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Data-informed partnerships: strengthening mental health crises responses in Texas

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Abstract

Purpose – This qualitative study explores the relationship between police departments and social service providers regarding on-site challenges and mental health crisis response.

Design/methodology/approach – Utilizing a social network recruitment method, the researchers semi-structured interviews with 17 law enforcement and mental health professionals. The researchers conducted thematic and narrative analyses to identify patterns in the data.

Findings – Four themes emerged around a holistic data-sharing approach to strengthen response and partnerships: (1) deinstitutionalization and limited emergency detention options; (2) the need for dual dispatch and law enforcement liaison projects; (3) community relations and (4) supporting families with loved ones who experience mental health crises through community partnerships.

Research limitations/implications – Although this study is limited in scope and generalizability, it provides an important foundation for further inquiry. Future research should examine comparative analyses of data-sharing practices and outcomes between law enforcement and mental health professionals.

Practical implications – The results of this study illustrate the proactive and collaborative strategies unfolding in a metropolitan community. Policy implications support the development of data integration strategies to bolster crisis communication and police response with trained social service professionals.

Social implications – This study highlights the social implications of data-informed police–mental health partnerships by demonstrating how coordinated information sharing can reduce the risk of violent encounters, improve continuity of care and promote safer outcomes for individuals experiencing mental health crises.

Originality/value – This study offers original qualitative insight into frontline law enforcement and community mental health providers' experience with data-sharing partnerships during mental health crisis response, a topic that remains underexplored.

Keywords Data-sharing, Policing mental illness, Crisis response, Community partnerships, Social services

Paper type Research article

Introduction

In 2023, Raul de la Cruz, a New York City resident, was suffering from a mental health crisis when his father called 311, a nonemergency helpline, to get help for his son. When the operator discovered De La Cruz had a knife, the call was transferred to 911. When police responded, he refused to drop his knife, which resulted in officers shooting him within 28 s of arriving on scene (Meko and Kriegstein, 2023). A similar situation occurred in Dallas in 2015 when officers shot and killed 39-year-old Jason Harrison, who was holding a screwdriver, within seconds of the encounter, despite Jason's mother, Shirley, informing the dispatcher that her son had bipolar schizophrenia and to specifically send out trained units (McLaughlin, 2015). Approximately 32% of fatal police encounters involve victims experiencing a mental health

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crisis, with dispatch becoming aware of a mental health crisis in only 27% of police calls for service (Khan *et al*., 2025). In 2022, police in the United States responded to 171,000 calls for emotionally distressed individuals, up from 158,000 in 2021 (Meko and Kriegstein, 2023). These volatile encounters between officers and individuals suffering from a mental health crisis are increasingly common, but data remains scarce, with limited accounts from those at the forefront of these crises.

Safe responses to high-risk situations require meticulous approaches with the appropriate professionals. In response to the growing concern for challenging police encounters with individuals with mental illness, many states have mandated officers to receive crisis response and de-escalation training during and after the police academy, with many agencies forming specialized emergency response crisis intervention teams (CITs) (Bohrman *et al*., 2018). Despite such efforts, required and recurring training for law enforcement often varies, and some departments rely on co-response models or mobile crisis response teams in collaboration with local social service or nonprofit organizations (Fuller *et al*., 2015; Woods and El-Mallakh, 2025).

The purpose of this study is to encourage multi-disciplinary collaboration that builds data-sharing information capacity between first responders and social service providers in the United States to better analyze and disseminate data while providing continuity of care for those receiving assistance. Specifically, the present study provides a qualitative analysis that supports the pressing need to develop and strengthen innovative data-sharing technology between police departments and social service providers to improve crisis response.

Literature review

Police decision-making in mental health crises

Most police officers today approach encounters by first accessing and processing available information through mobile terminals linked to multiple databases. Officers function as such "knowledge workers" to manage risk and minimize danger (Ericson and Haggerty, 1997). Information sharing enables key personnel to assess an encounter appropriately, better understand the situation before arriving at a scene and build confidence between communities and police (Aston *et al*., 2023; Plecas *et al*., 2010). The information available to officers mainly consists of criminal histories, warrants and, to a limited degree, mental illness information as it relates to previous police encounters (Fuller *et al*., 2015; Khan *et al*., 2025). If law enforcement lacks knowledge or understanding of mental illness, then officers may misinterpret a situation, which impacts their decision-making and future encounters based on prior experiences, leading to a negative and counterproductive response (Bohrman *et al*., 2018; Lindsay *et al*., 2009). In this article, the term "mental illness" suggests an underlying condition, whereas a mental health crisis refers to an acute event.

During calls for service, callers often voluntarily share mental illness information with police dispatchers, who document and relay the information to the officer. Prior studies suggest medical terminology can be miscommunicated during police responses, leading to problematic communications and misunderstandings (Abazi and Elshani, 2021). For example, researchers have found that depression can be interpreted as a formal diagnosis to describe a significant mental illness that requires hospitalization, or it can be used to describe a brief period. In Canada, the Mental Health First Aid Police (MHFA Police) training program goes beyond demonstrating appropriate interventions and interactions by ensuring that trainees understand the correct terminology when differentiating mental illnesses from a crisis encounter (Abazi and Elshani, 2021). Police officers are not responsible for diagnosing an individual, but can expand their knowledge through the training provided to them.

