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Partners in Crisis: A Phenomenological Exploration of Collaboration Between Crisis Intervention Team Officers and Mental Health Professionals

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PARTNERS IN CRISIS: A PHENOMENOLOGICAL EXPLORATION OF COLLABORATION BETWEEN CRISIS INTERVENTION TEAM OFFICERS AND MENTAL HEALTH PROFESSIONALS

by

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ABSTRACT

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Law enforcement officers (LEOs) are often the first responders to crisis situations, which increasingly include mental health crises. Collaborating with mental health professionals and organizations increases the likelihood that individuals will receive a response that is contextually and culturally informed by an understanding of mental health needs and considerations. For this reason, Crisis Intervention Teams (CIT) have been established to train LEOs and to unite efforts with mental health professionals, advocates, and community constituents. While there is existing and ongoing literature exploring the responses provided by CIT, there is limited research on the experiences of CITs related to their unique interdisciplinary team collaboration and support. LEOs are not only called upon to help others in a time of crisis, but they are also often their own resource for processing and training, all the while functioning in a dynamic system with increased exposure to traumatic events, psychological distress, and stigma around mental health support. This dissertation presents a phenomenological exploration of the lived experiences of Crisis Intervention Team (CIT) officers collaborating with mental health professionals for (1) training and (2) addressing and processing trauma and vicarious trauma. Through in-depth interviews with CIT officers, this study describes the complexities of their experiences and explores implications for counselors, counselor educators, training programs, and calls to advocacy. By highlighting the narratives of those in the midst of these experiences, this study

contributes to a deeper understanding of the intersection between law enforcement and mental health care and provides valuable insights into how interdisciplinary collaborations can be optimized to be multiculturally responsive and supportive of the wellbeing of those we call on to protect and serve.

This dissertation is dedicated to everyone in the following acknowledgements section, who will all be unsurprised by the length of that section (let alone this dissertation) as they have most likely suffered reading text messages and emails from me that are longer than this paper.

Most importantly, this is dedicated to my mom, without whom I would not have made it this far, nor believed that I could.

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I. INTRODUCTION

The intersection of law enforcement and mental health services is a prevalent commonality typically necessitated and highlighted by unfortunate and potentially dynamically dangerous circumstances. Crisis Intervention Teams (CIT) are composed of law enforcement officers (LEOs) that are specifically trained to respond to situations involving mental health crises. The focus of this dissertation study is to explore the lived experiences of CIT Officers collaborating with mental health professionals for training and support in navigating trauma and vicarious trauma. This chapter will briefly explore the statement of the problem, the purpose of the study, the research design and limitations, and end with a brief summary of key terms.

Statement of the Problem

Currently, much of the literature focuses on how mental health professionals can collaborate with CIT officers for responding to others experiencing mental health crises (CIT International, 2019; Compton et al., 2022; NAMI, n.d.. Rogers et al, 2019; Watson et al, 2021). Recommendations often include further training, further resources for support, and continued education and advocacy. Being a member of the CIT community puts mental health professionals in a unique position to experientially gain understanding of LEO culture and these suggested recommendations to provide culturally informed and critically considered collaborative support. This study aims to gain insight into CIT officers' experiences, perceptions, and needs for collaboration on support and training for themselves and their teams.

LEOs are not only called upon to help others in a time of crisis, but they are also often their own resource for processing and training, all the while functioning in a dynamic system with increased exposure to traumatic events and psychological distress, stigma around mental health considerations, and a strong protective influence due to the nature of the job's focus on

life and safety (Compton et al 2017; Daniel & Treece, 2022; Fleischmann et al, 2018; Kanno & Giddings, 2017; Mcdonald et al., 2021; Molnar et al., 2017; Otto & Gatens, 2022; Vukčević Marković & Živanović, 2022). As previously mentioned, while there is much literature and discussion evaluating the efficacy of the response and the impacts on the community, an important part of the community that is not fully represented in this literature is the team itself and how collaborative efforts with mental health professionals can influence the education and wellbeing of those on the team, not just those they are responding to.

With the co-creation of CIT response teams and an increasing focus on mental health responses and management in society, mental health professionals have been introduced as a part of these collaborative interdisciplinary teams to fulfill a multitude of dynamic roles; whether it be training, supporting, and even co-responding. With the proud and protective nature of both LEO and mental health careers, there is a wealth of knowledge and motivation on these teams, however, there is also stigma and perhaps existing biased assumptions of job roles and functions. While peer support is the general go-to for first responder wellness, there is a unique opportunity to utilize shared experience and a shared foundational platform to hear and incorporate the voices of any professional working in a CIT environment to best understand the contextual needs for support and training. Ideally, supportive training and processing measures coming from an already trusted or known individual may increase important buy-in and trustworthiness that encourages breaking barriers and shifting a culture towards mental wellness in a nonjudgmental, trusting environment.

As counselors and counselor educators, multicultural understanding and education is a required and critical component of the profession and is outlined as an imperative in ethical codes and guidelines. Addressing stigma and advocating for underrepresented populations is an

important duty, and one of the most salient and responsive ways to understand a need is by hearing from and collaborating with those experiencing the phenomena to form a holistic and experiential foundation for understanding. Cultural explorations and changes cannot come, however, without trust, increased awareness and education, and empathetic understanding; with the increased implementation of CIT in jurisdictions and a focus on redefining responses to mental health crises, there is an important door open for mental health professionals to become better informed advocates, partners, learners, and supporters within CIT culture.

Purpose of the Study

In an effort to fill gaps in the literature and explore previously posited recommendations, I am proposing the following research questions: *(RQ1) What are the lived experiences of CIT officers in their collaborative endeavors with mental health professionals for training, and (RQ2) What are the lived experiences of CIT officers in their collaborative endeavors with mental health professionals in navigating trauma and vicarious trauma?*

Research Design

One of the richest resources for understanding the essence of any experience is a community of voices of those living said experiences. Phenomenological approaches allow for the exploration and understanding of the phenomena to provide in-depth, authentic portrayals of individuals' lived experiences through their own voices (Creswell & Creswell, 2018). With this in mind, a descriptive phenomenology will be conducted to explore the collaborative endeavors of CIT officers working on interdisciplinary teams with mental health professionals.

In descriptive phenomenological research design, my role as the researcher is the instrument of the study and the utilization of a research team for data analysis is intended to facilitate consensus on rich descriptions of experiences. Data will be collected through semi-

structured interviews with the goal of incorporating 10-12 participants to achieve saturation through thick, rich descriptions of the phenomenon (Hays & Singh, 2023). Participants will be purposively and conveniently sampled through electronic contact methods such as email and social media. I will target relevant groups that may include individuals who have experienced the phenomenon or have community and/or professional connections to those who do, including department CIT leadership contacts, NAMI affiliates, and CIT-based educational and/or professional organizations and conferences. Participants will meet the following inclusion criteria: (1) be over the age of 18 years old; (2) be currently acting as a CIT officer; and (3) have been CIT certified and acting as a CIT officer for at least two years. Participants will only be excluded if they are (a) under the age of 18, (b) have not been CIT certified, (c) have not been acting on a CIT team for at least two years or (d) have not actively participated in a CIT role. Strict confidentiality guidelines will be followed and various reflexivity and trustworthiness strategies will be utilized to ensure credibility, transferability, dependability, and confirmability (Giorgi, 2009; Hays & Wood, 2011; Hays & Singh, 2023).

Limitations

One of the main concerns regarding phenomenological research is the inherent subjective nature, wherein researcher's interpretations play a significant role in analysis and engagement and may affect the reliability of findings, necessitating trustworthiness and reflexivity practices throughout the research timeline (Creswell & Creswell, 2018; Hays & Singh, 2023). By focusing on specific experiences with a limited sample size, findings may not be generalizable to larger populations and, due to ability of access and resources, the sample size may be concentrated within a specific location and require additional and further research to consider broader social, cultural, and environmental influences. Phenomenological research requires

complex data analysis that is time-consuming through conducting in-depth interviews and ensuring that analysis is in-depth to appropriately interpret and discuss the essence of experience. To address this possible limitation, the utilization of a research team is appropriate in not only sharing the time and energy demands, but also in enhancing the opportunities for rich and thick descriptions and culturally informed reflection. Finally, there may be language and/or communication barriers that may interfere with an individual's opportunity to engage in the research process as a participant or on the research team, which limits the scope of voices that may be included. This again points to necessary multicultural considerations and reflexivity practices throughout the research process.

Key Term Definitions

Mental Health Professional: CIT Core Elements (2007) defines mental health professionals as psychologists, psychiatrists, physicians, social workers, counselors, pastoral counselors, alcohol/drug counselors, educators, trainers, and criminologists. As a community-advocacy-based organization and interdisciplinary team, the definition of mental health professional is broad and allows for the collaboration of a multitude of individuals within the mental health field.

Crisis: CIT programs define crises (or persons in crisis) as situations where an individual has become unable to self-regulate thoughts, mood, or behavior and may be experiencing intense feelings of distress or changes in daily functioning. A crisis is individually defined and may occur due to any number of factors including mental health conditions, intellectual or developmental differences, brain injury, medical conditions, medical emergencies, or traumatic events.

Crisis Intervention Team: Crisis Intervention Team (CIT) programs are defined as "a community partnership of law enforcement, mental health and addiction professionals, individuals who live with mental illness and/or addiction disorders, their families, and other partners to improve community responses to mental health crises" (CIT International, 2019, University of Memphis, n.d.). Also known as the "Memphis Model," CIT programs provide specialized law enforcement (LE) curriculum aiming to reduce risks of serious injury or death during mental health crisis response interactions while also focusing on improving a multi-systemic crisis response system by engaging in advocacy and community partnerships (CIT International, 2019; Rogers et al 2019; University of Memphis, n.d.).

Phenomenology: Phenomenology views the role of human experience as an object of study, wherein researchers try to identify meanings and systemic interactions of phenomena, defined as first-person lived experiences, processes, or relationships (Hays & Singh, 2023).

Trauma: Trauma is defined as an emotional response to a critical event such as an accident, natural disaster, violence, etc. wherein shock and denial may be typical immediately after the event, and having long-term reactions such as unpredictable moods, flashbacks, relationship difficulties, and physical symptoms (American Psychological Association, n.d.).

Vicarious Trauma: Vicarious Trauma is a term describing the phenomenon in which emotional, psychological, and physical distress occurs when individuals are exposed to the traumatic experiences of others, particularly through work (American Counseling Association, n.d.). Also referred to as secondary traumatic stress or secondary victimization, vicarious trauma is a significant risk for counselors, first responders, and other caregivers who consistently interact with individuals experiencing or having experienced trauma (Office for Victims of Crime, n.d.). Vicarious trauma can occur through witnessing or supporting individuals through trauma, and

can also occur through exposure to traumatic images or stories second-hand (Office for Victims of Crime, n.d.). Concerns associated with vicarious trauma include shift in worldviews, emotional numbness, increased anxiety, and challenged sense of safety (Office for Victims of Crime, n.d.). If unaddressed, vicarious trauma can impact individuals' well-being and resilience over time - much like experiencing first-hand trauma.

Burnout: Burnout is a state of emotional, physical, and mental exhaustion due to prolonged and cumulative stress resulting from performing at a high level of stress and tension and overburdening workloads. It is characterized by decreased motivation, negative attitudes towards self and others, and lowered performance, and most often observed in service-oriented and helping professions (American Psychological Association, 2018)

Summary

The need to explore the collaborative efforts of CIT officers and mental health professionals has implications for counselors in dynamic roles within the counseling field. Understanding the lived experiences of this group through a phenomenological investigation provides an important and culturally informed foundation for filling a gap to understand collaborative and compassionate paths forward, as bolstered by recommendations and considerations in existing literature.

II. LITERATURE REVIEW

In this chapter, I present an examination and discussion on the literature related to CIT officers who collaborate with mental health professionals to navigate trauma and vicarious trauma. I will explore the implementation and ongoing development of CIT programs, the training they entail, the influence of LEO Culture, and the experience of CITS partnering with mental health professionals to train and support one another through their own trauma and vicarious trauma.

Law Enforcement Trauma and Vicarious Trauma

Helping professions come with higher risks of psychological distress due to experiencing trauma and secondary trauma (Kanno & Giddings, 2017; Mcdonald et al., 2021; Molnar et al., 2017; Otto & Gatens, 2022; SAMHSA, 2018). LEOs are routinely exposed to the worst days of individuals' and families' lives, i.e., exposure to traumatic events and situations increasing likelihood of symptoms of vicarious trauma.The consequences of vicarious trauma expand beyond the job title and requirements and infiltrate their daily lives and wellbeing (McDonald et al., 2021; Smirnova et al., 2022; Wagner et al, 2020). CIT officers have a unique increase in this frequency, as they are specifically and consistently called on for mental health crises and concurrently work in some collaborative manner with mental health professionals for these responses. While evidence-based training for responding and department-based stress management practices are in place, there are important opportunities for learning and growth of compassionate collaboration.

Symptoms

Vicarious trauma is also known as secondary traumatic stress (STS) or compassion fatigue. Vicarious trauma is a form of psychological distress that occurs when an individual is exposed to traumatic experiences of others on an ongoing basis - much like is asked of the daily

schedules of law enforcement professionals. Repeated exposure to this type of trauma and stress can lead to symptoms that are similar to those in individuals who have experienced direct trauma, such as nightmares, hopelessness, emotional numbing, destructive or negative coping mechanisms, flashbacks, and helplessness (American Counseling Association, n.d.; Daniel & Treece, 2022; Vukčević & Živanović, 2022). Researchers suggest that individuals who experience vicarious trauma should engage in practices such as supervision, peer support, self-reflection, and general self-care while also highlighting the importance of organizationally provided resources for employees for support, prevention, and processing (Fleischmann et al., 2018; Hanafi et al., 2008; Horan et al., 2021; Jones et al., 2017, McDonald et al, 2021, SAMHSA, 2018). The unique collaboration of mental health professionals and LEOs on CIT teams provides an internal foundation for processing, support, and training; however, it continues to be important to mention the foundational needs of trust, safety, and collaboration. While mental health professionals may have shared knowledge and education on working from a nonjudgmental, empathetic, and compassionate place, the voices and perspectives of LEOs are essential components to understanding and improving these dynamic relationships.

Consequences

Due to the nature of the job, LEOs are frequently exposed to traumatic events such as violence, disasters, accidents, and individuals in crisis (Jones, 2017; SAMHSA, 2018; Smirnova et al., 2021). There is no dearth of studies investigating the prevalence of Post-Traumatic Stress Disorders (PTSD) in law enforcement. A survey completed by Dr. Michelle Lilly and Sergeant Shawn Curry in 2020 highlighted that while PTSD and depression has been shown to affect LEOs at varying rates (between 7-35%), 47% of a 1,355 active-duty sample screened positive for PTSD which is 9-10 times higher than the general population. Notably, Lilly & Curry (2020)

mention how globally traumatic events, such as the COVID-19 pandemic, impact these statistics, reporting that 55% of the sample reported considering quitting the job on a daily or weekly basis and 38% reporting that their department does not provide adequate mental health services.

An added complexity comes in when the traumatic event(s) are responses to mental health crises, wherein an understanding of trauma and vicarious trauma is critical in responding empathetically and processing experiences in a safe and nonjudgmental environment. Responding to or witnessing a mental health crisis can have profound and lasting impacts due to the intense and often distressing nature of the situation (Kim et al, 2022; Molnar et al, 2017, Vukčević & Živanovi, 2022). In a CIT environment, LEOs and mental health professionals are already working together to train for response to the community and may also be on co-responding teams, so there may be increased opportunities for shared lived experiences to build a foundation of trust in seeking help. While there is limited research exploring the vicarious trauma of LEOs specifically responding to mental health crises, a 2022 scoping review of vicarious trauma interventions for service providers highlights the importance of trauma-informed approaches and education to build a foundation of knowledge and empathy (Kim et al, 2022).

Trauma-Informed

In the mental health field, strong theoretical frameworks inform trauma treatment and conceptualizations. Their application to law enforcement is emerging with the prevalence of CIT and overall mental health concerns and needs of communities. Trauma-informed care is an approach that recognizes symptoms of trauma and acknowledges roles that trauma can play in the lives of others, and how this knowledge can also be utilized for self-reflection; in LEO work, this can aid in avoiding retraumatization, increasing safety, supporting recovery, and building

partnerships for additional trauma-informed services and treatments (SAMHSA, n.d.). While this is a fundamental core building block of CIT implementation and training, the attention to trauma training and understanding may be less extensive than that of a mental health professional who is a part of a CIT environment. There may be opportunities for collaboration on processing how to understand trauma-informed approaches at their core, and how they can be applied to the individual experiencing vicarious trauma.

Unique Experiences of LEOs on CITs with Trauma and Vicarious Trauma

CIT Context

The Crisis Intervention Team (CIT) model, also known as the "Memphis Model" was developed in 1988 after 27-year-old Joseph Dewayne Robinson was fatally shot by officers responding to a 911 call from his mother in which she disclosed his substance use and mental health history. She had stated he was cutting himself and threatening people outside of her home after using cocaine (NAMI, n.d.; University of Memphis, n.d.) During the interaction, it was stated that Joseph Robinson was unresponsive to verbal requests, and eventually lunged towards the officers who then shot him several times. This incident sparked community uproar and emphasized a need for the community to examine procedures in response to crisis and seek alternative, collaborative means of response and consideration (CIT International, n.d.; NAMI, n.d.; University of Memphis, n.d.). In the wake of this incident, the National Alliance on Mental Illness (NAMI) provided the seed grant and partnership for Memphis to build the first CIT program with the ultimate goal of facilitating, training, and promoting a multi-systemic community crisis response foundation that prevents individuals from continually cycling through the criminal justice system (CIT International, 2019.; NAMI, nd.). Because CITs protect and serve citizens in the community, it is important to understand the support that teams and their

members need to perform at their best and healthiest in the face of regular and recurring vicarious trauma.

