious mental illnesses may be involved in some mass shootings, there is no evidential basis for presuming individuals with mental illnesses are more likely to be violent or that mental health professionals can predict mass shootings. Section II.B introduces the idea of stigma and considers how stigma can limit access to care, as well as place limitations on personal liberties. This section concludes by suggesting ways in which false narratives relating gun violence to mental illness contribute to stigma against people with mental health disabilities.

A. Mental Illness is a Poor Predictor of Mass Shootings

It is easy to assume that mental illness and mass shootings are related. Mass shootings defy reason and naturally prompt one to question how anyone in their "right mind" could commit such a heinous act.[15] The "deranged shooter" narrative is a convenient response to incomprehensible atrocities.[16] Moreover, some high-profile shootings have involved people with actual or suspected mental illnesses, such

15. Jonathan M. Metzl et al., *Mental Illness, Mass Shootings, and the Future of Psychiatric Research into American Gun Violence*, 29 HARV. REV. PSYCH. 81, 81 (2021).

16. *Id.*

as the shooting at Sandy Hook Elementary School, where the perpetrator's behavior suggested undiagnosed schizophrenia.[17] Complicating the empirical picture, federal funding could not be used to conduct research on gun violence, which means social scientists have not studied this problem as robustly as they should.[18] Politicians and the media therefore tend to focus disproportionately on mental health "warning signs" exhibited by perpetrators when proposing how such tragedies can be prevented.[19]

Existing empirical evidence overwhelmingly finds no causal relationship between mental illness and gun violence, especially mass shootings. In other words, the "deranged shooter" narrative is inaccurate.[20] Generally, people with diagnosed mental health conditions are not more likely than people who have not been diagnosed with a mental health condition to commit violent crimes.[21] People with mental health disabilities commit only 3% to 5% of gun crimes.[22] In a study of mass shootings at schools, colleges, or universities, an analysis of the Columbia Mass Murder database found that out of eighty-two school shootings, more than three quarters of shooters had no history of psychotic symptoms.[23] Although perpetrators in academic settings are more likely to take their own lives and are more likely to have a mental health diagnosis than other types of mass shooters, perpetrators with a documented history of mental illness still represent the minority of mass murderers, even in schools.[24] The biggest com-

17. Jonathan M. Metzl & Kenneth T. MacLeish, *Mental Illness, Mass Shootings, and the Politics of American Firearms*, 105 AM. J. OF PUB. HEALTH 240, 240 (2015).
18. Metzl et al., *supra* note 16, at 81.
19. *See, e.g.*, Davis, *supra* note 2 (describing a 77-page Texas legislative report discussing "missed signs" that the Uvalde perpetrator was mentally ill); *St. Louis school shooter had more than 600 rounds of ammunition, police say*, THE GUARDIAN (Oct. 25, 2022 2:29 PM), https://www.theguardian.com/us-news/2022/oct/25/st-louis-school-shooting-latest-gunman-ammunition; Kimberly C. Moore, *Mental Health: Columbine, Sandy Hook, Marjory Stoneman Douglas shootings seemingly rooted in mental illness*, THE LEDGER (updated March 1, 2022 2:13 PM), https://www.theledger.com/story/news/regional/2021/12/12/mental-health-columbine-sandy-hook-marjory-stoneman-douglas-rooted-mental-illness/8861268002/ [https://perma.cc/Y36E-LG3V] (highlighting examples of school shootings correlated with mental health "warning sights"). *See also* Metzl et al., *supra* note 16, at 82 ("Politicians and media commentators often quickly label mass shooters as 'mentally ill' without defining the term and before any valid psychiatric history is known, simply on the basis of the aberrant nature of the crime itself: '*What sane person could do such a thing*?'").
20. Metzl et al., *supra* note 16, at 81.
21. Metzl & MacLeish, *supra* note 17, at 241.
22. *Id.*
23. Ragy R. Girgis et al., *Mass murders involving firearms and other methods in school, college, and university settings: Findings from the Columbia Mass Murder Database*, 68 J. FORENSIC SCI. 207, 209 (2022) (finding that "80.7% of mass shooters had no recorded history of psychotic symptoms.").
24. *Id.* at 210.

monality between school shooters is that they are disproportionately White and disproportionately male,[25] but each mass shooting is unique. Therefore, predicting who might become violent in statistically anomalous circumstances is virtually impossible.[26]

Moreover, mass shootings perpetrated by "lone gunmen" represent a small subset of gun violence more generally—eighty-five per cent of shootings occur within social networks, meaning someone is "more likely to be shot by relatives, friends, enemies, or acquaintances than they are by lone violent psychopaths."[27] The relative rarity of mass shootings makes crafting harm reduction policy more difficult. Because mass shootings are rare, it is difficult to develop predictive statistical measures for them.[28] The subset of mass shooters who are also mentally ill is even smaller, rendering meaningful statistical analysis nearly impossible.[29] As such, there is little predictive or preventative value in tying mass shootings, let alone the broader phenomenon of gun violence, to mental illness.[30]

Treating mass shooters as "seriously mentally ill" is both inaccurate and reinforces an expectation that mental health professionals can predict and prevent mass violence.[31] To demonstrate the absurdity of trying to prevent gun violence by targeting people with mental illnesses, consider the claim that preventing mentally ill people from legally owning weapons will result in less gun violence. This claim relies on several (unproven) assumptions. First, it presumes a strong causal relationship between mental health diagnoses and violent behavior.[32] Second, it assumes that potential perpetrators who experience mental health symptoms will be seen by a psychiatrist who can accurately predict the risk they pose to others and confine them.[33] Such confinement would arguably undermine their civil and due process rights.[34] Third, it assumes that if someone has been involuntarily committed once, they are more likely to perpetrate gun violence in the future than the average person.[35] Finally, this person must not be

25. *Id.* at 209.
26. Metzl et al., *supra* note 16, at 83 ("No single variable emerged as a common feature of mass shooters.").
27. Metzl & MacLeish, supra note 17, at 242.
28. *See* JEFFREY W. SWANSON ET AL., PREVENTING GUN VIOLENCE INVOLVING PEOPLE WITH SERIOUS MENTAL ILLNESS, IN REDUCING GUN VIOLENCE IN AMERICA: INFORMING POLICY WITH EVIDENCE AND ANALYSIS 34 (Daniel W. Webster and Jon S. Vernick Eds., 2013).
29. *Id. See also* Metzl & MacLeish, *supra* note 17, at 241.
30. Metzl & Macleish, *supra* note 17, at 242.
31. Metzl et al., *supra* note 16, at 81.
32. Swanson et al., *supra* note 28, at 36.
33. *Id.*
34. *Id*.
35. *Id.*

able to obtain weapons from an alternative source.[36] If these assumptions are viewed as links in a chain of prevention, all of them would need to hold true—but, to the contrary, each assumption is empirically flawed.[37] There is modest support for the assertion that disqualifying people with a history of serious mental illness would marginally decrease violence.[38] Nonetheless, these findings are not sufficient to establish a causal relationship and are likely explained by other factors.[39] Moreover, intervening is not without cost, especially when considering the civil rights deprivations involved in involuntary commitment or other measures targeting the legal rights of people with mental health diagnoses.[40]

Statistics conflating mental illness and gun violence neglect that people with mental illness are more frequently victims than perpetrators of violence.[41] People with schizophrenia, for example, may experience social withdrawal and isolation, which would make them less likely to perpetrate violence.[42] However, people diagnosed with schizophrenia experience violence at rates 65 to 130% higher than the general public and are fourteen times more likely to be victims of a violent crime than to be arrested for one.[43] Specifically, these individuals are likelier to be targeted by police brutality or the victims of crimes such as robbery, theft, use of a weapon, and physical or sexual assault.[44] As

36. *Id.*

37. *See id.* ("As it turned out, all of the assumptions were flawed.").

38. *See id.* at 45 ("[O]ur data seem to suggest that the Brady Law background checks can have some positive effect, if enforced . . . These findings do not prove a causal relationship between the background check system and reduced violent crime. There may be other explanations, for example, that post-2007 improvement in the mental health and criminal justice system specifically affected people with gun-disqualifying mental health adjudications, resulting in improved treatment outcomes and a concomitant lower risk of criminal offending."). *But see id.* at 34 (suggesting that such policies stoke avoidance, social rejection, and discrimination, which may alienate people with serious mental health conditions from seeking treatment, worrying about what it may entail).

39. *Id.*

40. *See id.* at 34 (considering the "inherent tension between public safety and civil rights" and the civil rights effects of tying mental health to gun violence prevention).

41. Metzl & MacLeish, *supra* note 17, at 242.

42. *Id. See also* Metzl et al., *supra* note 16, at 83 ("Ironically in this context, disorders such as major depression and schizophrenia are often marked by psychomotor slowing, negative affect, intellectual disorganization, social isolation, and other symptom clusters that would seem to render a person *less* likely to plan and implement a complex gun crime. It is perhaps not surprising, then, that some studies have found that persons diagnosed with these mental illnesses are less likely than non-mentally ill offenders to use firearms in violent crimes.").

43. John S. Brekke et al., *Risks for Individuals with Schizophrenia Who Are Living In the Community*, 52 PSYCH. SERVICES 1358, 1364–1365 (2001).

44. *Id.* at 1364.

some commentators note: "persons with mental illness might well have more to fear from 'us' than we do from 'them.'"[45]

Moreover, data connecting mental health to violence is frequently racialized, both due to racialized constructions of mental illness[46] and over-reliance on biased criminal justice data.[47] Most empirical studies focusing on the link between mental health and violence rely on data from the criminal justice system or state psychiatric hospitals.[48] Therefore, Black and Brown people are often over-represented in these datasets.[49] For example, one study that used Florida data to study gun restrictions found that Black people made up fifteen percent of the population but thirty-one percent of those disqualified from owning guns due to a mental health adjudication.[50] Because data regarding the intersection between violence and mental illness considers only people with mental health diagnoses who are disproportionally poor and disproportionately Black, tying violence to mental illness exacerbates institutionalization or incarceration among these groups.[51] The connection between violence and mental illness is often used to justify further institutionalization and incarceration.[52] Therefore, the use of flawed data from the justice system "produc[es] an insidious feedback loop between biased data and discriminatory practice."[53]

In sum, using mental illness as a proxy for determining whether someone is likely to commit a mass shooting is a flawed approach. Easy access to firearms increases the likelihood of impulsive purchases, which are correlated to both gun-related homicides and suicides.[54] Easy access to firearms during emotionally charged moments with no "cooling period" may therefore increase the threat of gun violence.[55] Studies have found that homicide is more common in

45. Metzl & MacLeish, *supra* note 17 at 242.
46. *See* JONATHAN M. METZL, THE PROTEST PSYCHOSIS: HOW SCHIZOPHRENIA BECAME A BLACK DISEASE xii (Beacon Press, 2009) (documenting the development of schizophrenia diagnoses throughout the Twentieth century and finding evidence that diagnoses in schizophrenia among Black men increased drastically throughout the Civil Rights Movement, a trend that persists today).
47. Metzl et al., *supra* note 16, at 84.
48. *Id.*
49. *Id.*
50. *Id.*
51. *Id.*
52. *Id.*
53. *Id.*
54. *See* Cassandra Drifasi, *Gun Policy in the United States: Evidence-Based Strategies to Reduce Gun Violence*, 16 APPLIED HEALTH ECON. & HEALTH POL'Y. 579, 579 (2018) ("The built-in waiting period that results from the extended period of time to conduct a background check can also reduce impulsive purchases where the firearm may then be used to harm oneself or others.").
55. *Id.*

geographic areas with higher proportions of firearms ownership.[56] Missouri's repeal of background check laws led to an additional forty-nine to sixty-nine murders per year precisely because people were able to obtain guns more expeditiously.[57] The availability of guns is more predictive of gun violence than psychiatric diagnoses.[58] Limiting access to guns has an additional benefit of limiting the number of gun-related suicides, as states with permissive laws have more than twice as many suicides involving firearms.[59]

Empirical evidence therefore suggests that laws targeting mental illness misdiagnose the problems that lead to gun violence. Although readily accessible firearms are causally linked to higher rates of gun crime,[60] laws targeting people with mental health disabilities misdiagnose the problems that lead to gun violence.[61] Moreover, as the next section argues, linking gun policy to mental health policy creates multiple forms of stigma against people with mental health disabilities, in particular structural stigma.

