An Assessment of Crisis Intervention Team (CIT) Community Partnerships to Address Mental Health and Racial Disparities in Police Violence Across the United States

by

Elizabeth Hassett

BS, University of Pittsburgh, 2020

Submitted to the Graduate Faculty of the

Department of Health Policy and Management

Graduate School of Public Health in partial fulfillment

of the requirements for the degree of

Master of Public Health

University of Pittsburgh

2021

UNIVERSITY OF PITTSBURGH

GRADUATE SCHOOL OF PUBLIC HEALTH

This essay is submitted

by

Elizabeth Hassett

on

April 14, 2021

and approved by

Essay Advisor: Tina Batra Hershey, JD, MPH
Assistant Professor, Health Policy and Management
Co-Director, Multidisciplinary MPH
Interim Deputy Director, Center for Public Health Practice
Graduate School of Public Health
Affiliated Professor, University of Pittsburgh School of Law
University of Pittsburgh

Essay Reader: Richard Garland, MSW
Assistant Professor, Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

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Abstract

Background: Mental health and racial disparities as they relate to police violence continue to persist in the U.S.: those with mental illness are 16 times more likely to become the victim of a deadly police shooting, and black individuals are far more likely to face lethal force from police. Black individuals also face a higher rate of mental illness largely due to their lived experiences, which increases their chances of interacting with the police. Crisis Intervention Team (CIT) programs intend to decrease police violence by equipping officers with the necessary knowledge and partnerships to divert those in mental health crisis away from the criminal justice system.

Methods: This paper uses the University of Memphis' CIT Map to establish the distribution and types of CIT programs and partnerships across the U.S. It also uses the National Association of Mental Illness's (NAMI) partnership recommendations as the basis for rigorous CIT partnerships.

Results: The findings indicate that 2,886 CIT programs cover nearly one-quarter of the country's population, and most of these programs are organized by law enforcement. However, CIT partnerships are extremely limited in their distribution: 375 partnerships exist, meaning that for every county with a program, only 0.49 partnerships are engaged. The partnerships that do

exist cover four of five recommended partner areas, with public officials as the only missing category.

Public Health Relevance: Police violence, law enforcement, and lack of mental health treatment can lead to not only physical, but also to psychological, harm on the community level. CIT programs offer a mechanism to address these mental health and racial disparities as they relate to police violence, but they must engage rigorous community partnerships to do so. CIT partnerships are a direct indicator of CIT program success. Therefore, a properly-structured program should decrease police violence, connect individuals in mental health crisis with the appropriate resources, and increase the number of individuals that are put on a path to recovery.

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Preface

I am indebted to my essay readers, Professor Hershey and Professor Garland. Professor Hershey – thank you for keeping me grounded in my ideas but providing me with your time and patience to hear them out nonetheless. Professor Garland – thank you for inspiring me to think big and for your unrelenting energy in the field.

To Professor Van Nostrand, thank you for your unwavering support from the first day I stepped into your office. Your passion for the law and public health inspire my future career, and I will think back fondly on all of the classes and conversations we have had together. You helped me to find my place in the program, and for that, I am grateful.

Finally, I would be remiss to not thank my family and friends. Mom and Dad – your continuous support of my academic career has gotten me to where I am today, especially as I embark on my new law school journey. To my roommates and friends – thank you for supporting my late nights and moments of stress, yet still encouraging me to take much-needed breaks.

1.0 Introduction

Law enforcement across the United States represents a major point of interaction among individuals that experience mental illness. Police departments face a heightened number of calls that involve those with serious mental health needs, averaging 10% of calls.[1] These calls can be complex, since responders are often unaware of underlying mental health conditions prior to arrival onsite, and the situation can escalate quickly.[2] Nonetheless, a 9-1-1 call remains a natural step when a nearby person experiences a mental health crisis, which increases the likelihood that a person that requires help for mental illness will encounter police in place of mental health professionals.[3]

However, encounters with law enforcement can lead these individuals to experience violence and face incarceration at rates higher than the general population for an illness that could oftentimes otherwise receive treatment.[4] While individuals with a severe mental illness are not more likely to commit a violent act, they are 16 times more likely to become the victim of a deadly encounter with police.[3, 5] Regarding incarceration, those with a severe mental illness face a 4-6 times higher presence rate in U.S. jails compared to the rate of severe mental illness in the general population.[6] Similarly, in 44 of the 50 states, a prison or jail holds more individuals with mental illness than the largest state psychiatric hospital.[6]

These statistics indicate that the relationship between those with mental illness and the police does not function in a mutually-beneficial manner, and they provide insight into a significant public health problem. That is, the role of law enforcement in mental health encounters leads to an increased risk of violence and incarceration over mental illness treatment, causing a continuous cycle of involvement with the criminal justice system that involves population-level consequences.

With this, different methods of intervention require consideration to improve community health outcomes with respect to mental health.

This paper will focus its efforts on the effectiveness of Crisis Intervention Teams (CIT), with CIT partnerships as the primary determinant of effectiveness. A CIT is a specialized law enforcement training program in mental health for certain officers to learn how to respond to mental health calls and eliminate mental health and racial disparities in police violence. A best practice for CIT programs is rigorous partnerships.[7] It is important to understand how CITs interact with this complex system of disparity in order to best approach current and future police reform, and partnerships can highlight the ways in which police departments interact with community organizations to focus on these disparities. To set the foundation for why effective CITs and strategies to combat police violence are necessary, this introduction reviews the basis for how mental illness, race, and law enforcement are inherently intertwined.

1.1 Information on the Disparities of the Mentally Ill and Black Communities with respect to Law Enforcement and the Criminal Justice System

As it stands, 44 million individuals are diagnosed with a mental illness in the U.S., including eight million with a severe mental illness – four million of whom do not receive treatment.[5] According to the Treatment Advocacy Center, individuals with severe mental illness represent 1 in every 25 adults in the U.S., but *at least* 1 in 10 law enforcement calls, 1 in 5 of all jail and prison inmates, and 1 in 4 of fatal police encounters.[5] The Los Angeles Police Department, for example, reported that 37% of police shootings involved individuals with mental illness in 2015.[8] Even more stark lies the youth population: 17% of those aged 6-17 have a mental illness, compared to 70% of youth in the juvenile justice system.[9] This disparity represents a concern of

public health significance, as police violence, law enforcement involvement, and lack of mental health treatment can lead to not only physical, but also to psychological, harm on the community level.[10]

However, racial disparity lives within these mental illness disparities. 50% of white adults with a mental illness diagnosis receive treatment, but only 33% of black adults can say the same.[9] Meanwhile, proper mental illness treatment reduces the likelihood of police interaction and arrest.[5] This lack of healthcare based on race represents one contributing factor as to why black individuals face higher rates of police violence and arrest.

In addition, racial inequalities exist in the use of force. Through an analysis of over 2 million police stops in New York City from 2007-2014, researchers Rory Kramer and Brianna Remster determined that police treat white and black individuals fundamentally different; black individuals are far more likely to become the victim of lethal force when police uncover criminal activity. They find that "if there were no racial disparities in police use of force…approximately 61,000 fewer stops of black civilians would have included police use of force and 1,000 fewer stops would have included potential lethal force."[11] The nonprofit ProPublica analyzed 1,217 deadly police shootings from 2010-2012 as reported by police departments to the FBI. It found that police killed 31.17 young black males aged 15-19 per million people; the rate for young white males was only 1.47 per million.[12]

Some researchers question this type of data, arguing that it fails to take into account situational factors, such as the level of violence. However, a Washington Post reporting found that black individuals killed by police were less likely to have a lethal weapon compared to white individuals killed at the hands of law enforcement.[13] It compiled information on the race and ethnicity of those fatally shot by police from 2015-2016, specifically to analyze whether these

individuals were armed with a lethal weapon. It found that in these lethal police shootings, over 50% of white suspects, but less than 25% of black suspects, were armed with a lethal weapon. This information helps to illustrate that racial disparity exists within law enforcement itself and not solely due to differences in racial group tendencies. Nonetheless, the significant differences in the treatment that black individuals experience – whether that be 61,000 more violent police stops or 31.17 per million killed – clearly demonstrate the existence of a racial disparity whether or not external factors in racial group behavior play a role.

In addition to their higher likelihood of experiencing police violence, black individuals also have a higher likelihood of experiencing mental illness from factors of violence and trauma, largely due to their life experiences.[14] A major theory that explains the stress toll that black people face is John Henryism. Studied by social epidemiologist Sherman James, John Henryism attributes higher rates of disease, lower mental health, and lower life expectancy in the black community to the social inequalities and structural racism that it faces. These social barriers cause constant stress, which makes the body work twice as hard to overcome until the body's normal functioning diminishes.[15]

Scientific findings uphold this theory: Rewak, et. al. found shorter leukocyte telomere length, a marker of cellular aging, in black people due to social stress, despite having longer leukocyte telomere length at birth than white people.[16] Moreover, McFarland, et. al. established a connection between unfair treatment by police and shorter telomere length through an analysis of 514 individuals in Nashville-Davidson County.[17] This harrowing information provides insight into the connection of telomere length with the John Henryism theory and police violence.

