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Keywords

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Introduction

Over the years, law enforcement officials have increasingly dealt with mentally ill people performing the job of public health systems, therefore bringing to light a series of issues concerning officer misconduct and the widespread misuse of authority when engaging with disoriented individuals on a routine basis. There are approximately 52.9 million people with mental illnesses throughout the United States (National Institute of Mental Health, 2022). This number means that one in five persons is often categorized as mentally ill or severely mentally ill (National Institute of Mental Health, 2022). Individuals from these populations are likely to encounter the police, as mentioned in the study *Overlooked in the Undercounted.* They are 16 times more likely than the average citizen to be killed by the police (Fuller et al., 2015).On the other hand, a conservative estimate put this number to one in four, meaning that individuals with psychiatric illnesses who encounter police officers are likely to get killed due to their predicament (Fuller et al., 2015). However, when the Crisis Intervention Team (CIT) deploys individuals with more knowledge of mental illnesses, injuries are reduced considerably (Morabito et al., 2012). On the contrary, other studies suggest that scant data is available to determine the effectiveness of CIT team deployment and the use of force that results in injuries (Strauss et al., 2005). A large part of the reason the mentally ill homeless population faces the police so frequently is deinstitutionalization, which has been taking place over the last fifty years (Davis et al., 2012). This is due to the reduction in block grants by the Federal government for mental health treatment and the changes in the legal code introduced in the Social Security Act (SSA), passed by Congress and signed by President Lyndon B. Johnson in 1965 (Berkowitz, 2005). The Community Mental Health Centers Act of 1963 was first initiated by President John

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F. Kennedy, which was to reduce the state hospital psychiatric ward population by 50% but instead went to a staggering 90% (Davis et al. 2012; Kofman, 2012). Two national healthcare programs, Medicare and Medicaid, became available for eligible individuals to use for their psychiatric problem (Berkowitz, 2005). However, the problem is that people with psychiatric disorders cannot access these programs consistently, given their state of mind and other predicaments. Likewise, institutions and the psychiatric facilities staff had unrealistic expectations from the seriously mentally ill population to seek help and care without considering their difficult situation.

On the other hand, Neoliberal policymakers believed that mentally ill patients could receive good care from community psychiatry networks while staying close to family members rather than federal and state government institutions. Esposito and Perez (2014) explain that this portrays the consumerism framework of neoliberalism within the medical field. Similarly, many writers have expanded on neoliberalism preference which communicates that Neoliberal support for the healthcare system is a commodity instead of a right (Jasso-Aguilar & Waitzkin 2012; Shaffer & Brenner, 2004, as cited in Esposito & Perez, 2014). Additionally, Timimi (2012) mentions that neoliberal proponents consider patients to be customers where the entire idea of holistic treatments and interventions is undermined and marginalized. Additionally, big pharma companies have a powerful lobby present in Washington that advocates for deregulations of prescription drugs, resulting in rising cost of prescription medication and overmedication of users (Potter, 2013, as cited in Esposito & Perez, 2014). However, due to SSA regulations covered the costs for patients admitted into the psychiatric

hospitals, thus allowing them good care at the community hospitals.

In the same act, the government affirmed mentally ill patients' rights. They cannot be admitted into a psychiatric ward without their consent if they are not posing harm to society or to themselves (Testa & West, 2010). Nevertheless, the community psychiatric facilities cannot hold the patients for a long time and need to release them as soon as they are stable, given the need to make room for new patients. Upon release from the community psychiatric facilities, these patients often lapse, and many become part of a recidivism cycle. Families are not prepared to take care of their loved ones, leading to a rise in homelessness due to the complexity of the illness that often leads to violent and hostile situations. As these individuals become homeless, their conditions become more complex as their health deteriorates, and many of them indulge in substance abuse, alcoholism, and other drugs. Dhossche and Ghani (1998) studied recidivism in psychiatric emergency rooms and found that 400 out of 2212 patients accounted for 18% of repeat visitors over seven months, representing 36% of all visits. Additionally, socially disadvantaged individuals with serious mental illness (SMI) and substance abuse disorders utilized emergency psychiatric services as unemployment and homelessness are stark.