Crisis response models

Crisis call centers have been recognized as an intervention method to address ongoing crisis in efforts to reduce psychological stress, a crisis state, or the risk of suicide. Regarding the effectiveness of crisis lines, Hoffberg *et al.* (2019) argued that efforts should be directed toward establishing proactive response models for consistent, accessible treatment for those in need. While crisis call centers serve a high-risk population, it is critical to ensure safe, rigorous protocols through collaborative, continuous responses. More importantly, police serve as the dominant first responders among those experiencing mental health crises (Marcus and Stergiopoulos, 2022). Competent responders, such as mental health professionals and licensed professionals, would greatly assist law enforcement by providing efficient co-responses that lead to successful intervention and cooperative diversion and assistance.

Though it is not an established tradition for law enforcement to fully understand fundamental functions regarding people with a mental illness (Phillips *et al*., 2010), assisting these individuals has become more reactive than proactive. Responding officers often have difficulty delineating between a mental illness and a substance use disorder. Lord and Bjerregaard (2014) found that when law enforcement responded to a mental health crisis, officers believed that the person was intoxicated with either a psychotic or mood disorder. An officer's lack of knowledge and training may inadvertently escalate a call, leading to an avoidable use of force. For this reason, when attempting to identify a mental illness, police should not focus on determining which specific mental illness they are encountering but try to recognize basic signs and symptoms from a variety of diagnoses to generally assess and respond to encounters involving mental illnesses (Bohrman *et al*., 2018). Instead, co-assisted responses between law enforcement and social service providers with specific training and knowledge are imperative.

Interagency information sharing and governance

Information sharing among police departments and surrounding agencies remains limited. Factors influencing the ability and willingness to share information include competitiveness, department culture and management, privacy and security concerns, legal and confidentiality restrictions and available technology (Aston *et al*., 2023; Plecas *et al*., 2010; Schmit *et al*., 2019). State and federal data protection frameworks, including HIPAA (Health Insurance Portability and Accountability Act) compliance standards, complicate information sharing due to legal and security restrictions. Targeted information would improve evaluation and systemic response, enhance performance and coordinate appropriate care (Schmit *et al*., 2019). Police data can be analyzed and designed to improve current police practices and identify risk patterns to highlight target areas.

Data-informed partnerships are collaborative relationships among law enforcement and social service providers that facilitate the analysis, sharing and dissemination of data while promoting continuity of care for individuals receiving assistance. Effective data-sharing strategies and successful implementation often depend on support from senior leadership. Aston *et al*. (2023) argue that information sharing and data security are critical elements of procedural justice in police practice. Similarly, Russo *et al.* (2020) identified information-sharing as a priority need among law enforcement and community providers. Mainly, data-sharing can improve public safety and communication among external entities, including social service providers, county jails and prisons (Aston *et al*., 2023; Balfour *et al*., 2021; Russo *et al*., 2020). Integrating a multi-sector data system can improve service outcomes by increasing efficiency, coordination and appropriateness of responses for stakeholders and individuals experiencing crisis situations.

The following study presents qualitative data from law enforcement and social service professionals who serve individuals in the community experiencing mental health crises to explore the relationship between these calls to service and the potential for a data-sharing partnership that could proactively assist people in mental health crises. The findings from this

article are part of a larger study that broadly focused on mental health crisis response among police officers and social service providers, with subsequent findings revealing new themes related to the data-sharing infrastructure and need for interagency coordination.

Methods

Sample

Utilizing a social network recruitment method, the researchers conducted semi-structured interviews with social service providers and officers from various police departments in an urban Texas county who had experience in mental health crises. This nonprobability snowball convenience sample began with six known participants approached by the lead author, resulting in the recruitment of 11 participants from local social services and police departments. While 17 participants were involved in the study, 23 professionals received invitations to participate, yielding a 74% participation rate. Study participants provided the lead researcher with their availability for an in-person interview, as well as their personal preference on whether the interview would be held at their place of employment or an alternative setting.

After the 15th interview, the lead author noticed that no new codes had emerged, indicating many repeated codes in the data. Additionally, among the police respondents, all officers worked within one county and were either hostage negotiators or members of their department's crisis intervention or mental health unit. Participants also acknowledged the small size of these units and stated they were familiar with other departments' units and mental health response. Thus, the authors believed thematic saturation was achieved (see Hennink *et al*., 2017).

Eligibility criteria required all participants to be over 18 years old, work in the specified Texas urban county, have professional experience in working through mental health crises and be knowledgeable about crisis response. Participants in law enforcement were required to have at least 5 years of law enforcement experience. Licensed professionals were required to have at least 3 years of practice in their respective clinical field; these participants were licensed professional counselors (LPCs) or were licensed master social workers. Nonlicensed participants were required to have at least 2 years of experience in social services or crisis case management. All but one participant had either attended some college or earned at least a bachelor's degree. All licensed professionals in this study held master 's-level degrees.

