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Mental Health Professionals' Experience Bridging the Gap Between the Mental Health Community and Law Enforcement

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This is to certify that the doctoral dissertation by

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2024

Abstract

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MS, Walden University, 2019

MA, Amberton University, 2015

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Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

Clinical Psychology

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Abstract

Stigma associated with mental health is a prominent social issue stemming from maladaptive narratives about this population. Although law enforcement officers are tasked with managing psychiatric emergencies in the community, stigma about mental health often prevents proper management of interactions between law enforcement officers and persons with a mental illness. To combat this issue, the criminal justice system developed the crisis intervention team (CIT) model to teach law enforcement officers how to properly engage with the mental health community. Despite this effort, injuries and fatal use of force practices continue. The purpose of this general qualitative study was to understand the experience that mental health professionals had while training law enforcement officers for the CIT. This study was guided by the social distance theory and the cognitive dissonance theory. Data were collected from eight mental health professionals via semi structured virtual interviews through Zoom. Through manual coding and thematic analysis, five themes emerged: (a) effective model, (b) reinforces de-escalation, (c) volunteer versus voluntold, (d) humanization, and (e) relatability. Findings from this study may promote positive social change by confirming and adding context to previous literature that explores the gap between the criminal justice system and the mental health community. Additionally, the findings of this study may influence further research to understand and bridge the gap between these two communities, thus minimizing stigma about mental health.

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Chapter 1: Introduction to the Study

Background

As first responders for psychiatric emergencies, the crisis intervention team (CIT) teaches law enforcement officers how to properly manage those calls. Despite the extensive training required to become a CIT officer, fatal use of force incidents remain constant. This draws one to question if there are barriers to proper execution of the model's design. The purpose of this study was to understand the experience that mental health professionals have when attempting to bridge the gap between the mental health community and the criminal justice system during CIT training. This chapter provides context to the study's purpose, background information from the literature, theoretical orientation, research questions, definition of key concepts, limitations, and its significance to the field, including contribution to positive social change.

The actions of law enforcement have been under public scrutiny, primarily due to racial disparity. However, other populations, like the mentally ill, are largely overrepresented in terms of injuries and use of force incidents (Laniyonu & Goff, 2021). According to Laniyonu and Goff (2021), persons with a mental illness are 12 times more likely to experience use of force when interacting with law enforcement and are 10 times more likely to experience an injury from that force in comparison to persons without a mental illness.

There are multiple theories that explain the disparities that persons with a mental illness experience. The most prominent theory is stigma. Stigma about mental health often stems from and is perpetuated by the media, thus influencing how society views

this population (Frankham, 2019). Current and previous research has found that media have often labeled people with a mental illness in a negative way, such as incompetent, dangerous, helpless, volatile, and child-like (Frankham, 2019). These labels contribute to an overt and explicit stigmatization toward this population. According to Manago and Mize (2022), negative labels about a person or group of people can incite fear, prompting behavioral responses aligned with the fight or flight. An example of this is the use of force incidents and injuries that persist between law enforcement and persons with a mental illness as law enforcement officers may fear for their safety while interacting with a group deemed as dangerous.

The criminal justice system is aware of the maltreatment and misunderstanding that exist against the mental health population. Efforts to minimize stigma about mental health have been adopted across thousands of law enforcement agencies to educate law enforcement officers on how to properly manage psychiatric emergencies while on duty (Compton et al., 2022). Despite these initiatives, use of force incidents and injuries continue against this population during interactions (Laniyonu & Goff, 2021). This study turned attention to the professionals attempting to bridge the gap through minimizing stigma about mental health within the criminal justice system.

Problem Statement

Despite efforts by the criminal justice system to create anti-stigma initiatives about mental health, use-of-force incidents are on the rise (Wittman, et al., 2021). Crissman (2019) reported that having a psychiatric diagnosis significantly increased the risk of fatal use of force or death while in custody. With an estimated 9.8 million people

living with a mental illness (National Alliance on Mental Illness [NAMI], n.d.), the prevalence of police interactions with this population is elevated, making the need for proper care imperative. The CIT was developed to mitigate the disconnect between the criminal justice system and the mental health community; however, research supporting the effectiveness of the CIT model is limited. The CIT has improved law enforcement officers' understanding (Watson et al., 2017), but stigma continues to be a barrier to successful implementation of the model's design as law enforcement officers view persons with a mental illness as dangerous and unpredictable (Wittman et al., 2021). When use of force, fatality, or injuries are inflicted on persons with a mental illness due to stigma, a mistrust is developed between the criminal justice system and the mental health community which limits access to mental health treatment, thus perpetuating a diminished quality of life.

Purpose of the Study

The purpose of this study was to understand the experience that mental health professionals have while training law enforcement officers for the CIT. Mental health professionals are tasked with the role of educating law enforcement officers about mental health, including how to recognize signs and symptoms of a mental illness or substance use disorder, conduct role playing exercises, and educate law enforcement officers about local emergency services that can provide treatment to the individual in crisis. Through education, it is presumed, law enforcement officers will recognize when to implement the unique responsibility of providing specialized responses via CIT to people with mental

illnesses, thus improving the outcomes of encounters with people who have a mental illness.

Research Questions

The research questions that I wanted to answer in this study were the following:

- RQ1: What are mental health professionals' perspectives on the CIT training?
- RQ2: How does the perception of mental health shape law enforcement officers' use of the CIT model?

Theoretical Framework

This study was guided by Simmel and Park's social distance theory and Festinger's (1957) cognitive dissonance theory. Social distance theory provided context to key factors that create division between social groups. The cognitive dissonance theory illustrated how new information that is at variance with previously held beliefs can create cognitive dissonance, prompting changes in behavior that are more aligned with the new information. Because I wanted to understand the experience that mental health professionals have while attempting to bridge the gap between the criminal justice system and the mental health community, both theories were appropriate frameworks for this study.

Misconceptions about mental health have created a social distance between the mental health community and law enforcement. CIT training invites mental health professionals to provide psychoeducation to law enforcement officers who are on the CIT so that they can build a better understanding of persons with a mental illness, thus minimizing the stigma that divides these two populations. Additionally, learning new

information about mental health can challenge law enforcement officers to reframe how they perceive persons with a mental illness, thus change their behavior toward them during on-duty interactions.

Nature of the Study

I used a general qualitative research design to gather the needed data for this study. A qualitative study invites an understanding of a person's perception and experience (Burkholder et al., 2016). Because I sought to understand the perspective that mental health professionals have about CIT training, a general qualitative design was appropriate.

Data were collected via 1-hour semi structured virtual interviews with eight participants based on an interview guide (see Appendix A) consisting of 14 open-ended questions. Each participant was a mental health professional who has had experience training law enforcement officers for the CIT. I recruited participants using a flyer posted in mental health clinical groups on social media. All participants volunteered to be a part of this study by responding to the online flyer.

After the interview, I conducted a thematic analysis guided by Saldana (2021) to identify themes in the participants' narratives. These themes were then used to answer the research questions, providing insight into the experience that mental health professionals have during CIT training.

Definitions

The following terms were relevant in this study:

CIT model: A model designed to improve the outcomes of interactions between law enforcement personnel and individuals with mental illness (Bratina et al., 2020).

Internal stigma: The occurrence of police stigmatizing each other due to mental health problems (Stuart, 2017).

Intrapersonal stigma: Stigma occurring within an individual.

Mental health professionals: Licensed persons who specialize in the content of mental health (Council of State Governments Justice Center, 2008).

Mental illness: A condition that affects a person's mental health (Manago & Mize, 2022).

Stigma: Discrimination against individuals with devalued characteristics (Manago & Mize, 2022).

Stigma about mental health: Negative attitude or shame placed on an individual due to having a mental illness (NAMI, n.d.).

Assumptions

Multiple assumptions were made in this study. The first assumption was that participants were truthful in their interview responses about their experience during CIT training. Another assumption was that the mental health professionals understood the purpose of their role within the CIT model. A third assumption was that the mental health professionals were knowledgeable about mental health themselves to properly provide and assist law enforcement officers with recognizing signs and symptoms of a mental or substance use disorder. As participants were not selected through a specific law enforcement agency, a fourth assumption was that the various CIT training programs

were focused on the safety of persons with a mental illness as opposed to other designated goals of the CIT model.

Scope and Delimitations

This study was focused on the experience that mental health professionals have while educating law enforcement officers about mental health in preparation for the CIT. This approach was taken as stigma about mental health presents a barrier to successful execution of the CIT model's design during interactions between law enforcement and persons with a mental illness. Mental health professionals were recruited for this study as they are tasked with educating law enforcement officers about mental health. The information learned by mental health professionals are then used during on-duty interactions. Although other professionals are involved with the CIT training process, they were excluded from this study to strictly focus on mental health. The study was guided by Simmel and Park's social distance theory and Festinger's cognitive dissonance theory.

Limitations

There were several limitations to this study. First, because this study was limited to mental health professionals, despite other professionals that train law enforcement officers for the CIT, the results cannot be generalized. This limitation was addressed by using mental health professionals from a variety of law enforcement agencies to obtain a wider perspective. A second limitation to this study is recall bias as participants were not required to be presently training law enforcement officers for the CIT. The inability to accurately recall information could cause dishonesty during the interview process. This

limitation was addressed by placing a limit to the number of years that a mental health professional has not trained law enforcement officers for the CIT. Additionally, participants were assured that the interview data would be anonymous and would only be used for this research. One last limitation to this study is researcher bias as I was already knowledgeable about the research topic. This limitation was addressed by fulfilling the role as a participant observer. I only allowed the data from participant's interviews to be used in this study. Additionally, I considered and analyzed all data provided by the participants to ensure that pre-existing assumptions were minimized.

Significance

Understanding the experience that mental health professionals have while training law enforcement officers for the CIT assisted with enhancing the CIT model. These enhancements initiated effective training practices to improve law enforcement officers' responses to psychiatric emergencies. Through effective CIT practices, law enforcement officers minimized stigma about mental health and reduced use of force incidents during on-duty interactions with persons with a mental illness. Minimizing stigma about mental health within the criminal justice system promoted positive social change as the gap between these two communities reduced. Additionally, persons with a mental illness felt safer when interacting with law enforcement officers.

Summary

This chapter began by introducing the topic of study and providing background context to identify the need for this study. A synthesis of the research identified the risk of harm caused to persons with a mental illness at the hands of law enforcement officers

during on-duty interactions. This chapter identified the theoretical framework for this study and the research question that guided this qualitative inquiry. The rationale for this study's design was presented, as were key definitions, assumptions, and limitations. This chapter ended with identifying the significance of this study for social change by bridging the perceived social distance between the criminal justice system and the mental health community. The following chapter provides an in-depth review of present literature that further establishes the relevance of this study.

