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A Participatory Action Research Study of Police Interviewing Following Crisis Intervention Team Training

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A Participatory Action Research Study of Police Interviewing Following Crisis Intervention Team Training

Cover Page Footnote

Author's Note Dr. M. Félix-Ortiz is the corresponding author; correspondence can be sent to felixort@uiwtx.edu. Drs. Steele and DeGuzman were undergraduate research assistants on this project and are now both PhDs in neuroscience. The authors wish to thank Ms. Veronica Llanos-Davis (who was also an undergraduate research assistant but is currently a therapist and college instructor) for her assistance with data collection, the participating police departments, and chiefs, and the University of the Incarnate Word Faculty Development Fund for providing a travel grant. Part of this work was presented at American Psychological Association's Convention, 2013.

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A Participatory Action Research Study of Community Relations and Police Interviewing Following Police Crisis Intervention Team (CIT) Training

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Abstract

Estimates vary, but a third to one half of individuals shot and killed by police have a mental illness or disability, and many who are taken into custody languish in county jails where no treatment for their illness is available. The Crisis Intervention Team (CIT) model is an increasingly important adjunct to U.S. police training because it de-escalates tense situations, diverts people with mental illness away from jail and into treatment, and can reduce the risk of civilian deaths during a police encounter. As such, it is a strategy for reducing the social injustice of incarceration or deaths of people with mental illness during police encounters. Studies of CIT effectiveness are challenging due to mistrust between law enforcement and the community, policy that limits communication (including a hierarchical structure), and the danger involved in observing police behavior in the field. As a result, studies of CIT effectiveness typically rely on a survey of the CIT officers and do not observe behavior in the field to confirm reported changes. In this small participatory action research (PAR) study, we used a community-based participatory research method featuring "ride-along" observations of CIT-trained officers and untrained officers to examine the various effects of CIT training in one U.S. metropolitan community. We documented some evidence of changes in community relationships, as well as different interviewing styles among police officers following CIT training. CIT training increased the length of interviewing time and resulted in more diversions away from jails.

Authors' Note

Dr. Félix-Ortiz is the corresponding author; correspondence can be sent to felixort@uiwtx.edu. Drs. Steele and DeGuzman were undergraduate research assistants on this project and are now both PhD's in Neuroscience. The authors wish to thank Ms. Veronica Llanos-Davis for her assistance with data collection, the participating police departments, chiefs, and the University of the Incarnate Word Faculty Development Fund committee for providing a travel grant. Part of this work was presented at American Psychological Association's 2013 Convention.

An important commonality across the police shootings of Garner, Powell, Anderson, Gray, and Bland is usually overlooked: While these victims of police violence were all African Americans; they also had a disability.[1] Perry and Carter-Long found that a third to a half of all people killed by police are disabled.[2] Another investigation found the risk of being killed by police is 16 times higher for individuals with untreated serious mental illness than for others.[3] If individuals struggling with mental illness are not killed, they are often taken into custody where they often languish in jail where no treatment is available, and where their incarceration is on average three times longer than those without mental illness.[4] The largest public mental-health institution is not a state hospital, in fact. It is the Los Angeles County Jail which on average incarcerates 3,000 people needing mental health treatment.[5] These statistics suggest a need to reexamine police training and jail-diversion strategies. Crisis Intervention Team training addresses both issues.

The Crisis Intervention Team (CIT) model is a popular adjunct to police training in the U.S. CIT aims to de-escalate mental health crisis, divert people with mental illness away from jail and into treatment, and reduce risk for all people on-scene. When it was initially introduced, it was also recognized by parents of adults with mental illness as a more humane approach to working with people who are experiencing a mental health crisis since the police officers assist the individuals in accessing treatment instead of criminalizing and incarcerating them, or worse.

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[1] David M. Perry and Lawrence Carter-Long, "The Ruderman White Paper on Media Coverage of Law Enforcement Use of Force and Disability: A Media Study (2013-2015) and Overview," *Ruderman Foundation*, accessed on July 11, 2016, https://rudermanfoundation.org/wp-content/uploads/2017/08/MediaStudy-PoliceDisability_final-final.pdf
[2] *Ibid*.
[3] Doris A. Fuller, *et al*., "Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters," *Treatment Advocacy Center* (2015), accessed on July 11, 2016, https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf.
[4] Pete Earley, *Crazy: A Father's Search Through America's Mental Health Madness* (Berkeley: U of California P, 2007), 41-4.
[5] *Ibid.*, 45.

Although CIT is no longer considered a new approach to policing, there are various models of CIT and CIT is still being evaluated for effectiveness. Most studies of effectiveness focus on attitudinal change or are survey-based, and are limited by the shortcomings of self-reported data. Typically, these studies do not include additional and different data to validate the survey results. In this report, we examine the effectiveness of one CIT program implemented in a large, southwestern metropolitan area as evidenced through a small, community-based participatory action research (PAR) study where we observed CIT officers' behaviors in the field.

