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Walden University

College of Social and Behavioral Sciences

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Ashley Yinger

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2019

Abstract

Experiences of Police Officers Who Have Received Crisis Intervention Team Training

by

Ashley Yinger

MS, Kaplan University, 2011

BS, Shippensburg University, 2009

Dissertation Submitted

of the Requirements for the Degree of

Doctor of Philosophy

Criminal Justice

Walden University

November 2019

Abstract

Police officers are often the frontline responders to calls involving people in mental distress. The lack of specialized mental health training can influence stigmatization and criminalization of people with a serious mental illness (SMI). Crisis intervention team (CIT) training is a tool to provide law enforcement with specialized mental health training to enhance their skills and comfort level when responding to crisis calls. There is a gap in the research examining officers' experiences with CIT training and how they apply that training when encountering people who have a SMI. The purpose of this qualitative case study was to explore a select group of police officers in Central Pennsylvania who are trained in CIT and how they use the tools learned from CIT training while on the job. Using the social distance theory and procedural justice theoretical framework, the researcher investigated the experiences of CIT officers by using the information gained from CIT training with individuals they encounter with a SMI. This study also examined the components that officers find most valuable from CIT training when responding to individuals who have a SMI. Participants in the study consisted of police officers trained in CIT, from a rural department, and have responded to mental health calls. Key findings showed that CIT training improved officers' knowledge and understanding of mental health to be able to slow down on crisis calls and show empathy towards people who have a SMI. Implications for positive social change involve policy reform for law enforcement training. The data from this study reveals that CIT training should be utilized across police jurisdictions, as it has shown to improve the interactions between law enforcement and people who have a SMI.

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November 2019

Dedication

I dedicate this dissertation to my family, friends, former staff, and colleagues who supported me with encouragement, patience, and support throughout my journey to earn a doctoral degree. My husband remained encouraging and understanding when I needed time to concentrate and focus on our greater good. To my past and current supervisors, thank you for the patience and understanding of time that I needed to take from work in order to see this study through and achieve my goals.

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Chapter 1: Introduction to the Study

Police officers regularly intervene in crisis situations with disabled individuals who are in distress. This study analyzed the experiences of officers trained in Crisis Intervention Team (CIT) training as well as their use of the training when intervening with individuals with a serious mental illness (SMI). There are different mental health training curriculums that can help officers understand mental health and symptoms, but there are few studies that gather police trainees' experience in terms of using the information gained from that training and how they integrate the training when responding to people with a SMI. This study will add to research about CIT training and collaboration between law enforcement and mental health professionals. Social implications from this study include policy reform in mental health training for law enforcement and improved police encounters with people who have a SMI.

Background of the Study

The nature of police work entails working with all human beings, regardless of gender, age, race, ethnicity, religion, socioeconomic background, and encountering people when they may be at their lowest point in life (Gesualdi, 2002; Perez-Pena, 2016; Watson & Wood, 2017). Responding to 911 emergency calls could involve mental health crisis situations involving a child or an adult with a SMI exhibiting disturbing behaviors. Individuals with a mental illness (MI) who may be lost in their own, altered world may not respond to basic police commands, increasing the likelihood of danger to themselves or the officer (Perez-Pena, 2016). Individuals not following police commands combined with inadequate mental health training and understanding of mental

health symptoms can result in fatal situations. Lethal force towards mentally ill persons is not uncommon. Cases such as Alfred Olango in California when his sister called for help due to him displaying erratic behaviors, a Sacramento man running the street refusing to stop and drop his knife, and an autistic Florida man playing with a toy, mistaken for a weapon by law enforcement are just a few examples of fatal or injury related police incidents involving persons with a MI, who struggled to respond to police appropriately and officers resorted to lethal force first (Perez-Pena, 2016). When specialized mental health training is not provided, officers may not use de-escalation techniques towards people with a MI to prevent force. In a 2013 report of the Cleveland Police Department, it was found that officers do not adjust the way they apply force to account if the individual is disabled (Investigation of the Cleveland Division of Police, 2013). Officers receive numerous hours of training to be able to perform their job, but mental health training is not always part of the curriculum or if it is, it could be as little as 30 minutes or as much as three days (Bernstein, 2016).

Understanding that law enforcement are typically the first responders to begin the process of someone with a MI entering the criminal justice system, their role can influence the criminalization of mentally ill persons. The amount of people with a mental health diagnosis involved in the criminal justice system is a national problem that with much complexity as to why it started and why it continues (Slate, Buffington-Vollum, & Johnson, 2014). Stone (1997) indicated that:

> "There is no more complicated or intractable problem within criminal justice than that posed by the needs of persons with severe mental disorders, and the failure to

> rationally respond to the issues raised by the incarceration of persons with severe mental disorders results in the unfair and disproportionate criminalization of persons with severe disorders."(p.286)

Individuals with a MI do not physically look any different than a person without a mental diagnosis. It is estimated that 6% of the general population has a mental disorder, and 15% of male inmates and 31% of female inmates showing signs of SMI (Slate et al., 2013; Wilper, Woolhandler, Boyd, Lasser, McCormick, Bor, & Himmelstein, 2009). Youth offenders also have a high prevalence of mental health indicating between 50-75% (Slate et al., 2013). Diversion is a necessary tool to keep individuals with low criminogenic traits and mental health out of jails and prisons by linking them to treatment in the community first.

The sequential intercept model serves as a diversionary framework tool. A study from the National GAINS Center for people that have a co-occurring disorder and interface with the criminal justice system implied that the use of a sequential intercept model could help guide criminal justice and mental health professionals in addressing the criminalization of mentally ill people (Munetz & Griffin, 2006). The sequential intercept model has five phases where the criminal justice system can intervene to help divert mentally ill persons from entering the criminal justice system and address recidivism. The five phases are (a) law enforcement and emergency services, (b) initial hearings and detention, (c) jails and courts, (d) reentry from jails, prisons, hospitals, and (e) community corrections and services (Munetz & Griffin, 2006). For this study, law enforcement and emergency services relate the most to the topic.

As mentioned, police officers are the first responders in most cases, and it is not uncommon for people with a SMI to encounter police. Intercept one opens the opportunity for prearrest, prerelease, and diversion opportunities, in addition to law enforcement collaborating with mental health professionals (Munetz & Griffin, 2006). An approach during this intercept is the use of CIT training, known as the Memphis model, which shows faster response times, low arrest rates, and a higher likelihood of connecting those who are mentally ill to treatment (Munetz & Griffin, 2006). CIT training can also play a role during intercepts three, four, and five, but intercept one is the most appropriate time to use CIT training. CIT training is becoming more commonly used in jails and prisons to improve the handling and safety of mentally ill inmates, as well as, the safety of correctional officers, and improve interactions with law enforcement when individuals return to the community from prison (Cattabriga, Deprez, Kinner, Louie, & Lumb, 2007).

To address the ongoing concern of law enforcement and their interactions with persons who have a mental health diagnosis and the increase of criminalization, initiatives have started within multiple police departments across the United States. CIT training is one of the major initiatives, but it has not been adopted nationwide (Cross, Mulvey, Schubert, Griffin, Filone, Winckworth-Prejsnar, DeMatteo, & Heilbrum, 2014; International Crisis Intervention Team, n.d.; NAMI, 2017). The purpose of this study was to understand the experiences of a select group of police officers who are trained in CIT and how they use the information gained from CIT training with citizens they encounter who have a SMI. Studies have been conducted regarding CIT training, but

many are quantitative. In addition, there is a lack of CIT training research in rural police departments, specifically in Central Pennsylvania because the Memphis model is based upon a more urban area (International Crisis Intervention Team, n.d.; New River Valley Community Services, 2015). Therefore, this study will specifically look at a rural police department in Central Pennsylvania to add to the literature research of CIT training in a rural setting. The study was pertinent in addressing the missing research of officers' experience using the information gained from CIT training with people they encounter who have a SMI, specifically in rural areas. This study was completed by using a qualitative exploratory case study that may add to research regarding outcomes of CIT training implementation in a rural police department. Potential social implications will be policy reform in mental health training for law enforcement and improved police encounters with people who have a SMI, along with moving Pennsylvania towards a statewide CIT model.

Problem Statement

A lack of mental health training for police officers leads to an increase in criminalization of people with mental illnesses (Kara, 2014). Around 7% of calls with police involve individuals with a MI (Mulay, Vayshenker, West, & Kelly, 2016). Blevins, Lord, and Bjerregaard (2014) reported that people with a mental health diagnosis will get arrested at least once in their lifetime. According to the National Alliance on Mental Illness (NAMI), approximately two million bookings into jails involve individuals with a MI annually, and one out of four people involved in police officer shootings have a severe mental illness (NAMI, 2017). When officers do not have the

adequate experience or skills regarding mental health, it may impact their perceptions, beliefs, and attitudes towards individuals with a MI. Mental health training does reduce stigmatization, but there is less known regarding the impact of officers' attitudes towards people with mental health illnesses (Mulay et al., 2016). The NAMI and other organizations started working with law enforcement to develop CIT training programs to help officers obtain awareness, skills, and resources regarding MI to better respond to crisis calls and increase the safety of both officers and individuals with mental illnesses (NAMI, 2017). In terms of research, there is missing information regarding the effectiveness and outcomes of CIT training that include law enforcement officers' experience in terms of using the information gained from CIT training with citizens they encounter in the community who have a SMI. This study will contribute to the literature by exploring CIT training outcomes pertaining to a rural area and providing policy makers with data to consider when implementing any changes involving the need to address the number of persons with MI having police contact, in addition, for more specialized mental health training in police departments.

Purpose of the Study

The purpose of this qualitative exploratory case study was to understand the experiences of a select group of police officers who are trained in CIT and how they use the information gained from training with citizens they encounter who have a SMI. Officers who completed CIT training indicated that they show more interest and empathy towards individuals with MI and finding other resources rather than opting for the deposition of arrest and use of force (Broussard, McGriff, Neubert, D'Orio, & Compton,

2010; Camille-McKiness, 2013; Ritter, Teller, Munetz, & Bonfine, 2010). Data from this study will add to the literature by helping future research in terms of the evaluation efforts of CIT training programs.

Research Questions

The main research question for this study was:

RQ: What are the experiences of CIT officers in terms of using the information gained from CIT training with individuals they encounter who have a SMI?

A sub-question was:

SQ: What components do officers find most valuable from CIT training when responding to individuals who have a SMI?

Framework

The sequential intercept model, social distance theory, and procedural justice model were all used as frameworks to guide this study. The sequential intercept model is used as a framework for this study as it relates to law enforcement being first responders and the discretion and response they use towards individuals with a MI that can impact whether they enter the criminal justice system. The model has been referenced in this study because CIT training is a tool to use during the beginning process of when law enforcement encounters a person who has a SMI, but it is not the primary framework.

Social distance theory shows that the more experience people have with a population, the more comfortable they become. This theory served as one of the primary frameworks for this study. If police officers have more experience in mental health and interacting with persons with MI, they can become more comfortable when being

confronted with mental health calls (Eadens, Cranston-Gingras, Dupoux, & Eadens, 2016). More mental health training and experience in terms of responding to this population may also improve empathy, attitudes, and beliefs when working with individuals who have a mental health disorder.

Social distance theory informed this study because it involved exploring officers' experiences of CIT and how they use the information gained from the training when interacting with individuals who have a SMI. Social distance is used in research when using different groups such as those with MI. Corrigan, Edwards, Green, Diwan, & Penn (2001) said that stigmatize attitudes towards MI are endorsed by many Americans in the United States. Corrigan et al. (2001) also explained that social distance describes a person's self-report regarding their willingness to engage a person with MI. As part of this study in exploring officers' perceptions, the researcher asked questions regarding their beliefs, empathy, and attitudes in relation to mental health before and after they completed CIT training. A person who experiences MI such as schizophrenia can be greatly impacted by social stigma (Corrigan et al., 2001). Social distance was important in this study as it related to officers' perceptions regarding MI, their willingness to engage this population, and how mental health training influences their comfort level towards persons with a SMI.

Also, with this study primarily focusing on a rural area, social distance is important in terms of this topic. Perceived social distance for a person who has a SMI can keep that person from seeking treatment in rural areas (Rural Mental Health, 2017). According to Rural Mental Health (2017), there are a combination of factors that may

influence a person to avoid accessing care compared to urban residents; which include lack of knowledge, stigma, secrecy about mental health in the community because of smaller populations, and the perception of lack of privacy in small towns because they often have closely-tied social networks.

Tyler (2007) provided an overview of procedural justice in the courtroom and his theory of fairness, also known as procedural fairness, can also apply to police interaction with individuals with SMI. How people are treated by criminal justice professionals and how disputes are handled by the courts can influence how people evaluate and perceive their experiences (Tyler, 2007). The theory of procedural fairness includes principles of voice, neutrality, respect, and trust. The opportunity to communicate and allow people to tell their side of the story is very important because it allows them to feel respected and builds trust. Neutrality highlights the aspect of fairness because a person feels they are not being judged for who they are or what they have (i.e. a SMI). People want to be treated equally regardless of gender, age, race, religion, and presence of MI. Individuals want to be treated with respect and this includes starting with law enforcement and going all the way up to judges. The criminal justice system is complicated, and people need to be able to talk, understand what is going on, and be treated equally regardless of their background. How people are treated can easily relate to how they respond in return (Tyler, 2007). Lastly, if people get a chance to talk and are treated with fairness and respect, they are more likely to trust the process and the individuals they encounter, including first responding officers.

When officers respond to people with a SMI, that person may not understand what is going on or may display erratic behaviors that law enforcement may easily misunderstand. How officers respond to the person can impact the outcome of the situation. Procedural justice was also vital to this study because it explores the history of people with MI and how they were treated in the criminal justice system. Individuals with a SMI are impacted by stigma in various settings including, interactions with police (Treichler & Lucksted, 2018). How the police treat the person will result in how the person with a MI perceives law enforcement and trusts them, which can relate to how cooperative the person will be.

As discussed, multiple frameworks guided this study, but social distance and procedural fairness are the highlighted ones. The sequential intercept model was referenced because CIT training begins at the first phase of police contact with a person who has a SMI. Social distance and procedural fairness relate to the qualitative approach because they explore how comfort level can improve and stigmatization can reduce with specialized mental health training. In addition, these theories relate to the research question about officers' experiences using the tools learned during CIT training and how they have integrated knowledge from those experiences in terms of encountering people with a SMI because it will explore the impact regarding comfort level and stigmatization.

Nature of the Study

This study involved a qualitative method. Studies that are qualitative involve gathering knowledge from participants who can enrich the understanding of the topic (Rudestam & Newton, 2015). The goal is to explore and identify patterns and themes to

provide meaning regarding the topic (Creswell, 2009). For this study, the key concepts and phenomena include CIT training, law enforcement, and police interactions with the mentally ill persons while responding to mental health crisis calls.

The specific design for this qualitative study was an exploratory case study. Qualitative studies focus on interpretation, subjectivity, orientation towards processes, and concern with context regarding behavior as it is linked to forming experience (Kohlbacher, 2006). Case study research is one form of qualitative research and it is often used in social sciences, along with a growing confidence of supporting a rigorous research strategy (Kohlbacker, 2006; Stake, 2000; Yin, 2003). Yin (2003) said that a case study investigates a phenomenon within its real-life context, uses multiple sources of evidence for triangulation purposes (minimum of three), and supports prior developments of theoretical foundations to guide the collection of data and analysis. The purpose for using this design was to gather a full understanding of officers' experience in terms of using information gained from CIT training with people in their community that they encounter who have a SMI. Research continues to be conducted regarding CIT training, but there is a lack of knowledge in terms of how officers integrate tools learned from the training when they encounter citizens in the community who have a SMI. Speaking to officers who have completed the training and had time since the training to respond to mental health crisis calls will allow them to communicate their experiences in terms of how the training was valuable to them. Specific interview questions asked about components of the training that were the most valuable and how they have used the information gained in the training when encountering people with an SMI.

Qualitative studies are consistent with understanding and exploring how law enforcement uses CIT training when interacting with people who have a serious mental disorder. Understanding the officers' experience of mental health training and then interacting with individuals who have a SMI relates to the social distance theory of becoming more comfortable to the subject. This research strategy also relates to social distance when specifically looking at factors in rural settings that people encounter such as stigma and privacy if they have a SMI. The topic also relates to procedural justice to be able to explore if the information gained in CIT relates to how officers provide fairness to persons with mental disorders compared to people who do not and officers' attitudes towards the stigmatization of MI.

The unit of analysis for this study was CIT police officers. When collecting data for case studies, there are different methods such as interviews, documents, archival data, observation, and physical artifacts (Kohlbacher, 2006). Being able to use multiple sources of data is a unique strength for case studies and the type of data can be either qualitative or quantitative (Yin, 2003). Data collection for this study entailed one on one interviews with officers who have completed CIT training and review of documents that consist of previously completed CIT data sheets, and previously completed pre/post CIT surveys from the training. The data sheets and surveys are documented evidence through which the researcher conducted content analysis to review the narrative data. After collecting data, it was analyzed through coding and themes. Coding is the process of turning raw data into a more standardized form (Ravitch & Carl, 2016). Bryman (2004) said that qualitative analysis allows the researcher to search for underlying themes and

patterns to understand the meaning of the context regarding the phenomenon being analyzed. Qualitative software called DeDoose was used to help organize the data and see emerging patterns.

Significance of the Study

There is missing information regarding how CIT officers in rural settings use their experience from the training when interacting with people who have a SMI. This research fills the gap by understanding the experiences of police officers in terms of how they use the information gained from CIT training when encountering persons with a SMI, specifically in a rural area. The study may explain how mental health training influences behaviors, attitudes, and skills when interacting with persons with a SMI. The topic is important to the public policy and administration field because it involves two specific target groups that impact the community: police officers and the mentally ill. Since the policy implementation of deinstitutionalization, individuals with a SMI are living in the community more frequently rather than state psychiatric hospitals (Kara, 2014). There is a greater chance that police officers will therefore interact with them, and they are the first responders to many crisis calls. The criminal justice system is meant to serve and protect but there is also a need for officers to have the skills and understanding to meet the needs of this mentally ill population to ensure appropriate resources are used for their care. Due to the change in the mental health system, there is also more of a need for the criminal justice and mental health systems to collaborate. Policy administration for this topic is relevant because strategies and implementations are necessary to ensure

individuals with MI are referred to the appropriate level of care, as is decreasing the stigmatization and criminalization of these individuals.

Implications for positive social change for this study include informing policymakers regarding the importance of mental health training as a tool for law enforcement to help improve police encounters and reduce stigmatization and criminalization of individuals with psychiatric disorders. Results from this study should aid police departments in helping to recognize the need for specialized mental health training for officers. The study will add to current CIT training research by exploring the officers' experiences in how they have integrated the tools learned in CIT training when encountering citizens in the community who have a SMI, specifically in rural areas.

Significance to Practice

As mentioned, the results from this study can help policymakers address the negative interactions between law enforcement and individuals with psychiatric disorders. Service calls that officers get involving people with a SMI are often time consuming and difficult to resolve, which can result in incidents or injuries (Reuland, Schwarzfeld, & Draper, 2009). Policy implications can also be explored regarding the criminalization of mentally ill persons that continues to be a national concern. Officers do have discretion, especially in terms of minor offenses, to talk to the person without taking him or her into custody, and link the person to appropriate interventions, but sometimes this is missed (Reuland et al., 2009). Results from this study may help guide criminal justice and mental health professionals in terms of making data-informed decisions regarding police encounters with people who have a SMI.

Policy recommendations are often needed and useful for police departments when analyzing data regarding CIT training effectiveness (Reuland et al., 2009). Previous evidence continues to support CIT training as being evidence based in improving officers' knowledge of mental health, attitudes and stigma towards mental health, and reducing injury and arrest. Reuland et al. (2009) said that the San Jose, California police department saw a 32% reduction in officer injuries 1 year after CIT training implementation. Memphis, Tennessee and Birmingham, Alabama had arrest rates of 2% and 13%, where CIT training was implemented, but in another community, there was a 16% arrest rate and CIT training was not implemented (Reuland et al., 2009). Overall, Reuland et al. (2009) found that CIT training for police reduced their stigma attitudes towards individuals who have schizophrenia. If continued research adds to the positive outcomes of CIT training involving police encounters of mentally ill persons then advancement of the practice of criminal justice and mental health collaboration, law enforcement training, and policy reform can continue.

Significance to Theory

The defining problem is the lack of mental health training for law enforcement and how that influences the criminalization and stigmatization of mentally ill people. Negative outcomes of police interaction with this population continue to be discussed but there are minimal outcomes reported to advance knowledge about this in the topic. There is data regarding CIT training, but it continues to lack the support of evidence-based practices and lived experiences of officers. Looking at this study through the lens of social distance and procedural justice can help address and understand the problem and

both contribute to support of the CIT training model, and how this training can improve officers' perceptions of the problem.

Social distance can be measured using a scale to determine a person's comfort level with a group to assess stigma/social distance towards those individuals (Bahora, Hanafi, Chien, & Compton, 2008). In a previous quantitative study conducted by Bahora et al. (2008), (n=34 controlled and 54 pre-CIT) officers were asked questions such as (a) How willing would you be to live next door to a person with a MI and findings showed that CIT officers reported a reduction in social distance and there was a significance between pre-CIT and post-CIT in the prediction of social distance. Asking officers about their experiences regarding how they use the information gained from CIT training that includes their thoughts on social distance before and after CIT training was important to gather an in-depth understanding of whether their attitudes and beliefs changed based on the outcomes of the training. Knowing the meaning of social distance and how it relates to this population (law enforcement and mentally ill persons) is why the framework aligns with this study.

The way law enforcement and other criminal justice professionals interact with people in the community, can shape the public's view of the police and their willingness to cooperate (Procedural Justice, n.d.). Procedural justice is a framework often considered for how people with a SMI experience their interactions with law enforcement and how an officer's behavior can shape the cooperation and resistance from that individual (Watson & Angell, 2007). Watson and Angell (2013) conducted a study using individuals with a SMI (n=154) and found that perceived procedural justice that is

applied appropriately will reduce resistance and increase cooperation among this population and police officers. There is a need for future research to understand how procedural justice can benefit police interactions with people and how stigma is associated (Watson & Angell, 2013). This theory aligns with the study as it explores the experiences of officers' who completed CIT training and how they use the training in their interactions with people with a SMI. Watson and Angell (2013) said that procedural justice provides a theoretical foundation for specialized mental health training for law enforcement such as, CIT training that can teach officers in how to treat people with a SMI in a humane manner. For this study, officers were able to provide their experiences in how they use the training when interacting with persons with a SMI.

Significance to Social Change

Many social change implications are consistent and bounded by the scope of this study. As mentioned, informing policymakers of the problem, effectiveness of CIT training, the importance of mental health training for law enforcement, and improved encounters with police and individuals with a SMI are some major aspects. Other social change implications include enhancement of the criminal justice system and mental health system collaboration and efforts in changing the mindsets that contribute to the stigmatization of mentally ill people (International Crisis Intervention Team, n.d.; Kara, 2014; NAMI, 2017). There is also a need for social change in addressing the criminalization of individuals who have a SMI but low criminogenic factors, which hopefully the literature research in Chapter 2 will help support.

The purpose of this qualitative exploratory case study was to understand the experiences of a select group of police officers who are trained in CIT and how they use the information gained from CIT training with citizens they encounter who have a SMI. This purpose statement relates to the problem statement in addressing the lack of mental health training for police officers and how they can use the training in diversionary opportunities to address the criminalization of people with a SMI. In the study by Sullivan and Spritzer (1997), they said that 75% of their participant selection (n=132), people were held in local jails while they waited for a state psychiatric hospital, at least once in their lives. Sullivan and Spritzer (1997) said that people living in rural areas had an increased risk of waiting in jail longer compared to people living in urban areas. In addressing the criminalization of people with a SMI, especially in rural areas, mental health professionals and law enforcement must work together to provide crisis intervention services and create immediate access to inpatient care (Sullivan & Spritzer, 1997). The national social change needed is the criminalization of serious mentally ill persons. This study will add to the research involving CIT training and how officers apply knowledge gained during the training when encountering citizens with a SMI, specifically in a rural police department in Central Pennsylvania. Results from this study can lead to policy and procedure reform, training, and collaboration efforts among mental health and criminal justice professionals.

