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Police Officers' Attitudes Toward Mental Health and Crisis Intervention: Understanding Preparedness to Respond to Community Members in Crisis

Christine Tartaro[1] · Jess Bonnan-White[1] · M. Alysia Mastrangelo[1] · Richard Mulvihill[1]

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Abstract
The lack of robust mental health programs throughout the USA has resulted in police frequently being responsible for responding to calls about people with mental illness who are in crisis. Working with people with mental illness as offenders or as individuals needing emergency assistance is a regular part of the job for many in law enforcement, yet specialized training is not a regular part of most academy or in-service training curricula. Crisis Intervention Team (CIT) programs consist of a 40-h training for police and mental health personnel. The programs teach officers about mental illness, its causes and symptoms, and focuses on de-escalation tactics and use of available community resources as alternatives to criminal justice outcomes for calls. The current study explores officers' feelings of preparedness to work with community members with mental illness and their levels of endorsement of mental health stigma. Researchers surveyed police from nine different local departments in southern New Jersey. Half of the surveyed officers completed CIT training, allowing for comparisons between officers who were trained and those who were not. Results indicate that the CIT-trained officers were more likely to endorse different types of mental health stigma than non-trained officers, but those who were CIT-trained reported feeling better prepared for calls involving people with mental illness.

Keywords Police · Mental illness · Crisis intervention training · Stigma

Introduction

With renewed calls for improved police training in the wake of controversial encounters between police and different community constituencies, continued examination of police training is crucial. Changes to the practice of relying on inpatient psychiatric treatment in the 1960s resulted in the elimination of psychiatric beds in the USA, with a decrease from 559,000 beds in 1955 to just 35,000 in 2012 (Torrey 2016). Government funds for the community-based out-patient clinics also quickly disappeared, leaving too few psychiatric beds and little resources to care for people with mental illness (PwMI) in American communities (Frank and Giled 2006; Talbott 2004; Torrey et al. 2010). The inadequacy of the mental health system left few options or resources for PwMI facing a mental health crisis, and currently, the police are often the last resort (or, as it happens, first contact) for these individuals, with arrest and incarceration among the few avenues for accessing treatment (Lurigio et al. 2008). Markowitz (2006) studied arrest rates in 81 cities in the USA with populations of at least 50,000 and found an inverse relationship between psychiatric hospital bed capacity and arrests, even after controlling for cities' homelessness rates and other structural variables.

Interaction between police and PwMI is defined by two different types of involvement categories (Teplin and Pruett 1992). One category represents a law enforcement function, where police take action through application of criminal statutes to protect the public. People with mental illness commit crimes, just as those without mental illness do. During encounters where enforcement activities are taking place, police officers may be required to "talk down" or subdue suspects who are mentally ill or are in crisis during the arrest process. The second category of police involvement is non-criminal statute enforcement to protect physically and/or mentally disabled citizens. These actions are permitted

✉ Christine Tartaro
Christine.tartaro@Stockton.edu

[1] Stockton University, 101 Vera King Farris Drive, Galloway, NJ 08205, USA

under the *parents patriae* doctrine, allowing the government to take steps to assist residents unable to care for themselves. It is this latter function, combined with the lack of mental health resources in the community, that inspired Teplin and Pruett (1992, p. 339) to refer to police as "street corner psychiatrists." For many police officers, however, this is not necessarily seen as the primary role of policing (Bittner 1967; Lane 2019). Most officers lack even rudimentary training on mental illness and how to respond to calls involving people in the midst of a psychiatric crisis. A national survey of law enforcement training academies and police departments revealed that the median time spent on mental health topics in academies is 20 h out of an average of 18.5 weeks of training, while the departments offer a median of 4 h mental health in-service training (Fiske et al. 2020).

One intervention developed to address socio-political conditions contextualizing mental health treatment in the USA, and the lack of officer training has been the introduction of Crisis Intervention Team (CIT) response. CIT is currently one of the most popular types of police-mental health collaboration options, with over 2700 programs across the USA as of 2019 (Rogers et al. 2019). If the Biden administration works to act on the Obama administration's President's Task Force on 21st Century Policing recommendations, CIT will be incorporated into police policy and practice even more frequently in the coming years. CIT training aims to educate police about mental illness, substance abuse, and de-escalation while introducing officers to the mental health, substance abuse, and social service options available in the communities they serve. CIT training aims to improve officers' knowledge and attitudes about mental illness and produce better outcomes in the field, such as reduced arrests, less use of force, and more service linkages.

Literature Review

Stigma and Mental Illness

In the early days of the USA, PwMI were thought to be possessed by demons or witches and were subjected to inhumane treatments or otherwise shunned by society (Brattina 2017). Even today, an unfortunate consequence of mental illness is that people living with it must also deal with stigma. Public stigma includes three components. First, there are stereotypes or negative beliefs about a group. A few negative stereotypes commonly held by the public about PwMI are that they are too unstable to be able to develop meaningful relationships, are violent, and lack proper hygiene habits. Second is prejudice or an agreement with negative beliefs and/or an emotional reaction to those beliefs. Third, there is discrimination, meaning a behavioral response to the prejudice (Corrigan and Watson 2002). There has been little improvement in battling stigma of PwMI over the years. Phelan et al. (2000) compared survey data from 1950 to survey results from 1996. During both time periods, respondents were asked to define mental illness and provide descriptions of PwMI and their behavior. The odds of respondents in 1996 describing PwMI as violent were nearly twice that found in the survey from 1950.

