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Law Enforcement Interactions with Persons with Mental Illness

Introduction

This *TELEMASP Bulletin* summarizes a survey of 35 Texas police departments and six sheriff's departments about their interactions with citizens who are mentally ill. The police departments served cities of a wide range of sizes, from Houston and Dallas, to Trophy Club. All six sheriff's departments served populous counties.

Background

"Mental illness" is a term used to describe a variety of conditions which appear to influence a person's behavior and/or how the person perceives the world. Traditional labels like "crazy" or "maniacal" fit only a small number of the mentally ill and, even then, are mostly misinformed. Some mental conditions are chronic, although they may vary in intensity from time to time, while others are ephemeral, being obvious at one moment, then disappearing. Some are responses to special stresses, and some appear to present themselves without regard to the external environment. Mentally ill people might hallucinate and see or hear things that no one else around them can or become depressed and totally passive. On the other hand, others may become so excited that they cannot behave themselves without restraint. Most of the time,

however, people who are mentally ill are legally and factually competent and are able to manage their own affairs.

Peace officers interact with mentally ill persons who may be victims, offenders, witnesses, or bystanders. Police also interact with the mentally ill who need to be taken into custody or transported as part of mental health court proceedings or when they are in crisis and threatening harm to themselves and/or others. The second situation is often momentary—the citizen may be in crisis because of an external problem (e.g., marital or work related), but his current behavior is dangerous to himself and those around him. In some cases, the crisis turns into "suicide by cop," an occurrence which is traumatic to the peace officer, those around the citizen, and the citizen himself.

But if mentally ill citizens are much the same as others, they are also different. First, mentally ill people, especially when in crisis, respond differently to perceived threats. Police officers should be sensitive to those differences and act in such a way that the situation is under control and not made worse. Second, there is debate about the best way to respond to the mentally

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ill offender, consistent with public order and safety and consistent with the best interests of the offender. Advocates for the mentally ill argue that these offenders should be managed outside the criminal justice system.

Public cost is one argument for wanting to divert the mentally ill out of the criminal justice system. If mentally ill citizens can be served by the mental health system in a way that protects public safety and order and costs less than the criminal justice system, that approach is preferred. But diversion must be convenient if it is to work, and there must be something to which mentally ill offenders may be diverted.

Without a warrant, peace officers may arrest mentally ill persons in two situations. The first arises when a person commits an offense, regardless of whether or not mental illness exists. According to Code of Criminal Procedure, Art. 14.01(b), "A peace officer may arrest an offender without a warrant for any offense committed in his presence or within his view." The law also provides special authority to take a mentally ill person into custody without a warrant when the severity of the mental illness and other factors justify such custody. According to Health and Safety Code, Section 573.001,

- (a) A peace officer, without a warrant, may take a person into custody if the officer:
 - (1) has reason to believe and does believe that:
 - (A) the person is mentally ill; and
 - (B) because of that mental illness there is a substantial risk of serious harm to the person or to others unless the person is immediately restrained; and
 - (2) believes that there is not sufficient time to obtain a warrant before taking the person into custody.
- (b) A substantial risk of serious harm to the person or others under Subsection (a)(1)(B) may be demonstrated by:
 - (1) the person's behavior; or
 - (2) evidence of severe emotional distress and deterioration in the person's mental

condition to the extent that the person cannot remain at liberty.

- (c) The peace officer may form the belief that the person meets the criteria for apprehension:
 - (1) from a representation of a credible person; or
 - (2) on the basis of the conduct of the apprehended person or the circumstances under which the apprehended person is found.
- (d) A peace officer who takes a person into custody under Subsection (a) shall immediately transport the apprehended person to:
 - (1) the nearest appropriate inpatient mental health facility; or
 - (2) a mental health facility deemed suitable by the local mental health authority, if an appropriate inpatient mental health facility is not available.
- (e) A jail or similar detention facility may not be deemed suitable except in an extreme emergency.
- (f) A person detained in a jail or a nonmedical facility shall be kept separate from any person who is charged with or convicted of a crime.