CIT Training & Skills

Core Competencies. The intent behind the creation of CIT programs is to promote safety, connection, and hope through building collaborative and educated relationships between LE agencies, mental health professionals, advocates, and community resources and organizations (CIT International, 2019; University of Memphis, n.d). The infrastructure required to develop and sustain CIT programs is substantial, and training is extensive. CIT training programs follow three core elements which were developed in 2007 primarily by the University of Memphis and the Memphis Police Department with contributions spanning the nation to include stakeholders from various state and local NAMI affiliates, crisis organizations, community services boards, and universities. They developed operational definitions for all stakeholders, including the two at the heart of this study:

> The CIT Officer maintains their role as a patrol officer and gains new duties and skills through voluntary CIT Training, serving as the designated responder and lead officer in mental health crisis events
>
> Mental Health Coordinators are part of the mental health community who provides leadership and serves as a liaison with the advocacy and law enforcement communities. This position may be established or developed informally. When it is left as an informal liaison there may be several individuals who serve this function. It is important that each of them work with the overall community effort. This position has a significant operational component involving the training, curriculum, and the function of the receiving facility or receiving facilities. (p. 12-13)

The CIT program model as outlined by CIT International (2019) breaks down its core elements in to three categories with 10 total subcategories:

1. Ongoing Elements
    a. Partnerships: Law Enforcement, Advocacy, Mental Health
    b. Community Ownership: Planning, Implementation & Networking
    c. Policies and Procedures
2. Operational Elements
    a. CIT: Officer, Dispatcher, Coordinator
    b. Curriculum: CIT Training
    c. Mental Health Receiving Facility: Emergency Services
3. Sustaining Elements
    a. Evaluation and Research
    b. In-Service Training
    c. Recognition and Honors
    d. Outreach: Developing CIT in Other Communities

In order to become CIT certified, individuals engage in a 40-hour training program that emphasizes inclusive collaboration, training, and coordinated responses. This training covers mental-health related topics, crisis resolution skills such as de-escalation, and informational sessions regarding local relevant resources. These trainings typically include lectures/conversational presentations from stakeholder partners and training coordinators, site visits, and scenario-based role-plays. With the complexities of the material presented and the inability to truly experience a real-world response scenario until after the training, it is suggested that this initial 40-hour training is the minimum requirement, and ongoing education and

processing opportunities would be crucial to enhancing this response system and ensuring the welfare of officers and practitioners. Further, training-only approaches have faced criticism because of misrepresentations or inadequate applications of the CIT model, which heavily focuses on the importance of collaborative efforts and partnerships. It is emphasized that CIT training is not just understood and basically applied, but holistically understood and continually engaged in to reduce stigma, minimize further involvement in criminal justice systems, providing forums for effective problem solving, and creating context for sustainable and culturally responsive change (CIT International, 2019; NAMI, nd.).

Voluntary versus Mandatory Training. While this 2007 guiding document developed in Memphis provides an ideal outline for an ongoing, systemic response and advocacy community, it is up to each law enforcement department to implement its own training and to decide whether or not officers are voluntarily certified or if it is a mandate. In 2011, it was found that CIT officers who were self-selected for training were more likely to have had prior exposure to mental health concerns and working with mental health professionals and there was little difference between voluntary participants and mandated participants when it came to empathy and psychological mindedness (Compton et al., 2011). In a more recent study, however, this understanding was expanded. Compton et al. (2017) compared previous studies to explore whether or not volunteering for CIT trainings rather than mandatory assignment had a beneficial correlation to knowledge, attitudes, skills, and uses of force. Of 251 CIT officers from the study, 1, 68% were volunteers and of 91 CIT officers in study 2, 70% were volunteers. This research found that CIT officers who volunteered typically had higher levels of education, often some exposure to the mental health field, and consistently had better scores on a range of measures including attitudes towards self-efficacy for responding to individuals with mental illness,

stigma, and de-escalation. As indicated by Compton et al. in each study and by gaps in the literature, further research is still needed to understand CIT officers who have engaged in mandatory training and if their views, biases, and stigma regarding collaboration with mental health professionals differ from those who engage voluntarily. Understanding these perspectives is critical in forming a holistic understanding of the culture of individual teams, as there may be additional compounding factors and needs for support and training for those who do not feel they have had a choice.

Effectiveness and Outcomes. Researchers have shown that CIT programs are associated with improved attitudes and knowledge about mental illness, reduction of officer injuries, community cost-savings, and reduced use of force (Compton et al., 2022; Rogers et al, 2019; University of Cincinnati Center for Police Research and Policy, 2021; Watson et al, 2021). CIT officers are trained to have a foundational understanding of trauma and mental health conditions, including how behavior, emotions, and actions may be influenced, thereby helping them to have a more informed and possibly compassionate understanding and identification of these presenting factors in individuals they may be responding to (Rogers et al, 2019; University of Cincinnati Center for Police Research and Policy, 2021). The reduced force and use of weapons can be attributed to officers' ability to de-escalate situations, as CIT programs increase familiarity with de-escalation interventions and techniques and additional support for de-escalating crisis events, therefore leading to less uses of physical or lethal force and increasing safety (University of Cincinnati Center for Police Research and Policy, 2021). Additionally, CIT programs afford LEOs an awareness and understanding of community resources and building community partnerships. With this knowledge, CITs may help the population with diversion from the criminal justice system by identifying and referring to appropriate community mental

health treatment and support services for preventative and treatment interventions. With the additional time, information, compassion, and considerations that responding as a CIT officer may take, it is critical that mental health professionals are able to collaborate on a cultural understanding of these experiences to promote wellness through specifically informed processing resources.

Critical Incident Stress Management

Critical incident stress management (CISM) is an existing collaborative intervention that law enforcement uses to address immediate and long-term psychological impacts of critical and traumatic incidents (IACP, 2011; Russo & Courtney, 2017; University of Memphis, n.d.). While each department creates their own CISM teams and procedures, typically a mental health counselor or peer support specialist is called in to utilize debriefing techniques, group interventions, and individual counseling interventions to help LEOs process reactions and emotions after critical and traumatic incidents. In a CIT environment, mental health professionals are already included as a part of the team - whether it be in training, co-responding, referring, or a combination of several important roles. An existing collaborative environment founded on trauma-informed considerations creates an important opportunity for mental health professionals to utilize existing familiarity and trust to engage in conversations that inform further training and support needs of the teams and communities they work within. The IACP outlined concepts and issues for CISM in 2011 and specifically stated the need for departmental support and immediate debriefing and processing among peers. This presents with opportunities to address and utilize intersectionality; while some mental health professionals may not be able to identify as LEO peers, there can be instances where the mental health professional has been a part of the team in

some manner, thereby working to reduce stigma and break barriers to form a cultural understanding and ways to best provide further support and training as needed.

Protection Motivation

The instinct to survive is one that connects us across systemic and cultural borders, and both LE and MH professionals are faced with life-and-death considerations at a higher prevalence than the general public. Protection Motivation Theory (PMT) was introduced by Ronald Rogers in 1975 to better conceptualize and understand how individuals respond to fear based on two cognitive processes: threat appraisal and coping appraisal (Rogers, 1975). These processes form an explanation on how individuals are motivated to react when in the face of a threat based on the understanding that individuals protect themselves based on four factors: perceived severity of the threat, perceived probability of the occurrence, efficacy of recommended preventive measures, and self-efficacy to engage in preventive measures (add ci.) Allen and Campbell (2018) posit that the impact of fear can be reduced through healthy interventions aligning with the PMT framework. This framework provides strategies to strengthen systemic behaviors regarding mental health and addresses stigma by reframing from a bias or fear of individuals experiencing mental health crises to an approach that is founded in care and educated "soft diagnoses" in CIT encounters (p.99). This application is a culturally relevant approach especially within law enforcement, where law, life, and safety are not superseded by a diagnosis or presenting issue.

CIT and Mental Health

Considerations and research around collaboration between mental health professionals/organizations and LEOs typically is focused on providing crisis responses to the community or building peer-support programs for departments to implement. (Alden et al 2021;

Allen & Campbell, 2018; McDonald et al 2020; NAMI, n.d.). Most research regarding CIT focuses on the planning, application, and functioning of the response itself with the evaluative pieces, again, mainly focusing on outcome measures (CIT International, 2019; Compton et al, 2011; Compton et al, 2017; Compton et al, 2022; Rogers et al., 2019). While it is certainly important to review and understand the CIT implementation and efficacy in communities, it is critical to understand how these teams function, and normalize addressing needs for further education and support.

Barriers

Access to mental health resources is a global issue in and of itself, and this is certainly seen in LEO populations. Depending on the department, LEOs may have a wide range of supportive services and opportunities, or be left somewhat in the dark. It is worth noting that many resources for LEOs end up being peer-support or peer-led. While this is certainly a strength as it embraces the camaraderie and shared experiences of this unique population, it also poses several challenges, one being that it may lend to stigma in that officers may not feel comfortable discussing mental health concerns openly and authentically for fear of judgment (Daniel et al, 2022; Fleischmann et al, 2018; Mcdonald et al, 2021; Wagner et al, 2020). Another challenge is the perpetuation of an issue wherein first responders, especially LEOs, are asked to be a “catch-all” for individuals experiencing crises; even their own. This continues to highlight the importance of understanding collaborative relationships between LEOs and mental health professionals. In a CIT environment, mental health professionals have the unique opportunity to work within the LEO context and environment to form an experiential understanding of the culture and ways in which collaborative efforts may help improve the wellness of officers.

Culture

LEOs are not only responsible for navigating and responding to critical and traumatic events threatening the lives and safety of their communities, but they are also then often responsible for the emotional and physical wellbeing of themselves and their peers (Alden et al 2021; Horan et al, 2021; Lorey & Fegert, 2021; McDonald et al 2020, SAMHSA 2018; University of Memphis). While there is still minimal research exploring the mental health needs, concerns, and challenges specifically experienced by CIT officers, there is a large amount of research spanning the helping professions that outlines significant cultural considerations for LEO mental wellbeing.

Depression, stress & posttraumatic stress disorder/symptoms, substance use, and suicide/suicide ideation are the most prevalent concerns and occurrences in officer wellness (Daniel & Treece, 2022; Lanza & Rodgers, 2018; SAMHSA, 2018). SAMHSA's 2018 First Responder Behavioral Health Concerns and Trauma bulletin highlights that less than half of studied officers experiencing a traumatic event spoke about it within their departments and about half studied of officers reported personally knowing an officer that had died by suicide. Poor sleep, negative coping mechanisms, burnout, and aggression are common symptoms and agitators of the stress cycle potentially leading to trauma/stress disorders, chronic stress, PTSD, substance use, and suicide (McDonald et al, 202; Otto & Gatens 2022; SAMHSA 2018).

Research in to the unique and close-knit collaborative nature of LEO culture mostly identifies protective factors for LEO communities as access to social support and the "brotherhood" culture - however, these protective factors can also be sources of stress and risk due to perceived incongruences or lack of psychological safety (Horan et al., 2021; SAMHSA, 2018; Smirnova et al., 2021). More research is needed to identify and describe the systemic influences and considerations regarding protective factors in LEO culture, specifically protective

factors that are outside of peer support - perpetuating the notion that they are the only ones who can help others and themselves.

Systemic factors increase stressors beyond the consideration that LEOs are already responding to difficult, often high-stress situations. Otto & Gatens (2022) speak on an important consideration: while LEOs can expect and prepare for stressful situations as part of the nature of the job, there may be a lack of preparation or understanding of systemic issues within their own organization, which may lead to feelings of betrayal and loss of trust in the department. This trust is critical in ensuring safety and effectiveness, and particularly in situations where there is a response to an individual struggling with a mental health crisis. Additionally, there may be some important opportunities for clinicians to build effective trust and rapport with LEOs on CIT teams to not only provide effective and safe responses in the field, but to aid in comfort with processing and collaboration on incidents, responses, and personal struggles. However, one of the most mentioned barriers to mental wellness in LEOs is the consideration of stigma.

Stigma

An overarching stigma that is prevalent in LEO culture is that seeking help for mental health struggles is directly associated with weakness or an indicator that an individual may not be fit for duty. (Alden et al 2021; Compton et al, 2022; Kim et al, 2022; Lorey & Fegert, 2021; McDonald et al 2021; NAMI, n.d.; SAMHSA 2018;) Additionally, LEOs may have assumptions about what the conversation about mental health struggles may look like, with the biggest fear being professional consequences. There may be a fear that an officer may lose out on opportunities, be reassigned to desk duty, or, ultimately, lose their jobs, credentials, and LEO identity. This same stigma may also extend into peer relationships. While LEO culture typically has a strong sense of community and camaraderie, there is also the continued perception that

weakness may exclude LEOs from peer groups and invite judgment and shame. Further, an environmental barrier or stigma may be found in the access to confidential support. Even though departments are increasingly acting to provide sustainable and appropriate mental health resources and opportunities for LEOs, there may be a hesitancy to engage in departmentally-connected resources due to confidentiality and privacy concerns.

Researchers advocate for prevention and education measures to reduce stigma, promote awareness of mental health conditions and supportive resources, provide supportive resources, and overall normalizing conversations around seeking help and addressing mental health struggles; appropriately, these suggestions are all topics deemed as core considerations in CIT training (CIT international, 2019; Daniel & Treece, 2022; Fleischmann et al, 2018; Kim et al, 2022; Lanza & Rodgers, 2018).. By working on a CIT team, mental health professionals are positioned to learn not only about the specific system they are a part of, but also understand larger systemic influences and needs from a counseling lens bolstered by law enforcement support; providing a platform to develop, provide, and advocate for crucial resources and educational opportunities for LEOs and CIT teams. This may also inform efforts to increase educational opportunities and understandings between interdisciplinary roles and work to build trust while eliminating stigmas and biases.

Interdisciplinary Collaboration

Researchers increasingly suggest the importance of mental health trainings for LEOs, with suggestions including crisis intervention, de-escalation techniques, recognizing signs of mental health conditions and crises, and addressing stigma (CIT international, 2019; Daniel & Treece, 2022; Fleischmann et al, 2018; Kim et al, 2022). A report released by the Obama Task Force on 21st Century Policing in 2015 recommends a perspective shift in police training from a

warrior mindset to a guardian mindset, which focuses on community service, social justice, democracy, civil rights, and procedural justice. Helfgott et al. (2020) highlight how the guardian ethics and values contrast with the traditionally followed paramilitary style of police training and conceptualization, noting that guardian training "promotes interactions between police and the community by dignity and respect" through emphasizing communication skills and de-escalation tactics while still considering public and officer safety as the foundational building blocks (p. 403). While the 40 hour CIT standard training addresses many of the above mentioned areas of learning, there currently are no requirements for continued education or training, mostly leaving this up to departmental leadership to develop and implement as they see fit. With mental health clinicians involved in the team already, organizations can work together to identify and develop ongoing educational opportunities to bolster responses and wellness.

It is important to again note cultural considerations within this interdisciplinary team: LEOs and mental health practitioners are both considered under the "helping professions" umbrella, which typically includes motivations and core values of pride and protection throughout each profession. An important consideration of comparison between the two professions is the notion of compassion fatigue. It is no secret that burnout from any profession can create mental and physical difficulties, however, there is also an added stigma where in the LE realm, there may be a perception that it is "not okay" to disclose that this is the underlying cause of any stress or job difficulty; as it may indicate weakness, an inability to perform the job, and even raise gatekeeping concerns (Molnar et al, 2017; Otto & Gatens, 2022; Smirnova et al, 2022). Additionally, both of these helping professions have implications of procedures that may follow when disclosing struggles with mental health or processing the job - licenses can be suspended, officers can be given administrative duty or asked to not come in, and ultimately,

jobs and opportunities can be lost which can then turn in to a systemic cycle of barriers and silence.

While it is ultimately important to build a collaborative interdisciplinary team to provide effective and appropriate responses and services to the community, it is also important that these teams are communities in and of themselves that are healthy personally and interpersonally. An important foundational understanding of these roles and the ways they can work together collaboratively is crucial in building a healthy and effective team. Learning what considerations, biases, and understandings already exist from the voices of CIT officers are critical in moving forward in informed ways to bridge gaps of communication and collaboration, and can bolster the trust necessary to be able to process and address traumatic and complex experiences.

Rationale & Research Questions

With LEOs not having the choice of turning down the call to duty on their shift, knowing that includes responding to mental health crises puts counselors, counselor educators, and counseling supervisors in a unique and critical position to understand how to best support and collaborate with these responders, regardless of the level of interaction that may be had. We are taught to call 911 or 988 emergency response numbers when we need assistance or higher levels of care for our clients, so it is imperative that we are able to advocate for and with those who do not have another 911 to call for assistance. We may not be able to provide emergency response to the same levels, but we are able to provide education, advocacy, collaboration, and evidence-based/educated support to the individuals who are called to keep our communities and themselves safe at the same time.

Recommendations from existing research most frequently include: further training and support/continuing education, access to wellness resources, addressing stigma, supportive

programs and training, debriefing and peer support, organizational culture, and regular evaluation and feedback. In an effort to fill gaps in the literature and explore previous research recommendations, I aim to explore the following research questions: *(RQ1) What are the lived experiences of CIT officers in their collaborative endeavors with mental health professionals for training, and (RQ2) What are the lived experiences of CIT officers in their collaborative endeavors with mental health professionals in navigating trauma and vicarious trauma?*

As a result of this study, I aim to broaden the understanding of the experiences of CIT officers working on interdisciplinary collaborative teams with mental health professionals and engaging in training and processing. By utilizing a descriptive phenomenological approach, CIT officers will be able to inform this gap through their own voices and expressions of lived experiences to provide further cultural understandings and contexts for counseling professionals in a multitude of roles.