Chapter 2: Literature Review

In recent years, attention to the relationship between law enforcement and persons with a mental illness has revealed that mental health emergencies have been mismanaged (Haigh et al., 2020). It is estimated that at least 20% of police calls involve a mental health crisis (Abramson, 2021). Twenty-five percent to more than 50% of fatal encounters with law enforcement are with persons who have a mental illness (Degue et al., 2016; Lowery et al., 2015). To combat this, the criminal justice system developed the CIT model for law enforcement to improve interactions with individuals who have a mental illness (Mcguire & Bond, 2011).

Although there is limited research to support the effectiveness of the CIT model, one factor remains true: stigma about mental health remains a barrier to successful execution of the CIT model (Haigh et al., 2020). Stigma about mental health displays itself in two ways within law enforcement: (a) police officers' hesitancy to access mental health services for themselves (Jetelina et al., 2020) and (b) negative attitudes about persons who have a mental illness (Wittmann et al., 2021). As law enforcement officers are community-based first responders to mental health emergencies (Dempsey, 2017), mental health professionals have been employed to educate law enforcement officers about mental health signs and symptoms during CIT training to reduce mental health stigma. Understanding the experiences of mental health professionals during the CIT training process helped to identify barriers to reducing stigma about mental health. This understanding helped bridge the gap between the criminal justice system and the mental

health community by promoting empathy and understanding of persons with a mental illness.

This chapter highlights the search strategies used to identify current literature related to the development of stigma about mental health within law enforcement and its use of force consequences. It also provides an overview of this study's theoretical foundations. The chapter concludes with a summary of the major findings from the literature, thus identifying a need for this study and its implications for positive social change.

Literature Search Strategy

Information for this review was obtained through the Walden University Library, Google Scholar, and the following organizational websites: American Psychological Association, the U.S. Department of Justice, NAMI, the American Police Officers Alliance, the Police Firearms Officer Association, and the National Violent Death Reporting System. Databases accessed through the Walden University Library included EBSCOHost, Thoreau Multi-Database, Dissertations and Thesis, and PsycInfo. Key words used to conduct searchers in these databases included combinations of *law enforcement, police, cops, officers, crisis intervention team, mental illness, mental health, stigma, perception, attitude,* and *mental health professionals* between the years of 2010 and 2022. Google Scholar was used as a secondary source to access articles not readily available through the Walden University Library.

Theoretical Foundation

This study was rooted in Simmel and Park's social distance theory and Festinger's cognitive dissonance theory. The social distance theory provided an understanding of how stigma can influence the creation of distance between two social groups. This theory aligned with the purpose of this study by providing a basis to better understand how certain beliefs, such as those associated with stigma, create social distance between law enforcement and the mental health community. The cognitive dissonance theory is a valuable lens for this study because it provided a basis for understanding how new information prompts an individual to seek ways to align that new information with previously formed beliefs to reduce dissonance from prior beliefs. CIT training serves as the factor that creates dissonance for law enforcement officers. Both theories were used to understand the creation of stigma about mental health within the law enforcement sector and how mental health professionals use CIT training to create cognitive dissonance that changed law enforcement's behavioral responses toward persons with a mental illness.

Social Distance Theory

The social distance theory was developed by Georg Simmel and Robert Park during the 1890s. This theory is primarily used in the field of sociology to study social factors related to race and ethnicity, social class, status, and gender (Ethington, 1997). According to this theory, s*ocial distance* describes the social separation between groups due to perceived or real differences (Ethington, 1997). It refers to the extent to which people experience a sense of familiarity or unfamiliarity between themselves and people

belonging to different social, ethnic, occupational, and/or religious groups (Hodgetts & Stolte, 2014).

Sociologists identify three types of social distance: affective, normative, and interactive. *Affective* social distance refers to the empathy that one group feels to another (Ethington, 1997). *Normative* social distance is the difference that an individual feels exists between them and another group (Ethington, 1997) Lastly, *interactive* social distance is the extent to which different groups of people interact with each other (Ethington, 1997). In this regard, the more groups understand each other, the closer they are socially. This framework was used to understand how law enforcement officers developed stigmatizing beliefs about individuals with mental health disorders that contributed to social distance between law enforcements and the mental health community.

Cognitive Dissonance Theory

Leon Festinger (1957) described *dissonance* as the relationship that exists between two *knowledges*: the knowledge individuals have about themselves in the form of what they do, feel, want/desire, and so forth, and the knowledge they have about their world and surroundings. According to this theory, knowledge is synonymous with opinions, beliefs, attitudes, values, and cognitions. According to Festinger (1957), knowledge is developed in reality and is shaped by an individual's experiences and by what other people who are important think and do. When a person encounters a new type of knowledge that is inconsistent with their previously held beliefs, this new knowledge has the potential to disrupt previously held knowledges; the tension created in this

misalignment between new and older knowledge has the potential to create cognitive dissonance. In this study, the education provided by mental health professionals during CIT training is constituting new knowledge, which was at variance with law enforcement officers' previously held beliefs about mental illness and therefore created cognitive dissonance for law enforcement officers.

The emotional and cognitive discomfort that accompanies cognitive dissonance prompts an individual to want to correct the dissonance. Festinger (1957) reported that dissonance can be corrected in one of two ways: (a) change the previously held cognition to align with the new information or (b) affirm the previously held cognition by either disputing or minimizing the credibility of the new information. When dissonance is minimized by affirming previously held knowledges, the dissonance shifts to consonance. If an individual changes the previously held cognition to align with the new information, there will be behavioral changes that accompany the new knowledges or belief system. In either of these efforts, the discomfort associated with the dissonance is either eliminated or reduced causing an individual to feel more at ease about their future choices, actions, and behaviors.

When CIT training completed, law enforcement officers had empathy, felt less disconnected, and were more comfortable interacting with persons who have a mental illness. With the purpose of understanding the experience that mental health professionals have with law enforcement during CIT training, the social distance theory and the cognitive dissonance theory provided a lens through which to consider how affective, normative, and interactive components of the social distance theory complement the CIT

training model, thus bridging the gap between the two communities. The remainder of this chapter comprises a review of the literature related to key concepts of internal and intrapersonal stigma that contributed to stigmatization between law enforcement and the mental health community, thus identifying what led to the development of the CIT model.

Literature Review

Over 9.8 million people have a mental illness that impacts their daily functioning (NAMI, n.d.). As previously noted in this chapter, a significant portion of persons with a mental illness will interact with the criminal justice system. Misunderstandings and stigma about the mental health community have led to discrimination, institutionalization, and fatal use of force outcomes (Carleton et al., 2019). Historically, causes of mental health issues were attributed to demonic or spiritual possession. Media contributed to the narrative that links mental illness with violence or portrays individuals with mental illness as criminals, a danger to society, evil, or incapable of contributing to society (Morgan et al., 2023; Ross, et al., 2019).

Law enforcement officers' stigma about mental health stem from both internal (Stuart, 2017) and intrapersonal influences (Mulay et al., 2016). To reduce stigma about mental health, the CIT model was created. With limited research to support the effectiveness of the CIT model, the question remains: Is it enough? The following sections address factors contributing to stigmatization of the mental health community and the purpose of the CIT model, thus identifying a need for this study.

Internal/Police-by-Police Stigma

Policing is widely accepted as a high stress occupation. The nature of policing is to interact with an assortment of situations ranging from violent, threatening personalities (Carleton et al., 2018) to incidents like child abuse, domestic violence, car crashes and homicides (Jetelina et al., 2020). Aside from on-duty stress, additional challenges come from feeling a lack of support from management and high job demands (Ricciardelli et al., 2021). Due to its personal nature, stress is subjective and difficult to define medically; however, it is a natural part of life. It is when stress exceeds the individual's capacity to cope that it leads to mental health problems. Law enforcement officers with increased exposure to critical incidents are more likely to develop symptoms of posttraumatic stress disorder (PTSD; Carleton et al., 2019) and/or other mental health disorders that affect their ability to conduct their job (Carleton et al., 2018).

Death by suicide occurs frequently among law enforcement officers due to high stress (Gutshall et al., 2017). NAMI (n.d.) reported that the majority of police officers face alcohol abuse, depression, PTSD, and suicidal thoughts. The American Police Officers Alliance (2019) reported that 1 in 4 officers have considered suicide and that more officers die by suicide than in the line of duty. Mental health struggles impact law enforcement officers internationally as well. In the United Kingdom, half of law enforcement officers took a leave of absence citing mental health within the last 10 years (Police Firearms Officer Association, 2017). An Australian study reported that mental illness affected law enforcement and emergency service personnel more than any other profession (Harman, 2019). In Canada, mental illness was widespread among police

officers as 10% had reported suicidal ideation, 4% had planned suicide, and 0.4% had attempted suicide (Carleton et al., 2018). The prevalence of mental health related symptoms within law enforcement posed a financial risk as 16 million days were lost annually due to long-term absences from mental health conditions like stress, depression, and anxiety (Edwards & Kotera, 2021). According to Stuart (2017), factors that contributed to the high prevalence of mental health problems within law enforcement were connected to internal stigma.

Internal stigma occurs when law enforcement officers stigmatize each other due to mental health issues (Stuart, 2017). Many studies have explored the phenomenon of internal stigma and its influences on police occupational culture. Much of the work about police culture was founded by Jerome Skolnick (1966). Skolnick (1966) and Stuart (2017) argued that law enforcement officers developed a set of values, norms, and beliefs that arose during their profession and determined their behaviors on and off the job. These values, norms, and beliefs can be viewed from either a positive or negative lens.

Police culture is multifaceted, including organization, a sense of policing as a life mission, and solidarity (Ricciardelli et al., 2021). Conversely, police culture can be destructive and toxic (Hakik & Langlois, 2020), contributing to the deterioration of law enforcement officers' mental health and their courage to speak openly about their mental turmoil. Police culture has been associated with creating cynicism of the world, machoism, and conservatism promoting law enforcement officer isolation and separation from citizens (Carleton et al., 2018)). In a qualitative study about police culture, law enforcement officers verbalized fear of being open to senior management and/or

colleagues about their mental health because of stigma and negative reactions (Edwards & Kotera, 2021; Stuart, 2017). Law enforcement officers described their role expectations as maintaining a cool demeanor, suppressing emotions, and having control (Stuart, 2017). Speaking about mental health or seeking professional assistance compromised these expectations and led to an internal sense of failure (Stuart, 2017), a loss of weapon privileges (Edwards & Kotera, 2021), feeling devalued and unsupported by those in command, ostracization (Ricciardelli et al., 2021), and a passing over for career advancement (Hakik & Langlois, 2020).).

