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Walden University

College of Social and Behavioral Sciences

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Monique Allen

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Walden University

2018

Abstract

Crisis Intervention Team Training Among CIT-Trained Police Officers

by

Monique Allen

MS/AJS, University of Phoenix, 2016

MIS, University of Phoenix, 2014

BSIT/NTC, University of Phoenix, 2013

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Criminal Justice Program—Emergency Management

Walden University

August 2018

Abstract

The problem addressed in this phenomenological study was the lack of documentation that supported the lived experiences of crisis intervention team (CIT) trained police officers related to their encounters with persons with mental illnesses (PwMI). The purpose of the study was to explore the lived experiences of officers among CIT-trained police officers to address the problem. Using the Giles's communication accommodation theory and Rogers's protection motivation theory (PMT), the purpose of this study was to examine the perceptions of CIT-trained police officers of PwMI during CIT encounters. Rogers's PMT was aligned closest with the teachings of CIT training as described by the study's participants. Participants provided data which was comprised of completed questionnaires and transcribed interviews. The method of analysis used was a combination of inductive coding and theme analysis that established the results of this study. Key findings of the study identified a significant amount of frustration expressed in the lived experiences of the CIT-trained police officers. Pushback from the public mental health facilities helped with the frustration experienced by CIT-trained police officers who applied the fundamentals of PMT and attempted to navigate treatment with the limited resources available to help PwMI in crisis. The positive social change produced from this study includes recommendations to police leadership and mental health advocates to encourage certain CIT training-related practices that directly impact CIT field encounters with PwMI in crisis. Specialized training may promote improved departmental outcomes, assist with injury reductions, and enable police officer accountability and reliability.

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Dedication

I dedicate this dissertation to my family and the Universe who supported me with patience and joy throughout my journey to earn a doctoral degree. My children remained encouraging and understanding when I needed to concentrate and focus on our greater good. My doctoral degree belongs to me and my family. To my daughter, Miyoko Allen. She inspires me on a daily basis to be the best parent I can be to her. To my son, Kesean Culclager. He reminds me of my independent spirit with his desire to achieve greatness. Both of my children keep me grounded in unconditional love.

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To my daughter, Miyoko Allen, who continues to show great promise in her craft and impresses me on a daily basis.

To my son, Kesean Culclager, who continues to grow into his own talents and purpose that emulate success and happiness.

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Chapter 1: Introduction to the Study

In the 21st century, an estimated 1.5% of the U.S. population (3.9 million people) with severe mental illnesses receive no psychiatric treatment (Brown, 2015; Smith, 2012). Thus, the chances of police encounters with persons with a mental illness (PwMI) during daily duties are high. The impact of crisis intervention team (CIT) training among police officers in Contra Costa County, California was the topic of this study. Contra Costa County is one of only 17 counties in the state with an assisted outpatient treatment (AOT) program (California Crisis Intervention Training Association [CACITA], 2017). This study is important since it involved the exploration of CIT officer perceptions after being CIT-trained. A review of the literature has indicated that CIT training positively affects the outcomes for persons with mental illnesses (PwMI) in crisis such as reduced incarceration, arrests, and hospital stays (CACITA, 2017; California Institute for Behavioral Health Solutions [CIBHS], 2015; Dupont, Cochran, & Pillsbury, 2007; Rodriguez, 2016; Shapiro et al., 2015; Slade et al., 2012; Weller, 2015; Wells & Schafer, 2006).

CIT objectives only work by securing a top-down buy-in to sustain the mental health network collaboration such as AOT programs (Compton et al., 2014; Kohrt et al., 2015; Munetz, Morrison, Krake, Young, & Woody, 2006; Steadman et al., 2001; Teller, Munetz, Gil, & Ritter, 2006; Watson & Fulambarker, 2012). Further studies have demonstrated that CIT officers' awareness and knowledge of mental illnesses increased (Compton et al., 2014; Cross et al., 2014; Ellis, 2014; Khalsa, Denes, Pasini-Hill,

Santelli, & Baldessarini, 2017). In complement, the study's potential social implication supported tracking CIT related field encounters to help with the standardization of CIT-trained officer responses.

Chapter 1 entails an overview of the study and the background concerning American policing of PwMI. The problem statement indicated the lack of knowledge about the impact of CIT training on CIT-trained officers' perceptions during encounters with PwMI. The purpose of the study, research question, limitations of the study, and implications for social change ensue. I conclude Chapter 1 with the definitions of terms, theoretical foundation, nature of the study, significance of the study, and the Chapter summary.

Background of the Study

CIT training is a relatively new response for officers encountering PwMI in the field. Approximately 10% of all police contacts with the public involved PwMI (Deane, Steadman, Borum, Veysey, & Morrissey, 1999; Weller, 2015). Correctional officer and jail personnel do not prescribe psychiatric medications nor supply sufficient mental health care for PwMI and upon incarceration. Incarcerated PwMI detainees did not routinely receive adequate treatment (Council of State Governments, 2002; National GAINS Center, 2002; Wells & Schafer, 2006). Therefore, CIT training helps reroute PwMI away from the criminal justice process. Perception changes among police officers are necessary for effective participation with the new response. Rodriguez (2016) revealed that police officers' attitudes toward PwMI continued to be unfavorable, yet officers accepted working with PwMI as a vital job function. Campbell (2012) indicated

that police officers continued to perform community policing activities including new problem-solving strategies that improve quality of life. Thus, CIT-trained officers contribute to the longevity and quality of life for PwMI.

Collaborations with local mental health networks should consist of proper referrals for PwMI in crisis. Without that proper training, PwMI encounters in the field could result in tragic outcomes (Ruiz, 1993; Ruiz & Miller, 2004; Watson & Fulambarker, 2012; Weller, 2015). Additionally, Steadman et al. (2000) suggested that a designated mental health triage for police encounters with PwMI as an extension of criminal diversion programs. To this end, the state and local response to criminal diversion programs for PwMI includes psychiatric hospitals, mental health and behavioral courts, and outreach programs.

However, a lack of contribution by mental health collaboration networks can thwart the objectives of CIT training. Officers expressed concern with the inaccessibility to mental health services and inadequate community-based referral options (Borum, Williams Deane, Steadman, & Morrissey, 1998; Cooper, McLearen, & Zapf, 2004; Dupont & Cochran, 2000; Finn & Sullivan, 1989; Perkins, Cordner, & Scarborough, 1999; Wells & Schafer, 2006). Officers who responded to psychiatric emergencies demonstrated a desire to learn and appreciated additional mental health crisis resources (Dew & Badger, 1999; Rodriguez, 2016). Knowledge is lacking about the ways CIT training impacts police officer perceptions of PwMI. Therefore, this study was needed since successful interventions should provide a sustainability of gains that behooves the PwMI and increases life longevity.

Blevins, Lord, and Bjerregaard (2014) discussed the need to collect field data that corresponded to mental-health-related incidents that involved CIT-trained officers and the beneficial effect of pairing law enforcement and mental health agencies on encounters. Brown (2015) examined how officers could ensure an outcome of decriminalization that included a reduced stigmatization of mental illness, even with a lack of available mental health treatment. With respect to the length of CIT training, Rodriguez (2016) elaborated on the sufficiency of 24 hours of CIT training on San Diego police officers and claimed the 40-hour standard training was not necessary for encounters with PwMI. Researchers at the CIBHS (2015) noted the need for consistency in CIT training for police officers in California and described the required structure for encounters with PwMI that involved the best practices for the current CIT training curriculum. Equally concerned, Weller (2015) reported that the need for improvement of San Francisco CIT police officers' dispositions and referral codes that could be initiated by removing any ambiguity for mental health-related call closures.

Statement of the Problem

As noted, an estimated 1.5% of the U.S. population (3.9 million people) with severe mental illnesses have received no psychiatric treatment (Brown, 2015; Smith, 2012). Thus, the chances of police encounters with PwMI during daily duties are high. The problem addressed in this study was the lack of knowledge on how CIT training impacts police officers' perceptions of PwMI. Therefore, my study involved an attempt to build upon the study by Rodriguez (2016) to explore the gap of knowledge regarding the increase in officers' knowledge of mental illness after CIT training. I addressed the gap in

literature (Blevins et al., 2014; Rodriguez, 2016; Weller, 2015) where researchers of reintegrated studies have identified the need for structured CIT training for police officers. This study's research spoke to the gap concerning referrals with dispositions for CIT encounters by CIT-trained officers (see Weller, 2015). Finally, I addressed the gap in literature as indicated by the lack of data to support the impact on officer perceptions of PwMI once CIT-trained in Northern California.

Purpose of the Study

The purpose of this qualitative study was to explore perceptions among CIT-trained police officers in Northern California. The qualitative interviews involved exploring the shared lived experiences of CIT-trained officers regarding CIT training. This empirical study provided original contributions to law enforcement and mental health network collaborations. Findings may further validate the impact of CIT training, as the study revealed officers with improved perceptions of PwMI. Therefore, exploring the topic of CIT training led to an in-depth discussion about the elevated thought process police officers had toward PwMI. This study provided police organizations with global implications and with the information needed to make informed decisions in reference to tracking the outcomes of CIT encounters.

The information communicated through my study provided insight for police departments that implement CIT training, CIT trainers and CIT curriculum coordinators alike. Finally, my study informed CIT-trained police officers who encounter PwMI about increases in officer awareness, which may provide law enforcement agents ways to influence a procedure that reflects a standardized enhanced response concerning CIT

field encounters. Moreover, I suggested a standardized method of communication that reflects learned responses that encouraged common dispositions, de-escalation tactics, and referrals of CIT incidents. Improved communication strategies included referrals to the appropriate methods of treatment, such as outreach programs and psychiatric institutions.

Research Question

In this qualitative study, I attempted to understand officer perceptions among CIT-trained police officers in Northern California. Brown (2015) noted that researchers of outcome studies had indicated that CIT had been effective in decreasing injuries to PwMI, increasing transport to community mental health providers, and reducing jail suicides. My study included the following overarching question: How do officers' perceptions improve based on CIT training when encountering PwMI?

Theoretical Framework of the Study

The theoretical framework in this empirical study was trifold. Using a trifold approach worked best, as it demonstrated the evolution of police officer perceptions toward PwMI. To this end, the first theory, Van Maanen's (1978) asshole theory, provides a valuable context of officers' interpretation of misfits. Initially, the reaction was to enforce street justice to persons who did not meet the criterion of normalcy during the 70s. Thus, improving the swift and violent reaction and transforming it into a polished response requires supplemental treatment. As the first evolution to the asshole theory, Giles's 1973 communication accommodation theory (CAT), also known as the perception theory, referred to communicative behavior such as motivation and

consequences (Giles, 2007). The focus of the CAT was on improved cognitive responses by officers gained through the lens of enhanced perception. Researchers of the CAT predicted and explained many of the communicative modifications individuals made in creating, maintaining, or decreasing social distance in interactions (Giles & Ogay, 2007; Kwon, 2012). This study included an elaboration on CIT strategic communication training to de-escalate PwMI in crisis on scene that could matriculate into an improved officer perception. The more common term used to refer to the constant changing of communicative behavior as a strategy to move toward and away from each other is accommodation (Giles et al., 2006; Kwon, 2012).

Lastly, the protection motivation theory (PMT) represents the current evolution of officers' perceptions and exhibits the maturity level of the response by law enforcement agencies with CIT training. Milne, Sheeran, and Orbell (2000) discussed that Rogers's introduction of the PMT in 1975 in response to fear appeals. That is, the fear appeal of crisis specialty training that engages encounters with erratic-behaving PwMI in the field should reduce the number of volatile incidents per precinct. Chapter 2 includes an elaboration of each theory, where the culmination of each theory established the matriculation of enhanced perceptions that produced formidable results for CIT-trained officers who changed their response to PwMI in crisis. An improved response from a reaction of panic to understanding often saves lives and highlights the evolved perceptions and lived experiences of CIT-trained police officers.

Conceptual Framework of Study

Experiences of change often originate from root phenomena. Zahavi (2003) referred to Husserl's 1910 concept of phenomenology as outdated, as it disregarded the association of empirical consciousness that resulted in knowledge. A century later, and in vast contrast, the term *phenomena* referred to the building blocks of human science and the basis for all knowledge (Newton, 2007; Norlyk & Harder, 2010). The conceptual framework of this study included the shared lived experiences of CIT-trained officers concerning CIT training. The objective of phenomenological research methods was to obtain thorough descriptions of the basis for reflective structural analysis that depicted the essences of a lived experience (Moustakas, 1994; Ravitch & Carl, 2016). The qualitative interviews in my study were suitable for exploring the impact of CIT training on CIT-trained officers, which revealed both positive and negative experiences. For instance, the purpose of phenomenological research was to identify phenomena through the perceptions of the parties involved (Lester, 1999; Ravitch & Carl, 2016). Thus, an empirical phenomenological study was the best design for this study, and a discussion of the conceptual framework appears at length in Chapter 2.

Nature of Study

The nature of my study was qualitative with a phenomenological research design. That is, the focus of the conceptual framework was on the shared lived experiences of CIT-trained officers concerning CIT training. The objective of phenomenological research methods is to obtain thorough descriptions that serve as the basis for reflective structural analysis that depicts the essences of lived experiences (Moustakas, 1994; Ravich & Carl, 2016). Simultaneously, this qualitative research was consistent with

previous studies that addressed CIT police officer field responses. Therefore, keeping the focus on Roger's PMT supported findings of improved officers' perceptions of PwMI (Watson et al., 2010a, 2010b, 2010c). The study involved CIT-trained officer participants who completed a questionnaire and participated in a qualitative interview to increase topic breadth and depth. Unlike statistical studies, the data analysis entailed coding and theme detection by transcribing the interviews. For instance, police officers receive special skills from CIT training that are necessary to respond to PwMI both safely and effectively (Borum et al., 1998; Dean et al., 1999; Steadman et al., 2000; Weller, 2015). This understanding may help guide the extension of a standard method of response, where reports on CIT incidents and outcomes will be available to all participants of the mental health network. This qualitative analysis revealed growth in police officers' perceptions once CIT trained.

Definition of Terms

Conceptual definitions that demarcated the key terms in this study are as follows:

Crisis intervention team training: A specialized police-based program intended to enhance officers' interactions with individuals with mental illnesses (Bahora, Compton, Olivia, & Watson, 2008).

Mental illness: Establishes indisputable evidence that confirms mental illness as a serious public health issue (Keyes, 2005).

Officer perceptions: Decides whether persons with a mental illness influence police officers' perceptions, attitudes, and responses in different situations during encounters (Corrigan, & Ottati, & Watson, 2004).

Psychiatric referrals: Practices by police officers who make direct referrals to community programs using police-based diversion programs (Steadman et al., 2001).

Sustainability of gains: Ascertains emotional well-being that equates to happiness over long periods of time (Lyubomirsky, Schkade, & Sheldon, 2005).

Assumptions

One assumption in the study was that Rogers's PMT provided a reasonable explanation of the research topic and justified the perceptions questionnaire used for data collection. Another assumption was that CIT-trained officers involved in the study understood the questionnaire and provided honest and accurate responses. The third assumption was that the sample sufficiently represented the larger population of crisis-intervention-trained officers in Northern California.

Scope and Delimitations

As noted, the problem under study was the lack of knowledge about how CIT training affects police officers' perceptions of PwMI. The scope of this qualitative empirical phenomenological study included Wells and Schaefer's (2006) officer perceptions questionnaire to explore the impact of CIT training, officers' relationship with mental health clinicians, common dispositions and referrals, and the support of mental health collaborative networks. The questionnaire was in a paper-and-pencil format and included qualitative interview questions. The target population of CIT-trained officers in Contra Costa County, California, defined the study's boundaries. One delimitation was that only CIT-trained officers received invitations to participate in my study. Additionally, I did not include any other psychiatric first responders or members of

any mental health collaborative networks. The findings from this study should be applicable to other CIT populations and CIT encounters.

Limitations

I recognized this study's limitations. The use of a phenomenological design was the first limitation of the study. When researchers do not apply the bracketing process to phenomenological research, they do not suspend personal assumptions or bias from the qualitative study (Gearing, 2004; Ravitch & Carl, 2016). Therefore, I monitored reflexivity and set aside personal bias, which I discuss further in Chapter 3. Another limitation was the use of the Wells and Schafer (2006) questionnaire that led to an increased risk of participants not answering each question accurately and honestly. Participants may express a fear of reprisal when responding openly and honestly, but the questionnaire was voluntary, and participants did not have to respond to any questions that may have caused any stress to help reduce this type of limitation. The third limitation was the convenience of the purposive random sampling method. The population was person-centered and consisted of officers from one out of 24 random police precincts in Contra Costa County who voluntarily participated in the study. Further, a structured qualitative interview may not have allowed me latitude to combine open-ended questions that would have elaborated on officers' perceptions. Therefore, the semistructured qualitative interviews took place among an appropriate population of CIT-trained officers from an undisclosed site location.

Significance of the Study

The significance of my study was the shared phenomenological lived experiences that emerged from CIT training, such as empathy or pity among police officers' perceptions of PwMI. There was also an interest in whether enhanced officers' perceptions of PwMI after CIT training led to improved responses with CIT encounters. I used a questionnaire developed by Wells and Schafer (2006) to measure police officers' perceptions. Therefore, I attempted to analyze officers' perceptions, including a semistructured interview and a semistructured questionnaire. Accordingly, this type of research design allowed for follow-up questions that emerged during the interviews to gain insight into the possible impact of CIT training. The significance of the study provided a consequential focus that spoke to a measured maturity of perceptions by officers who respond to field encounters with PwMI. Research on this topic expanded the knowledge base in the field of criminal justice with regard to PwMI in crisis.

