LOS ANGELES POLICE DEPARTMENT'S MENTAL HEALTH INTERVENTION TRAINING: A QUANTITATIVE STUDY

BY

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DISSERTATION

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This dissertation, written by

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Submitted to the Faculty of Touro University Worldwide in partial fulfillment of the requirements for the degree of

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We, the undersigned, certify that we have read this dissertation and approve it as adequate in scope and quality for the Doctor of Human and Organizational Psychology.

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Dedicated to my mom, you selfishly gave up your dreams of higher education to raise 3 crazy kids. For this I thank you. I miss you dearly.

Abstract

This quantitative study examined the Los Angeles Police Department's (LAPD) 40-hour Mental Health Intervention Training (MHIT) course and its effects on police officer attitudes towards persons who are mentally ill before and after attending the course. The research study documents the evolution of the LAPD's mental health awareness training beginning in the 1940s to the present day. Pre- and Post-course surveys were administered to 165 attendees over 6 weeks. Aside from an overall demographic analysis, the 165 attendees were divided into subgroups to analyze the difference in attitudes between probationary police officers and permanent status police officers, officers who were mandated to attend the training versus volunteered to attend the training. The results showed significant overall positive differences in the officers' attitudes after attending the MHIT course. This research project adds to the limited amount of available data regarding Crisis Intervention Team (CIT) type training, officers who are mandated to attend CIT type courses, and officers who attend CIT type courses in the early phase of their career.

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Chapter 1: Introduction

Nationwide, since the 1950s, 96% of psychiatric hospital beds have been eliminated due to the closure of mental institutions (Treatment Advocacy Center, 2014). Since the 1960s, law enforcement and the community have seen an increase in mental illness-related issues. In California, nationwide, Governor Ronald Reagan signed the Lanterman-Petris Short Act of 1967 (LPS). The LPS Act was part of the mental health facility deinstitutionalization plan and paved the way towards reducing stigma and attitudes towards the mentally ill. The LPS Act intended to end the inappropriate, indefinite, and involuntary commitment of a person with a mental disorder, protect public safety, provide a judicial review for persons with mental illness, provide individualized treatment, protect persons with mental illness from criminal acts, provide consistent protection to personal civil rights, and to provide services in the least restrictive manner. The LPS Act also gave law enforcement officers and mental health clinicians the ability to civilly detain an individual to assess their mental health condition and determine if they are a danger to themselves, others, or gravely disabled due to their mental illness. If the mental health assessment shows that probable cause exists, the person can be involuntarily transported to a mental health facility for further treatment (Lanterman Petris Short Act of 1967). To understand professional responsibilities and meet the community's needs, law enforcement officers should have at their disposal effective training programs to help bridge the gap.

Law enforcement employee training and development play a vital role in the growth and sustainability of a department. For example, an organization that does not embrace training its employees on the benefits and use of social media marketing will be disadvantaged when attempting to promote its products or services to a more technologically integrated audience. There is a trend towards providing more relevant training for officers in implicit bias, uses of

force, de-escalation, internet-related crimes, and mental illness in the Law Enforcement field. Communities, in general, are currently calling for an overhaul of law enforcement's attitudes and behaviors across the board in relationship to how they serve the public. This dissertation will center around career development training for police officers and its effects on an officer's overall attitude towards the mentally ill.

There are approximately 450 million people who have mental illness worldwide, and one out of four people experience some form of mental illness at least once in their life (World Health Organization, 2001). Various media outlets such as film, television, news, and social media depict the interactions between the mentally ill and the police to be predominantly violent. According to publicly available Los Angeles Police Department (LAPD) data, I have compiled the following statistics, and they are important to consider concerning this topic. In 2018, there were 1,754,415 public contacts. Out of those contacts, 2187 contacts involved a use of force. Of those uses of forces, 35 ended up in a shooting. 13 of the 35 total suspects, or 37 %, engaged in Officer-Involved Shooting (OIS) incidents were perceived to suffer from a mental illness or a mental health crisis. These events accounted for a nine-percentage point increase compared to 28 % in 2017. Cumulatively, between 2014 – 2017, 25% of involved suspects have a mental illness or a mental health crisis. Historically from 2014 through 2018, suspects who were perceived to suffer from a mental illness or a mental health crisis accounted for 54 of the 200 total suspects (27% of contacts). These statistics and other nationally available statistics can perpetuate a two-fold stigma; police shoot the mentally ill, and those with mental illness are inherently violent. (Los Angeles Police Department, 2018)

Nationally, shootings involving the mentally ill took a turn for the worst in 1988. Memphis Tennessee Police shot and killed a man who had a history of mental illness and

substance abuse. A community task force that consisted of law enforcement, mental health, and addiction professionals collaborated to develop what is now widely known as the Crisis Intervention Team (CIT) model. The primary goals of the model are to increase safety in encounters and divert persons with mental illnesses from the criminal justice system to mental health treatment (Watson & Fulambarker, 2012). One of the CIT model requirements is to provide training to officers who are willing to volunteer for specialized employee development training. If an officer volunteers for the training, they will be more empathetic and open-minded when assisting those experiencing a mental illness event (Compton et al., 2008). Compton conducted a study and concluded that specialized training officers were more likely to be empathetic and manage calls for service better. A change in an officer's attitude can impact their behavior. A lack of preparedness and uncertainty not only can create anxiety for law enforcement officers (LEOs), but it can also negatively impact the individual requiring help. An anxious officer may wish to avoid conducting calls for service that involve the mentally due to their lack of understanding. The lack of knowledge may cause the officer to react too harshly (King, 2011) or do nothing at all.

The Los Angeles Police Department has adopted a training program based on the CIT model. Since its inception in 2014, The Mental Health Intervention Training (MHIT) has closely followed the core curriculum developed by CIT regarding the use of Andragogy, lived experiences, laws, and visits to community mental health resources. In aiding the Australian New South Wales Police Department in creating their mental illness response program, the LAPD elected to adopt the name MHIT for their flagship course. The adoption is to signify an international partnership towards the same mission regarding treating the mentally ill by law enforcement officers and providing practical training (Dempsey, 2020).

Statement of The Problem

As stated earlier, most Los Angeles Police Officers are mandated to attend a 40-hour Mental Health Intervention Training (MHIT) course. The course will be delivered weekly until the end of the 2020 calendar year. Compton et al. (2017) researched the officer's self-selection and determined this type of training was beneficial towards their knowledge, skills, and attitudes. Compton compared data from two prior studies and found that in study 1, out of 251 officers, 68% had volunteered to attend. They compared a second study where 91 officers were studied, and 70% volunteered to participate in the Crisis Intervention Training (CIT) course.

Effective January 1, 2017, California Senate Bill 29, Peace Officer Training: Mental Health (2015/2017), required all officers who work in a field training capacity must attend a 40-hour type CIT program. The MHIT course is a mixture of officers who volunteer and are mandated to participate in the training. Undocumented qualitative evidence suggests that the course positively impacts officers who are mandated to attend the class; however, qualitative verification is needed. As stated earlier, being mandated to participate in the training goes against the CIT philosophy.

In 2010, a law enforcement attitudinal study (Clayfield et al., 2011) was conducted on a sample of 412 police officers from a major city police department in the northeast. Police Officers completed The Mental Health Attitudinal Survey for Police (MHASP) scale at morning roll call throughout a police in-service training. Clayfield's study did not specify the length and nature of the training course.

The LAPD and the Los Angeles County Department of Mental Health (LACDMH) used the MHASP in a pre-and post- attitudinal data collection study. In 2016, the LACDMH researchers (Solomon & Mirkoff, 2016) surveyed 236 officers and presented their findings at the

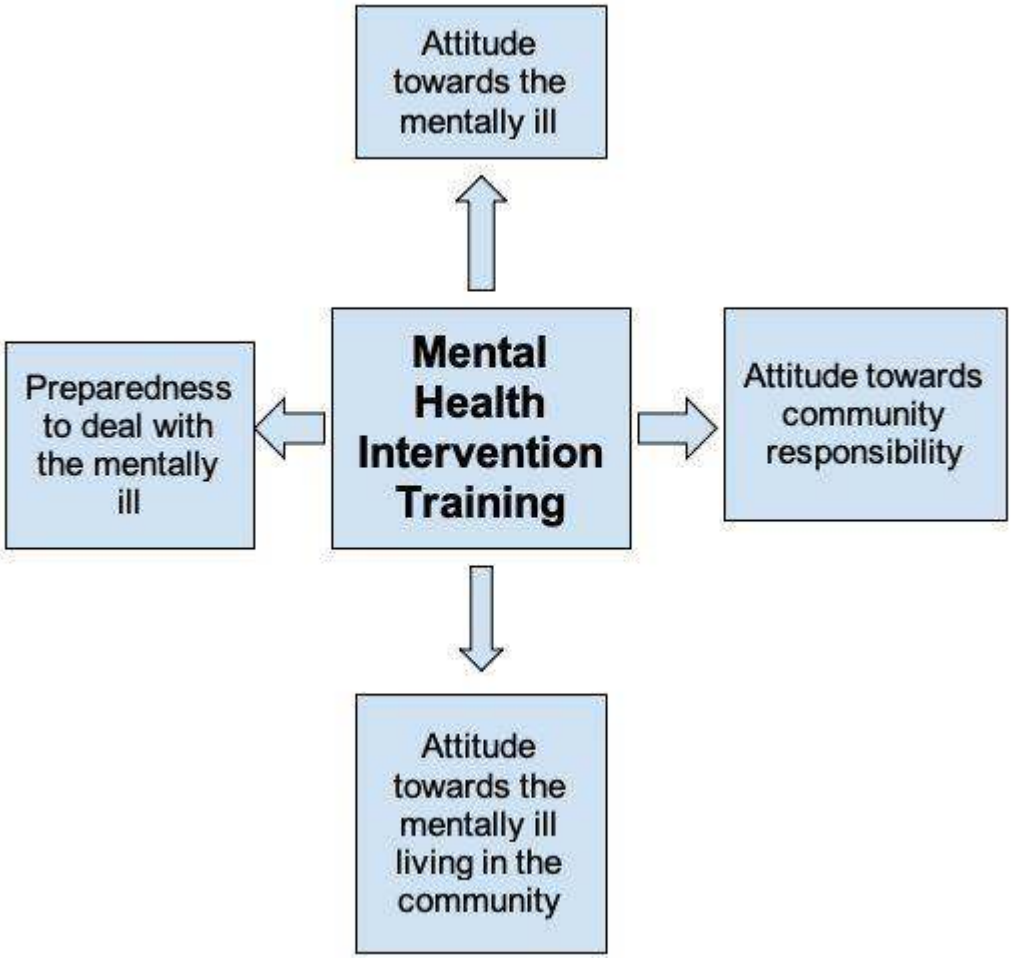
2017 California Forensic Mental Health Association Conference. The researchers conducted the data collection before implementing California Senate Bill 29, and the researchers did not capture data regarding student officers volunteering or required to attend the training. Currently, no published material reflects the attitudinal changes of probationary police officers, permanent status police officers, and officers who are volunteered and mandated to attend the MHIT course.

Conceptual Model

As previously mentioned, the MHASP is a 33- question survey that came from various studies examining attitudes toward persons who have a mental illness. The MHASP is on a six-point Likert scale across four subscales. The four subscales measure an officer's attitudes towards a person with mental illness, their attitude towards community responsibility in caring for the mentally ill, the officer's attitude on their preparedness in dealing with a person who is mentally ill, and their attitude towards the mentally ill living in their community.

The MHASP subscales will be the variables used to remove bias from this research project. The research project is a quantitative study, and the framework will focus on an officer's attitudes towards a person with mental illness, their attitude towards community responsibility in caring for the mentally ill, the officer's attitude on their preparedness in dealing with a person who is mentally ill, and their attitude towards the mentally ill living in their community. Primarily, this study will examine if there is any relationship between the different subscales and the effects of attitudes before and after attending a Mental Health Intervention Training course.

Figure 1 Dependent and Independent Variables



Research Questions

RQ1: Is there a significant difference in an officer's attitudes towards a person with mental illness before and after attending the Los Angeles Police Department's Mental Health Intervention Training Course?

RQ2: Is there a significant difference in an officer's attitude towards community responsibility in caring for the mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course?

RQ3: Is there a significant difference in an officer's attitude towards their preparedness to deal with a mentally ill person before and after attending the Los Angeles Police Department's Mental Health Intervention Training course?

RQ4: Is there a significant difference in an officer's attitude towards the mentally ill living in their community before and after attending the Los Angeles Police Department's Mental Health Intervention Training course.

Chapter 2: Literature Review

This literature review will focus on six sections, (a) an overview of the national mental illness response and training model, (b) a historical overview of the Los Angeles Police Department's (LAPD) mental illness awareness training, (c) a synopsis of public sector employee development training (d) relevant learning theories (e) an overview of attitudes towards the mentally ill (e) and a review of self-selection versus mandated training.

National Mental Illness Response & Training Model

The Memphis Model

The Crisis Intervention Team (CIT) model of law enforcement response to mental health emergencies is policing for the 21st century (Dupont & Cochran, 2002). The most widely recognized crisis intervention model for police officers was established in 1988 in Memphis, Tennessee, after an incident in which an armed person with a history of mental illness and substance abuse was shot and fatally wounded by local law enforcement. CIT is a police-based, specialized police response strategy involving the delivery of crisis intervention services by sworn law enforcement officers who have received specialized training and are active liaisons to the formal mental health system. CIT officer training incorporates mental health professionals, family advocates, and mental health consumer groups, and therefore can provide a more humane and calm approach to these crisis events (Oliva, 2008).

CIT's primary goal is pre-booking diversion interventions. Pre-booking diversion is determining if a mental health issue warrants psychiatric attention or an arrest. CIT promotes the increase of the tools available to the police to make fewer arrests and instead refer more people with mental illness to local treatment facilities (Draine & Solomon, 1999). When CIT first began, the primary goal was to reduce officer and citizen injuries. CIT has evolved to divert

persons with mental illness from the criminal justice system when appropriate towards a more collaborative approach with stakeholders such as advocacy groups and treatment centers. As of 2008, CIT is in 43 states and four countries (Watson et al., 2008).

CIT Training Model Curriculum

The CIT training program provides officers with 40 hours of classroom and experiential de-escalation training in handling crises (Compton et al., 2008), mental illness recognition, disabilities, legal aspects, role play, co-occurring disorders, and psychotropic education (Hannig, 2016). Officers are either self-selected to attend the training or selected after a police department CIT coordinator or other senior officers' review. These trained officers then serve as specialized front-line responders who are better informed about redirecting individuals with mental illnesses (Compton et al., 2008). A 2016 dissertation research project (Hannig, 2016) conducted a program evaluation study on the Chicago police department's CIT curriculum. The survey collected and processed feedback as well as data about the effectiveness of the CIT training curriculum. The study also addressed gaps in the curriculum as perceived by the CIT officers. The participants of the survey were officers who volunteered to attend the training. Twelve officers participated in the focus group and provided feedback regarding their training experience. Nine of the 12 participants shared that they had a member of their family struggle with mental illness. The vast majority of the comments made about mental illness signs and symptoms, as part of the curriculum, said that it opened the officer's eyes to the high prevalence of mental illness. When the officer's opinions about the overall curriculum of CIT were requested, Hannig (2016) stated that the responses were overwhelmingly positive. Hannig (2016) went on to say that one officer noted that the training is a "catalyst for change" within the police department because it changes the police officer's perception of the mentally ill.