Previous studies have revealed that supervisors often ignored law enforcement officers' mental health issues with hopes that they would go away because matters of that regard were deemed too difficult to handle (Bell et al., 2022). Additionally, supervisors and peers doubted the genuineness of law enforcement officers' report of mental health absences, attributing them to malingering (Bell & Palmer-Conn, 2018; Stuart, 2017). According to Bullock and Garland (2018), having the label of mental illness within policing was deemed as "weak" within a culture that promoted strength, steadfastness, and duty. They further found that mental illness caused a loss of status among colleagues in a law enforcement officer's ability, character, integrity, reliability, and commitment (Bullock & Garland, 2018). Other studies have shown that due to fear of internal stigmatization by leadership and colleagues, law enforcement officers opted to self-medicate their mental health issues with alcohol or to suffer from higher levels of depression and anxiety as opposed to seeking professional mental health assistance (Karaffa & Koch, 2015). With a police culture that stigmatizes mental illness within the

organization, it is difficult for law enforcement officers to improve their mental health literacy, thus creating a barrier to seeking mental health care (Reavey et al., 2018).

Because I sought to understand the experience that mental health professionals have during CIT training, it is crucial to note how law enforcement officers are discouraged, judged, and reprimanded for speaking about and/or asking for help due to a mental health concern. Police culture reinforces the idea that mental health and persons with mental illness are negative, contributing to the social distance that exists between these two groups. Anti-stigma initiatives, like the CIT model, are needed to reduce the gap between law enforcement and the mental health community (Stuart, 2017). Mental health professionals are tasked with this goal during CIT training. By understanding mental health professionals' experience as trainers of the CIT curriculum, we gained insight into whether the curriculum is effective in addressing internal or other-directed stigma by law enforcement officers toward individuals with mental health disorders.

Intrapersonal Stigma

As discussed, police culture influences stigma about mental health. Additionally, intrapersonal stigma, stigma that develops within an individual's mind, contributes to this phenomenon. According to Mulay et al. (2016), it is intrapersonal stigma that causes external judgements and behavior. While the research is scant, there is evidence to support how intrapersonal stigma negatively impacts interactions between law enforcement officers and persons with a mental illness.

One consistent finding is that law enforcement officers hold similar beliefs about persons with a mental illness as the general population (Gomez & Robertson, 2022;

Haigh et al., 2020). Through social withdrawal, discrimination, alienation, and stereotyping (Ponte, 2021), the general population deems persons with a mental illness as dangerous, incompetent, and violent (Haigh et al., 2020). To explore intrapersonal stigma within law enforcement officers, one study used the Mental Illness Stigma Scale that measured stigma on seven dimensions: interpersonal anxiety, relationship disruption, poor hygiene, visibility, treatability, professional efficacy, and recovery. In comparison to the general population, law enforcement officers viewed persons with a mental illness as more dangerous and violent than individuals without a mental illness (Oxburgh et al., 2016; Socorro & Yanos, 2019). Similarly, law enforcement officers reported feeling uncomfortable and anxious handling calls that involved persons with a mental illness as they presumed that the crisis would require the use of force (Haigh et al., 2020). Furthermore, law enforcement officers felt that mental illness was untreatable and that a person with a mental illness could not recover from having a mental illness (Haigh et al., 2020).

In comparison to other professions that interact with persons who have a mental illness, current and prospective law enforcement officers expressed congruent attitudes. Gomez and Robertson (2022) examined explicit and implicit attitudes prospective law enforcement officers had toward persons with a mental illness. They also explored whether empathy influenced stigma. When attitudes and empathy about mental health were compared between prospective law enforcement officers and psychology students, the researchers found that prospective law enforcement officers lacked empathy and held prejudicial attitudes (Gomez & Robertson, 2022). The exposure and understanding that

psychology students gained from coursework about mental health increased their empathy toward this population. This supported how the CIT's models attempt to expose law enforcement officers to the topic of mental health increased their empathy and understanding of this population.

Because of the high prevalence of people experiencing mental health crises, emergency personnel who are equipped to manage psychiatric emergences are necessary. When law enforcement officers have intrapersonal stigmas toward this population, there are increased risks of injury (Rogers et al., 2019) and the potential of improper police intervention that escalates and intensifies distress for the individual in crisis (White, 2021). The risk of death during engagement with law enforcement officers increases seven times when an individual is exhibiting signs of a mental illness (Selah et al., 2018). This demonstrates how preconceived ideas only escalate interactions between these two communities. In a personal narrative, White (2021) described his experiences during medical and mental health emergencies. During a medical emergency, White felt supported, encouraged, and comforted by law enforcement. Conversely, when White contacted law enforcement to voluntarily enter psychiatric treatment, law enforcement officers forced down his door, placed him in handcuffs, and pushed White against a police car. White described the experience as humiliating with no regard for personal safety and wellbeing (White, 2021). Intrapersonal stigma about mental health changes the response of law enforcement officers when responding to a mental health emergency. To change these forceful outcomes, law enforcement agencies created and implemented the

CIT model to increase exposure, increase understanding, and minimize stigma of mental health symptoms and disorders.

Because the current study sought to understand the CIT curriculum as an attempt to bridge the gap between the law enforcement division of the criminal justice system and the mental health community, it is necessary to understand that the stigma law enforcement officers hold about persons with a mental illness is severe. Law enforcement officers may enter policing with preconceived beliefs about mental health and/or are forced to create a negative attitude about this population following negative consequences when advocating for their own mental health. The next section will discuss how the criminal justice system attempted to address the stigma that exists between these two populations.

CIT Development

As previously discussed, intrapersonal beliefs and internal influences like police culture combine to create negative attitudes about the mental health community. These negative attitudes affect the way that law enforcement officers respond to psychiatric emergencies. An example of this is when the Memphis Police Department shot and killed an individual that was experiencing a psychiatric emergency in 1987 (Ellis, 2014; Haigh et al., 2020; Watson et al., 2017). According to Haigh et al. (2020), this fatal use of force sparked public outrage, prompting advocacy efforts to improve law enforcement officer's response to psychiatric emergencies.

Law enforcement agencies started strategizing approaches that bridged the gap between the criminal justice system and the mental health community (Watson et al.,

2017). Several interventions developed from these efforts. Willis et al. (2021) described the co-responder model that allowed mental health professionals to accompany a law enforcement officer while on patrol to assist with managing calls related to mental health. Another intervention, the Mobile Crisis Response Team, consisted of mental health professionals and community advocates responding to outreach from individuals and/or their families seeking support with mental health services and resources (Willis et al., 2021). Other models include the Mental Health Mobile Crisis Team (MHMCT), and the Crisis Outreach and Support Team (COAST) (Koziarski, et al., 2021). Out of these models, CIT was deemed the best practice model and has been adopted in over 2,700 police departments nationwide (Haigh et al., 2020; Watson et al., 2017).

Training

According to Willis et al. (2021), implementation of the CIT model requires law enforcement officers to complete a 40-hour training, have access to psychiatric crisis resources that have 24/7 availability, and partnerships between criminal, legal, and behavioral health professionals. Training initiatives involve law enforcement personnel, mental health professionals, family advocates and experts in related fields (Bratina et al., 2020). Training focuses on teaching officers about mental illness, substance use, psychiatric medication, and strategies for managing mental health emergencies. The training also builds law enforcement officer's awareness about mental illness through exposure by visiting mental health facilities, having conversations with individuals who have a mental illness, and role playing to strengthen de-escalation skills.

CIT training covers a multitude of topics requiring a diverse group of professionals, including law enforcement trainers, mental health practitioners/professionals, consumers and family members, and other criminal justice and health professionals (Bratina et al., 2020). The role of mental health practitioners/professionals during CIT training is to teach officers about the signs and symptoms of mental illness, provide information about community resources, educate law enforcement officers about psychotropic medications, teach de-escalation techniques, and how to interact with individuals who have a mental illness and is not in a crisis (Bratina et al., 2020). Mental health professionals also educate law enforcement officers about what qualifies an individual for community mental health support and the specific policies of those resources for treatment. Consumers and family members provide a personal perspective about the impact that mental illness has had on an individual, their families, and the community. This helps law enforcement officers to see an individual with mental health and/or their families outside of a crisis, promoting compassion. According to Bratina et al. (2020), successful CIT training promotes a positive, confident attitude about mental health thus reducing social distance, increased knowledge about the effects of mental illness, and de-escalation skills for crisis situations.

Some challenges that law enforcement agencies face during training initiatives are a lack of resources and support (Bratina et al., 2021). Law enforcement agencies have fought to minimize these barriers by ensuring that trainers are familiar, knowledgeable, and understand police culture, use techniques that engage law enforcement officers, respect law enforcement officer's safety concerns, and establish a shared commitment to

the process. This study focused on the experiences of mental health professionals during the CIT training process.

Participants

The way that a law enforcement agency conducts training is limited to the barriers they face, creating variations from the original CIT design. One example of this variation is how law enforcement officers become a part of the team. In its original context, law enforcement officers "self-selected" or volunteered (Compton et al., 2017). Volunteered law enforcement officers were assumed to be more empathetic and understanding of concerns specific to the mental health community (Compton et al., 2011; Compton et al., 2017). Volunteered candidates underwent a selection process using recommendations, a review of their personal disciplinary file and an interview. Compton et al. (2017), found that law enforcement officers that volunteered for the CIT were more empathetic, felt comfortable and referred to mental health services more often in comparison to law enforcement officers who were assigned to the CIT. This shows how the self-selection process helps to improve outcomes when using the CIT model.

Research about the effectiveness of the CIT model is mixed. Some research supports the CIT model for improving law enforcement's attitude about mental health and reestablishing rapport with individuals who have a mental illness and their families (Willis et al., 2021). Other studies conclude that further research is needed due to continued mishandling of psychiatric emergencies (Haigh et al., 2020). This study sought to understand this disparity by examining the lived experience of mental health professionals who assist with CIT training. As perceived and real differences expand the

social distance between these two communities, the CIT model attempts to address the way that law enforcement officers respond to psychiatric emergencies.