At the time of the interviews, the lead author worked at a large nonprofit organization specializing in community-based health services. The lead author avoided interviewing professionals she had worked with directly and recruited professionals from other departments with crisis caseloads. Some of these professionals had direct relationships with police departments in the area, which contributed to the snowball sampling strategy.

Data collection

The lead researcher conducted qualitative semi-structured interviews using open-ended questions to gain a deeper understanding of the need for information sharing between law enforcement entities and social service providers. The semi-structured approach enabled study participants to explore different areas for improvement in their positions, allowing them to draw on personal perspectives and ideal interests to enhance collaborative performance (Patton, 2014). The interview instrument used in this study included four sections, totaling 18 questions. The four sections concentrated on participant demographics, education and certifications, questions specific to the participant's current position and employment duties related to crisis knowledge and response. The interviews ranged from 9 min to 45 min.

Each interview was conducted face-to-face with only the study participant and researcher present, minimizing the possibility of coercion or undue influence, with participation being completely voluntary. All interviews were conducted in the fall of 2019 after university

approval through the Institutional Review Board (IRB). To initiate the discussion, the researcher used a printed interview script as a basis for the interview, allowing flexibility as the conversation unfolded between the researcher and the participant. Interviews were transcribed verbatim in Microsoft Word for thematic analysis by the lead author, who also took extensive field notes during each interview.

Data analysis

The semi-structured interviews conducted in this study were audio-recorded using the Voice Memos app on Apple iPhone. To complement these recordings, the lead author took notes during each interview to help interpret what each respondent discussed. Thematic and narrative analyses allow researchers to identify patterns in qualitative material, such as interviews (Patton, 2014). As the interviews were transcribed, the authors used inductive coding from the field notes and the interview data to develop a codebook. In accordance with the IRB protocol, the lead author was primarily involved in the coding rounds, although the co-author provided feedback and suggestions toward the end of the transcription phase. All audio recordings and interview transcriptions were uploaded and stored on password-protected devices (e.g. an iPhone and a MacBook), with restricted access to the first author.

Results

Interviews were coded inductively, where initial open coding produced 14 subthemes. Altogether, through iterative comparison, codes were consolidated into four themes. These themes represent structural dimensions of crisis response rather than isolated issues and center around a holistic data-sharing approach to strengthen response and partnerships: (1) deinstitutionalization and emergency detention use; (2) need for dual dispatch and law enforcement liaison projects; (3) community relations and (4) supporting family members with loved ones who experience mental health crises. The following results are part of a larger project that focused on police and social service provider responses to mental health crises.

Deinstitutionalization and limited emergency detention options

Deinstitutionalization, or the process of replacing large, monolithic psychiatric hospitals with smaller community-based mental health services, spanned over 2 decades after the Second World War, when many military service personnel returned with post-war mental health concerns. It quickly became apparent that psychiatric hospitals were inadequate and widely criticized for being inhumane places of abuse and neglect. During John F. Kennedy's presidency, the administration's plan was to replace these psychiatric hospitals with more effective and less costly community-based treatment centers under the Community Mental Health Act of 1963 (CMHA). However, a network of community treatment centers never materialized. Instead, politicians pivoted to a law-enforcement incapacitation model under a "nothing works" mentality with rehabilitation and treatment using Martinson's (1974) infamous meta-analysis, which led to a decades-long expansion of incarceration facilities that served as the de facto mental institutions.

A little over half of all participants ($n = 9$) mentioned the deinstitutionalization movement and its negative effects of inadequate and a lack of mental health treatment, with all five police departments represented in this subtheme. Concerning emergency detention, the majority of participants endorsed the use of detainment only if the person poses a danger to themselves or others. The John F. Kennedy and Lyndon B. Johnson deinstitutionalization campaign through the CMHA was referred to by a couple of LPCs in this study. One LPC believed that removing state hospitals may have been "great in theory," which encouraged the development of

community mental health centers and resources. However, access to these supports was limited by geographic location and funding:

> Now, what do we do? Our jail systems became our new mental health systems . . . trying to deliver the person from [correctional facilities] back into treatment services, so we don't just seat people in jail because they are trespassing, and we don't know what else to do.

A police corporal shared a similar opinion, noting that the mental health system's transition in the latter half of the 20th century, during and after the Kennedy and Johnson administrations, revolutionized health care service provision. He explained this transition:

> . . . gave a lot of power to the oath, and I get it, people having freedom over their choices, obviously. I'm sitting here wearing a uniform so everybody can have those rights, but there are certain people that have certain conditions that can't make decisions that are in the best interest of themselves, or their families, or their finances.

Similarly, a mental health peace officer noted that emphasizing human autonomy to individuals in crisis is tremendously helpful for compliance. For example, individuals who frequent psychiatric facilities may have a preferred facility or have active insurance established in a specific facility.