B. Stigma and Mental Illness Narratives

Researchers describe stigma in multiple ways, underscoring the complexities of how stigma produces health and other inequalities.[62] Stigma generally refers to the devaluation of certain attributes to discredit people or generally devalue their social identities.[63] However, stigma is also a relationship of power, which inhibits stigmatized people's ability to exercise rights to freedom and autonomy.[64] Stigma reproduces power relationships in a multitude of ways: by painting certain people as undesirable, by stereotyping people, by creating an "us versus them" mentality, by denying certain groups access to social,

56. Metzl & MacLeish, *supra* note 17, at 242.
57. *Id.*
58. *Id.*
59. Heather Saunders, *Do States with Easier Access to Guns have More Suicide Deaths by Firearm?*, KAISER FAMILY FOUNDATION (Jul. 18, 2022), https://www.kff.org/other/issue-brief/do-states-with-easier-access-to-guns-have-more-suicide-deaths-by-firearm/ [https://perma.cc/V6XR-K27T] ("More than twice as many suicides by firearm occur in states with the fewest gun laws, relative to states with the most laws.").
60. *See, supra*, notes 54–59 and accompanying text for additional explanation of how access to guns increases gun violence.
61. *See, supra,* notes 20–59 and accompanying text for a robust discussion of why people with mental health disabilities should not be targeted as part of gun prevention bills.
62. *See* Bruce G. Link et al., *Stigma as a Fundamental Cause of Population Health Inequality, in* THE OXFORD HANDBOOK OF STIGMA, DISCRIMINATION, AND HEALTH 53, 53–54 (Brenda Major, John F. Dovidio, and Bruce G. Link eds., 2018) (isolating stigma as a cause of health inequities, as well as defining stigma in numerous ways).
63. *Id.* at 53.
64. *Id.*

economic, and political power, and by overt and subtle mechanisms of disapproval, rejection, exclusion, and discrimination.[65] Stigma is moreover a social determinant of health, as well as many other social inequalities, such as: housing, education, employment, and access to resources necessary to live a healthy life.[66]

Stigma surrounding mental illness is a multilevel problem consisting of individualized, interpersonal, and structural stigma.[67] Stigma is often painted as an individual-level problem, particularly one of bias or prejudice.[68] However, such a view is reductionistic and ignores the structural and interpersonal features of stigma.[69] Stigma, according to researchers, is a multi-level concept.[70] Individual stigma is internal and "refers to the cognitive, affective, and behavioral processes in which individuals engage in response to stigma."[71] Stigmatized individuals may conceal the sources of their trauma, internalize other people's stigmatizing attitudes, and experience rejection sensitivity.[72] Interpersonal stigma is a way of expressing prejudice or discrimination between people—an interaction between the stigmatized and non-stigmatized parties.[73] Interpersonal stigma can be intentional or unintentional and may take the form of microaggressions or overt bias.[74] Both individual and interpersonal stigma can discourage people from seeking mental health care services.[75]

Yet stigma is also structural and can define the range of opportunities available to stigmatized individuals. Structural stigma is defined as a process that "[occurs] beyond the individual and interpersonal levels" and is constituted by "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and well-being of the stigmatized".[76] In other words, social, cultural, and attitudinal norms produce institutions that give stigmatized peo-

65. *Id.*
66. *Id.*
67. Mark L. Hatzenbuehler, *Structural Stigma and Health Inequalities*, *in* THE OXFORD HANDBOOK OF STIGMA, DISCRIMINATION, AND HEALTH 105, 106 (Brenda Major, John F. Dovidio, and Bruce G. Link eds., 2018).
68. Patrick W. Corrigan et al., *Structural Stigma in State Legislation,* 56 PSYCH. SERV. 557, 557 (2005).
69. Hatzenbuehler, *supra* note 67, at 106.
70. *Id.*
71. *Id.*
72. *Id.*
73. *Id.*
74. *Id.*
75. *See* Patrick W. Corrigan et al., *The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care*, 15 PSYCH. SCI. PUB. INT. 37, 40 (2014) ("Despite the availability of evidence-based services, epidemiological research suggests that many people who might benefit from care do not receive it. As we demonstrate below, stigma in its various manifestations often serves as a barrier to care seeking.").
76. Hatzenbuehler, *supra* note 67, at 106.

ple fewer opportunities.[77] Structural stigma does not rely on interpersonal relationships, but rather creates negative outcomes for stigmatized groups regardless of how the people they interact with view them.[78] Structural stigma would still exist even if no one harbored express animus against stigmatized individuals or groups.[79] Structural stigma limits the liberties of people with mental health disabilities through institutional rules, norms, and laws that limit the options available to people with mental health disabilities.[80]

Studies have shown that state laws often conflate incompetence with mental illness, which is a primary driver of stigma against people with mental health disabilities.[81] Most relevant to this Article, the federal government prohibits any person "who has been adjudicated as a mental defective or . . . committed to a mental institution" from shipping, transporting, receiving, or possessing firearms.[82] As of 2021, forty-six states banned a subset of people with mental illnesses from possessing firearms.[83] Denying people diagnosed with mental health disabilities the right to bear arms is a form of structural stigma.[84] It limits people from exercising what many would call a fundamental Constitutional right.[85]

However, structural stigma does not merely affect gun ownership prospects—it can pervade every aspect of a disabled person's life. People with disabilities are more likely to have their children taken away from them because many state statutes allow courts to presume parents are unfit due to disability.[86] Moreover, as of the time of writing,

77. *See, e.g.*, *id*. at 116 (suggesting that diminished opportunities for sexual minorities are examples of structural stigma).
78. *Id.*
79. *Id.*
80. Corrigan et al., *supra* note 68, at 563.
81. *See, e.g.*, *id.* ("Several states also limited firearm privileges for people with mental illness. . . .[T]his restriction is an example of a larger concern in the law—the stigma of targeting people with mental illness per se rather than people who are incompetent as a result of having a mental illness.").
82. 18 U.S.C. § 922(g)(4).
83. *See* Faith Karimi, *Colorado is one of four states whose laws don't prohibit someone with a mental illness from owning firearms*, CNN (Mar. 25, 2021, 10:28 AM), https://www.cnn.com/2021/03/25/us/colorado-firearms-mental-health-trnd/index.html [https://perma.cc/74NG-LEJL].
84. Corrigan et al., *supra* note 68, at 563 ("Several states also limited firearm privileges for people with mental illness. At first, this might seem to be a reasonable action to promote public safety—only those who are competent to use guns should be permitted to do so. However, this restriction is an example of a larger concern in the law—the stigma of targeting people with mental illnesses per se rather than people who are incompetent as a result of having a mental illness").
85. U.S. Const. amend. II (stating "the right of the people to keep and bear Arms, shall not be infringed.").
86. *See* Nat'l Council on Disability, Rocking the Cradle: Ensuring the Rights of Parents with Disabilities and Their Children 84 (2012) (reporting that 37 states still have such statutes on the books).

the mere act of leaving one's house can subject people considered mentally ill to involuntary commitment, meaning that their freedom is continually in jeopardy if they seem too "mentally ill" in public.[87] As a result of Mayor Eric Adams' expansion of New York City's involuntary commitment policy, some people with mental health disabilities are afraid to leave their houses.[88] Part of the justification for this policy is that seriously mentally ill people might be "dangerous," with people lauding the move as a way to reduce violence.[89] This policy marks the beginning of a broader trend, as other jurisdictions are following suit.[90] Involuntary commitment is the ultimate form of structural stigma, as it both forcibly removes people from society and deprives them of any modicum of freedom and autonomy based upon the idea that people with serious mental illnesses pose a danger to the public.[91] People experience structural stigma when the rights of citizenship are conditioned upon a person's diagnosis (or even perceived mental illness).[92] A single hospital visit or diagnosis may mark the difference between the law considering someone a fit parent, a fit gun

87. Greg B. Smith, *Judge Delays Ruling on Adams' Mental Health 'Involuntary Removal' Plan*, THE CITY (Dec. 12, 2022, 7:32 PM), https://www.thecity.nyc/2022/12/12/23506619/judge-delays-ruling-adams-mental-health-nypd-plan [https://perma.cc/539T-QVXY].

88. *Id.*

89. Sarah Maslin Nir, *On City Streets, Fear and Hope as Mayor Pushes to Remove Mentally Ill,* N.Y. TIMES (Nov. 30, 2022), https://www.nytimes.com/2022/11/30/nyregion/new-york-mental-illness-homeless-reaction.html.

90. *See, e.g.*, Lauren Dake, *Portland mayor suggests easing process to involuntarily commit people with mental health struggles*, OR. PUB. BROAD. (Dec. 13, 2022, 12:42 PM), https://www.opb.org/article/2022/12/12/portland-mayor-ted-wheeler-suggests-easing-process-involuntarily-commit-mentally-ill/ [https://perma.cc/F7EB-F365] (detailing a similar plan to be implemented in Portland).

91. *See, e.g.,* Ruth Sangree, *I was hospitalized against my will: I know firsthand the harm it can cause*, THE GUARDIAN (Dec. 23, 2022 3:00 PM), https://www.theguardian.com/society/2022/dec/23/involuntary-hospitalization-policy-new-york-city-eric-adams [https://perma.cc/SV36-EHY3] (describing the lack of autonomy for people who are involuntarily committed, stating: "Unless you have experienced it, I don't think you can fully comprehend what it means to lose autonomy over your own body, or to have to 'earn the privilege' of 30 minutes of fresh air and sunshine."); *See generally* SUSAN STEFAN, RATIONAL SUICIDE, IRRATIONAL LAWS: EXAMINING CURRENT APPROACHES TO SUICIDE IN POLICY AND LAW (Oxford University Press, 2016) (detailing the trauma that results from involuntary treatment).

92. *See, e.g.*, Corrigan et al., *supra* note 68, at 563 ("[T]he discrimination resides in the assumption that people who are labeled as being mentally ill are not competent to use guns. A majority of individuals who are labeled as being mentally ill by virtue of being hospitalized or receiving mental health care are in touch with reality, not psychotic or homicidal. Thus, those who are labeled as mentally ill are being discriminated against by virtue of their class.").

owner, or even someone who can live independently in their community.[93]

These kinds of restrictions are justified by the perception that people with mental health disabilities are incompetent—those the law deems unaffected by mental illness, are presumed legally competent when they reach the age of majority.[94] However when someone is deemed incapacitated on the basis of their disability, the law restricts several fundamental rights of citizenship.[95] Yet, in practice, capacity determinations are rarely value-neutral.[96] For example, research shows that practitioners adjudicating capacity frequently cannot tell the difference between a decision that is "incapacitous" and one that is merely "unwise."[97] Decisions about whether someone lacks capacity—determined by individual mental health professionals—always contain implicit assumptions about what a person with capacity would do.[98] The above, paired with generalized social stigma against mental illness, creates doubt about whether medical professionals should be the ultimate arbiters of people's capacity—or whether capacity should be used as a metric for determining someone's rights in the first instance.[99]

The Bipartisan Safer Communities Act creates opportunities for people with mental health disabilities to seek treatment.[100] More specifically, it enables people to seek treatment in their communities, which is an evidence-based way to improve mental health service provision.[101] However, as subsequent sections highlight, providing these vital services through a mental health bill further stigmatizes people

93. *See id.* at 562 (finding that 253 pieces of state legislation denote someone as incompetent regarding one or more facets of citizenship based on diagnostic categories or disabilities. "Examples include bills that restrict access to firearms for people with current or past mental illness (Kansas, Maryland, New Hampshire, and Ohio), diminish parental rights of individuals with a history of mental illness (Oklahoma and New York), and restrict placement of mental health programs in certain neighborhoods (Hawaii and Michigan).").