Summary and Conclusion

This chapter of the study reviewed the literature to illustrate the high probability of an interaction between an individual with a mental illness and law enforcement. It described how internal and intrapersonal stigma contributed to misconceptions and division between the criminal justice system and the mental health community, thus highlighting the need for a model to bridge the gap between the two. The CIT model was created to build awareness and understanding about mental health/illness to incite empathy and improve law enforcement responses during a psychiatric emergency. Several studies showed how misconceptions could perpetuate stigma about the mental health population, causing fatal use of force practices and/or injuries during police encounters. The present study sought to fill a gap by understanding the experiences of mental health professionals during attempts to bridge the gap between those two communities during CIT training. By filling this gap, we gained understanding of barriers that prevented the CIT model from being empirically supported as a model that effectively protects the lives of individuals living with a mental illness while interacting with the criminal justice system. The results of this study highlighted the contradictions that are narrated within police culture and the purpose of the CIT model that hoped to shift the culture by supporting and encouraging law enforcement officers to seek mental health care. Additionally, this study showed how increased empathy and understanding of

the mentally ill population reduced fatal use of force practices. The next chapter will detail the rationale for this study, how it was conducted, and how the data was analyzed.

Chapter 3: Research Method

According to Ravitch and Carl (2016), qualitative researchers pursue an understanding of the ways that people see, view, approach, and experience the world. Additionally, Creswell and Creswell (2018) recommended qualitative research as an opportunity to ask open-ended questions about topics of interest. As there is scant research about the effectiveness of the CIT model, the purpose of this study is to understand the experience that mental health professionals have while training law enforcement officers for the CIT. In this chapter, I provide details of the research design. The method used to explore the research problems will be explained, including participant selection, procedures, instrumentation, data collection and data analysis. Lastly, issues of trustworthiness and ethical considerations will be provided.

Research Design and Rationale

With the purpose of understanding the experience that mental health professionals have during CIT training, the following research questions guided this study:

- RQ1: What is mental health professionals' prospective on the CIT training?
- RQ2: How does the perception of mental health shape law enforcement officers' use of the CIT model?

To answer these questions, I used a general qualitative research design. A general qualitative design focuses on what can be learned about a problem to potentially minimize consequences and identify what will work best to resolve the problem. Through exploring the experience that mental health professionals have during the CIT training

process, the problem of use of force incidents and injuries can be considered as influenced by stigma about mental health.

Role of the Researcher

Ravitch and Carl (2016) reported that the positioning of the researcher is a key part of the research process as it directly influences the conceptualization of the study. In this study, my role and proximity to the participants was as a participant observer. Although I am a mental health professional, I have not worked with the criminal justice system, nor have I assisted with the CIT training process. As a citizen, I am privy to incidents involving law enforcement. Additionally, I am aware of societal concerns about the competency of law enforcement officers.

Advocacy efforts have influenced how, as a licensed professional counselor, I perceive stigma about mental health and maltreatment toward persons with a mental illness. Because of this, the potential of improving the CIT model is invaluable. To achieve this, I sought to limit my biases about law enforcement to accurately gather the data shared by participants. Bias can occur when the researcher interprets data in a way that aligns with their conscious or subconscious beliefs about the subject (Bryne, 2022). To limit the probability of distorting the results, I recorded the interviews and used the words of participants to guide the analysis and interpretation of the results. Doing so kept the focus on the meaning of the participant's experiences as opposed to the meaning that I brought to the research, or the meaning that is held in the literature (Creswell & Creswell, 2018).

I did not disclose my licensure background with participants as it is irrelevant to this research study. My identity throughout this process was that of a Walden doctoral student in the clinical psychology program, thus reducing the feeling of a power differential in the relationship with participants.

Methodology

Participant Selection Process

In this study, I was interested in interviewing mental health professionals who have trained law enforcement officers for the CIT. To minimize recall bias, participants who have worked with law enforcement within the last 10 years were preferred. With the goal of obtaining rich information that is specific to the purpose of this study (Ravitch & Carl, 2016), I used purposeful sampling by only recruiting licensed mental health professionals who have trained law enforcement officers for the CIT. This ensured that the participants could provide context to the research questions. I recruited 8 participants by posting a flyer in clinical mental health groups via social media such as *Crisis Intervention Team CIT, Clinicians of Color in Private Practice*, *Lubbock Police CIT*, *Mental Health Clinicians*, *Therapist Entrepreneurs*, and *Therapists in Private Practice (TIPP)*. These social media groups are made up of tens of thousands licensed mental health professionals from around the world who have worked in various positions within the mental health field, including law enforcement. Because the CIT model is standard, 8 participants sufficed in answering the research questions. Some participants were recruited using snowball sampling as referred through respondents of the social media posting.

The recruitment flyer consisted of information about the study, the rationale for the study, and basic information about myself, including my name, degree of study, and contact information. Prior to posting, I contacted administrators of the social media groups to obtain permission to post in their groups. The criteria for participation in this study were that the mental health professionals needed to be licensed and to have trained law enforcement officers for the CIT within the last 10 years. As a result, the experiences of these mental health professionals were relevant to this study.

Instrumentation

As previously stated, a flyer was used to recruit participants for this study. Prospective participants who responded to the flyer were then provided with an informed consent that outlined the nature of the study and their rights as participants. Once the prospective participants provided consent to participate in the study, they completed a demographic survey (see Appendix B) designed to gather basic information about the participant. I then scheduled and conducted semi structured interviews via a web-based platform to gather context about the experience that mental health professionals have during CIT training. I planned to allow 90 minutes for the interview to ensure sufficient time to gather information for the purpose of this study. Interviews were conducted and recorded using the secure online meeting platform Zoom (https://zoom.us). I began each interview with a brief introduction. Then, the questions became more exploratory in nature. I developed an interview guide (see Appendix A) consisting of 14 semi structured interview questions that are linked to relevant research and submitted them to my

dissertation chair and committee member for review. I then applied any feedback and made refinements before conducting interviews with participants.

Procedures for Recruitment, Participation, and Data Collection

Participants were licensed mental health professionals who have trained law enforcement officers for the CIT within the past 10 years. I recruited participants from clinical social media groups and used referrals from prior participants to garner the targeted sample size. Participants were able to contact me using the contact information detailed on the flyer. To ensure that participants met criteria, I required participants to confirm that they hold an active mental health license and have worked with law enforcement within the last 10 years as stated in the informed consent. Once participants were selected, I provided them with an informed consent that required them to respond with the words “I consent” to participate. Once the informed consent was returned, I scheduled a mutually agreeable time for the interview.

I conducted individual, synchronous, recorded interviews using Zoom. Interviews allotted 90 minutes to allow sufficient time for participants to provide in-depth responses. I conducted interviews keeping Ravitch and Carl’s (2016) interview characteristics in mind: relational, contextual, nonevaluative, person centered, temporal, partial, subjective, and nonneutral. The interview was semi structured using 14 open-ended questions to avoid leading the interviewee. After the interview, participants were thanked for their participation and compensated with a $25 electronic Amazon gift card. Lastly, I notified participants once their transcript was available for their review.

Data Analysis Plan

After completing the interviews, the first step in the data analysis process was to transcribe the interviews of each participant. From there, I manually completed Saldana's (2021) thematic analysis to identify overarching themes introduced by participants in the data. According to Rossman and Rallis (2012), coding is the process of organizing the data by bracketing chunks and identifying a word to represent a category. In this context, codes are words or phrases that assign an idea to the data. A category is a collection of codes or phrases that share meaning. Themes are created through one or more categories and represent an underlying aspect of the study's research questions. This study focused on the experience that mental health professionals have during the CIT training process. Overall findings focused on answering the question "what were the lessons learned?" as suggested by Lincoln and Guba (1985) in qualitative research. Therefore, identified themes were associated with this study's topic of interest. Any discrepant data were included in the results and will be identified as such in Chapter 4 of this manuscript. Participant information remained confidential. Upon completion of the thematic analysis, I saved the data on a portable drive that I stored in a locked and secured place.

Issues of Trustworthiness

According to Ravitch and Carl (2016), trustworthiness and validity should be considered throughout the research process. *Trustworthiness* is a term created by Lincoln and Guba (1985) that defines the evaluation process of qualitative research. Factors encompassing trustworthiness are credibility, dependability, transferability, and

confirmability. The following section will review issues of trustworthiness via consideration of these four elements in this study.

Credibility

The credibility of a research study occurs when participants agree with how the data were interpreted by the researcher. Additionally, Billups (2021) stated that a credible study captures a truthful and holistic depiction of the phenomenon being explored. In this study, I allowed ample opportunity for participants to answer the research questions thoroughly. I asked follow-up questions as needed to ensure I understood the participant's perspective clearly, which helped to offset my own bias.

Another strategy I used was member checking, wherein I provided participants with a copy of their interview transcript to ensure that it is an accurate depiction of their experience. This allowed participants to correct and provide additional context, if needed.

Lastly, I enhanced credibility via review by my chair and committee member. At each stage of this research process, my chair and committee member reviewed and provided feedback about how I planned to conduct this study. Based on the review process, I adjusted and made corrections to the research plan.

Transferability

Sultan (2019) suggested that when transferability is achieved, consumers of the research can make assumptions about other populations or contexts based on the research findings. Lincoln and Guba (1985) emphasized that transferability is not limited to generalizability but is about the findings and their ability to be applied to other settings. I attempted to achieve transferability by setting minimal limits to the participant criteria.

The only requirements of participants were that they are licensed mental health professionals who have had experience training law enforcement officers for the CIT within the last 10 years. These minimal limitations allowed for a variety of mental health professionals to participate in the study, including but not limited to individuals of different race, gender, and/or location. Additionally, I reviewed transcripts three times as recommended by Saldana (2021) to identify all possible themes introduced by participants in the data.

Dependability

The ability for results to remain consistent across researchers makes the results dependable (Ravitch & Carl, 2016). According to Burkholder (2016), dependability can be achieved by triangulation. According to Billups (2021), triangulation is when a researcher uses multiple sources in various points of the research process to produce a greater understanding of the phenomenon. Triangulation can occur at the methods, data, analyst, or theory phase. In this study, data triangulation involved using multiple participants and allowing them the opportunity to share their experience in training law enforcement officers for the CIT. Additionally, I had this study critiqued through several review processes to ensure alignment and review the findings, demonstrating analyst triangulation. Lastly, dependability was also achieved through a detailed account of the research process via reflective journaling or audit trails so that the study can be repeated by future researchers. Reflective journaling is a process that I used for confirmability as well, detailed in the next section.