Assumptions

The main assumption for this study was that some police officers do not receive adequate mental health training at the police academy prior to deployment and then

afterwards during their careers. Literature from Chapter 2 will explore this. The idea that law enforcement needs adequate mental health training that is also ongoing as a refresher will help prepare them in responding to mental health crisis calls and interacting with persons of SMI. CIT training is one major initiative to help officers learn about mental health and de-escalation techniques, which can be used as part of diversion when responding to a person with mental health in crisis. If officers are trained in CIT, it is important to explore their experiences of how they integrate the knowledge gained from the training in their responses to the mental health population.

In the next chapter, law enforcement being the first responders to much of the dispatch calls and the prevalence of individuals who have MI interacting with these officers will be explored. With that said, another assumption that aligns with this study is that most, if not all, officers during their work experience will encounter a person in mental health distress. How an officer applies the tools learned in CIT training during their encounters is relevant to understanding the effectiveness of CIT training. During the interview phase, questions were asked about the officers' contact and experience with this population both before and after completion of CIT training. These assumptions are necessary to this study as they align with the topic and explore both the importance of mental health training as a tool for diversion for nonviolent mentally ill persons, how CIT training can be a diversion factor, and to increase collaboration among the criminal justice and mental health system.

Scope and Delimitations

The research problem in this study was the lack of qualitative analysis regarding lived experiences of officers who have completed CIT training and how they apply that knowledge to impact the criminalization of mentally ill people. There is an increase of individuals with a SMI involved in the criminal justice system (Bouffard, Berger, & Armstrong, 2016; Farzana, 2014; Hnatow, 2015; Kara, 2014). Diversion, education, and training are areas identified by scholars that can influence this problem, and CIT training is one such response. However, many studies appear to be quantitative and there are minimal qualitative studies addressing CIT trained officer experiences in using the information gained from the training when interacting with the serious mentally ill. The qualitative design provides the opportunity to explore in-depth officer experiences regarding how they integrated the tools learned in the training when responding to community calls involving a mental health crisis. It is important to gather their individual experiences outside of work in relation to the topic of mental health to understand how this may influence their interactions and stigma towards this population before and after the training. The literature will show that many police departments have CIT officers complete any or few data sheets which can impact the evaluation of successful training models (Blevins et al., 2014; Cross et al., 2014; Skubby, Bonfine, Novisky, Munetz, & Ritter, 2013). Therefore, the scope of this study is officer experiences in using the information gained from CIT training from a qualitative exploratory case study strategy.

Two delimitations for this study were participant selection and geographic location. Participants for this study were officers who have completed CIT training in Central Pennsylvania. The goal was to recruit officers from a rural department to learn about their experiences of CIT training and how they have integrated the training in their responses to people with a SMI; therefore, it may or may not result in similar experiences of officers in other counties or states. By conducting this study with a rural police department, it added to the research about CIT training and the missing input from officers' experiences in a rural setting and how they use the training when encountering people with a MI. In the literature, it is explained that CIT training was developed in an urban area and police departments in rural areas may support CIT training implementations but run into barriers such as financial constraints, limited mental health resources, and lack of collaboration between law enforcement and mental health professionals (Compton, Broussard, Reed, Crisafio, and Watson, 2015; Jines, 2016; Skubby et al, 2013). Completing this study in a rural setting will add to the research about CIT training. The reason for only using CIT officers is based on the research question of solely looking at their experiences in using the information that they gained from the training when encountering people with a SMI.

Another delimitation to this study is due to the nature of the design being qualitative and interviewing CIT officers within an area, the findings are not going to be generalizable to all police officers who are trained in CIT. The findings to this study will only reflect the information that officers provide working at their police department in which the researcher will conduct the interviews. Using a quantitative design for this

topic and a larger sample size could produce more generalizable findings. However, a qualitative exploratory case study strategy provides a more in-depth experience to exploring officers' experiences regarding the use of CIT training compared to other methods. Quantitative does not explore thick rich data that is gathered from participants (Creswell, 2009). Chapter 2 will provide background information about past CIT studies and how this methodological approach bests addresses the research question.

Limitations

With one of the data collection methods being interviews, this does propose a limitation. The researcher was relying on officers being honest in their explanation of experiences related to the topic; therefore, the researcher needs to understand the trustworthiness of the results. Due to the study design being a qualitative case study, there were two other forms of data collection to help the trustworthiness of the results. Trustworthiness of data is more relevant in qualitative studies rather than validity and reliability in quantitative designs; where the researcher focuses more on credibility, transferability, dependability, and confirmability to meet trustworthiness (Devault, 2018). Trustworthiness is explained further down in the study in Chapter 3.

Bias is another area of concern that needs addressed. The researcher has over 13 years' experience working in the mental health system, with a previous role as a County Mental Health Administrator and this could have created potential bias. To avoid any bias, the researcher was honest and open during officer interviews about their work experience but asking open ended questions that did not lead to any potential bias

assumptions. The author did not provide any opinions, only information pertaining to the topic.

Definitions

Criminogenic factors/needs: When assessing the likelihood of someone committing a crime or how likely they are to reoffend or violate their conditions of probation/parole, professionals look to assess a person's criminogenic risk factors. Criminogenic risk factors according to the Council of State Governments Justice Center, can be split between static and dynamic (Englehardt & Bonilla, 2018). Static factors that contribute to a persons' risk of offending/reoffending can include their criminal history, current charges, age at first arrest, current age, and gender (Englehardt & Bonilla, 2018). The central eight dynamic risk factors are the history of antisocial behavior, antisocial personality pattern, antisocial cognition, antisocial associates, family, poor school/vocation output, limited leisure/ recreation opportunities, and substance abuse (Englehardt & Bonilla, 2018). After reviewing these factors, it is noted that MI is not one of the eight central criminogenic risk factors. A mental health diagnosis itself is not a major predictor for criminal behavior. People with a SMI diagnosis, who are involved in the criminal justice system tend to have more criminogenic risks factors compared to those who do not (Osher, D'Amora, Plotkin, Jarrett, & Eggleston, 2012).

Crisis intervention team (CIT) training: CIT training was established in Memphis, Tennessee after a fatal police shooting involving an individual with a MI. DeWayne Robinson, a 27-year-old, with a history of MI, was shot and killed in 1987 after he was harming himself with a butcher knife and refused to drop it when the officers ordered him

to (Connolly, 2017). After the incident, CIT training emerged and became a vital factor within the Memphis police force. CIT training is an innovative police-based first responder program, known as the "Memphis model" and provides mental health training to law enforcement and is part of a pre-arrest jail diversion for mentally ill persons in partnership with mental health agencies (CIT Center).

Deinstitutionalization: This definition can vary depending upon the setting and person, but the major movement of deinstitutionalization started in the late twentieth century throughout the United States and more so when certain state hospitals closed (Grinnell, 2016). For this study, the term deinstitutionalization refers to the process of transferring people with mental disorders or developmental disabilities from long-term care institutions involving isolation to reintegrate back into their communities and receiving community based mental health and/or developmental disability services (Grinnell, 2016).

Mental health consumer: This is a person who is receiving mental health services whether it is community-based or residential.

Mental Illness (MI): According to the American Psychiatric Association (APA), MI is treatable and a large majority of people living with a MI function in their daily lives (APA, 2018). MI tends to be less of a condition compared to SMI, which limits a person in terms of functioning of daily activities more severely. MI is defined as health conditions involving changes in one's thinking, emotion, behavior, or a combination of these, in addition to creating distress and/or problems functioning in terms of social, work, or family activities (APA, 2018).

Recidivism: When individuals return to the community, they may be at risk for recidivating, resulting in potential returns to prison or jail. Recidivism is measured based on criminal acts that would result in rearrests, reconviction, and returning to prison with or without a new sentence, all of which is measured based upon a 3-year period following their initial release (Office of Justice Programs, 2018).

Reentry: Offenders transitioning from prison to community supervision (Office of Justice Programs, 2018).

Serious mental illness (SMI): APA (2018) defines SMI as a mental, behavioral, or emotional disorder, which results in serious functional impairment and, substantially interferes with or limits one or more major life activities; this excludes developmental and substance use disorders. Diagnoses of SMI include major depressive disorder, schizophrenia, and bipolar disorder (APA, 2018).

Summary

There has been national attention involving the criminalization of individuals with a SMI who are overrepresented in jails and prisons. Some studies have been completed in counties within Central Pennsylvania to assess the volume of people with a SMI in the prisons and jails. One component of this concern is the use of diversion for this population through the combination of law enforcement, courts, and corrections. This study focuses on diversion using CIT training, specifically with law enforcement. Although CIT training has been studied, it has been primarily involved in quantitative studies. The researcher is exploring officer experiences involving training and interacting with mentally ill persons within Central Pennsylvania.

This study looks at officers' experiences with CIT training and how they use the information gained from this training with individuals that they encounter with a SMI. As noted, the study uses a qualitative exploratory case study design. Knowledge to be gained can help create policies, programs, procedures, and training programs, and potentially help Pennsylvania move towards a statewide CIT initiative.

Chapter 2 will thoroughly explore the available information from the literature to support conducting this qualitative study.

Chapter 2: Literature Review

The current problem is the criminalization of mentally ill persons and how specialized mental health training for law enforcement could influence that. CIT training was specifically addressed as a tool of diversion for police officers to link the person to treatment rather than arrest when appropriate. The purpose of this study was to understand the experiences of a select group of police officers who are trained in CIT and how they use the information gained from CIT training with citizens they encounter who have a SMI.

This chapter contains literature regarding what is already known about mental health training for law enforcement and specifically CIT training including qualitative and quantitative studies involving outcomes of CIT training and historical information about deinstitutionalization, the criminalization of mentally ill persons, procedural justice, and social distance theory.

When assessing the criminalization of mentally ill persons, it is important to understand the history and changes in policy. Since the movement of deinstitutionalization, there is a national need for more community-based treatment options for adults suffering from a SMI (Kara, 2014). Deinstitutionalization has led to an influx of people with mental health concerns becoming involved with the criminal justice system (Bouffard et al., 2016; Farzana, 2014; Kara, 2014). Since there is an increase in police response to crisis calls, it is necessary to ensure that officers have adequate mental health training and skills to divert those with a SMI from arrest and possible adjudication (Blevins et al., 2014; Bouffard et al, 2016; Wood and Watson, 201). Wells and Schafer

(2006) said that results from dispositions that involve people with MI often do not show desired outcomes for officers and training that officers receive to respond to the mentally ill is not enough. There could be various aspects that impact the criminalization of mental health individuals. Understanding the different impacts can help law enforcement, mental health professionals, and policymakers strategize solutions.

Deinstitutionalization (starting in the 1960s) is a policy implemented by mental health systems over the last few decades to place individuals in the community rather than state hospitals (Kara, 2014). With more people with MI living in the community, there are greater chances for police contact (Bouffard et al., 2016). Bouffard et al. (2016) reported that the mentally ill can successfully live in the community and proper training of professionals regarding mental health resources, such as specialized case management in jails and prison diversion can have a positive effect on individuals. Being able to manage the mentally ill effectively upon entering the criminal justice system is crucial for eventual reentry to the community. Biswas (2017) completed a review of reentry, mental illness in the prison system, the policy of deinstitutionalization and the role of collaboration among police departments. One such collaboration taking place in Washington State is known as the Mentally Ill Offender Community Transition Program (MIOCTP) (Biswas, 2017). MIOCTP is collaboration among the Department of Corrections and the mental health system coordinating services for individuals being released from prison. Biswas (2017) highlighted the need for collaboration among both systems as a key factor in removing individuals with a MI from the revolving door of

criminalization via successful community reentry. Having access to support and services after reentry is important for mentally ill offenders, who are returning to the community.

After deinstitutionalization, many areas lacked the necessary community mental health services causing an increase in mental health crisis situations (Kara, 2014). Due to this, law enforcement often becomes first responders when interacting with individuals during a mental health crisis (Bouffard et al., 2016). Reuland et al. (2009) said that policy trends in criminal justice and mental health, higher drug arrests and lack of funded community-based treatment are other reasons why those with MI have more frequent contact with police, courts, and correction facilities. Wood and Watson (2017) reviewed interactions between police and persons with MI after deinstitutionalization through the lens of police being guardians and found a need to enhance procedural justice and improve the practice of evidence-based programs within police departments (Wood and Watson, 2017). In their review of reform efforts, Wood and Watson (2017) suggested the need for future assessment of CIT training outcomes; they also indicated that the need for continuing data collection, assessment of procedural justice, hot spots (at-risk/high levels of crime within specific communities), and whether CIT training reduces the cycle of persons with MI and their involvement with the criminal system. CIT training is not recognized as being evidence-based but establishing outcomes could support the approach in addressing mental health training for law enforcement (Blevins, et al., 2014; Cross et al., 2014; Wood & Watson, 2017). The purpose of this study is to understand the experiences of a select group of police officers who are trained CIT officers and how

they use the information gained from CIT training with citizens they encounter who have a SMI.

Literature Search Strategy

The researcher used a multitude of scholarly research sources from Walden University. The researcher used terms related to law enforcement, police, mental health, mental health training, criminalization of mentally ill persons, crisis intervention team training, and crisis intervention teams were included as search terms. Different databases included: Dissertations & Theses, Criminal Justice, ProQuest, EBSCOHost, PsycINFO. In addition to scholarly resources, sources included government documents with statistical information pertaining to criminal justice, mental health practices, and trends.

Theoretical Foundation

The theories for this study were social distance theory and procedural justice. Social distance is widely used in the school of sociology and found in studies that discuss ethnicity, class, status, gender, and other relations (Ethington, 1997). The theory of social distance was originated by Georg Simmons and Robert Park, who studied under him in Berlin during the 1890s (Ethington, 1997). To measure social distance, a scale was created by Emory Bogardus in 1924, known as the Bogardus Social Distance scale, which continues to be widely used by researchers to measure prejudice (Wark and Galliher, 2007). Using this scale allows researchers to measure different attitudes towards diverse groups of people.

Bogardus developed the social distance scale, which measures the degree of closeness or acceptance that individuals feel towards other groups (Social Distance,

2017). Increase knowledge, awareness, and interaction will lead to more comfortability when interacting with individuals outside of a person's comfort zone (Social Distance, 2017). Eadens et al. (2016) examined police officer perspectives (n = 188 officers) across three law enforcement departments pertaining to intellectual and mental disabilities with a focus on social distance theory; they found that many officers lacked training when interacting with individuals who have disabilities, but most officers were willing to receive training. Eadens et al. (2016) said that across the United States, seven of 84 police departments surveyed offer on average 6.5 hours of training in the academy and only 1 hour of in-service training involving mental health. The more interaction and training that officers have regarding intellectual and mental disabilities, the more likely they are to understand and be willing to help.

The rationale for this theory is based on attitudes that law enforcement could have towards varieties of people, specifically individuals who have a SMI. Social distance theory studies the measurement between groups of people and how they feel towards one another. How a police officer responds to a person with a MI may impact their preconceived feelings that they already have towards this population. Eadens et al. (2016) explained that law enforcement often lacks training and awareness of mental health. Adequate mental health training could help with prejudiced feelings that officers might have and increase their level of comfort when responding to individuals who are experiencing moments involving mental distress. The research question for this study explored officers' perceptions and experiences with mental health training. The researcher built upon the existing social distance theory to describe how the officers'

experiences with mental health training has impacted their comfort level, as well as attitudes and beliefs regarding people living with MI.

How individuals perceive law enforcement is a factor of how they may react to officers and trust their intentions and actions. This study benefits from this framework because it provides an understanding of how people with a mental health disorder can perceive law enforcement based on the interactions that they have with them. Procedural justice and the use of force by the officer can impact the perception of the victim (Farzana, 2014; Mulvey and White, 2014). Farzana (2014) reported that when officers apply procedural justice and have experience about mental health to use as a discretionary tool, people have a more positive response to the officers. People with MI tend to respond to officers differently. Mulvey and White (2014) examined mental health problems through self-report of arrestees and found that individuals with MI showed an increase in resistance when interacting with law enforcement. At the time of this study, there were only three other studies to examine the use of force among persons with MI (Mulvey and White, 2014). Among the studies, there were mixed reviews about the use of force, but resistance remained high. Kara (2014) conducted a qualitative study in Canada involving mentally ill persons' attitudes towards police, her findings revealed the impact of procedural justice in how people perceive their interaction with police. Vancouver no longer follows the CIT Memphis model, instead, they offer less training in mental health even though officers report the need for additional training hours to avoid dangerous situations for the officer and victim (Kara, 2014). These studies continue to highlight the need for evidence-based police policies and practices in response to law

enforcement interacting with individuals with mental health. Collecting further data about officers' experience of CIT training and how they integrate the tools of the training when responding to mental health crisis calls could inform policy making.

Watson and Angell (2013) completed a mixed methods study that assessed procedural justice, stigma, resistance, and compliance. If individuals believed that law enforcement applied more procedural justice than they were more likely to be cooperative and less resistant (Watson and Angell, 2013). Thompson and Kahn (2016) conducted a study in Portland, Oregon involving 259 surveys pertaining to individuals who have a MI and their trust in police; they reported that there is an increase in lack of trust with the police from people with MI. Both Watson and Angell (2013) and Thompson and Kahn (2016) concluded their studies by discussing the need for further research of how procedural fairness can benefit relations between officers and community members and how perceived stigma may also impact their response and social interactions with the police. If CIT training is adopted widely in the United States and if the outcomes show improvements among interactions between the police and persons with MI, then trust is also likely to increase.

Schulenberg (2015) completed a mixed methods study using Canadian officers and citizens (n = 606) to determine whether procedural justice or decision-making bias exists when the police respond to calls with persons of MI, they found that MI was only a predictor for issuing citations and regardless of mental health status, a citizen who is under the influence of alcohol or drugs increases the likelihood of criminal charges and citations. Geller, Fagen, Tyler, and Link (2014) completed a survey consisting of young

men (n = 1261) between the ages of 18-26 in New York City and found that those having more contact with police reported higher anxiety levels for their mental health; men with Post-Traumatic Stress Disorder (PTSD) and who were involved with more invasive police stops reported higher levels of trauma but felt they were treated fairly when officers applied procedural justice. They then also reported having fewer PTSD symptoms (Geller et al., 2014). Both Schulenberg (2015) and Geller et al. (2014) indicated that the overall findings do suggest an indirect procedural bias when coupled with a lack of mental health resources can contribute to the criminalization of individuals with MI. They also suggest that procedural justice is necessary for all contacts but especially when handling individuals exhibiting mental health symptoms (Geller et al.,2014; Schulenberg, 2015).

As mentioned, it is not uncommon for people with a MI to encounter law enforcement. Livingston, Desmarais, Verdun-Jones, Parent, Michalak, and Brink (2014) examined via semi-structured interviews, and using procedural justice theory as a guide, perceptions and lived experiences of individuals (n = 60) with MI in relation to police interactions in Vancouver, Canada; most participants had frequent police contact but they perceived being treated fairly during their most recent interaction. Livingston et al. (2014) also reported that only 32% indicated negative experiences with police reiterating the importance of procedural justice for police when interacting with mentally ill individuals. Their findings also portrayed a more balanced outcome compared to what the media often displays (Livingston et al., 2014). Desmarais, Livingston, Greaves, Johnson, Verdun-Jones, Parent, and Brink (2014) surveyed police officers to examine

perceptions regarding mentally ill individuals in comparison to the general population also using procedural justice; they also surveyed 244 participants with MI in Canada finding most participants had positive perceptions about police but not as high as the general population. There continues to be a difference between perceptions of law enforcement among the general population and those with a MI.

Literature Review

Depending on the response of law enforcement, a situation can turn violent quickly. Mulvey and White (2014) reported that children or adults with MI are four times more likely to be shot by an officer than a person without a mental health diagnosis. People experiencing mental health symptoms are known to be impulsive, have irrational and/or delusional thoughts, a lack of problem-solving abilities, and different perceptions of risk (Blevins et al., 2014). How an officer handles and interacts with the individual can impact the response from the person, whether they comply with the officer or become combative; officers who are untrained or undertrained, using traditional police tactics can cause the person to go into distress quickly and act out in a violent manner causing potential injury to themselves, the officer, or others (Blevins et al., 2014). Adequate skills and training may help an officer respond appropriately to a person in mental distress to protect them, the community and the officer(s).

Due to the number of mental health persons' involvement with the criminal justice system, it has led to the study of the relationship between mental health and crime, determining if mental health is a correlation to committing a crime. In a study completed in Pennsylvania about the relationship between mental health and crime, Engelhardt and

Bonilla (2018) found that criminogenic risk factors are not consistently defined or collected when making informed decisions about mental health and crime. They found that when determining the risk of someone committing a crime or violating supervision (which can both lead to incarceration), SMI is not listed as a static or top central eight indicators of substantial risk levels (Engelhardt and Bonilla, 2018). Although, Blevins et al. (2014) suggested that a person with MI will be arrested on at least one occasion if not multiple times throughout their life. The increase of criminalization has left many individuals with mental health a negative connotation towards officers (Farzana, 2014). Officers have indicated needing more training because past training for dealing with individuals who have a MI is limited (Cross et al., 2014; Municipal Police Officer's Education and Training Commission, 2018). Wells and Schafer (2006) indicated from their study in gathering perceptions of officers in Indiana (n=126) that innovative reforms addressing the training component of mental health holds promise for improving an officer's ability to respond to situations where a mentally ill person is involved. After several fatal police shootings involving individuals with a MI, there was a national concern for more mental health training in law enforcement (Cross et al., 2014; Stanyon, Good, & Whitehouse, 2014). Officers have reported the need for specialized training including being able to identify someone exhibiting mental health symptoms, how to properly interact and handle people with MI, and the available community resources for mental health treatment (Wells & Schafer, 2006). Determining better practices and training procedures for officers is crucial.

According to Harte (2015), the criminal and mental health system differ; criminal justice professionals look to serve and protect the community whereas mental health professionals are more treatment focused. Collaborative training has challenges since both systems have different policy agendas and expectations however both systems are open to training and working with one another (Harte, 2015; Hean, Staddon, Fenge, Clapper, Heaslip, & Jack, 2015; Spence & Millott, 2016). It is also important to understand roles and expectations for frontline officers when policymakers are looking at training needs (Spence & Millott, 2016); they completed a qualitative study in Scotland exploring the attitudes of officers about suicide negotiation as a job function and mental health training and found that negotiators had an overall positive perception of this being part of their role. Since officers have an understanding that being frontline has certain expectations, it is vital that they receive the training necessary to help them perform their duties to the fullest. Job satisfaction and burn out have not been studied much, indicating that there is a need for future assessment about pertaining officers' job satisfaction (Compton et al., 2015). The current qualitative study gathered officers' perception using interviews to capture their input about the influence of the training, their role expectations, job satisfaction, and overall burn out.

Many police departments have adopted strategies to better equip officers responding to mental health situations and working with the mental health system (Mulvey & White, 2014). Spence and Millott (2016) noted that officers who are often first responders had little to no training about mental health and suicide negotiation. Training and different tactics are not accepted across all police departments to compare

before and after training (Krameddine & Silverstone, 2015). There is a lack of research about training of police interactions with individuals' MI and current trends reveal the need for repetitious training (Cross et al., 2014; Krameddine & Silverstone, 2015; Mulvey & White, 2014). The Municipal Police Officers' Education and Training Commission (MOPETC) (2018) highlighted the Act 120 amendments pertaining to the training of municipality officers, which includes officers receiving training to recognize MI, intellectual disabilities, and autism and they also discussed how training will involve officers learning proper techniques to interact and de-escalate individuals as well as services available to these individuals. It is also important for training to include real-world scenarios (Krameddine & Silverstone, 2015). Mental health training is one response taken by law enforcement to address the criminalization of MI. Preparing frontline officers is necessary. Gathering officer perceptions in the study was resourceful in learning about police academy training versus CIT training and if there was an influence in helping to better prepare the officers when interacting with mental health or developmentally disabled individuals.

