Policing and Mental Health

A White Paper from the Academy for Justice

Sandra Day O'Connor College of Law

Arizona State University

Academy for Justice

Acknowledgments

This white paper is a production of the **Academy for Justice** at the Sandra Day O'Connor College of Law at Arizona State University. The catalyst for this white paper was a roundtable held on November 30, 2022, at the Sandra Day O'Connor College of Law, in which a panel of experts and a number of professional participants gathered to talk about policing and mental health and ways we can think about the topic moving forward. The white paper is intended to provide proposed solutions and strategies in the overlapping fields of policing and mental health.

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Sergeant Rob Ferraro, Tempe Police Department, Co-Coordinator, Phoenix Metro CIT Program; Amanda Stamps, Training and Community Development Coordinator, Community Bridges, Inc.; Jesse Trevino, President and Co-founder of Solution Point+; Dr. Amy C. Watson, Professor, Helen Bader School of Social Welfare, University of Wisconsin-Milwaukee; and Dr. Clair White, Assistant Professor, Department of Criminal Justice and Sociology, University of Wyoming.

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About the Academy for Justice

The **Academy for Justice** at the Sandra Day O'Connor College of Law at Arizona State University is dedicated to bridging the gap between academia and on-the-ground criminal justice reform by making scholarly research and ideas accessible to policymakers, stakeholders, journalists, and the public. Our primary objectives include identifying the major challenges confronting our criminal justice system; developing and promoting fact-based, non-partisan scholarship that identifies potential reforms; and facilitating the sharing of information between academics and those responsible for making and implementing criminal justice policy.

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I. EXECUTIVE SUMMARY

The Wireless Communications and Public Safety Act (911 Act) took effect in 1999 to improve public safety by facilitating a nationwide communication infrastructure for emergency services.[1] Despite being intended for emergencies, 911 is often dialed for non-emergent and non-criminal behavioral health, homelessness, and substance use complaints. Even in communities with high crime and homicide rates, less than 4% of 911 calls are related to violent crime.[2] In the social background leading up to and contemporaneous to 911's establishment, there was a push for deinstitutionalization – moving those suffering mental illness from state institutions into the community. Unsurprisingly, 911 calls related to mental health crises have risen significantly since then. **This increase has amplified demand on law enforcement, pushing officers to respond beyond their capacity and training—sometimes with highly publicized, disastrous consequences.** In recognition of the untenable position law enforcement has been placed, many jurisdictions have developed and implemented programs that deploy crisis workers and public health professionals to situations involving mental health, substance use, and homelessness. The critical feature of these programs is that they utilize first responders specifically trained to resolve these unique crises with methods that address root causes and attempt to minimize involvement with law enforcement and the criminal justice system.

II. PROBLEM STATEMENT

With a well-intentioned push from civil rights advocates and state lawmakers motivated to reallocate tax revenues in the 1950s, state hospitals in the United States began a mass deinstitutionalization of those suffering from mental illness and cognitive impairments. A series of appellate court cases and a congressional commission, combined with changing social norms, political activism, and the development of anti-psychotic medications, solidified the move from institutions to the community. **As a result, from 1955-1994, 92 percent of the people who would have been institutionalized, were "in the community."[3]**

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[1] *911 and E911 Services*, FCC RCD. https://www.fcc.gov/general/9-1-1-and-e9-1-1-services#:~:text=911%20History&text=The%20purpose%20of%20the%20911,communications%20infrastructure%20for%20emergency%20services (last visited Mar. 24, 2023).

[2] Jeff Asher and Ben Horwitz, *How Do the Police Actually Spend Their Time?,* N.Y. TIMES (June 19, 2020), https://www.nytimes.com/2020/06/19/upshot/unrest-police-time-violent-crime.html.

[3] E. F. Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis* (John Wiley & Sons eds., 1997).