94. NAT'L COUNCIL ON DISABILITY, BEYOND GUARDIANSHIP: TOWARD ALTERNATIVES THAT PROMOTE GREATER SELF-DETERMINATION 15 (2018).

95. *See id.*

96. Lucy Series, *Relationships, autonomy, and legal capacity: Mental capacity and support paradigms,* 40 INT'L J. L. PSYCHIATRY 80, 81–82 (2015).

97. *Id.* at 82.

98. *Id.*

99. Some authors question the need to condition rights on disability status or capacity altogether. *See, e.g.*, Heather A. Swadley, *How #FreeBritney Exposes the Need to Disable the Model Rules of Professional Conduct*, 43 MITCHELL HAMLINE L. J. OF PUB. POL'Y & PRAC. 1, 35 (2022) (calling guardianship an "an unjust system in which disabled people are often needlessly stripped of their self-determination and independence.").

100. *See infra* section III.A–III.D for a discussion of the services provided.

101. *See infra* section III.B for a more thorough discussion of the benefits of community-based mental health services.

with mental health disabilities, both discursively and structurally.[102] The connection between mental health and gun violence creates the false perception that people with mental health disabilities are more likely to be violent.[103] Moreover, the services provided by the bill cooperate extensively with law enforcement agencies, placing people with mental health disabilities at increased risk of incarceration, involuntary treatment, or even death.[104]

III. THE BIPARTISAN SAFER COMMUNITIES ACT: STATED GOALS AND EVIDENCE BASE

This section considers the ways in which the Bipartisan Safer Communities Act improves upon existing community-based mental health infrastructure and therefore increases treatment options for people with mental health disabilities. Section III.A discusses the motivations behind the Bipartisan Safer Communities Act and its focus on mental health service provision. Section III.B considers the funding streams for community-based mental health services created by the bill. Section III.C considers school-based mental health expenditures. Finally, section III.D discusses the National Suicide Prevention Hotline.

A. Discursive Stigma in the Framing of the Bipartisan Safer Communities Act

The Bipartisan Safer Communities Act arose from a desire to create a bipartisan bill that would address gun violence; yet, the resulting bill focused extensively on mental health services.[105] This marked a departure from prior discussions in the House, which focused on controlling access to guns.[106] The Senate bill was negotiated by Senators Chris Murphy (D-Conn), Kyrsten Sinema (D-Ariz), John Cornyn (R-Texas), and Thom Tillis (R-N.C.).[107] These Senators hailed the bill as "commonsense legislation" that would not adversely affect the rights of "law-abiding" Americans.[108] This section juxtaposes the House and Senate bills, emphasizing the marked discursive and policy shift re-

102. *See infra* section III.A for a discussion of stigma in the Congressional debates and Part IV for a discussion of structural stigma.
103. *See supra* Section II.A for a discussion of the relationship between gun violence and mental health.
104. *See*, *infra*, Section IV.A for a discussion of the role law enforcement plays in services funded by the Bipartisan Safer Communities Act.
105. *See supra* notes 1–14 and accompanying text for a more thorough discussion of the political motivations underlying the Act.
106. *See supra* note 105–106 and *infra* notes 107–115 for a description of the House bill.
107. Snell, *supra* note 12.
108. *Id.*

sulting from the Senate bill's emphasis on the mental health service provision.

After the shootings in Uvalde and Buffalo, the House passed the Protecting Our Kids Act. The measure would have prohibited individuals under twenty-one from purchasing semi-automatic weapons, regulated bump stocks, and criminalized firearms trafficking, and other related measures.[109] At this point, Democrats focused on white supremacy as the root cause of much gun violence. They also rebuked Republicans' emphasis on mental health as a cause of gun violence. For example, Representative McGovern called the events in Buffalo a "hate-fueled rampage of white supremacy" and dismissed Representative Fischbach's claims that mental illness was a "root cause" of gun violence.[110] Specifically, McGovern stated: "Yes, we have people with mental health issues in America. So do other countries. Only here in America do we have widespread, fatal gun violence to the extent that we do, so spare us the lectures."[111]

Meanwhile, Republicans insisted that mental health services are the answer to gun violence. Representative Fischbach stated: "House Republicans condemn the violence in Buffalo, Uvalde, Tulsa, and Philadelphia. We stand ready to work with the majority to directly address school safety, mental health, and the root causes of gun violence."[112] She further argued that federal law already keeps dangerous and "unfit" individuals from purchasing firearms.[113] Among the unfit, she included "individual[s] involuntarily committed to mental institutions or adjudicated mentally defective."[114] Statements such as these seemingly indicate a desire to use mental health as a red herring to avoid addressing gun violence. Yet, at the time, House Democrats such as McGovern refused to center the conversation on mental health.[115]

Nonetheless, the narrative quickly shifted in the Senate to a discussion that framed the problem in terms of inadequate mental health services, rather than one about access to guns. Republicans and Democrats sought to negotiate a bipartisan bill that had the votes to overcome the sixty-vote threshold in the Senate.[116] The Bipartisan Safer Communities Act implemented some restrictions on gun ownership.[117] However, Senators appealed to a shared sense that mental

109. *See* H.R. 7910, 117th Cong. (2022).
110. 168 Cong. Rec. H5439–H5350 (2022).
111. *Id.* at H5350.
112. *Id.*
113. *Id.*
114. *Id.*
115. *Id.*
116. Snell, *supra* note 12.
117. Bipartisan Safer Communities Act, Pub. L. No. 117–159, 136 Stat. 1313 (2022) (codified as amended in scattered sections of 42 U.S.C.). The gun-specific mea-

health services should be funded adequately.[118] The bill itself contained many mental health service provisions.[119] One notable implication of this rhetorical and policy shift was the creation of a dichotomy between "law-abiding" gunowners and the "mentally ill."[120]

In debates on the Senate floor, references to mental illness as the root cause of gun violence were rampant. Senator Cornyn (R-Texas) began by stating that the Uvalde shooter was: "[a] high school dropout with a history of violence and mental health struggles. . . ."[121] He argued that "[l]aw-abiding gun owners are not the problem,"[122] insinuating that people with mental health disabilities are not law-abiding citizens. This theme was prominent throughout speeches on the subject. Cornyn stated:

> [T]he dirty little secret is that America is experiencing a mental health crisis. Our mental health delivery system is a scandal. Too many people are not getting the sort of attention and care they need in order to manage their mental health challenges. And many of them can be saved from the fate of Salvador Ramos or Adam Lanza if they can get access to timely care and the medication that will help them manage their mental illness.[123]

Cornyn repeatedly emphasized that unless someone was mentally ill or convicted of a crime, they would have full access to their Second Amendment rights.

Likewise, Senator Cassidy (R-LA) emphasized this division between "law-abiding citizens" and people with mental health conditions.[124] Cassidy, a physician, stated: "[p]ersonally, I would like to have an app. I would like to have an 'I am a troubled teenager' app and 'I need somebody to talk to.'"[125] He called the Uvalde shooter "troubled" and emphasized that the bill provided additional funding for mental health resources—even going so far as to ask: "[h]ow can someone be against that? This is a solution."[126] The idea that treating mental illness is a solution to gun violence was emphasized repeat-

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sures in the bill include expanding background checks for people under 21 to include juvenile records, toughening laws targeting gun trafficking and "straw guns," and banning domestic abusers from owning firearms; Cochrane & Kanno-Youngs, *supra* note 11; this paper focuses primarily on the mental health and school-based initiatives of the bill.

118. *See infra* notes 116–137 and accompanying text for examples of how mental health was discussed on the Senate floor.

119. *See infra* Part III for a more thorough discussion of these services.

120. *See, e.g.*, 168 Cong. Rec. S3,137, S3,115. (2022) ("Law-abiding gun owners are not the problem").

121. 168 Cong. Rec. S3,137 (2022).

122. *Id.* at S3,115.

123. *Id.* at S3,138.

124. *Id.* at S3,140.

125. *Id.*

126. *Id.* at S3,141.

edly, and news outlets hailed the bill as "the most significant gun measure to clear Congress in nearly three decades."[127]

This rhetorical shift is not insignificant. Discourse by public officials may socially construct unpopular groups in ways that are inimical to their citizenship.[128] The language used by officials matters, both because it produces legislative history and because it can stigmatize marginalized groups.[129] As two prominent scholars of communication note: "[l]aws are not just bundles of advantages or disadvantages, but are also messages about who matters and who does not."[130] Therefore, legislative framings of people with mental health disabilities as something other than "law-abiding citizens" may create the presumption that disabled citizens do not matter.

Framing mental health as the cause of gun violence is not new. Analyses of news media between 1997 and 2012 found that "dangerous people" with mental illnesses were more likely to be mentioned as causes of shooting than "dangerous weapons."[131] Such portrayals stigmatize people with mental health disabilities.[132] One study discovered that when people read news stories describing mass shooters with "serious mental illnesses," they reported perceiving those people as more dangerous and wanted more social distance from people with mental health conditions.[133] The result of these attitudes is structural stigma. According to researchers, negative public attitudes against people with serious mental illnesses are linked to structural factors like undertreatment, being unhoused, and poverty, according to researchers.[134]

The binary between people with mental health disabilities and "law-abiding citizens" therefore serves to perpetuate multiple layers of stigma. It contributes to the public viewing people with mental health disabilities as dangerous.[135] Furthermore, this binary justifies treating people diagnosed with mental illness as though they do not deserve what conservative groups have called "an inalienable right[ ]".[136] Conversations in the House and Senate do not occur in a

127. Cochrane & Kanno-Youngs, *supra* note 11.
128. ANNE L. SCHNEIDER & HELEN M. INGRAM, DESERVING AND ENTITLED: SOCIAL CONSTRUCTIONS AND PUBLIC POLICY 106 (2005).
129. *Id.*
130. *Id.*
131. Emma E. McGinty et al., *News Media Framing of Serious Mental Illness and Gun Violence in the United States, 1997–2012*, 104 AM. J. PUB. HEALTH 406, 406 (2014).
132. *Id.*
133. *Id.*
134. *Id.*
135. *See supra* Sections I.A–I.B for a discussion of how misconceptions about mental health create multiple forms of stigma.
136. Amy Swearer, *Gun Restrictions Handicap Law-Abiding Citizens Under the Guise of Making Them Safer*, HERITAGE FOUND. (June 10, 2019), https://

vacuum—they both indicate social prejudice on a public level and perpetuate it.[137] Therefore, the discursive framing of the Bipartisan Safer Communities Act is by itself a reason for skepticism.

