



JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS

The Variability in Law Enforcement State Standards:

A 42-State Survey on Mental Health and Crisis De-escalation Training

Law enforcement interactions with people who may have a mental illness or are in crisis are an issue of tremendous concern for the public and government leaders.¹ For good reason. At the extremes, these encounters hold the potential for successfully linking people in crisis to desperately needed appropriate care, or they can end in tragedy. While every encounter is different, by the time police are involved, there can be far-reaching consequences of any action. In an effort to improve these interactions and help officers better prepare to handle complex incidents, nearly all states have developed standards for mental health and crisis de-escalation training for their law enforcement officers.* This type of police training on how to respond to people whose mental health needs may be a factor in an incident has been shown to make a critical difference in how encounters are resolved.†

Training that consistently meets quality standards while adapting to local needs can help meet the following goals:²

- Enhancing the safety of the officer, person in crisis, family members, and bystanders
- Using law enforcement and criminal justice resources more effectively
- Diverting people, when appropriate, to behavioral health treatment to support their recovery and minimize future criminal justice involvement
- Helping to build or restore community trust in the police
- Encouraging compassionate responses to people in crisis

According to information received in a national survey conducted by the Council of State Governments (CSG) Justice Center in partnership with the International Association of Directors of Law Enforcement Standards and Training (IADLEST), despite consistent recognition of the value of this training, there is tremendous variability in those standards among states and the focus is mostly on entry-level training.

The Role of States in Law Enforcement Training

Over the past few decades, federal, state, and local efforts to improve law enforcement responses to people with mental illnesses have increased the availability and quality of training, policies, and practices across the country. There remains, however, a long way to go to ensure these efforts take root and

* Training alone will not achieve public health and safety goals. Whether training is put into consistent practice is dependent on it being part of a comprehensive strategy. That strategy must fully engage the law enforcement agency, behavioral health partner agencies, and other stakeholders to provide a supportive culture and infrastructure for all responding personnel.

† Mental health training, as defined for the survey, refers to a variety of training courses for law enforcement officers to inform them about mental illnesses and associated signs and symptoms. De-escalation training refers to training courses for law enforcement officers on verbal and non-verbal skills to effectively interact with individuals who may have mental illnesses or are in crisis and to defuse these encounters.

motivate law enforcement agencies from all states to undertake similar initiatives. This is a significant challenge as there are approximately 18,000 state and local law enforcement agencies in the nation³ and 660 training academies.⁴ Training decisions are mostly under local agency or academy control, particularly for in-service and specialized training. For all levels of training, however, states can assume a meaningful role in supporting quality instruction and facilitating consistency on key aspects of curricula. States can, not only, set minimum standards for policies and training, but can also develop statewide training initiatives.⁵ State leaders that want to join or more fully engage in this movement will benefit from an understanding of the current training landscape before determining if state standards can be developed or enhanced that are realistic and can be implemented with available supports.*

The Survey of State Peace Officer Standards and Training Authorities

To help provide an overview of state actions, the CSG Justice Center partnered with IADLEST to survey all state Peace Officer Standards and Training (POST) entities or other state training authorities.[†] With the U.S. Department of Justice, Bureau of Justice Assistance (BJA) funding, a survey was developed to gather information that could create a snapshot of the standards used by states and U.S. territories for police training on de-escalation and responding to people with mental illnesses. The survey was sent in August 2016 to the state POST or other state law enforcement training authority in 50 states and 3 territories. Responses were received from 42 states and 1 territory.[‡]

The report is organized into three parts:

1. The aggregate survey findings (including whether states have training standards, how they are developed or modified, and their characteristics)
2. The challenges and promising approaches shared by survey respondents
3. Key takeaways

Survey Findings

States with Training Standards and Factors Related to Their Revision

1. Nearly all responding states (41 of the 42) have standards for mental health training and about 40 states have them for de-escalation training.[§] As figure 1 indicates, the focus is primarily on entry-level training.**

* The “standards” identified by the survey include minimum requirements for training set out in legislation, administrative codes/regulations, or state curriculum. These requirements may be, and often are, exceeded by law enforcement agencies or academies. State standards and required police training curricula may be only part of a multi-faceted statewide effort. A comprehensive analysis of state legislation, regulations, and other actions that impact police authority and the nature of responses is not presented here. For more on state legislation related to law enforcement training on mental health and crisis interventions, see the summary of a review conducted by the National Conference of State Legislatures in November 2016 at <http://www.ncsl.org/GoogleResults.aspx?q=law%20enforcement%20overview%20states>.