Confirmability

Confirmability in qualitative research is a validation that research results are accurate (Billups, 2021). To ensure that another researcher can repeat the study, I detailed the step-by-step process of the study's procedures. If the results of a study can be replicated, confirmability is strengthened (Beck, 2021).

Another strategy I used to enhance confirmability is reflexivity, a process in which the researcher uses interpersonal strategies to consciously examine the data without compromising what the participants have shared about their experience (Beck, 2021). By conducting 90-minute interviews, I sought to allow sufficient time to build trust with participants and to ensure adequate understanding of their experience. As a licensed mental health professional, my interpersonal skills were useful throughout the data collection and analysis phase. It allowed comfort within the participants to share their personal experiences and ensured that I was objective in interpreting their experience.

Ethical Procedures

To ensure the safety and confidentiality of participants, there are many ethical standards that researchers should abide by. Before engaging in the research process, my research proposal was reviewed utilizing a multi-step review process by my dissertation committee and the Walden Institutional Review Board (IRB). The IRB seeks to protect safety and confidentiality of participants by assessing the potential risks and gaining an understanding of how those risks are justified for the study (Durdella, 2019).

To minimize risks, participants were required to sign an informed consent before engaging in the research process. The informed consent informed participants that their participation would be for research purposes and that participation was voluntary. It detailed the right for participants to withdraw from the study at any point based on their discretion. The informed consent also described the purpose and procedures of the study, potential risks and benefits, and details about compensation for participation. I received permission from social media group administrators before recruiting participants for the study. Drafts of the informed consent, recruitment flyer, and cooperation agreements were included with the IRB application for approval.

Ethical considerations related to semi structured interviews involved ensuring participant confidentiality by conducting the interviews individually. Participants were encouraged to speak openly about their experience, only sharing information within their area of comfort. The interviews allowed sufficient time for participants to thoroughly provide input into their experiences during the CIT training process.

As previously stated, participants were allowed to view their transcripts to reduce harm and to minimize misinterpretation of information. To prevent perceived power differentials, I identified myself merely as a Walden doctoral student in the clinical psychology program completing research for the dissertation requirement. Information regarding my clinician status, location, and/or other private information not conducive to the research process was not disclosed.

During the research process, I stored confidential information on a portable drive that was locked when not in use. I used the portable drive on a password-secured desktop

computer that is only accessible to me. Following the conclusion of data analysis, research data was locked and stored at my residence and will remain for 5 years. After 5 years, the data will be erased using a software application designed to remove secure data. As the researcher, I made substantial effort to follow ethical standards to minimize risk to potential participants and to protect their privacy throughout the research process.

Summary

This chapter presented the research design and rationale, my role as the researcher, the methodology, and issues related to trustworthiness. Ethical considerations to ensure the safety and confidentiality of participants were reviewed. In the next chapter, I will report results from the study and review the thematic analysis of participant responses.

Chapter 4: Results

A generic qualitative design was used to understand the experience that mental health professionals had while training law enforcement officers for the CIT. This approach allowed me to explore the problems that exist during interactions between law enforcement officers and the mental health community with hopes to identify solutions to use of force/fatal use of force practices. Semi structured interviews assisted to understand the perspectives of the population studied, mental health professionals. The following research questions were used to guide the study:

- RQ1: What are mental health professionals' perspectives on the CIT training?
- RQ2: How does the perception of mental health shape law enforcement officers' use of the CIT model?

In this chapter, I address the research setting, participant demographics, the data collection process, and the data analysis process with results. I also address the evidence of trustworthiness, to include credibility, transferability, dependability, and confirmability.

Setting

The research recruitment flyer was posted and shared across social media clinical and/or CIT group outlets. Additionally, I recruited participants via email as referred though snowball sampling with the flyer attached. Between May 23 and September 9, 2023, eight participants responded to the study's demographic survey and participated in an audio and video recorded Zoom interview. The demographic survey took approximately one minute to complete. The interviews lasted from just under 14 minutes

to just over 45 minutes. There were no technical issues during the recording, transcription, and interpretation of the interviews. During the interviews, I and the participants were situated in private areas to include places of residence or work. The participants were located in several states, including Colorado, Ohio, Tennessee, and Texas.

Demographics

The demographic inclusion criteria were indicated on the recruitment flyer and the informed consent. All participants were self-reported licensed mental health professionals who actively or previously trained law enforcement officers for the CIT within 10 years. To maintain participant confidentiality and privacy, an alphanumeric pseudonym was assigned. Table 1 outline participant demographics, including their age range, gender, years working as a mental health professional, and years working with law enforcement.

Table 1

Demographics

Pseudonym	Age range	Gender	Ethnicity	Years as a mental health professional	Years working with law enforcement
P1	31–40	F	White	6–10	6–10
P2	41–50	F	White	16–20	16–20
P3	31–40	F	Asian	0–5	0–5
P4	41–50	M	Black/Hispanic	11–15	0–5
P5	20–30	F	White	0–5	0–5
P6	41–50	F	White	11–15	0–5
P7	31–40	F	White	6–10	6–10
P8	61–70	F	White	6–10	6–10

Data Collection

Eight participants were recruited for this generic qualitative study. Recruitment of these participants occurred in two ways: social media and snowball sampling. After IRB approval, number 05-01-23-0730815, I posted the recruitment flyer in various clinical and CIT-related Facebook groups. Additional participants were recruited as referred by previous participants or supporting affiliates of the CIT model. The flyer explained the purpose of the study, the inclusion criteria, and my contact information. Once interested participants contacted me via email, I sent the informed consent for review. Referred participants were emailed with the flyer attached asking for a reply if they were interested in moving forward. Once I received a reply indicating interest, I emailed the informed consent. Interviews were scheduled based on my and the participants' mutual availability.

Upon scheduling, I emailed each participant a unique Zoom link to access the meeting. At the start of the meeting, participants completed the five-question demographic survey (see Appendix B). I then informed participants that I would start the audio and video recording to begin the interview. The interview consisted of 14 questions (see Appendix A) that inquired about the participants thoughts, feelings, and observations of the CIT training process and law enforcement's behavior throughout the training.

At the end of each interview, participants were advised that the recording was stopped. I then instructed clients about next steps that included receipt of the interview transcript, the member checking process, and receipt of a $25 Amazon gift card. Each participant was verbally thanked for their participation. Following the interview, I listened to the recorded interview and manually typed the transcript. Participants were

emailed a copy of the transcript along with instruction to review for accuracy and schedule a follow-up meeting as needed to make changes. None of the participants elected to schedule a follow-up meeting as allowed via the member checking process. A separate email was sent to participants with a $25 Amazon gift card as gratitude for participation. Interview length ranged approximately 14 to 45 minutes.

Data Analysis

Interviews were manually transcribed and typed into a Word document. I listened to the audio recording and typed the responses verbatim. By doing so, I gained familiarity with the data before formally starting the analysis. Completion of transcripts varied by the length of the interview. Each participant agreed to the transcription of their data, allowing me to move forward with data analysis.

I used both deductive and inductive thematic analysis methods to analyze the data. A deductive analysis breaks down concepts from the theory to align data that represents the concept (Ravitch & Carl, 2016). Inductive analysis allows the data to reveal codes that transition to overarching themes (Ravitch & Carl, 2016). I began the data analysis process by reading each participant's transcript three times. During the final reading, I highlighted similar words, phrases and meaning in the transcripts across each participant. This helped to conceptualize the data that provided context to the research questions. Conversely, I reviewed the research questions and looked for consistent data across the participants. From this process, RQ1 brought out two themes and three subthemes, while RQ2 brought out three themes and three subthemes (see Table 2). A detailed description of these themes and subthemes will be provided in the Results

section of this chapter. Discrepant data that brought a different and unique meaning to the research questions are also reported and detailed in the results section of this chapter.

Table 2

Themes and Subthemes in Relation to the Research Questions

Research question	Themes	Subthemes
RQ1: What are mental health professionals' perspectives on the CIT training?	Effective model	Exposure to mental health Resources
	Reinforces de-escalation	Full assessment
RQ2: How does the perception of mental health shape law enforcement officers' use of the CIT model?	Volunteer vs. voluntold	
	Humanization	Increased empathy
	Relatability	Teaching style Applicability

Note. CIT = crisis intervention team.

Evidence of Trustworthiness

Credibility

To ensure that the results of this study can be trusted, I allowed participants ample time to respond to the interview questions. Although none of the interviews reached the allotted 90-minute timeframe, participants were informed of this timeframe via the informed consent. At the beginning of each interview, participants were granted permission to provide as much information as they preferred. If the participant provided information that was specific to their county and/or agency, I asked follow-up questions to obtain clarity. The member checking process allowed participants the opportunity to review the transcript of the interview for accuracy. This process ensured that participants were satisfied with the message they sought to convey in their responses. Additionally,

because the interviews were video recorded, nonverbal communication was observed and reviewed such as facial expressions, tone of voice, and hand gestures.

Transferability

I coded the data based on identified patterns within the information provided by the participants. The interpretation of the data aligns with the theoretical frameworks allowing the participants to authentically share their experience. Additionally, the identified themes were in response to the research questions and offered insight for future quantitative and/or mixed method research. The findings of this study can be used to deepen understanding regarding stigma about the mental health community from the criminal justice system by further filling the gaps.

Dependability

Triangulation was used throughout this research process to ensure dependability of the results. Multiple participants were interviewed to gain their unique perspectives on their CIT training experience. Data analysis allowed an opportunity to find commonality between these experiences. Analyst triangulation occurred through the multi-step dissertation approval process that ensures alignment and thoroughness. Lastly, I used reflective journaling throughout to track the process while having the ability to review recorded data an unlimited number of times.

Confirmability

The use of reflective journaling supported confirmability as keeping track of observations and procedures allows for another researcher to replicate this study. How I conducted this study is detailed throughout this manuscript. Additionally, adequate time

allowed the participants to provide thorough explanations about their CIT training experience to enrich the data. Lastly, I used reflexivity to conceptualize the data and find overarching themes without compromising the message of the participant's experience.

Results

This section will detail the results of the study as organized by the themes and subthemes related to each research question. Two themes and three subthemes emerged from RQ1 (What are mental health professionals' perspectives on the CIT training?), whereas RQ2 (How does the perception of mental health shape law enforcement officers' use of the CIT model?) brought out three themes and three subthemes.

