Policing a Neurodiverse World:
Lessons from the Social Model of Disability*

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David Thacher
Gerald R. Ford School of Public Policy and
A. Alfred Taubman College of Architecture and Urban Planning
The University of Michigan
dthacher@umich.edu

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Policing a Neurodiverse World

ABSTRACT

Programs that aim to improve the police response to mental health crises and related incidents have implicitly relied on a medical/individual model of psychiatric disability, which emphasizes efforts to provide mental health treatments to individuals. This paper argues that this perspective has unnecessarily limited the range of options that police might draw from to manage these incidents. Advocates of an alternative, social model of psychiatric disability (as well as the "neurodiversity paradigm" it inspired) argue that we should view disability not as a property of individuals with certain impairments but as a property of the society that has failed to accommodate them. I argue that repeated calls to the police provide important information about the location and character of those failures, and that police have an important role to play in rectifying them. I illustrate how police have already played that role in several cities.

Introduction

Policing scholars and practitioners have long worried about the destructive role that the criminal justice system plays in the lives of people with psychiatric and cognitive disabilities. That is particularly true in the United States, where more than half of all prison and jail inmates apparently suffer from mental health problems (James and Glaze 2006), at least one in four people with a serious and persistent mental illness has been arrested (Livingston 2016), and nearly one in four fatal police shootings involves a person with a serious mental illness (Saleh *et. al.* 2018); but similar concerns have arisen throughout the English-speaking world (*e.g.* Law Enforcement Conduct Commission 2023; Huey, Schulenberg, and Koziarski 2022; Criminal Justice Joint Inspection 2021). Those concerns have fueled many efforts to develop more humane and effective ways of responding to incidents involving people with mental illnesses and other conditions that are often confused with them.[1]

This paper argues that so far those efforts have relied on an incomplete view about the nature and sources of psychiatric and cognitive disabilities; as a result, they have unnecessarily limited the menu of options that police can draw from. Influential programs like the Crisis Intervention Team model of police-mental health partnerships aim to connect people with mental illnesses to treatment, replacing punitive responses to mental health crises with therapeutic ones. That approach can sometimes be valuable and even life-saving, but it relies on an individualistic/medical model of mental illness whose limits have increasingly become apparent

[1] More recently, many cities have searched for ways to reduce police involvement in mental health crises altogether, particularly by expanding the capacity to send mental health specialists rather than police officers to respond to emergencies (e.g. Katz 2022; NAMI 2022; Seddon and Dilley 2023; Reach Out Response Network 2020), but it has proven difficult to divert many calls from police to alternative responders. Many mental health-related calls do not appear to be so at first (Ratcliffe 2021), and those that do often involve volatile situations that social workers and peer counselors are reluctant to respond to on their own (*e.g.* Lewis 2019).

(Scull 2022; Huey and Ricciardelli 2016). By focusing attention on the characteristics of individuals who come into contact with the police (such as their diagnoses, medications, and treatments), prevailing strategies divert attention away from features of the social context that may have contributed to the crisis or conflict that led the police to become involved.[2] I will argue that police can (and often do) successfully reshape those features by encouraging institutions and individuals to expand their capacity to accommodate a wider range of human capabilities.

I make this argument by drawing on a longstanding theme in disability and mental health activism and scholarship—the so-called "social model of disability", along with the closely related idea of "neurodiversity", which urge us to view psychiatric and cognitive disabilities not as a property of individuals with certain impairments but as a property of the society that has failed to accommodate them. From this perspective, a call to the police about someone with a psychiatric or cognitive disability may indicate that society's capacity to accommodate a wide range of human capabilities has broken down and needs to be repaired. In some of these cases, police intervention should focus not (or not only) on what can be done to help a neurodivergent person comply with social expectations but on what can be done to expand the community's capacity to accommodate that person's distinctive cognitive, sensory, or emotional functioning.

I develop this argument in several steps. The next section outlines the main claims made by advocates of the social model of disability and the neurodiversity paradigm, and the section that follows argues that leading policing models in this area have largely ignored them. The remaining sections draw out the implications of the social model of disability and the neurodiversity paradigm for policing practice. First, I consider incidents in which police are

[2] In that respect, they reflect a tendency across many different domains to search for the causes of social problems in individual characteristics rather than in social arrangements (e.g. Conrad 1975; Maynard 2019; Lantz, Goldberg, and Gollust 2023).

summoned to crises by institutions that play a large role in the lives of neurodivergent people (such as homeless shelters, psychiatric facilities, schools, and supported housing sites); in these contexts, repeat calls may be a sign that these institutions lack the capacity to accommodate the distinctive needs of the people they serve, and I illustrate the role that police have played in encouraging or forcing them to do so. Second, I consider incidents in which police are summoned to those crises by individual community members and families, and I illustrate the role that officers have played (or could play) helping them to accommodate neurodiversity more effectively. Finally, I consider incidents in which police are repeatedly summoned to situations that do not merit any police response at all; in these cases, the police have an opportunity and responsibility to expand the community's capacity for tolerance.