With racial discrimination and its effects on bodily functioning established, it becomes more clear how a disproportionate risk of police violence can influence mental health. Hudson,

et. al. shows a connection between racial discrimination and depression across all sociodemographic factors from 2,137 individuals in the National Survey of American Life Reinterview data.[18] In a study funded by the Robert Wood Johnson Foundation and the National Institutes of Health, Bor, et. al. established, for the first time, a quantitative report on the connection of police killings of unarmed black people to the mental health of other black people that lived in the same state in which the shooting occurred. It found that poor mental health days increased by 0.14 for each killing, up to 1.7 poor mental health days per year. This totals to 55 million poor mental health days per year in the United States for black Americans. The study found no such effect for white people.[10] These studies demonstrate the impact of police violence and its population-level consequences on the mental health of black individuals.

Through this review of literature, it is understood that the combined risk of police violence and mental health implications amplifies the need to address both in the criminal justice system. A combination of these factors illustrates how police violence and mental illness are racially-provoked, which creates a higher risk for black individuals to experience violence, to not receive mental health treatment, and to face incarceration.

1.2 A Brief History of Law Enforcement's Role in Mental Health

The role of law enforcement in the realm of mental health remains quite complex. It first became controversial after the deinstitutionalization of mental health care in the 1960s and the resulting lack of community resources attempted to fill the gap.[19] An inverse relationship was found between the population of psychiatric hospitals and arrests.[20] For the next 20 years, reformers tried to shift the policing ethos in an attempt to expand officers' role in public health.[19]

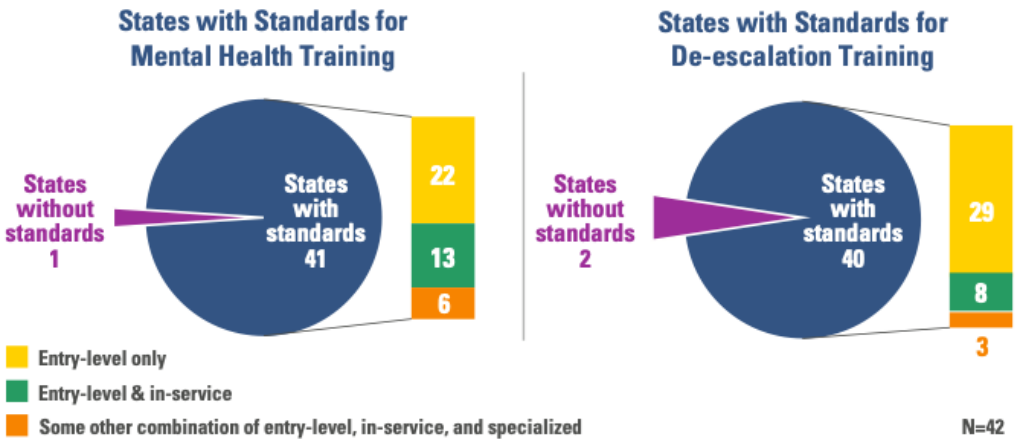
By the 1980s, communities started to implement reforms that took the structure of specialized training, such as CIT programs. These trainings were designed to educate law enforcement on mental health in order to shape their attitudes and provide de-escalation techniques for calls involving mental illness.[19] While necessary collaborations with mental health facilities do occur to support the training, some research shows that they are not sufficient to produce substantial beneficial changes in the system. For example, a 1984 study found that, after an 8-hour educational seminar, police officers' knowledge on mental illness did increase, but their attitudes towards the illness did not.[21] Without an attitude change, systemic barriers largely remain intact, as is seen in the continuation of these statistics to the present. As of 2020, 37% of people in state and federal prison and 44% in local jails have a diagnosed mental illness.[22]

Despite these efforts of training and a greater focus on this topic, the arrest rate for the mentally ill continued to climb.[20] Raphael and Stoll found that deinstitutionalization attributed to 4-7% of the increase in the incarcerated population between 1980-2000.[23] In addition, it also found that a significant amount of the mentally ill incarcerated in these decades would not have been incarcerated before this time.[23] This shows that some other factor contributed to the increase of incarcerated people with mental health concerns. Apart from police officers improperly trained to spot a concern of mental health, one primary factor includes "mercy-booking." This term refers to a police officer who decides to take a person charged with a misdemeanor, who also has a mental illness, to jail if they think no other options are available, largely due to a lack of community mental health resources or a presumption that the person will be put on a path to treatment through the criminal justice system.[24] Thus, systemic issues and lack of options for law enforcement remain at the forefront and contribute to the disparities discussed in Section 1.1.

1.3 The Variability in Law Enforcement State Standards: A 42-State Survey on Mental Health and Crisis De-escalation Training (2017)

Like many policy areas in the U.S., police training takes different forms dependent on state requirements, especially with the over 18,000 state and local law enforcement agencies across the country.[25] All states run an oversight agency for police, such as a Peace Officer Standards and Training (POST) board.[26] The Council of State Governments Justice Center conducted a 42-state survey with these oversight agencies to create a better "snapshot" of mental health and crisis de-escalation trainings across the nation, especially with respect to entry-level training.[25] It found that 41 of 42 states have requirements for mental health training and 40 of 42 states for de-escalation training. Of these, as can be seen in **Figure 1**, the majority of both types of training are provided only at the entry-level, as seen in yellow. Green indicates basic mental health and de-escalation training at both entry level and for those officers in-service. Finally, as part of the orange label, specialized programs, such as CIT training, is included. Most often, the state POST determined the standards for these trainings, sometimes including insights from the state legislature or mental health professionals and organizations.

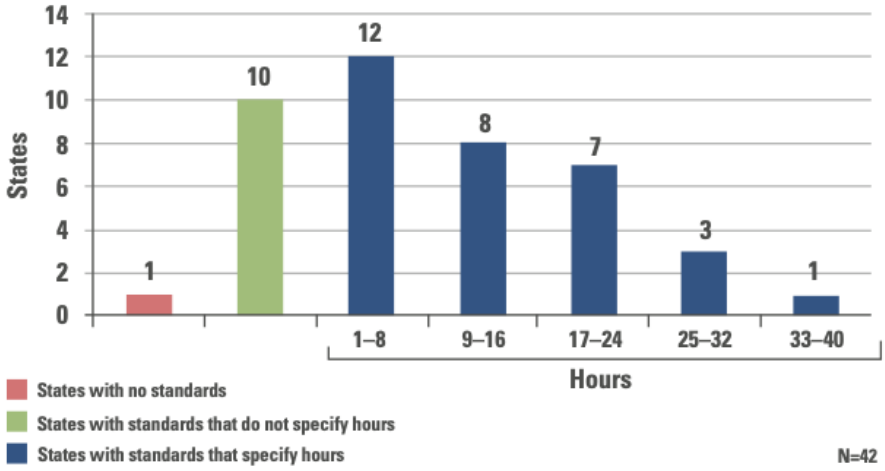
Figure 1: States with Training Standards for Mental Health and De-escalation at Different Levels of Service [25]



Of the 42 states that completed the survey, only 31 could specify the required number of combined hours that entry-level police officers receive in these two training areas. The majority of these 31 states provided somewhere between 1-16 hours of combined training, as shown in **Figure 2**, and an overall average of 14 hours. The report does emphasize that many local agencies exceed minimum standards, especially for specialized officers, such as those trained in CITs.

The states reported two categories of topics covered in these trainings: knowledge and skills. Most commonly identified knowledge topics included signs and symptoms of mental illness and state laws. They also covered different types of mental illnesses, developmental and intellectual disabilities, and cognitive disorders. Least covered knowledge topics included substance use, including its co-occurrence with mental illness, and medications for mental illness. The skills topics most commonly included nonverbal communication, officer safety, and active listening. These were followed by de-escalation strategies, suicidal calls, behaviors associated with mental illness, and conflict mediation.

Figure 2: Required Hours of Combined Mental Health and De-Escalation Technique Trainings in 42 Surveyed States [25]



The data included in this report point to three major takeaways that will provide insight into why CITs, along with other Police-Mental Health Collaboration (PMHC) strategies, should

receive more research and exploration. First, mental health and de-escalation training remain severely unstandardized across localities and states, from hours required to the topics covered in the trainings. While some flexibility remains necessary for the discretion of the community, a higher standard of training requirements should be consistent across all locales. CIT programs do provide extensive specialized training, but every officer requires a basic level of understanding of these topics.

Second, POST boards maintain the highest influence on the curriculum of mental health and de-escalation training in place of a greater focus on partnership expansion with the mental health community. Input from trained professionals could heighten the efficacy of these programs for all officers, not just those that choose to specialize in CIT. Additionally, a holistic approach requires meaningful community partnerships, which can help to prevent unnecessary incarceration by providing law enforcement with more resources for helping those with mental health concerns. It is for these reasons that this paper seeks to understand the CIT partnerships that *do* exist and where partnerships should expand to improve this capacity for police.

Third, and arguably of the most concern, is the lack of skills topics identified in the states regarding the identification of behaviors often associated with mental illness and conflict mediation. The study found these two indicators to be the least common among the training programs, but they are the most pertinent to law enforcement calls that involve mental health. As previously established, it is often difficult for a police officer to know if mental health issues will prove prominent in a call before arrival onsite.[6] Therefore, the ability to recognize these behaviors is of upmost importance for all officers. Additionally, conflict mediation is an integral skill in the presence of violent threats or actions to avoid escalation and the result of incarceration. Moreover, training on racial disparities was not included. CIT programs address these topics, but again, the

elimination of police violence and racial disparities rely on the efforts of all officers. Other PMHC directly involve mental health professionals in calls to take pressure off police in dealing with mediation.