A significant ethical obstacle law enforcement and all mental health professionals face is the use of force to accomplish treatment provisions. A police corporal elaborated on this obstacle:

> It's difficult to get these people the help that they need because we can't force them to. And it's not like an addiction where the person comes to terms with what they have – it has to be their decision, and then they get the help they need, and then they can recover: a lot of those mental health conditions don't have cures. There are just treatments to try and make the symptoms better, and if they go without their medicine for one week, they go right back into that cycle, and it's just tough. I think the biggest barrier is that law enforcement and mental health social workers really have their hands tied with what we are able to do.

Another LPC relayed there was no need to draft a new law, but drew attention toward the government's role in how the general public can and should acknowledge the seriousness of understanding mental illness. Similarly, a mental health peace officer described how mental health awareness and response had changed traditional police practices:

> Back in the old days, in order for us to take someone to [psychiatric hospital], they had to say they wanted to kill themselves, hurt themselves, kill themselves, or they were actually a danger to themselves or others. As time has progressed, there's so many other variables that are involved . . . and a lot of officers don't understand that. Unless you've gone to a mental health class, they still think the old way.

Among the respondents, emergency detentions either result in a transfer to a psychiatric hospital for evaluation or are cleared with a report if the person was not a danger to themselves or others. The police corporal described emergency detentions as tools "that we can use to go and take [the person experiencing a mental health crisis] for an evaluation." However, emergency circumstances arise and are appropriately assessed.

> An overdose, or let's say the person attempted suicide through a cut, or they were a cutter and got a little too enthusiastic about it, and we need some kind of medical treatment like literal physical medical attention.

A police mental health coordinator confirmed that officers provide limited medical attention to people experiencing mental health crises but do default to community resource centers "for an emergency stay," allowing individuals to receive treatment. The coordinator emphasized how "psychosomatic responses" can be confusing when a person in crisis has an anxiety disorder or is having trouble breathing and informs officers that "their chest hurts," which the police take

seriously to seek immediate medical attention to avert a heart attack. Once an individual is discharged from the hospital, the police mental health coordinator and a police officer complete a follow-up visit with the family and "make sure the person [is] taking their medications" has access to medication and is scheduling or attending their doctor's appointments.

In a different police department, a police lieutenant stated emergency detentions are "quite frequent," especially if the person in a mental health crisis is "paired with a threat." The threats range from shootings to threats of harming the public or anything that "raised red flags in the police department." The same police lieutenant provided an estimate of the number of emergency detentions her police department issues monthly, ranging from 100 to 160.

The police lieutenant shared the ethical challenge law enforcement faces when a mental health crisis presents the officer with two options: leaving the person at their home or taking the person involuntarily. Legally, police agencies in Texas can only take a person for a mental evaluation if they volunteer to go or they are "a substantial risk of serious harm to the person or others" (Texas Health and Safety Code 537.001(a)(1)(b)). The department's mental health unit and the police department work together to identify alternatives to response, such as safety planning or "leaving [the individual] with someone responsible." Importantly, the police lieutenant acknowledged that forcing people into treatment is not always beneficial:

> . . . but I don't know if officers realize that that's not good because they think they're helping because they aren't taking them to jail. A lot of police departments, they'll just take them to jail sometimes. So, we really do a good job recognizing mental health issues . . . but I think officers have a flawed sense of "well, I'll take them." It's not like a car wash where they take them, and they come out, and they're fine. And I think sometimes officers think that's gonna solve it. So, we're trying to look for more middle options, using programs, using outpatient, using maybe some counseling agencies that can help us out with some free pro bono counseling.

To close out this theme, one police department with a crisis intervention unit shared its use of public safety risk (PSR) classifications. Specifically, only officers in the crisis intervention unit can check off "Public Safety Risk" on affidavits. Regular patrol officers in the police department cannot select PSRs on their affidavits. The police sergeant explained how the PSR holds individuals in crisis in a respective facility longer, which requires additional training that only officers in the crisis intervention unit must assess their discretion:

> We can make sure that [psychiatric hospitals] know, "Hey this person is a public safety risk, even if they tell you here is in the next assessment that they don't wanna hurt themselves, they don't wanna hurt anybody else. But they've exhibited indications that they might do that to us within the last hour, day, and they need to be detained."

Ultimately, the PSR requires psychiatric hospitals and clinicians to hold the person inside the facility for additional evaluation to determine appropriate treatments or "what the next step should be." The police sergeant relayed how the department has seen the negative outcomes early discharges can produce, noting that although it is up to the medical personnel, PSRs prevent individuals who need mental health assistance from harming others or themselves. More importantly, psychiatric hospitals cannot override the PSR in the affidavit:

> Now, we put [PSR] on there, we list the reasons why we believe they are a public safety risk, if they decide to for whatever reason to kick that person out, and that person goes and does a mass act of violence, well the liability is going to fall back on the [psychiatric facility] and they know that, so they aren't going to kick them out. They are going to say, "okay, yeah we believe that." Which is one reason we don't give access- we don't allow patrol officers to have that ability to do a PSR. If that were the case, then everybody is going to get PSRed.

Medical professionals in this geographic area understand the seriousness of what a PSR on an affidavit stands for, crediting the additional training crisis intervention unit officers receive compared to their colleagues.