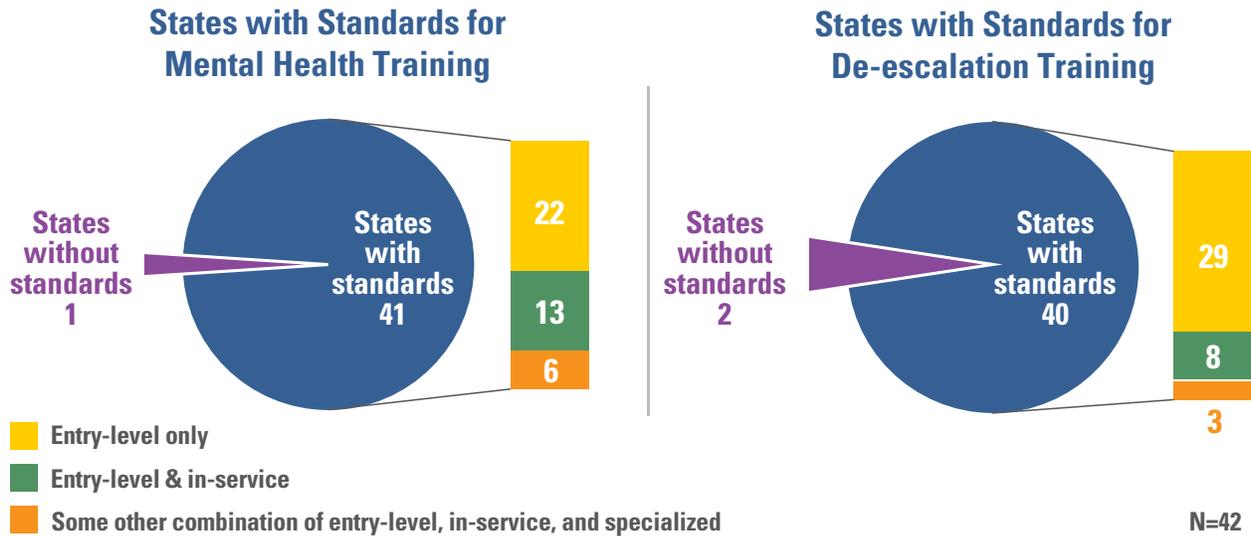
† POSTs use the term “Peace Officer” instead of Police Officer (with the latter commonly used to refer to municipal officers) because they often set standards for a much broader group of authorities with arrest powers such as sheriff’s deputies, state troopers, correctional officers, and many others that fit the more inclusive definition of Peace Officer. For states without POSTs, IADLEST sent the survey to the state-level authority responsible for oversight of training requirements. POSTs (and other state authorities) vary in their breadth of power to enforce standards and in the group of agencies or individuals they have under their purview (e.g., some POSTs may allow agencies to voluntarily abide by their standards, mandate all agencies meet standards, and/or exempt specific municipalities within a state). For more on the CSG Justice Center, visit csjusticecenter.org and for IADLEST see iadlest.org.

‡ Responses were supplemented by submitted curricula, lesson plans, and copies of state mandates. The response received by the only territory that completed the survey was excluded from the reported state totals in this paper. The territory did not currently have standards, but reported having plans to develop them for mental health and de-escalation training.

§ The survey results indicate that mental health training topics may be addressed separately from de-escalation strategies in state training standards/curriculum for entry-level officers (26 of the responding states have distinct modules/sessions), but may also be combined in training modules. In addition, this training may be addressed in the context of police use of force and other topic areas such as vulnerable populations.