Similarly, a study conducted by Wilson et al. (2011) analyzed recidivism of 20,112 individuals admitted to county jails in 2003 that showed people with different diagnoses categories, including (SMI), substance abuse, no diagnosis, and those with co-occurring SMI and substance abuse diagnosis. They uncovered that not only many recidivated within the first year, but about half of the population returned to prison over four years. Upon further dissecting each diagnosis category, SMI alone was not the leading factor, placing people with co-occurring SMI and substance abuse

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with the highest recidivism rates. As a result, this finding challenges the assumption that people with SMI are dangerous and have the highest recidivism rates. This is due to media and classic representative societal responses utilized to "resolve" the mental crises by scapegoating and exaggerating the mental illness and issues like psychosis, thereby altering the general public's cognitive bias and, as a result, restricting appropriate measures from execution (Riordan, 2019). Due to the failed policy of deinstitutionalization, the number of homeless people has grown to more than half a million throughout the United States (Flory & Friedrich, 1999). The adverse effects of such policies take a toll on the economy, environment, health care, and the criminal justice system.

Traditionally, the police's job is to maintain peace, order, uphold the law, and arrest while removing criminals from the streets. The large number of cases involving individuals from this population has overwhelmed both the police and the courts. Many of these individuals have placed their encampment on sidewalks, near airports, at stores front, creating disturbances while carrying many belongings and frequently begging for money or food. This leads business owners, residents, and neighbors to call the police to manage these situations, leading to tragic outcomes resulting in protests for police reform and accountability. This paper delves into the background of the current situation due to deinstitutionalization and its relationship to mental illness and homelessness. It will discuss police training concerning the mentally ill and challenges. Lastly, it will pose potential policy implications that suggest some plausible recommendations to help resolve this tense daily ordeal faced by police officers and the mentally ill population.

Review of Relevant Literature

Deinstitutionalization Policy and Its Consequences

Mental health disorders were considered a sign of insanity warranting imprisonment and deemed untreatable conditions. However, this changed in the 1840s, when Dorothea Dix, an activist, lobbied for improving mentally ill patients by spreading awareness which successfully motivated the U.S. government to build at least thirty state psychiatric institutions (Parry, 2006). Dix's campaign brought to light the barbaric treatment prevalent in different countries, including the United States, where mentally ill people were chained, shackled, or physically restrained using different means to manage harmful behaviors (Human Rights Watch, 2020; Nelson, 2021). At the same time, others were placed in cramped rooms or restrained (Human Rights Watch, 2020; Parry, 2006).

Similarly, in some households, families usually would restrain their loved ones in their homes or hidden places such as attics, cellars, shacks, and elsewhere to avoid people's perceptions, as mental illness was associated with being possessed with the devil (Nelson, 2021). Meanwhile, asylum workers retrained many mentally incapacitated individuals in cruel and unusual spaces without clothes (Levin, 2019). Patients often were jailed with criminals in the same room (Levin, 2019). The fate of these patients at the hands of family members or authorities results in being confined in cramped spaces for weeks, months, or years (Human Rights Watch, 2020). Still, it is a widespread brutal practice adding to mass incarceration (Human Rights Watch, 2020). Due to Dix’s efforts, awareness about the problematic situation of the mentally ill helped in removing the stigma claiming that psychiatric illnesses have no future for betterment.

Consequently, due to the lack of funding and understaffing, the patients' living conditions in these facilities

turned into human rights violations. CMHCA transferred the state-run institutions' responsibility to the federal government-funded community psychiatric facilities, which enabled the patients to receive medical help from professionals and non-medical professionals such as counselors (Kliewer et al., 2009). From this, one can see this transfer of responsibility from trained psychiatric staff to the general counselors led to dangerous outcomes given the complexity of the illness as the recidivism of these individuals increased to the streets. It is important to note that the psychiatric ward requires instruction from a patient's psychiatrist to be admitted into the hospital.