Despite the inclusion of mental health training in most states, these three takeaways provide insight into why traditional police training does not eliminate the significant disparities previously discussed in Section 1.1. For these reasons, this paper now turns its focus to CIT programs, the gaps in CIT partnerships, and recommendations to best combat police reform through CIT's and other PMHC strategies.

2.0 Background on Crisis Intervention Team (CIT) Programs

CIT is a program that specifically trains certain police officers in how to respond to calls that involve mental health needs to reduce the rate of violence often associated with these types of calls.[3] The police department can then prioritize these specialized officers to respond to mental health calls, or they can help fellow police that do not have this type of training. CIT programs intend to give police more knowledge on how to properly communicate with an individual in crisis to increase the safety levels of everyone involved in the call. They also should increase access to mental health services, increase the role of mental health professionals, and reduce the trauma associated with improper police responses.[7] The core elements of an effective CIT model are outlined in **Table 1**. Challenges persist in full attainment of these elemental goals, including insufficient training for dispatchers, insufficient availability of mental health services and psychiatric receiving facilities, and difficulties in the duplication of the CIT model from urban to rural settings.[27]

Table 1: Core Elements of an Effective CIT Model, as Identified by CIT International [7]

High Level Organization	Components
Ongoing Elements	Partnerships, Community Ownership (organized process), Policies and Procedures
Operational Elements	CIT-trained personnel, CIT curriculum, Mental Health Facility
Sustaining Elements	Research, Evaluation, Recognition, Outreach

To truly pursue these elements, CIT programs must involve partnerships, including those with mental health services, social workers, and stakeholders in mental health and racial disparities.[7] The U.S. Department of Health and Human Services also indicated the identification of partnerships as the first step in the creation of a CIT program.[28] The National Alliance on

Mental Illness (NAMI), an organization that helped to establish the first CIT program in Memphis in 1988, recently produced a guide to CIT programs alongside CIT International.[7] This guide heavily emphasizes these partnerships and establishes partnerships as the major determinant in a successful CIT program. At the same time, it acknowledges that CIT programs have been misconstrued throughout their expansion across the country to solely refer to specialized police training. The guide directly states that "training-only approaches do not improve safety and reflect a misunderstanding of the CIT model." It follows, "the most immediate measure of your program's success is the involvement of your community partners." [7]

CIT International, alongside NAMI, was formed in 2005 to support the expansion of CIT programs, as first established in Memphis. As a result, over 3,000 CIT programs now exist across the world, with over 2,700 in the United States.[7, 29] However, a holistic picture regarding the distribution and types of CIT's and their corresponding partnerships remain unclear; that is what this paper intends to address through the use of the University of Memphis' CIT Map (see Methods).

2.1 CIT Training Details

This paper uses Washington State Criminal Justice Training Commission's easily-accessible CIT materials as an example of what comprises CIT training.[30] CIT Training lasts 40 hours over the course of five days; Washington's program has 12 units in the course, including: (1) brain disorders, (2) signs and symptoms of mental illness, (3) risks to self and others, (4) psychotropic medications, (5) Involuntary Treatment Act, (6) community resources, (7) communication techniques, (8) needs of mental health consumers, (9) community perspective, (10)

co-occurring disorders, (11) resiliency for the officers, and (12) cultural sensitivity.[30] The guide includes function descriptions for three main positions included in the week's program: guest speakers, coordinator, and a training facilitator. Guest speakers are important to provide perspective from many areas of the community, a coordinator can organize the program and keep track of timing, and the facilitator guides the learning experience.

Washington's learning outcomes focus on the practical application of CITs in their police department. Discussion topics include the mental health system in the state and community, resources that officers can use, and community-based services. As a participative program, CIT Training in Washington includes interactions with those who suffer from mental illness and external partners, plus opportunities for feedback as they participate.[30]

One important additional point comes from CIT International. The organization released a position statement that highly recommends that CIT training should remain as a specialized training.[31] That is, not all officers should receive the full extent of this training. While mental health and de-escalation should be a component of general training under the POST board, not all officers, and especially not all beginner officers, are properly situated to handle these complex and straining calls. The CIT model situates CIT officers in a specialist role for those experienced officers that volunteer to take on such a role. Additional research shows that officers who volunteer for the role, rather than receive assignment to CIT training, show a "beneficial self-selection effect" in the areas of attitudes, skills, and behaviors.[32] Experienced officers are necessary for CIT training, as the skills taught are quite advanced, and officers should be able to use their prior experience to inform future responses.[31] When done this way, CIT officers are able to expand partnerships, develop relationships with partners and those with mental illness, and represent the community in a specific capacity.

The literature on CIT is limited and extensively varies in its findings.[27, 33] Moreover, it focuses mostly on officer-level outcomes, such as knowledge retention and use of force preferences, over downstream-level outcomes, such as arrest rates, mental health- and race-related complaints to police departments, and diversion rates from jail to mental health facilities. A 2017 systematic review of 25 studies conducted by Jillian Peterson and James Densley found an inconclusive impact with respect to officer characteristics and access to community resources.[27] It concluded that this array of both positive and negative results does not lend evidence to CIT as an evidence-based practice; it deemed more research necessary. Meanwhile, another systematic review from 2019, conducted by Rogers MS, et al., found that CIT has positive officer-level outcomes, including officer self-perceptions in satisfaction and a lessened use of force.[34] However, it still found limited evidence in downstream-level outcomes like arrests, injury, and use of force. Finally, a more dated, 2008 systematic review of the CIT literature described in detail findings from various cities.[35] It found that 100% of Memphis CIT officers included in the original study indicated that they felt prepared for calls with mental illness implications, versus 65% of their non-CIT counterparts. Ohio CIT officers saw a decrease in their likelihood to blame mental illness on bad character or the way a person was raised. Indiana saw improved officer ability to identify those with a mental illness and their knowledge of local treatment and mental health services options. It is interesting to note that studies that took an overarching approach, such as the first two systematic reviews, found less positive outcome data compared to the third study that broke down the data by location.

The third systematic review discussed above also considered a study that analyzed 100 police calls that involved mental health needs and 100 incident reports from three CIT programs (Memphis, Birmingham, and Knoxville).[35] It found that, of the 100 calls that should elicit a

specialized response, the three sites differed tremendously in how many calls they actually sent the proper response: 95% (Memphis), 40% (Knoxville), and 28% (Birmingham). The study concluded that the increased number in the Memphis CIT program was related to its structure, including the availability of a crisis triage center with a non-refusal policy for police referrals. This illustrates the importance of partnerships in CIT programs to elicit the best and most proper responses.

Nonetheless, the large majority of the literature remains focused on officer-level outcomes. A 2018 survey of 185 officers assessed mental illness stigma on CIT officers' perceptions of ability to engage with those with a mental illness. It found few differences between CIT officers and non-CIT officers, but it did find an impact of mental illness stigma in officer's confidence to engage with those with mental illness.[33] Another study from 2008 administered follow-up exams to 203 CIT-trained officers to assess knowledge retention from the original CIT certification exam to the follow-up exam.[36] Of the 88 exams that were able to be connected with each other, the original mean test score decreased from 16.7 to 14.7, with only five officers showing an improvement in the test score. The only variable that could be attributed to better retention was service years. As service years increased, retention increased. Age, educational attainment, and time since completion of CIT certification did not impact the outcome. Finally, a 2014 study assessed the connectedness of CIT officers' personal and professional experiences from the past with mental illness and their attitudes towards CIT.[37] It found a positive association between these variables: as past experience with mental illness increased, officers felt more confident in their ability to handle mental health calls. This demonstrates that the role of exposure to mental illness can represent an indicator for program effectiveness.

Starkly missing from this research is where exactly CIT's exist (apart from descriptions in localized studies), the extent of community partnerships with these CIT programs, and the types of organizations represented in partnerships. Partnerships allow for insight into how CIT's function, their capacity to connect those in mental health crisis with the appropriate mental health services, and their ability to engage the community in the issues of mental health and racial disparities as it relates to police violence. Findings on the level and types of partnerships that exist may inform the extensive variability in the CIT effectiveness literature and offer a mechanism to begin to explore downstream-level outcomes, which are largely missing from the existing literature.

2.2 CIT Literature Review

The literature on CIT is limited and extensively varies in its findings.[27, 33] Moreover, it focuses mostly on officer-level outcomes, such as knowledge retention and use of force preferences, over downstream-level outcomes, such as arrest rates, mental health- and race-related complaints to police departments, and diversion rates from jail to mental health facilities. A 2017 systematic review of 25 studies conducted by Jillian Peterson and James Densley found an inconclusive impact with respect to officer characteristics and access to community resources.[27] It concluded that this array of both positive and negative results does not lend evidence to CIT as an evidence-based practice; it deemed more research necessary. Meanwhile, another systematic review from 2019, conducted by Rogers MS, et al., found that CIT has positive officer-level outcomes, including officer self-perceptions in satisfaction and a lessened use of force.[34] However, it still found limited evidence in downstream-level outcomes like arrests, injury, and use

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3.0 Objectives and Expected Outcomes

The first section of this essay delineated the complexity of mental health calls for law enforcement, the disparities that exist within law enforcement responses to both the mentally ill and black communities, and why, based on the history of police involvement in mental health, CITs and other strategies require more research. The second section focused its efforts on basic information on CIT programs, including CIT training and the existing CIT literature, to position further research on partnerships.