We begin the report with an overview of CIT training and its importance to promoting social justice through diversion into treatment, and discuss PAR and its appropriateness for studies of this type. We follow this with a description of the research questions and hypotheses, method, and results. We conclude with a discussion of the results, limitations, and possible implications.

I. Brief Overview of CIT Training

The Crisis Intervention Team approach began in Memphis in 1988 as an initiative to develop a safer way to manage mental health and public intoxication calls.[6] The idea for the program began after an officer shot a man who was threatening suicide with a knife when the man threatened to attack the responding officer.[7] A community outcry encouraged collaboration between the police department and several mental health service providers to develop a more compassionate response to people in mental-health crises, and to reduce the number of people with mental illness who are incarcerated. Because of this incident and others similar to it, CIT

[6] "Crisis Intervention Team," *Memphis Police Department*, accessed April 14, 2011, http://www.memphispolice.org/crisis%20intervention.htm.
[7] Ron Hankinson, "CIT Training and the Mentally Ill," *American Jails*, 23.1 (2009), 15-17.

programs emerged to increase police officers' knowledge of mental illness beyond what is typically offered in police training and equip them with tools to prevent the use of excessive force and reduce risk of death during a police encounter. CIT training includes training in de-escalation through active listening, in recognizing mental illness, and in empowering officers to offer a more compassionate response, as well as a more appropriate disposition for the call. CIT training is especially important because, in many U.S. states, police officers, not mental-health-care providers, are the ones designated to decide whether or not to seek medical and mental health support for offenders.[8] Since the Memphis incident, over 2,700 CIT programs based on the Memphis model have been implemented in the United States.[9] All were aimed at reducing risk on-scene and diverting people with mental illness away from jail and into treatment.[10]

Our local CIT program emerged as part of a larger jail-diversion initiative started in 2001. It was a response to the high number of county-jail suicides, and overcrowding of the county jail with individuals who were obviously in need of mental health care.[11] Individuals from a local chapter of the National Alliance on Mental Illness approached two police officers, and, together, they lobbied the chief of police to begin a CIT unit and training program. Two officers were initially trained by CIT officers in another metropolitan police department. By 2005, the mental health unit was established with two full-time officers who responded to calls, but who also set an initial goal to train ten percent of their peers in the department. About a year later, the county opened the county crisis center, a facility that was always open to accept people

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[8] *Ibid*. See also Robert H. S. Van den Brink, *et al*., "Role of the Police in Linking Individuals Experiencing Mental Health Crises with Mental Health Services," *BMC Psychiatry* 12.1 (2012), 171-7.
[9] "Crisis Intervention Team," *Memphis Police Department*, accessed April 1, 2012, http://cit.memphis.edu.
[10] Randolph T. Dupont, S. Cochran, and S. Pillsbury, "Crisis Intervention Team core elements," *Memphis Police Department*, accessed on July 11, 2007, http://cit.memphis.edu/pdf/CoreElements.pdf.
[11] Jason G. Lozano and Kimberley D. Molina, "Deaths in Custody: A 25-year Review of Jail Deaths in Bexar County, Texas," *American Journal of Forensic Medical Pathology*, 36.4 (2015), 285-9. doi: 10.1097/PAF.0000000000000183. PMID: 26196271.

in mental health crisis. This was an important boost to the CIT program because officers could now “drop off” a person rather than wait with the person for hours in a hospital emergency room. By 2011, the training included dispatchers and fire department personnel, and cadets were included a year later. Training of all police officers began in 2006, including mandatory retraining of veteran officers, and seventy-five percent of officers in the department are currently trained in CIT.

Most CIT training programs are offered over the course of several days. Over our 40-hour course (Monday through Friday, 8-4 pm), officers spend the mornings in classes, lunches feature the speaker panels, and the last two hours of each day are spent in role playing and learning how to complete “emergency detention” paperwork. Two important elements of the program increase the likelihood of officer participation and “buy-in”: 1) This program is officer-led, and 2) an opening ceremony features police chiefs and local politicians endorsing the program. Program instructors include both police officers and volunteers (professors, judges, medical doctors, and social service/treatment providers), community members (people with mental illness, and their family members), and mental-health-advocacy organizations like National Alliance on Mental Illness. Mental-health treatment providers and volunteers serve as role players to ensure an accurate portrayal of mental illness. Officers are trained in how to respond to a person with mental illness or who is intoxicated so that the person can be calmly transported to mental health care. Other training goals include raising awareness about mental illness, community resources, and developing empathy.

