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Part II: The Consequences of Deinstitutionalizing the Severely Mentally Ill

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Abstract

This is Part II of a three-part series exploring the intersections of mental illness, violence, and firearms. As the nation sits in the midst of a serious discussion about gun violence in general, and mass shootings in particular, we must ensure that policy decisions regarding Second Amendment rights reflect an accurate understanding of the role mental illness does and does not play in gun violence, as well as an accurate understanding of why the United States is suffering from a crisis of untreated serious mental illness.

Beginning in the 1970s, several significant catalysts combined to lead the United States toward the mass-scale deinstitutionalization of the nation's seriously mentally ill, removing tens of thousands of individuals from long-term, in-patient psychiatric care without adequate alternatives in place. This well-intentioned but poorly planned policy shift has had disastrous consequences for both the mentally ill and the communities ill-prepared to care for them, and likely played a significant role in subsequent increases in violent crime.

As a result of deinstitutionalization, jails and prisons around the country are full of mentally ill individuals perpetually "reinstitutionalized" as the result of their lack of treatment. There are simply not enough psychiatric hospital beds of last resort, leading to a vicious cycle of mental health crises and emergency short-term care that continually burdens community health and safety infrastructures without solving the underlying problem. The longer individuals with mental health problems wait for treatment, the more likely it is that a mental health crisis will develop, and the individual will need more

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Key Points

- Mass-scale deinstitutionalization of the seriously mentally ill—without adequate alternatives in place—was well-intentioned, but likely helped facilitate dramatic increases in violent crime rates.
- Deinstitutionalization continues to occur today, and the effect has been devastating to both the mentally ill and the communities struggling to care for them.
- There are simply not enough beds of last resort for emergency treatment, and mentally ill individuals are routinely "reinstitutionalized" into jails and prisons, where they do not receive proper treatment.
- The cycle of crisis and emergency stabilization exacerbates existing problems within the nation's law enforcement, incarceration, and hospital systems, imposing significant socioeconomic burdens on state and local communities and endangering the welfare of many.

intensive treatment for a longer period of time—a situation in which both the mentally ill individual and the community ultimately lose.

To combat this growing problem and to ensure the safety of their communities, states should provide adequate numbers of public psychiatric beds and strengthen their mental health commitment laws while still affording necessary due-process protections. Further, states should more efficiently utilize their existing mental health commitment laws and infrastructure.

It is imperative that we understand how the mass deinstitutionalization of the severally mentally ill helped create the situation we now find ourselves in as a nation. Mental illness is too often not adequately treated, with devastating results—not just for those suffering from mental illness, but for the communities trying desperately to deal with the fallout. Individuals with severe mental illness are, as a result of deinstitutionalization, increasingly herded into state prisons and local jails, where they are less likely to receive treatment and more likely to be victims of violent crime and abuse.

The lack of necessary beds of last resort or any viable alternatives increases the risk of violent and fatal encounters between the severely mentally ill and law enforcement—and is associated with an overall increase in violent crime. Particularly with regard to gun violence, states can counteract the consequences of deinstitutionalization by providing adequate numbers of public psychiatric beds and strengthening their involuntary civil commitment and mandatory outpatient treatment laws without neglecting due-process protections.

I. Deinstitutionalization May Have Played a Significant Role in the Dramatic Increase in Violent Crime Rates During the 1970s and 1980s.

Before public psychiatric hospitals were in common use, America's mentally ill generally remained in their family's homes and were cared for by family members or friends, and their seemingly strange behaviors were often simply tolerated by their communities.[1] When these individuals either became too disruptive or had no one to look after their well-being, they were often confined to jails or "poorhouses."[2]

Beginning in the early- to mid-19th century, advocates for better treatment of the mentally ill, such as Dorothea Dix, began a quite successful lobbying campaign to persuade state governments to fund the building of 32 state psychiatric hospitals. While Dix attempted to persuade the federal government to use the proceeds from federal land sales to support state psychiatric institutes, President Franklin Pierce vetoed Congress's 1854 bill on the matter, calling it contrary to the Constitution and to the general idea that states—not the federal government—were responsible for their mentally ill citizens.[3] Indeed, until 1945, the care of mentally ill individuals was exclusively the responsibility of state and local governments.[4]

As a result of deinstitutionalization, jails and prisons around the country are full of mentally ill individuals perpetually "reinstitutionalized" as the result of their lack of treatment.

The goal of these hospitals was to remove from families the burden of caring for mentally ill individuals and allow those individuals to live in safe conditions where they could be treated by professional staff. Many of these facilities were originally developed around the "Kirkbride Plan," which focused on providing care for relatively small numbers of patients (no more than 250) in buildings designed to promote fresh air, privacy, and comfort—often in relatively secluded locations outside of crowded urban areas.[5]

By 1870, state taxpayer-funded "asylums" were considered critical to the well-being of poorer mentally ill individuals who could not afford the care provided by private hospitals, and nearly every state had one or more asylums available for public psychiatric care.[6] Economic considerations sometimes led to funding cuts or increased numbers of patients beyond the intended capacity, and by the end of the 19th century, physicians increasingly began opening small, private asylums for wealthy patrons.[7] But by the 1950s, there were well over one-half million patients in state-funded mental hospitals.[8]

There were several significant catalysts that eventually led to deinstitutionalization on a mass scale and the shuttering of many of these facilities.[9] First, there was a growing public awareness of truly horrific conditions that existed in some large state psychiatric hospitals, including overcrowding, abuse, and

poor—and sometimes a complete lack of— actual psychiatric treatment.[10] Exposés such as *Life Magazine*'s "Bedlam 1946" and Albert Deutch's *The Shame of the States* provided blistering criticisms of the shocking conditions at individual hospitals.[11]

Second, general liberalization trends that promoted community-based treatment centers coincided with the development of anti-psychotic medications that led many professionals to reconsider the possibility of managing mental illness outside of institutional settings.[12] The 1955 development of the so-called wonder drug chlorpromazine in particular showed incredible promise for increasing the reliability of outpatient treatment.[13] These trends toward community treatment and outpatient medication management were officially endorsed as national policy by the Community Mental Health Act of 1963, in which the federal government committed itself to the establishment of and funding for community-based mental health services.[14]

Third, when Medicaid was established in 1965, it *de facto* encouraged states toward deinstitutionalization by incentivizing them to eliminate state psychiatric beds: States were prohibited from using Medicaid dollars to cover the care of mentally ill adults in inpatient psychiatric settings, and in turn were also promised more federal dollars for each patient transferred to outpatient settings.[15] It became financially beneficial for states to have as few public psychiatric beds as possible and instead to rely on outpatient treatment, leading many states to alter how they provided mental health services in order to maximize their receipt of federal dollars, instead of basing their treatment decisions solely on the needs of their citizens.[16]

Finally, federal courts cemented this trend toward deinstitutionalization by fundamentally altering the legal standards for civil commitments, making it much more difficult for the government to impose treatment on mentally ill individuals. From the opening of state asylums in the mid-18th century until the 1970s, courts considered involuntary mental health commitments to be part of the state's *parens patriae* power,[17] and states could commit to mental institutions any person simply by showing the person suffered from mental illness and had a "need for treatment."[18]

Beginning in the 1970s, the Supreme Court—in tandem with other changes in social sciences regarding the mentally ill—delivered a series of opinions that greatly affected the ability of states to maintain custodial supervision of even the most clearly mentally ill individuals. In 1975, in *O'Connor v. Donaldson*,[19] the Court determined that, in order to involuntarily commit a person to a mental health treatment facility, the state must prove not just that the individual suffers from a mental illness and is in need of treatment, but that the individual poses a risk of danger to himself or others as a result of his or her mental illness and is incapable of surviving safely by himself or with the assistance of capable and willing friends or family members.[20]

Courts have recognized that individual liberty interests must be balanced against the state's interest in providing care to its citizens and protecting the community from dangerous individuals.