This paper now turns to focus on its primary aim: to identify how CIT programs across the U.S. use partnerships in order to help determine the effectiveness of these programs and areas of improvement. It will begin with an analysis on CIT's, including their distribution across the country and the types of organizations that implement them. An evaluation of CIT partnerships will follow, including the distribution of partnerships, their categorization, and the identification of gaps in these two areas. It will conclude with recommendations to improve police reform through improvements in CIT partnerships and other PMHC strategies as one way to inform the existing, inconclusive literature.

As previously discussed, CIT International directly indicated CIT partnerships as the primary determinant of a successful CIT program, with the most potential to decrease mental health and racial disparities as it relates to police violence.[7] As such, more partnerships can be a better indicator of access to mental health resources and diversion from jail to mental health services. However, if CITs were successful in the decrease of police violence and mental health disparities, it would be expected that these disparities would not persist to the extent that they do today. Because of this continued level of disparity, it is expected that CIT programs across the

country do not involve rigorous partnerships. As a result, this essay will identify gaps in CIT partnerships that can explain one reason why the literature shows largely inconclusive results on CIT effectiveness.

4.0 Methodology

This paper uses data compiled from the University of Memphis' CIT Map database.[38] This database is an interactive map that shows, at the county level, what counties in each state have at least one CIT program, county-level and local-level CIT programs, regional and statewide CIT programs, and the CIT partnerships that exist in each county. While this database has been infrequently updated since 2015, it is the most comprehensive database that provides this detailed, localized information. Although the Map does represent the provided information by state and county, to the author's knowledge, no formal analysis showing the comprehensive trends of the data has been conducted. That is what this paper intends to accomplish as a means to further analyze the partnerships as an indicator of CIT success.

To do this, all information from the University of Memphis' CIT Map was entered into an Excel document that was organized to track the number of counties in each state that maintain at least one CIT program, the number of local and countywide CIT programs in each state and county, the number of regional and statewide programs in each state, and the number of partnerships in each state and county. It also tracks the names of all counties in the U.S. that have a CIT program, the names of the local and county programs (plus their respective counties), the names of the regional and state programs, and the names of the partnerships that exist (plus their respective counties).

This information is analyzed in the following section by CIT distribution across states and counties based on population, CIT categorization, CIT partnership distribution across states and counties based on population, and CIT categorization. The partnership categorization used NAMI's identified key partnerships as a foundation (see **Table 2**), and it outlined additional

categories as necessary to show the extent of the partnerships. **Table 3** and **Table 4** outline these categories.

Table 2: Key Partnerships in CIT Programs, as Identified by NAMI [39]

Partnership Area	Stakeholders Included
Law Enforcement Agencies	Police departments Sheriff's offices
Mental Health Providers	Practitioners Community Health Clinics Behavioral Health Departments Crisis Response Organizations *
Hospitals	Emergency Rooms Hospital Representatives
Emergency Services	EMS Fire Departments
Public Officials	Mayor's Office Governors City Managers County Commissioners

*Crisis Response Organizations were separated into their own category upon further breakdown of CIT partnerships (in Section 5.0).

Table 3 shows the categorizations of CIT Programs on the local, county, and regional levels. The prominence of the categories or their pertinence to this discussion determined their presence in the list above.

Table 3: Categorizations for CIT Programs

Level of CIT Organization	Programs Included
Local Programs	Police Departments Sheriff's Offices EMS Veteran Affairs Colleges and Universities Corrections/Jails Mental Health Organizations Legal Organizations/Offices
County Programs	General county-associated programs

Regional/Statewide Programs	Programs that cover more than one county; includes a mix of different types of organizations

Finally, **Table 4** outlines the major categories for CIT partnerships that exist in the U.S., in addition to examples of the specific types of organizations that each category includes. Its foundation includes law enforcement, mental health providers, hospitals, emergency services, and public officials as identified by NAMI in **Table 2**. It also includes additional categories to fully illustrate the scope of the partnerships. This paper uses the above breakdown to identify the types of CIT partnerships that exist and gaps within them.

Table 4: Categorizations for CIT Partnerships

Types of Partnerships	Examples of Types of Organizations Included
Mental Health	Mental health clinics Health service organizations focused in mental health Advocacy networks Behavioral healthcare Community service organizations State departments of mental health Mental health associations
NAMI	State, county, and local NAMI offices
Law Enforcement	Police departments Sheriff's offices Reservation police departments
Hospitals	Hospitals Health systems Medical centers Hospital security
Court/Legal Dept.	State superior courts Judicial circuits County courts Mental health courts Municipal courts District attorneys' offices
Crisis Services	Mobile crisis services Crisis response organizations Crisis centers
Colleges	Colleges and universities

EMS	Fire departments Emergency communications organizations
Public Officials	[none]
Other	Departments of Children and Families Religious organizations Alcohol and drug abuse organizations Volunteer organizations Corrections departments Departments of Human Services

5.0 CIT Map Findings

Table 5 shows that of the 3,191 counties in the U.S., 771 (24.2%) maintain at least one CIT program. 2,886 CIT programs exist among these 771 counties, split into 2,729 local and county programs and 157 regional and statewide programs. Local programs exist on a level of government under the county level, and regional and statewide programs represent more than one county with CIT training.

The 2,886 CIT programs engage 375 partnerships. Of all U.S. counties, 4.6% have at least one CIT partnership. More specifically, of the 771 counties with a program, 146, or 18.9%, have at least one partnership.

Per every county in the U.S., 0.90 programs exist. Similarly, of every county in the U.S., 0.12 partnerships exist. The average number of partnerships per program is quite low at 0.13. Of every county that has a CIT program, it has 3.74 programs on average. Of every county that has a program, it has 0.49 partnerships on average. Finally, of every county that has a partnership, it has 2.57 partnerships on average.

Table 5: Overview of U.S. CIT Program and Partnership Statistics

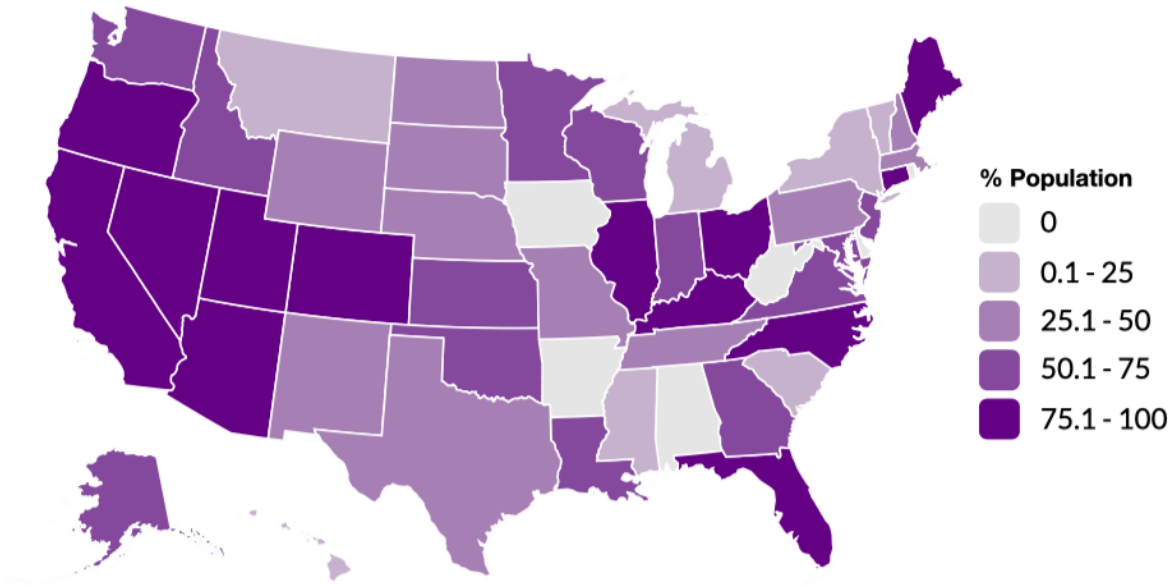
County Count	
Total # Counties in U.S.	3191
Total # Counties with at least one CIT program	771 (24.2%)
CIT Program Count	
Number of Local/County Programs	2729
Number of Regional/Statewide Programs	157
Total Number of CIT Programs	2886 (2729 + 157)

CIT Partnership Count	
Number of CIT Partnerships	375
Number of Counties with CIT Partnership	146
Percentage of all U.S. Counties with Partnership	4.6% (146/3191)
Percentage of Counties with CIT Program that have a Partnership	18.9% (146/771)
Average Statistics	
Programs/County	0.90 (2886/3191)
Partnerships/County	0.12 (375/3191)
Partnerships/Program	0.13 (375/2886)
Programs/County with CIT Programs	3.74 (2886/771)
Partnerships/County with CIT Programs	0.49 (375/771)
Partnerships/County with CIT Partnership	2.57 (375/146)

Figure 3 shows that CIT programs cover a large majority of people in the U.S. Each state's CIT coverage was determined by dividing the total population of counties with CIT programs by the total population of the state. Population data came from the 2010 U.S. Census' estimates for the 2015 population. For example, Pennsylvania has 15 counties with CIT programs. 5,405,183 people live in these 15 counties, and the total population of Pennsylvania is 12,901,989. 5,405,183 divided by 12,901,989 shows that CIT programs cover 42.2% of Pennsylvania's population, placing it in the 25.1-50% range.

Five states do not have any CIT programs: Alabama, Arkansas, Iowa, Rhode Island, and West Virginia. Delaware has only one state program that does not cover the entire state; it remains unclear where this program provides coverage, so it is included in this first grouping. Seven states illustrate 0.1-25% CIT coverage, 11 with 25.1-50% coverage, 13 with 50.1-75% coverage, and 13 with 75.1-100% coverage.