II. Components of CIT Training

The many different components of CIT training vary across programs. This CIT training program included:

1. Purpose and overview of CIT, and benefits of jail diversion
2. Understanding common mental illnesses likely to be encountered by officers;
    a. Substance dependence
    b. PTSD
    c. Suicide
    d. Psychosis and Schizophrenia
    e. Personality Disorders
    f. Child/Adolescent Issues
    g. Working with victims of child abuse
    h. Cognitive Disabilities and Dementia
    i. Intellectual Disability
    j. Autism
3. Active listening skills and skills in de-escalation;
4. Speaker panels that include both people with mental illness and their families;
5. Speaker panels of treatment providers and social-service representatives, and judges to orient officers to community resources;
6. An overview of medications and treatment options;
7. Role playing;
8. Updates on relevant state and federal legislation (e.g., the Emergency Medical Treatment and Active Labor Act [EMTALA]); and instruction on how to complete the required administrative forms for emergency detention;

9. Testing for mental health officer certification through the state law enforcement agency.[12]

Some components are particularly important and are part of the CIT program evaluated in this study. The speaker panels consist of two sessions, one with a person with a mental illness and the other with a family member of a person with mental illness. The intent of these sessions is to correct misperceptions about mental illness, reduce the stigma of mental illness, leave trainees with the understanding that anyone can become mentally ill, and to inform trainees that these same mentally ill people can recover when offered support and treatment. This session aims to increase empathy for those dealing with mental illness. After training, some officers have reported an attitudinal change; they no longer see the people with mental illness as a burden, rather they see them as a person who needs their help.[13] Trainees practice completing emergency detention paperwork during an informational workshop in the afternoon, and their work is evaluated to avoid legal disputes and facilitate processing. Finally, role playing is very important in reinforcing strategies learned during the morning class times and in gaining confidence with new skills and knowledge. The role-playing scenarios are based on situations encountered by officer teachers, and the trainees must use active listening and their knowledge of mental illness to de-escalate the situation while being observed and coached by the teacher officers and mental-health professionals.[14] A final important component is the use of course evaluations comprising a set of Likert scale and open-ended questions which assess the trainee's perceptions of program

[12] "Crisis Intervention Team Training," *San Antonio Police Department, NAMI-San Antonio, Center for Health Care Services, Bexar County Sheriff's Office*, 2012.
[13] Sonya Hanafi, *et al*., "Incorporating Crisis Intervention Team (CIT) Knowledge and Skills into the Daily Work of Police Officers: A Focus Group Study," *Community Mental Health Journal* 44.6 (2008): 427-432. doi:10.1007/s10597-008-9145-8.
[14] Janet Olivia, Rhiannon Morgan, and Michael Compton, "A Practical Overview of De-escalation Skills in Law Enforcement: Helping Individual in Crisis while Reducing Police Liability and Injury," *Journal of Police Crisis Negotiations* 10.1 (2010): 15-29. doi: 10.1080/15332581003785421.

strengths and areas needing improvement, and the perceived helpfulness of the program. This has been an important administrative function since the program's initial implementation allowing administrators to improve the program continually by keeping strongly endorsed components and eliminating weaker components of the training.

III. Differences between CIT and Standard Policing

CIT policing, as practiced in the model presented here, shares much in common with standard policing. The standard approach of policing that includes assessing the situation for possible threats, information gathering, and clearing it of vulnerable individuals is still important in the CIT model, and the first priority. In CIT policing, the responding officer also assesses the subject's appearance, and questions possible witnesses at the scene to aid in assessing the situation and responding appropriately. However, the CIT also prioritizes de-escalation of the situation through use of active listening, showing empathy, and taking time to gather information about the person's situation. Even though regular policing may attempt to obtain information about the suspect's mental state, standard police training may advise an attitude known as command presence to exert control over the situation. Although officers are often trained to use command presence to project authority and thereby encourage compliance, CIT trains officers to use command presence to project confidence while remaining compassionate, empathic, and responsive to a crisis, all of which are consistent with various definitions of command presence, but can be more time-consuming.[15] The optimal resolution for CIT officers is getting the individual with mental health problems to mental-health care and diverting them away from the

[15] For definitions of command presence, see Russel Honoré, "Battle Command," *Military Review* 82.5 (2002): 10-16 and James Smith, *Strategic and Tactical Considerations on the Fireground* (Boston: Pearson, 2012), 59-62.

criminal justice system. Effective CIT strategies promote a safer crisis environment for the person in crisis and the officer. A recent study found that implementing the CIT model reduced injuries during mental disturbance calls by eighty percent.[16] Until recently, traditional policing has historically focused on arrest, prosecution, and incarceration in the criminal justice system without much concern about recidivism or diversion. Instead of access to treatment, the individual with mental illness will be jailed or diverted through traditional post-arrest means such as pre-court diversion programs or probation, which generally provide minimal mental health services (if any) to individuals that are arrested and housed in local jails. Even when individuals are diverted out of the court system they are diverted after the initial arrest, booking, and processing. This can be quite stressful to anyone, but particularly traumatic for someone in a mental-health crisis.