Criminal justice personnel are not immune from being influenced by public stigma against mental illness. Watson et al. (2004) asked police in Chicago to complete some vignettes, all of which included stories of a minor criminal event or disturbance. The scenarios differed in that some included the word "schizophrenia" to describe one of the actors, while the other vignettes had no mention of a psychiatric diagnosis. All scenarios lacked specific information about the suspect's behavior or demeanor, as the goal was to examine how the presence of one word—schizophrenia—would impact results among officers. Officers rated the suspect with schizophrenia to be more dangerous and perceived witnesses diagnosed with schizophrenia to be less credible. There may be potential for adverse outcomes after initial police contact with PwMI if an individual officer holds stigma toward their own mental health and negative associations in regard to mental illness, criminality, victimization, and credibility (Bullock and Garland 2018).

Interaction Between Police and PwMI

Since officers occupy a dual role of protecting the public and assisting those in need, interaction with PwMI is a regular part of police work in departments of all sizes (Clayfield et al. 2011; Engel and Silver 2001; Ruiz and Miller 2004; Wells and Schafer 2006). Most police-citizen interactions end without an arrest or use of force, but a person's mental illness has the potential to make the encounter more challenging for both the police and civilians. The presence of a mental illness may inhibit effective communication between citizens and police, with some PwMI having difficulty obeying officer commands (Kerr et al. 2010). Ruiz and Miller (2004) identified fears PwMI may have that may cause them to act in ways police could misinterpret, prompting the use of force. For example, PwMI may fear being detained and taken away by strangers. They may fear people who are yelling and issuing stern commands, as officers are frequently trained to do to gain control at a scene. Finally, individuals in crisis may have a general fear of police and government authorities in general.

In addition to community members' responses to police contact, police officers may themselves fear PwMI due to perceptions of dangerousness and misinterpretation. For example, a PwMI's failure to comply with commands may be interpreted as aggressive behavior and prompt officer use of force (Kerr et al. 2010). Additionally, officers' lack of

understanding of mental illness and its symptoms may lead to an absence of empathy. In a study of Pennsylvania police officers' perceptions of PwMI, nearly half of the officers surveyed reported feeling uneasy or threatened when having to respond for calls for service involving PwMI (Ruiz and Miler 2004). Sixty percent of surveyed officers in Indiana identified repeat calls for service involving PwMi as either a moderate or significant problem (Wells and Shafer 2006), while approximately half of the sampled officers in Birmingham Alabama, Memphis Tennessee, and Knoxville, Tennessee considered mental health calls to be a moderate or big problem (Borum et al. 1998). In an analysis of de-escalation training, participating officers identified mental illness (and the combination of mental illness with drug and alcohol use) as a barrier to employing effective de-escalation techniques (Todak and White 2019). As communities rely more heavily on police resources to address issues of mental illness, attention should be paid to attitudes police officers hold about mental illness and the impact of relevant training on these attitudes. As with other areas of training, such as procedural justice (Dai et al. 2020), de-escalation (Todak and White 2019), social identity awareness (Israel et al. 2017; Miles-Johnson 2016), physical ability and neurodiversity sensitivity (Viljoen et al. 2017), and sexual assault assistance and trauma-informed practice (Franklin et al. 2020; Parratt and Pina 2017; Sleath and Bull 2012), indirect, attitudinal measures comparing trained and non-trained officers, as well as retention of training effects on attitudinal changes provide scholars and practitioners with insight on the professional impact of training. The value of this insight lies not only in evaluation of specific training interventions, but also in addressing expectations community members hold that training transforms police attitudes, behavior, and policy. Similar to other training foci (Viljoen et al. 2017), indirect assessments of CIT training's impact on officers' attitudes continue to compliment analysis of direct training outcomes (changes to observed behaviors, increased use of community partner resources, etc.). The current paper seeks to explore attitudes held by officers and whether previous with Crisis Intervention Team training is associated with a particular set of beliefs.

Preparing Officers for Police-Citizen Interactions Involving PwMI—Crisis Intervention Training

While the majority of police-citizen interactions with PwMI generally involve low-level criminal behavior and do end peacefully (Brekke et al. 2001; Kaminski et al. 2004; Wells and Schafer 2006), there have been well-publicized incidents of PwMI being injured or killed by police. Several of the most controversial police encounters in recent years have included PwMI or individuals in the midst of an emotional crisis. In an examination of 462 police shootings in the first 6 months of 2015, the *Washington Post* reported that a quarter of those shot by police were either diagnosed as mentally ill or in emotional distress at the time of the incident. Over half the law enforcement agencies involved in these incidents had provided little training to equip their staff with the ability to recognize the signs of a mental health crisis or understand the importance of de-escalation techniques (Lowery et al. 2015). This lack of knowledge and training among police has the potential to lead to harmful outcomes when officers respond to incidents involving people whose behavior is being impacted by mental illness.