Before turning to the main argument, a brief note on terminology is in order. The language used to refer to mental illness and other conditions that are often confused with it is contested, and it can become unwieldy in discussions that cover many different conditions. That problem is particularly difficult when discussing "mental health" programs in policing, which often use that term loosely—for example, to encompass not only core mental illnesses like schizophrenia and bipolar disorder but also conditions like autism and Tourette's syndrome that are not properly understood as mental illnesses (e.g. Kunard *et. al.* 2018: 116-26, 137-4; cf. Siberry 2020). I will often use the phrase "psychiatric and cognitive disabilities" to refer to the full range of conditions that influential policing models actually focus on.[3] As explained in more detail in the next section, sometimes I will also use the term "neurodivergent" to refer to some people with psychiatric or cognitive disabilities. The terms "neurodivergent" (a characteristic of

[3] I should also note that I use the term "cognitive" disability more broadly than some authors (for example, autism is often described as a "neurodevelopmental" disability rather than a cognitive disability) but that broad usage is not uncommon, and it allows for more concise expression.

an *individual* whose neurocognitive functioning differs from the "average" or "neurotypical" person's) and "neurodiverse" (a characteristic of a *group* that contains individuals with a wide range of neurocognitive styles) were originally coined by autistic activists, but they have been extended to many other psychiatric and cognitive categories, including schizophrenia, bipolar disorder, and ADHD (Walker 2021; Chapman 2023: 134-6). The exact meaning of these terms and the relationships among them are contested and inexact, but I hope my meaning will be clear enough from the context in which I use them.

The Social Model of Disability

As it emerged from the work of British disability activists during the 1970s, the social model of disability attributes the challenges faced by disabled people not to their physical and mental impairments but to the social and physical structures that fail to accommodate them (Oliver 2009). Michael Oliver, who coined the term "social model of disability", illustrates this perspective succinctly: "The communication problems faced by deaf people are not because they are unable to speak but because the rest of us do not speak their language" (2009: 57; cf. Groce 1985). Elsewhere he elaborates:

> This social model of disability. . . no longer sees disabled people as having something wrong with them—it rejects the individual pathology model. Hence, when disabled people are no longer able to perform certain tasks, the reasons are seen as the poor design of buildings, unrealistic expectations of others, the organization of production, or an unsuitable housing environment (Oliver and Sapey 2006: 35-6).

From this perspective, the concept of "disability" is fundamentally relational: disability does not refer to some characteristic of individuals in isolation but to the mismatch between individual capabilities and the social and physical environment those individuals must navigate. As Richard Scotch and Kay Shrivener put it: "Disability could be defined as an extension of the variability in

physical and mental attributes beyond the present—but not the potential—ability of social institutions to routinely respond" (Scotch and Shrivener 1997).

As that quotation indicates, this analysis applies to psychiatric and cognitive disabilities as well as the physical disabilities that the activists and scholars who originally developed it had in mind. That application crystallized in the "neurodiversity" paradigm, whose main architects relied extensively on the social model of disability to develop their ideas (Singer 1999: 61-2; Walker 2021: 43-7; Chapman 2023: 127-30). Neurodiversity theorists criticize the common tendency to assume that there is one right way for human minds to function, and they argue that many of the challenges faced by neurodivergent people result from the social arrangements that have failed to accommodate their distinctive neurocognitive styles (Singer 1999; Walker 2021: part I; Chapman 2023: ch. 9). Autistic activists, in particular, have argued for decades that the challenges they encounter arise "'not because of what we are, but because of the things that happen to us' in a world that failed to accommodate autistic modes of processing and communication"; for example, autistic students may fail academically because the prevailing approach to teaching in most schools has simply ignored their distinctive cognitive, emotional, and sensory styles (Chapman 2023: 129, quoting Sinclair 1993). As noted earlier, these early analyses of autism soon expanded to encompass a wide range of psychiatric and cognitive conditions (Chapman 2019). The basic point is simple: Human minds, like human bodies, take many forms, and at least some of the difficulties facing people with *a*typical minds should be attributed not to individual impairments but to social and physical arrangements that were designed by and for the neurotypical..

By relocating the source of the problems facing disabled people from individual characteristics to social arrangements, this perspective highlights possibilities for social change.

Instead of emphasizing medical and therapeutic interventions that will "fix" minds and bodies that do not conform to social norms, it emphasizes structural interventions that will allow social arrangements to accommodate a wider range of human capabilities (cf. Wolff 2009). For Oliver, the social model of disability was first and foremost a tool for criticizing dominant approaches to disability policy and practice: "We spend too much time and money searching for non-existent cures and not enough removing disabling barriers from the world in which we live," he insisted (2009: 44). Anti-discrimination laws need to combat the animus and stigma that hold disabled people back (Yanos 2019), regulatory structures that place an undue burden on disabled people must be reformed (tenBroek 1967), government agencies and private businesses must redesign their organizational routines and physical environments to accommodate a wider range of minds and bodies (Bagenstos 2000), and human service professionals must reorient their work away from an exclusive focus on efforts to change individuals and towards efforts to alleviate social barriers facing disabled people (Oliver and Sapey 2006).

In the context of psychiatric and cognitive disabilities, this perspective emphasizes interventions that focus on "making the world more neurodiversity friendly—broadening our conception of normality and making the world change to fit this broader conception" (Chapman 2020). As British disability rights scholar and practitioner Liz Sayce puts it:

> Social inclusion. . . does not mean fitting in and being accepted only if people pass as normal, any more than wheelchair users would need to walk again in order to be respected. It means including the experience of madness is part of our societies, valuing the people who experience it and recognizing the contribution that madness can bring, as well as the pain it entails (2016: 31).

