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Training Law Enforcement in Mental Health: A Broad-Based Model

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TRAINING LAW ENFORCEMENT IN MENTAL HEALTH:
A BROAD-BASED MODEL

A dissertation submitted to
the Graduate College of
Marshall University

In partial fulfillment of
the requirements for the degree of

Doctor of Psychology

by

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Abstract

Police officers respond to many calls involving people suffering from a mental illness; yet many law enforcement training programs and workshops do not include mental health training. A literature review was conducted to explore the problems resulting from the lack of mental health training available for law enforcement officers and identify specialized training programs currently being implemented to address those problems. The review identified several program models being implemented throughout the United States including: Joint Police/Mental Health Team Model, Mobile Crisis Unit Model, Crisis Intervention Team Model, and the Broad-Based Training Model. These models include empirically supported components used to increase learning and decrease stigma and result in significantly reduced arrest rates of the mentally ill and increase the safety of interactions between law enforcement and the mental health community. A broad-based training seminar was presented to volunteers from local policing agencies. A pre- and post-test analysis revealed significant positive changes in attitude, behavior, and improved knowledge of mental health issues as a result of the training. The limitations of the current research and the future implications in regard to the safety of law enforcement and the safety of those affected by mental illness are discussed.

Training Law Enforcement in Mental Health:

A Broad-Based Model

Law enforcement officers are trained to deal with various types of situations; as described by Reuland and Schwarzfeld (2008), these situations can be criminal or noncriminal as well as include various types of people. They are called to respond to criminal acts during commission (e.g. responding to a domestic dispute, burglary/assault in progress, drunk and disorderly conduct, etc.) as well as after a criminal act has been perpetrated (e.g. robbery, vehicular accidents, alarm calls, etc.). Law enforcement officers also respond to noncriminal situations including, but not limited to, school patrols, crime prevention checkpoints, and providing safety for emergency medical service men and women dealing with a patient who has been deemed a danger to themselves and/or others.

Police officers, according to Teplin (2000), can choose to handle 9-1-1 calls concerning mentally ill persons through formal or informal operations. They can formally resolve the matter through arrest or hospitalization or informally resolve the matter by playing the role of mediator between family members or attempting to calm down and reason with the mentally ill person. Formal options can be time consuming to the officer and may not be in the best interest of the person with a mental disorder; however, officers are sometimes left unable to resolve the matter informally due to inexperience or unfamiliarity with de-escalation techniques. Law enforcement officers are trained to assess a situation and take the best course of action to resolve an issue and, when dealing with the mental health community, the hope is that situations can be resolved peacefully; however, recent interactions between law enforcement agencies and mentally ill suspects have had deadly results (Teplin, 2000).

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Police officers who are not educated in mental health disorders could potentially respond to a call with more hypervigilance than is required (Teplin, 2000). The lack of training and the increase in hypervigilance can produce negative consequences for all parties involved in police interactions with the mentally ill (Reuland & Schwarzfeld, 2008). The mentally ill person can suffer possible physical/emotional trauma from the interaction and may be arrested or even killed due to the perception and reaction to the police officer's approach (Teplin, 2000). Similarly, according to Reuland and Schwarzfeld (2008), the police officer may feel he or she is in danger and may use deadly force and may suffer the subsequent psychological trauma of taking a human life. The repercussions from these realistic scenarios can extend to the victim's family, the police officer's family, and the public's perception of a police officer's role and the police department (Reuland & Schwarzfeld, 2008; Teplin, 2000).

Subsequently, law enforcement interactions with the mental health community are on the rise (Teplin, 2000). According to Kessler, Chiu, Demler, and Walters (2006), prevalence rates for mental disorders in the United States have steadily risen and are currently estimated to be 26.2% (approximately 53 million people), with 22.3% of those cases classified as severe (approximately 11 million people). The increase of contacts between police officers and the mentally ill is visible in news headlines. According to an article published by the Associated Press (2011), an analysis of police calls in Portland, Oregon, revealed six of the eight uses of deadly force during the previous year involved people suffering from a mental illness.

In September of 2010, San Francisco police officers were involved in three separate altercations with mentally ill suspects that resulted in two uses of deadly force and one use of less than lethal force (Revelle, 2011). Less than lethal force is the term used to distinguish weapons that are likely to cause death (e.g., guns) from weapons which are unlikely to result in

death such as batons, asps, and stun guns (Reuland & Schwarzfeld, 2008). In response to these altercations, the San Francisco Police Department implemented a training program focused on improving the safety and outcome of interactions between their police officers and the mentally ill (Revelle, 2011).

In February of 2011, officers in San Mateo, California responded to a call involving a man diagnosed with schizophrenia who was threatening people on the streets (Melvin, 2011). Upon the arrival of the police, the man fired a gun and ran into the backyard. The police officers followed the man and returned fire "ending the immediate threat" (Melvin, 2011). In November of 2011, a New York man in a manic episode stood in front of seven police officers and his sister holding a single-shot antique rifle, unloaded; police officers shot the man 42 times resulting in serious injury; he was taken off life support four days later (Orlando, 2013). In all of these cases, the officers were not penalized because they each followed their respective department's procedural code; however, in many police department protocols a suspect suffering from a mental illness does not receive individual recognition and tends to be lumped in with intentionally aggressive and dangerous subjects (Teplin, 2000).

These instances help illustrate that even though police officers are trained to handle a multitude of situations, mental health training is missing from most police officer training curricula (Reuland & Schwarzfeld, 2008; Teplin, 2000). Police departments throughout North America have been implementing training programs on mental health interactions as a reaction to tragic situations similar to those in Oregon, New York, and California (CMHA, 2003). However, instead of being reactive, police training programs should be proactive in training their officers. Comprehensive training on the types of psychological disorders, symptoms, general de-

escalation techniques, and contact activities for police officers may provide a" bigger tool box" of strategies for police officers to use during interactions with the public.

In order to convey the importance of including mental health training in the police officer training program, this section will first review the research on the prevalence and common types of police encounters with the mental health community. Next, an overview of the current police training curriculum required by the West Virginia state police guidelines will be provided and the lack of attention given to the mental health community in the training curriculum and department protocols will be discussed. Then, specialized mental health training programs will be described along with the current research regarding empirically supported components and each program's effectiveness.

Police Encounters with the Mental Health Community

In 1964, the Community Mental Health Centers Act was implemented to remove patients classified as mentally ill from the state psychiatric hospitals and integrate them back into the community (Reuland, Schwarzfeld, & Draper, 2009). The deinstitutionalization of the mental health system led to more humane practices and treatment for the mentally ill but also removed the central "government" previously used to supervise their behavior and manage their symptoms (Reuland et al., 2009). At a time when the diagnosis of psychological disorders was on the rise, the deinstitutionalization of the mental health system removed some patients from the state psychiatric hospitals only to send them to the prison system (Kessler et al., 2005; Teplin, 2000). The continued ripple effects of this transition have removed many of the 1mentally ill from the trained staff and professionals who knew how to handle and care for these individuals. Consequently, many are now contacted first by untrained law enforcement officers and corrections officers (Kessler et al., 2005).

Prevalence rates. The Connecticut Alliance to Benefit Law Enforcement, Inc. (CABLE; CABLE Inc., 2008) is a non-profit research and training organization which aims to study the frequency of interactions between law enforcement and the mental health community, join law enforcement (state and municipal) agencies with mental health professionals, and provide educational training. A study of the prevalence of inmate mental illness in the U.S. prison system reported 16%, about 283,000 inmates, were eligible for mental health services. In order to become imprisoned, a person must have some contact with law enforcement; therefore, according to the research produced by those at CABLE, there are a substantial number of encounters between law enforcement and the mentally ill.

Led by Reuland et al. (2009), the Council of State Government's Justice Center organized The Consensus Project in order to research the increasing overlay of the criminal justice system and the mental health system. According to the Consensus Project results, contacts with the mentally ill account for 7% of all police contacts in cities with populations greater than 100,000 people. The Consensus Project members also investigated the history of people diagnosed with severe mental disorders, defined as causing significant impairment to daily functioning. They found 20% reported having been arrested or having police contact during the previous four months. A year-long study of law enforcement activity with mentally ill citizens residing in the state of Florida reported officers transported more than 40,000 people to the hospital for involuntary commitments (Florida Department of Law Enforcement, Data, and Statistic, 2010). However, Reuland et al. (2009) did not report whether some individuals were involuntarily committed more than once, but the focus should be the number of contacts between the police and mentally ill persons.