To assess the extent of mentally ill persons in the criminal justice system, Animashaun (2017) completed a study across the United States that gathered the percentage of the population in the criminal justice system (prisons and jails) with mental health illness, and the number of people receiving treatment and costs. The average percentage in local jails is 45%, federal is 56%, and state is 64% (Animashuan, 2017; Biswas, 2017)). Animashuan (2017); Englehardt and Bonilla (2018) found that 18% of

United States adults report having a mental health disorder, and more than four percent have a serious mental health diagnosis.

Understanding the prevalence of MI in the criminal justice system, many areas focused their attention and funding resources towards developing programs. Stettin, Frese, and Lamb (2013) overviewed the prevalence of mental health courts, CIT training, and court-ordered outpatient across each state. Using 2010 census data to separate use of CIT training and mental health courts for each state results showed that needed programs were not available across the states (Stettin et al., 2013). Stettin et al. (2013) recommended that each state's criminal justice system improve their diversionary methods for the mentally ill and a review of legislation to address new specialized courts in areas that do not have access and matching funds through state governments. Stettin et al. (2013) acknowledged the need for implementation for CIT training across more jurisdictions and working with community members and mental health advocacy groups. This study looked at a rural jurisdiction that has implemented CIT training in Pennsylvania.

Recidivism is common for individuals with a MI. Torrey, Dailey, Lamb, Sinclair and Snook (2017) conducted a state survey to evaluate recidivism and mental health initiatives for improving conditions for individuals with a MI in the criminal justice system. Torrey et al. (2017) had an 80% response rate for a survey given to state forensic directors by each state and to 15 states that provided follow up care information once individuals are released. Pennsylvania received a D grade in this survey and no state received an A grade. Torrey et al. (2017) also found that Pennsylvania offered less

compared to larger states when offering diversionary solutions for people with a SMI who have committed major crimes. Pennsylvania was also found to have one of the highest punishment rates especially compared to states such as Texas, Georgia, Missouri, and Arkansas, who have traditionally been punitive states (Allen, 2016). Implementation of CIT training, mental health co-responder, and mental health court programs are initiatives taken in many areas of Pennsylvania to help divert mentally ill individuals from entering into the criminal justice system (Torrey et al., 2017). Input from officers in Pennsylvania that are trained in CIT was gathered as part of the study to assess the effectiveness of CIT training when officers interact with children or adults who have a SMI.

Stigmatization

Mulay et al. (2016) provided an overview of the stigmatization of individuals with MI by evaluating past studies of explicit and implicit stigma; described interventions improving the interaction between police and individuals with MI including CIT training. Olson and Wasilewski (2017) also completed a review of stigma perception towards mentally ill individuals; they found nine indicators that help police officers reduce mental health stigma including talking openly about mental health, educating themselves and others about mental illness, being conscious of the language they use, encouraging equality, showing empathy towards persons with MI, avoiding criminalization, and advocate for mental health reform and how individuals with MI are portrayed by the media (Olson and Wasilewski, 2017). Past studies of CIT training show that training can help reduce explicit stigma however there is a lack of research about impact on implicit

stigma (Mulay et al., 2016); they also found that a need to further explore implicit stigma, transfer of skills to real-world scenarios, and police referral decisions. Evaluating police attitudes as they relate to referral decisions and if CIT training helps officers with the transfer of skills in the real world are important implications for assessing the effectiveness of CIT training initiatives.

Lawson's (2016) quantitative study found that stigma was more associated with the use of mental disorder term and that people who had higher lifetime morbid risks of MI showed less desire for social distance. Watson, Swartz, Bohrman, Kriegel, and Draine (2014) studied officer thinking and perception by using a qualitative study to examine officers' schema of mental or emotional disturbance calls, they studied 147 officers (between Chicago and Philadelphia) including both CIT and non-CIT officers and found that most officers lean towards having positive thoughts about the mental health resources in their area. Having knowledge of the mental health system and resources available is vital when law enforcement encounters individuals with a MI and their ability to use discretionary decision-making to arrest.

Background about CIT: Memphis Model and Core Elements

CIT training originated out of Memphis, Tennessee after a fatal police shooting involving an individual with a mental disorder (Cross et al., 2014; Dupont, Cochran, and Pillbury, 2007). Davidson (2014) examined the training curriculum of the Memphis model among law enforcement officers and correctional officers in Florida through a quantitative design and found that objectives for the training of self-efficacy, knowledge, and enhancement of verbal de-escalation were met in the short term but there was measurable

decay in the follow up regarding self-efficacy and verbal de-escalation. Davidson (2014) concluded that a refresher course after some time to allow CIT trained officers to retain the skills would be beneficial. This study gathered officers' perceptions after a period of time from the completion of CIT training to obtain input if skills are being used and if a refresher would be needed for future planning of CIT training programs.

CIT Core Elements

CIT training includes core elements as part of the training curriculum. The International Crisis Intervention Team (n.d.) reviewed the core CIT elements, which includes partnerships between the police, mental health professionals, and the community. Planning and implementation of the training, along with policies and procedures are core elements that involve officers, dispatchers, and the CIT coordinator (International Crisis Intervention Team). Learning about community mental health facilities, evaluation and research, recognition, and outreach are other ongoing elements (NAMI, 2017). The International Crisis Intervention Team (n.d.) identified evidence that supports CIT training specific outcomes which included officer knowledge and skills, officer behaviors, organizational outcomes, community and call subject outcomes and reported there. A quasi-experimental study suggested CIT training is effective for improving behaviors and supporting CIT officers using less force and linking to mental health services more so than non-CIT officers (International Crisis Intervention Team). According to the International Crisis Intervention Team (n.d.) more research is needed to suggest CIT training as being an evidence-based practice especially in relation to a policing practice and overall effectiveness of subject, organizational, and community

level outcomes. More effective outcomes could add to CIT training becoming evidence based.

The Importance of CIT

Adults and children living with a MI face many obstacles throughout their life, with the increase of criminalization of law enforcement; there is a belief that officers can also stigmatize this population (NAMI, 2017). CIT training is one approach to address the stigma and the need for more specialized police training (Mulay et al., 2016). NAMI explains that CIT is a community policing strategy that consists of police officers, mental health professionals, emergency responders, and individuals with MI and their advocates to improve the quality of care and responses to people in crisis (NAMI, 2017); the training modality connects officers with clinicians to learn about the mental health system and available resources within that community, along with learning about de-escalation skills to help defuse a potentially violent situation and scenario-based training for crisis scenarios (NAMI, 2017). Jines (2016) conducted a review of the benefits of CIT training and implementation, and based on historical events involving responses to mental health and law enforcement, found a solution should be a CIT model within the department. Findings also suggested that CIT training can reduce injury to officers and persons with MI, reduce stigmatization and criminalization, and increase working as a team (Jines, 2016).

Most police departments recognize the need for specialized police training to improve the interactions with individuals who have a MI and CIT training is the most commonly known initiative today that provides a response to police and mental health

(Cross et al., 2014; NAMI, 2017). Jines (2016) introduced the first steps of implementation of CIT training by describing the benefits of mental health training, specifically how CIT training can help police officers' responses when responding to crisis calls and interacting with individuals who have a MI. Some police departments do not have CIT as part of their training curriculum. Compton et al. (2015) conducted surveys to learn about department initiatives to implement CIT training in Georgia and found that 55% of the departments were interested in implementing CIT training but ran into funding barriers, limited officer availability and minimal access to mental health services in the community. It would be important for policymakers to understand the barriers to CIT training implementation for interested law enforcement agencies.

Implementing CIT training can differ from urban to rural areas based on findings in Virginia (New River Valley Community Services, 2015). New River Valley Community Services (2015) is in rural Virginia and is known to have a successful CIT training operation but indicated that professional orientation towards MI and collaboration between police and mental health personnel is needed for successful implementation. Skubby et al. (2013) also assessed barriers and challenges for community stakeholders in rural Ohio with implementation of CIT training programs through a qualitative study using focus groups; from those focus groups, two main challenges for CIT training operations are the disconnect between the law enforcement and mental health professionals and internal resources needed to train small police departments (Skubby et al., 2013). Skubby et al. (2013) also found other barriers

included a lack of outcomes in evaluating data, costs, and coverage by other officers during the week-long CIT training.

New River Valley in Virginia not only implemented CIT training but also provided access to two crisis centers for law enforcement in separate cities (New River Valley Community Services, 2015); the purpose of these assessment centers is evaluation and triage via a therapeutic center rather than a law enforcement setting (such as the prison booking centers) and the officers can access these centers sixteen hours a day, seven days a week during peak hours.

Outcomes

CIT training outcomes are reported to be beneficial; Mulay et al. (2016) reported that police beliefs and attitudes towards MI improved when combining CIT training and additional training designed to reduce stigmatization. NAMI (2017) reported that victim and officer safety improved, and crisis calls to the police dropped 80%. CIT training implementation differs significantly than traditional policing strategies but could reduce workload, time spent on emergency calls, improve mental health symptoms identification skills and increase awareness and knowledge of service referral resources (Melissa, Watson, & Draine, 2013).

Not all police departments use CIT training or require all officers to become CIT trained. Officer willingness to participate and engage in changing behavior response may or may not impact the effectiveness of CIT (Melissa et al., 2013; Mulay et al., 2016). Future research may be necessary to further explore if officers who volunteered versus being mandated influenced their behaviors and perceptions of the training.

Understanding CIT training outcomes can guide future research and to help policy decisions regarding criminal justice and the mentally ill. Blevins et al. (2014) reported the need for empirical data to include data that is routinely collected; in a statewide survey and focus groups they found a lack of completed data forms, missing information, no automated data, an inability to follow a mentally ill person through the system to fully evaluate their outcome (after contact with law enforcement), no memorandums of understanding (MOU) for data sharing, and departmental need for policies and procedures. Cross et al. (2014) found in a study of learning outcomes that CIT training is effective in improving officer knowledge about MI, attitudes, and confidence in responding to mental health crisis calls, and that CIT trained officers were less likely to use force during an intervention. Blevins et al. (2014) and Cross et al. (2014) found CIT training to have a positive effect on officer understanding of mental health symptoms. There appears to still be a need to explore the data collection by law enforcement to determine actual outcomes overall within the departments.

Injury outcome analysis is one method to determine if CIT training is effective or not; Cross et al. (2014) found no current studies to test injury reduction using documentation other than self-report by the officers; behavioral outcomes suggested that CIT officers are more likely to transport or refer an arrestee to psychiatric services which might reduce injury outcomes (Cross et al., 2014). Robertson (2015) examined injury predictors for CIT officers in Portland, Oregon and found that MI was the only predictor and it did not increase the chance of injury and that other factors joining MI such as substance abuse, assaultive behavior, and arrest resistance did increase the chance of

injury for officer and victim. Tully and Smith (2015) found five major themes from their conducted literature review of CIT training which was police liability and injury; civilian injury and officer use of force; diversion aspects (such as knowledge of community resources); and police effectiveness (actual versus perceived). Tully and Smith (2015) also found in a survey of a sample of CIT trained officers in Connecticut that overall the officers thought that they were prepared to handle mental health crisis calls post training but lacked information regarding diversionary programs. Tully and Smith (2015) found a disconnect between police and dispatchers being that they were not communicating with one another and dispatchers were not screening the mental health calls that would entail sending a CIT officer on scene. In return, this had an impact on response time and outcome of the call (Tully and Smith, 2015). It would be helpful for mental health professionals to understand resources that criminal justice professionals feel they do not have as well as, dispatch and police working together.

CIT training is a relatively innovative approach but is not available across the United States. However, the areas that have implemented more specialized mental health training or CITs have produced positive outcomes, but there is a need to continue to research the impact of CIT training before and after the implementation (Wells & Schafer, 2006). Other limitations to CIT training research include the assessment of injuries before and after, the use of prison diversion numbers, and psychiatric inpatient hospitalization rates (Browning, 2011). Evaluating these factors can strengthen the outcomes of CIT training and other potential mobile crisis teams. Through the appropriate use of mental health training, researchers can assess the impact that it has on

officers, along with individuals who have mental health concerns. Consistency with training and policy procedures nationally can improve the collaboration between the criminal and mental health system, in addition to the quality of care of individuals.

Past Perceptions of CIT

As stated throughout, the purpose of this study is to gather perceptions of officers who have received their certification in CIT training and their view of the training and impact when interacting with individuals who have a mental disorder. While this study will add to the literature review, previous information about police perceptions regarding CIT training and mentally ill persons was also gathered, which is provided in this section.

Melissa et al. (2013) studied predictors of police officers' attitude towards CITs with both CIT and non-CIT trained officers across four police departments in Chicago; they found that CIT officers who were able to use the learned skills had more positive attitudes towards the program when responding to mental health crisis calls compared to other officers who did not. Compton, Bakeman, Broussard, D'Orio, and Watson's (2017) quantitative study compared CIT trained officers with non-CIT officers to evaluate any differences in attitudes, skills, and knowledge for officers who volunteered versus those who were assigned to CIT training; it was found that volunteered CIT officers used some level of force which could include the use of handcuffs but, were more likely to transfer the individuals to treatment services versus to arrest. Police departments fluctuate between allowing officers to volunteer for CIT training or to mandate' the training but these studies show better outcomes for those who volunteered (Compton et al., 2017; Melissa et al., 2013). It would be beneficial to gather perspectives from officers who did

not volunteer and see if the training helped with their perceptions of mental health and responding to crisis calls.

Ellis (2014) completed a quasi-experimental study to explore police officers' perceptions, attitudes, and knowledge to assess the effectiveness from CIT training both before and after interacting with mentally ill individuals. Ellis (2014) found an overall improvement in officer's perceptions, attitudes, and knowledge about mental health from the beginning to after completion of CIT training. Ellis (2014) found almost a 40% perception change of officers and MI, attitudes improved by over 34% and knowledge increased by over 25%. Bonfine, Ritter, and Munetz (2014) conducted a quantitative study of 57 Ohio officers assessing their experience with mental health and found that officers who perceived CIT training as beneficial in enhancing their skills reported an increase in their confidence to interact with persons with MI and respond to crisis calls. Ellis (2014) and Bonfine et al. (2014) both noted that there is limited evidence about interactive effects between perceptions of CIT training impact on the preparedness of officers and overall safety and familiarity with MI that is associated with departmental effectiveness. Ellis (2014) however, did conclude that effectiveness of CIT training being valid, and evidence based. Adding to the literature of officer perceptions could impact policymakers in addressing overall departmental changes.

Intrastate Studies about CIT

Chicago Study

Watson and Wood (2017) completed a mixed methods study involving 22 police districts in Chicago assessing effectiveness of CIT training between CIT and non-CIT

officers. Also, in Chicago, Wood, Watson, and Fulambarker (2016) completed an observational study participating in 31 rides along trips across 11 departments to evaluate police officers responding to mental health calls.

Watson and Wood (2017) found that 35% of the calls were resolved on the scene when CIT officers responded, 32% of those calls could have ended in charges but were resolved by other means with just over 5% ending in arrest (Watson and Wood, 2017). Watson and Wood (2017) found that overall, CIT officers are more often going to try to resolve the situation at the scene or transport the individual to the hospital for a mental health assessment.

Wood et al. (2016) reported a need for field-based research involving police decision making and systematic social observations to measure outcomes of the gray zone of police work and mental health encounters; they highlighted that although many departments have introduced efforts to respond to mental health crisis response, policy implications are needed to provide law enforcement with access to non- crisis resources that would help officers mitigate the gray zone problems.

Michigan Study

Kubiak, Comartin, Milanovic, Bybee, Tillander, Rabaut, Bisson, Dunn, Bouchard, Hill, and Schneider (2017) completed a case study from Oakland, Michigan where they included 79 CIT officers and of those, 67 CIT officers completed a pre-and post-survey about the training. Tyuse, Cooper-Sadlo, and Underwood (2017) completed a study in St. Luis, Michigan examining older adults encountering CIT officers, the purpose of contacting law enforcement and the outcome of the call.

Kubiak et al. (2017) found that majority of officers volunteered for the training because they dealt with past mental health crisis calls on the job, have family members with mental health concerns, or had a desire to increase their skills and knowledge about mental health and the system. Kubiak et al. (2017) also found that of the total amount of calls evaluated, less than 1% were arrested, 56% were referred to a mental health drop off center and 43% to the local hospital; officers also reported concern about always taking the individuals to the hospital in fear that they would not be linked to the necessary services (Kubiak et al., 2017).

Tyuse et al. (2017) found that most of the calls came from the family members (25.0%) and that 32% were related to suicide threats based on CIT training forms completed by the officers; they also found that over half of the older adults had some form of MI and suicide-related symptoms resulting in 70% being transported to the emergency room as the outcome.

Overall the officers felt the training increased skills when responding and interacting with individuals with MI but thought there continues to be a need for collaboration among the criminal and mental health system (Kubiak et al, 2017; Tyuse et al., 2017). This study gathered input from the officers' perception of the collaboration between the criminal justice and mental health system after completion of CIT training implementation.

Virginia Study

According to the APA (2014) there are 2700 police officers across the United States using the training model of CIT to help prepare officers in responding and

interacting with children and adults who have a mental health disorder; the APA reviewed a two-way study performed in Arlington, Virginia by Dr. Compton and colleagues. Wade (2015) also provided an overview of the CIT training program in Virginia that included a description of the CIT training coordinator's experience of CIT and the implementation.

The study performed in Virginia assessed 600 officers about their knowledge of MI and found that mental health training for police officers is effective in improving knowledge, attitudes, and skills and increased of them referring the individual to services and decrease arrests (APA, 2014). The Virginia results also show that with 12% of cases resulting in the use of physical maneuvers there was with a slight difference between CIT and non-CIT officers with CIT officers reporting more use of verbal force (APA, 2014).

Wade (2015) found that over 1,000 individuals had been assessed since the 2013 opening of two assessment centers in Virginia with an 80% reduction of law enforcement involvement in emergency custody cases and found that officers can return to patrol time faster as well as individuals referred to behavioral health settings as opposed to the criminal justice system.

California

Dempsey (2017) conducted an overview of CIT training and a co-responder team (CRT) with law enforcement in California, along with other mental health and case management initiatives and found that all probationary officers must attend CIT training and a two-week course about police science leadership after being in the field for one year and that police departments in Los Angeles (LA) increased behavioral health

training time from 11 to 15 hours. LA is one of two regions nationally to most use CRT and intensive case management and 65% of CIT and CRT cases are linked to services through the case management (Dempsey, 2017). Dempsey (2017) also found that in LA, 82% of the calls that involve responding to an individual in a mental health crisis came from a caregiver.

Washington

Helfgott, Hickman, and Labossiere (2016) completed a study evaluating Seattle's police department crisis response team and their partnership with mental health. Seattle's crisis response team consists of CIT officers that are paired with a mental health professional; they call the pilot program a Crisis Response Team (CRT). Helfgott et al. (2016) gathered and evaluated data using descriptive analysis and found that there was an overall change in police officers' response to behavioral crisis situations; about 80% of the cases were handled by non-law enforcement referrals and about one in every third case was referred to non-law enforcement agencies. Helfgott et al. (2016) findings suggested that the CRT pilot was relieving the unnecessary burden on officers and creation of a CIT training policy gave more discretion to officers handling mental health crises, as well as offenses eligible for diversion resources and that the CIT training policy set standards for oversight of the training curriculum and data collection, which continues to be a need in many police departments. How the CIT coordinator works with law enforcement in Central Pennsylvania for oversight and data collection is important to understand for addressing needs of improvement.

Other Countries Use of CIT

First responders of law enforcement interact with mentally ill persons across the world, not just the United States. Harte (2015) examined The Netherlands and found that there is also a disconnect between the criminal and mental health system and much of that is related to conflicting goals and different perspectives. Kohrt, Blasingame, Compton, Dakana, Dossen, Lang, Strode, and Cooper (2015) found in a mixed methods study in Liberia, Africa that individuals who receive mental health services reported violent interactions with officers and because of, a CIT training curriculum was implemented and adopted in Liberia. Lamanna, Kirst, Shapiro, Matheson, Nakhost, and Stergiopoulos (2015) found in a mixed method study in Toronto that individuals had better experiences with CIT trained crisis responders, who are more supportive and empowering, in addition to being more likely to transport the individual to the emergency department for assessment when compared to the non-CIT officers. CIT training appears to be a positive initiative in these countries, like the United States.

Use of Force

Compton, Bakeman, Broussard, Hankerson-Dyson, Husbands, Krishan, Stewart-Hutto, D'Orio, Oliva, Thompson, and Watson (2014) conducted a study in Georgia that assessed disposition and the use of force across six departments comparing officers who received CIT training (91) and those without CIT training (89) and they reported there was no difference between the use of force among CIT and non-CIT officers. CIT officers are 20% more likely to use verbal or negotiation as their highest level of force compared to only 11% with non-CIT officers (Compton et al., 2014). Compton et al. (2015) also surveyed CIT and non-CIT officers about the use of force and found that

when using examples of interacting with an agitated, psychotic man, CIT officers were less likely to use force.

The United States Department of Justice (2016) reported on Seattle, Washington's compliance with CIT training efforts and found that officers responding to a mental health crisis used force during less than 2% of incidents with about 80% having the lowest level of force used, even in elevated risk situations. Prior to organizational and operational changes within the departments pertaining to crisis intervention and de-escalation, there were higher rates of force being used when responding to people in mental health crisis (Compton et al., 2014; Compton et al., 2015; United States Department of Justice, 2016). Robertson (2015) suggested that further studies are needed to examine police use of force and injury for arrestees with or without a MI. Use of force is one outcome captured by CIT training to assess effectiveness. This qualitative study explores this outcome through the perception of trained CIT officers and CIT data sheets.

The U.S. Department of Justice (2016) also presented an overview of an investigation of Baltimore, Maryland's police department which revealed that officers were using force and providing unreasonable accommodations towards the mentally ill. A qualitative study conducted in Baltimore County, Maryland suggested that officers need more cultural competency and implicit bias training, CIT training, de-escalation and mental health first aid training (CSG Justice Center, 2018). Fuller, Lamb, Biasotti, and Snook (2015) completed an overview of data that assessed the role of MI and the use of force in police shooting fatalities across the United States but specifically in the state of California and found that there is a need to track police fatalities especially in the cases

involving a person with MI to capture the frequency compared to fatalities not involving mental illness. Taheri (2014) completed a systematic study and a meta-analysis review of CIT training and found that neither study found significantly positive effects of CIT training on use of force outcomes.

Jail Diversion and Arrest Reduction

Taheri (2014) reviewed CITs to assess if they reduce arrests and improve officer safety by measuring the association between CIT training on arrests of people with a MI and found that CIT officers were less likely to arrest individuals with a MI in comparison to the non-CIT controlled group. Taheri (2014) only had two of the seven studies measuring officer safety and indicated that the two studies were in Kentucky (2008) and Indiana (2009) demonstrating a gap in knowledge about CIT training effects on officer preparedness. It was helpful to gather officer perspectives from the new study about their preparedness's and safety before and after completion of CIT training in relation to interacting with serious mentally ill persons and responding to mental health crisis calls.

Texas Study

One aspect of CIT training in law enforcement is the use of jail diversion. Hnatow (2015) completed a study in Bexar County, Texas to evaluate an established crisis restoration center for police officers to drop off individuals for mental health or substance abuse evaluations rather than taking them to the hospital or jail and found that there were savings of at least 50 million dollars for local government through jail diversion, engagement in services, and treatment. There was also an increase in mental health training for officers in the county because state requirements are typically only 10

hours of mental health training compared to the 40 hours within the CIT training curriculum (Hnatow, 2015). Hnatow (2015) also found that mental health individuals had jail stays that were once five times higher than the general population but since the combination of CIT training, jail diversion, and the restoration crisis center, this number has decreased, and nonviolent mental health offenders referred to treatment have a recidivism rate below 10% now. Due to the successful outcomes, other counties in Washington, Minnesota, Montana, and North Carolina adopted similar crisis services in the community (Hnatow, 2015). Jail diversion and access to treatment appears to be a cost savings for these counties and lower recidivism.