B. Funding for Community-Based Mental Health Services

Given that the Bipartisan Safer Communities Act sought to provide mental health services as a solution for gun control, clarity about the bill's key provisions and funding mechanisms is necessary. The bill, funded through the Senate Omnibus Bill in December 2022, creates several streams of funding for mental health services nationwide.[138] Specifically, the bill provides: funding to increase the number of Certified Community Behavioral Health Clinic (CCBHC) demonstration grants, $250 million in block grants for states to provide comprehensive community mental health services, $80 million in grants to support expansion of pediatric mental health services, and $120 million to train first responders about how to appropriately respond to mental health crises.[139] This Part considers the expansion of the CCBHC demonstration program and block grants for states to provide more community-based mental health services, as these represent a large part of the Act's mental health expenditures. Notably, the Act expands the number of states eligible for grants to create state-run, certified, community-based mental health clinics (CCBHCs) so that up to ten additional states may participate every two years.[140] The bill

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www.heritage.org/firearms/commentary/gun-restrictions-handicap-law-abiding-citizens-under-the-guise-making-them [https://perma.cc/EN29-XPFF]; *See also* STEVEN DANIEL, THE SECOND AMENDMENT: REDISCOVERING THE INALIENABLE RIGHT TO FIREARM OWNERSHIP & SELF-DEFENSE (2022) (arguing the Second Amendment creates an inalienable right to bear arms); Nelson Lund, The Second Amendment and the Inalienable Right to Self-Defense, HERITAGE FOUND (April 17, 2014), https://www.heritage.org/the-constitution/report/the-second-amendment-and-the-inalienable-right-self-defense [https://perma.cc/5FUJ-HUQC] (suggesting self-defense is a natural right); Rich Lowry, *Yes, Gun Ownership Is a God-Given Right*, POLITICO (Sept. 4, 2019), https://www.politico.com/magazine/story/2019/09/04/yes-gun-ownership-is-a-god-given-right-228034/ [https://perma.cc/EU59-JVH2] ("The Bill of Rights puts flesh on the bones of those 'unalienable rights' of life and liberty, and numbers 'the right of the people to keep and bear Arms' among them.").

137. *See* SCHNEIDER & INGRAM, *supra* note 128, at 105.

138. *See* Alexander Bolton, *Senate passes $1.7 trillion omnibus spending package*, THE HILL (Dec. 22, 2022, 2:18 PM), https://thehill.com/policy/finance/3785395-senate-passes-1-7-trillion-omnibus-spending-package/ [https://perma.cc/6QFY-MRZJ].

139. Bipartisan Safer Communities Act, Pub. L. 117–159, § 13401 136 Stat. 1313, 1340–41 (2022) (codified as amended in scattered sections of 42 U.S.C.).

140. 42 U.S.C. § 1396(a) ("[A]s soon as practicable after the date of enactment of this paragraph, the Secretary shall award planning grants to States (other than States selected to conduct demonstration programs under paragraph (1) or (8) of subsection (d)) to develop proposals to participate in time-limited demonstration programs described in subsection (d) so that, beginning July 1, 2024, and every 2 years thereafter, up to 10 additional States may participate in the demonstration

also increases the period of time for which these grants are awarded, and provides technical assistance for states wishing to apply.[141]

CCBHC demonstration grants, also known as Section 223 grants, create and evaluate two-year demonstration programs in states to create certified community behavioral health clinics (CCBHCs).[142] The goals of CCBHCs are to improve behavioral health by (1) "providing community-based mental health and substance use" treatment services; and (2) integrating behavioral and physical health through better care coordination.[143] In other words, these clinics must take a "patient-centered" approach that treats the "whole person."[144] The program is funded through a Prospective Payment System that works with state Medicaid plans to guarantee payment of claims. However, certified clinic funding is conditioned on willingness to serve all patients, regardless of their ability to pay or where they live.[145]

To become certified, a clinic must meet several criteria. First, clinics must provide adequate staff for people in its target consumer population and account for the area's cultural, linguistic, and treatment needs.[146] Second, services must be available and accessible 24-hours per day and use a sliding scale for payment.[147] No individual may be rejected or receive reduced services based on their ability to pay or place of residence.[148] Third, CCBHCs must coordinate care across health care settings by forming partnerships or formal contracts with federally-qualified health centers, inpatient psychiatric facilities, community or regional social service organizations, Veterans Affairs medical centers, and inpatient acute care hospitals and hospital outpatient clinics.[149] Fourth, CCBHCs must provide a designated range of mental health services, such as crisis mental health services, outpatient services, and peer support and counselor services.[150] Finally, CCBHCs must meet quality standards and maintain its status as a nonprofit organization, local governmental behavioral health authority, or part of the Indian Health Service.[151]

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programs described in subsection (d) in accordance with paragraph (9) of that subsection.").

141. *Id.*

142. SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., CRITERIA FOR THE DEMONSTRATION PROGRAM TO IMPROVE COMMUNITY MENTAL HEALTH CENTERS AND TO ESTABLISH CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS 26 (2016).

143. *Id.* at 1.

144. *Id.* at 1–2.

145. *Id.* at 2.

146. *Id.* at 9.

147. *Id.* at 15.

148. *Id.*

149. *Id.* at 23.

150. *Id.* at 34.

151. *Id.* at 57.

Although there are more than 500 CCBHCs in forty-six states,[152] only ten states participate in the Medicaid demonstration currently.[153] States have reported that CCBHCs' care coordination efforts have helped them save money, given that people with mental health disabilities typically are hospitalized and utilize emergency services more frequently.[154] Anecdotal data from many states suggests that CCBHC demonstrations expand access to mental health and substance abuse care because they provide people with same-day appointments.[155] For example, in New York, the number of Medicaid clients receiving mental health services increased by 21% in the first year, and Missouri reported a 27% increase in access to client care by the fourth year of the program.[156] The increase in community-based services reduces the need for inpatient mental health services too. In the first year, New York reported a 54% decrease in the number of CCBHC clients who needed inpatient treatment for their mental illnesses.[157] 76% of people who had access to CCHBCs in Missouri experienced a reduction in emergency department visits and hospitalizations—most also reported fewer contacts with law enforcement.[158] Physical health outcomes also improved for consumers in CCBHC demonstration states, likely due to the emphasis on integrated care.[159]

The results from CCBHC demonstration states are consistent with studies about similar interventions, like Assertive Community Treatment (ACT) and mobile crisis teams (MCTs). ACT programs create packages of individualized, community-based services designed to meet the service and support needs of people with severe mental health disabilities.[160] They also dramatically reduce the needless institutionalization and incarceration of people with mental health disabilities.[161] One large study found a 50% reduction of days in jail for

152. *What is a CCHBC?,* NAT'L COUNCIL FOR MENTAL WELLBEING https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-overview/ [https://perma.cc/J2U4-5VLW] (last visited Oct. 11, 2022).
153. Colleen Becker, *The Value of Certified Community Behavioral Health Clinics*, NAT'L COUNCIL OF STATE LEG.'S, (July 7, 2022).
154. *Id.*
155. Rachael Matulis & Dorn Schuffman, *Transforming State Behavioral Health Systems: Findings from States on the Impact of CCBHC Implementation,* NAT'L COUNCIL FOR MENTAL WELLBEING 4 (2021), https://www.thenationalcouncil.org/wp-content/uploads/2022/02/Transforming-State-Behavioral-Health-Systems.pdf [https://perma.cc/N7XH-BQ9Q].
156. *Id.*
157. *Id.* at 5.
158. *Id.*
159. *Id.* at 6.
160. Susan D. Phillips et al., *Moving Assertive Community Treatment into Standard Practice*, 52 PSYCH. SERV'S. 771, 772 (2001) (describing the principles of ACT).
161. *See id.* at 771 ("Reviews of the research consistently conclude that compared with other treatments under controlled conditions, such as brokered case management

individuals with access to ACT services.[162] Smaller, more localized studies confirm that providing people the services they need in their communities can reduce needless incarceration and hospitalization. For instance, an Illinois study found an 83% decrease in jail days spent over the course of a yar for ACT participants, as well as an 85% decrease in the number of inpatient stays for study participants.[163] In Oklahoma, participants who received ACT for the first time spent 65% fewer days in jail and 71% fewer days in hospital than people who did not receive ACT.[164]

Likewise, studies show Mobile Crisis Teams (MCTs) prevent unnecessary hospitalization and institutionalization. Mobile Crisis Teams (MCTs) are teams of trained professionals whom the police can call to de-escalate mental health crises.[165] The goal of MCTs is to divert people from arrest or inpatient care to services in their communities. They are typically comprised of at least one peer specialist and an on-call psychiatrist.[166] MCTs see individuals in place immediately—meaning in their communities—to assess an individual's immediate support needs and should ideally be available twenty-four hours per day, seven days per week. The most successful MCTs have access to community crisis apartments with appropriate peer support and on-call psychiatrists where people can stay as an alternative to being hospitalized.[167]

MCTs are demonstrably more effective as a first-line response than police or emergency department contact and can minimize the probability of people being arrested or needing acute emergency care. Typical contacts between police officers and people experiencing mental health crises result in an average arrest rate of 21%, but when a mobile crisis team intervenes, the arrest rate is frequently below

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or clinical case management, assertive community treatment results in a greater reduction in psychiatric hospitalization and a higher level of housing stability."); J. Steven Lamberti et al., *Forensic Assertive Community Treatment: Preventing Incarceration of Adults With Severe Mental Illness*, 55 PSYCH. SERV.'S 1285, 1289 (2004) (finding that forensic assertive community treatment, which combines diversion programs with ACT, substantially reduces recidivism and unnecessary incarceration).

162. Lamberti et al., supra note 161, at 1289.

163. *Helping Mentally Ill People Break the Cycle of Jail and Homelessness, The Thresholds, State, County Collaborative Jail Linkage Project, Chicago*, 52 PSYCH. SERV'S 1380, 1382 (2001).

164. *Assertive Community Treatment (PACT), One Year Pre- and Post-Admission Comparison*, OKLA. DEP'T OF MENTAL HEALTH AND SUBSTANCE ABUSE SERV.'S. (last modified June 16, 2010).

165. BAZELON CTR. FOR MENTAL HEALTH LAW, *Diversion to What?: Evidence-Based Mental Health Services that Prevent Needless Incarceration,* 7 (2019), http://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf [https://perma.cc/8EXD-D3NF].

166. *Id.*

167. *Id*.

7%.[168] For example, in Verde Valley, Arizona, a well-resourced mobile crisis team was able to stabilize crises in the community for 55% of calls made by first responders.[169] Without the team's intervention, 90 of the 109 calls studied would have likely resulted in arrest or hospitalization.[170]

The above data suggests both the utility and need for community-based mental health interventions. Community-based services allow people to avoid needless hospitalization or incarceration and therefore increase people's treatment options during an acute crisis.[171] The operation of twenty-four hour crisis mental health services in out-patient settings is a vital, evidence-based step, one which is provided for by CCBHC funding. However, as discussed in section IV.A, the current variation in infrastructure for community-based services impedes the law's transformative potential.

C. School-Based Mental Health Programs

The Bipartisan Safer Communities Act also targets mental health in educational settings in schools and the community. First, the bill injects over $1 billion of funding for schools to create innovative ways of meeting their students' mental health needs.[172] The stated goal of this funding is, "recruiting, preparing, hiring, and training highly qualified school-based mental health providers, including in underserved communities and for students such as multilingual learners and those from low-income backgrounds and in rural communities where access to such services can be limited."[173] These funds come in the form of competitive grants to state educational agencies and local educational agencies, trauma services in schools, and demonstration programs for partnerships between schools and mental health service providers.[174]

168. H.R. Lamb, et al., *The Police and Mental Health*, 53 PSYCH. SERV.'S 1266, 1268 (2002).

169. Cheri Frost, *Spectrum Healthcare's Mobile Crisis Team Partnership Program*, VERDE INDEPENDENT (Sept. 12, 2016) https://www.verdenews.com/news/2016/sep/12/spectrum-healthcares-mobile-crisis-team-partnersh/ [https://perma.cc/2RWR-XJ3W].