III. METHODOLOGY

Phenomenological research aims to describe the essence and connection of participants' lived experiences through in-depth subjective exploration both individually and collectively (Creswell & Creswell, 2018; Goodman-Scott & Cholewa, 2020; Hays & Wood, 2011). This methodology was chosen to examine the lived experiences of crisis intervention team (CIT) officers collaborating with mental health professionals on training and navigating trauma and vicarious trauma. I utilized a descriptive phenomenological approach to explore core lived experiences of this particular phenomenon to begin building a collective understanding and perspective outside of my own existing biases and assumptions (Creswell & Creswell, 2018; Hays & Singh, 2023; Moustakas, 1994; Van Manen, 2014). In this chapter, I will review the following for this study: (a) the research questions, (b) methodology rationale, (c) researcher reflexivity and positionality, (d) sampling procedures, (e) research plan and design, and (f) trustworthiness strategies.

Purpose and Research Design

The purpose of this dissertation study is to begin forming an understanding of the essence of experiences of CIT officers and who work collaboratively with mental health professionals as an interdisciplinary team. The following research questions guided this study: *(RQ1) What are the lived experiences of CIT officers in their collaborative endeavors with mental health professionals for training, and (RQ2) What are the lived experiences of CIT officers in their collaborative endeavors with mental health professionals in navigating trauma and vicarious trauma?*

Methodology Rationale

While research exists that examines and posits suggestions for CIT officers and mental health professionals collaborating to provide a response or build a community program, there is a significant gap in the literature identifying lived experiences of CIT officers and mental health professionals collaborating for training and navigation of trauma and vicarious trauma, especially through the incorporation of the voices of those living through these experiences. Therefore, I utilized the descriptive phenomenological approach to provide the best platform for the creative integration of lived experiences with the goal of presenting collaboratively and holistically informed research representative of more voices than just my own (Creswell & Creswell, 2018; Hays & Singh, 2023; Moustakas, 1994; Van Manen, 2014).

Descriptive phenomenological research aims to explore the intricate and dynamic nature of lived experiences by allowing the researcher to immerse themselves in rich and complex details of individually lived experiences to form an in-depth and contextual understanding of the phenomenon (Hays & Singh, 2023; Moustakas, 1994). I embodied a holistic approach by considering underlying emotions, thoughts, perception, and contexts that shape lived experiences while gathering rich, contextually-informed data through in-depth semi-structured interviews that encouraged authenticity and honesty in descriptions. By focusing on subjective experiences, this qualitative method prioritizes the voices of the participants as contributors to a deeper understanding of a larger phenomenon with added empathy and compassion from researchers and readers (Goodman-Scott & Cholewa, 2020; Hays & Singh, 2023; Hays & Wood, 2011). Finally, this approach adds value in application as suggestions, considerations, views, and descriptions are subjectively informing areas of needed education, advocacy, continued research, and real-world practice.

Reflexivity and Positionality

To responsibly and credibly engage in this research, researchers are asked to remain mindful of the need to appropriately bracket experiences and perspectives and continuously reflect on how identities may be impacting the research work being done. (Goodman-Scott & Cholewa, 2020; Hays & Singh, 2023; Hays & Wood, 2011; Van Manen, 2014). As a researcher, it is important to acknowledge my identities and inform how they may be impacting and influencing my research agenda. I am a white, middle class, cisgender, heterosexual, able-bodied, monolingual, employed female with advanced college education. I recognize that most of my identities reflect power and privilege, allowing me to navigate many societal systems with general ease. I am a current clinical mental health professional working collaboratively with law enforcement which has certainly influenced my interest and passion in pursuing this research topic. Given that I work in a position of power with the population I will be researching, I continuously engaged in bracketing and reflection to ensure that the essence of the experiences being studied were articulated by the voices of those living them.

Researcher Paradigm & Philosophical Assumptions

The role of the researcher in descriptive phenomenological research is multifaceted and it is critically important to understand and manage preconceptions, biases, values, and processes to ensure open and authentic reflexivity and recognitions of how I may be influencing the research process and outcome (Hays & Singh, 2023). I align and identify with Hays and Singh's (2023) researcher-practitioner-advocate (RPA) model through a social constructivist paradigm. The RPA model, rooted in American Educational Research Association's ethical principles, addresses the interplay of research, practice, and advocate identities and encourages the researcher to be mindful of which role(s) may feel more comfortable and, as such, may be

utilized more heavily - prompting reflection and refocusing to find balance through authentic and genuine embodiment of facets of each role while remaining present (Hays & Singh, 2023).

Ontologically, I believe that individuals form their own reality; meaning there is not one primary truth, rather, multiple valid individual truths as informed by dynamic cultural and societal experiences and systems. I believe that knowledge is open-ended and dynamic, evolving as dynamically as individuals and societies. Epistemologically, I believe that subjective participant views matter as individuals perceive and interpret reality through unique perspectives. Individuals actively engage with and co-construct understandings of the world through social interactions and cultural practices. Axiologically, I am aware of my own perspectives, values, biases, and assumptions and understand how these have influenced my path towards this current research. I also acknowledge that my own experiences, interpretations, and context may influence co-construction of knowledge, highlighting the importance of reflexivity and bracketing practices throughout the research process which are discussed further in the trustworthiness section. The rhetoric for this research exemplifies the collaborative nature of knowledge co-construction, including personal language and participant voices through direct quotes. Methodologically, I engage in qualitative inductive research processes that begin with and are shaped by participant views and experiences which align with a descriptive phenomenological research design.

As phenomenological research requires deep, nuanced interpretation to appropriately illustrate subjective human experiences, I utilized MAXQDA, hand-coding, and an external auditor to engage in feasible and rich data analysis. External auditors can provide diverse and unbiased insights which enhance the depth of analysis through a constructive and collaborative environment wherein multiple perspectives are being considered, discussed, and interpreted

through a multifaceted lens (Goodman-Scott & Cholewa, 2020; Hays & Wood, 2023). Conversations with external auditors began with reflecting on research dynamics with attention to equity, advocacy, and cultural contexts. The external auditor for this research study is self-identified as having interest in the study, and had the ability to meet via zoom for reflective discussions and processes (Hays & Wood, 2023). I utilized Old Dominion University's email system to contact members of doctoral cohorts for possible collaboration from 2-4 potential research team members, and after engaging in discussions about the research process, it was determined that an external auditor would be a more appropriate role based on time limits and the confidentiality process of the initial interviews. Myself and the external auditor engaged in an initial meeting to identify roles and responsibilities, had the opportunity to ask questions, provide any initial insight, and collaboratively determined and agreed upon the purpose and working style of this collaborative effort. The external auditor engaged in the same reflexivity and trustworthiness strategies that I upheld throughout the research process, and added any additional processes that were aligned with their values of research integrity.

Sampling Procedures

Participants and Recruitment

Prior to conducting interviews, I obtained exempt approval from Old Dominion University's Human Subjects Review Committee. Once approval was documented, I contacted potential participants through email, specifically identifying groups that may have individuals fitting participant criteria or have community or professional connections to reach interested potential participants. Participants were chosen purposefully and conveniently, ensuring that they met inclusion criteria, have experienced the phenomenon, and could willingly and adequately engage in exploratory conversations about the essence of lived experiences (Goodman-Scott &

Cholewa, 2020; Hays & Singh, 2023). Participants met the following inclusion criteria: (1) be over the age of 18 years old; (2) be currently acting as a CIT officer ; (3) have been CIT certified and acting as a CIT officer for at least two years. Participants were only excluded if they were (a) under the age of 18, (b) have not been CIT certified, (c) have not been acting on a CIT team for at least two years or (d) have not actively participated in a CIT role.

Confidentiality and Safety

Ensuring participant confidentiality and safety is especially important in phenomenological research as participants may be sharing deeply personal and sensitive information, requiring a trusting environment that can safely facilitate open and honest disclosure (Creswell & Creswell, 2018; Hays & Singh, 2023; Hays & Wood, 2014). Participants were given an informed consent document electronically (appendix A) including any limits to confidentiality and the purpose of the study during the recruitment process prior to participating in interviews or collecting any demographic information. These rights and limitations were reiterated during interviews prior to beginning recordings with the opportunity for clarifying conversations as outlined in the interview protocol (appendix B). Informed consent was provided via email and any additional accessibility needs were addressed and met as needed.

Participants created pseudonyms prior to answering the informed consent and demographic questionnaire and all identifying information was removed from transcripts before analysis and review by other committee members. To further protect confidentiality and privacy, the pseudonyms chosen by each participant were shortened to an identifier that incorporated two letters (the first two syllables or two words of the chosen pseudonym) and one number (the order in which the interview took place). This information was kept separate from the raw data to minimize risks of unintentional disclosure. Interviews were conducted remotely via secure

HIPAA compliant Zoom interviews and all recordings will be destroyed immediately upon submission of this dissertation. Member checking was conducted throughout interviews by asking open-ended clarifying questions and providing brief paraphrases or summaries of statements. Transcriptions were created automatically through Zoom and then reviewed for clarity afterwards so that I as the researcher could meaningfully and intentionally engage and maintain presence in the interview process. Participants were also given copies of the transcription from their interview and asked to review it for additional clarity and interview integrity, especially if any edits had been made due to errors from automated transcription. All data was stored within a password protected university-sponsored Google Drive account, and all data files will be destroyed after five years.

Research Plan

Data Collection

I conducted 10 individual interviews for data collection to form a saturated foundation of thick, rich descriptions for understanding the lived experiences of CIT officers collaborating with mental health professionals as an interdisciplinary team (Creswell & Creswell, 2018; Giorgi, 2009; Hays & Singh, 2023). The interview protocol for this study is appendix B. To create an opportunity for the most salient expressions of experience, these interviews were semi-structured with adequate time to build rapport and employ the use of open-ended questions to gain non-influenced perspectives (Creswell & Creswell, 2018). Participants engaged in 60-90 minute interviews through a university-sponsored HIPAA compliant Zoom web conference platform with a password-protected, individually unique invitation link. Prior to recording, I spent time building rapport and providing an open opportunity for participants to ask questions and gain comfort in the interview process and research purpose. For triangulation purposes, I encouraged

participants to engage in brief reflective journaling and memo-writing about the process to include my responses during the interviews. Participants were given flexibility in scheduling and transparency regarding the interview process to collaboratively and congruently choose a time that was convenient, unrestricted, and allowed for the participant to find a safe and confidential space to engage in the process for a minimum of 60 minutes.

Data Management

Recordings and transcripts were automatically created and saved to a dedicated space on my password-protected computer upon ending the interview and closing the application. These files were then immediately uploaded and stored in my password protected university-sponsored Google Drive account and deleted from my computer storage. Recordings will be deleted upon submission of this dissertation, and all data will be destroyed after 5 years.

Participant Demographics

Demographic information was collected through a Google form which was created within and directly linked only to my password protected university-sponsored google drive folder for this study. Participants created pseudonyms prior to completing the demographic survey, and all identifying information including emails, jurisdiction, and name were separated from the demographic data prior to analysis and review to maintain anonymity and confidentiality. Participants were not excluded from this study on the basis of socioeconomic status, sexual preference, race, gender, religious affiliation, or any demographic variable other than age.

Data Analysis

While data collection and analysis are presented as separate processes, Hays & Singh (2023) highlight the importance of considering qualitative data analysis procedures as "something that continually influences research design from the very beginning of the study" and

encourage researchers to engage in this cyclical process intended to prompt thick, rich descriptions of participant experiences (p.341). Throughout the entire data collection and analysis process, I remained mindful of the descriptive phenomenological essence and aimed to gather "concrete and detailed descriptions of experiences by those who undergo [them]" by honoring the importance of participants using their own voices for their own contextually relevant descriptions, and asking clarifying questions in an open environment that do not impose biases or limitations, rather, to inform a collectively created perspective (Giorgi, 2009, p. 122).

Georgi (2009) posits a three-step holistic process for engaging in descriptive phenomenological data analysis. First, I read for the sense of the whole through a lens of scientific phenomenological reduction to gain a foundational understanding of the description as a whole. Second, units of meaning were identified and established through rereading descriptions and making appropriate indications in the data whenever shifts in meaning are experienced spontaneously. Third, I engaged in transforming participant's natural attitude expressions into phenomenologically psychologically sensitive expressions by holistically and mindfully integrating contextually-based descriptions, including awareness of possibilities of expression that may not align with my own biases, purposes, or values.

As a part of the third critical step, I engaged in descriptive coding to identify common themes to begin comparing across data sources and interpretive coding to reanalyze these initial themes into deeper and richer codes while being mindful of the presence of researcher subjectivity (Hays & Singh, 2023). Through a social constructivist lens, I identified thickly described codes through hand-coding and informational outputs from MAXQDA software before attempting to collapse or shorten them and then condense themes across descriptions. I engaged in memo development to reflect on impressions and prompt constant comparisons throughout the

analysis and coding processes. I bolstered consensus and reflexivity of coding with an external auditor to arrive at shared operational definitions of codes and themes (Hays & Singh, 2023).

Trustworthiness

As a qualitative researcher, I recognize my role and privilege as the instrument exploring this phenomenon. As the individual who chose the topic, collected the data, and was responsible for writing results, I am aware that the entire process can reflect and be influenced by my own thoughts, feelings, experiences, biases, values, and worldviews which may influence interactions with and interpretations of data (Goodman Scott & Cholewa, 2020). To maximize opportunities for participant voices to be heard throughout this research, I employed specific reflexivity and trustworthiness practices throughout the entirety of the process (Giorgi, 2009; Hays & Wood, 2011; Hays & Singh, 2023). To enhance credibility and dependability, I engaged in continuous self-reflection to acknowledge my own biases, beliefs, and experiences throughout the research process by keeping a reflexivity journal throughout the entire process and memoing throughout the coding process. I also utilized triangulation through data sources and investigators. For transferability, I provided rich and thick descriptions that offer comprehensive, detailed, deep understandings of the phenomenon of lived experiences. Member checking was conducted by providing participants with their individual interview transcriptions and sharing overall interpretations to verify accurate representation of lived experiences to help refine and validate interpretations (Creswell & Creswell, 2018; Hays & Singh, 2023). Finally, I maintained an audit trail and peer review practices for objective assessments and verifications of the research process.

Summary

A descriptive phenomenological approach is beneficial for exploring this research question due to its focus on understanding human experience from the perspectives of those encountering and living through highly stressful and emotionally charged calls to service. By exploring and describing these experiences through the voices of those at the heart of them, this approach provides valuable and collaborative insights and allows for the meaningful capturing and expression of diverse, complex, and unique experiences. As outlined above, this process was carried out with attention and respect to evidence-based practices and extensive reflexivity and trustworthiness strategies, to protect the integrity of the research and the confidentiality and safety of all participants. With an emphasis on the depth and richness of human experiences, a descriptive phenomenological approach offered a powerfully insightful contribution to the literature.

IV. RESULTS

In this chapter, I will report the results exploring lived experiences of CIT officers collaborating with Mental Health Professionals through a descriptive phenomenological lens. The following research questions were utilized to guide this exploration: (RQ1) What are the lived experiences of CIT officers in their collaborative endeavors with mental health professionals for training, and (RQ2) What are the lived experiences of CIT officers in their collaborative endeavors with mental health professionals in navigating trauma and vicarious trauma?

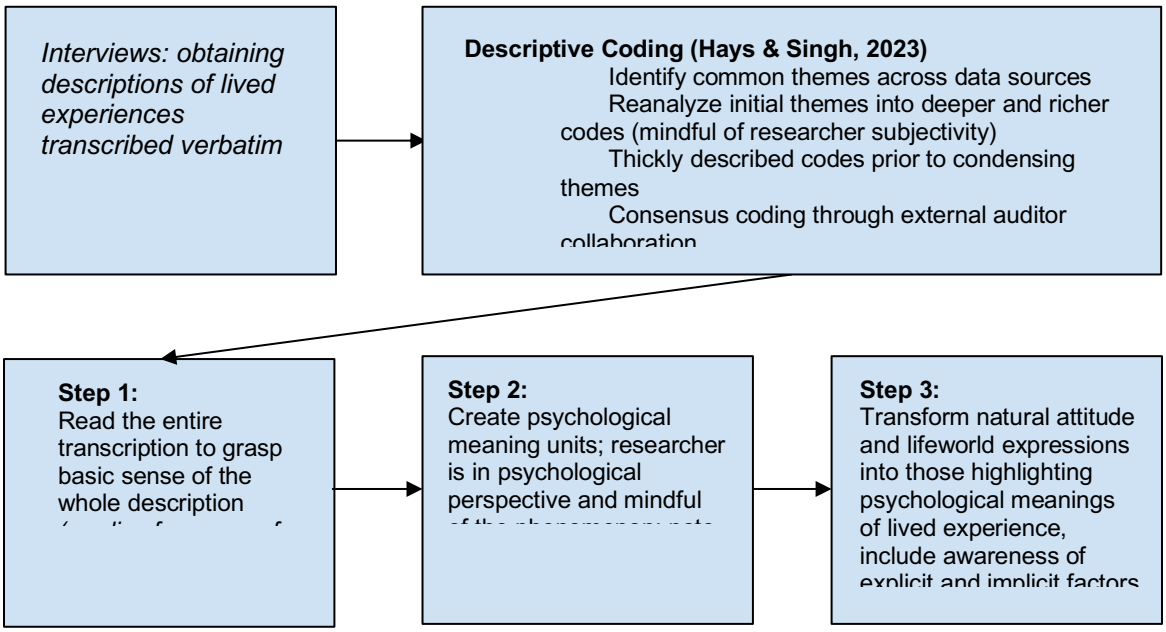
Data Collection and Analysis Review

Over the course of 2 months, I conducted semi-structured interviews with CIT officers from Virginia who met the inclusion criteria outlined in this study. Emails were sent to each participant that met criteria to sign up for an interview hosted on and recorded by the Zoom platform, and to independently review informed consent and study information through a secure google document. Each interview ($N = 10$) lasted approximately 60 minutes. An interview question protocol was followed; however, the semi-structured nature of these interviews allowed for person-centered conversational approaches guided loosely by question prompts and allowing participants to guide the exploration in directions that they felt were most meaningful. This also allowed for additional reflexivity and integrity of the nature of this study's purpose. After each interview, participants were emailed a debriefing statement and message of gratitude, with the opportunity to review their transcript or add any additional or lingering thoughts. No participants provided any additional statements, and the interviews were transcribed and coded after each interview.