Problematically, "the community" was now tasked with assuming care and treatment for those who would've been institutionalized. The congressionally funded Community Mental Health Centers didn't materialize as planned—only 800 of the planned 2000 were built.[4] As a result, services were haphazardly assembled into siloed mental health care, medical care, housing, drug treatment, and employment agencies. "The ultimate result was a version of 'the community' consisting of the flotsam of patients tossed back at their families (chiefly their parents) if they had any, but mostly the creation of single-room occupancy hotels (SROs) in the psychiatric ghettoes of cities."[5]

Caselaw steadily required states to push those with mental and cognitive impairments into the communities. Beginning with *Lake v. Cameron* in 1966, state hospitals were required to discharge patients to what was later coined the "least restrictive setting" doctrine.[6] In 1975, the U.S. Supreme Court declared that "a State cannot constitutionally confine[,] without more[,] a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[7] And in 1999, the U.S. Supreme Court declared mental illness a disability covered under the Americans with Disabilities Act, requiring all government agencies to make reasonable accommodations to place and move those with mental illness into community-based treatment rather than institutions.[8]

A variety of factors contemporaneous and subsequent to deinstitutionalization resulted in many of those with mental illness facing homelessness, lack of access to regular treatment and prescribed medications, and increased access to alcohol and illegal drugs. Reduction in federal block grants for mental health treatment and the implementation of the Social Security Act has led to the privatization of mental health care and, as a result, dramatically shifted the landscape of mental health services in the United States. In this new landscape, those needing care became responsible for navigating and accessing it on their own—a difficult or impossible reality for many. This complex combination places many of those with mental illness in the natural path of law enforcement. Criminal statutes for trespassing, disorderly conduct, resisting arrest,

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[4] Robert Weisberg, *Restorative Justice and the Danger of "Community,"* 2003 UTAH L. REV. 343, 364 (2002).
[5] *Id.* at 366.
[6] 364 F.2d 657 (D.C. Cir. 1966); Paul Applebaum, *Least Restrictive Alternative Revisited: Olmstead's Uncertain Mandate for Community-Based Care*, 50 PSYCHIATRIC SRV. 1271, 1271 (1999).
[7] *O'Connor v. Donaldson*, 422 U.S. 563, 563 (1975).
[8] *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 607 (1999).

failure to comply with an officer's commands, and drug possession, among others, are consistently implicated as police engage with the mentally ill.

Adding in the general public's discomfort with the signs, symptoms, and life consequences of mental illness and mental health crisis—thanks in large part to media depictions of the mentally ill as dangerous and criminal—has inevitably resulted in calls to the police to address both legitimate criminal concerns and to ease situational discomfort for the community.

The community regularly calls upon the police to address a broad swath of behaviors and concerns that often are not connected to crime. As a result, peace-keeping (or community caretaking) has become central to modern policing. **Since the 1990s, there has been a 227% increase in mental health-related calls, and estimates show that law enforcement spends at least 20% of patrol time responding to these calls.**[9] Because of this, prisons and jails have become the largest providers of mental health services in the nation. Deinstitutionalization from state hospitals has ultimately resulted in re-institutionalization in the carceral system.

Many cities, including Tempe, have employed a Crisis Intervention Team (CIT) model for police response to those suffering from mental illness. However, police intervention in non-violent, non-criminal, or low-level criminal conduct places officers in a "gray zone" of interacting with individuals with unmet mental health needs. This "gray zone" utilizes a "vast array of lower intensity and less formal interactions" to address these marginalized members of the community.[10] Both the formal CIT model and the types of interactions encompassed in the "gray zone" require training either not typically mandated, or minimally covered, in police academies. Nationally, **police cadets receive approximately 840 hours of instruction in the academy, on average only 10 hours are devoted to mental illness**—yet cadets receive an average of 71 hours of firearm handling training.

The recent push to divert mental health service calls to mental health service providers instead of police can potentially reduce police involvement in non-criminal matters and increase access to care for individuals experiencing mental illness and crisis. These **non-police system models and CIT pre-arrest diversionary programs for criminal matters can connect individuals back to care and**

[9] L.J. McTackett et al., *Police Perceptions of Irrational Unstable Behaviours and Use of Force*, 32 J. POLICE CRIM. PSYCH. 163, 163-171 (2017).
[10] Jennifer Wood et al., *The "Gray Zone" of Police Work During Mental Health Encounters: Findings From an Observational Study in Chicago*, 20 POLICE QUARTERLY 81, 83 (2017).

treatment before moving to court intervention. Both the non-police dispatch models and pre-arrest diversion programs have the potential to reduce repeated contact with law enforcement and ensure that individuals receive necessary care.