Figure 3: Percentage of State Population Covered by at Least One CIT Program



As seen in **Figure 4**, law enforcement – police departments and sheriff offices – unsurprisingly comprise the bulk of all CIT programs (74.6% combined). However, it is important to note that other types of CIT programs do exist. County and regional/statewide programs, comprising 8.6% and 5.4% of programs respectively, include CIT training organized on the county level. Additionally, 148 (5.1% of programs) colleges and universities have CIT implemented for their police departments and safety offices on campus. Corrections, jails, and prisons also have CIT programs for their safety teams (2.9% of programs). Hospitals, veteran affairs, legal departments, EMS, and mental health organizations have a limited number of CIT programs, but this graph includes them to show the full scope of CIT programs. The 'other' category includes a limited number of city-led programs, national park services, housing authorities, and municipal courts.

Figure 4: CIT Program Types

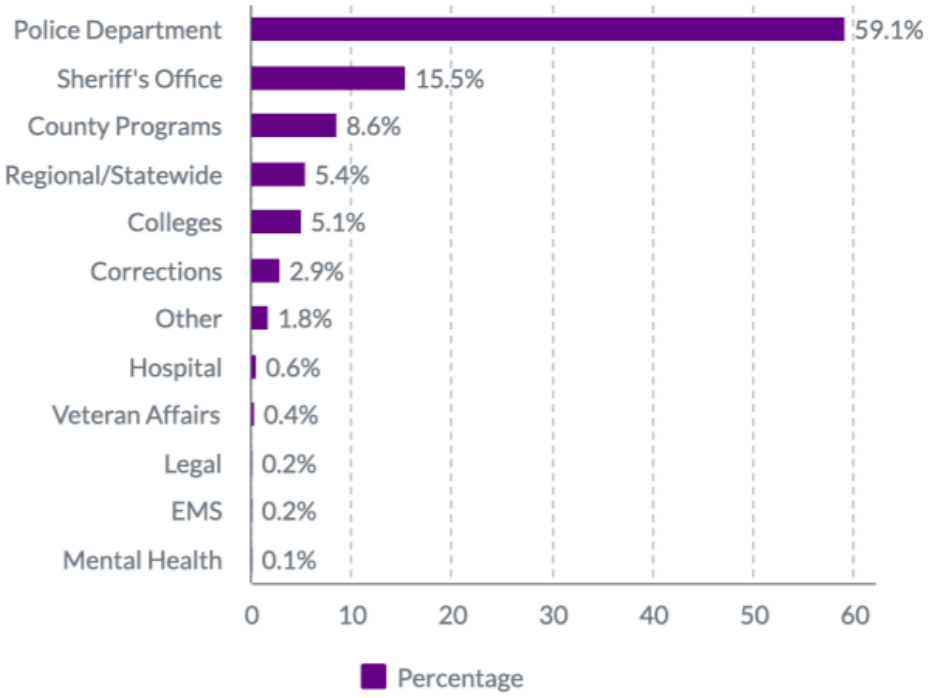
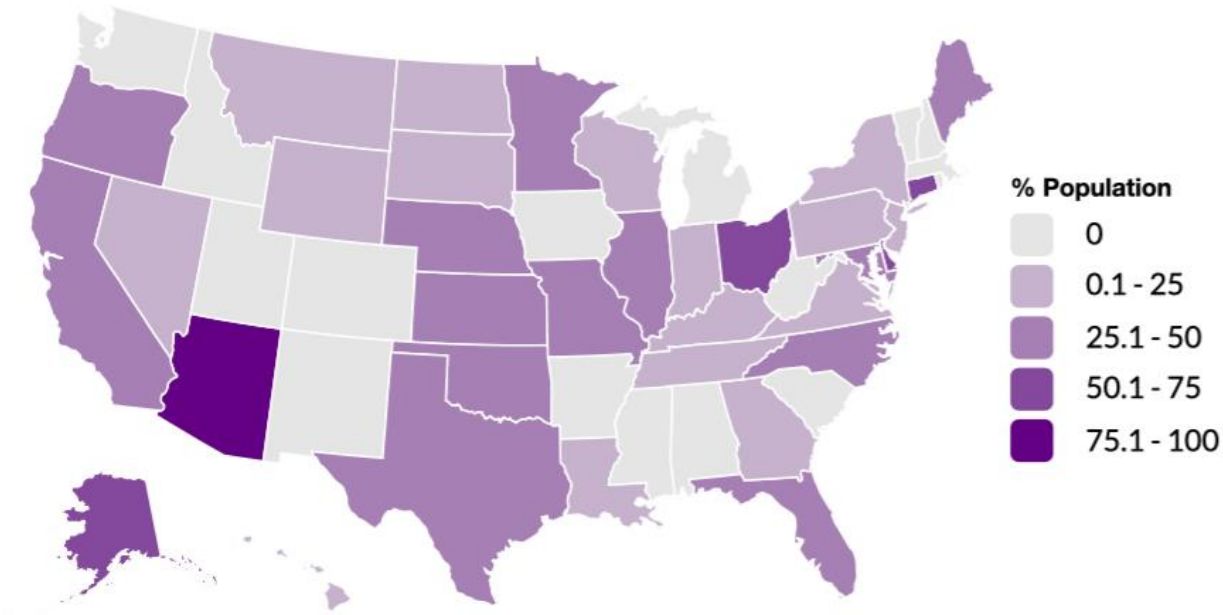


Figure 5 illustrates the density of CIT partnerships across the U.S. by calculating the population covered by a partnership in the same manner as the program calculations in **Figure 3** above. The counties that include at least one partnership were totaled for their population. They were then divided by the total population of the state. Using Pennsylvania as an example again, 2,851,333 people are covered by a partnership. This number was divided by the total population of Pennsylvania, 12,801,989, to provide a 22.3% coverage figure, placing the state in the 0.1-25% range.

As seen in **Figure 5**, 16 states do not have any partnerships. 16 states have .01-25% partnership coverage, 13 have 25.1-50% coverage, 4 have 50.1-75% coverage, and 1 (Arizona) has 75.1-100% coverage.

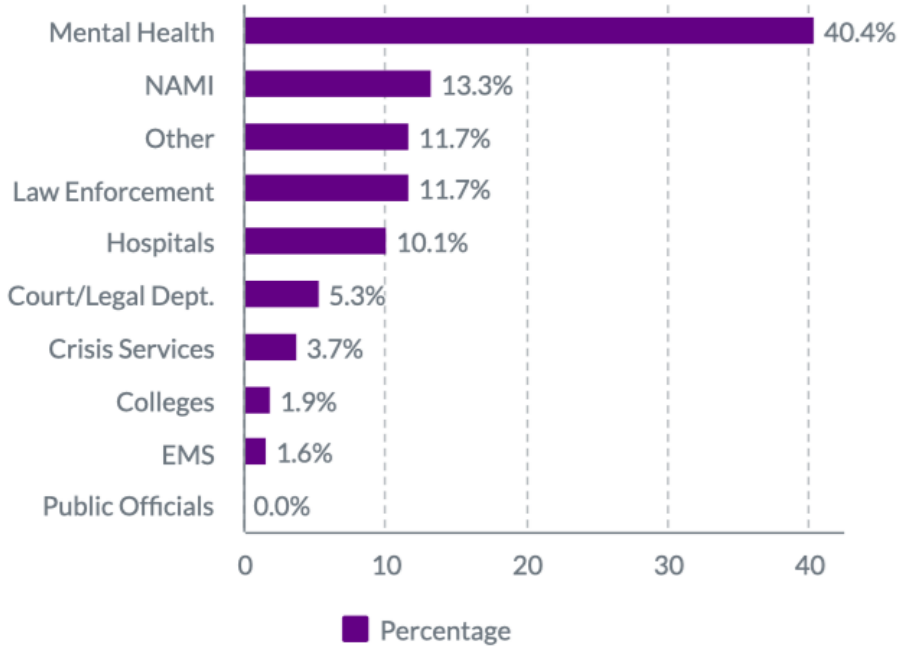
Figure 5: Percentage of State Population Covered by at Least One CIT Partnership



CIT partnership types are quite diverse. The list in **Figure 6** is based on the NAMI key partnership types as shown in **Table 2** and the organizations included in each category for the purposes of this paper as seen in **Table 4**. 153 (40.4%) partnerships include a mental health organization, and 50 (13.3%) partnerships are a NAMI office. 44 (11.7%) law enforcement agencies provide CIT training services and/or help other organizations to develop their programs. 38 (10.1%) hospitals and general health service organizations and 20 (5.3%) courts and legal departments partner with CIT programs. 14 (3.7%) crisis service organizations, considered a mental health organization by NAMI, are involved in CIT programs, but this essay shows them as a distinct category for their pertinence in connecting law enforcement with treatment options for those in crisis. 7 (1.9%) colleges and universities and 6 (1.6%) EMS departments partner as well. Of particular note are the zero public officials partnered with a CIT program, as this was one

category emphasized by NAMI for a successful CIT program. Finally, 44 (11.7%) organizations fall in the 'other' category.

