Case v. Montana and the Future of Behavioral Health Crisis Response

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In recent decades, the U.S. Supreme Court has increased the power of police in behavioral health crisis situations. Many of the court's decisions have circumscribed civil rights protections for people in crisis, while granting police immunity from liability when crises turn violent—and often deadly. Taken together, these decisions have underscored the urgency of developing mental health–oriented approaches to crisis responses that move away from police.

Yet the court's law enforcement–expanding trend has continued in its January 2026 decision in *Case v. Montana* (1). The petitioner, Mr. William Case, who had a long history of alcohol misuse and mental health problems, had called his ex-girlfriend, expressing thoughts of suicide. She called 911, and three law enforcement officers were dispatched to Case's home. The officers knew of his behavioral health history, that he might be armed, and of his prior *suicide-by-cop* attempt—a nonmedical colloquialism that describes when a person, as a means of suicide, behaves with the purpose of inducing a lethal police response. The officers entered Case's home without a warrant. One of them shot Case after perceiving him to be holding an object that looked like a gun. Case was taken to the hospital and recovered. He was subsequently arrested and charged with assaulting an officer.

During his criminal case, Case challenged the officers' warrantless entry into his home on constitutional grounds. He lost in the state courts. On appeal, the U.S. Supreme Court also sided with the prosecution, holding that police may enter a home without a warrant if they have an "objectively reasonable basis for believing" that a person needs "emergency assistance." Crucially, the court framed its opinion as simply reaffirming a previous decision—*Brigham City v. Stuart*—that first announced the "emergency aid exception" to warrantless home entries. Yet *Case* did more than reaffirm that decision. It confirmed that when police are providing emergency aid, they can enter a home without having to meet the comparatively higher standard of probable cause applicable in criminal investigations.

The implication is that in the event of a behavioral health crisis situation, police have great discretion to adopt two postures: emergency first response provider and criminal law enforcer. In *Case*, the police officers began their response in the role of emergency first response provider, genuinely worried about Case's health and well-being. But they then quickly pivoted to the second posture—ultimately entering Case's home with long-barreled guns and protective ballistic shields before shooting and arresting him. Accordingly, by affirming such broad police powers during crises, the Supreme Court's ruling illustrates how such situations often become criminalized, violent, or both. As such, *Case* carries important future implications for clinicians and policymakers who care or advocate for people at risk for such crises. Because now people in crisis do not have much more legal protection at home than in a hospital or on the street, a comprehensive health-oriented alternative for crisis responses is needed (2).

One key consideration is the well-documented health risks of police responses. Yet the majority opinion itself makes no mention of these complexities. Only Justice Sonia Sotomayor, who wrote a concurring opinion, highlighted those risks. Drawing on research in medicine and public health, she noted that people with behavioral health conditions are more likely to be injured and killed during police interactions than are individuals in the overall population. She also noted that police are almost three times more likely to kill people with mental health conditions in their own homes compared with people without such conditions. On that basis, Justice Sotomayor warned against careless home entries by police. Cognizant of the risks associated with a less-than-probable-cause standard, she noted that police "should carefully investigate and assess the nature of the potential crisis." Doing so might require police to work with clinicians directly to avoid worsening already volatile crisis situations, all the while ensuring a prompt response.

Although Justice Sotomayor is right in her diagnosis, her police-centric solutions are only partial ones. Attention must turn toward non–law enforcement actors—including clinicians and policymakers—to prevent potentially violent encounters between police and people in crisis. One solution is the use of alternative, non–law enforcement crisis response models, such as mobile crisis units or emergency medical service response teams. Many of these community-based programs comprise teams of unarmed first responders, such as licensed clinical personnel (e.g., emergency medical technicians and clinical social workers) and certified peer support

specialists (3). Now active in dozens of jurisdictions nationwide, such teams are trained to respond to crisis incidents that do not clearly pose a risk for violence to the individual or others. A growing literature has documented these programs' benefits, including their ability to prevent unnecessary police interactions, defuse potentially volatile situations, and connect people to needed services (e.g., health care and housing).

At the same time, these alternatives to police have limitations. First, crisis teams typically cannot enter private establishments without permission; this limitation would effectively preclude their involvement in scenarios like *Case*. Second, as soon as someone expresses thoughts of harm to self or others, police involvement may be required by law or policy. Even if clinicians are usually empowered to initiate psychiatric detention procedures in such situations, police are often de facto responsible for enforcement and involuntary transportation. Another related solution—although not an alternative to police per se—is co-response programs, in which police and clinicians are dispatched to crisis incidents together. However, the evidence of their benefits is mixed, including whether they reduce the risk for criminalization or use of force (4).

Accordingly, alternatives to police involvement should exist alongside other interventions. Many jurisdictions have supported replacements of the 911 emergency communication system, including by the 988 Suicide and Crisis Lifeline. Others have reformed the 911 system itself, such as ensuring that dispatchers have the power to call on alternative responses as well as embedding clinicians directly in dispatch centers. In still other jurisdictions, crisis intervention services have operated outside the scope of the government and formal clinical expertise entirely, such as peer-operated warmlines and services. Although these measures hold varying degrees of promise, they require capacity and resources that governments and community organizations often lack.

Moreover, both health professionals and people with lived experience must be involved in developing public safety policies that address exactly when police should enter a home of someone who is experiencing a crisis and what should happen if such a necessity arises. The majority's opinion in *Case* is silent about what police should do; by its silence, it seems to recognize that police are within their rights to resolve crises through criminal enforcement means. Once police are brought into a crisis situation, however, so are their abilities to use force and arrest. If guardrails are not installed to structure police decision making, clinicians and policymakers must understand that police responses will often cause harm (5).

More broadly, *Case* arrives against the backdrop of a rapidly changing behavioral health policy landscape. Millions of people are currently at risk for losing access to health insurance and care because of cuts to Medicaid and Affordable Care Act plans. The Substance Abuse and Mental Health Services Administration—one of the country's most important federal agencies responsible for allocating frontline resources to people with mental illness and substance use disorders—has lost resources and personnel since the beginning of the second Trump Administration. These changes—along with a recent federal executive order pushing for further criminalization and institutionalization of people with behavioral health conditions—threaten to reduce funding for needed behavioral health services, including alternative crisis response models, mental health and substance use treatment services, and social services (e.g., housing and employment). The likely consequence is more reliance on police-led, point-of-crisis interventions rather than early preventive care. Yet *Case* demonstrates the risks inherent to such reliance on policing—and suggests anew the urgency of investing in health-centered interventions for people at risk of behavioral health crisis.

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