It is no revelation to recognize how deinstitutionalization significantly contributed to the present-day challenges that police departments and mental health professionals in the community face. Officers described emergency detentions as a last resort, stressing the importance of cultivating community partnerships and using community resources to de-escalate crises. With this study in mind, a limited number of police departments have not only established CITs but have also strategized and implemented procedures proactively to respond to mental health crises in the community.

Need for dual dispatch and law enforcement liaisons

The majority of law enforcement participants (n = 8) discussed collaborating with local nonprofit organizations and nearby psychiatric hospitals alongside law enforcement liaisons to conduct follow-up appointments with individuals who recently experienced a mental health crisis. Law enforcement liaisons (also referred to as law liaisons) are licensed social workers housed within police departments or their respective behavioral health agencies external to the criminal justice system. Law liaisons are assigned to police departments that have established relationships with various social service organizations in the community. The objective of a law enforcement liaison project is to provide follow-up dispatch visits with people who were in a mental health crisis within at least the past 30–60 days alongside a police officer. The five police departments represented in this study claimed to all have access to and frequently engage with law enforcement liaisons. However, the police mental health liaison that participated in this study clarified that bigger police departments have divisions, such as a homicide division, a fraud division and a crisis intervention division, which typically also serves as the mental health division. As such, law enforcement liaisons are a vital asset to police dispatch and home visit follow-ups.

A police corporal explained follow-up visits are "to ensure that we do a follow-up and meet with [the person] face-to-face, see how they're doing, and see if they need assistance." The police corporal also confirmed that the network between police departments and law liaisons is to visit with people who have recently experienced a mental health crisis that involved a police officer going out to the person's home. These visits were to:

> . . . see if [the person] needs any of the programs that are offered and just offer them, let them know that we care. We express to them that we don't want another incident to happen again, and we are here to offer these services if they want to take part.

In the police corporal's department, the dual dispatch follow-up visits began about a year and a half ago (interviewee specified sometime in 2017), and the department has seen improvement. In other words, the department has seen a decrease in "things that a typical person wouldn't do." The law liaison brings in relevant information and determines whether this person is receiving outpatient services, services through a resource center, or alternative government assistance. The law liaison can also identify if the person in a mental health crisis has a confirmed health diagnosis. The information-sharing is a starting point and "will help our officers to mitigate those instances" where police use of force does not need to be exerted from "a lack of knowledge," expressed the police corporal.

A police lieutenant shared a similar opinion with the police sergeants regarding follow-up visits, as mental health peace officers are designated to ride with law enforcement liaisons. The lieutenant also underscored how all police officers in that specific police department hold a mental health peace officer certification. Some of the police officers are also LPCs, suggesting that the officers from that department hold "unique positions." The law enforcement liaisons respond to mental health crisis calls specifically with the mental health peace officers:

> [The police officers] go out, it may be something innocuous, like a disturbance, or someone is talking to themselves – they're concerned about them. They go out, they discover that this guy has a mental health issue, but he is not doing anything wrong, he's not harming anyone, and he seems okay, 'so what do I do?' So, what they do is they clear the call. When they clear the call, you have different numbers

> and what they do is they check a box that says "Mental Health" that [the report] is pulled each day by the law enforcement liaison project and they read it.
>
> In that call they're reading, 'Joe Brown: says he's hearing voices but there's no danger, says he's off his medication, he can't afford it. Here's his name, and here's his number.' So, our liaison will get that and go, 'we need to see them.' The next time they ride out with an officer, they go see Joe. 'Hi, I'm so-and-so officer with the mental health unit with the department, this is so-and-so from [law enforcement liaison project agency]. We are here to talk to you, maybe help you get some medication.' That's how it kind of works, and we've done a pretty good job in identifying and maybe averting some really bad things.

A mental health peace officer said nonprofit organizations assist with law enforcement liaison projects, especially when the police department receives a report that is lacking information on whether the person in crisis is receiving ongoing treatment. The mental health peace officer said police reports get forwarded to the liaison unit, "so they wind up being the central depositor for that information, and they forward that information out to a neighboring agency so at least they're aware of it." The peace officer provided a general example with a pseudonym:

> "Hey, we've got Bill. Bill belongs in your city and we're dealing with him over here so just letting you know so you are aware and maybe you need to go out and touch base with him too," or something of that nature.

To respect jurisdictional boundaries, the mental health peace officer emphasized the vital need for information-sharing and communication between police departments. In the mental health peace officer's department, the follow-up time frame begins two weeks after the crisis encounter is recorded. "That's usually enough time if they've been stabilized," allowing police officers and liaisons enough time to conduct meaningful home visits. Additionally, the mental health peace officer detailed the contact letter they mail to the individual who experienced a crisis:

> The first thing I do is I get the report, I'll send a letter out and just say, here's who I am, here's my normal process, so in a couple of weeks you should hear from me and here's a couple of phone numbers, so and so crisis line, [neighboring agency'. I just explain it. Suicide prevention hotline, VA hotline, and a handful of others – Legal Ais, and a couple of other resources. Just as a block at the bottom of the letter, just to get them started. If they get home, they get the letter, something to go, 'okay, maybe you can start here.' The back of [the letter] is like a checklist that if you or your family member calls 911, here's some information [the police department] needs, here is what you're gonna see.