Figure 6: CIT Partnership Types



6.0 Analysis

The information provided above gives clear insight into CIT programs, CIT partnerships, and their respective distributions across the country. The basic information of where CITs exist provide a new snapshot into the expanse of CIT programs in the last decade. It is helpful to understand how many exist and where they exist to better facilitate strategic developments in curving police violence. **Figure 3** shows that at least one CIT program covers about a quarter of the country's population (24%), which includes both urban and rural areas. This expansion of CIT programs demonstrates the inherent importance in understanding them and their connections to the communities they serve.

While not frequently updated since 2015, Memphis' CIT Map remains in line with current estimations on number of CIT programs. The total number of U.S. programs included in the CIT Map is 2,886. NAMI still uses an "over 2,700" estimation on its website, and CIT International estimated 3,000 worldwide programs in its 2019 best practice guide.[39, 7] Although it is reasonable to believe that more localities, counties, and states have established CIT programs since 2015, the similarity of these estimations illustrates that the information uncovered in the CIT Map remains pertinent to current CIT demographics.

Despite overall CIT expansion, some trends stand out. First, the three major regions of the U.S. have different program distribution patterns: Western states have largely 50.1-75% or 75.1-100% CIT program coverage, the Midwest is quite limited in its CIT programs, and the East is highly variable from state to state.

Second, the 13 states in the 75.1-100% program coverage category present interesting political party trends under further analysis (see **Table 6**). 'Democratic' or 'Republican' states are

those that have not changed political party outcome in the last six general elections (since 2000), and swing states are those states that have changed the party it voted for at least once in this time period. Swing states that 'lean' have only voted for their respective outlier one time. From this, it is seen that six Democratic states have significant CIT coverage, while only 2 Republican states can say the same. However, five swing states are also included in the 75.1-100% category, two of which lean Republican, and none of which lean Democratic. Moreover, Republican, Republican-leaning, and swing states comprise five of the six highest percent coverage rates. While largely-Democratic, there may be an opening for bipartisan policy-making in the realm of CIT programs given this information.

Table 6: Partisan Lean of those States that have 75.1-100% CIT Program Coverage

Democratic (% coverage)	Swing (% coverage)	Republican (% coverage)
California (78)	Arizona (84) – Leans Repub.	Kentucky (81)
Colorado (75.1)	Florida (96)	Utah (98%)
Connecticut (86)	Nevada (89)	
Illinois (89)	North Carolina (94) – Leans Repub.	
Maine (100)	Ohio (95)	
Oregon (80)		

Finally, regarding the types of CIT programs, law enforcement (police departments and sheriff offices) run the large majority (75%) of them. This fact is unsurprising given the nature of CIT programs, but it stands out that 25% of programs *do* stem from other organizations. The heavy focus on police casts a shadow on the 14% of programs organized by the county or state. Plus, there are opportunities for CIT programs to engage EMS and mental health personnel, as seen in **Figure 4**. Further research remains on whether these different departments can appropriately leverage CIT training to reach the same goals, but it is important to remember the diversity of those that interact with mental health needs when addressing police violence.

Turning focus to CIT partnerships, **Figure 5** illustrates their extremely limited prevalence. Only about one-fifth of counties that have a program also have a partnership, and of all counties in the U.S., only .12 partnerships exist on average. Of counties with a CIT program, it has about one-half of a partnership on average. However, of every county that has a partnership, it has over 2.5 partnerships on average. These figures account for the relatively localized nature of CIT partnerships. **Table 7** delineates the number of counties that have a respective number of CIT partnerships, which shows how partnerships are situated amongst each other. It shows that 53% of these counties have one partnership, 16% have two, 10% have three, and the remainder have at least 4. Maricopa and St. Louis counties each have 20 partnerships. Without these two counties included in the average, 2.3 partnerships on average exist per county that has a partnership. Therefore, the true average of 2.5 partnerships is not heavily skewed by these outliers. In all, partnerships are limited amongst counties that have CIT programs, and partnerships are somewhat localized in nature.

Table 7: Frequency of Partnerships in Counties that have at Least One Partnership

# of Partnerships	Number of Counties w/ this # of Partnerships
1	79
2	23
3	15
4	11
5	5
6	5
7	1
9	3
10	1
11	1
12	1
20	2

More important is the CIT partnership breakdown based on type, as seen in **Figure 6**. Four of the five major partnership types, as recommended by NAMI and as presented in **Table 2** are present amongst the 375 partnerships in different rates: mental health/crisis services (44.1%), law enforcement (11.7%), hospitals (10.1%), and emergency services (1.6%). However, there is a stark absence of public official involvement, which is the fifth major partnership type. This raises various questions: Who advocates to implement these programs? Is there ongoing policy support? Do public officials help to implement the programs but step away once established? These questions point to other areas of research on CIT implementation but are pertinent here as a fundamental missing piece of ongoing partnerships.

Similar to CIT program types, it is again important to highlight the wide variety of organizations that these lists include. Many partnership types go beyond those recommended by NAMI, such as courts/legal departments (5.3%) and colleges (1.9%). NAMI itself is also involved in a reasonable amount of partnerships (13.3%). In addition, there is a wide variety of organizations in the 'other' category – some of which would not directly be thought of as involved in policing and mental health (Departments of Children and Families and the Departments of Veterans Affairs, as examples). This 'other' category begins to reach the spirit of a true CIT program. That is, engage unique and meaningful partnerships that provide law enforcement with options of care for those with mental illness and create relationships within the community.

Table 8 helps to visualize how the different types of programs are distributed. It shows that only eight counties reach a minimum of five different types of partnerships. This is overall concerning in that the large majority of counties with a CIT program do not have robust partnerships established.

Table 8: Frequency of Types of Different Partnerships at the County Level

# Different Types of Partnerships	# Counties with this many Different Types
1	85
2	32
3	16
4	5
5	**5**
6	**2**
7	
8	**1**

The findings from the University of Memphis' CIT Map largely confirm the expected outcomes of this paper, as previously discussed in Section 3.0. Despite the wide coverage of CIT programs, CIT partnerships are not rigorous to any substantial extent. Moreover, the recommended number of different types of partnerships for each CIT program is only accomplished in eight counties (**Table 8**). This lack of both partnerships and diversity of partnerships points to one reason that the CIT literature is inconclusive on CIT programs' effectiveness and why mental health and racial disparities in police violence have not been improved despite the expanse of CIT programs across the country.

7.0 Discussion

This section focuses its efforts on the gaps that exist in CIT partnerships, major contributors to these gaps, potential methods to improve existing CITs, and other strategies apart from CITs to address mental health and racial disparities in police violence. It uses the findings discussed in this paper, along with current developments, to inform next steps.

7.1 Major Gaps in CIT Partnerships

Three major gaps in CIT partnerships include the complete lack of public official involvement, the limited involvement of emergency services, and a significant gap in the limited number and distribution of partnerships overall.

The lack of public official involvement presents a major concern as one of the primary types of partnerships recommended by NAMI. This missing piece of partnerships may indicate that CIT programs do not receive the policy and/or funding attention that they deserve, especially as an expanding mechanism to address police reform. The absence of policy and funding can adversely affect the ultimate goals of a CIT program. In addition, public officials could be critical in fostering CIT partnerships. Since their work in the community touches many departments and organizations, public official involvement, when harnessed in the correct manner, could accelerate the expanse of partnerships.

The limited involvement of emergency services, such as EMS and fire departments, as a CIT partnership is noteworthy for its inclusion as a primary partnership recommended by NAMI.

However, no clear guidance from NAMI exists as to why and how emergency service organizations are an essential component of rigorous CIT partnerships. CIT training places emphasis on providing law enforcement with alternative locations to take a person experiencing a mental health crisis apart from the criminal justice system. Therefore, an assumption exists that the officer is responsible for taking the individual to one of these resources, such as a crisis triage center. This paper does not disagree with NAMI that emergency services partnerships could benefit a CIT program, but it does point out that more information is required as to how to make the partnership most effective and in alignment with the training officers receive. A more clear understanding of this type of partnership may expand emergency service involvement.

Finally, the extremely limited number and distribution of partnerships presents a concerning, overall gap in CIT programs. This may extend from an unclear understanding of what exactly is a CIT program's main components, since the public framework for a CIT has been narrowed to solely police training in recent years. Additionally, it remains difficult to understand what exactly goes into the creation of a partnership, such as budget concerns or lack of the appropriate personnel to foster connections. Without partnerships, CIT programs cannot reach their potential to address systemic mental health and racial disparities in police violence.

7.2 Contributing Factors in the Major Gaps in CIT Partnerships

Contributing factors to the gaps aforementioned include the limited mental health workforce in the US., the reluctance of police departments to welcome outside partnerships, and the lack of a substantial prior working relationship between law enforcement and mental health services.

The limitations in the U.S. mental health workforce, and the resulting limitations in the number of facilities, makes it difficult to create mental health partnerships in all areas where a CIT program exists. The Substance Abuse and Mental Health Association (SAMHSA) produced a Behavioral Health Workforce Report to determine the shortage of mental health providers in addressing serious mental illness.[40] The Report found that the U.S. requires 4,486,865 more individuals in the behavioral health workforce, including occupations such as psychiatry, addiction medicine specialty physicians, social workers and case workers, nurses, and peer support specialists. Another SAMHSA report, Safe Policing for Safe Communities, identified the "lack of adequate and organized crisis services." [41] In addition to a limitation for those with serious mental illness to have access to the services they need, these reports also indicate that CIT programs do not have appropriate access to mental health services. It is difficult to create a partnership with mental health organizations when they are not robust themselves. However, more mental health organizations exist than the 152 engaged in CIT partnerships, so partnerships can be expanded as efforts to expand the behavioral health workforce occur simultaneously.

