SB 882 Advisory Council
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[DRAFT] Report of the

SB 882 Advisory Council on Improving Interactions between

People with Intellectual and Development Disabilities

and Law Enforcement

April 2026

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The Council is composed of nine members, appointed by the Governor, the Senate Committee on Rules, and the Speaker of the Assembly before the first Council meeting in 2023. These members are as follows:

CHAIR JIM FRAZIER, Public Policy Advocate, United Cerebral Palsy California Collaboration. *Appointed by former Speaker of the Assembly Anthony Rendon.*

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JOHN ROBINSON, Peer Relations Specialist, San Andreas Regional Center. *Appointed by the Senate Committee on Rules*.

EMADA TINGIRIDES, Assistant Chief, Los Angeles Police Department. *Appointed by former Speaker of the Assembly Anthony Rendon*.

Senator Susan Eggman

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Staff

The SB 882 Advisory Council would like to thank Attorney General Rob Bonta for his support of the work of the SB 882 Advisory Council.

The SB 882 Advisory Council would like to thank the following staff from the California Department of Justice for their assistance and contributions to the report:

[enter staff and contributors, 21 CP]

Additional Acknowledgements

The SB 882 Advisory Council appreciates the participation of community members, advocates, members of law enforcement, researchers, and other stakeholders. Public participation is essential to this process, and the SB 882 Advisory Council thanks all Californians who have attended meetings, submitted letters or emails, and otherwise engaged with the work of the Council.

Executive Summary

The SB 882 Advisory Council on Improving Interactions between People with Intellectual and Developmental Disabilities and Law Enforcement (Council) presents this report to the Legislature as required by Senate Bill No. 882 (2021-2022) (SB 882). SB 882 established the Council to evaluate existing training for peace officers specific to interactions with "the intellectually and developmentally disabled community" and with "individuals with mental health disorders," and to identify gaps in such training. The Council was also directed to make other recommendations to the Legislature that it deemed appropriate to improve outcomes between law enforcement and individuals who have a mental health condition or individuals who have an intellectual or developmental disability. SB 882 provided for the Council to operate for two years and for California Department of Justice (DOJ) staff to support the Council's work.

The Council first met on April 15, 2024, and used multiple methods to gather and evaluate information to fulfill its charge. The Council met thirteen times over the course of two years and heard testimony from 38 witnesses who were members of impacted communities, law enforcement agency representatives, researchers, service providers, and legal and other experts. To understand the scope of existing training and research, the Council reviewed literature related to training types and efficacy, crisis response models, the general system of care for people with mental health conditions or intellectual or developmental disabilities, and other relevant topics. The Council, with the support of DOJ staff, developed a survey for law enforcement agencies to share information about the trainings in use across California and law enforcement's experience with and impressions of those trainings. Council members also observed trainings offered throughout the state that covered interactions with people with mental health conditions and intellectual and developmental disabilities, and tracked features of the trainings and their impressions of training efficacy across several measures.

The Council identified the following topic areas for this report and collaborated to make recommendations to improve interactions between law enforcement and people with mental health conditions and intellectual and developmental disabilities:

Background: This report sets forth background information relevant to the development of the Council's recommendations, including historical trends that have led to law enforcement's role as a primary responder to crises related to mental health or intellectual and developmental disability; available statistics and research regarding the frequency and outcomes of interactions between law enforcement and individuals with mental health conditions and intellectual and developmental disorders; the rights of individuals with mental health conditions or intellectual or developmental disabilities; and an overview of California's system of care to which law enforcement often provides impacted civilians with linkages after an encounter with law enforcement. Existing research demonstrates that people with mental health conditions or intellectual and developmental disabilities are more likely to have

encounters with law enforcement and are more likely to experience uses of force in these encounters. The system of care to which such individuals may be connected, in turn, varies by region, and some individuals may experience barriers to or gaps in their access to services.

Crisis Response Models and Systems Interventions: The Council reviewed information about multiple crisis response models with varying levels of involvement from peace officers. This report provides an overview of the crisis response models and other systems interventions in use in California and in other jurisdictions across the country, as well as what is currently known about the efficacy of these models. Different jurisdictions in California use different, and sometimes multiple, crisis response models, including the Crisis Intervention Team (CIT) model that relies on specially trained peace officers, co-response models involving a mixed first-responder team that includes both peace officers and clinicians, or civilian-led response teams guided in full by clinicians, peers, or other service providers. The variety of models, among other factors, makes it difficult to research efficacy. Research is mixed as to whether these models result in fewer arrests of and uses of force against people with disabilities. However, research indicates that these crisis response models are better received by the community than a response from peace officers alone, and that community members are more likely to be connected with helpful services when they are assisted by agencies using CIT or alternative models of interaction. This section of the report also describes other elements of crisis response, including dispatch systems and peer support.