The Evolution of LAPD's Mental Illness Awareness Curriculum

LAPD Mental Illness Awareness Curriculum During the 1940s and 1950s

Historically, the Los Angeles Police Department's (LAPD) training regarding the mentally ill dates back to printed material from the 1940s (see appendix A). Department training bulletins were predominantly distributed to address the need for knowledge regarding an officer's legal responsibilities in various patrol-related circumstances. Very little was written regarding attitudes, behaviors, or empathy towards the mentally ill. A 1948 training document indicated that proper handling of a mentally ill person provides an excellent opportunity to build good public relations. It suggests that officers should treat a patient the same as a person suffering from a physical illness (Los Angeles Police Department, 1948). This document was part of the Standardized Roll Call Training Program that the LAPD developed. Former LAPD Deputy Chief Richard Simon created the program and wrote an article in the Journal of Criminal Law and Criminology. He stated that the program was developed to address common issues that supervisors and detectives had to correct due to inadequate investigations by patrol officers. The training program was designed as 15-minute daily segments that were given during pre-work shift briefings by supervisors. It was common practice that on any given day, any of the LAPD's 12 geographical police stations would provide their officers with the same information at the beginning of each shift (Simon, 1950).

Training in the 1950s continued the trend with an updated training bulletin regarding the mentally ill. The bulletin attempted to provide officers with an empathetic approach towards their interactions with the mentally ill. The document stated that, in many respects, they are no different from an ordinary person of stubborn nature. Like any average person, a mentally ill person can seldom be convinced that he is wrong in any belief that he has. The bulletin says that,

like many ordinary people, he will become aroused if no one seems to see his point of view (Los Angeles Police Department, 1952). Despite using archaic phrasing, the training bulletin attempted to show benevolence towards the mentally ill.

LAPD Mental Illness Awareness Curriculum During the 1960s and 1970s

The research did not find any significant changes to the LAPD's Roll Call Training program concerning mental illness. However, the study did find internal documents describing the roles and functions of specialized units within the Department, specifically those tasked with documenting encounters with the mentally ill. A 1965 department manual described the features of the Detective Headquarters Division-Hospital Section. The Hospital Section was responsible for the preliminary investigations of persons brought to an officer's attention. The requirements were for persons suspected of mental illness, persons who require psychopathic treatment, amnesia victims, people with epilepsy, alcoholics, and delirium tremens victims (Los Angeles Police Department, 1965).

In the 1970s, a four-part training series were distributed between June 29, 1971, and July 12, 1971. This series is written in a format reflecting current best practices regarding scenario-based training, which will be discussed later in this chapter. The training series explains an officer's legal obligations and insight on how to approach a person who is mentally disordered and ends with disposition best practices such as notifying the Hospital Detail, how to complete an application for 72- hour detention, and guidelines for non-detention placements (Los Angeles Police Department, 1971). The training gives an officer much-needed guidance on handling a mental illness call from beginning to end in a more easily relatable format due to the addition of a field-based scenario.

The document states that a mentally disordered person should be treated with understanding and courtesy. Officers must approach the mentally disordered person calmly and carefully. They should control the situation with firmness and authority in their words and actions and confidence in their knowledge of the proper procedures (Los Angeles Police Department, 1971). The following is an excerpt of the text-based scenario training:

Based on the scenario and addressed in the 3rd section of the training bulletin, it is suggested that if the officers approached this scenario improperly, they might spark a violent reaction. The initial contact involves not only the field situation but also the training and experience of officers. The bulletin suggested that officers derive from their background and draw comparisons to assess their current position. (Los Angeles Police Department 1971). Much like previous LAPD training, the language can be seen as archaic and politically incorrect. The document oddly perpetuates and validates the stigma associated with the mentally ill; however, it imparts that officers should conduct themselves with empathy and use verbal de-escalation skills.

In 1976, the LAPD released an update to the previous training bulletin. This bulletin superseded and canceled Training Bulletin, Volume III, Issue 30, dated June 29, 1971. The updated training bulletin addressed two new sections, "Authority to Apprehend" and "Apprehension and Transportation Orders." The bulletin also began with a scenario that included a hand-drawn visual aide depicting a mental illness scenario and a written narrative that included open-ended questions and procedures on best practices.

LAPD Mental Illness Awareness Curriculum During the 1980s and 1990s

In-service training in the 1980s and 1990s showed no significant development as far as structured training is concerned. Research showed that the majority of the 1980s and 1990s focused on developing the LAPD's specialized crisis management unit and field response units.

Internal correspondence from Police Chief Daryl Gates to the Board of Police Commissioners (Gates, 1984) laid out specific recommendations after two separate incidents involving Larry Plummer and Tyrone Mitchell.

The two incidents occurred in January and February of 1984, and they were both suspected of being mentally ill when they engaged in irrational behavior, which resulted in their deaths. Plummer was fatally wounded by LAPD Special Weapons and Tactics (SWAT) Officers after an 11-day standoff at his residence. A self-inflicted gunshot fatally wounded Mitchell after shooting rounds from his residence into the neighborhood. Mitchell fatally wounded an adult and a child who was walking by when he discharged his weapon. (Gates,1984). The one recommendation from the Police Commission that was not logistical was for the Department to develop a specific and complete training program on a mental health crisis for all department employees. It was suggested that the training be offered in two stages. Stage one was to be based on the current procedures and policies. Stage two was to be offered at the end of interagency deliberation and the resulting memorandum of agreement due to these recommendations. The agencies involved were not indicated in the document.

In 1997, The LAPD collaborated with the Los Angeles County Department of Mental Health (LACDMH). The two agencies formed a co-response field unit within the LAPD's Mental Evaluation Unit (MEU). The MEU distributed an internal guidebook that trained LAPD officers on internal procedures and legal knowledge regarding their responsibilities when interacting with the mentally ill (SMART Guidelines, 1997). There are no references in this document addressing attitudes and behaviors towards the mentally ill.

LAPD Mental Illness Awareness Curriculum During the 2000s and 2010s

Rampart Scandal and Federal Oversight.

On March 1, 2000, the Police Department's Board of Inquiry released a report on the Rampart scandal (Burcham & Fisk, 2001). The Rampart Scandal focused on Raphael Perez, who was a ten-year veteran with the LAPD. Perez was known as the whistleblower in a department-wide corruption scandal. In 1999, Perez pled guilty to taking narcotics from an evidence locker. He received a reduced sentence in return for providing information regarding criminal acts that occurred within the LAPD. Seventy police officers were investigated for committing crimes, misconduct, or covering up these activities. Aside from the investigations, 70 wrongful arrests and convictions were overturned (Reese,2002). Research showed that a major factor in the department-wide corruption scandal was a weakness in training (Lodestar,2002).

In May 2000, the United States Department of Justice (USDOJ) stated that it was prepared to sue the City of Los Angeles. In September 2000, the Justice Department and the City's negotiators proposed a consent decree to reform the LAPD. (Burcham & Fisk, 2001). The Consent Decree was intended to promote a greater sense of police integrity within the LAPD and prevent misconduct. The Consent Decree emphasized the following nine major areas: management and supervisory measures to promote civil rights integrity, critical incident procedures, documentation, investigation and review, management of gang units, management of confidential informants, program development for the response to persons with mental illness, training, integrity audits, operations of the Police Commission and Inspector General and, community outreach and public information (Civil Rights Consent Decree, n.d.).

Lodestar Report

In 2002 the LAPD and Lodestar Management Research, Inc collaborated on a comprehensive report due to the consent decree. The Lodestar report evaluated the LAPD's policies and procedures related to police encounters with persons with mental illness and searched successful program models in other law enforcement agencies (Lodestar, 2002). The Lodestar (2002) report cited several studies concerning calls for service regarding the mentally ill. A 1995 empirical study (Husted et al., 1995) was conducted involving California Law Enforcement. The study found that Sheriff departments reported that approximately 9% of their 911 calls were mentally ill-related. In a separate study by Borum (1998), 450 officers were surveyed in the southern part of the United States, Knoxville, TN, Birmingham, AL, and Memphis, TN. The officers reported that they had responded, on average, to six calls for service involving the mentally ill within four weeks.

Lodestar Patrol Survey

In 2002, Lodestar (2002) surveyed LAPD Patrol Officers to assess the patrol officers' perceptions of the frequency and significance of handling mental illness calls. Lodestar (2002) also wanted to assess the officers' self-reported level of preparation and training in dealing with individuals who may be mentally ill. Lodestar (2002) also wanted to identify officers' familiarity with the mission, operations, and effectiveness of current LAPD efforts to assist the mentally ill, identify barriers, and recommend improving the police response to people who may be mentally ill. A total of 222 surveys were completed in 6 of the LAPD's 19 patrol divisions. The six geographical divisions were selected because of their economic diversity and their reported mentally ill calls for service. Officers reported having, on average, 3.4 contacts with persons suspected of being mentally ill per month (Lodestar, 2002). Nearly half of the officers surveyed

believed that LAPD should provide additional verbal de-escalation techniques with subjects with a mental illness (Lodestar,2002). When asked about techniques, 75% responded that verbal de-escalation techniques are effective with subjects who have a mental illness (Lodestar, 2002). Officers also listed among the things they found helpful were interacting with a suspected subject of being mentally ill, speaking calmly and slowly, remaining calm, sympathetic, and empathic, building trust and rapport, and listening to the subject (Lodestar, 2002).

LAPD's CIT Pilot Program- 40 Hour Training Course

In 2001 the LAPD piloted the CIT training and response in the Central Division located in and around Downtown Los Angeles (Lodestar, 2002). The Central Division area is home to the Skid Row population, which houses many resources for those battling substance abuse and homelessness. Officers in the Central Division Area attended a 40- hour CIT course. According to Cohen (2001), the Skid Row district of Los Angeles is approximately one square mile in size and lies, roughly, to the south and east of the steel and glass skyscrapers of downtown Los Angeles. There were about 1,250 mentally ill homeless persons in the area on any given night. It should be noted that during the pilot program, the officers responded to 60 CIT calls for service; there were 13 incidents in which the subject was violent or aggressive, and only one was the use of force necessary (Lodestar, 2002).

Strengths of the CIT

After the pilot program, the Lodestar Management/Research company evaluated the strengths and limits of the CIT (Lodestar, 2002). Preliminary evidence suggested fewer uses of force and officer injury occurred when the generalist-specialist officers were available to respond to mental illness calls for service (Lodestar,2002). Regarding leadership, the CIT Coordinator was dedicated to the program and provided close supervision of CIT officers. The coordinator was also committed to the development of a comprehensive curriculum. The training made improvements on the already existing CIT curriculum based on local needs and resources. The program was able to use local community resources within the Central Division to help with the development of the program, which was essential to the Memphis CIT model (Lodestar,2002). Persons with a mental illness (consumers) with past substance abuse history were included in substance abuse training components to provide first-hand knowledge about the effects of substance abuse (Lodestar,2002).

Limitations of the CIT

The CIT pilot program functioned in isolation from other programs, and there was no cross-training during this pilot session. Only first responders were included in the training. LAPD's co-response officers and clinicians (SMART) were not selected to participate in the training course, and the LAPD's department psychologists were not involved (Lodestar,2002). There have been no changes in policies to quickly identify CIT officers in the field so that they are deployed automatically by 911 dispatches. The City of Los Angeles reported that the program was not integrated because it wanted to test the effectiveness of the pilot program before implementation (Lodestar,2002). According to Lodestar (2020), if the program continues, agency support is necessary. Due to a quick start-up, there was little attempt to develop

partnerships with other agencies, including the Los Angeles County Department of Mental Health (LACDHM) and psychiatric receiving facilities (Lodestar,2002). One of the expected outcomes of CIT program development is an improved relationship with the community, particularly consumers, families, and advocates, on a grander scale. The Central Division is approximately 4.5 square miles (lapdonline, n.d.) in size were as the entire LAPD geographic area of responsibility covers 468 square miles (U.S. Census Bureau Quickfacts: Los Angeles City, California, n.d.).

The Mental Illness Course - 24 Hour Training Curriculum

Based on the information learned during the Crisis Intervention (CIT) pilot program, in 2007, the Mental Illness Project Coordinator established the Admin-Training Detail. The Admin-Training detail was responsible for the development of delivery of Department-wide in-service training. The detail developed the twenty-four-hour / three-day Introduction to Mental Health (IMH) training course delivered from 2008 to 2012. Including the two previous CIT courses and the Introduction to Mental Health course, 930 Department personnel were trained over the four years (Dempsey, 2020). As previously mentioned, the IMH built on lessons learned from the CIT pilot program. The IMH built relationships with the Department's Behavioral Sciences Services (BSS) and Los Angeles County Department of Mental Health Clinicians (LACDMH). BSS is the LAPD's in-house police psychology unit, and the LACDMH clinicians were county employees embedded in the LAPD's field response unit. The police psychologists and county clinicians taught the core mental health-related courses. The curriculum followed a lecture-based format and was commonly referred to as being "death by PowerPoint." The class was decertified in 2012 by the Department to update the curriculum based on adult learning theories.

Mental Health Intervention Training Course - 40 Hour Training Curriculum

In 2014, the Mental Health Intervention Training (MHIT) was delivered for the first time to the Los Angeles Police Department's Mental Evaluation Unit on a trial basis. The MHIT is a 40-hour, 4-day course (see Appendix B) and was subsequently approved by the commission of California Peace Officers Standards and Training (POST). The training built upon the Introduction to Mental Illness Course. The course expanded from three days of training to four days. MHIT's curriculum mirrored the blocks of instruction from the Crisis Intervention Team (CIT) course curriculum. It focuses on small group activities, adult learning model, guest speakers from the Autism Society of Los Angeles and the National Alliance on Mental Illness, site visits to stakeholders within the local mental health system (mental health court, a community mental health clinic, and a mental health urgent care center), and utilized actors from a local acting school to assist in scenario-based training on the last day of the course.

CIT requires that officers specially trained to be dispatched to 911 calls for service that involve the mentally ill (Compton, 2008). Currently, the LAPD's Communications Division tracks officers who have attended the Mental Health Intervention Training (MHIT); however, it does not implement priority dispatching to mental illness calls for service to MHIT trained officers (Dempsey, 2020). The LAPD provides police services utilizing a two-person car deployment. Officers who are responding to calls for service do so as a duo instead of a single-person operation. Dempsey (2020) stated that despite not dispatching MHIT officers to mental illness calls, the Mental Evaluations Units (MEU) internal database has documented that at least 1 MHIT trained officer handles approximately 80% of mental illness calls.

Unpublished Attitudinal Study

As mentioned in Chapter 1, Los Angeles County Department of Mental Health (LACDMH) clinicians (Solomon & Mirkoff, 2017) used Clayfield's (2011) Mental Health Aptitude Survey for Police (MHASP) to conduct a pre and post MHIT survey (N=236) for a state forensics conference. In 2016, the clinicians sampled 236 officers using the MHASP and included demographic questions such as gender, race, time on the job, education, and age (see appendix 3). The data collection did not include being mandated or volunteering to attend training or uses of force with the mentally ill. 48% of the respondents were between 26-35 years old. Employment time as a police officer was close in comparison with respondents ranging from 9% (6-10 years), 9% (11-15 years), 10% (16-20 years), and 20 or more years (11%). No respondents indicated that they had less than five years of employment as police officers. According to Solomon & Mirkoff (2017), the results showed a lack of significant change in positives attitudes toward individuals with mental illness, a substantial decrease in negative attitudes toward community responsibility for individuals with mental illness, a significant increase in positive attitudes toward individuals with mental illness living in the community, and a significant decrease on reports of being inadequately prepared to deal with individuals with mental illness.

