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Lived Experiences of Law Enforcement Officers Assigned to Co-Response Teams Responding to Mental Health Crises

Roxanne Miller
Walden University

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Walden University

College of Psychology and Community Services

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Roxanne Pennington Miller

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the review committee have been made.

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Walden University
2026

Abstract

Lived Experiences of Law Enforcement Officers Assigned to Co-Response Teams

Responding to Mental Health Crises

by

Roxanne Pennington Miller

MA, Trevecca Nazarene University, 2018

BA, Mount Vernon Nazarene University, 2007

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Forensic Psychology

Walden University

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Abstract

Law enforcement officers are increasingly called upon to respond to mental health crises, yet their experiences as members of co-response teams (CRTs) remain underexplored. This study was conducted to address that gap by examining the lived experiences of officers assigned to CRTs that pair specially trained officers with mental health clinicians to respond jointly to calls involving individuals in crisis. The purpose of this qualitative phenomenological study was to describe how officers experience CRT work and how it shapes their perceptions, practices, and professional identity. The study was guided by Lazarus and Folkman's transactional theory of stress, appraisal, and coping, which frames stress as a dynamic process involving the appraisal of demands and available coping resources. Eight officers who had served on CRTs for at least 6 months participated in semistructured interviews. Participants were selected using purposive and snowball sampling. Data were analyzed using Groenewald's five-phase phenomenological explication process that included bracketing, identifying units of meaning, clustering themes, and validating findings through member checks. Key findings revealed three central themes: professional development, operational dynamics, and community engagement. Officers reported increased empathy, improved communication skills, and a shift from skepticism to support for the CRT model. Challenges included limited staffing, inconsistent program availability, and the need for stronger coordination with community mental health services. The findings of this study has implications for positive social change that include elevating CRT officers' voices and offering recommendations to improve training, staffing and public trust.

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Dedication

To God be the glory! Thank You for sustaining me through this journey.

This dissertation is dedicated to my perfect-for-me husband, Joshua, whose unwavering support, patience, and encouragement made this possible. To Bella, Olivia, Noah, Elijah, Gabby, Josiah, Judah, Clara, and the grandbabies, who inspire me to keep going and remind me why this work matters. To my parents, siblings, nieces, and nephews—thank you for believing in me and cheering me on no matter what.

To my Grandma Roxy, who always showed genuine interest in my work and never stopped learning. Your curiosity and love for knowledge live on in me.

I also dedicate this work to the law enforcement officers who serve with compassion, courage, and integrity—especially those who respond to mental health crises with empathy and care. Your dedication to protecting and serving vulnerable populations is both humbling and inspiring.

This work is for all of you.

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This dissertation may have my name on it, but it belongs to all of you who walked beside me and cheered me on. Thank you for believing in me.

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Chapter 1: Introduction to the Study

Introduction

Police departments around the country respond to thousands of calls for service every day involving a person with a mental illness (PMI). *9-1-1 Statistics* (n.d.) estimates that “240 million calls are made to 9-1-1 each year” (para. 1). Different police departments report different percentages of calls that involve a PMI based on department size and location population: Yang and Lu (2024) reported estimates that between 5% and 31% of all calls received involve a PMI. That means approximately 12 million to 84 million calls per year, resulting in 32,000–230,000 calls to police departments per day in the United States involving a PMI. As time goes on, this number is trending upward.

Many credit the upward trend to deinstitutionalization and transinstitutionalization. Deinstitutionalization is the process of closing state mental health hospitals, returning PMIs to their families and communities for care with the promise of mental health centers being constructed for more personalized and humane care. However, only a fraction of these centers was built, resulting in many PMIs engaging with the criminal-legal system as families relied more on law enforcement to help them manage PMIs who were experiencing a crisis. Now, there is an overrepresentation of people in the prison system suffering with mental illness. Efforts are being made to remove PMIs from that system as well. This results in transinstitutionalization, where groups of people are passed around from system to system in an effort to get them the care and services they need.

There are now several ways that police respond to calls for service for PMIs: police-only response, crisis intervention teams (CITs), co-response teams (CRTs), tri-response teams (TRTs), and nonpolice response models such as mobile crisis teams (MCTs). All models will be discussed in more detail in Chapter 2.

The focus of this study is on the CRT method of police response to calls for service for PMIs. There are several police departments around the world utilizing this method and research studies continue to be written on the topic to determine the efficacy and benefits to all involved. Many articles explore the experiences of PMIs with CRTs along with their family members or support people. Several studies have explored the experiences of mental health professionals involved in CRTs. However, at the time of this study, only six studies have been identified that specifically examine the perspectives of police officers regarding CRTs (Fisher et al., 2024; Kuehl et al., 2023; Plassmeyer, 2025; Plassmeyer et al., 2024; Robertson et al., 2019; Yang & Lu, 2024). In these studies, some officers reported utilizing CRTs to assist with calls involving PMIs, while a smaller number of officers were active members of the CRTs being studied. Three of these studies focused on CRTs operating in New Zealand and Australia (Fisher et al., 2024; Kuehl et al., 2023; Robertson et al., 2019), while one study examined a CRT based in the United States (Yang & Lu, 2024).

The topic of police experience with PMIs is worth considering due to the increasing calls for service, public demand for more empathic responses from police working with PMIs, and the officers' extensive experience with PMIs. Police are a part of the solution but often their experiences are not considered. This study will add police

experience and feedback to existing literature on CRTs, further improving future CRT implementation. Not only will future programs benefit from this study, but the field of Forensic Psychology will benefit as well.

Forensic Psychology is the study of the areas of society where psychology and the criminal justice system meet. This includes the specific topic of police psychology. Police psychology is the field of study that seeks to understand the experiences of law enforcement officers that are unique to this career path. This study will add to the field of police psychology specifically by increasing the understanding of law enforcement officer experiences when responding to calls for service for PMIs. The potential social implications of the study include improved interactions between police and PMIs, fewer uses of force and/or injuries on calls with PMIs, improved public perception of police, and decreased stress and burnout for police. It is also possible that this study may influence the improvement of mental health service availability in individual communities in the future.

Chapter one will cover the background of the study, the problem statement, purpose of the study, research questions, theoretical foundation, the nature of the study, relevant definitions, assumptions, scope and delimitations, limitations, and significance of the study. The purpose of this qualitative study is to describe the lived experiences of law enforcement officers who are assigned to CRTs responding to mental health crises.

Background

Programs have been created to partner mental health professionals with law enforcement officers to assist with calls related to mental health crises. Research has been

conducted on the efficacy of these programs (Donnelly et al., 2024; Fisher et al., 2024; Ghelani et al., 2022; Hassel, 2020; Semple et al., 2020; Williams, 2003; Yang & Lu, 2024). Mental health professionals (Daggenvoorde et al., 2022; Kuehl et al., 2023; Kuehl et al., 2024a), family members and support people (Kuehl et al., 2024b), and those suffering with a mental health challenge (Boscarato et al., 2014; Kuehl et al., 2024b) have been interviewed on their perceptions and experiences with CRT programs, but there are very few studies that have been conducted that have examined the subjective experience of law enforcement officers on these teams in the United States. One difficulty for conducting these studies is that there is not one single method of addressing calls with PMIs. Without a uniformed response, it is difficult to compare the effects of one program with another. Another challenge is that many CRT programs are in their pilot stages when being studied and therefore there are very few officers involved. Qualitative studies are not viable methods for research with such a small participant pool because confidentiality cannot be ensured.

There are several ways that police departments respond to calls for service for PMIs. The police-only response is the standard way that police officers are trained to respond to calls per their standard operating procedures. More attention is now being paid to police brutality and use-of-force, so new ways of responding to calls for PMIs are being explored and implemented. One of the first new methods is referred to as the Memphis Model, or CIT. This method gives specific officers 40 hours of training focused on de-escalation skills, understanding mental health diagnoses, becoming familiar with

community resources, and improving communication skills (Bailey et al., 2022; Blais et al., 2020).

The CRT method trains police officers using the CIT curriculum or other mental health curriculum and pairs that officer with a mental health clinician. Together in the same vehicle, they respond to calls for PMIs in crisis as a second-response protocol once the scene has been secured. The TRT adds a third member to the responding team, typically a paramedic or psychiatric nurse practitioner, however they usually arrive to the scene separately. Members from police, mental health, and emergency medical departments respond to PMI calls together to offer a holistic response.

Some communities are attempting to redirect PMIs away from the police through nonpolice models like MCTs. Generally, MCTs do not respond to the scene, but primarily offer consultation to officers over the phone. MCTs that do respond to the scene only do so once the scene has been secured and often many hours later. MCTs include a combination of mental health clinicians, social workers, and paramedics or psychiatric nurse practitioners. Even though law enforcement officers are not included on the MCT, the MCT has direct contract with police on these calls.

While there are many studies on the different models of police response, there is a lack of research regarding the experiences of law enforcement officers who are paired with mental health professionals and respond to calls for mental crisis. This is the gap that this study aims to address. Officers are key stakeholders in the delivery of co-response programs and have valuable information and experiences to share for the betterment of these programs. In 2022, most participants (76%) in a nationally

representative study from the United States indicated that they were in favor of funding and implementing co-responder programs in their local police departments (Ward et al., 2022). This indicates that the support for co-response programs exists within the community. One of the many ways to improve the implementation of co-response programs is to solicit expert feedback from those who are directly involved in the program, specifically for this study, police officers.

Despite public discontent regarding police response to mental health crises, police officers are arguably still the most qualified professionals to respond to mental health emergencies (Yang & Lu, 2024). That is why this study is needed. Hearing from the current experts on police response to mental health emergencies will allow future program developers to create processes that benefit all involved. Additionally, the stress that law enforcement officers experience regarding response to mental health calls for service can inform future training curriculum and procedural development in such a way that will ease the burden on officers through increased knowledge, teamwork, and collaboration with other community agencies.

Problem Statement

A lack of research regarding the experiences of law enforcement officers who are assigned to CRTs limits program development and increases the risk of injury to police and PMI alike. From years 2015-2020, approximately 2400 people with behavioral or mental health challenges were injured or killed by police, making up roughly 22% of injuries or fatalities by police in the U.S (Ward et al., 2024). Additionally, Ward et al. (2024) found that the odds of injury or fatality were higher when involving police contact

with people experiencing suicidal behaviors or other behavioral health crises. One thing to note within this study is that the researchers did not distinguish between injuries and deaths that were because of police brutality and those that were in self-defense due to the volatile nature of mental health crisis calls. It is implied or assumed that all the injuries and deaths in these instances were unjustifiable. This is an important distinction to make, especially when it relates to officer experience. If key stakeholders within the CRTs can share feedback and improve police response to mental health calls, the potential for reducing the number of injuries and fatalities for PMIs could improve. Additionally, the toll that these injuries and deaths have on the officers could also be understood more fully. Overall, the current cultural climate is favorable for revising and improving police response to mental health calls.

For example, most survey participants were in favor of funding (66%) and implementing (76%) co-response models (Ward et al., 2022). Interestingly, more participants were in favor of the implementation than were in favor of funding these programs. Support for the programs without providing adequate funding to make the programs successful results in inspiring talking points but disappointing outcomes, similar to the promise of mental health centers when the state institutions were shut down. Public support is high, but without the necessary funding coming from somewhere, the creation of new programs and methods for responding to PMIs is very limited.

Another alternative response that survey participants were in favor of is diversion from correctional institutions for people who are struggling with mental illness (72%;

Ward et al., 2022). The goal here would be to have programs and services available in the community that serve PMIs who have not committed criminal acts and therefore do not need to be involved in the criminal justice system. Unfortunately, in some areas, there are so few mental health resources available to the public that some officers find something small to charge a PMI with just so they can gain access to the mental health services that are currently available within the criminal justice system. Again, public support exists for these alternative programs, but funding continues to be a barrier for program implementation (Ward et al., 2024).

The issues that prompted me to search the literature is my experience working with law enforcement officers who are experiencing burnout and compassion fatigue because of the increasing expectations placed on police officers to handle every type of call with the highest degree of knowledge, expertise, and experience. Public perception of police officers has declined recently with mass media coverage of officer-involved shootings, the increase in mental illness, and the troubling reports of the mistreatment of mentally ill individuals by officers of the law. Often officers are not permitted to share their experiences with these types of situations, but I believe that their voices need to be heard.

If this gap is not addressed, program decisions will continue to be made without officer experiential data, which risks creating models that look good on paper but fail operationally in the field. This can result in continued preventable harm to PMIs, continued preventable trauma exposure to officers, and stalled momentum for scaling CRT models nationally. Without incorporating officer voice, we risk repeating the same

pattern as deinstitutionalization—promising new solutions without actual system capacity to support them.

Purpose

The purpose of this qualitative study is to describe the lived experiences of law enforcement officers who are assigned to CRTs and respond to mental health crisis calls. The data collection method will be phenomenological, semistructured interviews with law enforcement officers who have been or currently are assigned to a CRT to understand their personal experience of responding to calls for service for PMIs. This qualitative study is being conducted to address a gap in literature and to increase the knowledge base of officer experiences with PMIs. This information and insight will increase the field of knowledge concerning law enforcement officer response to calls for mental health crises and can be useful in improving the quality of CRTs.

Research Question

What are the lived experiences of law enforcement officers who are assigned to CRTs in a midsized police department in the southeast region of the United States?

Theoretical Foundation

This qualitative study is grounded in Lazarus and Folkman's transactional theory of stress, appraisal, and coping (1984). The concepts of stress, appraisal, and coping refer to the processes involved in addressing challenging situations, figuring out how to address the challenge, and how to live with the outcome. Lazarus and Folkman defined *stress* as the result of determining that the demands of a situation outweigh the resources available to meet those demands (1984). This suggests that stress is a transaction between

the person and their environment, but that it is also a process. *Appraisal* is defined as the process people use to decide if something is stressful to them (Folkman et al., 1986a). Unlike stress, appraisal does not involve a transaction, but only a process that involves asking two questions: What is at stake? And what can I do/what can be done about it (Folkman, 1982; Folkman et al., 1986a). Finally, *coping* is defined as methods or strategies people employ to deal with the stressful situation or event (Folkman, 1982; Lazarus & Folkman, 1984). This definition also suggests that coping is a transaction as well as a process. These concepts will all be discussed in more depth in Chapter 2.

Lazarus and Folkman's (1984) transactional theory of stress, appraisal, and coping relates to the current qualitative study by highlighting what is at stake for and what can be done by officers when they are attempting to help someone suffering with a mental illness. Additionally, this study will explore how the officers appraise and cope with being on a CRT. This theory will be described in greater detail in Chapter 2.

Nature of the Study

To address the research question of this qualitative study, I used a phenomenological approach which refers to the study of things as they are experienced or the idea that perception and experience are reality (Groenewald, 2004). This approach is ideal for this qualitative study because the job of the researcher is to describe the participants' experiences in the most pure and accurate way possible (Groenewald, 2004). The researcher accomplishes this by setting their own biases and interpretations aside to focus exclusively on what the participants are describing, a process known as *bracketing* (Groenewald, 2004; Tufford & Newman, 2012). The phenomenological approach

described by Groenewald (2004) provides a clear process for obtaining data and interpreting the data over the course of many reviews. This process will be useful for understanding the lived experiences of law enforcement officers who are assigned to CRTs and regularly interact with PMIs by allowing each officer to describe in detail their own experiences and then share the meaning they take away from those experiences.

Data will be collected through individual semistructured interviews. After a pilot study has been completed, participants will be recruited from the police department based on their experiences with CRTs. Informed consent will be obtained. “Explicitation” is a term used by phenomenologists which means to “let appear the pre-conscious experiential texture of the phenomenon” (Depraz, 2014, p. 142). Explicitation is used in place of data analysis because phenomenologists seek to understand experiences as the participant experiences it rather than attempting to insert their own interpretations and assumptions. Each transcript will be reviewed individually for common and unique themes. Then all transcripts will be reviewed together to discover common and unique themes across all interview participants. Themes and outliers will be identified and discussed in Chapter 5.

Definitions

Appraisal: The process people use to decide if something is stressful to them. This process involves two steps: primary and secondary appraisal. Primary appraisal asks, “What is at stake?” and secondary appraisal asks, “What can I do/what can be done?” (Folkman, 1982; Folkman et al., 1986a).

Coping: The methods or strategies that people employ to deal with stressful situations or events. Coping assesses the relationship the person has with the challenge as well as the steps or the process the person employs to increase resources or decrease demands (Folkman, 1982).

Co-response team (CRT): A model of police response that pairs a police officer with a mental health clinician from a local community mental health agency. The pair would then travel together to calls for service involving PMIs (Bailey et al., 2022; Kuehl et al., 2024a). Many departments elect to train the officers with the CIT curriculum or other mental health-based curriculum.

Crisis intervention team (CIT): A 40-hour curriculum that trains law enforcement officers on specific topics to improve their interactions with people with mental illness such as de-escalation skills, understanding mental health diagnoses, becoming familiar with community resources, and improving communication skills (Bailey et al., 2022; Blais et al., 2020). The theory behind this model is that CIT-trained officers would respond more appropriately to PMIs and have better success in getting the PMIs the help they need.

Person with mental illness (PMI): An individual with a diagnosed mental illness. To reduce stigma surrounding mental illness, person-centered language is preferred. For example, a “person with mental illness” is preferable to a “mental patient” (Volkow et al., 2021).

Stress: A relationship between a person and their environment in which the person appraises the environment as demanding or exceeding their available resources (Lazarus & Folkman, 1984).

Assumptions

Assumptions in research refer to concepts or beliefs that are a part of the study but cannot be verified. For example, for this study I assume that the participants are telling me the truth about their experiences and perceptions of being on a CRT. This is an ontological assumption in which reality is subjective and may be viewed differently from participant to participant within the study (Summer, 2003). Additionally, I assume that the personal experiences being shared by participants will uncover relevant insights and useful recommendations for future co-response programs. I also assume that eight to 10 participants will provide enough data to reach saturation and no longer produce new topics or themes. These assumptions are necessary due to the qualitative nature of the study where interviews and personal experience produce the data being collected. When utilizing interviews for research, it must be assumed that the participants are speaking their truth.

Scope and Delimitations

The scope of this study focuses on the lived experiences of law enforcement officers who are assigned to CRTs and respond to calls for service for people experiencing a mental health crisis. I am focusing on the officers' experiences due to a gap in the literature that I found on CRTs. Most CRT studies focus on the impact on the PMI, the perceptions of the PMI's family members or support people, the experiences of

the mental health professionals who are also a part of the team, and law enforcement officers who call the CRTs to come assist with a scene. Learning about and understanding the personal, lived experiences of the law enforcement officers on these CRTs will contribute to the literature and hopefully influence program implementation for future CRTs.

The delimitations of this study include only permitting law enforcement officers who are currently or were formally a part of the CRT, therefore officers who have never been on a CRT will be excluded from the study. One single department was utilized for this study due to accessibility and time constraints. Confidentiality is key in encouraging officer honesty regarding their experiences and opinions; therefore, the details of the specific department CRT program being studied will remain anonymous. The data gathered in this study and the themes that emerge may generalize to other midsized, urban police departments but may not be transferable to larger or smaller departments.

Limitations

Limitations for this qualitative study exist on three different levels. The first level of limitations revolves around methodological restraints on time and access to law enforcement officers who are assigned to a CRT. Due to time constraints, only one police department was included in this study which means the findings may not be generalizable or transferable to all police departments across the country. This department is a midsize police department in an urban setting with approximately 1,500 sworn employees, and the experiences of these police officers may differ greatly from the officers responding to calls for service involving PMIs in rural or less populated areas. Additionally, this study

involves semistructured interviews and assumes that the officers are sharing their true experiences. Officers who did not volunteer to participate in the study may have different experiences that they do not feel comfortable disclosing, and therefore this present study is limited to the experiences of officers willing to participate.

The second layer of limitation has to do with gender and cultural differences between police departments. At the time of this study the participating police department reported that its employees were 87% male and 13% female. Additionally, this police department reported that employees were 79% White or Caucasian, 11% Black or African American, and 10% identified as *other*. Officers from departments with greater or lesser gender or cultural diversity may have different experiences than the officers participating in this study.

The third level of limitation involves those who are not permitted to participate in this study. Officers who were a part of a CRT in a different department prior to joining the department being studied will not be permitted to participate in this study. Command staff from this police department will not be invited to participate in the study because the specific research question focuses on the officer-level experience. Special consideration will be given if there is a supervisor willing to participate who was originally a part of the CRT prior to being promoted.

As a mental health therapist and a police department employee there may be biases identified throughout the course of study that will need to be monitored. These biases may include personal opinions and experiences related to law enforcement responses to mental health crises. When these biases arise, they will be discussed with the

research committee to maintain objectivity during interviews and the explicitation process.

Significance

The significance of this study lies in the insight and experience shared by the law enforcement officers who are assigned to a CRT. The existing literature highlights the experiences of the PMI with CRTs, the PMIs family members experiences as well as the mental health clinicians experience with CRTs. There is even some research regarding officer experience of calling a CRT to assist with a call for service. However, there is a gap in the literature regarding the lived experiences of the law enforcement officers who are currently participating in the CRT response process. This personal insight and perspective will contribute to the current body of literature by offering a “boots on the ground” perspective for program implementation, resources, and effectiveness. When stakeholders gather to create and implement a new response to calls for service for PMIs, the law enforcement officer’s unique perspective of policy and procedure in action will provide much needed information to future program development.

Additionally, this study will contribute to positive social change by influencing the way in which PMIs receive care in their time of crisis from the police department and other local social services. This study has the potential to aid in the reduction of injuries by police, injury of police, and a reduction of traumatic experiences for the PMIs involved. This study also has the potential to improve communication and partnership between police departments and community mental health services as well as impact the number of people being involuntarily taken to the emergency room.

Summary

In this chapter, I have laid out the plan for exploring the lived experiences of law enforcement officers who are assigned to CRTs and respond to mental health emergencies. This chapter covered the background of the study, the problem statement, purpose of the study, research question, theoretical foundation, the nature of the study, relevant definitions, assumptions, scope and delimitations, limitations, and the significance of the study. All this information lays an important foundation for the plethora of literature that is reviewed in Chapter Two. Chapter Two describes in greater detail the types of police response to PMIs, Lazarus and Folkman's transactional theory of stress, appraisal, and coping, and the existing literature on the effectiveness and impact of police response programs all around the world.

Chapter 2: Literature Review

Introduction

Many programs have been created to improve the ways in which law enforcement officers interact with and respond to calls for PMIs. Some programs focus on increasing the knowledge and skill sets of the officers, such as CITs (Davidson, 2016; Hassel, 2020; Willis et al., 2023). Other programs pair an officer with a mental health clinician or other mental health expert to respond to calls together as a second-response team, like the CRT (Boscarato et al., 2014; Fisher et al., 2024; Kirst et al., 2015). Taking a nonpolice approach, MCTs are made up of non-law-enforcement personnel such as social workers, therapists, and psychiatric nurse practitioners who offer information, insight, and resources to the officer over the phone (Daggenvoorde et al., 2022). Having so many programs to choose from allows police departments to evaluate which option may best meet the needs of their specific community and resource level.

Research has been done to determine the efficacy and value of these programs for many of the stakeholders involved. Bailey et al. (2022) found that the CRT in Indianapolis reduced the number of arrests of PMIs and used force less frequently when compared with police-only responses. CIT-trained officers in Michigan also used force less often than officers without CIT training (Willis et al., 2023). Blais et al. (2020) found that a Canadian CRT in Quebec was effective in de-escalation, increasing connection with community resources, and were less likely to use force or transport people in crisis involuntarily.

One qualitative study has been done to capture the subjective experiences of the person suffering with the mental illness, their family, and caregivers (Kuehl et al., 2024b). In this study, PMIs were interviewed regarding their experience with CRTs versus police-only responses. Their family members were also interviewed to gain an understanding of the two different response-styles. Both the PMIs and their family members agreed that the CRT response was favorable over police-only response due to the compassionate and empathic way they and their loved one was treated (Kuehl et al., 2024b). One main difference described with the CRT response is that the clinician focused more on deciding on next steps *with* the PMI instead of *for* the PMI (Kuehl et al., 2024b). This allowed the PMI to feel more understood and cared for as an individual (Kuehl et al., 2024b). PMIs also appreciated having a paramedic as a part of the CRT because of the way the paramedic was able to tell them what was physically happening (Kuehl et al., 2024b). For example, if a PMI was having a panic attack, the paramedic could check vitals and let them know they are not having a heart attack (Kuehl et al., 2024b). Both PMIs and family members noted the difficulty of going back to police-only responses when the CRT was not available (Kuehl et al., 2024b).