170. *Id.*

171. *See supra* Section III.B for a discussion of the benefits of community-based services.

172. Press Release, U.S. Dep't. of Educ., Hundreds of Millions of Dollars in Funds to Increase the Number of School-Based Mental Health Providers in Schools Provided Through the Bipartisan Safer Communities Act (Oct. 3, 2022), https://www.ed.gov/news/press-releases/hundreds-millions-dollars-funds-increase-number-school-based-mental-health-providers-schools-provided-through-bipartisan-safer-communities-act [https://perma.cc/963Q-MTQ6].

173. *Id.*

174. *Id.*

The bill makes schools eligible for Medicaid funding when they provide direct health services to beneficiaries.[175] More specifically, the bill provides increased support for telehealth provisions in schools, as well as technical support to schools serving Medicaid beneficiaries.[176] Under existing law, states are already required to cover screening services for children and "any services 'necessary . . . to correct or ameliorate' a child's physical or mental health condition."[177] However, a 2019 report by the Governmental Accountability Organization found that many Medicaid-eligible children do not receive adequate screening services.[178] Only three states met legally-required targets.[179] Less than half of Medicaid beneficiaries age twenty and under received the recommended services.[180] The report recommended additional oversight to ensure that children receive proper services.[181] CMS recently provided updated guidelines about how schools can strengthen and expand behavioral health service for Medicaid beneficiaries.[182]

Moreover, the bill provides $50 million in competitive grants to create "21st Century Community Learning Centers" (CCLCs).[183] These grants are intended to create community-based learning activities for middle and high school students outside of school hours to increase student engagement and attendance.[184] The Department of Education

175. Letter from Xavier Becerra & Miguel A. Cardona, U.S. Dep't. of Educ., Key Policy Letters Signed by the Education Secretary or Deputy Secretary (July 29, 2022), https://www2.ed.gov/policy/gen/guid/secletter/220729.html?utm_content&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term= [https://perma.cc/VQ2X-C5AZ].

176. Madeline Guth & Elizabeth Williams, *The Safer Communities Act: Changes to Medicaid EPSDT and School Based Services*, KAISER FAM. FOUND. (Sept. 6, 2022), https://www.kff.org/policy-watch/the-safer-communities-act-changes-to-medicaid-epsdt-and-school-based-services/ [https://perma.cc/X3KQ-JCQE].

177. *Id.* (quoting *Early and Periodic Screening, Diagnostic, and Treatment*, MEDICAID.GOV. (last visited Sept. 6, 2022), https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html [https://perma.cc/L336-5SHQ]).

178. U.S. GOV'T ACCOUNTABILITY OFF., GAO-19-481, MEDICAID: ADDITIONAL CMS DATA AND OVERSIGHT NEEDED TO HELP ENSURE CHILDREN RECEIVE RECOMMENDED SCREENINGS, (Aug. 16, 2019), https://www.gao.gov/products/gao-19-481 [https://perma.cc/E8E2-MKZC].

179. *Id.*

180. *Id.*

181. *Id.*

182. Memorandum from Daniel Tsai, U.S. Dep't. of Health and Hum. Serv.'s, CMCS Informational Bulletin: Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth, 3–4 (Aug. 18, 2022), https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08 182022.pdf [https://perma.cc/5LSN-9VDK].

183. Memorandum from James F. Lane, U.S. Dep't. of Educ., Letter regarding Fiscal Year 2022 Supplemental Grant Awards for the Nita M. Lowey 21st Century Community Learning Centers Program under the Bipartisan Safer Communities Act (Oct. 27, 2022).

184. *Id.*

encourages grant recipients to engage with student families, specifically noting that using text messages and offering home visits may be used to improve attendance.[185] Grant recipients are also encouraged to create mentoring programs and providing relevant learning experiences, such as apprenticeships, project-based learning, tutoring, field trips, and service-learning opportunities.[186] These centers are also intended to share information with schools and form part of a broader "early warning indicator system" to track indicators of poor mental health or risk of dropping out.[187]

While many of these steps are welcome, many of the education provisions emphasize detecting "early warning" signs or other indicators of behavioral health struggles.[188] Indeed, the Department has explicitly "encourage[d] grantees to use funds to develop early detection, screening, or warning systems to identify students who may be at risk, a danger to themselves or others, or in need of additional supports."[189] Although this is a laudable goal, making educators responsible for detecting potentially "dangerous" children can create unintended consequences, as discussed further in section IV.C.

D. National Suicide Prevention Lifeline / 9-8-8

One of the largest provisions of the Bipartisan Safer Communities Act is an infusion of funding to enhance the 9-8-8 Lifeline program, which has contributed to a forty-five percent increase in overall volume, improvement in answer rates and wait times compared to 2021.[190] The hotline connects individuals with trained crisis counselors in hopes of preventing suicide.[191] In August of 2022, the hotline answered 152,000 calls, chats, and texts, and the average wait time was forty-two seconds.[192]

Studies of crisis hotlines have shown they can decrease callers' distress and potentially prevent suicide. One study, which taped 100 calls between March 1988 and March 1999 to the Kids HelpLine in

185. *Id.*
186. *Id.* at 2.
187. *Id.*
188. *See, e.g.*, U.S. DEP'T. OF EDUC., BIPARTISAN SAFER COMMUNITIES ACT: STRONGER CONNECTIONS GRANT PROGRAM: FREQUENTLY ASKED QUESTIONS 27 (Nov. 2022) (encouraging grant recipients to develop early detection systems for students who may be "a danger to themselves or others").
189. *Id.*
190. Press Release, U.S. Dep't. of Health and Hum. Serv.'s, HHS Secretary: 988 Transition Moves Us Closer to Better Serving the Crisis Care Needs of People Across America (Sept. 9, 2022), https://www.hhs.gov/about/news/2022/09/09/hhs-secretary-988-transition-moves-us-closer-to-better-serving-the-crisis-care-needs-of-people-across-america.html [https://perma.cc/PG85-THPC].
191. *Id.*
192. *Id.*

Australia showed a significant decrease in suicidal ideation and improved mental state during calls.[193] The imminent risk to the children decreased substantially.[194] Another cross-sectional study of veterans showed that out of 646 calls during a one-week period, eighty-four percent of calls ended with a favorable outcome, which the study defined as a resolution of distress during the call or a referral to local health care clinics.[195] Studies of chat services likewise show a dramatic decrease in distress and suicidal ideation after talking to a crisis counselor.[196] Two-thirds of suicidal chatters reported that the chat had been helpful, and approximately half reported that they were less suicidal.[197] While existing data remains limited, the available studies tentatively suggest crisis hotlines are a way to alleviate suicidal ideations, at least in short-term periods of crisis.[198]

Some studies have also shown that crisis hotlines are a cost-effective way to prevent suicide.[199] One study looked at the cost-effectiveness and budgetary impact of a suicide helpline in Belgium that provided both telephone and chat services.[200] The study developed a probabilistic model that measured the impact of helpline services on quality-adjusted life years (QALYs) and the overall budget.[201] Over ten years, the model predicted that the chat service could avoid approximately thirty-five percent of suicides and attempts in the high-risk population.[202] Moreover, the study found that an investment of $218,899 could save $1,452,022[203] for the public health service and had a small impact on QALYs as well.[204]

This Article does not take issue with suicide prevention hotlines intended to help people during times of distress. Existing evidence shows a modest to moderate benefit of making these services available to the public.[205] These services are likely a worthwhile expenditure if they do not come in the form of coercive treatment programs. How-

193. Adam S. Hoffberg et al., *The Effectiveness of Crisis Line Services: A Systematic Review*, 7 FRONTIERS IN PUB. HEALTH 1, 7 (2020).
194. *Id.* at 7.
195. *Id.* at 8.
196. Madelyn S. Gould et al., *National Suicide Prevention Lifeline Crisis Chat Interventions: Evaluation of Chatters' Perceptions of Effectiveness,* 51 SUICIDE AND LIFE-THREAT. BEHAV. 1126, 1134 (2021).
197. *Id.* at 1129–30.
198. Hoffberg et al., *supra* note 193, at 12.
199. Lore Pil et al., *Cost-effectiveness of a Helpline for Suicide Prevention*, 19 J. OF TELEMEDICINE AND TELECARE 273, 273 (2013).
200. *Id.*
201. *Id.*
202. *Id.*
203. In U.S. dollars, this means that an approximately $235,000 investment could save approximately $1.5 million, based on current exchange rates as of March 26, 2023.
204. *Id.*
205. *See supra* Section III.D for a discussion of why crisis line services are beneficial.

ever, these hotlines often work with law enforcement agents and inpatient mental health services, thereby undermining the autonomy and trust of people who call seeking help.

IV. STRUCTURAL STIGMA IN THE BIPARTISAN SAFER COMMUNITIES ACT

This section discusses potential unintended consequences of the Bipartisan Safer Communities Act. Specifically, the Act exposes people with mental health to increased state surveillance, police encounters, and involuntary hospitalizations in multiple environments. Section IV.A argues that the lack of local community-based infrastructure available to answer 9-8-8 crises, as well as the hotline's involvement with law enforcement, increases the risk of stigma and tangible harm toward people seeking its assistance. Section IV.B discusses school-based interventions, exploring how making educational institutions responsible for "intervening" in cases of suspected violence may reproduce existing race, disability, and class biases.

A. 9-8-8 and Police Interventions

In the wake of the Bipartisan Safer Communities Act, suicidologists and mental health advocates have urged caution regarding its crisis line services.[206] An Instagram post by Liz Winston called 9-8-8 "not friendly" and emphasized that calling these resources can land someone in involuntary psychiatric care.[207] Winston, who runs a peer support service, had been involuntarily hospitalized without receiving any treatment or counseling the year before.[208] Concerns like Winston's arise from crisis hotlines interfacing with local law enforcement agencies in instances where a hotline specialist deems a person to be in imminent danger.[209] The Substance Abuse and Mental Health Services Administration (SAMHSA) admits: "[t]he 988 and 911 systems will need to be closely coordinated to seamlessly allow referral of callers for appropriate care or response that addresses the unique circumstances present with each crisis encounter."[210] The SAMHSA FAQ

206. *See, e.g.*, Emily Krebs, PhD (@SaltySticky), TWITTER (July 17, 2022, 5:31 PM), https://twitter.com/saltysicky/status/1548782365941477376?s=21&t=KNZTo9vyarA42i1cSlfXIQ [https://perma.cc/53GJ-CAG4] ("Thoughts from a suicidologist on the new 988 crisis hotline. . . . It's still linked to nonconsensual active rescue, which means they can & will trace your call & send police if they deem it necessary.").

207. Liz Winston (@lizwins_peersupport), INSTAGRAM (July 16, 2022), https://www.instagram.com/p/CgFZqnRujWj/ [https://perma.cc/8H8W-AXV5].

208. *Id.*

209. *See* 988 FREQUENTLY ASKED QUESTIONS, SUBSTANCE ABUSE AND MENTAL HEALTH SERV.'S. ADMIN., https://www.samhsa.gov/find-help/988/faqs [https://perma.cc/8N4V-2822] (last visited Oct. 17, 2022).