CIT training was developed in response to a controversial police shooting in Memphis, Tennessee, in 1987. After being called to a scene where a citizen was injuring themselves with a knife and expressing suicidal thoughts, multiple police officers arrived at the scene and shot the suicidal man several times, killing him. Following the public outcry, faculty from the University of Tennessee, officers from the Memphis Police Department, and staff from the National Alliance on Mental Illness (NAMI) developed a curriculum for a 1-week intensive, 40-h training program. Unlike typical trainings, CIT aims to be a joint venture between police, mental health professionals, and community service providers. Officers learn about the symptoms of mental illness, practice de-escalation skills, get to know the mental health professionals in their communities, and gain an understanding of the non-criminal justice resources available in their jurisdiction. CIT programs aim to produce police officers who can serve as specialized first responders equipped with the skills and knowledge to reduce negative police-citizen interactions and utilize appropriate services to assist people with mental illness (Compton et al. 2008; Lurigio et al. 2008). After acknowledging the history of problematic police-community relations throughout the USA, President Obama's Task Force on 21st Century Policing called for more CIT training as one of several steps needed to help police fulfill the role of "guardians" of their communities (The President's Task Force on 21st Century Policing 2015).

CIT training has the potential to change officers' attitudes toward PwMI and give them the knowledge and skills to handle calls non-violently and link people with appropriate services (Lurigio et al. 2008). Research findings, however, have been mixed. Wells and Schafer (2006) surveyed police in Indiana before and after completing CIT training. Officers reported significant improvements in their levels of comfort in interacting and communicating with PwMI and their understanding of the work necessary to arrange for inpatient psychiatric hospital treatment. Ritter et al. (2010) tracked officers in a Midwestern city as they completed CIT training and found improvements in feelings of preparedness to handle calls involving PwMI. The officers' perceptions of the helpfulness of the mental health system also improved as they learned how to access community

services that could serve as alternatives to incarceration. Compton et al. (2011) compared CIT-trained officers to those who had not taken CIT training and found that the former were more likely to respond to vignettes about calls concerning PwMI by favoring options other than use of force. Compton et al. (2011a, b) compared police officers on their feelings of empathy before and after CIT training. Results were mixed, with officers experiencing changes on some, but not all, measures of empathy after CIT training. Compton et al. (2014) studied 251 CIT-trained officers and 335 officers without the training to compare the two groups on stigma levels, self-efficacy, de-escalation skills, referral decisions, and attitudes toward people with serious mental illness and their treatments. After controlling for officer age, gender, years of service, education, on-the-job experience, empathy scores, and personal and family experience with PwMI, CIT-trained officers received higher scores on their knowledge of mental-illness de-escalation skills, held more positive attitudes about treatment, and reported lower scores on fear and negative attitudes toward PwMI. Finally, Haigh et al. (2018) administered Day's Mental Illness Stigma Scale (Day et al. 2007) to officers and compared those who had CIT training to those who did not. The researchers found no significant differences in levels of stigma toward mentally ill individuals. This was an unexpected finding, and there are multiple possible explanations. One, of course, is that CIT does not impact individuals' beliefs in negative stereotypes among PwMI. Another possibility that the authors noted was that departments struggling with PwMI calls might be sending their staff members who are having the most problems with community interactions to training. In that case, the training might have impacted their stigma ratings but only brought them down to the same level of other officers who were deemed to not need CIT.

Previous research suggests personal and professional experiences could impact officers' thoughts about CIT training, PwMI, and feelings of preparedness for handling mental health calls. Several studies have explored the relationship between individuals' personal experience with psychological challenges and attitudes toward PwMI. In a large sample ($n = 5200$) of adults in the USA, respondents who knew someone with mental illness had more favorable attitudes toward PwMI (Kobau et al. 2010). Clayfield et al. (2011) reported that police reporting history of personal involvement with PwMI outside of work felt better prepared to interact with PwMI while on duty. Karaffa and Koch (2016) surveyed police officers in Texas and Oklahoma about their personal experience with mental health treatment. Nearly 60% of participants reported voluntarily participating in mental health treatment, and these individuals had better attitudes about seeking professional assistance and lower self-stigma scores. There was no difference in perceptions of public stigma. The authors did note that the prevalence of officer involvement in mental health treatment was high for this sample, and they attributed that to the voluntary nature of the survey. It is possible that some of these results are a product of sample bias, with individuals having more experience with and positive attitudes toward mental health intervention agreeing to complete the survey. Soomro and Yanos (2019) surveyed police officers and asked them about their current mental health symptoms and their opinions of PwMI. The officers who described symptoms matching characteristics of PTSD tended to endorse stigma at higher levels than other officers. The researchers speculated that it is possible the responding officers were unaware that they had PTSD, and the possible lack of awareness of their own mental health problems prevented them from feeling empathy toward people identified as mentally ill.

Compton and colleagues (2015) observed that, in their sample of Georgia police officers, CIT-trained police were more likely to have both family and friends with histories of mental health treatment than officers who had not been CIT trained. Using what appears to be the same set of data from Georgia, Compton et al. (2014) reported officers' own history with the mental health system and that of their family and friends was not associated with how officers completed vignettes involving PwMI once CIT training was considered in the models. In another example, Compton et al. (2011a, b) found that volunteering for CIT training was associated with having family and friends with histories of mental health system involvement. However, neither the association with these family or friends nor volunteering for CIT training were significant factors when measuring changes in empathy of officers before versus after CIT training. Cuddeback (2016) also considered the mental health of family and friends when studying the impact of CIT training on officers' opinions about mental illness. They also found that family and friends' mental illness did not impact officer opinions regarding PwMI. Therefore, although it might be tempting to assume exposure to mental illness and treatment within close social or family circles or willingness to engage in CIT training would impact an officer's sense of stigma regarding PwMI or attitudes toward mental illness, data presented in the scholarly literature are equivocal.

