SAY THEIR NAMES

This work is dedicated in memory of

Jamarion Robinson (1990 - 2016), Porter Burks (2002 - 2022), Miles Hall (1996 - 2019), Dontre Hamilton (1983 - 2014), Terrence Coleman (1985 - 2016), Lavall Hall (1990 - 2015), Ezell Ford (1988 - 2014), Marvin Scott III (1994 - 2021), Jordan Neely (1992 - 2023), Felix David (1965 - 2015), Darren Rainey (1962 - 2012), Karl Taylor (1960 - 2015), Mubarak Soulemane (2000 - 2019), Micahel Noel (1983 - 2015), Anthony Hill (1988 - 2015), Jason Harrison (1979 - 2014), Alfred Olango (1978 - 2016), Walter Wallace Jr. (1993 - 2017), Larry Price Jr. (1970 - 2021), Lashawn Thompson (1987 - 2022), Terill Thomas (1974 - 2016), Marcus-David Peters (1991 - 2018), Keith Lamont Scott (1973 - 2016)

and all African Americans with mental health illness whose lives were lost due to America's failure to serve and protect her people.

May your stories inspire change.

Introduction

Darren Rainey, an African American man with schizophrenia, was forcibly placed in a tiny shower in the Dade Correctional Unit, Florida, in 2012. The temperature could only be controlled from the outside by correctional officers who increased it to 180 degrees Fahrenheit and locked him inside. Inmates reported hearing Rainey screaming to be let out, which correctional officers ignored. After two hours of torture, he would be found dead on the shower floor (Laughland, 2016). Unfortunately, Darren Rainey is not the only African American man with a serious mental illness to be abused by the United States criminal justice system. His death reflects a similar treatment of African Americans with mental health issues. Structural injustices in medical, carceral, and law enforcement institutions, mutually reinforce an oppressive outcome for African American men, creating an ecosystem of abuse. Historical perceptions of African Americans guided by pseudo-scientific conclusions of this group has largely shaped current racial bias that is present within modern institutions, making African Americans victims of arrest, incarceration, abuse, and deprivation of essential medical services. One such result of this injustice is the overdiagnosis of schizophrenia in which African American men are diagnosed 2.4 times more than Whites (Olbert et al., 2023). These harmful historical perceptions lead to racial injustice, further mental health and physical health decline and in some cases, like that of Darren Rainey, death. Racial injustices are ever omnipotent within these institutions despite recent efforts to address the underlying cause: implicit bias. However, these solutions have not been proven to be effective despite their enthusiastic implementation. Why are African American men overpathologized with the diagnosis of schizophrenia, how does it exemplify injustice within the medical, law enforcement and carceral fields and why are current solutions to this injustice so ineffective? This article seeks to answer this question.

History

To understand how bias against African Americans still prevails within institutions today, we must first understand its origins. “Race science” was heavily influential in the perception of African Americans, pushing the narrative that Africans were subhuman. The medical field would use this perception to justify dehumanizing African Americans (Bernier, 1684; The Linnean Society, n.d.; Smith, 2021).

Race Science

The pursuit of science and research is celebrated and praised in Western society. Its merits include curing disease, advancing technology, improving our understanding not only of the world but also of the universe, and saving countless lives. However, this praise is met with disdain and disgust by many who have suffered the consequences of its method of attaining this cosmic power: unethical research. Although Western science is perceived as superior and righteous, for its victims, it has caused illness, destroyed traditions, burned lineages along with culture out of history, and taken countless lives (Smith, 2021). The too-often glorified Western pursuit of knowledge has ruthlessly abused marginalized groups, particularly African Americans, by propagating the belief that they are inherently animalistic (Smith, 2021). This was all done through crude and inhumane experimentation in the name of a pseudoscience called “Race Science.”

Classification of Races

The concept of races originated in the archaic beginnings of what is now called scientific research. The classification of “races” was first introduced by the French explorer and scientist,Franccois Bernier, who coined the term in 1684. His theory of races was subsequently published in an early issue of “Journal des Savants,” and spread like wildfire in the research and scientific community. Carl Linnaeus, a Swedish scientist, would later be inspired by the concept of races in the 1750s and would write the tenth edition of “Systema Naturae.” This text would lay the foundation for Race Science, classifying what Linnaeus called the “Europaeus” (people of European origin) as “muscular” and “wise.” In contrast, he would describe “Africanus” (people of African origin) as “lazy” and “fat” and so insolently mentioned that their women had “breasts that lactated profusely” (The Linnean Society, n.d.). Anthropologists today still use “Linnaean Taxonomy” to classify species, immortalizing Linnaeus’s influence on the scientific community.