As mentioned in the Statement of Problem section, in 2017, California Senate Bill 29 required all training officers to receive mental health awareness training (2015/2017). At the end of 2016, The Los Angeles Police Department (LAPD) also began requiring probationary police officers to attend MHIT at the end of their field training phase to extend their academy training as part of the Police Science Leadership course (PSL). Officers in the PSL course had a

maximum of 1 year of field experience and six months of academy training. The mandatory training ensures compliance with state law and early intervention regarding mental illness awareness and officer accountability.

Public Sector Employee Development Training

Officers are now accountable for their actions more than ever, and training is more important than ever for the United States' sworn officers (Landry, 2011). Different international companies provide training and development programs for their employees to improve their skills and abilities (Jehanzeb & Bashir, 2013). Traditionally, employees naturally want to climb the organizational ladder. Employee or career development is not about "getting ahead," but rather about getting to be the best an individual can be by finding a place in an organization where they can express excellence and contribute to the organization's goals. Career development is a lateral movement within the organization and horizontal movement throughout different niches (Merchant, n.d.). Despite increasing employee development training in mental illness over the last few years, generally speaking, the public sector has lagged behind the private sector in instituting these programs (Merchant, n.d.; West & Berman, 1993).

Relevant Learning Theories to CIT

Training and development are an integral part of an organization, whether public or private. (Hunter-Johnson, 2013). There is the initial pre-hire (academy training) with police work, which then continues with in-service training. The in-service training is essentially a continuation of the officer's initial pre-hire academy training. According to Baldwin & Ford (1988), the transfer process is described as having training and input factors, training outcomes, and transfer conditions. The two states that should be met to have training transfer into the workplace are (1) A generalization of learned material in context to the job and (2) maintaining

the learned material over some time on the job. In order for the Mental Health Intervention Training course to be effective, there has to be a general understanding of mental illness, the officer's responsibilities, communication skills, available resources, and continuing education after the initial course. Bass and Vaughan (1966) suggested that the input factors include training design and characteristics and work environment characteristics. Bass and Vaughan (1966) also said that significant training design factors include incorporating appropriate learning principles, which will be discussed later in this chapter. Baldwin and Ford (1988) also mentioned that 10% of knowledge learned while in a training environment is applied to the work environment.

Little is written concerning mental illness training and adult learning for law enforcement officers; what little information that is found has been buried in other research regarding the overall effectiveness of Crisis Intervention Team (CIT) training type courses. All law enforcement officers can learn the skills necessary for their job performance and be productive employees. The concept that is merely lecturing and showing the officers how to perform a skill, even with practical exercises (Landry, 2011), does not guarantee success in skill development and retention. This section will discuss the importance of understanding adult learning and how it applies to law enforcement training, specifically mental illness awareness training.

While there are many adult learning theories, one of the best-known methods of adult learning known is Andragogy (Knowles, 1980), Andragogy places at its center the premise that there are significant differences between how adults and children learn. Andragogy seeks to focus on those different needs exhibited by adult learners. Knowles differentiated between Andragogy and pedagogy, as viewed in the traditional sense, and thought it was important to consider what precisely each brought to learning (Murphy, 2017). Malcolm Knowles' widely accepted theory about adult learning is based on the principle that education should be "learner-

centered" As adults learn, they move from a dependent state to one that is more self-directed (Marcy, 2001). This leads us to the use and understanding of learning styles. Learning styles are a critical component of the effectiveness of teaching as well as learning. Identifying particular learning styles or preferences is a crucial component of the body of knowledge relating to the field of education, specifically law enforcement training (Landry, 2011). Reflecting on the Los Angeles Police Department's (LAPD) history of mental illness training, there is a shift from having their officers read documents to providing more interactive, self-directed training and ensures that all learning styles are incorporated.

Humans take in information about their environment through visual, auditory, read/write, and kinesthetic sensory modalities. Neil Fleming developed the visual, aural, read/write, and kinesthetic (VARK) methodology in learning (Chaundry et al., 2018). Flemming (2001) stated that some students learn while others tune out or have difficulty paying attention during class. In observing the best of teachers, there is no single best way to teach. However, teachers who cater to the different needs of students by using a variety of teaching approaches are rewarded with improved learning. The updated Mental Health Intervention Training (MHIT) takes advantage of VARK in its instructional design and course delivery.

Training has involved more than being able to understand and recall the elements of 5150 WIC. In 1956, educational psychologist Benjamin Bloom developed a taxonomy or classification of learning objectives that educators should set for their students. The lowest learning object is for a student to be able to recall or remember information. The highest level of learning objects is evaluating information or creating. Regarding mental illness awareness training, the highest level of Bloom's Taxonomy would be for students to create a new pattern of thought or belief system towards the mentally ill (Sarfraz, 2017). Referring back to the Los Angeles Police Department's

(LAPD) 1948 standardized roll call training program, Simon (1950) wrote that knowledge of the elements of the job did not ensure exceptional, satisfactory performance. Simon essentially was referring to Bloom's Taxonomy. Since the original mental illness awareness training materials, the LAPD's training has continued to evolve. The curriculum now incorporates and fosters critical thinking and transfer of training through Bloom's Taxonomy and hiring order of learning.

Attribution theory examines the perceived causes of the activities of others. Attribution theory states that the assumptions people make about the outcome influence emotions, expectancies, and behavior toward the individual affected by the outcome (Corrigan et al., 2000). In essence, if people believe that mental illness is not caused by bad parenting and is not a character weakness and that the disease is due to chemical issues in the brain, they will think differently about the individual with mental illness. Another example relates to the stigma of mental illness with the stigma of cancer. Once associated with cancer, shame and fear have mostly been dispelled by accurate information and understanding. It is believed that once the facts are known about the origins of the mental illness (Corrigan et al., 2000), the officer's attitudes toward the person they are interacting with will change.

A study conducted by Wiener et al. (1988) answered an essential question about stigma towards disabilities. Weiner (1988) concluded that, in general, the public seems to discriminate among disability groups. They view persons with mental illness more harshly. The study was conducted between two types of disabilities, mental/behavioral. The mental/ behavioral is identified as child abuse victims, a person who has Post-Traumatic Stress Disorder (PTSD) and Acquired Immune Deficiency Disorder (AIDS). The second group studied was of a physical genesis, such as Alzheimer's Disease, heart disease, blindness, and cancer. The Mental Health Intervention Training (MHIT) pays close attention to attribution theory during the delivery of the

course. Facilitators are keen on the fact and relay to students that as officers become age, they develop different health issues such as high blood pressure, vision issues, or lower back issues. Officers also developed other work-related problems via vicarious trauma. Vicarious trauma is defined as post-traumatic stress disorder (PTSD) (Adams & Riggs, 2008). Even though they may not have direct exposure to a traumatic event, officers will display symptoms almost identical to those of the victims of crime and trauma that they come in contact with. Researchers (Adams & Riggs, 2008; Herman, 1997) referred to this response as traumatic countertransference, from which an officer can experience the same terror, rage, and anguish as the patient, albeit to a lesser degree. This information is important because it brings to light that mental illness impacts everyone and not just those of other social and economic classes (Dempsey, 2020).

Attitudes Towards the Mentally Ill

When police officers encounter people who have mental illnesses, they often have negative or skewed views of the person they are coming in contact with (Watson et al., 2004). Frierson (2013) explained that officers who are better educated could have a better understanding of mental illness. Frierson also stated that exposure and experience with the mentally ill are more likely to lead officers towards empathy than other considered factors. When officers gave examples of the relationship between homeless and recidivism, Frierson stated that many officers do not recognize these issues related to mental health illnesses. The officers considered these social conditions. When the officers attended the training where the relationship was addressed, the officers were better equipped to connect their experiences with the mentally ill to the offenders with similar conditions in the field. Frierson (2013) also noted that taking from experiences and creating educational opportunities is the best case for increasing empathy in law enforcement officers regarding mental health illnesses.

Authoritarianism

Through personal experience, when police officers encounter a person who is experiencing a mental health crisis will usually have more tendency to become violent than the average citizen. This causes the first responder's mental state to become heightened and hyper-vigilant. Police officers are not overly prejudiced but do have harsher attitudes about mental illness than mental health professionals. Researchers have suggested that harsher attitudes may impede the officers' interactions with mentally ill persons (Stanfield, 2005). As mentioned in chapter 1, Clayfield (2011) defines Authoritarianism as reflecting a viewpoint that a person with mental illnesses is an inferior class and requires coercive handling. There is little research on officers' perspectives on Authoritarianism with the mentally ill, but there is research on nurses working in a hospital setting.

A study of health care works in Brazil surveyed health care workers (Siqueira et al., 2016). The cross-sectional study surveyed 246 health care workers (n=246) at a local university hospital. The sample population varied from professors to physicians/nurses and lab technicians. The study used the Community Attitudes towards the Mentally Ill (CAMI) scale to measure their attitudes towards mentally ill patients. Siqueria (2016) concluded that regarding Authoritarianism, staff members who did not have direct contact with patients who were mentally ill (lab technicians and staff nurses) coupled with low education levels have more authoritarian viewpoints regarding the mentally.

Benevolence and Community Mental Health Ideology

As defined by Clayfield (2011), benevolence is seen as a paternalistic, sympathetic view of persons with mental illnesses. Benevolence can further be viewed as the extracontractual behaviors of a firm (giving party) that helps another firm (receiving party) enhance the receiving

party's well-being. Benevolence involves the giving party showing consideration and sensitivity to the needs and interests of the receiving party, acting in the way that protects these interests, and refraining from exploiting the receiving party (Jin-Lee et al., 2004). In a 2015 study of police officers in Nigeria (Omoaregba et al., 2015), the majority of police officers (n=250), 129 males and 90 females, scored high on the benevolence scale, once again measured using the Community Attitudes towards the Mentally Ill (CAMI) survey. When surveyed, almost 60% of respondents did not see much difference between mental hospitals and prisons. Only 9.8% of the respondents disagreed with the statement, "we need to adopt a more tolerant attitude towards the mentally ill in our society." Perceptions of the severity of mental illness (benevolent attitude) are judged upon the nature of the police-citizen interactions and the officer's personality. Officers usually encounter people in a severe state of mental crisis (Omoaregba et al., 2015); therefore, they may have different levels of stigma with those who are mentally ill. Clayfield (2011) defined community mental health ideology as a medical model view of mental illness as an illness just like any other. A central theme in this ideology is a belief that genuinely helpful and comprehensive services can be provided only through the forging of systemic linkages that bring together the various caregiving agencies needed to offer a complex array of resources, technologies, and skills (Baker, 1974).

Social Restrictions

Social Restrictiveness is defined as viewing persons with mental illnesses as a threat to society. For example, the mentally ill should be isolated from the rest of the community (Clayfield, 2011). Attitudes influence behavior, primarily when explicitly related to the action in question (Atkinson, 2000). Similarly, attitudes towards mental illness and mental health patients have been found to influence the treatment given to the patients by personnel working with them

(Keane, 1991). According to Wallach (2004), having a negative attitude towards someone with mental illness is directly related positively to age, negatively with socioeconomic status and education, and positive experience and exposure. Wallach (2004) conducted a comparative study using 140 students in a psychopathology course and 53 students in an introductory psychology course (intro group) at two local colleges. The students who were in the psychopathology class were required to participate in an organized visit to a mental health institution as part of the course and provided with the voluntary opportunity to spend 2 hours a week working directly with patients who were mentally ill. Students in the introductory psychology course were not required to attend a site visit or work with mentally ill patients. Wallach (2004) used the Opinions about Mental Illness (OMI) questionnaire developed by Cohen and Struening (1962). The OMI consists of 51 questions, which are scored on a 6-point Likert scale ranging. Wallach (2004) found that using post hoc comparisons, all but one (comparing classroom exposure to work in a hospital) were significant ($p < 0.01$). Wallach (2004) found it clear that the magnitude of the decrease in Social Restrictiveness was most notable for the classroom exposure group and the workgroup and less for the introductory psychology class or for the students who visited a mental health treatment center. This group increased their Social Restrictiveness rather than decreased. This is important because the Mental Health Intervention Course (MHIT) conducts site visits to mental illness facilities. Officers are also in direct contact with persons who are mentally ill during their workday.

Behaviors

Camille-Mckiness (2013) stated that Crisis Intervention Training attitudes said that the experience transforms officers' attitudes and knowledge regarding mental illness and, therefore, changes how they respond to individuals experiencing a mental health crisis. A study conducted

by Glasman and Albarracin (2016), who set out to study the attitude-behavior relation, said that according to researcher Fazio (1989), people's attitudes are more likely to guide behavior attitudes are easy to retrieve from memory. There are two main premises for this belief. First, more accessible attitudes are likely to be available as criteria for a later behavioral decision. Second, accessible attitudes influence the interpretation of information associated with the object, in this case, mentally ill persons. People often retrieve and use their prior attitudes as a basis for behavior. However, they also adjust these attitudes based on information available at the time of the behavior decision. (Glasman and Albarracin, 2016). According to Dempsey (2020), the Mental Health Intervention Training has a purposeful design that saves the most impactful instruction module until the end of the course. Family members and persons in mental illness recovery share their experiences navigating life with a severe mental illness.

Researchers (Dekker et al., 2007) examined Dutch adolescent boys and their attitudes towards people of foreign countries, Germany in particular. Dekker (2017) hypothesized that the attitude towards Germany has no or a negligible effect on behavior towards German people. Dekker (2017) challenged previous researchers' belief that positive attitudes towards a foreign country and its people lead to positive behavior while negative attitudes result in negative behavior towards that country and people. Dekker (2017) concluded that this hypothesis has to be rejected. Dekker (2017) collected data regarding attitudes towards Germany, beliefs about Germany, including clichés of the country and stereotypes of the people, emotions concerning Germany, direct contact with Germany and Germans, and German socialization. Dekker (2017) concluded that despite study limitations, attitude towards Germany is the variable with by far the highest effect on behavioral desire concerning Germany in comparison to the effects of clichés,

stereotypes, emotions, and direct contact. Therefore, positive attitudes do have an impact on positive behavior towards people who are of different cultures.

Self-Selection vs. Mandated Training

The final component regarding the effectiveness of the Mental Health Intervention Training (MHIT) and its significance in changing police officers' attitudes is forcing officers to attend versus having officers volunteer to attend the training. According to a study conducted by Compton (2017), which was mentioned in Chapter 1, many law enforcement agencies are deliberating about training select officers versus training a fixed percentage of or all officers, and no research has yet been available to guide such decisions. A critical element of training effectiveness is the trainee's level of motivation to attend the course (Mathieu et al., 1993). Noe (1986) suggested that characteristics such as a trainee's level of motivation and attitudes are workable individual factors that play a critical role in achieving training effectiveness. Even if trainees have the ability to learn the course content, they may fail to benefit from training because of low motivation. Low motivation can be derived from being mandated to attend mandatory training. Other researchers (Mathieu et al., 1993) also suggest that the characteristics of trainees, such as motivation and attitudes, are more critical to training success than are course-content variables. There are several differences between those who volunteer for CIT training and those who are mandated to attend. While the attitudinal differences may be significant, volunteers for CIT training reported having more patience when interacting with persons who have a mental illness and were less likely to attribute mental illness to the person's family of origin. The most dramatic difference is that CIT volunteers reported before the training that they felt significantly less well prepared to handle mental illness calls for service and felt the same about their coworkers. (Wells & Schafer, 2006). The data suggests that volunteering for CIT

training represents an interest in addressing a perceived skill deficit among officers. Compton (2017) found that, although overall dispositions of encounters did not differ between those who had volunteered and those assigned when physical force was required, officers who had volunteered were more likely to transport or refer to mental health services and less to execute an arrest.