The purpose of the current study is to examine two groups of police officers, those with previous CIT training and those without, on stigma toward PwMI and personal preparedness to handle mental health service calls. According to Tully and Smith (2015), police perception of mental illness is one of five categories of analysis relevant to the assessment of CIT interventions and effectiveness. Given the content of CIT training, we expect that CIT-trained officers would report feeling more confident about handling calls involving PwMI and would be less likely to hold negative beliefs

about mental illness. Specifically, we tested the following hypotheses:

1.CIT-trained officers will report lower levels of stigma against individuals with mental illness.
2.CIT-trained officers will feel more prepared to handle mental health calls and incidents involving PwMI in crisis.

Methodology

Between September 2019 and March 2020, the researchers recruited nine police departments across five southern New Jersey counties. Data were collected as part of a larger study of officer experiences and attitudes regarding work and relationships with their service communities. The researchers approached the chiefs of the departments to explain the goals of the research, provide reassurances of anonymity, and discuss preferences for survey administration. Chiefs willing to distribute print versions of the survey were given the appropriate number of copies along with envelopes. The chiefs gave the officers the surveys, along with an IRB-approved cover letter from the research team explaining the study's purpose, the voluntary nature of the survey, and promises of anonymity. The cover letter asked officers who consented to participate to begin filling out the survey. If they did not consent, they were instructed to discard it. Participants placed the completed print surveys in sealed, unmarked envelopes and then dropped them in a collection box in the station. The research team then picked up the surveys after a few weeks. If the chiefs preferred email distribution, the research team emailed the chiefs a link to the consent form and survey, and the chiefs then forwarded it to the officers. The email link took participants to a Qualtrics-based survey. Between the print and electronic versions, surveys were distributed to a total of 590 officers, with 168 returned surveys complete enough to be included in the final dataset (28.6% response rate). One participant responded "I don't know" when asked whether they completed CIT training, so that case was removed, leaving 167 for analysis.

For this paper, the focus is officers' endorsement of mental illness stigma and perceptions of preparedness to handle calls involving PwMI. These are potentially sensitive questions that might prompt people to provide socially desirable answers. Officers might be hesitant to disclose their personal mental health treatment experience, and they also might be reluctant to admit to harboring negative thoughts about PwMI. To address potential concerns regarding participation, the research team took steps to protect the identity of both participating departments and individual respondents. First, we agreed to never identify the participating departments and to only discuss the results in aggregate. Second, to protect individual participants, we limited data collection to avoid compromising anonymity, so the surveys did not contain questions about participants' gender or race/ethnicity. The 2016 Uniform Crime Report data indicated departments in the sampled counties had only 4 to 9% of female officers (State of New Jersey 2017), so female officers would have likely jeopardized their anonymity by responding to such a demographic question. In taking these steps, the research team hoped to create a sense of anonymity among participants. While it is always possible that social desirability still impacted respondents' answers, these steps were taken to limit, to the extent we could, this possibility.

Results

Univariate Analysis

In the survey, respondents were asked whether they ever completed the 40-h CIT training. Responses were evenly distributed across the sample, with 83 individuals (49.4%) having completed CIT training while 85 (50.6%) had not (Table 1). We also asked about their years of law enforcement experience, with this agency or others, and the number of times they encountered a PwMI who was in crisis while on duty in an average month over the past year. Respondents had a wide variety of law enforcement experience, with 10% ($n=17$) being on the job for less than 5 years, 20% ($n=33$) working for 5 to 10 years, 39% ($n=66$) for 11 to 20, 27% ($n=46$) for 21 to 25 years, and 4% ($n=6$) for over 25 years. Due to the low frequencies for newer and very experienced officers, the five categories were condensed to 3 up to 10 years, 11 to 20 years, and 21 + years, for analysis. Similar to results of previous research, the officers in our sample varied a great deal in the extent to which they interacted with PwMI in crisis while on duty in an average month. No one in the sample reported having zero such interactions in a typical month. A quarter ($n=43$) of officers estimated that they had one to two encounters with PwMI in crisis, on average, each month, and a 21% ($n=35$) reported 3 or 4 such encounters. Slightly over half (52%, $n=88$) of the survey respondents recalled having at least five interactions with PwMI in crisis per month in the past year.

The survey included multiple questions to measure the mental health history of the officers as well as their friends and family (Table 1). First, officers were asked if they were currently or had ever received mental health treatment, such as therapy, counseling, or medicine for emotional problems. Next, they were asked the same question regarding family and friends. Officers were then asked if they had experience working or volunteering in the mental health field, such as therapy, counseling, psychiatry, or psychology. Finally, they were asked the same about their family and friends. For