The impact of PwMI among officers who received CIT training does not have a strong basis of support in the literature. Rather, studies have shown that the need for CIT-trained police officers as a response for supporting successful interventions was reinforced (Rodriguez, 2016; Weller, 2015). Thus, in this research, I addressed the gap in knowledge between enhanced officers' perceptions and CIT training. This research may lead to positive social change through the recommendation of a new mental health policy for police departments related to officer awareness based on the analysis of individual perceptions. The results supported the objective of improved CIT training outcomes by using a tracking mechanism for CIT encounters with PwMI. Hopefully, patterns of positive behavior continue to emulate from this practice.

Summary

CIT training should increase police officers' knowledge about particular mental illnesses and validate improved perceptions of PwMI. Initial officer resistance to CIT training is a challenge of CIT training. The lack of support from any unit within mental health collaborative networks is also a challenge. Van Maanen's (1978) asshole theory represented the flawed foundation of officers' perceptions of PwMI before CIT training. Giles's (2007) 1973 CAT contributed to the growth of CIT-trained officers' perceptions of PwMI during field encounters, and Rogers's PMT served as the core of CIT training acceptance by CIT-trained police officers. A qualitative empirical phenomenological research design was the most appropriate methodology for exploring the shared lived experiences of CIT training from CIT-trained police officers in Contra Costa County. Chapter 2 includes a literature review that comprises a synthesis of current research related to the problem statement and research question.

Chapter 2: Literature Review

In the 21st century, CIT training has become increasingly popular among law enforcement and mental health network agents who respond to PwMI in crisis. Effective communication is paramount to the success of the CIT program (CACITA Public Speakers, 2017; Rodriguez, 2016; Weller, 2015; Wells & Schafer, 2006). Researchers at the CIBHS (2017) noted that the memorandums of agreement between law enforcement, and mental health clinicians should have included a requirement related to sharing information. However, such alliances did not begin to gain acceptance until the late 1980s. Consequently, the recent phenomenon of the impact of CIT training on police officer perceptions of PwMI required exploration. The problem addressed in this study was the lack of knowledge about how CIT training affects police officers' perceptions of PwMI. The purpose of this qualitative study was to explore perceptions among CIT-trained Contra Costa County police officers in Northern California.

Chapter 2 includes an analysis and synthesis of empirical research on CIT training to help provide an understanding of the shared phenomenological lived experiences of CIT-trained police officers. The chapter includes a synthesized literature review on the historical criminal justice response to PwMI in crisis and an extensive exploration of the evolution of police response. The three theories that aligned with the study's purpose comprised of the following theoretical framework: asshole theory, CAT, and PMT. The chapter includes the history, models, and evolution of CIT training, a review of literature about the relationship between CIT trained officers and the mental health network, as

well as the effectiveness of the pairing. The chapter also includes a discussion of the theoretical basis of officers' perceptions of PwMI that included the evolution among law enforcement officers from reactions to responses. The chapter further includes an elaboration of the evolution of police awareness as well as the working relationship with mental health clinicians when responding to PwMI. Lastly, the chapter includes a discussion on the relationship between previous empirical research and this qualitative study.

Literary Search Strategy

The literature review consisted of peer-reviewed scholarly journal articles, dissertations, professional websites, books, and federal government and mental health professional publications. The sources of articles were Google Scholar and the following databases available from Walden University: ProQuest Dissertations & Theses Global and ProQuest Central (Telecommunications, U.S. Newsstream, Social Science, Research Library, Public Health, Nursing & Allied Health, International Newsstream, Library Science, Computing, Career & Technical Education, Arts & Humanities). Extensive database searches took place and included the following key words and phrases: *CIT, police perceptions, mental health interventions, police officers, mental health clinicians, mobile crisis team, outreach programs*, and *law enforcement*. Searchers also included term variances, such as *perception, perceptions*, and *officer perceptions*. The search strategies yielded over 200 articles, with 129 relating specifically to the topic under study.

Theoretical Foundation and Evolution of Officer Perceptions of PwMI

As noted, the theoretical framework of this study was trifold. For example, the initial perceptions officers had toward misfits of society or perceived nonnormal citizens were negative. Van Maanen (1978) developed the asshole theory to clarify how police officers used street justice with society's outsiders that required quick reaction strategies to gain control during field encounters. Accordingly, the asshole label applied to PwMI denoted a sense of right where officers felt justified for mistreating those who fit that description. The progression from swift street justice reaction evolved to a more advanced and educated response of reasonable communication accommodation. Giles's CAT increased awareness about how changes in police officers' behaviors led to positive attitudes toward the engaged party (Ball, Giles & Hewstone, 1985; Kwon, 2012). Communication accommodation (Kwon, 2012) is a positive technique police officers use to converse during nonthreatening encounters in the field.

In contrast, officers use noncommunication accommodation techniques for threatening encounters. Police officer reactions improved from a bad cop's reactions to the alternative of a good cop's verbal accommodations with the CAT that helped improve officer attitudes toward PwMI. However, to become a better cop, the PMT recommends a support system of referrals for PwMI in crisis and offers evolved police perceptions. Rogers's PMT, self-efficacy was a significant element when determining motivation and health-protective behavior (Milne et al., 2000; Schwarzer & Fuchs, 1996). CIT training promotes a strategic protective approach by officers when encountering PwMI in the field that benefits all parties involved in the mental health collaborative network.

Milne et al. (2000) noted that an association exists between cognitive change and real-world health education programs with regard to the dynamics of mental and physical health disorders. Therefore, cognitive change directly relates to attitude, behavior, knowledge, and enhanced perceptions. Emotion mediates cognition and action (Schmidt & Weiner, 1988; Watson et al., 2004). Although recent literature supported attitude and knowledge (Compton et al., 2014; Watson et al., 2004) more than officers' perceptions, both formats are in relatively early stages and require further research. Therefore, the research question is as follows: How does CIT training improve CIT-trained police officers' perceptions of PwMI during field encounters?

Asshole Theory

Van Maanen's (1978) asshole theory provides valuable context for officers' interpretation of misfits. Police officers' initial response was to enforce street justice to persons who did not meet the criterion of normal during the 1970s. The asshole theory dictates this type of response refers to a perception of how police interpreted misfits of society. Van Maanen classified police labels of misfits that define the asshole theory, which meant a number of anatomical, oral, or incestuous terms such as creep, bigmouth, bastard, animal, mope, rough, jerkoff, clown, scumbag, wiseguy, phony, idiot, shithead, and bum. Such stereotypes conceptualize PwMI as incompetent, irresponsible, dangerous, unpredictable, at fault for their illness, and unlikely to recover (Brockington, Hall, Levings, & Murphy, 1993; Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Hyler, Gabbard, & Schneider, 1991; Taylor & Dear, 1981; Wahl, 1999; Weller, 2015). The combined responses from asylums, the judicial system, state legislation, and law

enforcement applied unjust negative stigmas to PwMI, with elements of gross neglect and mistreatment. Corrigan (2004) indicated that PwMI were thought of as incompetent and required authority figures to make individual decisions. Correctional officers, jail personnel, and asylums personnel did not care for PwMI as patients or inmates, and inappropriate actions against this group of people only began to change with deinstitutionalization.

Communicative Accommodation Theory

Giles's CAT or perception theory included a number of ways speakers can adjust their speech behaviors in response to each other. CAT deems objective speech variables as goals of adjustment as well as how speakers and recipients experience the conversation. CAT included a proposal for an improved cycle of communication: initial orientation, psychological accommodation, behavior, perceptions, evaluations, and future intentions, and then the cycle would begin again with initial orientation. A new approach to responding to PwMI in crisis had evolved into advanced police perceptions. A desire to facilitate comprehension and increase communicative efficiency may motivate communicative adjustment (see Giles, 2007; Thakerar, Giles & Cheshire, 1982). Because of this, CIT training should emphasize the importance of over and under accommodating PwMI in crisis by reinforcing proper referrals as dispositions for CIT encounters in the field. With this in mind, the ability to change the reaction to a response takes a reasonable amount of patience, which is a strategy of appropriate verbal de-escalation.

Protection Motivation Theory

The biggest shift in the paradigm of treatment for PwMI in crisis was toward a method of protection. To elaborate, Milne et al. (2000) noted that Rogers introduced the PMT, which researchers primarily use as the framework for intervention in health-related behaviors that measure the correlation among the association between threat and coping appraisal variables. Milne et al. opined that the basis of Rogers's PMT was based on fear appeal with countermeasures to take that reduced the impact of fear with healthy interventions. Similar to CAT, PMT continues to exhibit evolved and more polished officer perceptions and encompasses new strategies that strengthen mental-health-related network behaviors. Thus, instead of fearing PwMI in crisis, officers can apply PMT to refer to such persons with care and give soft diagnoses of PwMI in CIT encounters. CIT training should reduce the fear response and turn such a response into a response of furthered educated reason.

In contrast to the asshole theory, Milne et al. (2000) identified that a strategic approach to eliminating fear arousal, which begins as a threat appraisal where the individual's perceptions of a threat and perceived vulnerability demonstrate how susceptible the person feels to the communicated threat. Milne et al. also noted that Rogers revised the PMT model in 1983 to encompass a reward element for committing to a change in behavior or habit, where the higher the reward is, the less likely the individual is to retreat to old habits. Therefore, successful intervention becomes the reward for CIT-trained officers who help PwMI reach a sustainability of gains where CIT

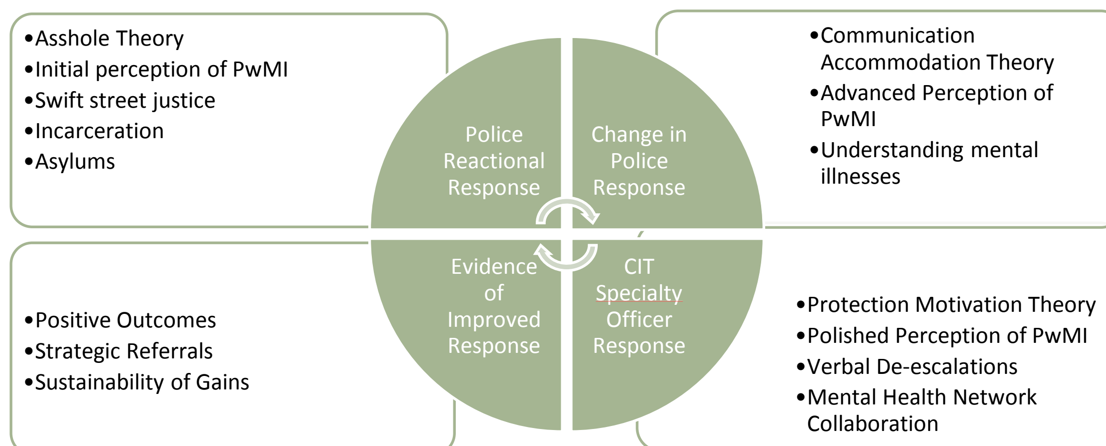
interventions are no longer required since the PwMI successfully achieved mental stability.

The apparent implication is that proper psychological accommodation will lead to the 1-year sweet spot where mental stability no longer requires crisis monitoring by CIT-trained officers (CACITA Public Speakers, 2017). To this end, emergency psychiatric first responders such as law enforcement agents and mobile crisis teams began a new movement to implement nationwide CIT training. A close alignment exists between PMT and the dynamics of CIT training for police officers. Brown (2015) noted that mobile crisis teams are interdisciplinary teams of mental health professionals, such as social workers, nurses, psychiatrists, psychologists, addiction specialists, and peer counselors. Together, the CIT and mobile crisis team units respond to PwMI in crisis and use any criminal diversion programs available to help stabilize individual mental capacity. Initially, the response to PwMI in crisis did not historically include this type of professional PMT pairing.

Figure 1 consolidates all three theories in an evolutionary cycle of improved responses from specialty officers. The evolved response from swift justice of jails and asylums to a response of patience and understanding is great progress in law enforcement. Today, the PMT is what sustains the lives of PwMI during CIT encounters.

Figure 1

Continuum of police officer response to PwMI and theoretical evolution of perception.



History of the American Response to PwMI in Crisis

Officers in the United States did not take care of PwMI in crisis until the late 20th century after the introduction of CIT training. Prior to this, the response PwMI in crisis involved placements in asylums or incarceration. Brown (2015) reported that many federal asylums subjected patients with mental illnesses to fatal treatments such as chains, corporal punishment, malnutrition, and isolation in filthy, small cells. Jails and prisons did not offer adequate medicinal or social support to help PwMI with coping mechanisms. That said, the treatment in many of the federal psychiatric institutions, asylums, did not bode well for PwMI in crisis. Augustyn (2016) reported that procedural

justice judgements are anchored in past perceptions. Because of this, mistreatment from law enforcement agencies and the federal government represented the response of cruel and unusual punishment by authoritative figures.

Brown (2015) noted that officers called to a scene expect obedience and compliance. Such officers must retain law and order through the swift enforcement of justice. Watson et al. (2010b) indicated that police officers have a great deal of coercive power that includes using suggestions, overt threats, and physical force to control a situation. Further, individuals involved in early American policing did not view PwMI as citizens, and the swift hand of street justice involved police officers using their own discretion to enforce the law upon the misfits of society.

American Policing

U.S. legislation and systematic approaches to the treatment and placement of PwMI in crisis were historically inhumane. Asylum personnel and police officers responded to the PwMI in crisis. In fact, early American police officer’s responses in the 1970s enforced street justice to persons who did not meet their criterion of normal. As noted, Van Maanen (1978) developed the asshole theory, which included perceptions of how police interpreted the misfits of society. Van Maanen indicated the mistreatment of PwMI by police officers was a status symbol among peers in law enforcement. However, once asylums were abolished by public demand abolished asylums, deinstitutionalization became the new solution regarding care for PwMI in crisis.

Deinstitutionalization

Public demand for liberation brought about the movement of deinstitutionalization. Deinstitutionalization occurred as a result of disgust with the condition of psychiatric hospitals and a belief that the patients removed from the hospitals would recover (Davoli, 2003). Yet, Davoli posited that statistics showed the populations of individuals with mental illness had extremely high rates of homelessness, high rates of incarceration, and shortened life expectancies as victims of both violence and suicide.

The original intention of deinstitutionalization was to give PwMI freedom, dignity, autonomy, and promised community-based treatments as a healthy alternative (Brown, 2015). However, without community-based treatment programs available for PwMI, an increase in homelessness and the prison population was inevitable. The medical community introduced new medication after deinstitutionalization to replace the need for community-based treatment, but law enforcement's continuum of response for PwMI did not improve with deinstitutionalization, and incarceration offers a life of victimization for PwMI.

Prison Response

Surviving encounters from law enforcement officers was just the first of many hurdles for PwMI once in the legal system. Prison overcrowding was also a concern, as a considerable amount of the incarcerated population had mental illnesses. Reuland (2010) reported that the largest psychiatric inpatient facilities in the United States are jails such as Riker's Island in New York City. Brown (2015) claimed that approximately 350,000

persons with severe mental illnesses are in U.S. jails and prisons, which have become the new asylums in the United States. Jails and prisons do not provide adequate medicinal and social support that help PwMI with coping mechanisms. Brown noted that jailed PwMI received extended sentences with earned additional infractions during incarceration because PwMI did not have the capacity to comply with orders from correctional officers. Additionally, Brown also remarked the right to mental health treatment during incarceration was a direct result of the Eighth Amendment to the U.S. Constitution, which prohibits cruel and unusual punishment and guarantees prisoners the right to treatment while incarcerated.

When the federal government abandoned federal asylums due to the public outcry regarding the horrific conditions for PwMI in their care, deinstitutionalization was supposed to uplift PwMI during their reentry to society. PwMI have extremely high rates of homelessness, incarceration, and shortened life expectancies as victims of both violence and suicide (Davoli, 2003). Law enforcement's continuum of response for PwMI did not improve following deinstitutionalization. Without federal support for psychiatric hospitals, prisons became a form of long-term care. Thompson, Reuland, and Souweine (2003) reported that law enforcement, court, and corrections personnel felt frustrated regarding the responses to PwMI, which failed the population and the judicial system did little to improve the general health in communities.

As noted, incarcerated PwMI often do not respond correctly to authoritative figures such as correctional officer and earn additional time for sentencing (Brown, 2015). When there were psychiatric hospitals to help PwMI in crisis, PwMI did not

populate the prisons. Brown also posited the quality of life for PwMI is shorter than for individuals without mental illness, as victimization, isolation, and homelessness are common occurrences in the lives of PwMI.

Psychiatric Hospitals

The medical community's response to deinstitutionalization included a limited number of psychiatric beds, unable to support PwMI in crisis. The dearth of psychiatric facilities was the response from the medical community and noted as a blatant disregard and neglect for PwMI in crisis. Torrey (2016) reported that there were approximately 35,000 nationwide psychiatric beds available, which was enough for approximately 11 beds per 100,000 people in the United States. Torrey indicated that beds in many state hospitals are available only for brief periods of hospitalization, which leaves no alternatives for patients who need longer periods for stabilization.

Despite the lack of reasonable options for long-term treatment, existing community-based programs do not offset the lack of inpatient psychiatric beds. Although some growth has occurred in community-based alternatives, it is insufficient to offset the declines in in-patient psychiatric beds. The responsibility of care shifted from the federal government to state prisons and community leaders with little to no resources to facilitate a smooth transition. Brown (2015) reported that states did not fund in-home psychiatric providers, outpatient clinics, and halfway houses with the money saved from the asylum closures, which led to arrests and deaths of PwMI. The limited number of in-patient psychiatric beds resulted in a ripple effect on nursing staff. For example, following the measurement of personal and professional characteristics of psychiatric nurses, Van

Bogaert et al. (2013) discovered that an association existed between satisfaction with the current job and emotional exhaustion. Van Bogaert et al. indicated emotional exhaustion was a reaction to sustained unmanageable workloads, depersonalization, and expressions of psychological withdrawal or cynicism. To relieve the placement of PwMI to psychiatric hospitals, individual United States implemented mental health courts and outreach programs.