The mental health peace officer further described the information on the back of the letter, which listed a step-by-step guide for the person in crisis to understand how law enforcement will approach the person if they are dispatched again:

> So-and-so is gonna come out, don't come running up to the officers and, it may look like you're getting arrested, but you're not. We do put people in handcuffs because we gotta make sure that we're safe and that you're safe.

These reports and follow-up letters are intended to provide additional assistance as personal screening tools for law enforcement and neighboring social service liaisons (e.g. law enforcement liaisons) who arrive at the individual's home.

Relatedly, a different mental health peace officer from a different police department stated, "mental health follow-ups occur after a person has been taken into the hospital for a mental detention." After the mental detention has been cleared, follow-ups take place between two to three weeks after a person is discharged, giving the individual time to get back into their routine or to adjust to any changes, especially if they are prescribed medication. "If they're taking medications, then that gives [the medication] time to process in their systems," said the mental health peace officer. Both the police officer and law enforcement liaison dispatched ask a set of questions:

> . . ..are they eating well; sleeping; are they making their follow-up appointments; do they still have a support system; if not, can we help them get a support system; are you taking your medications; do you think your medications are working; if not, how can we get you somewhere to maybe change them up.

And of course, the last thing we always like to do is to make sure that they don't wanna hurt themselves. More importantly, in all honesty, anybody else.

The same mental health peace officer acknowledged that "law enforcement liaison partners encourage the jail diversions," especially for those with bipolar disorder and schizophrenia who "were off of their medications for an extended amount of time, where they'd get these tic-tac violations for like public intoxication all the time." Law enforcement liaisons and jail diversion programs "alleviate these situations," expressed the mental health peace officer. A police sergeant from the same police department confirmed that the law enforcement liaisons and their dedication to jail diversion coordination significantly help a mentally ill individual who is arrested, increasing the likelihood of "get[ting] treated in hopes that once [they] figure out the issue, maybe they'll stop committing whatever crimes they are committing."

A different mental health peace officer affirmed that the law enforcement liaisons have "connections with hospitals and mental health facilities that help verify if there is room for that one person that we might be taking them to." The liaisons provide a supportive network to continue providing consistent treatment through their rapport with the person or their association with a previous facility, from where the person is more comfortable getting assistance.

Lastly, a police mental health coordinator, who had previously served in a similar role to the law enforcement liaisons in the county, described the difficulties liaisons face, specifically funding and staffing. The law liaisons who work in the field, along with the liaisons who work in community resource centers and hospitals, are also understaffed and sometimes unable to spend as much time as they would like with a client. Notably, more time is needed to take adequate precautions.

> I mean, if we have a liaison in these hospitals, I can tell [the hospital] "this is what we've got." We can tell [the hospital staff], "hey, if this person's threatened to kill a copy or shoot up a school, and they're getting released today." Well, now I can be back at their house today to follow-up with them. So, I think just having that follow-up piece would be huge.

A different police sergeant also acknowledged that neighboring liaison programs might not respond to or be present at the scene, "but we can call them to see what [the person's] background and history is. Within this police sergeant's department, the law enforcement liaison decides if a police officer and the liaison themselves "need to follow up more than once," or for just that one visit. In other words, the professionals give the person in crisis the freedom to express whether they would want additional follow-ups, respecting their human autonomy while assessing their condition and the matter at hand.

Law enforcement liaison projects across the county have benefited police departments when responding to mental health crises. Law enforcement liaisons provide valuable resources and de-escalation tactics for officers to adopt and utilize for future dispatch and crisis response. This partnership between law enforcement liaison agencies and police departments cultivates proactive communication and encourages police officers to receive mental health peace officer training.

Community relations

Study participants ($n = 12$) confirmed that community collaboration is essential to better serve people in mental health crises. Nearly all police departments ($n = 4$) were represented in this subtheme. Communities will continue to struggle if there is no progress in educating citizens on understanding and accepting mental health challenges. If citizens are educated on a surface level to recognize basic symptoms of mental illness and psychiatric disorders and are aware of resources in the community, then the public can better interact with the mentally ill.

A police sergeant noted that government agencies, such as their local Federal Bureau of Investigation (FBI) field office, have expressed interest in receiving educational opportunities for their agencies. The FBI "doesn't have a whole lot of mental health training, and they've gone out with us on a few referrals," noted the police sergeant. A mental health peace officer stated that different police departments have "little collaboration" of mental health peace officers, as not every department has full-time mental health peace officers. The mental health peace officer specified:

> Every month we'll have a meeting where we touch base with each other because some of these folks, especially if they are mentally ill, they don't sit in one city. So, we may let one another know, 'hey, we know that we are both working on this one person,' or we may staff a case ourselves, 'man, I've had this, and I can't seem to get anywhere, anybody have any ideas?' So, we'll bounce off of each other.