Table 1 Law enforcement experience

	f	Percent
CIT trained		
Yes	83	49.4
No	85	50.6
Years of experience in law enforcement		
Less than 5	17	10.1
5–10	33	19.6
11–20	66	39.3
21–25	46	27.4
Over 25	6	3.6
In an average month over the past year, how many encounters have you had with people with mental illness in crisis while on duty?		
0	0	0.0
1	24	14.3
2	19	11.3
3	18	10.7
4	17	10.1
5	19	11.3
6 to 10	34	20.2
More than 10	35	20.8
No answer	2	1.2
	Mean	SD
Exposure to the mental health system scale	1.82	1.68

this analysis, we created the same experience index used by Compton et al. (2014) in their study of officers participating in CIT training. The index was scored on a scale of 0 to 5. Respondents received a 0 if they indicated that they, their friends, and their family had no experience with the mental health system via receiving treatment, volunteering, or working in the system. Respondents scored a 1 if they, their family, or friends at some point held a volunteer position or worked in the mental health system. Scores of 2 were for respondents who had a friend who received mental health treatment, and 3 was for people who had a family member who experienced mental health treatment. If individuals replied that they had both a family member and a friend who received mental health treatment, they were coded as a 4. If the respondents themselves indicated that they received mental health treatment, it was coded as a 5. The mean level of exposure for the responding police was 1.82 ($Mdn = 2.0$; $SD = 1.68$). To measure officers' opinions about mental illness stigma, respondents completed Day's Mental Illness Stigma Scale (Day et al. 2007). The scale consists of 28 statements measured on a seven-point Likert-type scale (completely disagree = 1; completely agree = 7) and includes seven domains: treatability, relationship disruption, hygiene, anxiety, visibility, recovery, and professional efficacy. The *Anxiety* factor (7 items) reflects the extent to which respondents feel uneasy, nervous, or fearful for their safety when in the presence of someone with mental illness. *Visibility* (4 items) measures individuals' perceptions about their ability to recognize symptoms of mental illness. *Relationship Disruption* (6 items) assesses concerns about the impact of mental illness on quality of interpersonal relationships. *Hygiene* (4 items) measures opinions about the self-care and cleanliness of PwMI. Finally, *Treatability* (3 items), *Professional Efficacy* (2 items), and *Recovery* (2) reflect the respondents' beliefs about the prospects of recovery and the extent to which mental health professionals are able to contribute to effective treatment practices.

Mean responses to the Mental Illness Stigma Scale are displayed in Table 2. To test for reliability of the seven domains included in the scale as well as the total score, we calculated Chronbach's alpha, utilizing a value of 0.70 for

Table 2 Mental illness stigma

	α	M	Mdn	SD
Relationship disruption	.916	4.53	4.5	1.43
Hygiene	.934	4.89	5.0	1.38
Anxiety	.954	4.85	5.3	1.59
Visibility	.794	3.86	4.0	1.14
Treatability	.751	4.86	5.0	1.45
Recovery	.868	4.74	5.0	1.72
Professional efficacy	.801	4.66	5.0	1.38
Total mental illness scale score	.955	130.62	136.0	31.48

Table 3 Officer feelings of preparedness

	Very prepared	Moderately prepared	Somewhat prepared
Prepared to handle incidents involving PwMI in crisis	78 (46.4%)	80 (47.6%)	10 (6.0%)

acceptable inter-correlation. Six of the seven factors and the scale's total produced acceptable alpha scores. The reliability coefficient for *Visibility* was α = 0.664 but rose to 0.794 upon the removal of one of the four variables included in the factor. Following reliability analysis, means for each factor subscale were calculated. After reverse-coding some items, higher scores for each factor represent higher levels of endorsement of stigma. Respondents were given a 7-point scale to score each item, with 1 representing "completely disagree" and seven "completely agree." Most of the mean responses were in the 4.5 to 4.89 range, indicating slight agreement with stereotypes concerning the role of mental illness in *Relationship Disruption* ($M = 4.53$) and negative attitudes toward *Hygiene* ($M = 4.89$) stereotypes about PwMI. Respondents somewhat agreed with statements regarding them being anxious around people with mental illness (*Anxiety* mean = 4.85) and statements expressing skepticism about the *Treatability* ($M = 4.86$), prospects of *Recovery* ($M = 4.74$), and mental health professionals' ability to treat mental illness (*Professional Efficacy* mean = 4.66). Respondents had the lowest mean scores for the *Visibility* domain, with a mean of 3.86 and a median of 4.0, suggesting that officers lacked confidence in their ability to look at someone and determine that they have a mental illness. Possible total scores on the entire scale could have ranged from 28 to 196. Respondents' scores ranged from a low of 44 to a high of 191. The total mean was 130.62 ($SD = 31.48$). Reliability for the entire scale was high, with α = 0.955.

Table 3 includes summary responses to officers' feelings of preparedness to handle incidents involving PwMI in crisis. No officers reported feeling "not at all prepared." Forty-six percent ($n = 78$) felt "very prepared," while 48% ($n = 80$) were "moderately prepared." Only six percent ($n = 10$) of respondents reported being "somewhat prepared." Given the low frequency for "somewhat prepared," that category was combined with "moderately prepared," creating a dichotomous variable for further analysis.

Bivariate Analysis

The researchers conducted a chi-squared test to measure possible differences between the CIT-trained and not-trained groups on their years of law enforcement experience. There were no statistically significant differences between the CIT trained and not-trained officers based on their years of law enforcement experience (Table 4). CIT-trained officers scored a mean of 1.60 ($SD = 1.60$) on the mental health system exposure scale. Non-CIT-trained officers had a slightly higher score of 2.04 (SD = 1.74), but the results of the independent samples *t* test were not statistically significant. Finally, we conducted a Mann–Whitney *U* test to assess for differences in frequency of PwMI encounters on duty. While the CIT-trained officers did report more monthly interactions with PwMI (mean ranks = 88.92 and 78.21 respectively), the difference was not statistically significant.