** Entry-level training refers to the mandatory basic/recruit training curriculum used to prepare officer candidates with the cognitive and physical skills needed to become certified law enforcement officers. In-service training refers to the mandatory continuing education of law enforcement officers that may be required for officers to maintain their certification. Specialized training refers to courses for certified officers to develop knowledge and skills around a specific topic.

FIG. 1. STATES WITH TRAINING STANDARDS FOR RESPONDING TO PEOPLE WITH MENTAL ILLNESSES AND FOR DE-ESCALATING ENCOUNTERS



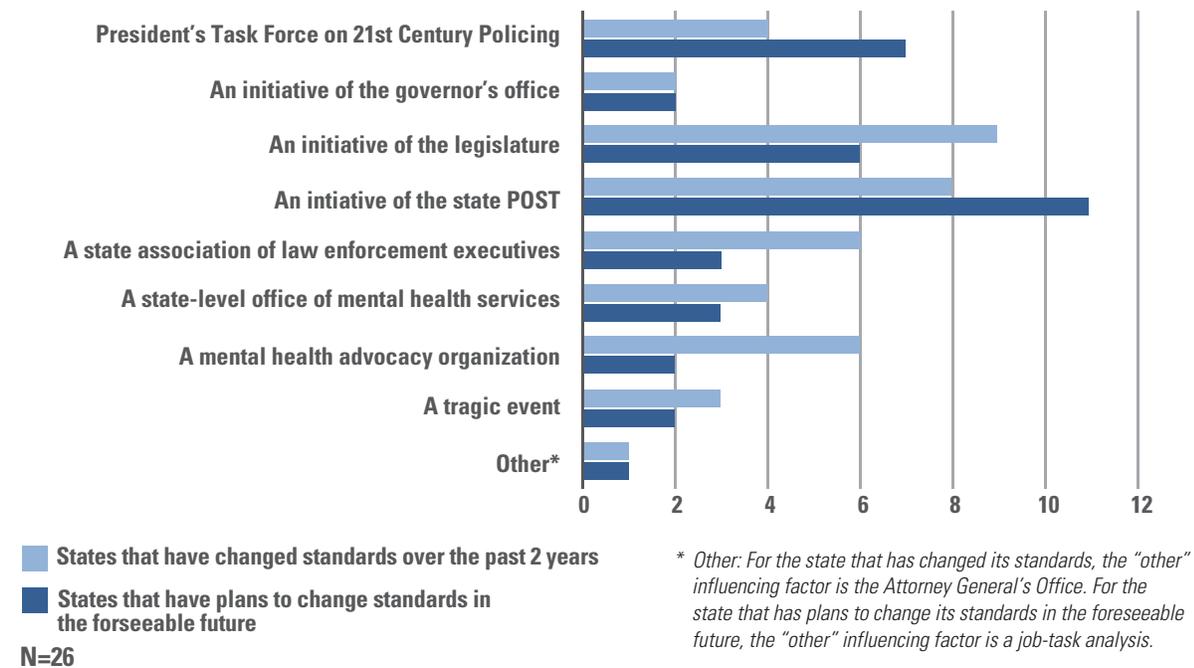
2. State standards are developed in various ways. The agency or entity that determines the state standards for mental health and crisis de-escalation training is most often the state POST, followed by the legislature. Some states also use other groups to advise, such as the state department of mental health, department of public safety, state training commission, or state and local affiliates of the National Alliance on Mental Illness (NAMI).
3. Of the 41 states with related standards, 16 changed them in the previous two years to require additional hours for mental health and/or de-escalation training.*
4. There are also 18 states that report having plans “in the foreseeable future” to expand the number of training hours (10 states that did not make changes within the previous two years and 8 states with plans to make additional revisions).
5. Other reported changes in the last two years include the integration of Crisis Intervention Team (CIT) training, including modified versions, or Mental Health First Aid (MHFA) in some states’ training curriculum.

Survey participants were provided with a number of factors that can potentially motivate state leaders to change their standards. Figure 2 displays which factors were identified as prompting change in the 25 states that responded they had or will be changing their standards to increase hours.

