Collaborative Efforts Between Law Enforcement and Mental Health Professionals When Responding to Mental Health Crises in the United States

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Abstract

Deinstitutionalization coupled with inadequate and strained community resources in the United States have resulted in many people with mental illness and psychiatric disorders without critical help and in the public. They often experience police encounters that can turn deadly. Injuries and death to both people with mental illness and officers underscore the need for mental health professionals and the police to establish effective and sustained partnerships to ensure the care and safety for this population. This qualitative study draws from interview data from 17 mental health professionals and law enforcement officers working with individuals with mental health needs to identify barriers to obtaining help. Initial findings suggest substance use, homelessness, trauma, and lack of funding are significant barriers. Societal issues and inter-organization factors are discussed with policy implications detailed to combat these barriers.

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Introduction

In 2015, the mother of mentally ill Jason Harrison called 911 for assistance with her son who was acting erratically, informing the operator her son was a bipolar schizophrenic and requested the department to send out "trained units." When Dallas Police Officers arrived on scene, the 39-year-old was shot five times within seconds of the encounter after refusing to drop a screwdriver (Martyn, 2015). In the wake of such tragic encounters, more collaborative partnerships between police and mental health services emerge, underscoring the unique conditions in dealing with individuals with mental disorders. However, such partnerships are often strained by inherent structural and cultural difficulties that exist in the intersection of mental health services and policing.

Individuals in the community needing mental health services usually have complex needs, including serious mental illness (SMI), substance use disorders (SUDs), and homelessness (Mihelicova et al., 2018). Research suggests that 1 in 5 adults in Texas experience a mental health concern in a 12-month period (Leonard, 2017; Texas Health and Human Services, n.d.), and approximately three percent of Texas adults suffer from SMI (Piedad, 2017). Reports suggest that Texas spends $1.4 billion in emergency room costs and $650 million in local criminal justice system expenditures on mental health and substance abuse each year (Piedad, 2017). Mental Health America (2020) ranked Texas 3rd in the U.S. regarding lower prevalence of adult mental illness but last (out of the 50 states and the District of Columbia) regarding access to mental health care. The purpose of this qualitative study is to use the insight from mental health professionals and law enforcement officers working in mental health to identify barriers to working with people in metal health crisis. Before detailing the methods and results of this study, the literature in this field is discussed briefly.

Literature Review

A combination of deinstitutionalization and inadequate community resources in the mid-20th century resulted in the criminalization of people with mental illness. Psychiatric hospitals, derisively known as "insane asylums," ended in the 1950s with criticisms of ineffective and inhumane treatment of patients coupled with growing costs. Community-based mental health programs were then expected to accommodate and successfully treat people with mental illness in place of inpatient and hospital treatments with the passage of the Community Mental Health Centers Construction Act in 1963 (Gray et al., 2017; Mechanic & Rochefort, 1990). However, these community-based treatment centers never materialized. Instead, the U.S.

went through an era of mass incarceration beginning in the 1970s lasting throughout the 1990s, netting many individuals with mental health disorders. Raphael and Stoll (2013) describe this shift as "transinstitutionalization."

Further contributing to the growing incarceration rates of the mentally ill population was the war on drugs and subsequent "tough on crime" era beginning in the 1970s. The large number of people incarcerated for the possession, use, and marketing of drugs, nuisance crimes, and other minor offenses significantly added to the prison population (Landess & Holoyda, 2017; Mechanic & Rochefort, 1990; Petersilia, 2003) and many of these people were dealing with a mental illness (Lamb & Weinberger, 2017; Sodhi-Berry et al., 2014).