The reluctance of police departments to partner or involve themselves in external partnerships stems from an increase of calls to "defund the police," especially since the killing of George Floyd in May 2020. A partnership may be viewed as relinquishing power to another organization, and thus, creating a window of opportunity to defund police departments in order to fund other community organizations to do the work of police. While CIT program training holds that specially trained police can contribute to the community in a unique manner, rigorous partnerships certainly involve the same external organizations that some people argue to fund more by decreasing law enforcement funding. This ongoing debate may deter law enforcement from creating methods to engage with community mental health organizations.

Additionally, the idea of a relationship between law enforcement and mental health organizations is relatively new. Partnerships, especially between two fields that do not have much prior contact, take time to develop and to properly function in a mutually-beneficial manner. These partnerships may require personnel resources and time that are not available to either party. Moreover, mental health stigma persists at all levels of law enforcement, which inherently impedes the development of such partnerships with behavioral health organizations.[42]

7.3 Methods to Improve Existing CIT Programs' Partnerships

Existing CIT programs must take the first step to improve their partnerships. This begins with heightened education in CIT Training and data collection, but it can expand to the political sphere and the developing mental health court programs.

CIT training programs must emphasize the importance of community partnerships and the expectation for officers to help establish and continue these relationships through their work with the community. The community speakers that help at CIT trainings should explain to officers and police departments exactly how their services can help CIT-trained police to better serve those with mental health needs and the capacity in which the two organizations work together. As a step further, law enforcement and partnering organizations should improve upon their data collection mechanisms. Immediate data, such as the number of rerouted mental health calls, and downstream-data, such as that relating to mental health and racial disparities, should receive the same emphasis. To accomplish this, partnerships should require goals and a strategic mechanism to obtain the appropriate data for measurement.

The political sphere can be a vital way to harness support for CIT partnerships. There exists a potential window of opportunity for bipartisan focus on police reform in the form of CIT programs and partnerships. As demonstrated in **Table 6**, some Republican states engage a significant number of CIT programs. While Republicans certainly do not advocate for the "defund the police" messages of the Democratic party, they have already shown support for CIT programs. Because Republicans are likely to be more receptive to creating partnerships within a program that is already established than an alternate strategy that coincides with or resembles the "defund the police" messages, CIT programs may provide an adequate starting point for bipartisan police reform. A political strategy for garnering this support to expand CIT partnerships is outside of the scope of this essay, but it must begin with the recognition of a mutually-beneficial relationship for both law enforcement and community partners as well as Democrats and Republicans.

Finally, this paper would be remiss not to mention the importance of mental health courts and mental health programs in local courts as they expand across the country. Through Public Law 106-515: "America's Law Enforcement and Mental Health Project" and Public Law 108-414: "Mentally Ill Offender Treatment and Crime Reduction Act of 2004," mental health courts aim to keep nonviolent individuals with mental health needs out of the criminal justice system.[43] With judicial supervision and coordinated delivery of services, these individuals receive connection to the appropriate mental health services for recovery. Mental health courts only represent three CIT partnerships, but they are a natural means for partnership expansion due to the programs' similar goals. They provide an innovative type of service that law enforcement can use to connect those with mental health needs to the appropriate resources.

7.4 Additional Strategies to Address Police Violence Disparities

Police-Mental Health Collaboration (PMHC) strategies include CITs and crisis triage centers, as discussed and identified in this essay. However, three additional strategies also exist that, within their inherent structure, directly engage multiple types of organizations: co-responder teams, mobile crisis teams, and case management teams.[3] These three PMHC strategies can be seen in **Table 9**.

Table 9: Additional PMHC Strategies to Address Mental Health and Racial Disparities in Police Violence [3]

Name of PMHC Strategy	Description
Co-Responder Teams	Officers and mental health professionals specially trained in mental health respond to these types of calls as a team. They work together as partners for their entire shift and respond together from the same car.
Mobile Crisis Teams	Mental health professionals, specially trained, respond to both law enforcement and mental health calls to use their expertise to stabilize individuals. These professionals do not travel with police.
Case Management Teams	Include professionals from an array of backgrounds, including behavioral health and law enforcement, plus the individual's peers, family, and/or caregivers. As a team, they coordinate care and identify ways in which to reduce repeat interactions with the criminal justice system.

Law enforcement ultimately can make the final decision on whether or not it is committed to establishing and fostering collaborative partnerships with a diverse set of community organizations. However, the continued mental health and racial disparities in police violence must not continue, and community resources must be harnessed in innovative ways to address this public health issue. Therefore, co-responder teams, mobile crisis teams, and case management teams can

offer a new approach to either work with police departments or situate other community personnel in a position to respond to mental health calls. This is especially important if CIT programs do not garner the appropriate partnerships to address the prominent disparities.

8.0 Recommendations

Table 10: Recommendations Overview

Primary Problem Area:	Recommendation(s) to Address Problem:	Stakeholders(s) Responsible for Implementation:
Overall Limited Number of CIT Partnerships	(1) Leverage existing community partnerships amongst local NAMI organizations already partnered with CIT programs.	Local NAMI organizations
	(2) Allocate funding to/within police departments with CITs for the sole purpose of expanding partnerships.	Local policymakers, U.S. Dept. of Justice, police chiefs/finance division
	(3) Establish a campaign to correct the public misunderstanding of what entails a CIT program.	NAMI and CIT International
No Clear Guidance on CIT Partnerships	(4) Send guidance documents to all CIT programs.	NAMI and CIT International
	(5) Ensure best practice criteria are prominent on both NAMI and CIT International websites.	NAMI and CIT International
	(6) Revamp partnership requirements in, and the publicity of, CIT International's CIT certification program.	CIT International
No Involvement of Public Officials	(7) Directly engage policymakers by politically harnessing CITs, with a focus on partnerships, as a bipartisan means to address police violence.	Public officials, police chief, communications division
Lack of Data to Measure Effectiveness	(8) Establish a data collection system with each CIT partner that includes both immediate and downstream measurements.	CIT lead at the police department and the appropriate personnel at the partnership organization

Recommendation 1: Leverage existing community partnerships amongst local NAMI organizations already partnered with CIT programs.

50 NAMI organizations across the country currently engage in CIT programs. These organizations should leverage their existing relationships with the community to forge connections between law enforcement and prospective partners. In addition to expanding partnerships, local NAMI offices can counsel their respective CIT program leaders on what encompasses a CIT program and best practices.

Recommendation 2: Allocate funding to/within police departments with CITs for the sole purpose of expanding partnerships.

CIT program personnel should seek out additional funding for the purpose of partnership expansion; if additional funding cannot be acquired, it should be allocated within the department with existing funds. Attention to an issue area inherently increases when funding (and thus, resources) exists to address it. Moreover, by funding the police and encouraging external collaboration in this manner, a major objective of the "defund the police" movement can be accomplished (i.e. empowering community organizations to respond to police calls and decrease police violence) without suppressing the role of the police – a potential compromise in a partisan country.

Recommendation 3: Establish a campaign to correct the public misunderstanding of what entails a CIT program.

The original CIT model heavily relied on community partnerships, but over time, the true meaning of a CIT program has been misconstrued into simply a specialized police training. As the two major, national organizations for CIT programs, NAMI and CIT International hold the responsibility to promote CIT partnerships as an essential element to any program.

Recommendation 4: Send guidance documents to all CIT programs.

Guidance documents, compiled by NAMI and CIT International, should contain information on how to establish, manage, and sustain CIT partnerships. In some cases, it remains unclear exactly *why* a type of partnership is recommended. The goals of each type of partnership and how they can be utilized in different community settings should be made transparent. With 2,886 CIT programs specifically located, NAMI and CIT International should be able to acquire the contact information of each of these organizations.

Recommendation 5: Ensure best practice criteria are prominent on both NAMI and CIT International websites.

The best practice criteria of a CIT program must be prominently displayed on the NAMI and CIT International websites, marketing efforts, and training materials. This will help to ensure that all those who work with a CIT program understand the importance of partnerships and other CIT necessities from their first point of contact with the organizations.

Recommendation 6: Revamp partnership requirements in, and the publicity of, CIT International's CIT certification program.

CIT International must strictly require rigorous partnerships at all levels of CIT program certification (bronze, silver, gold, platinum).[44] In the certification application itself, the applicant should list all partnerships, the capacity in which the organizations are partnered, and any outcome data from the partnership. Finally, the certification list should be made publicly accessible and prominent on the CIT International and NAMI websites as a way to incentivize CIT programs to acquire the highest level of certification and create accountability.

Recommendation 7: Directly engage policymakers by politically harnessing CITs, with a focus on partnerships, as a bipartisan means to address police violence.

Police department chiefs and other primary organizers of CIT programs should leverage the current, heated political climate to engage policymakers in a bipartisan manner on police violence – a major partisan topic. CIT programs offer a way for police to remain engaged in their duties, to empower community organizations to work on these same issues, and foster a relationship between law enforcement and the populations in which they serve. Politicians have an opportunity to participate in CIT programs by connecting police departments with the appropriate resources and partners, establishing themselves as proponents of both the police *and* community efforts to address reform. In turn, policymakers can advocate on behalf of these police departments and community organizations when partnerships are harnessed in the correct manner.

Recommendation 8: Establish a data collection system with each CIT partner that includes both immediate and downstream measurements.