Mental Health Court Response

Unfortunately, the United State federal government did not design the criminal justice system to be a treatment center for PwMI. A progressive response to help PwMI in crisis must be a feasible solution. Testa (2015) indicated that the most effective way to achieve reform in the United States was to invest resources in diversion, with a significant emphasis on pre-booking diversions. Mental health courts' objective was to provide an individualized treatment program and not to order jail sentences as punishment. Testa reported that after PwMI were arrested and charged with crimes, post-booking diversion should have steered PwMI toward treatment and rehabilitation services. Similar to the CAT, Brown (2015) noted that mental health courts existed as a response to the Americans With Disabilities Act of 2009 that acknowledged all courts had the responsibility to make accommodations for PwMI. In brief, Grudzinskas, Clayfield, Roy-Buinowski, Fisher, and Richardson, (2005) circumvented that mental health courts provides a team approach that entailed an immediate intervention, a non-adversarial process, a hands-on judge, and clearly defined rules and goals for treatment programs for the participants who were PwMI.

Treatment teams consist of a judge, prosecutor, defense attorney, mental health services providers, and a representative from the jail and adult probation staff who meet weekly before court proceedings and review each client (Kennedy, 2012). However, only nonviolent mentally ill criminals have access to mental health court accommodations. Kennedy indicated that only quality-of-life offenders with misdemeanors or felonies were eligible for mental health court; offenders who committed sexual offenses and violent offenders do not qualify for specialty courts. Mental health courts incorporate procedural adaptations that decrease stigmas and facilitate the therapeutic process for PwMI (Watson et al., 2010a, 2010b, 2010c). Participants in treatment courts must be willing to comply with any special court ruling and process to reach the desired goal of mental wellness. Furthermore, participants in treatment courts perceived higher levels of procedural justice than those in comparison courts, and participants noted treatment courts resulted in a more positive emotional impact of hearings and led to greater satisfaction with court outcomes (Watson et al., 2010a, 2010b, 2010c). However, failure to comply with the specialty court ruling may include incarceration as a possible sanction (Bureau of Justice Assistance, 2009). In contrast to this situation, the application of both CAT and PMT led to positive results in the evolution of police response to PwMI in crisis with the support of outreach programs that represented another form of criminal diversion.

Assertive Community Treatment Program

Mental illnesses range in the severity of the condition, types of diagnoses, and emotional crises. Forensic assertive community treatment is an emerging model for preventing the arrest and incarceration of PwMI adults who have substantial histories

with the criminal justice system as perpetrators (Lamberti, Weisman, & Faden, 2004). Qualifying participants of forensic assertive community treatment may find outreach programs represent a healthier and supportive means to help with self-stabilization within the criminal diversion process. Specifically, Lamberti et al. (2004) supported that the combination of intensive service delivery and legal leverage as representing a critical balance for PwMI who would normally continue to suffer from untreated illness on the streets and in jails. Kennedy (2012) identified comprehensive treatment plans for PwMI that included treatment progress based on individual behavior and compliance. Grudzinskas et al. (2005) reported that diversion programs had been effective both in reconnecting individuals with mental health services and in preventing criminal recidivism.

Participants in mental health courts and outreach programs include PwMI where teamwork is used to provide a sense of stability to the lives of the mentally ill. Brown (2015) posited that the goal of assertive community treatment programs was to prevent future incarceration, hospitalizations, homelessness, and rearrests; increase housing options; and improve the overall quality of life for PwMI. Davoli (2003) described success stories that involved moving psychiatric patients out of hospitals into the community. In many cases, assertive community treatment had a positive impact on PwMI, reconnected individuals with mental wellness services, and helped reduce recidivism. Mental illness is a worldwide problem, and the process of identifying and responding to PwMI differs in each country.

International Response and Recovery Colleges

Mental health disorders do not discriminate and occur around the world, although perspectives on treatment and the degree of label placements vary. A universal approach requires the human touch where experts in socialization skills can help PwMI most effectively. Gureje (2015) noted that, as long as mental disorders had consequences everywhere and although there have been debates about the labels ascribed to PwMI, practicing clinicians understand that the syndromes PwMI face have effects on the individuals' life. In contrast, Saxena, Thornicroft, Knapp, and Whiteford (2007) recognized that stigma and discrimination are important factors in the reluctance of many people worldwide to seek help or in accepting individual difficulties related to mental illness. Slade et al. (2014) noted that, to support personal recovery, leaders of mental health systems needed to shift away from the dominance of institutional responses, drug treatments, and coercive interventions.

Slade et al. (2014) also indicated that the aim of the strengths model of case management was to help PwMI attain personal goals set by identifying, securing, and sustaining the range of environmental and personal resources needed to live, play, and work in a normally interdependent way in the community. Universally speaking, education is thought of as a right and not a privilege so PwMI must be able to enrich their minds academically to mature socially. Slade et al. reported that recovery colleges or recovery education programs were an educational approach to supporting the recovery and reintegration of people with psychiatric disabilities, where researchers pioneered the model of service provision at Boston University in 1984 and then introduced it in Italy,

Ireland, and England. Italy's ideal response involves supporting PwMI with a robust community-based continuum of mental wellness care.

Some countries in the world have an entirely different approach and provide communities with mental wellness, where PwMI earn an income in a peer-supported environment. Giving PwMI civil and human rights was the basis for recovery with residents in Trieste, Italy. In the beginning, the transformation of the Trieste Asylum into an area for cooperative businesses and residences was a groundbreaking social concept. Davidson, Mezzina, Rowe, and Thompson (2010) reported that through a work therapy program, patients cooked meals, did their laundry, and helped to take care of the physical facilities, and a day care center was available for the staff's children on the property. Patients learned individual responsibility as the foundation for a full recovery and had the latitude to prove their self-worth and purpose.

Davidson et al., (2010) postulated that the Italian mental health reform personnel understood that PwMI needed their civil and human rights secured as a foundation for personal recovery. The challenge is to transform current systems into systems that no longer accept long-term disability but are instead based on the belief that recovery is possible by promoting and supporting individuals' own efforts toward condition management while pursuing a meaningful and self-determined life in the community (Davidson et al., 2010). The Italian government decided to convert the Trieste Asylum building structure into a mental wellness community. Davidson et al. reported the staff worked with each patient to determine the person's interests and needs and then helped the individual meet set objectives within the broader community. PwMI learned to be

self-sufficient. through work therapy programs. Trieste's business center satisfied the needs of the patient and fulfilled the basic human purpose that helps PwMI live healthy, productive lives.

Davidson et al. (2010) described that the types of organizations involved in social cooperatives, which included cleaning and building maintenance; furniture and design; hotels; cafeteria and restaurant services, agricultural production and gardening; handicrafts; carpentry; photo, video, and radio production; theatre; administrative services; and home assistance to elderly and other disabled people (p. 440). The asylum also facilitated a children's daycare and hosted outdoor activities to show that PwMI posed no danger to society. Davidson et al. indicated that activities that involved children were particularly valued and had a therapeutic effect on patients and outsiders with preconceived notions about PwM being dangerous. PwMI in North America could benefit from the mental wellness philosophy in Trieste. The approach may require philanthropists to fund communities all over the country as opposed to a federal-government-based movement. However, the police response to PwMI in the United States changed following the introduction of CIT training.

Law Enforcement Response: Memphis CIT Training Model

Leaders at the Memphis Police Department pioneered the CIT initiative that individuals in law enforcement agencies all over the United States can emulate. The original 1988 Memphis model consisted of 40 hours of CIT training over 5 days for officers who received CIT lapel pins at the end of the training (Dupont et al., 2007). Browning, Van Hasselt, Tucker, and Vecchi (2011) itemized that the training curriculum,

which included recognition and understanding of the signs and symptoms of mental illnesses, pharmacological interventions with possible side effects, crisis intervention and de-escalation skills, and knowledge of user-friendly mental health resources available to PwMI from CIT encounters. CIT has led to decreased injuries to PwMI, increased transport to community mental health providers, and reduced jail suicides (Brown, 2015). In concert, CIT training and positive outcomes are distinctly aligned with the PMT where PwMI experience networked mental and emotional support.

Reuland (2010) noted that it is important to recognize that the focus of much of an officer's training is taking control of a situation and resolving it swiftly, which is often counter to specialized response strategies. Role-playing exercises during CIT courses help police officers anticipate certain responses from PwMI in crisis. Reuland also indicated that programs that involved responding to safety concerns emphasized specialized training on policies and practices designed to help law enforcement officers take adequate time to identify the signs and symptoms of mental illnesses. Woods and Watson (2017) noted that specialized training for officers and cooperative agreements with the mental health sectors demonstrated improved knowledge and attitudes regarding the mental health needs of PwMI. Similar to the PMT, Reuland understood that certain behaviors are a result of mental illnesses, used effective communication and behavioral strategies, and was familiar with options to using lethal force.

By administering the CAT approach, patience and understanding can replace swift street justice. Wells and Schafer (2006) claimed that, before CIT training, 11 officers in the study reported that interactions with PwMI produced frustration and anger

among officers, whereas after training, only one officer continued to experience such feelings. In contrast to the asshole theory, Corrigan (2004) agreed that relatively brief educational programs led to significantly improved attitudes toward PwMI in crisis. Hanafi, Bahora, Demir, and Compton (2008) stipulated that reduced stigmas by police officers increased empathy for PwMI whether in crisis or not.

Mobile Crisis Team Response

The collaboration between CIT and mobile crisis teams is a mandatory part of CIT training. Mobile crisis teams are interdisciplinary teams of mental health clinicians that do not have the authority to make arrests but are available to help officers when needed (Brown, 2015). If police officers have the responsibility of making the correct decision about the need for transport to a treatment center versus no treatment, then the medical community must provide the proper services and training to make the process efficient and safe for both the officers and the PwMI (Barker, 2013). Notably, Brown contended that many states had implemented mental illness training where specialized units of officers and a mental health professional handled PwMI in crisis.

Brown (2015) noted that mobile crisis teams consisted mental health network representatives such as social workers, nurses, psychiatrists, psychologists, addiction specialists, and peer counselors. Scott (2000) indicated that the objective of mobile crisis teams was to stabilize persons experiencing psychiatric emergencies in the least restrictive environment, decrease arrests of PwMI in crisis, and reduce the time police officers spend handling psychiatric emergencies. Mobile crisis teams help CIT-trained officers with de-escalations techniques to restore mental capacity to PwMI in crisis.

De-escalation and Less Use-Of-Force Response

Canada et al. (2012) described how CIT officers' use of verbal conversation as a de-escalation technique, efforts to listen to PwMIs' stated needs, and efforts to pay extra attention to give sufficient time to resolve issues rather than implementing traditional forceful strategies. Rodriguez (2016) indicated that core challenges for law enforcement were the need to shift the standard police approach from authoritative and forceful to an emphasis on verbal de-escalation techniques and risk management (Kesic, Thomas & Ogloff, 2013). Also, Mulvey and White (2014) noted that a substantial link between mental illness an increased resistance against law enforcement officers. However, Compton, Bakeman, Broussard, Hankerson-Dyson, Husbands, Krishan, ... and Watson, A. C. (2014) reported that CIT-trained officers use verbal skills or negotiation as the highest level of force applied to CIT encounters in the field. The Police Executive Research Forum (2012) expressed that a change in use-of-force that includes words that replace guns, questions asked instead of orders given, and patience in lieu of a reactionary response.

In complement, Canada et al. (2012) shared that nearly every CIT-trained officer reported that talking to the PwMI was the most helpful response tactic. When officers communicate with PwMI in crisis, an action of response basic conversation is preferred to an action of force. During escalated encounters, some law enforcement officers use Tasers instead of guns to control the situation. Adams and Jennison (2007) noted that Tasers outranked pepper spray on the use-of-force continuum for CIT encounters. White and Ready (2007) reported that officers almost exclusively used Tasers against violent

suspects classified as disturbed PwMI by emergency service officers with supervisors present. White and Ready questioned whether Tasers posed an elevated risk to PwMI in crisis, under the influence of drugs and alcohol, or with preexisting heart and respiratory ailments. Stewart (2009) reported that the Bloomington Police Department changed its equipment policy and stopped issuing Tasers to officers after a fatal incident in 2003 in a jail that involved a Taser. Noticeably, the opinions of PwMI about CIT-trained officers and procedures are also germane to CIT training.

PwMI Response to CIT-Trained Officers

As mentioned, the new police officer approach to CIT encounters replaced swift justice with a slower form of responses such as verbal de-escalation and conversation. Reuland (2000) contended that programs that emphasize specialized training on policies and practices are helpful to law enforcement officers who need to take adequate time to identify mental illness signs and symptoms. PwMI may want to be able to explain behaviors and have officers on the scene treat them like human beings (Watson et al., 2008). In particular, Watson et al. noted several PwMI participants specifically spoke to the need for trained officers to help with the crisis response more effectively and keep situations from escalating. PwMI want people to treat them with respect, and they do not want to experience mistreatment or others to consider them as secondary citizens.

As law enforcement officers maintain a frontline stance as emergency first responders, the response for psychiatric emergencies should follow a different continuum of response that conveys a gentler approach. Ellis (2011) purported that the core elements of the CIT model included empathy, active listening communication skills, a

nonjudgmental and nonchallenging attitude, boundary setting, an acknowledgment of distorted thinking through reframing, and problem solving (p. 38). In alignment with assertive community treatment, this new technique gives PwMI a chance for authoritative figures to hear them while struggling with a mental health crisis without fear of reprisal. Outcome studies have indicated that CIT is effective with decreased injuries to PwMI, increased transport to community mental health providers, and reduced jail suicides (Brown, 2015). Recent history shows that California continues to rise to the challenges of adequate responses to PwMI in crisis.

California Prison Overcrowding

California may not have the finances or community support that Trieste has, yet mental health care reform has been substantial. The state's correctional system had to respond for the betterment of PwMI after the 2011 Supreme Court ruling in *Brown v. Plata*. The Supreme Court held that California's prison system violated inmates' Eighth Amendment rights (see, Newman & Scott, 2012). Moreover, the ruling ordered California Department of Corrections and Rehabilitations (CDCR) to decrease the inmate population and noted the primary cause of the sanction was inadequate medical and mental health care among inmates (see, Newman & Scott, 2012). Additionally, California seems to be trending away from using psychiatric hospitals as the long-term treatment protocol for PwMI in crisis.

Mental Health Community Response in California

To be clear, the CDCR thus released hundreds of PwMI into society, where the likelihood of mental health support was significantly lower than in prison. However,

lawmakers created specific legislation to help safeguard state residents as a reactionary response brought about by grave incidents. The first law mandated the medical community had a duty to inform. *Tarasoff v. The Regents of the University of California 1976*, when courts imposed a legal obligation on psychotherapists to warn third parties of patients' threats to the safety of others (Tarasoff, 1976). The second law required individual counties to have some accountability regarding the mental health response continuum.

California Legislative Information (n.d) reported that as a result of a mental health disorder where PwMI were a danger to self or others, peace officers had taken PwMI into a 5150 custody for 72-hours for assessment and evaluation. The 5150-hold refers to a PwMI who is taken into custody inside of a psychiatric hospital for 3 days. Alternatively, the 5250-hold expanded the term of custody from 72-hours to 14 days where the PwMI will remain confined to the psychiatric hospital grounds for approximately two weeks (California Legislative Information, n.d). California has only a few psychiatric hospitals in which health care professionals can assist PwMI in crisis. Researchers at the California Hospital Association (CHA) (2018) posited that experts estimated a need for a minimum of 50 public psychiatric bed for every 100,000 people for the hospitalization of individuals with serious psychiatric disorders, but the state had only one public psychiatric bed for every 5,922 people. The shortage of psychiatric beds led to new legislative orders discussed in chapter 5.

California Laura's Law

California Hospital Association (2002) researchers agreed that Laura's Law (AB1421) provided the resources to improved access and adherence to behavioral health services ordained voluntarily or by court order. Thus, Laura's Law is a mandated AOT program for PwMI for which only individuals with serious mental illness can qualify after they meet the criteria. CHA (2017) researchers reported that participants had a recent history of psychiatric hospitalizations, incarcerations, threats or acts of violence toward self or others. Once the PwMI receives a court order to join the AOT program, the judge embraces and conveys the black robe effect. CACITA Public Speakers (2017) noted that the black robe effect signified judges' natural role that commanded respect as the symbol of authority among both the civic culture and the treatment system. Thus, when PwMI were not able to participate in the AOT program, the court-appointed option gave more layers of support to help each PwMI with care.

Mental health services coordinators are responsible for the wellness of PwMI. Mental health services coordinators provide a complete assessment of clients' needs, develop a personal services plan, connect with all appropriate community services, monitor quality and flow, and advocate when necessary (California Hospital Association, 2015). The AOT program is most suitable for select PwMI who do not respond well to traditional methods of approach. CACITA Public Speakers (2017) noted there are no sanctions for participants who violate a court-ordered AOT regime dictated by a judge. In spite of no sanctions, participants in the AOT program tend to remain compliant with judges' orders for personal betterment. CACITA Public Speakers explained that judges in

AOT programs meet regularly with attorneys and patients, monitor progress, and promote the black robe effect upon attorneys to support patient outcomes.

Opposition to Laura’s Law

Advocates for PwMI do not recognize the optimism in Laura’s Law and have found major flaws within the origin of its design. Laura’s Law gives order to a small subset of PwMI who had been noncompliant with treatment and met a slimly defined criterion for acceptance for treatment as a condition of living in the community (Mental Illness Policy, 2017). That decision left little support for persons with other types of mental illnesses treatment in such programs.