Dispositions and Uses of Force

Compton's (2017) study on CIT training and officers being mandated or self-selected was limited in scope. It is limited in scope because of the ratio of volunteers to assigned students. Of the 251 CIT-trained officers in Study 1, 171 (68%) volunteered, and 80 (32%) were assigned to CIT training. In the second study, Of the 91 CIT-trained officers participating in Study 2, 64 (70%) reported having volunteered for, and 27 (30%) reported having been assigned to CIT training. The Mental Health Intervention Training (MHIT) course expects to have 90-100% of students mandated to attend the training. In the Compton (2017) study, for all calls for service dispositions (resolution on the scene, referral or transport to mental health services, or arrest), percentages were similar for self-selected/volunteered and assigned groups. Compton (2017) concluded that 47% and 48% of encounters were resolved at the scene among self-selected/volunteered and assigned officers, respectively. Volunteering CIT officers, however, were more likely to use physical force than assigned officers (77 of 279 encounters (22%) versus 20 of 127 (14%); OR = 2.24, p = .03, a moderate effect) in order to transport to a treatment facility (as many jurisdictions require), might explain the apparent increase in the use of physical force. In Compton's (2017) study, using force was defined as using handcuffs, other devices, or physical engagement. From the LAPD's perspective, using handcuffs or laying hands on a person does not constitute a use of force. Compton did clarify that the somewhat counterintuitive use of

physical force could be due to how they defined physical force. Compton's (2017) findings might have programmatic and policy implications for further disseminating the CIT philosophy. The findings are due in part because many law enforcement agencies are deliberating about training select officers versus training a fixed percentage of their patrol force or all of their officers, and no research has yet been available to guide such decisions (Compton, 2017)

Literature Review Conclusion

Nationally, mental illness awareness training took a turn for the better in the 1980s. Training for police officers before the mid to late 1980s was either non-existent or very basic. The training focused more on providing knowledge rather than seeking to understand. The Crisis Intervention Team (CIT) program has paved the way as a national model on mental illness response and training. With the CIT's requirement for a system-wide partnership with law enforcement, consumers of services, and service providers, CIT allows for a less restrictive approach to emergency mental illness care by police officers. The CIT philosophy also requires 100% self-selection to attend training and be part of the 911 response team. Currently, there is a trend towards mandating officers to attend CIT-type training. This comes with strengths and weaknesses. Current literature addresses the need for mental illness awareness training, but no literature addresses the evolution of such training.

Most of the research regarding police attitudes and mental illness training focuses on officers who have been self-selected to attend the training. Limited literature exists on courses that deliver training where more than 35% of their audience is mandated to attend a CIT or comparable course and where the attendees have less than three years of field experience as a police officer. It is also very little to no research regarding employee development training and adult learning theories. This dissertation will contribute to the current body of knowledge by

adding a historical evolution of mental illness training, curriculum design insight, and further research on mandated training that will hopefully better direct policy initiatives in the future.

Chapter 3: Methodology

Research Questions

This study examined the following research questions and hypotheses:

RQ1: Is there a significant difference in an officer's attitudes towards a person with mental illness before and after attending the Los Angeles Police Department's Mental Health Intervention Training Course?

H1: There is a significant difference in an officer's attitudes towards a person with mental illness before and after attending the Los Angeles Police Department's Mental Health Intervention Training Course.

H0: There is no significant difference in an officer's attitudes towards a person with mental illness before and after attending the Los Angeles Police Department's Mental Health Intervention Training Course.

RQ2: Is there a significant difference in an officer's attitude towards community responsibility in caring for the mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course?

H1: There is a significant difference in an officer's attitude towards community responsibility in caring for the mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

H0: There is no significant difference in an officer's attitude towards community responsibility in caring for the mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

RQ3: Is there a significant difference in an officer's attitude towards their preparedness to deal with a mentally ill person before and after attending the Los Angeles Police Department's Mental Health Intervention Training course?

H1: There is a significant difference in an officer's attitude towards their preparedness in dealing with a person who is mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

H0: There is no significant difference in an officer's attitude towards their preparedness in dealing with a person who is mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

RQ4: Is there a significant difference in officers' attitudes towards the mentally ill living in their community before and after attending the Los Angeles Police Department's Mental Health Intervention Training course?

H1: There is a significant difference in an officer's attitude towards the mentally ill living in their community before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

H0: There is no significant difference in an officer's attitude towards the mentally ill living in their community before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

As a series of additional data analyses, the research study compared two sets of two distinct groups who attended the Mental Health Intervention Training course to see a statistically significant difference between these groups. Specifically, the groups are individuals who are probationary police officers compared to non-probationary police officers and individuals who are mandated and not mandated to attend the training course. The research also studied the linear

regression between the number of years of police service of the police officer with their total scores (and four subscales) on the MHASP before completing the Los Angeles Police Department's Mental Health Intervention Training course.

Sample Population

The sample for this dissertation was permanent duty police officers and probationary police officers from the Los Angeles Police Department (LAPD). The City of Los Angeles employees approximately 10,000 personnel. An approximate and appropriate sample size goal was 176 officers. The sample size goal was analyzed using G Power Version 3.1. The officers were students in the Department's Mental Health Intervention Training (MHIT) course. Los Angeles Police Department Officers are hired to mirror the socioeconomic makeup for the City of Los Angeles, including having officers with diverse backgrounds and life experiences that allow them to relate to the public. The officers surveyed were of various ethnic backgrounds, education levels, genders, ages and will work in different socioeconomic and geographical areas. As of July 2020, the MHIT course resumed training that was halted due to the COVID-19 pandemic. A total of 8 weeks were allowed for data collection. The six courses were delivered weekly between September 22, 2020-October 30, 2020. The Los Angeles Police Department canceled the remaining two courses based on deployment needs for Election 2020 related concerns.

The MHIT's monthly schedule was divided into two types of student enrollment. Two courses a month were mainly devoted to probationary police officers with less than one year of field experience nearing the end of their formal probationary employment period. The probationary police officer course was selected by the academy class and was not controlled by the MHIT enrollment coordinator. The demographics of each MHIT course were dependent on

the demographics of the academy class upon hiring. The two additional monthly courses were made up of Field Training Officers (FTO) and other permanent status police officers of varying years of experience. The FTO's and other officers were scheduled to attend an MHIT course from an outside coordinator (FTO Training Coordination Unit and division training coordinator). The courses had an enrollment of 30-35 students per class.

Instrumentation

This was a quantitative research study. The instrument used was the Mental Health Attitude Survey for Police (MHASP). The MHASP was developed by Clayfield et al. (2011) to adequately inform persons charged with developing CIT type training as to whether such courses impact police officer attitudes towards persons with mental illness that they encounter. The 33-items on the MHSAP scale come from various studies examining attitudes toward persons who have a mental illness (Clayfield, 2011) and their research and experiences working with and training police officers. Clayfield (2011) used a panel of community advocates and consumers to help modify items from existing scales to reflect attitudinal inquiry that the panel believed to be necessary. Clayfield (2011) also revised the wording of scale items to incorporate police terminology regarding persons with mental illness. The MHASP has been validated with these prior research studies as being a reliable instrument.

Validity The MHASP has four distinct subscales, a) an officer's attitude toward the mentally ill (13 items), b) their attitude toward community responsibility for persons who have a mental illness (7 items), c) officers preparedness when dealing with a person who has a mental illness (3 items), and d) an officers attitude towards the mentally ill living in the community (10 items) (Clayfield, 2011). The subscales were validated using a vignette comparison measure that was taken from work derived from Martin (2000). Clayfield (2011) reported that three of the four

MHASP subscales showed significant correlations with all three Vignette comparison measure subscales demonstrating good convergent validity. Only one MHASP subscale #3 (officers feeling adequate to deal with persons who are mentally ill) did not show any correlation with the three Vignette comparisons. Clayfield (2011) concluded that preparedness might not reflect an officer's attitude but rather a knowledge scale regarding whether the officer feels adequately prepared.

Procedure

The researcher is a primary instructor for the MHIT course. To reduce bias, the researcher was not present during the administration of the pre-course MHASP. The MHASP was conducted by a supervisor who also facilitates the MHIT course. This supervisor also has graduated level experience administering surveys for academic data collection. At the opening of the Mental Health Intervention Training course (at approximately 7:00 am on day one) and before the opening module, the 12- question demographic face sheet and 33- question MHASP was distributed face down to each student. See Appendices A through F for material related to the demographic survey, MHASP, permissions to use material, permissions for access to the sample population, and informed consent. The participants were advised to keep the documents face down until all the instruments were distributed. Students were informed about the instrument and the reason for collecting the data. Students were informed that the data collection was anonymous, voluntary and if the student did not wish to participate, they still needed to turn in a blank copy of the MHASP. The survey distribution, survey completion, and survey collection took approximately 15 minutes to complete.

Post-Course Survey

To reduce bias, the researcher was not present in the classroom during the delivery of the post-course survey. The post-MHASP was distributed to each student face-down at the end of the 40-hour MHIT course. The distribution was done during the last hour of class before dismissal. Before distribution, the students were reminded that the surveys are voluntary and anonymous. Students were reminded how to complete the matching code before completing the MHASP to pair the post MHASP with the pre-MHASP accurately. The MHASP was distributed face down. Students were informed that if they did not want to complete the post-MHASP, they would still need to turn in a blank survey. The distribution, completion, and survey collection took approximately 15-minutes.

Data Analysis

The independent variable in this study was the Mental Health Intervention Training (MHIT). The dependent variables were the four factors that were measured in the Mental Health Aptitude Survey for Police (MHASP): An officer's attitudes towards a person with mental illness, their attitude towards community responsibility in caring for the mentally ill, the officer's attitude on their preparedness in dealing with a person who is mentally ill, and their attitude towards the mentally ill living in their community (Clayfield, 2011) which are measured before and after the attendance in the Mental Health Intervention Training (MHIT)

Scoring

Clayfield (2020) provided the researcher with a breakdown of the scoring procedure for the MHASP. The subscale scores are the sum of the scores of the component items. (1) Positive attitudes towards EDP's (higher score indicates more positive attitude). (2) Negative attitude toward community responsibility (higher score indicates less negative attitude). These items

were reverse coded. (3) Inadequately prepared to deal with EDPs (higher score indicates more feelings of inadequacy). (4) Positive attitude toward EDPs living in the community (higher scores indicate a more positive attitude). For the total score, the higher the score, the more positive the attitude will be towards EDPs.

Inferential Statistics

To examine the statistical differences between police officers' attitudes on the total score on the MHASP (and the four subscales of MHASP) before and after the attendance of the Mental Health Intervention Training (MHIT), the researcher used a series of paired t-test via SPSS. In addition, a follow-up MANOVA and ANOVA statistical analysis were used to compare probationary police officers versus non-probationary police officers upon their total score on the MHASP (and the four subscales of MHASP) after completion of the Mental Health Intervention Training (MHIT). Additionally, a follow-up MANOVA and ANOVA statistical analysis was used to compare the differences between police officers who are mandated to attend training versus police officers who volunteer to attend training upon their total score on the MHASP (and the four subscales of MHASP) after completion of the Mental Health Intervention Training (MHIT). Finally, the researcher also used MANOVA and ANOVA statistical analysis to examine linear regression between the years of police service of the police officer in comparison to their total scores (and the four subscales) on the MHASP after the completion of the Los Angeles Police Department's Mental Health Intervention Training course.

Chapter 4: Results

As previously stated, this research project is a quantitative study, and the framework focused on the subscales that were depicted in the Mental Health Aptitude Survey for Police (MHASP). The subscales measured were an officer's attitudes towards a person with mental illness, their attitude towards community responsibility in caring for the mentally ill, the officer's attitude on their preparedness in dealing with a person who is mentally ill, their attitude towards the mentally ill living in their community, and the officer's overall attitude regarding persons who are mentally ill. Primarily, this study also examined the relationship between the different subscales and the effects of attitudes before and after attending a Mental Health Intervention Training (MHIT) course. In this chapter, the findings of the data collection and analysis are presented. Frequencies and percentages were used for nominal-level variables. Cronbach alpha was used to examine the reliability coefficients of the scales. To address the research questions, a series of paired *t*-tests were conducted. In addition, MANOVAs and ANOVAs were used for additional analyses. Statistical significance was evaluated at the generally accepted level, $\alpha = .05$.

Participants-Descriptive Statistics

Of the 6 MHIT courses that were surveyed, 192 completed the courses. Of those attendees, a total of 165 participants completed the survey. Twenty-six students either did not participate or did not complete the course. There were several completed MHASPs that were missing values. Mean imputation was used to replace the missing values. A majority of the sample consisted of males (n = 120, 72.73%). Most of the participants were in the 26-35-year-old age range (n = 82, 49.70%). A majority of the sample consisted of Hispanic participants (n = 95, 57.58%). A majority of participants were single (n = 94, 56.97%). Division of assignments

was widely spread among the Los Angeles Police Department's geographic patrol divisions. Most participants had 0-9 years of experience (n = 110, 66.97%). Most participants had some college experience (n = 71, 43.03%) or a bachelor's degree (n = 57, 34.55%). Most participants did not have mental health training (n = 117, 70.91%) or mental illness in their family (n = 139, 84.24%). Among the participants who responded, most indicated that they were Christian (n = 38, 23.03%) or Catholic (n = 46, 27.88%). A majority of participants were probationary officers (n = 96, 58.18%) and mandated to attend (n = 149, 90.30%). Frequencies and percentages of the nominal-level variables are presented in Table 1.

Table 1 Frequency Table for Nominal Variables

Variable	*n*	*%*
Gender		
Male	120	72.73
Female	33	20.00
Did Not State	10	6.06
Missing	2	1.21
Age		
18-25	33	20.00
26-35	82	49.70
36-45	40	24.24
46-64	10	6.06
Ethnicity		
Caucasian	30	18.18
African American	17	10.30
Hispanic	95	57.58
Asian	14	8.48
Pacific Islander	1	0.61
Other	8	4.85
Marital status		
Single	94	56.97
Married	58	35.15
Divorced	10	6.06

Separated	3	1.82
Division of assignment		
Hollywood Area	12	7.27
Harbor Area	4	2.42
Newton Area	12	7.27
Northeast Area	6	3.64
Other Specialized Division	3	1.82
Southwest Area	7	4.24
77th Street Area	5	3.03
Van Nuys Area	17	10.30
North Hollywood Area	9	5.45
West Los Angeles Area	5	3.03
Topanga Area	5	3.03
Wilshire Area	8	4.85
West Valley Area	9	5.45
Central Area	11	6.67
Mission Area	8	4.85
Rampart Area	6	3.64
Pacific Area	6	3.64
Hollenbeck Area	4	2.42
Southeast Area	8	4.85
Foothill Area	6	3.64
Devonshire Area	6	3.64
Olympic Area	1	0.61
Missing	7	4.24
Years of service		
0-9 (early career)	110	66.67
10-20 (mid career)	51	30.91
21 or more (late career)	4	2.42
Education		
High School/GED	24	14.55
Some College/ AA	71	43.03
Bachelor's Degree	57	34.55
Master's Degree	12	7.27
Doctorate Degree	1	0.61
Missing	0	0.00
Previous mental health training		

Yes	48	29.09
No	117	70.91
Mental illness in family		
Yes	26	15.76
No	139	84.24
Religion		
Christian	38	23.03
Catholic	46	27.88
Jewish	2	1.21
Did Not State	70	42.42
Missing	9	5.45
Probationary officer		
Yes	96	58.18
No	69	41.82
Mandated to attend		
Yes	149	90.30
No	16	9.70

Note. Due to rounding errors, percentages may not equal 100%.