Another obvious difference between CIT and standard policing emerges in how the officer acts: the use of non-accusatory and supportive interviewing to de-escalate the situation instead of the traditional evidence gathering. In standard policing the officer is attempting to gather information to assist the local prosecutor in securing a conviction. The officer has been trained to collect information, witness statements, and additional relevant facts that will help the prosecution when the information is being presented in court. A CIT officer uses the same basic investigative techniques, but also employs alternative strategies to reduce tension in crisis situations and transport the mentally ill person to mental health care instead of the magistrate. This reduces use of an already over-burdened criminal justice system, and is a more humane,

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[16] Randolph T. Dupont, S. Cochran, and A. Bush, "Reducing Criminalization among Individuals with Mental Illness," paper presented at *US Department of Justice and Department of Health and Human Service, Substance Abuse and Mental Health Services Administration Conference on Forensics and Mental Illness*, Washington, DC, 1999, accessed on July 11, 2016, https://www.nami.org/Law-Enforcement-and-Mental-Health/What-Is-CIT#_edn4.

just, and appropriate disposition for people who have mental illness. Recent studies have found that appropriately diverting individuals in need of mental services away from the criminal justice system also saves taxpayer resources; diversion can produce a total savings of over $20,000 per individual.[17]

Some law-enforcement officers rely on interviewing styles inspired by the Reid Technique rather than balancing such an approach with the use of Rogerian style interviewing.[18] The Reid Technique aims to elicit a confession by inducing stress through accusations of guilt, isolation of the offender, and, in some cases, implying an offer of leniency if the offender cooperates.[19] The use of "alternative questions" exemplifies this approach where the officer asks a multiple-choice question where both alternatives imply guilt, as in, "When you ran the red light, were you texting or were you just rushing to get someplace fast?"[20] Reid Technique has been associated with false confessions especially when used with youths, people with mental illness, and those who are intoxicated.[21]

An alternate interviewing strategy is Rogerian interviewing and mental health assessment as taught in CIT training. Rogers stresses the importance of empathy through active listening and unconditional positive regard. To convey empathy, Rogerian interviewing uses reflections and paraphrasing to clarify the person's needs and allow the person to discover their own answers. Rogerian interviewing also de-emphasizes the use of questions; in its most strict application, it

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[17] Jay Greene, "Mental health Cuts in Detroit have Increased Law Enforcement Problems, Flooded ER's, and Created General Misery," *Crain's Detroit Business*, May 6, 2011, accessed July 11, 2016 from https://www.nami.org/Law-Enforcement-and-Mental-Health/What-Is-CIT#_edn4.
[18] On the Reid Technique, see "Interviewing & interrogation," *John E. Reid & Associates, Inc.*, accessed July 11, 2016 from http://www.reid.com/training_programs/interview_overview.html. For the Rogerian methodology, see Carl Rogers, "Empathic: An Unappreciated Way of Being," *The Counseling Psychologist* 5.2 (1975), 2-10.
[19] Saul Kessin, *et al.*, "Police-induced Confessions, Risk Factors, and Recommendations: Looking Ahead," *Law and Human Behavior* 34.1 (2010), 3-38, 29-31. doi:10.1007/s10979-010-9217-5.
[20] Kessin, *et al.*, "Police-induced Confessions," 29-31.
[21] *Ibid.*

entirely avoids the use of questions and offering advice. In modified application, some will use open-ended questions rather than a series of closed questions, a strategy commonly used in policing to control the conversation and obtain the minimal information required. Thus, as taught, CIT's strategy of Rogerian interviewing is a more compassionate and appropriate response to someone who is ill and has not committed a crime.

IV. Participatory Action Research as an Approach to Police Research

The present research is based in principles of participatory action research (PAR), which aim to bring about change in the community by combining community-directed research and social action, either through structural change of oppressive conditions or through community empowerment.[22] PAR involves the population or community of interest in all stages of research, including when defining the research questions and hypothesis, designing a method for study or intervention, determining program implementation, and evaluating results. There are advantages and disadvantages to this type of research. Such an approach can encourage community endorsement of and engage the participants in the research, increase the likelihood of successful and culturally competent implementation, enhance understanding of the results, and promote sustainability, all while addressing a social problem in the community. Some disadvantages include that PAR can lack internal validity (it is difficult to control much of anything in community research) and so results can be difficult to replicate, so it is less valued by the scientific community.[23] Other problems relate to finding a role for all who want to participate, and effectively dealing with "spoilers," those who are wary or weary of collaboration. Also,

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[22] Kausar Khan, Sohail Amir Ali Bawani, and Ayesha Aziz, "Bridging the Gap of Knowledge and Action: A Case for Participatory Action Research (PAR)," *Action Research* 11.2 (2013): 157-175. doi: 10.1177/1476750313477158.
[23] John Moritsugu, *et al*., *Community Psychology* (Boston: Pearson, 2013), 93-119.

since no two communities are ever the same, a research program conducted in one community may still require cultural adaptation ("tweaking") to obtain effect in another.[24]

A major issue in PAR is that the research process can be time consuming because the community directs and participates in the research process as collaborators and participants.[25] To involve community members, there is usually some capacity enhancement required, of both the community and the investigators. While the community learns about research, the investigators must also learn the community's cultural customs, values, and beliefs. Additionally, community readiness for program development and evaluation waxes and wanes along with budget concerns and political priorities, which can also lengthen the research process. Nevertheless, this kind of careful collaboration can result in the pursuit of research that is more meaningful to the community. Because of the community's involvement in designing and implementing the research, they can be more invested in obtaining results and trust the results more given their participation in obtaining them. Ultimately, this can generate greater change in the community.