Social Darwinism

Another notable theory that supported Race Science is possibly the most well-known among the scientific community to this day: Darwin's theory of Natural Selection. This theory of "survival of the fittest," insofar as it posited observable differences among species, was unfortunately misapplied to variations within our own species. This would become the concept of "Social Darwinism," used to characterize different races of humans. The theory attributed "negative racial differences" as a result of Natural Selection, creating the common belief that lesser races should be left to die out. This can be observed within Britannica's ninth edition as it states that Africans are at the "lowest position of the evolutionary scale" (Encyclopaedia Britannica, 1884).Even so-called "extraordinary, leftist thinkers" like Clémence-Auguste Royer, a French scholar, would accept this theory as fact. Her book, "Origine de l'Homme et des Sociétés" would explain how "only the European branch of the Aryan family is capable of achieving the highest perfectibility" (Darwin Project, n.d.). As a translator of Darwin's work, Royer would use her profession as a means of twisting meaningful scientific discovery into a hateful perversion, contributing to the popularization of negative perceptions associated with Africans. Her mistranslation would shape not only the French perception of Darwin's theory, also of White Supremacy.

Just across the Atlantic Ocean, these theories of classification would pave the way for perceptions of African inferiority and the notion that Europeans were the most evolved race.

Perception that African Americans are Subhuman

The perception that Africans are less evolved than other races led to the placement of African Americans as a subordinate group of humans who were more akin to animals in the eyes of Whites. In many descriptions of Race Science, Africans are described as having smaller brains compared to Europeans based on a pseudoscience called craniometry. This idea was further reinforced in Britannica's ninth edition, which noted that African brain size was closer to that of a gorilla than to that of a European (Encyclopaedia Britannica, 1884). This inferred relation to animalistic traits among Africans made it more plausible for researchers and scientists to attribute higher reported crime rates in African Americans within the United States.

An example of this conjecture from Frederick Ludwig's writing, an American statistician, in his book "Race Traits and Tendencies of the American Negro" (1896) states, "...the criminality of the negro exceeds that of any other race…" (Hoffman, 1896). This increasingly popular rhetoric within the scientific community would create the stereotype of the African American criminal, rhetoric that remains popular.

Conclusions

The history of the treatment of African Americans in the United States had a powerful impact not only on its victims but on society as a whole. Although these events may seem distant and bygone, their influences and remnants are hardly antiquated. These perceptions of African Americans are a sediment in our history, compacted into our foundations, and can be observed in many concentrations (Olbert et al., 2023). Societal differences, diagnostic bias, and mass incarceration have scars of this history beneath the surface of their modernity.

Modern-Day Perceptions, Implicit Bias

Implicit bias as defined by the American Psychological Association (APA) is known as "implicit prejudice or implicit attitude, is a negative attitude, of which one is not consciously aware, against a specific social group" and further explains that implicit bias plays a role within implicit social cognition which can be defined as "the phenomenon that perceptions, attitudes, and stereotypes can operate before conscious intention or endorsement." (APA, 2018).

The brain interacts with many inputs constantly, and it is impossible for the mind to be conscious throughout all of this processing. For this reason, many of our thoughts and actions are processed through "nonconscious systems" or "...processes that do not themselves reach consciousness, although they may have consciously experienced outcomes' such as reflexes, startle responses, postural/balance adjustments,

habitual motor actions, "gut" reactions and most importantly for the given topic: implicit bias (Kandel et al., 2021; Forscher et al., 2019; LeDoux & Brown, 2017; Wood & Rünger, 2016). These systems are highly interconnected neurologically, as they operate continuously and do not require intention or attention, allowing these networks to strengthen more than other conscious neural network systems (Suri & McClelland, 2025).

This psychological phenomenon is a significant contributing factor in racially biased decision-making, particularly under conditions of stress, uncertainty, and time pressure, and is influenced by stereotypes that are perpetuated in society almost constantly.