Mental health clinicians, paramedics, and officers were also interviewed to determine the kind of experiences they have had with CRTs (Kuehl et al., 2023; Stauss et al., 2023). Kuehl et al. (2023) found that police officers generally feel unprepared to deal with mental health crises but have mixed feelings about whether it is the police's job to address mental health crises in the first place. Both police officers and mental health clinicians reported frustration with the management of calls and unrealistic expectations

(Kuehl et al., 2023). Mental health clinicians and social workers reported that there is a general lack of community resources in place to properly manage the care of PMIs (Kuehl et al., 2023; Stauss et al., 2023). Police and paramedics are hopeful about the CRT programs but find mental health organizations are more difficult to deal with than the mental health clinician that rides with them (Kuehl et al., 2023). All participant groups agreed that the success of the CRT response will depend on adequate staffing and availability of CRTs as well as appropriate community mental health services to which PMIs can be referred (Kuehl et al., 2023; Kuehl et al., 2024b).

Additionally, Plassmeyer et al. (2024) did a mixed-methods study assessing the change in police employee perceptions of the CRT in Fayetteville, Arkansas, over a 2-year period. The entire department was required to participate in a quantitative survey regarding their perceptions of the pilot CRT program that began in 2021. Participants were asked to complete the survey in 2021 and then again in 2023. This resulted in statistically significant improvement in perception over time (Plassmeyer et al., 2024).

The experience and perspective of the law enforcement officer who is assigned to these types of specialized teams are valuable to the research community because they can provide real-world experience and occupational knowledge that is significant for the development and improvement of the response strategies for those who are experiencing a mental health crisis. Officers are tasked with providing safety and security to the community and protecting the well-being of all involved in mental health crisis calls, making their viewpoint a vital one to the success of these initiatives. In this chapter I describe the literature search and strategy, theoretical foundation, literature review of

topics related to key concepts, and synthesize the findings. The purpose of this qualitative study is to describe the lived experiences of law enforcement officers who are assigned to CRTs responding to mental health crises.

Literature Search Strategy

Research for this study was based off the question, “what is the lived experience of law enforcement officers assigned to CRTs responding to mental health crises?” The following databases were used to identify articles that are relevant to this topic: APA PsychInfo, Gale Academic OneFile Select, ProQuest, Research Gate, and Sage Journals. Additionally, I looked through all the reference lists of the articles of interest to see if there were any additional relevant articles that should be included. The Walden University Library was also searched. The years 2019-2025 were selected and only peer-reviewed journals were included in the final list. All final articles were confirmed as peer-reviewed by filtering them through Ulrich’s Library webpage.

The terms that were used in the search are: *co-response team*, *crisis intervention team*, *mobile crisis intervention*, *tri-response team*, *mental health triage*, *mental health crisis*, and *policing mental health*. The terms were combined with *police* OR *law enforcement officer*. Duplicates and non-peer-reviewed articles were removed, resulting in 30 relevant articles. I read through the abstracts to determine their relevance to my research question. Many articles used the terms *co-response team* and *crisis intervention team* interchangeably, so I sorted through which articles specifically addressed the co-response model. Additionally, some articles used the term *mobile crisis intervention team*

to describe a variety of service delivery types, so I read through those to pull out the articles that referenced true CRTs (police officer paired with mental health clinician).

Theoretical Foundation

The theoretical foundation of a dissertation is meant to provide structure and direction for the gathering and interpretive tasks of research. This structure helps a researcher keep one foot planted in established scientific knowledge while the other foot is exploring new territory in their field of study. The firm foundation for this dissertation is built on Richard S. Lazarus and Susan Folkman's (1984) transactional theory of stress, appraisal, and coping. They define psychological stress as the result of determining that the demands of a situation outweigh the resources available to meet those demands (Lazarus & Folkman, 1984). This framework will be used to better understand the experiences of law enforcement officers as they respond to calls for service for mental health crises and the ways in which those calls may tax or exceed their resources.

Lazarus and Folkman's Transactional Theory of Stress, Appraisal, and Coping

Stress

Lazarus and Folkman wrote the seminal book on stress in 1984 entitled *Stress, Appraisal, and Coping* in which they explore all research that existed on stress and summarized the contradictions, flaws, and gaps. They then went on to explain their new concept of appraisal and more clearly defined the idea of coping. Until the writing of the book, stress was viewed as both a stimulus and a response to stimulus, which was a circular way of thinking that did not fully encompass the stress and coping response Lazarus and Folkman were observing (1986). Through many experiments, Lazarus

(1981) concluded that stress has three observable effects on performance: no effect, a detrimental effect, and an improving effect. In some cases, adding stressors to an experiment had no effect on the participants. For other participants, adding stressors prevented them from functioning at their ideal level, either through increasing speed and decreasing accuracy, or by distracting participants from clear thinking and processing through a problem. The final effect of stressors on some participants improved their performance, causing them to focus and become more efficient and proficient.

The transactional theory of stress, appraisal and coping has been around for several decades, but it is still relevant in research today. Some recent topics that have been studied through this theory include social media overload (Gao & Zhao, 2024), job insecurity and performance (Anwar, 2023; Nath et al., 2024), coping with natural disasters (Littleton et al., 2024), and organizational stress (Hilal, 2023). Social media overload, job insecurity and performance, and coping with natural disasters are stressors that law enforcement officers encounter in their jobs, sometimes daily. With the additional burden of transinstitutionalization, officers are expected to address mental health crises as appropriately as if they were trained psychologists. The demand and expectations for officers are high, with limited community mental health resources available, ongoing coverage and pressure from external stakeholders, and chronic organizational stressors. The transactional theory of stress framework will clarify the different demands that law enforcement officers may experience and highlight the ways they have found to cope with stress.

Cognitive Appraisal

Adding to the knowledge they had gathered on stress, Lazarus and Folkman (1984) introduced a new concept of *cognitive appraisal*, which they defined as the process people use to decide if something is stressful to them. This process involves two parts: primary and secondary appraisal (Folkman et al., 1986a). Cognitive appraisal involves asking two questions: What is at stake (primary cognitive appraisal; Folkman, 1982) and what can I do/what can be done (secondary cognitive appraisal; Folkman et al., 1986a). The first question assesses the demand that is taking place, and the second question assesses the resources that are available or unavailable to meet that demand.

The amount of stress increases for an individual according to the amount of challenge, threat, or harm and loss a person identifies through cognitive appraisal (Folkman, 1982). Appraising a situation as a challenge indicates that what is at stake and what a person can do about it are relatively equal. This would be a situation where learning and mastery would suffice to address the demand. Threat is appraised when there is a fear of harm or loss, but it has not yet happened. This would be a situation where planning, delegating, or reaching out for support would address the demand. Appraising a situation as harm and loss means that the damage has already been done and now the individual is using cognitive appraisal to figure out how to cope with the loss and address residual demands (Folkman, 1982). Folkman et al. (1986a) found that appraisal and coping can have a significant impact on psychological symptoms of distress, but evidence is inconclusive regarding appraisal and coping's effect on somatic symptoms of

distress. Psychological symptoms increased as the stakes increased during appraisal (Folkman et al., 1986a).

There was some disagreement among researchers in the 1980s that argued against the appraisal process, stating that there were too many opportunities for confounding variables when appraisal was assessed as a part of the stress and coping process (Dohrenwend et al., 1984). Lazarus et al. (1985) contested that purely objective research on stress is impossible because the experience of stress relies on the individual, subjective experience of the participant, stating that “no environmental event can be identified as a stressor independently of its appraisal by the person” (p. 776). Lazarus et al. (1985) maintained that the stress, appraisal, and coping process is a *relational process* that is dependent upon the relationship the person has with the environmental stressor.

Coping

Coping is defined as the methods or strategies people employ to deal with the stressful situation or event (Folkman, 1982; Lazarus & Folkman, 1984). Folkman (1982) clarifies the definition of coping by highlighting two main components: the process and the relationship. The steps a person takes to increase resources or decrease demands is the process of coping (Folkman, 1982). The relationship of coping refers to the closeness or connection that a person has to the demand (Folkman, 1982). For example, the *process* of coping might involve taking a class, asking for help, or delegating a task. The *relationship* of coping might involve a demand within marriage or a work environment, in the privacy of their home or out in public. The relationship to the demand informs the process a person will take to cope. In summary, the transactional theory of stress and

coping describes stress as experienced when a situation is appraised as exceeding one's resources or abilities. In response to that negative cognitive appraisal, coping is the act of figuring out what is at stake and what can be done.

Folkman and Lazarus (1984) made the distinction between coping and automatic responses. They assert that certain coping strategies, when repeated over and over, could become automated. For example, when learning to drive a car, it is at first awkward and nerve wracking. Practicing driving can be a form of coping to master the skill, but once it becomes more natural and easier, it ceases to be coping—it has converted into an automatic skill. What makes a skill coping versus automatic is the novelty of the situation. If a seasoned driver is on their commute home from work, they can easily think about dinner or groceries or taxes as they drive. But if the road is closed or they come into a construction zone, they would have to think through and cope/navigate through that challenge through cognitive appraisal and coping.

Folkman et al. (1986b) describe different categories of coping: emotion-focused coping and problem-focused coping. In this study, Folkman et al. (1986b) found that appraisal can determine the type of coping that an individual selects. For example, if secondary appraisal concludes that a situation can be fixed, problem-focused coping is implemented more often than emotion-focused coping (Folkman et al., 1986b). However, if secondary appraisal concludes that a situation cannot be fixed, emotion-focused coping is selected more often (Folkman et al., 1986b). Additionally, Folkman et al. (1986a) describe different types of coping. Confrontive coping is the act of standing up for oneself or using assertive measures to address the problem (Folkman et al., 1986a).

“Distancing” is the act of removing oneself from the challenging or threatening situation either physically or emotionally (Folkman et al., 1986a). Coping through self-control is when a person restrains their thoughts and feelings and attempts to address the situation in a measured and rational manner (Folkman et al., 1986a). Additional forms of coping involve seeking social support, accepting responsibility, escape-avoidance, planful problem solving, and positive reappraisal (Folkman et al., 1986a). It was also found that different types of coping were sometimes paired together for greater effect (Folkman et al., 1986b). For example, planful problem solving and self-control were often paired together when dealing with a work-related stressor (Folkman & Lazarus, 1980). Similarly, accepting responsibility and positive reappraisal were often found paired together when a challenging situation was appraised as changeable, such as studying for a school examination (Folkman et al., 1986a).

The transactional theory of stress and coping has since been applied to many topics such as emotions (Lazarus, 1968; Lazarus & Folkman, 1987; Lazarus et al., 1980b; Lazarus et al., 1982), cognitive processes (Folkman et al., 1979; Lazarus, 1978; Lazarus et al., 1980a), personality (Opton & Lazarus, 1967), and depression (DeLongis et al., 1982). Folkman and Lazarus (1986) found that people with high depressive symptoms appraise and cope with stressors differently than those with low depressive symptoms. Specifically, those with high depressive symptoms are more susceptible to threat and hostility and are more likely to respond with emotional outbursts than nondepressed people (Folkman & Lazarus, 1986). Folkman and Lazarus (1986) believe emotional outbursts happen because people with depressed symptoms are more likely to appraise a

situation as having more at stake, assuming more of the responsibility and blame, and struggle with social support than their nondepressed counterparts.

Medical situations have been viewed through the transactional theory of stress and coping as well (Cohen & Lazarus, 1983; Folkman et al., 1986b). Heart and skin conductance (Lazarus et al., 1963), hypertension (Lazarus, 1978), somatic adaptation (Holroyd & Lazarus, 1982), the aging process (Folkman & Lazarus, 1980; Folkman et al., in press; Lazarus & DeLongis, 1983), daily hassles (DeLongis et al., 1982; DeLongis et al., in press; Kanner et al., 1981; Lazarus, 1984), and effects on performance (Folkman & Lazarus, 1985) are just some of the topics that have been studied through this theoretical lens. Regarding the effect of stress on performance, Lazarus et al. (1952) found that depending on the situation and the demands, stress could have an improving or detrimental effect on performance. In some cases, stress improved performance for Army Air Forces participants (Lazarus et al., 1952). In other studies stress reactions caused participants to rush and speed up their performance which had a negative impact on the accuracy of their performance (Lazarus et al., 1952).

Threat was examined by Lazarus and Alfert (1964) and they concluded that the appraisal of threat can be short-circuited by preparing participants in advance for what the threat, or stressor, will be. Lazarus and Alfert (1964) examined this through an experiment by showing groups of people a distressing video. One group watched the video without explanation. A second group watched the same video and had a commentary to listen to explaining what was happening and denying that the video subjects were under any distress. A third group was given an introduction prior to the

video letting them know what they would be watching and denying any distress felt by those in the video. All groups were assessed for skin conductance, heart rate, concentration, aggression, pleasantness, egotism, social affection, activation-deactivation, depression, and anxiety (Lazarus & Alfert, 1964). Out of the three groups, the group who was introduced to the video prior to watching it had the lowest rates of distress, indicating that prior knowledge and denial of distress may reduce the appraisal of threat for participants (Lazarus & Alfert, 1964). Lazarus et al. (1965) also found that adopting a mentality of intellectualization or detachment provided a buffer against the appraisal of threat in a similar study where participants watched a distressing video. Through these experiments it was found that denying the pain of others, intellectualizing, and emotionally detaching from a situation can reduce the appraisal of threat and decrease stress reactions (Lazarus & Alfert, 1964; Lazarus et al., 1965).

I chose to use the transactional theory of stress and coping because of the language and structure the theory gives to assessing and interpreting law enforcement officer experiences in the high-demand role of the CRT. Law enforcement experience and opinion are not often studied. Using this theory will help the research community and hopefully other police departments understand how participation on a CRT is appraised by officers and how they cope with the stressors of this unique position.

Literature Review Related to Key Concepts

Historical context is necessary to understand the complexities of law enforcement work. Policing in the 21st century looks different from when it first began. Specifically, within the United States, national events, politics, and cultural and societal challenges

have forced police departments to shift to meet the current demands. The militarization of police and transinstitutionalization of mental health services are two of the key drivers for current policing methods.

A Brief History of Police

The function and role of police and policing has evolved over time. Groups of people have been policing the public and ensuring order and safety going back as far as ancient Greece. Over centuries policing has evolved from landowners guarding their property to elite citizens paying the poor or destitute to take their assigned neighborhood-watch shift. These neighborhood watches often contributed to the rates of crime. Modern day policing began to take shape in London in 1829 when Sir Robert Peel reformed English police law with the Metropolitan Police Act (Lyman, 1964). This was the first time that full-time patrolmen, in uniform, were employed to keep the peace and prevent crime (Williams, 2003). Peel is also credited with “Peel’s Principles for Policing” which gave police departments a universal standard and expectation for the role of police. The nine Peel’s Principles are:

1. The basic mission for which the police exist is to prevent crime and disorder.
2. The ability of the police to perform their duties is dependent upon public approval of police actions.
3. Police must secure the willing cooperation of the public in voluntary observance of the law to be able to secure and maintain the respect of the public.

4. The degree of cooperation of the public that can be secured diminishes proportionally to the necessity of the use of physical force.
5. Police seek and preserve public favour not by catering to public opinion, but by constantly demonstrating absolute impartial service to the law.
6. Police use physical force to the extent necessary to secure observance of the law or to restore order only when the exercise of persuasion, advice and warning is found to be insufficient.
7. Police, at all times, should maintain a relationship with the public that gives reality to the historic tradition that the police are the public and the public are the police; the police being only members of the public who are paid to give full-time attention to duties which are incumbent on every citizen in the interests of community welfare and existence.
8. Police should always direct their action strictly towards their functions and never appear to usurp the powers of the judiciary.
9. The test of police efficiency is the absence of crime and disorder, not the visible evidence of police action in dealing with it. (Williams, 2003, p. 100)

Peel's principles are still regarded today as the ideal policing model, although some argue that policing in the United States has taken a detour from these standards. While policing in the United States does not look the same as it did in 20th century England, according to Peel's principle number two, policing ought to change to reflect public approval of their actions. As the United States navigated its way through various

significant wars such as the World Wars, the Korean War, and the war in Vietnam, the militarization of police reflected the social and cultural desires and priorities of that time. Significant advancements of the military were reflected in policing.

The path that followed for policing in the United States was influenced by people like August Vollmer and J. Edgar Hoover. Vollmer started the first college-level educational program for policing (Vollmer, 1931), and Hoover created the Federal Bureau of Investigation (FBI) which elevated the law enforcement professional to the image “G-Men” (Hoover, 1950). Vollmer and Hoover elevated policing into a desirable and elite profession. This heightened status gave the policing career more authority and clout and gave postwar veterans a way to enter back into civilian life. This was useful for apprehending dangerous mobs and gangs and addressing serious issues of crime; however, it began to drive a wedge between the officers and the community members they were called to serve and protect.

The idea of *community policing* began to gain momentum in the 1980s to address this separation between the police and the public. Seagrave describes community policing as a change in policing philosophy which involves more community engagement with the public (1996). This is where policing, again, modeled Peel’s principles of changing with the desires and values of the community. Community engagement now plays a big role in current policing strategies, and programs like CRTs have gained popularity. To understand where policing has landed in the 21st century regarding CRTs, an additional and parallel understanding of psychology and mental illness during this time is necessary.

A Brief History of Psychology and Mental Illness Interventions

Broadly, psychology is the study of the mind (James, 1890). In the 18th century, PMIs were categorized into two groups: chronic and acute. The chronic group was able to be cared for in their homes and by their communities. Acute patients were more difficult to manage, and were, therefore, housed in asylums with doctors who hoped to cure them. The first hospital dedicated solely to psychiatric patients in America was the Eastern State Hospital or Eastern Lunatic Asylum, opened to the public in 1773 (Simonsen, 2007).

Over the course of many years, doctors and psychiatrists tried to prevent and treat mental illness with a variety of methods and theories. Facilities that housed PMIs were often overcrowded resulting in inhumane living conditions and many of the treatment modalities were experimental, harsh, misguided and violent. Some treatments even involved removing organs and operations on the brain. In the 1900s, demands for the humane care and treatment of PMIs were made, resulting in deinstitutionalization and transinstitutionalization.

Transinstitutionalization—Where Policing and Mental Illness Meet

In 1946 the National Mental Health Act was signed, increasing the role of the federal government in the research of psychiatric disorders, including their causes, diagnoses, and treatment options (National Institute of Mental Health, 2023). In 1963 President Kennedy offered state governments millions of dollars to build mental health centers, shut down state psychiatric institutions, and offer more humane care to PMIs (Erickson, 2021). Deinstitutionalization is described as moving mental health care from

institution-based care to community-based care which means that PMIs could be treated in a mental health center within their community and close to family and support systems (Novella, 2010).

Unfortunately, many of these centers were never built, leaving a lack of available and affordable mental health support. Deinstitutionalization was the goal. However, transinstitutionalization has become the reality. Transinstitutionalization is the shifting of a person from one institution to another (Bronstein, 2022). When families and community care could no longer care for the PMI, they would end up in prison. Now, there is an increase in *decarceration* where status offenders are no longer imprisoned in hopes that PMIs would be able to get appropriate care and mental health services elsewhere. However, there are not enough mental health service providers to effectively take on this additional influx of clients (Bronstein, 2022). In the meantime, law enforcement officers are tasked with maintaining order in their jurisdictions but are without the training and education needed to adequately address a mental health crisis. Thus, the concept of CRTs was introduced.

Types of Mental Health Crisis Response

When a new way of addressing a situation is created, it often goes through many iterations before a complete solution is found. The same is true regarding the formulation of a crisis response team. Various community agencies, such as ambulance, police, and community mental health agencies, collaborate to form crisis response teams and respond to calls from a trauma-informed approach. Crisis response teams are composed of staff from police, ambulance, and community mental health agencies. Some crisis response

teams are police-only teams who receive 40-hours of training on many mental health-related topics. It is difficult to pinpoint an exact origin date, but police departments and other civic organizations can trace crisis response programs back to the 1980s where special response teams were deployed in hopes of addressing the gap in care left by transinstitutionalization.

Crisis Intervention Teams

In 1987 in Memphis Tennessee, the police department was dispatched to a call for a man who was experiencing a mental health crisis. When the officers arrived, the situation escalated, and the man was eventually shot and killed by police. This was the catalyst for the Memphis police and the National Alliance on Mental Illness to partner together and come up with a 40-hour curriculum on several mental health topics such as de-escalation skills, understanding mental health diagnoses, becoming familiar with community resources, and improving communication skills (Bailey et al., 2022; Blais et al., 2020). This model became known as a CIT (*CIT Center Home*, n.d.). CIT-trained police officers are assigned to various precincts and units throughout the police department and respond quickly to any calls related to a PMI. This police-only model is the most researched crisis response model to date.

Co-Response Teams

The Los Angeles County Sheriff's Department created the first CRT in 1991 (*Co-Response models in policing*, 2024). In this model, police officers are paired with a mental health professional from a community mental health agency and respond to calls, typically together in the same car (Bailey et al., 2022; Kuehl et al., 2024a). Ghelani et al.

(2022) note that the CRTs assist in de-escalating and provide mental health assessment and referral to community services. The officer can provide the needed safety and security measures and the mental health clinician can assess the situation and help provide the PMI with the right kind of care or service, such as psychiatric care, resources to address homelessness, addiction, poverty, and other needs that are out of the scope of the police officers' training (Blais et al., 2020; Fisher et al., 2024). Many police departments combine the CIT and CRT models by training the officer with the CIT curriculum and then partnering the officer with the mental health clinician to respond to calls together.

Tri-Response Teams

TRTs are becoming more popular in international jurisdictions. This team is often comprised of a CIT-trained police officer, a mental health clinician, and either an emergency medical technician or a psychiatric nurse practitioner (Heffernan et al., 2022; Kuehl et al., 2023). These teams do not arrive on scene at the same time or necessarily in the same vehicle. Instead, they are dispatched from various locations when a call is received involving a PMI. These teams can address the legal, mental, and medical needs of the citizen and quickly direct them to the right services (Heffernan et al., 2023). Because they do not arrive on scene together, a delay in service is often experienced while police and PMIs wait for the other units to arrive.

Nonpolice Response Teams

Many studies have indicated that PMIs prefer a nonpolice response if the situation is less than critical (Kuehl et al., 2024a). These nonpolice response teams are sometimes

referred to in the literature as MCTs, which deploy from the local community mental health agency (Daggenvoorde et al., 2022). When someone is experiencing an emergency, 9-1-1 is often the first call because it has become the normalized phone number to call when in distress. MCTs are usually called upon once an officer has responded and declared the scene safe enough for civilian assistance. The MCT team member can assess the PMI in person or over the phone for suicidal thoughts, personality disorders, and mental health disorders and the like. The MCT team member is then able to direct the PMI to more appropriate care than an emergency department. The difficulty with these teams is that they are truly a second-response team and will often wait until the police have assessed the call for safety before going to that location, resulting in a delay in service for the PMI and still does not keep them from having an encounter with the police.

Current Studies of Co-Response Teams

Of the fourteen peer-reviewed articles currently addressing CRTs, five articles focus on CRT programs in the United States (Bailey et al., 2022; Plassmeyer et al., 2024; Plassmeyer et al., 2024; Shefner et al., 2023; Wood & Anderson, 2023). Six articles examine CRTs in New Zealand and Australia (Every-Palmer et al., 2023; Fisher et al., 2024; Kuehl et al., 2023; Kuehl et al., 2024a; Kuehl et al., 2024b; Robertson et al., 2019) while three focus on Canadian programs (Blais et al., 2020; Ghelani et al., 2022; Semple et al., 2020).

Seven of these studies employed qualitative designs using semistructured interviews to explore stakeholder experiences and perceptions of CRTs. These include

perspectives from PMIs and family members (Kuehl et al., 2024a; Wood & Anderson, 2023), law enforcement officers (Fisher et al., 2024; Plassmeyer, 2025; Robertson et al., 2019), and mental health professionals (Fisher et al., 2024; Robertson et al., 2019). Plassmeyer et al. (2024) conducted a mixed-method study examining changes in police employees' perceptions of a pilot CRT over a 2-year period. These studies will be discussed in greater detail in the following sections.

CRT programs in New Zealand and Australia

Dr. Silke Kuehl and her team have conducted a set of four studies on one specific CRT program in Aotearoa, New Zealand. First, they conducted a mixed-methods study to establish a baseline of opinions and experiences from frontline staff including police, paramedics, and crisis mental health clinicians regarding how prepared they feel to respond to a mental health crisis call (Kuehl et al., 2023). A survey utilizing open- and close-ended questions was distributed and analyzed so that the data collected could inform the development of future studies once a CRT program was piloted. The new CRT program was implemented from March of 2020 to March of 2021 (Kuehl et al., 2024b). Conducting a pre-implementation evaluation is a step that many researchers have not taken when examining the impact of a CRT. Collecting site and call information before a CRT is implemented is identified by several authors as a goal for future research as it allows for a more thorough understanding regarding CRT impact postimplementation (Fisher et al., 2024; Robertson et al., 2019; Semple et al., 2020). This adds to the strength of Kuehl et al. (2024a, 2024b) by giving the authors an understanding

of perceptions of mental health crisis calls before a new intervention is introduced as well as mitigating factors that may confound the results of future studies.