However, the lack of community partnerships, resources, and equipped staff also led to the failure of deinstitutionalization. Homelessness, arrests, substance use, and incarceration became increasingly common, and consequently, a revolving door for people when released from institutions. The absence of community services exposes this vulnerable population in a community without adequate supports, increasing the likelihood of being incarcerated and worsening their mental conditions (Allen & Tracy, 2009; Lamb & Weinberger, 2017). Research has found that people with mental illness are three times more likely to be incarcerated than hospitalized (Sodhi-Berry et al., 2014). Without medications and treatments, self-medication paves the way for substance use (Boland & Rosenfeld, 2017; de Tribolet-Hardy et al., 2015; Tartaro, 2016).

Law enforcement then became the "first line of contact" when people experience a mental health crisis (Jensen, 2019, p. 131). The solution is not found in arrests and incarcerations but treatment programs and community collaborations among mental health professionals, policymakers, researchers, and law enforcement at a minimum. Rehabilitative programs and interventions appear to be the straightforward solutions when assisting people with mental illness or psychiatric disorders, whether this involves incorporating therapies, or other resources inside jails and prisons. They are also available upon release in the community (Allen & Tracy, 2009; Lamb & Weinberger, 2017). Unfortunately, there may be some law enforcement professionals, social workers, or even medical professionals, including licensed staff, that do not necessarily perform as expected. Previous studies have concluded that medical professionals with little to no experience working with individuals with a mental illness or psychiatric disorder often feel unprepared when working with this population (Lamb & Weinberger, 2017). The uneasiness of these professionals can also misguide and complicate the clients they appear to be working with, which can then foster fear and anxiety within individuals in need.

Methods

The purpose of this qualitative study is to use the insight of mental health professionals and law enforcement officers working in mental health to identify barriers to working with people in metal health crisis. A social network recruitment approach, a type of convenience sample, was utilized to recruit law enforcement and mental health professionals in a large urban county in Texas.

The research sample consisted of 17 law enforcement officials and mental health professionals. To meet eligibility criteria, participants had to be over the age of 18, work in the studied urban county in Texas, have professional experience delivering assistance to people with mental health needs, and have a knowledge of mental illness and how to best respond to people in crises. For law enforcement professionals, all participants had at least five years in law enforcement. Social workers and counselors had a minimum of three years of experience working with people with mental health needs.

The sample consisted of six known participants who were directly approached by the researcher, and 11 recruited through the snowball sampling procedure utilizing the recruitment social script, which resulted in a total of 17 participants. A total of 23 professionals were invited to participate in the study, yielding a 74% acceptance rate. See Figure 1 for participant information.

Qualitative semi-structured interviews were conducted with open-ended questions to gain a deeper understanding of how working professionals interact with and assist people with mental illness or psychiatric disorders when in crisis. The semi-structured approach allowed study participants to elaborate on the initial question and branch off into different areas of their respective profession or discuss themes of interest to them. All interviews were conducted face-to-face with only the researcher and single participant present in the interview. This minimized any possibility of undue influence or coercion, and participation was voluntary. The researcher utilized an interview script to begin the interview, allowing for flexible questioning and thoughts by both the researchers and the participant. The average interview was approximately 35 minutes.

Figure 1. Participant Information (n=17)

Professional Title	Educational Attainment	Experience (years)
LPC I	LPC License	3
LPC II	LPC License	10
CCPD	LMSW	3
CCAPD	B.S. in Psychology	7
Social Worker I	B.A. in Psychology	7
Social Worker II	B.A. in Social Work	3
Program Manager	B.S. in Criminal Justice	3
PMHC	LPC License	17
Police Lieutenant	LPC License	20
Police Sergeant I	B.A. in Philosophy	15
Police Sergeant II	Some college	18
Police Corporal	B.A. in Criminal Justice	8
MHPO I	B.S. in Psychology	15
MHPO II	B.S. in Criminal Justice	17
MHPO III	High School Diploma	18
MHPO IV	Some college	6
MHPO V	Some college	25

The instrument used in the interviews consisted of four sections: employment demographics, education, employment duties in regard to crisis, and profession-specific questions. The interview guide was constructed by the researchers with concentration on the literature review to enhance content validity. Questions included “What do you think affects mental health crises?” and “What do you think about the resources law enforcement has when working mental health crisis calls?” Other questions were “What are some resources that would help law enforcement working with people in mental health crises?” and “What are some barriers between effective mental health resources/treatment and the criminal justice system?” The semi-structured interviews provided a deeper understanding of the critical and unique roles of participants when responding to mental health crises. All interviews conducted in this study were audio-recorded and transcribed verbatim for analysis.