Reliability

Composite scores were developed for the MHASP scales by taking a sum of respective survey items in each scale. Cronbach's alpha test of internal consistency and reliability was examined for the overall scale and four subscales. The strength of the Cronbach alpha values were assessed through use of the guidelines suggested by George and Mallery (2016), in which $\alpha \geq .9$ Excellent, $\alpha \geq .8$ Good, $\alpha \geq .7$ Acceptable, $\alpha \geq .6$ Questionable, $\alpha \geq .5$ Poor, and $\alpha < .5$ Unacceptable. A separate Cronbach alpha calculation was utilized for the MHASP Pre Test and MHASP Post Test component of the survey. Nine of the ten alpha levels met the acceptable threshold for internal consistency. The pretest reliability for subscale the subscale measuring an officer's attitude towards their preparedness in dealing with a person who is mentally ill had poor reliability ($\alpha = .57$). The low reliability could be attributed to the examination of only three

survey items on this measure. The statistical findings of this scale will be interpreted with a level of caution. Table 2 presents the descriptive statistics for the interval-level variables.

Table 2 Chronback Alpha for MHASP Measures

Variable	Number of survey items	Pretest	Posttest
		α	α
Overall MHASP	33	.89	.90
Officer's attitudes towards a person with mental illness	14	.80	.72
Officer's attitude towards community responsibility in caring for the mentally ill	7	.78	.82
Officer's attitude towards their preparedness in dealing with a person who is mentally ill	3	.57	.78
Officer's attitude towards the mentally ill living in their community	10	.85	.89

Normality Assumption

A series of Kolmogorov-Smirnov tests were utilized to assess the normality assumption for the scales. The Kolmogorov-Smirnov test compares the test data to a theoretical bell-shaped curve, and significance on the test indicates that the test data significantly deviates from a normal distribution (Tabachnick & Fidell, 2013). Three out of the ten Kolmogorov-Smirnov tests were significant ($p < .05$), suggesting that the data may deviate from a bell-shaped curve for three of the variables. However, Howell (2013) indicates that data tend to approximate normality when there are at least 50 participants in the sample. Therefore, it is not problematic that the tests of normality indicated deviations from a bell-shaped distribution. Table 3 presents the findings of the Kolmogorov-Smirnov tests.

Table 3 Kolmogorov-Smirnov Tests for MHASP Measures

Variable	Pretest		Posttest	
	KS test	*p*	KS test	*p*
Overall MHASP	0.07	.346	0.06	.683
Officer's attitudes towards a person with mental illness	0.05	.789	0.05	.874
Officer's attitude towards community responsibility in caring for the mentally ill	0.08	.308	0.11	.033
Officer's attitude towards their preparedness in dealing with a person who is mentally ill	0.13	.007	0.16	<.001
Officer's attitude towards the mentally ill living in their community	0.06	.627	0.06	.687

Research Questions and Hypothesis Testing

RQ1: Is there a significant difference in an officer's attitudes towards a person with mental illness before and after attending the Los Angeles Police Department's Mental Health Intervention Training Course?

H1: There is a significant difference in an officer's attitudes towards a person with mental illness before and after attending the Los Angeles Police Department's Mental Health Intervention Training Course.

H0: There is no significant difference in an officer's attitudes towards a person with mental illness before and after attending the Los Angeles Police Department's Mental Health Intervention Training Course.

A paired *t*-test was conducted to assess for differences in subscale 1, officer's attitudes towards a person with mental illness, before and after attending the Los Angeles Police Department's Mental Health Intervention Training (MHIT) course. The result of the paired sample *t*-test was statistically significant, $t(164) = -4.83$, $p < .001$, indicating that there were statistically significant differences in officer's attitudes towards a person with mental illness

before and after the training. Scores increased by approximately 2.59 units following the training (see Figure 2). Table 4 presents the findings of the paired sample *t*-test.

Table 4 Paired Sample t-test for Subscale 1 Before and After Training

Variable	Pretest		Posttest				
	M	*SD*	*M*	*SD*	*t*(164)	*p*	*d*
Officer's attitudes towards a person with mental illness	54.65	9.03	57.24	8.48	-4.83	< .001	0.38

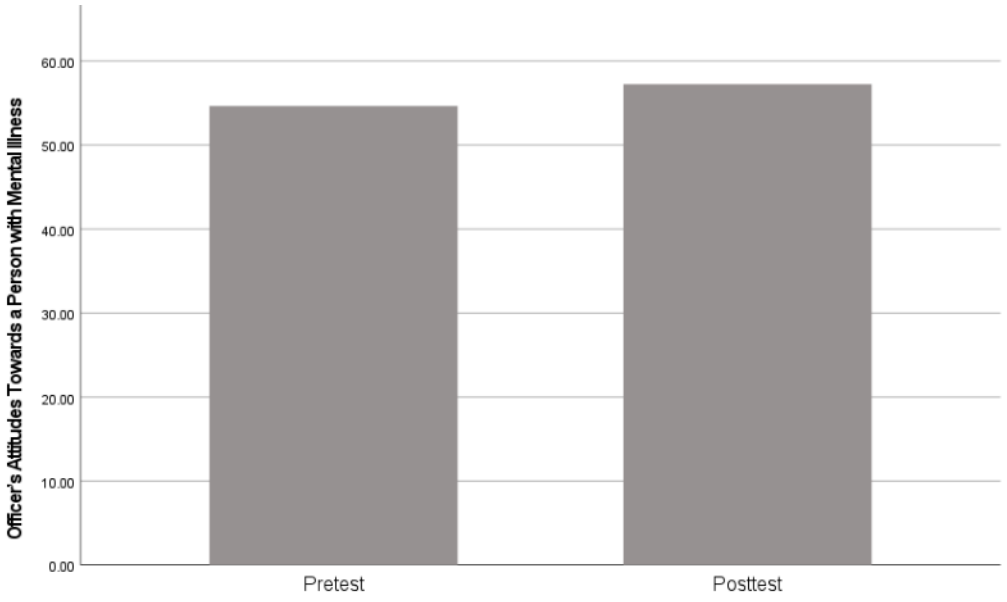


Figure 2 Bar chart for subscale 1 before and after attending course.

RQ2: Is there a significant difference in an officer's attitude towards community responsibility in caring for the mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course?

H1: There is a significant difference in an officer's attitude towards community responsibility in caring for the mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

H0: There is no significant difference in an officer's attitude towards community responsibility in caring for the mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

A paired *t*-test was conducted to assess for differences in officers' attitudes towards community responsibility in caring for the mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course. The result of the paired sample *t*-test was statistically significant, $t(164) = -12.86$, $p < .001$, indicating that there were statistically significant differences in officer's attitude towards community responsibility in caring for the mentally ill before and after the training. Scores increased by approximately 5.11 units following the training (see Figure 2). Table 5 presents the findings of the paired sample *t*-test.

Table 5 Paired Sample t-test for Subscale 2 Before and After Training

Variable	Pretest		Posttest				
	M	*SD*	*M*	*SD*	$t(164)$	*p*	*d*
Officer's attitude towards community responsibility in caring for the mentally ill	29.50	5.68	34.61	5.47	-12.86	< .001	1.00

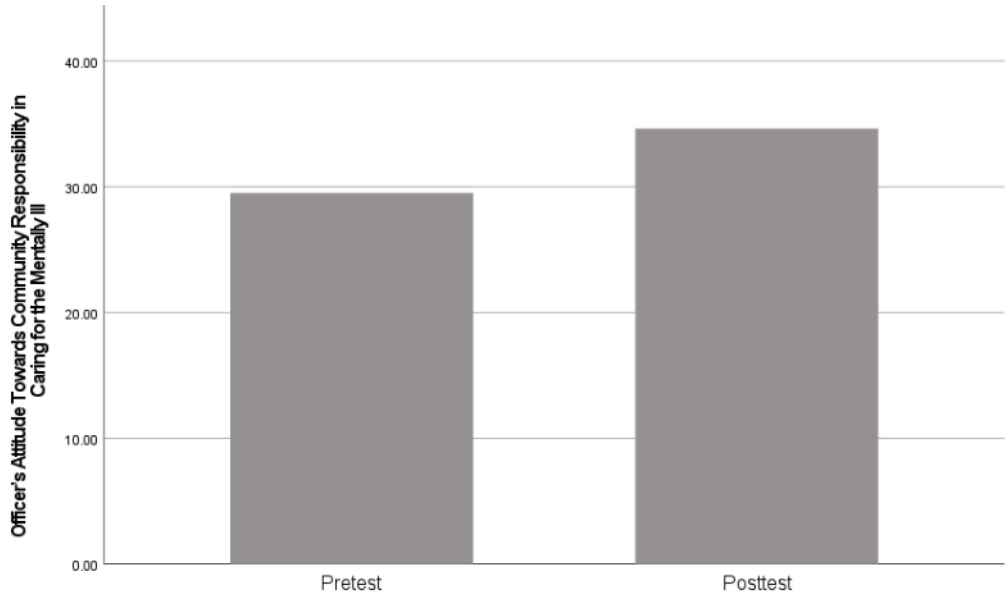


Figure 3 Bar chart for subscale 2 before and after attending course.

RQ3: Is there a significant difference in an officer's attitude towards their preparedness in dealing with a person who is mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course?

H1: There is a significant difference in an officer's attitude towards their preparedness in dealing with a person who is mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

H0: There is no significant difference in an officer's attitude towards their preparedness in dealing with a person who is mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

A paired *t*-test was conducted to assess for differences in officers' attitudes towards their preparedness in dealing with a person who is mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course. The result of the

paired sample *t*-test was statistically significant, $t(164) = 10.75$, $p < .001$, indicating that there were statistically significant differences in officer's attitude towards their preparedness in dealing with a person who is mentally ill before and after the training. Scores decreased by approximately 2.44 units following the training (see Figure 4). Table 6 presents the findings of the paired sample *t*-test.

Table 6 Paired Sample t-test for Subscale 3 Before and After Training

Variable	Pretest		Posttest				
	M	*SD*	*M*	*SD*	$t(164)$	p	d
Officer's attitude towards their preparedness in dealing with a person who is mentally ill	8.33	2.29	5.89	2.41	10.75	< .001	0.84

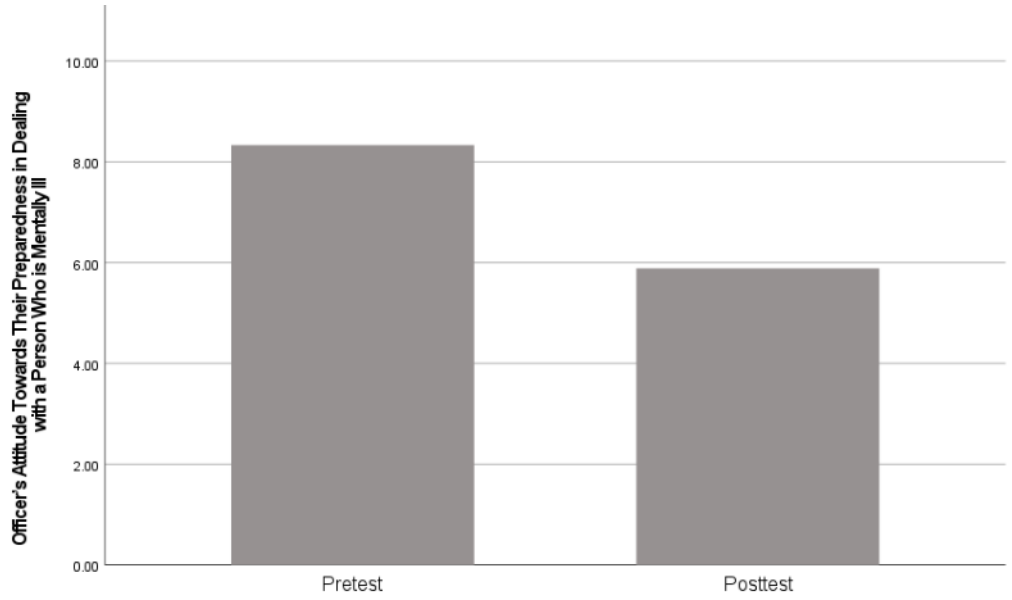


Figure 4 Bar chart for Subscale 3 before and after course.

RQ4: Is there a significant difference in an officer's attitude towards the mentally ill living in their community before and after attending the Los Angeles Police Department's Mental Health Intervention Training course?

H1: There is a significant difference in an officer's attitude towards the mentally ill living in their community before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

H0: There is no significant difference in an officer's attitude towards the mentally ill living in their community before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

A paired *t*-test was conducted to assess for differences in the officer's attitude towards the mentally ill living in their community before and after attending the Los Angeles Police Department's Mental Health Intervention Training course. The result of the paired sample *t*-test was statistically significant, $t(164) = -7.54$, $p < .001$, indicating that there were statistically significant differences in officer's attitude towards the mentally ill living in their community before and after the training course. Scores increased by approximately 3.76 units following the training (see Figure 4). Table 7 presents the findings of the paired sample *t*-test.

Table 7 Paired Sample t-test for Subscale 4 Before and After Attending Training

Variable	Pretest		Posttest				
	M	*SD*	*M*	*SD*	$t(164)$	p	d
Attitude toward mentally ill living in their community	36.62	8.71	40.38	9.45	-7.54	< .001	0.59

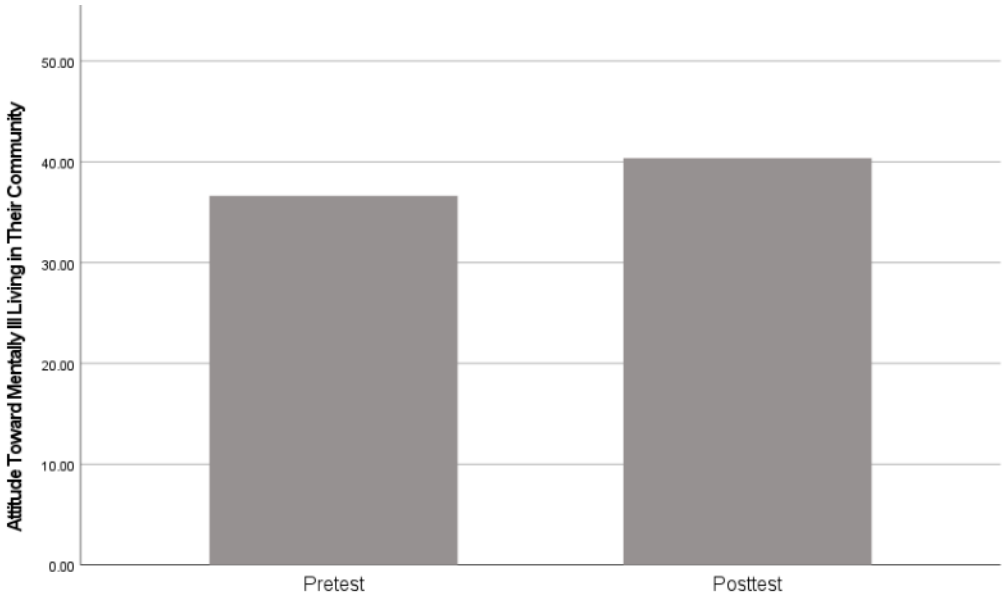


Figure 5 Bar chart for Subscale 4 before and after attending the course.