Watson, Compton, and Draine (2017) found in their study of CIT training outcomes in Texas that diversion from jail by CIT officers did increase an individual's chance in linkage to mental health services and that mentally ill individuals received fewer days in jail but there were no differences in recidivism.

Both studies suggested mixed results for CIT training being evidence-based with more support of evidence-based officer outcome but not as many findings to support subject outcome (Hnatow, 2015; Watson et al, 2017). Watson et al. (2017) also reported that the model was based on urban settings and further examination is needed in how to adapt the model for rural settings and their barriers and effectiveness. For this study, the goal was to look at a rural police department and officer experiences of CIT training and how they use the information gained from the training when responding to mental health crisis calls.

Pennsylvania Review

Currently, Pennsylvania is assessing the prevalence of mental health and law enforcement responses through the Stepping Up initiative, which is a national initiative to reduce the number of people with MI in jails and prisons (Engelhardt and Bonilla, 2018). The Treatment Advocacy Center (2017) reported that Pennsylvania incarcerates people with a SMI more times than hospitalization (2:1 ratio), but this is comparable to all other states as well. However, in the Englehardt and Bonilla (2018) quantitative study, they found that adults with a SMI in a county jail, where they collected their data, showed that SMI people had 40% more longer stays and returned more frequently compared to non-SMI. SMI people were not arrested any more than non-SMI in the Pennsylvania study, but they were more like to have probation/parole revocation at 1.38 times higher compared to non-SMI (Englehardt and Bonilla, 2018). Pennsylvania Mental Health and Justice Center of Excellence (n.d.) provided a comprehensive review of specialized police training that includes CIT training (intensive and less intensive), mental health first aid, and advanced CIT training for veterans' issues and correctional settings and they concluded that over half of law enforcement reported that their counties did not engage in behavioral health training as of 2010-2011 because a lack of engagement and budgetary concerns. The Treatment Advocacy Center (2017) assessment reported that Pennsylvania received a B- grading when responding to the criminalization of mentally ill persons. Pennsylvania serves about 60% of the criminalized mental health population across the state through mental health courts and 40% using CIT training. Englehardt and Bonilla (2018) suggested in their study that Pennsylvania does have an opportunity to reduce the prevalence of MI among inmates in the criminal justice system by improving their

diversion tactics including growing the use of CIT training among law enforcement and revising their community supervision policy (to reduce revocation). The Pennsylvania Mental Health and Justice Center of Excellence (n.d.) reported that Pennsylvania plans to move towards a statewide implementation of a specialized police training program such as CIT training. Pennsylvania appears to be taking approaches in addressing MI in the criminal justice system. CIT training is one initiative but not all police departments have become on board for the statewide initiative. Continued research to evaluate the program may be necessary for policymakers and law enforcement. This study provides additional outcomes related to Pennsylvania.

Barriers/Other Solutions

As noted earlier, the mental health and criminal justice system do differ. Hodges (2017) analyzed reasons why police should not respond to non-violent mental health calls and discussed the need to develop mental health response teams that are available 24 hours a day to help expose these individuals to the mental health system and not the criminal justice system.

Hodges (2017) also stated how there is a continued need for de-escalation that differs from CIT training to help officers defuse situations involving the mentally ill and learning the difference between an angry person and a mentally ill person; having mental health teams to respond to non-violent situations avoids the need for police to always respond in addition to officers lacking adequate mental health response training and that the criminal justice system is not the appropriate response team to handle individuals who suffer from MI because the hours of training and college education for a mental health

professional at the psychologist or psychiatrist level is nowhere near the training of a police officer to learn mental health. In many areas there is a lack of psychologists/psychiatrists, however, crisis workers and case managers who can respond to non-violent situations also have more mental health training compared to law enforcement (Hodges, 2017). Having mental health training can be helpful to officers in de-escalating situations and knowing symptoms of psychosis to be better prepared in responding but they are not trained to the level of mental health professionals.

Frontline officers will continue to be the first person showing up on scene and therefore interacting with individuals who may or may not have a SMI (Bouffard et al., 2016). CIT training may not be the full solution to decreasing criminalization among mentally ill persons, but continued outcome studies could help show specific needs for mental health training aside from the police academy and the importance of collaboration between the two systems.

Summary and Conclusions

Aside from CIT training, law enforcement has considered other resources addressing mental health responses by police officers. Plotkin and Peckerman (2017) completed a survey to assess state standards (which consisted of 42 states) and found that 40 of the state's training curriculum consists of de-escalation and implementation of either CIT or mental health first aid training. Plotkin and Peckerman (2017) also found that 16 of the 40 states have recently changed training requirements in the last two years to increase the number of hours of mental health and de-escalation training because specialized training is not often provided at the same level across states for entry-level

and recruit training. Steadman and Morrissette (2016) reviewed police in a crisis care continuum model going beyond their CIT training; there is an importance of addressing how police can engage as partners with behavioral health as opposed to what they need to do when responding to individuals in mental health crises. Steadman and Morrissette (2016) also highlighted how officers respond and interact with individuals with MI can improve both public health and public safety and that influential factors that lead to mental health training for law enforcement involves legislative actions and advocacy from mental health organizations. CIT training is one initiative to help law enforcement in working with mentally ill persons, but it is intended to be more than just training, it is a collaboration effort of bringing the criminal justice and mental health system together. It is important to understand officer experiences of the training and how they use the information in the training when interacting with serious mentally ill persons.

Research demonstrates that criminalization of the mentally ill continues to exist as a national problem. Many law enforcement agencies have taken initiatives to address the concern, with CIT training being that primary initiative. There continues to be a gap in the literature from understanding the officers' experience of the training and how they have used the training when encountering with individuals who are in a mental health crisis, especially in rural settings. By completing this study, it provided additional research on CIT training in rural settings, added to the literature, and can potentially support the training as being evidence-based, which can also help policymakers in advocating financial resources to mental health and law enforcement collaborative approaches and supporting Pennsylvania in becoming a statewide CIT training program.

Chapter 3: Research Method

The purpose of this study was to understand the experiences of a select group of police officers who have undergone CIT training and how they use the information gained from training with citizens they encounter in the community who have a SMI. Based on the purpose, a qualitative exploratory case study research design was an appropriate method to elicit personal and professional experience of officers who have taken CIT training to learn intervention techniques with the mentally ill. To conduct this qualitative study, the researcher interviewed police officers who have completed CIT training in the State of Pennsylvania, specifically a rural area in Franklin County. The reason for seeking out a rural police department was because the original CIT training model was based upon an urban setting and there is a lack of studies exploring rural areas and specifically how they integrate the training into their encounters with people who have a SMI. This chapter will present the design, role of the researcher, methodology, instrumentation, procedures for recruitment and data collection, data analysis plan, and trustworthiness of the study.

Research Design and Rationale

Many studies involving CIT training tend to be quantitative, comparing CIT officers to non-CIT officers. This study focused on a qualitative exploratory case study design to fill missing gaps involving officers' experiences and perceptions of CIT training and how they use that information when interacting with serious mentally ill persons. According to Trafimow (2014) researchers can select a case study approach

when they want to explore an issue by using a real-world context. The main research question for this study was:

RQ: What are the experiences of CIT officers in using the information gained from CIT training with individuals they encounter who have a SMI?

A sub-question used was:

SQ: What components do officers find most valuable from CIT training when responding to individuals who have a SMI?

This study was intended to help assist in creating policies and procedures that will provide education and training that officers need to improve diversion opportunities among nonviolent mentally ill people. Gathering data regarding personal and professional experiences will add to the literature regarding how rural police officers have integrated information gained in CIT training when they encounter people who have a SMI. In addition, this research on CIT training outcomes may or may not show the relation to the criminalization of mentally ill persons.

Qualitative designs differ from quantitative designs, with one major difference being the voice of the participant (Sutton & Austin, 2014). In qualitative studies, researchers can gain an understanding of why people have thoughts and feelings, which can affect the way they respond in certain ways (Sutton & Austin, 2014). For this design, the researcher asked the participants about their experience regarding the specific phenomena being studied. There is more than one type of qualitative design. The distinct types include ethnography, narrative, phenomenology, grounded theory, and case study (Sauro, 2015). An exploratory case study design aligns with the purpose and

research questions for this study. The purpose of an exploratory case study is to understand and explore a complex phenomenon or issue (Zainal, 2007). Zainal (2007) said that researchers will often use a small geographical location and limited number of participants to explore real life experiences that are then described through a detailed content analysis of their relationships. For this study, the researcher used one rural police department to interview 10 CIT trained police officers and examine how they use tools learned during training when encountering people with a SMI. Interviewing more than one police officer meets the standards of a multiple case study and allows the researcher to obtain a deeper understanding of CIT training implementation in a rural setting from an officer's perspective (Yin, 2013). In determining if a case study is the most appropriate, the researcher needs to look at the research question, control over behavioral events, and if there is a focus on contemporary events (Yin, 1994). Yin (1994) explained that the form of research questions that meet the condition of a case study use terms of how, what, and why, there is no control over the behavioral events, and there is focus on contemporary events. This study meets these conditions. How one CIT officer uses the information gained in training when interacting with individuals with a SMI will be different than how another officer experienced the same training and their personal and professional experiences interacting with this specific population. The researcher did consider other designs, but the purpose and research questions suited a case study approach.

In this study, the researcher wanted to understand officers' experiences when interacting with SMI persons and how they apply the information gained from CIT

training when responding to this specific population. The researcher relied on interviewees' own perspective to provide insight into their motivations. In return, this information will add to the literature regarding how the components learned in CIT training are being used by officers when encountering citizens in the community who have a SMI. Furthermore, this study will inform how CIT training plays a role in diversion and how adequate mental health training for police can better prepare them to interact with this population.

Role of the Researcher

There were various aspects involving the role of the researcher in this study. One aspect was the general role of the researcher as it relates to qualitative studies. For qualitative studies, the researcher needs to be able to be observant and reflective to attempt to gather the thoughts and feelings of the participants (Sutton & Austin, 2015). The researcher looked to build rapport and trust with the officers, while listening, recording, and engaging in conversation with them to obtain and understand their experiences involving interacting with individuals who have a SMI and how they have used the information gained during the training when encountering this specific population.

The researcher was aware of their own bias and experiences related to this population and topic; the researcher's professional role was explained up front to the officers so that everyone has a better understanding. To reduce bias, the researcher can ensure a few items. One, qualitative inquiry means the researcher goes into the field to help with description and understanding of external behaviors and internal states, which

allows them to understand the program and get to know the person on a personal level to put oneself in the other person's shoes (Patton, 2015). However, the researcher needs to be objective, relaxed, and detached. Being able to detach can help reduce bias (Patton, 2015). Reflexivity is a practice to help reduce bias. The researcher needs to reflect on past experiences, bias, and prejudices to acknowledge how they may shape the interpretation and approaches to the study (Ravitch & Carl, 2016). One way to help with reflexivity is journaling, which helps the researcher reflect on their own position as a mental health professional and a researcher in relation to the focus of the study.

The professional experience that the researcher had, first as a County Mental Health Administrator who worked with mentally ill persons and the District Attorney's office as criminal justice personnel was an advantage to completing this study. The researcher's experience working in the mental health system and the criminal justice system provided the researcher with opportunities and familiarity in terms of the specific aspects associated with MI and the interrelation it can have in the criminal system. Having this experience helped in formulating the interview questions and during the actual interviews. Not being a police officer, the researcher will not have firsthand experience, but the researcher does have knowledge of the mental health system and experience with interacting with persons in mental distress; therefore, this allowed the researcher to understand the complexity that an officer may experience when interacting with someone during a mental health crisis. The police officers are experts regarding their own experiences to help the researcher understand how they perceive this population and CIT training during their professional work. The researcher's experience

in the mental health field, in addition to completing CIT training with police officers was important in providing a foundation for this study and developing a rapport with the officers as well as relevant and appropriate interview questions.

As far as the participants who were CIT officers, the researcher did not have any personal relations with them or in any supervisory capacity. The researcher did not know them aside from maybe in passing or at a training. There was a chance that we have worked with mutual mental health consumers but as the role of administrator, more than likely staff directly worked with the police officers, not the researcher. There were no concerns of power over the participants.

Data collection was one-on-one interviews. In addition to reviewing CIT data sheets and pre and post surveys, both were already completed prior to the study. CIT officers are to complete data sheets after contact with a mental health person and submit these sheets to the Central Pennsylvania CIT coordinator. Pre and post surveys are completed at the time of the training and are also submitted to the Central Pennsylvania CIT coordinator. The researcher interviewed officers that have completed the training at least six months or more so that the researcher was able to ask how they have integrated the information gained from the training. All confidentially requirements were assured, and the researcher had names removed from the data sheets that included the officer name and mental health consumer name to keep everything anonymous from the start to end of review. The review of the surveys also did not include any names, but the researcher only reviewed the surveys completed by law enforcement since the focus of the study was on law enforcement.

Methodology

Participant Selection Logic

Participation selection for this study was police officers who work in Central Pennsylvania, in a rural area. The selection of participants was limited to those who have completed CIT training only since the purpose was to gather their experiences of how they have used the training in their encounters with people who have a SMI. According to Yin (2013), it is important for the researcher to hand select the participants when using a multiple case study design, which will help with replication. Yin (2013) also stated that the number of participants selected in qualitative studies is the same number of experiments in quantitative studies. What people perceive and how they make sense of their own experience is different for everyone, hence the importance of interviewing CIT officers to get an in-depth understanding from an array of people pertaining to the phenomenon.

The sampling strategy for this study was purposeful sampling. Purposeful sampling is beneficial for qualitative researchers who are looking to gather an in-depth description and information about the phenomena from the participants (Ravitch & Carl, 2016). Specific participants are chosen based on the topic. This type of sampling is appropriate because it will entail interviewing only police officers who have experience with interacting with individuals who have a mental health disorder and that completed CIT training.

For this study, the researcher worked with the Central Pennsylvania CIT coordinator who has a list of all participants that completed CIT training. The list

contains professionals in law enforcement, corrections, and mental health. The coordinator only provided the list of names for police officers since the study was limited to law enforcement and which police department they are employed with. From there, the researcher selected one police department since it was a case study strategy and communicated with the chief of police about the study before having any communication with the CIT officers. From there, the researcher sent out letters to those officers requesting participation (letters were sent through email and officers could choose to participate off duty or on duty, depending upon their preference and approval from their supervisor if on duty). The letter contained information about the study and asking if they were interested and willing to participate. In the letter, confidentiality precautions were addressed. All precautions and how the researcher ensured confidentiality are discussed later.

Instrumentation

The primary data collection instrument for this study was in-depth, one on one interviews with CIT trained police officers and review of two separate types of documents. Yin (1994) stated that a case study strategy uses multiple sources of evidence and multiple-case studies support a more robust study. Therefore, the researcher stayed within a specific police department since it was a case study design and conducted in-depth interviews of a handful of CIT officers within that same department. Responsive interviewing was the primary style for this study during the interview data collection process. Responsive interviewing is important for building trust and a relationship between the interviewer and interviewee, as well as offering a friendly,

supportive tone (Rubin & Rubin, 2012). An interview protocol was developed to help guide the researcher throughout. According to Rubin & Rubin (2012);

"In-depth qualitative interviews let us see which is not ordinarily on view and examine that which is often looked at but seldom seen." (p.29)

When researchers use the instrumentation of interviewing, they can reach across many barriers and examine a variety of people, services, programs, and communities. The strength of in-depth interviewing is that it allows the researcher to obtain knowledge and experience from the actual person who has experience with the problem of interest (Rubin & Rubin, 2012). The protocol included each interview questions and probing questions as needed. Interview questions that guided the study consisted of examples such as (a) Tell me about your CIT training experience from the beginning of the week to the end, (b) How have you used the training when responding to individuals with a SMI, (c) What was your experience with interacting with individuals who have a serious mental illness before CIT training, (d) What was your experience in responding to mental health calls after CIT training, (e) Tell me about your thoughts and experience with mental health before CIT training and did any thoughts change after CIT training, (f) Is there anything you would have changed about your training, (g) Tell me about your experience with mental health and law enforcement collaboration within your working community. These are a few examples of questions that were asked. A full list of each question is available in an attached appendix. Each interview was recorded, and the researcher took notes as necessary for clarification purposes. As previously discussed, the literature supported that there are not prior qualitative studies conducted in this area,

therefore, the instrumentation was researcher produced. Previous studies included pre and post surveys to participants completing CIT training, more of a quantitative approach or mixed methods.

The other two forms of data collection entailed review of documents. Police officers are encouraged to complete a CIT data sheet after responding to a mental health call. Once a CIT officer responds to a situation involving a person with MI, they are to complete a data sheet that describes the incident and the outcome of the interaction. These data sheets are used to capture information about CIT officer responses with mentally ill person, which can help support data regarding CIT training. A blank example is provided in an attached appendix as observation only to avoid any concerns with confidentiality. Specific interview questions from the interview protocol are attached in Appendix A as well.

During the data collection process, interviews occurred in areas of preference by the officer, which was at the police department that allowed confidentiality to be met. Audio recording occurred for each interview as recording offers minimal risks of missing important data as well as proof and/or evidence related to the study and participant, should it be needed in the future. The researcher used an audio recording tool that is secure and helps with recording, which was a LiveScribe pen. In addition, the audio recordings help at the time of data analysis. All recordings and notes will be kept for five years in a locked storage cabinet and then destroyed in a shredder to dispose the sensitive information.

Procedures for Recruitment, Participation, and Data Collection

The researcher gathered all the data for this study. As mentioned, recruitment was solely based on Central Pennsylvania CIT officers, in a rural police department. There is a CIT coordinator in the area that compiles a list of the current CIT officers that the researcher worked from to obtain the list of names and police departments to reach out to for recruitment. If recruitment resulted in too few participants, the researcher would seek out another rural police department and work with the CIT coordinator and the chief of police to help receive participants. Data was collected from the in-depth interviews, which were scheduled in 1-hour increments and the location was at the preference of the officer and confidentiality standards were met. It was also mentioned that all interviews were audio-recorded, and an interview protocol was created prior. The interview consisted of open-ended questions and semi structured.

The researcher was looking for richer, detailed information, not yes or no answers, but rather examples, experiences, and stories so keeping it open ended, allows the participant to elaborate (Rubin & Rubin, 2012). By using an interview protocol, questions are prepared in advance, as well as follow up questions, keeping it semi structured since there is a specific topic to be learned about (Rubin & Rubin, 2012). At the end of each interview, the researcher allowed time and offered the opportunity for debriefing. The researcher concluded the interview by reiterating the purpose of the study, confidentiality standards, described the next steps that the researcher will take, which also explained follow up interviews if necessary, and thanked the participant.

Data Analysis Plan

Based on the purpose of the study and the research questions, a qualitative exploratory case study design was an appropriate method to allow the researcher to understand the implementation of CIT training within a specific police department and how officers are using that training when interacting with citizens in the community who have a SMI. Collecting data using in-depth interviewing allowed the researcher to describe in rich detail the lived experiences of these officers. Additional data collection consisted of a review of two separate documents to provide a more robust study and further assessment of a rural police department in their experience of responding to mental health calls and their experience before and after the training completion of CIT. As supported in Chapter 2 and previously, many studies regarding CIT training have been more quantitative or mixed studies. By using a qualitative case study strategy, the researcher is adding to the literature of CIT training to include data about a rural police department and the lived experiences of CIT officers. The previous studies have often used pre and post surveys about CIT training to collect data. In addition, many CIT training studies are conducted in larger urban areas, lacking research from smaller rural areas. This study looked to obtain data from a rural police department and how they have implemented and experienced CIT training and how they use the information learned when responding to mental health calls. To date, there have not been any qualitative studies conducted in Central Pennsylvania to capture the experiences of officers who have completed CIT training and how they use the tools learned in the training when interacting with citizens in the community who have an SMI. Reviewing pre/post surveys completed by officers in this police department and their mental health call

sheets supported triangulation of the data. This specific instrument was researcher developed.

The researcher took notes as needed for better clarification purposes, in addition to the audio recordings. After the interviews were completed, they were dictated into text by a third-party professional. Having everything dictated helped in organization to then identify themes and categories.

During the data analysis process, coding was used. Coding is the process of assigning a meaning to the data (Ravitch & Carl, 2016). Prior to collecting data, the researcher determined what software to use (e.g. DeDoose). The data analysis software helped formulate the data into categories, patterns, and themes. Coding was used to help analysis the data by looking at word recognition and repetitiveness throughout the word documents. As part of preparing for the interviews and data analysis, questions were designed based on an array of pre-determined categories.

The review of the CIT data sheets, and the pre/post training surveys were described through content analysis. The researcher reviewed the narrative data on the documents, aligning the study to stay within a qualitative design. Documents provide a rich source of evidence, often not included in other research, but a vital aspect in case study approaches (Case studies and qualitative research, 2007). For this study, the use of interviews and documents supplemented one another. Analysis of the documents were like analyzing the information received by the interviews which was searching for underlying themes. The researcher explains and describes in full detail the content and findings after interpretation in Chapter 4.

Issues of Trustworthiness

Credibility

Readers and other researchers will want to know the study results are credible. One part of achieving credibility is making sure you interview people who are informed about the research questions (Rubin & Rubin, 2012). This was done through the recruitment process to ensure only CIT officers are interviewed. The research also needs to be carefully carried out by reporting the findings in a transparent manner and keeping all notes and recordings that way anyone can check the data if they want to if confidentiality is protected (Rubin & Rubin, 2012). This helps to ensure credibility.

There are different strategies that the researcher can take to improve the internal validity of the study. Triangulation is one strategy and a specific form related to this topic is data triangulation. Data triangulation is like purposeful sampling and the researcher is mindful of gathering data from various sources (Ravitch & Carl, 2016). In case study strategies, triangulation is met on two levels; one being the integration of different evidence and by applying qualitative content analysis (Kohlbacher, 2006). Data collection in this study included different CIT officers from a rural police department, in addition to two types of documents. The researcher took on a reflexive role of providing an assessment of identity, position, and subjectivity (Ravitch & Carl, 2016). Triangulation is vital in ensuring credibility throughout the study.

Transferability

Transferability is another way of ensuring external validity so that the qualitative study can be applicable and transferable (Ravitch & Carl, 2016). One strategy to help

with external validity is by having the results transferred into deep, descriptive text that is context specific. In qualitative research, the participants' experiences are the primary fidelity and the goal is not to have the findings be directly transferred to other settings and context, but it can be transferable to allow other researchers to replicate aspects of the study design and findings to different contextual factors (Ravitch & Carl, 2016). To help researchers with transferability for this study phenomenon, the researcher describes in deep detail the purpose of the study, the design, participant selection, and findings.

Dependability

Studies should be dependable. For qualitative studies, that means stable and consistent (Ravitch & Carl, 2016). Triangulation is a strategy to help with dependability and this technique was already discussed in relation to the topic. The design and method must also be consistent with the researcher's argument for the study and how data will be collected (Ravitch & Carl, 2016). The rationale for why a qualitative design and how the data will be collected were discussed previously based on the research questions and supportive research in the literature review.

Confirmability

Reflexivity is an important aspect for qualitative studies. Qualitative researchers do not claim to be objective but rather subjective (Ravitch & Carl, 2016); however, the findings to need to be confirmed and one way to establish this is through reflexivity. The researcher needs to be reflexive and explore the ways that bias can form interpretations (Ravitch & Carl, 2016). For this study, the researcher built a positive, trusting relation with the participants that explained any potential researcher bias but also ensured that

they have freedom to express their feelings without feeling judged. By describing the participants' experiences in great length in a manner that is descriptive, the researcher established that any potential influence was not valid within the findings and the researcher's personal bias did not impose on the data.