Additionally, the first antipsychotic drug was introduced in 1954, which triggered the quick discharge of patients from the government psychiatric hospitals to community psychiatric wards (Pow, 2012). The policymakers assumed that deinstitutionalization would help the patients in the community psychiatric wards by allowing them to be independent and enjoy a quality life in a community-based setting (Forrester-Jones et al., 2002, as cited in Kliewer, 2009). However, many of these facilities were not ready due to a lack of trained staff, treatment plans, shortage of rehabilitative services - especially long-term care - for chronically ill patients, and other resources (Pow, 2012). Here it can be inferred that these patients did not receive timely support from the community, families, or friends. Thereby furthering the gap between mentally ill people and non-mentally ill people, given that the latter generally do not understand the severe incapacitation encountered by these individuals in a holistic manner.

In addition, obtaining these medications for many patients is difficult, not to mention taking them promptly to stay sound and sane. Some of these antipsychotic drugs have severe side effects,

and at the same time, it is difficult for patients to see doctors who can further treat them on an ongoing basis (Muench & Hamer, 2010). There is a disconnect between understanding the need for long-term care facilities, which also impacts inpatients who have been in government psychiatric institutions for decades. When these long-term patients are discharged from the facilities, they lack social and survival skill sets to successfully transition into the community and adapt to new norms (Forrester-Jones et al. 2002). Though antipsychotic drugs can aim to help, patients increase socialization and can potentially help adapt to change, fully believing that antipsychotic medication is an easy fix to all illnesses has led to dangerous consequences (Muench & Hamer, 2010).

Overall, untreated illness can severely impact individuals' emotional, behavioral, and physical health. The correlation of experiencing homelessness with a psychiatric illness is more complicated than without an illness (Balasuriya et al., 2020). Regardless of mental health issues, homelessness has historically categorized and associated these individuals with poverty and social disadvantage (Sullivan et al., 2000, cited in Balasuriya et al., 2020). Nevertheless, rough living circumstances and poor mental health can trigger particular disorders (Balasuriya et al., 2020). Individuals from these populations can be seen on the streets talking or shouting to themselves, making awkward movements and gestures, following orders in their heads, among other unexplainable actions. Often, these individuals, to no fault of their own, instill fear, hopelessness, and a sense of mockery to some passersby. Nevertheless, they are purely misunderstood by law enforcement and others. Though understanding the perception of law enforcement through the lens of the mentally ill is not well known due to the complexity of the situation, especially when enduring a mental health crisis. It is apparent through analyzing

various research on psychotic disorders, which discloses that the seriously mentally ill are usually unaware of their actions and what is occurring around them, thereby, cannot react accordingly.

Joseph and Siddiqui (2021) explained that people with delusional disorders have a fixed false belief of a realistic situation despite evidence to prove otherwise. This shows the perplexing situation wherein changing the state of mind or perception is unachievable. Despite the countless efforts made by trained medical staff or anyone else to help people with these illnesses through facts and reasoning, it does not improve their long-term predicament by these endeavors. Nevertheless, people with such disorders are convinced that they are mistreated and conspired against, attacked, and are at the receiving end of a harmful plan that can impact them and their loved ones (Joseph & Siddiqui, 2021). These scenarios vary, and paranoia can exacerbate their perception of the "situation" (Pinkham et al., 2016). Similarly, hallucinations can impair one's understanding when one hears, sees, feels, and smells things that do not exist (Chaudhury, 2010; D'Arrigo, 2020). This ties into the standard narrative of mentally ill people interacting with law enforcement, viewing them as "bad" or "evil." The constant vulnerability of the mentally ill when dealing with law enforcement can lead to several tragedies due to the lack of compliance.

A common issue concerning SMI individuals in households, hospitals, and other settings is medicine non-compliance. One reason for medicine non-compliance is due to a condition called Anosognosia, also known as “lack of insight,” where one is unaware of having an illness or due to the severeness of illness impairs the ability of an individual to understand their predicament (Treatment Advocacy Center, 2014). Other reasons include alcohol and drug abuse, weak ties with a mental health

provider, and medication side effects (Treatment Advocacy, 2014). As doctors and psychiatrists have difficulty encouraging patients to take medication for chronic illnesses such as bipolar disorder and schizophrenia, the relapse rates are concerning as it is high and severe. Analyzing the dynamics of individuals suffering from chronic illnesses and their relationships with family members, friends, and others is equally challenging. This shows that while this policy, in theory, had good intentions, the consequences of deinstitutionalization uncovered the vast naivety of individuals who did not understand the gravity of mental illness (Iodice & Wodarski, 1987, as cited in Kliewer, 2009). As a result, it worsened the health of those suffering from various disorders, if not resulting in death. Similarly, proper medication and treatment were delayed or unavailable, indicating how lightly the health crisis was perceived.

