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Police Officers' Perceptions of their Mental Health Preparedness Training in a Southern (US) State

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Abstract: One of the most important contemporary topics in policing is the preparedness that police officers have for interacting with persons that have a mental health concern. This study examined police officers' perceptions on the effectiveness of their mental health awareness training. An online survey was distributed to Texas (USA) police officers using a convenience sample and 232 officers completed the survey. A multi-nominal logistic regression analysis was used to examine three levels of mental health awareness training they received (state mandated, additional in-service training, and mental health peace officer certification). The results suggest that rural officers do not have the same level of mental health awareness training as officers in urban areas and officers perceive their training beyond the state mandated minimum requirement to be adequate for the demands of the job.

Keywords: critical incident training, mental health, police training, rural policing

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The responsibilities and expectations of a police officer or first responder in a law enforcement capacity have evolved over time. The original expectation of the police was to focus on investigation and suppression of crime, while addressing problems associated with persons suspected of having a mental health concern was not a police responsibility. In fact, the criminal justice system was never designed to solve the complex and devastating problems of people with serious mental illnesses (PWMI) (Lurigio *et al.*, 2008). Only recently, the responsibility of providing for the safety and security of persons experiencing a mental health concern became a police responsibility (Watson *et al.*, 2008). This change of responsibility for law enforcement began with the deinstitutionalization movement in which individuals suffering from a mental health concern began populating America's communities. Lurigio *et al.* (2008) reported many PWMI were forced to engage in illegal behavior in order to survive on the streets due to being unemployed and homeless (p. 298). Additionally, since there were not sufficient mental health service providers available in

communities, the onus for solving situations involving those with a mental health concern fell to the police. Thus, addressing situations involving persons with a mental health concern shifted from a civil issue to a quasi-criminal issue involving the police.

Most people with mental health concerns do not commit criminal or violent acts, but contact with the police is common (Livingston *et al.*, 2014). This is problematic because police officers are not trained clinicians or therapists to effectively address non-conforming behavior with this population. The problem is further exasperated because the police do not have the proper training to interact with a person suffering from a mental health concern, which can result in the situation escalating. Unfortunately, efforts to properly equip police officers with the necessary skills to deescalate situations involving persons with a mental health concern have not been responsive. Research has suggested the best facilitator for police change has been litigation (Bittner, 1967; Honberg, 2015; Lurigio *et al.*, 2008; Ritter *et al.*, 2010). For example, Crisis Intervention Training (CIT) was the result of litigation against the Memphis Police Department where deadly force was used against a mentally ill individual (Krishan *et al.*, 2014; Ritter *et al.*, 2010; Watson *et al.*, 2008). This training (CIT) is recognized as the "gold standard" for training officers how to interact and deescalate situations involving persons with mental health concerns. However, there was not widespread acceptance or implementation of CIT, especially in the smaller and rural agencies in the United States. This may be due to those agencies not having significant training dollars (Skubby *et al.*, 2013) and a minimal number of officers to replace those away at training (Buttle *et al.*, 2010).

Regardless of the efforts and mandates for continued police training in regard to interacting with persons possibly having a mental health concern, officers are ambivalent to the quality of the training received. There is also an absence or lack of community coordination/facilities to accommodate someone suffering from a mental health concern, especially in smaller or rural areas (Skubby *et al.*, 2013; Weisheit *et al.*, 1994). Despite the increased attention, not all officers receive the same level of training. Police administrators recognize the value of training for their officers, but may not be aware of how officers perceive the efficacy of the training. Research suggests officers recognize the importance of mental health awareness training but realize the mechanisms in their agency and community to enable them to be effective is absent (Clayfield *et al.*, 2011; Louden *et al.*, 2018).

The purpose of this study is to examine the perceptions and attitudes that Texas (USA) police officers have about their preparedness (through training) to effectively interact and deescalate incidents involving persons with a mental health concern. The authors examined the officers' perceptions to the various types or levels of mental health training they received and how the levels of training prepared them for the potential daily interactions with a person that has a mental health concern. Further, the authors examined whether there was a difference in the perceptions, attitudes, and amount of mental health training between rural and urban police agencies.