Ethical Procedures

In addition to issues of trustworthiness, the researcher also needs to take into consideration ethical procedures. For this study, especially the data collection, followed all IRB policies and procedures. The researcher submitted the IRB application and obtained approval to conduct the study and collect data.

Regarding the participants, their participation was completely voluntarily, and they could choose to not participate or end the interview during any time. During the recruitment process and prior to the interview, the researcher reviewed all confidentiality procedures and had the participants sign a consent form. All the participant's information remained anonymous throughout the study and they were identified by a number or police department. The participant and researcher did not have any relations prior to conducting this study. Each may have a general knowledge of the work they do and know each other by names due to potentially working on the same cases within the community but the researcher is not employed by any police department, therefore, there are no concerns of conflict of interest or power differentials. The study was not within the researcher's own work environment. The researcher was the Mental Health Administrator for the County Government and data collection occurred with police officers from a rural police department in Central Pennsylvania. When the researcher

reviewed the documents already mentioned as part of data collection (completed CIT data sheets and pre/post surveys), the CIT coordinator blocked out all demographic information. The researcher only had access to reading about the call and response from law enforcement, and the questions/answers from the completed surveys, which also does not identify the officer. By eliminating this information, it protected the mental health individual and the police officers to protect ethical dynamics.

All data will be kept in a locked filing cabinet and disposed after five years. Only the researcher will have access to the raw data.

Summary

The paucity of experiential research insight about CIT training hampers an understanding of how it may remedy unnecessary criminalization of SMI individuals by police officers. A case study strategy allows the researcher to investigate how people respond to a social problem. This study focused specifically on specialized mental health training as a response (CIT training) and how law enforcement officers who are CIT trained use the skills learned from the training in response to interacting with people who have a SMI. It was mentioned throughout that CIT training plays a role in diversionary opportunities, specifically in the sequential intercept model, stage one with police officers; therefore, it is important to understand the experiences of CIT officers and how they use this training during that intercept.

This qualitative study will add to the literature based on the missing gap of officers' experiences in using the information gained from CIT training when encountering citizens in the community who have a SMI. The study provides insightful

and descriptive experiences from CIT officers who have completed the training and interacted with individuals who have a SMI in Central Pennsylvania. To date, there is not a qualitative study in this region that interviews CIT police officers to learn about their experiences and how they have used the information gained from the training throughout their course of work with people who have a SMI. Adding to the literature will help with CIT training outcomes to address the model being evidence based and assess whether Pennsylvania should initiate CIT training statewide. Obtaining data from interviewees who have lived experience, along with review of already received valuable data to interpret helped answer the research questions and ensure the data is credible and valuable.

Chapter 4: Results

The purpose of this qualitative exploratory case study was to understand the experiences of a select group of police officers who are CIT trained and how they use the information gained from CIT training with citizens they encounter who have a SMI. The problem addressed in this study was the missing research from CIT officers in a rural setting to gather their perceptions of the training and how they use the tools gained in the training during their work. Information from the available literature on this subject suggests that law enforcement lacks specialized mental health training and there is missing data about the effectiveness and outcomes of CIT training that include law enforcement officers' experiences in using the information gained from CIT training when interacting with community members who have a SMI. This study helps to fill the gap in the literature and to add to the literature about CIT training outcomes. The following research questions were used:

RQ: What are the experiences of CIT officers in terms of using the information gained from CIT training with individuals they encounter who have a SMI?

SQ: What components of the training did officers find most valuable from CIT training when responding to individuals who have a SMI?

This chapter presents descriptive demographic information regarding participants, as well as data collection, data analysis, evidence of trustworthiness, and the research results.

Research Setting

The setting of the interviews was predetermined by the chief of police and the CIT officers who volunteered to participate. After IRB approval was granted (# 01-23-19-0673482), the chief received the invitation letter and consent form that would be provided to the officers who volunteered (see Appendix A). Shortly thereafter, the training officer within the department, as directed by the chief provided a list of CIT officers. For those CIT officers who volunteered, a time and date for the interviews were agreed upon by the researcher and each officer. On the days of the interviews, a private room was made available. Prior to conducting the interviews, the CIT coordinator expressed that the chief in this department has a goal of ensuring all officers become CIT trained, the chief himself has also received CIT training.

There were no personal or organizational conditions that influenced participants or their experience at the time of the study, to my knowledge, that would have impacted the interpretation of the results.

Demographics

This study included three different data sets; individual face to face interviews, an analysis of completed CIT data sheets, and CIT surveys (both pre and post). The three sets of data were used for triangulation purposes outlined in Chapter 3 and to add to the overall collection of CIT outcomes. Each participant in the interview data set was a certified CIT officer from a randomly selected police department in rural Central Pennsylvania. There was a total of 10 participants (N=10), with nine male (90%) and one female (10%). All participants were Caucasian. Interview participants reported both

their years in the profession and as CIT trained officers. Overall experience ranged from 3 years to 19 years, with a mean of 11.8. CIT trained experience ranged from 1 year to 6 years with a mean of 3 years as a CIT officer.

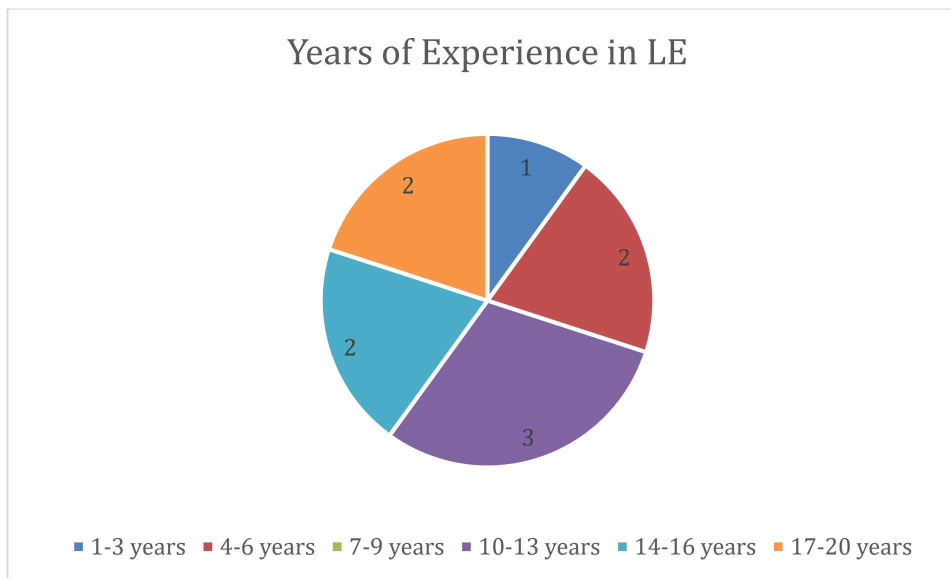

Figure 1. Demographics: Years of experience as a police officer.

Figure 2. Demographics: Years of being a CIT officer.

For the CIT data sheets, there were 179 sheets completed consisting of 123 in 2017 (69%) and 56 in 2018 (31%), indicating either a decrease in data sheets being completed or the amount of MH calls received from 2017 to 2018 or both. Ninety-three out of the 123 sheets completed in 2017 were completed by CIT officers (76%) whereas the remaining were completed by non-CIT officers (24%). For 2018, 45 out of 56 were CIT officers (80%) and the remaining were non-CIT officers (20%). Combined, 138 of 179 (77.1%) data sheets were completed for both years. The CIT data sheets were completed when officers responded to individuals who were in mental distress.

Demographics were reported by officers on the sheets for the individuals in mental distress. Age ranged from one to 10 years of age up to 90 years of age. (Note that there were three data sheets in 2017 that did not report age and four in 2018 so this data is not included in Figure 8 and 9 below). There were 60 males (49%), 61 females during (50%) and two people did not identify gender (1%) in 2017. In 2018, there were 32 males (57%), 22 females (39%) and two unknowns (4%). There were 84 Caucasian in 2017 (68%) and 37 in 2018 (66%). In 2017, there were 18 African American (5%) and nine in 2018 (16%). Only two (2%) identified in 2017 as Asian and one (2%) in 2018. Race was not identified and was marked as unknown on the CIT data sheets for (15% in 2017 and 16% in 2018).

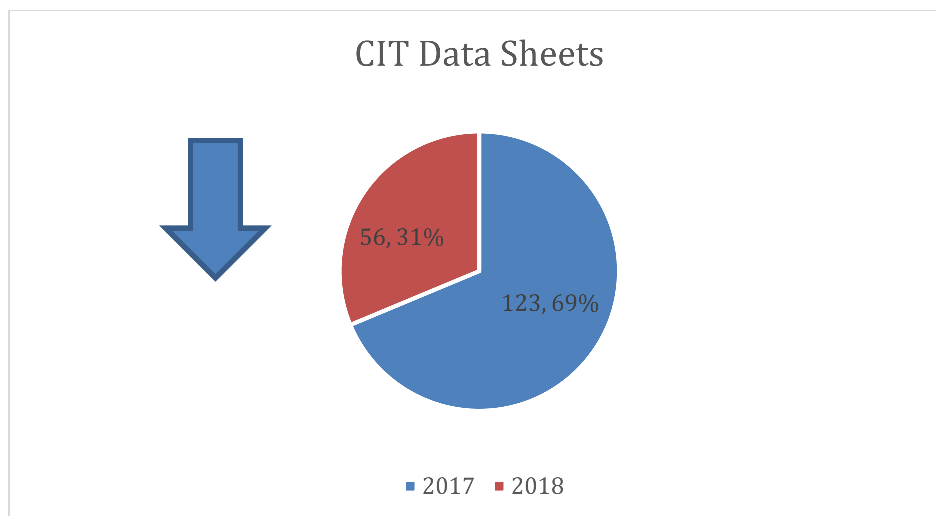

Figure 3. Demographics: Completion totals for CIT data sheets.

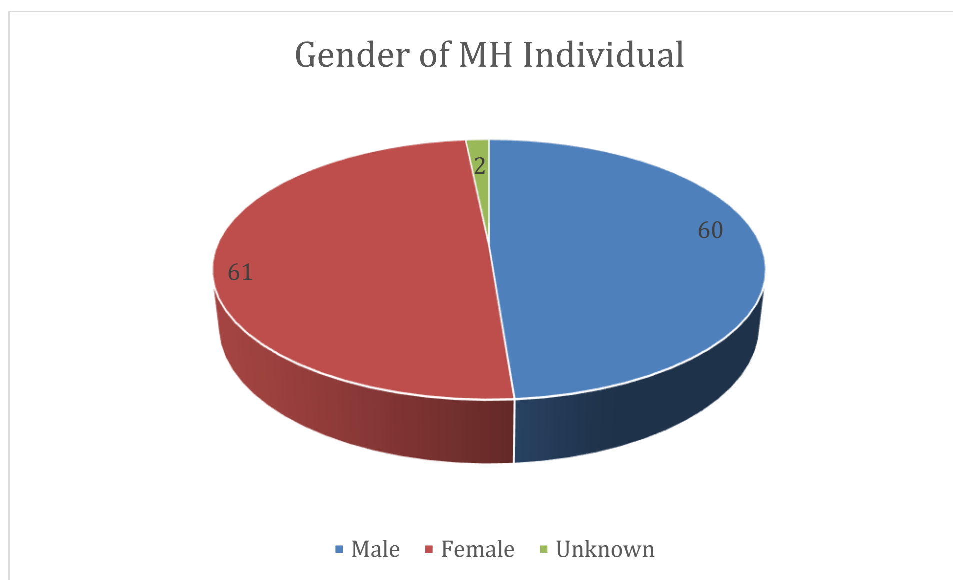

Figure 4. Demographics 2017: Gender.

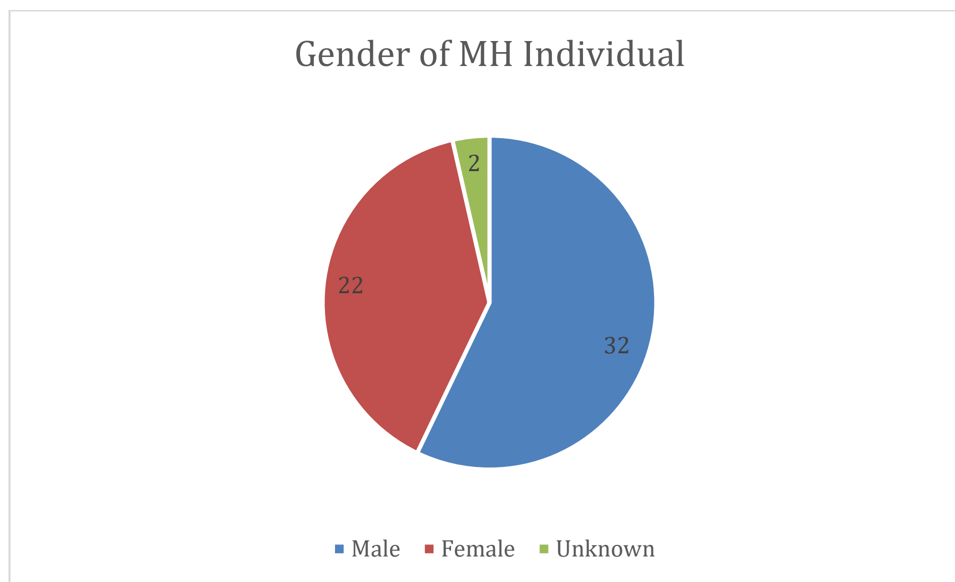

Figure 5. Demographics 2018: Gender.

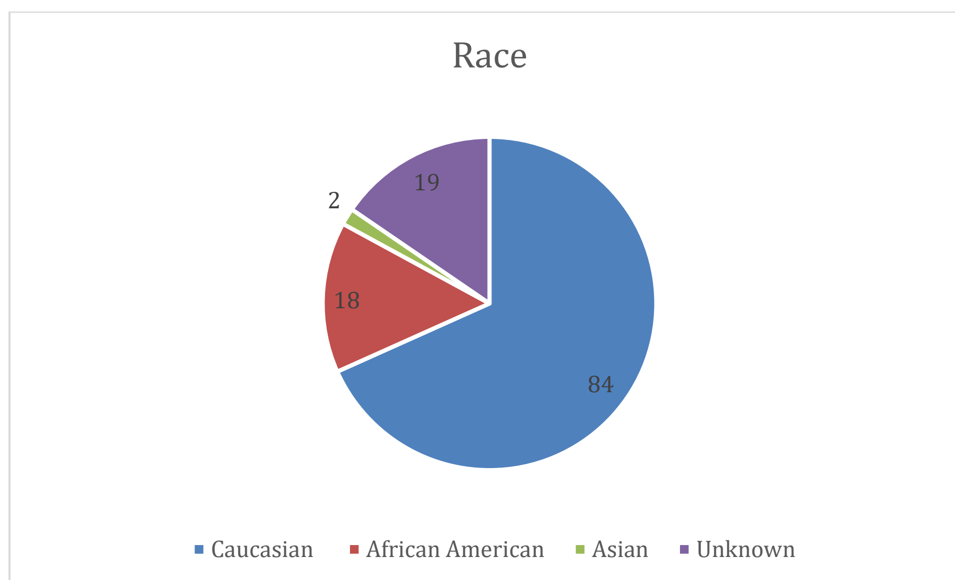

Figure 6. Demographics 2017: Race.

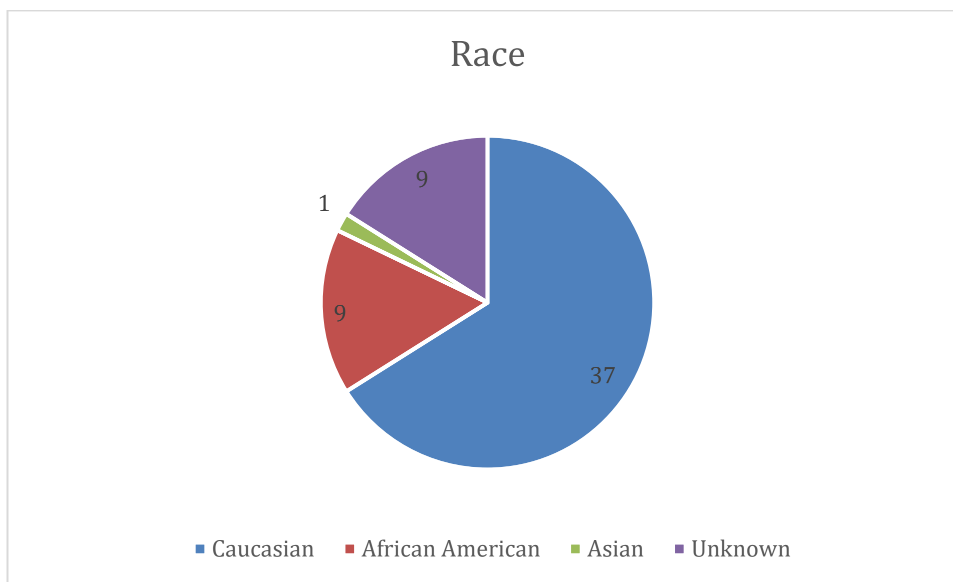

Figure 7. Demographics 2018: Race.

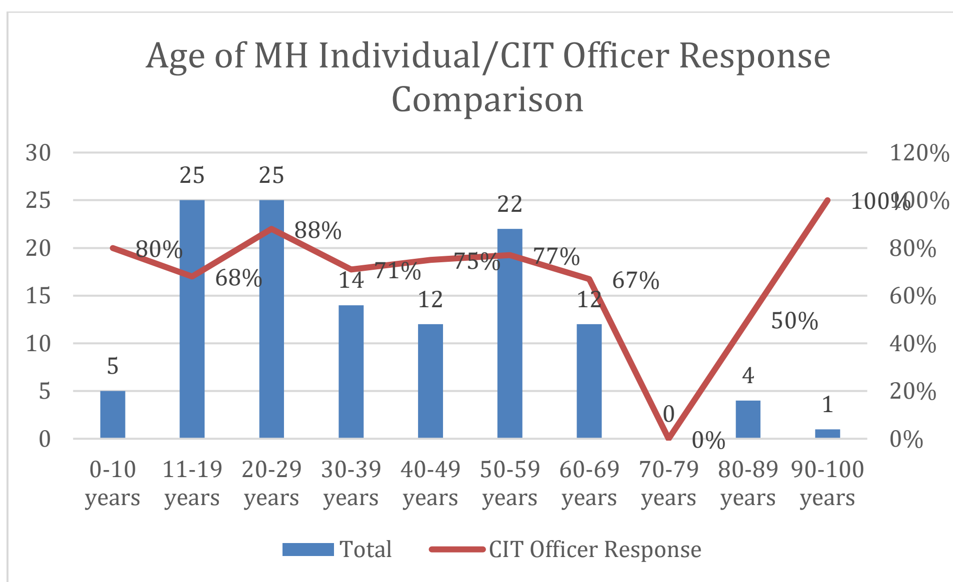

Figure 8. Demographics 2017: Age/CIT officer response.

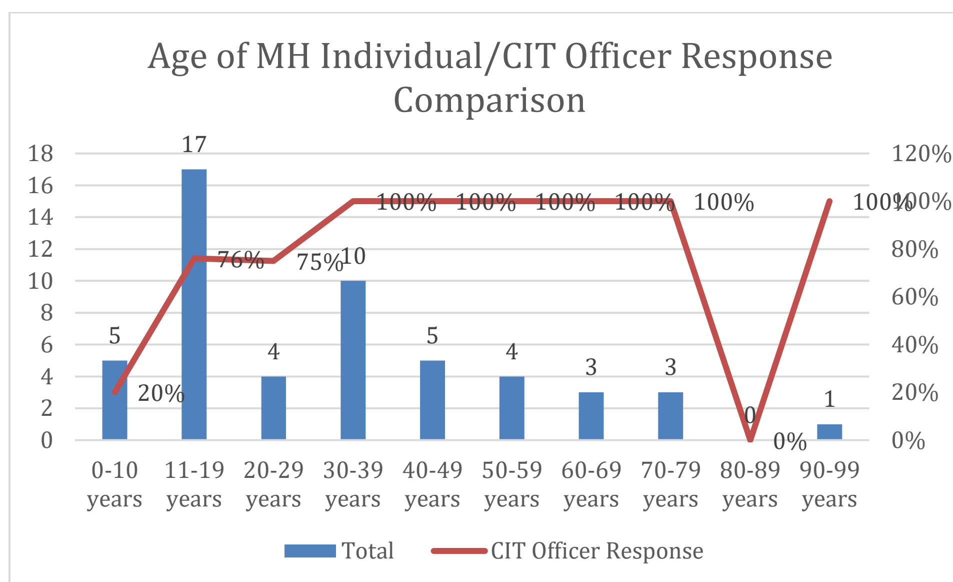

Figure 9. Demographics 2018: Age/CIT officer response.

The last data set included completed pre and post CIT surveys from 2017 and 2018, all of which were done by police officers getting certified in CIT (see figures 10-13 below). In 2017, there were six surveys (*N*=6), all completed by male officers (100%). Five of the officers were Caucasian (83%) and the other one was Asian (17%). Over half of the officers reported having their bachelors (67%) and two reported having their Masters (33%). Age demographics comprised of two officers being between 20 and 30 years of age (33%), one officer between the ages of 30 and 40 (17%), two officers between 40 and 50 years of age (33%), and the oldest was between 50 and 60 years of age (17%). There was one who reported being a veteran (17%).

In 2018, there was a total of 13 and all were male again (100%). There was 12 Caucasian (92%) and one African American (8%). Eighty-four percent reported having only a high school education and/or took some college courses, but no degree. One officer had their bachelors (8%) and one had their Masters (8%). Two officers ranged

between 20 and 30 years of age (15%), eight officers between 30 and 40 years of age (62%), and three officers were between 40 and 50 years of age (23%). There were 10 who reported being a veteran (77%).

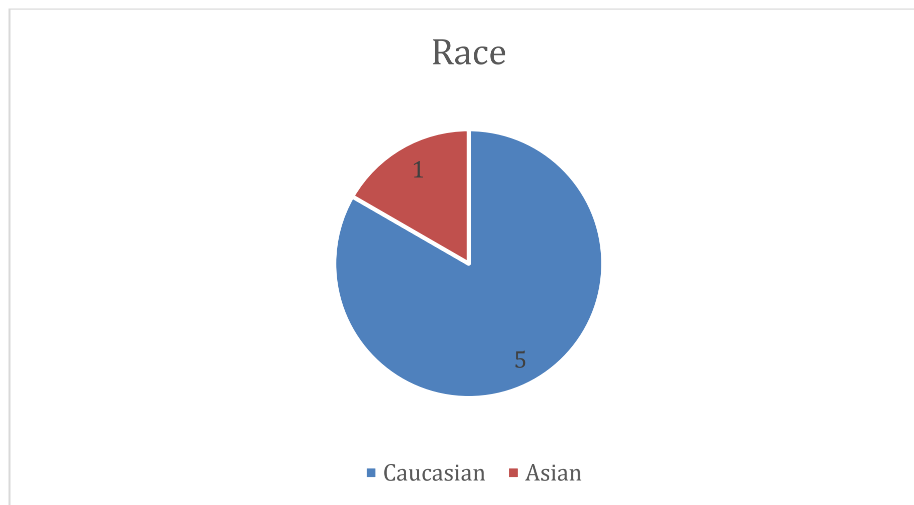

Figure 10. Demographics 2017: Race.