Data Analysis

Thematic content analysis identifies and analyzes repeated patterns and themes found in the data explored (Crowe et al., 2015; Vaismoradi et al., 2016). Thematic content analysis was appropriate for this study, as it enabled the researchers to identify commonalities and differences in terms of participants' experiences. A narrative analysis was also used to compare different responses and interpret those commonalities and differences. The researchers uncovered three themes: substance use, homelessness, and trauma.

Results

Substance Use

A consistent theme among respondents (n=9) was that people with mental illness self-medicated by some form of substance use. Nearly all police departments with respondents in the study (n=4 of 5) were represented in this subtheme. Study participants explained the challenges substance use by self-medication led to among both mentally ill individuals and first responders, specifically law enforcement and mental health professionals. In addition, substance-induced psychosis was another commonality mentioned among participants as a frequent factor. A mental health peace officer stated, "It's always difficult to tell which one came first," referring to the substance use problem or the mental illness "were they mentally ill and trying to self-medicate or did we start off with meth and have an amphetamine-induced psychosis now? If a person specifically has manic bipolar disorder, there tends to be lots of alcohol going on."

A police mental health coordinator noted co-occurring disorders with self-medication and mental illness, often lead into substance-induced psychosis. This coordinator is also an LPC, recognizing the importance of treating "underlying mental health first in hopes of stabilization to get a person in for substance abuse treatment." The coordinator was confident that if a person's substance use is looked at before the mental health need, then the hospital is more likely to release the person after they are sober, which "starts a cycle again." A police sergeant's claim supports the police mental health coordinator's approach, emphasizing the importance of treating a person's mental illness before "looking at their criminality and the severity of the charge."

A non-traditional approach the police mental health coordinator described was a person's compliance with treatment. The coordinator disclosed, "sometimes the only compliance we have is jail because then they can be mandated and forced into

treatment," serving as the alternative to arresting the person on a drug charge. The mental health peace officer stated, "I would rather take them to jail over [psychiatric hospital] because they can still get help from non-profit organizations and the Sheriff's department," which includes assessments, medications, and post-discharge follow-up visits.

However, a social worker countered the police mental health coordinator's statement of treatment compliance: with "if the person wants to get clean, it needs to be their decision to get clean." The same social worker affirmed the decision to "get clean" and be sober is ultimately up to the person themselves, not necessarily law enforcement or mental health service providers. With a similar mindset, an LPC mentioned that for "a lot of people with mental health issues, it's easier to quiet the voices with drugs, or take medication to make it go away." The rejection and misunderstanding tied to mental health disorders is rather difficult to understand. The LPC suggested professionals must keep in mind that "there's nothing that's going to take [the illness] away, but there are things that can be given that can make life more manageable."

Homelessness

Nine study participants tied substance use and homelessness as "direct correlations" with mental illness. Respondents from three of the five represented police departments discussed topics in this subtheme. A police corporal argued, "the main two causal factors of homelessness [are] addiction and mental illness." Mental illness has influenced a person's drug dependency, their ability to have a stable environment, and for some, it has inhibited a person from holding a job, or has even caused family problems. Specifically, law enforcement professionals describe homelessness as a "large difficulty" when responding to crisis calls that involve someone who is both homeless and exhibiting mental health symptoms.