6. As indicated in figure 2, the top three influences reported by POST and other state training authorities for past revisions to standards have been (1) an initiative of the state POST, (2) legislative action, and (3) the efforts of a mental health advocacy organization. For upcoming changes, the recommendations of the [President’s Task Force on 21st Century Policing](#) is helping to drive revisions to training standards on police responses to people with mental illnesses or in crisis.

* The previous two-year period is from August 2014 thru July 2016 when the survey was received by respondents.

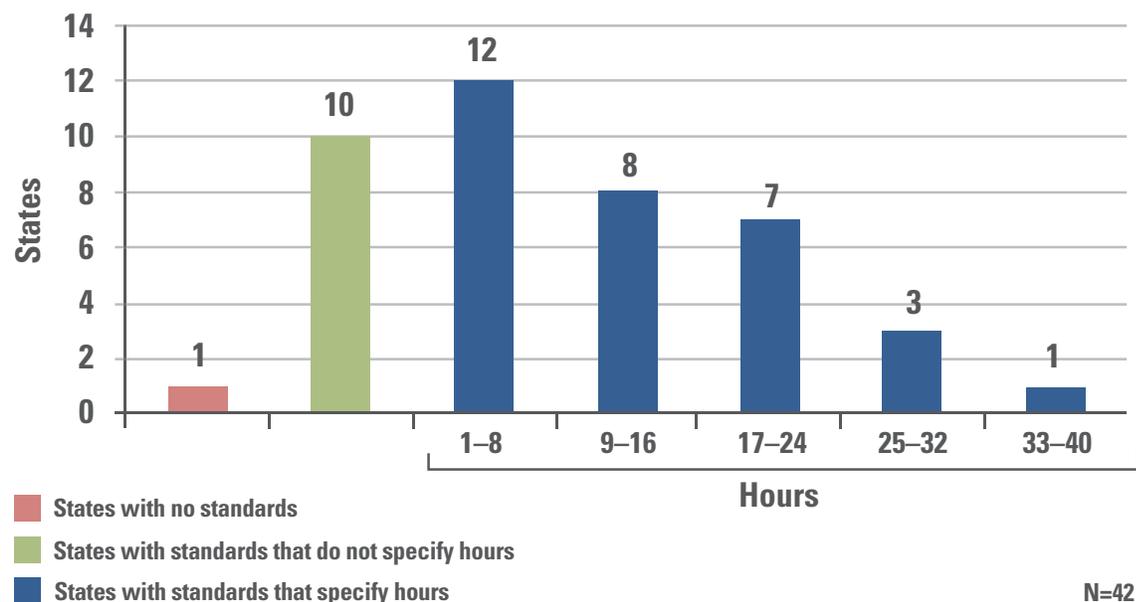
FIG. 2. FACTORS THAT INFLUENCE CHANGES TO STATE STANDARDS ON MENTAL HEALTH AND DE-ESCALATION TRAINING



States' Entry-Level Training: Duration, Content, and Delivery

Thirty-one of the states with training standards were able to specify the number of hours required for mental health and de-escalation training. Comments revealed that the remaining 10 states with standards were unable to specify the number of hours, due in part to the discretion and flexibility afforded trainers regarding how long to spend on a particular topic. In addition, some training programs that focus on competencies and achieving performance objectives do not require set hours. The hours can vary by local academy within the state as well.* Of the states that do specify hours, survey respondents reported a wide range for mental health and de-escalation topics (2–40 hours when combined).

FIG. 3. COMBINED DE-ESCALATION AND MENTAL HEALTH TRAINING HOURS (ENTRY-LEVEL)



* It is important to recall that local agencies often exceed minimum standards, with many moving toward 40-hour trainings for specified officers.

7. The average number of training hours spent on mental health and de-escalation topics, whether the entry-level curriculum separates these topics or addresses them together, is just more than 14 hours.*
8. Five states also indicate that they require entry-level officers to complete CIT or MHFA training, with 14 other states reporting they tailor some aspects of those trainings for their current curriculum. Moreover, some states noted the inclusion of officer wellness training and working with vulnerable populations (e.g., people with autism, adults experiencing homelessness, or elderly individuals).