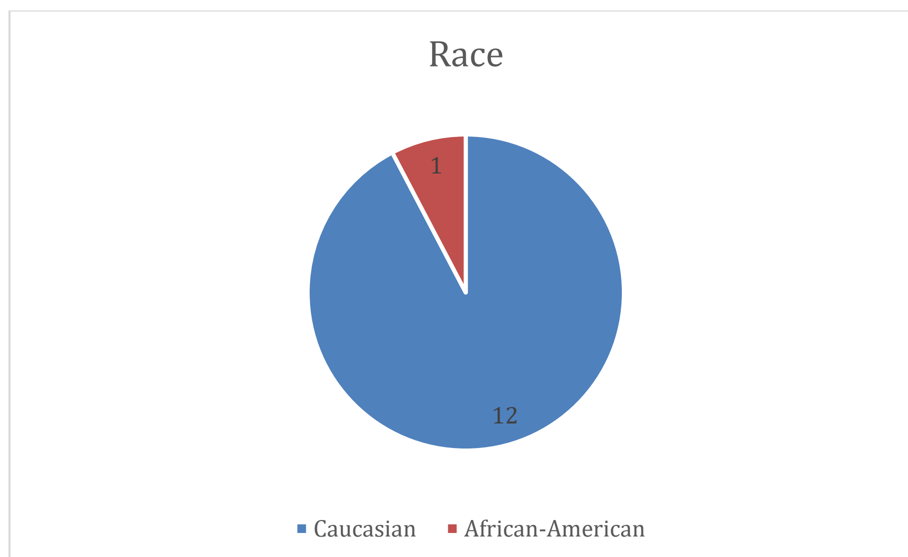

Figure 11. Demographics 2018: Race.

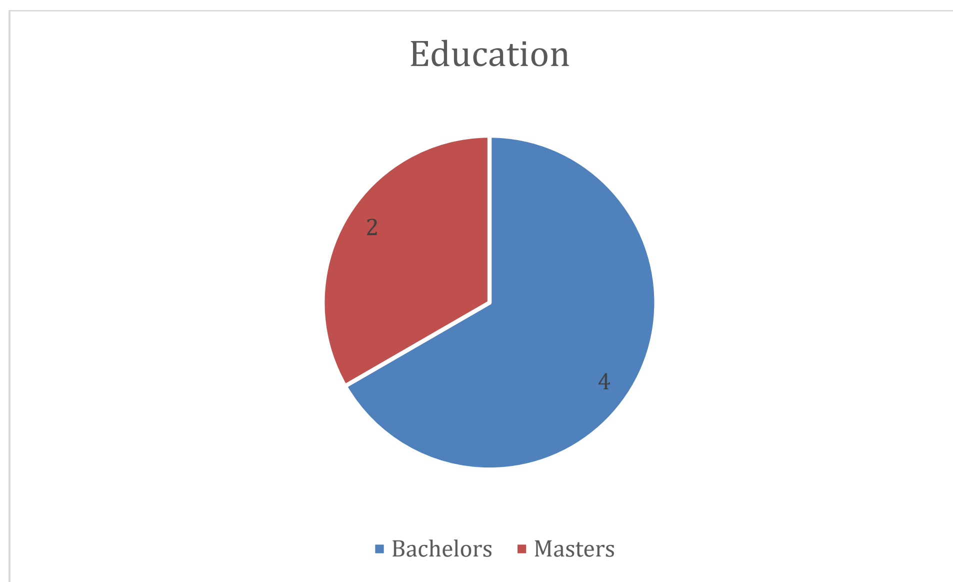

Figure 12. Demographics 2017: Education.

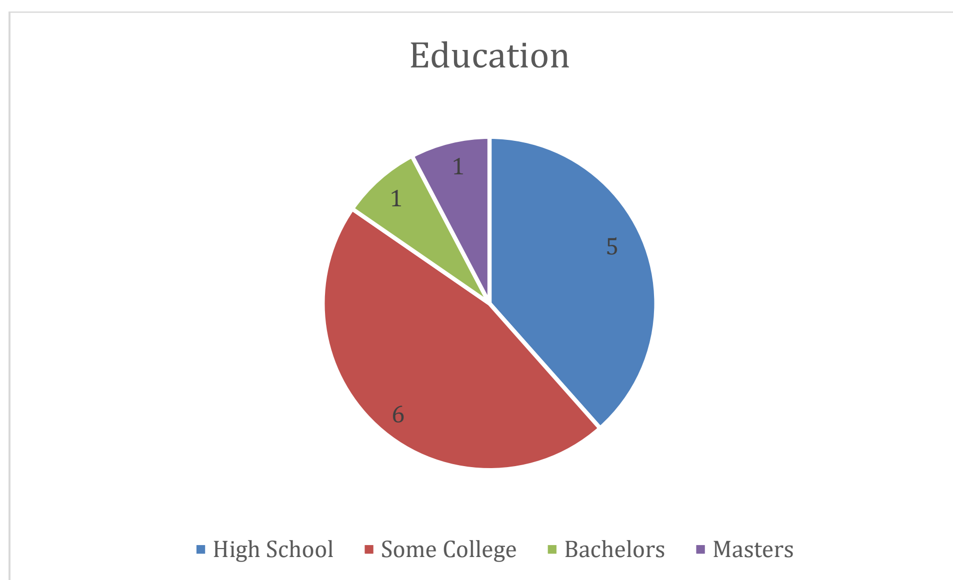

Figure 13. Demographics 2018: Education.

Data Collection

The sample for the experiential interview part of the study was made up of face to face interviews with 10 CIT trained officers, all within the same police department in

Central Pennsylvania. After speaking with the chief of police for recruitment and this study, the chief provided contact information for the training coordinator officer within their department. This officer then reached out via email and provided a list of names of officers who completed CIT training. Each officer was contacted by the researcher via email to schedule an appointment to meet individually to conduct the interview. The email initially consisted of an invitation letter and consent form as outlined in Chapter 3 and then once the officer agreed to participate, there were follow up emails to schedule at their convenience. Each of the officers were interviewed one at a time at the police department in a private room. Before each interview was conducted, the consent form and confidentiality standards were reviewed again, and each officer was provided a hardcopy of the signed consent form. The interviews were conducted over two different days (February 18, 2019, and March 3, 2019) and recorded by handwritten notes and audio recordings with a Smartpen and iPod Touch recording app to preserve and maintain all data. Each interview ranged from 20 to 45 minutes.

For the CIT data sheets and the pre/post surveys, the data collection methods consisted of documented reviews. Both types of documents completed comprised of officers within the rural setting of Central Pennsylvania and consisted of a year worth of data in both 2017 and 2018. There was a total of 179 CIT data sheets reviewed and a total of 28 surveys reviewed (19 for pre-survey and 19 for post-survey, the same officer for each pre/post). Each document data set was reviewed carefully, and the data was recorded by handwritten notes and with a Smartpen, again to maintain the data. The CIT

data sheets and surveys were gathered from the CIT coordinator for the county as outlined in Chapter 3 via email, phone, and in-person contact.

For all three sets of data collection, there were no unusual circumstances encountered throughout the data collection process. When setting up the first round of CIT officer interviews, there were seven officers at first, but two declined. During the first day of interviews, there was an officer that asked to participate, making it a total of six interviews completed on day one. The study and consent form were discussed, reviewed, and completed prior to the interview, in addition, all information was also sent via email. At the first day of interviews, one of the sergeant's provided an additional four CIT officer names to reach out to, in order to help reach data saturation. These four CIT officers were contacted individually via email with the invitation letter and consent form, all of which agreed to participate. All four interviews were arranged and conducted on another day. Recruitment for all 10 interviews was arranged via the chief, the training coordinator officer, and a sergeant. All other steps were followed as outlined in Chapter 3 data collection method for this study.

Data Analysis

The experiential interviews were semi-structured and semi-open ended to allow each participant the opportunity to explain their experiences with interacting with individuals who have a SMI and their overall experiences with the CIT training. At the end of each interview, the officers had the opportunity to add any further information to help explain this phenomenon. After collecting all the data, the information was sorted to be analyzed more thoroughly through content analysis and sorting for codes, themes, and

patterns. The interviews were transcribed verbatim by a third party (Rev.com) to maintain data integrity and validity. After transcribing, I then took the information gathered and sorted it by grouping all responses with the corresponding question (i.e. Question 1 response were grouped with Question 1) to help better understand the responses and look for emerging themes. All the data consisted of sorting through the sentences, line by line, looking for repeated words and patterns. All responses for the interview questions were grouped under themes that were reoccurring in order to assist with synthesizing the data.

The CIT data sheets and surveys were also sorted. I counted and analyzed each document manually using handwritten notes and then typed up all my notes using Microsoft Word for better clarity and organization. Initially, each document was broken down into sub-groups based on the information that each document had, similar to how the interviews were organized (i.e. by the question-Question 1 response were grouped with Question 1).

All data collection was coded to detect themes and patterns and then the DeDoose software application was used for organization, theme validation, and to ensure all patterns were reviewed and analyzed. In addition to the software application, I also used Microsoft Word and utilized a word recognition search for each interview and for my notes that were typed up for the CIT data sheets and pre/post surveys and Microsoft Excel to help develop a variety of charts for visualization. Any repetitive words and phrases were highlighted and grouped together. By individually analyzing the data in Microsoft Word and using DeDoose, it helped to improve accuracy. The researcher also

calculated weighted means for the CIT data sheets and pre/post surveys to see if any trends could be identified and support the experiential analysis. By doing this, it also improved the overall data and triangulation. One summary table is included in the results section and the remaining weighted scale tables are included in an attached Appendix at the end for additional visualization of the results.

Evidence of Trustworthiness

Ensuring reliability occurred before the study was conducted which consisted of reviews by Walden University, Institutional Review Board (IRB) at Walden University, and completion of the Collaborative Institutional Training Initiative (CITI) program. There were 10 questions as part of the interviews conducted, all of which each officer answered. In addition, each participant for the interviews was provided the opportunity to present their experiences and add clarity to their responses during and after. The officers were clear in their responses and were provided assurance of confidentiality before and after. By doing this, it adds to the validity of the study knowing the officers were able to be truthful when discussing their experiences.

The researcher's profession as a former Mental Health Administrator and currently working in the criminal justice field provided the opportunity to not only having expertise but being able to ask the questions in a non-biased and non-leading manner. This experience helped to understand the culture of law enforcement and those with a SMI as well as it helped build a rapport and trustworthiness with the officers. The role of the researcher based on their experience and expertise can impact validity. Sharing

information about overlapping knowledge to help with rapport and building trust will help with ensuring validity and accuracy in collecting data.

Credibility

Credibility strategies were followed as outlined in Chapter 3. Strategies that were accomplished to meet credibility were through precise data collection and analysis. Triangulation was used by the researcher to enhance the credibility of the study. Triangulation helps to test for consistency by using different methods of data collection (Patton, 1999). For this study, there were three forms of data that consisted of interviews and two forms of documentation reviews. Studies that only use one method for data collection are more susceptible to error (Patton, 1999). The interviews and CIT data sheets came from one rural police department, while the CIT pre/post surveys included more than one rural police department, which helped to reduce bias. For this study, the researcher looked for consistency among the data, along with comparing each data results to one another. The interviews were transcribed by a third party, to also improve credibility. Preparation of the researcher is essential. The researcher dedicated time and commitment to building rapport with the study process and officers. The credibility of the researcher is important to strengthen the validity of qualitative studies (Patton, 1999). Building rapport was important for this study and the researcher was able to do that based on prior and current experiences, along with providing perspectives pertaining to the field. These experiences were outlined in Chapter 3. There were no adjustments made.

Transferability

Transferability strategies were followed and outlined in Chapter 3, with no adjustments made. Results from this study only represented a select group of CIT officers in Central Pennsylvania and may not be generalizable to other CIT officers across the United States, where police departments may be different in their training methods. Policies that are used across the United States in different police departments, along with documentation and training will impact generalizability due to the differences (Creswell, 2009). However, the interview questions could be transferable to other police departments with similar populations given that credibility was addressed previously. The documentation can be transferred also if other police departments and CIT coordinators use those specific instruments to record. Having accurate results will help others to relate (Yin, 2013). Although results could vary from one police department to another, the data analysis used in this study and describing the findings in thorough detail can help other CIT officers relate.

Dependability

All strategies were followed to ensure the study was dependable, as outlined in Chapter 3 and no adjustments were made. The researcher’s data collection process, experience, and knowledge of the topic, along with active listening helped with enhancing the dependability of the study. Having the interviews recorded by using a SmartPen and an iPod Touch recording app aided with dependability, in addition to handwritten notes throughout. Afterward each interview was transcribed verbatim using a third party to ensure all information was collected accurately. Yin (2013) stated that

dependability increases when the researcher removes any ethical concerns and bias. The researcher also repeated their coding techniques to help eliminate mistakes.

Each participant was also able to read their results if they wished to ensure everything they stated was reflected appropriately. It is important to note that the researcher in this study described each data collection method using rich detail as part of the qualitative content analysis. Results from this study only pertain to the individuals and specific areas that collected information per the documents. Therefore, officers or departments in other areas could have other perceptions pertaining to CIT training.

Confirmability

No adjustments were made to confirmability strategies, which were previously outlined in Chapter 3. As discussed in Chapter 3, reflexivity was a tool used to strengthen confirmability for the study. To minimize potential bias, the researcher developed standard, open-ended interview questions that each participant was asked. As previously mentioned, the researcher took notes, used a SmartPen, iPod Touch recording app, and had the results dictated to minimize distortion. The officers were able to follow up afterward to ensure their responses were captured and accurate. By using member checking, it allows the participants to evaluate the data to ensure the study was understood and could be confirmed by others (Edwards & Kennedy, 2017). Using thick description and ensuring results are described in a data-driven manner helps enrich confirmability (Yin, 2013). The interview participants were informed that they would be provided a copy of the findings after the dissertation was completed. In the section of

study results, quotes by the participants are provided to minimize threats of confirmability and any biases.

Study Results

This study results answered the research questions, gaps in the research, and addressed the purpose of the study. The results of all three data sets (interviews, data sheets, and surveys) also provided additional literature to address CIT training outcomes. The purpose of this qualitative exploratory case study is to understand the experiences of a select group of police officers who are trained in CIT and how they use the information gained from CIT training with citizens they encounter who have a SMI.

CIT Interviews

As noted, there were 10 interviews conducted with CIT officers. Interviewing these officers aided in answering the two main research questions:

RQ: What are the experiences of CIT officers in using the information gained from CIT training with individuals they encounter who have a SMI?

SQ: What components of the training did officers find most valuable from CIT training when responding to individuals who have a SMI?

From the interviews, the officers were able to provide information about the training and their experiences to help answer these questions and provide further information to improve CIT training outcomes. From answering the interview questions, emerging themes developed, which included:

1. Empathy/Understanding
2. Time

3. Knowledge/Resources
4. Content
5. Collaboration

Theme 1: Empathy/understanding

One of the interview questions consisted of finding out if these officers have had mental health training prior to CIT training. Over half of the officers reported no prior training. Those that indicated training reported that they took a few college courses, one reported having a few hours spent in the academy going over videos of "emotionally disturbed individuals" and one reported being part of a pilot program in the academy where they practiced hands-on scenarios, and then one officer indicated prior case management experience. Overall, other than already working in the field and responding to calls and talking to citizens, CIT training was the first in-depth training about mental health.

Another interview question consisted of asking the officers about their perceptions before and after CIT training and their interactions of handling a person in mental distress. Being able to empathize and have a better understanding of the symptoms to identify what was going on such as anxiety, psychosis, etc. was an overall pattern when discussing the answers to these questions. Officers reported that the training helped them to understand the different diagnoses and how one may respond on or off their medications. Being able to identify that something is wrong was helpful to the officers. For example, participant 2 stated, "Afterwards you know how to look at the surroundings of them, see beyond such as something they like, in order to help build a

rapport with them. You show empathy towards them and by doing that, you can speak to them easier and try to convince them to get help rather than being quick to just say, hey, you need help." Participant 8 indicated, "I received a call yesterday about a girl cutting her arms. Before CIT training, I would have got there and responded hard and dominant, but after CIT, I respond with more empathy."

Subtheme 1.1: Beliefs and perceptions. Despite the interactions that officers already had out in the field prior to CIT training, some of their own personal beliefs or lack of understanding, endorsed the theme of having a challenge of being able to recognize MI. One participant worded it as, "personally, I would look at those people like, you're crazy, why are you so crazy? Afterward, you really look at them as an individual with a problem." Participant 3 stated, "CIT definitely changed my perception. I did not realize all the studies that went into understanding mental health and you do not get a full aspect of it until you go through particular training like CIT." Participant 4 added, "just understanding mental illness in its entirety, just a bigger picture of it, helps you offer treatment to people."

All 10 of the participants used the language of empathy throughout in their responses and being able to understand better after completing CIT training. One participant indicated, "knowing the different illnesses helps you to know how to respond to each one." Over half of the participants reported that their overall perceptions changed after CIT training. Some of the interviewees who reported no change in perception were primarily due to having experiences with family members, so they were already more aware.

Theme 2: Time

Aside from the pattern of empathy, time was a frequent word used by the participants to describe their experiences with CIT training and how they used the tools gained in the training when interacting with a person who has a SMI. Many of the officers described responding to calls and handling the situation as soon as they could in order to respond to the next call. However, after CIT training and being able to identify and understand better, empathizing and spending time with the person was much more common. For example, participant 8 stated, “CIT definitely taught me to slow down. Before I wasn’t may be able to identify and now, I can see more signs, symptoms, and address them the best that I can. I spend more time with the person and show more empathy.” Participant 7 added, “Before I would go in and just handle the call, not understand or try to understand. CIT made me become more personable with the person and listen to their stories. It gave me more compassion.” Almost all the participants discussed their response time and not rushing. Participant 6 reported, “CIT makes you take a step back and spend more time to get the result that you want.” Having a better understanding after CIT training allowed the officers to show more empathy and spend more time with a person in crisis. Participant 6 explained it as, “slowing down versus rushing and the training helped me with that. You cannot rush a person into compliance for them to seek assistance. It takes time and if it takes an hour, you have to be prepared for that but knowing you are helping someone.” Taking a step back, listening, and not rushing appeared to be a very common pattern that the CIT officers all use when responding to a person with SMI, all of which they gathered from the training.

Theme 3: Knowledge

While speaking to the CIT officers, it was prevalent that not only did their understanding of MI increase so did their knowledge. Knowledge was also a key pattern when analyzing the pre and post CIT surveys. Participant 2 indicated, "Before CIT, I had a bunch of different skills that I used already when dealing with a person who has a mental illness, but after CIT, I had more tools and options." Participant 3 added, "Before I was not sure how to handle these certain things, like how am I supposed to talk to or relate and get them to calm down?" "I just don't know how to deal with you," said participant 10. Being able to learn more about the different diagnoses and symptoms seemed to be very beneficial to the CIT officers and this also holds true to the pre and post surveys. Having a better understanding and knowledge was useful to the officers in being able to de-escalate a person and show empathy.

Sub-theme 3.1: Resources. Over half of the participants indicated that one of the most beneficial aspects that they took from the training was the resources. For example, participant 5 stated, "The training does focus on how we can divert people from the criminal justice system when we can." Throughout the training, the officers heard from different presenters and the services available and they indicated that was very helpful in being able to build a connection and know where to go. Participant 9 added, "After the training, I was working with a guy and I was able to send him to case management to get help for counseling and housing. Before CIT, I would not have taken that extra step, I may have only referred to crisis because I did not know the other places in the community." Some officers reported that there was a community resource fair where

they learned more about the local providers at the end of the week and that was also beneficial. Some did note the frustration with where to turn to for additional resources other than jail or crisis due to the closure of community and state hospitals. However, the majority did note that they did not understand the other current services available, only crisis, prior to CIT training.

Theme 4: Content

While interviewing and analyzing the pre and post surveys, an emerging theme of content and quality kept appearing. Officers reported in the post-survey that the overall quality and organization of the training was put together well. During the interviews, a question was asked about changing anything to the training and there were no officers that reported any dislikes. They all indicated that the content was good, and they were able to get something out of it even if they were apprehensive in the beginning. Adding another tool to their toolbox was described more than once. The participants reported that all the information was relevant and helpful to them in their everyday roles. Scenarios and the hands-on role-playing to help with de-escalation were described in all the interviews as being helpful to add another tool to their toolbox, as they stated.

Theme 5: Collaboration

Prior to CIT training, all the participants reported that taking a person to crisis intervention services was typically their only response to a mental health call. “We dropped them off at crisis and not sure what the outcome would be and hope they would get help until we saw them again,” was how one participant described the process. CIT is more than just training. The basic goals are to improve officer and consumer safety and

help persons with SMI and/or addiction to access treatment rather than place them in jail, but CIT is also a community partnership of law enforcement, individuals who live with SMI, their families, other advocates, and human service professionals (CIT International, Inc.). There were two participants that indicated the collaboration between the criminal justice and behavioral health system was poor. The majority indicated that there still needs to be an improvement but overall it is much better than what it used to be. Others indicated no concerns.

The police department that was part of this case study does have a mental health professional embedded within their department, known as the co-responder. Most of the participants discussed this role during conversations throughout the interview. They found this role to be an additional step to CIT training and helping individuals with SMI. One of the areas that this role seemed to be the most beneficial to them was communication and follow up. A participant indicated, "with the co-responder, they will email us or tell us the outcome and what they are doing to help the person." The officers elaborated that prior to this role, they never knew the outcome unless they saw the person on the streets again so having the co-responder, they have more communication and follow up. The participants described how they complete a CIT data sheet to serve as the referral and then the co-responder follows up with the individual to provide additional assistance and ensure they get the help and services they need to eliminate further police contact. The CIT data sheets are analyzed and will be discussed later. Future research regarding a co-responder will also be discussed in Chapter 5.

Overall, the participants had more positive thoughts about CIT training than negative. Any negative comments stemmed more about a presenter, not the training. For example, participant 2 stated, "the way she presented was more negative to police officers and that is going to turn them off as we are the most opinionated people in the world, and when you give us something negative that is about us, we are just not going to listen to you." Their responses helped to answer the research questions and provide in-depth insight to the researcher regarding their perceptions about CIT training and their interactions with a SMI person. Listed below are additional open-ended quotations from participants that stemmed from their CIT training encounters that were described during the in-depth interviews:

> "Before, it did not matter if you had a mental illness or not. You did the crime; you went to jail. Now, after the training, jail is not for everybody, so I am more open to diversion."
>
> "Before CIT, it was relying on personal instinct, after it was more of an educated approach."
>
> "The hands-on interaction was the most effective part of the training to help with on the job." "The role-playing part was the most effective and watching people acting out and then you had to use the skills learned that week to resolve the problem."
>
> "Teaches you that time is the key for these calls."
>
> "The knowledge, learning about the process and differences between 201 and 302 hospitalization commitments."

"A frustrating thing is when you know they need help and should be hospitalized but the doctor dismisses it and then we see them again."

"They know there are CIT classes and we are here to help them. Out on calls, they say they only want to talk to officers that have a CIT badge."

"I think people trust you more because the majority of our guys are CIT trained." Figure 14 illustrates a visual of the codes found during content analysis of the interviews from using Microsoft Word and DeDoose. These themes were the most common and repeated terms used throughout the interviews.

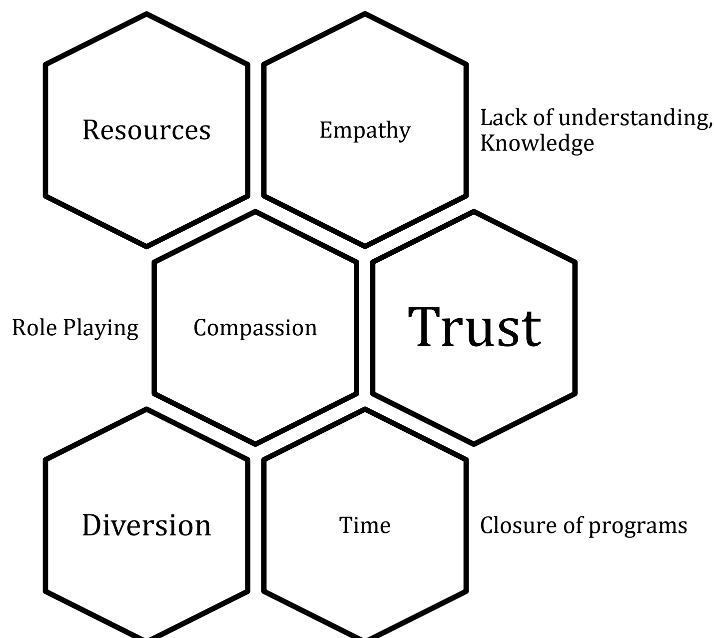

Figure 14. CIT interview codes.