The authority to take a mentally ill person into custody (the statute avoids the word "arrest") because of his mental illness is civil and not criminal in nature and is limited to cases in which the person, without some intervention, constitutes a risk to himself or to someone else. The custody must be by a mental health treatment facility. Jails and detention facilities are usually not appropriate. This custody is also short-term: either the citizen is released or an appropriate court decides that he remain in custody and under care, a decision periodically reviewed.

The key word in both statutes is "may." A peace officer has many responses to citizen misconduct or disorder other than arrest. An officer's actual response is a function of the facts, the desires of the affected parties, his own expertise and judgment, departmental policy, the practical availability of possible responses, and community expectations.

The mental health system is composed of courts, private/governmental mental health providers, and public mental health authorities. Most mental health care is voluntary: the patient has the capacity to consent to treatment and does so. Courts become involved when there is a concern that the citizen really needs care, but either cannot or will not consent. A court may order care, but only in limited circumstances, when "there is a substantial risk of serious harm to the person or to others."

Private/governmental mental health care providers are paid by their patients, insurance, or governmental programs for which the patient is eligible. Examples include people whose health insurance covers the cost of their care, veterans, and those eligible for Medicare and Medicaid. Their services are not necessarily voluntary; a court may order mental health hospitalization by a provider who can be paid through a source for which the patient is eligible.

In Texas, public mental health authorities provide services primarily to those who are severely mentally ill and who are unable to fund the cost of their care. Mental health authorities usually act as mental retardation authorities and are typically referred to as mental health-mental retardation (MHMR) authorities. For the most part, they are the mental health care providers of last resort¹ and will usually not be involved with mentally ill citizens who are only moderately impaired or who have insurance or other coverage. However, they may be the provider of first resort in crises when the existence and availability of other providers is unknown.

Some citizens' problems are obviously and exclusively mental health matters, but many that police officers deal with are both criminal and mental. When the mentally ill citizen is a victim or complainant, the responding peace officer may need special skills to elicit important information and to take proper action. When the mentally ill citizen is an offender, there are a range of cases in which a peace officer may properly dispose of the matter informally, arrest the offending citizen, or transfer the citizen for mental health care. In such situations, the practical problem for the police officer or the officer's supervisor is how to respond to

the case and be available for the next call for service. When the practical choice is between jail or mental health care, the jail is almost always available, but the mental health system is not always available and is not always convenient even when it is available.

The most important decisions are made by the officer who responds to the request for service. He must assess the situation and identify appropriate responses. If mental health care is one of the options, the officer needs to know when a referral is available or appropriate. It is also desirable to have access to someone who can inform that judgment. In some cases, information from the citizen or his family or friends can turn involuntary care into a voluntary referral. But sometimes, an involuntary referral must be made and emergency mental health care initiated.

When emergency mental health care is the appropriate response, the typical first police access to the mental health system is through designated psychiatric facilities or emergency rooms. The mental health authority initially acts as the gateway to mental health care and will frequently require that other causes be ruled out before evaluation. This is not unreasonable, given that many apparent crises are due to excess drugs or alcohol or more prosaic medical problems: when the substance or medical issues are resolved, the mental health problem disappears. In emergency rooms, unless there is bleeding or other obvious trauma, the medical staff will not rush to attend to a patient simply to clear him medically for psychiatric attention.

An important theme in the survey responses was inconvenient access to mental health attention. The Bryan Police Department summarized the problem in observing that the department's typical crisis is a suicidal intoxicated person. The hospital will not take custody, and the mental health people will not screen until the citizen is sober. Since no one else will take custody, at least one officer must stay with the citizen for five to ten hours until he sobers up and is no longer suicidal. The mental health contact then becomes pro forma, with the citizen signing a form saying that he is no longer suicidal, told to call the mental health people should he become suicidal again, and then released.