Likewise, another concern is when mentally ill individuals are placed into state facilities without their consent. For instance, the American Civil Liberties Union (ACLU) filed a lawsuit on behalf of Kenneth Donaldson, a patient of paranoid schizophrenia (Mizner & Ne'eman, 2019). Donaldson repeatedly demanded his release throughout the years but without success (Mizner & Ne'eman, 2019). Though Donaldson was not a danger to society or himself, he was confined for 15 years based on a mere complaint by his father, who believed his son was delusional (Fields, 1976). Donaldson, prior to his confinement, received treatment (Lottman, 1977). However, the doctors and his psychiatrist unjustifiably withheld Donaldson from psychiatric care and prevented his release due to him being dangerous, where in fact, that was not true (Lottman, 1977). The Supreme Court decision ruled in *O'Connor v. Donaldson* said that if people do not feel comfortable around a person or find them disturbing, it does not justify placing an individual in any institution depriving them

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of their freedom (Fields, 1976). In short, the Supreme Court decision affirms the individual's freedom as long as they do not pose a danger and can survive independently or with the help of family members, and friends should be allowed to live in the community (Mizner & Ne'eman, 2019). Similar cases acknowledged that even healthy individuals under "suspicion" of having an illness can be confined and "treated," as in the case of E.P.W Packard, a woman confined in an Illinois state mental institution by her husband's misconception for three years (Goldman et al., 1981, as cited in Yohanna, 2013). This shows how easy it is to perceive someone as insane, which calls for safeguarding people's rights in hospitalization.

As the policy of deinstitutionalization continued, Ronald Reagan, as governor of California, was the first to formally end the government's role in providing resources to the mentally ill in state institutions. This was because the funding for mental health was now the federal government's responsibility. The passage of SSA allowed Medicaid recipients with mental illness eligible for treatment in community psychiatric wards. One problem with the SSA's bill is that it did not cover patients in the state hospital's psychiatric institutions (Lave & Frank, 1988). Reagan, as President, further reduced the federal funding drastically of the state mental institution. The sole purpose was to reduce the federal deficit and was criticized heavily for these cuts (Boffey, 1968). Before the budget cut, California mental hospitals rated by the staffing standard report of 1967 stated that they operated at a 68% acceptable standard to take care of recipients; meanwhile, hospitals for intellectual disability at 62% (Boffey, 1968). One of the consequences of this reduction was that homelessness increased multifold and placed an additional burden on the hospitals and the police department to deal with this ever-growing

population. Mitch Snyder, an advocate for the homeless, waged a campaign to criticize the Reagan administration and demanded the government increase funding to address the homeless population (Jones, 2015). The figure he often cited was 2 to 3 million people, a large number at that time (Jones, 2015).

Life Challenges of the Homeless and Mentally Ill Population

Several studies conducted in the past few decades illustrate the need for long-term facilities availability for severely ill patients to secure, support, and accommodate the specialized requirements for their well-being. Approximately 15 out of 100,000 people from the general population would require long-term care - other studies placed this number to 12.4 out of 100,000 individuals (Gronfein, 1985, as cited in Yohanna, 2013). In 1955, 340 state beds were available per 100,000 individuals, but this number was reduced to approximately 14 state beds per 100,000 in 2010 (Torrey et al., 2008, as cited in Yohanna, 2013). Experts have estimated that at least 50 beds per 100,000 are more reasonable to meet the needs of individuals who need acute, long-term care (Torrey et al., 2008, as cited in Yohanna, 2013). Nevertheless, this grave need has been reflected in some states to be as low as 5 per 100,000 beds (Torrey et al., 2008, as cited in Yohanna, 2013).