California Crisis Intervention Team Training

California CIT training is similar to the Memphis model, yet the California version has a flexible shorter training periods and applies the same team concept of support. CACITA Public Speakers (2017) noted that any training less than the original 40-hour model cannot have the name CIT training. Therefore, California has many crisis intervention training programs that encompass the same team theme throughout the state. In 2014, 33 out of 58 California counties had CIT training, where the training ranged from 1 day to 5 days (CIBHS, 2015). Rodriguez (2016) noted how 24 hours of crisis intervention training were enough to show a difference in the response to PwMI in crisis. Partnerships among law enforcement and the mental health community remain the backbone of support for CIT officers in the field. Bonkiewicz, Green, Moyer, and Wright (2014) noted that staff from post-crisis assistance programs should accompany specialty trained officers and police officers. Each county must find individual resources such as

mental health, housing, and outreach programs that apply to the communities individually.

Contra Costa County Demographics

The Bay Area Census (n.d.) indicated that 1.04 million people resided in Contra Costa County in 2010, and 62% of the population was between 18 and 64 years old, and the County of Contra Costa (2017) estimated that a projected influx of residents to 1.13 million for 2017. Counties with such a large population should have adequate means of employment for its residents and anticipated newcomers. Ascertaining educational attainment involved sampling the population aged at least 25 years old, and the majority varied only slightly among high school graduates (19.7%) and held bachelor's degrees (22.8%), whereas only 12.2% of the sampled population held graduate or professional degrees (Bay Area Census, n.d.). The 2017 historical voter registration reported 44.8% Democrat, 25.9% Republican, and 24.5% no party affiliation (California Secretary of State, 2017). White-collar workers comprise 67.3% (management, professional, sales, office, and related), and blue-collar workers comprise 32.9% (service, construction, transportation, and related) of the population (Bay Area Census, n.d.). The gender profile indicated 51.2% females and 48.8% males in the county (Bay Area Census, n.d.).

Furthermore, the Bay Area Census (n.d.) indicated that the population of Contra Costa County consists primarily of Whites (58%), Latinos (of any race, 24%), Asians (14.2%), and African Americans (9.3%). Ninety-nine percent of residents lived in a household (Bay Area Census, n.d.), but the homelessness rate was still present. According to Contra Costa Health Services (2017), the *2017 Point in Time Count* report

indicated that 1,600 persons were without housing after a count took place over a span of 24 hours. Even with a substantial job market, unemployment rates could contribute to the county's homeless population. However, the unemployment rate for Contra Costa County in October 2017 was 3.5% (State of California Employment Development Department, 2017). Compared to previous months, the unemployment rate for the county was low. In neighboring Alameda County, Berkeley Police Department's CIT Coordinator J. Shannon contended the most common age range for a first psychotic episode was between 17 and 24 years of age (Berkeley Police Department, 2010). The Contra Costa County Sheriff's (n.d.) office claimed that it had more than 1,100 sworn and professional employees who served the 715-square-mile county.

Contra Costa County Mental Health Resources

Behavioral Health Court is a program for persons with chronic mental illness or co-occurring disorders who have opted in to Behavioral Health Court rather than serve jail or prison time (Contra Costa Health Services, 2017a). The Central Contra Costa County program involves mental wellness coaching and support with coping mechanisms and aspects of daily living. CACITA Public Speaker (2017) Stettin indicated Contra Costa County was one of only 17 counties that implemented Laura's Law and had AOT services available for PwMI. The staff of the Mental Health Administration attempts to create a high-quality integrated system that meets the continued needs of all county residents. Central County AOT services offered by Contra Costa Behavioral Health Services (BHS) pertain to individuals with a progressive declining mental health condition that remains in compliance with the specifics of Laura's Law (BHS, 2017).

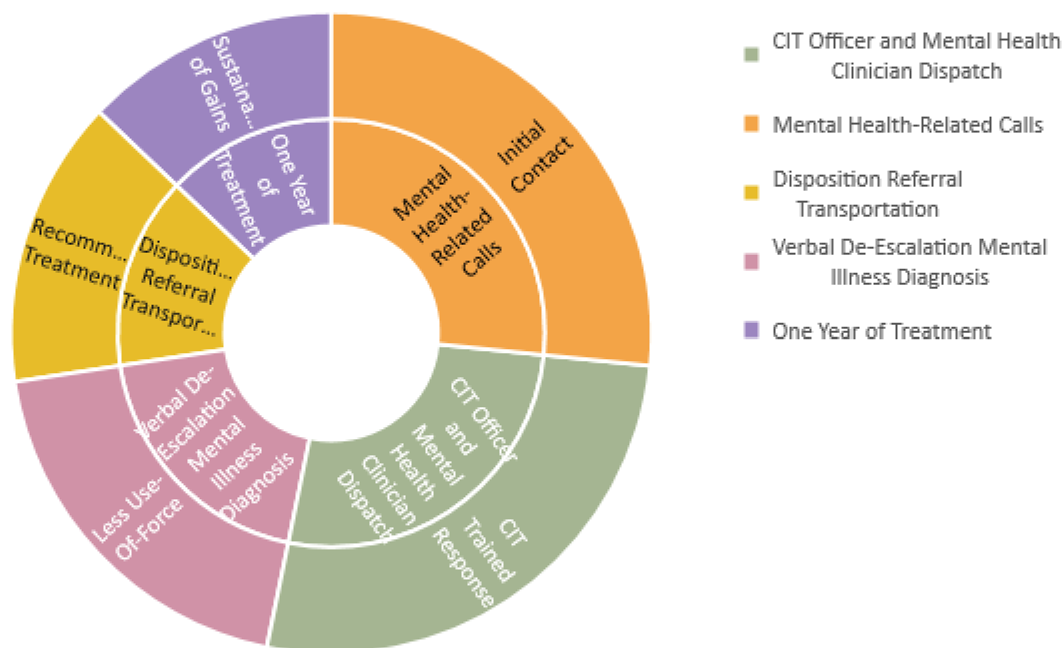
Contra Costa Health Services (2017b) licenses mental health clinicians from BHS and mental health systems along with a care team respond to AOT investigations.

Furthermore, Contra Costa Health Services (2017a) indicated how the leaders at the Coordinated Outreach Referral and Engagement (C.O.R.E.) program established relationships with clients through establishing communication and visiting camps and shelters as points of contact for many social services throughout the county. Central County BHS can refer PwMI who refuse to participate in the AOT program voluntarily. BHS filed a petition where a judge held a hearing with the PwMI and attorney when court ordered AOT participation was mandated (Contra Costa Health Services, 2017b). The staff of Contra Costa AOT programs also evoke the black robe effect. According to the Contra Costa Superior Court Attorney, successful referrals are tracked and monitored for progress while the judge established the black robe effect by holding all parties accountable for the wellness of PwMI (A. Din, personal communication, September 18, 2017).

Figure 2 displays the continuum for CIT-trained officer care for PwMI. In Central County, a care team provides PwMI with contacts for appropriate services that help ensure the sustainability of gains.

Figure 2

Continuum of CIT-Trained Officer Care for PwMI



Successful Interventions

Calls involving individuals in a mental health crisis are multifaceted and complicated and can require more time and effort than the general population (Bittner, 1967; Chappell, 2010; Hanewicz et al., 1982; Wells & Schafer, 2006; Rodriguez, 2016). Ellis (2011) noted that significant benefits exist to having mental health clinicians on scene for assessing PwMI in crisis. Lamb (1984) recognized that professionals realize the degree of rehabilitation possible for each patient and that it cannot take place unless simultaneous full support was available. To build on the Italian mental health reform, Cochran, Deane, and Borum (2000) acknowledged that mental wellness interventions

should provide a social structure that is accepting and empowering for PwMI. As mentioned, CACITA Public Speakers (2017) reported that the positive impact of CIT training for PwMI was the sustainability of gains that happened about a year into the AOT process.

CACITA Public Speakers indicated that without a method of tracking CIT incidents, successful interventions often go unnoticed. Slade et al. (2012) noted that follow-up studies conducted after 8-12 years confirmed the significant effectiveness of interventions over the longer term. Ideal support systems do not reside in prison care, on the streets, or in isolation. Thus, successful interventions happen when PwMI take the initiative to seek help, adhere to a mental wellness plan, and maintain a healthy lifestyle and daily routine to function normally in society. The AOT process has proof of concept. Researchers at Mental Illness Policy (2017) reported that hospitalizations decreased by 46%; incarceration decreased by 65%; homelessness decreased by 61%; emergency contacts decreased by 44%; and Nevada County saved $1.81–$2.52 for every dollar spent as a result of reducing incarceration, arrest, and hospitalization in Nevada County, California.

Gaps in Research

My study addressed the gap in literature indicated by the lack of data to support the impact on officer perceptions once CIT-trained. My study involved an attempt to build upon the study by Rodriguez (2016) by exploring the gap in knowledge regarding the increase in officers' knowledge of mental illness after CIT training and the relationship between CIT trained officer and mental health clinician. Further, my study

addressed the gap in literature (Blevins et al., 2014; Rodriguez, 2016; Weller, 2015) where researchers of reintegrated studies identified the need for structured CIT training for police officers. Rodriguez (2016) noted that the relationship between mental health clinicians and law enforcement agents remained unexplored but could help with perceptions in the field.

This case study involved an attempt to capture knowledge that might indicate CIT-trained officers are offering referrals to criminal diversion programs as a result of specialty training. Weller (2015) indicated that there is no efficient system to track if officers are indeed offering referrals to community-based mental health programs during CIT encounters. Consequently, my study attempted to decrease the gap concerning referrals with dispositions of CIT encounters by CIT-trained officers (Weller, 2015). My study addressed the gap in literature on this issue indicated by the lack of data to support the impact on the perceptions of CIT-trained officers in Northern California. This study contributed to knowledge concerning how to track the course of treatment for PwMI from on-scene encounters with police officers to diversion program outcomes.

Summary and Conclusions of Literature Review

In the 21st century, CIT training has become increasingly popular among law enforcement and mental health network agents who respond to PwMI in crisis. The literature review included analyses and syntheses of empirical research on police officer perceptions and attitudes that informed the understanding of the phenomenon that confronts CIT-trained officers. The review consisted of three sections of empirical research regarding the theoretical evolution of policing PwMI. A review of current

literature revealed the contentious debate regarding whether CIT training affects officers' attitudes and perceptions. The literature review included a discussion on the history of the police response to field encounters with PwMI that began as a quick reaction that evolved into patient CIT-trained responses (CACITA, 2017; Rodriguez, 2016, Weller, 2015). Researchers have noted that CIT training positively affects officer attitudes and knowledge (Ball et al., 1985; Brown, 2015; Compton et al., 2014; Rodriguez, 2016; Watson et al., 2010a; Weller, 2015) and perceptions (CACITA, 2017; CIBHS, 2015; Dragojevic, Gasjorek & Giles, 2015; Kwon, 2012; Milne et al., 2000; Watson et al., 2004, 2010b, 2010c; Wells & Schafer, 2006). The results of the study addressed gaps in the literature through an exploration of the impact of CIT training among CIT-trained officers.

My study addressed the gap in literature as indicated by the lack of data to support the impact of CIT officer perceptions after becoming CIT-trained. This qualitative study also addressed why researchers do not know how to track the course of treatment and referrals for PwMI from on-scene encounters with CIT officers. Chapter 3 includes a detailed account of the selected methodology derived from the qualitative approach via a questionnaire and interviews.

Chapter 3: Research Method

Early American policing did not involve viewing PwMI as citizens. Police officers would assume PwMI were dangerous and would inadvertently escalate situations with threatening body language and speech (Corrigan et al., 2003; Link, 1987; Ruiz, 1993; Watson et al., 2004). Furthermore, Watson et al. (2010a, 2010b) noted that police officers have a great deal of coercive power that ranges from suggestions to overt threats to physical force to control a situation. CIT training has helped immensely with the evolution of officer response to PwMI in crisis. In my study, I built on the study by Wells and Schafer (2006), who discussed officer perceptions of PwMI among CIT-trained officers. Additionally, I attempted to address the gap in literature (Blevins et al., 2014; Ferguson, 2014; Rodriguez, 2016; Weller, 2015), where researchers have identified the need for structured CIT training for police officers. However, researchers have yet to address the lack of data that indicate whether CIT training affects officers' perceptions of PwMI.

Chapter 3 includes the qualitative methodology, phenomenological research design framework for the study, a discussion of the alignment of method instrumentation with the research problem, and a comprehensive description of the theoretical and conceptual framework. The chapter includes a description of the research procedures, questionnaire, data collection, methodology, coding, and theme analysis. Further Chapter 3 addresses the research question, research method and design, appropriateness of design,

population and sample plan, instrumentation, data collection, analysis, and triangulation, and ethical consideration of participants.

Research Design and Rationale

Research Design

Ravitch and Carl (2016) noted that researchers who employ a phenomenological research method tend to have an interest in individuals' lived experiences of a phenomenon. The purpose of phenomenological research is to gain an understanding of individuals' perceptions derived from the lived experience. Hence, this phenomenological study involved an attempt to understand CIT-trained officers' perceptions of PwMI. The objective of phenomenological research methods is to obtain thorough descriptions that form the basis for reflective structural analysis that depicts the essences of the lived experience (Moustakas, 1994; Ravitch & Carl, 2016). In contrast, a grounded theory approach was not suitable for my study because I did not attempt to discover a theory. Grounded theory studies originated from a variety of sources such as interviews, observations, documents and other sources (see, Ravitch & Carl, 2016). Additionally, a focus group did not align with the purpose of my study, as I did not target a consumer group. Rubin and Rubin (2012) contended that, in a focus group, a researcher's participants are representative of the population of interest.

Rationale

CIT research relies upon qualitative studies that include in-person interviews and questionnaires rather than authentic police data (Broussard et al., 2011; Browning et al., 2011; Canada et al., 2012; Compton et al., 2011; Cotton, 2004; Rodriguez, 2016). Rubin

and Rubin (2012) documented that researchers who conduct semistructured interviews discuss how events took place as an extended conversation between researcher and interviewee, with limited questions and follow-up questions. Accordingly, I conducted semistructured interviews with a focus on the perceptions questionnaire with follow-up questions. I answered the research question, which addressed how officers' perceptions improved based on CIT training when encountering PwMI. The interviews were face-to-face, as opposed to Internet of phone interviews. Rubin and Rubin noted that Internet interviews are useful when communicating with people who are either hard to reach or unwilling to converse publicly. With video communication delays, Internet interviews are time consuming. Disadvantages to face-to-face interviews include setting up the site, conducting the interviews, transcribing the interviews, and analyzing the interviews, which can all be labor intensive. However, advantages of in-person interviews include me being able to read micro expressions and being able to note visible changes in the mannerisms or moods of the interviewees.

Role of the Researcher

This qualitative research study involved a responsive interview to eliminate any bias that may obstruct the interview process. Rubin and Rubin (2012) ascertained that in-depth qualitative interviewing has an association with interviewees who have experience with the problem of interest. The qualitative interview strategy included primary questions, probes, and follow-up questions (Rubin & Rubin, 2012). I had no personal or professional relationships that involved power over the participants. Therefore, I had a population closely associated with the topic of the research question, which is how

officers' perceptions improved based on CIT training when encountering PwMI. In contrast to ordinary conversations, interviews are likely to include a focus on the topic of the research question, which researchers pursue in great depth (see, Rubin & Rubin, 2012). Further, Rubin and Rubin stressed that the responsive interviewing approach accepts that both the researcher and individuals under study are people with emotions. To eliminate bias, I used the bracketing technique during the interview process. Ravitch and Carl (2016) documented that researchers must bracket, or set aside, their everyday assumptions. The purpose of reflexivity is for researchers to account for their influence over the research process (Gentles, Jack, Nicholas, & McKibbon, 2014). Therefore, I did not place personal opinion or judgment on the experience of the interviewee, and I recognized my potential influence over the study's methodology for reflexivity.

Methodology

I used a qualitative methodology to explore the phenomenological lived experiences of the target population. The random sample consisted of what Ravitch and Carl (2016) described as the single significant case sampling strategy, which is one in-depth case (N = 1) that provides researchers with a rich and deep understanding of breakthrough insights. The research unit of analysis was CIT-trained officers. The purposive random sample constituted of seven out of 20 possible CIT-trained police officers in the precinct. To this end, the structured questionnaire (see Appendix A) and open-ended questions (see Appendix A Continuance) focused on the perceptions of CIT trained officers of PwMI and CIT training as the basis for research design. CIT-trained officers were the participants of the study, and I did not include any non-CIT-trained

officers. One purpose of this qualitative approach was to demonstrate the coding theme behind the rationale of data analysis.

The alignment from the study's research topic to the research question on how officers' perceptions improved based on CIT training when encountering PwMI to the methodology and to the design was consistent. The purpose of the phenomenological study was to explore the impact of CIT training for CIT-trained police officers. The focus of the outcome of CIT training pertained to officers' perceptions of PwMI. However, I had not predetermined the outcome of the study. For example, participant answers from the questionnaire could have revealed particular disdain for CIT training or referrals and other officer resistances to change. Participants could also exude a type of personal evolution as a result of CIT training, such as a positive attitude about CIT encounters.

Participation Selection Logic

When researchers collect qualitative data, the intention is to explore the topic with selected participants at sites (Creswell & Creswell, 2017). This qualitative study required a limited number of candidates as participants. Out of a random selection of 24 police precincts in Contra Costa County, one precinct (Precinct Q) voluntarily agreed to serve as participants. Precinct Q was a midsized police department with 20 CIT-trained officers out of 39. Thus, seven out of 20 CIT-trained officers from the precinct participated in this study. The purposive random sample population who voluntarily participated in the study was from a Northern California precinct where the data came from seven Contra Costa County CIT-trained police officers. I did not interrupt daily operations by interviewing every CIT-trained officer in the precinct and did not defer to the chief of police to choose

ideal candidates for this study. The department had an interest in the procedural improvement that I suggested based on the anticipated findings. Therefore, with respect to gender, race, and age of the participants, the police chief gave me the liberty to select which CIT-trained officers participated in this study.