210. *Id.*

page states that "a small percentage of Lifeline calls require the activation of the 911 system. . . In these cases, the crisis counselor shares information with 911 that is crucial to saving the caller's life."[211] One study of 9-8-8 service users found that 24.6% of callers required "non-collaborative" measures like involuntary psychiatric services.[212] Additionally, patients who are viewed as "uncooperative" or "noncompliant" face additional risks.[213]

The localized nature of the 9-8-8 service provision exacerbates the risk that law enforcement will play an inordinate role in responding to crises. Significant regional variation in implementation is already emerging. For instance, California has announced $20 million in funding to provide for necessary infrastructure like mobile crisis teams and follow-up care to supplement federal funding for 9-8-8.[214] Many states will not provide these services—much like many states have not expanded Medicaid funding offered by the Affordable Care Act.[215] Missouri is increasing police involvement and hopes to use law enforcement in "more cost-effective early intervention[s]".[216] A survey of local service providers revealed that most areas are not ready for an influx of caseloads due to 9-8-8 and that most jurisdictions have not expanded local mental health infrastructure in line with demand.[217]

SAMHSA admits these problems with regional variation, acknowledging that necessary supports are not available in most places.[218] On its FAQ page regarding 9-8-8, it says that "[a]nyone in a U.S. state, territory, or tribe who needs suicide or mental health-related crisis support. . . can connect with a trained counselor. . . ."[219] SAMHSA also admits that these services do not exist in many places:

> SAMHSA's longer-term vision is that the transition to 988, which began in July 2022, will spur the growth of a robust crisis care system across our country that links callers to community-based providers who can deliver a full range of crisis care services (like mobile crisis teams or stabilization centers). Currently, these crisis care services do not exist in all areas of the country,

211. *Id.*

212. Hoffberg et al., supra note 193, at 8.

213. *Id.*

214. Jocelyn Wiener, *Call 988: California finds $20 million to help pay for new crisis hotline*, CALMATTERS (Sept. 2, 2021), https://calmatters.org/health/2021/09/988-911-funding-crisis-hotline-suicide-california/ [https://perma.cc/RCR6-DVPE].

215. *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Sept. 20, 2022), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ [https://perma.cc/L662-UYSM].

216. Valerie A. Canady, *Missouri Sees Uptick in 988 Calls One Month Following Launch*, 32 MENTAL HEALTH WEEKLY 3, 3 (2022).

217. Gary Enos, *Survey: More Work Needed to Address Weak Points as 988 Rollout Nears*, 32 MENTAL HEALTH WEEKLY 1, 2–3 (2022).

218. SAMHSA, *supra* note 209.

219. *Id.*

> and it will take time and sustained support for this crisis care system to evolve.[220]

One must therefore consider the current state of mental health services in the United States when considering the potential implications of expanding 9-8-8 infrastructure. As psychiatrists Leah G. Pope and Michael T. Compton persuasively argue, "[i]n an ideal system, 988 will be a convenient portal to access [a] continuum of services, but in practical terms, 988 personnel will be able to connect individuals only to existing services."[221] Mental health services are not created equal, and increasing law enforcement responses to mental health crises risks harming people experiencing mental health crises.

When 9-8-8 shares information with law enforcement officers, people with mental health disabilities are endangered. In 2020 Walter Wallace, a Black Philadelphia resident with a history of mental illness, was experiencing an acute mental health crisis.[222] He was brandishing a knife, and police were called to deescalate the situation.[223] Upon their arrival, family members told police about Wallace's crisis.[224] However, instead of deescalating the situation, officers shot Wallace multiple times on camera while his mother pleaded with them not to shoot.[225] Wallace's death is one example of a broader trend. Although data on police killings of civilians is incomplete, one study found that twenty-three percent of civilians killed by police in 2015 had mental illnesses.[226] The same study found signs of a mental illness were associated with more than a sevenfold increased risk of death when police intervened.[227] Even when police officers are trained using Crisis Intervention Training (CIT), recent studies show that fatalities involving people experiencing mental health crises do not decrease.[228]

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220. *Id.*

221. Leah G. Pope & Michael T. Compton, *"If This Is an Emergency, Hang up and Dial 911" in the Era of 988*, 73 PSYCH. SVCS. 1179, 1180 (2022).

222. Johnny Diaz, *Philadelphia Settles Lawsuit in Fatal Police Shooting of Walter Wallace Jr.*, N.Y. TIMES (Oct. 29, 2021), https://www.nytimes.com/2021/10/29/us/walter-wallace-jr-settlement.html [https://perma.cc/393X-NBYV].

223. *Id.*

224. *Id.*

225. *Id.*

226. Amam Z. Saleh et al., *Deaths of people with mental illness during interactions with law enforcement*, 58 INT'L. J. OF L. AND PSYCH. 110, 114 (2018).

227. *Id.*

228. *See* Michael S. Rogers et al., *Effectiveness of Police Crisis Intervention Training Programs*, 47 J. AM. AC. PSYCH. & L. 414, 419 (2019) ("After 20 years of CIT training programs and the recent increase in dissemination, large-scale studies of the quantifiable benefits of CIT as applied to the reduction of lethality and effect on overall arrest rates remain limited. Some studies have demonstrated little significant difference between CIT-trained officers and untrained officers in terms of the characteristics of PMI diverted to psychiatric emergency services. Studies

Beyond the potentially lethal consequences, involving law enforcement increases the risk of involuntary hospitalization or incarceration. According to a report by the National Conference for State Legislatures, at least 700,000 people per day are held in local jails, suggesting that jails are often de facto mental health treatment centers.[229] Nonetheless, inpatient treatment is not the answer; studies increasingly show that inpatient therapy is anything but therapeutic.[230] Inpatient hospitalization is one of the most robust predictors of suicide.[231] A woman who has been discharged from inpatient hospitalization in the past four weeks is three times more likely to die from suicide.[232] For men, that risk increases to seven-times that of the other forty-eight weeks of the year.[233] A study conducted on ex-patients provides context for those figures, finding that many people experience more trauma than support in in-patient settings.[234] A United Nations Special Rapporteur has called involuntary hospitalization "torture" under human rights law, reasoning that involuntary hospitalization or deprivation of liberty constitutes profound "powerlessness," which is a form of coercive control and mental torture.[235] Although the causal picture is complicated and more research must be conducted, studies such as these should give pause to inpatient treatment advocates.

9-8-8 services' routine collaboration with local law enforcement agencies creates a heightened probability that callers will be subjected to involuntary police encounters or inpatient treatment. Although treating people in crisis is a social good, it is critical to interrogate what treatment means and how it is provided. Vast regional variation in implementation means the 9-8-8 hotline, a federally funded program, may not decrease the risk of police encounters and may even

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have not shown consistent reduction in the risk of mortality or death during emergency police intervention.").

229. Amber Widgery, *The Legislative Primer Series for Front-End Justice: Mental Health*, NAT'L CONF. OF STATE LEG. 1, 2 (Aug. 2018).

230. *See generally* STEFAN, *supra* note 91 (conducting a study of people who had experienced in-patient treatment and finding the experience generally traumatic for them).

231. *See* Michael F. Armey et al., *Ecologically Assessed Affect and Suicidal Ideation Following Psychiatric Inpatient Hospitalization*, 63 GEN. HOSP. PSYCH., 89, 90 (2020).

232. *Id.*

233. *Id.*

234. *See generally* STEFAN, *supra* note 91 (discussing the traumatic effects of in-patient treatment).

235. Special Rapporteur on Torture, *Torture and other cruel, inhuman, or degrading treatment or punishment, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, U. N. DOC. A/HRC/43/49 HUMAN RIGHTS COUNCIL (Mar. 20, 2020.)

increase them.[236] Crisis lines are an excellent solution when paired with robust community services, such as mobile crisis teams. However, widespread regional and local variation in how 9-8-8 employees respond to people experiencing acute mental health crises may do more harm than good.[237]

The 9-8-8 rollout may have the unintended consequence of reproducing multiple forms of stigma. Fear of stigma when calling 9-8-8 could dissuade people from seeking care.[238] Moreover, individuals seeking help from mental health services already experience a high level of "epistemic injustice" because service providers doubt their credibility.[239] When providers send police in response to an acute mental health crisis without a person's consent, they are making a decision about the individual's competence and credibility to decide whether they want to seek additional treatment.[240] Sending unwanted services reflects a 9-8-8 operator's opinion that a person cannot accurately decide if they need treatment, meaning there is a heightened risk for epistemic injustice because 9-8-8 operators themselves harbor stereotypes about mental illness.[241] Adding coercive encounters to the mix heightens the stakes of this bias—as discussed throughout this section, involuntary treatment deprives people of freedom and may even place them in danger. Because some states' guidance encourages 9-8-8 service providers to contact law

236. *See* Canady, *supra* note 216 (discussing Missouri's plans to increase the role of law enforcement).

237. It is important to note there are crisis hotlines that are not tied to involuntary interventions, including TransLifeline (which has a bill of rights for callers) BlackLine, and Samaritans NYC. *See* Leah Harris, "*You Can't Coerce Someone into Wanting to Be Alive*": *The Carceral Heart of the 988 Lifeline*, MAD IN AMERICA (Jan. 14, 2023) (discussing suicidologists' responses to 9-8-8's reliance on emergency services and recommending alternatives).

238. *See supra* section I.B for a discussion of how both intra and interpersonal stigma may decrease the likelihood of people seeking care. It is also important to note, marginalized communities such as Black Americans are more likely to distrust psychiatry initially, meaning nonconsensual interventions may further reduce marginalized groups' confidence in psychiatric services. *See, e.g.*, Arthur L. Whaley, *Cultural Mistrust: An Important Psychological Construct for Diagnosis and Treatment of African Americans*, 32 PROF. PSYCH.: RSCH. & PRACTICE 555, 556 (2001) (finding that Black patients treated by White psychiatrists are more likely to distrust psychiatry as an institution).

239. Paul Crichton et al., *Epistemic Injustice in Psychiatry*, 41 PSYCH. BULL. 65, 66 (2017).

240. *See* 988 Frequently Asked Questions, *supra* note 240 (acknowledging that "some safety and health issues may warrant a response from law enforcement and/or Emergency Medical Services." 988 operators are the people who decide whether the situation warrants this response).

241. Crichton et al., *supra* note 239, at 69 (noting that stereotypes can lead providers to jump to conclusions, and "jumping to conclusions on limited evidence can lead to prejudice ('people with schizophrenia are violent') and hence to epistemic injustice, if a patient says she does not have violent thoughts and is not believed.").

enforcement[242] the 9-8-8 rollout may actually increase providers' reliance on law enforcement and first responders. Regional variation in 9-8-8's implementation means that a person could either be greeted by a mobile crisis team or a police officer—a simple call to 9-8-8 could entail a loss of freedom or worse.[243]

B. School-Based Interventions and the Family Policing System

The rollout of 9-8-8 is not the only provision of the Bipartisan Safer Communities Act that may reproduce structural stigma. The school-based interventions sanctioned, and sometimes required, by the Act risk reproducing elements of structural stigma like the school-to-prison pipeline and the family policing system.[244] This section conducts an analysis of resources available to educators through the new SchoolSafety.gov website and other Department of Education guidance that may exacerbate existing inequities in public schools rather than ameliorating the causes of gun violence. In general, this Article identifies two general trends in this guidance that puts students and families at risk. First, school personnel are encouraged to "detect" potential cases of violence. Second, focusing on "at-risk" students' families risks furthering the criminalization of poverty due to parent-centered interventions.

1. Teachers Are Tasked with "Identifying" Potentially Violent Students

At its core, the Bipartisan Safer Communities Act seeks to prevent gun violence.[245] One of the goals of the bill is to invest in "anti-violence programs" that target "the people who are most likely to commit these crimes or become victims of gun crimes."[246] Therefore, the Act emphasizes detecting potentially violent children before they commit acts of violence.[247] Detection programs subject students with disabili-

242. *See, e.g.*, Harris, *supra* note 237 (discussing newly released New York City guidance encouraging engagement with law enforcement).