More than any other type of research, support for a particular hypothesis builds slowly through PAR over the course of many so-called "flawed" studies. Although small effects or group differences in a research study may be undetectable due to problems with the study's internal validity (e.g., not being able to use a control group), an effect can be considered robust when it is detected across many studies, each with different methods, samples, and shortcomings.[26] Fortunately, community collaboration enhances external validity. For example, the probability of successful program replication with another community cohort or in a similar

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[24] Marlyn Bennet, "A Review of the Literature on the Benefits and Drawback of Participatory Action Research," *First Peoples Child & Family Review* 1.1 (2004): 19-32.
[25] Moritsugu, *et al*., 102.
[26] *Ibid.* See also Keith E. Stanovich, *How to Think Straight about Psychology*, 9th ed. (Boston: Allyn & Bacon, 2010).

community elsewhere is more likely with PAR. Better external validity is an advantage that PAR always has over research based in a clinic or university where conditions are carefully controlled.[27]

PAR was the ideal approach for the type of research described here. In this instance of PAR, we worked within a culture of law enforcement, a culture that is wary of outsiders who might violate the confidentiality of some of their work or otherwise make their job more difficult. Particularly in recent years, police officers have also had to confront a great deal of community suspicion. As a "civilian" and a woman of color, the first author had everything going against her as she began her relationship with our local police department. However, PAR involves intensive relationship building, sometimes over years and awareness of political power structures to facilitate collaboration and avoid possible conflict.[28] To build rapport and really understand the department's needs, the first author volunteered with the police department for 5 years before offering to assist with program evaluation when it was clear they needed some assistance in mobilizing more support from local policy makers.

The investigators used a bottom-up approach in mobilizing support for and designing the research. After obtaining the mental-health unit's endorsement and their ideas about what they wanted to do, we asked permission of their commanding officer (their sergeant), then requested permission from the police chief and his assistance in designing the studies. His office provided a liaison, an assistant chief, who linked us with appropriate police resources.

Three small studies evolved after some consultations with the police department. For the study presented here, the mental-health officers invited us to study interviewing behavior in the

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[27] Moritsugu, *et al*., 102.
[28] T. N. Madan, "Community Involvement in Health Policy: Socio-structural and Dynamic Aspects of Health Beliefs," *Social Science Medicine* 25.6 (1987): 615-620. doi: 10.1016/0277-9536(87)90086-4.

field. Mental-health-unit officers immediately welcomed us to "ride-along" with them, especially since citizen ride-alongs are allowed through the local municipal code and since we had been part of their volunteer instructor team. The two other studies involved a review of CIT course evaluations and a survey of commanding officers' impressions of CIT impact on the community. Results of these studies are briefly reviewed in the discussion.

Despite the successful research engagement, none of the three studies were flawless because the research team made concessions to preserve relationship with the officers and these concessions usually reduced internal validity of the study. Nevertheless, the studies as a group provided an excellent opportunity for community/university collaboration, and there were some intriguing indications that CIT training appeared to be positively influencing police officers and the community, including the university community that became involved in this effort.

V. Study of CIT Effectiveness

Overall, training officers were interested in whether or not the training was having any impact on fellow officers' behavior, on diversions, and on community relations, particularly since the community had assisted them in establishing and implementing the program. The training officers modeled their program after another successful program in another city nearby, but the other city's program was not a manualized, evidence-based program developed from systematic efforts in a controlled environment with research subjects. Despite the officers' enthusiasm to learn about their program's impact, there were several challenges to conducting research to answer their questions. There was no logic model designed to focus any later research

efforts; no thought had been given to additional goals aside from diversions from incarceration.[29] The officers themselves developed this program from observing others. Police officers invited us to answer their questions late into their training program implementation, and there was no pre-testing of any kind. Aside from the course evaluations administered after each training day, there was no survey of knowledge or attitudes *before* each course. As a teaching university, our main research team consisted of the lead researcher and two undergraduate students; we had limited time and resources. We advised our collaborators that our efforts would offer only a starting point, a framework for future research, and that any results would be preliminary and indicative, not firm support for one hypothesis or another.