Blevins et al. (2014) noted that street-corner psychologists become first responders and law enforcement personnel when confronting crises in the field. It therefore made sense to have law enforcement agents participate in the study because police officers tended to work as psychiatric emergency first responders.

CIT training consists of a collaboration among police officers and mental health clinicians who work together to help PwMI (CACITA Public Speakers, 2017). After I secured permission by the Institutional Review Board (IRB) to gain access to the specialty officers, data collection began. With regard to the sampling strategy, I purposefully excluded members of the fire department and ambulatory personnel from my study. No representatives from such agencies provided data for the study. I contacted the chief of police for the precinct to provide access and permission to interview CIT-trained officers in the Contra Costa County. The identification and recruitment of study participants took place at my discretion.

The sergeant for the precinct selected the specific site location for the qualitative interviews. However, the study limitations also served as strengths, as exhibited by the research design. The study's strength originated from the participant pool with a focus solely on police officers in one region. With regard to providing an original contribution,

my study was the first to involve exploring officers' perceptions of PwMI by analyzing the impact of CIT training in the Contra Costa County.

Instrumentation

This phenomenological research used a published data collection non-standardized instrument from a Midwestern region that explored CIT-trained officers' perceptions of PwMI. The creators of the non-standardized instrument (see Appendices A and Appendix A Continuance) were a few people in a consensus-building project team in Lafayette, Indiana (W. Wells, personal communication, May 23, 2017). Wells gave access and consent to the non-standardized instrument, as well as permission to use it for the current study and to modify it if necessary (personal communication, May 23, 2017). I made one modification that included one additional interview question to answer the research question of this study. To ensure research credibility, I used audio-tape recorders to collect open-ended data from the population. Ravitch and Carl (2016) contended that not relying on memory will eliminate bias in an in-depth qualitative interview. Wells and Schafer (2006) distributed the pencil-and-paper structured questionnaire with closed- and open-ended questions for their study on perceptions, and this research study included the same format as well as open-ended questions (see Appendix A Continuance) for the qualitative interviews. Thus, the semi-structured questionnaire and interview questions (see Appendix A; Appendix A Continuance) consisted of two sections: a pencil-and-paper format and a face-to-face interview.

Published Data Collection Instrument

Wells and Schafer (2006) originally distributed the perceptions questionnaire instrument selected for this study, which is a non-standardized instrument created by a few people in a consensus-building project team (W. Wells, personal communication, May 23, 2017). After the National Alliance for the Mentally Ill (NAMI) West Central Indiana chapter received funding by the Substance Abuse and Mental Health Administration in 2002, a consensus-building project team was born (see Wells & Schafer, 2006). The consensus-building project team was vital to the development of the perceptions instrument. Wells and Schafer noted the consensus-building project team developed the needs assessment to have a better understanding of police officers' perceptions during encounters and responses to PwMI (p. 583).

Instrument Reliability and Validity

The consensus-building project team included an eclectic group of stakeholders, including police officials, social workers, judicial representatives, mental health service providers, PwMI, and family members of PwMI (see, Wells & Schafer, 2006). Although the authors did not discuss the reliability and validity of the instrument, the authors did discuss pretest and posttest training surveys. The authors shared the survey with the target population. Wells and Schafer elaborated how, in 2003, members of the consensus-building project team distributed paper-and-pencil surveys to patrol officers in five police agencies that served the greater Lafayette community of Indiana. Wells and Schafer indicated that pre- and post-test surveys of CIT-trained officers offered results that

indicated the officers had heightened abilities to both identify and respond to PwMI appropriately.

Procedures for Recruitment, Participation, and Data Collection

The purposive random sample included seven out of 20 possible CIT-trained police officers in Precinct Q. I created a recruitment e-mail (see Appendix E) that introduced and explained the purpose of my study for the chief of police in Precinct Q. Shortly thereafter, the chief of police sent me a list of 10 CIT officers in the day shifts (6am – 6pm) as options to randomly choose for my study. However, two of the 10 officers had been moved to the night shift and a third was on vacation during the time of the interviews. Therefore, I created an invitation letter for the randomly selected CIT officers to review for study participation. The sergeant for the precinct selected the specific site location for the qualitative research interviews. I did not know the exact location for data collection before the sergeant made that choice on the day of the interviews. Essentially, each interview took place at the precinct on-site and in a private room. I randomly selected the order of participating CIT officers in the day shift by the list of initials provided by the department's Lieutenant. There was no financial compensation for officer participation, although I provided refreshments for the in-depth qualitative interviews. When officers arrived to the scheduled interview, each participant received an informed consent form with information about their voluntary participation and a space to provide consent in lieu of a signature. I collected individual data upon the conclusion of each interview from the site location. The reliable questionnaire had a descriptive design approach that originally involved measuring the officers twice since, at

that time, there was a need existed for an update on police perceptions for CIT-trained officers.

Nevertheless, as there was no follow-up planned for this study, and there was no need for more than one instance of data collection. I recruited participants via random selection, the Chief of Police did not select participants for interview process. I sent invitations to participate to the selected participants via the Lieutenant. During each qualitative interview, the confidential consent form was distributed first. The questionnaire (See Appendix A) was distributed second along with the demographic questions (See Appendix B) and three interview questions (See Appendix A Continuance) were asked last. This was a phenomenological study where I explored the lived experiences of CIT trained officers through in-depth interviews. I used two tape recorders, a notebook, and pencils to collect all data. The time allotted for the interview session was 60 minutes per participant. Completed questionnaires were collected at the end of every interview. Individual questionnaires from each qualitative interview were placed in a locked bag in my briefcase. To ensure participant privacy and data protection, all data was stored in my home for safekeeping.

Data Analysis Plan

Proper qualitative data analysis is a reiterative process used to establish researcher validity. Creswell and Miller (2000) noted that qualitative interviewers use a second lens that establishes validity of the researcher’s accounts: the participants in the study. Therefore, I used a recording device to sustain interview integrity. Moreover, the unit of analysis used an embedded design. Thus, my study encompassed multiple units of

analysis meant to ascertain consistent patterns of evidence across units (Yin, 2013). The study involved an attempt to demonstrate shared lived experiences among CIT-trained officers as a result of CIT training. Saldaña (2016) indicated that researchers use epistemological questions to address theories of knowing and understanding of the phenomenon of interest. Hence, the research question complemented the research design. Saldaña noted that qualitative studies require coding in cycles to flush out research themes from in-depth interviews.

My study's data analysis involved using exploratory methods of coding that evolved into a code pattern and themes. The study reached data saturation through data triangulation. Fusch and Ness (2015) reported that researchers reach data saturation after a sufficient amount of information is available to duplicate the study, additional information is acquired, and further coding has reached feasibility. Probing questions posed to the participants of the qualitative interviews also helped to achieve a point of research saturation. To this end, data from Weller (2015) and Rodriguez (2016) helped to confirm or refute qualitative data collected from the participants as a means of triangulation. Triangulation represents how researchers explore various levels of perspectives of a similar phenomenon (Fusch & Ness, 2015). Since my purposive sample size was seven, I manually calculated the paper questionnaires digitally in Microsoft Excel. The National Foundation for Educational Research (n.d.) reported that qualitative researchers used an excel spreadsheet and placed individual question numbers from the paper questionnaire to represent the column heading and indicated participants' responses in rows to calculate results. Further, I hired a third-party (see Appendix E) for the

verbatim transcription of the interviews and used NVivo software (QSR International, n.d.) to break down the data collected from both the questionnaires and the qualitative interviews for emerging themes detection. Miles and Huberman (1994) indicated that outliers or exceptions can take a variety of forms, and McPherson and Thorne (2006) recognized such anomalies in research data sets as discrepant cases, atypical settings, unique treatments, or unusual events. Fortunately, the data analysis results in Chapter 4 identified and explained any discrepant cases.

Issues of Trustworthiness

Credibility, Transferability, Dependability, Confirmability

Rudestam and Newton (2015) reported that it may not be necessary to use the traditional terms *reliability, internal validity,* and *external validity* in writing a qualitative dissertation. Moreover, Lincoln and Guba (1985) recommended that the alternative constructs of credibility, transferability, dependability, and confirmability. Rudestam and Newton (2015) noted that researchers can ascertain the credibility or truth value of findings by spending sufficient time with participants and exploring participants' experiences in sufficient detail. With this in mind, I conducted qualitative interviews with open-ended questions to make certain my study's transferability emphasized a thick description.

That is, this study's results served as the basis of the sample generalizations to other participants for future replicated studies. Rudestam and Newton (2015) also cautioned that the reliability of an instrument depended in part on the population for which a researcher uses that instrument. Thus, the Wells and Schafer (2006)

questionnaire instrument achieved high reliability with one sample. However, isolated results may not necessarily attain that same level of reliability in another sample representing a different population. Finally, Rubin and Rubin (2012) established that confirmability is present when researchers report research findings in a transparent manner that allows the audience to understand the process of collecting and analyzing the data.

Ethical Procedures

This study took place in compliance with Walden University's Institutional Review Board. Minimal risk is acceptable, but researchers must provide it up front (Walden University, n.d.). That said, pregnant women, participants in crisis, and the elderly are vulnerable groups that could have possibly participated in my study. However, the exclusion of pregnant women can only happen when there is no medical benefit from participation and/or questions caused foreseen harm to fetus from participation. The exclusion of participants in crisis can only happen when the mental crisis impairs the ability to respond to the questions and causes psychiatric harm. The exclusion of the elderly can only happen when the interview process causes physical harm such as sitting for a long period of time, or sight and sound impairments prohibit the participant from fully understanding the interview questions or responding to the questionnaire. However, no participant randomly selected for this study represented any vulnerable groups. To ensure participant confidentiality, I used a locked box to store the completed questionnaires, recording devices, and transcribed notes to minimize unwanted solicitation or data intrusion as a possible minimal risk.

Institutional Procedures

My study remained in compliance with Walden University's IRB guidelines for review and publication. Should any voluntary participant had become visibly upset at any time during the qualitative interview whether when answering the questionnaire or during the interview, I would have reminded the participant of the clause in the consent form that stated not all questions have to be responded to should discomfort occur. If another participant was required as a possible replacement, data collection stoppage would have occurred with the visibly upset participant. I would have terminated the interview and randomly selected another participant. Further, my Chair and the IRB would have been informed as to possible participant injury. However, that was not the case with this study.

Ethical Concerns

The strategy of my study aligned itself with the lens of perceptions that explored CIT-trained officers' lived experiences during field encounters with PwMI. Thus, participants were solely CIT-trained officers and excluded all other psychiatric emergency personnel or anyone else related to the mental health network collaboration. I respected the opportunity to interview and retained voluntary participants without any coercion as identified in the verbiage of the consent form. Thus, individuals had the option and right to decline to participate in the study or to refuse to answer stressful questions (see Appendix A and Appendix A Continuance). Also, sharing results with participant managers while naming individuals is not an ethical practice and did not happen in my study. Each participant felt safe, was not forced to speak with me, and did

not worry about the need to provide guarded responses during the qualitative interview for fear of reprisal.

Protections for Confidential Data

Rubin and Rubin (2012) noted that the importance of ensuring that data remain transparent and that researchers keep interview notes or recordings so that anyone who wishes to check or duplicate the research can do so, provided the researchers secure the confidentiality of the interviewees. I kept a confidential log of how I transcribed, whether directly from tape, from notes, or from memory; how I verified it; and the level of detail it contained (Rubin & Rubin, 2012). To provide clarity, I noted and logged edited versions of the audio recording transcripts as left out material. I kept all data recordings, transcriptions, and questionnaires in a locked box in an undisclosed location. Since I hired third party transcription services, a confidentiality agreement (See Appendix E) was necessary for the study concerning access to raw data records**.** The research procedures and analysis/write-ups took all possible plans and measures to ensure that there are no disclosures of the participants' identities in the study. Participants' recruitment for this study were selected in a random order by the researcher using the list of CIT-trained officers provided by the Lieutenant of Precinct Q. There were no foreseeable psychological, economic, professional, personal, or physical risks beyond daily life for participant in this study. To this end, the research procedures were not expected to reveal or create an acute psychological state as the goal of the study was to explore the impact CIT training has on police officers. Additionally, I did not share notes or recordings with the Chief of Police at any time**.**

Summary

Chapter 3 included the rationale for using a qualitative phenomenological research design to answer the research question regarding how officers' perceptions improved based on CIT training when encountering PwMI. The chapter included the research question, research method and design, issues with trustworthiness, population and sample plan, instrumentation, data collection and analysis, and an ethical consideration of the participants. Chapter 3 also included the rationale for selecting a phenomenological design that addressed the study's research question. A qualitative interview consisting of a questionnaire and open-ended questions was suitable to explore participant experiences. This chapter included evidence to support the exploratory methods of coding that evolved into a code, pattern, and themes of participant lived experiences. Chapter 4 includes a comprehensive account of data analysis that includes certain shared lived experiences among CIT-trained officers. Chapter 4 also includes information about the demographic characteristics of the interviewees who participated in the qualitative interviews, as well as the coding and themes that emerged while exploring the participants' shared lived experiences from CIT training.

Chapter 4: Results

The purpose of this qualitative study was to explore perceptions among CIT-trained police officers in Northern California. The problem addressed in this study was the lack of knowledge about how CIT training impacts police officers' perceptions of PwMI. The research question addressed how officers' perceptions improved based on CIT training when encountering PwMI in the field. The results of the study in Chapter 4 show numeric variables with categoric tables that reflect the absolute frequencies of the number of observations in each variable within the questionnaire's categories (Bastos, Bonamigo, Duquia, González-Chica, & Martínez-Mesa, 2014). Chapter 4 also includes a detailed account of the study's setting, such as the demographics of the population, the data collection procedures performed, the data analysis technique used, the evidence of trustworthiness, and the data results.

Setting

The setting of the interviews was predetermined by the chief of police. After the IRB approval was granted (approval #03-07-18-0668953), the chief of police received the questionnaire interview protocol for review (See Appendix A and Appendix A Continuance). Shortly thereafter, a time and date of the scheduled qualitative interviews was agreed upon by me and the lieutenant. On the days of the conducted interviews, the room made available was private and suited my needs. There were no personal or organizational conditions that influenced participants or participant lived experiences at

the time of the study that may have influenced the interpretation of the study's results. All the qualitative interviews took place within the same week.

Demographics

The demographic questionnaire (See Appendix B) distribution happened before I proceeded with the open-ended questions of the in-depth interview (See Appendix A Continuance). That said, the seven participants for this study consisted of all males whose ages represented Generation X. In general, Generation X tolerates diversities better than Baby Boomers, due to the changing world and ability to think globally (Berkup, 2014). The male races were mixed: two Asian-Americans, two Hispanics, and three Whites. Participants' initials selection was in done random order of preference by me. All CIT-trained officers participants had some college education, with the majority holding bachelor's degrees.

Data Collection

As noted, the data collection site was predetermined by the police department's sergeant. Random participant selection entailed my choice of CIT officers' initials in the day shift by order of researcher preference. Invitations to participate in the study were distributed to the randomly selected participants via email by the lieutenant. On the days of the interviews, confidential consent forms were distributed first to each participant for signature prior to initiating the in-depth interview process. Next, the questionnaire distribution was followed by the interviews (See Appendix A and Appendix A Continuance). Each participant of the seven interviews was allotted 1 hour with me. All participants in Precinct Q interviewed with me in the same week.

I used two clipboards for the one-time interviews. I gave one to the participants to use when filling out the questionnaire (see Appendix A) and reserved the other for personal usage. Questionnaires (see Appendix A) were collected upon the conclusion of each interview and placed in a locked bag for data integrity and privacy. Two recording devices were used to collect the phenomenological data that derived from participant clarification requests while filling out the questionnaire (see Appendix A) as well as from the open-ended questions (see Appendix A Continuance). As has been noted, the demographic questionnaire (see Appendix B) distribution preceded the in-depth interviews (see Appendix A Continuance), and there were no variations from the plan presented in Chapter 3. However, there were unusual instances that occurred in this study.

Initially, I had access to two populations in Contra Costa County who voluntarily participated in this study. I would have had the opportunity to collect data from two separate departments. Unexpectedly, 6 months after securing access to both populations and obtaining IRB approval, the second precinct changed its mind with no prior notice. The removed department decided against participating the same week that I was ready to schedule interviews. There was no reason given other than the department opted to reserve the right to volunteer participation in my future studies. The impact of this last-minute decision prevented my study from consisting of two populations with an anticipated 10 participants in total, five from each Contra Costa County precinct. However, Precinct Q accommodated me with two more participants, which gave me the ability to achieve research saturation for this study.

Data Analysis

I counted and analyzed paper questionnaires manually, using Microsoft Excel via frequency tallies and percentages calculated from the participants' confidential responses. Approximately 4.5 hours of recorded audio interviews were transcribed and analyzed for this study. I transcribed the interviews intelligently, and then the audio files were transcribed verbatim by a third party to maintain data integrity and validity. I coded the interviews to detect themes and used the NVivo software application for theme validation and to determine if other emerging themes existed.

Evidence of Trustworthiness

My study's transferability emphasized a thick description and spoke to the study's credibility and dependability. This study's results served as the basis of the sample generalizations as transferability to other participants in future replicated studies, and isolated results may not necessarily attain that same level of reliability in other samples representing different populations. I transparently presented the data in a manner that atones for the study's confirmability, and no changes were made to adjust to credibility, transferability, dependability, and conformability as stated in Chapter 3.

Results

This study's results answered the research question, gaps in research, and addressed the study's purpose. The purpose of this study was to demonstrate the impact CIT training had on CIT-trained officers during CIT field encounters. Saldaña (2016) noted that epistemological research questions that began with ”How does” suggested the exploration of participants' found perceptions within the data. Thus, the aligned research

question of this study, how do officers' perceptions improve based on CIT training when encountering PwMI, was answered in this study's data results. The majority of officers agreed CIT training was personally beneficial while the minority vote of officers explained they already had patience and compassion for PwMI during field encounters prior to receiving the specialty training. Subsequently, the consensus of the participants' response was that CIT training shared useful mental illness knowledge and taught excellent verbal de-escalation skills to handle PwMI in crisis. In-depth conversations revealed how the specialty training improved officers' perceptions as individual responses to pause and analyze CIT encounters established the required connection and the ability to use effective communication calmly.