243. *See supra* notes 214–218 and accompanying text for a discussion about how regional variation in service provision will lead to different outcomes in different states.

244. *See infra* Sections IV.A–IV.B.

245. *See supra* notes 11–14 and accompanying text for further discussion of the bill's aims and intents.

246. REMARKS BY PRESIDENT BIDEN AT SIGNING OF S.2938, THE BIPARTISAN SAFER COMMUNITIES ACT, WHITE HOUSE (June 25, 2022), https://www.whitehouse.gov/briefing-room/speeches-remarks/2022/06/25/remarks-by-president-biden-at-signing-of-s-2938-the-bipartisan-safer-communities-act/ [https://perma.cc/5SQF-VPSX].

247. *See, e.g.*, U.S. DEP'T OF EDUC., *supra* note 188 ("The Department encourages grantees to use funds to develop early detection, screening, or warning systems to identify students who may be at risk, in danger to themselves or others, or in

ties and emotional struggles to additional surveillance by school professionals.[248] Additionally, school districts are encouraged to coordinate with law enforcement agencies as part of safety and violence prevention programs.[249] Indeed, one provision of the bill that has not received widespread attention is a $1.5 billion annual investment in the Department of Justice that expands funding for "school hardening" measures.[250] This section argues that these detection programs will likely have a disproportionate effect on students with disabilities and racial minorities.[251]

SchoolSafety.gov contains several guidance documents to aid teachers in preventing gun violence. Many emphasize that race is a predictor of gun violence by providing detailed demographic information.[252] Other documents describe "warning signs" for violent behavior that are highly correlated to both race and disability. For example, according to a training compiled by the Substance Abuse and Mental Health Administration (SAMHSA), the risk factors for violent behavior include: poor behavioral and impulse control, deficits in social, cognitive, or information-processing abilities, high emotional distress, history of treatment for emotional problems, antisocial beliefs and attitudes, exposure to violence and conflict in the family, a history of violent victimization, attention deficits, hyperactivity, or learning dis-

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need of additional supports. . . . Schools may want to consider implementing . . . school-wide supports; (2) progress monitoring; (3) tiered systems of academic and behavioral interventions; and (4) the use of evidence-based instructional and behavioral interventions.").

248. *Id.*

249. *Id.* at 15 ("This planning also requires communication and shared responsibility between local school and community leaders, including leaders in the following spaces: schools, emergency responders, public health, and behavioral health.").

250. Isha Weerasinghe et al., *The Bipartisan Safer Communities Act: Mental Health Wins Undermined for Black and Brown Youth*, CLASP 10 (2023), https://www.clasp.org/wp-content/uploads/2023/01/2023.01.12_The-Bipartisan-Safer-Communities-Act-Mental-Health-Wins-Undermined-for-Black-and-Brown-Youth.pdf [https://perma.cc/UE5D-CZDR]; *See also* NATHAN JAMES, CONG. RSCH. SERV., IN11968, 1 DEPARTMENT OF JUSTICE GRANT FUNDING IN THE BIPARTISAN SAFER COMMUNITIES ACT 1 (2022) ("BCSA provides $300 million for school security grants." This includes using law enforcement officers in schools, as well as data sharing with law enforcement.).

251. Studies show teachers tend to perceive more "problem behaviors" from Black and Brown students, as well as underestimating their abilities. *See* Sharif El-Mekki, *Far Too Many Educators Aren't Prepared to Teach Black and Brown Students*, EDWEEK (Apr. 26, 2021), https://www.edweek.org/teaching-learning/opinion-far-too-many-educators-arent-prepared-to-teach-black-and-brown-students/2021/04 [https://perma.cc/G7AU-29AZ] (discussing American educators' insufficient cultural competence to teach in low-income, predominately Black and Brown schools.).

252. *See, e.g.*, Office of Juvenile J., and Delinquency Programs, *Gun Violence and Youth*, Literature Review, 1, 2 (2016), ("[T]hese trends reflect that the majority of firearm-related homicides involving known youths are perpetrated by males and African Americans.").

orders, academic struggles, a history of aggressive behavior, and involvement with drugs, alcohol, or tobacco.[253] Despite the training's emphasis that students with mental health disabilities are not likely to be perpetrators of violent crimes, at least six of these "predictors" of violence are simply symptoms of mental health, psycho-social, learning, or intellectual/developmental disabilities.[254]

Surveillance also negatively impacts Black and Brown students, who are already subjected to higher suspicion on the basis of their race.[255] Several studies demonstrate the risks attendant to subjecting racial minorities, especially Black students, to more surveillance in hopes of stopping school violence.[256] Punitive forms of surveillance and student control are more likely to be exercised in poor, predominately Black schools.[257] While White student behavior is frequently subjected to "soft surveillance" on the basis of their disabilities, Black children are frequently under-diagnosed and subjected to punishment as opposed to treatment.[258] Rates of corporal punishment of racial and ethnic minorities with disabilities are also disproportionately high, compared to students without disabilities and white students.[259] Prominent nonprofits fighting racial injustice fear that school harden-

253. ADDRESSING RISK OF VIOLENT BEHAVIOR IN YOUTH, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., https://safesupportivelearning.ed.gov/sites/default/files/icons/SAMHSA%20Addressing%20Violence%20in%20Youth%20Presentation_Reader%20Notes%20Version_6-1-18.pdf [https://perma.cc/LB5L-RLVC] (last visited Oct. 15, 2022).

254. *Id.* (The training states oppositional defiant disorder is the only mental health condition statistically linked to youth violence.).

255. *See, e.g.*, Deanie Anyangwe & Clarence Okoh, *The Bipartisan Safer Communities Act: A Dangerous New Chapter in the War on Black Youth*, CLASP 3 (2023), https://www.clasp.org/wp-content/uploads/2023/01/2023.01.12_The-Bipartisan-Safer-Communities-Act-A-Dangerous-New-Chapter-in-the-War-on-Black-Youth.pdf [https://perma.cc/L5MM-RY4G] (although Black students make up 15.1 percent of the U.S. public school population, they make up 28.7 percent of referrals to law enforcement and 31.6 percent of school-based arrests).

256. *See, e.g.,* Steven R. Shaw & Jeffrey P. Braden, *Race and Gender Bias in the Administration of Corporal Punishment*, 19 SCHOOL PSYCH. REV. 378, 379 (2019); Laura S. Abrams et al., *The Criminalization of Young Children and Overrepresentation of Black Youth in the Juvenile Justice System*, 13 RACE & SOCIAL PROBLEMS 73, 73–74 (2021); Lily Lamboy et al., *Paternalistic Aims and (mis)attributions of agency: What the over-punishment of Black girls in US classrooms teaches us about just school discipline*, 18 THEORY AND RSCH. IN EDUCATION 59, 60 (2020).

257. Katherine Erwin et al., *The Race to Punish in American Schools: Class and Race Predictors of Punitive School-Crime Control*, 21 CRITICAL CRIMINOLOGY 47, 58–64 (2013).

258. Myles Moody, *From Under-Diagnoses to Over-Representation: Black Children, ADHD, and the School-to-Prison Pipeline*, 20 J. AFR. AM. ST. 152, 153 (2016).

259. Ashley S. MacSuga Gage et al., *Disproportionate Corporal Punishment of Students with Disabilities and Black and Hispanic Students*, 32 J. DISABILITY POL. STUDIES 212, 212 (2021).

ing measures mark a return to "fund the police" rhetoric, as opposed to anti-carceral solutions.[260]

Making educators decide which students are potentially violent risks reproducing individualized prejudice and structural inequalities against students with disabilities and racial minorities who are already subject to the "school-to-prison pipeline."[261] Because of this link, students who are already at risk of disproportionate surveillance and punishment may be stigmatized more by educational professionals. SAMHSA states that teachers should intervene by "developing a pathway for concerns."[262] The training states:

> Depending on the nature of the situation, it may be useful to develop a team-based, school-centered strategy that follows the progress of the child over time and periodically reviews the situation until it is resolved. Sometimes this is known as a threat assessment and management team.[263]

Such "teams" may include teachers and school-based mental health professionals but may also include law-enforcement and school resource officers.[264] Another government resource manual for limiting school violence recommends interfacing with child protective services, the foster care system, and even the juvenile justice system.[265]

There is no evidence that school hardening measures are effective. One study even indicates that firearm offenses are more prevalent when police are present.[266] Additionally, encouraging further police presence in schools reduces educational outcomes for racial minorities and students with disabilities. For example, research shows that federal funding for police in schools increases discipline rates.[267] Students younger than fourteen are frequently arrested on school grounds when officers are present.[268] The increase in discipline by law enforcement disproportionately affects Hispanic and Black students, who are disciplined at one and a half times the rate of White students.[269] Black and Hispanic students are statistically less likely to

260. Anyangwe & Okoh, *supra* note 255, at 2.
261. *See, e.g.*, *School-to-Prison Pipeline*, DISABILITY RIGHTS EDUCATION & DEFENSE FUND (last visited Jan. 14, 2023), https://dredf.org/legal-advocacy/school-to-prison-pipeline/ [https://perma.cc/9Z33-6844] (describing the interplay between disability, race, and the school-to-prison pipeline).
262. SAMHSA, *supra* note 253.
263. *Id.*
264. *Id.*
265. David Osher & Sandra Keenan, *Instituting School-Based Links with Mental Health and Social Service Agencies,* NW. REG'L EDUC. LAB'Y 1, 7 (2002).
266. Lucy C. Sorenson et al., *The Thin Blue Line in Schools: New Evidence on School-Based Policing Across the U.S.* 1–55 (Annenberg: Brown University, Ed., Working Paper No. 21-476, 2021).
267. Emily K. Weisburst, *Patrolling Public Schools: The Impact of Funding for School Police on Student Discipline and Long-term Education Outcomes*, 38 J. POL. ANALYSIS & MGMT. 338, 338 (2019).
268. *Id*. at 352.
269. *Id.* at 338.

graduate from high school and enroll in college when exposed to federally funded school policing initiatives.[270] Finally, low-income students are twelve percent less likely to enroll in college when exposed to school policing.[271]

Surveillance in schools jeopardizes other educational outcomes as well. The coping skills Black students develop in response to school social control has been linked to poorer health outcomes, educational attainment, and college admissions.[272] Attending a high surveillance school significantly decreases twelfth grade math scores for Black students.[273] College enrollment rates are lower at high surveillance schools, even after considering whether an individual student has been suspended.[274] Because all students who attend heavily-policed schools suffer the consequences, researchers often argue that the presence of police on campus acts as a form of "safety tax."[275] All students pay the price of having police presence on campus in the form of reduced educational opportunities.[276] Since Black students are four times more likely to be in high surveillance schools than White students, the safety tax unfairly disadvantages Black students.[277]

Given the dangers of increased surveillance for Black students and students with disabilities, Department of Education and SAMHSA guidance regarding early detection may produce negative outcomes for students subjected to increased monitoring and interactions with law enforcement officers. While the goal of violence prevention is laudable, efforts must be made to prevent violence in a way that does not unnecessarily compromise students' autonomy, wellbeing, and academic performance. Given the legislative focus on "detecting" potential offenders, the Bipartisan Safer Communities Act and SchoolSafety.gov guidance documents reproduce structural stigma against students with disabilities and racial minorities by identifying them as targets for surveillance. Students targeted by educators are subject to increased surveillance, which increases the risk of punishment in schools, as well as future encounters with the criminal justice system. Students with disabilities, as well as Black and Brown students, pay a

270. *Id.* at 360–61.