Data collection systems are necessary to fully evaluate CIT programs and clarify the existing literature on the role of these programs in communities. The main goal of evaluation is to ensure the diversion of those in mental health crisis away from the criminal justice system. However, all opportunities for data collection should be leveraged, including the demographics of the diverted persons, the smoothness of transition from police to facility, the officers' comfortability levels with those in mental health crisis, etc. For this reason, all partnerships should include data collection roles for both parties, including the establishment of responsibility for tracking each variable.

9.0 Limitations and Areas for Future Research

Some limitations exist as it pertains to this paper. A primary limitation, as mentioned throughout, is that the University of Memphis' CIT Map has been infrequently updated since 2015. While all available estimates of number of CIT programs from NAMI and CIT International align with the 2,886 programs from the Map, it is safe to assume that more programs have been established in the past six years. However, it is not expected that the major trends in CIT program distribution nor CIT partnerships have substantially changed.

Additionally, it remains unclear the exact capacity in which an organization partners with a CIT program. This would be helpful information in determining the exact amount of the population covered by a partnership and in understanding how CIT programs and community partners interact with one another. Moreover, this unknown may affect partnership categorization. For example, the CIT program in a hospital may be led by its behavioral health department, which would change its classification from a hospital partnership to a mental health partnership. Nonetheless, it is helpful to know the number of hospitals involved in CIT programs regardless of the specific department leading the effort.

Another limitation pertains to county versus locality data. This paper considered all population estimates on the county level, even though local programs and local partnerships are included in the analysis. This can skew the population distribution data for both CIT programs and partnerships. For example, data may be skewed if one local program (covering a smaller population than the county level) maintains the only CIT program for the county, thus, accounting for a higher estimate of population coverage than it should.

The findings on CIT partnerships in this paper inform numerous areas for future research. Especially important is clarification in the literature on the level of effectiveness of CIT programs. To start, future research can consider the implications of rigorous CIT partnerships versus no CIT partnerships, using the CIT Map and findings in this paper as a means to identify locations of study. In addition, the literature is largely missing downstream-level outcomes of CIT programs, so future research can use CIT partnerships as one method of measurement to determine CITs' effects on mental health and racial disparities.

Future research should also provide more detailed information on CIT partnerships. As of now, it is unclear the cost burden and the resources required for developing and sustaining CIT partnerships for either the police department (or other organizing group) or the community partner. Moreover, research into the proper strategies for partnership is required. As previously mentioned, relationships between law enforcement and mental health organizations are new; therefore, the proper research is required to understand how these can be established, fostered, and sustained. Questions on this topic include what the partnership should involve and who from each organization should be involved to see the most benefit. Researchers can then use this information to inform CIT program effectiveness as a function of partnerships. It must be further understood how CIT effectiveness changes when rigorous partnerships are put into place.

Finally, to fully address the concern of mental health and racial disparities in police violence, the alternative PMHC strategies mentioned in **Table 9** each require further research of their own. The current research is quite limited, even more so than CIT programs. Therefore, as new programs are established throughout the country, they should receive the proper evaluation to understand their potential to decrease disparity as well as to situate them in the literature.

10.0 Conclusions

This compilation of the University of Memphis' CIT Map indicates that 2,886 CIT programs exist in the U.S. on the local, county, regional, and state levels. In total, they cover about one-quarter of the country's population, and most are organized by law enforcement. However, of most concern is the extremely limited distribution of CIT partnerships, the main indicator of CIT success according to NAMI. 375 partnerships exist in 146 of the country's 3,191 counties. This shows that of counties that have a CIT program, only 0.49 partnerships are engaged. On a positive note, four of the five partner areas that NAMI recommends (law enforcement, mental health organizations, hospitals, and emergency services) do exist in differing capacities. The one missing partner is public officials.

These findings provide a snapshot of CIT programs and partnerships in the U.S., providing one explanation for the inconclusive literature on CIT effectiveness. Without community partnerships, CIT programs cannot provide their CIT-trained officers with the appropriate resources to divert individuals in mental health crisis away from the criminal justice system. While immediate outcomes have been measured in the literature, such as the perceptions of the officers themselves with respect to dealing with calls involving mental illness, the lack of CIT partnerships contributes to why research is quite limited in the downstream-level outcomes of CIT programs. For example, without partnerships, it is difficult to measure CIT outcomes related to proper treatment for those with mental health concerns or a reduced level of police violence towards black individuals.

To address these downstream-level outcomes, this paper identifies four primary problem areas in CIT programs: (1) the overall lack of community partnerships, (2) no clear guidance on

CIT partnerships, (3) no involvement of public officials, and (4) lack of data to measure effectiveness. Recommendations to address these areas include action items such as leverage existing NAMI partnerships, allocate funding solely for the purpose of partnership development, improve communication and outreach conducted by NAMI and CIT International, engage policymakers, and establish data collection systems alongside all partners.

With these recommendations, it ultimately becomes the option of law enforcement agencies and other organizers of CIT programs to establish the necessary partnerships to provide CIT-trained officers with the appropriate resources for success in this endeavor. While the limited behavioral health workforce contributes to the difficulty in establishing these programs, existing partnerships are not proportional to the existing workforce. Thus, increasing both can occur simultaneously. Additionally, partnership engagement provides a means for law enforcement to include community organizations as part of the solution in the policing, and resulting, political crises, without the threat of defunding. With Republican states already engaged in CIT programs, it becomes a viable, bipartisan measure to expand CIT partnerships as a means to address police violence.

Regardless of how leaders of CIT programs decide to act, it is of public health concern to promptly address police violence and its resulting disparities. It cannot be continued that those with mental illness face a rate of being killed by the police 16 times greater than those without mental health concerns. Similarly, it cannot be continued that 31.17 black youth, per million people, are killed, compared to 1.47 white youth. These disparities make it so that the impacts of police violence, law enforcement, and lack of mental health treatment options lead to both physical and psychological harm on the community level, which is of upmost public health concern. A properly-structured CIT program has the potential to decrease police violence, connect individuals

in mental health crisis with the appropriate resources, and increase the number of individuals that are put on a path to recovery in the U.S.

Appendix A: CIT Programs and Partnerships Breakdown by State

State	CIT?	# local/county-wide programs	# Regional/Statewide Programs	# partnerships	# counties with Programs	% Pop Covered by Program	% Pop Covered by Partnership
Alabama	no	0	0	0	0	0.0%	0.0%
Alaska	yes	2	0	2	2	52.6%	52.6%
Arizona	yes	13	4	24	4	84.3%	76.0%
Arkansas	no	0	0	0	0	0.0%	0.0%
California	yes	40	1	6	23	78.2%	25.5%
Colorado	yes	90	4	0	13	75.1%	0.0%
Connecticut	yes	45	1	14	5	86.2%	66.2%
Delaware	yes	0	1	1	1	0.0%	57.4%
Florida	yes	216	8	28	44	96.2%	48.2%
Georgia	yes	90	1	3	44	72.9%	0.9%
Hawaii	yes	2	0	7	2	16.9%	11.8%
Idaho	yes	13	7	0	10	66.5%	0.0%
Illinois	yes	154	21	4	49	88.7%	46.1%
Indiana	yes	53	1	2	25	52.2%	2.9%
Iowa	no	0	0	0	0	0.0%	0.0%
Kansas	yes	36	0	9	11	61.8%	29.6%
Kentucky	yes	145	13	3	73	81.1%	20.6%
Louisiana	yes	60	4	8	31	56.6%	28.6%
Maine	yes	61	2	14	16	100.0%	42.6%
Maryland	yes	8	1	11	9	53.9%	36.5%
Massachusetts	yes	4	0	0	4	29.6%	0.0%
Michigan	yes	2	0	0	2	3.3%	0.0%
Minnesota	yes	48	0	6	24	72.0%	36.2%
Mississippi	yes	9	0	0	4	18.8%	0.0%
Missouri	yes	72	6	27	9	34.6%	27.9%
Montana	yes	4	1	3	3	21.3%	10.6%
Nebraska	yes	18	1	12	4	42.5%	29.5%
Nevada	yes	4	0	2	2	88.9%	15.3%
New Hampshire	yes	4	0	0	3	45.9%	0.0%
New Jersey	yes	70	0	3	11	51.9%	14.3%
New Mexico	yes	6	1	0	3	50.0%	0.0%
New York	yes	7	0	2	4	20.5%	10.8%

North Carolina	yes	284	20	13	81	94.0%	28.8%
North Dakota	yes	6	1	5	3	45.3%	23.9%
Ohio	yes	541	8	60	87	95.4%	58.7%
Oklahoma	yes	13	0	2	8	52.3%	36.6%
Oregon	yes	41	0	25	14	80.8%	33.7%
Pennsylvania	yes	178	4	25	15	42.2%	22.3%
Rhode Island	no	0	0	0	0	0.0%	0.0%
South Carolina	yes	2	0	0	2	16.4%	0.0%
South Dakota	yes	4	0	4	3	36.3%	23.4%
Tennessee	yes	50	4	17	18	45.2%	23.6%
Texas	yes	12	0	14	9	43.9%	42.3%
Utah	yes	105	21	0	21	98.0%	0.0%
Vermont	yes	1	0	0	1	9.4%	0.0%
Virginia	yes	78	18	14	53	62.8%	5.2%
Washington	yes	58	3	0	12	64.5%	0.0%
West Virginia	no	0	0	0	0	0.0%	0.0%
Wisconsin	yes	72	0	5	30	74.2%	21.5%
Wyoming	yes	8	0	1	4	42.8%	5.0%

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