The second study was led by Susanna Every-Palmer and her team (including Dr. Kuehl), and they performed a quasi-experimental study to determine if there were any statistically significant effects of the CRT program versus business as usual with immediate and 1-month follow-up (Every-Palmer et al., 2023). They looked at police and health reports and analyzed call data based on whether it was a day that the CRT was available. Calls were analyzed and assigned to one of three groups: face to face CRT response, CRT response over the phone, and business as usual (Every-Palmer et al., 2023). The results of this study found that receiving a CRT response resulted in 30% of PMIs being taken to the emergency department and were there 32 minutes less than 45% of PMIs on non-CRT days (Every-Palmer et al., 2023). Additionally, PMIs who went to the emergency department with the CRT were less likely to return to the emergency department during the 1-month follow-up (Every-Palmer et al., 2023).

The third and fourth studies in this set were conducted parallel to each other, with one study focusing on the PMI experience, which is the perspective of the person who was experiencing the mental health crisis as well as the person who was there to support them (Kuehl et al., 2024b) and the other study focusing on frontline staff experience such as police, ambulance, and crisis mental health clinicians (Kuehl et al., 2024a). The CRT in these studies was made up of two specially trained police officers, two mental health clinicians, and one paramedic (Kuehl et al., 2024b). They were available Tuesday through Friday from 0800 to 1800. They rotated in two teams between being the *field*

team and the *home team* and the paramedic was always on the field team. The home team was located at the central police station.

The aim of these studies was to gather insight from those directly involved in the CRT program to aid and inform future program development and to determine if CRTs are a viable option for crisis response moving forward. Overall, both groups found the CRT response an improvement over the police-only response, with one exception. The mental health clinicians who do the assessments in the emergency department or in the community mental health agencies prefer business as usual rather than the CRT response (Kuehl et al., 2024a). The clinicians reported that there was poor connection to services with the CRT response, often having to duplicate work that the CRT clinician had already completed (Kuehl et al., 2023). The clinicians also felt that the expectations placed on them by the CRT were too high regarding time management and the availability of staff (Kuehl et al., 2024a).

Initially, the crisis mental health clinicians were the only group of participants who felt prepared and qualified to respond to mental health crises (Kuehl et al., 2023). Neither police nor ambulance participants felt prepared to respond to a mental health crisis and they reported feeling dread, fear, and concern for the PMI when a call for mental health assistance comes through (Kuehl et al., 2023). Police reported dreading the calls because they take up so much time and they often feel like they are babysitting the PMI while waiting to be assessed in the emergency room, making it impossible for them to respond to other calls for service (Kuehl et al., 2023). Ambulance participants reported feeling like a taxi service for transportation to other services rather than being utilized in

an emergency (Kuehl et al., 2023). Police and ambulance reported shorter call times, shorter amounts of time waiting at the hospital, and increased safety for the PMI while utilizing the CRT program (Kuehl et al., 2024a).

All three agencies agreed that their conflicting policies and procedures made it difficult to efficiently assist a PMI (Kuehl et al., 2023). The CRT greatly improved the process through more planned and intentional collaboration between police, ambulance, and mental health agencies (Kuehl et al., 2024a). Another challenge that was identified by all three agencies was the issue of staffing shortages (Kuehl et al., 2024a). On that point, police and ambulance agencies agreed that the CRTs should be available 24 hours a day, but that would involve taking people from other important posts or assignments, so increasing the available workforce would be necessary to expand CRT hours (Kuehl et al., 2024a). More paramedics needed to be involved, not just one, to prevent burnout (Kuehl et al., 2024a). Both agencies, as well as the PMIs, reported that they appreciated the CRT response so much that it was difficult to go back to police-only responses when the CRT was not available (Kuehl et al., 2024a; Kuehl et al., 2024b).

PMIs reported appreciating the compassionate approach that the CRTs took when answering their questions and meeting their needs with patience and empathy (Kuehl et al., 2024b). PMIs and their support people were enthusiastic about the role that the mental health clinician and paramedic play in the CRT response (Kuehl et al., 2024b). One PMI specifically described feeling comforted by the paramedic's ability to explain the difference between having a panic attack and a heart attack, reassuring the PMI that they were okay by checking vitals and using heart monitors (Kuehl et al., 2024b). Family

members appreciated the wrap-around care they received, rather than having to go to many different places to speak to each agency (Kuehl et al., 2024b). Even when PMIs had a difficult time remembering the specifics of the situation, they still remembered the way that they were treated by the CRT as a positive difference from a traditional police-only response (Kuehl et al., 2024b).

Some areas for improvement that were identified by PMIs included increased awareness and sensitivity to cultural differences and, again, more CRT coverage so that they do not have to go back to a police-only response (Kuehl et al., 2024b). There were mixed emotions about the role of the police on the CRT, acknowledging that there is a need for safety, but also noting that seeing the police in their uniform and marked cars was intimidating and embarrassing (Kuehl et al., 2024b). PMIs and their support people agreed that having the officer be in an unmarked car and in civilian clothing could help that concern (Kuehl et al., 2024b).

There are two different CRT programs that were studied in Australia. One is the Cairns Mental Health Co-Responder Project (CMHCP) in Cairns, Queensland (Robertson et al., 2019) and the other is the Mental Health Co-Responder (MHCORE) in Brisbane, Queensland (Fisher et al., 2024). The goal of both studies, even though they happened years apart, was to identify barriers and enablers to their respective CRTs. The CMHCP was composed of a mental health nurse, a mental health clinician, and a uniformed police officer. They operated from 0800 to 1630 Monday through Friday and were located within a mental health crisis care facility (Robertson et al., 2019). The MHCORE program operated from 1400 to 0000, 7 days a week (Fisher et al., 2024). It is not

documented where this team is housed, only that there are three districts with MHCORE teams at present (Fisher et al., 2024). The MHCORE team is made up of a mental health clinician and a police officer who travel together in an unmarked police car and act as a second response after the scene has been deemed safe (Fisher et al., 2024).

The enablers to the CRTs that were identified in both studies were leadership and project support and the complimentary skills shared between police, ambulance, and mental health staff (Fisher et al., 2024; Robertson et al., 2019). Support from top leadership in decision-making and resourcing processes were key to the implementation of both CRTs as well as the collaborative teamwork between all the agencies involved (Fisher et al., 2024; Robertson et al., 2019)

Specific enablers identified only in the CMHCP study primarily focus on the importance of agency collaboration, data sharing agreements, and the location of the team (Robertson et al., 2019). Agency managers met regularly to discuss procedural concerns and assist with determining jurisdiction and specific responsibilities among the staff members on the team (Robertson et al., 2019). Participants agreed that the success of the program was due in part to its location within a crisis mental health facility as a way for police personnel to become well-versed in the dynamics of mental health crisis (Robertson et al., 2019).

One essential element to the success of the MHCORE was the data sharing agreement between agencies (Fisher et al., 2024). Many times, when medical or clinical information is involved, laws and regulations prevent that information from being shared, specifically within a policing context. This data-sharing agreement gives clinicians

permission to share relevant and pertinent information with MHCORE staff to provide the best care for the PMI as possible (Fisher et al., 2024). Another key element to the MHCORE program is the learning culture that was established between MHCORE staff. After each call, the team debriefs the response to learn and improve for next time. The culture of learning on the team helped each member to grow without feeling criticized or blamed (Fisher et al., 2024). Finally, one last item that participants agree was essential for the success of the MHCORE program was the many community mental health resources in Brisbane (Fisher et al., 2024). Participants highlighted this key component, noting that without other services to refer PMIs to, the MHCORE team would have to continue to rely on police or hospital options that often fall short on meeting the needs of the PMI (Fisher et al., 2024).

The primary barrier identified in both Australian studies was the concern around confidentiality (Fisher et al., 2024; Robertson et al., 2019). The establishment of the Mental Health Collaboration Memorandum of Understanding in 2017 between Queensland Health and Queensland Police Service was key in overcoming this barrier by allowing the sharing of relevant information between police and mental health clinicians (Fisher et al., 2024; Robertson et al., 2019). Once that concern was resolved, the only remaining barrier identified by both Australian studies was the same as that of the New Zealand studies: staffing shortages (Fisher et al., 2024; Kuehl et al., 2024a; Kuehl et al., 2024b; Robertson et al., 2019). Across the board in this region, the consensus was that the co-responder programs were an improvement over police-only responses, but for the

teams to reach their full potential, dedicated staffing positions would need to be established on a 24/7 basis.

An additional barrier that was identified was the lack of evaluation plan from the beginning of the CMHCP program (Robertson et al., 2019). Lack of planning at the beginning of implementation made it more difficult to know how to evaluate the program after the yearlong pilot was over. Establishing recording practices and identifying key markers that they wished to analyze should have happened prior to implementing the program (Robertson et al., 2019). One other barrier that was identified with the MHCORE program was that the police officers needed more mental health training than they had originally received (Fisher et al., 2024). Unlike other co-response programs (Kuehl et al., 2024b; Robertson et al., 2019) the police officers involved in the MHCORE program did not receive specialized mental health training before being added to the co-response rotation (Fisher et al., 2024).

A lack of agreement among police participants in the MHCORE program centered around the question of police responsibility in working with mental health crisis (Fisher et al., 2024). Some officers reported feeling frustrated with mental health calls because they do not feel trained or equipped to respond effectively. They argued that mental health crises are not the responsibility of police officers and should be taken care of by community mental health agencies. Other officers believe that responding to mental health crises is unavoidable because they often are accompanied by other challenges such as domestic violence, substance use, and homelessness (Fisher et al., 2024). An additional challenge to this point is that the authority to take someone against their will to

a hospital for treatment lies mostly with police when they perceive that the PMI or other community members are at risk of harm to self or others (Fisher et al., 2024). Therefore, even if they do not think it is their responsibility, all officers in this study agreed that they must be involved in mental health crisis calls regardless (Fisher et al., 2024). For those who are opposed to it, the MHCORE program is not a priority and does not warrant additional staffing or resources (Fisher et al., 2024).

Regarding crisis response options, all the current studies from New Zealand and Australia point to the overall improvement that CRTs bring to mental health crisis calls when compared to police-only responses. Benefits to a co-response program include a more compassionate experience for the PMI and a more efficient experience for the police officers and paramedics. Mental health clinicians in the hospital or community mental health setting have mixed feelings about co-response programs as they begin to feel the added burden of increased crisis response (Kuehl et al., 2024a). In addition to the recommendation for more police and ambulance staffing, it will be important to also consider the increased need for resources and staffing for the community mental health agencies who are receiving PMIs into their care.

CRT Programs in Canada

The call for new ways of responding to mental health crises are also heard in Canada, where police departments and community mental health agencies are looking for ways to collaborate and offer better services to their communities. Agencies in Sherbrooke, Quebec and South Simcoe, Ontario both have implemented and evaluated

co-response programs in their communities. The programs have different names, but the make-up and the goals are very similar.

In Sherbrooke, the Mobile Crisis Intervention Team (MCIT) is made up of one trained police officer and one social worker who respond to calls from 1600 to 0000 on Wednesdays and Fridays (Blais et al., 2020). The research team began evaluating the police-only response in May of 2015 and the MCIT pilot program began in May of 2016. This gave researchers the opportunity to plan evaluation from the start and collect data prior to implementation, which is key for providing a control group and understanding the mental health crisis response status prior to CRT implementation (Blais et al., 2020). The pilot lasted for a year and concluded in May of 2017.

Similarly, the Crisis Outreach and Support Team (COAST) operating out of South Simcoe was composed of one police officer and two mental health clinicians on rotation (Semple et al., 2020). The team responded to calls in plain clothes and unmarked cars from 1000 through 2000 Tuesday through Friday. Semple et al. (2020) evaluated the police-only response from May 2017 through May 2018 to have a control group prior to COAST implementation. The COAST pilot program began in November 2017 and went until May 2018 and was considered the treatment group for this study (Semple et al., 2020).

Blais et al. (2020) found that the MCIT program was more effective with de-escalation for PMIs than the police-only response. Both MCIT and COAST programs referred PMIs to community resources more than the police-only response prior to program implementation (Blais et al., 2020; Semple et al., 2020). The MCIT was also

found to be less likely to use force with PMIs, and both MCT and COAST were less likely to transport PMIs to the hospital involuntarily (Blais et al., 2020; Semple et al., 2020). Additional findings from Semple et al. (2020) included COAST detaining PMIs less than police-only responses, a reduced time spent on calls for police when COAST was on call, resulting in a reduced cost for service for police and mental health agencies alike.

A unique finding that came from the evaluation of police-only responses before and during implementation is the “contamination effect” (Blais et al., 2020, p. 55). The data showed that police-only responses to mental health crises improved after the implementation of MCIT and COAST, even on days when the CRTs were not available (Blais et al., 2020; Semple et al., 2020). This improvement in police-only responses could be due to variables that were not evaluated or a part of the program, but researchers in both studies hypothesized that the officers in the police-only responses may have learned from positive experiences with MCIT and COAST and began to implement some of their strategies as well (Blais et al., 2020; Semple et al., 2020). More research is needed to explore this further.

Like the research from New Zealand (Kuehl et al., 2024b) and Australia (Fisher et al., 2024; Robertson et al., 2019), Blais et al. (2020) recommended increased staffing and availability for the MCIT to operate around the clock. Additionally, the MCIT does not have the same information sharing policy that the CRTs in New Zealand and Australia have, making communication and procedural decision-making difficult between agencies (Blais et al., 2020). Finally, it was recommended that community mental health resources

in the area be examined to determine if they have the necessary resources and staff available to manage an increase in referrals and mental health crisis response (Blais et al., 2020). There is a concern that MCIT success is somewhat dependent on community services that are available for referral instead of the standard police procedure of escorting PMIs to the emergency department (Blais et al., 2020). The benefits of the MCIT would be stunted if there becomes a similar backlog or bottleneck in community mental health resources.

CRT Programs in the United States

Recently, within the United States Indianapolis, Philadelphia, Fayetteville, and the Clemson University Police Department have implemented CRTs that have been studied and evaluated. In 2017, Indianapolis launched a pilot program with a two-pronged approach. The Crisis Response Team (CRT) is composed of a CIT-trained officer, a mental health clinician and a paramedic who provide on-scene support both as a first- and second-response option (Bailey et al., 2022). The Behavioral Health Unit (BHU) is composed of a CIT-trained officer and a mental health clinician who follow-up with PMIs that received support from the CRT within 48 hours (Bailey et al., 2022). The BHU provides follow-up contact in person and on the phone, helps the PMI get connected to local mental health services, and provides some case management as needed (Bailey et al., 2022).

Bailey et al. (2022) matched CRT calls with police-only calls that were made in different parts of the city to examine the impact of CRT and BHU responses on the likelihood of arrest, emergency detention, and additional arrests and emergency

department visits during a 6- and 12-month follow-up. PMIs who received a CRT response were less likely to be arrested than by police-only responses (Bailey et al., 2022). At 6- and 12-month follow-up contact, initial arrests predicted subsequent arrests, specifically for Black PMIs (Bailey et al., 2022). Black PMIs had an arrest rate of 3% with a CRT response versus a 15% arrest rate with police-only response (Bailey et al., 2022). CRT did not have an impact on psychiatric detention compared with a police-only response (Bailey et al., 2022). Future use of the emergency department increased for White PMIs who received a CRT response, possibly diverting crisis response to the emergency department (Bailey et al., 2022). The rate of White PMIs utilizing the emergency department also increased when they received a BHU follow-up contact, which is the only discernible impact of the BHU follow-up contact (Bailey et al., 2022).

When PMIs use the emergency department for their mental health crises, it is an example of transinstitutionalization, when care is being transferred from the police department to the emergency department, neither of which are fully equipped to manage mental health crisis response in a large capacity. Lack of follow-through for PMIs may be a result of poor community mental health resources in Indianapolis (Bailey et al., 2022). The potential of long-term impact of the CRT response relies heavily upon the availability and quality of local mental healthcare services, a barrier that is also noted in New Zealand (Kuehl et al., 2024a; Kuehl et al., 2024b), Australia (Fisher et al., 2024; Robertson et al., 2019) Canada (Blais et al., 2020; Semple et al., 2020), and Philadelphia (Shefner et al., 2023; Wood & Anderson, 2023).

The Crisis Intervention Response Team (CIRT) in Philadelphia is composed of two trained officers and one mental health clinician (Shefner et al., 2023). In early 2021, four CIRT teams were deployed across the city with the goal of improving outcomes for mental health crisis calls. Police from all ranks were assigned to 10 focus groups to discuss their impressions of mental health crisis calls and their experiences utilizing the CIRTs (Shefner et al., 2023). This is not a robust qualitative study, but many of the themes and opinions of the officers are in line with those from other studies.

First, there was some debate among the officers on whether police should be responding to mental health calls in the first place, with some mentioning that it limits resources from responding to other calls and oftentimes appears to make the caller feel worse with police presence (Shefner et al., 2023). However, since there are currently no other options for crisis response, police involvement is inevitable due to the potential for danger (Shefner et al., 2023). As a result, officers acknowledge that they might be open to the idea of a CIRT response but feel doubtful about how it would work in real life (Shefner et al., 2023).

The second theme that emerged is the understanding that 911 dispatchers cannot always get all the information about a call right away, so officers may not know it is a mental health crisis until they arrive (Shefner et al., 2023). This concern is confirmed by another study on the Philadelphia CIRT program by Wood and Anderson (2023) who identified the difficulty of determining when CIRT should and should not be called out and the trouble that comes with misidentifying a call due to lack of information. If calls cannot be safely and accurately assessed by 911 dispatchers, then police also must ensure

the safety of the CIRT clinician, which not only draws the officer's attention away from the PMI, but also brings concerns of liability (Wood & Anderson, 2023).

The third theme raised the question of the capacity and capability of the local mental health service options to effectively respond to a mental health crisis. One officer noted that they did not think the CIRT clinician was assertive enough to be helpful with de-escalation and therefore questioned the usefulness of a civilian clinician in the field (Shefner et al., 2023). Additionally, the officers questioned what the options would be for PMIs who call police repeatedly for help. For example, what are the options for this individual long term rather than repeated involuntary commitment (Shefner et al., 2023)? If the goal of the CIRT is to provide better and more appropriate responses to a PMI, then there should also be community mental health services available to help that person long-term (Wood & Anderson, 2023). Again, if the community mental health services in a city are lacking, then CIRT responses become more about short-term care than long-term solutions (Wood & Anderson, 2023). Even though these police participants expressed concerns and doubts regarding the impact of CIRTs, they did agree with previous studies that CIRTs would need more staffing and more coverage hours (Shefner et al., 2023).

The Fayetteville Police Department (FPD) in Arkansas partnered with the University of Arkansas (UA) School of Social Work in 2021 to conduct a mixed-methods study on the changing perceptions of police employees regarding the new CRT pilot program (Plassmeyer et al., 2024). The FPD and UA allowed one Master of Social Work intern to partner with two CIT-trained police officers to provide a CRT response during the pilot phase of the program. The CRT program is called the Crisis Intervention

Response Team (CIRT). Since beginning this pilot program, the CIRT has expanded to two full-time Social Service Advocates (SSA) working with the two CIT-trained officers to provide specialized responses to calls for service for PMIs. During this 2-year period, the CIRT initially did not provide real-time support and by 2023 they were operating full-time during the dayshift. The work done by Plassmeyer et al. (2024) examines the police employee response and change in perception to the new CIRT program.

Quantitatively, all FPD employees were asked to complete a survey that was emailed to them through their police department email in April of 2021 and then again in March 2023 (Plassmeyer et al., 2024). 167 employees participated (72.5% sworn officers and 27.5% civilian employees) (2024). Noted in the study, there was a 12.6% and 26.9% turnover rate for sworn and civilian employees respectively between 2021 and 2023, therefore indicating a slightly different participant pool. Results were calculated using a Mann-Whitney *U* Test and found that there was a significant increase in optimism toward changing police response to mental health crisis with a medium effect size ($r = 0.46$) (2024). Using the same test, Plassmeyer et al. (2024) found that there was not significant change in pessimistic feelings toward autonomy and authority in policing from 2021 to 2023, indicating that police employees did not come to regret including social workers in their responses to mental health crises.

Qualitatively, thirteen police employees were recruited by convenience sampling to participate in individual, semistructured interviews (10 sworn, and three civilian; Plassmeyer et al., 2024). The participants were interviewed by one of the researchers who was an intern with the CIRT, however, during the study their direct involvement with the

CIRT was limited (Plassmeyer et al., 2024). Interviews were transcribed and coded by the research team with the main researcher coding them all and assistant researchers coding a selection to confirm (Plassmeyer et al., 2024). Any discrepancies were discussed and clarified until they were all in agreement.

Theme one is “what has worked” (Plassmeyer et al., 2024). The subthemes are the right people, FPD’s leadership, FPD’s progressive culture, apolitical program, and collaborative partnership between police and social workers. Participants agreed that the personalities and working relationships between the intern and the officers played a critical role in the success of the pilot program. Similarly, the leadership of FPD’s top administrative leaders contributed to the program’s success. Conviction and motivation from the top police leaders opened doors for the partnership with UA. The department’s progressive culture and apolitical stance when creating the CIRT prevented roadblocks between political parties in the city and allowed for quick implementation of the program. Finally, the collaborative partnership between FPD and UA was highlighted as a reason that the CIRT pilot went as well as it did. FPD participants acknowledged that the experience and skill set of the social work program and participants greatly benefited the officers while responding to calls. Other participants noted that there is a lot that both the FPD and UA can learn from each other.

Theme two involved the progress that was seen during the 2-year period. The subthemes for this category are increased buy-in, another tool/resource, workload ease, and a decrease in high utilizers (Plassmeyer et al., 2024). With increased understanding of how the CIRT is meant to work, police employees became increasingly supportive of

the program. Other participants continued to feel some hesitation because the CIRT program is in its pilot stage, fearing that as time goes on the program will fade away. Additionally, interview participants acknowledge that the CIRT is an additional tool and resource that officers can use to serve the community more effectively. This contributes to the increased optimism surrounding the program because it fills a need that the officers have experienced when responding to mental health emergencies and feeling like they do not have the resources necessary to help the person in need. Finally, participants recognize that the CIRT program has eased the workload for many officers by partnering with social workers to help with calls that would otherwise take officers away from their other duties. One way this happens involves the PMIs who frequently call for police service due to mental illness. These repeat callers now receive more specialized follow-up and connection to resources that better meet their needs rather than the limited options available to police.

The third and final theme included participant feedback on what could be improved about the CIRT program (Plassmeyer et al., 2024). Subthemes in this category include expanding the program, increasing training and exposure, and providing results/follow-up for FPD/CIRT edification. Participants of this study share similar sentiments as New Zealand, Australia, Canada, and other U.S. study participants that more shifts and time coverage is needed from the CIRT. During this pilot program, CIRTs were only active during the dayshift, and FPD employees agreed that overnight shifts need this resource available to them as well. Ideally, the CIRT teams would be available 24/7/365.

Participants also reflected on the lack of information that FPD and the local community had access to, therefore limiting their understanding of the goals of the CIRT (Plassmeyer et al., 2024). Participants commented on the need for more intra-office training and updates, especially with a new program that goes through many iterations in the first few years. Additionally, FPD employees reported confusion in the community through vague social media posts. Increasing the public knowledge and awareness of the CIRT program could allow community members to utilize the resources available and support the program through public endeavors.

Overall, this study is in alignment with the others that have been discussed. One additional piece of feedback that was not found in other studies is the hope that embedding social work professionals into the police department will serve to reduce stigma around officers seeking mental health services in the future (Plassmeyer et al., 2024). Moreover, the experience that this opportunity provides social work professionals the opportunity to develop cultural competence regarding work with law enforcement officers. This would mean deeper understanding of first responder work for social work professionals allowing them to provide more tailored and specific services to law enforcement officers in the future.

Additionally, Plassmeyer (2025) conducted a quantitative study with the FPD CIRT to determine CIRT effectiveness in reducing the number of mental health related calls for day patrol shift officers while the program was available compared to the night patrol shift when the program was not available. Plassmeyer (2025) used two interrupted time series analyses to explore the data. The results were mixed. There was an immediate

increase in self-initiated follow-up calls by police for PMIs, witnesses, and to perform other casework after the CIRT program was implemented compared to before implementation. There was also a significant reduction in the number of specific call types that were assigned to patrol officers and diverted to CIRT officers, such as intoxicated person, suicide threat, and welfare concerns (Plassmeyer, 2025).

Conversely, there was a lack of significant change for some other call types such as loitering, mental health crisis, and trespassing calls being assigned to patrol once the CIRT program was implemented (Plassmeyer, 2025). This might indicate a limitation experienced by the CIRT teams to be able to respond to many calls at one time (Plassmeyer, 2025). The lack of change may also be evidence of the CIRT prioritizing some mental health crisis calls over others. Plassmeyer also noted that CIRT limitations may also be due to gaps in community services and indicate a need for improved community infrastructure to support the needs of the mental health community, in agreement with previous studies (Bailey et al., 2022; Yang & Lu, 2024).