Literature Review

Historically, peace officers were called upon to investigate crimes, arrest violators, and maintain the peace in local communities. Rumbaut and Bittner (1979) reported that police officers were originally "watchmen" whose task was to walk their rounds and maintain order in the streets (p. 261). These watchmen handled many situations that did not include law enforcement or evidence gathering tasks (Rumbaut & Bittner, 1979, p. 262). In essence, early police officers provided a social services type of role. Bittner (1967) argued that the early executives of the London Metropolitan Police understood their organization had a dual function of enforcing the law while also maintaining the peace within the community. Therefore, Bittner (1967) stated, "there exists a public demand for police intervention in matters that contain no criminal and often no legal aspects" (p.703). This mandate would include interacting with persons that may potentially have a mental health concern. Even though police officers readily acknowledge that dealing with persons with emotional and psychological problems may be an integral part of their work, they do not believe it is a proper task for them (Bittner, 1967). Furthermore, Bittner argued officers lack proper training and knowledge to effectively resolve situations within this population, and such interactions do not comport to their idea of the community protection role. Today, police officers are likely the most responsible element in society for resolving the mental health crisis for an individual. However, consternation about this exists among police officers.

Over that past 50 years, there have been significant procedural changes in policing for interacting with individuals suffering from a mental health concern. This has resulted in a vacuum of mixed perceptions within the police culture about how to effectively train and respond to mental health related calls for service. The conundrum is that most officers prefer the law enforcement function of policing, but recognize the need to be service oriented (Finn & Sullivan, 1989). However, research specific to rural officers found they have a "generalist officer" mindset and are able to balance those dual roles (Ricciardelli, 2018). The issue is how prepared officers are for resolving incidents involving individuals with a mental health concern, regardless of agency location? Policing is complex and officers do not have the authority to compel individuals to do anything without probable cause or reasonable suspicion that criminal activity is afoot (see *Terry v. Ohio,* 1968) and resolving incidents involving persons in mental health crises is difficult. Thus, without sufficient mental health training and resources available in a community, the police have become the last resort to calm community apprehension of an incident involving persons with mental health concerns.

Deinstitutionalization

In the 1960s society evolved by recognizing the moral issue of institutionalizing people with mental health concerns was not consistent with an individual's right to freedom (Engel & Silver, 2001). Prior to this time, substantial numbers of persons with mental

health concerns were treated in large, publicly funded hospitals (Markowitz, 2011). The belief that individuals with mental health concerns should not be institutionalized resulted in the release of these individuals into local communities. The local mental health service providers were non-existent or did not have adequate resources to assist these people (Finn & Sullivan, 1989; Health, 2003; Wells & Schafer, 2006), which resulted in the police filling the void. Krieg (2001) stated this shift in care from long-term psychiatric hospitalization to independent living environments was termed deinstitutionalization (p. 367). The deinstitutionalization concept consisted of three components: the release of patients from state psychiatric hospitals into the community, the diversion of potential new admissions to alternative community mental health facilities, and the development of specialized services for training for the care of non-institutionalized, mentally ill persons (Ellis, 2014; Lamb & Bachrach, 2001). Unfortunately, the unintended consequence of deinstutionalization resulted in over-reliance on the police to fill the void. To gain a sense of the impact deinstutionalization had on communities, in 1960 there were over half a million beds available in the United States to care for those with mental health concerns (Markowitz, 2011, p. 37), but by 2005 this decreased to less than 50,000 (Torrey *et al.*, 2008, p. 4).

Need for Mental Health Training for the Police

Research indicates that seven to ten percent of law enforcement contacts involve someone who has been diagnosed with a mental health concern (Blevins *et al.*, 2013). Those numbers only represent individuals who have been either seen or treated for a recognized clinical diagnosis. Unfortunately, contemporary policing thrusts police officers into situations involving psychiatric emergencies without the proper training or resources (Clayfield *et al.*, 2011; Honberg, 2015). This has placed the criminal justice system in a position to resolve the complex and devastating problems of people with serious mental health concerns (e.g.; bipolar disorder, depression, post-traumatic stress disorder, schizophrenia, traumatic brain injuries; American Psychiatric Association, 2007; Lurigio *et al.*, 2008). Furthermore, Watson and Angell (2007) stated "the frequency of contact between police officers and persons with mental illness, in crisis or otherwise, has increased significantly, with departments reporting that, on average, 10% of their contacts with the public involve persons with mental illness" (p. 787).