Although it appears the use of deadly force with aggressive or violent mentally ill suspects is becoming more prevalent, it is still the exception and not the norm (CMHA, 2003; Revelle, 2011). In Hawaii, a study reported that, during 148 police encounters with mentally ill suspects, only 18 involved the use of force (Reuland et al., 2009). In fact, most cases of police involvement with the mentally ill are not due to serious or violent offenses. A further analysis of the study in Hawaii revealed 67 of the 148 encounters involved no criminal offenses and 40 of the remaining 81 participants were reported for simple disorderly conduct (Reuland et al., 2009). A similar study conducted in the Midwestern United States reported the majority of the encounters with mentally ill suspects involved "trouble makers" and "relatively unobtrusive" individuals (Reuland et al., 2009, p. 5).

Even though violent altercations between police officers and mentally ill persons do not account for the majority of police interactions, police officers face other obstacles when handling a situation with mentally ill suspects. Officers are susceptible to the same stereotypes of the mentally ill as the general public, and one strategy used to combat stereotypes is the exposure to accurate information and contact with the stereotyped group (Heijnders & Meij, 2006). Unfortunately, as the following section reveals, training focused on interactions and addressing stereotypes with the mentally ill is one area that is not included in basic police training curricula.

Current Police Training

The type of law enforcement training required by each police agency is decided by the state in which that agency is housed (Reuland & Schwarzfeld, 2008). Statewide training institutes are used to train state police officers, county and municipal officers, department of natural resources officers, and campus police officers (Kentucky Department of Criminal Justice

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Training, 2010). These institutions offer comprehensive courses that span a four to six month period (West Virginia Division of Justice and Community Services, 2011).

West Virginia's law enforcement training program is housed in a state-wide institution referred to as the West Virginia State Police Academy or WVSPA (2007). During the first month of WVSPA (2007) training, the officers' courses focus on uniform crime reporting techniques, West Virginia statutes, police ethics, domestic violence procedure, and constitutional law and arrest. The first month of training also serves as an introduction to federal and state laws along with physical training and defensive tactic training (i.e. hand-to-hand combat training). During the second month, the officers' training focuses on community-oriented policing, report writing, child abuse crimes, investigation procedures, search and seizure laws, use of force, and crime scene procedures. The second month also introduces weapon training and oleoresin capsicum (also known as O.C. or pepper) spray training.

The third month of the WVSPA (2007) training includes further education on West Virginia law including the laws of mental hygiene warrants; however, the training only covers the law and neglects to inform the officer of de-escalation techniques to improve interactions when serving the mental hygiene warrants. In West Virginia, any adult can file an application for "Involuntary Custody for Mental Health Examination" of another individual which allows a mental hygiene commissioner to issue a warrant to involuntarily commit a mentally ill individual who is in danger of harming themselves or others (Williams, Wilmoth, & Shryock, 2011). Some jurisdictions in West Virginia require police officers to transport mentally ill persons to the nearest state or psychiatric hospital; regardless of their lack of training in the management and transportation of persons who have been deemed unfit for the public setting (WVSPA, 2011).

The third month also includes training on crowd control techniques, first emergency responder (basic first-aid training), lethal and less than lethal weapon use (weapons that are unlikely to result in death), interviewing techniques, drug identification and handling, court procedures, juvenile law, hate crimes, and racial profiling. The third month also includes the emergency vehicle operator course, which introduces the officers to the proper protocol for the use of their emergency lights, siren, and special driving skills for operating their vehicle during police pursuits. The fourth month of training includes classes on firearm laws, traffic law enforcement, the use of informants, courtroom testimony and witness identifications, and laws regarding driving under the influence of drugs or alcohol. During the last month, officers are required to pass a WVSPA (2007) comprehensive exam of all course work, simulation exams, a physical agility exam, and a firearm accuracy exam.

In 2011, the WVSPA implemented two new training classes into their month two curricula: Mental Hygiene Responsibilities and Identifying Mental Disorders. The class on mental hygiene responsibilities provides a refresher course on current West Virginia law regarding mental hygiene warrants as well as additional information regarding the process and subsequent responsibilities in enforcing these laws (WVSPA, 2011). The class on identifying mental disorders introduces officers to most psychological disorders found in the Diagnostic and Statistical Manual of Mental Disorders IV: Text Revision (American Psychiatric Association, 2000) and provides an overview of symptoms associated with each disorder (WVSPA, 2011). However, both classes fail to provide training on specific techniques or considerations when dealing with a person diagnosed with a mental disorder or a domestic disturbance involving a person or persons exhibiting symptoms of a mental disturbance. In fact, one object lesson from the class presentation is to treat people suffering from a mental disorder like every other person

the police comes into contact with during their patrol. Although this lesson goes on to specify a person suffering from a mental disorder has the same ability as any other person to harm an officer and appears to be focused on the dangers to the police officer, it fails to clarify whether or not people exhibiting mental disturbances should be approached in a different manner.

The WVSPA is a state accredited institution that is also supported by Marshall University in that upon graduation from the academy, State Police Academy Basic Class Officers receive college credit and State Police Cadets receive an associate's degree in police science from Marshall University (Stroupe, 2003). In order to allow college credit to be given for course completion, Marshall University must approve the course list and the course requirements (Stroupe, 2003). However, the State Police Academy and Marshall University fail to include comprehensive training of police encounters with the mental health community in the academy syllabus (WVSPA, 2007; 2011).

The Kanawha County Sheriff's Department, like many police departments, has their own Department Policy, Standards, and Operating Procedures Manual that explicitly defines the administration's expectations of officer conduct. According to the Department Policy, Standards, and Operating Procedures Manual, created by Rutherford and Rutherford (2005), the police officers do not receive a protocol describing their options (hospitalization, community resources, etc.) when dealing with someone who is presenting with mental disturbances, nor do they receive a protocol describing a standard operating procedure or continuum for the use of deadly force with mentally ill suspects. Police departments in West Virginia, comparable to police departments in other states, are not addressing the increasing interactions of police officers with mentally ill persons. Currently, Tennessee, Kentucky, Florida, Georgia, Ohio, Virginia, and Colorado are just some of the few states that have implemented mental health training programs

designed specifically to educate officers in mental disorders and improve the outcome of interactions between law enforcement and the mental health community (Dupont, Cochran, & Pillsbury, 2007).

Specialized Mental Health Training Programs

One solution to the lack of mental health training problem is the use of "specialized law enforcement-based response programs" (Reuland & Schwarzfeld, 2008, p. 1). Specialized law enforcement-based response programs, as described by Reuland and Schwarzfeld (2008), provide officers with alternative strategies for resolving situations involving people with mental illnesses, strengthen the connection between law enforcement and mental health resources, but remain housed in law enforcement agencies. The programs supplement the regular curriculum of police officer training and, similar to other police training, require hands-on practice. Other training programs use role playing exercises, invite members from the mental health community into the classroom, and require field training hours in order to complete the course.

Joint police/mental health team model. Specialized law enforcement-based response programs come in a range of models. The Joint Police/Mental Health Team Model can be implemented as either a mental health system-based model or police force-based model as described per the Canadian Mental Health Association (CMHA, 2003). Mental health system-based programs assign a police officer to a mental health crisis team; the police officer functions as a crisis intervention member and represents the law enforcement agency in case the situation involves a mentally ill person and requires law enforcement intervention. Police force-based programs employ mental health professionals as civilian officers and assign them to calls involving people with mental disturbances as long as there is no report of violence. The Joint Police/Mental Health Team Model allows officers the chance to resolve the incident on-site and

reduces the possibility of arrest and the risk of causing further trauma to the individual (CMHA, 2003).