Broader Notions of Implicit Bias

African Americans have historically been seen as animalistic or subhuman in White societies, and this bias still lives on in many fields. A study done in 2017 revealed that Americans believe that African Americans are more "physically formidable" and therefore are capable of causing more harm (Holmes et al., 2017). A study conducted in 2016 revealed that 40% of first-year medical students at the University of Virginia believed that "blacks' skin is thicker than whites'" (Hoffman et al., 2016). In a 2010 NORC survey, Whites were rated higher than African Americans in intelligence (44% vs. 30%) and work ethic (37% vs. 20%) (Opportunity Agenda, 2011*)*. Additionally, a study done by Harvard compared the perceptions that White teachers had for their White students as opposed to their African American students. The study found that 4.3% of White teachers believed that their White students were lazy, while almost 24% of White teachers believed that their African American students were lazy. Even more disturbing, about 20% of White teachers considered their White students to be violence-prone. In comparison, more than 50% of White teachers believed this about their African American students among children of only eight years or younger (Goff et al., 2014). This ubiquitous bias can perhaps answer the question of why African Americans receive higher diagnoses of schizophrenia among African American men. To examine this, it is necessary to further analyze the fields of medicine, law enforcement and incarceration.

Oppression in Psychiatry

Implicit Bias

Jerome Wakefield, a Professor of Psychiatry at NYU, suggests that psychiatrists run the risk of misdiagnosing individuals because of a lack of understanding of the causes. He explains how easy it can be for medical professionals to confuse normal distress with [mental] disorder, as "normal human distress contains many of the same symptoms of disorder" (Wakefield, 2010). Historically, African Americans have endured significant trauma and therefore a vastly different experience than White Americans in the United States. This distinction creates a barrier of understanding the American racial experience between these two racial groups. When a White psychiatrist assesses an African American, they often do not understand many of the societal implications that they face, and they conflate symptoms of an unjust society with symptoms of a disorder or illness. Additionally, only 10% of psychiatrists in the United States are African American, making it difficult for African Americans to receive competent care (PBS NewsHour, 2021). When considering Wakefield's theory, lack of consideration of the African American experience in the United States directly leads to misdiagnosis.

So if psychiatrists lack contextual information to make an accurate diagnosis, what do they use instead to fill in the gaps? Jack Glaser, a professor of social psychology at the University of California, Berkeley, argues that decision-makers exhibit implicit bias. Glaser states that in the absence of contextual information, people rely on their implicit biases and social conditioning to fill in the rest of the picture (Glaser, 2024). This can be observed in a famous study by economists Bertrand and Mullainathan (2004), titled "Are Emily and Greg More Employable Than Lakisha and Jamal?" (Bertrand & Mullanithan,2004).

Bertrand & Mullainathan conducted a study in which hiring managers were tasked with hiring applicants in two rounds: one before background checks and one after background checks were conducted. In the second round, when background checks were used, African Americans were hired more often. This study exemplifies Glaser's theory: when information about applicants was limited, hiring managers relied on

implicit biases to make decisions, thereby discriminating against African American applicants (Bertran & Mullanithan, 2004).

Implicit Bias and Schizophrenia

Avicenna, often considered the father of modern medicine, describes schizophrenia as "severe madness" in his book *Canon Medicinae* (1025 A.D.), which is revered as one of the foundational texts in the medical field (Avicenna, 1025). According to the DSM-5 (our modern-day Canon Medicinae), to be diagnosed with schizophrenia, a patient must display two of the following symptoms: delusions, hallucinations, disorganized speech and thinking, extremely disorganized or unusual motor behavior, and negative symptoms (American Psychiatric Association, 2013). However, in practice, it is critical to examine the manifestations of these symptoms in healthcare to understand their real-world implications.

Mental health professionals are often relied upon to assess mental health illnesses accurately. However, overpathologizing schizophrenia is disturbingly common within African American communities. According to a study done in 2023, "...black Americans are 2.4 times more likely to be diagnosed with [S]chizophrenia" (Olbert et al., 2023). This disparity can be attributed to the common practice of discretionary judgment, which leaves room for implicit bias to influence diagnostic decisions.

A comparative table has been constructed to understand the eerie comparison, as perceptions of race and the symptoms of schizophrenia happen to overlap. This comparison displays the potential for professionals, such as police officers and mental healthcare providers, to make connections between symptoms of their implicit bias and the symptoms of schizophrenia.