This scenario presents two questions. The first is “who should be responsible for taking care of the citizen while he waits in the hospital?” and the second question becomes, “who is actually responsible?” The Bryan Police Department’s response to the first question would be “someone else, probably the mental health authority and maybe the hospital.” Their answer to the second would be “the Bryan Police Department, because we were first to respond and couldn’t get anyone else to take the case from us.” While the “suicidal drunk” described is substantially mental health-related, and police intervention indisputably saved a life, it also strained limited police resources that could have been used in other ways.

This also comments on the police department’s vision of its role, to which this transaction is not central. This also involves a transaction in which every actor performed his duties properly as he saw them. As first responder, the police cannot morally release the citizen before he is safe unless someone else takes responsibility. The hospital does not claim to be equipped, authorized by law, or specially funded to take custody of citizens—particularly intoxicated persons—who are making suicidal gestures. The mental health authority is not robustly funded, these transactions do not normally occur during regular business hours, and a “drunk acting badly” is not the reason an authority is funded. In addition, all the actors endeavor to maximize their scarce resources by not taking on someone else’s additional workload.

Another viewpoint is that artful responses sometimes depend on experience. Bryan is small enough that this type of transaction occurs often enough to be irritating but not often enough to handle comfortably. They also do not happen frequently enough to develop standard responses or to obtain special funding for responding to these calls.

While peace officers are not mental health professionals, they do need some special skills if they are to be effective when dealing with mentally ill citizens, especially those in crisis. TCLEOSE standards mandate a specified level of training in mental health issues for all peace officers. Some Texas departments take a more

assertive view about their role and supplement the basic TCLEOSE training requirement with special mental health staffing and training. The survey revealed that special police staffing for mental illness was most likely to occur in large urban counties with mental health authorities eager to connect with the law enforcement community, and the law enforcement community eager to use mental health resources and expertise. Included are Harris, Tarrant, and Travis counties and the cities and counties in or near them.

There are a variety of ways to organize police and sheriff services for mentally ill citizens. One approach is the Galveston County model, the first of its kind in the nation. In 1976, the Galveston County sheriff and the Gulf Coast Center—the mental health authority serving Galveston County—observed that at least some of their clients were served by both agencies. Both agreed that these citizens might more effectively be managed by mental health providers. Two major problems were limited mental health skills of the deputies and confidentiality duties of the two agencies. Mental health information, like other patient medical information, is confidential. Similarly, criminal justice information about citizens is not eagerly shared.

The Galveston solution was to train regular deputies in mental health care and make them employees/officers of the mental health authority who could function more effectively with mentally ill citizens. Since the deputies were in both structures, they could bridge the confidentiality gap and assure that the sheriff and the mental health people were not acting at cross-purposes. The mental health deputies are tasked whenever a known person comes to the dispatcher’s attention, becomes a treatment problem, or a transaction appears to need their special skills (Winburn, 2003.) Although none of the responding departments have explicitly adopted the Galveston model, various aspects of their operations address the same issues.

A related approach is the Memphis model response to a crisis. In 1987, a mentally ill person was waving a knife around and threatening to kill himself when his family called the police. Upon arrival, the responding officers tried, but failed, to overpower him. Unfortu-

nately, when he attacked the police with his knife, he was fatally shot. Chaos erupted in the community over the tragic shooting of this African-American man, resulting in two changes that bear on this survey.

First, the Memphis Police Department saturated its own ranks with Crisis Intervention Team (CIT) officers who had special training in dealing with people in crisis.² Approximately 10 percent of Memphis officers are now CIT trained and are available whenever their skills are required. Second, new mental health resources became available. A drop-in center, locally referred to as "the Med," was opened for citizens in need of custody and mental health treatment. The facility receives all patients, including those whose apparent problem is drug or alcohol induced.