Since the police have a variety of job tasks, the most common solution for resolving problems with this population was to release them to a relative or friend with information about local services (Wells & Schafer, 2003, p. 580). These interactions between the police and individuals with a mental health concern were not always positive. When the contact was a poor interaction, the individual with the mental health concern had increased feelings of hopelessness and a negative outlook about hospitalization (Krameddine *et al.*, 2013). Thus, officers' attitudes and beliefs about mental illness affect their behavior on mental

health related calls for service (Ritter *et al.*, 2010). Therefore, educating officers to recognize the symptoms, causes, and treatment of mental health related issues and to understand the relative risk of violence, while equipping them with de-escalation techniques, may result in interactions that are less likely to negatively impact people with mental health concerns (Ritter *et al.*, 2010; Watson *et al.*, 2008).

The police have a significant amount of discretion in their daily decision making. They have both formal and informal options when deciding the best choice when resolving a mental health related incident. Informal dispositions can range from providing advice to the individual, releasing him or her to the custody of another responsible individual, or transporting the subject out of their jurisdiction. Whereas, a formal disposition may be an involuntary commitment to a hospital for a psychiatric evaluation or an arrest for a criminal law violation. However, a majority of those arrested are indigent and may be deemed mentally incompetent. Ultimately, the police are the gatekeepers and decide whether the individual they encounter should enter the criminal justice system through an arrest or the mental health system through referral (Patch & Arrigo, 1999; Wells & Schafer, 2006).

The Emergence of the CIT

As the police developed into mental health first responders, people with serious mental health concerns became overrepresented in jails and prisons throughout the United States (Ritter *et al.*, 2010). Often the easiest and simplest solution was an arrest, but that does not solve the "institutionalization" concern. Thus, specialized training or a paradigm shift in existing training in how officers recognize and interact with individuals suffering from a mental health concern was essential to protect the rights of these individuals. In essence, the police serve as "street-corner psychologists" and "gatekeepers" who must decide how to best handle the situation based on both preserving public safety and meeting the needs of the individual (Blevins *et al.*, 2013, p. 485). In 1988, the fatal shooting by Memphis police of an individual known to have major psychiatric and substance abuse problems led to an effort in that community to develop a specialized police unit, the Crisis Intervention Team (CIT) (Fisher & Grudzinskas, 2010).

A CIT is referred to as an innovative community-based program model whereby law enforcement officers are trained to successfully interact with a mentally ill person (Arey *et al.*, 2015). According to Arey *et al.* (2015) the basic premise of all CIT programs is to improve safety of officers, improve safety of consumers, and redirect consumers away from the judicial system and into the health care system (p.143). CIT involves three core components: intense training, partnership with community resources, and the adoption of the new role that CIT trained officers have within their department (Canada *et al.*, 2010).

In 1988, Major Sam Cochran of the Memphis Police Department and Randolph Dupont with the University of Memphis met the challenge by designing and promoting the core elements of CIT (Ayer *et al.*, 2015, p.144). The Memphis CIT program was a

solution toward better preparing police officers. This training curriculum was designed to recognize the characteristics of mental illness, de-escalation, and awareness of local community mental health resources (Ritter *et al.*, 2010, p. 135). Since the inception of CIT in 1988, it has been adopted by agencies and been described as the most visible pre-booking mental health related diversion program in the United States (Bonfine *et al.*, 2014). This program was designed to alter the attitudes about persons with mental health concerns and provide officers with skills to more effectively resolve encounters (Ritter *et al.*, 2010). The CIT also represents a partnership between local law enforcement agencies, the public mental health system, and the consumers of mental health services along with their family members.