CIT Pre/Post Surveys

The CIT pre/post surveys that were completed by law enforcement during 2017 and 2018 were carefully reviewed question by question, line by line for content analysis and developing any themes and patterns. The pre-survey was provided at the beginning

of the week and then the post on the last day. Each survey had the same questions from pre to post except there were an additional six questions added at the end of the post-survey to gather additional information. Overall, the rankings from the post surveys were higher than the pre, concluding that the training was helpful, and the officers gathered more knowledge and skills throughout the week from what they had when they started the training. The officers had to rate themselves on a scale from low to high, which ranged in numbers 1 through 5 (1=low, 5=high). See Table 1 below for a summary of the surveys that include weighted means.

Table 1

CIT Pre/Post Survey-Weighted Means

Pre-Training and Post-Training Data – Weighted Means

	2017			2018		
	Pre	Post	Difference	Pre	Post	Difference
Comfort Level dealing with person with an MI	2.7	4.0	+1.3	4.2	4.3	+.1
Preparation of dealing with person with MI.	2.7	4.0	+1.3	3.5	4.4	+.9
Knowledge of psychiatric illness	1.7	3.7	+2.0	3.0	4.0	+.1
Knowledge of Developmental Disorders	1.5	3.3	+1.8	2.9	4.1	+1.2
Knowledge of Geriatric Issues	1.8	3.0	+2.0	2.7	4.0	+1.3
Comfort Level with a Suicidal Person	2.8	4.0	+1.2	3.2	4.5	+1.3
Knowledge of Psychiatric Medications	1.5	3.3	+1.8	2.2	3.6	+1.4
Knowledge of PTSD	1.8	3.3	+1.5	3.0	4.1	+1.1
Familiarity with Civil Commitments	2.2	3.7	+1.5	2.2	4.6	+2.4
Familiar with Treatment Resources in the Community	2.8	3.8	+1.0	2.8	4.5	+1.7

When analyzing Table 1, it was noted that the 2018 group had stronger pretest scores for 8 of the 10 questions, which could reflect their lower education status or their veteran status as an assumption. Any of the veterans could have served as a military police officer. They have an incarceration system that could have the exact same lack of resources and problems as the community criminal justice system. Their scores did not change as much as the 2017 group, but they were more skilled to start. Weighted means can be used as a way of comparing Likert scale answers when there is a big difference in the group size.

Table 2 below provides further details pertaining to the scale scores of pre and post CIT surveys for 2017 and 2018. In addition, as previously stated, the researcher attached an appendix to show the breakdown of each question in a weighted scale format.

Table 2

Officers' Experiences of CIT training

Comfort Level in Dealing with a Person with MI

Scale **2017**	1	2	3	4	5
Pre CIT	0	3	2	1	0
Post CIT	0	0	0	6	0

Scale **2018**	1	2	3	4	5
Pre CIT	0	1	6	5	1
Post CIT	0	0	1	7	5

Preparation of Dealing with a Person with MI

Scale **2017**	1	2	3	4	5
Pre CIT	0	2	4	0	0
Post CIT	0	0	0	6	0

(table continues)

Scale	1	2	3	4	5
2018					
Pre CIT	0	1	6	5	1
Post CIT	0	1	0	5	7

Knowledge of Psychiatric Illnesses

Scale	1	2	3	4	5
2017					
Pre CIT	2	4	0	0	0
Post CIT	0	0	2	4	0

Scale	1	2	3	4	5
2018					
Pre CIT	0	4	7	2	0
Post CIT	0	0	2	9	2

Knowledge of Developmental Disorders

Scale	1	2	3	4	5
2017					
Pre CIT	4	1	1	0	0
Post CIT	0	0	4	2	0

Scale	1	2	3	4	5
2018					
Pre CIT	0	4	8	1	0
Post CIT	0	0	2	8	3

Knowledge of Geriatric Issues

Scale	1	2	3	4	5
2017					
Pre CIT	3	2	0	1	0
Post CIT	0	1	4	1	0

Scale	1	2	3	4	5
2018					
Pre CIT	0	6	5	2	0
Post CIT	0	0	2	9	2

(table continues)

Comfort Level with a Suicidal Person

Scale	1	2	3	4	5
2017					
Pre CIT	0	1	5	0	0
Post CIT	0	0	0	6	0

Scale	1	2	3	4	5
2018					
Pre CIT	1	0	7	5	0
Post CIT	0	0	1	5	7

Knowledge of Psychiatric Medications

Scale	1	2	3	4	5
2017					
Pre CIT	3	3	0	0	0
Post CIT	0	0	4	2	0

Scale	1	2	3	4	5
2018					
Pre CIT	4	4	3	2	0
Post CIT	0	0	6	6	1

Knowledge of PTSD

Scale	1	2	3	4	5
2017					
Pre CIT	2	3	1	0	0
Post CIT	0	1	1	4	0

Scale	1	2	3	4	5
2018					
Pre CIT	0	2	9	2	0
Post CIT	0	0	1	10	2

Familiarity with Civil Commitments

Scale	1	2	3	4	5
2017					
Pre CIT	2	1	3	0	0
Post CIT	0	0	3	2	1

(table continues)

Scale **2018**	1	2	3	4	5
Pre CIT	4	3	5	1	0
Post CIT	0	0	3	5	5

Familiarity with Treatment Resources in the Community

Scale **2017**	1	2	3	4	5
Pre CIT	0	1	5	0	0
Post CIT	0	0	1	5	0

Scale **2018**	1	2	3	4	5
Pre CIT	0	5	6	2	0
Post CIT	0	0	1	5	7

Overall, the participants' knowledge and skills increased from the pre-CIT survey to the post-CIT survey. In the beginning of the week, majority of the officers were providing a rating of 2 in 2017 (50%) and a rating of 3 in 2018 (46%) for their comfort level in dealing with a person who has mental health. By the end of the week, the comfort level improved with training. In 2017 and 2018, it increased to a level 4 rating (100% in 2017 and 54% in 2018) for most. Preparation of dealing with a person who has mental health also increased. In 2017, most officers listed a scale rating of 3 (67%) in the beginning and a scale rating of 4 (100%) by the end of the week. For 2018, about half (46%) listed a rating scale of 3 also, but by the end of the week, over half (54%) listed a 5, being the highest on the scale. Officers who mainly listed a scale of 2 (67%) for knowledge of psychiatric illness in 2017, later listed a 4 rating after the training (67%). In 2018, the psychiatric illness knowledge for most started with a 3 (54%) rating but increased to a 4 afterwards (69%). Officers in 2017 reported a low (scale 1) knowledge

of developmental disorders (67%), but after the training, the majority stated that their knowledge increased to the scale of 3, being medium (67%). In 2018, officers started with a medium scale (62%), but the same percentage listed a 4-scale rating after the training. Knowledge of geriatric issues ranged between a scale of 1 (50% in 2017) and 2 (46% in 2018) for most prior to the training and then improved to a scale of 4 after (67% in 2017 and 69% in 2018).

Getting training in dealing with a suicidal person is uncommon in the police academy as discussed in the literature. Being comfortable when talking to a suicidal person is also low. In 2017, 83% reported only having a scale rating of 3, but after the training that included material on question, persuade, and refer (QPR) and role-playing, all officers stated that their comfort level increased to a rating of 4 (100%). In 2018, over half (54%) also reported that their comfort level was on a 3 rating, but after training, the same percentage reported that it went up to a high scale rating of 5. Officers are not expected to know and understand every psychiatric medication, but having some training is important as it helps to learn why some people with mental health may choose to not take them, the side effects of some medications, or how it may help. Prior to CIT training, in 2017 half of the officers (50%) reported a low scale rating of 1 for having a knowledge of psychiatric medications, but after the training, over half improved to a scale of 3 (67%). In 2018, most reported either a scale of 1 or 2 (62%) prior to training, but after, most stated their knowledge increased to either a 3 or 4 rate scale (92%). Knowledge of post-traumatic stress disorder (PTSD) also improved before and after the training. In 2017, half (50%) indicated a scale rating of 3 prior and a scale rating of 4

(67%) after. For 2018, over half (69%) also indicated a scale rating of 3 prior and a scale rating of 4 (77%) after. Having a familiarity with civil commitments is important for officers as this can serve as a potential diversion from incarceration. Prior to training in 2017, half of the officers (50%) had a medium level (scale of 3) familiarity and the same percentage and scale rating of 3 after so there was no change for most officers in this training class. Two officers did indicate a 4 (33%). However, the class in 2018 did show improvement overall. Prior to the training, the highest scale rating was 3 (38%), but after the highest was 5 (38%). In addition to hospitalization being a possible diversion, treatment in the community can also be.

Frustration with the lack of community resources is often common among law enforcement, indicating that often, arresting is the only option as they know they can receive treatment more than likely in the jail setting. Even if there are minimal resources, as this can be more common in rural settings, officers need to be familiar with them. In 2017, most (83%) responded with a scale rating of 3 before training and a scale rating of 4 after the training (83%). A scale rating of 3 was for most in 2018 (46%) before training, but after the training, more than half (54%) indicated a 5-scale rating being the highest.

Table 3
Officers' Experiences of post CIT training
Rating of the Training Providing Information on MI and Community Resources Overall

Scale	1	2	3	4	5
2017 Post	0	0	1	2	3
2018 Post	0	0	0	6	7

(table continues)

Rating of the Training Providing Additional Skills to use in De-Escalation Overall

Scale	1	2	3	4	5
2017 Post	0	0	1	0	5
2018 Post	0	0	0	7	6

Rating of the Information Presented and Organization

Scale	1	2	3	4	5
2017 Post	0	0	2	2	2
2018 Post	0	0	0	6	7

During the post-survey, there were an additional three open-ended questions asked for the officers to fill in. These questions consisted of asking what the officers liked best, least, and then if they had any suggestions to improve the CIT training program. Some officers chose to leave them blank, more so for the suggestions and participants in 2018, but the majority provided information for the best and least aspects of the training.

Listed below are responses from participants that revealed information about the last three open-ended questions:

> "The presentations on Drugs and Alcohol and Mental Health diagnosis was the best." "Drug and Alcohol segment was very informative."
>
> "Scenario training made me practice my skills."
>
> "Medical explanation of mental illness and drugs was the best part."
>
> "A lot of information provided to help in the workplace."
>
> "Scenarios were in depth and helped understand what is needed." "Scenarios puts all tools together."
>
> "211 and the amount of downtime was the least."

"Fewer voices for the hearing voices exercise, too long."

"Family perspectives was the least favorite."

"The legal aspect session became too dry."

"Suicide by Cop session-little was covered in the time allotted."

"Some power points were dry."

"Some scenarios took too long."

"I think a course could be offered for people that already have a basic understanding. Maybe a 3-day course covering days 3,4,5 only."

The organization and material covered throughout the week were the two emerging themes from analyzing the surveys. The officers comfort level and additional skills were found to be the most prominent differences between the beginning of the week to the end. Prior to training, most respondents listed their scale rating between 1 to 3, but most improved to either a scale rating of 4 or 5 after being trained. Role-playing/scenarios was another code found throughout the 2017 and 2018 surveys, indicating that the quality of the training was a pattern throughout.

CIT Data Sheets

For the rural police department that was part of this case study, officers were not only CIT trained but any time an officer (whether it was a CIT officer or non-CIT officer) responded to a mental health call, they were to complete a CIT data sheet. These sheets help to capture data about the number of mental health calls, dispositions and serve as a referral to the co-responder (mental health professional embedded within law enforcement) for this police department. When analyzing the CIT data sheets completed

by police officers when they encountered a person with MI, there were patterns identified to illustrate the most common responses from law enforcement when interacting with this population. In addition to basic demographic information previously reviewed, other information that the officers gathered entailed the nature of calls, mental health history, medication prescribed/compliance, threat assessments, weapons and force used, injuries, drugs and alcohol, and dispositions. Mental distress was the number one reason for the nature of the call that resulted in police interactions (75% in 2017 and 77% in 2018). In 2017, 26% of people reported that they had a history of mental health when law enforcement responded and 36% reported in 2018. Officers would also ask whether the person was prescribed medication and if they were taking them as prescribed. In 2017, 32% reported being prescribed, but only .05% reported compliance. For 2018, 41% indicated that they were prescribed medications, but only .05% compliance as well. When completing the data sheets, the officers also indicated whether the person was under the influence of drugs and alcohol. In 2017, 17% were found to be under the influence and 13% in 2018.

As stated, the primary reason for the law enforcement contact was due to the individual being in mental distress. When the officer arrived on the scene, there may not have been any threat to self or others witnessed, such as in 2017, 55 encounters out of 123, there was no threat observed (45%). In 2018, 20 out of the 56 encounters did not involve any threat observed (36%). When there was a threat observed, the primary one for 2017 (28%) and 2018 (46%) was a suicide threat of the individual wanting to harm themselves. Attempt to harm others was the secondary threat assessment in 2017 (11%)

and actual suicide attempt in 2018 (11%). The threat to others (0.07%) was the least in 2017 and attempt to harm (0.02%) was the least in 2018. With these threats, the use of weapons by the individual or force by the officer may have been present. In 2017, there were 15 incidents of having the use of weapons (12%), which typically ranged between an edged weapon such as a razor blade or scissors to the most serious being a firearm. There were eight times that the officers had to use force in 2017 (.07%), seven of those times were the use of handcuffs for transportation and one time was the use of a taser. In 2018, there were 12 times that weapons were present (21%), which ranged from nail clippers, scissors, garden hoe, BB gun, to a firearm. During the encounters, there were 10 times that officers had to use some level of force in 2018 (18%). Again, the level of force ranged between handcuffs and taser, with two times being the use of restraint.

When police contact involved a person with MI, whether it was a CIT officer or a non-CIT officer, the most common disposition of the encounter entailed transportation to the ER (65% in 2017 and 64% in 2018) and/or psychiatric hospitalization (19% in 2017 and 20% in 2018). There were only three arrests in 2017 (0.02%) and none in 2018. Dispositions also consisted of no action or other such as simply de-escalating the person, taking them to a shelter or family/friend, encouraging them to take their medications, providing resources for service referral, or putting them in custody of another agency such as juvenile probation (14% in 2017 and 16% in 2018). Out of the encounters, 14 individuals in 2017 (11%) and two individuals in 2018 (0.04%) incurred injuries but only one of those injuries were a result from an officer, which was taser probes. One officer

reported in 2017 that they abstained injuries but did not report any details. See the tables below for further visualization of the results.

Table 4

CIT Data Sheets, Dispositions

	Taken to ER	Hospitalization	Arrest	No Action/Other
2017	80	23	3	17
2018	36	11	0	9

Table 5

CIT Data Sheets, Threat Assessment

	No Threat	Threat to Others	Attempt to Harm	Suicide Attempt	Suicide Threat
2017	55	8	14	12	34
2018	20	3	1	6	26

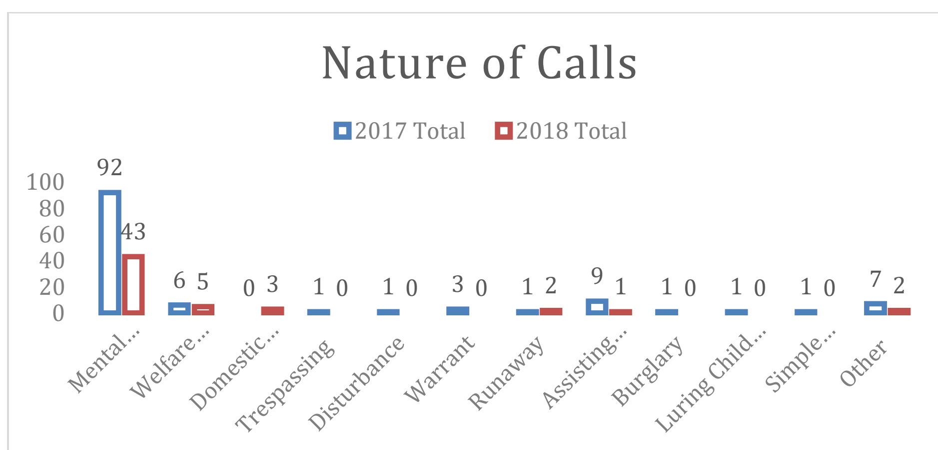

Figure 15. 2017-2018 Nature of calls CIT data sheets.

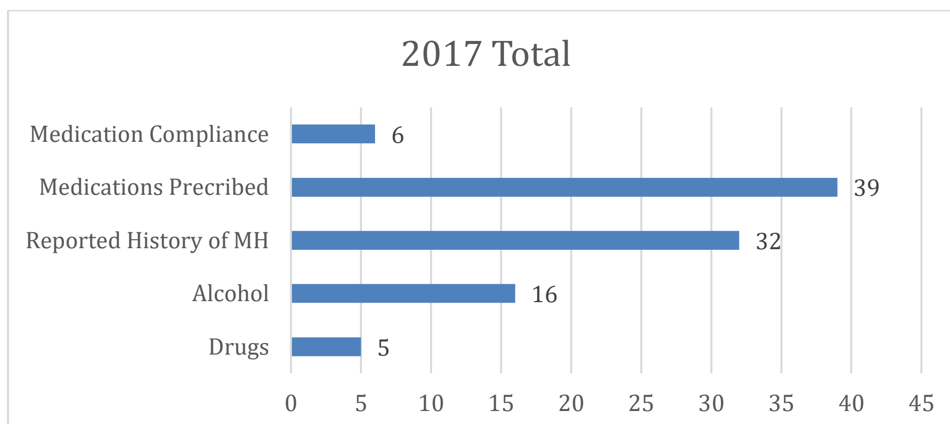

Figure 16. 2017 CIT data sheets.

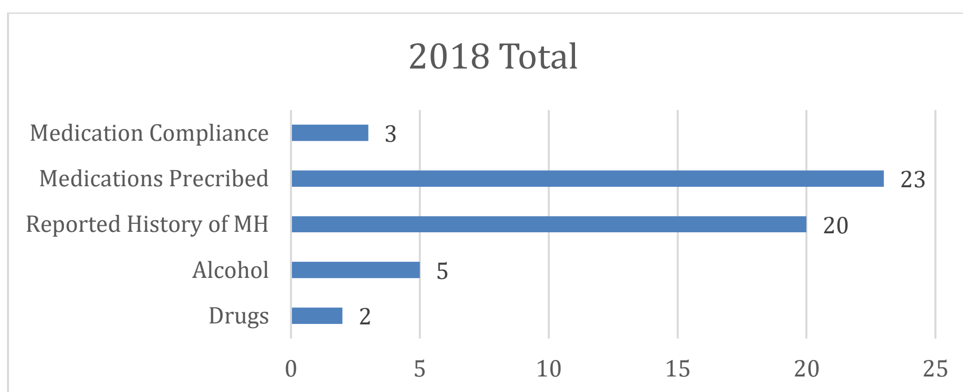

Figure 17. 2018 CIT data sheets

Summary

Chapter 4 provided a detailed summary of the study that consisted of the setting, demographics, data collection, data analysis, techniques utilized, the evidence of trustworthiness, and the study results. The results showed that CIT training increased the knowledge of the officers (these results stemmed from the in-depth interviews and content analysis of the pre and post surveys). The ratings that the officers provided post-survey increased in every area of rating compared to the scores provided pre-CIT. During the one on one interviews, the results also showed that CIT training helped the

officers with realizing that spending time with calls involving a person with SMI is beneficial and their willingness to show more empathy and compassion increased. The results of the content analysis for the CIT data sheets showed that the depositions primarily resulted in the officers seeking help for the person in mental health crisis rather than arrest. Attempting to harm or suicidal attempts were among the biggest threat assessments for why a CIT officer may respond. The CIT data sheets also revealed that the individuals had a history of mental health and prescribed medications, but their compliance was very low. This chapter reviewed emerging themes from all three data set collections. Quotes were also used to support any additional themes and patterns discovered from the data. Chapter 4 illustrated through description and visualization of how the findings were able to answer the research questions of officers' experiences with CIT training and how they can use the content of the training while on-duty.

The chapter also discussed the use of third-party verbatim transcription and the use of Microsoft Word and DeDoose Software for validation of themes discovered in this study. Chapter 5 includes interpretation of the findings, recommendations, social change implications, future research suggestions, and limitations of the study. There will also be a discussion in Chapter 5 of how the findings from this study align or refuted prior that were described in the literature review.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative exploratory case study was to understand the experiences of a select group of police officers who are CIT trained and how they use the information gained from CIT training with citizens they encounter who have a SMI. The study involved interviewing CIT officers in the rural Central Pennsylvania area, along with reviewing CIT data sheets and pre/post CIT surveys. By using these data collection methods, the researcher was able to gather a deeper understanding of the officers' perceptions of CIT training and how they use the information gained during the training while performing their job duties. Literature suggested that there was a lack of mental health training among police officers. This study was conducted to fill the gap in the literature regarding how officers use the tools gained during mental health training when responding to people in a mental health crisis. Results from this study will help add to the literature involving CIT training outcomes and could help determine which training models are effective in helping officers to understand MI and respond to individuals with a SMI.

This study produced major themes across all data sets. First, a significant finding was the lack of mental health training that officers had prior to CIT training. Almost all police officers indicated no training involving mental health until the 40-hour CIT training. This was also apparent in the pre/post surveys as the ratings during the pre-CIT survey were much lower compared to the post-CIT survey, revealing a higher comfort level and knowledge. Second, the officers' perceptions of mental health and encountering a person with SMI improved after training and gaining more knowledge and

understanding about MI. Officers reported an increase in empathy and compassion. A third key finding was that officers realized that rushing on mental health calls could impact the result. Officers reported that CIT training helped them to see that they needed to slow down to get a better outcome for the individual and themselves. The CIT data sheets also revealed better dispositions than arrest.

Interpretation of Findings

The interpretation of these findings is supported by the literature review. More importantly, the findings provided additional research and knowledge regarding this topic area.

Since the movement of deinstitutionalization in the 1960s, there are more people with SMI living in the community (Kara, 2014), resulting in more contact with police (Bouffard et al., 2016). The study findings supported this as all 10 police officers discussed interacting with individuals with a SMI on several occasions both before and after CIT training. Literature also supported that there was a lack of mental health training among law enforcement. Most of the officers interviewed reported that they received no prior mental health training until CIT training and for those that did, it was very minimal.

As mentioned in Chapter 4, the results demonstrated an increase in knowledge and understanding of mental health for CIT-trained officers and that these officers also have improved perceptions of people who have a SMI as well as an increased desire to spend more time on the call to seek an appropriate disposition to the case. These outcomes are like previous studies (see Cross et al., 2014; Melissa et al., 2013; Mulay et

al., 2016, NAMI, 2017; Tully and Smith, 2015). Officers respond to calls and need to make decisions and often may not know the background of the person or be able to identify any mental health symptoms. Findings indicated that after CIT training, officers were able to recognize symptoms and diagnoses better. Stigmatization was reviewed in the literature and Mulay et al. (2016) said that CIT training can help reduce explicit stigma, which also aligned in this study as officers reported having an increase in empathy and compassion after the training.

The frameworks used in this study was the sequential intercept model, but primarily social distance and procedural justice. Several of the assumptions outlined in these frameworks were implemented in the completion of this study. Bogardus (Social Distance, 2017) measured the degree of acceptance towards other groups and reported that an increase in knowledge, awareness, and interaction will lead to more comfortability when interacting with someone outside of a person's comfort zone. This study applied that initial degree of acceptance by finding that officer's comfort level improved with greater knowledge and understanding of mental health to better prepare them when interacting with a person in mental distress.

Farzana (2014) said that how people's interactions with law enforcement go, will impact how they react and trust police officers. Again, findings from this study supported the use of this framework as officers reported that wearing CIT badges help bring awareness in the community and trust. As one participant stated, "they know the CIT badge and will ask to speak to an officer with that badge as they know they will help them."