The potential benefit of reshaping interactions between police and those suffering from mental illness is enormous for all involved. **More conservative estimates show that those suffering from a mental illness account for almost one-fourth of all fatalities involving law enforcement and they are 16 times more likely to be killed in encounters with law enforcement.[11] Engaging daily with those in crisis undoubtedly affects responding officers. All involved parties are situated to benefit from rethinking law enforcement's role and manner of engaging in the mental health sphere.**

To recognize the complexity of these ongoing issues, and reach tenable solutions, decision-makers must ask:

1. **How can non-police dispatching ease the burden on law enforcement and improve outcomes for those with mental health needs?**
2. **What alternatives to traditional policing models exist for responding to those suffering from mental illness and crisis?**
3. **Are violence and mental illness actually linked as the media often portrays?**
4. **What are the necessary components of a mental health infrastructure and can a robust infrastructure meaningfully reduce the burden on law enforcement to be the first responders for mental illness in the community?**

III. PROPOSED SOLUTIONS AND STRATEGIES

A. Moving from Police to Community Response

The historical push from institutions to the community and the contemporaneous lack of development of social services to support those with mental illness has resulted in law enforcement serving as the first intervener for many of those suffering from mental health crises. **Regardless of whether criminal conduct or a**

[11] Doris A. Fuller et al., TREATMENT ADVOCACY CENTER, *OVERLOOKED IN THE UNDERCOUNTED: THE ROLE OF MENTAL ILLNESS IN FATAL LAW ENFORCEMENT ENCOUNTERS* (Dec. 2015), https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf.

true emergency exists, 911, and therefore the police, have become the primary responders to public displays of mental illness and families' inability to manage the mental health needs of their loved ones. As de facto mental health providers, the police are tasked with the near impossible – to shift from their namesake role (law enforcement) and respond instead from the viewpoint of a social service provider. Recognizing the evolving expectations and realities of law enforcement responding to mental illness, several models have been developed to balance the needs of the community, individuals with mental illness, and the capacity of police officers in the field.

B. Alternatives to Traditional Policing Models

1. Crisis Intervention Teams

Crisis Intervention Team (CIT) programs provide a community-based approach to improving the outcomes of encounters with individuals suffering from mental illness. Dating back to 1988 in Memphis, Tennessee, the CIT program is now nationally recognized as the "Memphis Model" for pre-arrest jail diversion.[12] The Memphis Model is a law-enforcement-created training to improve outcomes for people living with mental health challenges when they encounter police.[13] The CIT training program consists of a specialized, 40-hour crisis intervention curriculum for law enforcement officers where they work in partnership with mental health providers to offer a variety of services for those in need.[14]

From its inception in 1988, the CIT model has expanded and adjusted to fit the needs and resources of the jurisdictions adopting the program. **However, the primary feature—rerouting or diverting individuals suffering from mental health crises to an appropriate mental healthcare provider instead of a jail cell—defines CIT programs throughout the country.**

CIT-trained officers perform their standard patrol duties but also respond to specific calls due to their specialized training and increased understanding of mental illness and substance use disorders. **A CIT-trained officer's goal is to de-escalate the crisis, thereby decreasing the likelihood of injury and violence for the individual in distress, family members, members of the public, and the**

[12] City of Memphis, *Crisis Intervention Team*, https://www.memphistn.gov/government/police-department/crisis-intervention-team/ (last visited Mar. 24, 2023).
[13] Michael T. Compton, et al., *A Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs*, 36(1) J. OF THE AM. ACADEMY OF PSYCHIATRY AND THE L. ONLINE 47, 47 (2008).
[14] *Id.*

responding officers.[15] Utilizing CIT training and policing experience, officers will assess an individual in crisis to determine whether they need to be transported for a mental health evaluation.[16]

The CIT program serves many purposes, most critically crisis de-escalation and diversion, with the ultimate goal of increased safety for the community and the police. In Memphis, **employing the CIT model for mental health calls reduced officer injuries by 80 percent.**[17] Some communities have also found that CIT saves taxpayer money while also reducing the time officers spend responding to mental health calls, putting officers back into the community to focus on serious crime more rapidly.