271. *Id.* at 361.

272. Odis Johnson Jr. & Jason Jabbari, *Infrastructure of social control: A multi-level counterfactual analysis of surveillance and Black education*, 83 J. CRIM. JUST. 1, 2–3 (2022).

273. *Id.* at 5.

274. *Id.* at 6.

275. *Id.*

276. *Id.*

277. *Id.*

heightened share of the "safety tax" when teachers are made responsible for detecting mass violence.[278]

2. The Act's Emphasis on "Detecting Violence" Harms Black and Brown Families

In addition to increasing surveillance of individual students, the Bipartisan Safer Communities Act encourages violence prevention efforts that involve students' families.[279] The U.S. Secret Service's Analysis of Targeted School Violence emphasizes the correlation between home life and violence, identifying negative home life factors as parental separation or divorce, financial difficulties, parents having been arrested/incarcerated, family discord, family mental health, abuse/neglect, or non-parental custody/care.[280] It is notable that while the report cautions against using these experiences as predictors of violence, it heavily implies a causal relationship by arguing that the more negative home factors a child experiences, "the greater the risk for negative outcomes for the field."[281] The guidance encourages educational professionals to speculate and raise flags about students' home lives by making them responsible for detecting acts of violence before they happen.[282] However, as this section demonstrates, such speculation risks reinforcing existing biases against Black and Brown families.[283]

Government-funded manuals on SchoolSafety.gov provide guidance that targets low-income families for invasive surveillance tactics. For example, one manual encourages interfacing with "child protection services, financial assistance, home aid services, respite care, shelter services, foster care, and adoption."[284] The manual suggests implementing an intervention program to "fix" problems at

278. *See, supra* note 272 and accompanying text for a more thorough discussion of this "safety tax."

279. *See* U.S. DEP'T OF EDUC., *supra* note 188, at 13 ("Engaging students, parents, families, and community members is critical to the successful implementation of activities supported by Stronger Connection funds.").

280. U.S. SECRET SERVICE, PROTECTING AMERICA'S SCHOOLS: A U.S. SECRET SERVICE ANALYSIS OF TARGETED SCHOOL VIOLENCE 29–32 (2019).

281. *Id.* at 29.

282. *See id.* at 1 (encouraging schools and law enforcement "to identify, assess, and manage students" who are at risk of violent behavior in hopes of preventing gun violence).

283. Educators' bias against Black and Brown students and their families is well-documented. *See, e.g.*, El-Mekki, *supra* note 251; Melissa D. Anderson, *How Discrimination Shapes Parent-Teacher Communication*, ATLANTIC (Nov. 15, 2016), https://www.theatlantic.com/education/archive/2016/11/which-parents-are-teachers-most-likely-to-contact/507755/ [https://perma.cc/5N8B-WF4J] (describing a study showing that teachers are more likely to reach out to Black and Brown parents regarding discipline and less likely to reach out about their accomplishments).

284. Osher & Keenan, *supra* note 265, at 7.

home, such as engaging in early childhood home visitation and requiring that parents take parenting skill and family relationship programs.[285] According to the manual, "[a] family-driven focus broadens the scope. We no longer look only at specific problems, but how to affect an entire system for good. We look more holistically at a child and family and attempt to improve the quality of that child and family's life."[286] It is noteworthy, however, that such supports do not include safety net programs that might enable parents to work fewer hours or to take time to attend parenting classes.

The familial risk factors listed by a SAMHSA training on SchoolSafety.gov include: the family is isolated; the family has limited communication; the family does not engage in regular activity together; parents/caregivers have inconsistent or absent schedules; the family has limited or no involvement in social activities; and the family has limited ability to use constructive strategies for coping with problems.[287] Most of these attributes are merely indicators of single parenthood or familial poverty, both of which are heavily racialized.[288] Black families and White families are held to different standards by educators and child welfare professionals.[289] For example, what might be considered a "trendy" bar cart in a White mother's home could be taken as evidence of neglect in a Black mother's space.[290]

Considering a parent's involvement in school activities or inconsistent schedule as an indicator of violence disproportionately targets Black mothers. Black mothers are statistically less likely to be married.[291] However, Black mothers also have always had higher workforce participation than White mothers.[292] Nevertheless, they are marked as "deviant" or "welfare queens" when they experience structural racism.[293] Black mothers' workforce participation is taken

285. *Id.* at 12.
286. *Id.* at 9.
287. SAMHSA, *supra* note 253.
288. *See, e.g.*, DOROTHY E. ROBERTS, TORN APART: HOW THE CHILD WELFARE SYSTEM DESTROYS BLACK FAMILIES—AND HOW ABOLITION CAN BUILD A SAFER WORLD (2022) (describing how the child welfare system holds single Black mothers to different standards than affluent White families).
289. *See, e.g.*, *id.*; *see also* Anderson, *supra* note 283 (noting differential treatment of Black and Brown families by teachers).
290. *See* ROBERTS, *supra* note 288 (detailing an officer's search where a stand in the living room with alcohol bottles set on it was used as evidence of neglect).
291. Chanell Washington & Laquitta Walker, *Marriage Prevalence for Black Adults Varies by State*, U.S. CENSUS BUREAU (July 19, 2022), https://www.census.gov/library/stories/2022/07/marriage-prevalence-for-black-adults-varies-by-state.html [https://perma.cc/SY68-JYYM].
292. Dorothy E. Roberts, *Black Women and Their Families: Deviants or Resistors*, 5 DRAKE L. REV. 77, 80 (1994).
293. *Id.*

as a sign of neglect, as it contradicts the myth of "female domesticity."[294] Nevertheless, the myths surrounding single Black mothers pathologize Black motherhood and belie the realities Black mothers face.[295] Black women often do not marry for reasons of economic independence or to "challenge the relegation of women to a subservient role within the family."[296] Moreover, Black mothers frequently work long hours due to punitive welfare policies, at which time they are demonized for being away from their children but derided for accepting welfare payments.[297] Federal welfare policy devalues Black women's roles as caretakers by refusing to provide adequate child care or welfare supports to allow them to spend time caring for their children—and in doing so, devalues Black children's welfare.[298] For example, if a parent is non-communicative, rarely engages in school-based social activities, or has an inconsistent schedule, it is likely because they need to work multiple jobs to support their families as a single earner. No parenting class can overcome systemic poverty.

Dorothy Roberts identifies the problems related to requiring struggling families to expend further resources to prove their "fitness" as parents and subjecting them to further surveillance.[299] Roberts critiques the injustices of family policing, including what she dubs the "foster-care industrial complex;"[300] families who become entangled in the family policing system do not enjoy a modicum of due process.[301] Parents viewed as neglectful often become embroiled in years of surveillance and state intervention from child welfare services.[302] Oftentimes, the result is the permanent dissolution of parental rights, meaning that a parent cannot communicate with or regain custody of the child again.[303] Social workers, teachers, and police often exhibit

294. *Id.* at 84.
295. *Id.* at 81 ("[S]tigmatizing Black women and their families blames family structure for problems actually caused by a combination of racism, sexism, and poverty. It attributes miseducation, crime, unemployment, shamefully high Black infant death rates and all the other tragedies that plague Black communities, on Black mothers' deviant lifestyle. Unfit Black mothers become the scapegoats for the causes of Black people's social predicament.").
296. *Id.*
297. *See* Laura Meyer et al., *Ending Behavioral Requirements and Reproductive Control Measures Would Move TANF in an Antiracist Direction*, CTR. BUDGET & POL'Y. PRIORITIES (Feb. 23, 2022), https://www.cbpp.org/research/family-income-support/ending-behavioral-requirements-and-reproductive-control-measures [https://perma.cc/Q5FF-LP5G] (examining the racist history of welfare programs and arguing that behavioral requirements for TANF reproduce racism against Black mothers).
298. Roberts, *supra* note 292 at 84.
299. ROBERTS, *supra* note 288.
300. *Id.*
301. *Id.*
302. *Id.*
303. *Id.*

overt racial animus, as well as painting symptoms of poverty as indicators of neglect.[304] Definitions of neglect are vague, giving caseworkers substantial discretion.[305] "Neglect" is in the eye of the beholder, and a family's lack of resources may be mistaken for neglect.[306] Instead of infusing resources into providing the supports parents need to better provide for their children, the family policing system places additional burdens on struggling families, scrutinizing their every move.[307] Requiring parenting classes is a particularly insidious intervention, as inconvenient timing often forces parents to forego income to attend.[308]

To the extent that the Bipartisan Safer Communities Act involves parents in violence prevention programs, these programs might require additional time and resources from parents who lack support. Because the emphasis is on preventing violence rather than supporting families more generally, these expectations may exacerbate structural inequalities. For example, if a family member cannot take time off work for a suggested parenting classes or meeting, will that be used as a sign that they are unfit to care for their child? If a parent is divorced or single, will a teacher think that student has an "unstable" home environment, prompting involvement with the family police system? The overlap between alleged predictors of "violence" and indicators that a child's parents are simply impoverished is too significant to overlook.[309] By exposing Black and Brown families to programs that interface with law enforcement and violence protection,[310] the Bipartisan Safer Communities Act risks placing families at risk for surveillance and involvement with the family policing system.

V. CONCLUSION

Expanding access to mental health service provision is something this country desperately needs, but providing those mental health services through a gun control bill is also inappropriate and reproduces stigma. First, the discursive constructions of people with mental health disabilities as "other" from "law-abiding citizens" creates both interpersonal and structural stigma. It reinforces the bases for denying people rights that Congressional Republicans see as vital for citizenship, as well as insinuating that mental illness is something to be feared. Moreover, the specific provisions within the Act reproduce structural stigma by limiting the rights and freedoms of people with

304. *Id.*
305. *Id.*
306. *Id.*
307. *Id.*
308. *Id.* at 29–30.
309. *See generally supra* Section IV.B.
310. *See generally supra* Section IV.B.

mental health disabilities. Building up 9-8-8 infrastructure without clear standards for the services local agencies must provide will lead to unwanted interactions with law enforcement, which could result in inpatient treatment, incarceration, or even death. Making educators responsible for "detecting" cases of mental illness that could lead to violence, likewise creates structural stigma. Clear data predicting mass shootings does not exist, and educators will likely impute their own biases to determine who is "at risk" for violent behavior. Community-based health service provision is vital—many people rely on a broken system that funnels them into inpatient and carceral settings. Relief from these systems cannot be accomplished through a bill that seeks to eliminate gun violence. Congress's decision to do so will have adverse consequences marginalized groups.

Given the significant harms posed by some of the programs in the Bipartisan Safer Communities Act, some readers may come away wondering: what is the alternative? Is it not better to do *something* than nothing? Saying we did something to stop gun violence with one bill may feel cathartic, but it will not solve gun violence or the mental health crisis in the United States. The answer is neither new nor revolutionary—indeed, ex-patients, psychiatric survivors, and suicidologists have been fighting for noncoercive ways to help people in states of acute crisis for decades.[311] The evidence consistently shows that noncoercive, community-based treatment options are effective and less costly.[312] However, because the mental health funding authorized by the Bipartisan Safer Communities Act has been provided under the auspices of preventing gun violence, even good programs like the 9-8-8 crisis line or funding mental health services for children may end up causing substantial harm. Even if many grant projects do support the creation of evidence-based community alternatives, progress will not be uniform. Ultimately, society will need to carefully consider what "treating mental illness" entails and provide robust community services to prevent future tragedy.

311. *See, e.g.*, Harris, *supra* note 237.
312. *See supra* Section III.B.