Effective Model

Of the themes that emerged for RQ1, one consistent narrative across all eight participants is that the CIT model is effective. This theme emerged from asking participants what they would change about the CIT model, how the CIT model is effective, and how is the CIT model ineffective. P1 stated, "I don't think I would change anything because if you stick to the true CIT training, and do it by the book, it is great." P4 stated, "I don't think there's anything to change. It's very flexible. It's very adaptable" regarding the need to tailor the mental health topics to the population served which the CIT model encourages. One factor that contributed the CIT's effectiveness was the exposure that law enforcement officers acquired to the topic of mental health.

Exposure to Mental Health

According to the participants, one subtheme to the CIT's model effectiveness is the exposure to the topic of mental health that law enforcement officers gain. P5 stated,

"So I went through the 40-hour training week and fell in love with it. I was like this is awesome. I can't believe officers have this." Throughout the 40-hour training process, mental health professionals present on various topics about mental health, invite presenters to speak about their knowledge and/or lived experience with mental health/illness, and provide an opportunity for law enforcement officers to practice what they have learned. All participants detailed the resources and aides that they used during the CIT training process. Resources include presentations (P1–P8), role plays (P3, P4, P5, P6, P8), and direct interactions with community resources (P2, P4, P5, P6). All of these components of CIT training supported law enforcement officers' preparedness to respond to a psychiatric emergency. According to P6, "I think they're more resourceful. They are definitely more understanding of what that person is going through." To add, P3 stated, "I think it gives them a better idea of what questions to ask and what behaviors to be clued in to." P6 spoke about the process of riding along with law enforcement officers to expose them to the various lifestyles within the psychological realm like group homes, apartment style living for individuals who have aged out of foster care, and the homes of clients who have accessed care in the community:

> We take them to our local crisis unit. We take them to some of our group homes on the ride along and then sometimes a client's home but not usually. Usually, it's a group home, a crisis unit, and then, last year, we started Heisel, which is an apartment complex for ages 18-24 who are aging out of foster care.

Resources

Another subtheme that mental health professionals voiced that contributed to the CIT model's effectiveness is law enforcement officers learning about community resources/supports that assist with managing the psychiatric emergency on scene. Seven of the eight participants emphasized the value of discussing resources to the training process. P6 provided details about the various community supports that law enforcement officers are exposed to during the training process so that they can utilize those resources when plausible. Additionally, P6 reported how the training staff made cards for law enforcement officers to access in their squad cars so that they can review available resources 24/7 to make an informed decision about the best course of action to support the civilian in crisis. P6 stated,

> We have been implementing more resources. Like, we made a wrap card that lists all of the resources that an officer might need to reach out for at 3am when nobody's available. We had them put them all in there, one in every one of their squad cars in the community so every officer has that available to them and it lists after-hours for MRDD, after-hours for area agency on aging, after-hours for mental health or substance abuse.

P1 discussed the multirole that law enforcement officers have to embrace to be an effective CIT officer:

> Training just gives them every tool under the sun to cope with folks in crisis and because they have also been doing it for so long in this area, they are a wealth of knowledge for resources that are available. The resources for family members if

> you want to pursue guardianship. Here is who you talk to. Any of that kind of stuff. They are going above and beyond to respond to a mental health crisis. They have to be social workers. They have to be officers and have to be everything.

Reinforces De-escalation

A second theme that emerged that provides context to RQ1 is how CIT training helped law enforcement officers enhance their de-escalation skills. All of the participants spoke about de-escalation tactics that law enforcement officers learn in CIT training that assist them in managing on-scene psychiatric emergencies.

Full Assessment

The act of completing a full assessment was a subtheme from the data that supported the reinforcement of de-escalation. The CIT training process educates law enforcement officers on how to slow down and exercise patience to fully assess the scene. P2 stated,

> We have seen a huge shift in their response and knowing that it is okay to slow things down and that it is okay to ask these questions. Here are the things that you are looking for and why you are looking for that. It just makes it make sense to them.

P4 similarly stated,

> You know, I think just generally speaking, they have slowed down with calls overall because they are trying to figure things out instead of pushing into it but especially with the mental health calls, they are trying to slow things down and de-escalate things. They are trying to avoid having to go hands-on and use force. I

> think they are trying to gather as much information as they can, and they are trying to think things through more thoroughly.

P7 added,

> we would call and at times, request a CIT officer and I do think those calls that we went on when they were CIT trained, those officers were much more patient, were able to de-escalate, were more understanding and easier to work with majority of the time.

Additionally, P5 reported,

> Basically, just, I mean, I don't want to use the word de-escalation in CIT but just to de-escalate the situation. You know, if someone is maybe out of touch with reality, kind of figure out what is going on deeper like let's not jump to the word crazy, right? Let's kind of dig deeper. What's really going on? Does this person have a support system? Are they all alone? Have they ever received treatment before? But at the same time, how can we respond to them effectively?

This skill differentiates CIT trained law enforcement officers from non-CIT law enforcement officers.

The following identifies the themes and subthemes that emerged from RQ2: How does the perception of mental health shape law enforcement officer's use of the CIT model? Three themes and three subthemes emerged.

Volunteer Versus Voluntold

All eight participants responded to questions regarding law enforcement officer's attitude before, during, and after CIT training. One variable that determined the attitude

of law enforcement officers before and during CIT training was whether they volunteered to be a part of the CIT or if it was a mandatory assignment (i.e., they were "voluntold" to do the training). P2 described the level of excitement that law enforcement officers presently show when asked to work with mental health professionals while on duty:

> We recently sent out an email asking for interest for who would be interested in having one of the clinicians ride out with them and spend some time out in the field with them and the response has been overwhelming. I would say that about over half of every shift … has had officers say, "Yea we want to spend time with you. We want to ride out with you", so that has been a huge response from when I first got here.

P4 agreed that whether officers were volunteers or voluntold made a difference:

> I think that can be a barrier at times. Especially when dealing with older officers that have been around for a while and have seen a lot and then they have to go through the model because they are coming from a department that is forcing them to go through the model and not necessarily volunteering to go through it. I think that makes a difference as well. An officer that is volunteering to go through it and an officer that is voluntold to go through it makes a big difference.

P5 added that when law enforcement officers volunteer for the CIT, they present to the training differently: "They usually love it. They usually come to me and feel, they just feel super confident in themselves. I think that's the best way to describe it. They do. They just feel more in control of the situation." According to P8, voluntolds enter CIT training with a disregard for the information, however, experience a mindset shift:

> Those that are volunteers are already doing most of CIT and it just reaffirms what they already believe. The fun part is the voluntolds. When we get to the end of the week and they're like "I had no idea. This really is going to change how I do my job." It's rewarding to see the volunteers but it's even more rewarding to see the voluntolds.

P3 also detailed the attitude change of law enforcement officers who are voluntold from beginning of training to the end. She stated,

> I think some of them are annoyed that they have to be there. They, you know, voluntold don't want to do it. I would say that is a smaller portion … I think that the larger percentage of law enforcement are excited to be there [and] are excited to learn the skills. I think that they realize that a large percentage of the calls that they are going to have, have some mental health component, so they realize the value of the training.

P7 similarly shared,

> Historically, there is a rumor that some departments utilize CIT as punishment, so, if you are not performing well or you've needed reprimanding a couple of times, then it's like, "Oh, we're just sending you to CIT training." So, there is that stigma at times that going is a negative thing but majority of the time, it's positive. On the first day, it is apparent they're pretty closed off based on their demeanor. Based on their attitude. Based on their engagement. But I would say by the end, majority of our survey results have consistently showed over the years that they have found it beneficial. That they felt they learned a lot and that they

> felt as though they are more familiar with community resources and with mental health symptoms.

Humanization

Another attitudinal shift that the participants detailed was the increased empathy that law enforcement officers gained toward persons with a mental illness because of the knowledge acquired during training. All eight participants responded to questions about how their observation of how law enforcement officers think about mental health, misconceptions that they have about mental health, and how CIT training shifted those beliefs.

Increased Empathy

Increased empathy was a subtheme of humanization that emerged from the data. Prior to CIT training, the participants detailed the misconceptions that law enforcement officers expressed about mental health. According to P2:

> I think some of the biggest ones were that they just didn't want to take their medications. That they didn't want to get help. That they didn't want to get better. Some of them just needed to be in jail because they continue to do the same thing over again, so it just isn't working.

Several participants voiced how law enforcement officers believed that mental health was unreal or that it is a choice. P4 stated:

> I think a lot of people, especially if they're not necessarily in mental health or they don't have a family member of their own or a close friend of their own who's dealing with mental health [so] they don't understand mental health because of

> the stigmas that are so prevalent within mental health. They just don't know any better and so they think mental health is a choice and don't know that there are a lot of different factors that come into mental health.

To add, P7 stated:

> I would say feeling as though some individuals are attention seeking…I guess that other is not understanding the symptoms and just believing that everyone is crazy." Similarly, P8 stated, "The belief about addiction being a moral failing and mental health being a behavior choice. Those are the misconceptions that primarily I encounter.

After CIT training, the participants detailed a shift in law enforcement officer's attitude about mental health. P3 stated:

> I think some law enforcement officers don't understand the biological or genetic components of mental health, and [think] it's like a choice. Like, this person is choosing to be crazy, or they just did drugs and they made them act this way. But I think CIT kind of gives a broader perspective. We have one presenter. She is amazing…She shares her story and …I look around the room every time that she presents, and I just see people's opinions about things changing. You can just see the expression on their face. Obviously, she didn't choose that, and you know it wasn't her fault. Those kind of stories, personal accounts, make a difference.

P8 provided a detailed account of how exercising empathy and understanding changed the outcome of a dangerous situation for a person who was experiencing a psychiatric emergency in the community. She stated:

I use an example quite often. Something I saw on the news. An individual who was in a mental health crisis was rushed by an officer and ended up stabbing the officer, okay? And then, I compare that to an incident with a CIT officer here locally where there was a young man withholding a knife and threatening to kill people, threatening to kill himself and threatening his mother. And, you know, of course five different police cars all pull up from five different angles and they jump out of their cars, "Drop the knife! Drop the knife! Drop the knife!" The CIT officer got on scene, and you know, backed them all down and said, "I got this. Everybody put away their guns, except you. You cover me." He put his gun away and started talking. And eventually, the young man dropped the knife. And then, he approached him and told him, "I'm going to have to put the cuffs on you but I'm not taking you to jail. I'm taking you to the hospital where we can have you assessed and figure out what's going on." And then, the young man's mother came up to the officer and said, "I was so sure my son was going to die today. And he didn't (tearful). Sorry. You know, the difference in the approach from the CIT officer to the officer who just went in gung-ho and ended up getting stabbed…mental health calls are 10%, maybe slightly more than 10% of the calls that you get, but how you handle that 10%, makes all the difference." Lastly, P6 reported, "By the second day for sure, they are already changing their minds about certain things. I know like in the last class we had, a lot of them were very very negative about substance abuse and I understand it because they deal with it so often. But we had one of our speakers who is actually a recovering drug user

> and I think that really changed them and helped them to see at least a person in recovery as more of a human than just this piece of crap out in the community. I think that definitely helped. I guess that's another good thing about CIT is using people with lived experience to build that empathy for these officers through the four days that we're together. When they saw that, they definitely had more empathy, had more understanding, and like I said, more like, "These are real people. They're not just another number.