Training: The Council gathered a wide range of information regarding law enforcement training related to individuals with mental health conditions or intellectual or developmental disabilities, including types of training available, training modalities, and the efficacy of trainings. As with research regarding crisis response models, is the variety of type and quality of studies makes it difficult to draw consistent conclusions from the research regarding the efficacy of law enforcement training, and more research is needed linking training to improvements in concrete elements of the interactions between people with mental health, intellectual, or developmental disabilities and law enforcement. However, some themes do emerge, and are consistent across the Council's literature review, training observations, and law enforcement agency survey. Trainings employing active techniques such as role-playing and realistic simulation appear to be more engaging and more effective as learning tools. Law enforcement agencies can make good use of virtual reality and other technologies to deliver this type of training. And trainings delivered by individuals and family members who are impacted by mental health, intellectual, or developmental disabilities are also particularly effective and well-received by both community members and the peace officers themselves. Finally, more trainings should be developed to support community members in understanding and becoming more comfortable with peace officers.

Throughout this process, the Council confronted the tensions between the nascent state of the research, the desire to improve training, and evidence that the best way to improve the safety of these interactions is to implement systems that reduce their occurrence in the first instance.

The Council therefore has included different types of recommendations appropriate to a developing field of study. First, the Council has developed guiding principles for its recommendations. The Council has also identified promising practices for law enforcement agencies, service providers, community members, and others to consider as they implement existing programs. Finally, the Council has made a series of recommendations to the Legislature that the Council believes can be implemented now to improve interactions between law enforcement and people with mental health conditions and intellectual or developmental disabilities. Among these is a recommendation to create structures to continue to learn and innovate in this area after the Council ceases to operate, in order to evolve alongside systems of care that are actively changing, respond to ongoing research findings, and evaluate the efficacy of proposed and newly implemented interventions on an ongoing basis.

The recommendations of the SB 882 Advisory Council are set forth below and at the end of each chapter.

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[Final text to be entered after March 16 & 19, 2026 meetings of the Council, as follows:

1. *Final Guiding Principles*
2. *Final Recommendations, Data*
3. *Final Recommendations, Crisis Response Models and Other Systems Interventions*
4. *Final Recommendations, Training]*
2. ~~*Final Potential Promising Practices, Data*~~
3. ~~5.~~ *Final Potential Promising Practices, Crisis Response Models and Other Systems Interventions*
4. ~~6.~~ *Final Potential Promising Practices, Training*
5. ~~*Final Recommendations, Data*~~
6. ~~*Final Recommendations, Crisis Response Models and Other Systems Interventions*~~
7. ~~*Final Recommendations, Training]*~~

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Introduction

Senate Bill No. 882 (2021-2022) (SB 882), Penal Code section 13016, established the SB 882 Advisory Council on Improving Interactions between People with Intellectual and Developmental Disabilities and Law Enforcement (Council) to evaluate California's current training for peace officers regarding such interactions, identify gaps in such training, and offer recommendations to the Legislature to improve the trainings and other policies impacting these interactions. SB 882 established the Council for a period of two years and required the Council to meet at least quarterly. The statute further charged the Council with submitting a report to the Legislature within 24 months of its first meeting with recommendations to improve the outcomes of peace officer interactions with people with intellectual and developmental disabilities and/or mental health conditions. The Council operated under the jurisdiction of the

California Department of Justice (Department). The Attorney General's Office (a division of the Department) provided staffing to coordinate and support the Council.[1]

The Council was required by statute to meet at least quarterly.[2] Since its inception in 2024, the Council has held 13 meetings, where various speakers have given presentations and public comments were received. The Council held its inaugural meeting on April 15, 2024, followed by meetings on July 25, 2024, and October 18, 2024. In 2025, the Council met on January 17, March 6, April 1, July 15, September 18, October 14, and December 10. The Council held three meetings in 2026, on January 30, March 16, and April 14. All Council meetings have been held simultaneously by Zoom and in person, and have been recorded, with agendas, minutes, and materials made available on the Attorney General's SB 882 website.[3]

The Council first met on April 15, 2024, and therefore submits this report by April 14, 2026 as required by Penal Code section 13016.