Human service agencies guided by this perspective have revisited what they expect and train their staff to do. They do not aim only to diagnose individual symptoms and weaknesses but to diagnose the environmental factors that contribute to the suffering and conflict that their clients encounter (Turnbull and Cahalane 1994); they do not strive only to deliver better treatments to

disabled individuals but to restructure the social environment to make it more hospitable to them (Carling 1995; Nelson, Lord, and Ochoka 2001; Corrigan and McCracken 2005; Sayce 2016). Their staff do not only work with clinicians to deliver better treatments to individual patients; they also work with landlords, employers, and others to develop reasonable accommodations for their clients (either by modifying the conventional physical and organizational arrangements that hold them back or by providing *in situ* support that can help them succeed as workers, tenants, and community members).[4]

The social model of disability is valuable because it has the potential to advance dignity, inclusion, and justice for disabled people. It advances dignity by respecting people as they are, emphasizing the responsibility of society rather than blaming or pitying the individual for many of the problems that they face (Bagenstos 2000; Wolff 2009; Sayce 2016). It advances inclusion by insisting that we should strive to expand the opportunities for disabled people to live independently and participate more widely in community life (Brisenden 1985; tenBroek 1967; Carling 1995). And it advances justice by reconsidering whether taken-for-granted social arrangements (typically designed by the physically able and neurotypical majority) do everything they can to accommodate the full range of people whose rights and welfare should command our moral attention (Rawls 1971; Wolff 2009; Nussbaum 2009; Lim 2015).

None of this is to say that medical model interventions have no place in disability policy and practice, nor is it to deny the real suffering and limitation that some disabilities bring. It is

[4] For example, housing interventions may provide a tenant with financial management support or access to 24/7 crisis intervention, arrange for them to move to a quieter part of an apartment building, or provide a landlord with de-escalation training and access to problem-solving and mediation resources when problems arise (cf. Carling 1990, 1995: ch. 7; Hannigan and Wagner 2003; Quinlen and Christenson 2017). Similarly, employment programs may work with employers to identify a job that (perhaps with feasible modifications to working hours or other conditions of work) is well matched to a neurodivergent person's unique skills and then provide ongoing support for needs like transportation, job coaching, and mediation to help that person succeed in their role (Sayce 2016; Drake, Bond, and Becker 2012). Similar approaches may be applied to education, volunteering, and other domains of community life (Carling 1995; Choma and Ochocka 2005; Mowbray *et. al.* 2005).

simply to say that the "treatment" strategy is only one possibility among others, and that sometimes an alternative "social change" strategy may be both possible and desirable. Moreover, that alternative strategy is not necessarily incompatible with the "treatment" strategy, and the two can sometimes be used in tandem (Lim 2019). Even disabled people who reject efforts to frame their serious impairments merely as "differences", and who insist that the treatment strategy should be pursued whenever possible, may find the core insights of the social model of disability and the neurodiversity paradigm important; indeed those insights apply even to conditions that are almost universally understood as "disabilities" rather than "differences", such dementia and Down's syndrome (Nelson 2021; Shakespeare, Zeilig, and Mittler 2019).

Policing without the Social Model

The social model of disability has not yet had a significant influence on policing. It is not easy to characterize the way police manage incidents that involve psychiatric and cognitive disabilities across a wide range of contexts, but this section will try to summarize the main assumptions and goals that guide the most influential program models. Particularly when those efforts turn from the short-term work of managing immediate crises to the long-term work of preventing their recurrence, they typically emphasize medical and therapeutic interventions that aim to normalize neurodivergent individuals, rather than social changes that aim to accommodate their distinctive capabilities.

The most influential model for managing "mental health" incidents in policing is the so-called "Crisis Intervention Team" (CIT) model, which emerged in Memphis, Tennessee more than three decades ago and now operates in more than 3,000 North American police departments (University of Memphis 2022). Although it has had the greatest impact in the United States, it has become increasingly influential throughout the English-speaking world (Wood *et. al*. 2011:

2, 16, 43). The CIT model deliberately takes different forms in different cities, since its core element is a partnership among key local stakeholders that aims to improve the way the jurisdiction responds to mental health crises (Usher et al 2019: 4), but a few key commitments shape all CIT programs.

The first is a commitment to improve safety during police encounters with people in mental health crisis. CIT emerged in the wake of the police shooting of a Memphis man undergoing a mental health crisis, and its evolution was shaped by many other troubled interactions between officers and people with psychiatric or cognitive disabilities. One of CIT's central goals was to help police manage these encounters more humanely. By training officers to recognize signs of mental illness and deescalate encounters with people in crisis, CIT aims to resolve those encounters more successfully. That commitment does potentially advance the social model's ideals: it insists that police must adapt their own practices to a wider variety of cognitive, sensory, and emotional styles, considering how their usual tactics have been shaped by neurotypical assumptions and how they might be *re*-shaped to accommodate neurodiversity. For example, model CIT training curricula encourage officers to rethink the forceful, authoritarian approach that they often use to manage tense situations in favor of a "LESS authoritative, LESS controlling, LESS confrontational approach" that will "give the consumer a sense that he or she is in control" and thereby facilitate a safe resolution of the crisis (Saunders n.d.: 7).

The second core commitment of the CIT model is a commitment to respond to behavioral health crises with therapeutic rather than punitive responses. This aspect of CIT reflects a longstanding concern that the deinstitutionalization of mentally ill people in the U.S. during the 1960s and 1970s actually led to transinstitutionalization—that people released or diverted from long-term stays in state mental hospitals often ended up in jail instead (Abramson 1972; Teplin

1983; Compton and Kotwicki 2007: ch. 2). To combat this problem, CIT programs aim to reduce the use of arrest and jail when police are summoned to people in mental health crisis, trying whenever possible to connect them with mental health services instead (Franz and Borum 2011; Usher et al 2019: 3 and *passim*). A central goal of CIT is to build stronger connections between police and mental health treatment institutions that will facilitate quick, no-refusal handoff practices for treatment (e.g. Sellars et al 2005; Stewart 2009: 43-5), and the model CIT curriculum encourages trainers to organize site visits to local mental health treatment facilities (Kunard *et. al.* 2018: 135). A major goal of research about CITs has been to determine whether it increases referrals to mental health treatment (*e.g.* Bratina *et. al.* 2020).