Mobile crisis model. Mobile crisis units, also called reception centers, are another type of specialized law enforcement-based response program as described per the Canadian Mental Health Association (2003). In the reception center model, all officers are trained in identifying symptoms of mental illness; and once a person with mental disturbances has been identified, the officers transport the individual to a reception center. The reception center is operated by the police agency and has specially trained officers who assess the individual to decide whether he/she should be referred to a mental health system rather than the prison system. This model allows the individual exhibiting mental disturbances to have the option to receive mental health services instead of being arrested. This model also gives the patrol officers quick alternatives to the formal options of arrest or hospitalization.

Crisis intervention team model. Specialized police crisis intervention teams, such as the Crisis Intervention Team (CIT) described by Canadian Mental Health Association (2003), are the most widely used and most empirically supported models of specialized law enforcement-based response programs. The CIT model was developed in Memphis, Tennessee and is usually referred to as the Memphis Model. In the Memphis Model, each shift, patrol area, or precinct is equipped with at least one officer who is a member of the crisis intervention team. Each member of the CIT undergoes extensive training in identifying symptoms of mental disturbances, utilizing non-violent interventions, de-escalation techniques, and available community options. The Memphis Model equips a department with at least one CIT member per shift instead of one team per department; therefore increasing the response rate (CMHA, 2003; Dupont et al., 2007).

Broad-based police training program model. A model similar to the Memphis Model is the broad-based police training program model. Broad-based police training programs provide extensive training to every police officer and enables officers to identify the symptoms of mental disturbances, use de-escalation techniques, and be aware of the potential legal issues (United States Department of Justice, 2001). Broad-based training programs can be costly to large departments especially if the officers receive overtime pay for training; however, the benefits of having every officer of a department receive mental health training and learn effective alternatives to handling 9-1-1 calls involving the mentally ill may outweigh the financial cost to the department (United States Department of Justice, 2001).

Effectiveness of Specialized Law Enforcement-based Response Programs

The effectiveness of specialized law enforcement-based response programs has been demonstrated through the use of empirically supported components and result comparisons of arrest rates and officer attitudes before and after a training model is employed. An examination of the training programs' components reveals common techniques which have been repeatedly used to educate law enforcement personnel, mental health workers, health care providers as well as various workers from various disciplines (Brummel, Gunsalus, Anderson, & Loui, 2010; Paladino, Minton & Kern, 2011; Taplin, 2007). An examination of the law enforcement-mental health interactions pre and post implementation of a training program also reveals the implementation of a mental health training program results in lower arrest rates for the mentally ill, larger number of calls resolved on site, and changes in the way law enforcement officers view people who are mentally ill (CMHA, 2003; Ritter, Teller, & Munetz, 2006; Steadman, Deane, Borum, & Morrissey, 2000).

Techniques to Reduce Stigma. Physical contact or media contact interventions coupled with educational programs have also demonstrated success in reducing the stigma attributed to those suffering from a mental illness (Kolodziej & Johnson, 1996; Mann & Himelein, 2008). Current research has demonstrated teaching programs that include educational components to counteract stereotypes, activities to increase contact, and personal accounts of a person's experience with a mental illness can reduce stigma (Mann & Himelein, 2008). These programs also improve the social distance, defined as a person's physical distance from another person and their subsequent comfort level during social interactions, between the normal population and members of the stigmatized group (Mann & Himelein, 2008).

Many law enforcement-based mental health training programs have assessed attitude change following training (CMHA, 2003; Reuland & Schwarzfeld, 2008; Ritter et al., 2006). The Memphis Model or CIT training program has been shown to affect a police officer's perception of people diagnosed with mental disorders (Ritter et al., 2006) An analysis, post CIT training, of the attitudes of police officers towards the mentally ill revealed police officers reported lower levels of anxiety and lower desires for physical distance between themselves and an individual suffering from schizophrenia (Ritter et al., 2006). Also, police officers who had completed CIT training were able to better identify the symptoms of mental disturbances and reported feeling more comfortable in situations involving the mentally ill (Wells & Schafer, 2006). More recent research has shown officers who have undergone training are likely to respond with less force to a difficult or resisting person in comparison with officers who have not been trained (Morabito, Kerr, Watson, & Draine, 2012).

Model comparisons. Empirical studies measuring the effect of mental health training for law enforcement on the outcome of interactions between law enforcement and the mentally ill

are limited. The most empirically supported model is the Memphis Model and its respective reincarnation by various police departments (Compton, Bahora, Watson, & Oliva, 2009; Dupont et al., 2007). Other models such as the Joint Police/Mental Health Team Model and the broad police training program model have been compared in studies measuring the effectiveness of CIT models, but they have not been studied in comparison with police departments who do not use specialized law enforcement-based response programs (CMHA, 2003).

The Joint Police/Mental Health Team Model based in law enforcement is effective in resolving calls onsite and decreasing the arrest rate of mentally ill persons (CMHA, 2003; Steadman et al., 2000). An analysis of 100 consecutive emergency calls reported to involve mental disturbances revealed the civilian officers made arrests in only 13% of calls, which was a decrease from the study's average arrest rate of 24% (Steadman et al., 2000). Despite the good result when team members are called to the scene, the civilian officers were dispatched to only 28% of the incidents reported to involve mentally ill persons (Steadman et al., 2000). The small proportion of mental health calls directed toward the civilian officers has been reported to be due to slow response time and the shortage of civilian officers available per shift (CMHA, 2003).

The Mobile Crisis Unit Model has been shown to be more time efficient and result in a lower arrest rate in comparison to the Joint Police/Mental Health Team Model (CMHA, 2003; Steadman et al., 2000). An analysis of 100 consecutive 9-1-1 calls involving people with mental disturbances revealed the mobile crisis unit had a 5% arrest rate (Steadman et al., 2000). The mobile crisis unit demonstrated quicker response times in comparison to the Joint Police/Mental Health Team Model and answered a higher proportion of mental health related calls (Steadman et al., 2000). The mobile crisis unit's ability to answer more calls than the Joint Police/Mental Health Team model could be due to the larger number of police officers involved in the crisis

unit. However, according to the study on the mobile crisis model, 60% of calls involving mental disturbances were being handled by untrained police officers (Steadman et al., 2000).

The Memphis Model has shown to the be the most effective in enabling officers to answer the largest proportion of mental health calls while maintaining the quickest response times, in comparison with the Joint Police/Mental Health Team Model and the Mobile Crisis Unit Model (Steadman et al., 2000). Members of a crisis intervention team were dispatched to 95% of the 97 consecutive 9-1-1 calls examined in the study and reported a 6% arrest rate (Steadman et al., 2000). The Memphis Model allows for more calls to be resolved by a trained officer since the department places at least one CIT officer on each shift.

Although there is little research examining the effectiveness of broad-based training programs, the education and technique training of broad-based training programs appear to be similar to the education and technique training component of the CIT model (Dupont et al., 2007; United States Department of Justice, 2001). Both models provide training on identifying symptoms of mental disturbances, quick assessment techniques, role playing to practice de-escalation techniques, contact activities, and intervention techniques to use in order to reduce the risk of danger to the officers and others (Dupont et al., 2007; United States Department of Justice, 2001). Therefore, it is likely the outcome results may be similar. Although the Memphis Model has been the most researched model and has been shown to be the most effective it may not be the most appropriate and cost-effective model for all agencies, especially those in rural settings. As a result, broad-based models may be more suitable for some agencies.

Limitations of Research

The current research regarding the effectiveness of specialized law enforcement-based response programs is limited. Although the proportion of police departments using specialized

law enforcement-based response programs is increasing, there is still not a standard method for collecting information regarding the number of police interactions with mentally ill persons or the outcomes of those interactions. Most training programs are designed to equally cover all mental disorders because demographic information is not available (CMHA, 2003; Reuland & Schwarzfeld, 2008; United States Department of Justice, 2001).

The FBI gathers frequency data regarding the content of law enforcement interactions (e.g., frequency of murder investigations, burglary reports, automobile accidents, etc.); however, the Uniform Crime Report does not include a section to report calls involving the mentally ill or police action stemming from a call regarding a person exhibiting mental disturbances (United States Department of Justice, 2011). It is unknown whether most police interactions involve persons diagnosed with more serious disorders (e.g. those characterized by psychosis, high suicide risk, hallucinations, or aggression) or persons diagnosed with less serious disorders; therefore, it is difficult to know what population of mental disorders has more conflict with law enforcement. To better understand the magnitude of police interactions with the mentally ill and the nature of these interactions, the data need to be reported as regularly as other frequency reports.