Additionally, the link between deinstitutionalization and homelessness did not surface until the 1980s. Much of the support needed by these individuals were being continuously curtailed and redistributed for poor to high-income people, including income support, medical care, and housing accommodations (Moffitt, 2015; Scallet, 1989). Budget cuts in the welfare state started during the 1970s and became even more extensive during the Reagan era in the 1980s. It impacted the vulnerable people due to their socio-economic situation; as they had little to no income and affordable housing, making them

more reliant on the support of the welfare state, including hospitalization. Goldfinger et al. (1996) promptly analyzed 287 SMI clients in community housing after the screening process, which filtered out clients that obstructed safety for themselves and others. Two-thirds of the sample qualified as safe for independent living. More specifically, 24% of clients were deemed fit to live without any supervision, which describes that a sizable population can live an independent life if the proper care is provided, thus reducing the homeless population (Goldfinger et al., 1996).

In many cases, people from this population need special housing due to a lack of social skills to manage their affairs. Likewise, one can argue that other low-income people face the same affordable housing challenges; however, mentally ill people are even more likely to lose their housing due to an acute episode that leads to hospitalization (Schutt & Goldfinger, 2009). As previous findings indicate that subsidized housing can help resolve accommodation problems; however, it cannot guarantee losing it due to individual risk factors and vulnerabilities, as discussed before. Padgett et al. (2006) discuss the housing programs in New York City, which ensure permanent housing for mentally ill people with substance abuse, for forty-eight months during the study. Housing first clients were reported to be stably housed 75% of the time (Gulcur et al., 2003, as cited in Padgett, 2006). The study shows that the importance of providing fair housing to individuals, readily accessible healthcare, and community-based psychiatric care can help improve and provide an excellent form of standard care. It was observed that even though the participants were still consuming drugs and alcohol during the study, since they had access to housing and treatment, they could recover quickly from their

relapses. The participants were more likely to use the treatment services to maintain stable health.

Police Training Concerning the Mentally Ill

According to Cordner (2006), officers train in integrated role-playing lectures, discussions, tours of mental health facilities, and lesson plans to educate and familiarize them in handling people going through a mental health crisis. However, these activities are not a complete resolution for the police encounters with the mentally ill. The primary purpose of these training exercises is to "enhance officers" understanding of the situation and develop communication skills by making decisions free of preformed attitudes, prejudice, and other stereotypical approaches (Cordner, 2006). Role-playing exercises help mirror real-life instances that reduce and curtail the use of force by the officer when they are responding to a call.

Learning about such encounters and facing them are two different scenarios. Many officers express that even after receiving training from their police academies, they still feel ill-prepared to respond to calls involving the mentally ill. For example, a British survey indicates that 61% of the officers felt inadequately trained for such situations (Dunn & Fahy, 1987). In comparison, another study in Pennsylvania reported that 47% of the officers felt unqualified to manage such instances (Ruiz & Miller, 2004). Additional reviews of these strategies show insufficiency and do not improve the dialogue between the two parties. It is easy for officers to become agitated. They

might assume that citizens with mental illness should comply with their commands as they failed to recognize the citizens' disruptive state of mind and behavior. Instead, officers believe that they are resisting and ignoring their commands when the citizen may lack the comprehension of the situation due to

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their illness and additional factors in that given moment (Borum, 2000, as cited in Cordner, 2006).

As deinstitutionalization occurs, it has decentralized the treatment of mentally ill people resulting in the growing homeless population. A lack of treatment has led to financial instability as individuals are not mentally fit to work, impacting other core factors such as housing and life security. The ever-increasing price of prescription medicine and lack of professional care detracted from a vulnerable population, compounding their struggle to integrate into the community. This increases the police encounters with people with behavioral health issues that often lead to an arrest. Many of these individuals are drug addicts and alcoholics, creating disturbances in the public sphere. As a result, they are taken to the hospitals by the police to seek treatment for their illness. However, due to the lack of expert staff availability at the emergency room, these individuals are often not admitted (Quanbeck et al., 2003). Instead, they are released within a few hours, returning them to the street, thereby overwhelming the police. Releasing a mentally ill patient within a few hours is a clear violation of the Welfare and Institution Code (WIC) Section 5150, which requires 72 hours holds (Quanbeck et al., 2003). Nevertheless, in cases where these people are cited and prosecuted for misdemeanors through the justice system, they are eventually placed into jails and prison, which lacks the proper resources to address their illness and add to the existing problem of mass incarceration.