Definitions

Penal Code section 13016 defines "intellectual and developmental disability" as having the same meaning as "developmental disability" in Section 4512 of the Welfare and Institutions Code, which defines "developmental disability" as:

> … a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.[4]

This report will use the acronym IDD to refer to intellectual and developmental disability where appropriate.

Penal Code section 13016 requires the Council to evaluate trainings related to law enforcement interactions with "the intellectually and developmentally disabled community" as well with "individuals with mental health disorders."[5] Section 13016 also requires the Council to "make recommendations to the Legislature for improving outcomes of interactions with both individuals who have an intellectual or developmental disability and mental health conditions."[6]

[1] Pen. Code, § 13016, subds. (b), (f). The full text of SB 882 is available in Appendix B.
[2] Pen. Code, § 13016, subd. (g).
[3] *SB 882 Meetings and Materials*, Cal. Department of Justice, https://oag.ca.gov/sb882/meetings.
[4] Welf. & Inst. Code, § 4512, subd. (a)(1).
[5] Pen. Code, § 13016, subds. (h)(1), (2).
[6] Pen. Code, § 13016, subd. (h)(5).

Section 13016, however, does not define the terms "mental health condition" or "mental health disorder." [7]

This breadth in definitions, along with the fact that SB 882 covers a diverse population, makes precision in the terminology used in this report difficult. While SB 882 uses definitions from California law, federal law definitions may differ, which may translate to differences in eligibility for services at the federal versus state level.[8] Individual members of the community of people living with these conditions also will have varied preferences as to how to refer to themselves.

This report will use the term "SB 882 population" at times when making statements that apply both to people with intellectual and/or developmental disabilities and people with mental health conditions. Even when this general term is used, readers of this report should keep in mind that the SB 882 population experiences a broad spectrum of disabilities and conditions that differ in qualities, severity, and visibility to others. This report will use more specific language when called for, such as when discussing a study of or a service for people with a particular diagnosis, and will use the inclusive "mental health conditions" term to refer to the large and varied set of conditions other than intellectual and developmental disabilities that are covered by the statute.

Methodology and Limitations

The Council employed a multi-pronged methodology to collect and analyze information pertinent to its charge. This section discusses the Council's methods of inquiry and their limitations.

Literature Review

To inform the Council and select appropriate witnesses, the Council and staff reviewed numerous studies, reports, and best practices regarding interactions between law enforcement and individuals with intellectual or developmental disabilities and/or mental health conditions. These documents and presentations helped inform the Council's recommendations to the Legislature in this report, which includes a summary of this review and key themes and takeaways. This review is limited by the availability of existing research, which is weighted in two significant ways. First, much more research has been conducted relating to the efficacy of CIT than of other approaches, which makes it difficult to evaluate non-CIT modalities. Second, most currently available training discusses mental health generally but rarely focuses

[7] Pen. Code, § 13016, subds. (h)(2), (4), (5).

[8] Compare, e.g., Welf. & Inst. Code, § 4512, subd. (a)(1) (to be eligible for California regional center services, IDD cannot be a disability that is solely physical in nature, must manifest before the individual turns 18, and is limited to four enumerated diagnoses in addition to "conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability") with 42 U.S.C. § 15002(8) (under federal law, IDD can be "attributable to a mental or physical impairment," manifests before the individual turns 22, and results in substantial limitations in three or more areas of major life activity but is not limited to specific diagnoses).

specifically on intellectual and developmental disability. This makes it difficult to draw research-backed conclusions about best practices for training or other interventions aimed at addressing issues experienced by persons with intellectual and developmental disabilities.

Law Enforcement Survey

The Council, through Department staff, distributed a survey by email to all California law enforcement agencies beginning in Fall 2024. The purpose of the survey was to solicit input regarding features of existing training and other policies or programs agencies rely on to support their interactions with the SB 882 population, and perceptions agencies have of these trainings and programs. To develop the survey, the Council created a Survey subcommittee to work with Department staff to draft and review questions to present to the full Council for approval. The survey had a relatively high response rate, with approximately 34 percent of agencies representing a mix of urban, suburban, and rural locations across California responding by the February 2025 deadline.

The survey provided the Council with invaluable information, such as identifying available trainings on peace officer interactions with persons with intellectual or developmental disabilities and/or mental health conditions, which trainings are required, and what organizations (such as the Commission on Peace Officer Standards and Training (POST) or third-party vendors) offer the trainings. The survey also provided the Council with insight into strengths and gaps that law enforcement agencies themselves perceive in current trainings; whether agencies have special units or programs focusing on these types of interactions; whether agencies have adequate connections with community-based providers; and what relevant resources, if any, agencies perceive to be lacking in their respective jurisdictions. The survey responses are discussed below in the Training section and the Crisis Response Models and Other Systems Intervention section.