Being mindful of Georgi's approach to descriptive phenomenological research (2009, 2017), and Hays and Singh's guidance for descriptive coding (2023), I engaged in reading for a

sense of the whole, identifying units of meaning, and transforming participant's natural expressions into phenomenologically sensitive descriptions. To appropriately organize and bracket the experience of applying this method, I followed a flow process as outlined in figure 1 below:

Figure 1
Analysis and Coding Process



To fully engage in this process, each interview transcript was read and re-read after each interview, and uploaded into MAXQDA CAQDAS coding software as a supplemental unbiased support. Each transcript was hand-coded and compared with MAXQDA results, and extensive notes, journaling, and memos were created throughout this process to identify and integrate researcher exploration and transparency. This process was completed after each individual interview, and then each transcript was re-read by researcher and external auditor after all the interviews were complete to ensure immersion into the data, rich descriptions, and identifying patterns and themes.

Participant Demographics

Each participant was required to be over the age of 18, currently acting as a CIT officer, and have been CIT certified and active for at least two years. Participants created a pseudonym prior to interviews and data collection, and to further ensure anonymity and confidentiality, each pseudonym was then turned into a three-character identifier based on the chosen pseudonym and the order in which they responded to the call for participation. To achieve saturation through thick rich descriptions, ten participants engaged in this research study (Creswell & Creswell, 2018; Giorgi, 2009; Hays & Singh, 2023). The demographic data of the participants in this study are outlined in Table 1 below:

Table 1
Participant Demographics

Identifier	**Years in Law Enforcement**	**Years in CIT**	**Gender Identity**	**Racial/Ethnic Identity**
DF1	6-10	5+	Male	White/Caucasian
ZM2	25+	5+	Male	White/Caucasian
MP3	16-20	5+	Male	African American
BP4	16-20	5+	Male	White/Caucasian
FN5	16-20	5+	Female	African American
MM6	6-10	5+	Male	White/Caucasian
EC7	11-15	5+	Female	Hispanic/Latinx
TO8	25+	5+	Male	White/Caucasian
AB9	16-20	5+	Male	White/Caucasian
SR10	11-15	5+	Male	White/Caucasian

Themes and Subthemes

After following the process outlined above, six themes, each with three or four corresponding subthemes, were identified as outlined in table 2 below. Further Themes one, two, and three pertain to RQ1, and Themes four, five, and six pertain to RQ2:

Table 2
Themes and Subthemes

Theme	Subthemes
1. Sense of Self and Others	1.1 Knowing Professional Roles 1.2 Pride 1.3 Personality
2. Purpose of Training	2.1 Voluntary versus Mandatory 2.2 Co-creation of Continued Learning 2.3 Calls to Advocacy 2.4 Perspective Shifts
3. Continuing Education	3.1 Belief and Commitment 3.2 Making Connections Through Training 3.3 Confidence
4. Safety and Protection	4.1 Trusting Others in Mental Health Support Roles 4.2 Counselor Competence 4.3 Barriers
5. Cumulative Impacts on Wellbeing	5.1 Helplessness as a Helper 5.2 Effects Outside of the Job 5.3 Resilience
6. Stigma	6.1 Vulnerability 6.2 Compartmentalization 6.3 Buying In

In keeping with the essence and purpose of phenomenological research, themes borne out of the lived experiences of participants are described as often as possible through sharing the voices of the officers' in-depth subjective exploration individually and collectively. Each theme and

subtheme was collaboratively analyzed and explored, and participants were given the opportunity to review the themes and provide any additional insight as needed. No participants provided further feedback on themes, and I utilized extensive reflexivity and external auditor resources to ensure the perspectives and understandings being described and discussed were outside of and acknowledging my own personal biases, experiences, beliefs, and values.

RQ1: What are the lived experiences of CIT officers in their collaborative endeavors with mental health professionals for training?

1. Sense of Self & Others

The first research question focused on experiences in CIT training programs, where the importance of understanding the intersectionalities of law enforcement and mental health responses was highlighted. Participants expressed the need for both CIT officers and mental health professionals to have an understanding of responsibilities and implications that each role carries. In a similar line of conversation, participants mentioned the pride that comes into play, and how that might be authentically addressed in a training environment prior to working together on calls for service. The ability to co-create training experiences and include experiential learning was emphasized, and participants also identified that there are specific personalities of mental health professionals that were more likely to successfully facilitate meaningful training experiences.

1.1 Knowing professional roles. A critical consideration mentioned by participants was understanding the roles and responsibilities of mental health professionals and CIT officers and how they work together - especially when it comes to understanding law. It was emphasized that this foundational understanding is imperative for future collaborative endeavors. BP4 illustrated

an instance in which the difference in foundational priorities and awarenesses of each role were highlighted in a real-world scenario:

> I was in the office [in a local community services board] by myself and this guy, I guess he was in session [with a clinician] or something but he apparently goes into crisis. They bring him to me in crisis in the office and didn't tell me anything. I'm sitting here eating my lunch and here comes this dude and, you know, he's in crisis! I haven't searched this room, haven't searched through anything like that, I haven't done anything safety-wise to make sure that we're all safe in this room, and he's just brought right in to me and I'm like oh, alright, here we go! So yeah those priorities are like a little different sometimes.

Beyond understanding the base functionalities and guiding principles of each role, a large emphasis was placed on the importance of understanding responsibilities within the law in the jurisdiction of work. MP3 stated:

> There's a statute that says why CSB does what they do, they're not lying, they're not trying to place the blame on other people or force you to do your job. They are held by a mandate, by a state code…you may not agree with it, but if you would take five minutes to read the state code and ask questions, you can't get mad at [the clinician] because she put someone on an ECO and the hospital doesn't want to take them. That has nothing to do with [the clinician] and that has nothing to do with us. That's just the state code, but we just bicker about it and people want to be right or not be like oh its my fault its your fault...if we don't have the conversation, we can't make it better.

Additional insight from ZM2 further highlighted the experiences he has had due to lack of understanding on the side of mental health professionals:

> What amazes me is the doctors and counselors that work in the field that have no understanding of how the law works. We get calls all the time from psychiatrists like 'I want him hospitalized' and I'm like…okay? Why? He's not taking his meds? He's just out of control? Oh he's not suicidal? And they have no clue why I'm not coming to get this guy and then they're like 'but I'm a doctor.' Well, okay doctor…clearly you have no idea how the state hospitalization thing here works…and some of them come in from other states asking why we can't Baker Act them or 51-50 them and I just have to say like…that's not our law in Virginia. So maybe if you're going to work in Virginia you should probably educate yourself on the law and how it works. I can't force hospitalization on someone because you say so. So I think there is a lot of lack of education on the role the police play in the mental health field.

It was shared by participants that an essential and basic foundation of role knowledge on each side was crucial in building an effective foundation for working together, especially as these gaps of understanding can escalate into barriers.

1.2 Pride. In discussing the importance of knowing roles and responsibilities, the concept of power dynamics and pride came up as another prevalent theme that is tied in. As both mental health professionals and law enforcement officers hold great pride and subject matter expertise in their respective fields, it is not infrequent that conversations become a battle for the ultimate decision. AB9 stated: "I've had scenarios where I see a big problem and they do not, so that's when things go like…like who's right in this scenario?" MP3 further stated:

> I can tell you first hand, pride is one of the biggest things that we deal with and not wanting to be wrong or not trying to get better. Understanding is our biggest thing…I think we all have this sense of like, 'I don't want to be blamed for something' like it's not my fault.

DF1 further illustrated the dynamics that pride can create, including taking away focus from the individual(s) in need and touching on a larger narrative:

> It's that pride thing, and a lot of us have that pride in which it's like 'I don't wanna be wrong, so if I'm not wrong, you have to be wrong.' And meanwhile you're saying 'well, I know I'm not wrong so if I'm not wrong that means you're wrong' so we're going back and forth and, you know, no one's winning this. No one's benefitting from this…there's a lot of officers out here that honestly want to see people do better.

Officers each shared anecdotal experiences where they described how, similarly to the descriptions above, a sense of "not wanting to be wrong" and considerations of control seemed to become the task at hand, often overshadowing the larger picture of a person or family in need. With this consideration, a discussion about a need for collaborative relationships established through training experiences and extended through field exposures emerged.

1.3 Personality. Particularly when asked about challenges collaborating with mental health professionals in a training environment, all participants brought up aspects of personality,

or “ways-of-being” that were either helpful or barriers to fully engaging in the learning environment. SR10 shared:

> [The mental health professional teaching] definitely knew a lot right and I felt like I was in Harvard for the hour she was there but like it was too much, you know. She was like…I don’t know how to put it…like not an asshole but also kind of? Like that was clearly her lane and she knew that we weren’t in it but how much of that did we really need to know? Like now I’m stressed out because I feel like I knew less but somehow had more responsibility.

ZM2 also described a negative training experience with a mental health professional that was also tied in to senses of pride showing up foundationally:

> One time, the [mental health professional] asked a question - ‘has anyone had any problems with mental health in general?’ I brought up a scenario that had happened twice to me and then afterwards, I guess she didn’t like what I said, went to the Sergeant and said ‘you know, does he really want to be in CIT school?’ So it sort of bothered me that…you know, she asked. I hate people who ask you for a problem and then complain about the problem after you say it. I guess she didn’t see it as a problem from her side or whatever it was. But it had literally happened twice and she was like dismissing it and somehow thinking that meant I didn’t even want to be in the CIT training?

MP3 described how attention to personality traits, and cognizance of pride being one of them, has prompted successful collaborative efforts in training for his department:

> I had a coordinator from another city get bummed out that they couldn’t come to our [CIT 40 hour] class to help because they wanna learn from us. Like that’s a big thing for somebody to say…we think we know everything like you could have a PhD, a masters, and think to yourself ‘I know it all.’ Who am I to tell you what you don’t know, but it's like there’s still something out there that you don’t know and I don’t care what kind of documentation you have hanging on your wall to say I’m qualified or I’m certified. So for us it's about the person you are and you know having that understanding of like, yeah I know a lot and hey you know a lot too so how can we learn from each other and then put that together to help keep educating, keep learning and teaching. It's about communication and really coming together for the bigger picture and for us that has, that has really worked in building something that other people want to be a part of or benefit from.

Underlining these traits was also a sense of the importance of conveying authenticity in intentionality, especially for participants who were initially “voluntold” to participate in the CIT trainings.

2. Purpose of Training

As EC7 mentioned, “If they don’t say why I have to do this other than I have to do it or I’m voluntold to do it, I can almost guarantee I’m not really paying attention and just going to check off the boxes that I need to and get on with it.” Similarly, all participants made some mention of how the intent and purpose behind training is essential in a meaningful training experience, as well as providing insight on differences in engagement based on their own personal purpose for being involved in the training. Advocacy efforts for collaborative relationships between law enforcement and mental health professionals were frequently discussed as an important topic to address and expand upon during CIT trainings, with the systemic factors requiring continued education coming up frequently. A critical foundation for collaborative endeavors was identified as opportunities to co-create continued learning through meaningful and insightful conversations between officers and mental health professionals. Through these conversations, participants also identified a key purpose they felt in training experiences as identifying calls to advocacy bolstered by opportunities to collaborate with mental health professionals. Finally, perspective shifts due to training and experiential learning were highlighted as a valuable process and outcome of CIT training environments.

2.1 Voluntary versus mandatory. The difference between voluntary and mandatory participation in CIT training was an initial discussion point that became a gateway for a larger discussion identifying that purpose and intent to become CIT trained was a critical consideration that opened up implications for collaboration with mental health professionals in training. ZM2 shared:

> When you are a newer officer, you’re actually forced…I shouldn’t say force. You’re voluntold to go to these trainings. So it’s something that I just was kind of told to do. The experience during the training was good, it was well done, a lot better than the Academy where, like I said, you just kind of got your feet wet. Then you go to the 40 hour which is

> actually…they do a good job with that, with making it a little more realistic and having, you know, different mental health professionals teaching different aspects and doing like the role plays and stuff, giving feedback and all of that. So that was definitely, that was more beneficial at least to me than the quick overview they did in the Academy.

BP4 shared what prompted him to engage in the CIT training, discussing how subject matter most appropriately taught by mental health professionals became an area of needed education in his perspective:

> I had a 15 year old come at me and try to kill me with a knife [during a mental health crisis call]. I was very fortunate that I did not shoot. Professionally, that definitely made me think that I need to be trained on this stuff. I like psychology and…I have the gift of gab, I'll just sit there and talk all day, and I'm also watching everyone around me. I like doing that. You know, [people] don't always show the same signs [of mental health struggles] and so you gotta really learn to listen, pick up on what people are doing, and it could be the simplest thing. So yeah I had to, I wanted to learn like, you know more professional ways of knowing that, more professional ways of interacting with that and learning from people with a different perspective, different experiences. One of the things I really learned was just, you know, slow down and take the time to listen and observe, like I already liked doing but with now a little bit better information to be like oh, yeah, maybe this is what is going on.

Participants all described that, whether they sought out this training on their own or not, they gained personal and professional insight through the collaborative training efforts led by mental health professionals. Further, participants also indicated that these interdisciplinary collaborative relationships prompted efforts to intentionally continue and grow these collaboratively educational opportunities.

2.2 Co-creation of continued learning. When it comes to application of collaborative efforts, participants described their experiences with engaging in both established and organically occurring educational experiences, mainly expressing the value of having collaborative conversations with mental health professionals to strengthen the foundation and further build upon CIT programs and values. When asked about training experiences beyond the 40-hour standard CIT class, participants all described circumstances that were co-created and

often self-led based on foundationally established relationships between mental health professionals and their teams, as formal training opportunities are either unavailable or manpower to cover shifts for those wanting to engage in further training is lacking. EC7 summarized:

> I work in [a community organization] so every day is a training day because you do deal with different tests, different stuff, so between regular shift stuff, [the mental health professionals and I] will sit down in general in their observation room and talk about it. Talk about what we're seeing, what we're doing, and how to build forward from there. I've learned a lot through those conversations and hopefully they've learned a lot too, like why I ask what I ask first because you know I'm thinking about the safety of the space and the police stuff and then you know I get their points of view as to why they're doing what they're doing and then moving forward there are less tensions less confusion and we're building a good thing.

SR10 expressed the benefits of being able to engage in collaborative co-creation of learning through conversations at CIT conferences:

> I go to all the CIT conferences, whether it be out of town or internally, you know, within the state. It's cool to see people from other jurisdictions, and we all get in one place and we all build and talk about our programs and how we can help people and we learn how they do things and they learn how we do things. It's a real good feeling.

With these discussions and the expressed benefits of collaboration through experiential learning, participants illustrated the desire to build culturally responsive collaborative relationships for continued learning, which also brought up some implications for advocacy within these programs and relationships.

2.3 Calls to advocacy. After having gone through the training and having varying levels of real-world experiences on CIT calls, participants shared that CIT training built a foundational understanding of important implications for advocacy within CIT systems. A sentiment shared by several participants was the need for continued education and collaboration to address a systemic push to take policing out of mental health, and the realities of needing more resources and education to co-create effective collaborative teams and relationships. ZM2 described:

> When you sign up for this job they don't tell you that you're gonna be more of a psychologist than a police officer and then…I just wasn't expecting it. It's what it's become now and it's just, I don't know what it is but it's just getting worse and worse. Like the mental health calls I hear every day on the radio, I'm like 'Jesus, guy, can we like…have a break one day?' If you go to the hospital you see eight police cars there because there's always someone on a TDO or an ECO. And those take two officers because you have to sit with them and it's just stressful on us because it takes us off the street. But that's pretty much what policing has become so yeah, the more collaboration the better between both parties. You can never get too much training on this, and it's not going away.

TO8 summarized advocacy considerations for the direction that many CIT programs are taking, which is a co-responder model with mental health professionals:

> They want to take the police out of the mental health aspect, but we're still going to get called. That's why I like our MCRT [mobile crisis response team] units where the clinician will go out with the officer and I can handle everything pretty much on site. You're able to do that with certain cases, and in some places you're not going to be able to do that. It would help to add more [clinicians] but obviously manpower is an issue, so we don't have enough to do it. I like that [collaborative] aspect of it, but I don't like sending [clinicians] out by themselves to do things. I just think it's asking for problems in my opinion. So yeah there's still some growth to do there but I do like that idea.

Participants also expressed the need for advocacy within department processes, such as AB9 stating:

> I mean you get a little bit of training in the Academy but not as much after, and no experience or anything prior to the academy probably. But now that I've seen stuff on the streets and those calls, I'm like they should probably give you more training in the academy, because its not like you aren't going to run into it just because you aren't you know officially a CIT certified officer. These are the calls we get.

As each participant individually shared their experiences, they each brought up similar stories of being prompted to be more involved in and knowledgeable about advocacy efforts systemically within their own communities and departments and within larger systems - much of which stemmed from gaining expanded or newer perspectives in to the mental health system coupled with real-world experiences and professionals working in collaborative roles.

2.4 Perspective shifts. Shifts in perspective came up as a fourth subtheme that was a valuable outcome of CIT training and experience which provides implications for continued

collaborative efforts in education. Participants expressed how their perspectives on the mental health system, mental health professionals, and their own processes have changed over time due to being in the CIT role. Participants indicated how continued collaborative educational opportunities to address the influence of these perspective shifts would be critical. MP3 described:

> I had no background as a CIT officer. I had no background in mental health. I had no background dealing with anything other than 'you committed a crime, here's the law that you broke, I'm taking you to jail.' I've had to kind of step back a little bit and reevaluate how I address people and how I interact with people. I know how we like to put on this badge and have this gun on our hip and say to ourselves 'I'm gonna walk around here and you're gonna do what I Say because of this because of this' and its not about that. I'm not a rude person but I definitely like I said I had to take some steps back and really evaluate, reevaluate how I was interacting with people.