Gaps in Research Results

This study produced results for each of the three gaps in research briefly introduced in Chapters 1 and 2. I explored the relationship between CIT-trained officers and mental health clinicians (Rodriguez, 2016). For example, one of the participants was a student resources officer who works with mental health clinicians onsite and has a great relationship with the support system on the school's campus during school hours. Another participant was the department's mental health liaison who works with other divisional county Mental Health Evaluation Team (MHET) officers and has a great relationship with the MHET team. Paradoxically, this partnership is nonexistent with patrolmen in the County who respond to CIT encounters in pairs for protection and support. Subsequently, this study addressed increased officers' knowledge of mental

illnesses during in-depth conversations with me that confirmed enhanced knowledge of certain types of mental illness.

CIT-trained officers demonstrated and verified increased knowledge of verbal de-escalation skills and new perspectives about PwMI in crisis. This case study captured the knowledge that indicated CIT-trained officers offered referrals to criminal diversion programs as a result of specialty training. County officers have extensive knowledge about 211 Contra Costa Crisis Center dispatch for mental health resources, outreach programs, and mission centers to refer PwMI experiencing crises. Weller (2015) indicated that there is no efficient system to track if officers were indeed offering referrals to community-based mental health programs during CIT encounters. This study revealed a slight improvement in that CIT encounters were tracked through paper through investigation reports and referrals to MHET. This study addressed the gap concerning lack of referral dispositions for CIT encounters (see Weller, 2015). Participants from this study disclosed there were still no clear dispositions for CIT encounters other than jail, hospital, or release.

Result Tables

Taxonomy tables presented in a pre-determined order and derived from qualitative in-depth interview results, tabulated results from questionnaire responses, and emerged themes. All displayed results were rounded to the nearest ten to reflect and even 100% for all data calculations. The data listed in paragraph format described the discrepant cases. I created taxonomy tables and paragraphs below the tables that displayed detailed participant responses transcribed from questionnaire results and open-

ended comments. Finally, the coding pattern and theme detection displayed emerging themes on a separate table and figures.

Table 1 indicated CIT-trained patrolmen (71%) had at least five contacts with PwMI per month. Order-related calls such as disturbances and loitering (100%) were considered as the most common reason for CIT encounters. Officers (72%) agreed (28% disagreed) that resolving the CIT encounter in a timely manner was important. Officers (100%) expressed an importance of the safety of people involved in CIT encounters. Repeat calls were a problem (28% big; 28% moderate; 44% small). Ensuring PwMI received mental health services was important (100%) to this study's participants.

Table 1

Officers' Perceptions of CIT Field Encounters

On average, how many contacts do you have per month with a PWMI?	Frequency	Percent
Less than 1	1	14.5%
1 to 2	1	14.5%
3 to 4	0	0%
5 or more per month	5	71%
Single most common reason for officer contacts with PWMI	Frequency	Percent
General order maintenance, such as a disturbance & loitering calls	7	100%
Crimes PWMI are most commonly responsible for	Frequency	Percent
Order-related crimes	7	100%

(table continues)

Resolving the situation in a timely manner	Frequency	Percent
Very important	3	44%
Somewhat important	2	28%
Not very important	2	28%
Repeat PWMI calls in crisis are a problem	**Frequency**	**Percent**
Big problem	2	28%
Moderate problem	2	28%
Small problem	3	44%
Ensuring the safety of people involved	**Frequency**	**Percent**
Very important	7	100%
Ensure PWMI received mental health services	**Frequency**	**Percent**
Very important	4	56%
Somewhat important	3	44%

Listed below are open-ended discussions from participants that revealed additional details of CIT field encounters during the in-depth interviews:

> "Confrontations are unpredictable. By using effective communication, I'm able to drop a little bit, take a leap of faith, and have a sit-down talk with PwMI."
>
> "Officers should take ownership, refer PwMI to point of contact for treatment, not cop out, and help to resolve the issue instead of papering them as 5150."
>
> "If PwMI has medical insurance, we cannot do anything with them. County should work with private insurance for public resources access."
>
> "If you are a parolee, then public help is not available."

Table 2 detailed results of officers' perceptions of CIT encounter outcomes. Some officers took less than 30 minutes (44%) for CIT encounters while the majority (56%) took up to 1 hour for situation resolution. Officers (85.5%) in the department took the time to get PwMI admitted for treatment (14.5%) did not answer. Officers did not ride in the transport from the field to the treatment facility located in Martinez. Although, most officers (72%) agreed (28%) disagreed that the mental health facility was optimal to jail. Officers (71%) agreed (14.5%) disagreed that the mental health providers gave adequate treatment to PwMI and (14.5%) did not answer. Officers (71%) agreed (29.5%) disagreed that the general hospital was not an alternative to jail. Coincidentally, most officers (71%) agreed (14.5%) disagreed that jails provide adequate treatment to PwMI and (14.5%) did not answer. Officers (56%) agreed (44%) disagreed that there need to be an easier way to get PwMI to treatment facilities. All officers were dissatisfied (72% very dissatisfied; 28% somewhat dissatisfied) with the process of placing PwMI in a mental health facility.

Table 2

Officers' Perceptions of CIT Encounter Outcomes

On average, time spent with contact with PWMI	Frequency	Percent
Less than 30 minutes	3	44%
30 minutes to 1 hour	4	56%

(table continues)

Officers in my department take the time to get PWMI admitted to treatment	Frequency	Percent
Strongly agree	1	14.5%
Somewhat agree	5	71%
(Did not answer)	1	14.5%
Mental health facility is the alternative to jail	**Frequency**	**Percent**
Strongly agree	3	44%
Somewhat agree	2	28%
Somewhat disagree	2	28%
Mental health providers give adequate treatment	**Frequency**	**Percent**
Somewhat agree	1	14.5%
Somewhat agree	4	56%
Somewhat disagree	1	14.5%
(Did not answer)	1	14.5%
General hospital is the alternative to jail	**Frequency**	**Percent**
Strongly agree	1	14.5%
Somewhat agree	1	14.5%
Somewhat disagree	1	14.5%
Strongly disagree	4	56%

(table continues)

PWMI are given adequate treatment in jail	Frequency	Percent
Strongly agree	1	14.5%
Somewhat agree	4	56.5%
Somewhat disagree	1	14.5%
(Did not answer)	1	14.5%
Getting PWMI to mental health facility should be easier	**Frequency**	**Percent**
Strongly agree	2	28%
Somewhat agree	2	28%
Somewhat disagree	2	28%
Strongly disagree	1	16%
How satisfied are you with the process of placing PWMI in a mental health facility?	**Frequency**	**Percent**
Somewhat dissatisfied	2	28%
Very dissatisfied	5	72%

Participants during open-ended conversations discussed the three possible outcomes for CIT encounters, verbal de-escalations for street dispositions, psychiatric hospitals, or jail:

> "Give the time to build a relationship if possible. Try to resolve peacefully."
>
> "I guessed the PwMI reached mentally stability when I stopped getting calls from that house."

> "We send someone to get evaluated at the psychiatric facility, and it's frustrating to see they get through the process that quick with the same sickness. Not getting what they need."
>
> "Jail intake is not real in-depth. They identify the mental issue and whatever PwMi was arrested for then that person is released. 48hrs in jail then released for misdemeanor crimes, PwMI get ticket and walk out which may not be enough time to get treatment. There's no follow up."

Table 3 demonstrated participants' perceptions of PwMI. Officers thought CIT encounters made them feel tense or uptight (88%) disagreed (12%) agreed. Officers (72%) disagreed (28%) agreed that CIT encounters made them feel angry or frustrated. Officers (72%) agreed (28%) disagreed CIT encounters as physically dangerous. Officers (56%) agreed (44%) disagreed that CIT encounters posed departmental liability risks.

Table 3

Officers' Perceptions of PwMI

CIT encounters make me tense or uptight	Frequency	Percent
Somewhat agree	1	12%
Somewhat disagree	3	44%
Strongly disagree	3	44%

(table continues)

CIT encounters make me very frustrated or angry	Frequency	Percent
Somewhat agree	2	28%
Somewhat disagree	2	28%
Strongly disagree	3	44%

I believe CIT encounters are physically dangerous	Frequency	Percent
Strongly agree	1	16%
Somewhat agree	4	56%
Somewhat disagree	2	28%

I believe CIT encounters pose departmental liability risks	Frequency	Percent
Strongly agree	2	28%
Somewhat agree	2	28%
Somewhat disagree	2	28%
Strongly disagree	1	16%

Participants open-ended responses about perceptions of PwMI from in-depth interviews were captured here:

“We don’t roust the homeless, that’s not what we do.”

“Homeless reasons, from the officers’ perspective, are due to an illness experienced by PwMI not people who experienced a job loss or who fell on hard times.”

“Persons with mania change their story once getting admitted to psychiatric ward: ‘If I say the right things, I’ll be out of here very quickly.’”

“If you can save one you have done a good job.”

"Homeless PwMI really don't have an advocate. You see an cop. The cop says bye to you in the ambulance. The ambulance says bye at the hospital. The hospital says what's up and bye. No one to help hold them accountable and get them the help they need. Because they don't know better at that point in time."

Table 4 consisted of participants' perceptions of CIT dispositions. Officers (100%) thought obtaining the appropriate CIT disposition was very important. Most common CIT dispositions were outright release (56%) and take to mental health facility (44%). Officers (56%) decided the single most appropriate disposition was to transport PwMI to mental health facility, (16%) outright release, (28%) other. Participants had mixed results regarding the ability to obtain the most appropriate (28% often; 44% sometimes; and 28% rarely) CIT dispositions for field encounters. Officers felt CIT disposition options should be improved (84%) agree (16%) strongly disagree. Officers were dissatisfied with and trying to obtain CIT disposition options (56%) agreed (44%) disagreed.

Table 4

Officers' Perceptions of CIT Dispositions

Obtaining the most appropriate disposition	Frequency	Percent
Very important	7	100%

(table continues)

Most common CIT encounter disposition	Frequency	Percent
Take to mental health facility	3	44%
Outright release	4	56%
Single most appropriate disposition for CIT encounters	**Frequency**	**Percent**
Take to mental health facility	4	56%
Outright release	1	16%
Other	2	28%
Able to obtain the most appropriate CIT encounter disposition	**Frequency**	**Percent**
Often	2	28%
Sometimes	3	44%
Rarely	2	28%
CIT encounter disposition options need to be improved	**Frequency**	**Percent**
Strongly agree	4	56%
Somewhat agree	2	28%
Strongly disagree	1	16%
I am dissatisfied with the CIT encounter disposition options	**Frequency**	**Percent**
Strongly agree	2	28%
Somewhat agree	2	28%
Somewhat disagree	2	28%
Strongly disagree	1	16%

(table continues)

I am often dissatisfied when I try to obtain the CIT encounter disposition I think is appropriate	Frequency	Percent
Strongly agree	2	28%
Somewhat agree	2	28%
Somewhat disagree	3	44%

As noted in the open-ended interview, most officers were dissatisfied with the current CIT disposition selections and the missing CIT dispositions officers deemed most appropriate:

> "PwMI goes to the psychiatric facility and says, 'I wanted to hurt myself 20 minutes ago but now I'm good' and is released."
>
> "Some PwMI get 5150'd. Some of them go to jail with mental health notes. Then the jail says no PwMI needs to be 5150'd. The jail should have 5150 capabilities."
>
> "Jail will take PwMi based on the severity of the crime then the courts will put that person in an off-site treatment facility."

Table 5 displayed officers' perceptions of CIT training and resources results as well as open-ended comments listed in the paragraph below the table. Almost all officers (85.5%) had CIT training less than 2 years ago so naturally, all participants (100%) heard of the CIT approach and most officers (72%) heard about NAMI in the area prior to this study (28%) did not. Officers (88%) agreed (12%) somewhat disagreed that the CIT training received was adequate. Officers attended either the 8hr or 40hr training in neighboring Alameda County or Contra Costa County. Majority of officers (56%)

confirmed their department would benefit from adopting the CIT approach, (44%) didn't have enough information to make that evaluation. unsure how to respond to CIT encounters, and understood the services available for PwMI. Officers (88%) agreed (12%) disagreed that CIT training needed improvement in the department. Officers (88%) agreed (12%) disagreed that the department provided adequate guidance about how to respond to PwMI. Officers (44%) agreed (56%) disagreed that there should be a new place for evaluation in the area. Officers (58%) agreed (42%) disagreed that there were not enough CIT-trained patrolmen. Officers (100%) disagreed that they were unsure about how to respond to PwMI. Officers (100%) understood services available for PwMI. Participants were split with the confidence that most officers were willing to receive additional CIT training (42% agree; 44% disagree, 14% did not answer). There were more mixed perceptions displayed among the study's participants. For example, participants (44% agree, 28% disagree, 28% did not answer) thought jails needed to better serve PwMI. Only majority of officers felt police and mental health clinicians have a good working relationship.

Table 5

Officers' Perceptions of CIT Training and Resources

How long ago were you CIT trained?	Frequency	Percent
Less than 2 years	6	85.5%
More than 2 years but less than 5	1	14.5%

(table continues)

Prior to this questionnaire I have heard about the CIT approach	Frequency	Percent
Yes	7	100%

I have adequate training on CIT encounter responses	Frequency	Percent
Strongly agree	3	44%
Somewhat agree	3	44%
Somewhat disagree	1	12%

My department would benefit from adopting CIT approach	Frequency	Percent
Yes	4	56%
No	0	0%
I don't have enough information to evaluate this	3	44%

CIT training needs to be improved in my department	Frequency	Percent
Strongly agree	3	44%
Somewhat agree	3	44%
Strongly disagree	1	12%

My department provides adequate guidance about how to respond to PWMI	Frequency	Percent
Strongly agree	3	44%
Somewhat agree	3	44%
Somewhat disagree	1	12%

Most officers are willing to receive additional CIT training	Frequency	Percent
Strongly agree	1	14%
Somewhat agree	2	28%
Somewhat disagree	3	44%
(Did not answer)	1	14%

(table continues)

Not enough officers are not assigned to respond to patrol functions	Frequency	Percent
Strongly agree	1	14%
Somewhat agree	3	44%
Somewhat disagree	2	28%
Strongly disagree	1	14%
Most of the time I am unsure how to respond to PWMI	**Frequency**	**Percent**
Somewhat disagree	3	44%
Strongly disagree	4	56%
I understand what services are available for PWMI	**Frequency**	**Percent**
Strongly agree	4	56%
Somewhat agree	3	44%
I have heard about National Alliance for Mental Illness in the area	**Frequency**	**Percent**
Yes	5	72%
No	2	28%
Police and mental health service providers have good working relationship	**Frequency**	**Percent**
Strongly agree	2	28%
Somewhat agree	2	28%
Somewhat disagree	2	28%
Strongly disagree	1	16%

(table continues)

Jail needs to better serve PWMI	Frequency	Percent
Strongly agree	1	16%
Somewhat agree	2	28%
Somewhat disagree	2	28%
(Did not answer)	2	28%

There needs to be a new place for officers to take PWMI for evaluation	Frequency	Percent
Somewhat agree	3	44%
Somewhat disagree	3	44%
Strongly disagree	1	12%

Subsequently, here are some open-ended comments from the in-depth interviews that addressed the importance of CIT training:

> "Officers are on board after CIT training, not before. So training is a positive, it opens officer's eyes to other perspectives."
>
> "40hr training is important for ALL officers new and vets to find out new ways of coping with CIT field encounters."
>
> "We, CIT coordinators, go to meeting with allied agencies in Mental County Health we round table the topic of the habitual homeless PwMI population and we discuss the issue with DA in attempts to figure out the best ways to remedy the situation."

Listed below, represents more conversation from the interviews that was based on the availability or lack thereof of mental health resources for the PwMI population in the area:

> "The resources have gotten a lot better since times of past, but not great yet."
>
> "Each county division has a mental health evaluation team (MHET) point of contact."
>
> "Generally homeless PwMI get referred within the County division for limited care, not to psych hospital or to other Central County resources."
>
> "There are not enough mental health resources in the County for PwMI."

NVivo Questionnaire Results

NVivo Software expanded the results to include the sentiment of responders via the data collection from the questionnaires. Participants thought CIT training had positive results regarding the acquired knowledge of enhanced verbal de-escalation practices and the knowledge of available resources. However, resources unavailable to officers when dealing with CIT encounters attracted attention to the negative aspect of the specialty training.

Figure 3 detailed conflicting sentiments CIT-trained officers expressed via the questionnaire collected data. The consensus displays a positive overall appreciation for the specialty training. However, the negative sentiments reflected the lack of resources and support CIT-trained officers had with CIT field encounter outcomes. NVivo auto code sentiment results consisted of a range from zero to 30 with output as follows: Very

positive (25 / 30); Moderately positive (0 / 30); Moderately negative (14 / 30); and Very negative (7 / 30).