The current study examined the effect of a broad-based law enforcement training seminar on increasing factual knowledge about the mental health community, decreasing stigma via measuring the pre and post attitudes of the participants, and reported behavior change via written responses to real-life scenarios. The following hypotheses were tested: H1: The results of the posttest will show a significant increase in knowledge regarding the mental health issues, H2: The results of the posttest will show a significant attitude change regarding people diagnosed

with a psychological disorder, and H3: The results of the posttest will show a significant change

in reported behavior in response to real-life scenarios.

Method

Participants

This study used a convenience sample of local police officers currently associated with a

law enforcement agency. The inclusion criteria for study participation were a police officer

currently employed by a West Virginia law enforcement agency with at least one year of

employment ($M_{experience} = 13.1$ years, range: 2—21 years in law enforcement). This criterion

ensured all participants had been exposed to the similar training provided by the West Virginia

State Police Academy. One year of employment ensured each participant had some patrolling

experience, including interactions with the public (86% of participants had executed a mental

hygiene warrant, 100% of participants had prior experiences with a person exhibiting a mental

disturbance). There were 151 police officers (139 men, 12 women) who participated in the study

($M_{age} = 36.2$ years, age range 22—56).

Materials

Demographic Data Questionnaire. A questionnaire to gather basic participant

demographic information was developed specifically for this training. The questionnaire

consisted of 10 items: seven questions and three likert scales. The seven questions include

questions regarding the participant's age, number of years working in the law enforcement field,

and approximate number of encounters with people with mental health problems. The three likert

scales assessed the participant's personal opinions on current exposure to adequate training, level

of knowledge regarding mental health, and subsequent level of comfort when interacting with

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someone with a mental disturbance. The Demographic Data Questionnaire can be viewed in Appendix A.

Mental Health Knowledge Questionnaire. A questionnaire to assess participant knowledge of psychological disorders and accurate definitions of psychological terms was designed specifically for this training. The questionnaire consists of 25 items (16 multiple choice and nine true/false). The questionnaire was designed similarly to exams encountered in academic situations and assessed information exclusively presented in the training. In regard to scoring, each item on the Mental Health Knowledge Questionnaire (MHQ) was worth one point, making the maximum score of correct answers equal 25. The Mental Health Knowledge Questionnaire can be viewed in Appendix B.

Attitudes Questionnaire. A questionnaire to assess participant attitudes toward people diagnosed with mental illness or people who exhibit mental disturbances was adapted from the Health and Social Care Information Center Questionnaire (National Health Statistics Information Center, 2011). The questionnaire was shortened to include 26 items (21 likert scales and five multiple choice) to allow adequate time for participants' to complete all pre- and post-assessments. For the purposes of this study, this reduction in items should not impact the scoring and interpretation of this instrument. Participants are asked to indicate how much they agree or disagree with statements about mental illness. Other questions covered a range of topics including descriptions of people with mental illness, relationships with people with mental health problems, personal experiences of mental illness, and perceptions of mental health-related stigma and discrimination. The answers on the likert scales were weighted (i.e. Strongly Agree = 5, Slightly Agree = 4, Neither Agree nor Disagree = 3, Slightly Disagree = 2, and Strongly Disagree = 1); lower scores correspond to negative attitudes and higher scores correspond to

positive attitudes toward mental illness. The Attitudes Questionnaire can be viewed in Appendix C.

Law Enforcement Course of Action Scenarios Questionnaire. A questionnaire to assess participant behavioral response to scenarios involving people diagnosed with mental disorders and/or exhibiting mental disturbances was developed specifically for this training. The questionnaire consisted of four general scenarios inspired by news stories and/or police officer descriptions. Each scenario included three follow-up questions: report best course of action upon arrival, following the assessment there is no immediate danger, report next best course of action, and report whether the chosen course of action will lead to hospitalization, arrest, or no action. The scenarios did not include indications of violence to avoid participant answers which reflect a specific agency protocol (e.g. use of less-than-lethal force such as a stun-gun, asp, or pepper spray toward suspects exhibiting violent behaviors).

The post-test version of the questionnaire included two open ended questions following each scenario asking the participant if he/she would change any of the previously chosen course of actions and which de-escalation techniques would be beneficial in this situation. In order to make sure the course of action choices are realistic and the scenarios provide enough information, a focus group consisting of twelve police officers determined plausibility of the scenarios and possible courses of action. Each answer was given a corresponding score (1 through 4) based on feedback from the focus group. Scores from each scenario were added to create the participant's composite score; higher scores indicate better course of action choice. Law Enforcement Course of Action Scenarios Questionnaire can be viewed in Appendix D.

Procedure

Local law enforcement officials were contacted either via telephone or a scheduled in-person meeting to inform them of the upcoming and free training opportunity. If the law enforcement official was interested in involving some of his or her officers, further information regarding the date, time, and place of the training seminar was provided. An application to receive in-service credit authorization was submitted and approved by the West Virginia Division of Justice and Community Services and participants were able to complete eight hours of annual in-service credit by attending the training.

Eleven training seminars were held from July until October 2012 in locations ranging from law enforcement department training facilities to college/university classrooms. The duration of the subject's participation in the study was eight hours: 10 minutes for consent process, 20 minutes for initial questionnaires, 7.0 hours for training (broken up by lunch), and 30 minutes for final questionnaires. Upon arrival, participants were asked to sign in and read an anonymous informed consent form. Then each officer was randomly given a folder with a designated identification number. Each folder included three envelopes; each envelope included questionnaires with the participant's identification number. The first envelope included the pre-tests assessments: Demographic Data Questionnaire, Mental Health Knowledge Questionnaire, and Attitudes Questionnaire. The second envelope included the Law Enforcement Course of Action Scenarios Questionnaire, pre- and post-test version. The third envelope included the pos-ttest assessment: Mental Health Knowledge Questionnaire and Attitudes Questionnaire.

The questionnaires in the first envelope were filled out and collected before the training began. Once all study questionnaires were completed, the co-investigator collected the closed envelopes. The participants filled out the first section of the Law Enforcement Course of Action Scenarios Questionnaire located in the second envelope and, once completed, placed it back in

the second envelope. The training seminar consisted of three sections: 1) Identification and Behavioral Indicators of Mental Disturbance, 2) Mental Status Examination Techniques, and 3) De-escalation Techniques. The training was presented via PowerPoint presentation with audio/visual examples of specific symptoms

Following the training, the participants opened the third envelope and completed the enclosed assessments. Participants also reopened the second envelope and completed the second section of the Law Enforcement Course of Action Scenarios Questionnaire. The completion of all items signaled the end of the training seminar. The co-investigator once again collected and placed all data sheets into a closed envelope.

Results

Paired-samples t-tests were conducted to evaluate the effect of the training on participants' scores on the Mental Health Knowledge Questionnaire, Attitudes Questionnaire, and the Law Enforcement Course of Action Scenarios Questionnaire. A test of the three a priori hypotheses was conducted using Bonferroni adjusted alpha levels of 0.017. There was a statistically significant increase in Mental Health Knowledge Questionnaire scores from pre-training ($M = 14.85$, $SD = 3.68$) to post-training ($M = 19.87$, $SD = 3.17$), $t (150) = -24.07$, p < .017 (two-tailed). The mean increase in Mental Health Knowledge Questionnaire scores was 5.03 with a 98.3% confidence interval ranging from 4.61 to 5.44. The eta squared statistic (0.80) indicated a large effect size.

There was a statistically significant increase in Attitude Questionnaire scores from pre-training ($M = 64.84$, $SD = 12.04$) to post-training ($M = 80.96$, $SD = 13.51$), $t (150) = -22.96$, p < .017 (two-tailed). The mean increase in Attitude Questionnaire scores was 16.12 with a 98.3%

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confidence interval ranging from 14.73 to 17.51. The eta squared statistic (0.80) indicated a large effect size.