Both the university IRB committee and the police department's chief administrators approved the study, and we adhered to our discipline's code of conduct and ethics in conducting the study.[30]

VI. Observation of Ride-Alongs

Questions and hypotheses. One question for the observations was: What elements of CIT training are used most in the field? We examined the extent to which mental-health assessment was conducted and examined how Rogerian interviewing was being used by CIT officers during calls compared to other types of interviewing. We hypothesized that CIT officers would ask more questions about mental health than untrained officers, and spend more time with people during the call, use more empathy, and fewer Reid-style, closed questions in their response to calls. A second question of the observations was: Do the CIT officers actually

[29] For such modelling, see "Logic Model Development Guide," *W. K. Kellogg Foundation*, (Battle Creek, MI: W. K. Kellogg Foundation, 2004).
[30] For more on this, see the American Psychological Association's "Ethical Principles of Psychologists and Code of Conduct," *American Psychologist* 57.1 (2002): 1060-1073.

transport more people to mental health than other officers? We anticipated that most calls addressed by CIT officers would result in jail diversion.

Participants. The participants were police officers from two large, southwestern U.S. metropolitan cities of predominantly Hispanic populations. In both cities, participant recruitment involved working with a commanding officer who oversaw the different shifts.

In the target community, the participants were four of the six members of the CIT ("mental health") unit. Three of the participants were two white men in their early forties (senior officers with about fifteen years in the department) and one white man in his early thirties (five years in the department). All had high school diplomas. One of the participants was a thirty-year-old white woman (also five years in the department) with a Master's degree. Their sergeant assigned officers to provide citizen ride-alongs to three members of the research team over a period of six months, and across different shifts and days of the week. Although not randomly assigned, all CIT officers had an equal chance of being observed; whoever was on duty when observers were available and scheduled were the officers who provided the ride-along.

In addition to observations of CIT trained officers, the research team collected data from a "control group," another police department in a demographically similar community that had not been CIT trained. Because the target city was also training its other police officers in CIT, we could not easily obtain a control group in this city despite our efforts to do so. Untrained officers in the target community would call for a CIT officer rather than address the call themselves. The team initially observed officers in small unincorporated communities near the target community, but these communities tended to be either much more affluent and with no mental-health calls, or very poor and without a police department (under the supervision of the sheriff's department).

As a result, the research team spent a week in another demographically similar metropolitan area in the same state region to observe police officers who had not yet been trained in CIT. This community matched the target community in ethnicity, socioeconomic statuses, and size, but their police department was not yet trained in CIT. However, the officers of the comparison community were all Hispanic, the majority were very junior in their career (most were within five years of their academy training), and all Spanish-speaking. This differed from the officers observed in the target community who were all white, some with more years of experience in the department, and all English-speaking only.

We purposely over-sampled the police in the control community to compensate for their fewer mental-health calls, and their officers' inexperience; we hoped to find some examples of active listening among the untrained officers. The target community data came from only four officers observed for between six and eleven (or more) calls, whereas the control community data came from eighteen officers (over just one week) most of whom were observed for six calls or less (total per officer).

Although observations of police responses in the target community were made during thirteen citizen ride-alongs, there were thirty-four calls answered during the thirteen ride-alongs. We sampled primarily from the night time shifts to catch people at home: about a third of the calls in the target community were observed on day shift, and the rest were observed during one of the night time shifts (early evening shift, 3:30-11pm, or early morning shift, 11:00pm-7:00am). Observations in the control/comparison community were made during twenty ride-alongs, and there were seventy-seven calls during such rides. Because the comparison/control city was much smaller than the target city, all officers in the control community were observed

during the evening shifts to increase the likelihood of observing officers dealing with intoxicated individuals, and those in mental-health crises.

Table 1. Officer Participant Demographics.

	CIT (n=4)	Untrained (n=18)
Gender		
Male Officer	3	17
Female Officer	1	1
Ethnicity		
White	4	0
Hispanic	0	18
Language Proficiency		
English only	4	0
English and Spanish	0	18
Years of Police Experience		
5 years or less	1	17
More than 5 years	3	1

In addition to the different demographics of the police officers in the control community sample, the control community also differed substantially in the support services available to officers regarding mental health. The control community did not have a twenty-four-hour, mental-health crisis center or a twenty-four-hour public sobering unit/detox facility as did the target community. Instead, police officers had to either wait hours in a hospital ER to obtain

services for people who were experiencing a psychotic or delirium episode, or detain the person over the weekend until the person could be transported to the state hospital 150 miles away. We observed one officer transporting an intoxicated individual to "the Park," the city park where, as reported by the officer, individuals were left to "sleep it off" away from others and in an environment safer than where they were initially located. Thus, the attempt to collect control/comparison data was not very successful since the control/comparison group participants and their community resources were so different from the target community data. Data from this imperfect control group are presented here anyway for comparison, but with many reservations about their adequacy; these data should be considered as quite preliminary and in need of replication.