The Court did not clarify the standard by which the state must prove dangerousness until 1979, when it held in *Addington v. Texas*[21] that the State must prove the element of dangerousness by clear and convincing evidence.[22] This standard sets a higher bar than that of "preponderance of the evidence," which was the standard used by many states at the time, making it significantly more difficult for states to ensure that individuals who might reasonably pose a danger to themselves or others received adequate treatment.

Courts have also made it easier for people to refuse treatment.[23] The common law reflects a right to be free from unwarranted personal contact, and this has evolved into a general right of patients to refuse medical treatment "however warped or perverted his sense of values may be in the eyes of the medical profession, or even of the community, so long as any distortion falls short of what the law regards as incompetency."[24] Courts have found that this right applies even to individuals who are mentally ill, and that even patients involuntarily committed to mental institutions are not necessarily incompetent or incapable of giving informed consent to medical treatment.

Despite the recognition of the right of mentally ill individuals to refuse medical treatment, courts have recognized that their liberty interests must be balanced against the state's interest in providing care

to its citizens and protecting the community from dangerous individuals. Further, the procedures for determining whether a mentally ill individual can be forcibly medicated must satisfy the Fourteenth Amendment's procedural protections. For example, in the 1990 decision in *Washington v. Harper*, the Supreme Court held that the state can treat a seriously mentally ill inmate against his will only if it first proves he is gravely disabled or dangerous to himself or others, the treatment is in his medical interest, and sufficient due-process protections exist in the diagnosis and treatment decisions.[25]

II. Deinstitutionalization Is Still Occurring Today, and Its Effects Are Devastating.

Despite the best of intentions by those pushing deinstitutionalization, the movement has been called "the largest failed social experiment in twentieth-century America."[26] States began a large-scale reduction of the number of inpatient psychiatric beds, but on the whole failed to establish or fund an adequate network of community care centers or outpatient treatment facilities to fill the void left by the closing of state mental institutions.

Between 1955 and 2016, the United States experienced a *95 percent decrease* in the number of available public psychiatric beds.[27] The average among 34 Organization for Economic Co-operation and Development (OECD)[28] countries is 68 psychiatric beds per 100,000 people, while the United States' average of 25 beds per 100,000 people places us near dead last.[29] That was in 2011. Between 2010 and 2016, another 6,000 state hospital beds were eliminated in the U.S., while the population increased by 14 million.[30]

The dramatic reduction in available beds has been compounded by equally dramatic reductions in state mental health spending. Between fiscal years 2009 and 2012, states cut a cumulative $4.35 billion from their mental health budgets.[31] There are far too few psychiatric beds of last resort to adequately treat mentally ill individuals, and there is too little coercive power to force treatment upon seriously mentally ill individuals until they are actively dangerous—at which point, it may be too late.

The Devastating Results of Continued Deinstitutionalization. This decades-long trend toward closing down public psychiatric hospitals without first having in place—or even later building—an effective and sufficient network of alternatives has been devastating to both the severely mentally ill and to the communities to which they have been returned.[32] Many of the severely mentally ill simply refused to accept voluntary treatment once they were released from inpatient care, and "deinstitutionalization returned them not so much to the community, as to park benches, the lobbies of public buildings, and alleys."[33] Chronic homelessness, a concept scarcely heard of prior to deinstitutionalization, was thrust into the national spotlight in the late 1980s in large part because of the ever increasing numbers of seriously mentally ill individuals with nowhere else to go.[34]

Further, in a shameful twist, many seriously mentally ill individuals have been reinstitutionalized, but this time into prisons, not treatment facilities. America's jails and prisons have become its new psychiatric facilities, to the detriment of taxpayers and the seriously mentally ill, who are given less-than-adequate care as a result.[35]

The bare statistics on the prevalence of serious mental illness in state and federal inmates underscore the significance of the problem. According to a Bureau of Justice Statistics report based on survey information during the 2011–2012 fiscal year, 37 percent of state and federal prisoners, and 44 percent of jail inmates had been told in the past by a mental health practitioner that they had a mental health disorder.[36]

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A similar 2006 survey by the Bureau of Justice Statistics indicates that the number of inmates exhibiting symptoms of mental illness is likely much higher than the number of inmates who had actually received a diagnosis: 43 percent of state prisoners and 54 percent of jail inmates reported symptoms meeting the criteria for mania in the last 12 months, while 15 percent and 24 percent, respectively, reported that they had exhibited symptoms meeting the criteria for a psychotic disorder in the last 12 months.[37] A 2016 report by the Treatment Advocacy Center found that

44 states and the District of Columbia have higher populations of mentally ill individuals in their jails and prisons than they do in their public psychiatric facilities.[38]

The financial costs of this influx of mentally ill inmates are staggering, as mentally ill inmates cost jails and prisons considerably more money to house than do non–mentally ill inmates.[39] And because most jails and prisons are not designed to adequately treat serious mental illness, inmates with serious mental illness stay incarcerated for a far longer average number of days than do inmates without mental illness.[40] This is, in part, because seriously mentally ill inmates often rack up new charges while in prison or on parole.[41] They are also victimized at far higher rates than non–mentally ill prisoners.[42]

State psychiatric hospitals traditionally played roles rarely duplicated elsewhere in the mental health system, including housing and treating pretrial detainees in need of being restored to competency, defendants being evaluated for insanity defenses, and convicted inmates in need of intensive psychiatric care. As the number of hospital beds continues to shrink, inmates requiring psychiatric evaluation or treatment are increasingly monopolizing public psychiatric beds, causing lengthy waitlists for many non-violent individuals in the midst of mental health crises. These non-violent, non-criminal (but seriously mentally ill) individuals are left to overcrowded emergency rooms.[43]

In some areas of the country, hospital emergency rooms have been forced to compensate for the lack of mental health beds by becoming *de facto* psychiatric units, with individuals suffering from acute psychiatric crises being boarded for days—sometimes weeks—in the emergency department instead of in a proper psychiatric facility.[44] This, in turn, exacerbates the problem: Seriously mentally ill individuals who could otherwise have received proper and continuing treatment are increasingly discharged to their homes instead of hospital beds, only to be returned to the emergency department at the onset of another mental health crisis.[45] These individuals often return in the midst of even worse psychiatric crises, requiring even longer periods of time to stabilize for discharge. The longer stays in the emergency department substantially affect the flow of other non-psychiatric emergency patients.[46]

Not only have our penal institutions been turned into *de facto* psychiatric care facilities—diverting scarce resources and creating a dangerous environment for prison personnel and other inmates—but the burden of dealing with the mental health crises of individuals released into the community has increasingly fallen upon law enforcement officers instead of mental health professionals. Millions of man-hours are lost every year from traditional law enforcement duties as officers often find themselves dedicating their shifts to mental health–related tasks such as transporting mentally ill individuals.[47]

The burden of dealing with the mental health crises of individuals released into the community has increasingly fallen upon law enforcement officers instead of mental health professionals.