The survey prompted respondents to indicate which of the listed mental health topics (knowledge components of the training) were included in entry-level training.† Those content issues are presented in Table 1 (in descending order) followed by specific skills training.

TABLE 1 SURVEY TOPICS USED IN ENTRY-LEVEL CURRICULUM*

Knowledge Topics	
tied [Signs and symptoms of mental illness
	State laws and involuntary commitment
tied [Schizophrenia and other psychosis
	Mood disorders (depression, bipolar disorder, etc.)
	Suicidality
tied [Developmental /Intellectual disabilities
	Cognitive disorders (Alzheimer’s, Dementia, etc.)
	Post-traumatic stress disorder and trauma
tied [Substance abuse
	Co-occurring substance use disorder and mental illnesses
	Medications for mental illnesses
Skills Topics	
	Nonverbal communication
	Officer safety
	Active listening
tied [De-escalation strategies
	Responding to suicidal people
	Identifying behaviors possibly associated with mental illness
	Conflict management and mediation
* Other reported topics include community resources for people in crisis and those with behavioral health disorders, transportation of people with mental health problems, military personnel/veterans interactions, stigma, use of force, and crisis management.	

* It is unclear how training authorities determine which topics fall within sessions on responses to people with mental illnesses versus de-escalating potentially volatile situations. To complicate matters further, responses to mental illness comes up frequently in use of force/alternatives to force training (see, e.g., the Police Executive Research Forum’s 2016 recommendations at <http://www.policeforum.org/trainingguide>) and may be used for more than people with mental illnesses (e.g., domestic violence).

† Training topics presented as options in the survey for both knowledge and skills were largely drawn from the [Memphis CIT training curriculum](#) and were supplemented by other commonly covered topics. The CIT “Memphis” Model is a 40-hour evidenced-based course for training on this subject (see, e.g., Amy Watson and Anjali J. Fulambarker, “The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners,” *Best Practices in Mental Health*, 2012; 8:71).

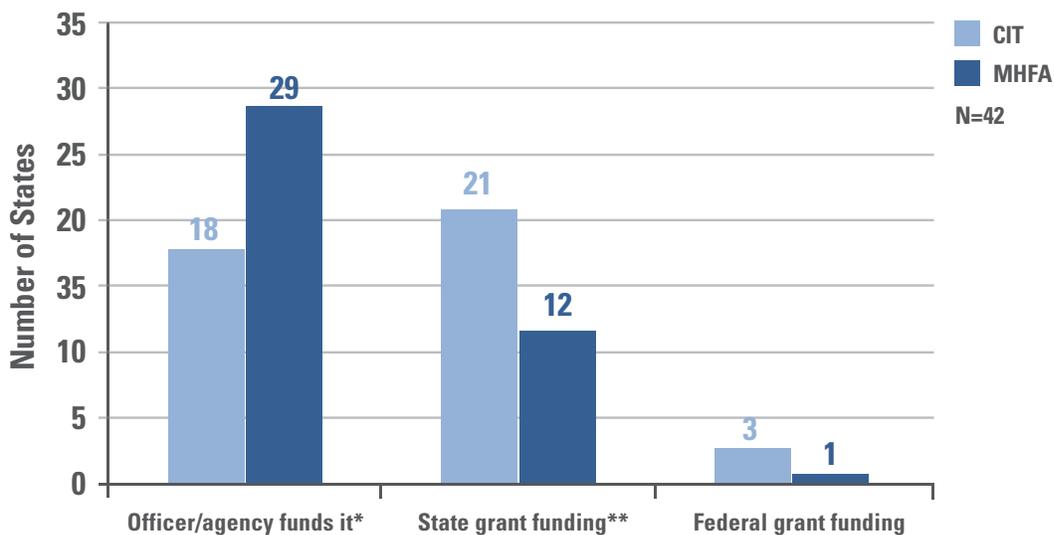
9. Respondents used role play for both knowledge and skills instruction, but most often in skills training (in which half of the responding states used it for at least one topic). Role-play scenarios were more frequently used for gaining skills such as how to better respond to people who feel suicidal, safely interacting with people in crisis, and other de-escalation and crisis intervention strategies.
10. Many agencies use both mental health professionals and law enforcement trainers to lead sessions for entry-level officers. Mental health professionals teach more knowledge-based topics than skill-based topics (engaged by 18 of the 42 responding states for at least one topic). For example, common training topics they cover include signs and symptoms of mental illnesses, as well as frequently prescribed medications and their effect. Several agencies also mentioned that as part of these collaborations, they invite people with mental illnesses, or their family members or advocates, to participate.