A study was conducted through the Justice and Mental Health Collaboration Program with Clemson University Police Department (CUPD) to see how police officers and mental health clinicians work together during calls for service for PMIs. Virtual reality simulations, think-aloud protocols, and semistructured interviews were used to obtain information related to the research question (Powelson et al., 2025). One mental health professional and six officers were trained by the CUPD and Anderson-Oconee-Pickens Mental Health Center and had field experience before participating in the study. Each officer participated in four simulation scenarios within a lab environment: three

scenarios involved a mental health crisis, and one did not. The mental health clinician was used for two of the scenarios. Audio recording of the think-aloud protocol and semistructured interviews were entered into NVivo software and was analyzed by the researchers using a grounded theory approach (Powelson et al., 2025).

Four themes emerged from the data: Safety and distance management (subthemes: far distance, intermediate distance, and close distance), information access and sharing, trust, and identity (Powelson et al., 2025). Safety and distance management were the officers' primary focus, noting the responsibility they feel to ensure the safety of all involved. During the think-aloud protocols, officers mentioned different distances that counselors were permitted to be in proximity with PMIs based on the severity of the crisis and the perceived utility of the counselor to de-escalate the situation (Powelson et al., 2025).

Participants identified information access and sharing as essential to CRT effectiveness (Powelson et al., 2025). When counselors are positioned at a distance for safety, officers must relay information which can delay response and introduce interpretation errors. Allowing counselors to remain at an intermediate distance enables them to gather information from bystanders or family members while officers engage with the PMI. When counselors can speak directly with the PMI, officers are free to coordinate services and gather collateral information, reducing the potential for miscommunication. Additionally, counselors can contribute to administrative documentation, enhancing the overall quality of the response (Powelson et al., 2025).

Trust in the CRT counselor was identified as a critical component of effective team dynamics (Powelson et al., 2025). Officers reported that the degree of trust they have in a counselor directly influences how close the counselor is permitted to be to the PMI and how involved they are in resolving the call. When working with a new or unfamiliar counselor, officers tended to limit the counselor's involvement regardless of their clinical expertise. As trust developed, officers granted counselors greater access and autonomy on scene. This shift was attributed to a reduction in the officer's cognitive load and an increase in confidence in the counselor's decision-making skills and situational awareness (Powelson et al., 2025).

Finally, officers in this study acknowledged that shared identity can be a significant factor in successful de-escalation with PMIs (Powelson et al., 2025). However, this emphasis on identity matching has the potential to overshadow the clinical expertise of CRT counselors. Participants reported that whether or not the counselor was there, they would often seek out other officers or supervisors who shared demographic or experiential similarities with the PMI. This suggests that in some cases clinical knowledge may be undervalued or overlooked during mental health crisis interventions (Powelson et al., 2025).

Summary

New programs have been developed in hopes of improving the efficiency of supporting people who are suffering with mental health challenges. This chapter focuses on the programs being developed to improve law enforcement response, such as CITs, CRTs, and MCTs. Researchers have explored impacts of co-response programs on

stakeholders such as PMIs, their family and support people, and mental health clinicians who work on the CRT as well as community mental health service programs. Few studies have asked law enforcement officers what their experiences have been while assigned to a CRT, so that is the aim of this study.

Chapter 2 has discussed the literature search and strategy of this research as well as the theoretical foundation upon which it is built. Lazarus and Folkman's transactional theory of stress, appraisal, and coping was examined, and concepts were defined as they relate to law enforcement officers' experience of CRTs. Additionally, brief histories of law enforcement and the mental health field were explored to develop an understanding of why CRTs are needed. Transinstitutionalization has played a big role in shifting those with mental health challenges out of the state institutions, into the legal institutions, and now into a purgatory of cycling between home, the emergency department, prison, and back home. Current studies of CRTs in New Zealand, Australia, Canada, and the United States were also reviewed.

Chapter 3 will discuss the research method used to examine the lived experiences of law enforcement officers who are assigned to CRTs. Topics covered in this chapter are the research design and rationale, the role of the researcher, methodology including participant selection, instrumentation, procedures for the pilot study, procedures for recruitment, participation, and data collection, and data analysis plan. Issues of trustworthiness are discussed, and the steps taken to address those issues will be outlined. The chapter will conclude with an overview of ethical considerations and a summary.

Chapter 3: Research Method

Introduction

The department being observed is a midsize police department in the southeast region of the United States. This law enforcement agency has over 1,000 sworn and civilian employees and is an appropriate location for this study because of its CRT program. A CRT consists of a sworn law enforcement officer and a trained mental health clinician responding to calls together when the call involves a person experiencing a mental health crisis. This program was first implemented in this city in 2021 and has trained over 300 officers to date. The program is established enough to have worked through some initial challenges yet still young enough for its impact to be distinguished from other units within the department.

The police department has partnered with a local community mental health agency to train the officers on the topics of ethics, cultural competency, general mental health, understanding psychosis, mood and personality disorders, autism, dementia, active listening, and de-escalation, and working with the unhoused. The training involves lectures, reality-based scenario practice, virtual reality goggle simulations, information on community resources and tours of the local mobile crisis centers and behavioral health crisis facilities. There are currently 364 law enforcement officers, and 108 supervisors (sergeants and above) trained to be a part of a CRT. Additionally, at the time of this study, 16 mental health professionals have participated in training offered by the police department to familiarize them with standard operating procedures and policies. Once

both parties are trained, the pair then travel in the police car together to calls involving people experiencing a mental health crisis.

The identity of the department and participants involved in this study has been masked to ensure confidentiality and privacy, and to improve the likelihood of officer participation.

Research Design and Rationale

The research question being addressed in this study was, what is the lived experience of law enforcement officers assigned to a CRT responding to mental health crises? The specific research design that was used to explore this question included a qualitative phenomenological approach. Phenomenology refers to the study of things as they are experienced or the idea that perception and experience are reality (Groenewald, 2004; Moustakas, 1994). Developed by the philosopher Edmund Husserl (1859-1938), phenomenological studies focus on the first-person experience or the meaning that people give to their experiences (Smith, 2018). The primary role of the phenomenological researcher is to describe the participants' experience as accurately as possible (Groenewald, 2004).

An additional layer to phenomenological study involves determining whether a transcendental or hermeneutic path is needed. Husserl adhered to the transcendental approach which asserts that researchers should make themselves as free from bias and personal influence as possible (Neubauer et al., 2019). Speaking about the process of scientific investigation, Husserl asserted that qualitative research should be free from suppositions, meaning that it is important to observe what is seen rather than interpret

what is seen (Moustakas, 1994). Alternatively, Martin Heidegger (1889-1976) developed and adhered to the hermeneutic approach which theorized that one's subjective, lived experience is influenced by social, political, and environmental factors (Neubauer et al., 2019). This approach factors in the interpretive and biased perspective of the researcher. Ultimately, both approaches work from the assumption that data are held within the personal, lived experience of the participants who have interacted with the subject matter or topic being studied. The transcendental approach was used in this study to decrease the potential for researcher bias and increase the opportunity for true understanding of the police experience on a mental health crisis call.

For this study, it was assumed that valuable data and information is held within the lived experiences of officers who are assigned to CRTs. By describing those lived experiences, this researcher has distilled thematic and common patterns that can assist future officers and departments in developing and managing CRTs that function at the highest and healthiest levels.

Role of the Researcher

My role as the researcher in this project was to take on the task set forth by Husserl and Heidegger of describing the lived experiences of the police officers assigned to CRTs (Groenewald, 2004; Neubauer et al., 2019). I do not have a direct relationship with anyone in charge of this program or any of the officers currently assigned to this team. There are no concerns regarding conflicts of interest.

I was the one reaching out to recruit participants for this study. I also created the interview guide based on the work of Plassmeyer et al. (2024). Additionally, I scheduled

and conducted the semistructured interviews on my own. I believe my experience as a therapist will aid me in building rapport with participants and help them feel comfortable sharing their experiences.

Methodology

While studying the experiences of law enforcement officers who are a part of a CRT, I utilized a phenomenological approach and developed a qualitative study. Obtaining an understanding of what it is like to be a part of a CRT was made possible by interviewing the participants of the study with a semistructured interview process. The interview provided qualitative information that could not be obtained through an assessment or inventory that would be used in a quantitative study. Qualitative research allows the readers to get an inside look at personal experiences and offers a depth of knowledge that is unique in the field of research.

Additionally, a phenomenological approach was used to focus on the experiences of officers on CRTs. Phenomenology allowed me to approach the topic of study with an open mind without having to know what themes or topics will emerge. It was a participant-driven approach that gave the interviewee the freedom to lead the research in ways that align with their experience. I then reviewed the information received and distilled it in such a way as to allow readers and the research community to gain understanding from a personal perspective.

Participant Selection Logic

The population targeted for this study was police officers who have been trained for and assigned to CRTs. I used purposive and criterion sampling to recruit between

eight and 10 law enforcement officers who are currently or were previously assigned to a CRT. Purposive sampling is frequently used in qualitative studies to find participants who are most likely to have experienced the phenomena being studied (Campbell et al., 2020; Peterson, 2019; Subedi, 2021). Criterion sampling limited participant samples to only those who met specific criteria, in this case, being assigned to a CRT (Moser & Korstjens, 2017). In the case of this study, it was important to find participants who have experienced being part of a CRT, otherwise research time and resources would be wasted (Campbell et al., 2020). The benefit of this type of sampling was that a depth of information and understanding was obtained with a smaller number of participants as opposed to a wide yet shallow range of information that may be obtained by a larger sample (Palinkas et al., 2013).

Purposive and criterion sampling did not produce an adequate number of participants to obtain saturation, so I used snowball sampling to recruit one last participant. Snowball sampling is used to recruit additional participants if saturation is not met by the purposive sample. Snowball sampling involves asking current participants if they know of any other people who may also have experience with the phenomena being researched (Peterson, 2019; Stadlander, 2015).

Additional selection criteria required that all participants have gone through the standard CRT training provided by the police department and the local partnering mental health agency. Specifically, inclusion criteria involved the length of time spent on the CRT. A minimum of 3 months' experience will be required for inclusion in this study.

Instrumentation

Data were collected for this research study through semistructured interviews with questions based on the work of Mark Plassmeyer et al. (2024). They interviewed police employees in Fayetteville, Arkansas, regarding their perceptions of the CRT program that was recently implemented (Plassmeyer et al., 2024). The questions have been adjusted to fit the context of this study and tested through a pre-pilot and pilot study. According to Chenail (2016), a pre-pilot study is used to interview the interviewer with the planned open-ended questions that will be used for the official semistructured interviews. By taking the perspective of the interviewee, a researcher is able to appreciate the process of being interviewed as well as increase their appreciation for the vulnerability of the participants for their study (Chenail, 2016). The pre-pilot study was conducted with a former counselor from the CRT program being studied. She was able to give feedback regarding verbiage and terms that were appropriate for this department. A pre-pilot study was also a good way to uncover researcher biases that may exist within the questions as well as vague, confusing, or difficult wording of the questions. Biases may be present with the interviewer if he or she has a special connection with the group being studied or are a part of the group themselves (Chenail, 2016; Stadtlander, 2015).

Procedures for Pilot Study

I have revised the questions based on the pre-pilot study outcomes and observations and then performed a pilot study with the supervisor of the CRT. This allowed me to continue to develop the interview questions without bias or confusion. Utilizing the supervisor gave me perspective and insight to the topics and themes that

may arise from the interviews without using an individual who is fully qualified to participate in the study. It also gave the supervisor an idea of the questions being asked so they were informed about what the study entailed. Data obtained in the pilot study was not included in the results of the research (Chenail, 2016). Using the supervisor saved participant data from being used prematurely.

Procedures for Recruitment, Participation, and Data Collection

Recruitment was accomplished by meeting with the commanding supervisor of this unit and, after obtaining their permission, discussing with them the most appropriate method of communication with their team. The first wave of recruitment was through an internal office email drafted and sent out by me. Seven people responded right away that met the inclusion criteria. I then used snowball sampling to recruit the eighth participant. Saturation was met and therefore no further recruitment was necessary.

Once participants were identified, this researcher scheduled in-person interviews at a time convenient to the participant. The participant was given an informed consent form to sign describing the rights of the participant and any potential risks involved in participating in the interview. The participants were reminded that even if they initially agreed to participate, they may withdraw from participation at any time and request that their information not be included in the study. The shortest interview was 31 minutes, and the longest interview was an hour and 16 minutes with the average length of time being 50 minutes. All interviews were audio recorded only (no video recordings were made). Once I completed the explication of the interview, a summary was provided to the participant so they could add or amend it as needed. This was done via email until the

participant approved of the summary. Ultimately all summaries were approved by the participants.

In addition to the semistructured interview questions, I was also an important instrument in qualitative research (Chenail, 2016). I was the instrument responsible for developing rapport with participants, asking good questions and follow-up questions, going with the flow of the interview, and interpreting the data once the interview was over (Poggenpoel & Myburgh, 2003). This came with risks, too, as I was subject to human error including biases and prejudices for or against the population being studied (Chenail, 2016). Potential researcher bias was self-monitored as well as discussed regularly with the research committee. It was important that I remain transparent and open throughout the research process so that the readers can judge for themselves if my biases and beliefs have had an influence on the interpretations I have made and applications I recommended (Peterson, 2019).

Data Analysis Plan

Explicitation involved in-depth phenomenological interviews like the example given by Groenewald (2004). Explicitation is the term preferred by phenomenologists in the place of data analysis (Groenewald, 2004; Hycner, 1985) which means to “let appear the pre-conscious experiential texture of the phenomenon” (Depraz, 2014, p. 142). This is different from data analysis in that there is a strict adherence to the whole context of the interview rather than taking pieces and quotes from the interview and interpreting themes and patterns (Groenewald, 2004). Hycner (1985) outlined a fourteen-step plan for reviewing qualitative interviews that Groenewald (2004) simplified into five phases: (a)

bracketing and phenomenological reduction; (b) delineating units of meaning; (c) clustering units of meaning to form themes; (d) summarizing each interview, validating it and when necessary, modifying it; and (e) extracting general and unique themes from all the interviews and making a composite summary (pp. 49–50).

Data were collected through semistructured interviews that I conducted with eight law enforcement officers who were currently or had previously been a part of a CRT. Informed consent was obtained for all participants. After the interviews were recorded and transcribed, I began reading and listening to the interviews many times, utilizing bracketing techniques that prevented my own preconceptions and biases from clouding my ability to hear what the participant was really saying. Bracketing is the process of setting aside the researcher's presumptions about the research phenomena and fully experiencing the world of the participant (Groenewald, 2004; Limpaecher, 2023; Tufford & Newman, 2012). This was accomplished by journaling and bracketing interviews by writing memos and free-flowing thoughts in a document for the sake of identifying and setting aside researcher bias and preconceptions (Limpaecher, 2023; Tufford & Newman, 2012). The task of bracketing was necessary throughout the explicitation process so that I could continue to look at the interviews with as much openness and objectivity as possible.

The second phase of explicitation is identifying units of meaning (Groenewald, 2004). This is the process of pulling out statements and direct quotes from the interview that relate to the research phenomena. These are called units of meaning (Groenewald, 2004). Initially, all statements and quotes were set aside, even the ones the researcher was

unsure about or were repetitive. Then, looking at the list of units of meaning, the researcher removed redundant statements, only after ensuring that the context from which they come did not change their meaning and relevance. This involved looking at the literal context as well as making notes of any auditory or visual cues that may give different meaning or emphasis to the statements (Groenewald, 2004; Hycner, 1985).

The third phase involved clustering units of meaning together that have similar themes. This, again, involved the task of bracketing so that the researcher continued to remain open to the themes that emerged from the participants lived experiences. Reviewing the interview transcripts and audio recordings helped to immerse the researcher in the participants' context and experience. It was important to review both the units of meaning from phase two as well as return to the original transcripts and recordings to stay true to the participants' experience (Groenewald, 2004; Hycner, 1985). Themes evolved from the repetition of experiences and statements made by the participants. Qualitative researchers refer to this as the "essence" of the experience and it required creative insight and judgment calls made by the researcher (Groenewald, 2004; Hycner, 1985; Limpaecher, 2023).

The fourth phase was to summarize each interview individually. I have gone through each interview several times, having worked to identify units of meaning, themes, and obtain an overall sense of the inner experience of the participant. After writing the summary, I compared the summary back to the original transcripts and steps one through three. I then emailed the summaries to the corresponding participant for their review. I asked them to look it over and let me know if there was anything that needed to

be added, removed, or adjusted. I also reminded them that they were still able to withdraw from participation at this time. This is referred to as a *participant check* (Groenewald, 2004; Hycner, 1985) or *member check* (Stadtlander, 2015) and is useful in two ways. One is that it allowed me to confirm with the participant the accuracy of the summary and the emerging themes (Hycner, 1985). Secondly, it allowed the participant to correct and/or add more information (Hycner, 1985). This step added strength to the trustworthiness of the research by confirming that the observations made by me were accurate representations of the experiences of the participant, which then were confirmed or corrected by the participant (Groenewald, 2004).

Phase five was only completed once all the previous phases were performed on each individual interview (Groenewald, 2004). In this phase, the researcher looked at all the interviews together to see if there were similar units of meaning and themes experienced among the participants. It was also important in this phase to look for the units of meaning or themes that were uncommon or only experienced by one or two of the participants. This information added a richness to the data that accounts for distinct experiences during common experiences that all or most of the participants identified. Hycner refers to this step as finding the “general and unique themes” (1985, p. 292). Once these themes were identified, the researcher wrote a final summary of all interviews together, detailing the general and unique themes and experiences among the participants.

Issues of Trustworthiness

It is important in a qualitative study to address issues of trustworthiness. Trustworthiness in qualitative research is similar to rigor, validity, and credibility in

quantitative research (Peterson, 2019). Addressing these topics ensured that I have conducted reliable and trustworthy research, interpreted the data without bias, and the results have addressed the research question. Together, these checks and balances have allowed the data to contribute meaningful information to policing and the field of forensic psychology. The methods I have used to address the issues of trustworthiness are prolonged contact, member checks, thick description, audit trail, saturation, and consultation.

Credibility

Credibility addresses the internal validity of the research data. Liao and Hitchcock (2018) describe credibility as interpreting the experiences in a way that is true to the way the participant experienced them and drawing reasonable and accurate conclusions. These faithful descriptions and believable claims will hold me accountable to the accurate reporting of data free from bias and personal influence. I have ensured credibility in my interpretation of the qualitative interviews by working through the five-phase model set out by Groenewald (2004). Having this model in place to reference helped me keep focused with proper and accurate explication of the data.

Prolonged Contact

Prolonged contact involves spending a considerable amount of time with each participant during the interview and any follow-up interviews to review summaries and themes. This will allow the participant and me to build rapport and spend quality time hearing and listening to their real-life experiences. This supports the credibility of the research by requiring me to spend an unhurried amount of time with the participants to

gain clear, deep, and insightful data (Liao & Hitchcock, 2018). I sought to balance this with respect for the participants' time by not rushing through the interview questions and also not dragging out the review process by spending excessive amounts of time on follow-ups and member checks.

Member Checks

Member checks or participant checks involved secondary contact where participants are given the summary of their interview to review the units of meaning and themes that I identified (Hycner, 1985). This gave the participant an opportunity to validate what I have explicated as well as add or amend the units of meaning. This adds a layer of trustworthiness because I confirmed with the participant that the lived experience was correctly and fully understood (Stadtlander, 2015). I conducted member checks virtually, via email, to review the units of meaning and themes to ensure correct interpretation and allow the participant to add to or edit their responses.

Transferability

Transferability addresses concerns of external validity which is the ability for other researchers to replicate the study. Researchers accomplish this by describing their participants in such detail that readers can immerse themselves in the participants' experience (Campbell et al., 2020). Transferability also allows readers and other researchers to decide if the participants are a good fit for the study as well as give the researchers an idea for the kind of participants they would need to recruit should they wish to replicate the study (Younas et al., 2023). I addressed this by collecting demographic information such as gender, race, length of years in service, and length of

time on the CRT. I have also informed the readers about the setting and type of program that was researched.

To support transferability, I used thick description of participant context, agency type, and CRT structure. I provided verbatim excerpts to show the phenomenon in the participants' own language. These details allow readers to determine whether the findings may transfer to similar midsized agencies in comparable urban settings.

Thick Description

Thick description is a very in-depth and detailed explanation of the participants, location of the interview, the interview itself, and the phenomenon being studied. I have shared these thick descriptions to provide the reader and future researchers with a clear understanding of the type of participants, experiences, and programs that I studied (Stadtlander, 2015; Younas et al., 2023). More specifically, thick descriptions in qualitative research include the social, cultural, and political contexts of a participant as well as their views, motives, feelings, beliefs, and the meaning they give to the experience of the phenomenon being studied (Younas et al., 2023). I have used this to develop the richness of the interview that so that I gained a better understanding of the lived experience of the participant and judged if the participants were appropriate for the study (Peterson, 2019).

Dependability and Confirmability

Under the umbrella of trustworthiness, dependability addresses the concern of continuity and consistency over time (Moser & Korstjens, 2017). This means that the readers can be confident that the participants' experiences have been accurately and fully

described and that similar themes would be found in future studies replicating the same process. Keeping an audit trail has allowed me to verify the steps I have taken to describe the data in a trustworthy manner. It will also make it easier to duplicate the study in the future for different departments.

Confirmability on the other hand has to do with the reliability of the researcher. Moran (2021) describes confirmability as the step that ensures the experiences, narratives, and interpretations are based on the participants' words, experiences, and influence rather than the researcher's perspective or bias. I have addressed this issue of trustworthiness through an audit trail, saturation, and frequent consultation.

To support dependability, I created an audit trail documenting sampling decisions, coding decisions, memos, and theme development. I met regularly with my committee to review analytic decisions, which allowed for external oversight, traceability of coding logic, and protection against researcher drift.

Audit Trail

Audit trails are an effective way to show the readers the logical flow and process of interpreting themes and patterns in qualitative studies from the raw data (Carcary, 2021). This addressed the dependability and confirmability challenges of trustworthiness by showing the reader exactly how I came to my conclusions (Stadtlander, 2015). This involved keeping meticulous records of the whole process including interview development, data collection processes, participant selection processes, interpretation and explicitation of the data (Carcary, 2021; Stadtlander, 2015). There are physical audit trails which document the exact steps taken to develop the study and there are intellectual

audit trails which document the thought processes of the researcher (Carcary, 2021). Both are useful in strengthening the dependability and confirmability of the study by allowing readers to see how the results of the study came directly from the data. I have kept an electronic journal to show my work and thought processes along the way.

Saturation

Saturation is accomplished when no new data are being given by participants (Groenewald, 2004; Moser & Korstjens, 2017; Stadlander, 2015; Subedi, 2021). There is much debate on how many participants are required to reach saturation (Subedi, 2021) and in large part it is determined by the kind of qualitative research being conducted. Boyd (2001), Creswell (1998), Gentles et al. (2015), Morse (2000), and Moser and Korstjens (2017) believe that for phenomenological qualitative research the necessary number of participants to reach saturation is between two and 30 participants, with the majority being satisfied with 10 participants or fewer. I have achieved saturation by interviewing eight participants.

Consultation

Consultation was sought throughout the study development to ensure that good research questions and methods were developed, ethical standards were observed in contacting participants and conducting interviews, and explicitations were thorough and accurate (Hycner, 1985). Sources of consultation included the dissertation committee chairperson, second chairperson, and the supervisor of the CRT unit.

Ethical Procedures

In 1974, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research was formed as the National Research Act was signed into law. This commission was tasked with the responsibility of creating ethical procedures and guidelines for researchers who want to use humans as participants in their studies. The commission came up with what is now known as The Belmont Report. The report focuses on three main principles for ethical research: respect for persons (autonomy and protection), beneficence (protection from harm and promotion of well-being), and justice (ensuring that specific groups are not exploited or kept from receiving benefits; United States et al., 1978).

I have taken the following steps to ensure that the participants in my study were treated ethically and responsibly. First, I presented my research plan to the Institutional Review Board for approval and permission to proceed. Next, I obtained signed informed consent forms from my participants which explained the nature and purpose of the study and highlighted that their participation is voluntary. This form was useful for educating the potential participant on expectations of the study, their rights to participate or withdraw at will, and the protection of their privacy and confidentiality (Stadtlander, 2015). Finally, I discussed with potential participants the relevant risks and benefits to participating in the study. Risks were small but include feelings of distress or overwhelm while sharing personal stories. If a participant experiences distress, phone numbers for local support options (counselors and peer support) will be provided.

Audio recordings, transcripts, summaries, and notes have been stored securely and will remain secure for 5 years according to university guidelines. Only the researcher and the committee members have access to these data. After 5 years, the data will be deleted and destroyed. The organization and the participants shall remain anonymous to protect confidentiality and privacy.