Relatability

All of the participants answered a question about law enforcement officers' level of engagement during the CIT training process. How law enforcement officers engaged depended on two variables: teaching style and applicability.

Teaching Style

One subtheme of relatability from the data is teaching style. Several of the participants reported that how the mental health professional or presenter approached teaching law enforcement officers about mental health impacted their engagement during CIT training. P1 stated:

> I think it depends on the teaching style. Cops do not like lectures so the more engaging and ties to current events you can make it. So, when talking about personality disorders, talk about a political figure. When you're talking about mania, talk about people like celebrities that have been doing crazy things. So, those tend to get things more engaged.

P2 reported:

> I used to joke that I'd rather teach a room full of adolescent boys than teach a room full of officers because it was like dawn of the dead. But I think that I have to attribute that to being the right clinician too because I can't go in there overly touchy feely and expect to get a welcomed response from this population. I have to go in there with a very realistic viewpoint of these are the hardships that officers face and these are the hardships that mental health consumers face and once they recognize that everyone is facing the same hardship, then it opens them up a bit.

Additionally, P7 stated:

> I think it increases as days go on. Day 1, they drag their feet in. They are very closed off, arms crossed, minimal engagement. But we have a lot of really great speakers that are able to encourage conversation and as they see that they are not under attack and that CIT is not to attack them, they do start to open up. By day 5, I do feel like they are a lot more engaged compared to day 1 but I don't have a way to scale that.

Applicability

Another subtheme that influences law enforcement officer's buy-in to the CIT process is the ability to apply the training concepts to their work responsibilities. P5 stated:

> I know we've even tweaked a little bit from our last training to give some presenters more time that I know they had more questions for and just more

engagement towards that maybe they felt was more applicable to actual scenes. I would say engagement is pretty well.

P3 added:

I think that they realize that a large percentage of the calls that they are going to have some mental health component, so they realize the value of the training. And then, there is networking value too. They meet other officers and other professionals and just kind of get an idea of how to better respond on calls. It really makes their job easier in the end so most of them are into it.

Table 3

Participant Response per Theme

Themes	Participants							
	P1	P2	P3	P4	P5	P6	P7	P8
Effective model	X	X	X	X	X	X	X	X
Reinforces de-escalation	X	X		X	X	X	X	X
Volunteer vs. voluntold		X	X	X	X	X	X	X
Humanization		X	X	X	X	X	X	X
Relatability	X	X	X	X	X		X	X

Summary

This chapter detailed the setting and demographics of participants. It also described how data was collected and analyzed. Evidence of how this study was credible, transferable, dependable, and confirmable was described. Through this process, I was able to understand the experience that mental health professionals had while training law enforcement officers for the CIT. Through 5 themes and 6 subthemes, context supported the two research questions. All of the participants agreed that the CIT model was an effective approach to teaching law enforcement officers about mental health and how to

properly de-escalate a person who is experiencing a psychiatric emergency in the community. Through the training, law enforcement officers gained a better understanding about various mental health topics thus, increasing their empathy and approach to managing psychiatric emergencies on duty. Additionally, their attitude about navigating psychiatric emergencies depended on if they elected to be a part of the CIT or if they were instructed to. Furthermore, how the mental health professionals or presenters taught the course and applied the subject to their on-duty responsibilities aided in the engagement of law enforcement officers during the CIT training process.

The next chapter will describe how this research findings compare to findings detailed in the literature review and the theoretical orientations. Additionally, chapter 5 will describe limitations of this study, recommendations for further research, and the potential impact for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this general qualitative study was to understand the experience that mental health professionals had while training law enforcement officers for the CIT. Eight mental health professionals with CIT training experience within 10 years participated in this study. After analyzing interview data, five themes and six subthemes emerged to answer two research questions:

- RQ1: What are mental health professionals' perspectives on the CIT training?
- RQ2: How does the perception of mental health shape law enforcement officers use of the CIT model?

In this chapter, I discuss an interpretation of the research findings, limitations of this study, recommendations for further research and how this study potentially contributes to positive social change.

Interpretation of the Findings

This general qualitative study was designed to explore the experience that mental health professionals had while training law enforcement officers for the CIT. Chapter 2 detailed the disjointed relationship between the criminal justice system and the mental health community due to internal and intrapersonal maladaptive beliefs that law enforcement officers held about this community. To combat this issue, the criminal justice system developed the CIT model to support law enforcement officers' management of psychiatric emergencies in the community. Despite this effort, research has shown that law enforcement officers continued to mismanage psychiatric emergencies while on duty. In this study, mental health professionals provided their

experience of training law enforcement officers for the CIT to provide context to potential barriers with hopes to bridge the gap between these two communities. Under the guidance of the social distance theory and the cognitive dissonance theory, the following interpretation of the findings confirms and extends the literature reviewed in Chapter 2.

As previously detailed, Simmel and Park's social distance theory, dating to the 1890s, described the social separation between groups due to real or perceived differences. This theory offered an explanation of how affective, normative, and/or interactive variables could either enhance or diminish a sense of familiarity between groups. Festinger's (1957) cognitive dissonance theory explained how new knowledges about a subject could influence an individual to think, feel, and value beliefs about that subject differently. With these two theories in mind, five themes emerged in this study: (a) effective model, (b) reinforces de-escalation, (c) volunteer vs. voluntold, (d) humanization, and (e) relatability.

Effective Model

As stated in Chapter 2, research on the CIT model's effectiveness is limited. The results of this study add to the current literature as the CIT model's effectiveness was evaluated from the perspective of mental health professionals; those who are trained in and also use the model to train law enforcement officers for the CIT. The participants in this study expressed the usefulness of the CIT model due to its interactive nature, the exposure it grants law enforcement officers to the mental health community, and the increased knowledge it allots to mental health resources. The participants described the CIT model in two parts, a classroom/psychoeducation portion and roleplay/interactive

portion. The classroom portion focuses on law enforcement officers learning about mental health diagnoses and the sign/symptoms that accompany them. It is also during the classroom portion that guest speakers may present knowledge about mental health. The guest speakers may be community experts, those living with a mental illness, or family members of someone with a mental illness. These guest speakers lend knowledge about their unique experiences navigating mental health.

Law enforcement officers have the opportunity to reflect on prior on-duty interactions and conceptualize the experience under a mental health lens. Additionally, law enforcement officers have the opportunity to ask questions and process those on-duty interactions with the expertise of individuals who have practiced and/or lived with a mental illness. Through this dialogue, the perception that law enforcement officers had about prior on-duty interactions with individuals in the community may be challenged.

The second part of the CIT model is interactive and allows law enforcement officers to take new, acquired knowledge and apply it to real-life on-duty scenarios via roleplay. The participants described this portion of the training as the most significant because it provides a firsthand look at how law enforcement officers will utilize the knowledge learned in CIT training during on-duty interactions in the community. Some participants noted that this portion of training was when many law enforcement officers recognized the value of the CIT training.

The findings under this theme add to and confirm the literature reviewed in Chapter 2. Both the social distance theory and the cognitive dissonance theory were affirmed. The design of the CIT model reduces the perceived social distance between law

enforcement officers and the mental health community. Through increased knowledge and interaction between these two groups, law enforcement officers learned about the challenges that the mental health community face, thus contributing to an increased empathy and an overall positive attitude change about mental health. As stated in Chapter 2, this positive attitudinal shift is necessary to improve use of force outcomes.

Reinforces De-escalation

The majority of the participants spoke about an on-duty slowing-down reaction from law enforcement officers post CIT training. The participants described the slowing down reaction as law enforcement officers sought to acquire sufficient information to fully assess and understand the purpose of the call prior to making a decision on how to assist. One factor that prompted a need for an intervention, like the CIT, was law enforcement officers' mishandling of psychiatric emergencies. Historically, law enforcement officers have displayed aggressive behavior toward individuals with a mental illness, leading the mental health population to being disproportionally represented in injuries and use-of-force incidents during interactions with law enforcement (Laniyonu & Goff, 2021). One participant reported feeling like fear of the unknown was an adequate rationale for law enforcement officers' maltreatment of persons with a mental illness.

In Chapter 2, the reviewed literature suggested that stigma about mental health developed from a lack of knowledge or misunderstanding about mental health, ultimately creating a sense of fear. This fear is then reinforced and perpetuated by sources such as media outlets that often equate mental health/illness to violence and incompetence. As

law enforcement officers go through the CIT training, their preconceived ideas, and beliefs about persons with a mental illness are either affirmed or challenged. Based on the responses from participants in this study, the majority of the law enforcement officers in their department experienced a cognitive shift about mental health, from a negative perception to a positive perception.

Volunteer Versus Voluntold

In this study, the participants described the differing attitudes of law enforcement officers upon the start of CIT training. When law enforcement officers volunteered for the CIT, they presented with an excited, readiness attitude. Law enforcement officers who were voluntold to the CIT were disgruntled and minimized the necessity of the training. This descriptive difference provided by the participants of this study confirmed previous literature reviewed in Chapter 2 that suggested that law enforcement officers who volunteered for the CIT were more empathetic toward persons with a mental illness and sought out mental health resources more in comparison to law enforcement officers that did not volunteer. However, the findings of this study disconfirmed the notion that law enforcement officers who volunteered for the CIT were more suitable applicants.