Measures and Procedure. Ride-alongs were conducted in fall, winter, and spring. Permission to ride with the officers was granted by the watch commander in charge, who then assigned the researchers to one or two participants (researchers sat in the passenger seat). During each ride, calls were dispatched to and answered by the officers. The researchers observed the participants assigned to them at each call. Each research team member agreed upon a safety signal with their officer; when the officer determined the situation to be safe, they would signal research team members to exit the vehicle and join the officer at the interview. Research team members stood to the side, and slightly behind the officer to observe and listen to the interview, and to minimize the effect of the research team member's presence on the interview. Research team members continued to silently shadow the officer as they moved from place to place, person to person. In only a few instances did researchers provide assistance to officers (e.g., translation assistance in one case, talking to a distressed woman in another situation), and they simply observed silently in all other situations. At the conclusion of each call, the riders would

complete field notes describing how the officers responded to the call. The researchers included details about the situation, whether or not the officer assessed mental health status, and what kind of questions and investigation they utilized.

Developing the template for field notes. We developed the template for field notes after some initial ride-alongs to experience a ride-along, and observe how the two original training officers conducted a call. We discovered that they had memorized a set of seven questions used by a clinician who was part of a sheriff's mental-health warrant service. These questions were used early on in the interview to determine whether or not there was psychosis (How have you been sleeping? How are you feeling? Are you hearing or seeing things that others can't see? For how long have you been feeling like this?), the extent to which someone might be suicidal (Are you feeling like you want to kill yourself? Do you have a plan?), and whether or not someone had used substances (Have you been drinking or using anything else?). We also noted the behaviors regularly used in the mental health calls, like assessment of person's appearance and environment, questioning of others present, and then included those in the template as well. We used the assessment template to guide our observation, and we indicated the presence or absence of these ten elements of the interview in our field notes. We also made additional observations about the actual incident and officer interview style noting their use of open-ended relative to closed questions, their patience and attitude to classify their style as more Rogerian or otherwise, but we did not count the number of reflections and summaries used. We decided to use the length of interview time as an imperfect proxy for counting specific interview elements for two reasons. First, both the identification of such elements and enumerating them is subject to a lot of error, especially when just one person is identifying and counting. Second, the lead researcher wanted her students to monitor the situation for any signs of increasing danger. Finally, we noted the

dispatch code, the time the call began and ended, and the person's demographics (age, gender and ethnicity/race), and call disposition or outcome. Because only one citizen at a time could accompany a police officer, the research team developed this assessment template together after each research team member was able to go on several individual ride-alongs, and in consultation with the training officers. We were unable to obtain inter-rater reliability for our observations because no audiovisual footage of the calls was available to rate officer behavior at the time of this study.

Results. We hypothesized that CIT officers would ask more questions about mental health than untrained officers, and spend more time with people during the call, use more empathy, and fewer Reid-style, closed questions in their response to calls. We found that the CIT officers spent, on average, eighty-two minutes responding to a mental health call; officers who were not CIT trained (but very demographically similar to the subjects of their call) spent, on average, thirty minutes per call ($t(93) = 6.160$, $p \leq .05$). CIT officers asked an average of six questions per call and untrained officers asked less than one question per call ($t(93) = 18.732$, $p \leq .05$). CIT officers conducted a mental health assessment by asking open-ended questions (e.g., "How are you feeling?" and "How have you been sleeping?") and using active listening. Consistent with standard policing, CIT officers always scanned the environment, assessed the appearance of the individual, and questioned others at the scene. Surprisingly, CIT officers also called relatives to inform them of the situation and gather more details about the person in crisis that could aid in making a dispositional decision. The CIT officers had difficulties when encountering Spanish-speaking persons since they did not speak Spanish. CIT officers were consistently empathic and patient in their response. However, these attitudes were also apparent

in the comparison group of untrained officers when they encountered people with mental illness or who were intoxicated, contrary to our expectations.

We hypothesized that most calls addressed by CIT officers would result in jail diversion. CIT officers resolved all calls on scene or transported the person in crisis to treatment; no one in this study was taken to jail.

Discussion

CIT policing was observed to be different from standard policing in these observations of ride-alongs. The results showed that CIT officers spent nearly three times as much time screening for mental health crises, using active listening skills, and observing the scene than officers who were not trained in CIT.

In addition to using Rogerian interviewing strategies which differed from Reid-style interviewing, the CIT officers used specific questions to assess people in crisis. In our area, assessors of mental health (affiliated with the local mental-health authority) worked with deputy sheriffs as part of a “Deputy Mobile Outreach Team” serving the county outside the city limits, and this “DMOT” included a mental-health service provider who used a one-page list of questions to assess dangerousness, suicidality, and other important issues in mental-health crises. The CIT unit adopted this screening approach and used these questions in their work. The questions eventually became part of the CIT role playing because the initial actors participating were mental health-service providers and other state mental-health staff who used this assessment regularly. While the officers may spend more time on a call, they are also screening for danger to self or others to ensure the person is safe before departing or transport and trying to obtain information from others at the scene.