In 2009, North Carolina officials estimated that law enforcement in this state alone spent 228,000 hours on these non-traditional policing jobs. Anecdotes from individual police departments about the dramatically increasing number of mental health–related service calls abound,[48] including from Tucson, Arizona, where in 2013 police averaged more mental illness–related calls per day than calls regarding stolen cars or burglaries.[49] Nationwide, a steadily increasing number of state and local law enforcement agencies are offering (in many cases, mandating) specialized mental health training for their officers.[50] They are also generally playing an increased role in the provision of psychiatric services traditionally assumed by health-specific agencies, often hiring mental health professionals or social workers to help manage the case loads of seriously mentally ill individuals who regularly come into contact with officers.[51]

The increased contact between untreated, seriously mentally ill individuals and law enforcement officers is detrimental to both the officers—who, even with training, are far from mental health professionals—and the mentally ill individuals. The majority of the 107 individuals tasered by Sheriff's deputies in Ventura County, California, in 2007 were mentally ill, while in Santa Clara County, California, 10 of the 22 officer-related shootings from 2004 to 2009 involved mentally ill individuals.[52]

Similarly, according to various studies, individuals with mental illness accounted for a disproportionate

number of police-involved shootings in Portland, Oregon, between 2009 and 2012,[53] New Hampshire in 2011,[54] Maine between 2000 and 2012,[55] and Albuquerque, New Mexico, between 2010 and 2012.[56] Some studies suggest that as many as one-third of all shootings by law enforcement officers are the result of victims attempting "suicide-by-cop."[57] According to one 2012 analysis, at least half of all physical attacks on police officers are by individuals suffering from mental illness, many of whom are untreated.[58]

According to several prominent criminologists, mass-scale deinstitutionalization of the mentally ill better explains the sharp increases in violent crime during the 1980s and 1990s than any other factor—including the availability of firearms or differences in gun control laws.

According to several prominent sociologists and criminologists, the mass-scale deinstitutionalization of the mentally ill—without adequate alternative mental health services in place—better explains the sharp increases in violent crime during the 1980s and 1990s than any other factor, including the availability of firearms or differences in gun control laws.[59] Further, the equally sharp and prolonged decrease in violent crime that occurred over the past three decades can be explained at least in part by the "incarceration revolution," which has resulted in large percentages of the mentally ill population being "reinstitutionalized" in jails and prisons rather than in mental health facilities.[60]

In fact, studies have shown that if the population of mentally ill prisoners is included with mental hospital inmates, there is "an astonishingly strong negative correlation between the institutionalization rate, and the murder rate"[61] (meaning the higher the institutionalization rate, the lower the murder rate).[62] This pattern is consistent with a 2006 study of 81 American cities, which reported a statistically significant correlation between the number of public psychiatric beds available in a city and that city's rate of violent crimes such as murder, robbery, assault, and rape.[63]

A 2011 study of various states similarly concluded that having fewer public psychiatric beds was statistically associated with increased rates of homicide,[64] while a 2012 study found an inverse relationship between state hospital expenditures per capita and rates of aggravated assault, and between the loss of public psychiatric beds and violent crime.[65]

III. States Should Provide Adequate Numbers of Public Psychiatric Beds and Strengthen Their Involuntary Civil Commitment and Mandatory Outpatient Treatment Laws Without Neglecting Due Process.

Recent studies have produced strong evidence that the strictness of a state's mental health and civil-commitment laws (i.e., how hard a state's law makes it to order those with untreated mental illness to submit to outpatient or inpatient treatment) is substantially related to that state's murder rate.[66] In fact, according to one recent study, over 25 percent of state-to-state variations in murder rates can be explained solely by differences in their civil-commitment laws: States that make it easier to treat mentally ill individuals tend to have lower murder rates as a result.[67] Currently, Supreme Court precedent requires that the state prove by clear and convincing evidence that a person is both mentally ill and dangerous. These terms, however, have not been defined, allowing states significant leeway in determining the language of their civil-commitment statutes.

The states that give officials the weakest power to involuntarily commit citizens are those that require a showing of danger that is imminent or likely to occur in the near future. Other states eliminate the imminence requirement and instead focus on whether the risk of danger is substantial. Still a third subset of states has removed any time frame, requiring only that the person pose a threat of harm to self or others. There are, finally, a number of states that provide additional grounds for civil commitment unrelated to dangerousness—grave disability and risk of future deterioration. These additions allow for persons with mental illness to be involuntarily committed to mental health treatment if they are unable to provide for their basic physical needs or will otherwise, without treatment, deteriorate to the point of presenting a risk of harm or of being in grave disability.[68] These broadened standards allow the state's *parens patriae* authority to be used for civil commitment before an individual poses a direct danger.

Strengthening the ability of law enforcement officers to involuntary detain an individual suffering from a mental health crisis on an emergency basis could, like gun-violence restraining orders and better reporting to the FBI's National Instant Criminal Background Check System, have realistically prevented a significant number of mass public killings. Consider the case of Aaron Alexis. In the month prior to committing a mass shooting in the Navy Yard area of Washington, D.C., Alexis told Newport, Rhode Island, police that he heard voices speaking to him through the walls of his hotel room and felt a machine sending vibrations into his body.[69] Alexis was convinced that others in the hotel wanted to harm him or use the vibrations to control him.[70] Officers were apparently so concerned with his mental stability that they asked him to discuss his own mental health history and that of his family members.[71] It is unclear whether officers were aware of the man's long history of unhinged and violent behavior, including violent behaviors with firearms.

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Under Rhode Island's emergency-mental-health-commitment statute, however, the officers felt there was little they could do, and they eventually left Alexis at the hotel.[72] The language of the state statute limited temporary involuntary commitments to situations when a person "is in need of immediate care and treatment" because leaving him or her at large "would create an imminent likelihood of serious harm by reason of mental disability." Had Rhode Island utilized the less restrictive language of Arizona[73] (which does not necessitate an "imminent" likelihood of serious harm and provides for civil commitment on the basis of "grave disability" or deterioration without hospitalization), Alexis could have been temporarily detained for a mental health evaluation, which would almost certainly have resulted in the determination that he needed court-ordered mental health treatment.[74] This, in turn, would have both prevented Alexis from legally purchasing the firearm he used to kill nine people and greatly benefited the life of a mentally ill young man. Instead, the incident report was merely forwarded to Navy officials, who, it appears, did not follow up.[75]

States should also ensure they are effectively utilizing the mental health–commitment procedures they have on the books already, as this, too, could have prevented a number of acts of mass public violence. Perhaps the most stunning example of the failure to adequately use the mental health–commitment system is that of the Parkland, Florida, school shooting in 2018. There, Nikolas Cruz showed signs of a troubled mental state for nearly *two years* prior to committing a horrific act of violence. Focusing on mental health history alone—though there were certainly concerning threats of violence and even criminal actions—it is unconscionable that Cruz managed to avoid court-ordered mental health treatment.

School and county mental health officials were alerted after a five-day period in 2016 in which Cruz posted social media threats directed at himself and others, was found to be cutting himself, and drank gasoline in a possible suicide attempt.[76] The school initiated a "threat assessment" and the Florida Department of Children and Families opened an investigation. At least two guidance counselors and a sheriff's deputy concluded that Cruz should be referred for an involuntary psychiatric hold for further assessment and that his home should be searched for weapons.[77] For reasons that remain unclear, the deputy later changed his mind and both school and county officials ultimately recommended against seeking a civil commitment.[78]

Within the next year, Cruz was also removed from the school, at least in part, because of inappropriate stalking behaviors toward an ex-girlfriend that progressed to a physical altercation with her new boyfriend.[79] In the months prior to the shooting, Cruz called 9-1-1 on himself after a violent encounter with his foster family, and he described punching walls and being unable to cope with his mother's recent death.[80] Even more concerning is the fact that these incidents occurred during the same period that the Broward County Sheriff's Department received 18 calls for service directly related to Cruz, five of which included specific concerns about his access to weapons given his mental state.[81] Taken together with the previous concerns in 2016, there was ample evidence that Cruz was in desperate need of psychiatric care and that, had he been placed under a psychiatric hold, he would have been adjudicated mentally defective, ordered to treatment, and prohibited from purchasing or possessing firearms.