The 'Scary Black Man'	**Symptoms of schizophrenia**
Paranoid; stupid; cowardly; mentally disturbed	*Delusions* are fixed beliefs that are not amenable to change in light of conflicting evidence.
Paranoid; stupid; cowardly; mentally disturbed	*Hallucinations* are perception-like experiences that occur without an external stimulus.
Uneducated; unsophisticated; less evolved; stupid; illiterate	*Disordered Thinking (formal thought disorder)* is typically inferred from the individual's speech.
Uncivilized; uncontrollable; angry; dangerous	*Grossly disorganized or abnormal motor behavior* may manifest itself in a variety of ways, ranging from childlike "silliness" to unpredictable agitation.
Anti-social; evil; lazy; stupid	*Negative symptoms* account for a substantial portion of the morbidity associated with schizophrenia but are less prominent in other psychotic disorders. Two negative symptoms are particularly prominent in schizophrenia: diminished emotional expression and avolition.

(American Psychiatric Association, 2013)

In order to avoid this discrimination, it would be undeniably essential for African Americans with a mental health concern to visit a competent health care professional. It would be extremely pertinent for a careful selection to be made while the presence of implicit bias remains so rampant. However, this life-altering luxury is not afforded to many African Americans, especially those who are experiencing an SMI.

The Attempt to Receive Competent Medical Care

As African Americans face higher rates of poverty, many cannot afford private medical care or

even remain uninsured. According to a study done by the Kaiser Family Foundation in 2025, 9.7% of African Americans lack medical insurance while 6.5% of Whites face this issue (kffcarenec, 2025). The barrier of receiving medical insurance can be in-part attributed to job-linked insurance coverage which puts African Americans at a disadvantage as African Americans face systemic discrimination when applying to jobs that have such benefits. As a result, many African Americans rely on Medicaid, a program "designed to provide health coverage for low-income people" (Medicaid, 2025). This connection between African Americans and users of Medicaid can be demonstrated by this group making up 21% of Medicaid enrollees, while only representing 13% of the general population (Medicaid Awareness, 2024). Despite Medicaid's humanitarian mission, the program unfortunately does not have the capacity to achieve its ultimate goal.

The U.S. Department of Health and Human Services, Office of Inspector General (2025) reports that only 45% of behavioral health specialists were able to accept patients with insurance from Medicaid, Medicare, or Medicaid managed-care. This number plummets to 33% among Medicaid enrollees in rural communities (Medicaid Awareness, 2024). Another study found that one-third of psychotherapists in private practice did not accept any insurance at all (Zhu et al., 2024). Mental health providers are less likely to accept Medicaid because they incur a significant pay cut in doing so. The Medicaid and CHIP Payment and Access Commission (MACPAC) reports that mental health care providers lose about 17% of their earnings when being reimbursed by Medicaid due to administrative errors and denials. MACPAC also cites that health care professionals who provide long-term treatment, like psychiatry, more frequently deny Medicaid than Medicare or private insurance. Additionally, Medicaid displays outdated providers who are no longer in service, making the search for mental health care even more difficult (MACPAC, 2025).

Consequences of an Untreated SMI

Due to this disparity in access to medical care, African Americans are often unable to access critical medical mental health services needed for treatment of an SMI. Left untreated, those with SMIs are at higher risk of substance use and being unhoused and thus, being arrested. The high rate of unhousing and substance use among African Americans are undoubtedly a significant factor in their high rates of arrest. Deeply embedded ideas of the past are directly linked to a high risk of unhousing and drug abuse for African Americans, which leads to disproportionate abuse within the criminal justice system (Olbert et al., 2023; Kennedy, 2021).

Socioeconomic Drivers of Criminalization

The increased risk of arrest is not simply because of the disorder alone; rather, it stems from the everyday struggles associated with an SMI, such as drug use and unemployment. A study done in 2014 suggests that the risk factors associated with people with a SMI do not inherently come from the symptoms of a mental illness itself, but from the challenges brought upon by circumstances created by an SMI, for example, being unhoused (Skeem et al., 2014). Similarly, African Americans are not inherently more susceptible to poverty, being unhoused, or using drugs, but rates are higher due to systemic oppression and historical wealth distribution (The Century Foundation, 2020).

Unhousing

African Americans *and* individuals with an SMI are disproportionately affected by homelessness. The 2022 Annual Homeless Assessment reports that 21.1% of the unhoused population has a serious mental health condition (HUD, 2022). A 2022 study found that 28.2% of veterans with schizophrenia had experienced being unhoused (HUD, 2022). African Americans make up about 12% of the U.S. population but account for nearly one-third of the unhoused, according to the 2024 Annual Unhoused Assessment (HUD, 2024). These overlapping factors create significant challenges for African Americans with SMIs. While these statistics on their own are concerning, the fact that unhoused people are also more vulnerable to arrest makes the intersection even more alarming.