The assumptions and goals that guide CIT are not unique to that model; they are common among specialized police programs related to psychiatric and cognitive disabilities, and even among critics of CIT. The literatures about alternative interventions like street triage, investment in inpatient beds, and co-responder programs explore whether those interventions address "unresolved mental health needs" by "increasing access to mental health treatment" (Reauland, Schwarzfeld, and Draper 2009: v-vi; cf. Steadman *et al* 2000; Wood *et. al.* 2011: 33; Rogers *et al* 2019: 5; Rohrer 2021), and they stress the need to strengthen the mental health system's own capacity for treatment and follow-up (Lamb, Weinberger, and DeCuir 2002: 1270). As with the literature about CIT, the literatures about these interventions presume that their overriding goal is to connect disabled individuals with effective treatments.

In this respect, the ideas that dominate progressive thought about policing and mental illness continue to rely heavily on a medical/individual model of psychiatric and cognitive disability. Insofar as CIT and other leading program ideas try to do more than manage the immediate conflict that prompted police involvement, they aim to normalize neurodivergent

people by connecting them with mental health treatments, rather than to restructure social arrangements to accommodate them as they are.

Limits of Treatment

Jay Meehan's intensive study of an ambitious police-mental health partnership in one progressive U.S. agency—based on hundreds of hours of observations of police officers with special mental health training and several more months of close observation of community mental health workers—clarifies what this approach looks like in practice, and it clarifies the limitations it encounters. Although Meehan conducted his research just before Memphis developed CIT, the city he studied developed a strategy that closely resembled the Memphis model, emphasizing partnerships with mental health providers and training about mental illness and de-escalation for officers (Meehan 1995: 182). In many respects, the program he studied provides an especially ambitious illustration of the general approach just summarized.

In the city where Meehan conducted his research, the partnership between the police and the local mental health system aimed to improve access to and use of mental health treatments—particularly medications—by mentally ill people who came into contact with the police. The local county mental health agency had invested heavily in an Assertive Community Treatment (ACT) model (see Brodwin 2013), which fielded caseworkers in the community to help people with serious mental illnesses manage the problems they encountered in their daily lives. In practice, the ACT teams primarily aimed to ensure that clients consistently took their medications (Meehan 1995: 168). Police officers actively supported that strategy, serving as part of the network of people who encountered mental health clients in the community and who could therefore help case workers enforce medication compliance—most directly by serving court

orders that required individuals to take their prescribed medications, but also by coordinating with caseworkers less formally to help them encourage their clients to take their medications.

Through their partnership with county mental health staff, officers came to accept a medical model of mental health that emphasized the role of medication in keeping people out of trouble. Training encouraged officers to call ACT whenever they encountered someone who appeared to be mentally ill so they could find out whether that person was already known to county mental health staff and, if so, whether they were currently taking their medications. An officer's first question when encountering such people was invariably, "are you on your meds?" As Meehan explains, "most officers work under the assumption that 'meds work' and that compliance is the main problem" (Meehan 1995: 173; cf. Wood, Watson, and Barber 2021: 33-4, 41).

For many patients, this strategy was valuable, even life-saving, but police themselves gradually became disillusioned by its limitations. Officers became frustrated as they discovered medication's limits in reducing psychiatric symptoms for many people they encountered, and they sometimes resented doing the mental health system's "dirty work"—forcing clients to take medications even when they had plausible reasons for refusing them (many complained about severe side-effects and insisted that the benefits were minimal or nonexistent) and forcing them to enter inpatient treatment when they did not want to (Meehan 1996: 176-7). Officers also concluded that some community members and mental health workers were simply intolerant. For example, one officer who felt that the emergency commitment order he had been asked to serve was unjustified commented privately to Meehan: "This guy is well known to us. I see him around all the time. He doesn't cause us any trouble. He's a little strange but he doesn't bother anybody. Is he a danger to anyone? I doubt it. . . He doesn't want to go to the hospital, that's his problem" (Meehan 1995: 178).

Meehan concludes his study with a warning about the limits of the approach this city took:

> Reliance upon the mental health system seems ultimately to lead officers to recognize the limits of the mental health system's effectiveness; and the use of the officer's coercive powers for therapeutic rather than legal purposes creates tension. As a result, the officer eventually recognizes they have other options in situations involving the chronically mentally ill. . . Recognition of the limitations of the medical model by the police results in a change in perspective which impacts upon their practices. Perhaps, in the long run, it provides an important, but not necessarily conscious, counterbalance to the control exerted by the medical model (Meehan 1995: 180-1).

Meehan's implied critique of this city's exclusive focus on normalizing, medical-model interventions has not been taken up by later research and practice in this area, which remains committed to the treatment framework. For example, recent research in the Chicago police department (which had enthusiastically embraced CIT) found that officers repeatedly attributed the crises they were asked to manage to people who had "gone off their meds", and more than anything else, officers seemed to long for some follow-up strategy to ensure medication compliance (Wood, Watson, and Barber 2021: 33-4, 38, 41). The desire to help people who benefit from medications to take them more consistently is, of course, laudable, but it is sometimes expressed uncritically, without acknowledging the manifest limitations of this strategy (*q.v*. Scull 2022; Huey, Schulenberg, and Koziarski 2022: ch. 6).[5]

When confronted with the limitations of the medical-individual approach to psychiatric and cognitive disabilities, those who have been taught to rely on it may become defensive: What other options are there, really? The remainder of this paper attempts to answer that question. Building on the core insights of the social model of disability and drawing from emergent practices in several police agencies, it articulates several roles that the police can play helping to

[5] For example, although Meehan himself stressed the limits of any single-minded focus on medication compliance, the Center for Problem-Oriented Policing's otherwise excellent monograph on "People with Mental Illness" cites his study solely to support the claim that "an important aspect of community-based mental health care is getting noninstitutionalized people with mental illness to take their medication as prescribed" (Cordner 2006: 7).

make social arrangements more accommodating to a wider range of human capabilities. I begin by focusing on the institutions that call the police to respond to crises and conflicts involving people with psychiatric or cognitive disabilities.