Pre and post scores in the Law Enforcement Course of Action Scenarios Questionnaire were also significantly different ($M = 17.33$, $SD = 3.16$; $M = 18.43$, $SD = 2.41$), $t (150) = -7.52$, p < 0.017 (two-tailed). The mean increase in Law Enforcement Course of Action Scenarios Questionnaire was 1.10 with a 98.3% confidence interval ranging from 0.81 to 1.39. The eta squared statistic (0.28) indicated a medium effect size.

Discussion

As previously outlined, there were three hypotheses to be tested in this study: H1: The results of the posttest will show a significant increase in knowledge regarding the mental health issues, H2: The results of the posttest will show a significant attitude change regarding people diagnosed with a psychological disorder, and H3: The results of the post-test will show a significant change in reported behavior in response to real-life scenarios. The results of this study revealed all three hypotheses to be true and lent statistical support to the rejection of the null hypothesis.

In regard to the first hypothesis, the participants' post scores on the Mental Health Questionnaire increased significantly in comparison with pre-training scores. These results indicated the participants increased their knowledge of the behavioral indicators of psychological disorders and accurate definitions of psychological terms. These results are in line with previous findings supporting the role of information-based police officer training in improving knowledge and identification of mental disturbances (Steadman et al., 2000; Wells & Schafer, 2006).

In regard to the second hypothesis, the participants' post scores on the Attitudes Questionnaire increased significantly in comparison with pre-training scores. These results

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indicated participant attitudes toward people diagnosed with mental illness or people who exhibit mental disturbances became significantly more positive after the training seminar. These results are in line with previous findings supporting the role of educational components of training in the reduction of negative attitudes toward persons with mental disorders (Mann & Himelein, 2008; Reuland & Schwarzfeld, 2008; Ritter et al., 2006).

In regard to the third hypothesis, the participants' post scores on the Law Enforcement Course of Action Scenarios Questionnaire increased significantly in comparison with pre-training scores. These results indicated participants' changed their reported behaviors toward a person with a mental disturbance and whether or not they would resolve the call through formal or informal action after they were provided with further information via training. These results are in line with previous findings supporting the role of mental health training programs in lower arrest rates for the mentally ill, larger number of calls resolved on site, and changes in the way law enforcement officers view people who are mentally ill (CMHA, 2003; Ritter et al., 2006; and Steadman et al., 2000).

Furthermore, these results further support the claim broad-based training models demonstrate similar effectiveness in comparison to CIT models in affecting officer knowledge, attitudes, and behaviors in regard to mental health issues (Dupont et al., 2007; Steadman et al., 2000). For some agencies, broad-based models are a more cost-effective way to train police officers, especially if the training is provided during the certification process (United States Department of Justice, 2001). Police agencies functioning within rural areas, such as West Virginia, could incorporate a broad-based training—such as this—into their training academy curriculum and have every officer educated in basic identification and de-escalation techniques.

Limitations and Future Research

In interpreting these findings, several limitations exist. First, the lack of standardization in training methods and data collection protocols with law enforcement officers in mental health training creates the possibility of problems with the reliability and validity of the assessment protocols. The instruments were face valid and it is possible the phrasing of the questions on the Law Enforcement Course of Action Scenarios Questionnaire biased participants' responses. Although common in new research, it would benefit future researchers to attempt to use well established measures in which reliability and validity have been adequately assessed. Correspondingly a pilot study, if performed, could have provided some data on the reliability and validity of the instruments.

It is also possible, given the nature of the training, the change in assessment scores could be a result of hypothesis guessing (Cook & Campbell, 1979). The participants were informed of the reason behind this training and were most likely privy to other training initiatives being implemented nationally. Although it is difficult to avoid hypothesis guessing by participants, according to Cook and Campbell (1979), it is important for researchers to be aware and to try to make adjustments when necessary. In this study, a Bonferroni adjustment was used to make alpha levels more stringent and reduce Type I error (e.g., stating the training was significant, when it was not); however, statistical adjustments can only be made after data are collected. Future researchers may be able to avoid hypothesis guessing by making instruments less face valid or finding ways to measure attitude/behavior changes via other means (e.g. arrest statistics or 911 Monthly/Annual Reports).

Furthermore, participants were assessed directly following the training seminar in which information was new and handouts were readily available. Therefore this study measures immediate change in knowledge, attitude, and reported behavior change and not the application

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of these changes in real-world patrols. Future researchers should not only measure knowledge, attitude, and reported behaviors directly following training but also via delayed follow-up assessments and possibly assess arrest statistics for a designated period of time following the training.

Future research needs to include the study of the effectiveness of broad-based training programs. Broad-based training programs train all officers in a police agency, as opposed to the CIT model. The CIT model was developed in Memphis, Tennessee for an agency including over thirteen hundred officers and calls for only 20% of a police agency's force to be trained (Steadman et al., 2000). Although the exact reasoning for the 20% goal was not given, it was most likely chosen as a means to keep the balance between having a significant number of trained officers per shift, while still remaining cost-efficient for the department. Financial cost of training is an important consideration for police agencies; however, small police departments with large areas of coverage would undoubtedly benefit more from a training program available for all officers instead of a small percentage. Specifically in states similar to West Virginia where all police officers are trained by the same institute, the training institute could offer broad-based training programs and educate every police recruit in the identification of mental illness and de-escalation and problem solving focused techniques.

Conclusion

Police agencies need to be proactive as opposed to the recent trend of being reactive to interactions between law enforcement and the mentally ill (CMHA, 2003; Reuland & Schwarzfeld, 2008; Teplin, 2000). Many police agencies wait until an interaction results in a tragic death before they require their officers to have mental health training (CMHA, 2003; Dupont et al., 2007; Orlando, 2013). Police departments should implement training programs as

a means to try to prevent tragedies, not react to them. Community mental health organizations and families of the mentally ill should also lobby to increase law enforcement training as a means to assure the safety and humane treatment of those affected by mental disease (CMHA, 2003). The human population is increasing, the crime reports and mental health services statistics also reveal increases (Kessler et al., 2005; United Stated Department of Justice, 2011); therefore, it is a safe assumption that law enforcement interactions with the mental health community will continue to reflect those increases. It is logical to request the institutions provide the best training to law enforcement so they can protect and serve the entire public, not just the "normal population."

     As previously stated, the statistical analysis of prisoners diagnosed with psychological disorders reveals the large amount of interaction law enforcement officers have with the mental health community (CABLE, Inc., 2008). Similarly, our national population of returning veterans who may be experiencing acute mental health issues is also on the rise (Weaver, Joseph, Dongon, Fairweather, & Ruzek, 2013). Even with the limitations described earlier, the present study does provide further insight into law enforcement training and the effects of a broad-based training model on police officer knowledge of mental health issues, attitudes toward people with mental disorders, and reported behavior toward people exhibiting mental disturbances. Historically, broad-based training models have not been as heavily researched as training for specialized law enforcement-based response programs. Even though this study is one of the first utilizing a broad-based training model, further research examining the correlation between changes in attitudes and course of action decisions and broad-based training models is definitively warranted.

It is important that all emergency responders are trained in accurately identifying mental disturbances and are equipped with the proper techniques to de-escalate high-risk situations (CMHA, 2003; Dupont et al., 2007). The mental health needs of the public have not shown any sign of declining and contact with emergency responders seems inevitable (CABLE, Inc., 2008). Emergency responders need to possess appropriate skills to handle these types of situations to decrease the potential for harm to an already vulnerable population as well as to bystanders when a situations occurs, improve the outcome for those exhibiting a mental disturbance, and increase the safety for both the responder and the public.

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Appendix A

Demographic Data Questionnaire

Date: _____

Age: (Please Check One)

- ☐ 18-24
- ☐ 25-40
- ☐ 41-55
- ☐ 55+

1. Number of years as a police officer:

_____

***Include all years, even if under other agencies

2. What year did you go through basic training at the West Virginia State Police Academy?

_____

***If you went through training before WVSPA was the established training academy, please put the year you were certified as a police officer for West Virginia

3. Following your police officer training, have you received any additional training on dealing with people diagnosed with a mental disorder?   Yes   or   No

If yes, where did you receive your training?