Unfortunately, Parkland was but the latest in a long line of failures by numerous officials in several states to take the appropriate legal actions regarding a known and dangerously mentally ill individual. James Holmes, perpetrator of the 2012 movie theater shooting in Aurora, Colorado, had met with at least three mental health professionals at the University of Colorado prior to his act of violence.[82] At least one of those professionals was so concerned about Holmes' mental state and reports of homicidal thoughts that she reported her concerns to the campus Behavioral Evaluation and Threat Assessment (BETA) team and discussed her concerns with a campus police officer.[83]

However, when officers asked if the psychiatrist wanted to place Holmes under a 72-hour psychiatric hold, she declined, apparently in part because Holmes was withdrawing from the University and the BETA team would soon lack jurisdiction.[84] Unfortunately, had the psychiatrist requested the psychiatric hold, it appears likely that doctors would have seen the significant evidence that Holmes was in a state of severe and potentially dangerous mental instability and would have begun the process of seeking a long-term mental health commitment.[85] Similar failures occurred in the cases of, among others, Jared Loughner, Seung-Hui Cho, Travis Reinking, and Eliot Rodger.[86]

If states are to effectively utilize their own mental health–commitment procedures, they need to ensure that they have adequate numbers of public psychiatric beds to accommodate individuals ordered to treatment or otherwise seeking treatment. Currently, health policy experts generally place the minimum number of inpatient beds necessary to adequately meet the needs of a state's population at between 40 to 60 beds per 100,000 people.[87] On average, states provide roughly 11.7 beds per 100,000 people—woefully inadequate by most estimations.[88] In the first quarter of 2016, the latest date for which reporting is available, only two states maintained more than 20 beds per 100,000 people, while four states maintain fewer than five beds per 100,000 people.[89]

This inadequate ratio of psychiatric beds causes serious problems for both the mental health and criminal justice systems. Numerous studies show that longer periods between the onset of symptoms and the initiation of treatment are associated with poorer prognoses and worse overall outcomes.[90] It should absolutely worry us that, currently, estimates of the average duration of untreated psychosis range from 61 to 166 weeks.[91] As the number of inmates in need of forensic beds increases, the number of beds available for long-term treatment required by non-criminal mentally ill individuals decreases, leaving many individuals in serious need of treatment on long waiting lists, allowing them to grow sicker—and in some cases, violent—before beds open up.[92] This can have catastrophic results, as shown by the 2007 case of David Logsdon. Logsdon had been committed to a mental hospital in 2005 for suicidal actions but was released after just six hours because of a shortage of beds in Missouri's public psychiatric hospitals.[93] He did not receive any more mental health treatment, and his condition deteriorated to the point that he killed his neighbor, then used her rifle to shoot randomly at people in a crowded mall parking lot.[94] Two people were killed in the parking lot and another seven were wounded before a police sharpshooter ended the would-be massacre.[95]

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Congress can help move this process along by revising the "Institutions for Mental Disease (IMD) Exclusion" provision of the Social Security Act, which largely prohibits Medicaid from reimbursing states for adults with mental illness between the ages of 22 and 64 who receive long-term care in a psychiatric hospital or facility with more than 16 beds.[96] In 2016, the effects of the IMD Exclusion were limited by legislation that allowed "Medicaid-managed care organizations" to provide IMD coverage for an enrollee up to 15 days per month—still well under the normal length of stay for many inpatient facilities.[97] Revisions to the IMD Exclusion should discourage states from closing long-term-care facilities while still ensuring that states do not exploit the availability of federal resources to shift state costs to the federal government.

Even when the resources are not available to immediately increase the number of beds, states are not without options for facilitating the process of getting the severely mentally ill to the first available psychiatric beds. In 2014, Virginia established a registry of

available beds in public and private psychiatric clinics to help law enforcement and mental health officials find placements for individuals requiring temporary detentions as the result of a serious mental illness.[98] Moreover, while the up-front costs of providing adequate numbers of public psychiatric beds and strengthening a commitment to providing appropriate mental health treatment may seem daunting, they pale in comparison to the long-term costs of shifting the burden of housing and treatment to the criminal justice system,[99] not to mention the human and economic costs associated with crimes committed by these individuals.

States that do not have Assisted Outpatient Treatment should consider establishing legal frameworks for this intermediate step between voluntary treatment and inpatient commitment.

Finally, states that do not have or otherwise underutilize Assisted Outpatient Treatment (AOT) should consider establishing legal frameworks for this intermediate step between voluntary treatment and inpatient commitment. AOT laws vary by state, but generally allow judges to, after due-process hearings, order individuals with serious, untreated mental illness who meet specific, narrow criteria to participate in mandated, monitored mental health treatment while still living in the community. This has proven to be a very effective option when implemented properly.[100] Like the measures outlined above, the long-term economic benefits of more fully utilizing AOT far outweigh any up-front costs.

Conclusion

Deinstitutionalization started with the best of intentions, but its disastrous consequences continue to put lives in danger and devastate communities. While individuals with milder forms of mental illness can and often do thrive outside of mental institutions, there are, quite simply, too few beds of last resort for individuals with severe mental illness who suffer in the aftermath of deinstitutionalization. They are too often reinstitutionalized in the nation's jails and prisons, where they are more likely to be victimized or to have their mental states further deteriorate.

Further, enforcement of current mental health mechanisms is often too lax and allows individuals who are known to be dangerous to themselves or others to access firearms legally by failing to properly disqualify them from purchasing those firearms through legal means. This has been a primary factor in many otherwise preventable mass public shootings. In order to help combat the effects of deinstitutionalization, states should:

- Ensure that law enforcement officers and other first responders are properly trained in best practices for interacting with mentally ill individuals;
- Invest in adequate treatment programs for prisoners with mental health issues;
- Provide adequate numbers of public psychiatric beds so that individuals in the midst of mental health crises have ready access to appropriate treatment facilities; and
- Strengthen involuntary civil commitment and mandatory outpatient treatment laws without neglecting due process.