Substance Use

The NAACP cites that although African Americans only make up 5% of illicit substance users, this population represents 29% of those arrested for illicit substance use (NAACP, 2025). This statistic indicates how African Americans have harsher outcomes and are more targeted by the criminal justice system (Kennedy, 2021). Additionally, African Americans are more likely to self-medicate as many cannot access prescription medication (PBS NewsHour, 2021). Unfortunately, for many African Americans, the absence of accessible psychiatric care does not end in treatment, but in neglect—where untreated illness gives way to becoming unhoused or substance use, and the first real intervention comes only in the form of arrest, long after meaningful help could have been given.

Mental Health within the Inarceration System

African Americans lack access to medical care essential for treating an SMI due to underfunding and administrative errors within the Medicaid insurance system, leading to their first interaction with mental health services to be simultaneous with their first interaction with the incarceration system and often are forced to rely on that system for medical services.

Police Assessments of SMIs

A study done in 2018 indicates that police officers have three main ways of assessing mental illness: information from dispatch, collateral contacts, and using on-scene judgments based on their own understanding of mental illness (Bohrman, C., Wilson, A. B., Watson, A. C.,& Draine, J., 2018). However, most departments lack a standardized mental health screening tool, forcing officers to use their own personal knowledge of mental illness as a way to enforce the law. This type of assessment is highly discretionary, which has been proven to lead to more cases of racial implicit bias within policing. The San Mateo County 2023 Annual Program Summary underscores the outcome of such discretionary policing: 86% of detainees in the Acute Stabilization Unit were diagnosed with schizophrenia or schizoaffective Disorder, and nearly 30% were African American, despite African Americans making up only 2% of the county's general population (Liberty Healthcare Corporation, 2023).

Bookings within Jails

Jails are legally required to perform mental health screenings during bookings, resulting in many schizophrenia diagnoses as a result of becoming system-affected. As this is not a requirement for most other government systems in the United States and those with limited access to mental health services receive mental health examination only upon becoming system-affected. As demonstrated in Iowa, 99% of all mental health diagnoses within the incarcerated population were identified during incarceration (Al-Rousan et al., 2017). Substance Abuse and Mental Health Services Administration (SAMHSA) reports that 44% of those in jail suffer from a mental health issue, despite that proportion amounting to only 18% of the general population. This data implies that a significant portion of those arrested and diagnosed with an SMI did not receive mental health care before being arrested.

Within Prison Walls

Within the American incarceration system, the lives of African Americans have been disproportionately impacted, exemplified by the fact that "African Americans make up 13% of the U.S. population but 40% of its prison population" (Bureau of Justice Statistics, 2012). This harrowing disparity puts African American communities at a greater risk of facing the prison system's structural failures, such as inadequate mental health care and disproportionate abuse, which can leave this vulnerable group traumatized. Additionally, African Americans are far more likely to face further discriminatory abuse from prison personnel, making their experience while incarcerated even more damaging to their mental well-being, even after release.

Racial Disparity of Prison Population

Prisons are not equipped to deal with the large number of incarcerated people with poor mental health. A study done in 2018 indicates that correctional facility personnel felt that "there are too many inmates with SMI in jail who would benefit from more comprehensive treatment elsewhere" (Watson et al., 2018). The DOJ reports that 63% of incarcerated people who had a mental health indicator were not receiving treatment (Bureau of Justice Statistics, 2012). As African Americans represent a disproportionate amount of incarcerated people in the United States, that means that they are also disproportionately not receiving the medical care that they so desperately need. This intersection of racial bias and neglect is even more harmful to the community and points to a larger structural failure within the prison-industrial complex. African Americans are not being cared for within prisons, but when they are, they are being treated for mental health disorders that they do not have.