The goals of the CIT are to reduce arrests of individuals who would more appropriately be diverted to the community mental health system, as well as to increase safety for officers and civilians (Bonfine *et al.*, 2014). However, research suggests officers do not believe the training always increases their ability to recognize mental health related signs and symptoms, but believe it is an officer safety mechanism as it reduces the potential of officer injury (Tully & Smith, 2015, p. 60). Overall, the research reported that the fundamentals of how to interact and recognize the signs of mental illness were adequate, but suggested that recurring training on CIT principles was necessary along with establishing relationships and communication with local mental health resources. Whereas, in regard to rural agencies, research has reported CIT may be ideal for rural agencies because the number of officers is low so training all officers would be beneficial because they cannot rely on a specialized team as seen in urban agencies (Skubby *et al.*, 2013). Furthermore, available treatment options might be limited because of a lack of space or regulations that prohibit certain mental health facilities from accepting some types of patients (e.g. those exhibiting violent behavior or intoxicated individuals), and this is only exacerbated in rural areas where mental health resources are rare (Blevins *et al.*, p. 487).

Texas and Police Officer Mental Health Awareness Training

The state of Texas recently began addressing the issue of police interacting with the mentally ill through enhanced training. There was no significant emphasis on training officers in mental health awareness and subject interaction until 2015. The impetus for the training was the result of the publicized incident involving Sandra Bland in July 2015. Sandra Bland was driving in Waller County, Texas, and committed a minor traffic infraction (failing to signal), which resulted in a traffic stop by a state trooper. Ms. Bland stopped her vehicle but refused to exit it at the request of the state trooper and was subsequently arrested for the traffic violation and resisting arrest. While detained in jail, Ms. Bland died from an apparent suicide. This incident resulted in legislation required enhanced mental health awareness training for police officers and jailers.

This study was designed to answer whether officers with more advanced police officer mental health training in Texas perceive themselves as better able to serve the mental health population compared to those that received the basic, state mandated training. And, if rural officers have similar levels of training as officers working in urban areas. This led to the following hypotheses: (1) rural officers will have less mental health awareness and response training than officers that work in urban agencies and (2) officers are satisfied that the training they received was adequate for them to address the demands of their jobs.

Methods

The data for this study were obtained from an online survey distributed to police officers that were employed in rural, suburban, and urban police agencies in the state of Texas.[1] The survey link was sent to officers that one of the researchers had email access to due to his affiliation with providing state mandated licensing training for certified peace officers. Three email requests were sent to the officers requesting participation in the survey. The email explained the purpose of the study was to ascertain the level of mental health awareness training the respondents completed and their perceptions of their training. The survey was distributed to 617 officers and 250 officers opened the online survey link and 232 officers completed the entire survey, which resulted in a 37.6% response rate. This response rate was consistent with online survey research (Nix *et al.*, 2017; Tourangeau *et al.*, 2013).

The survey collected data that pertained to the officers' perceptions of the type of mental health awareness training each officer received, their perceptions of the efficacy of their mental health awareness training, the size of the agency they work for, along with several demographic variables. The demographic variables included the respondent officer's gender, race, and ethnicity. The sample contained 32.8% of officers that received the minimum state mandated mental health training, 43.7% that received an intermediate amount of training (minimum state mandated training plus additional in-service training), and 23.5% that received the highest level of mental health awareness training that categorizes the officer as certified mental health peace officer. Two-thirds of the respondents were employed in rural agencies with an average of 38 officers in each department. The sample was primarily comprised of male officers (69.9%), that are White (82.4%), non-Hispanic (87.2%), with some college, and an average of 15.6 years in the profession. The descriptive statistics for the sample are located in Table 1.

Dependent Variable

The purpose of this research was to explore whether police officers perceive a difference in their preparedness, through three levels of mental health awareness and response training (minimum state mandated, minimum state mandated training plus in-service, and mental health peace officer certification training), to effectively address the incidents involving persons with mental health concerns. The dependent variable in this study was the type of

training the officer completed. This was operationalized through the three types of training categories officers completed: (1) the minimum state mandated training, (2) the minimum state mandated training plus additional mental health awareness training, and (3) the mental health peace officer certification training.