Building Institutional Capacity

Many institutions that play a large role in the lives of neurodivergent people have not developed the capacity to accommodate their distinctive capabilities. That failure may produce crises and conflicts that lead someone to call the police. Through those calls, police gain a unique window into the limits of society's capacity to accommodate neurodiversity. Officers often keep that knowledge to themselves, responding dutifully to the recurrent emergencies produced by those limits without alerting policymakers and service providers to what they are seeing (Goldstein 1990: 46). Police can and should be more vocal about the recurrent problems they encounter. By doing so, they raise an alarm about the failure of these institutions to adequately accommodate a wide range of human capabilities, alerting the people who manage and oversee them about the need for institutional repair (Scott 2005; Thacher 2022). In that respect, they contribute to the important regulatory work of monitoring and strengthening the capacity of service delivery institutions to meet the needs of their clients (Braithwaite 2008: 94-7).

The Croft Unit

An episode in Durham County, England illustrates this role for the police.[6] In 2015, the county constabulary became concerned about the high volume of police calls coming from a for-profit supported housing complex in Stanley parish. The facility, called the Croft Unit, housed about two dozen people with various psychiatric and cognitive disabilities, including

[6] The account in this section draws from Martin (2018).

schizophrenia, bipolar disorder, obsessive-compulsive disorder, attention deficit disorder, and autism. Like other supported housing facilities, the Croft Unit was designed to provide continual support for its residents, each of whom had a detailed care plan that described how staff could support them with common challenges.

By 2015, it became clear that the facility failed to support its residents adequately. Emergency calls from the Croft Unit had grown substantially, averaging around 10 per month for more than a year. Most of these calls came from Croft Unit staff, who reported assaults and property damage directed at them and the facility, as well as disruptive behavior that had drawn complaints from the neighborhood. Police made more than two dozen arrests at the Croft Unit in 18 months, and they issued formal citations to residents on many other occasions. Overwhelmed by the demands the facility made on them, and concerned about the criminalization of its vulnerable residents, police began gathering information and meeting with Croft staff to try to understand why so many problems had arisen there.

That investigation made it clear that the facility's staff were overwhelmed by their assigned tasks. Calls to the police often occurred after a minor conflict spiraled out of control because staff lacked the skills to defuse an emerging conflict; what little training they did receive appeared to emphasize restraint and control tactics rather than techniques they could use to deescalate low-level conflicts. Turnover was high and pay was low, so few staff had the experience and skills to provide the support residents needed, and responses to common situations were inconsistent. New staff did not receive adequate information about the specific disabilities that may residents had, and the individualized care plans were apparently not being followed. In principle, a senior staff member could field calls about difficult situations during nights and weekends, but on-site staff rarely contacted him; instead, they simply called the

police. Some staff members expressed their belief that the behavioral conflicts they encountered were “not their problem” but the responsibility of the police, and they regularly asked officers to remove difficult residents for the night; sometimes they exaggerated the nature of an altercation to ensure a quick response. The result was a high rate of arrest and formal criminal justice action against residents, most of whom had little criminal justice involvement before they moved to Croft. On paper, staff were required to inform the Care Quality Commission (the agency charged with oversight of all health and social care facilities in England) every time they contacted the police, but in practice they did not. As a result, CQC was oblivious to the facility’s troubles.

Durham police raised these concerns with Croft’s management and the Durham County Council, which funded the facility. The site manager agreed to work with police to retrain staff in restorative justice tactics, increase staffing at night, reaffirm a commitment to accurate reporting, and reestablish expectations about staff behavior. Calls from Croft fell somewhat in the ensuing months, and managers reported that their staff were better able to manage minor conflicts on their own, but officers still believed that the staff were calling them in circumstances that they should have handled themselves.

Eventually, police leadership contacted CQC. The regulatory agency conducted two surprise inspections that found that the facility did not follow established standards of care, and it gave Croft a month to make significant changes or be shut down. The company that owned it fired the site manager and replaced her with someone who had extensive mental health experience. The new manager then reduced the number of residents from 25 to 16, relocated particularly high-needs residents to other facilities that could more adequately meet their needs, and improved routine training for the staff to manage conflicts. Calls to the police fell dramatically, from roughly 10 per month in 2014-15 to one or two per month in 2018.

Reforming Institutions

The Durham Constabulary's response to the Croft Unit illustrates the role the police can play in efforts to build more accommodating society, which it did by mobilizing and supplementing the regulatory structures responsible for the pursuit of that goal. In Durham itself, that role emerged out of the Constabulary's commitment to problem-oriented policing, which turns out to have considerable potential to advance social model ideals.[7]

In a problem-specific guide on "People with Mental Illnesses" written a decade before the Croft Unit saga, Gary Cordner recommended that police should focus on the environments where mental health-related incidents seem to be concentrated, observing that "hospitals, clinics, homeless shelters, drop-in shelters, and group homes" often generate a significant share of mental health-related calls (Cordner 2006: 15).[8] Police often complain that institutions like these rely too heavily on the police to manage problems they should be able to manage independently. In fieldwork from Los Angeles, for example, Natalie Pifer describes patrol officers' deep frustration with institutions like group homes and schools that repeatedly call police to manage people with mental illnesses, complaining: "Shouldn't these places be able to do their job?" (Pifer 2019: 439-40; cf. Huey, Schulenberg, and Koziarski 2022: 43). This sentiment reflects an important and apparently growing problem. In the United States, for example, a growing proportion of people living with serious mental illnesses live in assisted living facilities and nursing homes, many of which are of poor quality and lack adequate capacity to support this

[7] Indeed the social model of disability and the theory of situational crime prevention (which often informs problem-oriented policing interventions) share important conceptual affinities: Both insist that police should focus on restructuring environments rather than (or in addition to) reforming individuals, and both imply that police should work closely with the regulatory institutions that shape those environments (Eck and Madensen 2011; Eck 2018).