Abuse and Racism in Prison

Not only are African Americans at a high risk of suffering from societal factors like disproportionate unhousing and drug use, misdiagnosis, and inadequate care within prisons, but they are also re-traumatized by prison personnel, further deteriorating their mental health.An article in 2023 states that in a Washington D.C. prison, when incarcerated persons expressed feelings of suicidal ideation to overnight staff, the protocol was to subject the victim to a padded, confined room with a small drain in the floor to defecate. The drain is not functional without assistance from a staff member to flush it, which was supposedly done every few hours (Washington City Paper, 2023). Furthermore, investigations have been conducted in California prisons, revealing that incarcerated people spend days at a time in these "temporary" holding cells (Disability Rights California, 2021). In a federal investigation conducted in 2019 for a prison in Massachusetts, it was revealed that the prison "...fails to Provide Adequate Supervision to Prisoners in Mental Health Crisis and Thus Protect Prisoners from Serious Harm in Violation of the Constitution." Some of these constitutional violations included "failing to remove instruments that could be used for self-harm." For example, incarcerated people on "mental health watch" were permitted to access razors and other items with potential use for self-harm. One particular instance was so absurdly negligent that an incarcerated person on mental health watch had access to a razor and cut himself so severely that pools of blood gathered around his body. In CCTV footage, officers can be seen shrugging at the incident and chatting among themselves after the incarcerated person is known to be harming himself. The iman began to cut himself so deeply that blood began to spray. Officers still neglected him. After 45 minutes of the man continuously bleeding, officers finally intervened. (U.S. Department of Justice, 2021).

Re-entry / Recidivism

Incarcerated people face many barriers upon release, including being stripped of their right to vote, limited access to education with little to no eligibility for student aid, and being ineligible for public housing (The Leadership Conference on Civil and Human Rights, 2016).Along with these barriers to success, released incarcerated people have inadequate mental health check follow-ups and further difficulty obtaining medication. With these difficulties subsequently increasing medication non-compliance, incarcerated people have a higher likelihood of crises leading to recidivism.

Medication Non-Compliance

Symptoms of schizophrenia do not inherently lead to arrest; rather, it is the surrounding societal factors that contribute to a decline in well-being, placing an already vulnerable group at greater risk of incarceration (Skeem et al., 2014). Studies have shown how symptoms of schizophrenia like hallucinations, delusions, and depression, do not predict violence, but instead link violence as a greater risk due to medication non-compliance (Swanson et al., 2019). Consideration of these societal factors is a critical point in explaining why African Americans are often unable to access necessary medication.

Accessing Insurance

Consideration of societal factors is a critical point in explaining why African Americans are often unable to access necessary medication. Many lack the resources to afford insurance, are unhoused, or may be traumatized or reluctant to trust the medical field due to years of abuse of African Americans (PBS NewsHour, 2021). Upon reentry, incarcerated people are not automatically provided with health insurance and need to acquire it themselves. This causes a gap in medication which can severely affect a person's well-being, making them very vulnerable to being unhoused. Even the installation of halfway homes acts as an insufficient buffer. Many of those who are moved into halfway homes end up unhoused upon release and face further struggles to support themselves, and recent studies have shown that halfway homes have no effect on the rate of recidivism (Wong et al., 2025).

Crisis Intervention Team Training as a Solution

Although it may seem as though these issues are being ignored, policy and lawmakers are taking steps to mitigate the disparity. The discrimination and abuse of African Americans can never truly be abolished without true radical revolution, however there are some solutions that could be achieved before a more permanent and fundamental revolution. One such solution that has recently been implemented is the usage of Crisis Intervention Teams.

Crisis Intervention Team Training, Defined

Crisis Intervention Team (CIT) training is a current method used in law enforcement agencies that seeks to provide officers with insights and skills regarding SMIs. The National Alliance on Mental Health (NAMI) claims that CIT training 'create[s] connections between law enforcement, mental health professionals between law enforcement, mental health providers, hospital emergency services, and individuals with mental illness and their families' (NAMI, 2025).

The training is delivered in a didactic, classroom-based setting in which mental health professionals, law enforcement personnel, and, at times, individuals with lived experience of SMI (e.g., substance use disorder or schizophrenia) give presentations and encourage officers to reflect on how they might respond in encounters involving individuals with SMIs (CIT International, 2025). The course reviews and explains a variety of SMIs and their symptoms, providing officers with mental health literacy, and presents de-escalation techniques, encouraging officers to reduce excessive use-of-force. It provides role-playing scenarios in which officers may enact the steps they might take when interacting with someone with an SMI, using the techniques and knowledge provided by the training and guidance on navigating mental health treatment settings to divert arrests and jail time.

Effectiveness of CIT Training

It may come as a surprise that, despite CIT's efforts to build community connections and limit undesirable interactions between law enforcement and individuals with SMIs, the program has shown limited and inconsistent effectiveness, with benefits largely confined to officers' perceptions rather than to measurable reductions in arrests, racial disparities, or long-term community harm.