- ☐ College Classes

When/Where_____

- ☐ In-Service Training

When/Where _____

- ☐ Other _____

When/Where_____

4. Have you ever transported an individual following a mental hygiene petition to a hospital or residential setting? Yes   or   No

If yes, can you estimate how many times in the past year?_____

5. In the past year, have you answered any calls involving people who have been diagnosed with a mental illness?   Yes   or   No

   If answered yes, can you estimate how many times?_____

6. Has your think your mental health training, thus far, has been adequate?   Yes   or   No

   If answered no, what information would be beneficial to your work as a police officer?

   _____

Place an "x" at the place on the line which corresponds with your response.

7. How comfortable are you interacting with someone with a mental illness?

   1--------- 2 --------- 3 --------- 4 --------- 5 --------- 6 ---------7

Not at all Comfortable   Comfortable   Extremely comfortable

8. Rate your knowledge of psychological disorders?

   1--------- 2 --------- 3 --------- 4 --------- 5 --------- 6 ---------7

   "Nothing"   "Some"   "Expert"

9. To what extent do you consider yourself to be adequately trained to interact with the mental health patients?

   1--------- 2 --------- 3 --------- 4 --------- 5 --------- 6 ---------7

"Completely Inadequate"   "Some"   "Completely Adequate"

Mental Health Knowledge Questionnaire

Please choose the <u>best answer</u>.

1) Mental Health is defined as
   a. a constant feeling of contentment
   b. striking a balance in all aspects of your life – social, spiritual, economic, & mental
   c. achieving a period of 12-18 months without a psychotic episode
   d. the absence of a mental disorder diagnosis
2) Depression and Bipolar Disorder are collectively known as:
   a. Anxiety Disorders
   b. Affective Disorders
   c. Personality Disorders
   d. Cognitive Disorders
3) What disorders are characterized by a "break from reality" with perceptual and/or thought disturbances?
   a. Psychotic Disorders
   b. Affective Disorders
   c. Anxiety Disorders
   d. Cognitive Disorders
4) Delirium states can be induced by substance use as well as illness—true or false?
   a. True
   b. False
5) Depression in childhood appears essentially the same as Depression in adulthood—true or false?
   a. True
   b. False
6) Those with a mental illness are normally the perpetrators of violence—true or false?
   a. True
   b. False
7) A person who has attempted suicide once typically is unlikely to attempt it again—true or false?
   a. True
   b. False
8) It is possible to make judgments about the severity of, or status of, a chronically mentally ill patient's condition by observing his living quarters, even if the patient is not at home—true or false?
   a. True
   b. False

9) In order for an individual's symptoms to be considered a psychological disorder, which of the following must be true?
   a. There must be a breakdown in cognitive, emotional, or behavioral functioning
   b. The symptoms must be present before age of 7
   c. The individual must have an updated diagnosis from a medical professional
   d. The symptoms cannot be due to drug or alcohol use

10) Which of following symptoms characterize a Manic Episode?
   a. Expressions/feelings of guilt
   b. Irritability/Anger
   c. Increased Energy/Talking fast
   d. Feelings of worthlessness

11) All of the following are risk factors for suicide EXCEPT:
   a. Sense of hopelessness
   b. Shameful or humiliating experience
   c. Previous suicide attempt(s)
   d. Vague suicidal fantasy without detailed plans

12) A person who has an elevated mood, decreased need for sleep, and easily distracted is most likely experiencing:
   a. Panic disorder
   b. Mania
   c. Depersonalization
   d. Hallucinations

13) Enduring and pervasive predispositions which affect a person's ability to perceive, relate, and think are:
   a. Personality Disorders
   b. Psychotic Disorders
   c. Cognitive Disorders
   d. Mood Disorders

14) One distinction used to characterize symptoms of Schizophrenia divides them into what two broad categories?
   a. Paranoid and Catatonic
   b. Episodic and Chronic
   c. Psychiatric and Somatic
   d. Positive and Negative

15) Emotional and social withdrawal, apathy, and evident deficits in speech and thought are examples of what type of symptoms in Schizophrenia?
   a. Psychiatric
   b. Negative
   c. Disorganized

d. Positive

16) Rhonda fears that her employer is trying to poison her with gas emitted from the overhead lights in her office. Given what you know about Rhonda's thoughts, what subtype of Schizophrenia is she most likely to have?
   a. Catatonic
   b. Disorganized
   c. Paranoid
   d. Undifferentiated

17) A Mental Status Exam is:
   a. A psychological assessment performed by professionals in a medical setting
   b. An assessment of a person's appearance, behavior, thought process, and sensory ability.
   c. An assessment of brain functioning through the use of MRIs and CAT Scans
   d. A written test to assess intelligence

18) _____ is characterized by short attention span, difficulty understanding consequences/directions, lack of social inhibitors, and eagerness to please others.
   a. Schizophrenia
   b. Autistic Disorder
   c. Mental Retardation
   d. Dementia

19) Mental Illness is caused by:
   a. personal weakness or frailty
   b. hereditary factors
   c. biological, psychological, and social factors
   d. childhood environment

20) People with a mental illness are more likely to be the victims, rather than the perpetrators of violence—true or false?
   a. True
   b. False

21) Someone who has slurred speech, uncoordinated motor movements, and disorientation may be exhibiting:
   a. Intoxication via substance
   b. Psychotic Disorder
   c. Delirium
   d. Both A and C

22) Mentioning suicide to a depressed person makes them more likely to commit suicide—true or false?
   a. True
   b. False

23) There are few treatment options for people with a mental illness—true or false?
   a. True
   b. False
24) A person who reports to have PTSD may exhibit all of the following EXCEPT:
   a. increased aggressive response
   b. possible alcohol/drug abuse
   c. lack of control over anger
   d. fear of enclosed places
25) Incidence of substance abuse is higher among persons with chronic mental disorders—true or false?
   a. True
   b. False

Attitudes Questionnaire

Adapted from Health and Social Care Information Center Questionnaire (2011).

A. Please answer how much you agree or disagree with the following statements:

	Strongly Agree	Slightly Agree	Neither agree nor disagree	Slightly Disagree	Strongly Disagree
1. One of the main causes of mental illness is a lack of self-discipline and will-power					
2. There is something about people with mental illness that makes it easy to tell them from "normal" people					
3. As soon as a person shows signs of mental disturbance, he should be hospitalized					
4. Mental illness is an illness like any other					
5. Mental hospitals are an outdated means of treating people with mental illness					
6. Virtually anyone can become mentally ill					
7. People with mental illness have for too long been the subject of ridicule					
8. People with mental illness are a burden on society					
9. Increased spending on mental health services is a waste of money					
10. There are sufficient existing services for people with mental illness					
11. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered					
12. I would not want to live next door to someone who has been mentally ill					
13. People with mental illness are far less of a danger than most people suppose					
14. People with mental health problems should have the same rights to a job as anyone else					
15. Residents have nothing to fear from people coming into their neighborhood to obtain mental health services					

B. Which of these do you feel usually describes a person who is mentally ill?
(Circle All That Apply)

1) Someone who has serious bouts of depression

2) Someone who is incapable of making simple decisions about his or her own life

3) Someone who has a split personality

4) Someone who is born with some abnormality affecting the way the brain works

5) Someone who cannot be held responsible for his or her own actions

6) Someone prone to violence

7) Someone who is suffering from schizophrenia

8) Someone who has to be kept in a psychiatric or mental hospital

The following questions ask about your experiences and views in relation to people who have mental health problems. By this I mean people who have been seen by healthcare staff for a mental health problem.

C. Are you currently working, or have you ever worked, with someone with a mental health problem?

1) Yes

2) No

3) Don't Know

D. Do you currently have, or have you ever had, regular contact with a friend or family member with a mental health problem?