Table 1: Descriptive Statistics

	Mean	*SD*	*Range*
Dependent Variable			
Minimum State-Mandated Training	0.328	0.462	0-1
Minimum Training Plus In-Service	0.437	0.497	0-1
Mental Health Peace Officer Training (CIT)	0.235	0.425	0-1
Independent Variables			
Rural Agency	0.660	0.475	0-1
Adequacy of Training	4.225	1.166	1-6
In-sufficiency of State-Mandated Training Only	4.025	1.363	1-6
Control Variables			
Male	0.699	0.460	0-1
White	0.824	0.382	0-1
Hispanic	0.128	0.335	0-1
Tenure	15.6	9.637	1-41
Department Size			
Extra-Small (1-24 officers)	0.376	0.483	0-1
Small (25-50 officers)	0.288	0.454	0-1
Medium (51-99 officers)	0.128	0.335	0-1
Large (100-500 officers)	0.068	0.252	0-1
Extra-Large (501+ officers)	0.14	0.348	0-1

Independent Variables

The independent variables used in this study examined the association between the dependent variable and working in a rural agency (compared to an agency located in an urban area) had on the level of training, along with the officers' perceptions that they have received adequate mental health training, and their belief that officers only having the state mandated training is not sufficient for dealing with persons suspected of having a mental health concern. Rural officers were operationalized by self-identifying as working in a rural part of the state (=1) and otherwise (=0).[2] The other two independent variables, receiving adequate mental health training and whether the minimum state required training was sufficient was operationalized using a six-point Likert-type scale ranging from 1 (strongly

disagree), 2 (disagree), 3 (somewhat disagree), 4 (somewhat agree), 5 (agree), and 6 (strongly agree). The authors recognize there are merits to including and excluding a neutral response in surveys (Bradburn *et al.*, 2004), but decided this research would be enhanced if a neutral response was not provided because from the authors' experience, which exceeds 40 years of police experience, that officers possess an opinion of the efficacy of training they are exposed.

Control Variables

The authors controlled for both individual officer and organizational variables. The officer variables were gender, education, ethnicity, race, and number of years working as a police officer. All of these variables, except an officer's level of education and years working as a police officer, where operationalized as dichotomous variables as suggested by previous research (Reynolds & Helfers, 2017; Wolfe & Nix, 2017). Gender was operationalized as male=1, female=0; ethnicity as Hispanic =1, non-Hispanic=0; and race as White=1, non-White=0 which was consistent with other police survey research (Reynolds & Helfers, 2017; Wolfe & Nix 2017). The education variable was operationalized as a categorical variable by earning a high school diploma or general education equivalent (GED), earning some college hours, earning a college degree or higher; this operationalization was consistent with previous research (Nix *et al.*, 2015). The tenure variable was operationalized as a continuous variable based upon the self-reported number of years working as a police officer as of January 1, 2019. This was also consistent with previous police related research (Helfers *et al.*, 2019). Lastly, the organizational variable was the size of the department the officer worked. This variable was operationalized as a categorical variable by the number of officers in an agency as extra small (1-24 officers), small (25-50 officers), medium (51-99 officers), large (100-500 officers), and extra-large (501 or more officers)—these categories were consistent with previous police research (Klockers *et al.*, 2000).

Analysis Plan

The dependent variable, with the three categories for officers' mental health awareness training, was ordinal in nature because there is a rank order for each level of training. Every officer is required to complete the minimum state mandated training. The minimum training plus in-service not only "refreshes" the minimum state mandated training, but extends officer knowledge of mental health awareness and responses. The mental health peace officer training is specialized training to further educate officers for advanced crisis intervention and is the most advanced training available for officers within this domain. Thus, the researchers initially considered an ordinal logistic regression model. However, the parallel regression assumption was violated, but that is a common concern using an ordinal model (Long & Freese, 2006). Therefore, as Long and Freese recommend, the researchers used a multi-nominal logistic regression model. The researchers then tested the assumption

of independence of irrelevant alternatives using the Hausman test and the results failed to reject the null, but the statistics were negative suggesting the assumption had not been violated, which confirmed a multi-nominal logistic regression model would be acceptable for the analysis (Hausman & McFadden, 1984).