Table 5 displays independent samples *t* test and chi-squared results, with officers' CIT training as the dichotomous independent variable. The Bonferroni correction was used to account for possible Type I errors. Since there were eight *t* tests, we divided the customary alpha of 0.05 by 8, resulting in a much more conservative alpha of 0.006. *T* tests on the domains of the Mental Illness Stigma Scale did produce

Table 4 Bivariate analysis: CIT training and officer characteristics

	CIT trained ($N = 83$)		Not CIT trained ($N = 84$)		
	f	%	*F*	%	X^2
Years of experience in law enforcement					
10 years or less	23	46.0	27	54.0	4.402
11 to 20 years	39	59.1	27	40.9	
21 + years	21	40.4	31	59.6	
	Mean	SD	Mean	SD	*t*
Respondents' exposure to the mental health system	1.60	1.60	2.04	1.74	− 1.654
	Mean rank		Mean rank		Mann–Whitney *U*
Number of encounters with PwMI in crisis in average month	88.92		78.21		2999.5

Table 5 Bivariate analysis: CIT training and dependent variable

	CIT trained		Not CIT trained			
	M	SD	M	SD	*t*	*d*
Treatability	5.33	1.29	4.43	1.45	−4.210*	.62
Relationship disruption	4.91	1.39	4.16	1.39	3.487*	.52
Hygiene	5.33	1.20	4.49	1.43	4.064*	.60
Anxiety	5.23	1.37	4.51	1.70	2.965*	.45
Visibility	3.68	1.18	4.03	1.09	−2.003	−.31
Recovery	5.13	1.48	4.39	1.85	−2.860	.43
Professional efficacy	4.78	1.29	4.51	1.46	−1.274	
Total mental illness scale score	140.64	26.89	121.10	32.71	4.065*	.65
	f	%	*f*	%	X^2	Cramer's V
Prepared to handle incidents involving PwMI in crisis						
Very prepared	47	56.6	31	36.5	6.859**	.202
Moderately/somewhat prepared	36	43.4	54	63.5		

*$p < .006$; **$p < .01$

several statistically significant differences between officers. Most of the differences, however, were in the opposite direction as hypothesized. CIT-trained officers had statistically higher mean responses for *Treatability*, *Relationship Disruption*, *Hygiene*, and *Anxiety*, indicating greater stigmatizing attitudes toward mental illness. Cohen's *d* statistics for all demonstrated a moderate effect size, with statistics for each ranging from 0.45 to 0.62. The strongest relationships were found with *Treatability* ($d = 0.62$) and *Hygiene* ($d = 0.60$). Mean differences for *Recovery* were not significant after application of the Bonferroni correction. The only domain in which the CIT-trained officers had somewhat lower scores than the non-trained officers was for *Visibility*, but those differences were not statistically significant. There was no relationship between officer training and beliefs regarding *Professional Efficacy*. There was a significant difference in total scores, with CIT-trained officers having a mean score of 140.64 ($SD = 26.89$), while non-trained officers scored an average of 121.10 ($SD = 32.71$) ($t(154) = 4.065$, $p < 0.06$).

To test whether CIT officers felt that they were more prepared to handle incidents involving PwMI who are in crisis, we conducted a chi-squared test (Table 5). Fifty-seven percent ($n = 47$) of CIT-trained officers felt very prepared to handle incidents involving PwMI, compared to 37% ($n = 31$) of non-trained officers. This difference was statistically significant at the $p < 0.01$ level, but association was rather weak (Cramer's V = 0.202).

Additional officer-level factors that might be associated with preparedness for working with PwMI and levels of mental illness stigma are years of law enforcement experience and personal and family/friend experience with the mental health system. Officer experience was divided into three categories: 10 years or less, 11 to 20 years, or 21 years or more, so it was necessary to use one-way ANOVA (Tables 6 and 7). Years of experience was not associated with officers' feelings of preparedness when working on mental health calls with people in crisis, nor was it related to endorsement of stigma. We asked officers about how many encounters they had with PwMI in crisis in a typical month while on the job. Respondents were able to choose any number from 0 to 5 or from two other categories: "6 to 10" or "more than 10". Given the ordinal nature of this variable, we used Spearman's Rho to test for correlations between officer encounters with PwMI and the dependent variables. We did not find any relationships between officers' reported experience with PwMI and endorsement of mental illness stigma or feelings of preparedness to handle encounters with PwMI (output available upon request).

For personal or vicarious exposure to the mental health system, the researchers used Pearson's *r* correlation coefficients with Bonferroni's correction ($\alpha = 0.05/8 = 0.006$). Personal, family, and friend involvement with the mental health system was not associated with any of the individual domains of the stigma scale, nor was it correlated with the scale's total score. Logistic regression analysis was used to test the relationship between exposure to the mental health system and officers' perceptions of preparedness to handle incidents involving PwMI in crisis (output available upon request), but the two variables had no association.