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Endnotes

1. *See* Sara G. Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness*, 66 Case W. Reserve L. Rev. 657, 662–63 (2016), https://scholars.law.unlv.edu/cgi/viewcontent.cgi?referer=https://www.bing.com/&httpsredir=1&article=1934&context=facpub; Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 Psychiatry 30, 31–32 (2010), http://europepmc.org/articles/PMC3392176; Ellen Holtzman, *A Home Away from Home*, 43 Monitor on Psychol. 24 (2012), http://www.apa.org/monitor/2012/03/asylums.aspx.
2. *See* Testa & West, *supra* note 1, at 32.
3. E. Fuller Torrey, American Psychosis 19 (2014).
4. *Id*.
5. *See* Patricia D'Antonio, *History of Psychiatric Hospitals*, U. Penn. School of Nursing, https://www.nursing.upenn.edu/nhhc/nurses-institutions-caring/history-of-psychiatric-hospitals/ (last visited Apr. 30, 2018).
6. *Id*.
7. *See* Holtzman, *supra* note 1.
8. E. Fuller Torrey et al., No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals, Treatment Advocacy Ctr. (July 19, 2012), http://www.treatmentadvocacycenter.org/storage/documents/no_room_at_the_inn-2012.pdf.
9. *See generally*, Clayton E. Cramer, *Mental Illness and the Second Amendment*, 46 Conn. L. Rev. 1301, 1325–1331 (May 2014).
10. It is difficult to overstate the horror of the regrettable and callous positions of many prominent individuals regarding proper treatment of the mentally ill during the early 20th century, including the advocation of eugenics and sterilization. By the 1920s, many states had enacted compulsory sterilization procedures that were unfortunately upheld by the Supreme Court in the infamous 1927 case of *Buck v. Bell*, in which Justice Oliver Wendell Holmes, writing for the majority, stated: "It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind... Three generations of imbeciles is enough." *Buck v. Bell*, 274 U.S. 200, 207 (1927). By 1963, over 63,000 sterilizations had been performed on individuals in the United States suffering from chronic mental illness. *See* Justin L. Joffe, *Don't Call Me Crazy: A Survey of America's Mental Health System*, 91 Chi-Kent L. Rev. 1145 (2016), https://scholarship.kentlaw.iit.edu/cgi/viewcontent.cgi?referer=https://www.bing.com/&httpsredir=1&article=4140&context=cklawreview. And in 1972, a young reporter named Geraldo Rivera did an exposé entitled "Willowbrook: The Last Disgrace" that brought the nation's attention to the opprobrious conditions that existed at a state facility on Staten Island in New York. *See* Matt Reiman, *Willowbrook, The Institution That Shocked a Nation into Changing Its Laws*, Timeline (June 14, 2017), https://timeline.com/willowbrook-the-institution-that-shocked-a-nation-into-changing-its-laws-c847acb44e0d.
11. *See* Sally Satel & E. Fuller Torrey, *A Prescription for Mental-Health Policy* 6, Nat'l Affairs (2016).
12. *See id*.; Joffe, *supra* note 10, at 1152; Testa & West, *supra* note 1, at 33. It is also worth noting that, during this time, the views of Dr. Thomas Szasz were becoming increasingly popular as well. Szasz, a psychiatrist, was a well-known social critic of the moral and scientific underpinnings of psychiatry, arguing in several influential books that, with the exception of a few identifiable brain diseases, mental illness was a myth and a metaphor for standard human life problems, and the use of medication to treat mental illness was often a form of social control. *See* The Myth of Mental Illness (1961), The Manufacture of Madness (1970), and Ceremonial Chemistry (1973). His views were never taken seriously by the academic world or government officials, but they did gain some support from laymen.
13. *See* Joffe, *supra* note 10, at 1152; Testa & West, *supra* note 1, at 32.
14. The Act's stated purpose was to "provide assistance in combating mental retardation through grants for construction of research centers and grants for facilities for the mentally retarded and assistance in improving mental health through grants for construction of community mental health centers, and for other purposes." *See* Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Pub. L. 88–164 (1963), https://www.gpo.gov/fdsys/pkg/STATUTE-77/pdf/STATUTE-77-Pg282.pdf. Title II of the act authorized grants for constructing public and nonprofit community mental health centers: $35,000,000 for fiscal year (FY) 1965, $50,000,000 for FY 1966, and $65,000,000 for FY 1967. *Id*. In his speech accompanying the Act's signing, President Kennedy explained the grand vision for the act: "Under this legislation, custodial mental institutions will be replaced by therapeutic centers. It should be possible, within a decade or two, to reduce the number of patients in mental institutions by 50 percent or more. The new law provides the tools with which to accomplish this." Press Release*, Remarks of the President at the Signing of S. 1576 Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 in the Cabinet Room*, Office of the White House Press Secretary (Oct. 31, 1963), https://www.jfklibrary.org/Asset-Viewer/Archives/JFKPOF-047-045.aspx.
15. *See* Torrey, *supra* note 8, at 17; Cramer, *Mental Illness and the Second Amendment*, *supra* note 9, at 1329.
16. *See* Gordon, *supra* note 1, at 666–68; Cramer, *Mental Illness and the Second Amendment*, *supra* note 9.
17. From the earliest times of organized governance, the state has been presumed to have the power to intervene on behalf of the best interests of citizens who are not mentally or physically capable of acting in their own best interests. In the context of the severely mentally ill, the power of *parens patriae* traditionally "obligates the state to care for people whose mental illness renders them unable to make appropriate medical decisions for themselves." Gordon, *supra* note 1, at 664.
18. *Id*. at 668–73.

19. 422 U.S. 563 (1975).
20. *Id*. at 575–76 ("A finding of 'mental illness' alone cannot justify a State's locking up a person against his will and keeping him indefinitely in simple custodial confinement.... [T]here is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.... Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty. In short, a State cannot constitutionally confine without more a [sic] nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.").
21. 441 U.S. 418 (1979).
22. *Id*. at 433 ("Having concluded that the preponderance standard falls short of meeting the demands of due process and that the reasonable-doubt standard is not required, we turn to a middle burden of proof that strikes a fair balance between the rights of the individual and the legitimate concerns of the state.... [D]etermination of the precise burden equal to or greater than the 'clear and convincing' standard which we hold is required to meet due process guarantees is a matter of state law....").
23. *See* Jennifer Colangelo, *The Right to Refuse Treatment for Mental Illness*, 5 Rutgers J. L. & Pub. Pol'y 492 (2008). Some states, like New York and Massachusetts, have laws or constitutional provisions that have imposed even more barriers for the government to overcome in forcibly medicating individuals who are involuntarily committed to mental institutions, such as requiring a full judicial process instead of an administrative hearing. See Rogers v. Okin, 738 F.2d 1 (1st Cir. 1984) (finding that Massachusetts law "requires judicial process for determining whether an involuntarily committed mentally ill patient is incompetent to make his own treatment decision"); Rivers v. Katz, 495 N.E.2d 337 (N.Y. 1986) (holding that under New York law, "there must be a judicial determination of whether the patient has the capacity to make a reasoned decision with respect to proposed treatment before the drugs may be administered pursuant to the State's *parens patriae* power. The determination should be made at a hearing following exhaustion of the administrative review procedures.... The State would bear the burden of demonstrating by clear and convincing evidence the patient's incapacity to make a treatment decision.").
24. Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914).
25. 494 U.S. 210, 227 (1990) ("We hold that, given the requirements of the prison environment, the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest."). The State's procedures for determining whether forcible medication was necessary, which utilized an independent lay advisor who "understands the psychiatric issues involved," provided sufficient due process. *Id*. at 236.
26. *See* Joffe, *supra* note 10, at 1153. *See also*, Torrey, *supra* note 3, at 91 ("Thus, in 1981, as the last remnants of the federal mental health centers program were being block-granted to the states, its failure was complete.... Dr. Donald Langsley, who had been the director of the highly regarded Sacramento Count CMHC, similarly reflected: 'Those of us who were once so enthusiastic now weep a little as we look backwards at what has happened to the promising child of the 1960s and early 1970s.'").
27. Doris A. Fuller et al., *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds, 2016*, Treatment Advocacy Ctr. (June 2016), http://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf.
28. The OECD is an intergovernmental organization to "promote policies that will improve the economic and social well-being of people around the world" by "provid[ing] a forum in which governments can work together to share experiences and seek solutions to common problems." *The Organization for Economic Co-operation and Development (OECD): Our Mission*, Org. Econ. Cooperation & Development (last visited Aug. 17, 2018), http://www.oecd.org/about/. As of 2018, there are 35 member countries: Australia, Austria, Belgium, Canada, Chile, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, the Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey, the United Kingdom, and the United States. *Members and Partners*, Organization for Economic Cooperation and Development (last visited Aug. 15, 2018), http://www.oecd.org/about/membersandpartners/.
29. Fuller et al., *Going, Going, Gone*, *supra* note 27, at 2. According to 2011 estimates, the United States placed only ahead of New Zealand (20 beds per 100,000); Chile (14 beds per 100,000); Italy (10 beds per 100,000); Turkey (6 beds per 100,000); and Mexico (4 beds per 100,000). Emily Hewlett & Valerie Moran, Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care, Figure 3.1, https://read.oecd-ilibrary.org/social-issues-migration-health/making-mental-health-count_9789264208445-en#page113. Latvia did not become an OECD member until 2016 and is therefore not included in the report. Of further concern is the fact that, for most OECD countries, "relatively low rates of psychiatric care beds usually reflect a strong policy emphasis on community-based mental health care." *Id*. For example, Italy has a low rate of in-patient psychiatric beds but "has historically demonstrated significant leadership in moving mental health care... to institutions in the community." *Id*. But according to a 2011 World Health Organization report, the United States' per capita placement availability for community residential facilities is only slightly higher than it is for inpatient beds in psychiatric hospitals, while the availability of mental health outpatient facilities is only 1.95 facilities for every 100,000 people. World Health Organization, Mental Health Atlas 2011: United States of America (2011), http://www.who.int/mental_health/evidence/atlas/profiles/usa_mh_profile.pdf.
30. Fuller et al., *Going, Going, Gone*, *supra* note 27, at 7.
31. *See* Carolyn Reinach Wolf & Jamie A. Rosen, *Missing the Mark: Gun Control Is Not the Cure for What Ails the U.S. Mental Health System*, 104 J. Crim. L. & Criminology 851, 869 (2015). While few states' budgets were unaffected by the economic downturn during those years, almost 25 percent of the cumulative reduction in mental health spending was from the combination of cuts seen in California ($587.4 million cut between 2009 and 2011), New York ($132 million cut between 2009 and 2011), and Illinois ($113.7 million cut between 2009 and 2011). *See* Nicole Fisher, *Mental Health Loses Funding as Government Continues Shutdown*, Forbes (Oct. 10, 2013, 12:06 PM); Michael Ollove, *Easiest Path to Mental Health Funding May Be Medicaid Expansion*, Stateline (Jan. 18, 2013).