[8] In Cordner's own coauthored study of mental health-related calls in Lexington, Kentucky, 20% came from 17 locations, including a psychiatric hospital, a general hospital, two shelters, three group homes, and 10 apartment buildings (Biebel and Cordner 2003).

population (Jester, Hyer, and Bowblis 2020; Hua et. al. 2021; Hugunin *et. al.* 2022); the regulatory structures charged with strengthening that capacity are often anemic (Street, Molinari, and Cohen 2013; Braithwaite, Makkai, and Braithwaite 2007). Group homes, board and care facilities, supportive housing arrangements, and adult foster care providers have also housed a substantial share of people with serious psychiatric and cognitive disabilities since the 1970s (*e.g.* Davis *et. al.* 2012; Lamb 1979), and although the best providers offer extensive supports that help residents succeed as tenants (*e.g*. Hannigan and Wagner 2003), others do not (*e.g.* Coote *et. al.* 2023). Homeless shelters, too, count many people with psychiatric and cognitive disabilities among their residents, but some of them fail to provide their staff with the support they need to respond effectively to that group (*e.g.* Kaufman 2022).

In short, many of these institutions resemble the Croft Unit in that they suffer from poor management, inadequate staffing, and other capacity gaps that make them unable to accommodate their disabled residents but that have gone undetected by existing regulatory structures charged with overseeing them; their recurrent calls to the police can be viewed as a symptom of those underlying institutional weaknesses. Like the Durham Constabulary, police may be able to encourage, support, or force the facilities to fulfill their responsibilities to vulnerable residents and patients more adequately, especially by appealing to the regulatory bodies that are supposed to oversee them to require better staff training, management, and other relevant practices (Cordner 2006: 35-7; Biebel and Cordner 2003; Fresno Police Dept. 1996).

Although housing providers illustrate this dynamic most clearly, it arises in other institutional domains as well. For example, public schools often contact police to manage students with psychiatric or cognitive disabilities who have become disruptive (e.g. Wood, Watson, and Barber 2021: 33; Cheely et. al. 2012: 1859), and many of those schools have failed to equip teachers and

other staff with the knowledge and skills they need to manage neurodivergent students (Greene 2014). Frequent mental-health related calls from a particular school may indicate that school staff need to reconsider the way they interact with those students (cf. Maynard and Turowetz 2020: 59). Sophisticated police practitioners have sometimes pushed back against the demands that these schools make on them, insisting that school staff need to expand their own capacity to manage the behaviors they have repeatedly asked the police to respond to (*e.g.* Siberry 2020: 227).

These examples illustrate the longstanding but often neglected role that the police play as regulatory actors who help define and enforce institutions' responsibilities to prevent conflict and disorder from arising in the first place, rather than their more familiar role enforcing the law against individuals *after* conflict or disorder erupts (Scott 2005; Mazerolle and Ransley 2006; Thacher 2022). That regulatory role raises important concerns and challenges. In their pursuit of community tranquility, the police may easily overreach, creating new problems as they try to resolve the current one;[9] regardless, the institutions they aim to change rarely appreciate the pressure. What authority can and should the police draw from to encourage those institutions to expand their capacity to accommodate neurodiversity when they will not do so willingly, and how can officers become more adept at using it (as the Durham Constabulary became familiar with and adept at working with the CQC)? What ethical commitments and external oversight should guide the use of such authority? Questions like these stand out as urgent topics for future research and practice in this area.

[9] For example, the easiest way to prevent conflict in and around housing for people with mental illnesses is simply to force it to close, but that response reduces the supply of a desperately needed resource and may simply displace problems elsewhere. Better, it seems, is the approach taken by the Fresno police to problems that arose in several group homes: officers worked with providers to identify the practices used by facilities with a low rate of police calls, and they established forums where more successful providers could share their operational tactics (Fresno PD 1996).

Building Individual Capacity

Although some emergency calls related to psychiatric or cognitive disabilities come from formal organizations like the Croft Unit, many do not. The distinction matters because formal organizations often rely on routines that can become a coherent target for the kind of intervention the Durham Constabulary developed (Thacher 2023), and they are often governed by regulatory bodies that have the authority to shape their practices (Braithwaite 2008). By contrast, when a family member, shopkeeper, neighbor, or pedestrian calls the police about a neurodivergent person who is behaving in a way that they find alarming, it may seem unrealistic to expect that police intervention could strengthen the community's capacity to accommodate neurodiversity, since the relevant capacity is so much less formalized and less regulated in such cases.

Sometimes, however, police may be able to play an important role in helping these community members to accommodate neurodiversity more effectively. Consider a commonplace example.[10] Police respond to two calls from an apartment where a mother and her teenage daughter have been fighting, and eventually the mother hit the daughter. The responding officers immediately tried to deescalate the situation by talking separately with the mother and daughter, pointing out that it can be difficult to get along with each other in tight quarters like the small apartment where they lived. Once emotions had cooled and the mother and daughter had reaffirmed their love for one another, the lead officer turned her attention to helping the family prevent such conflicts from escalating in the future. The mother explained that she had only recently been reunited with her children, who had temporarily gone to live with their aunt, and the daughter reported that she struggled with bipolar disorder and other psychiatric disabilities. The officer asked whether the daughter had access to treatment for her mental health needs, and

[10] I thank Jessica Gillooly for this example, which she observed during field work for the Policing Project.

she confirmed that she did (she regularly took medications and met with both school-based and private therapists). At this point, the officer suggested that the mother and daughter might benefit from conflict resolution and prevention strategies. After debriefing the conflict that had led to the police call, she suggested that the mother and daughter should consider choosing a "safe word" that either of them could use to indicate that she was reaching her breaking point and needed space to disengage. The officer indicated that she would have a mediation specialist follow up to help the family learn strategies for managing their interactions.