Summary

This chapter has outlined the processes and procedures necessary for the completion of this qualitative research study. The research question being explored is “what is the lived experience of law enforcement officers assigned to CRTs responding to mental health crises?” A total of eight law enforcement officers were asked to participate through semistructured interviews conducted by me and their experiences have been examined through a phenomenological lens.

A CRT is made up of a sworn law enforcement officer and a mental health professional who responds to calls involving individuals who are experiencing a mental health crisis. Both the officer and the mental health professional have received specialized training in responding to these calls more effectively. The IRB approval number from Walden University for this study is 06-17-25-1024013.

Specifically for this study, attention was given to the role of the CRT officer and semistructured interviews were completed once informed consent forms were signed. All participants were reminded that their participation is voluntary, and their identity would remain confidential. They have also been reminded that they may withdraw at any time.

Risks and benefits of participation were discussed. The interviews have all been conducted in-person. All interviews were audio recorded for review.

At the completion of each interview, I completed steps one through four of Groenewald's phenomenological process (2004). I then went back to the participants to review the summaries of their individual interviews to validate or correct my interpretations. This took place via email. I then moved forward with the fifth step of reviewing all the summaries and transcripts together to identify common and unique themes and units of meaning and writing one final compilation summary.

In chapter four I will discuss the pilot study, describe the interview settings, participant demographics, and the processes of data collection and explicitation, followed by the results of the interviews and evidence of trustworthiness.

Chapter 4: Results

Introduction

This chapter presents the results of the study. I begin with a review of the pilot study, setting, and participant demographics. I then describe the data collection and explicitation procedures used in this phenomenological design. Next, the evidence of trustworthiness is summarized, followed by the presentation of major themes and subthemes derived from participant interviews. The chapter concludes with discrepant cases and a brief summary. The purpose of this chapter is to present the data as experienced and described by the participants, not to interpret or compare them to theory or prior literature. Interpretation occurs in Chapter 5.

Pilot Study

The pilot study included two participants from the same department who had prior experience with CRT response calls. Their interviews were used to refine the semistructured interview protocol and ensure questions would produce rich, meaningful data. The pilot process revealed that participants preferred a conversational style of interviewing that allowed them to share stories naturally rather than answer a rigid sequence of questions. This feedback informed the final approach, leading to more open-ended prompts such as “Please describe a significant call that you’ve been on with co-response” and “What other experiences did you have with the counselor riding with you/in your car?” The pilot also identified key areas of interest such as officer safety concerns, collaboration with clinicians, and the emotional toll of repeated exposure to crisis situations. These insights allowed for the development of follow-up probes

designed to elicit deeper reflections and more nuanced descriptions of stress, appraisal, and coping strategies. No substantive changes to the protocol were necessary before full data collection. This final iteration of the interview guide is what was submitted and approved by my committee and the IRB and was not changed or edited from this point forward in the study.

Setting

The study took place in a midsized urban police department with approximately 1,000 sworn officers. CRT operations are housed within the Office of Alternative Police Strategies and function as a partnership with a local mental health agency. The community served by this department has experienced an increase in mental health related calls for service. The CRT program was launched to address these challenges more effectively and to reduce the number of individuals in mental health crisis entering the criminal justice system. Officers assigned to CRTs receive 40-hours of specialized training in crisis de-escalation and work closely with licensed clinicians who provide on-scene assessments, connect individuals with services, and determine whether hospitalization or other interventions are necessary. The CRTs operate out of each precinct for first and second shift but are not available at night or on weekends. The department provides dedicated vehicles and equipment for CRT use, signaling organizational commitment to the program.

Cultural attitudes within the department toward CRT participation are generally positive, with some officers viewing CRT assignment as a positive and meaningful role.

This aligns with research showing that voluntary participation and institutional support are key factors in the success of co-response models (Shapiro et al., 2020).

Participants were invited to the study through an email invitation sent to the whole CRT. They were given the option to fill out a short contact survey or email me directly to indicate interest. When the necessary contact information was received, I reached out to each individual participant according to their preferred contact method. We then worked together to set up a time to meet that worked with their schedules. I texted them the day before our interview to confirm the time and we communicated via text message on the day of the interview when some of them were running late or were delayed by a call.

For most participants, I met with them directly after rollcall at the beginning of their shift. For the others, I was able to meet with them in the middle of their shift when they had time to step away. I met with five of the participants in conference rooms at the precincts where they were assigned. Two participants met me at police headquarters because they had to go there for other business already and we met in a conference room there as well. One participant had their own office. All interviews were conducted privately, with doors closed and no other supervisors or coworkers present. Before the interviews started, I obtained consent to record from all participants and reminded them of the confidentiality of the study. Additionally, I reminded them that participation was voluntary, and they were free to withdraw from the study at any time. There were no organizational conditions that interfered with the responses or experiences of the participants.

Demographics

Eight participants were interviewed for the main study, all of whom had served on the CRT for at least 6 months. Participants ranged in age from late 20s to mid-50s, with policing experience spanning from four to 23 years. Three were male, five were female, and their racial and ethnic representation generally reflected departmental demographics: six identified as White, one as Mixed, and one as Asian. No Black CRT officers volunteered to participate in this study. Conversely, this is a male-dominated department, yet there were more female participants than male in this study. Several participants had prior CIT training and three had previous experience in other specialized units such as investigations or SWAT. This diversity of background enriched the data set by providing multiple perspectives on CRT work. To protect the anonymity of the participants their names were not used and the specific demographic information was not listed in connection with the individual participant. The label P1, P2, and so on were used in the order in which the participants had their interviews.

Table 1 summarizes participant characteristics and is shown below to enhance transferability and allow readers to assess whether findings may be applicable to other settings. The demographic spread ensures that the themes identified are not limited to a narrow subset of officers but instead represent a cross-section of those engaged in CRT activities.

Table 1*Participant Demographic Characteristics at the Time of the Interview*

Demographic characteristics	<i>n</i>
Gender	
Female	5
Male	3
Race	
Caucasian	6
Asian	1
Mixed	1
Length of time at department	
1-5 years	6
6-10 years	1
11-20 years	1
Length of time with CRT	
3 months to 1 year	2
2 years	3
3 years	2
4 years	1

Data Collection

Semistructured interviews were conducted in person at various locations.

Interviews lasted between 31 and 76 minutes. Each participant was interviewed one time using the interview guide that was created for this study and received follow-up email communication to ensure that the summary of their interview was complete and accurate. During interviews there were minor environmental interruptions, however these did not hinder the interview process. By interview seven, no new codes emerged. An eighth interview was conducted to confirm stability and saturation was reached.

Each interview began with a brief rapport-building conversation, followed by informed consent procedures and a reminder of confidentiality protection. Participants were encouraged to speak freely about both positive and negative experiences. Probing

questions were used to clarify meaning and explore emerging areas of interest. Digital recordings were transcribed verbatim within 72 hours to preserve accuracy.

Data were recorded in two ways. Each interview was recorded using the voice memo application on my phone and transcribed with a password protected application called Ottr for transcription purposes. The transcripts and audio recordings have been saved in a secure, password protected location and will be stored for 5 years per Walden requirements. There were no variations in data collection from the plan laid out in chapter three.

During data collection one participant arrived late because they were delayed on a call for service. During another interview the motion-sensor lights went out in the conference room which interrupted the flow of the interview. One interview was slightly rushed at the end due to other scheduled appointments for the participant. All questions were asked and answered, however, based on the length of answers in the beginning of the interview, the answers towards the end may have been rushed.

Data Analysis

In chapter three I described the five-phase process that I would use for explication of the data, using a phenomenological approach. Those five phases were developed by Groenewald (2004) and are as follows: (a) bracketing and phenomenological reduction; (b) delineating units of meaning; (c) clustering units of meaning to form themes; (d) summarizing each interview, validating it when necessary, modifying it; and (e) extracting general and unique themes from all the interviews and making a composite summary (pp. 49–50).

For phase one, I kept a running Word document to track any thoughts, feelings, or concerns I had leading up to and after the interviews in the form of an audit trail. This bracketing process helped me to set aside my fears and worries, clarify my thought process, and keep an open mind for each individual interview.

For phase two, I read through each interview and highlighted any statement that was relevant to the research question. This is how I identified units of meaning. Any statement that indicated an experience the officer had with the CRT was highlighted and given a code that categorized the experience. I reviewed all the interviews in this manner and kept a spreadsheet of all the codes along with a definition or description of what that code was capturing, which participant shared it, and how many times it was shared in that interview. For example, many of the participants shared challenging experiences with the CRT, and those statements were highlighted and given the code: challenge. The definition I gave to this code was: challenges of the CRT program. For this code, I noted that every participant mentioned challenges of the CRT program ranging from five mentions to 33 mentions of a challenge. Additionally, as I reviewed each interview transcript, I highlighted statements or phrases that had potential to be quotes used to describe the officer's experience. For example, for the code "justification" I highlighted the following quote from P4: "getting the actual help they (PMI) need, instead of going to jail and wasting resources, and then they get a record, and they have to go to court and a bunch of other stuff, that's just not necessary in the moment" (P4). After I finished coding the final interview, I returned to P1's interview and recoded it to ensure that the

coding process remained the same and to see if there were any codes that I missed in P1's interview now that I had gone through all the others.

For phase three, I reviewed the codes and clustered related items together to form themes. An example of a theme that was created is: community trust and legitimacy. This theme combined the codes of community trust and justification for the program. "Community trust" was defined as "building trust within the community" and "justification" was defined as "justification for having a CRT program." These two codes are related because of how the community sees and supports the program. If the community does not trust the CRT program, then it will be difficult to justify its continuation or expansion in the future. I also took step three a bit further by combining the themes into three categories. For example, the themes of "compassion and humanization" and "community trust and legitimacy" were combined into the category of "community engagement." Going from units of meaning, codes, themes, and categories is a comprehensive way to look at small, individual pieces of information and expand to a broader view and scope of the overall officer experience. By the end of this step, I had identified 28 codes, 10 themes, and three categories as shown in Tables 2 and 3.

Table 2*Codebook Table*

Code	Definition	Number of participants	Number of mentions	Quote
Challenge	Challenges of the CRT program	8	123	“We were on two back-to-back calls where these people just would not stop talking about their delusions, and I was like, ‘I need an emotional support corn dog’...I need something to just decompress...you take that all in and it sits with you.” P3
Community trust	Building trust within the community	8	22	“I think getting it across to the community that we do want to help, from the officer’s perspective, and here’s our proof, we have somebody riding with us. We do want to help.” P5
Experience	Personal history of mental illness personally or with family/friends	4	10	“It just hit too close to home. He was really personable and presented how my sister did. My sister’s not dumb. He’s not dumb...I just made sure that affairs were in order after that call for my sister.” P8
Frequency	How many days per week were participants assigned to CRT? Also how many calls per shift?	7	9	“I do it every week, at least once, sometimes twice when there’s an opening...I always volunteer because I like doing it.” P2
Future questions	Questions that should be asked of CRT officers in the future	6	10	“I would be inclined to know if they ever have dealt with in their personal or professional life with a mental health crisis...it would be insightful to know, what could have been handled differently when you were having that crisis? Would you have wanted to talk to a [CRT] and would you have been accepting of the help they were offering?” P7
Helpless	Feeling helpless, untrained to respond to mental health calls	6	20	“I feel like being able to have an appropriate response to mental health calls is very essential as a patrol officer...a lot of times I almost feel helpless, because I’m like, I don’t even know where to start or what to do.” P1
Improvements	Recommendations for program improvement	8	37	“More coverage would make it better for us as officers, because the weekend people don’t have the luxury the same way the officers do in the week.” P3
Justification	Justification for having a CRT program	8	33	“It has helped cut back on a lot of unnecessary staffing and manpower being diverted when you can just have one dedicated [CRT] car that can handle that.” P7
Limitations	Limitations of CRT, police, and mental health clinicians	6	36	“I think citizens always forget that this is a temporary fix, not a full time fix...it’s a fix for this moment, but that person or the family members have to continue their assistance.” P6
Location	Location of the CRT call	8	22	“Got this call about a missing suicidal, homicidal, mentally ill individua who jumped out of a moving car and ran into the woods.” P8
Mental health experts	Mental health experts, different skills and knowledge; role of the mental health clinician	8	67	“Their role has been to basically assess somebody in crisis that could be depending on the situation, like people with mental disabilities in crisis, people that are having homicidal statements, suicidal statements, even threats of mass violence. I’ve even had it with people of homelessness that just want resources, and oddly enough, we as officers don’t have those resources that the counselors do. So she helps with all that.” P8
Misunderstand	Misunderstandings or preconceived notions	8	34	“It’s definitely changed my views a lot with mental health disorders and things like that.” P4

Code	Definition	Number of participants	Number of mentions	Quote
New mindset	and biases about mental health clinicians and mental illness New mindset about how to address mental health needs and personal biases	8	55	“Forget about policing with you’re a [CRT] officer, because at that point you’re just safety, security. You can’t be as proactive. You have to be focused on...the well-being of people. You can’t be the motherfucking police...I’m here to assist the social worker.” P6
New skills	Learn new skills to use when answering calls, regardless if CRT that day or no	8	42	“It’s definitely impacted how I respond to calls without it. Being able to have the training in general, but also because I like to learn stuff...when she’s talking to people...I’m always trying to pick stuff up from them, or afterwards, pick their brain about certain things...most of them are really knowledgeable about medications and what disorders do what. So having that has helped me a lot, being able to talk to people and knowing what questions to ask...or just being a human being...knowing how to interact with people that are kind of going through crisis better.” P4
No heroes	Counselors sometimes want to do more than they ought to	3	5	“I know counselors are here to help and stuff like that. Don’t get too excited and run into a call.” P1
Outside resources	Community resources outside of the police department	8	40	“You’re a partner with your counselor, you’re partners with your other fellow brothers and sisters on shift, your supervisors, the fire department, the paramedics, the dispatchers, other agencies,...like all the other agencies are trying to help people...but as long as you’re trying and you try to give information to each other and help each other out, I think that helps out a lot.” P7
Personal benefit	Personal benefit for the officer to have a counselor in the car to talk and debrief tough calls with	8	39	“She and I talk about family issues, family things that are going on. Life issues, somebody that’s not an officer, that is a great partner, a great friend. We’ve become friends and she’s friends with pretty much everybody she rides with out here” P2
PMI	Person with mental illness	8	70	“What happens if I take your gun from you?” P1 “I’m autistic and I don’t pick up social cues.” P2 “I’m dead and my corpse is on the ground over there.” P3 “She was convinced her and Morgan Wallen were going to go Washington DC to meet with Kamala Harris, President Biden, and Donald Trump and sign a peace act that was going to disband all government parties and make it just a one party system for the people.” P4 “One lady she just doesn’t like being alone, so she calls and gives the buzz words to the call taker. And we get there...and she’s just sitting there in her wheelchair with no pants on, and the counselor just goes in, talks to her, safety plans because she’s not actually suicidal, homicidal, or harmful to herself or others.” P5 “The husband committed suicide and now the female is becoming manic.” P6 “She was very out of sorts...1000 yard stare, saying she was hearing things. She was trying to strip off her clothes. And you couldn’t have a conversation with her without her just screaming and yelling, and she didn’t know what was going on.” P7 “The Mexican Mafia is out to get me. The U.S. government’s out to get me. Everybody’s out to get

Code	Definition	Number of participants	Number of mentions	Quote
Police experts	Police experts, different skills and knowledge. Role of the police officer	8	64	me...you gotta take me to witness protection...bring me my sundial." P8 "Sometimes officers are going to make decisions you disagree with. Know that we have to make the decision based on the law. And sometimes somebody's gonna go to jail and you're not gonna want them to." P2
Positive	Positive view of the CRT program	8	89	"It's beneficial for officers to see there are other resources available for people who are struggling, who are in crisis. It's beneficial for the community too, to build that trust with police officers and counselors." P1
Process	How does the CRT program work?	8	106	"They're there to determine if somebody is 0-4-able or not, if they're suicidal, homicidal, a danger to themselves...and then determine whether they need to go to a hospital or not, where that's not something I'm qualified to do." P5
Right fit	Officers need to be the right fit for co-response; not all officers are the right fit	6	26	"I do think that there are some officers that don't really know how to talk to people experiencing a mental health crisis...rather than just rile them up, making them feel what they're experiencing isn't real or not validating it." P5
Safety first	Police are responsible for counselor and citizen safety	7	41	"Most of our job is safety and security because there are times where we were dealing with a suicidal but to do with manic and hitting some type of excited delirium. I mean, I got to like, full on fight, and I told her not to come, and I knew it was gonna be bad. So I handled the situation until we had him fully cuffed up, and then that's when she did her job." P6
See a lot	Counselors are exposed to a lot with the police department	7	12	"It is a lot because there are days where we'll go back to back to back to back, to suicide, schizophrenia, suicide, kid, kid wants to feel this way...so you see a lot. So you just have to be able to compartmentalize." P3
Stay lane	Police stay in their lane; counselors stay in their lane	5	36	"It was laid out pretty clear to us...what our role is, what their role is. She does make it very clear in the training." P4
Teamwork	How do the two work together?	8	114	"The counselor and I were on the same page of what the outcome was going to be." P1
Three words	Three words to describe the CRT	8	35	"This. Shit's. Crazy." P6
Volunteer	Did you volunteer for the CRT or were you told? Why did you volunteer?	8	10	"I was there when they took volunteers. I signed up because I'm educated in the mental health realm." P8

Table 3*Theme Table*

Theme	Definition	Contributing codes	Quotes
Community trust and legitimacy	Ways that CRTs help build trust between police and the community	<ul style="list-style-type: none"> • Community trust • Justification 	<p>“It helps the community too because they know officers aren’t necessarily going to go arrest this person because they are having a mental crisis.” P1</p> <p>“Getting out and getting to people before their actions become a criminal action, knowing and recognizing that they need help over everybody that day.” P2</p>
Compassion and humanization	Increased compassion and empathy for PMI and personal benefit of having a counselor in the car; realistic expectations of each other	<ul style="list-style-type: none"> • Helplessness • Personal benefit • See a lot 	<p>“I just didn’t want to deal with the crazies...but once you are certified and know how to communicate with these people and you know that your counselor is kind of a first line of defense...it was literally like night and day...so I would say it definitely changed from being ignorant...you actually become more aware and compassionate.” P2</p>
Evolution of understanding	The way that beliefs and biases change as a result of the training and experience of being on a CRT	<ul style="list-style-type: none"> • Future questions • Misunderstand • New mindset 	<p>“I was always very big on it’s [the system] fine. There’s nothing wrong with it. It’s just people being babies...people just need to be tougher...it’s kind of shined that light...it’s not always controllable and it’s not always their fault what they’re going through...it’s definitely changed my views a lot.” P4</p>
Flexibility and discretion in response	The opportunity to tailor the police’s response to the needs of the PMI with CRT response	<ul style="list-style-type: none"> • Positive • Process • Teamwork 	<p>“They made a plan, like they talked to him. Do you want help? Do you want to go talk to somebody? Do you want to get admitted into a facility? He’s like, ‘I think that would probably be a good idea.’ So we were really respectful of him. We’re not going to tow your car. Your significant other is going to go drop off her car...Are you willing to go in the back of the ambulance? ‘I’d rather ride in the car with the counselor.’” P7</p>
Holistic crisis understanding	Deepening understanding of the nuance of mental health response	<ul style="list-style-type: none"> • Location • PMI 	<p>“It was such an astounding call that it changed my perspective of how caregivers are and how they should be. Because you can tell when somebody doesn’t give a fuck about their patient, and it was clear as day that she wanted him dead. So it was very heartbreaking, but that is the unfortunate, sad reality, truth that there are caregivers out there like that, that are just here for a paycheck or whatever. I don’t know. But it’s unacceptable in my book, and so I try to hold them to a high standard.” P8</p>
Importance of CIT training and role Modeling	CRT training and experience changes (improves) police response across the board	<ul style="list-style-type: none"> • New skills 	<p>“I think for younger officers, it’s good, because younger officers don’t have the experience, and today, more so than before, they’re not great at talking to people when they come in. They don’t have a lot of experience of human interactions. We didn’t have cell phones, we didn’t have tablets, we didn’t have online school. We had human interaction all day, every day, where they get a lot more tablet interaction. So I think it does help watching somebody that interacts with people differently, kind of shapes how you approach calls.” P2</p>
Operational constraints and recommendations	Challenges and limitations of the program	<ul style="list-style-type: none"> • Challenge • Improvements • Limitations • Right fit 	<p>“They don’t really want you to do a lot of stuff that could put your counselor in jeopardy, because she is a civilian. She does wear a vest...I think they’re about to give them TECC training, like medical training. But at the end of the day, you do have somebody in the car who’s not trained like this. We can’t get into pursuits. She can’t get out on warrant services anymore. They just kind of want to keep her safe from all that.” P3</p> <p>“We can offer services. We can offer help and counseling and stuff, but I mean, we can’t really do much on our end, other than trying to hold him down to stop hurting</p>

Theme	Definition	Contributing codes	Quotes
Personal connection and storytelling	Connecting CRT experience with personal history and experience. Sharing stories of impactful calls	<ul style="list-style-type: none"> • Experience 	<p>himself. And we don't want to do that because that looks really bad, especially for a young kid being held down by a bunch of first responders." P7</p> <p>"If they get certified to drive our car, because then we have to have somebody sit on our car...taking the time out from somebody coming all the way across their district, all the way across the county, to come and sit on an unoccupied car that can't even be driven by anybody else, it's almost like a waste of resource to me." P8</p> <p>"I work with some good officers that have good ability to do certain things in policing, but really bad ability to go out and talk to somebody and get some information and not make the person feel like a piece of crap." P2</p> <p>"So when I got there and I saw that he was not okay, I went zero to 100 because I was extremely upset that this is now negligence on the caregiver's home, and I've already reported so many other caregiver homes that have autistic children...I always think of my sister...would my sister want to live here? Or would I want my sister to live here?" And if the answer is no because the living conditions are fucked then I report them." P8</p>
Role clarity and collaboration	Providing an accurate representation of what the role of CRT officer is like and how to interact with the counselor	<ul style="list-style-type: none"> • Frequency • Mental health experts • Outside resources • Police experts • Stay lane • Three words • Volunteer 	<p>"It's one thing to be a police officer and be like, oh hey, I just wanted a crime happen. But being [CRT] is like, okay this person is having a mental health crisis, and you need to look beyond that person in front of you into what's going on in their head, whether it's a child, adult, someone who is successful and has a job or may just be down on their luck and be unhoused right now, and you need to look beyond what's in front of you and see what's going on in their head and try to help them out as best you can." P7</p>
Safety and protection of counselors	Different considerations having a civilian partner	<ul style="list-style-type: none"> • No heroes • Safety first 	<p>"We only brought them in when we have like...5% chance you'll get hurt...but like, if something did happen, a car accident, or we got into a fight and then I got somehow hurt or killed and down, she's vulnerable. She didn't carry weapons. She only cares a ballistic that's it. So it kind of puts you more on heightened skill...oh crap, now I got someone with me. I didn't worry about myself. Now I gotta worry about this person." P6</p>

Next, in phase four, I once again reviewed the individual interview transcripts and wrote a summary for each of them. I listened to the recordings of the interviews, reviewed the transcripts and compared them to the codes, themes, and categories that I had identified. Member checking was conducted with all participants by sending them the summary of their interview, not the whole transcript, giving the participants an opportunity to review the preliminary thematic structure and confirm that the themes accurately reflect their experiences. This step enhanced the credibility of the findings and

ensured that the officers' voices were authentically represented as recommended by Birt et al. (2016).

The process for phase five involves looking at the general and unique themes from all the interviews and writing one big summary of them all. This summary reveals both shared and individual experiences that illuminate the transformative impact of CRTs on officers' professional presence and personal perspectives. Initially, some officers were required to participate in the CRT training and others joined the CRT program out of a desire to improve their response to mental health-related calls. Many expressed feelings of helplessness in prior encounters and recognized a gap in training and resources. While some were initially skeptical of the program, direct experience often led to a shift in perception and growing advocacy for the model. This department is now adding CIT training to the end of their academy curriculum so that every incoming officer will be CIT trained.

A consistent theme was the importance of clear delineation of roles: officers ensured scene safety and counselors provided mental health assessments and interventions. This partnership was described as synergistic, with officers introducing counselors once the scene was safe and working together to determine the best course of action. The presence of a counselor provides alternatives to arrest or hospitalization.

Participation in CRTs led to significant personal and professional growth. Officers reported increased empathy, a deeper understanding of mental health, and improved communication strategies. Many developed strong working relationships with

counselors, which enhanced their ability to navigate complex calls. The experience reshaped their views on mental illness and policing.

Officers highlighted several benefits of CRTs including faster and more effective responses to mental health crises, reduced criminalization of individuals with mental illness, improved community trust and perception of law enforcement, and decreased time spent on mental health calls, freeing officers for other duties. The challenges and areas for growth identified by officers were inadequate coverage during nights and weekends, inconsistent follow-up care after hospital referrals, and the personality fit of the officer for CRT work. Recommendations for these limitations include expanding CRT availability to 24/7 coverage, integrating mental health training into police academies, developing distinct units or roles for mental health response, and expanding the training of the counselors to include medical care and transportation permissions.