A police sergeant specified in her overall career in law enforcement, she has "maybe met three people that were homeless that did not have a mental health issue." Excluding those three individuals, the rest of the homeless population this police sergeant came across had severe mental illness and did not like taking their medication. An LPC believes substance use and homelessness "go hand in hand because [the person] doesn't have to disappoint anybody, they can just medicate it or go wherever they want to go and don't have to worry about making anybody feel safe." The only routine, or "cycle" homeless people know is "they don't know another way of life, or they don't have another opportunity."

A police lieutenant from the same police department pointed out that police officers must consider their own safety as the top priority:

> *I think the biggest thing is safety because you have people who are homeless, and of course they, they carry their home with them almost, so that can mean weapons, that can mean, you know, anything that can hurt others or hurt officers. What we try to do is in our trainings talk to officers about the fact that they could have something, and it isn't predictable, so we always respond with at least two officers.*

The police sergeant's police department has both a mental health unit and a homeless outreach unit, allowing specialized police officers to provide valuable information, resource connections, and safety tips for all officers.

Trauma

When people with mental illness or psychiatric disorders encounter law enforcement, there may be a previous negative experience, including any association with someone wearing a badge, the sound of the sirens, or the fear of aggression and unknown results. Nine participants noted that trauma in people with mental health needs is common, especially when the person has had frequent encounters with the criminal justice system. Only two police departments respondents (n=2) were represented in this subtheme.

A clinical crisis program director discussed the importance of trauma-informed care. The program director believes the Texas Commission on Law Enforcement (TCOLE) certification training offers a "pretty intense" training to police officers that includes the concept and implementation of trauma-informed care. Police officers receive a basic introduction to trauma-informed care and "learn grounding techniques" should officers respond to a crisis call involving a mental health need or disability. One of the mental health peace officers described a challenge when responding to people with any form of trauma involves the comfort level to share their previous experience, as "most people won't share their trauma." A different mental health peace officer countered this claim with people trusting mental health peace officers and opening up to officers. This mental health peace officer stated, "a lot of times you'll have somebody who has trauma that may open up to us, whereas they didn't open up to their medical providers in the field because they genuinely feel that we we're there to protect them and help them."

An LPC participant believes law enforcement has progressed in training and education, specifically with the current "push for trauma-informed care and psychiatric disorders" among police departments. The LPC has a background in working with both adults and children with mental illness and psychiatric disorders, concentrating in the trauma branch of counseling as well. Forensic interviews and soft interview rooms have also improved interview processes between "regular

offenders" and those with a mental health need. The same LPC emphasized the importance of training on how people with a mental illness or psychiatric disorder must be treated differently than an average offender:

> *I know there's a huge push everywhere for trauma-informed care, but I know there's certain instances where you can't treat them as you do a regular offender, and so I do think there needs to be training on the best way to handle that, how to talk to them, how to approach them, how to interview them, instead of doing, you know, your normal interrogation.*

In addition, the LPC classified trauma as "a gateway drug," given the likelihood of co-occurrence between mental illness and substance use. The same LPC asserted, "I don't think that any certain drug is a gateway drug, but I think trauma is directly correlated to mental illness." The drugs themselves are a coping mechanism and easy fixes, which facilitates self-medication.

The subtheme of trauma was not consistently discussed in other interviews, but there were some participants who believe past experiences should be considered when law enforcement becomes involved with crisis encounters. A police lieutenant stated that some people who find themselves in mental health crises might have a negative reaction toward police officers due to a bad experience in the past. "We don't want things to be worse, we don't want to escalate things," the lieutenant said. This lieutenant claimed that calling the police is "probably not the best thing to do, and that's probably not what the person wants." A mental health peace officer said it would be beneficial for dispatch to note any past interactions with law enforcement to benefit the current crisis. The same mental health peace officer believed the difference in patrol officer uniforms and the crisis intervention team's uniforms can help ease the trauma from negative experiences with police officers, especially with "the regular people that we see on a frequent basis that are trauma-affected with mental illness."