Misleading Language

Contrary to the name's implications, CIT training does not function as specialized teams within law enforcement agencies (Compton et al., 2025). The training is self-selected; therefore, participation is not required by law enforcement agencies. While law enforcement agencies encourage officers to complete CIT training, there is no financial incentive for them to do so. Law enforcement agencies rely on individual officers to participate in a 40-hour training (while also working their regular 40-hour workweek) out of their own desire to learn about crisis intervention—voluntarily (Compton et al., 2025).

Yielding Little Evidence of Success

Most studies on the effectiveness of CIT programs have inadequate data to prove a reduction in

arrests, racial disparities, or other long-term harm, while others conclude that available data is insufficient to determine its effectiveness. Although reports (mostly self-reported) of increased understanding of mental health rose, the amount of arrest-reduction due to CIT training efforts remains unknown (Taheri, 2016). Another study conducted in 2024 found no significant difference in arrest rates between officers with CIT training and those without (Boddy et al., 2024). The study confirmed that both trained and untrained officers utilized outreach programs at the same rate, and even more surprisingly, CIT-trained officers were more likely to arrest people with mental illness.

Misleading Statistics

Despite the existence of a plethora of heavily researched literature that proves CIT training's ineffectiveness, its creators often boast misleading statistics that promote the usage of the program.

Although CIT training participants report increased confidence in responding to mental health crises, the program's empirical support relies almost entirely on officers' subjective assessments. This reliance is blatantly inconsistent with the program's alleged objectives, as existing evaluations of CIT effectiveness fail to cite statistical evidence indicating lower crime rates or improved public attitudes toward police. As a result, CIT effectiveness is assessed primarily through officer perceptions rather than through objective measures of public safety, community trust, or crime rate.

According to Stanford's psychology lab, 'Stanford Psychological Answers to Real Questions' (SPARQ), and the California Department of Justice (CA DOJ), participants of CIT training often report heightened feelings of understanding of procedural justice and implicit bias, heightened confidence of the course's effectiveness of increasing community trust and decreasing police-community tension (SPARQ & CA DOJ, 2016). The CA DOJ and SPARQ insist that these statistics offer enough proof to conclude that the program has been successful in 28 police departments across California and strategically omit statistics that prove that crime rates, mental health arrests, and racially motivated arrests have failed to decrease even with the implementation of CIT training (SPARQ & CA DOJ, 2016). These willfully ignorant claims offset essential statistics such as the fact that 44% of those who are jailed have an SMI despite only representing 18% of the population (SAMHSA, 2024). Statistics like the CA DOJ's and SPARQ's attempt to overshadow statistics that actually hold value to vulnerable populations, and furthermore, reward systemic oppressors by converting measurable harm into institutional achievement.

The only study that offers some positive outcomes from CIT training states that officers' "comfortability" with mental health crises is increased after receiving the training (Compton et. al, 2025). Mental health organizations like NAMI promote CIT training, citing that Memphis's *police* injuries decreased by 80% after implementation. (NAMI, 2025). NAMI charges $60 for a two-hour CIT session (NAMI, 2025). NAMI also makes bold claims such as 'CIT reduce[s] arrests of people with mental illness,' while providing no literature that establishes this claim. Instead, it relies on the mischaracterization of tentative, context-specific findings as evidence of general effectiveness. Additionally, subsequent CIT research has yet to replicate these findings; however, organizations that promote and sell CIT training, such as NAMI, continue to cite and misrepresent these articles on their websites (NAMI, 2025).

Although the concept may seem like a step in the right direction, the only possible beneficiaries of CIT training are police officers and mental health professionals—not wrongfully arrested individuals.

CIT Does not Help with Implicit Bias

The methods of CIT training are wholly reliant upon explicit bias and encourage officers to utilize logic, reason, and deliberate judgment. Although perhaps well-intentioned, CIT training fails to consider the most crucial factor that goes into motivated police brutality against those with an SMI: implicit bias.As implicit bias neurologically occurs before any conscious, logical thought, meaning that attempts to rely solely on critical thinking are insufficient, as implicit bias will always precede critical thought in high-pressure encounters, which law enforcement officers often experience. This poses a unique problem when addressing police brutality, as intervention methods such as CIT encourage officers to utilize critical thinking skills in mental health crises, which directly contradict theories of neurological processing. When

implicit bias precedes critical thinking, it is nearly impossible to exercise metacognitive control in life-altering split-second decisions.