Overall MHASP

A paired *t*-test was conducted to assess for differences in overall MHASP scores before and after attending the Los Angeles Police Department's Mental Health Intervention Training course. The result of the paired sample *t*-test was statistically significant, $t(164) = -12.33$, $p < .001$, indicating that there were statistically significant differences in overall MHASP scores before and after the training course. Scores increased by approximately 13.91 units following the training (see Figure 5). Table 8 presents the findings of the paired sample *t*-test.

Table 8 Paired Sample t-test for Overall MHASP Scores Before and After Training

Variable	Pretest		Posttest				
	M	*SD*	*M*	*SD*	*t*(164)	*p*	*d*
MHASP total score	133.43	20.17	147.34	21.19	-12.33	< .001	0.96

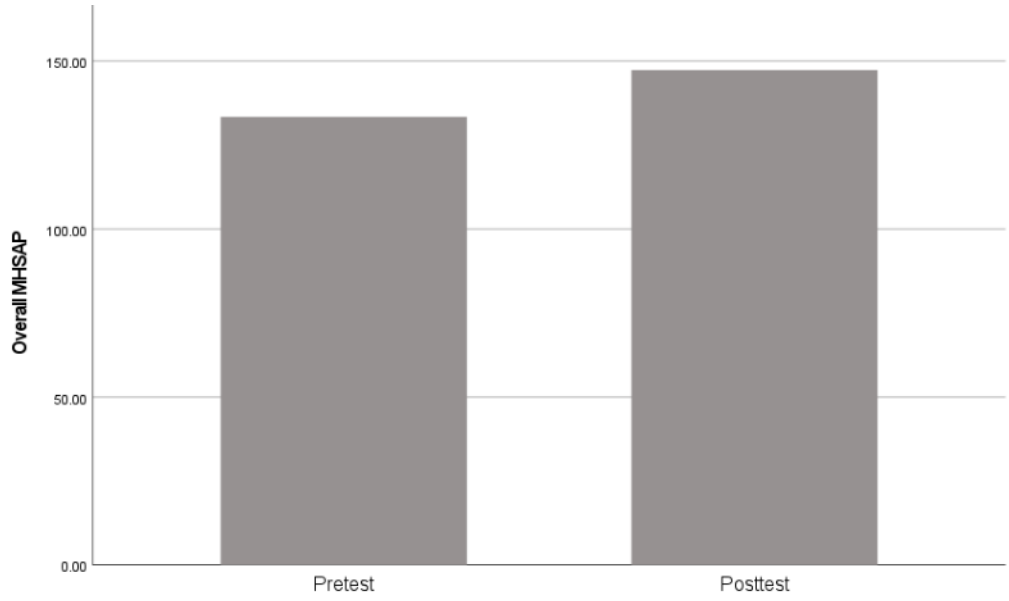


Figure 6 Bar chart for overall MHASP scores before and after attending the course

MANOVA for MHASP Subscales by Probationary Police Officers

The results of the overall MANOVA were significant (Pillai's Trace = 0.09, $F[4, 160] = 3.96$, $p = .004$), indicating that there were significant differences in the MHASP subscales by probationary officer experience. Due to the significance of the overall MANOVA, individual ANOVAs were conducted to examine each MHASP subscale individually. Table 9 presents the findings of the overall MANOVA for MHASP subscales by probationary officer experience.

Table 9 MANOVA for MHASP Subscales by Probationary Officer Experience

Variable	Pillai	$F(4, 160)$	p	$\eta_p 2$
Probationary officer	0.09	3.96	.004	.09

There were significant differences for subscale one, $F(1, 163) = 4.16$, $p = .043$, indicating that there were significant differences in mean scores of "officer's attitudes towards a person with mental

illness" based on whether participants were probationary officers. Those who were probationary officers (M = 58.37) had higher mean scores in comparison to non-probationary officers (M = 55.67).

There were significant differences for subscale two, $F(1, 163) = 4.08$, $p = .045$, indicating that there were significant differences in mean scores of "officer's attitudes towards community responsibility in caring for the mentally ill" based on whether participants were probationary officers. Those who were probationary officers (M = 35.33) had higher mean scores in comparison to non-probationary officers (M = 33.61).

There were not significant differences for subscale three, $F(1, 163) = 2.38$, $p = .125$, indicating that there were not significant differences in mean scores of "officer's attitude towards their preparedness in dealing with a person who is mentally ill" based on whether participants were probationary officers.

There were significant differences for subscale four, $F(1, 163) = 15.44$, $p < .001$, indicating that there were significant differences in mean scores of "officer's attitude towards the mentally ill living in their community" based on whether participants were probationary officers. Those who were probationary officers (M = 42.73) had higher mean scores in comparison to non-probationary officers (M = 37.11).

Table 10 presents the individual ANOVAs for the MHASP subscales by probationary officer experience. Table 11 presents the descriptive statistics for the MHASP subscales by probationary police officer experience.

Table 10 ANOVA for MHASP Subscales by Probationary Officer Experience

MHASP Subscales	$F(1, 163)$	p	$\eta_p 2$
Officer's attitudes towards a person with mental illness	4.16	.043	.03
Officer's attitude towards community responsibility in caring for the mentally ill	4.08	.045	.02
Officer's attitude towards their preparedness in dealing with a person who is mentally ill	2.38	.125	.01
Officer's attitude towards the mentally ill living in their community	15.44	<.001	.09

Table 11 Descriptive Statistics for MHASP Subscales by Probationary Officer Experience

MHASP Subscales	Probationary officer			Non-probationary officer		
	n	*M*	*SD*	*n*	*M*	*SD*
Officer's attitudes towards a person with mental illness	96	58.37	7.78	69	55.67	9.20
Officer's attitude towards community responsibility in caring for the mentally ill	96	35.33	5.20	69	33.61	5.70
Officer's attitude towards their preparedness in dealing with a person who is mentally ill	96	5.65	2.23	69	6.23	2.61
Officer's attitude towards the mentally ill living in their community	96	42.73	9.31	69	37.11	8.71

ANOVA for Overall MHASP Scale by Probationary Officer Experience

There were significant differences for overall MHASP, $F(1, 163) = 10.72$, $p = .001$, indicating that there were significant differences in overall MHASP scores based on whether participants were probationary officers. Those who were probationary officers ($M = 151.79$) had higher mean scores in comparison to non-probationary officers ($M = 141.15$). Table 12 presents the individual ANOVA for overall MHASP scores by probationary officer experience. Table 13 presents the descriptive statistics for the overall MHASP scores by probationary officer experience.

Table 12 ANOVA for Overall MHASP by Probationary Officer Experience

Variable	$F(1, 163)$	p	$\eta_p 2$
Overall MHASP	10.72	.001	.06

Table 13 Descriptive Statistics for Overall MHASP by Probationary Officer Experience

MHASP Subscales	Probationary officer			Non-probationary officer		
	n	*M*	*SD*	*n*	*M*	*SD*
Overall MHASP	96	151.79	20.11	69	141.15	21.24

MANOVA for MHASP Subscales by Mandated to Attend Training

The results of the overall MANOVA were not significant (Pillai's Trace = 0.02, $F[4, 160] = 0.81$, $p = .521$), indicating that there were not significant differences in the MHASP subscales by mandate to attend training. Due to non-significance of the overall ANOVA, individual ANOVAs were not conducted to examine each MHASP subscale individually. Table 14 presents the findings of the overall MANOVA for MHASP subscales by mandate to attend training. Table 15 presents the descriptive statistics for the MHASP subscales by mandate to attend training.

Table 14 MANOVA for MHASP Subscales by Mandate to Attend Training

Variable	Pillai	$F(4, 160)$	p	$\eta_p 2$
Mandated to attend training	0.02	0.81	.521	.020

Table 15 Descriptive Statistics for MHASP Subscales by Mandated to Attend Training

MHASP Subscales	Mandate to attend training			Not mandated to attend training		
	n	*M*	*SD*	*n*	*M*	*SD*
Officer's attitudes towards a person with mental illness	149	57.59	8.54	16	53.96	7.34

Officer's attitude towards community responsibility in caring for the mentally ill	149	34.79	5.42	16	32.92	5.81
Officer's attitude towards their preparedness in dealing with a person who is mentally ill	149	5.85	2.29	16	6.30	3.35
Officer's attitude towards the mentally ill living in their community	149	40.61	9.56	16	38.21	8.32

ANOVA for Overall MHASP Scale by Mandate to Attend Training

There were not significant differences for overall MHASP, $F(1, 163) = 2.26$, $p = .134$, indicating that there were not significant differences in overall MHASP scores based on whether participants were mandated to attend training. Table 16 presents the individual ANOVA for overall MHASP scores by probationary officer experience. Table 17 presents the descriptive statistics for the overall MHASP scores by probationary officer experience.

Table 16 ANOVA for Overall MHASP by Mandate to Attend Training

Variable	$F(1, 163)$	p	$\eta_p 2$
Overall MHASP	2.26	.134	.01

Table 17 Descriptive Statistics for Overall MHASP by Mandate to Attend Training

MHASP Subscales	Mandated to attend			Not mandated to attend		
	n	*M*	*SD*	*n*	*M*	*SD*
Overall MHASP	149	148.15	21.39	16	139.79	18.11

MANOVA for MHASP Subscales by Years of Service

The results of the overall MANOVA were significant, (Pillai's Trace = 0.16, $F[8, 320] = 3.47$, $p < .001$), indicating that there were significant differences in the MHASP subscales by years of service. Due to significance of the overall ANOVA, individual ANOVAs were conducted to examine

each MHASP subscale individually. Table 18 presents the findings of the overall MANOVA for MHASP subscales by years of service.

Table 18 MANOVA for MHASP Subscales by Years of Service

Variable	Pillai	$F(8, 320)$	p	$\eta_p 2$
Years of service	0.16	3.47	< .001	.08

There were significant differences for subscale one, $F(2, 162) = 3.67$, $p = .028$, indicating that there were significant differences in mean scores of "officer's attitudes towards a person with mental illness" based on years of service. Those who had 21 or more years of experience ($M = 65.75$) had higher mean scores in comparison to those with 0-9 years of experience ($M = 57.82$) or 10-20 years of experience ($M = 55.33$).

There were significant differences for subscale two, $F(2, 162) = 3.66$, $p = .028$, indicating that there were significant differences in mean scores of "officer's attitudes towards community responsibility in caring for the mentally ill" based on years of service. Those who had 21 or more years of experience ($M = 37.50$) had higher mean scores in comparison to those with 0-9 years of experience ($M = 35.25$) or 10-20 years of experience ($M = 33.00$).

There were not significant differences for subscale three, $F(2, 162) = 2.68$, $p = .072$, indicating that there were not significant differences in mean scores of "officer's attitude towards their preparedness in dealing with a person who is mentally ill" based on years of service.

There were significant differences for subscale four, $F(2, 162) = 8.45$, $p < .001$, indicating that there were significant differences in mean scores of "officer's attitude towards the mentally ill living in their community" based on years of service. Those who had 0-9 years of experience ($M = 42.37$)

had higher mean scores in comparison to those with 10-20 years of experience (M = 36.07) or 21 or more years of experience (M = 40.50).

Table 19 presents the individual ANOVAs for the MHASP subscales by years of service. Table 20 presents the descriptive statistics for the MHASP subscales by years of service.

Table 19 ANOVAs for MHASP Subscales by Years of Service

MHASP Subscales	$F(2, 162)$	p	$\eta_p 2$
Officer's attitudes towards a person with mental illness	3.67	.028	.04
Officer's attitude towards community responsibility in caring for the mentally ill	3.66	.028	.04
Officer's attitude towards their preparedness in dealing with a person who is mentally ill	2.68	.072	.03
Officer's attitude towards the mentally ill living in their community	8.45	<.001	.09

Table 20 Descriptive Statistics for MHASP Subscales by Years of Service

MHASP Subscales	0-9 years			10-20 years			21 or more years		
	n	*M*	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*
Officer's attitudes towards a person with mental illness	110	57.82	8.32	51	55.33	8.55	4	65.75	5.50
Officer's attitude towards community responsibility in caring for the mentally ill	110	35.25	5.20	51	33.00	5.89	4	37.50	0.58
Officer's attitude towards their preparedness in dealing with a person who is mentally ill	110	5.62	2.26	51	6.53	2.62	4	5.25	2.63
Officer's attitude towards the mentally ill living in their community	110	42.37	9.11	51	36.07	8.79	4	40.50	10.97

ANOVA for Overall MHASP Scale by Years of Service

Finally, there were significant differences for overall MHASP, $F(1, 162) = 6.65$, $p = .002$, indicating that there were significant differences in overall MHASP scores based on years of service. Those who had 21 or more years of experience ($M = 159.50$) had higher mean scores in comparison to those with 0-9 years of experience ($M = 150.82$) or 10-20 years of experience ($M = 138.87$). Table 21 presents the individual ANOVA for overall MHASP scores by years of service. Table 22 presents the descriptive statistics for the overall MHASP scores by years of service.

Table 21 Descriptive Statistics for Overall MHASP by Years of Service

Variable	$F(2, 162)$	p	$\eta_p 2$
Overall MHASP	6.65	.002	.08

Table 22 Descriptive Statistics for Overall MHASP by Years of Service

Variable	0-9 years			10-20 years			21 or more years		
	n	*M*	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*
Overall MHASP	110	150.82	20.30	51	138.87	21.19	4	159.50	15.02

Chapter 5: Summary, Interpretations, Limitations, and Conclusion

Introduction

The purpose of this study was to expand on the body of knowledge regarding the currently existing Crisis Intervention Team (CIT) type training and its effects on police officer's changes in their attitudes towards persons who are mentally ill. This study also aimed at documenting the evolution of the Los Angeles Police Department's (LAPD) mental illness training for police officers. Lastly, this study adds to the limited body of knowledge regarding the LAPD's version of CIT training titled Mental Health Intervention Training (MHIT). A qualitative research methodology was used to evaluate LAPD officers who attended the training. The officers were surveyed before and after attending a 40-hour MHIT course. Chapter 5 presents the findings as applicable to the research questions and implications for practice and future research.

Summary of Research

This study examined the Los Angeles Police Department's (LAPD) 40-hour Mental Health Intervention Training course (MHIT) and its effects on police officer attitudes towards mentally ill persons before and after attending the course. This study was designed to build upon a previous 2017 unpublished study by Los Angeles County Department of Mental Health (LACDMH) clinicians who presented their research and findings to a 2017 California Forensics Conference. As stated in Chapter One, one of the nationally recognized Crisis Intervention Team (CIT) training model requirements is to provide in-service education to officers who are willing to volunteer for specialized employee development training. If an officer volunteers for the training, they will be more empathetic and open-minded when assisting those experiencing a mental illness event (Compton et al., 2008). The MHIT course is modeled after the national CIT

curriculum to align with national best training practices. Currently, no published material reflects the attitudinal changes of probationary police officers versus permanent status police officers and officers who are volunteered and mandated to attend the LAPD's MHIT course.