The Memphis model produced a number of effects, including a reduction in the number of officer injuries and a reduction in the number of arrests arising from mental health calls, thereby reducing jail and judicial costs. While the Memphis model does not require officers to function as quasi mental health personnel or address liaison issues like the Galveston model, many of the CIT officers have established relationships with citizens. They are often personally requested by the citizens and their families when problems arise, and a fair proportion of those contacts avoid more difficult work in the future (Borum, Deane, Steadman, & Morrissey, 1998; Vickers, 2000).

When the advantages of having officers with extra training in mental health issues became apparent, TCLEOSE adopted the Galveston County training program as a model and began certifying mental health peace officers. In April 2002, there were almost 1,000 officers in Texas with mental health special certification, and many more have received similar training, but have not been certified (Campbell, 2003).

Some of the responding departments had adopted a model similar to Memphis. For example, in 2002, there were 341 certified mental health peace officers in Harris County. Houston implements the CIT training with mental health peace officer training plus additional elements (Campbell, 2003). Houston re-

sponded that it had trained over 700 CIT officers and another 450 from its region. Harris County responded that it had 150 CIT deputies. Similarly, Travis County, surrounding counties, and the cities within them had committed heavily to the Memphis model.

In a follow-up interview, Officer Frank Webb of the Houston Police Department said that the current Houston approach (especially the deployment of CIT officers) began as a pilot study in 1999 but followed at least a decade of dialog between the Mental Health-Mental Retardation Authority of Harris County and the Harris County law enforcement community. One of the shared issues was expedited processing of mental health crises and commitments. When a mental health referral is appropriate, an officer can take a citizen to the Neuro-Psychological Center and complete the paper work in fifteen minutes. Like Memphis's Med, the Neuro-Psychological Center accommodates those whose problems appear to be drug and alcohol induced. Additionally, Houston has had a reduction in arrests from calls for service initially classified as mental health calls (Webb, 2003).

Tarrant County provides an alternate approach. The Arlington Police Department provided a 2001 report on improvements in Tarrant County and, in particular, in Arlington. Tarrant County enjoyed a great amount of dialog between mental health providers, community advocates, and government agencies, including law enforcement. Although no Tarrant County agency adopted the full Memphis model with CIT officers, they did require that all officers receive a four-hour First Responders to Persons with Mental Impairments course. By May 1, 2001, 440 Arlington officers had completed the training as had 2,188 out of 3,000 officers in the county, representing 29 police agencies. Additionally, 51 Arlington officers had completed the Mental Health Peace Officer course by May of 2001 (Fisher, 2003).

The mental health authority also obtained funding for three mental health liaisons who are authority employees and are always available to any Tarrant County peace officer. If a question arises about an apparently mentally ill citizen, the liaisons can advise an officer on



how to proceed. They also can determine if the citizen is already a mental health consumer and coordinate referrals to appropriate social service agencies.

After Tarrant County police agencies expressed dissatisfaction about delays in emergency room processing, the county hospital provided for expedited processing of broadly defined mental health referrals. Now it takes roughly fifteen minutes for the hospital to accept mental health apprehensions. As officers discovered the convenient process, the number of warrantless mental health apprehensions increased. However, the question remains, what proportion of the increase is avoided criminal arrests and what proportion is mental health warrants that officers walked away from before the hospital process became so convenient?

Overall, communities that had adopted techniques like the Memphis model were pleased.

The CIT program has proven to be very effective in helping law enforcement respond to these very difficult and volatile situations.

We have provided our officers with a new and different set of tactics/techniques/tools to add to their repertoire of skills (Webb, 2003).

Similarly, the approach taken in Tarrant County and in the Arlington Police Department were also effective responses to their needs and environment (Fisher, 2003).