Miami-Dade County, Florida is an example of a successful CIT program. Between 2010 to 2017, the City of Miami and Miami-Dade County police handled over **71,000 mental health-related calls but were only able to make 138 arrests.**[18] Jails were inundated with inmates struggling with serious mental illness, costing taxpayers millions.[19] In response, the county **provided crisis intervention training to more than 5,400 of its officers and saw such a decline in arrests and incarcerations that it enabled the county to close a jail, saving taxpayers $12 million a year.**[20] The City of Seattle also saw positive results after implementing a CIT program and ultimately passed a bill in 2015 mandating the state police academy to provide all new recruits with eight hours of CIT training.[21]

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[15] Wood, *supra* note 10, at 82.
[16] ANGELA KIMBALL, ET AL., INT'L CRISIS INTERVENTION TEAM, CRISIS INTERVENTION TEAMS (CIT) PROGRAMS: A BEST PRACTICE GUIDE FOR TRANSFORMING COMMUNITY RESPONSES TO MENTAL HEALTH CRISES, 57 (Aug. 2019), https://www.citinternational.org/resources/Best%20Practice%20Guide/CIT%20Guide%20Interactive%20Web%20Version%20Final.pdf.
[17] City of Memphis, *supra* note 12.
[18] Norm Ornstein & Steve Leifman, *How Mental-Health Training for Police can Save Lives—and Taxpayer Dollars*, THE ATLANTIC, (August 11, 2017), https://www.theatlantic.com/politics/archive/2017/08/how-mental-health-training-for-police-can-save-livesand-taxpayer-dollars/536520/ (last visited Apr. 23, 2023).
[19] *Id.*
[20] *Id.*
[21] Seattle Police, *2015 Crisis Intervention Program Report*, 6 (2016), https://www.bing.com/ck/a?!&&p=e20fe055d0970459JmltdHM9MTY4NjI2ODgwMCZpZ3VpZD0xNTNlNWMyOS03NDJmLTZmYzYtMTY5NC00ZjAxNzU3ODZlMzcmaW5zaWQ9NTIwMQ&ptn=3&hsh=3&fclid=153e5c29-742f-6fc6-1694-4f0175786e37&psq=seattle+cit+training+2015+bill&u=a1aHR0cHM6Ly93d3cuc2VhdHRsZS5nb3YvRG9jdW1lbnRzL0RlcGFydG1lbnRzL1BvbGljZS9QdWJsaWNhdGlvbnMvMjAxNV9DcmlzaXNfSW50ZXJ2ZW50aW9uX1JlcG9ydC5wZGY&ntb=1 (last visited Jun. 9, 2023).

Today, the CIT program is implemented in some form by over 2,700 communities nationwide and has demonstrated the reward of successful collaboration between law enforcement, medical providers, social services, and community providers.[22]

2. Alternative Dispatching

Alternative dispatch programs send civilians to certain calls for service where their specialized training may be valuable to resolving low-level or non-violent crises such as mental illness, suicide attempts, substance abuse episodes, homelessness, community disputes, and noise complaints. As trained and specialized mental health professionals, emergency personnel, and social service providers, these civilians are equipped to address the unique needs of these calls for assistance. Alternative dispatch programs seek to provide quality crisis services and treatment, thereby avoiding a cycle of arrest and incarceration.[23]

The longest-running, nationally recognized, alternative dispatch program, "Crisis Response Helping Out On The Streets," or CAHOOTS, is located in Eugene, Oregon. When there is a non-criminal call for help, the police department's central 911 center dispatches mental health and medical professionals to respond instead of uniformed police officers.[24] These professionals respond to crises involving mental health issues, substance abuse, and homelessness. **The results have been astounding: with an annual budget of about $2 million, the CAHOOTS program saves the city of Eugene approximately $8.5 million each year in public safety costs and $14 million in ambulance and emergency response costs.[25] Moreover, responders require police assistance for roughly 2 percent of calls.[26]** The program initially only served the residents of Eugene on select days and times, however, with the program's success and cost-saving benefits, the program has expanded to include around-the-clock service in the cities of Eugene and Springfield.