Results

The first model examined the association of the independent variables (officers in rural agencies, officers' perceptions pertaining to the adequacy of their training, and their level of agreement about whether the minimal state mandated training was sufficient) with the dependent variable---the level of training the officers received (state mandated minimum level of training, state mandated minimum training plus at least four hours of in-service training, and the mental health peace officer certification training). The baseline comparison group for the model was the state mandated minimum level of training ($\chi^2(6)=22.52$, $p<0.001$). Model 1 indicated that the odds for a rural police officer compared to an officer in a metropolitan area of the state having at least four additional hours of mental health awareness training (in-service) versus an officer that has no more than the minimally mandated mental health awareness training decreased by a factor of 0.51, while holding all other variables constant. While the odds for a rural officer having the most advanced training, the mental health peace officer training decreased by a factor of 1.66. In regard to officers' beliefs about the adequacy of the training, those officers that have the mental health peace officer certification training are more confident that their training is sufficient. For example, officers that have the mental health peace officer training have an increase in the odds by a factor of 2.07 compared to officers that have the minimum state mandated training, holding all other variables constant.

Model 2 included the control variables (gender, race, ethnicity, tenure, education, and department size) in addition to the independent variables. Again, the baseline comparison group for the model was the state mandated minimum level of training ($\chi^2(26)=65.27$, $p<0.001$). This model suggested the odds for rural officers compared to metropolitan officers having at least four hours of additional mental health awareness training decreased by a factor of 0.39, holding all other variables constant. And, a rural officer having the mental health peace officer certification training decreased by a factor of 1.63. These findings confirmed hypothesis 1. The odds that officers believed their training was adequate for the demands of their job increased by a factor of 1.35 for those officers that had at least four additional hours of mental awareness training compared to officers that only had the state mandated minimum training. Furthermore, the odds that officers believed their training was adequate increased by a factor of 2.20 for officers that have the mental health peace officer certification training compared to those that only have the minimum training, holding all other variables constant. Thus, hypothesis 2 was confirmed. In regard to the control variables, the odds increased by a factor of 2.38 for male officers that have

four or more hours of mental health awareness training compared to the state mandated minimum, holding all other variables constant; but there was not a statistically significant difference among the other variables. Comparing officers with the mental health peace officer certification training to those with only the state mandated training, there was not a statistically significant difference for gender, but there was for race and tenure. For white officers, the odds increased by a factor of 11.29, and for each additional year an officer is employed, the odds increased by a factor of 1.07, holding all other variables constant.

Table 2: Multinomial Logistic Regression Results

	Model 1			*Model 2*		
Variable	*β*	*SE*	*Exp (β)*	*β*	*SE*	*Exp (β)*
Minimum Training Plus In-Service v. State Mandated Only						
Rural[a]	-0.68*	0.34	0.51	-0.95**	0.37	0.39
Training Adequacy	0.22	0.14	1.25	0.30*	0.15	1.35
Training Not Sufficient	-0.02	0.12	0.98	0.07	0.13	1.07
Education[b]						
HS Graduate				0.02	0.54	1.02
College Degree or Higher				-0.02	0.35	0.98
Male				0.87*	0.36	2.38
Hispanic				0.66	0.69	1.94
White				0.51	0.57	1.66
Tenure				0.03	0.02	1.03
Department Size[c]						
Small				-0.39	0.41	0.68
Medium				-0.11	0.54	0.90
Large				-0.90	0.67	0.41
Extra-Large				-0.76	0.58	0.47
Mental Health Peace Officer v. State Mandated Only						
Rural[a]	-0.51**	0.18	1.66	-0.49**	0.19	1.63
Training Adequacy	0.73***	0.19	2.07	0.79***	0.21	2.20
Training Not Sufficient	0.08	.014	1.08	0.15	0.16	1.16
Education[b]						
HS Graduate				-1.29	0.87	0.27
College Degree or Higher				-0.36	0.42	0.70
Male				0.32	0.42	1.37

	Model 1			*Model 2*		
Variable	*β*	*SE*	*Exp (β)*	*β*	*SE*	*Exp (β)*
Hispanic				1.79	1.00	5.99
White				2.42**	0.96	11.29
Tenure				0.07***	0.02	1.07
Department Size[c]						
Small				0.56	0.51	1.76
Medium				1.04	0.63	2.84
Large				-0.10	0.87	0.91
Extra-Large				0.92	0.64	2.51
R^2						
Cox and Snell	0.090			0.241		
Nagelkerke	0.102			0.273		