The Survey

The survey asked respondents to rank order the frequency with which their department encounters mentally ill citizens. There was a variety of responses, as shown in Table 1. However, most items fit into relative ranges for which there was a consensus that it was a high frequency, but some disagreement about how high. The differences between agencies are most likely due to the instrument requesting a subjective guess about frequency and also the differences between communities. Community demographics, the availability of private resources for responding to mental illness, and the local context of social disorder

Table 1

Rank Order of Frequency of Encounter and Difficulty of Transactions

Types of Transactions	Rank of Frequency*	Difficulty Rating**
Family, friends or other concerned persons call the police for assistance during a psychiatric crisis.	1	2
Mentally ill person feels suicidal and calls the police as a cry for help.	2	1
Street encounter with a mentally ill person behaving inappropriately.	3	2
Citizens call the police because they feel threatened by unusual behavior or the mere presence of a person with mental illness.	4	2
Mentally ill person calls the police for assistance because imaginative threats exist.	5	2
Mentally ill person is the perpetrator of a crime.	6	2
Mentally ill person is the victim of a crime or accident.	7	2
Mental health agencies or hospitals call for security when a client is disruptive.	8	2
Mental health agencies or hospitals call for assistance with transport.	9	3
Court order or petition to detain, commit, or transport a person with mental illness.	10	3
Physician petition or certification to detain or transport a person with mental illness.	11	3

*Low number is high frequency

**1=very difficult; 2=some difficulty; 3=relatively routine



all affect the frequency of the transactions involving the mentally ill.

The survey asked about the stress and difficulty of the same types of transactions. Table 1 also reports the predominant response for each type of transaction. Most were deemed as slightly more difficult than the typical police transaction. Requests to transport patients were seen as relatively routine, but responses to a suicidal citizen who calls police as a cry for help were seen as very difficult and stressful.

The survey asked for the perceived likelihood, on a five point scale, ranging from much more likely to much less likely, of mentally ill citizens to be victims of different types of crimes. Table 2 shows that a mentally ill citizen is less likely to be a victim of homicide or motor vehicle theft, and slightly more likely to be a victim for the other listed offenses.

Table 2

Perceived Likelihood that Mentally Ill Citizen Will Be a Victim of Specified Crimes (Lower scores indicate greater likelihood)

Score	Type of Crime
Personal Crime Victimization	
2.45	Simple Assault
2.53	Larceny/Theft
2.65	Sexual Assault
2.85	Robbery
2.88	Aggravated Assault
3.38	Murder/Manslaughter
Household Victimization	
2.68	Offenses against family and children
2.78	Larceny
2.98	Burglary
3.45	Motor Vehicle Theft

Agencies were also asked about special patterns of victimization for persons with mental illness. Most respondents noted no special victimization problems, and a few observed that the frequency of cases in

which the victim was obviously mentally ill was rather low. However, a common theme of those who did comment was that mentally ill people were easy to exploit and often the victims of people they knew and trusted. The Carrollton Police Department stated, "The mentally ill are often victimized by people they know and are unaware that they are being victimized," and the Rosenberg Police Department responded that "Friends and close associates tend to be suspects in thefts from mentally ill citizens." Some subpopulations drew special attention. The Arlington Police Department noted, "Mentally ill persons are easy victims to sexual predators, who believe victims will not understand or report an offense and will not be believed if they do report." The Amarillo Police Department added that "Homeless mentally ill are much more likely to be victimized."

The survey asked how problematic, on a five point scale ranging from a critical problem to almost never a problem, were certain behaviors of mentally ill citizens. Although none of the behaviors were exclusive activities of the mentally ill, responses varied, depending on the circumstances and the various interpretations of the question. One department might regard a behavior as problematic if it does not occur often enough, while another might regard the same behavior as non-problematic because it happens frequently. And, of course, some departments see the behaviors as part of police work and not as problems. Table 3 shows the mean scores.