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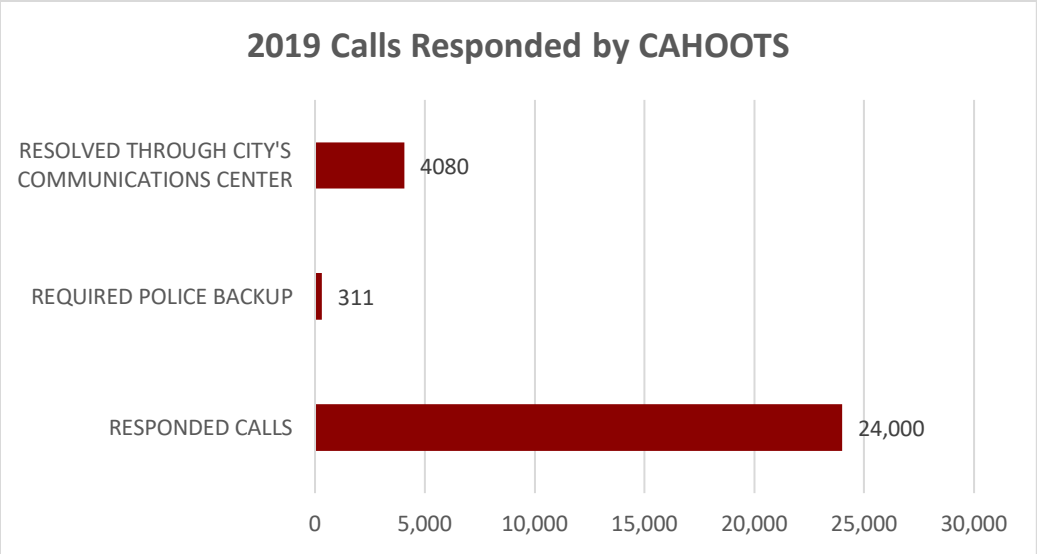
[22] *Crisis Intervention Team Programs*, NAT'L ALL. ON MENTAL ILLNESS, https://nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs#:~:text=A%20Crisis%20Intervention%20Team%20%28CIT%29%20program%20is%20an,and%20individuals%20with%20mental%20illness%20and%20their%20families. (last visited Mar. 15, 2023).

[23] Jackson Beck, et al., *Behavioral Health Crisis Alternatives: Shifting from Police to Community Responses*, VERA INSTITUTE OF JUSTICE (Nov. 2020), https://www.vera.org/behavioral-health-crisis-alternatives (last visited Apr. 23, 2023).

[24] *Id.*

[25] Bach, Trevor. *One City's 30-Year Experiment with Reimagining Public Safety*, U.S. NEWS & WORLD REPORT (Jul. 6, 2020), https://www.usnews.com/news/cities/articles/2020-07-06/eugene-oregons-30-year-experiment-with-reimagining-public-safety.

[26] Beck, *supra* note 23.



3. Co-Responder Models

A third model used in many communities is the co-responder or co-dispatching model. **Under this police-based intervention model, trained police officers are paired with mental health professionals and co-respond to individuals experiencing behavioral health crises.** Through collaborative response, this model seeks to improve the outcomes of individuals in crisis by providing crisis de-escalation, diversion, and specialized treatment with service providers.[27] The co-responder model can be implemented both as a stand-alone program and integrated as part of existing collaborative models. While the model has been implemented in varied ways, these programs typically involve a specially trained response team including at least one police officer and one behavioral health professional who respond together to crisis intervention calls.[28] The teams work to safely engage and assess individuals experiencing crisis so that they can be directed to appropriate behavioral health services. While police officers and clinicians often co-respond in patrol cars, clinicians and peer specialists are also able to respond remotely over the phone when appropriate.

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[27] *See* Ashley Krider et al., *Responding to Individuals in Behavioral Health Crisis Via Co-Responder Models: The Roles of Cities, Counties, Law enforcement, and Providers*, INT'L ASS'N OF CHIEFS OF POLICE, 1, 3 (2020), https://www.theiacp.org/sites/default/files/SJCResponding%20to%20Individuals.pdf.
[28] *Id.* at 4.

While studies and research on the co-responder model are difficult to aggregate because of the model's varied use across communities, available research suggests that **this model: (1) enhances crisis de-escalation; (2) reduces pressure on the criminal justice system and decreases the amount of time officers spend on calls for service; (3) reduces pressure on the health care system by reducing emergency visits; (4) increases individuals' connection to behavioral health services; and (5) often results in cost-effectiveness.**[29]

C. Increased Understanding of the Ways Mental Illness Manifests

While several training models exist for providing higher quality and more efficient mental health services to those in need, a fundamental question still remains: How do officers identify individuals with mental illness? **Accurate identification is crucial to the approach officers take during police encounters, including whether force should be used, an arrest should be made, a mental health evaluation is needed, and whether law enforcement is the appropriate first responder.** Moreover, accurate identification of mental health symptoms can substantially improve the outcomes of such police encounters.[30]

One factor that complicates an officer's ability to make a mental illness assessment is that mental illness can often mimic symptoms of substance abuse.[31] Programs similar to the CIT, alternative dispatch, and co-responder models discussed above can increase officers' confidence in recognizing signs of mental illness, but not much data is available about how officers can assess the presence of mental illness during a police encounter.[32] One potential solution is to provide training to all police officers about mental health symptoms and how they manifest in individuals. This type of training would require the assistance of mental health professionals and should be conducted for new recruits as well as veteran officers.