AB9 also illustrated another perspective shift, identifying that with added awareness in to CIT and mental health systems and processes, perceptions of collaboration with clinicians is brought to the forefront:

> I don't know if it's desensitization or just detachment or what, but I've realized that some clinicians, especially doing the CIT stuff and pre-screenings and whatnot, they're quick to just…basically for a lack of a better term, dismiss what's going on. And be like 'oh its normal' and especially if people have been around a while, that is one of those things that maybe hangs in the air…but I can only argue so much because its not…I don't have a degree in it, I'm not licensed or anything of that nature but like, I look at the safety of everything and I'll arrest somebody or take them to get the prescreen or whatever needs to be done and we're thinking this person needs help and [the clinician is] like 'no, this is them every day' and I'm like ok then, I have to eat my own pride for that, like okay I guess you're the one with licensing for that, but I have noticed that over the years and it just kind of blows my mind.

3. Continuing Education

With CIT training being either a 40-hour certification program or a brief inclusion in the academy, the push for continued education was a big factor that came up in participant interviews. Participants described their belief and commitment to the program and how that was

influenced by and continuing to be built upon through collaborative efforts. Participants also described how collaborating with mental health professionals in the field brought up implications for continued education in further facilitating these symbiotic relationships. Finally, participants discussed the importance of confidence in the role and how that was driving future endeavors and collaborative relationships that could be discussed in learning environments.

3.1 Belief and commitment. As active CIT officers, participants all shared that their belief and commitment to the CIT program and model grew exponentially after going through the training, and the desire to bolster and continue those educational experiences expanded even further. AB9's description highlights a sentiment shared by all participants, in that the academy-based training regarding mental health did not provide as much education as needed, which was not recognized until real-world experience and going through the 40-hour training:

> In the academy I was never taught anything on mental health. I was never given any information on how to help people who go into a mental health crisis you know or where to go other than [a local hospital or local community services board]. That's like the only thing we knew, so I knew nothing about the ECO process or the TDO process other than what I learned on the street, so very limited experience. But then going through the program and learning what I learned and making the connections I now have is giving me a lot of confidence in helping people and knowing what else I want or need to learn about. There should definitely be more of it.

MP3 illustrated how the collaborative foundation of the program itself with NAMI provided what he felt was the most impactful part of his CIT training experience:

> I went through the class, and it was day 2 when we had the NAMI presentation, and one of the coordinators, or one of the speakers, came and spoke that day, and it was just. It was just her message. It was just what she said, and how she never let her mental health define who she was. She never let her mental health ever dictate what she should do in life like…just because I have a mental illness doesn't mean I can't get a masters degree. It doesn't mean I can't get a well paying job. It doesn't mean I can't have a family and raise children like anybody else who is normal. So going through that class, that was my light bulb moment. That was my Aha! Moment where I realized that although I know I wasn't hurting anybody on the street, so to speak, with my actions or my lack thereof. I know I wasn't helping. So I took it upon myself to be more invested in this program since that day.

All participants were generous in sharing their similar “aha!” moments, both personally and professionally, such as DF1 who shared:

> I have grown a lot in this program. It has given me a lot of insight on myself. This program has really allowed me to grow as an officer, as a CIT officer, and as a human being just trying to make it out here. Seeing it, learning about it, and working in it. It's always an opportunity to do more and learn more, and I will keep saying how valuable this training has been for me just as a person. There definitely needs to be more of it, it isn’t going away anytime soon and the CIT program itself can only get better.

With growing personal belief and commitment in the program, officers expressed how that has encouraged them to continue advocating for continued educational opportunities and the growth of the CIT programs in their respective jurisdictions and departments.

3.2 Making connections through training. Collaborative efforts on the job were brought up by most participants who described how just being in the same field and working together with mental health professionals has created platforms and opportunities to bridge gaps of knowledge, service, and education that could be further fostered through training and learning environments. Participants expressed the value of organically grown collaborative relationships, and identified a need for continued opportunities to connect and experientially learn with and from mental health professionals and crisis intervention team members in various spaces. For instance, MP3 expressed the privileges of these collaborative relationships not only in continued training, but in adding to a network of resource access and understanding:

> I think one of the great things about CIT is that I don’t just interact with people of my city, I interact with other agencies and other jurisdictions. So it's wonderful that I can still meet people in my jurisdiction and then go 50 miles off the street and take part in someone else’s training and give them feedback and input. If anything, if there’s something not provided on my side from mental health experts, maybe they have a door for that. Or maybe they have some kind of advice for that, or maybe just anything that we don’t have that we can benefit from. So it really has opened up a lot of opportunities, a lot of doors, as it relates to building those bridges, building those relationships and really trying to put out a better program than we did the day before.

Participants also mentioned the possibility of mental health professionals not just teaching the courses, but also going through them as an important means to bridge gaps of understanding and knowledge for cultural understandings. As TO8 stated:

> I think all the clinicians, I really do believe, should go through that [40 hour CIT] course…whether they work the street or the ones that work in the office. They can take the calls we work with and they should all have to go see it too. They can understand our training a little bit better and what we're hearing and seeing.

As evidenced by the participant descriptions and conversations, it is evident that the value of the connections created within training environments builds a meaningful foundation for collaboration moving forward, with culturally responsive implications described by the officers.

3.3 Confidence. Having the skills to effectively work in a law enforcement role is a piece of the foundation, but the confidence to execute the skills and knowledge learned can mean life or death in taking a split second too long to act. In a CIT role, there are dynamic factors at play wherein the officers must be ready to jump in to action at any given moment while also attempting to take careful time and consideration to deescalate a situation and, ideally, get individuals connected with resources or referrals for more adequate care and assistance. The importance of continuing collaborative educational efforts with mental health professionals beyond the initial 40 hour training was emphasized in the consideration of building intentional and evidence-backed confidence beyond just experiential learning on the job. BP4 shared:

> Now that I work with [mental health professionals] pretty much on a daily basis, you know, I trust their expertise…when I was on the street you would call them frequently for cases and you would tell them what you have, they would give you their opinion, and you would pretty much work with echo other to come up with an outcome, and you would have to trust their decisions. Those opportunities have really, really built relationships so now I feel like I know what I'm doing when I make those calls and, you know, we can have some really good conversations. I don't know how that would be turned into training experiences but that, having that collaborative rapport and learning how those calls go or maybe talking about them could be something.

DF1 also touched on how his experience being an active trainer in his department's CIT program has provided continued opportunities for confidence in learning and insight, even as a leader:

> From the initial class and now running scenarios you know, it also helped me maybe see some of my own stuff that I didn't see before, and helped me through these conversations being a little more self-aware. It helps me recognize a lot of stuff, whether it's personal or professional, and helps me better understand where another person is coming from. I come out with something new after each CIT course and I've been doing this for about seven, eight years now.

The importance of confidence in collaboration in this realm was described by participants as more than just helpful with performing effectively as co-responding teams for individuals in crisis, but ultimately gaining an understanding through multiple perspectives that provided confidence within each other - leading to systemic implications and needs for continuing to foster collaborative relationships and learning opportunities.

RQ2: What are the lived experiences of CIT officers in their collaborative endeavors with mental health professionals in navigating trauma and vicarious trauma?

4. Safety and Protection

Research question 2 explored the experiences of CIT officers collaborating with mental health professionals in navigating trauma and vicarious trauma. In a line of work where safety and protection are the calling of the job, it makes sense that this was the most prevailing theme for this research question. Participants immediately discussed the importance of trust - even further highlighted through the research process by each participant having mentioned the reason they even engaged in the conversation with me was feeling safe after having done their own research and asked for endorsements from trusted peers. Participants were also quick to emphasize - just like within the training environment - there are certain competencies and "ways-of-being" that would facilitate an appropriate environment for the therapeutic process. Participants also mentioned that there were added barriers whether it be lack of resource

availability or the perception of limited or no confidentiality due to being tied to or provided by the department or city that they work for.

4.1 Trusting others in mental health support roles. Possibly the most touched on subtopic throughout this study, and particularly when discussing safety and protection, was the importance of trusting others in mental health support roles as a protective factor. Participants commented on existing peer support and EAP services, with one of the major concerns being confidentiality. MM6 shared:

> I got into some shit and made some…bad choices and it had to do with drinking, so I did I was encouraged to reach out to EAP and peer support stuff and I had done counseling before so I wasn't like super against it, but my buddy showed me a group chat that had a member of the peer support team in it talking about all these rumors and honestly like kind of talking shit….like you really learn about people when you're in these situations…but then that same guy [on the peer support team] reached out to me the next day saying, you know, like hey I'm peer support blah blah if you need anyone to talk to I'm here for you whatever, and I was like yeah fuckin right.

Participants also discussed the perceived mistrust of resources provided to them by the city or their individual departments due to the lack of separation from job and personal needs. When asked what would facilitate a trusting relationship, ZM2 stated:

> I guess them not being affiliated with the city or the police department in any way…I mean, I feel like there's some people I could call and I trust that it's not going anywhere unless I say I want to hurt myself or something, I understand that…but for me, I guess it's just over the years working for the city I've seen some supervisor roles where they tell you one thing and then do another thing and you trusted them, I've seen that enough, so it's hard for me to say what I would do to trust them. It would depend on the person I have to talk to. I'd have to feel them out ahead of time, and you know, figure out that's someone I could trust.

Through sharing their own experiences within their departments, participants provided insight into senses of mistrust and concerns for confidentiality that are then exacerbated by working within the mental health system and having familiarity with clinicians and the deficits within the system. As participants continued the conversation, they were open about sharing what

competencies and safeguards they have either experienced or are wishing to experience when it comes to connecting with a mental health professional for their own processing needs.

4.2 Counselor competence. As with the discussions on personality types that were described as having been more or less preferred in a training environment, the competencies of mental health professionals working with CIT officers to process their own trauma and vicarious trauma were mainly focused around "ways-of-being." For instance, BP4 described his personal therapist:

> Very few people, in the middle of a conversation, call me on my shit. [My therapist] will in a heartbeat. And I'm the same way so I mean, you know, it was like the first session and the first time she did that that's actually when I realized like okay, I like this, I like her, I'm good with this…As soon as I walked in I saw how she was, how she worked, no bullshit you know. I'm very direct, no fluff, face the decision, take action one way or the other, you know, and she knows that.

Other participants also highlighted similar traits of transparency, openness, and "getting it," such as TO8 who mentioned:

> I honestly feel way better if I am talking to someone that like I know gets it like…you get how we are, you don't give me some bullshit and try to give me solutions that sound fluffy or like even worse if their first suggestion is well just get out of the job you know that sounds difficult type of thing, yeah no shit but if I wanted to quit I would just quit you know, that's not what its about, you know, listen to me and work with me.

Along with "getting it" is also the ability to hear it, as FN5 illustrated:

> If I'm telling you like my worst story and you're sitting there you know shocked, or start to cry or something, or just start focusing on how awful that thing was like…yeah no I get that like…that's why I'm here? So like as a female and as a helper part of me goes in to like 'oh okay now its my responsibility to make you feel better' and the other part is like, you know, like…'fuck you you didn't actually have to see it' you know? Like its that stuff like. If you can't hear our stories or like you know on the other hand if you are only asking me about my stories and it sounds like you're just trying to get some free exclusive episodes of COPS out of me, like I'm out.

Similarly to how personality influences the CIT training environment, indicators of counselor competence as described by the participants revolved heavily on ways-of-being with the ultimate

foundation being the ability to effectively hear the types of stories that may be shared by this population and responding with authenticity, transparency, and empathetic collaboration and working to not create additional barriers to a journey of finding and receiving crucial support.

4.3 Barriers. Barriers to psychological safety were described as limited access, limited knowledge, or limited availability of resources in which participants described feeling unable to engage in mental health care at all, or feeling underwhelmed by what was available. SR10 mentioned:

> There's not a lot for us. I mean internally, through our department we have the EAP program where, if I'm having a hard time, I can go to my symptom section…and then they could point me in the direction of resources. So there's plenty out there that the city does internally but we have very limited [resources] as it relates to mental health professionals dealing with us personally other than just being referred out.

MM6 shared:

> I honestly just keep it close to the vest, I don't think the city has anything other than EAP and I've heard the stories you know of like the therapist being all about yoga or something or really just like not getting it you know. I wouldn't really know how to find someone that I'd be comfortable talking to other than like what other people have recommended but you know we don't talk about that anyways so it's just kind of like, I mean, I don't know I just wouldn't probably use the city resources and then the only other resources I really know about are from places we've taken people or worked with clinicians during CIT calls so I'm definitely not you know going there either.

BP4 highlighted how he is hoping to address barriers of access and how this creates a platform for continued and embedded collaboration:

> Effectiveness of the mental health professionals with us…it's lacking, but it's growing, meaning that we are trying to build it. We are trying to do something in which, if I'm having a bad day, [somebody is] already in place. I don't need to go elsewhere. I don't need to check a box. I don't need to try to, you know, get put on a waiting list. [Somebody is] already in place so I can talk, if not that day, very soon thereafter.

With these considerations, participants highlighted needs not just for access to resources, but open conversations and educational opportunities that would bolster understanding of service

providers and openness in to what a collaborative, healing relationship with a mental health professional may look like; especially when addressing topics that are so deeply impactful such as trauma and vicarious trauma exposures.

5. Cumulative Impacts on Wellbeing

As described in earlier chapters, the vicarious trauma experiences of law enforcement officers are already a major concern, but there were additionally unique cumulative concerns as described by crisis intervention team officers. Every participant described experiences where they were heavily impacted by feeling as though they were unable to help to the extent that they wanted to, or even, as MP3 strikingly put it, "I felt so inadequate as a human being." Participants also shared the effects they felt outside of the job or the specific CIT role, to include their own changes in personal habits as well as feeling unsupported in the media and public perceptions. Within this conversation, participants also described their own personal experiences with building resilience, and expressing their individual mindsets when it comes to continuing forward.

5.1 Helplessness as a helper. When discussing experiences processing trauma and vicarious trauma, each participant shared stories about experiences that continue to impact them. While the overarching traumatic impacts of a law enforcement career are often discussed, as outlined in the literature review for this study, the complexities of feeling helpless within a helping profession are not as immediately or readily addressed. MP3 expressed the instance in which he felt "inadequate as a human being":

> I have had experiences in which I have had to ask a young mother to sign a piece of paper for me while she's holding her comatose child in her hands, and I felt so inadequate asking for that when she is trying to spend literally the last moments with her child before he passes away. And I'm asking you, hey ma'am, can you sign this paper form real quick so I can go in your house? I just felt so inadequate as a human being, taking that away from her.

BP2 called attention to the additional complexities that arise when a call for service is with a member of their own department:

> We've had to go to a couple people's houses that I'm acquainted with that are having problems with the department and some retirees that were having some problems. So we've gone there and tried to talk them into getting some help. Most of it was alcohol related…I had worked for this [one] person several times throughout my career, and it was just hard seeing him in the state he was in [when I responded to his house]. Unfortunately he passed away about a year later as a result of his addiction…so that was a little traumatic. Well, I'll maybe not say traumatic, but a little difficult to deal with, because we couldn't get…we couldn't convince him to get the help he needed.

With these multifaceted and compounding factors, FN5 expressed the impact on collaborating with or considering collaborating with a mental health professional for processing:

> I mean I can see how talking to a clinician, like if they were co-responding right and saw the same things and were there like, I have had I guess like you can call it a casual debriefing conversation when we're all just standing around or after we've written reports but I don't know that I would just go to any clinician and be like hey, this thing happened and I feel all types of ways about it unless I knew they got it, you know. And like I don't want to, you know, create that feeling in someone else either so yeah, but there are some clinicians that work with us that will just hang around and give that space to process right then and there without making it feel like, you know, there's a spotlight on me or like its a mandated CISM thing and so that really I think has been more helpful to me personally than trying to hold on to it and wait until my next therapy session. Which I still do too.

With the multitude of factors weighing in on these experiences, it was emphasized by each participant that the sheer depth of feeling helpless in a helping profession was an area in great need of attention, especially as the impacts of these cumulative experiences affect their lives beyond just the hours of their shift.

5.2 Effects outside of the job. When asked about the emotional and psychological impacts of dealing with trauma as a CIT officer and how that is related to collaboration with mental health professionals, participants mainly described how they have gained additional insight and awareness into how their lives and wellbeing are affected outside of the job and the importance of mental health professionals being collaborators in support beyond personal

interactions. For instance, MP3 described how his experiences in comforting his children has changed after responding to a case where a young child was accidentally suffocated by their parent:

> There's been plenty of times with my children where I've slept in the same bed with them, and I could have easily been that parent that potentially did this to my kids. So now I'm hyper vigilant in my mind about what I do with my children and now…my daughter wants to sleep with me, and I'm like 'you know what baby you can sleep in the bed and I'll sleep on the floor' and I remember that I did that, and but then when she realized I wasn't in the bed with her, she came and laid on the floor with me and at that time I got in the bed and left her on the floor. Then she realized I wasn't down there so she got back into bed with me…and so I always felt like, you know, that's kind of funny in the back of my mind and you know I just accepted it as like, okay, you know, I'm keeping my family safe so I'm doing good. But it was stressing me out and in the back of my mind I'm like I don't want to end up like this family and I don't even know that family. So I had to be honest about that, those impacts you know. Being able to see and process that now has at least helped me be like okay I'm not losing it but, you know, this is because of something that affected me and here's how it's showing up.

BP4 also added to the importance of how mental health professionals can impact the sense of safety within collaboration in their roles outside of the job:

> We were told that the director of human services came down and pretty much told us that the jail here had better [mental health] programs than the state hospital. And then, like those same people coming down here and saying good job you know, you see in the media like 'why are they arresting these people with mental illnesses.' So it's like, you know, damned if you do damned if you don't type of thing.So yeah that, that affects my trust in general because why would I go to someone for my own shit if that's your public opinion of us when you're not right in front of me or I'm not doing something for you.

As discussed in earlier chapters and further illustrated by the lived experiences of these participants, exposure to trauma and vicarious trauma, especially when accumulating over years of service in law enforcement, has unique effects on wellbeing that counselors must be culturally informed about to even be considered as a safe collaborator for processing or even just as a co-navigator on a path to connecting with personally helpful resources.