32. *See* Clayton Cramer, *Madness, Deinstitutionalization & Murder*, 13 Engage 37 (2012), https://fedsoc.org/commentary/publications/madness-deinstitutionalization-murder; Gordon, *supra* note 1, at 660–668; Cramer, *Mental Illness and the Second Amendment*, *supra* note 9, at 1331–1335. This is not to say that deinstitutionalization has been a complete disaster for individuals with mild-to-moderate mental illness and who have strong support systems from their families and communities. As E. Fuller Torrey notes, "Many of those with less severe symptoms and with awareness of their need for medication have done reasonably well, especially if they live in areas where rehabilitative programs are available. The employment of mentally ill individuals by state or county mental health agencies has been especially successful." Torrey, American Psychosis, *supra* note 3, at 115.
33. *See* Cramer, *Mental Illness and the Second Amendment*, *supra* note 9, at 1330. *See also*, Torrey, American Psychosis, *supra* note 3, at 128–31 (describing how the increasing numbers of homeless individuals with serious mental illness has impacted traditional community spaces, such as shopping centers, parks, and public libraries).
34. Torrey, American Psychosis, *supra* note 3, at 102.
35. One 2014 study found that more than half of those inmates who reported taking medication for a mental health condition at intake also reported that they did not continue receiving this medication while incarcerated. Jennifer M. Reingle Gonzalez & Nadine M. Connell, *Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity*, 104 Am. J. Pub. Health 2328 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4232131/. An investigation by journalist Alissa Roth into the mental health treatment afforded to prisoners revealed that, in Oklahoma, "if you are not actively suicidal or actively psychotic, you're not going to get to see a psychiatrist—or you're not going to get to see a psychiatrist for months, and months and months." Ailsa Chang, *'Insane': America's 3 Largest Psychiatric Facilities Are Jails*, NPR (Apr. 25, 2018), https://www.npr.org/sections/health-shots/2018/04/25/605666107/insane-americas-3-largest-psychiatric-facilities-are-jails.
36. Jennifer Bronson & Marcus Berzofsky, Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011–2012, Bureau of Justice Statistics (June 2017), https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf. This percentage has been increasing substantially over the past few decades. Department of Justice surveys in 1998 reported that 16 percent of state prison and local jail inmates "reported either a mental condition or an overnight stay in a mental hospital." Torrey, American Psychosis, *supra* note 3, at 110. Those same estimates averaged 5 percent throughout the 1970s and 10 percent throughout the 1980s. *Id*.
37. Doris J. James & Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, Bureau of Justice Statistics Special Report NCJ 213600 (Sept. 2006), https://www.bjs.gov/content/pub/pdf/mhppji.pdf.
38. Fuller et al., *Going, Going, Gone*, *supra* note 27.
39. In Broward County Jail in 2007, the cost per non–mentally ill inmate was $80 per day compared to $130 a day for mentally ill inmates. Washington estimated that, in 2009, the most seriously mentally ill prisoners cost $101,653 each, compared to approximately $30,000 per non–mentally ill prisoner. The Corrections Center of Northeast Ohio reported that nearly half of its medical budget was dedicated to providing psychotropic medications to approximately 25 percent of its inmates. Torrey, American Psychosis, *supra* note 3, at 119.
40. In Florida's Orange County Jail, the average stay for all inmates is 26 days; for mentally ill inmates, it is 51 days. Torrey, American Psychosis, *supra* note 3, at 118. In New York's Riker's Island Jail, the average stay for all inmates is 42 days; for mentally ill inmates, it is 245 days. *Id*.
41. DJ Jaffe, Insane Consequences: How the Mental Health Industry Fails the Mentally Ill 48 (2017).
42. *See* Nancy Wolff et al., *Rates of Sexual Victimization in Prison for Inmates With and Without Mental Disorders*, 58 Psychiatric Servs. 1087 (2007) (finding that 15.1 percent of male inmates with a mental disorder reported being sexually victimized over a six-month period compared with 8.9 percent of male inmates without a mental disorder, while 27.2 percent of female inmates with a mental disorder reported sexual victimization over a six-month period compared to 20.9 percent of female inmates without a mental disorder). It also appears that inmates with serious mental illness are particularly vulnerable to experiencing the use of excessive or punitive force by prison and jail staff, in part because staff are often ill-trained on recognizing and handling the symptoms of mental illness. Human Rights Watch, Callous and Cruel: Use of Force Against Inmates with Mental Disorders in US Jails and Prisons (May 12, 2015), https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and.
43. *Id*. at 6–7.
44. Torrey et al., No room at the Inn, *supra* note 8, at 11–12.
45. *See* Jaffe, *supra* note 41, at 80; Fuller et al., *Going, Going, Gone*, *supra* note 27, at 5.
46. Fuller et al., *Going, Going, Gone*, *supra* note 27, at 5.
47. Torrey, American Psychosis, *supra* note 3, at 121.
48. E. Fuller Torrey, *Justifiable Homicides by Law Enforcement Officers: What Is the Role of Mental Illness?*, Treatment Advocacy Ctr. (Sept. 2013), http://www.treatmentadvocacycenter.org/storage/documents/2013-justifiable-homicides.pdf.
49. *See* Darren DaRonco & Carli Brosseau, *Many in Mental Crisis Call Tucson Police*, Arizona Daily Star (Apr. 14, 2013), https://tucson.com/news/local/crime/many-in-mental-crisis-call-tucson-police/article_a03800d9-6608-5907-9fc4-74ad7f9c441a.html.
50. Torrey, American Psychosis, *supra* note 3, at 122.
51. *Id*. at 122–23
52. Linda Goldston, *Former Cops Changing Way Santa Clara County Deals with Mentally Ill in Crisis*, Mercury News (Nov. 4, 2010), https://www.mercurynews.com/2010/11/04/former-cops-changing-way-santa-clara-county-deals-with-mentally-ill-in-crisis/.