Figure 3

NVivo Questionnaire Sentiment Results

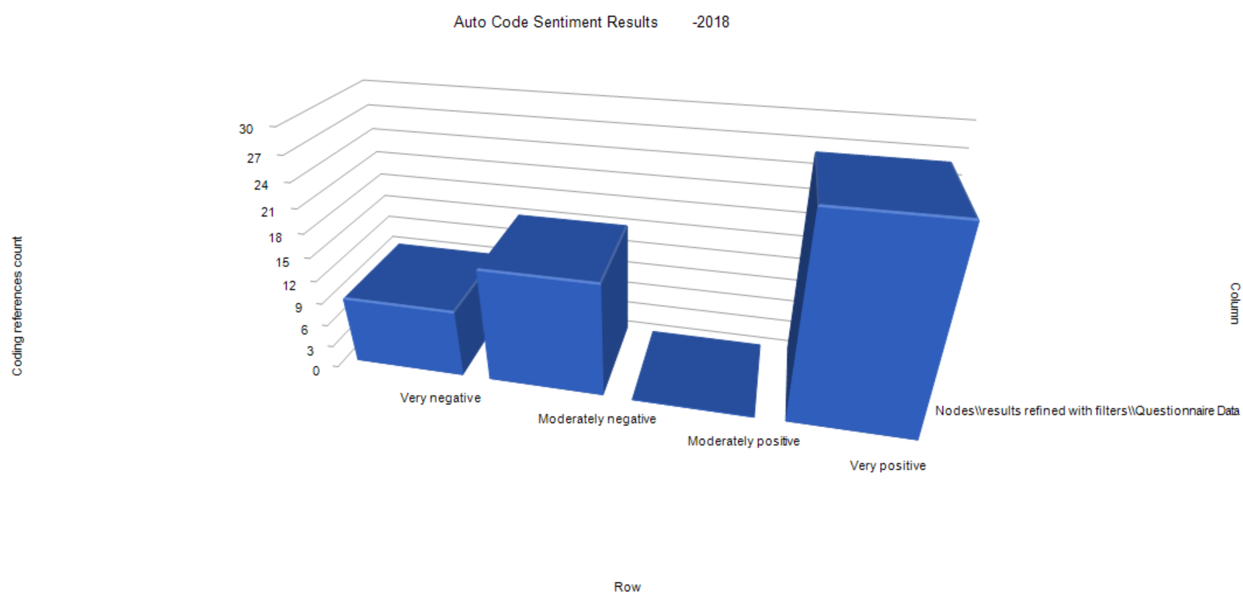
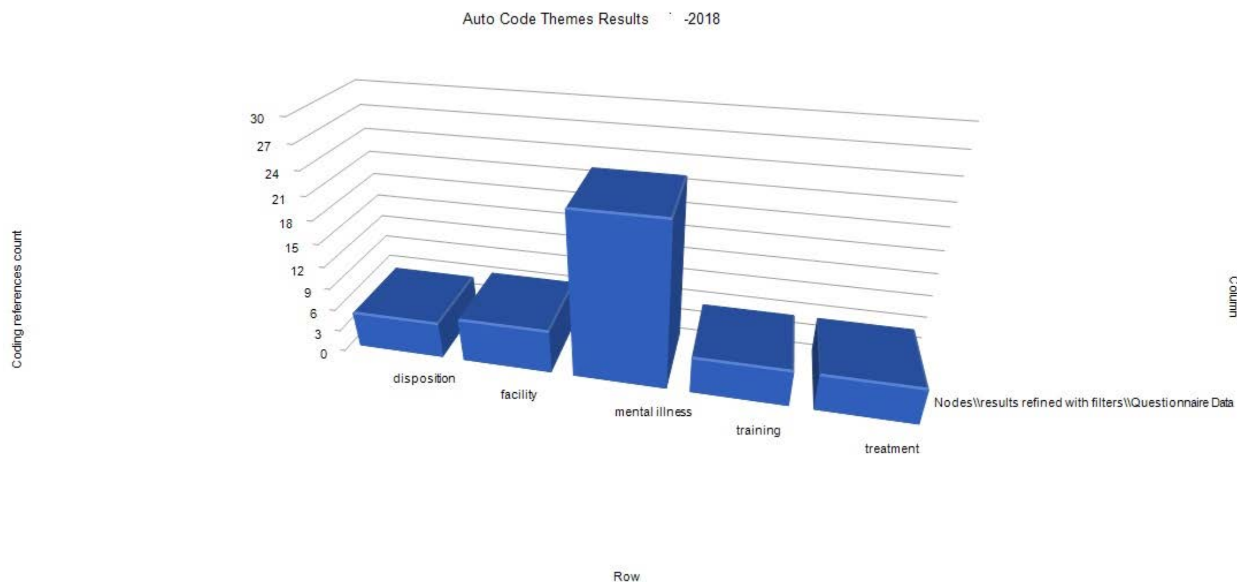


Figure 4 displayed the uphill workload battle of CIT-trained officers shared lived experiences in the field between the combined lack of resources and support to respond and the abundant state of mental illness in the County. NVivo auto code theme for the questionnaire results used a range from zero to 30 with output as follows: treatment (4 / 30); training (4 / 30); mental illness (20 / 30); facility (5 / 30); disposition (4 / 30).

Figure 4

NVivo Questionnaire Theme Results



Codes Patterns and Themes

I transcribed 4.5 hours of interviews and used the intelligent transcription method to analyze the audio files. With this in mind, I hired a third-party to transcribe the in-depth interviews who used the verbatim method, so I could double-check results against my intelligent transcription. Furthermore, verbatim transcriptions and completed questionnaire results were uploaded into the NVivo Software application which supplied emerging themes and sentiments (QSR International, n.d.). I manually coded the verbatim transcribed qualitative interview data to reveal the results of this study. Specifically, I used the lumping and splitting technique to analyze the data via In Vivo Code that captured and represented the essence of the interviews (Saldaña, 2016). For the

first cycle of coding, I used lumping and splitting to demonstrate exploratory methods of holistic coding.

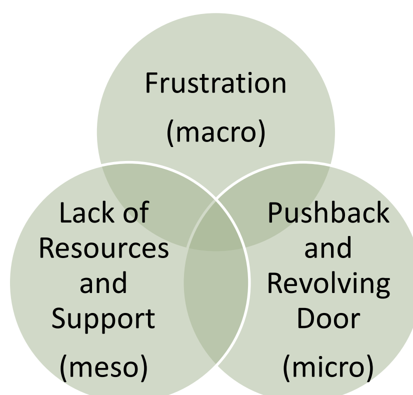
Further, eclectic coding was used to group In Vivo and Emotion codes, discovered in the first cycle of coding, as the combined elements that evolved into pattern coding. Second cycle coding methods represent ways of reorganizing and reanalyzing data coded used in the first cycle methods (see, Saldaña, 2016). That said, I used evaluation and pattern coding methods as the second cycle of coding to maintain the research question alignment of this study. Evaluation coding applies to the data assigned as a judgment about program effectiveness and worth (see. Saldaña, 2016). Subsequently, Saldaña clearly stated researchers should be able to identify three key issues after the second cycle of coding to denote the final phase of qualitative analysis.

Figure 5 detailed the frustration trinity theme of this study which was based on the collected data from the participant's interviews and populated into three categories: macro, meso and micro. Macro consists of the population structure of systems of meso (Dopfer, Foster & Potts (2004). Therefore, Contra Costa County's district attorney's office jail and the psychiatric hospital represented the macro category of the emerged theme. Further, Dopfer, Foster and Potts posited the economic system is a rule-system contained in the meso which consists of a rule and its population of actualizations. That said, the lack of mental health resources and support in the County represented elements of the meso category in this study. Micro refers to the individual carriers of rules and the systems organized (Dopfer, Foster & Potts (2004). Thus, pushback received by officers

from the jail, psychiatric hospital and PwMI qualified as the micro category of the frustration theme. I discovered the study's trinity theme as shown below:

Figure 5

Frustration Themed Trinity



The in-depth interviews helped me determine the frustration trinity theme I discovered during the data analysis process. I detected the theme break down from the In Vivo coding that revealed three emerged categories from the patterns found in the 3rd party transcription: frustration, lack of resources and support, pushback and revolving door. As noted, frustration at the county level was the macro category and the data associated with this theme is listed in the comments below:

> "I've sent out the same PwMI multiple times to mental health facility in the same shift, writing up the same thing over and over." "District Attorney offers programs but usually is in Central County, and DA needs to work better at sharing

> information with the entire county." "5150 form is too tiny to make a case." "Realistically, there are not enough psychiatric beds." "It's kind of a big machine where the hospital's goal is to just triage and get this person admitted or get them down the road, and I think that's where we kind of fail them." "Many PwMI could have meaningful lives if they just had a mental health wellness plan." "Mental health is prevalent problem with the transient population." "Some PwMI in the County refuse the resources available in Central County because of the commute." "We are the front line for PwMI in crisis with little to no resources and local support." "One person who was suicidal did not get treatment from the psychiatric facility and ended his life."

The meso category was established by repeating the same method I used to determine the macro category. Participant comments from the transcribed interviews listed below explain the lack of support and resources theme:

> "Mobile mental health clinicians need to visit / find PwMI in their environment to begin the baseline for help to bring them into places for assistance." "We need proactive mental health clinicians to co-respond with police." "We need a contact for parolee PwMI for CIT encounters." "PwMI need someone to supervise or monitor them taking their meds like a case worker or social worker to help." "There needs to be more of a push for mental health care at the probation level that involves more clinicians." "CIT training in neighboring Alameda County did not give us Contra Costa County mental health resources." "I don't think we have adequate training

about mental illnesses, we have generic knowledge but do not know the prescriptions and side effects to help with evaluations." "More money and more resources increase quality of life and reduce order-related crimes." "Central gets more services because of affluent population. This division of the county is left out of services because of its lower-end position on the socioeconomic scale."

Lastly, the micro category rounds out the trinity theme detected from data analysis. Participant comments from the interviews listed below gave insight to the types of pushback / revolving door experienced during CIT field encounters:

"PwMI do not want to leave their cart for treatment and cannot bring their drugs into a facility." "Cannot force PwMI to take meds." "Martinez psychiatric hospital only has 10 psych beds, I sent someone there twice in one shift who was stark naked and schizophrenic who came back twice." "We send someone to get evaluated at the psychiatric hospital and it's frustrating to see they get through the process that quickly with the same illness. Not getting what they need." "Initially jails had no mental health. Now they have clinicians there who do the intake process. But it's a shallow coverage. Intake is not real in-depth. Identify mental issue identification and reason for arrest then released. No follow up." "48hrs in jail then released with a misdemeanor crimes ticket and PwMI may leave untreated." "The hospital has sent PwMI out that really needed to be treated. It's been proven because they come right back with and they're crisis hasn't been remedied yet. And so, we're going back out, repeatedly."

NVivo Interview Results

Theme validation and verification required the services of the NVivo Software application. I created three nodes named Lack of Resources, Lack of Support, and Pushback. I used third party verbatim transcribed interviews, and placed passages from open-ended comments into the nodes accordingly.

Figure 6 detailed the lack of resources and support as well as the amount of pushback experienced by CIT officers in this study. NVivo auto code sentiment results from the verbatim transcription ranged from zero to 20. The frustration theme validation occurred as the macro representation of the county Lack of Resources Node (9 / 20) people; (12 / 20) mental health; (0 / 20) hospital; (8 / 20) county. Further, Lack of Support Node (4 / 20) people; (8 / 20) mental health; (2 / 20) hospital; (13 / 20) county represented the meso category. Alas, the micro category defined as the Pushback Node (2 / 20) people; (11 / 20) lack of support; (6 / 20) hospital; (4 / 20) county. NVivo results validated the researcher's conclusions with the software application's combined results that reflected a lack of resources and support, along with constant pushback that created frustration experienced by CIT-trained officers.

Figure 6

NVivo Interview Theme Results

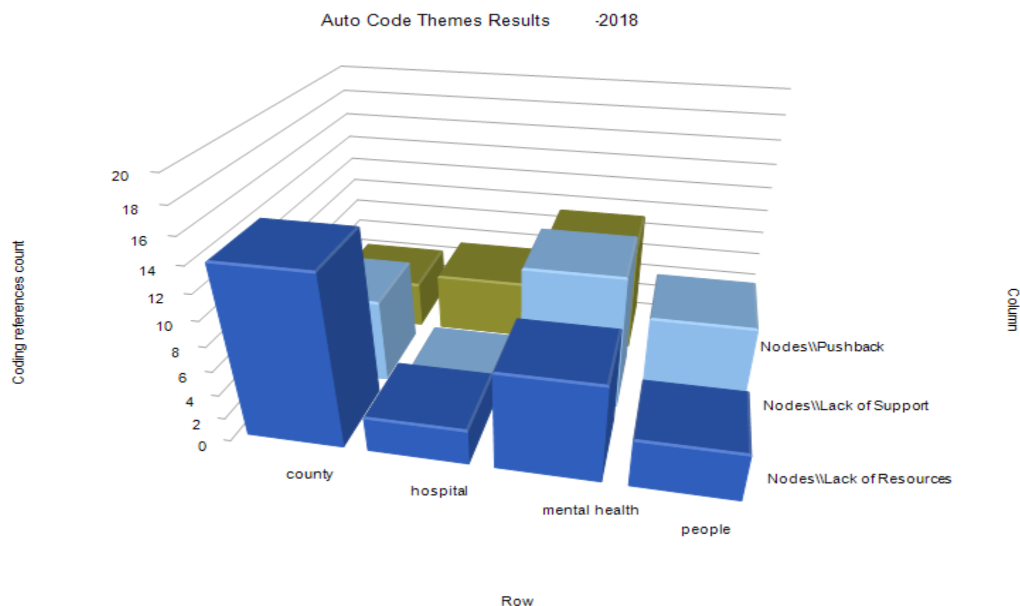
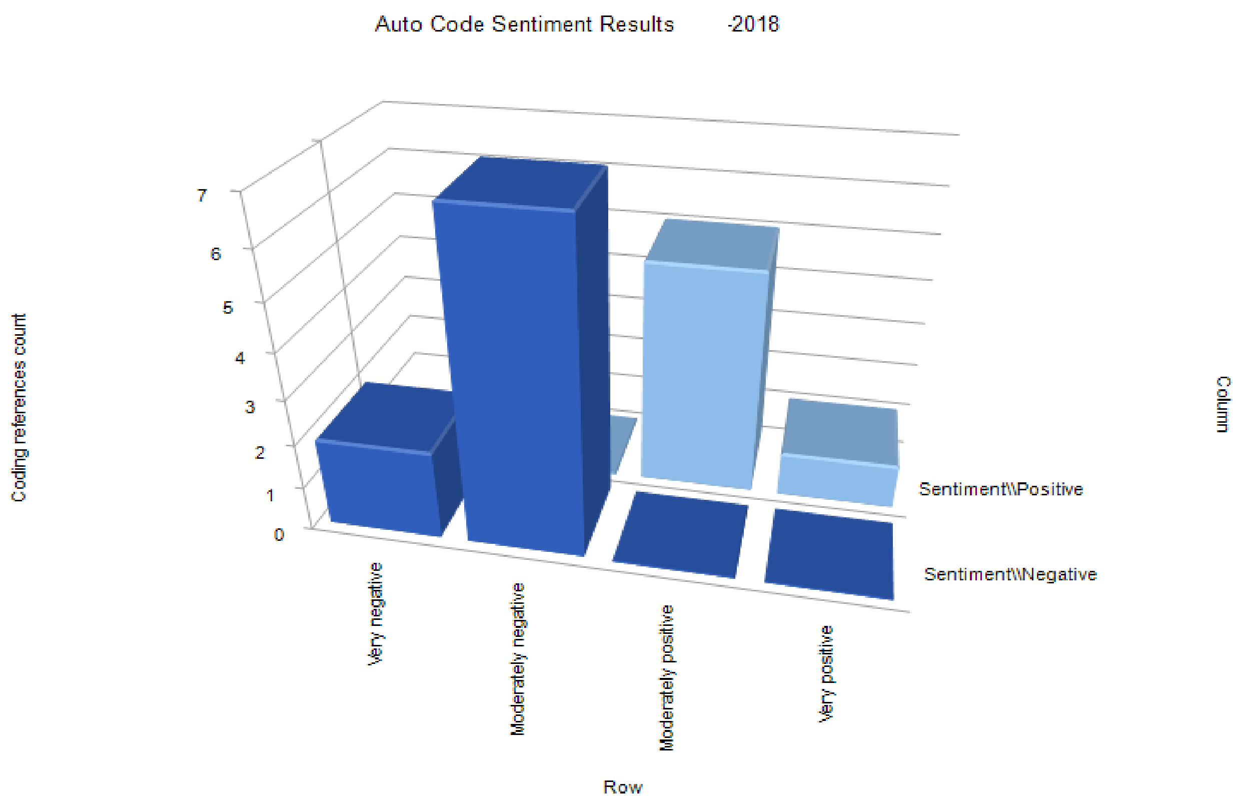


Figure 7 displayed the sentiment results from the theme detected by the NVivo Software application. Verbatim transcription inserted in the node configuration ascertained the themes' sentiment. NVivo results from the application were similar to the sentiment detected by the researcher's results. NVivo auto code sentiment results from the verbatim transcription ranged from zero to seven with the following output from negative to positive and right to left. Participants shared lived experiences included mostly negative sentiments from the frustration theme: Negative Sentiment Very positive (0 / 7); Moderately positive (0 / 7); Moderately negative (6 / 7); Very negative (1.8 / 7). Mostly positive sentiments from the teachings of CIT training was captured here: Positive

Sentiment Very positive (.9 / 7); Moderately positive (4.9 / 7); Moderately negative (0 / 7); Very negative (0 / 7).