The crisis intervention team does not wear the traditional police officer uniform with weapon visibility. One of the mental health peace officers confirmed that the team modified their uniforms to khakis and a t-shirt or polo with the department's logo and approach their crisis calls in a calm manner and "not in an authoritative, psychological aspect" in comparison to traditional police officers. Additionally, the crisis intervention team operates in vehicles different from the traditional "black and white" police cars, driving white vehicles with a "ghost marking" to "soften [the] approach" and help the person or people in a high-risk situation recognize "it is not a normal patrol officer, it's a crisis intervention officer," stated the police sergeant over the crisis intervention unit.

With trauma-informed care trainings, law enforcement professionals can understand past experiences that involved a mental health crisis, how to not trigger a person's reaction, and understand how trauma in general affects a person's reaction and relationship in specific situations. Many of the study participants claimed some of these people only know a toxic lifestyle, which may include substance use, homelessness, and trauma, making them not only comfortable with this lifestyle but also making it difficult for them to see the alternative: recovery. Other participants described trauma as an interpersonal challenge that is not as physical and obvious as other traumas. These traumas can include physical, emotional, or sexual abuse, and even environmental trauma, including homelessness.

Discussion

Mental health barriers all create disempowerment and fear for people suffering from a mental illness or psychiatric disorder. Two main categories: societal and inter-organizational issues were found to negatively impact the effective and efficient delivery of services by mental health professionals and law enforcement.

Societal Issues

Our data show the difficulties in getting public and political support, including funding, for community mental health resources to provide treatment. This lack of support can in part be attributed to the persistent societal negative stigma associated with mental illness derived from lack of public understanding. Stigma perceived by landlords, employers, health services providers, and criminal justice actors have a profound impact on individuals with mental illness to successfully function in society (Corrigan & Kleinlein, 2005).

Compounding the issue of treatment is public stigma of mental illness, homelessness, and drug addiction. People with mental illness and drug addictions are commonly perceived to be dangerous by the general public. Studies have found that drug addiction, which is often tied directly to mental illness, has a higher level of negative social stigma compared to just mental illness alone. Barry et al. (2014) found both mental illness and drug addiction affected marriage decisions, employment, and housing. Without addressing addiction, our study shows many individuals end up homeless.

As shown by the data, police reluctance in dealing with homeless individuals with mental health disorders often stems from the frustration derived from structural factors out of their control and often beyond the scope of their

traditional crime-control roles. For instance, officers interviewed frequently expressed their dismay at the lack of mental health treatment, addiction treatment, and difficulty finding permanent housing solutions. This is to no surprise, as police interactions with the homeless population historically has centered on either a source of social disorder that leads to crime or physical safety of the officers from infectious diseases. This is reflected in two large bodies of research. The first was popular in the 1990s with NYPD's "quality of life policing" based Kelling and Wilson's (1982) "broken windows policing," which perceived the homeless population as one in need of control in order to address social disorganization. The second body of research focused on officer safety against infectious diseases from needlestick injuries, especially with mentally ill homeless populations (See Cepeda et al., 2017).

Inter-Organizational Factors, Policing, and Resources

Social service and police collaborations are essential when managing people with a mental illness (Lamberti, 2016). While all parties interviewed recognized the need for collaboration and the growing problem of mental health, joint efforts were often strained by divergent measures of success and non-complementary or even conflicting functions. This finding of inter-agency conflict is consistent with studies that show factors such as inefficient communications pre- and post-event, difficulties accessing support resources between organizations, delays in hospital treatment, and occasional inter-organizational staff conflict during interfaces (Hollander et al., 2011).

Inherent structural and functional factors contribute to inter-organizational conflicts. (Authors) found that differential court dates with child sexual abuse cases between police detectives and child services organizations often translated into different case priorities, resulting in compromised cases and services not rendered (2021). The police prioritized catching the sexual predators they felt would prevent further victimization while child service organizations felt addressing trauma should come first during the critical period (Authors, 2021).