Discussion

Officers participating in this study interacted with PwMI somewhat frequently, with half of the sample responding to more than one call per week in a typical month. Recent highly publicized incidents involving officer use-of-force have been met with calls to provide less funding to law

Table 6 Bivariate analysis: officer experience and dependent variables

	10 years or less		11 to 20 years		21 + years		
	M	SD	M	SD	M	SD	F
Treatability	4.68	1.54	4.79	1.49	5.12	1.29	.272
Relationship disruption	4.64	1.50	4.56	1.38	4.38	1.44	.655
Hygiene	5.10	1.28	4.73	1.41	4.89	1.45	.358
Anxiety	5.09	1.76	4.69	1.55	4.80	1.48	.412
Visibility	3.80	1.13	3.84	1.11	3.94	1.20	.817
Recovery	4.86	1.91	4.73	1.65	4.67	1.63	.906
Professional efficacy	4.54	1.56	4.71	1.25	4.66	1.37	.794
Total mental illness scale score	132.70	32.29	127.26	31.65	132.13	30.95	.502
	f	%	*f*	%	*f*	%	X^2
Prepared to handle incidents involving PwMI in crisis							
Very prepared	20	49.0	30	45.5	24	46.2	.157
Moderately/somewhat prepared	26	51.0	35	54.5	28	53.8	

enforcement and, instead, give greater funding and responsibility to social service agencies to address calls for PwMI. While we may have more human service involvement in cases involving PwMI in the future, it is likely that police will still be first responders and participate in calls for service, especially ones involving reports of criminal behavior. If CIT programs are to be expanded and relied upon to help police navigate calls for service with individuals in crisis, more research is necessary to determine what, if any, impact this has on officers' perceptions and behaviors. The current study focused on the former, as the researchers were unable to measure officers' actual use of CIT lessons on duty with the current dataset. Instead, we focused on officer perceptions. Corrigan et al. (2000, 2001, 2012) researched methods for combatting stigmatizing attributions about mental illness and identified education as an effective tool. CIT training involves educating police about mental illness and its symptoms while also debunking myths. As it is designed, CIT training should potentially improve officers' perceptions of PwMI, prompt officers to favor nonuse-of-force options during calls for service, and have them feel more prepared to handle calls involving PwMI.

We found no support for our first hypothesis. There were some differences in officer endorsement of stigma against PwMI but, contrary to our prediction, CIT-trained officers were more likely to hold more negative opinions about PwMI than the non CIT-trained officers. We did find support for Hypothesis 2, in that CIT-trained officers were more likely to report feeling "very prepared" to handle calls and incidents involving PwMI in crisis than non-trained officers who were more likely to indicate they felt "moderately" or "somewhat" prepared. Possible explanations for these findings are provided below.

In Hypothesis 1, the researchers predicted that CIT-trained officers would be less supportive of stigmatizing attitudes toward PwMI than officers who have not yet had the training. For four of the seven domains of the stigma scale and the total score, CIT-trained officers had higher levels of stigma endorsement than the non-trained officers. Years of law enforcement experience, frequency of contact

Table 7 Exposure to the mental health system and mental illness stigma

	MH system exposure	Treatability	Relationship disruption	Hygiene	Anxiety	Visibility	Recovery	Professional efficacy	Total mental illness stigma score
MH system exposure	1.00	−.053	.019	−.069	−.058	.122	−.065	.034	−.040
Treatability		1.00	.659*	.606*	.757*	−.107	.704*	.431*	.829*
Relationship disruption			1.00	.728*	.744*	.212*	.711*	.186	.891*
Hygiene				1.00	.695*	.275*	.621*	.198	.841*
Anxiety					1.00	.021	.800*	.213*	.920*
Visibility						1.00	.034	−.243*	.168
Recovery							1.00	.287*	.842*
Professional efficacy								1.00	.341*

*$p < .006$

with PwMI in crisis on calls for service, and the extent of officers' personal or vicarious exposure to the mental health system were not associated with stigma scores. Most previous research on CIT training found that CIT officers have better attitudes and opinions about PwMI. One exception was the Haigh et al. (2018) research, which used the same mental illness stigma scale as the current study and found no relationship between training and perceptions of stigma. Haigh and colleagues provided two potential explanations for their findings. One was that CIT training does not impact perceptions of officers after they have been out of CIT training for some time. Another possibility was that officers who have been more problematic in their interactions with the public, particularly PwMI, might find themselves assigned by their supervisors to CIT training in an effort to improve their attitudes and behavior. If the latter was the case, Haigh et al.'s null findings could signify an actual improvement in the problematic officers' attitudes to put them more in line with their colleagues. Both explanations are potentially applicable to the current findings. We did not measure whether officers volunteered for CIT training or were ordered to attend. Compton et al. (2014, 2015) collected data comparing non-trained officers, CIT officers who volunteered, and CIT officers who were assigned to the program. Volunteering for CIT, however, was not a significant predictor of levels of empathy when included in multivariate analysis (Compton et al. 2014, 2015). A third possible explanation is that the two groups of officers are conceptualizing mental illness differently. Mental illness is a broad term that can refer to a wide array of diagnoses, symptoms, and behaviors. It could mean moderate depression, severe schizophrenia, or even drug and alcohol abuse. Researchers found that people have different opinions about stigma depending on the specific type of diagnosis (Day et al. 2007; Mann and Himelein 2004: Phelan et al. 2000). The survey used for the current study asked questions about mental illness in general rather than identifying a particular diagnosis, such as depression or schizophrenia.

The current analysis did find support for Hypothesis 2. Our results support previous findings of similar feelings of confidence and preparedness among CIT-trained officers (Bonfine et al. 2014; Compton et al. 2008; Ritter et al. 2010; Taheri 2016). A higher frequency of CIT-trained officers reported feeling "very prepared" to handle calls involving PwMI in crisis. However, the impact of confidence and preparedness on field practice outcomes remains unclear. Certainly, recognition of bias and stereotypes regarding mental illness is an important factor in creating organizational-level priorities for professional development and creating informed department policies. However, beyond policy development and organizational recognition, future research must incorporate assessment of specific community experience or policing practice outcomes beyond officer perceptions.