Table 3

How Problematic Are Certain Behaviors? (Lower scores indicate more of a problem)

Score	Behavior
2.78	Threatening suicide
2.90	Nuisance behaviors
3.13	Wandering the streets
3.18	Physically threatening family members
3.30	Loitering in public places
3.30	Homelessness
3.45	Physically threatening other citizens

Agencies were asked, "In non-custodial situations that nevertheless require longer-term intervention, who does your agency normally contact?" These would entail situations in which the responding police officer sees no need to take someone into custody but does observe a possible need for services. To whom would the citizen be referred for services? Table 4 reports the number of times departments named each type of provider. These choices were not exclusive, leaving several possible alternatives. The Houston Police Department noted that services were not available except in crisis situations.

Table 4

Provider to Whom Non-Custodial Contacts Might be Referred

Number	Type of Provider
24	Community mental health center
13	Hospital
9	Local mental health professional (psychologist or psychiatrist)
9	Specially trained officers
3	Specific mental health components
1	Local citizen volunteers trained in intervention

A follow-up question asked, "In a custodial situation, to what facility is the mentally ill person normally transported?" Respondents usually selected one possible choice, although several could be indicated. The results are provided in Table 5.

Table 5

Type of Facility Used for Transfer

Number	Type of Facility
28	Hospital
14	Community mental health center
5	County jail
4	State hospitals
1	Lockup or holding facility

Respondents were asked whether the department had an agreement with a community health center for crisis intervention services. Seven responded that they had such agreements and 33 replied that they did not. They were then asked whether the department had a written policy on interactions with mentally ill citizens. If so, a copy of the policy was requested. Twenty-four departments had policies and 17 did not. A few of the policies merely cited the law, but most were succinct, containing concrete guidance on steps to take and where to go.

Another question asked about the kind of mental health training provided, mental health interventions, and crisis intervention. These issues were normally addressed through basic and in-service training but were also provided by the local mental health authority. Respondents were asked if any of the department's officers had special training in dealing with mental illness or crisis situations, and how many and what kind of training? Nineteen departments indicated some type of special training and had at least some CIT and MHPO officers or hostage negotiators.

Departments were asked to rate a set of topics in terms of training needs on the following scale: critical training need, training very important, training definitely useful, some training might be helpful, and training unnecessary. Table 6 reports the mean responses. Interestingly, regarding use of force training, respondents rated it at the two extremes, indicating either it was very important or not important.

A series of questions were directed to departments that operated jails or lockups. All six counties and 21 police departments responded to these questions. The six county jails and 16 police department facilities had some kind of formal screening for mental illness during booking. When asked about mental health screening if behavioral indicators were present, the remaining five facilities would contact the mental health authority. Twenty-one agencies had a procedure for immediate transfer of a severely mentally ill person to a designated facility for such transfers, but five departments did not, including Bexar County, which noted that it had 130 employees and could handle any

Table 6
**Importance of Mental Health Training
(Lower scores indicate greater importance)**

Type of Training	
2.17	Recognizing behaviors indicative of mental illness (including distinguishing from drug influence)
2.32	Techniques for handling specific situations (subject is hallucinating, paranoid statements, non-responsive)
2.39	Appropriate approaches and interactive behaviors
2.61	Legal requisites pertaining to emergency detention
2.66	Police role in involuntary commitment
2.88	Use of force guidelines
2.93	Custodial versus non-custodial decision criteria
2.93	Appropriate transport techniques
2.95	Categories and characteristics of mental illness
2.98	Custodial procedures
3.07	Attitudes toward mental illness
3.15	Availability of community mental health services
3.20	Terminology associated with mental illness
3.46	Non-custodial consultation and counseling

psychiatric emergency onsite. The Harris County Sheriff's Department stated that the Harris County MHMR Authority provided services at the jail.