5.3 Resilience. The topic of and push for cultivating resilience in law enforcement careers is not an unfamiliar discussion. When asked about personal coping strategies learned or

developed through collaborative efforts to process trauma, participants shared how access to and familiarity with relationships with mental health professionals afforded by involvement in CIT programs bolstered personal resilience efforts. MP3 stated:

> I'm not gonna try to, you know, edit myself or short change this answer, but let me just start by saying 18 years. You know, it's 18 years of dealing with everything under the sun that this city and citizens have thrown at me. I have done well with processing and I have done well with not keeping it inside anymore, to the point where it's like okay, I know I'm not doing good today. Instead of me going to work today where I know I'm going to be a wet blanket, let me just stay home and let me just take the day to myself, or you know what, let me talk to somebody. Let me just get it out there, and maybe we can laugh together. We can cry together. Maybe just hear me talk. But I have totally dealt with trauma far better now than I did early in my career and I really do believe that a lot of that is just learning how to see it in others, learning how to give that compassionate response to the citizens and learning, you know, the deeper warning signs and processes and also why certain resources may work and some may not. Like every response is individual, and I'm an individual too so hey I can apply this to me, I can be a better and stronger person every day and that doesn't look like, you know, just keeping it all in anymore.

EC7 also illustrated personal insight in to dynamic resilient growth:

> I've seen families that have to deal with it on a regular basis, individuals that have to deal with it on a regular basis, I've had my own friends, you know, harm themselves and kill themselves and its like. I get angry about that. Why. Why would you do that you know? And I mean, that shit used to just end there with the anger but I have seen how bad it can get and I learned more about all of the stuff that goes into that now so I can't be out here angry and pissed off and ignoring it all the time. I have learned better ways to deal with it and to recognize it and part of that is helpful is talking, is addressing that stigma, and you know helping myself. I can't help anyone else if I'm out here pissed off about the same stuff and not doing anything about it.

As most officers described, resilience is a term used throughout law enforcement settings, however, having the ability to learn generally with and from mental health professionals as subject matter experts prompts insight not just into better serving others, but implications and tangible resources to promote individual resilience and self-reflective awareness. Through an established collaborative environment, officers can also engage in conversations that work towards breaking barriers of cultural stigmas in a safe environment that is not spotlighting

individuals, rather, set up as an approachable and meaningful training environment that may prompt insightful considerations and holistic wellness needs.

6. Stigma

As another main topic outlined in the literature review and purpose for this study, participants all mentioned stigma as a critical factor both personally and professionally - even, or especially, as they are working in the mental health arena. When it comes to seeking mental health care for themselves, participants touched on the complexities of vulnerability in the field and how their unique identities as CIT officers have multifaceted implications that may lead to compartmentalization as a necessary coping mechanism. Each participant also shared what led to their own "buy-in" of engaging in mental health care.

6.1 Vulnerability. It is already an interesting dichotomy to explore the aforementioned experience of "helplessness as a helper" and seeking help as an individual who is also the one called on in others' times of need. When asked about collaborating with mental health professionals for their own processing, participants described the complexities of being vulnerable or considering being vulnerable with a mental health professional due to cultural "norms." ZM2 provided insight in to not just his own general experience, but also self-reflected in the moment noting that his mood had shifted when he shared:

> You don't wanna bring it home with you, but you don't want to hold it in either, which I do. So I really don't talk about it. I mean, besides my couple of close officers that I work with, yeah well talk about stuff but…I have those two because they're my academy mates. They're probably the ones I talk to the most about stuff. But yeah, other than that, I keep it pretty close to the chest. This mood has changed completely by the way.

MP3 provided a description that spoke to conversations about additional stigmas based on identity alone:

> As an officer, we don't deal with trauma well. As a human being, we don't deal with trauma well. And to personally put it, to me as a black person, we don't deal with trauma.

> We internalize it and I know that answer can go under any one of those categories I just gave you - a black man, an officer, a human being. We don't deal with trauma well. We rarely want to tell somebody that I'm hurt, that I'm broken, that I don't feel good. And I was that person. So it's hard to talk about it in general, and then to consider who you are sharing that with, who you are opening yourself up to, yeah thats, that could be dangerous you know? So just finding the authenticity. Finding the space to be like, hey, I can't carry this on my own anymore, and that's okay. But even I still get nervous about that sometimes and I'm out here telling everyone I know to get to therapy! But yeah we have really come a long way but we still, we just have some ways to keep going and that involves just like I said those open doors of safe communication and letting it take time.

As described by participants, conceptions of vulnerability are deeply linked to the LEO identity, which is dynamically shaped by the specialized role as part of a CIT unit when being a part of responding to others' mental health crises. As a cultural coping mechanism and as outlined by the above descriptions, participants all expressed how they compartmentalize their experiences and ways in which they personally unpack or process, if at all.

6.2 Compartmentalization. With the previously discussed identities and traits of LEOs, participants mentioned the added complexities when it comes to working within the mental health system and responding to uniquely traumatic calls for service. Participants described experiences wherein they felt compelled to further compartmentalize their own traumatic experiences due to cultural "norms," such as MP3 who shared

> I explained a story [of a difficult instance] to [coworkers], and I remember at the end of that story there were two Sergeants that laughed and joked on me for not doing more. Now they weren't being, you know, malicious, they weren't being mean. That's how we do, that's our sense of humor, and I remember I laughed along with them and I paid for all of our breakfasts and I got out to my car by myself and then I cried for like five minutes. Like I'm in the car bawling, because I still felt the guilt and the shame and the hurt for not doing more.

When it comes to collaborating with clinicians, participants that worked frequently alongside clinicians mentioned how they have felt encouraged to compartmentalize further and discouraged from collaborative processing, as their role as a protector takes precedence. As described by BP4:

> To be honest if I was having a problem I probably wouldn't connect with [the mental health providers] because I have a working relationship with most of them, so I'd probably do something outside of that. There's been a couple of times…like this one clinician I ride with, we rolled up on a fatal accident and it was her first time and they were doing CPR on a person, it was the first time she had seen that I guess. She was pretty upset about it, I had to…get her out of there and help her with that, you know, help her deal with it, and she had a hard time understanding like 'why aren't you upset?' And I had to explain that it's not the first time I've seen that and it just doesn't…you gotta deal with the scene first and you deal with the other stuff later. It was probably the first time she'd ever seen someone die I guess.

As participants discussed, the cultural norms that encourage compartmentalization as a protective tactic are not then addressed with encouragement to "unpack." For an officer to even consider opening the compartments, experiencing clinicians in response to others' crises is representative of how officers may see the capabilities of the profession as a whole and begin moving towards or away from their own consideration of a path towards collaboration for their own processing needs.

6.3 Buying in. With education and experience working in the mental health system, CIT officers are exposed to a multitude of encounters when it comes to addressing mental health; most often involving aforementioned frustrations, challenges, and barriers. As active advocates for and executors of mental health care, it makes sense that each participant had unique journeys towards the "buy-in" when it came to seeking their own help and continuing collaboration with mental health professionals. To address ongoing stigma, the importance of the continued "buy in" and encouraging this in themselves and others was discussed by participants. BP4 expressed:

> I go to [my therapist] for a reason. You know, having people try to kill you over the years kind of does that. But like I said before, there's no way I could deal with [something more severe] at home…so my hat is off because there are those ones there every day dealing with more than I am dealing with and managing it. You know its funny, once I started working on my own stuff…I can have a 5 minute conversation with somebody and they end up dropping a whole bunch of information on me and maybe it's the whole, you know, like I'm a safe space now. Like I've always liked dogs and they always come up to me, and one walked across a parade once and was sitting on my shoe and I made the joke like 'oh hey there, do you need an emotional support policeman?'

MP3, who holds a leadership role within his department, stated

> Look, if I can go to the gym and I can push all this weight, if I can run on the track and run as fast as Jesse Owens, I could do all these things to make my body better - I can eat right, I can go on crazy diets, I can do nothing but vegetarian foods or nothing but meat, like I'm taking all these vitamins and all these supplements to make my digestive system better…but what are you doing for your mind? What are we doing for the thing thats controlling all of that? Because if I'm broken up here, none of this matters. I don't care how fast I could run. I don't care how much muscle or weights I can push if I'm not good up here. All of the rest of this stuff is invalid, so I try to push that on everybody.

The ultimate buy-in, shared by all participants and summed up succinctly by SR10, is "It's just, it's a good feeling knowing that you're not in this by yourself."

Conclusion

After ten participants in active CIT roles shared their experiences pertaining to collaborating with mental health professionals for training and for processing trauma and vicarious trauma, the above themes and subthemes were identified with rich, thick descriptions being provided as often as possible in the voices of those who lived them. In the following chapter, I will elaborate on the findings and provide in-depth discussion including implications for counselors and counselor educators, possibilities for CIT programs, the limitations of this study, and considerations for future supportive research.

V. DISCUSSION

This chapter delves into the experiences shared through a descriptive phenomenological exploration of crisis intervention team officers collaborating with mental health professionals for training and processing trauma and vicarious trauma. Participants shed light on the multifaceted dynamics and considerations that shape collaborative interactions and perceptions, providing deep insight into a unique interdisciplinary realm. The individual voices of the officers came together to form a dynamic collective of experiential discussion, which informed implications for counselors, counselor educators, and crisis intervention team programs. Limitations of the study will also be reviewed with culturally responsive considerations for future research to support CIT officers and collaborative relationships with mental health professionals.

Themes

Through semi-structured in-depth interviews and analyses, 10 CIT officers shared perspectives, challenges, and insights emerging from their experience at the intersection of law enforcement and mental health care. Participants described their experiences in response to two research questions: *RQ1: What are the lived experiences of CIT officers in their collaborative endeavors with mental health professionals for training; and RQ2: What are the lived experiences of CIT officers in their collaborative endeavors with mental health professionals in navigating trauma and vicarious trauma.* Through an in-depth descriptive coding and analysis process, six main themes emerged for each question: RQ1- Sense of Self and Others, Purpose of Training, Continuing Education; RQ2- Safety and Protection, Cumulative Impacts on Wellbeing, and Stigma.

Sense of Self and Others

A multitude of awarenesses are pivotal aspects of collaboration between crisis team intervention officers and mental health professionals. Through this study, participants provided insight on the first critical step to any collaborative relationship; knowing and being able to work with the individuals within the system. As mentioned in the literature review, while there is extant literature exploring the collaborative relationships between law enforcement and mental health professionals in a CIT context, the focus of study is most often on the response to the individual in crisis and positing that the roles involved are already able to work interdisciplinarily (Compton et al., 2022). Miller (2023) illustrates the concerns of mental health professionals not knowing the law enforcement role, citing concerns of safety and liability. Adding insight to these beginning conversations, participants described the most critical foundations for collaborating with mental health professionals for training involved knowing roles, addressing pride, and general ways-of-being that worked within the LEO culture.

Knowing Professional Roles. Emerging as a critical sense of both self- and other-awareness was the first subtheme highlighting the importance of knowing and understanding professional roles and responsibilities for effective collaboration, with most participants sharing that knowing the law was a critical foundation for any effectively collaborative relationship with mental health professionals. Though literature regarding CIT program training highlights the importance of educating law enforcement officers on critical understandings of mental health processes and conceptualizations, basic understandings of the laws within the jurisdiction and training for the mental health professionals leading classes or working within these programs is not often addressed (Compton et al., 2022; Miller, 2023; NAMI, n.d.. Rogers et al, 2019; Watson et al, 2021). Mental health professionals are called on as educators within CIT training programs;

however, they are not required to have gone through CIT training and would arguably only have cultural understandings about law enforcement through their own immersion in the field, if applicable (CIT International, 2019). During this study, every participant expressed how it was valuable to learn how the mental health system worked from the perspectives of mental health professionals, but also often paired that with expressions of frustrations from learning from adversity or "what not to do" rather than having formally collaborative discussions provided within the CIT training context.

Pride. Immediately emerging as a second subtheme, and mentioned by all participants, was how pride affects the collaborative relationships between mental health professionals and CIT officers, which is congruent with existing literature (Lorey & Fegert, 2021; NAMI, n.d.; Rogers et al., 2019; Watson et al, 2017) This study shone light on the personal experiences of officers with added insight - most especially, that each officer recognized the sense of pride in themselves and others and did not want to see it as a point of continued contention;, however, recognizing the needs to address it and get out of a battle that leaves the person truly needing help as the true victim of circumstance. Participants described this self-awareness and the assumption of similar internal processes in mental health professionals based on their personal experiences both in the field and through training. This provides a unique and open foundational space for collaboration in training by opening these conversations and being receptive to authentic collaboration and not collaboration to be "more right," as most participants expressed. These experiences also brought an additional insight in to addressing collaboration with an awareness of the protection motivation theory, in that both CIT officers and mental health professionals may view the other as a threat to their safety within their role (Alden et al, 2020; Allen & Campbell, 2018; Otto & Gatens, 2022; Smirnova et al, 2021). From this shared space of

consideration, mental health professionals and CIT officers may incorporate time within training to address pride in the roles as a common thread of strength and pride that does not hinder the relationship, rather, bolsters understanding and opportunities to work together congruently.

Personality. Finally, participants were very open about expressing what personality types, or ways-of-being in the counseling world, were most effective within collaborative educational settings. Existing literature does not provide implications for counselors working as educators within a law enforcement context, and mainly focuses on how counselors should interact with law enforcement populations - mostly focusing on the need for a trauma-informed approach (Alden et al, 2020; Daniel & Treece, 2022; Fleischmann et al, 2018; Horan et al, 2021; Kim et al, 2022; Lanza et al, 2018). However, this study provided additional insight from those working within these interdisciplinary and collaboratively educational settings where participants ultimately described the traits of an effective collaborator in training to be authenticity, vulnerability, humility, and self-awareness; the very same traits that counselors ask of clients and those showing up in educational spaces. While this insight corroborates existing literature on general ways-of-being for counselors and counselor educators, the unique cultural considerations provided by participants included willingness to hear and use dark humor and explicit language, willingness to be collaborative even during an already planned lesson (e.g. openness to having conversations as part of the learning space and receiving real-time feedback and questions), and ultimately having a collaborative spirit that is open to all voices and experiences as valuable insight going beyond the amount of certifications or licenses one may hold.

Purpose of Training

In specialized educational and training realms, a key need for engagement and overall understanding is a clear and stated purpose. The experiences of the participants in this study

provided deep discussions and considerations that focused on the influences of purpose and intent behind CIT training and the implications that come out of and advocate for continued collaborative relationships with mental health professionals.

Voluntary versus mandatory. Through sharing meaningful encounters within their respective CIT training programs, participants described the importance of expressing intentionality leading into the trainings regardless of being voluntary or mandatory for attendance and participation. Participants shared how this was a space that was bolstered by and provided implications for collaboration with mental health professionals. Experiences were congruent with existing literature describing how those who were voluntarily participatory in the 40-hour CIT training had prior experience with the mental health system; as most participants shared in some way that the job was going to involve mental health responses regardless of whether or not they went through the training (Compton et al, 2011; Compton et al, 2017). These participants also provided descriptions to begin filling the gaps of literature that were missing the opinions on whether or not views, biases, and stigma regarding collaboration with mental health professionals differed from those who engaged voluntarily; with all participants sharing that their experience was beneficial in gaining both personal and professional insight and understanding with barriers to this collaboration or acceptance of collaboration being more based on personal and protective factors than whether or not they were "forced" to be in the training.

Co-creation of continued learning. Conversations about collaboration were especially insightful in regards to co-creation of learning. Officers described their own unique efforts to continue these collaborative relationships, which are more often than not provided by self-led efforts to continue attending trainings, or by being placed in environments where opportunities to organically collaborate with mental health professionals were afforded by the nature of the

setting (e.g. hospitals, local community services boards.) Again, the importance of authenticity and the ability to address pride through open conversations and learning opportunities were described as ultimately important over assumed expertise with credentials or ranks. Through the descriptions of these efforts, several more gaps were implied that could be areas of advocacy for continued learning, as currently the only "standard" offerings for continued education are CIT conferences or attending the same 40-hour training provided by other jurisdictions. While participants did describe all of these opportunities as having been exceptionally beneficial for growing a collaborative network, the needs for continued growth and opening these experiences to those who may not have the privilege of existing co-responder or co-created environments and relationships were highlighted.

Calls to advocacy. As discussions of co-created learning environments continued, calls for advocacy to incorporate and facilitate these conversations and educational experiences were described by the officers as desirable future directions of CIT training programs. As each participant described, the systemic needs that called for the creation of CIT programs as indicated in the literature are still in existence and perpetuating the need to continue the growth of these programs with continued collaboration from stakeholders in multidisciplinary roles (Lorey et al, 2021; CIT International, 2019; Compton et al, 2022). The participants who mentioned abilities to engage in continued learning through conferences and other CIT programs were notably in leadership roles, allowing different freedoms in their schedules and abilities due to the ranks that they hold. While the 40-hour training was described as beneficial by all members, the need to provide continued learning environments that are accessible to those engaging in the system at any level was critically identified as an area in which mental health

professionals and CIT officers could collaboratively come together to advocate for and co-create opportunities for congruent continued education opportunities.

Perspective shifts. A valuable outcome of the CIT programs already backed up by existing literature, is the purposeful shift in perspectives - however, these perspective shifts are again mainly focused on perspectives of law enforcement officers on those being responded to for mental health crises (Lorey & Fegert, 2021; Rogers et al, 2019; University of Cincinnati Center for Police Research and Policy, 2021; Watson et al, 2021). Participants in this study provided additional insight on how they not only gained insight into deeper understandings of mental health processes, but also shifts in perspective on mental health professionals and the system at large. While having to work together in a mental health system as part of a response to a crisis, the foundation for these perspectives has the opportunity to be set within a training environment, starting from the perspective of the mental health professional as an educator. Each participant described their own experience with taking a step back and being able to see a larger and more complex picture, while also discussing how this has led to them having different perspectives on the mental health professionals they collaborate with, such as being able to recognize burnout and compassion fatigue and the aforementioned factors of pride and personality traits all coming together as one piece of a dynamic puzzle. This illustrates an opportunity for collaborative relationships in training environments to set precedence and values for interacting within and continuing collaboration through the mental health system both personally and professionally.