***$p<0.001$, **$p<0.01$, *$p<0.05$

[a] compared to Metropolitan Area

[b] reference category is some college hours

[c] reference category is extra-small department

Discussion

Compassion for those experiencing mental health concerns is a question of morality and decency that is aligned with the basic American values where all people are expected to be respectful of each other (Watson *et al.*, 2008). In the not too distant past, individuals that experienced mental health disorders were segregated and ostracized from mainstream society (Torrey *et al.*, 2008). However, the evolution of society has recognized that individuals with mental health concerns should enjoy all the rewards of the free American society, which lead to the deinstitutionalization movement. Additionally, society recognized through treatment and support, individuals with mental health concerns can be valuable members of society.

The police occupy a vital role in the American society to ensure all members of the public are afforded constitutional protections—and the most effective way the police can provide those protections to individuals with mental health concerns is to be able to effectively recognize the signs and symptoms of an individual in crisis. This is accomplished through training. Unfortunately, any shortfalls in police officer training are often accompanied by a tragic event. For example, CIT training for police officer mental health awareness was developed as a result of a lawsuit that stemmed from a police shooting involving a person with a mental illness (Bonfine *et al.*, 2014). In Texas, after the death of Sandra Bland, the state recognized the need to enhance officers' training to better identify the signs and symptoms of mental health concerns. However, the question remains if the training is

sufficient to better equip officers with the knowledge to determine more effective solutions to assist those suffering from mental health concerns. This was the first study to the authors' knowledge that examined police officers' perceptions of the adequacy of the state mandated training in Texas as a result of the Sandra Bland incident that occurred in 2015. This study also examined if rural officers have commensurate training as officers in metropolitan areas.

The demands placed upon police officers are immense. Today, officers are expected to be street-legal experts in mental health, understand the various types of mental disorders, the medications and their side-effects, and have a working knowledge of the available community mental health resources; in addition to preventing and investigating crime in local communities. However, due to the collective factors surrounding a lack of community mental health resources, jail diversion efforts, and limited space in state hospitals, police officers now find themselves in the role as front-line responders to situations involving those with mental health concerns (Wells & Schafer, 2003). Furthermore, youth with mental health concerns frequently interact with law enforcement officers because of threatening and maladaptive behaviors (Douglas & Lurigio, 2014), but there has been scant research on the perceptions of officers' mental health awareness training.

Also, police interactions with people with mental health concerns can be time-consuming with officers waiting hours with a person in crisis to be admitted to a hospital only to have that person discharged shortly thereafter (Morabito, Kerr *et al.*, 2012). Furthermore, in jurisdictions with more limited services, advanced training beyond the minimum required may be viewed less positively, as officers may recognize the futility attempting to link people to inadequate or non-existent services (Morabito, Watson, & Draine, 2012). This study advances our knowledge within two important domains concerning the efficacy of police officers' training related to interacting with persons having a mental health concern. First, we specifically focused on an under researched segment of the police, which is rural officers (Weisheit *et al.*, 2006). Second, we explored police officers' perceptions of their mental health training by comparing three levels of training officers receive (state mandated training, additional agency driven in-service training, and mental health peace officer certification training) to determine if the additional training has merit through officers' perceptions.

Rural agencies, in this study, had a lower amount of training. This is unfortunate as research suggests rural agencies are more in need of advanced mental health awareness training than urban agencies. Skubby *et al.* (2013) posited that urban agencies can afford to train just a few officers because they have the officers available and the potential to disperse specially trained officers on various shifts. This study found officers employed in rural agencies were less likely to have mental health awareness training beyond the state required training. The lack of additional mental health awareness and response training reportedly left officers in rural areas with a sense of being underprepared for an encounter with a person suffering a mental health concern. These officers may value having supplemental training (in-service) beyond the state minimum required training. This is also concerning

because rural communities do not have access to social service agencies or specialized treatment centers that can assist them effectively resolve a mental health crisis for an individual (Ricciardelli, 2018; Skubby *et al.*, 2013). Or local mental health services do not operate or exist in rural areas making emergency room admissions or arrest the only choice for a police officer. Unfortunately, rural agencies have many constraints that hinder their ability to provide advanced training to their officers. First is the issue of personnel. Falcone *et al.* (2002) argued even police chiefs in rural agencies routinely must be in the role of a first responder because there are not sufficient personnel to address community concerns. Thus, the lack of personnel in rural agencies may not allow officers to take additional time away from their duties to attend advanced training. Second, financial constraints abound because the areas do not have the tax base to support adequate salaries and training budgets (Tully & Smith, 2005).