In-Service and Specialized Training

There are far fewer states whose standards require in-service or specialized training than states that provide entry-level training requirements on law enforcement encounters involving people with mental illnesses or de-escalation for people in crisis.

11. About half the responding states (21) require in-service* and/or specialized training as compared with 40 states that have training standards for entry-level training.
12. Those that specify hours range from 2–24 hours for in-service training.
13. As for specialized training, 11 of the 42 responding states certify or provide officers with 40-hour CIT training or some modification, and 9 of the 42 states provide 8-hour MHFA training or some modification.
14. Train-the-trainer programs were also offered by 9 of the 42 states, ranging from 6 to 40 hours.
15. Funding to help offset costs for CIT training and MHFA come from a combination of officer/agency payments and state and federal funding (which are sometimes competitive grants). Respondents also indicated that funding could include other local partner contributions.

FIG. 4. FUNDING FOR CRISIS INTERVENTION TRAINING AND MENTAL HEALTH FIRST AID



* States that selected “Officer/agency funds it” did not also have state or federal grants available.

** States that selected “State grant funding” or “Federal grant funding” include both partial and full funding support for training.

* In-service topics can change from one year to another—more frequently than entry-level or specialized training.

Reported Challenges and Successes

The most common training challenges identified by responding states include

- (1) time,
- (2) staffing,
- (3) the impact of creating standards with mandated hours or delivery mechanisms, and
- (4) costs for covering both officers and trainers.

Time. There are persistent efforts by many different interest groups for law enforcement to extend training to accommodate an extensive list of potential training topics (or lengthen time for a particular segment). Some respondents expressed frustration that the demands to train on so many topics fail to recognize that a course cannot be continually expanded. Some respondents also noted that even when they weave additional topics through existing trainings, instead of creating stand-alone modules, topics often go unnoticed or are undervalued. Academies already struggle with trying to cover all the mandated and recommended training topics within the time allotted. With each expanded training module, there are also concerns about how to maintain the quality of the content, as well as ensure effective training delivery methods (e.g., several respondents noted that although important, scenario-based training in large classes can extend the training time and may affect the ability to cover other critical issues).

Staffing. For law enforcement agencies, there is also concern with how to meet minimum deployment needs while officers are in training and how to cover any associated overtime costs, particularly for specialized training courses. In addition, many states experience impediments to developing and deploying trainers statewide, including securing their instructor's own training or contracting with outside entities to provide the training. Some states not only lack qualified trainers, but also the ability to develop instructors as well as skilled individuals to quickly update their curriculum.

Impact. In developing standards, several states cautioned that mandated hours, particularly by topic, can have the unintended consequence of shortening attention to other similarly important topics. At least one state expressed the need for more "tools" for skill-based learning in basic training that has become part of the required curriculum (e.g., on conducting role-play scenarios). There is also concern that state standards can undermine local efforts if they do not account for jurisdictions' diverse needs. This is particularly pronounced for small rural agencies that have considerably fewer mental health resources.

Costs. As with all state actions, there is concern about unfunded mandates (through state standards, legislation, or administrative action without adequate state support to cover the costs incurred by local agencies). The costs for training officers such as paying over-time, covering shifts by back-filling positions, and developing curriculum (and revising modules) are considerable. Respondents also report that making needed changes and updates to mandates can be difficult and time-consuming. Finally, respondents voiced concern that behavioral health resources must be available to officers in the community to appropriately divert people to needed services. If officers cannot access sufficient community resources, training for law enforcement will not yield the desired results.