Some mentally ill confinees must remain in custody. Respondents were asked if they were separated from other inmates, provided mental health services, and handled differently in any other way. As to separating the mentally ill, 19 responded in the affirmative and two each said either "no" or "it depends." All the counties and Texas City provided counseling and psychiatric services. None of the other city facilities provided such services, most likely because confinees remain in their custody for short periods. Mentally ill

confinees did receive some special treatment. Counties provided separate housing and mental health treatment as appropriate. Some reported that they use padded isolation cells when necessary, and several of the cities reported that they expedited the transfer of mentally ill confinees to the county jail.

Most of the preceding questions about lockups and jails assumed that the mentally ill were being managed in connection with criminal law enforcement functions of the departments. But mental health is also a civil issue for sheriff's and police departments. When mentally ill citizens are taken into custody and directed to court or to a treatment or diagnostic facility, someone has to transport them. Traditionally, this is a sheriff's department function, but other arrangements are possible.

Respondents were asked how frequently per month their department transports mentally ill persons in response to court orders or petitions. Five sheriff's departments and 13 police departments answered. The record for number of transports was set by the Travis County Sheriff's Department, with 65 per month, followed by Dallas (20), Randall (5), Bexar (3), and El Paso county sheriffs' department (2.5). Arlington and Harlingen police departments reported five transports per month, and ten police departments reported between two per month and one every couple of months. Some of the answers suggest that many of the transports occurred when the police initiated mental health commitments, and their time included arriving at the hospital and waiting for mental health screening.

Follow-up questions asked if anyone else provided transportation, how many officers are engaged in a transport and how long a typical one takes. In answer to the first question, the constables in Harris and Dallas counties and the mental health authority in Tarrant County transport mentally ill persons in response to court orders and petitions. One or two officers are involved in any single transport, depending on the patient and the agency. The briefest transport, by the Bexar County Sheriff's Department, takes 45 minutes, but the El Paso County Sheriff's Department

takes 48 hours. (Bexar and Travis counties have local state mental hospitals, but the nearest state mental hospital to El Paso is several hundred miles away.)

The survey also requested additional comments. Twenty-three departments expressed concerns ranging from the need and importance of training to problems in connecting the police to the mental health system, in particular, the confusion and delay involved in waiting for screening. Others voiced opinions about reverse diversion or the movement of the mentally ill back into the criminal justice system. Frustration was expressed about those who needed mental health care, but were not severe enough that a court could order treatment. One respondent observed that some mentally ill offenders had been released numerous times and were becoming more violent. A member of the Austin Police Department complained that officers were burning out because reductions in city and county funding were shifting social work and emergency mental detention work to the law enforcement community. Another commented that mental health services for the homeless and those with personality disorders were inadequate.

On a positive note, a lieutenant responding for the El Paso Police Department observed that the key components of effective management when interacting with mentally ill citizens are frequent quality training, close partnerships with social agencies, and specific guidelines for staff. A captain who responded for the Harris County Sheriff's Department opined that mental illness was taken seriously through training and awareness of possible signs of mentally disturbed behaviors.

Notes

¹The care that mental health authorities make available is through private and governmental providers.

²Memphis used trainers from Galveston when it began its program (Winburn, 2003).

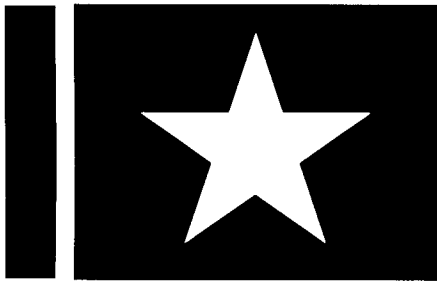
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- Winburn, M. 2003. Conversation. Winburn is the executive director of the Gulf Coast MHMR Center, which serves Galveston and Brazoria counties.



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Brownsville Police Department	North Richland Hills Police Department
Bryan Police Department	Pasadena Police Department
Carrollton Police Department	Randall County Sheriff's Department
College Station Police Department	Richardson Police Department
Dallas County Sheriff's Department	Rosenberg Police Department
Dallas Police Department	San Antonio Police Department
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Denton Police Department	Texas City Police Department
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