Continuing Education

As has been alluded to or indicated already, the conversations regarding collaboration on training ultimately all veered towards a call for continued education and strength in collaborative relationships as the vehicles for growth in CIT training programs.

Belief and commitment. Beyond sharing their lived experiences, each participant made note that their belief in the CIT program was a main driving force for participation in this study in the first place and, as touched on above, each described ways in which they were continuing facilitating educational opportunities for themselves and others on their own accord due to this belief and commitment. The foundational values of CIT programs shone through in the participants descriptions; having been formed through a collaborative relationship with NAMI, law enforcement entities, and other mental health professionals, participants shared the impact of these collaborative roots on their own education, all of them mentioning the incorporation of a NAMI representative with lived experience on the other side of the CIT process. Through descriptions of their own "aha" moments, participants' experiences were each closely tied to a collaborative educational foundation and ended with encouragement to continue pushing for continued learning; an endeavor that can only be further bolstered by strengthening these collaborations and sharing spaces of advocacy that may only be initially available within the cultural contexts of the roles being represented.

Making connections through training. Understandably, opportunities to learn from mental health professionals afforded by the CIT 40-hour curriculum also presented opportunities to learn with and about mental health professionals, allowing for bridging gaps and connection of efforts and values from an interdisciplinary standpoint. As CIT officers are provided with built-in opportunities to learn from mental health professionals, this opens up an opportunity for mental

health professionals to utilize this access point to cultivate continued collaborative relationships and work together to bridge gaps of knowledge, understandings, and training needs which is limited in the literature, mostly being mentioned as a need for future research and consideration (Compton et al, 2011; Compton et al, 2017; Compton et al, 2022; Fleischmann et al, 2018; Russo et al, 2017 Helfgott et al, 2021; Watson et al, 2021). Participants described how the connections made through training environments provided implications and opportunities for future learning simply through opening up doors of communication and access, which provides implications for mindfully and intentionally cultivating these relationships and collaborative opportunities as parts of established CIT training programs and follow-up training opportunities.

Confidence. While existing literature addresses the importance of confidence in the role of a CIT officer as an important factor lending to the success and efficacy of CIT responses, the participants in this study also provided insight on how CIT training programs fostered critical confidence in working with mental health professionals collaboratively in a training environment and, subsequently, in the field (Lorey et al, 2021; Rogers et al, 2019; University of Cincinnati Center for Police Research and Policy, 2021). Tying in with the ability to open connections and co-create learning experiences, participants described the value of gaining new understandings and perspective shifts and growing confidence in working with the mental health professionals simply based on intentional connections and collaborative abilities. Participants in leadership roles further described how they gained confidence in their ability to lead and educate, but also confidence in the ability of mental health professionals to provide culturally responsive educational opportunities to their departments. This paves an important path for mental health professionals to enter the close-knit law enforcement environment as a vetted and trusted

collaborator, providing unique opportunities as subject matter experts to provide holistic and systemically-based educational opportunities for working in the mental health field as a team.

Safety and Protection

For a profession that has the universal tagline of "protect and serve," it is understandable that safety and protection was at the forefront of participants' descriptions of working with mental health professionals collaboratively to process their own trauma and vicarious trauma. The most immediate subtheme emerging in this realm was the trust of others in mental health support roles, followed by expected or effective counselor competencies and identification of barriers unique to this population.

Trusting others in mental health support roles. There is some research showing the disparities and challenges of law enforcement working with department-based mental health support resources, such as EAP services, that support the participants' descriptions of concerns regarding trust and confidentiality (Mcdonald et al, 2021; Otto & Gatens, 2022; Smirnova et al, 2021; Russo & Courtney, 2017; Wagner et al, 2020). Through this study, the participants provided additional insight that is unique to the CIT officer experience; that is, they are often forming working relationships with mental health professionals in their jurisdiction and they are seeing how the mental health system works (or doesn't) during crisis scenarios. Participants described their own experiences specifically mentioning that they would prefer to process their own trauma and vicarious trauma with mental health professionals that are not affiliated with the city or the police department; which makes access to resources increasingly difficult for those who now have to find a mental health professional outside of the city they are most familiar with. With concerns of confidentiality already being a huge concern within the law enforcement population, experiences of others knowing confidential information and being a part of

interdisciplinary teams wherein cases are staffed openly and collaboratively lend to a bias that there is little to no confidentiality, and an increased need to "feel out" and build trust and rapport with a clinician before even feeling safe to identify deep presenting issues. This also directly ties in with the protection motivation theory, as participants described their own personal protective measures when considering collaboration with a mental health professional similarly to those outlined by Rogers (1975) for individuals facing perceived threats: assessing severity, assuming probability of the occurrence, efficacy of recommended prevention measures, and self-efficacy to engage in preventive measures. This brings up unique needs for additional coping methods and education, led by mental health professionals that are authentically able to gain the trust and confidence of CIT officers.

Counselor competence. As previously mentioned above, most literature regarding collaboration between mental health professionals and law enforcement for processing trauma and vicarious trauma urges counselors to be trauma-informed, mindful of police culture, and work from evidence-based short-term focused modalities that were culturally accepted within law enforcement such as CBT (BJA Valor, 2018; Craw, 2022). However, the participants in this study described knowledge of the mental health system in general and the above mentioned concerns about safety and protection as huge considerations when seeking support from a mental health professional. Participants who have had successful collaborative relationships for their own processing described counselor effectiveness as being authentically honest and willing to call attention to incongruences or "bullshit," as they put it, in ways that were supportively challenging. Participants also described the importance of the counselor being able to hear the stories that they are telling without creating an environment in which the officer feels they have to go back into work mode to protect the counselor from their own vicarious trauma.

Additionally, throughout these conversations it became evident that through working in the mental health system, participants had gained insight on what to say and what not to say when working with a clinician as they have seen the "tricks of the trade" on others and subsequent processing conversations as an interdisciplinary team afterwards. This further strengthens the need for foundational counselor competencies to have open transparency, with descriptions indicating a unique need for integration of appropriate self-disclosure in the way of describing why certain questions are being asked and explaining the process as it is happening as a way to gain trust and open rapport rather than creating an environment where officers are perpetuating a constant mode of analysis and hypervigilance.

Barriers. In this realm, barriers were described as barriers to psychological safety and again highlighted the aforementioned basic needs of understanding and connection prior to considering engaging in supportive collaborative relationships with mental health professionals. Participants continued describing the intersectionalities of being a part of a mental health system and then needing mental health care - as they have seen and been a part of engagement in city resources for individuals they respond to, participants described that they were less likely to reach out for themselves which, again, creates a barrier to access. Additionally, participants described how they still did not have full understandings of what mental health collaborative support might look like outside of what they have experienced as responders to crises, describing opportunities for collaborative endeavors to describe what mental health support can look like - including that it does not have to have reached a point of crisis to be deserving of attention. Those that have had successful collaborative processing relationships described that there are huge needs to provide basic understandings and discussions surrounding what mental health care can look like.

Cumulative Impacts on Wellbeing

Discussions on the impacts of cumulative stress from trauma and vicarious trauma exposures are certainly not missing from literature (SAMHSA, 2018). Through the conversations in this study, participants identified unique experiences and provided rich descriptions of the deepest impacts unique to being in a CIT role.

Helplessness as a helper. Perhaps the most profoundly impactful descriptions in this research conversation highlighted an essence of feeling helpless as a helper as being the biggest impact of vicarious trauma on participants. While research does describe the effects of constantly and consistently seeing and being a part of others' most traumatic experiences, participants shared that it was not necessarily the assumed traumatic event (witnessing death or violence), rather, the experience of not being able to fully help as a human and having to maintain a sense of professionalism - MP3's quote bears repeating again in that he "felt so inadequate as a human being" during an instance where he had to ask a young grieving mother to sign paperwork per policy while she was still holding her child who was moments away from taking their final breath. All participants described instances in which they felt similarly, and also incorporated the increased complexities and difficulties when, as members of CIT teams, having to respond to the houses and crises of their own department members. This is a critical understanding in moving forward collaboratively and culturally informed, in that it is easy (and again justified in literature) to assume that witnessing traumatic events is what should be ultimately addressed, however, having the awareness of the deeply complex feelings that come with being helpless as a helper can make a difference in forming that authentic and genuine rapport up front. If an individual doesn't feel like they can provide help as part of the mental health system, it is understandable that they would feel even more so that they could not receive help. This is also a

consideration that is not just unique to CIT officers, and can certainly be a point of connection between mental health professionals and CIT officers.

Effects outside of the job. Participants shared experiences that were congruent with existing literature identifying how their own experiences with calls has shaped how they act or react in their personal lives, including increased vigilance and changes in personal habits or connection abilities, which is aligned with common impacts of vicarious trauma (American Counseling Association, n.d.; Alden et al, 2020; Daniel & Treece, 2022; Mcdonald et al, 2021; SAMHSA, 2018;) Participants also provided unique insight into how their experiences as CIT officers have affected their perceptions of safety and ways in which mental health professionals can collaboratively support or perpetuate these feelings. One of the biggest considerations highlighted by participants, tying in with all of the subthemes under the safety and protection umbrella, was the experiences of mental health professionals as collaborative advocates outside of the job or processing environment. As touched on above, participants continued describing instances where their experiences in seeing mental health professionals interact with them or others has shaped their perspectives and considerations of engaging in their own mental health supportive practices. Participants also described incongruences that destroyed senses of trust where mental health professionals may be supportively collaborative in an individual space, then express their concerns or advocacy against police involvement in the mental health system on a public forum. As participants described, this added to a sense of mistrust and helplessness, indicating the importance of the responsibility of mental health professionals as responsible and ethical advocates with mindfulness of the populations they are serving.

Resilience. Cultivating and encouraging resilience-building strategies is the go-to in wellness considerations and research for law enforcement officers, most often being focused

around LEOs helping LEOs (Fleischmann et al, 2018; Horan et al, 2021; Jones et al, 2017; McDonald et al, 2021; SAMHSA, 2018). Conversations in this study allowed for additional insight in to how collaborative relationships with mental health professionals through CIT experiences have and could add to facilitating and fostering conversations and personal resilience needs. Participants shared how the education they received and the experiences they then had as interdisciplinary teams within mental health crises provided insight and abilities to build resilience for themselves through collaborative and informed efforts. The importance of individual and contextually sound understandings was highlighted as each participant shared their experiences - most especially in recognizing that they did not want to be out in the field encouraging or enforcing connections to mental health care if they themselves were not also engaging in it. Participants described how their own resilience efforts have been bolstered by abilities to connect and collaborate with mental health professionals on levels beyond having to make an appointment or referral; identifying the stage of collaboration built in to CIT programs as a holistically beneficial space wherein they were able to learn about resilience as a set of individual and personal skills and plans that can be further supported through collaboration with subject matter experts in the mental health field.

Stigma

Another theme that is not missing in the literature is the general considerations of stigma regarding LEO involvement in mental health care for processing trauma and vicarious trauma, which was further expanded by descriptions of the unique experiences of stigma specifically described by participants in this study.

Vulnerability. Participants described the experiences of being vulnerable or considerations of vulnerability with mental health professionals already being difficult due to

long-standing cultural “norms” in the police environment, and then highlighted the additional complexities that are added in when mental health professionals become, in some way, an extension of the brotherhood of law enforcement that has perpetuated these stigmas. It was described again that involvement in others’ mental health crisis calls necessitating collaboration with mental health professionals has provided additional considerations into vulnerability, as they have often seen individuals’ rights taken away in the moment as they are taken to a hospital or required to connect with certain resources. With mental health professionals now being a part of the interdisciplinary team, CIT officers have an additional stigma in vulnerability in that similar feelings of speaking to a supervisor or member of their department may arise with considerations of who will be telling who, will the entire department know, and will they be seen as weak or incompetent if a clinician knows they were also having their own mental health struggles. This aligns with previous descriptions regarding the safety of seeking collaborative support outside of their own working environments, which adds another level of vulnerability in going outside of a comfort zone and into a different location’s system of care and support availability.

Compartmentalization. Participants described how the aforementioned stigmas and barriers often encouraged them to create personal compartmentalization systems when it comes to processing needs. As is expected, officers are encouraged to appropriately compartmentalize while on the job so that they are able to effectively carry out their job duties (Daniel et al, 2022; Fleischmann et al, 2018; Horan et al, 2021; Mcdonald et al, 2021; Wagner et al, 2020) Aligned with protection motivation theory, participants described that the perceived threat to their psychological safety when working with mental health professionals was typically personally addressed by keeping their concerns “close to the vest” - with participants describing that having

a working relationships with some professionals would deter them from going to those same professionals even for discussing options for referrals or resources. Along with the continuation of cultural norms, the participants described the unique challenge of their CIT officer role as seeing the need for mental health care and their own needs for processing, yet also gaining more insight in to the continuations of stigma and needs for compartmentalization within their own organizations. This calls back to feelings of helplessness as a helper, wherein officers now feel complexly vulnerable when considering talking to their own peers *and* when considering talking to mental health professionals.

Buying in. Just as it takes purpose and intent to engage in the specialized CIT training environment, a huge component of officers' willingness to engage in mental health care for themselves was the "buy-in." In line with extant literature, officers mentioned aspects of modeling, cumulative trauma, and growth in understanding of mental health resources either due to their own experiences or as officers in response to mental health crises (Daniel et al, 2022; Fleischmann et al, 2018; Mcdonald et al, 2021; Vukčević & Živanović, 2022; Wagner et al, 2020). Each participant shared their stories of vulnerability, with an overarching theme of healing being that they felt heard, not alone, and empowered in their abilities to build resilience. As has been mentioned throughout this study, CIT environment places officers at the helm of the worst parts of the mental health system, so it stands to reason that they would be even more hesitant and reluctant to engage in it themselves, especially if they have not been exposed to any approaches or outcomes outside of a justice-involved scenario - which was conveyed by the participants. This understanding is a critical space of cultural responsiveness and call to advocacy for mental health professionals as allies and supportive collaborators within this population.

Implications for Counselors

As is hugely addressed and focused on in counseling programs, it is understandable that the loudest call for counselor competencies is the importance of multicultural responsiveness and education. As discussed in the literature review, peer support is the evidence-based go-to for law enforcement, and this study has highlighted numerous opportunities for counselors to be able to better provide culturally-informed and higher-level supportive care for this population that is already called on to manage the worst days of others' lives. At a minimum, it is any counselor's responsibility to understand the laws and regulations under which they work, and that includes the possibilities of working collaboratively with law enforcement. This can also benefit those we work with, as we can provide more in-depth discussions that allow for informed consent and autonomy if we are able to describe the processes that may happen in a crisis scenario and if we can clearly outline the protections and values that are afforded to our clients through the legalities of the state(s) in which we are practicing.

In counseling programs, it is taught to ensure that basic needs are met, regardless of what modality, lens, or background you are coming from to engage in a collaborative relationship whether it be for education or for healing. The stories shared by the participants in this study hearkened back to those fundamental and foundational needs; while existing literature speaks to complex and nuanced approaches for responding to the general public facing mental health crises, it does not address the need to meet basic needs of trust and safety in collaboration first.

Regardless of the roles a counselor may take on, an understanding on how to work collaboratively with law enforcement on a fundamental level is critical; especially as we are taught to call on them in crisis situations and are bound by a code of ethics that encourages multitudes of cultural and competence considerations - including being effective interdisciplinary

team members, understanding professional and ethical obligations, (American Counseling Association, 2014). One of the most important considerations is how pride for this profession may be influencing our ability to interact with others who also have a sense of pride and ranking systems - counselors have credentials and certifications, law enforcement has ranking systems and credentials as well; and unless either party has taken time on their own through personal or professional endeavors, the colors of badges and the certificates hanging on the wall do not matter as much as far as gaining or expecting trust as an expert. Though counselors may not be working closely with or for law enforcement or CIT programs, it has been highlighted through this study that police involvement in mental health is not going away, and basic understandings of these cultures and processes is ultimately beneficial for any emerging counselor to have a foundation of systemic knowledge.

Implications for Counselor Educators

The most prevalent considerations for counselor educators that came out of this study were additional avenues of cultural competence and intentionality in education specifically when it comes to the importance of understanding laws and perspectives of those that we are taught to call on when we are experiencing a crisis beyond our ability to manage. There is a unique and crucial opportunity to open avenues of access for future counseling professionals to work embedded in law enforcement or public safety entities as an interdisciplinary team member through education, provision of services, or any amalgamation of a supportive role within a law enforcement or other public safety agency. The ACA code of ethics (2014) specifically outlines multicultural competencies and educational responsibilities for all counselors, however, if we do not have any counselor educators with competencies working with and for public safety, we are

getting in our own ways in limiting the possibilities of the counseling profession and gatekeeping by not even having the key.

A contributing factor to the dearth of literature and cultural competencies is the fact that the literature is written, understandably, by those in the mental health field. For research in general, and especially for research that is geared toward publications, it is a requirement that all cited sources are peer-reviewed; while there were many valuable articles and forums that would have added a wealth of insight and information into this study alone, not to mention form foundations for evidence-based practices and procedures, they are still not accepted as "valid." Yet, law enforcement officers are not publishing research unless their identities are intersecting with a researcher or additional endeavor. This ultimately results in a deficit in the literature, only filled by a very limited group of researchers - as evidenced by the references section of this study itself. As subject matter experts in the field with the privilege of being in seats of power to shape and inform not only narratives stemming from our own research but those that are considered in the future; we have to find ways to incorporate the voices of those who otherwise are not considered "valued" by research standards. This study is an example of the importance of true phenomenological research as a platform to include the voices and experiences of those that may otherwise never have a say in this arena.