Figure 7

NVivo Interview Sentiment Results



Summary

Chapter 4 contained a detailed account of the setting of the conducted study, demographics of the population, data collection procedures performed, data analysis technique used, the evidence of trustworthiness, and the results. The results showed

increased knowledge of mental illnesses in CIT-trained officers, healthy relationships between CIT-trained officers and mental health clinicians existed, specialty trained officers had improved perceptions of PwMI, and confirmed the need of clear dispositions for CIT encounters. The chapter discussed how third party verbatim transcription and NVivo Software validated themes discovered in this study. Chapter 4 also outlined the frustration trinity theme derived from participant in-depth interviews. Chapter 5 includes an interpretation of the research findings, recommendations for CIT trainers and mental health clinicians, implications for social change, suggestions for future research, recommendations for the Contra Costa County CIT responses, and the limitations of this research study. Chapter 5 also includes a discussion on how the findings from the current study aligned or refuted findings of prior research studies described in the literature review of Chapter 2.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative phenomenological study was to explore CIT-trained officers' perceptions once CIT trained. In this study, I discussed the lack of knowledge about how CIT training impacts police officers' perceptions of PwMI. Further, my study addressed the gap in the literature (see Blevins et al., 2014; Rodriguez, 2016; Weller, 2015) where researchers of reintegrated studies identified the need for structured CIT training for police officers. Subsequently, my study addressed the gap in the literature indicated by the lack of data that supported the impact on officers' perceptions once CIT-trained. Also, my study built on the study by Rodriguez (2016) by exploring the gap in knowledge regarding increased officers' knowledge of mental illnesses after CIT training as well as the gap of knowledge about the relationship between CIT-trained officers and mental health clinicians. Chapter 4 included a completed data analysis that resulted in the findings of my study. Chapter 5 contains a summary of the research study, which includes the interpretation of significant findings, limitations of the study, recommendations for further research, recommendations for Contra Costa County's mental health network, implications for policy recommendations and social change, and conclusions.

Interpretation of Findings

As mentioned in Chapter 4, the study's results demonstrated increased knowledge of mental illnesses in CIT-trained officers and revealed that a healthy relationship exists between CIT-trained officers and mental health clinicians. Further, I demonstrated that

specialty trained officers have improved perceptions of PwMI once CIT trained and continue to desire clear dispositions for CIT field encounters. Lastly, I outlined the frustration trinity theme derived from in-depth participant interviews. Data triangulation consisted of comparing previous studies to this study's findings that demonstrated similarities and dissimilarities in my data results. Wells and Schafer (2006) insisted that the goal of CIT training is to not only enhance police training but also to seek to change the larger system that responds to and seeks to enhance the quality of life of PwMI.

Consistent with prior assessments, once CIT-trained, officers spent more time on mental health-related emergency calls (Rodriguez, 2016). Also, as mentioned by Rodriguez, officers confirmed that spending more time with on-site mental health assessments goes against law enforcement's customary aim for an officer to apply swift responses to gain control of such encounters. Similar to previous studies (see Wells & Schafer, 2006), participants in this study agreed that CIT training improved their ability to identify PwMI in crisis and anticipate symptoms exhibited during CIT encounters. In agreement with previous studies, CIT-trained officers possessed greater knowledge and improved attitudes about PwMI (see Weller, 2015). Findings also agree with previous studies that indicated that CIT training led to increased utilization of mental health services in districts where these resources were available (see Weller, 2015).

However, real frustration still exists among CIT-trained officers who do not have the assistance of mental health clinicians and struggle to obtain treatment for PwMI in crises (Wells & Schafer, 2006). Synonymous with Wells and Schaefer's findings, officers seek to avoid arrests in favor of connecting a PwMI with a mental healthcare provider.

However, the satisfaction of CIT training increases exponentially when the psychiatric care facility does not refuse police referrals of PwMI brought in for mental health treatment (Borum et al., 1998; Steadman et al., 2001). Without all the components of CIT training, CIT-trained officers remain as psychiatric emergency first responders with no real field support that often leads to frustration with the entire response system.

Limitations of the Study

The study's limitations also served as strengths, as exhibited by the research design. The study's strength originated from the participant pool that focused solely on police officers in one region. The use of a phenomenological design was the first limitation of the study. Therefore, I monitored reflexivity and set aside personal bias, which underwent further discussion in Chapter 3. Another limitation was the use of Wells and Schafer's (2006) questionnaire that could have led to an increased risk of participants not answering each question accurately and honestly. Participants could have expressed a fear of reprisal when responding openly and honestly. However, the questionnaire was voluntary, and participants did not have to respond to any questions that may have caused any stress, which helped reduce this type of limitation. The third limitation was the convenience of the purposive random sampling method. The population was person-centered and consisted of officers from one out of 24 random police precincts in the Contra Costa County who voluntarily participated in the study. Further, a structured qualitative interview may not have allowed me latitude to combine open-ended questions that elaborated on a discussion about perceptions of CIT training and PwMI. Consequently, no females participated in this study, and further studies should involve

researching gender differences in CIT-trained officers' perceptions. Lastly, study duplications should include additional precincts in the entire Contra Costa County.

Recommendations

Contra Costa County's socioeconomic scale and has little to no support or advocacy available for the vast number of the PwMI homeless population. Officers who respond to CIT encounters receive constant pushback from the county psychiatric hospital who continuously releases gravely disabled PwMI still in crisis. The Assembly Bill (AB) 1971 (2018) states that local facilities shall consist of staffed licensed professionals or any physician and surgeon in the hospitals, provide emergency medical services in any department of those hospitals to PwMI, and have 8- to 24-hour detention and 5150 hold capabilities. New local resources and support will provide substantial relief to the constant pushback from the distant psychiatric facilities with limited in-patient capacity. To this end, Contra Costa County may also want to strongly consider becoming a participating county that provides conservatorship for gravely disabled PwMI (Senator Bill (SB) 1045, 2018) since this County has a significant population of homeless PwMI. Conservatorship is for 1 year and can be petitioned for an additional year for PwMI who qualify for an appointed guardian (SB 1045, 2018). SB states that appropriate placement established must be a licensed health care of psychiatric facility, community-based residential care setting, in supportive housing that provides wraparound services. To qualify, the PwMI must have experienced the following: five or more monthly visits to the emergency department, five or more monthly bookings/detentions or any other processing with PwMI in custody, or four or more detentions in a 12-month span for

evaluation and treatment (see SB 1045, 2018). With this in mind, local resources and support require a local and feasible CIT vehicle to transport PwMI in crisis.

Contra Costa County ambulatory care requests are fulfilled by the American Medical Response ambulances that get pulled out of rotation over 30 miles away, during noncommute hours, to respond to the entire county for CIT encounters. Each division of Contra Costa County needs the ability to physically transport consumers to various treatment facilities using its own CIT vehicle that protects the identity of PwMI. In neighboring Alameda County, Berkeley Police Department has a designated CIT vehicle with tinted windows that provides private transportation of PwMI to the mental health care facility (J. Shannon, personal communication, September 1, 2016). Further, Contra Costa County emergency mental health-related calls should have coresponders, both CIT-trained officers and MHET clinicians, to assist with psychiatric evaluations. The Berkeley Mobile Crisis coordinator teaches CIT training to officers and has staffed mental health clinicians who corespond with officers for mental health-related calls in both Berkeley and Albany cities (Y. Tenli, personal communication, September 2, 2016). Finally, I suggest that MHET teach CIT training to officers in each Contra Costa County division it represents.

Future Studies

Future studies should include interviewing female CIT-trained officers since that gender of the population was unavailable for this study. Different officers' generations may have alternative viewpoints about specialty training, which makes for noteworthy future research. Also, further studies should research the parole and probations

departmental response to PwMI in crisis and the impact of CIT training or the impact of mental wellness training provided to the department. Lastly, the Ventura County iCOP tool app records CIT encounters, takes notes, logs soft diagnoses, and tracks CIT encounter history (CACITA Public Speakers, 2017). Therefore, further research could explore if Ventura County participating police agencies are benefitting from the iCOP tool application during CIT encounters.

Implications

This empirical study provided original contributions to law enforcement and mental health network collaborations. This study's findings may further validate the impact of CIT training, as I discovered that specialty officers had improved perceptions of PwMI once CIT trained. Further, the exploration of the topic of CIT training led to an in-depth discussion that revealed elevated thought processes police officers had toward PwMI. My study's implication for social change also supported the objective of CIT training outcomes by providing tangible ways of mental health wellness for PwMI and significant, reliable levels of mental care. The combined components of my recommendations and strong suggestions provided the resources and support for the study's implication of social change regarding the treatment of PwMI in crisis.

Conclusions

A close alignment exists between the PMT and the dynamics of CIT training among police officers. However, successful interventions happen and often go without officers knowing what treatment types achieve long-term mental stability. Contra Costa County needs the resources as mentioned in the Assembly and Senator Bills to help

decrease the significant PwMI homeless population. The purpose of this study established the answer to the study's research question concerning CIT-trained officers' perceptions of CIT training. CIT-trained officers embraced the specialty training and practiced its teachings during CIT encounters. However, the officers in the county require field support from MHET by providing coresponder pairings with CIT-trained patrolmen. Mobile mental health clinicians have a great relationship with officers during hours of operation (J. Shannon, personal communication, September 1, 2016; Y. Tenli, personal communication, September 2, 2016). Giving the required attention to the socioeconomically challenged areas of Contra Costa County is an admirable start to fully supporting CIT-trained officers in the field and the beginning of the mental wellness healing process for PwMI in crisis.

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Appendix A: Questionnaire and Interview Protocol

Section 1: Questionnaire Form

In this section I would like to know about your on-the-job contacts with persons who have a
mental illness. When responding to these items please refer both to individuals who you believe
are diagnosed with a mental illness and/or individuals you believe should be evaluated for a
mental illness. Please select only one response for all questions and items.

1. On average, about how many contacts do you have per month with a person who has a mental illness?

___ Less than 1 contact per month, but some contacts each year

___ 1 to 2 per contacts per month

___ 3 to 4 per contacts per month

___ 5 or more contacts per month

2. What is the single most common reason for your contacts with a person who has a mental illness?

___ A call for service about general order maintenance, such as a disturbance & loitering

___ A call for service about a minor crime

___ A call for service about a serious crime

___ Contacts while on patrol, not a call for service

___ Other (please specify)____

3. Based on your contacts with persons with a mental illness, what crimes are these individuals most commonly responsible for?

___ Order-related crimes, such as disturbances & loitering

___ Property crimes

___ Violent crimes

___ Other (please specify)____

4. About how much time do you spend on the average contact with a person who has a mental illness?

___ Less than 30 minutes

___ 30 minutes to 1 hour

___ More than 1 hour but less than 2 hours

___ More than 2 hours

5. In your agency, how big a problem are repeat calls for service that are related to persons with a mental illness?

___ A Big Problem

___ A Moderate Problem

___ A Small Problem

___ Not a Problem at all

6. How important are the following concerns during your encounters persons who have a mental illness?

	Very Important	Somewhat Important	Not Very Important	Not At All Important
a. Resolving the situation in a timely manner.				
b. Obtaining the most appropriate disposition.				
c. Ensuring there is not a repeat call for the situation.				
d. Ensuring the safety of people involved.				

e. Ensuring the person receives mental health services.				

In this section I want to learn about the dispositions and outcomes of encounters you have had with persons who have a mental illness. When responding to these questions and items please refer both to individuals who you believe are diagnosed with a mental illness and/or individuals you believe should be evaluated for a mental illness. Please select only one response for all questions and items.

7. What is the most common disposition when you have contact with a person with a mental illness?

___ Take to jail

___ Take to a mental health service facility (not the general hospital)

___ Take to the general hospital

___ Release into someone else's custody

___ Outright release

___ Other (please specify)____

8. In your experiences, what is the single most appropriate disposition for a person with a mental illness?

___ Take to jail

___ Take to a mental health service facility (not the general hospital)

___ Take to the general hospital

___ Release into someone else's custody

___ Outright release

___ Other (please specify)

____

9. Compared to getting a person with a mental illness admitted to jail, how easy is it to get a person with a mental illness admitted into a facility for evaluation or treatment.

___ Very Easy

___ Somewhat Easy

___ Somewhat Difficult

___ Very Difficult

10. If you have attempted to place a person with a mental illness in a treatment facility, how satisfied have you been with that process, on average?

___ Very Satisfied

___ Somewhat Satisfied

___ Somewhat Dissatisfied

___ Very Dissatisfied

___ I have never attempted this

11. When you have contact with a person with a mental illness, how often are you able to obtain the disposition you think is most appropriate?

___ Often

___ Sometimes

___ Rarely

___ Never

12. When responding to these items think about your on-the-job contacts with individuals who you believe are diagnosed with a mental illness and/or individuals you believe should be evaluated for a mental illness.

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
a. I understand what services are available for persons who have a mental illness.				

b. If I believe a person should not go to jail then I can take them to a mental health facility for evaluation.				
c. If I believe a person should not go to jail then I can take them to the general hospital for evaluation.				
d. Persons with a mental illness are given adequate				

treatment at the jail.				
e. Persons with a mental illness are given adequate treatment by mental health service providers.				
f. It needs to be easier for me to get a person with a mental illness into a treatment facility.				

I would also like to learn about your attitudes toward potential changes to the way police and

service providers respond to persons who have a mental illness. Again, when responding

to

these questions and items please refer both to individuals who you believe are diagnosed

with a

mental illness and/or individuals you believe should be evaluated for a mental illness.

Please

select *only one response* for all items.

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
a. The disposition options available to me when I have contact with a person who has mental illness need to be improved.				

b. The police and mental health service providers in the Contra Costa County area have a good working relationship.				
c. Mental health services in the Contra Costa County area need to change to better serve persons with a mental illness.				
d. There needs to be a new place for				

officers to take persons with a mental illness for evaluation.				
e. The jail needs to change to better serve persons with a mental illness.				

In this section I want to know about the training you have received for responding to encounters that involve persons who have mental illnesses. Please select only one response for all questions and items.

14. How long has it been since you received specific training on how to respond to persons who have a mental illness?

___ Less than 2 years

___ More than 2 years but less than 5 years

___ More than 5 years

___ No specific training for this

15. I have received adequate training on how to handle encounters with persons with mental illnesses.

___ Strongly Agree

___ Somewhat Agree

___ Somewhat Disagree

___ Strongly Disagree

___ No specific training for this

16. The training my department provides on responding to persons with mental illnesses needs to be improved.

___ Strongly Agree

___ Somewhat Agree

___ Somewhat Disagree

___ Strongly Disagree

17. Most officers are willing to receive additional training on how to respond to persons with mental illnesses.

___ Strongly Agree

___ Somewhat Agree

___ Somewhat Disagree

___ Strongly Disagree

In this section I would like to learn about your perceptions of stress and workload. Please select *only one response* for all questions and items.

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
a. I believe encounters with persons who have a mental illness are physically dangerous.				
b. Most of the time I am unsure about what to do with persons who have a mental illness.				
c. I am dissatisfied with the disposition options				

available when I have encounters with persons who have a mental illness.				
d. I believe encounters with persons who have a mental illness pose significant liability risks for my department.				
e. I am often dissatisfied when I try to obtain the disposition I				

want when I have encounters with persons who have a mental illness.				
f. My department provides adequate guidance about how to respond to persons who have a mental illness.				
g. Encounters with persons who have a mental illness				

make me tense or uptight.				
h. Encounters with persons who have a mental illness make me very frustrated or angry.				
i. Most officers I work with are willing to take the time to get a person with a mental illness admitted into a treatment facility.				

j. There are not enough officers assigned to patrol functions to handle the demands from calls for service.				

With these three items I want to understand what you know about NAMI and about the Crisis Intervention Team model for responding to persons who have a mental illness. Please select only one response for all questions and items.

19. Prior to this questionnaire had you heard about the work of the National Alliance for the Mentally Ill in the Contra Costa County area?

___ Yes

___ No

20. Prior to this questionnaire had you heard about the Crisis Intervention Team approach to responding to persons with mental illnesses?

___ Yes

___ No

21. Based on my understanding of the Crisis Intervention Team, I believe my department would benefit from adopting this approach to responding to persons with a mental illness.

___ Yes

___ No

___ I don't have enough information to evaluate this

Appendix A Continuance: Questionnaire and Interview Protocol

Section 2: Interview Questions

22. Please describe what you think is the most important problem for police in terms of responding to persons with a mental illness.

23. Please describe what you think could be changed about the current mental health and/or

criminal justice systems in the Contra Costa County area that would allow you to achieve the

most appropriate outcomes of encounters with persons who have a mental illness.

24. Do you think your performance related to PWMI responses during CIT encounters has

improved since taking CIT training? If yes or no, please explain why?

Appendix B: Demographic Questions

INSTRUCTIONS

The demographic information provided by research participants is a very important part of the

questionnaire. Sometimes demographic data can help to illuminate study findings and results.

PLEASE REMEMBER responses to the questions below are strictly on a voluntary basis AND

as a reminder will be kept confidential.

24. How many total years of law enforcement experience do you have? ___________

25. How many years have you worked as a sworn officer in your current agency?

    ____

26. What is your gender?

    ____ Male

    ____ Female

27. What is your current age? ______

28. What racial or ethnic group do you belong to?

    ___ African American

    ___ White, non-Hispanic

    ___ Hispanic, non-white

    ___ American Indian

    ___ Asian American

___ Other (please specify)_____________________

29. What is the highest level of formal education you have completed?

___ High school or GED

___ Some college but have not earned a bachelors (4-year) degree

___ Bachelors (4-year) degree

THANK YOU FOR YOUR TIME AND PARTICIPATION

Appendix C: Letter of Cooperation

Precinct Q

March 8, 2018

Dear Monique Allen,

Based on our review of your research, we give permission for you to conduct the study entitled 'Crisis Intervention Team Training Among CIT-Trained Police Officers' within the Q Police Department Precinct. As a part of this study, I authorize you to use random sampling for specific recruitment, data collection with paper questionnaires and interviews. Individuals' participation will be voluntary and at their own discretion.

I understand that our organization's responsibilities include: providing the participant availability and a private room to conduct the interviews. We reserve the right to withdraw from the study at any time if our circumstances change.

I understand that the student will not be naming our organization in the doctoral project report that is published in Proquest.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

Precinct Q

Appendix D: Confidentiality Agreement

Name of Signer: [redacted]

During the course of my activity in reviewing data for this research: "Impact Crisis Intervention Team Training has on CIT-trained police officers" I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.

7. I will only access or use systems or devices I'm officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: **Date:** 1/25/2018