Furthermore, Adelman (2003) narrates the findings of a study conducted in British Columbia, where Canadian officers relay the frustration that they are seen as pervasive in communities. They perceive handling the mentally ill population

as not their responsibility; instead, they believe the public health care systems should take these individuals to care.

Officers' reluctance to deal with these kinds of situations is partly attributed to the lack of cooperation they receive from the emergency personnel who do not take their findings of patients seriously (Adelman, 2003). Officers also complain about the high criteria of admitting the patient into the hospital and the long waits to complete the process (Kofman, 2012). Individuals mentally ill but not chronic or severe were rejected from hospitalization due to the expansion of services leading to being neglected in the community (Kofman, 2012). In several cases, the individuals are accepted into the hospital to be released within the same shift (Greco, 2021). This shows how important long-term facilities are needed to prevent recidivism.

Another difficulty on-duty officers face is the dispatchers' lack of information about the unfolding situation, especially when a psychiatric emergency involves behavioral health individuals (Adelman, 2003). This could be because the dispatcher does not inquire about such information from the caller or because it is not part of their protocol as it violates patients' privacy (Adelman, 2003). The same study mentions that if the detailed context of the situation was known, the officers are likely to collaborate with a health system team with expertise in handling psychiatric emergencies. Similarly, officers who have approached or interacted with the same individual in the past are more likely to handle the situation successfully. A database regarding these health instances for repeated cases involving the same individual can help deploy appropriate team units and resources to successfully assess the emergency.

Present Challenges of the Police

The deinstitutionalization policy has created an overflow of the homeless population on the street as they lack medical

resources to treat their illnesses; at the same time, it has overwhelmed the untrained police officers to contain the situation. The media has further exacerbated the problem by depicting the mentally ill as dangerous criminals while reporting exaggerated and inaccurate mental health diagnoses and treatments (Smith, 2015). A good portion of the police work involves working with the mentally ill, so they are the gatekeepers determining whether a person goes to a healthcare facility or the prison system (Watson et al., 2014). In many cases, police officers have no choice but to arrest them due to either not understanding the situations or their violent and aggressive behavior. Unfortunately, these arrests contribute to the incarceration of mentally ill people into the jail and prison systems. There is no other place for them to stay without causing disruption.

Meanwhile, the three largest jails, including Los Angeles County Jail, New York's Rikers Island Jail, and Chicago Cook County Jail, are known for providing health services to inmates with SMI (Treatment Advocacy Center, 2016). This report emphasizes how these jails serve more of the mentally ill population than any psychiatric hospital in the United States, which shows a significant imbalance of responsibility in our society. Many prisons do not have sufficient resources to treat the mentally ill population. A 2004 conservative estimate indicates that over 300,000 inmates with severe mental illnesses were housed in the prison systems across the states (Treatment Advocacy Center, 2016). Approximately 560,000 individuals were in mental health facilities in 1955. Still, in 1994-1995 this number dropped to just over 71,000 (Satel & Torrey, 2016). As opposed to 2004, there were 100,000 beds available in private and public psychiatric wards for a population of 300,000,000 (Satel & Torrey, 2016). Here we can correlate that as the number of patients

decreases in the state facilities, their number increases in the prison system. From the above numbers mentioned, the police's job has become challenging as they have to deal with a segment of society for which they lack proper training and expertise. The growing homelessness and behavioral health issues of this population impact their lives and call for interested parties such as the police, medical staff, and facilities to reduce these ongoing challenges using meaningful resources. Overall, the police need to be better equipped with field training, strategies, and techniques to help the communities minimize the risk faced for all parties involved.

An incident in San Francisco involving a police shooting resulted in the death of a mentally ill homeless man in 2016. A passerby called the police on a homeless man named Luis with visible signs of insanity. He was walking in circles with a ten to the twelve-inch-long blade and ignoring the officer's commands in English, whereas Luis only spoke Spanish. He was ultimately shot with seven bullets by at least two officers (Salinger, 2016). This incident shows two things; one, the police are doing the job of a first responder, maintaining peace, and enforcing the law, where some people can attribute this to the police doing their jobs and are under much stress. Secondly, many people viewed this as the excessive force used by the officer and called it police brutality. Nevertheless, in a psychiatric emergency like this, the situation escalated and resulted in a loss of life.