With law enforcement liaison projects, the majority of police officers commended the project as a primary community resource. The same mental health peace officer conducts training with other police departments, jailers, and even court employees throughout the northeastern part of the county. The mental health peace officer specified that the training is a 40-h course and includes de-escalation skills, which the courts need. The clinical crisis program director noted that the crisis unit also provides training for police departments, hospitals, fire departments and even community colleges and local universities:

> There's a lot of [community] outreach on our part in terms of focusing on. One of our goals is to help develop supports, for the people that we serve and another one of our goals is trying to build capacity within the system . . . so, it's not just outreach to other agencies to help our people, but also to build up the community in terms of knowledge and resources.

Collaborative efforts among nonprofits, courts and correctional facilities can serve to garner public support. A jail program manager posited that the community benefits from hearing about success stories in the media, which allows the "voting public" to see firsthand how the criminal justice system is working to reduce criminal activity in the community and "changing the perception of others."

Diversion programs can serve as an effective alternative to incarceration before a person in crisis gets charged. The same program manager expressed, "If [police officers] had this option of taking this person to a facility rather than taking them to jail or psych unit, then they might be willing to consider maybe not just arresting this person." Diversion facilities would expedite the rehabilitation process, as clinical professionals could attend to people in crisis and help them transition smoothly back into the community. This claim was supported by a mental health peace officer. A different mental health peace officer believed "there is a growing dilemma in our community" for mental health resources and the decline in group homes and diversion programs for people with a mental illness who lack a support system.

Participants underscored the need for community education on mental health awareness. However, public perception and willingness to understand mental health may limit public support. One police mental health coordinator expressed his frustration, stating, "the community has to want to be educated, adding especially since officers are pressured to be society's "new frontline social workers." Nevertheless, his department continues to try to educate the community watch groups through workshops and presentations.

Some police agencies have started early education efforts, integrating mental health into high school curricula. A police sergeant explained the positive effects of a mental health curriculum, stating, "The same reason we started adding chemistry and biology to schools should be the same reasons we are adding psychology to high schools." Furthermore, educated youths can help break the culture of stigmatizing mental health while simultaneously increasing mental health awareness. An LPC described regulating mental health in health education at both the high school and collegiate levels can normalize mental health as "a part of all of us" and "cared for and included" as a normal part of society."

Supporting families through community partnerships

The final subtheme among participants ($n = 4$) was support from family members, friends and loved ones, along with obstacles they encounter and even engage in. Only two of the five police departments ($n = 2$) elaborated on perspectives in this subtheme. Family members provide as much assistance as they can, but often struggle with providing support for treatments, interventions and access to medications and medical professionals. Police officers who are personally motivated to aid those with mental illness, whether they have a family member or loved one with mental health needs, are often driven to help others. A police corporal explained how these officers specifically "tend to be more involved with these types of calls, more involved with trying to come up with solutions," and are "more involved with attending continuing training."

The same police corporal pointed out that family members cannot be the ones to force their loved one into treatment:

> The main issue is that we kind of have our hands tied, and the families do too. You have a family that is dealing with a person that, just say they're bipolar, right? I mean, what do they do? The family can't shove the pill down their throat, or like physically restrain them. I mean, you could, but how incredibly cumbersome is that for a family that is already dealing with whatever this bipolar individual is already doing, in between their cycles.

The police corporal highlights a need for establishing a balance between the person's freedom and acknowledging their mental impairment. If a family member or friend sees the need to obtain a Medical Power of Attorney, then:

> . . . those Power of Attorneys can allow for crisis intervention to take place and help that individual with Power of Attorney get that person to a doctor, the same way if we had a warrant for someone. Like, I have an arrest warrant, let's take him to jail. "I have a medical Power of Attorney, he's not taking his medication, this is what he is diagnosed with, can you please help me take him to the doctor?" And then they will become involved in that way.

Though the corporal did not explicitly encourage applying for a Medical Power of Attorney, the corporal thinks families who are involved with a mentally ill person who is constantly in crisis would benefit from a Medical Power of Attorney when it comes to enrolling their loved one in treatment or medication prescriptions.

Structural factors often limit family support. A police mental health coordinator cited limited funding, long wait times, and inflexible hours of operation often limit families' ability to take their loved ones to get services or treatments. He explained that patients without appointments must "stay there all day." The same mental health coordinator claimed that the biggest challenge in working with people who suffer from a mental illness or psychiatric disorder is that people who are mentally ill "typically don't have a lot of family support because law enforcement gets involved." Families themselves may not understand what their loved one is experiencing or may simply not be in the picture. Some families may confide in the police and trust that officers will be able to provide the support an individual needs. The police mental health coordinator believed in connecting families to organizations such as NAMI, the National Alliance on Mental Illness, to encourage families to attend training sessions or join local support groups that could help them gain a better understanding of mental illness. Yet, the subsample alluded to how families face internal struggles to address the crisis at hand adequately. As families lose motivation, they sometimes turn to the Internet, which is not a reliable source:

> Honestly, I think the Internet has been a hindrance. I see a lot of people who, everybody I go talk to is self-diagnose bipolar, you know? Or they've diagnosed their loved one with bipolar. I think we Google things too much, we self-diagnose too much, we self- diagnose loved ones too much. I think that you know you really don't see a lot of people going to classes anymore to get educate, they just wanna sit at home and read it on the internet. We can find anything to validate anything we want.