This study will aid in the future development of mental health training for law enforcement. During the interviews, officers answered questions related to the overall quality of CIT training and training received prior to CIT training. Examination of the pre/post surveys also revealed the quality of CIT training. The CIT data sheets provided an understanding of the volume of mental health calls to show the need for training and how mental health calls are primarily handled by CIT officers. Further completion of the data sheets among CIT officers and non-CIT officers can aid in more research and outcomes for CIT training. As previously discussed, findings from this study confirmed knowledge in the discipline that was compared to findings in the peer-reviewed literature in Chapter 2, which was a lack of mental health training, successful findings and implementation of CIT officers, and an overall improvement in the disposition of mental health calls when CIT-trained.

Limitations of the Study

The study's research design could be a limitation but was also originated from a participant pool of a select group of CIT officers that focused solely on one police department in a rural area. Since this study focused on a rural area, it helped to add to the overall literature regarding CIT training outcomes. Due to the geographic limitation, findings obtained may or may not be like experiences or information gathered from other officers in other geographic counties or states. Since the design was a qualitative case study, I was mindful of reflexivity and monitored any personal bias. The interviews were conducted on a voluntary basis and participants had opportunities to share additional information and were assured confidentiality to help enhance trustworthiness.

Another limitation involved gender and race. There was only one female participant and all participants were Caucasian. The pre/post surveys were also limited to only male participants during 2017 and 2018 and only two different racial backgrounds in addition to Caucasian. This limitation could be due to the rural geographic area, but their information may or may not be generalizable to other geographic locations. Future studies should include more females and other race and ethnicities to study gender or culture implications. A future study can also include an exploration of how the race of officers match the results of the CIT data sheets if sorted by race and gender.

The volume of overall participants was limited. Rural areas tend to be smaller in comparison to urban locations. This police department strives to have 100% CIT-trained officers, so there were more CIT officers to interview than those who volunteered. The CIT surveys only included 2017 and 2018 data; previous years could also be reviewed for more data and to determine any differences since the beginning CIT training. The number of CIT data sheets completed in 2017 from 2018 dropped significantly. This could be due to the overall volume of mental health calls dropping generally but also due to officers not consistently completing forms as required. Due to confidentiality, it was difficult to determine if there were many duplicates or if the count reflects unduplicated individuals with SMI. If CIT data sheets are completed in all departments across the county, further studies should include a comparison across departments and/or nearby counties. The research design specifically stemmed around a case study with one police department when analyzing the interviews and CIT data sheets. Future research could include additional precincts across the county.

Recommendations

This study provided valuable information pertaining to mental health encounters with law enforcement and CIT training. However, there are areas where recommendations can be made. From the literature and research, continuing to educate law enforcement in mental health would be appropriate and ensuring the quality and quantity of the training is evaluated. Based on the previous research and the results from this study, CIT training is thorough to help officers understand mental health, identify various symptoms, learn about additional services, and also provides hands-on, role-playing scenarios for officers to practice de-escalation on a person in mental distress to become more comfortable during SMI encounters.

Some officers expressed concerns with dismissed commitments to inpatient, revolving doors, and the shutdown of past programs. They discussed that crisis intervention services are one of the main areas where an officer can drop a person off for an assessment, if not jail. Although officers expressed the need to not rush and take time with a person in mental distress, this also impacts officers return to the streets or following up with the next call. In other urban and rural communities, crisis assessment centers have been developed. Crisis assessment centers allow officers to transfer a detainee to be evaluated by a mental health professional and the center takes custody after the transport (CIT Assessment Centers, 2019). The CIT program in New River Valley, Virginia operates the centers, specifically for local law enforcement. Law enforcement can drop the person off to obtain an evaluation immediately and then triage into a therapeutic program versus jail. The CIT coordinator in New River Valley reported that

the assessment center reduces the time law enforcement must remain on site during commitment processes, which allows them to return to other policing duties (Wade, 2015). New River Valley reported that data showed law enforcement involvement reduced over 80% where the previous emergency order process could take up to four hours, but utilization of the crisis assessment center is around 50 minutes (Wade, 2015). Funding can be a barrier for many communities but a further exploration into crisis assessment centers for law enforcement, operated by the CIT members could provide an additional resource to help police and justice-involved individuals with SMI.

Another recommendation would be to continue to use the CIT data sheets and increase consistency across the county in all precincts to capture more data about mental health calls providing a more generalizable sample, which could also help provide support for additional community resources when working with policymakers and budgetary processes.

Future Studies

Future studies should include other racial backgrounds and female officers since this population was very limited in this study. Qualitative studies involving CIT officers and non-CIT officers would also be beneficial. Different demographics and comparison between CIT and non-CIT may have other viewpoints, making it noteworthy for future research. During the interviews, a few officers commented that they believed having an embedded mental health professional improved the collaboration between the human services and criminal justice system. More data is needed to determine if the use of a co-responder model is effective. Interviewing co-responders could be a future research

topic. Recommendations to increase the interview population when conducting future studies could also be beneficial as this study only had 10 participants. This study only focused primarily on one department aside from the pre/post-CIT surveys that were random across the county. Future studies could explore multiple police departments across the county. Also, since there is only one police department documenting on the CIT data sheets, if additional departments start this protocol, it could allow for more research and policy implications. Lastly, CIT training originated with focusing on law enforcement. Future studies could explore the impact of CIT training in rural communities that involve probation and parole departments, sheriff departments, and correctional officers. Another future study could also include looking at the military justice system and their method of training to determine if they are better or have similar or worse issues than the community criminal justice system.

Implications

The creation and implementation of policies and social change are just a few highlighted implications from this study pertaining to the research of this phenomena. Literature indicated that there was a lack of mental health training among law enforcement, which has impacted the negative interactions within the community, some of which resulted in injury or fatality. There have been quantitative studies conducted to show CIT training outcomes, but minimal qualitative studies, specifically in rural areas to include how material learned in CIT training can be used out in the field and thorough evaluation of the CIT data sheets and pre/post surveys. This study served as a step

toward more qualitative research being conducted to help lead to effective policies, training models, and positive social change.

There were obvious outcomes of this study (an increase in comfort, understanding, and knowledge of MI and the willingness to take time and divert versus automatically arresting), but there are other potentials of positive social implications. Continued policy building and effective training models will continue to support the theoretical framework of social distance and procedural justice; which provides the foundation of better interactions due to increase comfort, equality, and reducing negative perceptions towards a group of people. The sequential intercept model is the other framework where CIT training can impact officers' decisions on diversion as they are more than likely going to be the first responders to a person in mental distress and how that outcome can impact whether a person goes to jail/prison or receives treatment. Increasing the use of treatment will decrease the criminalization towards the number of people with SMI going into jail or prison. Also, the use of treatment will help improve the stability of the person, therefore, impacting the safety in the community. CIT training can also be used for other criminal justice professionals. Cattabriga et al. (2007) reported that CIT training is increasing among correctional officers to improve the handling and safety, which also helps improve interactions with law enforcement post-release. An individual with a SMI has a higher rate of recidivating once they go into jail/prison and successfully returning to the community, therefore, increasing the use of treatment can also reduce recidivism rates. In addition, the use of CIT officers across both professions

of corrections and law enforcement will improve the overall quality of handling and interactions with a person who has a SMI.

CIT training can help inform practice across law enforcement and corrections. The literature supports that mental health training is not only lacking for law enforcement but necessary to help prepare them for encounters with persons who have a SMI. Mental health training for law enforcement and other criminal justice professionals such as corrections can improve the overall encounters, increasing safety of the individual and the officer. Watson and Fulambarker (2012) said that CIT training is one of the best practice approaches for mental health training in improving encounters among police and persons with MI. As research continues to increase for CIT training, outcomes are showing the model to be evidence-based. Although the training is specialized and studies support officers volunteering versus non-volunteering, CIT training is more extensive, being that it is 40 hours unlike other mental health trainings that are only four to eight hours (i.e. mental health first aid training) (Mental Health First Aid, n.d.). It is important that law enforcement understands the core elements of CIT training and why the outcomes support the training as being the most favorable approach in helping police officers in handling mental health distress calls.

Municipal police officers each year must attend a minimum of 12 hours of training that can consist of in-service training or other training that is approved by MOPETC and/or Continuing Law Enforcement Education (CLEE) (MOPETC, 2018). CIT training has been approved by MOPTEC and CLEE, but it is a 40-hour basic training offered once for officers to become certified. In Henrico County, Virginia they

implemented the basic 40-hour CIT training in 2008, but in 2017, they started to implement an eight-hour refresher course (National Association of Counties, 2019). It was observed that there were evolving services and a lapse in time from when first responders were CIT trained. Henrico County reported that the eight-hour refresher course comprised of any current trends in the law, updated CIT officers in any recent advances and issues such as the opioid epidemic, and a refresher in CIT skills (National Association of Counties, 2019). During this study, there were officers that reported having a refresher course would be beneficial. Law enforcement has ongoing training in tactical advances, but it is rare to have ongoing mental health training. From literature and this study, CIT training has positive outcomes, but it is also necessary to have a refresher after a period to review any current trends and a review of the de-escalation strategies. Ongoing training is important so that the officers have knowledge and feel comfortable in the topic to help them when responding to calls.

Informing practice and policy is important in order to see change. One important component of this study that will inform policy is continuing to increase the number of CIT officers to ensure police departments have the availability of officers across shifts to support coverage for mental health calls. Depending the size of the police department, the percentage of officers who should have this specialized training could vary. When CIT training originated, it was suggested that 20-25% of police departments should have CIT officers (CIT International Inc.). CIT International (n.d.) said that was geared more towards urban settings, whereas in rural, 5% could be appropriate. With an increase of

CIT officers, it can help improve the overall encounters that police have with persons who have a SMI and the criminalization of mentally ill persons in jails and prisons.

CIT is more than just training. It is to empower law enforcement and mental health collaboration, along with trust within the community to families and individuals dealing with SMI. This empirical study may validate further impacts of CIT training from its findings. Officers reported how the use of CIT training has helped bring more trust within their community, especially towards individuals who have a SMI. Continued studies involving the use of CIT training will also help support the training being evidence-based.

Conclusions

With the close of many state hospitals and lack of additional community services, officers will state that they have become the response to individuals with a SMI as opposed to mental health professionals. Unfortunately, community resources were not available when state systems were primarily the answer to handling a person with a SMI. There was always a new person as police are the first responders to a troubled person in the community. The only way to afford community resources was to discontinue the costs associated with the state systems. However, police and other community members will continue to argue that there still are not enough community resources after the closure of many state hospitals. Due to this, and minimal evidence to show this will change, it is imperative that officers continue to receive mental health training to effectively assist people with a SMI. The researcher was able to establish the answers to the current research questions concerning perceptions of CIT training and how CIT

officers incorporate the tools learned during CIT training when responding to mental health calls.

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Appendix A: Interview Questions for CIT Officers

1.) Tell me about your CIT experience from the beginning of the week to the end.
    a. Overall impression of the training?
    b. Did your impression of the training change from the beginning of the week to end?

2.) What was your experience with interacting with individuals who have a serious mental illness before CIT?

3.) What is your experience with interacting with individuals who have a serious mental illness after CIT?

4.) Prior to taking this training, have you had any other mental health training? If so, what was it and how was CIT different?

5.) Tell me about your thoughts and perceptions of people with a SMI before CIT and did any thoughts change after CIT?

6.) What did you find to be the most effective part of the training to help you on the job?

7.) Is there anything you would have changed about CIT?

a. Anything you wished you learned more about to help you while on duty?

8.) How have you used the training when responding to individuals with a serious mental illness?

9.) Tell me about your experience with mental health and law enforcement collaboration within your working community.

10.) How do you think CIT training will change law enforcement's relationship with community members who live with mental illness?

Appendix B: Invitation to Participate

March 3, 2019

Hello CIT Officer,

I hope this note finds you well.

My name is Ashley Yinger, PhD student at Walden University, studying Criminal Justice. I am conducting a qualitative study on police officer's experiences with crisis intervention team training (CIT) within their department. I would like to interview a selection of officers from a rural police department that received training in CIT. Participation is voluntary, and you may decline to answer any questions or stop the interview at any time. I will be taking notes, but the interview will also be recorded and transcribed afterwards. Please let me know if you would like a copy of the transcribe afterwards, if you choose to participate. I will keep your identity anonymous and demographic information will only be provided as it is relevant to the study. Please feel free to ask any questions before, during, or after.

The questions entail gathering information about officers' experience during the training of CIT, mental health experience prior to CIT, using the tools gained from CIT, and so forth. Data from this research may help improve policies and procedures towards training and working with individuals who have a serious mental illness and CIT outcomes.

Should you choose to participate, the plan would be for you to only participate in one, face to face interview with only the researcher and it should not take more than an hour. Would you be interested in participating in this study?

Thank you for your time.

Sincerely,

Ashley Yinger

CRISIS DATA SHEET
Franklin County
Crisis Intervention Team

Date of Incident ____________ 20__ Day of week _____________ Time _______ hours
Location of Incident _____________________________
Police Station __________________ Officer on Scene/badge # ______________
CIT Officer present? Yes__ No ___ Was a CIT officer called if not present? Yes__ No__

Consumer Name _________________________________ **DOB** _____ **Gender** ☐ *M* ☐ *F*

Race: ☐ *Caucasian* ☐ *African American* ☐ *Hispanic* ☐ *Native American* ☐ *Asian* ☐ *Other* _____________

On Probation? ☐ *Yes* ☐ *No*

Previous LE contact ☐ *Yes* ☐ *No*

Armed Forces Veteran? ☐ *Yes* ☐ *No*

Address: ____________________________________
____

Phone #: ____________________________________

Nature of call ____
____

Was Crisis called? ☐ *Yes* ☐ *No* **Does Consumer want follow up from Crisis?** ☐ *Yes* ☐ *No*

Was the consumer under the influence of: ☐ *Drugs* _________________ ☐ *Alcohol* ☐ *Unknown* ☐ *None*

List any reported mental illness ____________________________ ☐ *No mental illness reported*

Medications prescribed? ☐ *Yes* ☐ *No* ☐ *Unknown* **Medication Compliance?** ☐ *Yes* ☐ *No*

Threat Assessment: ☐ *No Threat Observed* ☐ *Suicide attempt: method* ________________ ☐ *Suicide threat* ☐ *Threat to others* ☐ *Attempt to harm others: method* _________________

Weapons present? ☐ *None* ☐ *Blunt Weapon* ☐ *Edged Weapon* ☐ *Other:* __________________________

Injuries to Consumer? ☐ *Yes* ☐ *No* *Describe:* ____

Injuries to Staff? ☐ *Yes* ☐ *No* *Describe:* ____

Force Used: ☐ *None* ☐ *open hand* ☐ *Taser* ☐ *Baton* ☐ *Spray* ☐ *Firearm* ☐ *Handcuffs* ☐ *Other*____________

Method of Transportation ☐ *Police* ☐ *EMS* ☐ *Other private vehicle* ☐ *None*

Outcome of Incident: ☐ *Hospitalization* ☐ *Taken to ER* ☐ *Incarceration* ☐ *Arrest* ☐ *Referred to CBL* ☐ *No Action* ☐ *Other*______________ **Description of Outcome** ____
____

CS 6/18/18 (Coordinator to complete) Forwarded to MH/IDD ☐ *Date*______

Appendix D: Core CIT Training

Pre CIT test

Please answer the following the questions for demographic data collection purposes.

Age:______________Gender:____________ Veteran: Yes No

Ethnicity origin (or Race): Please specify your ethnicity.

A. White
B. Hispanic or Latino
C. Black or African American
D. Native American or American Indian
E. Asian / Pacific Islander
F. Other

What is the highest degree or level of education you have completed?

A. Less than high school
B. Some college, no degree
C. Bachelor's degree
D. Ph.D.
E. High school graduate (includes equivalency)
F. Associate's degree
G. Master's degree

How would you classify for profession?

A. Advocacy
B. First Responder
C. Law Enforcement
D. Mental Health Professional
E. Probation
F. Other

For questions 1-10, please rate yourself by circling an answer as of today and a second circle to indicate before class began on Monday.* *(1 = Low 5 = High)

1. **How would you rate your comfort level in dealing with an individual suffering with mental illness?**

   1 2 3 4 5

2. **How prepared do you feel in dealing with someone suffering with mental illness?**

   1 2 3 4 5

3. **How would you rate your knowledge of psychiatric illnesses?**

   1 2 3 4 5

4. How would you rate your knowledge of Developmental Disorders (aka Mental Retardation)?

1 2 3 4 5

5. How would you rate your knowledge of geriatric issues?

1 2 3 4 5

6. What is your comfort level with someone voicing thoughts of suicide?

1 2 3 4 5

7. How would you rate your knowledge about psychiatric medications?

1 2 3 4 5

8. How would you rate your knowledge of PTSD?

1 2 3 4 5

9. How would you rate your familiarity with civil commitment?

1 2 3 4 5

10. How familiar are you with treatment resources in the community?

1 2 3 4 5

Core CIT Training
Post CIT test

For questions 1-10, please rate yourself by circling an answer as of today and a second circle to indicate before class began on Monday. (1 = Low 5 = High)

1. **How would you rate your comfort level in dealing with an individual suffering with mental illness?**

   1 2 3 4 5

2. **How prepared do you feel in dealing with someone suffering with mental illness?**

   1 2 3 4 5

3. **How would you rate your knowledge of psychiatric illnesses?**

   1 2 3 4 5

4. **How would you rate your knowledge of Developmental Disorders (aka Mental Retardation)?**

   1 2 3 4 5

5. **How would you rate your knowledge of geriatric issues?**

   1 2 3 4 5

6. **What is your comfort level with someone voicing thoughts of suicide?**

   1 2 3 4 5

7. **How would you rate your knowledge about psychiatric medications?**

   1 2 3 4 5

8. **How would you rate your knowledge of PTSD?**

1 2 3 4 5

9. **How would you rate your familiarity with civil commitment?**

1 2 3 4 5

10. **How familiar are you with treatment resources in the community?**

1 2 3 4 5

Please respond as indicated:

11. **How would you rate this training in providing you information on mental illness and community resources overall?**

1 2 3 4 5

12. **How would you rate this training in providing you additional skills to use in de-escalation overall?**

1 2 3 4 5

13. **Did you feel the information was presented and organized well?**

1 2 3 4 5

What did you like best and why? ____

____

What did you like least and why? ____

____

Do you have any suggestions for us to improve the program?__________________

____

____

Appendix E- CIT Pre/Post Survey-Weighted Means

2017

Comfort Level dealing with person with an MI										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	0	0.0	3	50.0	2	33.3	1	16.7	0	0.0
Post	0	0.0	0	0.0	0	0.0	6	100.0	0	0.0

Pre-Weighted Mean	2.7	Post Weighted Mean	4.0

Preparation of dealing with person with MI.										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	0	0.0	2	33.3	4	66.7	0	0.0	0	0.0
Post	0	0.0	0	0.0	0	0.0	6	100.0	0	0.0

Pre-Weighted Mean	2.7	Post Weighted Mean	4.0

Knowledge of psychiatric illness										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	2	33.3	4	66.7	0	0.0	0	0.0	0	0.0
Post	2	33.3	0	0.0	2	33.3	4	66.7	0	0.0

Pre-Weighted Mean	1.7	Post Weighted Mean	3.7

Knowledge of Developmental Disorders										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	4	66.7	1	16.7	2	33.3	2	33.3	2	33.3
Post	2	33.3	0	0.0	4	66.7	2	33.3	2	33.3

Pre-Weighted Mean	1.5	Post Weighted Mean	3.3

Knowledge of Geriatric Issues										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	3	50.0	2	33.3	0	0.0	1	16.7	0	0.0
Post	0	0.0	1	16.7	4	66.7	1	16.7	0	0.0

Pre-Weighted Mean	1.8	Post Weighted Mean	3.0

Comfort Level with a Suicidal Person										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	0	0.0	1	16.7	5	83.3	0	0.0	0	0.0
Post	0	0.0	0	0.0	0	0.0	6	100.0	0	0.0

Pre-Weighted Mean	2.8	Post Weighted Mean	4.0

Knowledge of Psychiatric Medications										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	3	50.0	3	50.0	0	0.0	0	0.0	0	0.0
Post	0	0.0	0	0.0	4	66.7	2	33.3	0	0.0

Pre-Weighted Mean	1.5	Post Weighted Mean	3.3

Knowledge of PTSD										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	2	33.3	3	50.0	1	16.7	0	0.0	0	0.0
Post	0	0.0	1	16.7	1	16.7	4	66.7	0	0.0

Pre-Weighted Mean	1.8	Post Weighted Mean	3.3

Familiarity with Civil Commitments										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	2	33.3	1	16.7	3	50.0	0	0.0	0	0.0
Post	0	0.0	0	0.0	3	50.0	2	33.3	1	16.7

Pre-Weighted Mean	2.2	Post Weighted Mean	3.7

Familiar with Treatment Resources in the Community										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	0	0.0	1	16.7	5	83.3	0	0.0	0	0.0
Post	0	0.0	0	0.0	1	16.7	5	83.3		

Pre-Weighted Mean	2.8	Post Weighted Mean	3.8

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Comfort Level dealing with person with an MI										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	0	0.0	1	7.7	6	46.2	5	38.4	1	7.7
Post	0	0.0	0	0.0	1	7.7	7	53.9	5	38.4

Pre-Weighted Mean	4.2	Post Weighted Mean	4.3

Preparation of dealing with person with MI.										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%

Pre	0	0.0	1	7.7	6	46.2	5	38.4	1	7.7
Post	0	0.0	1	7.7	0	0.0	5	38.4	7	53.9

Pre-Weighted Mean	3.5	Post Weighted Mean	4.4

Knowledge of psychiatric illness										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	0	0.0	4	30.7	7	53.9	2	15.4	0	0.0
Post	0	0.0	0	0.0	2	15.4	9	69.2	2	15.4

Pre-Weighted Mean	3.0	Post Weighted Mean	4.0

Knowledge of Developmental Disorders										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	0	0.0	4	30.7	8	61.6	1	7.7	0	0.0
Post	0	0.0	0	0.0	2	15.4	8	61.6	3	23.0

Pre-Weighted Mean	2.9	Post Weighted Mean	4.1

Knowledge of Geriatric Issues										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	0	0.0	6	46.2	5	38.4	2	15.4	0	0.0
Post	0	0.0	0	0.0	2	15.4	9	69.2	2	15.4

Pre-Weighted Mean	2.7	Post Weighted Mean	4.0

Comfort Level with a Suicidal Person					
	1	2	3	4	5
	Low Knowledge	Low to Medium	Medium	Medium to High	High Knowledge

	#	%	#	%	#	%	#	%	#	%
Pre	1	7.7	0	0.0	7	53.9	5	38.4	0	0.0
Post	3	23.0	0	0.0	1	7.7	5	38.4	7	53.9

Pre-Weighted Mean	3.2	Post Weighted Mean	4.5

Knowledge of Psychiatric Medications										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	4	30.7	4	30.7	3	23.0	2	15.4	3	23.0
Post	3	23.0	3	23.0	6	46.2	6	46.2	1	7.7

Pre-Weighted Mean	2.2	Post Weighted Mean	3.6

Knowledge of PTSD										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	0	0.0	2	15.4	9	69.2	2	15.4	0	0.0
Post	0	0.0	0	0.0	1	7.7	10	76.9	2	15.4

Pre-Weighted Mean	3.0	Post Weighted Mean	4.1

Familiarity with Civil Commitments										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%
Pre	4	30.7	3	23.0	5	38.4	1	7.7	0	0.0
Post	0	0.0	0	0.0	3	23.0	5	38.4	5	38.4

Pre-Weighted Mean	2.2	Post Weighted Mean	4.6

Familiar with Treatment Resources in the Community										
	1		2		3		4		5	
	Low Knowledge		Low to Medium		Medium		Medium to High		High Knowledge	
	#	%	#	%	#	%	#	%	#	%

Pre	0	0.0	5	38.4	6	46.2	2	15.4	0	0.0
Post	0	0.0	0	0.0	1	7.7	5	38.4	7	53.9

Pre-Weighted Mean	2.8	Post Weighted Mean	4.5