Summary of Methodology

The instrument used to survey the police officers was the Mental Health Attitude Survey for Police (MHASP). Clayfield developed the MHASP, et al. (2011) to adequately inform persons charged with developing CIT-type training regarding whether such courses impact police officer attitudes towards persons with mental illness that they encounter. The survey was administered immediately before and at the end of the LAPD's MHIT course. The MHASP has four distinct subscales, a) Positive attitude toward emotionally disturbed persons (EDPs) (13 items), b) their negative attitude toward community responsibility for persons who have a mental illness (7 items), c) officers not feeling adequately prepared when dealing with a person who has a mental illness (3 items), and d) an officers attitude towards the mentally ill living in the community (10 items) (Clayfield, 2011). These subscales were used as research variables, formation of research questions. To address the research questions, a series of paired t-tests were conducted. In addition, MANOVAs and ANOVAs were used for additional analyses.

Summary of the Literature Review

In Chapter 2, currently available literature was reviewed relevant to the independent factors that impact the officers' attitudes towards the mentally ill. The literature review focused on six sections, (a) an overview of the national mental illness response and training model, (b) a historical overview of the Los Angeles Police Department's (LAPD) mental illness awareness training, (c) a synopsis of public sector employee development training (d) relevant learning

theories (e) an overview of attitudes towards the mentally ill (e) and a review of self-selection versus mandated training.

Research Summary

RQ1: Is there a significant difference in an officer's attitudes towards a person with mental illness before and after attending the Los Angeles Police Department's Mental Health Intervention Training Course?

H1: There is a significant difference in an officer's attitudes towards a person with mental illness before and after attending the Los Angeles Police Department's Mental Health Intervention Training Course.

H0: There is no significant difference in an officer's attitudes towards a person with mental illness before and after attending the Los Angeles Police Department's Mental Health Intervention Training Course.

The paired sample t-test for the first research question was statistically significant, indicating a significant difference in officers' attitudes after attending the MHIT course. This data coincides with the hypothesis; therefore, the null hypothesis can be rejected.

RQ2: Is there a significant difference in an officer's attitude towards community responsibility in caring for the mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course?

H1: There is a significant difference in an officer's attitude towards community responsibility in caring for the mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

H0: There is no significant difference in an officer's attitude towards community responsibility in caring for the mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

As stated in Chapter 4, a paired t-test was conducted to assess for differences in officer's attitude towards community responsibility in caring for the mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training (MHIT) course. The result of the paired sample t-test was statistically significant. This data coincides with the hypothesis; therefore, the null hypothesis can be rejected.

RQ3: Is there a significant difference in an officer's attitude towards their preparedness to deal with a mentally ill person before and after attending the Los Angeles Police Department's Mental Health Intervention Training course?

H1: There is a significant difference in an officer's attitude towards their preparedness in dealing with a person who is mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

H0: There is no significant difference in an officer's attitude towards their preparedness in dealing with a person who is mentally ill before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

As stated in Chapter 4, a paired t-test was conducted to assess for differences in officers' attitudes towards their preparedness in dealing with a mentally ill person before and after attending the MHIT course. The paired sample t-test was statistically significant; however, the scores decreased after attending the MHIT course. Since there was a significant difference in scores, the hypothesis can be accepted.

RQ4: Is there a significant difference in officers' attitudes towards the mentally ill living in their community before and after attending the Los Angeles Police Department's Mental Health Intervention Training course?

H1: There is a significant difference in an officer's attitude towards the mentally ill living in their community before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

H0: There is no significant difference in an officer's attitude towards the mentally ill living in their community before and after attending the Los Angeles Police Department's Mental Health Intervention Training course

A paired t-test was conducted to assess for differences in officer's attitudes towards the mentally ill living in their community before and after attending the Los Angeles Police Department's Mental Health Intervention Training course. The result of the paired sample t-test was statistically significant. Since there was a significant difference in scores, the hypothesis can be accepted.

Probationary Police Officers Versus Non-Probationary Police Officers

MANOVA and ANOVA were used to assess differences in the MHASP subscales in probationary police officers and non-probationary police officers. The overall MANOVA indicated significant differences in the subscales of these two groups before and after attending the MHIT course.

Volunteered Versus Mandated to Attend Training

A MANOVA was used to assess the differences in the MHASP subscales in the officers who were mandated to attend the MHIT course versus officers who were not mandated

to attend the MHIT course. There were no significant differences in scores between the two groups.

Overall Mental Health Attitude For Police (MHASP Score)

A paired t-test was conducted to assess differences in overall MHASP scores before and after attending the Los Angeles Police Department's Mental Health Intervention Training course. The result of the paired sample t-test was statistically significant. This indicated statistically significant differences in the overall MHASP scores before and after the training course.

Years of Service

A MANOVA was also used to assess the difference in years of service. The officers were divided into three different groups: 0-9 years of service (early career), 10-20 years of service mid-career), 21 or more (late-career) years of service. The MANOVA indicated that there were significant differences in the MHASP subscales by years of service. For subscale1, an officer's positive attitude toward emotionally disturbed persons (EDP), officers who had more than 21 years of service had higher mean scores before and after attending the MHIT course. Officers with 0-9 years of experience ranked 2nd, where officers with 10-20 years ranked third. In subscale 2, an officer's negative attitude toward community responsibility for persons with a mental illness, officers with more than twenty-one years of service had higher mean scores before and after attending the MHIT course. Officers with 0-9 years of services ranked second and officers with 10-20 years of services ranked third. In subscale 3, Officers not feeling adequately prepared to deal with EDP's, there was no significant difference between the officers according to years of service. In subscale 4, officer's positive attitudes towards EDP's living in the community showed significant differences between the groups. Officers with 0-9 years of

service had higher mean scores. Officers with 10-20 years of service ranked second, and officers with 21 or more years of service ranked third.

Interpretation and Comparison

According to Clayfield (2019), to interpret the Mental Health Attitude Survey for Police (MHASP) scores, higher overall scores indicated more positive attitudes in subscales 1 and 4. Higher scores indicated less negative attitude in subscale two and more feelings of inadequacy in subscale 3.

Subscale 1: An Officer's Positive Attitude Toward Emotionally Disturbed Persons

It is safe to interpret that there were significant differences between the officer's pre-and post-course MHASP surveys. There was an increase of approximately 2.59 units between the pre and post-test scores. The data suggests an increase in an officer's positive attitude towards mentally ill persons after attending the Mental Health Intervention Training (MHIT) course. In the unpublished 2017 MHIT research project (Solomon & Mirkoff, 2017), the data indicated that officers did not significantly differ in positive attitudes towards EDPs before attending the course and after attending the course. Solomon & Mirkoff (2017) indicated a .04 unit decrease from 4.07 to 4.04 units, respectively.

Subscale 2: An Officer's Negative Attitude Toward Community Responsibility For Persons Who Have a Mental illness.

It is safe to interpret that officer's negative attitudes towards community responsibility in caring for the mentally ill decreased after attending the MHIT course. There was an approximately 5.11 unit increase in scores following the training. In Solomon & Mirkoff's (2017) study, the data gathered and analyzed suggested that officers had a significant decrease ($p<.001$) in their negative attitude, 2.49 units after attending the training and 1.69 units before attending

the training. A 0.52 unit increase towards community responsibility for persons who were mentally ill after attending the MHIT course.

Subscale 3: Officers not feeling adequately prepared to deal with EDP's

Due to the data results, It is safe to interpret that officers had fewer feelings of inadequacy in their preparedness in dealing with mentally ill persons after attending the MHIT course. Scores decreased by approximately 2.44 units following the course. In Solomon & Mirkoff (2017), officers had a significant decrease in their scores by .08 units ($p < .001$). Before attending the MHIT course, officers had a score of 2.49 units regarding 1.69 units after attending the MHIT course.

Subscale 4: Officers' Positive Attitudes towards EDPs living in the community.

Due to the data results, it is safe to interpret that officer had more positive attitudes towards mentally ill persons living in their community after attending the MHIT course. Scores increased by 3.76 units after the course. Solomon & Mirkoff (2017) also concluded that officers had a significant increase in their positive attitudes towards mentally ill persons living in their community. Solomon & Mirkoff's (2017) data showed that officers had a significant increase ($p < .001$) in their scores. Officers had a score of 3.73 units before attending the course and 3.93 units after completing the course, a difference of .02 units.

Probationary Versus Non-Probationary Officers

It is safe to interpret that probationary police officers had overall positive attitudes after attending the MHIT course. A probationary police officer is a temporary police officer who is still in their training phase (Dempsey, 2020). As mentioned in chapter 1, in 2017, the Los Angeles Police Department (LAPD), as an extension to the academy training, probationary police officers were mandated to attend the MHIT course during their last month of probation.

An LAPD probationary police officer must complete a minimum of one year (12 months) of field probation. (LAPD, n.d). It is important to reiterate a study discussed in chapter 1, Compton (2017), who conducted two studies on CIT officers. In both studies conducted by Compton (2017), the average years of service for officers attending a CIT training was ten years. There is no research available that studies officers' attitudes with less than 12- months of probationary field experience.

Volunteered Versus Mandated to Attend Training

Once again reiterating Compton's (2017) study, there is a debate in the Crisis Intervention Team (CIT) community regarding the self-selection of officers to attend a CIT type training. The nature of the self-selection bias remains unclear. Unfortunately, an inadequate sample of officers volunteered to attend the MHIT course to initiate a detailed analysis of the two groups.

Limitations

There were several limitations in this study. The sample population was limited due to the cancelation of courses due to election-related protests. The sample population may also not have been an accurate representation of the demographics of officers employed by the Los Angeles Police Department. The research is limited in scope to Los Angeles Police Department and may not be able to be replicated with other police agencies. This research was also limited in scope without the use of a control group to enhance the data collection further. The control group would have allowed for a deeper study of the variables that were studied. There were also limits on other aspects of this study concerning knowledge. Including a post-course, the knowledge-based study would have also provided more depth to the attitudinal survey. The attitudinal survey was self-reported, which can leave room for error in reporting. Future studies may benefit from observing rather than self-reporting. There may also be a bias towards the nature of the

mental health radio calls that are handled. Lopez (2021) stated that officers in the field usually are called to handle violent mental illness service calls. Stuart (2013) stated that mental disorders are neither necessary nor sufficient causes of violence. The significant determinants of violence continue to be socio-demographic and socioeconomic factors such as being young, male, and of lower socioeconomic status. Stuart (2013) also said that public members tend to exaggerate both the strength of the relationship between major mental disorders and violence. It is far more likely that people with a severe mental illness will be the victim of violence. Suppose officers cannot identify mental health issues within themselves or in their family of origin. In that case, the only basis they have with the verifiably mentally ill is with a violent schizophrenic. According to Lopez (2021), it only makes up about 1% of the mentally ill but makes up a majority of a police officer's calls for service in some geographical regions.

Discussion

Training

The Crisis International, INC (n.d.) released a statement regarding Crisis Intervention Team (CIT) training and pre-service academy. According to the statement, officers volunteer for the training and are selected based on their maturity and experience to complete the training and become certified. Compton (2008) found that the more experienced an officer was, they tended to retain more CIT-related knowledge. The knowledge retention was better than peers with less time on the job. To reiterate information stated in chapter 2 regarding adult learning, and also stated in the CIT statement (n.d), adult learning theory and the andragogical approach to adult learning maintains that adult learners accumulate a reservoir of experience that is a resource that trainers can capitalize on. Lopez (2021) stated that when a Mental Health Intervention Training (MHIT) course comprises senior officers, even though rough around the

edges, more conversations involve critical thinking. When we have a younger audience, the conversations sometimes fall flat despite using our best adult learning activities to engage the audience. The younger officers do not have much work-related experience to work with.

Self-Selection

Crisis International, INC (n.d.) also released a statement regarding self-selection. The CIT International recognizes that agencies are deviating from the CIT training model and understands the need to deviate based on current events. CIT supports all officers receiving training that establishes a basic level of competency; mandating CIT training blurs the officer as a specialist component. It is believed that when officers are mandated to attend training, the focus is solely on completing the training and not the overall message.

Policy Implications

It does not appear that the Los Angeles Police Department (LAPD) will slow down their Mental Health Intervention Training Course thanks in part to California Senate Bill 29, Peace Officer Training: Mental Health (2015/2017), requiring all officers who work in a field training capacity must attend a 40-hour type CIT program, and LAPD policy mandated all probationary officers to attend the MHIT beginning late 2016. As well as, in June 2020, the Los Angeles City Board of Police Commission (BOC, 2020) released a statement that in reinstated the Mental Health Intervention Training course despite canceling all department-wide Inservice training due to COVID- 19, to reach a goal of training 900 additional officers by the end of 2020. Policy and current events appear to be blurring the lines of the true CIT philosophy.

Recommendations

Training

It is recommended that the Los Angeles Police Department create secondary training for its officers. The current 40-hour Mental Health Intervention Training (MHIT) course has become a baseline training for police officers. Preliminary research indicates no training in existence that helps investigative or specialist officers manage mental health and criminal cases. Reed (2019), a patrol supervisor in a local jurisdiction, stated that his officers in his small agency are patrol officers and investigative officers for many criminal and mental health cases. Reed also stated that his officers have basic mental health training and basic skills in investigating criminal issues and lack the knowledge and experience navigating the mental health court system. An enhanced mental health investigation course for police officers that builds on the Crisis Intervention Team (CIT) training philosophy that already exists in the current MHIT course would pull from the LAPD's wealth of knowledge in marrying criminal and mental health cases to provide better customer service to the public at large. The LAPD is unique in that a patrol officer handles an initial investigation and hands the information off to a divisional detective. An LAPD detective or investigative officer, when securing such assignment, can stay in this assignment for the majority of their career, as can a patrol officer remain in a patrol assignment. Many other smaller agencies rotate their officers throughout patrol and investigative assignments. This type of enhanced training would not only benefit the LAPD's divisional detectives. However, it will also benefit California Peace Officers who take on more roles besides being a patrol officer.

Further Studies

It is recommended that a closer look be taken at the MHIT curriculum and training staff. Many of the MHIT training staff are dual trained as therapists, social workers, school

counselors, and psychiatric nurses from previous or current part-time careers. Those who do not have cross-training share their lived experiences with personal and family struggles with mental illness or developmental disabilities. This level of expertise adds to the MHIT experience. A qualitative study could build upon this quantitative study to further capture the change in officers' attitudes and perhaps answer the reason as to why the attitudes have changed. It is also recommended that a longitudinal study be conducted with officers who have completed the MHIT training and implement the tactics learned in training to field-based scenarios.

Conclusion

This dissertation chronicles the evolution of the Los Angeles Police Department's in-service training for police officers on mental illness response. The Los Angeles Police Department's (LAPD) Mental Health Intervention Training (MHIT), despite being used as a tool for the masses, has done an excellent job mirroring the philosophy of The Crisis Intervention Team (CIT) Training model. Like CIT, MHIT uses the theory of Andragogy, Bloom's Taxonomy, community involvement, site visits, guest speakers from advocacy groups, support groups, and persons and family members. They have experienced severe mental health crises to help aid the positive shift of police officer attitudes towards the mentally ill. With key social justice events demanding a change in police officer attitudes towards the public in general, there is a rush to push officers through training to meet the public's demands.

Given that CIT is widely considered the "gold standard" in police training on mental illness, The MHIT should fall in line with being the gold standard training for the Los Angeles Police Department. Given the culture shift to mandated training rather than volunteering to attend training based on state assembly bills and department policy, there is a gap in enhanced training for officers required to manage persons who are impacted by severe mental illness.