The lived experiences of officers on CRTs reveal a powerful narrative of transformation, collaboration, and compassion. Challenges remain however, the program is widely viewed as a critical and effective tool for modern policing. Officers emphasized the importance of continued investment, training, and structural support to ensure long-term success and sustainability of CRTs.

Evidence of Trustworthiness

An important issue to address in qualitative research is the issue of trustworthiness. In qualitative research, trustworthiness ensures that the researcher interprets participant experience in a true and pure way, free from bias. Credibility was supported through triangulation of pilot and main interview data, prolonged engagement

with participants, and member checking. Dependability was ensured through detailed documentation of the analytic process, including an audit trail and recoding.

Confirmability was addressed through reflexive journaling and bracketing, which allowed the researcher to acknowledge and set aside personal biases as a mental health professional and department employee. Transferability was strengthened by providing thick description of the setting, participants, and context so that readers may judge applicability to other CRT programs (Lincoln & Guba, 1985).

Credibility

Credibility addresses internal validity within the research data. To prioritize the credibility of this study, I had prolonged engagement with eight police officers which allowed me to build rapport with the officer through active listening, paraphrasing, and humor. Additionally, I wrote an interview summary for each participant and utilized member checks to verify that my understanding and interpretation was correct. This allowed them to confirm or correct the notes and observations that I made and gave them another opportunity to add information or withdraw from the study if they changed their minds. They all confirmed that the summary was accurate and complete and none of them withdrew from the study.

Transferability

While credibility addresses the internal validity of the study, transferability addresses the external validity of the study. This is crucial for future researchers who may wish to replicate the study. I utilized thick description and collected demographic information. Thick description was used to thoroughly describe the recruiting process, the

setting, and the explicitation process. Thick description was also enhanced by using tables to display demographic information and the coding process. By describing things in great detail, future researchers will have all the information necessary to replicate the study.

Dependability

Dependability addresses the concern in qualitative research for continuity and consistency over time. This means that similar themes would be found in future replicating studies. I have kept a running audit trail that included bracketing my thoughts, describing the thought process throughout the study and keeping dated versions of the interview guide as it was updated. Additionally, I performed a recoding of P1's interview after I had coded all the interviews to show stability in coding.

Confirmability

The trustworthiness of the researcher is addressed with confirmability. Confirmability ensures that the explicitation of data is done based on participant experience rather than researcher bias. I have addressed this issue of trustworthiness through an audit trail, bracketing, saturation and consultation. I used a password protected document for my audit trail, adding the most recent entries on top for quick reference. I used this tool for bracketing and to document the thought process throughout the explicitation process. Saturation was reached after seven interviews as evidenced by no new themes emerging. An eighth interview was conducted for confirmation. The dissertation committee chairperson, second chairperson, and the supervisor of the CRT unit were consulted throughout the data collection and explicitation process.

Results

In this study, I wanted to learn about the lived experiences of law enforcement officers who are a part of the CRT in their police department. I conducted eight semistructured interviews with officers utilizing an 11-question interview guide that I developed based on the work of Plassmeyer et al. (2024). The research question that I have used is “what is the lived experience of law enforcement officers assigned to CRTs responding to mental health crises?” The stories they shared offered insight into the practical and professional effects of this position such as improved people and procedural skills, mindset shifts concerning mental health, and a deepened compassion for PMIs as just a few examples. I identified units of meaning within the interview transcripts and combined them into codes. Seven major themes and multiple subthemes emerged from the analysis, each offering insight into the officers’ lived experiences on CRTs.

Category 1: Professional Development

Professional development is the first category and is comprised of the following themes: evolution of understanding, flexibility and discretion in response, holistic crisis understanding, importance of CIT training and role modeling, and personal connection and storytelling. These themes capture the experiences of the officers as they relate to their job duties and performances, the differences in police response for mental health calls versus other types of calls, and a deeper understanding of police response to mental health emergencies.

Evolution of Understanding

Across interviews, officers ($n = 8$) described a shift from treating mental health calls as indistinct from other crisis calls to seeing them as situations with different goals, timelines, and success markers. Early in their assignments, several officers approached these calls with a “stabilize and clear” mentality, aiming to move quickly to the next call, often dreading mental health crisis calls because they knew they would take an extended amount of time. Over time, with repeated co-response exposure and observation of the counselor’s work, that orientation broadened into a more patient, appraisal-driven approach. Officers talked about learning to pause, to observe, and to check their assumptions at the door. Several linked this shift to reduced personal stress and greater clarity about what “success” and “police response” looks like for these calls: safe outcomes, preserved dignity, and fewer escalations.

P3 explained the early mindset this way: “Before I was trained, I avoided suicidal or mental health calls like the plague if I could. I did not want to go out there.” Now, after the training and experience with the co-response counselor, P3 shared that after seeing how the counselors appraise the situation and assess the need through a different lens, it has changed the way that she feels about those calls. Now she loves being a CRT officer and feels better equipped to handle the calls with more compassion and patience. P4 described the way he was raised as “old school” and believed that people who struggled with mental illness were just “being babies” and need to “be tougher.” After participating in the CIT training, P4 said that his view drastically changed, and he now has more compassion for people in mental health crises. He specifically mentioned his changed

view on the mental health system after speaking with people who have an extremely hard time getting medication and struggling with the various side effects of that medication.

P7 explained his shift in mindset this way:

Coming out of the military where there was a stigma for us to go get mental health support, and then seeing how this department does things, I think it is very good. My opinion has changed from “people who need help should go seek help on their own” to “hey, sometimes people who need help don’t know how to seek help on their own, and sometimes you just need to talk to someone who can point you in the right direction.”

Another mind set shift that officers spoke about was shifting from traditional crime-fighting police work to protecting your counselor. P6 stated, “You can’t be proactive; you have to be focused on the well-being of people.” P2 noted, “Being ‘crazy’ doesn’t always mean that a person is committing a crime.” Several participants described situations where they were able to direct a PMI to community mental health resources when they were with the counselor but other times, when the counselor was not on shift, they did not have as many options and in some cases, PMIs were charged with misdemeanors and other charges as part of a more standard police response.

Officers also described an initial misunderstanding of what a counselor could and could not do in the field and how involved they could or could not be on a call. P2 said that prior to the training she thought that the counselors just had to stay in the car until someone was cuffed and put in the back of the car. She then realized that the counselor was able to get out of the car and respond to calls with her, assisting with questioning

victims and witnesses with their own unique mental health perspectives. P2 also noted that there were times when people would tell the counselor more than they would tell the officer, so she now views the counselor as an asset in the field. P3 noted that they initially thought the counselors would only respond to suicidal calls, but after training and field experience realized that they are very helpful in a variety of contexts and provide a lot of resources. P5 described a limitation that others do not always consider is that even when the police are dealing with a PMI, the scene has to be safe first before they can bring in the counselor. For example, if the person is deeply in crisis and armed, the counselor will not be allowed on the scene, and the police negotiators will take care of deescalating or resolving the situation. Safety is paramount.

Another misunderstanding that several participants mentioned is the misunderstanding or unrealistic expectations that the community has of officers and their abilities to respond to mental health crisis calls. P6 has noticed that community members often get frustrated when a person is struggling on a repeated basis, showing frustration with officers that they have not been able to “fix” the situation. P6 wishes that the community understands that the CRT is a temporary fix for mental health challenges and that the long-term solutions lie with available mental health services in the community. P6 said, “[the CRT] is a fix for this moment, but that person or the family members have to continue their assistance or aid.” P7 described a situation where parents continued to call the CRT for assistance with their son with autism every time he had a meltdown: “We educated the parents as best we could. It’s not like we don’t want to help.” So

sometimes there is a disconnect between what the community thinks officers and counselors can do and what they can actually do.

As a final question for the participants, I asked if there were any questions that they would ask other CRT officers if they were the ones conducting the interviews. P8 would like to know if there are any other tactics or tricks that other CRT officers have found useful when working with a PMI. P3 would like to know why some officers do not like the program. P4 is curious about the change in mindset over time, such as “what your thoughts were before you were a part of the program, what your thoughts are like since, how they’ve evolved.” P7 was curious to know if any CRT officers have dealt with mental illness personally, and if they think a CRT response would have been helpful for them.

As officers reflected on their lived experiences within CRTs, a clear theme emerged: the evolution of understanding mental health crises as fundamentally distinct from other emergency calls. Initially marked by avoidance, urgency, and a “stabilize and clear” mindset, officers described a gradual transformation shaped by training, field exposure, and collaboration with mental health counselors. This shift involved not only tactical changes, such as learning to pause, reassess, and prioritize dignity, but also deeper attitudinal changes, including increased compassion, reduced stigma, and a redefinition of success beyond arrest or resolution. Officers began to see counselors not as peripheral figures but as essential partners whose presence expanded the scope of response and improved outcomes. This evolution also extended to recognizing the limitations of law enforcement and the unrealistic expectations placed on them by the

community, reinforcing the need for broader systemic support. Ultimately, the lived experience of these officers reveals a journey from resistance to receptivity, from reaction to reflection, underscoring how co-response work reshapes both professional identity and the meaning of public safety in the context of mental health.

Flexibility and Discretion in Response

Another way that the CRT program has impacted officers' professional development is by giving them flexibility and discretion on a call to respond in ways tailored to the specific need of the PMI and connect them with the proper care they require rather than the limited options they have with a police-only response. The success of the CRT program was attributed to having a licensed mental health professional in the field with the officer for immediate involvement, consultation, and recommendations. All officers acknowledged the benefit of having a professional counselor with them in the car for these mental health crises as opposed to when they must answer the calls on their own. During the days or shifts when a CRT is not available, officers often must wait an hour or more for one of the local community mental health agencies to send a counselor for an assessment. Officers also noted that learning from the counselor on these calls has improved their responses when not on a CRT rotation, asking better questions, assessing the situation from a different perspective, and having more efficient outcomes for the people they are serving.

Role discretion was also mentioned in the work of Powelson et al. (2025) as a potential risk or challenge within the CRT program, noting that if officers feel skeptical or distrusting of the role of the counselor, they would have the discretion and authority to

limit the work of the counselor by insisting that they stay in the car or keep them from participating in de-escalation. Officers in this study noted that they prioritized safety over everything, so there were times when they would have the counselor wait before engaging with the PMI. However, contrary to the warning of Powelson et al. (2025), the participants in this study valued the skills and knowledge of their counselors and happily gave them room to work with the PMI as the counselor deemed necessary.

Teamwork was mentioned often as critical to the success of the CRT program. P8 described a situation where they were first on-scene to a car wreck where both the driver and the passenger had overdosed and there was a baby in the backseat. P8 shared that the CRT counselor did not have to do anything in that situation but offered to help and was able to hold the baby for the CRT officer while the officer tended to the driver and the passenger. P8 said that it was “kind of a small thing, but they add up, and so they (the counselors) help a lot.” P5 says that together with the counselor they can “figure it out faster. Diagnose it faster.” P3 shared that they “trust that she’s (the counselor) making the right decisions for these people, so you actually feel like you’re helping somebody who really does need help, because the human brain is so insane.”

P7 explained that having a plain-clothed clinician responding with them to a call often de-escalates things right from the start. P7 said, “Other agencies and jurisdictions do things where you just have an officer who is CIT certified, but they’re still a police officer. It’s still a uniform. It’s still a badge and a gun.” P7 continued, the CRT program however, is “less intimidating because they (the counselors) look like a mental health professional.” P3 says “[PMIs] look at us [the officer] and they think, ‘You’re going to

shoot me. You're going to hurt me. You're going to take me to jail.' But when you have somebody who is just there to talk, most people respond pretty well.”

P4 appreciates that it helps them not be “tied up for hours” like they sometimes are without the CRT, noting the efficiency of the CRT process. In a situation described by P7, officers were responding to a person sitting on the edge of a bridge railing. Through a coordinated effort, several officers, including the CRT car, were able to coax the gentleman off the railing and to a safer place. Then the officers and the counselor were able to speak to the gentleman and his significant other to come up with a safety plan for him. P7 described the flexibility they had to work with the significant other to take care of the man's car so it would not get towed and gave him options for in-patient care. The man was willing to go and so then the officer described the options they were able to offer to get him there; riding in the ambulance or riding in the police car with the counselor. Having many options available provided the man with some agency and control over his outcomes and having the resources (the counselor) immediately on-scene opened the opportunities quickly and efficiently.

P8 noticed the difference between responding to mental health crisis calls and other calls, such as domestic violence. P8 noted that with domestic violence calls, it is often difficult to know where to start to get the victim help. But with mental health crisis calls, the process is a little clearer; according to P8:

They need the hospital, they need the medication, they need to detox, whatever the case is, and they want to, some of them really want to get clean, and so you just help them through that, and you take them to their first step.

Officers also identified ways that the CRT program has given more options and discretion to the community members who need that type of assistance for themselves or for a loved one. P2 said that there is a woman in her precinct who needs a CRT response on a fairly regular basis. P2 said, “People will call in now, family members, and ask ‘is the CRT car available today’ or ‘is the car with the counselor available?’” P3 noted that people are generally grateful to see a counselor show up: “It’s a friendly face to have in the field that doesn’t carry a gun.”

The lived experience of law enforcement officers assigned to CRTs reveals that flexibility and discretion are central to their evolving role in responding to mental health crises. Officers consistently described how the presence of a licensed mental health professional in the field expanded their options beyond the standard protocols of traditional policing, allowing for tailored, compassionate interventions that better meet the needs of PMIs. This flexibility not only reduced waiting times for assessments and improved de-escalation outcomes but also empowered officers to offer choices, such as transportation methods or care pathways, that restored a sense of agency to PMIs. The discretion afforded by the CRT model also extended to community members, who began to request the CRT car by name, recognizing its value in repeated or complex situations. Officers noted that the counselor’s plain-clothed presence softened the perceived threat of law enforcement, making it easier to build trust and diffuse tension. Through these experiences, officers came to view discretion not as a luxury, but as a necessity for effective, humane crisis response, reshaping their professional identity and reinforcing the CRT’s role as a bridge between law enforcement and mental health care. This sense

of purpose is consistent with literature suggesting that specialized assignments can enhance job satisfaction and improve retention (Compton et al., 2021).

Holistic Crisis Understanding

Officers shared that through their CRT experience, there are a lot of layers that must be peeled back to know what is really going on with a mental health crisis and what the next steps ought to be. One thing to consider is the varied locations these calls take place. Stories shared by participants included locations such as a group home, inside a vehicle, at a community health organization, a strip mall, beside railroad tracks, police headquarters, the PMI's home, at a bar, walking on the side of the road, on a bridge, inside an ambulance, in the woods, at the hospital, and an adult care home. Another complicating layer is the kind of mental health crisis that someone is having. Officer stories involved people threatening to harm the officer, harming themselves, or harming someone else, people who were noncompliant and resisting assistance, vulnerable populations such as the elderly, children, or people with co-occurring mental health disorders such as autism or substance misuse, and people experiencing delusions and/or hallucinations.

P2 described a situation that took place at a local community health organization where a walk-in said she had been sexually assaulted. The officer described the questions she and the counselor were able to ask and the information they were able to glean. The individual told them upfront that she was "autistic and I don't pick up social cues" and after further conversation with the CRT counselor they were able to determine that she was not sexually assaulted, and she was not being "groomed" as she feared. Through a

series of questions, they were able to determine that it was not a call that required a CRT response, because she was coherent and able to answer questions about the day and time and was not a threat to herself. However, because of the holistic crisis care that they were able to provide, they were able to give her a ride to the local women's shelter and get her connected with appropriate services there. The officer was able to determine that no crime had been committed, the counselor was able to assess the real need and together they were able to get the individual to the appropriate service provider.

P7 described a call where a mom and dad were seeking assistance for their young son who was severely autistic. He was having a meltdown, throwing things and "flailing and wailing." The parents were distraught and unable to calm him down. By speaking with the parents, the CRT determined that the child was a danger to himself, but they wanted to be very cautious with him so they would not upset him more. They called the fire department and the paramedics along with a supervisor to help come up with a plan. They were able to share some educational resources with the parents and get the boy to the hospital. P7 said that they were called back to that house many times and continued to support the parents and encourage them to seek the right care for their boy. The officer understood that they were calling for help in the emergency of the moment but also recognized the limitations of their services and continued to point the parents in a more suitable direction.

P8 shared a story of finding a PMI who was having suicidal thoughts down a deep slope in a wooded area. P8 and the counselor made their way down to her:

She's like, 'I ain't moving. I'm not doing it. I'm gonna freaking kill myself.' We removed all of the branches and glass that she was cutting herself with...she was bleeding, but not significantly, but she was a bigger girl too. Like, I couldn't have moved her up that [hill] and the counselor couldn't have either ... We were sitting there talking to her for over 20 minutes, trying to get her up and nothing worked. So there's a bit of silence, and the counselor looks at me, I'm freaking out 'cause I see this goddamn spider. And so I look at her [PMI] and I was like 'hey, can we at least go up? There's a spider. I'm deathly afraid. Can we please go up right now and at least talk about it up there?' ...and she was just like, 'yeah, sure. I don't like bugs either.' And that was it.

The lived experience of law enforcement officers assigned to CRTs reveals a deepening appreciation for the complexity and nuance of mental health crises, what many described as a need for holistic crisis understanding. Officers shared that their CRT work exposed them to a wide range of unpredictable environments and diverse presentations of mental illness, requiring them to peel back multiple layers to determine the true nature of the crisis and the most appropriate response. Through specialized training and real-time collaboration with counselors, officers developed new skills in questioning, rapport-building, and needs assessment, which improved their effectiveness even when operating without a CRT partner. These experiences reshaped their understanding of what constitutes a "mental health call," emphasizing that resolution often lies not in enforcement, but in connection to services, to families, and to the deeper human needs

beneath the surface. This holistic lens has become a defining feature of their professional identity and a cornerstone of their co-response work.

Importance of CIT Training and Role Modeling

All participants acknowledged the benefit of the training they received prior to becoming CRT officers. Some of the things the officers appreciated was the breadth of knowledge they received about the program itself, what to expect from their counselors, as well as a crash course in mental health diagnoses, de-escalation techniques, relevant laws and codes that are necessary to comply with, and an introduction to the services and resources that are available in the local community. Additionally, officers reported that they were able to develop new skills for these kinds of calls because of the specialized training and the presence of the counselor in the car with them. Officers described learning a new set of questions to ask individuals such as “do you take medication?” or “when was the last time you took your medication?” They also reported developing skills that allowed them to build rapport with the PMIs more quickly and sincerely. Quicker assessment of call needs was also mentioned as a benefit of the CRT program. All these new skills are useful to the officer even when the counselor is not available for that shift.

P3 had this to share, “I’ve learned a lot as far as signs and symptoms. I’m obviously not a certified counselor, but I pretty much 99.9% of the time, can tell you what they’re going to do because of how many times I’ve done it.” P1 said that the training gives a good overview of where to even start on mental health calls. Responding to calls with a counselor makes officers more thorough, according to P2, because they see

a different way of interacting with people and observe counselors asking questions the officer would not normally think to ask.

P5 and P7 both enjoyed being a part of the training process, volunteering time to run role playing scenarios with the new CIT trainees. Both officers value the knowledge and experience they have had and can attest to the benefits of the training out in the field. They share a passion for teaching other officers how to respond to mental health crises in a new, more compassionate way.

The lived experience of law enforcement officers assigned to CRTs underscores the critical role that CIT training and counselor role modeling play in shaping effective, compassionate responses to mental health crises. Officers consistently credited their initial training with equipping them with foundational knowledge ranging from diagnostic awareness and de-escalation techniques to legal frameworks and community resources that prepared them for the unique demands of CRT work. Beyond the classroom, officers described how riding with counselors deepened their understanding through real-time observation and collaboration, allowing them to adopt new questioning strategies, build rapport more quickly, and assess situations with greater nuance. These skills proved transferable even when counselors were not present, enhancing officers' confidence and competence in solo responses. Several participants also expressed a strong commitment to mentoring new trainees, using role-play and shared experience to model the empathetic, informed approach they had come to value. This cycle of learning and teaching reflects how CIT training and counselor partnership are not just preparatory

tools, but ongoing influences that reshape officers' professional identity and elevate the standard of care in mental health crisis response.

Personal Connection and Storytelling

Three of the officers shared that they had some personal connection or experience with mental illness that has impacted their experience on the CRT. One officer described their personal experience with ADHD, having a daughter with ADHD, and how this program has helped shift his perceptions. Three officers shared they had friends or family who struggle with mental illness. They said that they already had a compassionate perspective before they joined the CRT program, but that experience is what prompted them to volunteer for the training and motivates them to volunteer for more frequent CRT rotations.

On a different note, some officers reported changes in the way they respond to friends and family with mental health challenges, often reporting more empathy and increased patience. Officers who were once dismissive or indifferent to people struggling with mental illness came to understand the complexities and challenges that these individuals face and now respond with more empathy and compassion.

P4 described growing up with an "old school" mentality toward mental illness despite having ADHD. The officer admitted that even when he found out that his daughter also has ADHD, he was dismissive. His thought was that he didn't need help during school so she should be fine too. However, through the CIT training and CRT experience, he can see how the interventions his daughter is receiving at school are helping her and that she's thriving because of it. P1 shared that she wasn't new to the

concepts of mental health or mental illness because she has a close friend who is a social worker. P2 explained that she grew up with some people who struggled with mental illness, so she never shied away from mental health crisis calls saying, “I always try to be understanding of that community.” P8 has a sibling with Autism and thinks of them often when responding to mental health calls asking themselves how they would want their sibling to be treated in this circumstance.

The lived experiences of law enforcement officers assigned to CRTs are deeply shaped by personal connections to mental illness, which often serve as a catalyst for empathy, motivation, and professional growth. Several officers shared stories of family members, friends, or their own diagnoses, particularly ADHD, that influenced how they approached mental health crisis calls and how their perspectives evolved through CRT involvement. These personal narratives not only prompted some to seek out CIT training and CRT rotations but also fostered a more compassionate and patient response to both community members and loved ones. Officers who once held dismissive or “old school” views described a shift toward understanding the value of mental health interventions, especially when witnessing their positive impact firsthand. Through storytelling and reflection, officers revealed that CRT work is not just procedural, it is also personal. Their lived experience is enriched by the blending of professional duty and personal insight, reinforcing the CRT model as a space where empathy and expertise intersect.

Category 2: Operational Dynamics

Category two involves operational dynamics. These are the practical implications of being a part of the CRT program and officers describe things like how many times a

week they are the CRT, the process of getting onboarded, differences between the police role and the counselor role. Roll clarity and collaboration, operational constraints and recommendations, safety and protection of counselors will all be discussed in this category.

Roll Clarity and Collaboration

The theme of role clarity and collaboration emerges as the participants describe the practical process of the CRT. All eight participants (P1-P8) shared how they came to be involved with the CRT, how frequently they are assigned to that role, the differences between the role of the police and the role of the counselor, the value that outside resources add to the program, the challenges of each participant to stay within those parameters, and their general impressions and feelings about the CRT program. The collaborative nature of CRT, where officers and counselors operate as complementary partners, allowed officers to navigate mental health crises with greater confidence, flexibility, and precision. This theme reveals that role clarity is not static but develops through experience, training, and teamwork, ultimately enhancing the effectiveness and humanity of police response to mental health emergencies. Officers described the complexity of balancing enforcement duties with the therapeutic goals of CRT work. This role-blending often required them to adapt quickly to situational demands.

Most officers reported being assigned to CRT duties approximately once per week, though some noted variability based on staffing, counselor availability, or personal requests. P3 shared, “I request to be it once per week. Sometimes it’s a chiller day because you’re not assigned to a zone, so you can go anywhere and do anything”

highlighting the flexibility and appeal of CRT shifts. Others noted that their supervisors assign them to CRT duties once a week to maintain CIT skills. Some officers volunteered to attend the CIT training and others were told to attend. All participants agreed that the information and experience is useful in enhancing their job performance and providing resources for calls that are otherwise difficult to find.

Officers repeatedly described counselors as the “experts” in the field, particularly in diagnosing, assessing, and determining appropriate interventions. P1 noted, “They are the ones that are more trained, obviously, as social workers, so they have a better understanding of how to handle the situations.” This expertise was not only respected but relied upon, especially in high-stakes decisions such as involuntary hospitalization. P3 explained, “It’s nice to know we have a literal licensed counselor... it’s not just me being like, ‘yeah, Joe, you’re crazy.’ It’s somebody who knows the right avenue.” P5 expressed relief at the reduced liability for involuntarily hospitalizing someone, “it takes the liability of how this is treated off of us and puts it in more professional, more knowledgeable hands.”