Another solution might be to equip law enforcement with live information about an individual's known mental health history within the community. This might be accomplished by creating a database available to dispatch that tracks those individuals with whom law enforcement has previously had contact and who have a

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[29] *Assessing the Impact of Co-Responder Team Programs: A Review of Research*, Int'l Ass'n. of Chiefs of Police, 2, https://www.theiacp.org/sites/default/files/IDD/Review%20of%20Co-Responder%20Team%20Evaluations.pdf (last visited Mar. 24, 2023).
[30] *See* Sarah L. Desmarais, et al., *Community Violence Perpetration and Victimization Among Adults With Mental Illnesses*, 104-12 AM. J. OF PUB. HEALTH 2342, 2347 (Dec. 2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4133297/pdf/AJPH.2013.301680.pdf; Krider, *supra* note 27 at 9.
[31] Casey Bohrman et al., *How Police Officers Assess for Mental Illnesses*. NAT'L LIBR. OF MED. (Nov. 2018) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6707744/ (last visited Jun. 9 2023).
[32] *Id.*

known mental health history, or have been transferred to mental health professionals during or following police response. To be effective and ensure individuals' rights are protected, this database would need to be well developed and sufficiently protected. However, understanding the factors that influence how police officers assess and respond to those with mental illness, and improving the quantity and quality of information available to officers to inform their assessment, is crucial to successful intervention.

D. Increased Understanding of Mental Illness and Violence

The discussion surrounding police response to those suffering from mental health crises—and the sometimes-fatal consequences for police, individuals, and community members—is often framed by inaccurate perceptions between mental illness and violent behavior. **Media portrayals that depict violent perpetrators as mentally ill or attribute mental illness as the driver for violent episodes further exacerbate the community's discomfort with mental illness and place law enforcement in an untenable position to reconcile legitimate threats with mental health crises.** With the rise in mass shootings across the country, the relationship between mental illness and violence has been intensely scrutinized in recent years.[33]

Studies suggest that individuals with mental illness are not violent.[34] In fact, **perpetrating violence is uncommon among those with serious mental illness.**[35] To better understand whether a nexus exists between mental illness and violent behavior, a contextual approach that considers symptoms, circumstances, and other factors is needed. For example, when violence does occur, it is often co-occurring with substance abuse or rooted in adverse childhood experiences or other environmental factors.[36]

In the MacArthur Violence Risk Assessment Study, which looked at violent acts among psychiatric inpatients twenty weeks after discharge, *only two* clinical symptoms were associated with violence and aggression: command hallucinations and psychopathy. A patient may experience command hallucinations by hearing voices that order them or hurt to harm someone, whereas a patient experiencing

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[33] *See* Jeffrey W. Swanson et al., *Mental Illness and Reduction of Gun Violence and Suicide: Bringing Epidemiologic Research to Policy*, 25 ANNALS OF EPIDEMIOLOGY 366, 367 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4211925/pdf/main.pdf.
[34] *See* Tori DeAngelis, *Mental Illness and Violence: Debunking Myths, Addressing Realities*, AM. PSYCH. ASS'N. 52-3 (2022), https://www.apa.org/monitor/2021/04/ce-mental-illness.
[35] *Id.*
[36] *Id.*

psychopathy is characterized by a lack of empathy and impulse control.[37] The more commonly perceived danger behind schizophrenia has been debunked as well: individuals suffering from this disorder are far less violent than those who suffer from major depressive disorders.[38]

Overall, incidents of violence among those who are mentally ill are isolated. **Some studies suggest that individuals with mental illness are more likely to be victims, not perpetrators, of violent acts.**[39] One study looked at a diverse sampling of adults with mental illness over a six-month period of time.[40] Over this period, the study found that almost one-third of adults with mental illness are likely to be victims of violence.[41] The study defined community violence broadly, including acts like pushing, kicking, choking, throwing an object, sexual assault, threatening with a weapon, and using a weapon, among others.[42] While 23.9 percent of participants committed a violent act during those six months, 30.9 percent were victims of violence during the same period on one or more occasions.[43] Taken together, the study showed that participants who had been victimized by violence were eleven times more likely to commit violence, illustrating a strong correlation between being victimized by violence and committing a violent act.