Further research also suggests the need to study the MHIT curriculum and the quality of staff that facilitates the MHIT and CIT type courses.

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Appendix A

LAPD Training Bulletin 1948

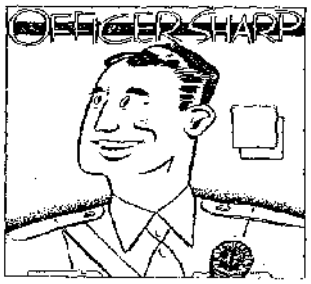
Daily Training Bulletin

LOS ANGELES POLICE DEPARTMENT — VOLUME I, BULLETIN 16 — FIELD TRAINING UNIT — C. B. HORRALL, CHIEF OF POLICE — Wednesday, Nov. 10, 194(

HOW TO HANDLE MENTALLY ILL PERSONS--LEGAL

This lesson treats of the legal provisions of calls involving mentally ill persons. Subsequent material will cover *field procedures* in responding to mental case calls.

Today science recognizes mental illness as a condition which can result from the rigors of everyday life just as easily as it can from organic disturbances. Mental illness is not necessarily inherited, any any one of us under certain conditions might become mentally ill just as readily as we might become physically ill.



Officer Sharp Says:

An officer's attitude and demeanor in cases involving mentally ill persons leave a lasting impression. An understanding considerate, and efficient manner reflects credit upon the policeman and his profession.

CIVIL CASES: The Welfare and Institutions Code, Sec. 5040a describes mentally ill persons as those who are of such a mental condition that they are *in need of supervision, treatment, care, or restraint.* They do not necessarily come under police regulation, but as a matter of public relations the Hospital Division can advise concerned relatives of the civil action that may be taken.

POLICE CASES: Welfare and Institutions Code, Sec. 5040b applies to mentally ill persons who, without supervision, treatment, care, or restraint, *may be or might become DANGEROUS to themselves or to the person or property of others.*

CRIMINAL ACTIONS BY MENTALLY ILL PERSONS: Whenever a mentally ill person commits a felony he must be charged with the appropriate Penal Code violation and must be booked at the division of arrest. In this instance the suspect *should not* be transported to the Hospital Division as this would strengthen any plea of not guilty by reason of insanity he might make later. It is not within the province of the policeman to adjudge a felon's sanity---that is within the jurisdiction of the court only.

FILING A MENTAL PETITION: Welfare and Institutions Code, Sec. 5047 provides that anyone may file a petition in the Superior Court (locally through the Psychopathic Division of the County Clerk's Office, 205 South Broadway) alleging that there is a mentally ill person in the county who is in need of care. *If acting with good intent* when filing a petition, the following persons *cannot be rendered liable, criminally or civilly:*

1. Any peace officer.
2. Probation officer.
3. Physician attending a patient.
4. Physician attached to a public hospital or institution where the person is a patient.
5. Legal guardian.

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Appendix B

Demographic Questionnaire

DEMOGRAPHIC QUESTIONNAIRE

INSTRUCTIONS: The following questions are designed to obtain information about your background. Please answer the following questions as it best applies to you. Read each question carefully and **CIRCLE** the answer that most accurately reflects you. Remember, your answers are completely confidential. Thank you for your participation!

Age: 18- 25 26-35 36-45 46-64 over 64

What is your gender? Male or Female

What is your ethnic background (circle one):
Caucasian
African American
Hispanic
Asian
American Indian
Pacific Islander
Other

Marital Status (circle one): Single Married Widowed Separated Divorced

Division of Assignment: _____

Years of Service: 0-9 years (early career) **or** 10-20 years (mid career) **or** 21 or more years (late career)

Highest level of education (circle one): High School/GED **or** Some College/AA
Bachelor's Degree **or** Master's Degree **or** Doctorate Degree

Have you had previous mental health training? Yes No

Is anyone in your family diagnosed with mental illness? Yes No

What is your religious/spiritual affiliation: _____

Are you a probationary police officer? Yes No

Were you mandated to attend this training course? Yes No

Appendix C

Mental Health Attitude Survey For Police

Your Matching Code (Please write your response on the line following each question. Put "**Z**" if the item does not apply to you)

What is the **first letter** of your **middle name**?..... ____ What is the **first letter** of the **month in which you were born**?..... ____

What is the **first letter** of your **mother's first name**?..... ____ What is the **LAST letter** of your **first name**?..... ____

What are the **last two digits of your home telephone number**? ____

MHASP

The statements below represent attitudes or opinions you may have about mental illness and about dealing with emotionally disturbed persons or EDPs (a term widely used in policing to describe calls involving persons with mental illness). For each statement, please circle the one response that best reflects your opinion. There are no right or wrong answers.

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
1. Emotionally disturbed persons take up more than their fair share of police time.	1	2	3	4	5	6
2. As soon as a person shows signs of mental disturbance, he/she should be hospitalized.	1	2	3	4	5	6
3. Emotionally disturbed persons need the same kind of control and discipline as a young child.	1	2	3	4	5	6
4. Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community.	1	2	3	4	5	6
5. It is frightening to think of emotionally disturbed persons living in residential neighborhoods.	1	2	3	4	5	6
6. More tax money should be spent on the care and treatment of emotionally disturbed persons.	1	2	3	4	5	6
7. We have a responsibility to provide the best possible care for emotionally disturbed persons.	1	2	3	4	5	6
8. Nowadays, police officers need to have specialized training in dealing with emotionally disturbed persons.	1	2	3	4	5	6
9. It is best to avoid anyone who is emotionally disturbed.	1	2	3	4	5	6
10. One of the main causes of mental illness is a lack of self-discipline and will power.	1	2	3	4	5	6
11. It would be foolish to marry a person who has suffered from a mental illness, even though s/he seems fully recovered.	1	2	3	4	5	6
12. I would not want to live next door to someone who has been emotionally disturbed.	1	2	3	4	5	6
13. Residents have nothing to fear from people coming into their neighborhood to obtain mental health services.	1	2	3	4	5	6
14. Mental health facilities should be kept out of residential neighborhoods.	1	2	3	4	5	6
15. Emotionally disturbed persons should be isolated from the rest of the community.	1	2	3	4	5	6
16. Locating mental health facilities in a residential area downgrades the neighborhood.	1	2	3	4	5	6
17. Dealing with emotionally disturbed persons should be an integral part of community policing.	1	2	3	4	5	6
18. I feel that I am adequately trained to handle situations/calls involving emotionally disturbed persons.	1	2	3	4	5	6
19. Emotionally disturbed persons should not be given any responsibility.	1	2	3	4	5	6
20. There is something about emotionally disturbed persons that makes it easy to tell them from normal people.	1	2	3	4	5	6
21. Responding to calls involving emotionally disturbed persons is <u>not</u> really part of a police officers' role.	1	2	3	4	5	6

(Please answer items on other side)

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
22. We need to adopt a far more tolerant attitude toward emotionally disturbed persons in our society.	1	2	3	4	5	6
23. Emotionally disturbed persons are a disadvantaged group who deserve special consideration from the police.	1	2	3	4	5	6
24. Locating mental health services in residential neighborhoods does not endanger local residents.	1	2	3	4	5	6
25. I feel more comfortable responding to EDP calls involving females in crisis.	1	2	3	4	5	6
26. Local residents have good reason to resist the location of mental health services in their neighborhood.	1	2	3	4	5	6
27. Increased spending on mental health services is a waste of tax dollars.	1	2	3	4	5	6
28. I know when to implement an application for emergency commitment.	1	2	3	4	5	6
29. Having emotionally disturbed persons living within residential neighborhoods might be good therapy but the risks to residents are too great.	1	2	3	4	5	6
30. There is pressure from my department to solve the problems associated with emotionally disturbed persons on an informal basis.	1	2	3	4	5	6
31. I feel confident in my ability to handle situations involving emotionally disturbed persons.	1	2	3	4	5	6
32. If mental health services were adequate, the police would not have to deal with emotionally disturbed persons.	1	2	3	4	5	6
33. There is pressure from emergency room personnel to solve the problems associated with emotionally disturbed persons on an informal basis.	1	2	3	4	5	6

Appendix D

MHASP Author's Consent to Use Instrument

University of Massachusetts Medical School
UMASS

Department of Psychiatry
University of Massachusetts Medical School
55 Lake Avenue North
Worcester, MA 01655
508.856-5498 (office) 508.856.8700 (fax)
http://www.umassmed.edu/cmhsr/ (web page)

Center for Mental Health Services Research

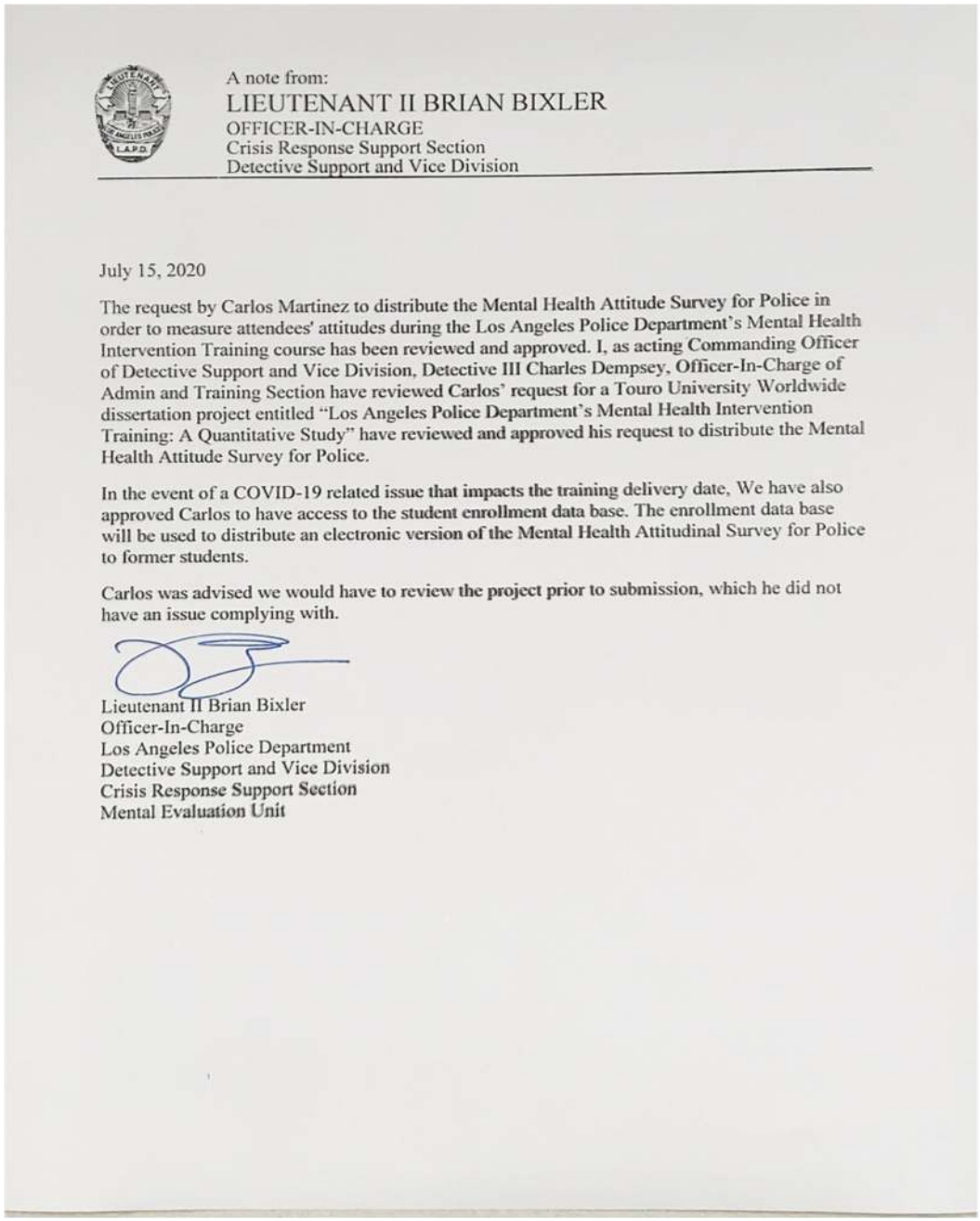
Terms of use for the Mental Health Attitude Survey for Police (MHASP)

I, Carlos Martinez (print name), agree not to modify the Mental Health Attitude Survey for Police (MHASP) survey instrument developed by Jonathan C. Clayfield, Kenneth E. Fletcher, and Albert J. Grudzinskas, Jr., without written permission of these authors. I also agree not to disseminate the MHASP survey instrument, including not posting it to any website, as the MHASP is a copyrighted instrument. I also agree to provide a dataset containing the pre- and post-administration survey responses, in order for the authors to continue to analyze and refine this survey instrument.

Signature _____ Date 2/12/20

Appendix E

Los Angeles Police Department Consent to Access Sample Population



A note from:
LIEUTENANT II BRIAN BIXLER
OFFICER-IN-CHARGE
Crisis Response Support Section
Detective Support and Vice Division

July 15, 2020

The request by Carlos Martinez to distribute the Mental Health Attitude Survey for Police in order to measure attendees' attitudes during the Los Angeles Police Department's Mental Health Intervention Training course has been reviewed and approved. I, as acting Commanding Officer of Detective Support and Vice Division, Detective III Charles Dempsey, Officer-In-Charge of Admin and Training Section have reviewed Carlos' request for a Touro University Worldwide dissertation project entitled "Los Angeles Police Department's Mental Health Intervention Training: A Quantitative Study" have reviewed and approved his request to distribute the Mental Health Attitude Survey for Police.

In the event of a COVID-19 related issue that impacts the training delivery date, We have also approved Carlos to have access to the student enrollment data base. The enrollment data base will be used to distribute an electronic version of the Mental Health Attitudinal Survey for Police to former students.

Carlos was advised we would have to review the project prior to submission, which he did not have an issue complying with.

Lieutenant II Brian Bixler
Officer-In-Charge
Los Angeles Police Department
Detective Support and Vice Division
Crisis Response Support Section
Mental Evaluation Unit

Appendix F

Informed Consent Form

Participation in a Research Study

Institutional Review Board

Touro University Worldwide

Title of Dissertation: Los Angeles Police Department's Mental Evaluation Unit: A Quantitative Study

You are invited to participate in a research study by Police Officer III Carlos Martinez #37301. The purpose of this research is to evaluate the Mental Health Intervention Training (MHIT) course and its effects on your attitudes after attending. Your participation will involve answering a Mental Health Attitude Survey for Police (MHASP) prior to the start of training which will take 15-minutes. You will also be answering a Mental Health Attitude Survey for Police (MHASP) after you attend training, prior to dismissal, which will also take approximately 15-minutes.

You may experience some anxiety answering the questions. Rest assured the information collected will be anonymous, confidential and any data collected will be used only for this research project.

All data will be kept in a locked cabinet that only I will have access to. All data collection will be anonymous and confidential.

Your participation in this research study is voluntary. Should you choose not to participate, your course credit will not be compromised. If you choose to participate in the study and do not feel

comfortable with the questions that are being asked, you are more than welcome to stop participation at any time.

If you have any concerns, please contact Officer Carlos Martinez #37301, email: 37301@lapd.online.

If you acknowledge and understand the informed consent, please write YES on the line below.

_____

All survey questions will be collected regardless of completion at the end of the 15- minute time period.

_____

Signature

Thanks, and be safe out there!