53. Kelley Bouchard, *Across Nation, Unsettling Acceptance When Mentally Ill in Crisis Are Killed*, Portland Press Herald (Dec. 9, 2012), https://www.pressherald.com/2012/12/09/shoot-across-nation-a-grim-acceptance-when-mentally-ill-shot-down/.
54. *Id.*
55. *Id.*
56. Jeff Proctor, *Database to Warn Cops of Dangers*, Albuquerque Journal (Updated May 25, 2012 at 2:10pm), https://www.abqjournal.com/104243/database-to-warn-cops-of-dangers.html.
57. Torrey, *Justifiable Homicide*, *supra* note 48, at 7.
58. Bouchard, *supra* note 53.
59. *See* Barnard E. Harcourt, *From the Asylum to the Prison: Rethinking the Incarceration Revolution*, 84 Tex. L. Rev. 1751 (2006); Torrey, *No Room at the Inn*, *supra* note 8, at 17–18.
60. *See* Cramer, *Madness, Deinstitutionalization & Murder*, *supra* note 9; Jaffe, *supra* note 41, at 48–49.
61. Bernard E. Harcourt, *From the Asylum to the Prison: Rethinking the Incarceration Revolution—Part II: State Level Analysis* (University of Chicago Law & Economics, Olin Working Paper No. 335, Public Law Working Paper No. 155, March 2007), *available at* http://ssrn.com/abstract=970341.
62. This is certainly not the first time researchers have noticed the link between institutionalization rates of the mentally ill and the number of individuals in prison—as early as 1939, "Penrose's Law" declared that the number of individuals in a given society's mental institutions is inversely related to the number of individuals in that same society's prison system. *See* David B. Kopel & Clayton E. Cramer, *Reforming Mental Health Law to Protect Public Safety and Help the Mentally Ill*, 58 How. L. J. 716, 747 (2015). Unfortunately, many of these prisons are not designed to adequately provide for the needs of severely and chronically mentally ill inmates, which can exacerbate existing symptoms and increase the risk of future violence.
63. Fred E. Markowitz, *Psychiatric Hospital Capacity, Homelessness, and Crime and Arrest Rates*, 44 Criminology 45 (2006).
64. Steven P. Segal, *Civil Commitment Law, Mental Health Services, and US Homicide Rates*, 47 Social Psychiatry & Psychiatric Epidemiology 1449 (2011).
65. Fuller et al., *Going, Going, Gone*, *supra* note 27, at 15 ("These are relatively weak statistical associations but, given the many possible causes of increased violence, it is surprising to see even a weak association emerge.").
66. *See* Segal, *supra* note 64. *See also* M. M. Large et al., *The Danger of Dangerousness: Why We Must Remove the Dangerousness Criterion from our Mental Health Acts*, 34 J. Med. Ethics 877 (2008); Gordon, *supra* note 1.
67. *See* Segal, *supra* note 64.
68. *See* Gordon, *supra* note 1.
69. *See* Sari Horwitz, Leslie Minora & Marc Fisher, *Before Navy Yard Shooting, Alleged Gunman Heard Voices and Sought Help*, Wash. Post (Sept. 17, 2018), https://www.washingtonpost.com/local/before-navy-yard-shooting-alleged-gunman-heard-voices-and-sought-help/2013/09/17/874970d8-1fd2-11e3-94a2-6c66b668ea55_story.html?utm_term=.73a8e6d02610.
70. *Navy Was Told of Aaron Alexis "Hearing Voices" Incident Last Month*, CBS News (Sept. 18, 2013) [hereinafter *Navy Was Told of Aaron Alexis*], https://www.cbsnews.com/news/navy-was-told-of-aaron-alexis-hearing-voices-incident-last-month/.
71. Alexis was arrested by Seattle police in 2004 after firing three bullets into the tires of a car construction workers had parked near his house. *Id.* He told officers he had suffered "a blackout fueled by anger," but was never charged because relevant paperwork was misplaced. *Id.* In 2008, he was arrested in Georgia after damaging furniture in a nightclub and cursing at employees who ordered him to leave. Two years later, he was arrested in Fort Worth, Texas, for firing a bullet through his upstairs neighbor's apartment floor. During Alexis' four years in the Navy Reserve, he was cited for misconduct on eight occasions, but received an honorable discharge despite reports that the service initially sought a general discharge. *Id.*
72. Rhode Island law is unclear in this regard, as the wording indicates that emergency involuntary commitment can only occur when leaving the individual at-large "would create an imminent likelihood of serious harm by reason of mental disability." However, as Kopel and Cramer note, the only relevant case law on the topic in Rhode Island deals with lawsuits against hospitals that were alleged to have improperly failed to commit individuals who later caused harm, and not lawsuits where hospitals allegedly committed individuals absent sufficient cause. *See* Kopel & Cramer, *supra* note 62, at n.214.
73. *See* Ariz. Rev. Stat. § 36-501.
74. This is even more likely given reports from several friends that Alexis would sometimes go for days without sleep and was increasingly withdrawn. *See* Horwitz, Minora & Fisher, *supra* note 69.
75. *Navy Was Told of Aaron Alexis*, *supra* note 70.
76. Patricia Mazzei, *School Officials Wanted Florida Gunman Committed Long Before a Massacre*, N.Y. Times (Mar. 18, 2018), https://www.nytimes.com/2018/03/18/us/nikolas-cruz-baker-act.html; Audra D. S. Barch, Frances Robles & Patricia Mazzei, *Florida Agency Investigated Nikolas Cruz After Violent Social Media Posts*, N.Y. Times (Feb. 17, 2018), https://www.nytimes.com/2018/02/17/us/nikolas-cruz-florida-shooting.html.
77. Mazzei, *supra* note 76.
78. *Id.*