Devine-Style Implicit Bias

Unfortunately, most studies have shown limited and inconsistent effectiveness in reducing implicit bias. Most studies have encouraged participants to use critical thinking to adjust their biases. However, many have failed to demonstrate lasting effects beyond a short period following participation (Compton et al., 2025). Most studies on bias reduction aim to modify participants' internal belief systems to alter their overall attitudes toward a marginalized group. These methods therefore, assume that bias is a result of moral individualism, thus implying that implicit bias is a choice that can be made, rather than a nonconscious response due to long-term socialization, cultural conditioning, and implicit cognitive processes (Bellah et al., 1985).

There is, however, hope for practical training. There has been one influential study that has yielded modest but statistically significant results following an anti-bias training. This study was conducted by Dr. Devine, a professor of psychology at the University of Wisconsin–Madison, who took a different approach by teaching participants to frame reducing implicit bias as an actionable goal rather than a moral goal. The study showed that participants who expressed awareness of their bias demonstrated no reduction. In contrast, participants who actively used strategies to reduce bias were able to reduce it over several weeks. The strategies were also actionable goals—not merely moral. Dr. Devine used strategies such as stereotype replacement, which encouraged participants to immediately recognize stereotyping as an error and replace it with a non-stereotypical thought. Another strategy included counter-stereotyping imagery, which prompted participants to recognize the activation of a stereotypical response and intentionally substitute it with a non-stereotypical or individuated thought. The study also yielded reductions in implicit bias lasting up to twelve weeks—longer than many prior bias-reduction interventions. The researchers attributed much of the study's success to participants' ability to apply bias-reduction strategies without assistance. Devine's study demonstrates that implicit bias is not a moral choice, but a learned cognitive habit that can be regulated with appropriate procedures and training (Devine et al., 2012).

However, there is still much progress to be made as participants of the study were only able to reduce their biases from 'moderate' to 'low.' The study also found a higher success rate when participants had motivation to reduce implicit bias, leaving a large gap for those who may have implicit bias but are unwilling to change.

Conclusions of CIT Training

A long history of structural racism and continuous socialization has resulted in strong implicit bias. Unfortunately, law enforcement agents also suffer from implicit bias and have therefore made split-second decisions that have left individuals, families, and communities devastated. Government intervention has introduced CIT training as a way to reduce the brutality and abuse as a result of this bias. Still, it has yet to demonstrate consistent effectiveness beyond officer self-reported confidence. Devine's study has demonstrated comparatively greater effectiveness, but it has not been implemented within government-funded programs. Programs like CIT training have failed to demonstrate consistent effects on crime rates, yet continue to be widely implemented. Further research on implicit bias is required before implementation. The low success rates of implicit bias studies are an invitation to perform even more research as opposed to choosing one that may yield some effectiveness. Even studies that have shown measurable bias reduction still require further research before they can be implemented in law enforcement agencies.

Conclusion

The treatment of African Americans as well as those with mental health illness in the United States is nothing short of deeply appalling. When compounding these two groups, a disproportionately high amount of abuse and neglect can be observed across a multitude of institutions, including medical, policing, and carceral systems. The enduring and grave influence of race science in modern psychiatry has only

exacerbated systematic misdiagnosis of mental illness within the African American community, causing many to be routinely mistreated or untreated. With African Americans often unable to access adequate and consistent mental health treatment, and frequently mistreated even when they are able to access it, many interact with the medical world concurrently with the incarceration system. This deeply entrenched mental illness–to–prison pipeline leaves millions of individuals cycling between untreated illness, incarceration, and persistent institutional neglect.

The most current solutions have been to introduce CIT training in order to mitigate implicit bias in law enforcement agencies as a means to reduce the rate of abuse and incarceration among those with an SMI. CIT training neglects sustained discussion of implicit bias, a central feature of these interactions. A study has been conducted to demonstrate the usefulness of considering nonconscious systems, but this approach has yet to be meaningfully implemented in practice within government-funded law enforcement agencies.

While these stopgap solutions are far from ending the disparities faced by African American communities, addressing the root causes that exacerbate this crisis is a first step in the pursuit of equity within medical institutions and the greater criminal justice system. Efforts to prevent vulnerable people from being unjustly arrested should go towards those vulnerable people, not towards the people who are unjustly arresting them. Giving more funding to the police to prevent a problem *caused* by the police is not only immensely hypocritical but also has historically been futile or has often inevitably caused even more damage.

“Prisons do not disappear social problems, they disappear human beings.” — Angela Davis

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