There were many different limitations in this small study of CIT. A major limitation is that it was lean on demographic information describing the officer participants, and no *matched* comparison groups could be included. Because the department was new to research collaborations, we did not request demographic information and we gathered no signature as part of the informed-consent process so we could ensure confidentiality. Even after a five-year relationship, familiarity with the investigator, and despite the PAR process, there was still some trepidation about entering into a research collaboration. Replication of these studies might include larger samples of CIT officers, and a comparison to officers who are matched on important officer demographics like race/ethnicity, police-force experience, and languages spoken. In addition, all officers studied, including those in the comparison group, should have access to the same community resources across target and comparison communities. Otherwise, their interviewing style and decision-making may be more related to a lack of diversion options than to the presence or absence of CIT training; finding this perfect control group might be quite difficult.

Despite the problems with the comparison group used in this study, the officers in the comparison group were more similar to the population they served, even able to speak Spanish, and, yet, they still spent less time per call than the CIT officers who were demographically different from many they served. The comparison officers' shorter engagement time with people who were mentally ill or intoxicated might be attributed to the fact that there was nowhere to take a person who was intoxicated, and that there was no special mental-health crisis center in their city apart from the regular ER services. We were not able to observe many mental-health calls in the comparison city, and it would be important to replicate this study focusing solely on

calls relating to mental health but it is often difficult for dispatchers to correctly classify a call, and officers often find mental health as part of a complex situation.

Another limitation, but also a strength, is the sample of CIT officers. The CIT officers in our study were exceptionally well-trained because they were part of an established mental health unit. These may not represent the typical outcome of CIT training. However, there was some evidence that CIT training really did work for other first responders as well as the mental-health-unit officers. On one call, a paramedic, who was CIT trained, and an untrained officer were at the scene first before we arrived. When we arrived, the paramedic was already completing an assessment of mental health after having de-escalated the situation. At the request of the person in distress, the paramedic dismissed the untrained officer from the room so that the CIT-trained paramedic could maintain calm in the situation to conduct a thorough assessment. Despite this success, CIT officers were not always able to work well with other mental health personnel on scene, and sometimes did not integrate themselves seamlessly with an on-site assessor or share interviewing well with others on scene.

Despite these limitations, two small separate studies provided additional evidence of this CIT program's effectiveness. An analysis of CIT course evaluations showed that officers learned the appropriate skills, appreciated being able to develop those skills with officer-led training and role play, and felt more prepared to handle situations in the field. Officers also valued the opportunity to directly listen to lived experience of those with mental illness and receive relevant mental-illness education and resources. Such results would suggest a positive impact on subsequent officer and community relations so we surveyed commanding officers' views on community impact of CIT training. There was a perceived reduction in community complaints, increase in diversions away from jail to mental-health treatment, and a sentiment among

commanding officers that their officers were better able to respond to calls involving potential mental illness.

In addition to these data presented here, there have been other indicators of success. This mental-health unit and the department training of about eighty-five percent of its staff and many others (e.g. dispatchers, fire department, university and school police) were part of a county-wide jail diversion initiative. The initiative included other strategies like diversion from the magistrate court and from the county ER, as well as jail diversion into county crisis center and county detox and rehab programs. Over the first five years of this initiative for jail diversion, the number of diversions led to $50 million dollars in cost avoidance, *and the lowest jail census in five years: From a high of 4357 to 3743 in May of 2011*.[31] The police department's mental-health unit has grown, and there have been only two uses of excessive force in the entire decade of the unit's history.

Considered together, these data suggest that CIT training changes policing behavior and benefits the community served by CIT officers. CIT officers divert people with mental illness away from jail and into appropriate treatment, thus benefitting the people with mental illness and their families, relieving crowding and suicides in the jail system, and reducing costs associated with continual recidivism into the criminal justice system. In the city studied, CIT training is offered to those working dispatch, and to all first responders including paramedics and firemen because these individuals often arrive on scene before the police arrive.

There are benefits for the mental health system in cities that deploy CIT-trained police. These officers can de-escalate a situation and usually pacify an agitated person making the

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[31] Gilbert Gonzales and Leon Evans, "The Case for Jail Diversion of People in Recovery: Compassion and Cost Savings," presented at the *American Psychological Association's Annual Convention*, Honolulu, Hawaii, 2013.

situation much easier at the treatment facility, and reducing the use of restraints. Officers and other first responders' reports of a person's mental-health status will help the professionals trained to treat mental health in addressing that person's crisis to better and more quickly understand the person's situation. CIT training also seems to open communication and improve the relationship between law enforcement and mental-health professionals. Such collaboration between such important community systems can inspire a sense of safety, support, and hope, and may further support a consumer's recovery experience.

Although the study presented here is limited by the typical shortcomings of community-based PAR, the study results provide some additional support for use of CIT, and suggest that CIT may be an effective strategy to improve police response to those experiencing mental illness and to reduce the number of people with mental illness in the criminal justice system. Mental illness is not a crime and CIT training promotes social justice over criminal justice through jail diversion, and so this training merits further, more rigorous study.