Points of inefficiency among collaborating parties reduce the overall effectiveness of mental health treatment and services. This structural limitation was explained by Pontell's (1985) System Capacity Theory, which posited that the overall ability of a system to achieve a goal was dependent upon legal structures and sustained investments in all stages of a process. Pontell identified legal structural and procedural law, formal and informal inter-relationships with criminal justice organizations, sustained resources to all processes, including the courts, addressing social, political, and cultural contexts, and other processual factors (p. 33). This means not just increased training, but investments in personnel in the public and private sectors, including courts and medical facilities.

While police have been reluctantly thrust into often taking roles as *de facto* mental health professionals, they are in a unique position when dealing with trauma. As shown by the data, individuals can trust officers during crises. This is consistent with recent research that showed officers who take a trauma-informed approach during interviews and interactions can elicit useful information for rape cases without a re-victimization effect (Rich, 2018). However, most officers are inadequately prepared for crisis and trauma in relation to mental health. According to the Bureau of Justice Statistics (BJS), officers on average have 10 hours of total training in dealing with mental illness (Reaves, 2016). In Texas, mental health is usually designated to specially trained officers who take a minimum of 40 hours of training to obtain state certification for mental health proficiency (Mental Health Officer Proficiency Certification, see https://www.tcole.texas.gov/).

Furthermore, relatively scarce mental health resources by private service organizations and police often undermine effective and sustained treatment. As our data has shown, these scarce resources often result in competitive relationships with neighboring agencies instead of complementary arrangements. The scarcity of resources is also contextualized in decades of deinstitutionalization and debunked justifications for prison and criminal justice expansion since the 1970s, when Martinson (1974) infamously posited the question of "What works?" in questioning the value of offender treatment and rehabilitation. This "nothing works" mentality has perpetuated public resistance in funding a free mental health infrastructure. It has served as the academic justification and impetus for abandoning rehabilitation and treatment and increasing politically-motivated investments in crime control and incapacitation, leading to decades of prison expansion.

Policy Implications and Conclusion

Multidisciplinary team approach with police-community partnerships

The multidisciplinary team framework is centered around trauma-informed service delivery through evidence-based practices. The community practitioners that construct the teams offer suggestions, best-practice models, and an array of knowledge to better serve the intended populations (Nicholson et al., 2000). The majority of police officers interviewed had frequently encountered an individual experiencing psychosis when responding to mental health crises. Birch and Martin (1985) advocated for the adoption of a "mental health triage" response method among various professionals that encounter people who are high-risk for emotional disturbances and those frequently admitted into emergency room or psychiatric

crisis centers. The fundamental concept of a multidisciplinary team would prioritize basic mental health diagnoses and mental illness symptomology for appropriate intervention across all professions.

From this study, five participants confirmed their collaboration through a multidisciplinary collaboration: Two clinical professionals, two non-clinical professionals, and one police officer. A social worker added that developing a system where law enforcement can register a person's historical information, or "key indicators" that include trauma, or a confirmed diagnosis could help police officers "if they ever come in contact with those individuals." The social worker believes registering negative experiences, symptoms, and diagnoses can help police officers "know how to handle the situation based on their mental illness or condition."

The feedback these participants provided justified the appropriateness of a collaborative practice that entails a variety of professions with different field experience, as practices are shared, challenges are addressed, and ideas are created. As police departments strive to collaborate with mental health service providers and social services to adopt this approach, police officers will strengthen their ability to recognize psychological impairments and modify their response methods.