1) Yes

2) No

E. How much do you agree or disagree with each of the statement:

	Strongly Agree	Slightly Agree	Neither Agree nor Disagree	Slightly Disagree	Strongly Disagree
1. Most people with mental health problems want to work and be paid for their employment					
2. If a friend had a mental health problem, I know what advice to give them to get professional help					
3. Medication can be an effective treatment for people with mental health problems					
4. Psychotherapy (e.g., talking therapy or counseling) can be an effective treatment for people with mental health problems					
5. People with severe mental health problems can fully recover					
6. Most people with mental health problems go to a medical healthcare professional to get help					

F. Do you think that people with mental illness experience stigma and discrimination nowadays, because of their mental health problems?

       1) Yes- a lot of stigma and discrimination

       2) Yes- a little stigma and discrimination

       3) No

G. Do you think mental health-related stigma and discrimination has changed in the past five years?

       1) Yes - increased

       2) Yes – decreased

       3) No

E. How much do you agree or disagree with each of the statement:

	Strongly Agree	Slightly Agree	Neither Agree nor Disagree	Slightly Disagree	Strongly Disagree
7. Most people with mental health problems want to work and be paid for their employment					
8. If a friend had a mental health problem, I know what advice to give them to get professional help					
9. Medication can be an effective treatment for people with mental health problems					
10. Psychotherapy (e.g., talking therapy or counseling) can be an effective treatment for people with mental health problems					
11. People with severe mental health problems can fully recover					
12. Most people with mental health problems go to a medical healthcare professional to get help					

F. Do you think that people with mental illness experience stigma and discrimination nowadays, because of their mental health problems?

4) Yes- a lot of stigma and discrimination

5) Yes- a little stigma and discrimination

6) No

G. Do you think mental health-related stigma and discrimination has changed in the past five years?

4) Yes - increased

5) Yes – decreased

6) No

Appendix D
Law Enforcement Best Course of Action Scenarios Questionnaire
Pre Test

Please check the step which represents the best course of action.

Scenario One
A family member, friend, or other concerned person calls the police for help during a psychiatric emergency. The information you have is: subject is a Caucasian 24 y/o male who has been "off his meds" for an unknown amount of time. The subject has not been violent but is shouting and moving around "erratically."

- What's the best course of action when you arrive on scene?

    ___ a)   Make attempts to calm the person to further assess the situation
    ___ b)   Restrain the person with handcuffs to protect officer and person from future physical conflict
    ___ c)   Allow person to continue to move around erratically until they appear to become violent

- You have assessed the situation and it is determined that the male is no immediate danger to himself or others, but medics are en route, what is the next best course of action?

    ___ a)   Refer family to Mental Hygiene Office and wait for medics
    ___ b)   While waiting for medics, continue to attempt to calm the person and keep family and surrounding people safe
    ___ c)   Keep the person detained and wait for medics.

- Your course of action is likely to end in what result for the person?

    ___ a)   Hospital
    ___ b)   Prison
    ___ c)   No Action
    ___ d)   Other
              Please explain _____

Scenario Two
Police officers encounter a person with a mental illness behaving inappropriately in public. The person is a middle-aged female who appears disheveled and is wearing mismatched clothing. It has been reported she has been talking to herself and frightening customers of a local grocery store.

- What's the best course of action when you arrive on scene?
-
    ___ a)   Contact medics and wait for them to assess whether person is intoxicated
    ___ b)   Restrain the person in handcuffs to protect officer and person
    ___ c)   Make contact with the person and try to assess what type of help is needed

- You have assessed the situation and it is determined that the female is no immediate danger to herself or others, what is the next best course of action?

    ___ a)   Ask for family contact information and proceed to contact them.
    ___ b)   While waiting for medics, continue to attempt to calm the person and keep everyone safe
    ___ c)   Keep the person detained and wait for medics

- Your course of action is likely to end in what result for the female?
    ___ a)   Hospital
    ___ b)   Prison
    ___ c)   No Action
    ___ d)   Other
              Please explain _____

Scenario Three
Citizens call the police because they feel threatened by the unusual behavior or the mere presence of a person with mental illness. The person is a male, middle aged, who appears disheveled. He is walking down a public street, and although appears to be acting strange, he is currently not breaking the law.

- What's the best course of action when you arrive on scene?

    ___ a)   Speak with the person and make attempts to evaluate mental status
    ___ b)   Observe person from a distance and clear the call if the person
              does not break any laws.
    ___ c)   Refer to medics if the person has not broken any laws.

- You have assessed the situation and it is determined that the male is no immediate danger to himself or others, what is the next best course of action?

    ___ a)   Clear the call
    ___ b)   While waiting for medics, continue to attempt to calm the person and keep
              everyone safe
    ___ c)   If person refuses medical attention, detain him until medics arrive

- Your course of action is likely to end in what result for the male?

    ___ a)   Hospital
    ___ b)   Prison
    ___ c)   No Action
    ___ d)   Other
              Please explain _____

Scenario Four

A person with mental illness calls the police for help because of threats. The person is a male and will not give his full name and is reluctant to give his address. He reports he is currently being followed and "hazed" by a group of people. He reported they almost ran him off the road earlier today and he does not feel safe in his home. When you arrive on the scene, the man asks you to listen to the television (which is off) and asks "can you hear them?"

- What's the best course of action when you arrive on scene?

    ___ a)   If no law has been broken, clear the call.
    ___ b)   Call for medical support and continue verbal contact and focus on
              the person while assessing the situation
    ___ c)   Request family contact and attempt to acquire additional information from
              family/neighbors, call for medical support

- You have assessed the situation and it is determined that the person is no immediate danger to himself or others, what is the next best course of action?

    ___ a)   Restrain person to prevent violence and await medical support
    ___ b)   Continue to speak calmly with the person and request they move outside
              or at least away from the TV while waiting on medical support
    ___ c)   Tell the person a report will be filed but they must go with the medics
              when they arrive

- Your course of action is likely to end in what result for the male?

    ___ a)   Hospital
    ___ b)   Prison
    ___ c)   No Action
    ___ d)   Other
              Please explain_____

Law Enforcement Best Course of Action Scenarios Questionnaire
Post Test

Please print neatly.

1. Please review the synopsis and your response to Scenario One
   a. Following the training, what would you change about your previously chosen course of action?

   b. Which de-escalation techniques, if any, would you be likely to use in this situation?

2. Please Review the synopsis and your response to Scenario Two
   a. Following the training, what would you change about your previously chosen course of action?

   b. Which de-escalation techniques, if any, would you be likely to use in this situation?

3. Please review the synopsis and your response to Scenario Three
   a. Following the training, what would you change about your previously chosen course of action?

   b. Which de-escalation techniques, if any, would you be likely to use in this situation?

4. Please review the synopsis and your response to Scenario Four.
   a. Following the training, what would you change about your previously chosen course of action?

   b. Which de-escalation techniques, if any, would you be likely to use in this situation?

Appendix E

IRB Approval Letter

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Office of Research Integrity	FWA 00002704
Institutional Review Board	
401 11th St., Suite 1300	IRB1 #00002205
Huntington, WV 25701	IRB2 #00003206

June 7, 2012

Keith Beard, Psy.D.
Psychology Department

RE: IRBNet ID# 331033-1
At: Marshall University Institutional Review Board #2 (Social/Behavioral)

Dear Dr. Beard:

Protocol Title:	[331033-1] Training Law Enforcement in Mental Health: A Closer Look at the Current Standard

Expiration Date:	June 7, 2013	
Site Location:	MU	
Submission Type:	New Project	APPROVED
Review Type:	Exempt Review	

In accordance with 45CFR46.101(b)(2), the above study and informed consent were granted Exempted approval today by the Marshall University Institutional Review Board #2 (Social/Behavioral) Designee for the period of 12 months. The approval will expire June 7, 2013. A continuing review request for this study must be submitted no later than 30 days prior to the expiration date.

This study is for student Rachel Harper-Hatfield.

If you have any questions, please contact the Marshall University Institutional Review Board #2 (Social/Behavioral) Coordinator Michelle Woomer, B.A., M.S at (304) 696-4308 or woomer3@marshall.edu. Please include your study title and reference number in all correspondence with this office.

Rachael Elaine Hatfield, M.A.