This study supported the research that suggests that the response for more training when interacting with persons potentially having a mental health concern has merit (Wells & Schafer, 2006). We found that the more training officers are exposed to, the more they perceive their training as being adequate. Those with advanced mental health awareness and response training, beyond the minimum state mandated training, perceive their additional training as important because it better prepares them for the demands and complexity of their job tasks (e.g.; interacting with an individual with a mental health concern).

The amount (or level) of training that officers in the study experienced varied by their personal characteristics. For example, white officers were much more likely than non-white officers to have the highest level of training. This is a finding that should require further inquiry to determine the reasons white officers are more likely to receive the mental health peace officer certification training than officers of color. We are unable to parse out the reason to determine if it is because white officers are more likely to request the highest level of training, or some other reason. However, the results revealed that the more experience an officer has, the more likely an officer is to have the mental health peace officer certification training. This was expected because as officers have more experience with an organization, they are more likely to be selected for this highest level of mental health certification within the profession because they have demonstrated exemplary performance in their agency or their agency leadership has confidence these officers should be in a specialized unit that focuses on interacting with persons suspected of suffering from a mental health concern.

Limitations

As with most social science research studies there are limitations the authors must acknowledge to assist the reader develop a better understanding of the findings. First, this was a convenience sample of police officers that one of the authors had access to through prior training experiences. This could lead to potential selection bias among the respondents because they may have a reciprocal relationship with one of the authors through possessing

an obligation to participate. Second, the design of the study was cross-sectional in nature. The sample was taken at one point in time, which precludes the determination of causality. Third, the specific agencies the respondents were employed were not determined. In an effort to enhance the response rate, the authors did not ask the respondents to identify their agency. This was primarily due to police officers being distrustful of researchers and hesitant to participate in research for concern their responses could be traced back to their agency leadership and result in being ostracized at the agency (Gordon, 2010). Fourth, the survey did not inquire into the type or number of mental health services available to the officers. Thus, analysis of whether the presence or lack of mental health services impacted officers' perceptions of their preparedness was beyond the scope of this study. However, it is an area of inquiry for future research.

Conclusion

This was an exploratory study to examine police officers' perceptions of the efficacy of their training in regard to interacting with the persons suspected of having a mental health concern. The intent was to determine if the state mandated minimum level of training was sufficient according to police officers that have had advanced mental health awareness training, especially in rural areas. The study advances the current knowledge by supporting that mental health training is critical for police officers to effectively serve and safely interact with persons having a mental health concern. The police profession is making strides to better serve this segment of our society and officers recognize that more training is desired and warranted. As more officers have the opportunity to seek advanced mental health awareness training, officers are more knowledgeable about mental health related issues, including how best to approach persons suspected of having a mental health concern, and ways to de-escalate the situation. This can result in more positive encounters with decreases in the areas of use of force, litigation alleging civil rights violations, and officers' injuries including line of duty deaths. Therefore, policy makers and police administrators should prioritize the most advanced training available for all police officers, regardless of agency location, to ensure the most effective and positive interactions occur between the police and persons with mental health concerns.

This study is a positive step toward recognizing the value officers' place on enhanced levels of training. However, the training is only a part of the solution. Aside from enhancing the levels of training, there also must be community involvement and facilities designed to specifically address the needs for those the police interact with that may be in need of mental health intervention.

Notes

1. Prior to the distribution of the survey, the entire research protocol was approved by the Institutional Review Board at the researchers' institution.

2. In addition to asking respondents to self-identify as working in a rural or urban area of the state, the survey also asked which county their agency primarily resides in. Then the authors confirmed if rural was selected that it corresponded to a rural (non-metropolitan county) as designated by the Texas Department of State Health Service and the US Office of Budget and Management. (see https://dshs.texas.gov/chs/hprc/counties.shtm?terms=rural%20counties)

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