Successes. Many of the respondents reported that they have efforts underway to improve or expand their training in de-escalation techniques while responding to people with mental illnesses. In addition, they applauded the work of smaller local agencies that have organized regional trainings that are more cost-effective forums and help engender resource-sharing. Collaboration with other state and local agencies was also a common theme among states' reporting successes. These partnerships include assistance with training and curriculum development from state mental health agencies, state CIT associations, NAMI, and people living with mental illnesses.*

* For more information and resources on promising practices, see the CSG Justice Center Learning Sites at <https://csgjusticecenter.org/law-enforcement/projects/mental-health-learning-sites/> and the resources text box p. 9.

Key Takeaways

The survey findings highlighted below can inform state and local leaders interested in working together to support law enforcement training on responding to people with mental illnesses or who are in crisis among their many academies and local agencies.

- ✓ Nearly all responding states have some minimum standards (mostly for entry-level recruits) for training related to officers' encounters involving people with mental illnesses and de-escalation strategies. There is, however, tremendous variation in required hours, topics, teaching methods, and more. Some of that variation may be due to the lack of uniformity—and related inability to quantify—how training programs integrate instruction regarding these encounters into modules on use of force, de-escalation strategies, behavioral health concerns, vulnerable populations, and other issue areas.
- ✓ To influence revisions to state standards (particularly for hours dedicated to behavioral health/crisis encounter training), the findings suggest that agents for change (such as mental health agency leaders and advocates) must engage state POSTs and other training authorities. Other change agents credited with helping motivate improvements to state standards are legislative and administrative bodies, executive offices (such as the Governor or Attorney General), behavioral health agencies, and public safety and advocacy organizations. Although changes may be made following a tragic event, it was not a leading determinant. Federal task force recommendations have also sparked changes to state training standards.
- ✓ There continue to be state-level efforts to lengthen training times on mental health (as well as substance use) and responding to people in crisis that reflect a strong commitment to addressing these issues. States are cautioned by respondents, however, to consider the impact of expanding hours on other training topics, and to ensure that performance objectives and skill training remain.
- ✓ Recognizing that these encounters are particularly complex, respondents from states with training standards acknowledged that role playing/scenario-based training is important, particularly for skill building. Similarly, collaborations are valued with local behavioral health experts, advocates, and people living with mental illnesses and co-occurring substance use disorders who can engage with training participants.
- ✓ In-service and specialized training are not given the same level of attention as entry-level/recruit training in state training standards (about twice the number of states have entry-level training). Providers of all levels of training, however, are increasingly integrating aspects of the CIT and MHFA courses into the training, if not supporting the entire curriculum. As training must be responsive to local resources and needs, states are advised by some respondents to work with local academies and agencies to ensure that training can be adequately tailored and can be implemented with available resources.
- ✓ Funding for officer training (and in some cases, training for Field Training Officers, trainers, supervisors, dispatchers, or other personnel) continues to be a significant concern. Survey results indicate that training is still being supported fully or partially by local agencies or officers in many states (offset by state grant funding, and to a lesser degree federal grant funding). Comments suggest that any training mandates should be accompanied by adequate funding supports (for personnel and trainers), as well as investments in behavioral health services in the community to support efforts that result from successful training.
- ✓ There is tremendous variability in the number of hours and types of approaches used for training. Given that as many as 1 in 10 calls for police service involve an individual with a severe

mental illness,⁶ state leaders are considering how much training time should be allocated to these complex calls. At least one responding state is conducting a job-task analysis to inform the standard training hours devoted to mental health and de-escalation among other topics.

Despite variability in standards and training curricula, all states can play an important role in supporting local law enforcement training. State minimum standards can help build momentum for change, encourage behavioral health-law enforcement partnerships at a systems level, and encourage academies and local police agencies to consistently address key issue areas.