Participants also described the way the understanding of their role shifted with training and experience. Initially there was some role confusion based on what the officers knew about co-response programs in different states and rumors they had heard about the few piloted precincts before the CRT program rolled out department wide. Once they understood that they would likely only be the CRT car once a week, P4 expressed relief because he was under the impression that he would have to do it all the time. P6 described how he interacted with the counselor in the beginning was very

compliant and go-with-the-flow, but after a few shifts and answering some calls together, he began to get comfortable with speaking up and saying, “Hey, this is not our job. We gave her resources. We’re done.” The participant described the difficult time the counselor had with that because they wanted to spend more time on that call, but the officer was able to determine that they had done what they were able to do and had to move on to the next call. P3 said she likes to joke that “I’m basically the counselor’s bodyguard” and notes the responsibility of keeping the counselor safe in every call. All the participants acknowledged that their priority as the CRT officer, and as an officer in general, is to ensure the safety of everyone involved.

Some of the officers described the tension of trying to keep everyone in their own lane of expertise. P6 described being used to just handling all the calls, but now there is another expert in the car so, “let’s talk it out...I’m in my lane, you’re in your lane. Let’s come together. Let’s figure it out.” P3 talked about the freedom of someone else making the decision to involuntarily hospitalize an individual, giving them the ability to calm a situation down saying, “we are legally taking you there, but it’s up to a doctor to figure out if you need to stay there...I’m just your Uber there.” Sometimes officers and counselors may not be on the same page, as P1 mentioned, just “explain to your officer why you think this is the better option, let them (the officer) explain their side too.” Participants emphasized that clear communication between officers and clinicians was critical for effective collaboration. They reported that early misunderstandings about authority and decision-making gradually gave way to mutual respect as teams gained experience.

Overall, the participants had generally positive feelings and experiences of the CRT program. The most used words were helpful, compassion, and fun. When asked what three words they would use to describe being a CRT officer, P6 comedically said, “this shit’s crazy.” P4 shared a similar sentiment by saying that “we’re (officers) are just crazy enough to think it’s fun.” P4 also humorously observed that for counselors, “there’s no other job where you can get the benefits of the fun part of being a police officer without all the 6 months of getting screamed at in the academy.” P7 appreciated and acknowledges the partnership aspect of the program, not just with the counselor but with other local agencies as well such as fire and EMS, dispatch, the hospitals and community mental health agencies, as well as other government agencies working together to serve their communities.

Officer experiences with role clarity and collaboration were described as a work in progress and something that had to be navigated personally and relationally with the counselor. As the officers settled into the CRT program and became comfortable with the process and expectations, they described feeling more comfortable speaking from their expertise and experience and using that to collaborate with the mental health experts to provide the best possible care for the community. Officers also expressed humor and enjoyment out of responding to calls with out-of-the-ordinary characteristics and challenges, such as speaking with someone who was convinced that they were dead, and their corpse was “over there.” Officers also expressed satisfaction in knowing that they were really helping people in a meaningful way by being able to bring the resource (the counselor) straight to the person in crisis.

Operational Constraints and Recommendations

Officers offered numerous suggestions for strengthening the CRT model, including expanded hours of coverage, additional clinician staffing, and more cross-training opportunities. While the overwhelming impression of the program is positive amongst participants, a few key challenges were named, chief among them, the challenge of staffing. The CRT officers so highly value the resources they have in their counselors that they expressed deep empathy for the officers on shifts who do not have access to a CRT. They also feel the void when they work on days where the CRT is not available. Participants also mentioned that there is often confusion, sometimes willful confusion, around when and how CRTs should be utilized. P4 said that sometimes you “kind of get roped into something because someone that was trained didn’t care to be and then doesn’t care to apply what they didn’t care to learn...it’s just a dismissive attitude.” Personnel fit is another staffing issue with participants recognizing that some officers are not interested or are ill-suited for the CRT program based on personality traits and beliefs that are incongruent with a patient, empathic response. This mismatch undermines the efficacy of the program and can escalate tension between officers, counselors, and PMIs, especially in high-stress situations. P2 said that they “work with some good officers that have good ability to do certain things in policing, but really bad ability to go out, talk to somebody, get some information and not make them feel like a piece of crap.”

Participants spoke at length about the emotional toll of repeated exposure to crisis situations. Several described feelings of compassion fatigue, frustration with systemic limitations, and a sense of helplessness when services were unavailable. These calls are

often intense, continuously evolving, and involve interacting with people who are experiencing psychosis or hearing and/or seeing things that do not match the reality around them. P3 described a day when they “were on two back-to-back calls where people just would not stop talking about their delusions, and I was like, I need an emotional support corn dog...I need something to just decompress because you take all that in and it sits with you.” Several officers observed that the CRT program can only do so much without strong community services and resources for PMI referrals. The rapid release of PMI from hospitals can undermine the long-term impact of this program, limiting it to strictly short-term support for PMIs who have long-term mental health needs. P3 described this limitation like this: “I think where it lacks, not the program, but where people get failed is once we send them there (to the hospital), it’s the doctors that are releasing them back out, and then we see them the next day, and we have to do it all over again. And that’s just annoying for everyone.” Officers reported using humor, food, and informal peer support as coping mechanisms. These strategies align with problem- and emotion-focused coping approaches described by Lazarus and Folkman (1984), suggesting that officers actively seek to manage the stressors inherent in CRT work.

An additional limitation of the current program is that there are more officers with CIT training and CRT experience than there are supervisors with the same training and experience. Supervisors may find it difficult to manage these teams effectively, resulting in inconsistent oversight. Another observation made by several participants was that gender dynamics may also play a role in call resolution. Female officers and female counselors may relate differently to PMIs or be perceived by PMIs to be more nurturing

and kind. While most of the CRT counselors are female, most officers in this department are male, and study participants, both male and female, noted the difference in PMI response.

Regarding safety, CRT officers noted that there are some calls that are just not safe enough for a civilian counselor to be a part of. P5 shared a story about someone having a mental health crisis on the side of the highway. The PMI was armed and ultimately shot by police, but the situation was never safe enough for a counselor to even call and speak to the PMI from a safe distance, much less to be on scene to intervene. That is something that P5 wished the community understood more, “we do want to help, and we do have these resources. This (shooting) is not what we want. This is not what we want to do. We don’t want this to happen...I don’t think the community understands that all the time.”

The recommendations for program improvement address these challenges and limitations. Officers across the board would like to see 24/7 CRT staffing availability, specifically on the weekends, as well as ongoing training for themselves and their supervisors.

P1: “Having them (counselors) on the weekends...would be good, because a lot of times you get stuck on the weekends, and people don’t work Saturday or Sunday, and that’s when you know, everybody’s home, everybody’s not doing stuff. So, I feel like there’s more of an influx of those types of calls.”

P2: “I think having them (counselors) available through the weekend would improve the program.”

P3: “Have them (counselors) on the weekends

P5: “They don’t have that (counselors) on overnights, and I think they should.”

P7: “More staff coverage for the overnight hours and on the weekends.”

Role clarity and expectations for the CRT officer often comes with time and experience with the counselor, but participants would like more education and clarity for what constitutes a CRT response for dispatch and other officers when requesting a CRT response. P4 talked about how some supervisors have had the training but they do not have the direct experience of being a CRT officer so “when the supervisor is the one making the calls, it’s like, you don’t even know how the program works, what the parameters for it are. So, if they don’t know, they can’t help us on the street either.”

There was one limitation that the participants did not have a clear solution for and that is the concern of the right fit of the officer for the position. The goal of the department is that everyone would be CIT trained at some point, and the participants do not disagree with that, however they do think there needs to be a little more discretion when it comes to which officers are assigned to the CRT for any given shift. P5 shared, “I do think that there are some officers that don’t really know how to talk to people experiencing a mental health crisis, and I know we all have to be trained, we all have to have this certification, but I feel like some people, maybe they need some extra training on how to speak to people experiencing a mental health crisis. Rather than just rile them up, making them feel what they’re experiencing isn’t real or not validating it.” This officer went on to share a story as an example,

We had this call and this lady was ... a sexual assault victim ... I guess she had some people in the family with mental health schizophrenia, and she was experiencing some sort of crazy episode, just super manic. And this one officer went in there to kind of make sure she doesn't leave or touch anything in the bedroom, and then all of a sudden, you know that he's just a type of guy, like, this is not the guy you want to be in a bedroom with ... anyway, she was in there and she started screaming, and then I go in there, and I'm not saying I'm the best, but I gave her just this big hug, and then she laid down in my lap, and I rubbed her hair like...I'm not saying I'm the best, but I wasn't that guy.

CRT officers described their lived experience as a complex combination of empathy, exhaustion, and program/systemic limitations. Participants overwhelmingly value the presence of professional mental health support, they also recognize the void on the days or during the shifts when the CRT counselors are not available, the unclear roll expectations, and the mental drain of repeated exposure to acute psychiatric distress. Participant observations highlight a concern for colleagues without CRT access and frustration with personnel incompatibility that can undermine the goals of the program. Officers describe moments of profound human connection alongside instances of professional discord, underscoring the need for better training, supervision, and community resources to sustain the CRT's impact. These insights offer a nuanced understanding of what it truly means to serve on the front lines of mental health crisis intervention.

Safety and Protection of Counselors

Participants emphasized that officer safety remained a top priority, particularly when responding to volatile or unpredictable situations. Several shared stories of near misses or incidents in which rapid decision-making prevented harm to themselves or others. Each participant described safety measures taken to ensure the specific safety of their counselor, as that is an additional responsibility for them. Having a partner who is riding around with the officer but does not have the same training or equipment available as the officer provides a different set of mental hoops for the officer to jump through. Having a civilian partner also changes the types of calls that an officer can respond to that day and has changed over the development of the CRT program. For example, CRTs used to be allowed to serve warrants when they were not responding to mental health calls, but now that is not permitted because of the increased risk potential for the officer and the counselor. The counselor is not armed and is not allowed to engage in hands-on defense, which increases the risk for the officer who must protect themselves as well as the counselor. For some counselors it is tempting to want to “run and gun” with the officers with all the lights and sirens, but the added safety measures an officer must take may have the potential for more risk than reward. It is important for CRT officers to understand the roll expectations of the CRT and ensure the safety of all involved.

Participants described their mindset around their counselor and scene safety along with different steps they have taken to creatively work around the dangers of the situation to still provide the PMI with the mental health support that they need in that moment.

P3: "I always joke that I'm basically the counselor's bodyguard...I'm here in case they try to hurt you (the counselor)."

P5: "I'm her security."

P7: "There's always the safety aspect...but if I'm going to a situation where my counselor could possibly be put at risk, another officer is going to key up and come with me so there's going to be at least a two-officer minimum."

Police are responsible for counselor and scene safety. Generally, if weapons are involved, counselors remain in the car until the weapons are secured (P5). If someone is experiencing psychosis and is being aggressive, the officers will make sure they are restrained or contained somehow before the counselor approaches (P6). P6 also described a situation where he parked three blocks away from the scene and ran to it while the counselor remained in the car because the situation was so volatile. Depending on the location, counselors can remain in a separate room from where the officers and the PMI are and speak to them over the phone (P6). Sometimes, after officers have ensured that there are no weapons available and the scene is safe enough, the counselor will be able to speak with the PMI with the officer standing far enough away for a bit of privacy but close enough to intervene if the PMI becomes aggressive (P7). The officers described having a good partnership with their counselor as helpful because they can both read a scene and have an idea of how safe or unsafe it is and work together to come up with a safe response.

A few officers talked about the eagerness of some counselors to be helpful and involved in tense situations. P3 said of the counselor, "she would get into a pursuit if she

could, she wants to be a part of us. So, it's nice to have someone who gets to see both sides...she tries to be helpful." P1 advises counselors, "Don't get too excited and run into a call." CRT officers observed that sometimes counselors want to run in and help too, but they need to refrain. Do not try to be a hero. P6 shared a situation where it was nice to have the counselor available to use the radio, but the risk of having a civilian involved in the situation was stressful.

"It kind of puts you more on heightened skill, because now it's like, oh crap, now I've got someone with me. I didn't worry about myself. Now I've gotta worry about this person...there was a time when me and a partner (officer) of mine, we were in a full-on fight. We have the dude on the ground. I mean, he was kicking, screaming, and we couldn't get to our radio. So, she (the counselor) had to call for backup which was great on one hand, because she helped us, but at the same time, what if something happens to us? What if I had been by myself and it was just her and then she gets hurt...You have a partner who cannot fight, and that's a horrible thought because she's not gonna help, that's not her job. She can't back you up...but now you have to protect her like any other citizen. But now she's at closer range."

Another concern that P6 brought up was the unpredictability of seemingly simple police responses.

"Or like, what if you do a traffic stop in your car and they start shooting at you and your partner, or if she gets hit? Shit...now the suspect's gone. Now she's dying, right? Like, shit. I'd rather get hit than her, because I get paid more, I get

time off, right? But there's that gymnastic mindset, what do I do? I gotta think about different things...they're not gonna fight. They're not gonna help us fight because then they would be committing a crime."

CRT officer experience is heavily influenced by the endless prioritization of safety, both for themselves and their civilian partners. In contrast to traditional policing, CRT officers must navigate a multifaceted landscape where the presence of an unarmed, nontactical partner introduces a unique set of responsibilities and mental calculations. CRT officers described the need to assess volatile scenes not only for threats to themselves and the PMI, but also for the vulnerability of their counselor, who cannot engage in physical defense and must often remain at a distance until the scene is secured. Participants described themselves as "bodyguards" and "security" for their counselors, highlighting the emotional and tactical weight of protecting someone who is close enough to help but too close to risk. Their lived experience is marked by heightened vigilance, adaptive teamwork, and a constant recalibration of risk, all in service of delivering mental health support without compromising safety. Despite these tensions, participants overwhelmingly valued the collaborative model, noting that it improved outcomes for PMIs and reduced unnecessary arrests. This theme highlights the dual responsibility of ensuring safety while also maintaining a calm environment conducive to de-escalation.

Category 3: Community Engagement

Category 3 explores the themes of community engagement that the CRT officers highlighted throughout their experiences with the CRT program. The themes of community engagement are compassion, humanization, community trust and legitimacy

of the program. The CRT program was born largely out of the broader community demand for more compassionate response to mental health crises. National stories of PMIs dying by cop or being injured have spurred communities to seek and fund programs that address these mental health needs in a different way. The department began a pilot co-response program 5 years ago in response to that demand. Community partnership and the legitimacy of the CRT program are crucial building blocks for a sustainable and effective mental health response.

Compassion and Humanization

Participants shared that early in their career and prior to CIT training, they felt extreme discomfort and helplessness when responding to calls for service for mental health crises. Study participants reported trying to “avoid mental health calls at all costs” (P3), citing lack of training and feeling ill-equipped for the job. As officers they are often called on to “rescue” in a time of crisis and run toward an emergency, but with mental health calls the “suspect” is not a person, it is a person’s mental illness causing chaos within them. P1 said that prior to CIT training, “you go to calls and you feel like your hands are tied, but you just have no idea what you’re supposed to do.” Officers also experienced a feeling of helplessness when listening to a person’s delusions or hallucinations. Officers are trained to deal with the facts of the situation, but when dealing with an altered sense of reality that cannot be reasoned against, officers feel ill-equipped to respond in a helpful manner. P4 shared a story about how even with the CIT training there are some calls where the CRT is just helpless to comfort or help someone.

“Just severe delusions. He was hearing things and seeing things on his video, like his Ring camera video and stuff like that. And it just wasn’t there. I mean, he was hearing thunder on it, and he’s like yeah, it’s people like banging, like trying to break into my house. And he was just horrified. I mean he was so scared to be there. He was begging us not to leave. And it’s he was like, trying to pay some dude, like 80 bucks an hour, or something crazy like that, looking up security companies, or like 500 for the night for someone to stay outside his house. Because he was just horrified that people were trying to break into his house and walking through his house as he’s showing us stuff, there’s like his stairwell is barricaded. So, like, when he goes to bed, he barricades a stairwell so he can hear if someone’s coming up his stairs. But shows like a Ring. Shows us a Ring camera video of like his hallway, and like his automatic dog feeder would go off, and he’s like, it only goes off for motion, so someone had to walk in front of it. And it’s like, but do you see anyone? And he’s like, no, but there’s no other way it goes off. So, someone had to have been there, and you just can’t see him. And I’m like, you can see this whole hallway from this and he’d be like, yeah. And then he’d go right back to it, like, you’d kind of breakthrough, and he’d go right back to it, and then, like, it’d be thundering or lightning outside his house, and he’d see, like, the lightning hit on his Ring camera, and it would change the color, like the saturation, for a second. And he’d be like, yeah, that’s people, like covering it up. And he’s like, don’t you hear you can hear him, like, talkin in the woods, and it’s like rain hitting his roof, and he would bring that up to him and

not feed into his illusion. Be like, he's like, you hear it, and it's like, no, I just hear rain hitting your roof. And he'd be like, well, yeah, but I think it's people talking and it's like, I disagree. I understand that you think that, but I disagree. And he just wouldn't have it. And I mean, there was genuinely nothing we could do. He had appointments set up. He wasn't dangerous. He wasn't, you know, 0-4-able. But he was just so scared. And it just felt horrible to just be like, well, there's nothing else that we can do" (P4).

Additionally, officers are accustomed to going from call to call, solving problems and restoring order, but feel stumped at a mental health crisis because there is nothing there to be "fixed" or "solved." Officers are confronted with the limitations of their own humanity as well with the mental fatigue that comes from experiencing a person's split from reality and from the knowledge that many mental illnesses simply cannot be fixed by a CRT. P7 described a family with a son who would frequently have severe Autistic meltdowns. The CRT was called many times in response to these situations. P7 became familiar with the family and attempted to make referrals to more appropriate care than a police response. P1 said that "as officers, we're the ones that people call. They have no idea what's going on and they call us. And yeah, sometimes we're like, I don't even know how to help." Participants frequently cited limited community resources and lack of follow-up care as persistent challenges. These systemic issues often undermined the progress made during crisis interventions. This theme shows the challenges of transinstitutionalization and underscores the importance of addressing larger systemic gaps to maximize the impact of CRT programs.

Further mental fatigue is experienced through the hypervigilance CRT officers have regarding scene and counselor safety. Some PMIs can be very volatile and aggressive, with tenuous situations evolving and sometimes devolving over time, requiring officers to always remain on high alert. P1 described a situation where they were responding to a call at a group home for a kid who was making homicidal and suicidal statements. As they spoke with him and tried to assess the situation, things began to escalate and at one point the kids said to P1 “what happens if I take your gun from you?” and looked at another officer and said, “I can take her.” Even as they got him to the hospital he still resisted and fought against his restraints. P1 said it just seemed to go back and forth so much, “is it good? Is it not good?” It was mentally exhausting.

Participants are also aware of the amount of exposure their counselors experience and the mental fatigue that is shared between them. This highlights both the officer and counselor’s humanity by exposing the limits of their compassion, patience, and emotional bandwidth to deal with such intense crises. P3 shared a mentally exhausting story about a woman named Deborah:

“She is often dousing herself in gasoline to stay warm. We get calls on her all the time. She went to police headquarters, and she was telling us that...her corpse has been tampered with. She has been shot in the head. The government is using body doubles of her. She works for the Secret Service. She tried to show me a \$10 bill, and she’s like, do you see that? And I was like, see what? And it was just like scribbles. And she was like, I’ve been in Secret Service for 20 years, something like that. And then she’s like, look in my eyes, they’re all cut up. And I was like,

no, they're not. Like, I got to the point, because a big indicator of these people, they will just talk and talk and talk and talk and talk and talk, and nothing will make sense. It will just be one subject after another. Nothing will relate to each other, and they will just go on and on and on tell stories. And that's how you kind of know. And so, she just stuck out to me because she literally was like, I've been shot in the head. I've been all these things. And I'm like, you are a perfectly put together, well, beside for being homeless, but like, perfectly put together person. And she was saying that she was raped, even though she had not had sexual relations in 20 years."

On a more hopeful note, CRT officers shared the personal benefits they receive by having a professional counselor in the car with them all day long. Participants discussed opportunities they have to talk to someone throughout the day, often about things of a personal nature such as family and friends or hobbies and interests. P4 noted that sometimes it's more comfortable to talk about personal things with someone who is not a cop but still understands cop life. P2 experienced this as well saying that "(the counselor) and I talk about family issues, family things that are going on. Life issues. Somebody that's not an officer, that is a great partner, a great friend. We've become friends." Participants also mentioned being able to debrief with a counselor after an intense call, even calls that were not CRT related. P4 shared that he responded to a call involving a 1-year-old overdose that really hit home with him because he has small children, saying that the counselor was "always willing to talk about it" and joked that the counselor probably did not know that she was signing up for a counseling session with a police

officer instead of a civilian. Many participants commented that they are friends with the counselors outside of work and will call the counselor for personal advice or consult with them about a call.

Early in their careers, many officers described feeling helpless and ill-equipped to handle mental health crises, often avoiding such calls due to a lack of training and clarity. Unlike conventional emergencies, where officers are trained to confront external threats, mental health calls present internal chaos, where the “suspect” is not a criminal but a person battling their own mind. Even with CIT training, officers often face situations where no tactical solution exists, and the limits of their ability to help become painfully clear. These moments of helplessness, compounded by the mental fatigue of hypervigilance and the emotional toll of witnessing severe psychosis or delusion, underscore the complexity of CRT work. Yet, amid the strain, participants reported unexpected support and camaraderie in their embedded counselors who not only assist in crisis management but also offer a space for personal reflection and emotional decompression. This partnership, while challenging, adds a layer of humanity to the role, revealing that the lived experience of CRT officers is not just about managing risk, but about navigating the emotional intersection of human suffering and police work.

Community Trust and Legitimacy

Themes of community trust and legitimacy emerged in the interviews as participants described the impacts they saw as the community experienced the co-response model in comparison to the standard police response. Understandably, there has been distrust and a disconnect with the police and the way interactions with PMIs have

been reported across the nation. This department is seeking to mend that trust by building a legitimate co-response approach to serve and protect some of its most vulnerable citizens. Building trust takes time, and participants hope that the community continues to see their efforts to improve mental health crisis response.

P2 shared that within their precinct people in the community are starting to notice the difference in the CRT response and occasionally call in to request that particular response for their loved one. P2 also shared a story about responding to a mental health crisis and the family was present. It was happening at a strip mall, so there were bystanders watching and taking videos of the officers interacting with the PMI, and the family was advocating for the CRT response by telling the bystanders to stop recording and go away. P5 hopes that the fact that they have a professional counselor riding in the car with them is proof to the community that the police department does care about their loved ones.

P6 thought that the community would appreciate the reduced response times by having a CRT designated specifically for those kinds of calls. By having one officer from each precinct assigned to mental health response, it not only speeds up the response for the mental health crisis, but it also improves response times for other calls because officers are not having to sit for hours with someone waiting on a counselor or mobile crisis to arrive. P7 lists the benefits in this way, “We can assess on scene. We can get people the help they need. We can point them in the right direction or even offer transportation” all of which are benefits of the program that they hope the community recognizes.

Funding and resource availability are always under scrutiny in any department. Participants made several points about the legitimacy of the CRT program and how they hope that the city will continue supporting it through the budget and through resource allocation for training and staffing. Some of the justifications for the CRT program is its improvement of call response time and the way that it frees up other officers to respond to calls elsewhere. P2 said that “in situations where people don’t like the police, they’ll directly start talking to the counselor and you can get a lot of information that way.” The training also provides officers with more confidence and resources with which to respond to these calls for help. It has made CRT officers more confident, thorough, and efficient with their calls even when not assigned to the CRT that day. The CRT program also gets a counselor out in the field and on scene much faster than waiting for mobile crisis or a community mental health agency to respond. It also reduces waiting times at the hospital when someone needs to be committed.

Participants described a noticeable shift in public perception as the CRT model offered a more compassionate, timely, and collaborative approach compared to traditional policing. Officers observed that families and community members increasingly advocate for CRT involvement, recognizing the value of having a professional counselor on scene and the benefits of faster, more specialized responses. This evolving trust is not only reflected in community requests for CRTs but also in the way families defend the model during tense encounters. Officers shared that the presence of a counselor often opens lines of communication that might otherwise be closed, especially in communities wary of law enforcement. The CRT program, while still dependent on sustained funding and

resources, has empowered officers with training and confidence, allowing them to respond more effectively and humanely.

Discrepant Cases

Booth et al. (2023) note that researchers are naturally inclined to seek patterns and continuity in data which is known as the “averaging effect.” Specifically for qualitative research, however, identifying discrepant or disconfirming cases is essential for developing a deeper, more credible understanding of a phenomenon. While no participants in this study explicitly criticized the CRT program, some disclosed experiences that were not universally experienced. Several officers referenced colleagues who were dissatisfied with their CRT roles, however, these individuals declined to participate despite outreach efforts. Although direct accounts of dissenting views were unavailable, the following section presents unique experiences that diverge from the dominant narrative and may reflect exceptions within the broader context.