Implications for CIT Programs

As highlighted throughout this study as a whole, there is a need for continued education beyond the 40-hour standardized training. Even just through conversations with ten individuals, ideas for continued learning opportunities came up throughout the interview process, and motivations for supporting these were expressed by each participant regardless of rank or role within the CIT programs. As collaborative relationships are already embedded within the 40-

hour training, there are opportunities to continue utilizing and opening these paths of collaboration and communication in ways that entire departments can benefit from, such as establishing a continuing education program schedule and importantly having conversations with any interested participant to help co-create the most meaningful trainings and educational experiences that are relevant to the communities and individuals being served as well as abilities to share and adapt these trainings for other localities. Additionally, there are spaces in CIT programs that may allow for conversations to be had focusing on officer wellness and addressing some of the concerns, barriers, and questions regarding engaging in mental health care for themselves - including in-depth reassurances and explanations of confidentiality procedures and processes, and how those pertain to needs for referral and collaborative care. As officer wellness segments are already included in CIT 40-hour training programs, this is an opportunity to be mindful of how these segments can be most culturally informed for delivery and continued collaboration moving forward.

Limitations

The biggest limitations of this study is the small concentrated sample size. Though empirically backed to justify having reached saturation, having just ten officers from the same general area within the same state with limited diversity represented indicates this study as being but one brick in an entire foundational need. As was brought up in speaking about educational needs, experiences are imaginably going to be different in other environments. Further, as described above, participants all made mention of their reasoning for participating in the study, which always involved having vetted me through their own research and the endorsements of someone else that they knew and trusted and that had sent out the call for participation for this study on my behalf. This indicates that even though I did not personally know any of the

participants prior to their participation in this study, there was at least some degree of familiarity or mutuality through the individuals who provided access to participant pools in the first place.

With the nature of this study being to explore vulnerable topics to identify how collaborative relationships between the population the participants represent and the population that I as the researcher represent, it stands to reason that there may have still been layers of mistrust or calculation in response - especially as the interviews were being recorded and several participants were on duty while engaging in the study. I was mindful to try and mitigate this as much as possible by having off-the-record conversations for as long as any participant needed to feel comfortable beginning the semi-structured interview, however, participants would often hesitate a bit or apologize after providing responses that were meant to illustrate negative experiences and barriers with collaboration with mental health professionals.

Future Research

As with many qualitative research endeavors, the implications for future research incorporating the voices of those not otherwise represented in literature or educational spaces are multifaceted. Perhaps most prevalently, future research is needed to evaluate and begin a foundation of evidence-backed literature to facilitate continued education standards and offerings for CIT officers. As the spirit of collaboration was described as a helpful and much needed experience, there are opportunities to continue exploring more specific collaborative endeavors for training and for processing that can eventually form applications to be piloted, studied, and eventually incorporated into this interdisciplinary realm. Additionally, as CIT is an international endeavor, much more research is needed to incorporate the voices and experiences of those in a multitude of environments and systems to form as comprehensive of a widely cultural understanding as possible.

Summary

This study examined the lived experiences of CIT officers in their endeavors to collaborate with mental health professionals for training and processing trauma and vicarious trauma through a phenomenological lens. The results of this study were congruent with implications in existing literature, and provided rich new insight into these dynamic relationships. As the researcher in this study, I have had the privilege of being the one to tie these voices together to begin filling a gap in the literature and identifying steps forward. In keeping with the essence of descriptive phenomenology and addressing how my own values have interpreted that essence, I feel it is an additional privilege and an ultimate responsibility to allow the voices of those living these experiences to shape this narrative as holistically and authentically as possible, which includes having the final words in wrapping this study up:

"There's a lot of ups and there's also a lot of downs, but I think within those moments is where you really find out who you are and what you can do for each other. And you can actually open up those doors of communication…and how can we make it better? How can we get out of each other's way to increase our productivity, to increase our relationship, to increase the help that we give and are given."

"As far as my advice for you guys, just always keep that line of communication open. Be willing to tell us when we're wrong, be willing to be straight up. Sometimes you might get pushback. Sometimes you may have to be the person to say 'you know what, you were right, how can I work better with you moving forward' and in turn I'm hoping that [CIT officers] will do the same for you, and if that does happen, be open for that conversation"

"I think all officers should be CIT trained and I think all clinicians should go through the 40-hour training too. I understand why it's a voluntary program, I think it should be mandatory

but obviously that's out of my pay grade. I don't make that decision. But I know how valuable it has been to me as a person and as an officer and it isn't ever going away so we need to be doing more to make it better, expand it, really learn."

"I am not gonna do everything correctly, and you're gonna mess up, and I'm gonna mess up. But its the fact that we can sit down and have a conversation about what we did and what we can do to fix it. That's how we collaborate and build. Being open to the conversation in the first place and getting away from wanting to not be wrong."

"If this program fails, it's because we made it fail. If this program fails, it's because we wanted it to - we didn't do enough to make it thrive. We didn't do enough to evolve it. So as far as the future of the CIT program, I see it being a billion times better than it is today. If we are still in a position to make things better, we need to make things better."

"I am not ashamed to tell anybody, whether it be you or recruits or anybody, I go to therapy. I go to therapy once a month, and sometimes we talk about work, sometimes just personal stuff, sometimes we just talk about things just to talk about it. But it took me a long time to get there. If I'm a person enough, if I'm human enough to say 'I know I"m not right,' if I'm big enough to say I'll sit for an hour on somebody's couch and tell them what's on my mind, there's no reason why you can't do it. And I don't push it on anyone, I don't get referral bonuses, and I'm not telling people that this is the only way, but its an option, you know. There's nothing wrong with it and I have learned that through therapy, through that relationship - so yeah building those bridges are critical because we can help each other only to so much extent you know, and maybe the way of helping each other moving forward is, you know, working to end that stigma and getting people to try whatever kind of therapy it is they need. It is a process, and its okay."

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APPENDIX A - INFORMED CONSENT

OLD DOMINION UNIVERSITY

PROJECT TITLE: Partners in Crisis: A Phenomenological Exploration of Collaboration between Crisis Intervention Team Officers and Mental Health Professionals

Principle Investigator: Dr. Kristy Carlisle, Ph.D., LPC-R (VA), HS-BCP, Department of Counseling & Human Services, College of Education

Graduate Student Investigator: Jessica Huffman, MA, LPC, NCC, CTP, CFRA, Doctoral Candidate in Counselor Education and Supervision, Department of Counseling and Human Services, College of Education

DESCRIPTION OF RESEARCH STUDY

While there is existing and ongoing literature exploring the responses provided by CIT, there is limited research on the experiences of CITs related to their unique interdisciplinary team collaboration as it relates to training and support through trauma and vicarious trauma. LEOs are not only called upon to help others in a time of crisis, but they are also often their own resource for processing and training, all the while functioning in a dynamic system with increased exposure to traumatic events, psychological distress, and stigma around mental health support. The consequences of this work are multidimensionally detrimental to mental and physical health.The unique collaboration of mental health professionals and LEOs on CIT teams provides an internal foundation for processing, support, and training; however, foundational needs of trust, safety, and collaboration are critical. While mental health professionals may have shared knowledge and education on working from a nonjudgmental, empathetic, and compassionate place, the voices and perspectives of LEOs are essential components to understanding and improving these dynamic relationships. This proposed study will explore the lived experiences of CIT officers collaborating with mental health professionals for training and support in navigating trauma and vicarious trauma through a descriptive phenomenological approach. This study aims to gain insight into CIT officers' experiences, perceptions, and needs for collaboration on support and training and inform a foundation for counselors and counselor educators rooted in cultural understanding and responsiveness as informed by the voices of those we call on to protect and serve.

If you volunteer to participate, you will join a study involving the research of practicing CIT officers. You will engage in a brief screening questionnaire, at least one 1-hour to 90-minute interview, and will be asked to read through interview transcriptions to ensure clarity and have the opportunity to provide additional explanation if necessary. If you say YES, participation will

last approximately 3 non-consecutive hours total through online means such as email and Zoom. Approximately 11 other similar subjects will be participating in this study.

INCLUSIONARY CRITERIA

To participate in this study, individuals must meet the following criteria: (1) be over the age of 18 years old; (2) be currently acting as a CIT officer; (3) have been CIT certified and acting as a CIT officer for at least two years

RISKS AND BENEFITS

Risks: If you decide to participate in this study, then you may face a risk of minimum distress including unwanted and unforeseen personal reactions to the information you share. The researcher tried to reduce these risks by providing study information up front and removing any identifying information such as name and place of employment. All Zoom recordings will be deleted after data analysis and all identifying information will be removed and kept separate to protect confidentiality and safety. Some of the lived experiences with trauma and vicarious trauma reflected during the interviews may result in emotional distress. The researcher will provide additional mental health resources if further support is needed. And, as with any research, there is some possibility that you may be subject to risks that have not been identified.

Benefits: The main benefit to you for participating in this study is you will have an opportunity to reflect on your lived experiences with a confidential source. This study will have implications for counselors, counselor educators, researchers, and interprofessional teams. The findings will enlighten and advance our knowledge of these lived experiences to include identification and consideration of measures that could be taken to support this vital profession. In addition, all participants will receive a $20 Amazon gift card as a small expression of gratitude for time and sharing experience.

COSTS AND PAYMENTS

Participation in this study is voluntary. Researchers recognize that your participation may pose some inconvenience due to time commitments. There is no cost to participate in this study.

NEW INFORMATION

If the researchers discover new information during this study that would reasonably change your decision about participating, then this will be shared with you.

CONFIDENTIALITY

The researchers will take reasonable steps to keep private information obtained in this study confidential, such as the demographic questionnaire and identifying information unless disclosure is required by law, court order, or by government bodies with oversight authority. The researcher will assign each participant a pseudonym to protect identity. All study data will be

kept in a password-locked computer in a password-locked file accessible only by the researchers and will be destroyed within 5 years of its collection. Summarized data and responses to the open-ended questions will be presented at meetings, in presentations, reports, and publications. However, the researcher will not identify you or your agency in these presentations. Participants are responsible for the confidentiality of their setting during the interview process.

PERMISSION TO AUDIO AND VIDEO RECORD

During data collection, participants will be audio and video recorded. By noting your agreement with the consent, participants are giving the researcher permission to audio and video record the interviews. These recordings will be destroyed after data analysis.

WITHDRAWAL PRIVILEGE

Even if you have agreed to participate in this study, you are free to withdraw at any time. Even if you say yes now, you are free to say no later and walk away or withdraw from the study at any time. The researchers reserve the right to withdraw your participation in this study, at any time, if they observe potential problems with your continued participation.

COMPENSATION FOR ILLNESS AND INJURY

If you volunteer to participate in this study, your consent in this document does not waive any of your legal rights. However, in the event of harm arising from this study, neither Old Dominion University nor the researchers are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in this research project, you may contact the responsible investigator (Jessica Huffman, 703-254-3802); or Dr. John Baaki, DCEPS Human Subject Review Committee chair jbaaki@odu.edu; 757-683-5491 who will be glad to review the matter with you.

VOLUNTARY CONSENT

By clicking and signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researcher should have answered any questions you may have had about the research. If you have any questions later on, then the researcher should be able to answer them.

If you have any questions, concerns, or complaints, please contact the Responsible Project Investigator, Dr. Kristy Carlisle, at kcarlisl@odu.edu.

If at any time you feel pressured to participate, or if you have any questions about your rights or this form, contact Dr. John Baaki, DCEPS Human Subject Review COmmittee chair jbaaki@odu.edu; 757-683-5491

By signing below, you are telling the researcher yes, that you agree to participate in this study. The researcher should give you a copy of this form for your records.

Subject's Printed Name & Signature	**Date**

INVESTIGATOR'S STATEMENT

I certify that I have explained to this subject the nature and purpose of this research, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws, and promise compliance. I have answered the subject's questions and have encouraged him/her to ask additional questions at any time during the course of this study. I have witnessed the above signature(s) on this consent form.

Investigator's Printed Name & Signature	**Date**

APPENDIX B - INTERVIEW PROTOCOL

Partners in Crisis: A Phenomenological Exploration of Collaboration between Crisis Intervention Team Officers and Mental Health Professionals

Introduction

This interview will take approximately 60-90 minutes to complete. Before we begin, I want to confirm that you can commit to a minimum of 60 minutes.

[Participant answers yes or no. If yes, move forward. If no, reschedule the interview]

I also want to confirm that you are in a private space to conduct this interview without interruptions, which helps us to preserve your confidentiality and privacy as well as ensuring there are no disruptions or distractions that may interfere with your responses. Understanding the nature of your role is not without unforeseen calls for service, I want to ensure you feel as able and comfortable within your context to engage in this interview.

[Participant answers yes or no. If yes, move forward. If no, reschedule the interview]

Finally, I am confirming that you have read and understood the informed consent for this research project, and are agreeing to participate in this recorded interview.

[Participant answers yes or no. If yes, move forward. If no, end the interview]

What questions do you have about the interview, research, or process?

[Answer participant questions or move forward if there are no questions or clarifying conversations]

As a reminder, you may decline to answer any question or prompt, and I will move on to the next question. You may also end the interview at any time without penalty. I have provided a list of confidential and safe mental health resources for you in the event that additional support is needed due to talking about potentially distressing experiences. I also invite you to engage in reflective note taking, journaling, or consideration throughout this process to provide any feedback or questions about the process. Finally, you have the option to turn your camera off for the interview if you prefer the recording only to capture our audio to further protect your privacy. Would you like to leave your camera on or turn it off?

[Participant indicates preference, move forward]

Throughout this interview, we will be utilizing the terms Crisis, Trauma, and Vicarious Trauma. I will provide you with operational definitions of these terms in the chat now and open the opportunity for any additional questions or needs for clarification on these terms.

[Paste definitions in chat box, address any participant questions or needs for clarity. Move forward]

The informed consent pieces have been covered. Are you ready to begin?

[Participant answers yes or no. If yes, move into the interview protocol. If no, terminate the interview]

I am starting the recording now.

BEGIN RECORDING

Before we begin the interview questions, to confirm you reviewed and understood the informed consent and that I have answered all of your questions about the study procedures, do you consent to participate in this interview?

[Participant answers yes or no. If yes, move into the interview protocol. If no, terminate the interview]

Interview Questions

Main	Supplemental
Please describe your background and experience as a CIT officer. *[RQ 1&2]*	● How long have you been working in this field, and what motivated you to become a part of the crisis intervention team? ● Please describe your initial training experience as a CIT officer.
Please describe your experience collaborating with mental health professionals during your training. *[RQ1]*	● How do you perceive the role of mental health professionals in CIT training? ● Please share specific instances where collaboration with mental health professionals was particularly impactful or challenging. ● How has working closely with mental health professionals changed or reinforced perspectives on mental health in law enforcement?
What challenges have you faced in collaborating with mental health professionals during training? *[RQ1]*	● Please share any success stories or positive outcomes from this collaboration. ● How has this collaboration personally impacted you as a CIT officer? ● Please describe collaborative efforts with mental health professionals, if any, that have been facilitated outside of the required 40-hour training for continued education or support.
I am going to begin asking about experiences with trauma and vicarious trauma, the operational definitions are in the chat, and I have provided you with a list of supportive resources in the event that they are needed. As a reminder, you are not required to answer any question that you are uncomfortable discussing, and you are able to end the interview at any time. Proceed?	
Please describe any personal experiences with trauma or vicarious trauma in your role as a CIT officer. *[RQ2]*	● How have these experiences impacted you personally and professionally? ● In what ways have you collaborated with mental health professionals to address trauma or vicarious trauma? ● Please discuss the emotional and psychological impacts of dealing with trauma as a CIT officer, and how that has related to collaboration with

	mental health professionals.
Please describe your approach to handling traumatic experiences, and if it has changed or been influenced by collaboration with mental health professionals. *[RQ2]*	● What kind of support systems or resources have been provided to you through this collaboration? ● How effective have these supports and resources been in helping you process trauma? ● What challenges have you experienced related to trauma/vicarious trauma , if any, and how have they been addressed?
How do you perceive the role and effectiveness of mental health professionals helping CIT officers process trauma? *[RQ2]*	● What improvements or considerations would you suggest in the way mental health support is provided? ● What personal coping strategies have you developed or learned through this collaboration for processing trauma and vicarious trauma?
Based on your experiences, what are your thoughts on the future of CIT programs and the collaboration with mental health professionals? [RQ1 & 2]	
Is there anything else you would like to share or address about your experiences?	

Closing Statement

Thank you for your contribution to this important study to help better inform counselors how to compassionately and relevantly collaborate with and support CIT professionals. You will be receiving a copy of your interview transcript via email within one week for you to read over the transcript so you can edit and clarify your responses if needed before proceeding to the data analysis phase. We ask you to return your edits to the research team within one week so that we can move forward with the data analysis in a timely manner. Again, I am very appreciative of your time and participation.

End Recording

VITA

Jessica L. Huffman | JCARP026@odu.edu

EDUCATION

Old Dominion University, Norfolk, VA
PhD, Counselor Education and Supervision - May 2024
Dissertation: *Partners in Crisis: A Phenomenological Exploration of Collaboration between Crisis Intervention Team Officers and Mental Health Professionals*

Wake Forest University, Winston-Salem, NC
Master of Arts, Clinical Mental Health Counseling - May 2021

Corcoran College of Art & Design
Bachelor of Fine Arts, Photojournalism - May 2013

LICENSURE/CERTIFICATIONS

Licensed Professional Counselor, Virginia #
Nationally Certified Counselor (NCC)
Certified Trauma Professional (CTP)
Certified First Responder Counselor Associate (CFRA)
Crisis Intervention Team 40-hour Training

TEACHING EXPERIENCE

Old Dominion University
COUN 601: Principles of Professional Counseling and Ethics
HMSV 346: Diversity Issues in Human Services
HMSV 368: Case Management & Crisis Techniques through Field Observation
HMSV 444: Psychoeducational Groups
HMSV 447: Introduction to Substance Abuse
HMSV 452: Substance Abuse Treatment and Research

PROFESSIONAL MEMBERSHIPS

NAMI Coastal Virginia Board of Directors
Chi Sigma Iota
American Counseling Association