Conflicts like this one are not uncommon in families where one or more family members has a serious psychiatric or cognitive disability. Caring for those relatives can be a rewarding but also a demanding job, and family members—who may struggle with their own emotional and psychological challenges—need to develop skills that will allow them to communicate and relate with their loved ones more effectively. Mental health professionals have developed curricula designed to teach these skills to family members, and community mental health workers and mental health support groups can connect family members with other families in a similar position to help them share knowledge and other forms of needed support (e.g. Jönsson, Wijk, Danielson, and Skärsätter 2011; Wynaden 2007: 385; Carling 1995: 22, 54ff.; Hatfield 1990).

Many police officers in the field probably already recognize that interventions like these may be useful when a family becomes overwhelmed with recurrent conflicts, but it is striking how often formal "mental health" programs in policing focus narrowly on interventions that aim to secure treatment for the person with a mental illness rather than those that aim to develop the skills of the people around them. Perhaps because of that void in the programs that guide and support them, many of the police officers observed by researchers seem to do the same. For example, in Jennifer Wood's coauthored study of Chicago police, private homes were the most

common source of mental health-related calls, but the response to those calls seemed to focus entirely on the person with a psychiatric disability; officers apparently never suggested or brokered strategies that family members might use to manage difficult interactions to prevent escalation (Wood, Watson, and Barber 2021: 33-4). By contrast, the example described at the beginning of this section illustrates a different strategy—one that shifts the focus of police intervention from the neurodivergent to the people around them, aiming to help the rest of the household develop the skills they need to prevent escalation.

This basic approach could apply more broadly than families. When conflicts arise with neighbors, landlords, and others who come into contact with people with psychiatric and cognitive disabilities, police usually seem to assume that the best (or only) way prevent those conflicts from recurring is to treat or isolate the disabled person. By contrast, for decades progressive community mental health agencies have developed strategies for supporting landlords, employers, friends, neighbors, and others who interact with their clients—for example, by providing free consultations with landlords to help resolve problems that have arisen with tenants (Carling 1995: 54, 61-2, 211-3, 250). Similarly, many local chapters of the National Alliance on Mental Illness coordinate programs and support groups that aim to support friends, teachers, neighbors, coworkers and others in the community who interact frequently with psychiatrically disabled people,[11] and community mental health workers may be able to mediate between their clients and their landlords, neighbors, and employers (e.g. Brodwin 2013: 5, 41, 102). As Paul Carling explains, these interventions aim to supplement or replace a focus on individuals with a focus on social support: "When crises occur, the focus is not only on assisting the individual but on repairing and strengthening the natural support network, so that it is

[11] https://www.nami.org/your-journey/family-members-and-caregivers

increasingly able to manage and resolve future crises with a minimum of professional help" (1995: 61).

Once again, further work is urgently needed to flesh out these possibilities more concretely. What resources can front line officers draw from to strengthen the "natural support network" that a more accommodating society requires, and what challenges and dilemmas are likely to arise along the way? Close study of the tactics that officers who specialize (formally or informally) in this kind of work could clarify the landscape of possibilities and the challenges that they are likely to encounter. Skilled officers frequently go beyond their formal training to develop the skills they need to manage encounters with people who have psychiatric or cognitive disabilities (cf. Wallace et. al. 2022); close study of their practice can refine and disseminate their innovations more widely (Bittner, 1970: 62).

Building a Tolerant Society

Finally, in some circumstances the police may have an important role to play in building a more tolerant society. In some respects, that role involves the simplest response to incidents that involve psychiatric or cognitive disabilities: It simply entails refusing to take action when someone in the community asks them to "do something" about behavior they find disturbing, yet which does not actually warrant police intervention.[12] More ambitiously, police may use such requests as an opportunity to reinforce the limits of coercive legal intervention and the virtues of a tolerant society.

In her classic work on the way the police manage mental health encounters, Linda Teplin wrote that police took formal action against publicly visible behavior that "exceeded the

[12] As Schenwar and Law (2019) insist, often the most important "alternative" to traditional criminal justice practices is not to devise a more humane and therapeutic alternative but to do nothing (2019: 201).

tolerance for deviant behavior within the community" (Teplin 1986: 9). For Teplin, that line of community tolerance was a constant—an exogenous influence on the way police use their discretion. On her account, police passively react to community expectations about what kind of behavior is unacceptably "deviant". That is, in fact, a common posture for American policing, which frequently defers to the views of those who call for police intervention in a specific circumstance, whether it is the views of a complainant about whether to make an arrest in many minor assaults and property crimes (Black 1980; Engel *et al.* 2019) or the views of callers who deem some circumstance "suspicious" or a "nuisance" and want the police to investigate it (Gillooly 2020; Herring 2019). This responsive commitment of policing can be problematic, transforming the police into an instrument of the community's dominant voices. Those voices may express intolerant and discriminatory attitudes towards people with psychiatric and cognitive disabilities (Yanos 2019; Carling 1995: 42), and they may ultimately lead to overwrought calls to the police about fundamentally harmless behavior (Stanford 2012).