Wrongful 0-4

One participant described a situation where they felt that someone was involuntarily hospitalized, “0-4’d,” unfairly due to political reasons.

“This girl was wrongfully 0-4’d twice, and it was because one of the supervisors said, you’re 0-4-ing her because she just was harassing (city council). But she wasn’t really harassing them like she was bringing attention like matters or attention to matters to them, and they were just so annoyed by her that they basically like he, I feel like he, he did it in a way that was like, Okay, we’ll put her in the hospital to appease them, but she did not need to be in the hospital,

which then probably ruined we had just gotten better rapport with her, because she hated us police since February, and we went out there, like in May or June, and she started with not even speaking us through the door, to finally coming out and speaking to us. She's like, you guys are cool, like, I like you guys. And then literally, the next day, because we didn't 0-4, he had a different counselor go out there and forced her to 0-4 her. So, then she goes, wrongfully sent to the hospital again, gets released. And I basically told I was like, somebody needs to tell her to sue them, because I would be on board for that lawsuit. Because she was not in crisis. She is not homicidal; she is not suicidal. She is very passionate about certain things that come off as, oh okay somebody who rambles or whatever, but she was like a single mom who was got kicked out of her house and she's trying to get her housing back and it's, it's back and forth, and all these things. And so, I just thought that was wrong for the supervisor to step in and do that when I think they we can all put our trust in our counselors. They're not going to ignore something like that. If she was actually meant to be 0-4'd, they would have 0-4'd her. And so that's the only gripe I've had in the 2 years that I've been doing it."

P3

Officers must often navigate complex ethical tensions, particularly when decisions about involuntary hospitalization intersect with political or administrative influence. This decision to "0-4" someone to appease city officials undermined the rapport the CRT had worked to build. This account highlights the emotional investment CRT officers make in building trust with individuals in crisis and their reliance on

clinical partners to make unbiased, evidence-based decisions. When that trust is compromised, officers may feel powerless and frustrated, revealing a deeper layer of their lived experience: the challenge of advocating for fairness and ethical treatment within a system that can be influenced by external, sometimes political, pressures.

Improvement Recommendation

P8 had two improvement recommendations that differed from the other participants. One was the recommendation to have counselors become certified in tactical emergency casualty care (TECC) so that in the event of a large critical incident, the counselor could carry a medical bag and assist in applying chest seals, tourniquets, and other first aid needs. The other recommendation that P8 had was for the counselors to be given permission and training to drive the police car if the circumstances are warranted. P8 gave the example that when a PMI is transported to the hospital, sometimes the officer has to ride in the ambulance to provide security for the PMI. In that situation, two other officers would need to come to the scene, one to pick up the counselor and take them to the hospital and the other to sit on the empty police car until the officer returns from the hospital or another officer could take it to the hospital or precinct. The suggestion is that if the counselor could drive the police car, they could just follow the ambulance to the hospital and additional officers would not be needed to sit on an empty police car.

Separate Mental Health Response

Another unique topic that was only addressed by one officer in this study is that of an entirely separate mental health first responder program. P6 expressed frustration with increasing responsibilities beyond standard law enforcement, stating that “we’re

stacking so much shit on top that at some point the shit's gotta fall.” Referencing the Standard Operating Procedures (SOP) manual for the department, P6 noted that the SOP is 1700 pages of policy that officers must know and adhere to. The expansion of the CRT creates operational strain and legal tension, raising concerns about liability and job security. P6 values rapid, competent response to mental health crises and proposed a separate mental health emergency branch, like fire, EMS or DCS, might better serve the community. The new department could have their own uniforms, vehicles, and SOPs that are specific and relevant to mental health needs. They could even have their own specially trained officers, like hospitals and university campuses do. While this new department would have similar challenges such as potential burnout and resource limitations, this perspective reflects a desire for structural reform that could improve efficiency and safety in responding to mental health crises.

Right Fit of the Counselor

Many participants noted that there were CRT officers whose personality did not align well with the CRT program. In a similar vein, P8 described a situation where the fit of the counselor was not right for the CRT program. P8 described unprofessional comments from the CRT counselor that crossed the line professionally and personally for this officer. Additionally, P8 described two separate occasions where they responded to a mental health crisis call with this same counselor and the counselor did not engage or attempt to assist with de-escalation at all. The second time struck a personal nerve for the officer because the PMI was someone struggling with Autism and the officer has a sibling with Autism. The way that the counselor interacted with the PMI was severely

lacking, according to the officer, and the officer felt they could have done a better job than the counselor de-escalating the situation. At that point, the officer said, it made things more complicated to have the counselor along and that defeats the point of the CRT program. This is in line with what Shefner et al. (2023) described when they noted that the fit of the counselor is also a very important variable in the success of any CRT program.

Summary

This chapter presented a comprehensive analysis of law enforcement officers' experiences serving on CRTs. Themes revealed a nuanced portrait of the CRT role, encompassing ambiguity, emotional labor, collaboration, safety considerations, professional growth, systemic barriers, and recommendations for improvement. These findings contribute to the growing literature on co-response models and highlight the importance of including officer perspectives in program development. Chapter 5 will interpret these results, discuss their theoretical and practical implications, and offer recommendations for future research and policy development.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative study was to learn about the lived experiences of law enforcement officers who are assigned to CRTs. To obtain this information, I conducted eight semistructured interviews with CRT officers who have been serving in this capacity for 6 months or more. I asked the participants about their experiences as CRT officers, including questions about how their mindsets may have changed in regard to mental illness and responding to mental health crisis calls, how the experiences have impacted their views on policing, and what recommendations or improvements they think would enhance the program. Through thematic analysis, three overarching themes and 10 subthemes emerged:

1. Professional development
 - a. Evolution of understanding
 - b. Flexibility and discretion in response
 - c. Holistic crisis understanding
 - d. Importance of CIT training and role modeling
 - e. Personal connection and storytelling
2. Operational dynamics
 - a. Role clarity and collaboration
 - b. Operational constraints and recommendations
 - c. Safety and protection of counselors
3. Community engagement

- a. Compassion and humanization
- b. Community trust and legitimacy

Interpretation of the Findings

This section interprets the findings from Chapter 4 in relation to the existing literature and theoretical framework. The goal is to explore how lived experiences of law enforcement officers assigned to CRTs confirm, challenge, or extend current knowledge in the field of mental health crisis response. These interpretations are organized around three themes: professional development, operational dynamics, and community engagement.

Category 1: Professional Development

A prominent theme that emerged from this study was the evolution of officers' perceptions of the CRT model over time. This finding is partially consistent with Plassmeyer et al. (2024) who reported a statistically significant improvement in law enforcement attitudes toward CRTs following a pilot program. Most participants in the present study described initial skepticism, particularly regarding the value of CIT training and the presence of civilian mental health professionals in the patrol car. However, after gaining practical experience and developing working relationships with counselors, many participants reported increased confidence and a more favorable view of the program. This shift underscores the importance of experiential learning and suggests that early resistance may be mitigated through a clearer explanation of the program and expectations of the officer from the very beginning. Those who remained skeptical of the CRT program wrestled with the question of appropriate police involvement in mental

health crisis response in general. They acknowledged that involvement is inevitable at this time but are curious about what a separate mental health crisis response department would look like instead of incorporating it into police work, similar to the findings of Fisher et al. (2024) and Shefner et al. (2023).

This finding aligns with Plassmeyer et al. (2024), who found increased officer endorsement of CRT benefit after operational exposure. Fisher et al. (2024) similarly noted that officers initially skeptical became supportive once they experienced CRT advantage in real time. My findings extend these conclusions by showing HOW that shift happens—through increased empathy and perceived skill mastery.

In terms of operational flexibility, officers noted that CRTs enabled more efficient and tailored responses to mental health-related calls. This observation supports the findings of Kuehl et al. (2024a) who documented reduced call times and enhanced safety outcomes for PMIs. Officers in this study attributed these improvements to the presence of trained mental health professionals who could assess and manage crisis on scene.

Another key insight was the development of a more holistic understanding of mental health crisis. Prior to CRT involvement, many officers reported feeling unprepared and emotionally burdened by such calls, a sentiment which was echoed in Kuehl et al. (2023) where officers described dread and frustration when responding to mental health emergencies. Participants in this study similarly described a shift from apprehension to competence and even enthusiasm to respond to mental health calls, suggesting that CRTs may alleviate role strain and enhance officers' sense of efficacy.

Finally, the influence of CIT training and peer modeling emerged as a significant factor. Several participants noted that their approach to mental health calls when not a part of the CRT had improved because of their training and experience. This finding extends the work of Blais et al. (2020) and Semple et al. (2020) who identified a “contamination effect” in which non-CIT-trained officers learned from their interactions with CRT officers and adjusted their call responses accordingly before they ever received the CIT training. In this study, officers identified a personal improvement in the way they responded to mental health calls even on days they were not a part of the CRT.

Category 2: Operational Dynamics

The findings also provide insight into the operational functioning of CRTs. Role clarity and collaboration were consistently identified as essential to program success. Officers and counselors were seen as bringing complementary skill sets to the scene, with officers ensuring scene safety and counselors providing clinical expertise and assessment. This confirms earlier findings by Fisher et al. (2024) and Shefner et al. (2023) who emphasized the importance of clearly defined roles in co-response models.

These results are also consistent with Kuehl et al. (2023), who reported that conflicting policies and workflow between agencies were a primary operational barrier. Robertson et al. (2019) also identified agency coordination as a central enabling or disabling factor. My findings add to this body of knowledge by showing the unique emotional burden officers experience when the operational system does not match their on-scene reality.

Participants expressed high regard for the communication and de-escalation skills of their counselor partners in contrast with the findings of Plassmeyer (2025) who identified trust between the counselor and officer as a power struggle at times. Additionally, a minority of participants in the current study reported occasional mismatches in counselor fit, citing instances of poor engagement or inappropriate and unprofessional interactions. These outliers highlight the need for careful selection, training, and supervision of mental health professionals assigned to CRTs. Participants also noted that the fit of the officer for a CRT role is also an important consideration, as some officers do not have an interest or the appropriate empathy to reasonably respond to mental health crisis calls.

Staffing limitations and CRT program availability were also recurrent concerns. Officers strongly advocated for 24/7 CRT coverage, a recommendation that aligns with nearly all the literature on co-response models (Blais et al., 2020; Fisher et al., 2024; Kuehl et al., 2024a; Kuehl et al., 2024b; Plassmeyer et al., 2024; Robertson et al., 2019; Shefner et al., 2023). Participants noted that without consistent coverage the benefits of the program are diminished, and officers are left to manage complex calls without adequate support on-scene. This often results in officers having to wait an hour or more for the community mental health crisis response counselor to arrive.

Another operational consideration was the safety and liability associated with transporting civilian counselors in patrol cars. Officers described a heightened sense of responsibility for their partners' well-being, often modifying their behavior and carefully selecting what calls to respond to in order to ensure safety. This finding aligns with the

work of Wood and Anderson (2023) and Plassmeyer (2025) who observed that officers often feel personally accountable for the safety of CRT counselors. Participants described this shift as a fundamental change in mindset, requiring different situational awareness and restraint.

Category 3: Community Engagement

The final category of interpretation centers on the impact of CRTs on community relationships. Officers reported a noticeable increase in empathy and compassion toward PMIs. This humanization of PMIs suggests that CRTs may contribute to a broader cultural shift within policing, fostering more trauma-informed and person-centered care. This directly reinforces Kuehl et al. (2024b), who found that PMIs and families experienced CRT encounters as more respectful and less stigmatizing than police-only response. Officers in my study described parallel shifts in their own perception of community interaction. Thus, both sides of the interaction (officer and PMI) converge in acknowledging CRTs as a more humanizing model.

Participants discussed the role of CRTs in enhancing community trust and legitimacy. While they believed the program improved public perception of law enforcement, they also acknowledged that its effectiveness is contingent upon the availability of community-based mental health resources. This finding is consistent with Kuehl et al. (2023) and Stauss et al. (2023) who noted that systemic gaps in care often undermine the long-term success of crisis interventions. Unlike the departments that Kuehl et al. (2023) and Stauss et al. (2023) studied, the officers in this study acknowledged that the community mental health services in this jurisdiction provide

quality short term care, but better quality and more readily available long-term care is still needed.

Moreover, these findings support the need for community mental health care to prevent continued transinstitutionalization of PMIs (Bailey et al., 2022; Blais et al., 2020; Fisher et al., 2024; Kuehl et al., 2024a; Kuehl et al., 2024b; Robertson et al., 2019; Semple et al., 2020; Shefner et al., 2023; Wood & Anderson, 2023). Officers recognize that CRTs are not a comprehensive solution to the mental health crisis, but rather a stopgap measure in the absence of robust community infrastructure. Without adequate housing, treatment, and follow-up services, individuals in crisis are likely to re-enter the system or worse, enter the judicial system, perpetuating a cycle of instability.

Theoretical Interpretation: Transactional Theory of Stress, Appraisal, and Coping

The findings of this study align closely with Lazarus and Folkman's (1984) Transactional Theory of Stress, Appraisal, and Coping which conceptualizes stress as a dynamic process involving the individual's evaluation (appraisal) of a situation and their perceived ability to cope with it. This framework provides a useful lens for understanding how law enforcement officers assigned to CRTs experience and adapt to the demands of mental health crisis response.

Primary and Secondary Appraisal

According to Lazarus and Folkman (1984) individuals engage in primary appraisal to determine whether a situation poses a threat, challenge, or harm/loss, and in secondary appraisal, to assess their available coping resources. Prior to CIT training and CRT involvement, many officers in this study appraised mental health calls as

threatening or overwhelming. Participants described feelings of dread, avoidance, and helplessness, responses that reflect a perception of high demands and insufficient resources. These appraisals often lead to stress that had a detrimental effect on performance, consistent with Lazarus's (1981) assertion that stress can impair accuracy, increase distraction, and reduce effectiveness.

However, after receiving CIT training and gaining experience on CRTs, officers' appraisals shifted. They began to view mental health calls as manageable challenges rather than threats. This reappraisal was accompanied by increased confidence, improved communication strategies, and a greater sense of preparedness. In line with Lazarus (1981) this shift in appraisal resulted in stress that enhanced performance, officers became more efficient, more empathetic, and more capable of navigating complex calls. This evolution supports the theory's proposition that stress can have a positive, performance-enhancing effect when individuals perceive themselves as adequately resourced.

Coping Strategies

The findings also illustrate the use of both problem-focused and emotion-focused coping strategies as described by Lazarus and Folkman (1984, 1986). Officers employed problem-focused coping when they believed a situation could be improved through action, such as using de-escalation techniques, collaborating with counselors, or advocating for hospital transport. These strategies were particularly evident in calls when officers felt they could directly influence the outcome. Over time, many participants reported that the new responses they learned from training and experience became more

automatic and intuitive, reflecting Lazarus and Folkman's (1984) assertion that appraisal and coping can become a learned and routinized skill. In contrast, emotion-focused coping emerged in situations where the outcome was largely outside the officer's control, such as when community resources were lacking or when individuals refused services. In these cases, officers described relying on informal debriefing with counselors, reframing the situation, or drawing on personal values to manage emotional strain.

Training as a Resource

The combined role of CIT training and CRT experience in shaping officers' appraisal and coping responses is particularly noteworthy. Lazarus and Alfert (1964) emphasized that stress can be mitigated when individuals are prepared in advance for the demands they will face. In this study training, role-playing exercises and field experiences were cited as critical resources that helped officers anticipate and manage the stressors associated with mental health calls. These preparatory experiences increased officers' perceived control of the situation and reduced the likelihood of appraising calls as threatening. It is important to note that officers believed that CIT training on its own was not sufficient to feel prepared to answer mental health calls. The CIT training combined with field experience with the CRT counselor is what was believed to have made the biggest impact on CRT officer's confidence.

Demands, Resources, and Meaning-Making

Finally, the findings support the theory's emphasis on the relationship between demands and resources. Officers who perceive a balance between the two were more likely to appraise calls as challenges rather than threats. This balance also facilitated

meaning-making, as officers began to see their role in CRTs not just as a job requirement, but as a meaningful contribution to community well-being. In some cases, officers expressed a sense of moral responsibility, particularly when responding to vulnerable populations such as youth in group homes, individuals with developmental disabilities, or people experiencing a suicidal crisis. These reflections suggest that appraisal is not only cognitive but also deeply value driven.

Limitations of the Study

While this study provides meaningful insights into the lived experiences of law enforcement officers assigned to CRTs, several limitations must be acknowledged. First, the study utilized a purposive sample of officers from a single geographic region. Although this approach is appropriate for qualitative research, it limits the transferability of findings to other jurisdictions or departments with different organizational cultures, community dynamics, and available resources.

Second, participants were self-selected, which may have introduced self-selection bias. Officers who volunteered to participate may have held more favorable views of the CRT model or had more positive experiences than those who declined. Officers with a less favorable view of the CRT program were contacted for participation through the snowball method, but they declined to participate. As a result, the findings may reflect a more optimistic portrayal of CRTs than is representative of all officers involved in such programs.

Third, the study focused exclusively on the perspectives of law enforcement officers. While this lens was intentional and aligned with the research question, it

excluded the voices of other key stakeholders such as supervisors, mental health professionals, dispatchers, PMIs and their families. Other researchers have studied these stakeholders, but including these perspectives in this study could have provided a more comprehensive understanding of CRT operations and outcomes.

Finally, of the eight participants in this study five identified as female. This ratio of female to male participants does not accurately reflect the female to male ratio of the whole department or even the CRT roster. It is possible that having a more representative sample of participants may have yielded different experiences and perceptions of the CRT program therefore the results of this study may not be transferable to all CRT officers.

Recommendations for Future Research

Based on the strengths and limitations of the current study, the following recommendations are offered for future research:

First, broaden participant diversity. Future studies should include a more diverse sample of officers across multiple jurisdictions, including rural, suburban, and urban departments. Comparative studies could enhance the transferability of findings and identify contextual factors that influence CRT implementation and effectiveness.

Second, incorporate multiple stakeholder perspectives. To develop a more holistic understanding of CRTs, future research should include the perspectives of supervisors, mental health clinicians, dispatchers, PMIs, and their families. Multiperspective studies could illuminate areas of alignment and divergence in how CRTs are experienced and evaluated.

Third, conduct longitudinal research. Longitudinal studies could explore how officers' perceptions, coping strategies, and professional identities evolve over time. Such research would build on the current study's findings related to stress, appraisal, and professional development.

Fourth, examine training and preparedness. Given the significance of CIT training combined with experiential learning in shaping officers' approach to mental health calls, future research should investigate which specific training components are most effective in shifting officers' appraisals from threat to challenge, as described in the Transactional Theory of Stress, Appraisal, and Coping (Lazarus & Folkman, 1984).

Finally, organizational and systemic influences. Additional research is needed to examine how organizational culture, leadership support, and interagency collaboration affect the sustainability and perceived success of CRTs. While these factors were noted by participants, they were not the primary focus of this study.

Implications

The findings of this study have several important implications for research, practice, and social change. By exploring the lived experiences of law enforcement officers assigned to CRTs, this study contributes to a deeper understanding of how officers perceive, adapt to, and are impacted by collaborative mental health crisis response models. These implications are discussed below in terms of methodological, theoretical, and empirical contributions as well as practical applications and potential for positive social change.

Methodological Implications

This study demonstrates the value of qualitative inquiry in capturing the nuanced, evolving experiences of officers engaged in CRT work. The use of in-depth interviews allowed for the exploration of complex emotional, cognitive, and relational dynamics that would be difficult to capture through quantitative methods alone. Future research may benefit from employing similar qualitative approaches, particularly phenomenological or narrative designs, to further explore the subjective experiences of officers, counselors, and other stakeholders involved in co-response models.

Theoretical Implications

The findings support and extend Lazarus and Folkman's (1984) Transactional Theory of Stress, Appraisal, and Coping. Officers' shifting appraisals of mental health calls from threat to challenge demonstrate how training and experience can alter stress responses and improve performance. The study also illustrates the interplay between problem-focused and emotion-focused coping strategies in high-stakes, emotionally charged environments. These findings suggest that the theory remains a useful framework for understanding occupational stress and adaptation in law enforcement, particularly in the context of evolving roles and responsibilities.

Empirical Implications

Empirically, this study confirms and builds upon existing research that highlights the benefits of CRTs, including improved officer confidence, reduced call response times, and enhanced community trust. It also adds to the literature by documenting officers' internal transformations, such as increased empathy, improved communication, and a

more nuanced understanding of mental illness, which are less frequently captured in outcome-based evaluations. These findings underscore the importance of examining not only what CRTs do, but how they are experienced by those who implement them.

Recommendations for Practice

Based on the findings, several practical recommendations emerged:

1. Expand CIT and CRT training to include experiential components such as role-playing, scenario-based learning, and reflective debriefing, which were identified as critical to officers' growth and confidence.
2. Ensure consistent staffing and availability of CRTs, particularly during nights and weekends to maximize program effectiveness and reduce officer burnout.
3. Foster strong officer-counselor partnerships by prioritizing interpersonal compatibility and providing opportunities for team-building and mutual feedback.
4. Integrate mental health response training into police academy curriculum (already in place for this department) to prepare officers earlier in their careers for the demands of CRT work.
5. Consider a selection process for officers who are assigned to CRTs.

Participants acknowledged that the CIT training is good for all staff, but not all officers have the passion or personality to participate well on a CRT.

6. Increase counselor training to include medical/First Aid training so that counselors can carry medical bags and assist with chest seals and tourniquets as needed in emergencies.

7. Conduct a cost-benefit analysis to determine if it is reasonable to train counselors to drive patrol cars, but only on rare occasions like following an ambulance to the hospital.

These recommendations are grounded in the lived experiences of participants and are intended to enhance the effectiveness, sustainability, and human-centered nature of CRT programs.

Implications for Positive Social Change

This study also holds implications for positive social change at multiple levels. At the individual level officers reported increased empathy, emotional intelligence, and job satisfaction because of CRT participation. These personal transformations may lead to more compassionate and effective interactions with individuals in crisis, reducing the likelihood of escalation and harm. Officers reported developing deep friendships with their counselors, often sharing personal concerns and worries with one another.

On a family level, officers who feel more supported and less emotionally burdened by their work may experience improved well-being at home, potentially reducing the secondary stress experienced by their families. Additionally, a change in mindset regarding mental illness may have a positive effect on how officers interact with friends and family members who suffer with mental health challenges.

On an organizational level, law enforcement agencies that adopt CRT models may benefit from improved morale, reduced liability, and enhanced public trust. These outcomes can contribute to a healthier organizational culture and more sustainable

policing practices. Agencies may also benefit from reduced call times, more efficient use of officer time and resources, and decreased number of arrests for PMIs.

On a societal/policy level the findings support the continued investment in and expansion of co-response models as a means of addressing the intersection of mental health and public safety. By demonstrating that officers can adapt to and embrace collaborative, nonpunitive approaches, this study contributes to ongoing policy discussions about the role of police in mental health crisis response. Several officers in this study advocated for the continued development and expansion of the CRT program and hope that department and community funding and support will continue.

Importantly, these implications remain within the boundaries of the current study, which focused specifically on the experiences of law enforcement officers. While the findings suggest potential benefits for other stakeholders and systems, further research is needed to explore those perspectives directly.

Conclusion

This study examined the lived experiences of law enforcement officers assigned to CRTs who respond to mental health crises. Through in-depth, semistructured interviews, participants shared how their perceptions, practices, and professional identities have evolved through their involvement in CRT work. The findings revealed that officers who initially felt uncertain or unprepared for mental health-related calls developed greater confidence, empathy, and clarity in their roles because of training, collaboration with mental health professionals, and repeated field experience.

The CRT model, as described by participants, offers more than an operational alternative to traditional policing. It represents a shift in how officers approach individuals in crisis moving from a reactive, enforcement-based mindset to one that prioritizes safety, dignity, and connection to care. Officers consistently emphasized the value of having a trained mental health clinician on scene, not only for the benefit of the person in crisis but also for their own professional development and emotional well-being.

At the same time, participants identified several challenges that limit the full potential of CRTs, including inconsistent program availability, staffing shortages, and gaps in community mental health infrastructure. Officers also noted that not all personnel are well-suited for CRT work, and that both officer and counselor fit are critical to the success of the model. These insights underscore the importance of thoughtful program design, adequate training, and sustained investment in both law enforcement and mental health systems.

Framed within Lazarus and Folkman's Transactional Theory of Stress, Appraisal, and Coping, the findings illustrate how officers' appraisals of mental health calls shifted from threat to challenge as their resources and confidence increased. This theoretical lens helps explain how CRT participation can transform stress into an opportunity for growth, skill development, and more effective crisis response.

Ultimately, this study affirms that when law enforcement and mental health professionals work together with mutual respect and shared purpose, they can provide a more humane and effective response to individuals in crisis. The voices of CRT officers

are often absent from academic literature but offer valuable guidance for future program development, training, and policy. Their experiences highlight the need for continued collaboration, structural support, and a commitment to compassionate, community-centered policing.

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