Similarly, another common phenomenon reported in media is "suicide by cop," where a responding officer is provoked by a suicidal individual who intentionally or unintentionally communicates that they want to be killed (de Similien & Okorafor, 2017). Many of these individuals suffer from psychiatric disorders, substance use disorders, and other diagnoses. Grieving family members are furious and confused about why police

officers feel the need to kill a suicidal family member in a mental crisis holding a screwdriver, pocket knife, or other objects (Malmin, 2017). The immediate reflection is that mental health crises are criminalized and asserts that law enforcement officers are not qualified to be in such situations. Officers can claim decades of working with mentally ill people yet still be more harmful to the person they report to with the mental health crises. Being ill-equipped will result in anything but de-escalation. Amid these kinds of situations, the call for defunding the police has gained momentum. Still, defunding can impact the mentally ill population, given that they are the significant drivers of calls to the police (Ferguson & Huey, 2020). Furthermore, Greco (2021) mentions that defunding will risk the community's security, resulting in a spike in crimes and other social problems. An emphasis on police officers' mental health evaluation is also needed, given they can have untreated mental illness posing a danger to public life (Thomas, 2021). Thomas (2021) elaborates that the current psychological test for police applicants should be considered a personality test given it checks the compatibility to work in a high-risk profession. If officers on duty have a mental illness, it can lead to suspension or job loss, but there need to be those criteria determining the call for proper action (Thomas, 2021). Officers are asked to speak with a psychologist only after fatal shootings, but it is not a requirement. There should be a periodic evaluation of police officers' ability to work in the field, especially when they are dealing with the mentally ill population.

Policy Implications

Often, people with mental illness come into contact with the police and are taken to psychiatric wards and emergency rooms for treatment for the first time. If not already aware, the mentally ill individual can become self-aware at this stage and

realize that they have a condition and will need to receive proper treatment to be stable. This realization can be traumatic as interaction with police officers is not the best situation for an individual to discuss their medical condition and treatment. Officers need to be appropriately trained for these interactions and understand that these individuals need to be redirected to receiving the appropriate treatment (Cordner, 2006). The risk of having a fatal interaction can be reduced as officers will know how to approach, interact, and support these individuals.

As of late, many police departments across the state have implemented the CIT training as part of their department's academic curriculum. Canada et al. (2010) analyzed 216 officers across four Chicago Police Departments where both the reporting officer and the mentally ill subjects sustained injuries. The officers in this study completed their forty-hour training in the Crisis Intervention Training (CIT), a program that is praised for producing positive outcomes by reducing the perceived danger for both parties as low violence is observed even in risky situations which would require the use of force (Teller et al., 2006, as cited in Canada et al., 2010). The author mentioned that an officer with CIT expertise has a better understanding when dealing with mental illness individuals. The outcome of the situation and encounter is relatively positive. However, it may sometimes result in injuries, mostly minor. This shows that forty hours of CIT training is a good start. Still, officers need extensive training to develop their response better as the situation unfolds to reduce the injuries and arrest rate, which is ambiguous data due to the lack of written reports.

National Database on Mentally Ill Patients

One of the challenges is that police do not keep statistics, records, or a database of officers facing individuals with mental illnesses. There should be a proposal for creating a database of

mentally ill patients accessible across police departments, healthcare experts in the fields, hospitals, and psychiatric institutions. This will allow all those involved to provide updates on patients' health in the database, equipping the responding police officer to be aware of the situation beforehand and deal with it accordingly. Though it is difficult in larger cities to put psychiatric staff and officers in a team together, there are no formal protocols or procedures to make it acceptable by city officials and healthcare advocacy groups. A comprehensive strategy needs to be implemented after screening the police officer interested in working with special needs individuals; an emphasis should be made on continuous training from both educational and field engagement perspectives (Cordner, 2006).

Likewise, the medical staff should work with appropriate police officers in violent and dangerous situations. The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule essentially protects a patient's personal health information (PHI) from being shared without his or her permission. If the patient has signed HIPAA authorization, the healthcare providers can disclose their PHI to family, friends, and caretakers (Langjahr, 2018). Though patient permission is not needed when sharing with HIPAA-covered agencies, law enforcement does not fall in this category of HIPAA compliance (International Association of Chiefs of Police, 2020).