Co-responder Crisis Intervention Team Models

One growing strategy among police departments are Crisis Intervention Team (CITs) that embed mental health professionals with law enforcement first-responder teams for identified mental health incidents. The first CIT model, the Memphis CIT model, was developed in the late 1990s by Memphis Police to address drug addiction, which paired police officers with mental health and addiction professionals, and mental health advocates in an emergency response task force (Dupont & Cochran, 2000). Today, CIT models are endorsed by the National Alliance on Mental Illness (NAMI) and employed by policing agencies throughout the country. NAMI notes an 80% reduction in officer injuries, quicker response times, and significant cost savings associated with CIT models (See nami.org).

Our data supports current findings on the effectiveness of the CIT model, as well as more ongoing collaborations. The attitudes of officers interviewed in this study matched attitudes of CIT-trained officers in existing studies, showing reduced officer stigma towards mentally ill individuals, improved officer satisfaction and self-perception, and lower likelihood of use of force (Rogers et al., 2019). While a growing body of research increasingly supports the effectiveness of CIT models, it

remains that mostly larger departments and municipalities have the capacity and resources for such collaborations and specialized units.

Training

Ideally, every police officer in every police department would have adequate training and certification in crisis intervention. Assigning mental health incidents to specialized CIT teams may foster a "not-my-responsibility" attitude among untrained officers, which may overburden CIT-certified officers and disincentivize non-certified officers from developing relationships with mental health professionals and familiarizing themselves with available resources. Training every officer, however, can be costly to departments. The TCOLE certification requires 40-80 hours of training, which is often paid for by police departments. In addition to the direct cost of training courses, the certification is costly in terms of time away from regular duties for officers.

Mental Health and Wellbeing During the COVID-19 Era

The Kaiser Family Foundation (KFF) conducted a poll mid-July 2020 among adults in the United States that found that 53% reported their mental health had been negatively impacted by COVID-19, with 12% reporting an increase in alcohol consumption or substance use (2020). The negative effects on mental wellness include difficulty sleeping, increased rates of depression from social isolation, and increased anxiety. As these numbers increase among the general population, those with preexisting conditions of mental illness, substance use, and those who experiencing homelessness are no exception. The Overdose Detection Mapping Application Program (ODMAP) analyzed a 17.59% increase in overdoses after state-mandated stay-at-home orders were issued mid-March (2020). The same analysis noted 61% of participating counties saw an increase in overdose submissions as well. From the unprecedented effects of the pandemic, police departments should be mindful of the societal changes and encourage departments to mandate Mental Health Officer Proficiency Certifications among all officers as a proactive measure.

Funding During the COVID-19 Era

In 2020, the novel coronavirus COVID-19 global pandemic placed a high financial strain on police departments and mental health services across the country. When coupled with the growing *defund the police* movement, many departments saw the deepest budget cuts in decades. The NYPD, for example, cut funding by $1 billion, while LAPD slashed its budget by $150 million in 2020. A USA Today's poll of 258 police agencies surveyed showed half the agencies have already cut or proposed cuts to their future budgets, creating "a recruiting, retention crisis" (Johnson & Phillips, 2020). When these cuts occur, police often reduce activities to core crime

control functions centered around patrol and call response. Protecting and growing mental health funding, such as for CIT training, remains difficult in this political climate.

In addition to policing budgets, mental health funding is in jeopardy. The 2019 fiscal year budget for the Department of Health and Human Services (HHS) included a $600 million cut in Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health and Substance Abuse Treatment Programs, and discontinued funding for the Screening, Brief Intervention, and Referral to Treatment program (Howard, 2020). These budgetary constraints also trickle down to the municipal level, as well as grant funding opportunities for nonprofit mental health service organizations. Securing funding should be a top priority for every organization.

Despite the climate of growing uncertainty, there is widespread support for mental health services among police and the general public. The hit 2019 HBO documentary, Ernie and Joe: Crisis Cops, featuring the San Antonio Police Department, shows a growing public awareness and interest in mental illness and police. Despite this, there is a lack of evidence based research devoted to effective collaboration among social services and law enforcement. History reminds us that agencies working with the mentally ill cannot work in silos unless we want to perpetuate the problem.

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