None of this is to say that the community's "tolerance for deviant behavior" should have no limits. In some cases, the behavior that led someone to summon the police is in fact dangerous, threatening, or otherwise inappropriate, and it does warrant an official response; disability activists themselves stress that they have no desire to "excuse bad behavior" (Sayce 2016). In other cases, however, the stigma associated with mental illness fuels exaggerated fears and unjustified deference to them (Sayce 2016: 49). In the worst cases, those exaggerated fears can lead to vigilante responses to people with psychiatric and cognitive disabilities and attempts to make police into an instrument of prejudice (Sayce 2016: 49, 241; Stanford 2012). Police should not always defer to the current standards of "tolerance for deviant behavior within the community"; they should actively question whether those standards are defensible.

The front-line officers who are tasked with making these judgments are sometimes uncomfortable with the demands the community has placed on them. The officer described earlier who told Meehan that he did not particularly want to serve the emergency commitment order against an eccentric but "harmless" man illustrates that discomfort (Meehan 1995: 178). Throughout the literature on policing and mental illness, researchers repeatedly document the sense that patrol officers are being asked to do something impossible and perhaps inappropriate (*e.g.* Pifer 2019; Huey, Schulenberg, and Koziarski 2022: ch. 4). Particularly when it comes to what Jennifer Wood and her coauthors call the "gray zone" of mental health-related encounters—complaints about "people regarded as being disruptive, or acting in ways that made others felt uncomfortable", which were by far the most common type of encounter in their study—officers are being asked to intervene in circumstances where there is little basis for an arrest or coercive treatment. In those circumstances, legal authority is often limited and police themselves may be reluctant to intervene (indeed they often describe these demands as "bogus calls") (Wood, Watson, and Fulambarker 2017: 95). These officers, however, may operate under a management-driven "customer service" norm that expects them to do as much as they possibly can to placate the people who call the police and places very little value on the interests of those they call about (Gillooly 2020). Under the pressure of that norm, many officers try to placate the complainant by taking some informal action (such as issuing an order to move along) even when they do not believe the complaint is warranted (Wood, Watson, and Fulambarker 2017: 89).

When they do that, police miss an opportunity to insist on the need for community members to tolerate merely eccentric behavior when it does not harm or avoidably disrupt others. A society that accommodates neurodiversity must sometimes authoritatively tell its neurotypical members that they must learn to live or overcome their discomfort. At minimum, it must not use

its police to enforce their unreasonable expectations. In extreme cases, officers may need to go further. Disability rights leader and scholar Liz Sayce has urged activists to try to enlist police as potential allies "to prevent harassment, attack or exclusion" and "marginalizing those who remain obstinately bigoted" (2016: 241). CIT training curricula already embrace these ideals in principle, recognizing the possibility that law enforcement has a role to play in shaping "the norms, beliefs, assumptions, and values held by the community or the department related to mental health and wellness" (Kunard *et. al.* 2018: 55).

This imperative clearly raises important challenges and concerns for the police, both within police organizations themselves and in their relationships with the community. Particularly in agencies that suffer from a culture that stigmatizes people with psychiatric or cognitive disabilities, "doing nothing" may represent an abdication of responsibility more than a principled strategy for working towards a more tolerant society, and efforts to encourage the latter may unintentionally fuel the former.[13] Community members concerned about non-violent disturbances (and the police leaders who hear from them) may protest an officer's refusal to apprehend the person involved. To manage these tensions, police will need to clarify and justify the standards of public behavior that do and do not warrant police intervention as concretely as possible (cf. Thacher 2014; Kelling 1999). That task, too, is an urgent priority for future research and practice in this area.

Conclusion

The social model of disability calls attention to an important but neglected possibility for policing practice. Calls related to psychiatric and cognitive disability are common, and everyone recognizes that officers should try to do more than manage the immediate crises that prompted

[13] I thank an anonymous reviewer for pressing this point.

them; they should also try to prevent similar crises from recurring (*e.g.* Cordner 2006; Wood *et al* 2011; Meehan 1995). So far, however, the menu of options that leading program models like CIT have offered for achieving this goal have largely focused on therapeutic interventions that aim to normalize neurodivergent people. The social model of disability calls attention to a different possibility—that social arrangements, not just individuals, can and should be a target for change.

From this perspective, a call to the police about a neurodivergent person may signify not (or not only) that a particular *individual* needs help from adapting to social expectations, but that the *social environment* needs help adapting to neurodiversity. Schools, shelters, landlords, family members, neighbors, and other members of the community may lack the skills they need to interact appropriately with neurodivergent people. When their failures repeatedly lead them or others to call the police, the police may have a role in raising an alarm about the need for change. That is what the Durham constabulary did when its officers were repeatedly summoned to the Croft Unit: they insisted that Croft's managers had a responsibility to prevent and manage the problems that they were increasingly asking the police to manage, alerting both local and national oversight bodies to the facility's failures. As that example illustrates, the police role in these cases is not usually to repair those breakdowns themselves but to sound an alarm with institutions that have more direct responsibility for that task—for example, to alert the CQC or the Durham county council that the Croft unit is failing, or to alert a service provider that a particular family needs help developing the skills they need to interact more successfully with a loved one. In this way the police extend the capacity of regulatory and service delivery institutions to fulfill their complex mandates (cf. Braithwaite 2008; Eck 2018), drawing their

attention to institutional breakdowns that existing regulatory and quality control practices have failed to detect.

The fundamental point is that apart from the work they do in improving access to mental health treatment, police also have work to do to improve society's capacity to accommodate neurodivergent people. That capacity is fragile, and police are systematically exposed to its weak spots because of the nature of their role (Thacher 2022). Although the leading program models in this area have largely overlooked this role for the police, future research can and should explore how officers can carry it out and what challenges they are likely to encounter along the way.

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