79. Matthew Haag & Serge F. Kovaleski, *Nikolas Cruz, Florida Shooting Suspect, Described as a 'Troubled Kid'*, N.Y. Times (Feb. 14, 2018), https://www.nytimes.com/2018/02/14/us/nikolas-cruz-florida-shooting.html.
80. Del Quentin Wilber et al., *Months Before Florida Shooting, 911 Calls Show a Teenager in Crisis*, Wall St. J. (updated Feb. 23, 2018, 11:59 PM ET), https://www.wsj.com/articles/months-before-florida-shooting-911-calls-show-a-teenager-in-crisis-1519423400; Merris Badcock, *Parkland Shooter Nikolas Cruz Recorded During 911 Call in Palm Beach County*, WPTV 5 (updated Feb. 23, 2018), https://www.wptv.com/news/region-c-palm-beach-county/lantana/parkland-shooter-nikolas-cruz-recorded-during-911-call-in-palm-beach-county.
81. *See* Brett Murphy & Maria Perez, *Florida School Shooting: Sheriff Got 18 Calls about Nikolas Cruz's Violence, Threats, Guns*, USA Today (updated Feb. 23, 2018 1:11 p.m. ET), https://www.usatoday.com/story/news/nation-now/2018/02/23/florida-school-shooting-sheriff-got-18-calls-cruzs-violence-threats-guns/366165002/.
82. *See James Holmes Saw Three Mental Health Professionals Before Shootings*, CBS News (Sept. 19, 2012), https://www.cbsnews.com/news/james-holmes-saw-three-mental-health-professionals-before-shooting/.
83. *See* Allison Sylte & Brandon Rittiman, *Theater Shooter's Psychiatrist Found His Behavior Bizarre*, USA Today (June 16, 2015), https://www.usatoday.com/story/news/nation/2015/06/16/aurora-theater-shooting-psychiatrist/28812505/. Under Colorado law, this action is considered a serious breach of a psychiatrist's duty of confidentiality unless the patient has made serious threats of violence against an identifiable individual, and it is the psychiatrist's professional opinion that the patient is likely to act on those threats. *See* CO Rev. Stat. § 12-43-218 (2016). The fact that the psychiatrist actually reported her concerns indicates she believed these conditions were met, underscoring the serious nature of the concerns.
84. Jeremy P. Meyer, *Source: Psychiatrist Rejected Offer to Put James Holmes on Psych Hold*, Denver Post (updated Apr. 28, 2016 at 6:58 pm), https://www.denverpost.com/2012/12/05/source-psychiatrist-rejected-offer-to-put-james-holmes-on-psych-hold/; Mark Greenblatt & Enjoli Francis, *Psychiatrist Called Threat Team About Aurora Shooting Suspect James Holmes*, ABC News (Aug. 1, 2012), https://abcnews.go.com/US/james-holmes-psychiatrist-schools-threat-assessment-team/story?id=16908862.
85. This seems particularly likely given that Holmes' defense at his criminal trial rested on a plea of not guilty by reason of insanity.
86. *See* John G. Malcolm & Amy Swearer, *Part I: Mental Illness, Firearms, and Violence*, Heritage Found. Legal Memorandum No. 239, at 6–8 (Jan. 31, 2019), http://report.heritage.org/lm239.
87. *See* Fuller et al., *Going, Going, Gone*, *supra* note 27, at 3.
88. *Id.*
89. *Id.* at 13.
90. *See, e.g.*, Jean Addington et al., *Duration of Untreated Psychosis in Community Treatment Settings in the United States*, 66 Psychiatric Servs. 753 (2015), https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201400124; Diana Perkins et al., *Relationship Between Duration of Untreated Psychosis and Outcome in First-Episode Schizophrenia: A Critical Review and Meta-Analysis*, 162 Am. J. Psychiatry 1785 (2005), https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201400124; Max Marshall et al., *Association Between Duration of Untreated Psychosis and Outcome in Cohorts of First-Episode Patients*, 62 Arch. Gen. Psychiatry 975 (2005), https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1108403.
91. See studies cited in Addington et al., *supra* note 89, at n. 6–10.
92. Take, for example, the recent experiences of the Delta County, Colorado, Sheriff's Department in attempting to secure adequate mental health treatment for a low-level offender in the midst of an acute mental health crisis. *See* Gabrielle Porter, *No Center In State Will House Inmate In 'Acute Mental Crisis'*, The Daily Sentinel (Oct. 12, 2018), https://www.gjsentinel.com/news/western_colorado/no-center-in-state-will-house-inmate-in-acute-mental/article_621baa66-cddc-11e8-9665-10604b9f6eda.html. In an open letter to reporters, Sheriff Fred McKee detailed the months-long saga in which all 12 facilities in the state meeting appropriate criteria refused to accept the severely mentally ill man, claiming to be full despite the fact that one mental health care provider described the man as "the most seriously mentally ill person she has ever worked with." *Id.* A judge's order stated that long-term care was appropriate and allowed the man to be temporarily given emergency treatment at a local hospital, but the sheriff said he expected the man to be back in the jail facilities within 24 hours. *Id.*
93. *See* Cramer, *Madness, Deinstitutionalization & Murder*, *supra* note 32, at 38.
94. *Id.* Maria Sudekum Fisher, *Police: Mo. Mall Shooter Planned 'Havoc'*, Wash. Post (Apr. 20, 2007), http://www.washingtonpost.com/wp-dyn/content/article/2007/04/30/AR2007043000193.html.
95. Logsdon managed to fire 31 rounds in the parking lot before being neutralized. Steve Bell & Laura Spencer, *Police Tapes Tell Mall Shooting Story*, KCUR 89.3 (last accessed Oct. 17, 2018), http://www.kcur.org/post/police-tapes-tell-mall-shooting-story#stream/0.
96. An "IMD" is defined as any "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." Social Security Act § 1905(a)(B).
97. *See* 81 C.F.R 27555–56 (2016), https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
98. This measure was enacted after a state senator's mentally ill son killed himself only hours after being released from emergency detention because officials were unable to find a hospital with an available bed. Unfortunately, the system appears to suffer from a number of problems, including a lack of effective and timely updates on available beds. *See* Michael Martz, *Report Says Psychiatric Bed Registry Not Updated Often Enough to Fulfill Purpose*, Richmond Times–Dispatch (Jan. 29, 2018), http://www.richmond.com/news/virginia/report-says-psychiatric-bed-registry-not-updated-often-enough-to/article_902ec883-9768-5205-a973-c85da40c0971.html.

99. According to Judge Steve Leifman, former Chair of the Supreme Court of Florida Task Force on Substance Abuse and Mental Health Issues in the Courts, in his testimony before Congress, the cost of burden-shifting to the criminal justice system is staggering. Citing a study conducted by the Florida Mental Health Institute at the University of South Florida, which analyzed arrest, incarceration, acute care, and inpatient service utilization rates among 97 "frequent recidivists" in Miami-Dade County, "over a five-year period, these individuals accounted for nearly 2,200 arrests, 27,000 days in jail, and 13,000 days in crisis units, state hospitals, and emergency rooms. The cost to the community was conservatively estimated at $13 million with no demonstrable return on investment in terms of reducing recidivism or promoting recovery. Comprising just five percent of all individuals served by problem-solving courts targeting people with mental illnesses, these individuals accounted for nearly one[-]quarter of all referrals and utilized the vast majority of available resources." Statement of Judge Steve Leifman, Substance Abuse and Mental Health Issues in the Courts, before the Subcommittee on Oversight and Investigations of the Energy and Commerce Committee of the U.S. House of Representatives, https://docs.house.gov/meetings/IF/IF02/20140326/101980/HHRG-113-IF02-Wstate-LeifmanS-20140326.pdf. Further, DJ Jaffe notes: "The failure to focus funds on the seriously mentally ill causes the most seriously ill to cycle in and out of the most expensive settings: jails, prisons, and hospitals. The former president of the American Psychiatric Association found in Maryland that just five hundred 'high utilizer' patients accounted for 20 percent of the state's inpatient psychiatric costs and they have been treated in emergency rooms six or more times a year. Their average annual hospital bill was $72,000, $36.9 million, not including the cost of medications." *See* Jaffe, *supra* note 41, at 53. While five hundred individuals may not seem disproportionate without further context, there are estimated to be over 150,000 people with serious mental illness living in Maryland, meaning those five hundred individuals account for less than 0.4 percent of all persons with serious mental illness in the state. *See Maryland*, Treatment Advocacy Ctr. (last visited Jan. 24, 2019), https://www.treatmentadvocacycenter.org/browse-by-state/maryland.

100. *See* Jaffe, *supra* note 41, at App. D (presenting studies on the effectiveness of AOT in New York and elsewhere).