As far as linking families and friends with resources for a person with a mental health need, a program manager over jail staff commended nonprofit organizations and how social workers and employees "talk with family members about the services provided and what [non-profit organization] can do when [they] are dealing with community resources." A social worker from a nonprofit organization suggested that educational opportunities for families should begin at the point of a person's diagnosis. The social worker believed that if a mental illness or even a disability runs in a person's family, then "intervention needs to take place and given the resources to understand" the genetic patterns and better understand the person's diagnosis. This perspective was akin to the clinical crisis assistant program director's perspective, as early intervention is a targeted approach:

> Families may not know that their loved one has a mental illness. Not every mental illness is physically visible. If families don't know the symptoms, then they aren't going to necessarily support their family member. It's a silent killer that needs more awareness and advocacy. If [mental illness] runs in the family, then it's easier to perhaps treat early on.

The majority of participants support educating the community, but more specifically, families and those who have daily interaction with the person suffering from a mental illness.

Discussion

This study contributes to the limited body of research advocating for data-informed partnership between police departments and community-based organizations, including nonprofit service providers. The results identified structural and organizational elements, tensions between liability and care, and challenges within information coordination that impact the overall response to mental health crises. Cross-agency communications and collaborations contribute to a proactive solution by developing liaisons and novel classifications that bolster police response with crucial, relevant case information.

A data-informed partnership allows key personnel to understand and promote effective response strategies by identifying a person's essential demographics and pertinent information before arriving on the scene. Cross-sectoral development will help implement care plans for rapid follow-up for those who are experiencing a mental health crisis or have a history of emergency detention or inpatient psychiatric facilities. By collecting and exchanging data, staff on both ends can utilize the information available on the servers to respond effectively, assess adequately, and ensure officer, client and neighborhood safety. Study participants noted that increased social work collaboration with police officers could enhance productivity by enabling quick communication in time-sensitive scenarios.

Based on participants' interviews and experiences, data-informed partnerships have the potential to strengthen community policing by encouraging proactive, rapid responses rather than reactive ones (Aston *et al*., 2023; Balfour *et al*., 2021; Redmond and Baveja, 2002). Key points from the results encourage a joint data system to generate critical reports to target priority needs and to establish focus groups among crisis support staff, dispatchers and police departments. These focus groups or meetings have the potential to establish critical community relationships that address crisis response. Findings are also consistent with Florence *et al.* (2011), as streamlining data can enhance proximity to locations rather than focusing on common hot spots, thereby improving prevention efforts and expanding support reach.

Compiling accurate data to improve day-to-day performance will also increase response productivity. The findings from this study further support the work of Russo *et al*. (2020), as law enforcement entities would greatly benefit from establishing a data-driven management approach between various service providers. Similar to Aston *et al.*' (2023) comparative study across European countries, responsiveness and efficiency are tied to public perceptions. Respondents in the current study promote the development of community partnerships to establish – or continue supporting – a safety net that

intentionally serves citizens in need. With current information and more immediate access, staff from both responding ends can input new reports and analytics to enable cross-reference. Duplicated information can then be troubleshooted, a common issue that study participants also expressed concern about.

The respondents generally noted that collaboration often begins and is strengthened by developing individual personal relationships. It is often the case that personal phone calls and text messages are made during crises and when handling difficult cases. For this reason, law enforcement investigators often share office space in the same building. Moreover, successful collaborations require shared responsibility for financing, accountability, training, such as racial bias, and health equity (Balfour *et al*., 2021). Aligning outcomes and incentives can alleviate cultural and structural barriers, suggesting that addressing the mental health crisis goes beyond simply increasing funding.

Conclusion

Recently, Texas saved nearly $90 million by sharing data among government agencies through a "uniform methodology," enabling coordination to help people with incarceration records find and keep employment (Wood, 2019). Similar efforts must continue to develop to strengthen collaborations and community trust. Cooperation between jurisdictions and communities offers opportunities to inform first responders and reduce the impact of these crises.

Recommendations include local and statewide studies on data-informed partnerships to assess the need to leverage external system integrations to improve officer responses. The luxury of housing data analysts within police departments is rare, as is access to updated software and technology. Departments are significantly constrained in improving communication because they rely on federal funding. Existing web applications that are specifically designed for helplines and crisis lines, such as iCarol software, specialize in data stewardship and collaboration for nonprofit organizations (iCarol, 2026). Additionally, not all 911 dispatch units are housed in police departments; some are in fire departments and operated by hospital districts, which can create additional medical and legal barriers for communication. Further recommendations include strengthening police dispatch training, community resource awareness and collaborations.

This study, while limited in scope and generalizability, serves as a basis for further inquiry. Future research should expand collaborations beyond Texas to other states and metropolitan areas for comparative studies. Moreover, quantitative analysis may be possible with large sample sizes using thematic variables identified with this study.

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