In Chapter 2, I discussed police culture related to mental health. Because of a perceived "machoism" that is required to work in law enforcement, law enforcement officers often criticized law enforcement officers who struggled with or sought out mental health support. As previously stated, it is this intrapersonal stigma that has a direct influence on law enforcement officers' behavior while on-duty. As many participants described, this preceding attitude about mental health led to a dismissive demeanor upon

entering the training. As the reviewed literature suggested, many law enforcement officers suffer from mental health disorders such as stress, depression, anxiety, and PTSD. Based on these two conflicting ideas, there may be concern about law enforcement officers criticizing the CIT model to appear favorable to their peers. This study found that majority of law enforcement officers, despite their volunteer vs. voluntold status, found the CIT training to be valuable and beneficial to their on-duty responsibilities. Furthermore, the participants described the continued excitement and sense of accomplishment that law enforcement officers felt while successfully navigating psychiatric emergencies after CIT training. This finding illustrates how the CIT model has the potential to shift police culture related to mental health, thus promoting a safer environment for law enforcement officers to seek mental health treatment and speak about their mental health concerns with peers and superiors without consequence. One participant described how their department started an anonymous program for law enforcement officers to individually or collectively discuss how they were mentally impacted by an on-duty incident. Although this specific program is anonymous, it challenges previous literature that suggested the concealing of mental health related issues among law enforcement officers due to perceived judgement from colleagues and/or superiors.

Humanization

As mentioned in Chapter 2, Bratina et al. (2020) described how the role of mental health professionals during the CIT training process was to educate law enforcement officers about signs and symptoms of mental illness, educate about community resources,

discuss psychotropic medications, teach de-escalation tactics, and teach law enforcement officers how to interact with persons who have a mental illness in and outside of a psychiatric emergency. When the eight participants of this study were asked about their understanding of the purpose and how they conducted CIT training, they described each of these responsibilities as areas of focus within their training process. One participant described how a team of law enforcement officers at her division supported a homeless citizen who was causing a public disturbance due to having an item stolen from them. Although this situation does not necessarily align with the definition of an emergency, the CIT-trained law enforcement officers were able to use knowledge learned from the CIT training process to empathize with the citizen in distress and assist them with their needs.

Additionally, the participants described how, while in training, law enforcement officers often recalled on-duty experiences that they had. One participant reported that a law enforcement officer reviewed one experience and realized that the citizen they previously assisted may have had a mental illness and began to perceive the interaction differently than before. Through countless examples provided by the participants of this study, the findings confirmed that when law enforcement officers were exposed to and taught about mental health resources in the community, interacted with citizens that either had a mental health disorder or was a family member of someone with a mental health disorder, and practiced how to utilize the provided tools, that their compassion and/or empathy for the mental health population shifted, contributing to a desire to understand and provide support as needed.

As the two aforementioned theories proposed, increased knowledge, engagement with, and confrontation of previously held beliefs led to the minimization of the gap that real and/or perceived differences existed between these two groups. Another participant discussed how her team of CIT trained officers wore badges that identified them as a CIT law enforcement officer in the community. She reported that the officers wore those badges proudly and prompted a reverence from community members. Not only does the CIT training process result in a shift in how law enforcement officers think about citizens with a mental illness, but citizens also grow a respect and perceived safety toward those law enforcement officers. This further disconfirms previous literature that suggested that law enforcement officers who did not have a positive attitude about mental health from the beginning were not appropriate officers for the CIT.

Relatability

As suggested in Chapter 2, one of the barriers to a successful CIT training experience is the ability for law enforcement officers to buy-in to the CIT training process. Law enforcement agencies have attempted to combat this issue by ensuring that trainers are knowledgeable about mental health, understand police culture, and can engage law enforcement officers to the training process. The findings of this study support how necessary these variables are. The participants described how an understanding of police culture and proper classroom management is crucial to obtain respect from law enforcement officers. One participant described how they enter into the classroom with a humbling spirit to minimize the risk of law enforcement officers perceiving them as superior. This factor ties into another participant who expressed how

many law enforcement officers feared the CIT because they believed that they would experience bullying due to their lack of knowledge about mental health.

Additionally, one participant reported how being mindful of the terminology used was important to ensure that law enforcement officers understood what they were attempting to teach. Another participant discussed how important it is to be mindful of their attire during CIT training days. They encouraged the need for professional dress, also to acquire a level of respect from the law enforcement officers in training. Each of these considerations are necessary from the beginning of training, just to set a tone for how the 40-hour training would be. After that, the participants either presented on or used experts from the field to aid in the process of increasing law enforcement officers' knowledge about mental health. During the actual teaching phase, law enforcement officers are allowed to reflect on their on-duty experiences and see how applicable the information is to their on-duty responsibilities. Per the participants, once the law enforcement officers realized how applicable the information was to their job, they appreciated the information more.

Limitations of the Study

One limitation of this study is the ability to generalize the findings due to its qualitative nature. Eight individuals representing various demographics participated in this study; however, the limited sample size and method of collecting data reduce the findings from being dependable and transferable to all mental health professionals who have trained law enforcement officers for the CIT. Although the results of this study provide an in-depth review of the experience that mental health professionals have while

training law enforcement officers for the CIT, a mixed method or quantitative research approach allows greater context to use a larger sample size.

Another limitation to the study was the participant criteria that specifically sought licensed mental health professionals. Currently, it is not a requirement that mental health professionals be licensed to train law enforcement officers for the CIT. The inclusion of licensure for the participants in this study excluded a mental health professional population that may have added to the research findings. Lastly, data were collected via Zoom interviews, which inhibited my ability to fully observe nonverbal communication in the research participants, which may have added to the interpretation of the study's results.

Recommendations

The findings of this study may inform further quantitative and/or mixed method research in various ways. There is a potential need to understand why fatal use of force practices continue between law enforcement officers to persons with a mental illness. Many professions appropriately manage persons with a mental illness or substance abuse concern without harm or death daily. Law enforcement officers have a model that effectively prepares and supports them to manage psychiatric emergencies in the community. Understanding barriers that make this a challenge for law enforcement officers may be helpful. Additionally, further research can explore how implementing a CIT model in law enforcement agencies may affect attitude about mental health, thus affecting police culture for CIT-trained and non-CIT-trained law enforcement officers. Furthermore, there may be a need to compare and contrast the attitude of law

enforcement officers that are volunteers for the CIT training vs. law enforcement officers that are voluntold for the CIT training. To add, research that explores the CIT model from the perspective of either law enforcement officers or from persons that have received aid through the CIT model may bring additional context to its effectiveness. Lastly, it is not a requirement that the CIT training be completed by a mental health professional. Research that explored attitudinal differences between law enforcement officers who are trained by a mental health professional vs. a non-mental health professional can add to the literature.

Implications

This study contributed to bridging the gap between the criminal justice system and the mental health community. The findings suggest that the CIT model contributes to a positive attitudinal shift in law enforcement officers about mental health from pre-CIT training to post-CIT training. These findings add to current literature by suggesting that the purpose of the CIT model is fulfilled. Although the data showed that law enforcement officers that were voluntold to CIT training presented with a resistance to the training process, majority of those law enforcement officers reported experiencing a positive attitude change by the end of the training. Those law enforcement officers realized how applicable the CIT training information was to their daily duties. Because of this, it may be helpful to make the CIT training mandatory for all law enforcement officers to ensure that all officers are prepared to respond to those type of calls, especially when a CIT trained law enforcement officer is unavailable. Although all law enforcement officers may not be a part of the CIT, having them trained on the CIT model may support proper management of mental health calls, increase empathy toward this vulnerable population,

and minimize stigma about mental health within police culture. The results of this study may challenge law enforcement agencies to re-evaluate how they determine which law enforcement officers receive CIT training.

Additionally, as detailed in Chapter 2, present police culture discourages law enforcement officers from acknowledging, accepting, and supporting themselves with personal mental health struggles and hardens their disposition toward those who are struggling with a mental illness. As this findings of this study suggest, increased awareness about mental health within the criminal justice system not only minimizes stigma about mental health but increases compassion when interacting with this population, thus potentially reducing harm. Increased compassion and reducing harm supports positive social change as a mutual respect is established between these two communities.

Conclusion

This study sought to understand the experience that mental health professionals have while training law enforcement officers for the CIT. Previous research highlighted stigma about mental health that presented from held beliefs by law enforcement officers or was influenced by interdepartmental police culture. Because of this stigma, law enforcement officers mismanaged psychiatric emergencies within the community despite being tasked to handle these calls. The CIT model was developed to support law enforcement officers on proper management of these calls; however, use of force/fatal use of force practices continued. To understand why, I interviewed mental health professionals to understand their perspective of the CIT training process. The findings of

the study showed that the CIT model is an effective model for changing how law enforcement officers think about mental health, thus improving their attitude and use of de-escalation tactics when managing on-duty psychiatric emergencies. Although the findings from this study are promising, further mixed method and quantitative research is needed to continue whether CIT training has a significant impact upon reduction of stigma. Further exploration of the topic of stigma regarding individuals with mental health conditions who encounter law enforcement can promote positive social change.

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Appendix A: Interview Guide

Introduction

I am interested in understanding the experience you had while training law enforcement officers for the Crisis Intervention Team. There are no right or wrong answers to these questions. I am only interested in your experience. Feel free to provide as much detail as you'd like. Any information that you share is much appreciated.

1. How did you begin working with law enforcement for the Crisis Intervention Team?
2. What interests you in the CIT training process?
3. What is your understanding of the purpose of the CIT?
4. How do you conduct CIT training? For example, what resources and aides do you use for the training?
5. What did law enforcement officers express about being a part of the CIT?
6. In your experience, how do law enforcement officers think about mental health?
7. What were some of the misconceptions that you encountered from law enforcement officers during your training?
8. How would you describe law enforcement officer's level of engagement during the training process?
9. From your observation, how does the CIT model affect law enforcement officer's skills for responding to psychiatric emergencies?

10. What differences did you notice about law enforcement officer's readiness to respond to psychiatric emergencies from pre-CIT training to post CIT training?
11. What is your experience with law enforcement officers in the role of managing psychiatric emergencies?
12. What do you think is effective with the CIT training model?
13. What do you think is not effective with the CIT training model?
14. What would you change about the CIT training model.

Appendix B: Demographic Survey

1. Age:
   a. 20-30 years
   b. 31-40 years
   c. 41-50 years
   d. 51-60 years
   e. 61-70 years
   f. 71 and above

2. Sex:
   a. Male
   b. Female
   c. Other (specify) _____

3. Ethnicity:
   a. American Indian/Alaska Native
   b. Asian
   c. Black/African American
   d. Hispanic/Latino
   e. Native Hawaiian/Other Pacific Islander
   f. White

4. Years as a mental health professional:
   a. 0-5 years
   b. 6-10 years
   c. 11-15 years
   d. 16-20 years
   e. 21-25 years
   f. 26-30 years
   g. 30 years + (specify)_____

5. Years working with law enforcement:
   a. 0-5 years
   b. 6-10 years
   c. 11-15 years
   d. 16-20 years
   e. 21-25 years
   f. 26-30 years
   g. 30 years + (specify)_____