To overcome this issue, law enforcement agencies can create and operate their independent medical services, which can fall under HIPAA- covered agencies. A provision that should be added to HIPAA laws is rules and regulations that suggest a modified Crisis Intervention Team that meets the standard to be considered HIPAA compliant. To overcome HIPAA constraints, a passage of legislation can facilitate such a record-keeping

database where only the authorized people can access it, including law enforcement with the medical personnel. Currently, the available database keeps track of the caller's premises with mental illness and its threat. The new database will optimize time addressing the medical need instead of asking others to figure out the matter apart from the general information needed. The database needs to be built within appropriate legal and ethical frameworks. All the information collected will be confidential, such as the diagnosis, medication, hospitalization history, and psychiatric knowledge. Health workers will share with the responding officer on a need basis. Also, proper protocols need to be developed for police and mental health system collaboration teams to resolve matters when there are authoritative-power conflicts between the two. Finally, all parties should constantly review these strategies to measure their impact on the people and community. The above process will be successful with the collaboration between police and mental health staff to monitor health advocacy communities. The policy should be flexible to be implemented in different areas with minor modifications.

Treatment Diagnostic Availability to Formerly Incarcerated Mentally Ill Individuals

A second policy recommendation and implication should focus on the needs of those incarcerated in prison facilities suffering from mental illness. Out of the prison population of at least 2 million, over 300,000 inmates suffer from SMI (Sawyer & Wagner, 2022; Torrey et al., 2014, as cited in Treatment Advocacy Center, 2016). In other words, between 15 to 20 percent of jails and state prison populations have inmates suffering from SMI (Torrey et al., 2014, as cited in Treatment Advocacy Center, 2016). There are no set standards and unified protocols in the prison system to screen and diagnose inmates for mental health and provide care for those suffering from such illness (Gonzalez

& Connell, 2014). For example, suppose an inmate suffers from overt conditions like schizophrenia. In that case, he will receive medication, whereas depression will be less likely to receive treatment as it is less overt (Hills et al., 2004, as cited in Gonzalez & Connell, 2014). There should be a consistent procedure for diagnosing the inmates for mental and general health needs from this information. Those who fall into the mentally ill category should be given a referral to the prison psychiatric ward instead of keeping them with the general prison population. The state should pass legislation to reform the criminal justice system to guide those known to have a mental illness to appropriate treatment programs rather than sending them to prison. The state also needs to allocate significant financial resources and trained medical staff willing to work in a prison environment. Finally, upon the inmate's release, a treatment diagnostic mechanism should be implemented, monitoring formerly mentally ill incarcerated individuals to get the care they need. This can be achieved by referring them to the mental health counselors in their community, where a social worker is assigned to them to follow up with their treatment plan, housing, food, and other requirements weekly for nine to twelve months to ensure their health and stability.

Conclusion

To summarize, since implementing the deinstitutionalization policy, the homeless crisis has grown as many of them have a mental illness. This policy has created several problems in the communities where these individuals reside, and many are displaced on the streets. People with mental illness can quickly get into unstable conditions due to non-compliance with medication, substance abuse, and alcohol dependency; therefore, they become aggressive and disturb their surroundings. This situation leads to police encounters which

often result in injuries or fatalities. As discussed before, many mentally ill people end up in prison systems where they do not receive proper care. A negative correlation can be seen as the number of patients with mental illness decreases in psychiatric wards and increases in the prison system. This dire situation directly results from the deinstitutionalization policy, impacting the environment, healthcare system, police departments, justice system, and businesses across the states.

Since the public health crisis has extended to wide lengths, it is only appropriate to mend these problems by improving the facilities that we have in place. A comprehensive strategy has to be adopted to reduce the number of homeless people on the street and put them into permanent shelters and community housing. Those with chronic illness should be placed into the appropriate programs to rehabilitate and be a productive part of society. To ensure no lapse in their treatment, a national database and a treatment diagnostic mechanism must constantly monitor these individuals' well-being. If these suggestions and policy recommendations are adopted, it can be hoped to improve policing with the mentally ill and homeless population.

Hence, the lives of many people with mental health problems can become better; therefore, flourish while seeing better days as they should be, given they are integral members of our society.

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