The studies noted above discredit the claims that mental illness is the driver of violent behavior. This is an important clarification for both the community and law enforcement. **Community and officer education about the reality of the threat posed by those suffering from mental illness is a critical piece of any model implemented to improve police response to mental illness.**

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[37] *Id.*
[38] *See* Heather Stuart, *Violence and Mental Illness: An Overview*, 2 WORLD PSYCHIATRY 121, 122–23 (2003), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525086/pdf/wpa020121.pdf.
[39] Desmarais, *supra*, note 30 at 2342, 2347.
[40] *Id.* at 2342.
[41] *Id.* at 2344.
[42] *Id.* at 2343.
[43] *Id.* at 2345.

IV. CONCLUSION

Decades of deinstitutionalization, a focus on only treating critically ill or violent individuals, and a prolonged failure in many states to fund mental health response systems are some of the factors driving those with mental illness straight into the criminal justice system. As a result, America's jails have become the primary address for the mentally ill. In fact, mental illness is so prevalent behind bars that jails and prisons are routinely referred to as the "new asylums."[44] **In forty-four states, jails and prisons house more mentally ill individuals than the largest state psychiatric hospital.[45] Those with psychiatric diseases are ten times more likely to be in jail or prison than in a hospital bed.[46]**

All too often, individuals with mental illness are willing to get help, but they are boxed into a jail cell instead of a hospital bed. They are often incarcerated for longer periods of time and are more likely to be placed into solitary confinement.[47] Seldom do they receive treatment while incarcerated, and when they do, it is most often in the form of medication, not therapeutic interventions. **Furthermore, mentally ill inmates are more likely to become victims of abuse or other altercations while in jail, often leaving them more battered and sicker than when they first arrived.[48]** Diverting mentally ill individuals away from the criminal justice system by instituting a front-end shift could dramatically reduce the mass incarceration numbers seen around the country and improve overall health and well-being. The proposed solutions and strategies mentioned above would do just that.

The unfortunate reality is that law enforcement is the only 24/7 resource available to respond when individuals, communities, and families need help managing the impacts of mental illness in their lives. **Until public perceptions shift and sufficient supports are in place, police officers will undoubtedly continue to be the call of first and last resort.** The community-based mental health models discussed above have been successfully implemented across the country. Some cities have spent

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[44] Treatment Advocacy Center, *Serious Mental Illness Prevalence in Jails and Prisons*, 1 (Sep. 2016), https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf.
[45] *Id.*
[46] Treatment Advocacy Center, *Criminalization of Mental Illness*, https://www.treatmentadvocacycenter.org/key-issues/criminalization-of-mental-illness (last visited Apr. 23, 2023).
[47] Crime and Justice Research Alliance, *Study: Prisoners with Mental Illness Much More Likely to be Placed in Solitary Confinement*, Phys.org (Mar. 10, 2021), https://phys.org/news/2021-03-prisoners-mental-illness-solitary-confinement.html#:~:text=The%20study%20found%20that%20one,solitary%2C%20depending%20on%20their%20diagnosis.
[48] Timothy Williams, *Mentally Ill Inmates are Routinely Physically Abused, Study Says*, N.Y. TIMES (May 12, 2015), https://www.nytimes.com/2015/05/12/us/mentally-ill-prison-inmates-are-routinely-physically-abused-study-says.html.

years cultivating programs that outsource some of the roles police officers have traditionally held. For law enforcement officials and lawmakers, cost often remains the largest barrier to implementation. However, after the cost of development and implementation are factored in, the three models discussed above require a shift in resources, not necessarily the addition of resources. **After developing a cohesive and robust mental health service infrastructure, cities can divert police response to social service response. The return on initial time and cost investments would be twofold: effective social response to mental illness and long-term cost savings. In hundreds of cities across the country, these collaborations are alleviating demands on police departments and helping to connect individuals to needed services**. Together, these rapidly expanding models highlight how jurisdictions can effectively and thoughtfully respond to their communities' specific needs.