ADDITIONAL RESOURCES

There are extensive resources on law enforcement training related to responding to people with mental illnesses. To get started, see

- ✓ CSG Justice Center Resources at csgjusticecenter.org/law-enforcement.
- ✓ Police Mental Health Collaboration Toolkit (BJA) at www.bja.gov/pmhc.
- ✓ CIT Training at www.citinternational.org/.
- ✓ Mental Health First Aid Training at www.mentalhealthfirstaid.org/cs/.

The CSG Justice Center prepared this paper based on the survey conducted by IADLEST. The work was conducted with support from the Bureau of Justice Assistance (BJA), U.S. Department of Justice, under grant numbers 2012-MO-BX-K001 and 2016-MU-BX-K003. BJA is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering and Tracking. Visit www.bja.gov for more information.

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Suggested Citation: Martha Plotkin and Talia Peckerman, *The Variability in Law Enforcement State Standards: A 42-State Survey on Mental Health and Crisis De-escalation Training*, (New York: CSG Justice Center 2017).

This report was written by the CSG Justice Center's Martha Plotkin and Talia Peckerman. Survey development and report review were conducted by Gerard Murphy and Nicola Smith-Kea. Editing was provided by Karen Watts and Darby Baham. Michael Becar and Mark Damitio of IADLEST provided guidance and direction on the overall effort, as well as overseeing a focus group and survey implementation. Thanks are also due to Maria Fryer and Ruby Qazilbash at BJA for their unflagging support for this project.

Endnotes

- 1 Evidence that law enforcement training on responding to people with mental illnesses has become a national priority includes recommendations by the U.S. President's Task Force on 21st Century Policing (see https://cops.usdoj.gov/pdf/taskforce/taskforce_finalreport.pdf) to advance standards and quality training, as well as initiatives from such national policing groups as the International Association of Chiefs of Police (see iacp.org/onemindcampaign) and the Police Executive Research Forum (policeforum.org/assets/icattrainingguide.pdf).
- 2 For more on what the research has shown on this type of law enforcement training, see e.g., Melissa Reuland, Matt Schwarzfeld, and Laura Draper, *Law Enforcement Responses to People with Mental Illness: A Guide to Research-Informed Policy and Practice* (New York: Council of State Governments Justice Center, 2009); See also, Amy Watson and Anjali J. Fulambarker, "The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners," *Best Practices in Mental Health*, 2012; 8:71.
- 3 Brian A. Reaves, *Census of State and Local Law Enforcement Agencies, 2008* (Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, July 2011), NJC 233982 at <https://www.bjs.gov/content/pub/pdf/cslea08.pdf>.
- 4 Brian A. Reaves, *State and Local Law Enforcement Training Academies, 2013* (Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, July 2016), NJC 249784 at <http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5684>. Nearly all basic training programs in state and local law enforcement training academies that provide special topic instruction addressed mental illness at the time of the study (on average 10 hours per recruit (see Table 9)).
- 5 For examples of statewide crisis intervention training, see, e.g., Ohio's statewide training plan at <http://www.neomed.edu/academics/criminal-justice-coordinating-center-of-excellence/pdfs/cit-strategic-plan-final-with-attachments-8-15-compressed.pdf>; California POST's training and resources at <https://www.post.ca.gov/mental-health-training-in-law-enforcement.aspx>; Washington's state-sponsored classes at https://fortress.wa.gov/cjtc/blog/index.php?option=com_content&view=article&id=376&Itemid=312; and Oklahoma's mental health/criminal justice partnership for statewide training at [https://www.ok.gov/odmhsas/Mental_Health_/Specialized_Programs_and_Services/Correctional_and_Criminal_Justice_Programs/Crisis_Intervention_Team_\(CIT\)](https://www.ok.gov/odmhsas/Mental_Health_/Specialized_Programs_and_Services/Correctional_and_Criminal_Justice_Programs/Crisis_Intervention_Team_(CIT)). For earlier examples, see Melissa Reuland et al., *Statewide Law Enforcement/ Mental Health Efforts: Strategies to Support and Sustain Local Initiatives* (New York: Council of State Governments Justice Center, December 2012).
- 6 Duncan Chappell, ed., *Policing and the Mentally Ill: International Perspectives* (Boca Raton, FL: CRC Press, 2013).