Email: rachaelhatfield@outlook.com

EDUCATION

Pursuing Doctor of Psychology	Marshall University, Huntington, WV
	Degree Anticipated: August 2014
	Dissertation: *Training Law Enforcement in Mental Health: Identification and De-escalation Techniques*

Master of Arts	Marshall University, Huntington, WV
	August 2011
	Major: Psychology

Bachelor of Arts	Marshall University, Huntington, WV
	May 2009
	Major: Psychology
	Minor: Sociology

TEACHING EXPERIENCE

August 2010 to May 2013   **Marshall University Department of Psychology Huntington, WV**

Position: Teaching Assistant
Supervisor: Steven Mewaldt, Ph.D.
Population Demographics: Undergraduate students enrolled at Marshall University. Populations include urban and rural students from diverse backgrounds.

Responsibilities: Instructor of Introductory Psychology (4 sections) and Abnormal Psychology (4 sections) with full course responsibility.

PRACTICA EXPERIENCE

May 2012 to May 2013   **Department of Veterans Affairs: Community-Based Outpatient Center Prestonsburg, Kentucky**

Total Direct Intervention/Assessment Hours (to date): 105
Position: Psychology Student

Supervisors: Megan Green, Psy.D.
       Cheryl Scott-Richard, Psy.D.
       Roslyn Feierstein, Ph.D., A.B.P.P.
       Lauren Davidson, Psy.D.

Population Demographics (to date): Age range: 24-65; Sex: males; Sexual Orientation: heterosexual; Race/Ethnicity: Caucasian; Setting: Outpatient; Area: rural and underserved area of Kentucky.

Responsibilities: Provide individual therapy to veterans and members of their families; use cognitive-behavioral, evidence-based, behavioral health, and substance abuse/dependence interventions; work as part of an interdisciplinary team with psychiatrists, physicians, nutritionists, nurses, and social workers; participate in didactic trainings; conduct PTSD and general mental health diagnostic interviews and compose reports; complete diagnostic clarity assessments, and provide psychological consultation for veterans in the Prestonsburg, Kentucky area.

August 2011 to May 2013   **Department of Veterans Affairs Medical Center**
                                     Huntington, West Virginia

Total Direct Intervention/Assessment Hours (to date): 500
Position: Psychology Student
Supervisors: Cheryl Scott-Richard, Psy.D.
       Agnes Hornich, Psy.D.
       Megan Green, Psy.D.
       Roslyn Feierstein, Ph.D., A.B.P.P.

Population Demographics (to date): Age range: 24-76; Sex: males and females; Sexual Orientation: heterosexual; Race/Ethnicity: Caucasian, African-American, Native American, and Multiracial; Type: Outpatient; Area: patients are from urban, rural, and underserved areas.

Responsibilities: Provide individual and group therapy to veterans and members of their families; use cognitive behavioral, evidence based, substance abuse/dependence, and interpersonal interventions; work as part of interdisciplinary treatment teams with psychiatrists, physicians, nutritionists, nurses, and social workers; participate and present cases in PTSD, substance abuse, and general mental health clinical treatment team meetings; attend special topics trainings; conduct PTSD and general mental health diagnostic interviews and compose reports; complete neuropsychological, pre-operative (spinal cord stimulator, morphine pump, and organ transplant), chronic pain, response bias (malingering or feigning functional impairment), and

diagnostic clarity assessments; provide consultation to Polytrauma, Pain Management, Neurology, and Surgical departments.

August, 2010 – August 2011   **Marshall University Psychology Clinic**
                                            Huntington, WV

Total Direct Intervention/Assessment Hours: 324
Position: Psychological Trainee
Supervisors: Marty Amerikaner, Ph.D.
          Marianna Footo-Linz, Ph.D.

Population Demographics: Age Range: 8-44; Sex: males, females, and transgender; Sexual Orientation: heterosexual, gay, lesbian, and bisexual. Type: Outpatient, Individual and Couple's Therapy; Area: patients were from urban, rural, and underserved areas.

Responsibilities: Provided individual therapy to university students and community members; used cognitive behavioral and humanistic interventions; completed diagnostic intake interviews and composed reports; developed treatment plans; completed personality, Attention Deficit/Hyperactivity Disorder and Learning Disorder, and neuropsychological assessments; provided feedback on assessment results to referral sources; provided consultation to social workers with Employee Assistance Programs; conducted psycho-educational presentations on campus; and provided behavioral and psychological consultation for area Head Start (state-funded pre-school) Programs.

January, 2009 – May, 2009   **River Park Hospital**
                                            Huntington, WV
Total Direct Hours: 60
Position: Observer (undergraduate practicum placement)
Supervisor: Joseph Wyatt, Ph.D.
Responsibilities: Observed staff and therapist interactions with patients through group and individual therapy; developed and presented a case study to other practicum students.

RESEARCH EXPERIENCE

April 2011 to April 2013   **Primary Investigator**. Dissertation: Law Enforcement Training in Mental Health: Identification and De-escalation Techniques. Marshall University. Research Chair: Keith W. Beard, Psy.D.

January-May, 2009   **Research Assistant**. Data collection for unpublished study of religiosity factors and attitudes about

paranormal activity. Marshall University. <u>Principal Investigator</u>: Chris LeGrow, Ph.D.

PUBLICATIONS

Hatfield, R., & Meese, M. (2009). Money Matters More Than Manners. *Behavior Analysis Digest International*, 21, 15.

PROFESSIONAL DEVELOPMENT

Cognitive Processing Therapy Training (Lauren Davidson, Ph.D). Approximately 8 hours (to date) of skill development training and supervision of individual therapy cases. August, 2012 to Present.

Cognitive Behavioral Therapy-Insomnia Training (Roslyn Feierstein, Ph.D., A.B.P.P.) Approximately 20 hours (to date) of foundational training and supervision of CBT-I case. May, 2012 to Present.

Integrated Care: Smoking Cessation Training. Three-hour workshop at the Veterans Affairs Medical Center in Huntington, West Virginia. November 2012.

Treating Anxiety Related Disorders: Practical Applications of EBTs. Three-hour workshop at WVPA Spring Conference on foundational training in clinical skill development for treating anxiety disorders. May 2012

PTSD Evaluation and Treatment (Clifton Hudson, Ph.D. and Billy Rutherford, Psy.D.) Three-hour workshop at WVPA Spring Conference on foundational training in clinical skill development for PTSD evaluation and treatment. May 2012.

War Zone to the Home Front: Supporting the Mental Health of Veterans and Families (NAME). 14-hour online training in intermediate skill development of identifying and resolving common conflicts faced by returning Veterans and their families. February-May 2012.

Advanced MMPI-2 Interpretation: VAMC Huntington. (Roger Green, Ph.D.) 14-hour workshop on advanced interpretation of the MMPI-2. September 2011.

Motivational Interviewing Training Workshop: VAMC Huntington. 15-hour workshop on foundational skill development in Motivational Interviewing for clinicians. September, 2011.

PROFESSIONAL AFFILIATIONS

- *Student Member*, West Virginia Psychological Association
- *Campus Representative for Marshall University*, American Psychological Association of Graduate Students (APAGS)

- *Student Affiliate*, American Psychological Association

COMMUNITY OUTREACH/SERVICE

Outreach Representative, Marshall University Psychology Clinic. June 2012 to October 2012. Provided training to local law enforcement officers to increase their knowledge of mental health problems and services as well as de-escalation techniques to provide the safest and most compassionate response possible.

Mentor, West Virginia University's Energy Express Program. June, 2008 through August, 2009. During this summer program for elementary-aged children, I worked as a mentor and helped children who were at risk for malnutrition, behavioral problems, and learning difficulties. It was my duty to design a curriculum for eight-ten students and daily activities focused on language, nutrition, and social skills. During the two summers I participated in this program, I completed a total of 600 community service hours.

Provided approximately sixty hours of volunteer service to Huntington, WV-area community organizations throughout undergraduate studies, including YWCA and Dress for Success. January-May 2009.

REFERENCES

Marianna Footo-Linz, Ph.D.
> Program Director, Marshall University Psy.D. Program
> (304) 696-2774
> linz@marshall.edu

Keith Beard, Psy.D.
> Assistant Program Director, Marshall University Psy.D.
> Director, Marshall University Psychology Clinic
> (304) 696-2781
> beard@marshall.edu

Additional references are available upon request.