The current research consisted of a survey of police employed at several different departments, half of whom previously attended CIT training. Learning whether officers have attended the training is only part of the story when we attempt to understand organizational culture and how officers might view PwMI and their responsibility for their health and safety. Cotton and Coleman (2017) identified three generations in the evolution of police policies for interacting with PwMI. The first generation focused on offering or mandating education and awareness programs, including CIT. The second generation included creating police-mental health agency partnerships where mental health workers assist police in the communities as they respond to calls. Cotton and Coleman noted that what is rare, yet necessary, is the third generation of policy wherein each department identifies and articulates a systematic strategic approach to address whole problems in their communities. Cotton and Coleman also argue this broader approach prioritizes changing the entire organizational culture to require all staff to treat PwMI with respect, adhering to principles of procedural justice. The concern is that anything short of this results in mere reaction to symptoms of the problem instead of a comprehensive, proactive plan for a solution. CIT is a good start to addressing the challenges of working with PwMI in our communities, but even supporters of the first and second generation policies note that training is just one step that is likely to be ineffective without cultural change and leadership buy-in (Council of State Governments 2019; Hartford et al. 2006). Measuring departmental-level shifts requires a more nuanced attempt at examining officer attitude—one not possible with the current project's approach. Future research, therefore, would benefit from localized evaluation strategies embedded in objectives determined by department leadership and their reasons for sending officers to CIT training.

Limitations

There are a number of limitations associated with this study. The cross-sectional nature of the data collection prevents an examination of time-order. It is not possible to ascertain the CIT-trained officers' levels of confidence and perceptions of mental health stigma prior to their training. Given the findings here of increased levels of agreement with mental illness stigma among CIT-trained officers, it is important to have pre-test measures to understand where all participants were at baseline. Additionally, we are unaware of how long ago each officer completed CIT training, so we cannot determine whether our findings are a product of the CIT training or if the training's impact has worn off over time. While previous research did not find the means by which officers entered CIT training (by volunteering or being

assigned by supervisors) to be related to officer knowledge and empathy levels post-training, future research should include reason for entering the training as a control variable. In this study, officers were not asked about any other mental health–related training that they might have received in addition to or instead of CIT. Participating officers were from nine different police departments in five different counties, meaning that respondents attended different CIT programs. One problem with conducting large-scale CIT studies is the range in fidelity to the original Memphis model CIT program (Peterson and Densley 2018; Watson et al. 2017). The researchers were unable to identify and study each CIT program that participants attended.

All of the survey questions regarding mental illness were very broad, as the term "mental illness" is an umbrella term for conditions experienced by millions of people, all with different symptoms and levels of severity. Research reveals that people have different responses to questions about PwMI depending on the specific diagnosis or how they operationalize mental illness themselves. For example, Phelan et al. (2000) compared survey responses from Americans in 1950 and 1996 and found that, in both time periods, people who used the word "psychosis" to describe mental illness were more likely than others to also use the word "violence." Mann and Himelein (2004) found greater levels of stigma when vignettes described a person as having schizophrenia compared to when the subject had depression. Given how new information is being incorporated into the public's understanding of different mental illnesses, it might be of benefit to be more specific in future research on police attitudes toward different mental illness diagnoses. It is likely, we speculate, that greater specificity on survey questions might have produced different results. Finally, validity of the results is limited in that the data reported here represent self-reports and perceptions of opinions, not field-based research or researcher observation of interactions by the participating officers. Additionally, police officers, especially those who have been through multicultural or bias training, may be sensitive to the questions regarding mental illness stigma and want to provide the "correct" or socially desirable answers to questions. While we took multiple steps to ensure respondent anonymity, we cannot rule out the possibility of explicit bias. Implicit bias, however, is much more difficult to control, as people are unaware of it, so it is more likely to become evident when observing officer behavior (Mulay et al. 2016).

Conclusion and Suggestions for Future Research

The current study found that CIT-trained officers felt more prepared to handle on-duty encounters with PwMI. We also found that the trained officers were more likely to endorse negative stereotypes of these same individuals. Feelings of preparedness and attitudes of mental illness are just two of several different CIT-related outcomes identified by Peterson and Densley (2018). Others include impacts on dispositions, number of arrests, and incidences of use of force. As with all police training, it is necessary to conduct research as to whether the trainings are influential beyond attitudes and feelings of preparedness and impacts officer behavior. Previous research reviewing methods of implicit bias (FitzGerald et al. 2019; Forscher et al. 2019; Payne and Vuletich 2018) and sexual assault (Parratt and Pina 2017; Sleath and Bull 2012) training have not demonstrated a clear pattern of translation of individual motivation and concept comprehension to changes in behavior of training participants. Depending on the procedures utilized in training, the focus of learning goals (for example, change in implicit bias, changes to practiced behavior, or changes to social environment), and focused subject of bias, effects on behavior were varied (FitzGerald et al. 2019; Forscher et al. 2019; Payne and Vuletich 2018). To the extent possible, future research should focus on how elements of officer training prepare officers for successful (or not) officer behavior in the field when faced with PwMI.

Availability of Data and Material The datasets generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics Approval The study was approved by the Stockton University IRB.

Consent to Participate Informed consent was obtained from all study participants.

Competing Interests The authors declare no competing interests.

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