Training Observation

The Council also observed law enforcement trainings on relevant topics presented to law enforcement agencies across the state. The Council elected to move forward with a case study model for the training reviews. While some quantitative data were collected, the primary purpose of the evaluation was to identify features of the reviewed trainings that should or should not be emulated in other trainings. The survey was not designed to provide a generalizable snapshot of the trainings presented throughout the state. The Council also anonymized its review of trainings to increase the likelihood that law enforcement agencies and other organizations would voluntarily agree to invite the Council to observe its training courses.[9]

[9] To support anonymity, the standard observation form did not record information regarding the identity of the law enforcement agency or other organization providing the training. Rather, the form provided a

To assist in their evaluation, the Council approved a standard observation form that each Council Member would use to capture their impressions of the most important aspects of the trainings they observed.[10] Department staff collaborated in developing the form with Dr. Randy Dupont, a professor and clinical psychologist at the University of Memphis School of Urban Affairs and Public Policy, Department of Criminology and Criminal Justice and Co-Chair of the Crisis Intervention Team (CIT) International Board of Directors.

During training observations, Council members considered the following factors: basic course description, instructor information, focus and goals of the training, training methodology, whether the course was developed using community guided resources or committees or with other agency partners, whether the course actively referenced and/or included the perspective of members of the SB 882 population and/or their family members or loved ones, and whether and how the training agency measured the effectiveness of the course.

Council Members also recorded their overall impressions of the training course, including how accurately and thoroughly the training addressed the core subject matter, goals, and objectives reflected in the syllabus. Finally, Council Members had space to identify which major areas of subject matter or presentation style were well developed as well as which they believed needed further development.

The Evaluation Tool was designed to be completed on-line and submitted electronically to the California Department of Justice for analysis but also allowed for completion on paper. The Department then provided the results of the compiled analysis to the Council for its consideration.

Creating Recommendations

The Council collaborated to draft recommendations after receiving input from a variety of stakeholders, reviewing survey responses, hearing public comments at Council meetings, and hearing and interacting with presentations from first responders, advocates, researchers, and others at Council meetings. In September and October 2025, the Council created six subcommittees to explore the following topics in depth:

- Background
- Systems Interventions Recommendations
- Training Recommendations
- Data Recommendations
- Best and Emerging Practices

place for an anonymous Training Agency ID to be noted on the form. The Department provided the Council members with a randomly selected identification number for each of the courses observed.

[10] See SB 882 Council Meeting (Jan. 17, 2025) Agenda Item 14: Discussion and Potential Action Items Regarding Law Enforcement Training Evaluation Tool and Proposed Training Attendance Plan, https://www.youtube.com/watch?v=vAIndu5KVfM.

- Community/Non-Law Enforcement Recommendations

In October and November 2025, subcommittees met multiple times to develop proposed recommendations and questions for the full Council to discuss at its public meeting on December 10, 2025. After discussing the recommendations in the public meeting, the subcommittees reconvened in December and January to make revisions. Some recommendations were revised while others were identified for further discussion. The Council ultimately reviewed 40 potential recommendations at its January 30, 2026, meeting. The Council revised and adopted some of those recommendations at that January 2026 meeting, while the subcommittees reconvened to make final revisions as to others. At the Council's March 16 [and 19], 2026, meetings, the Council adopted its final recommendations and approved this report. The recommendations of the Council to the Legislature, and other potential promising practices identified by the Council through the subcommittee process, are included at the end of the Crisis Response Models and Other Systems Interventions section and at the end of the Training section.

Background

California law enforcement agencies engage in a variety of interactions with members of the SB 882 population. Peace officers will encounter such individuals in the course of their regular work promoting public safety and are also frequently the first responders to calls regarding people experiencing a crisis related to their condition or disability.

Law enforcement encounters with the SB 882 population take place against a backdrop of laws, systems, and services that affect these populations and impact the course of such encounters. For example, people with disabilities have legal rights during interactions with law enforcement, which mandate that peace officers make reasonable accommodations to allow people with disabilities to receive the same level of service and support as others.

Moreover, the availability and peace officer knowledge of local services also can have an impact on outcomes. People with mental health conditions are offered varied services from multiple types of providers—people have access to different services depending on where they live, their income, and what insurance they have, among other variables.[11] Many people with IDD, on the other hand, are entitled to services coordinated through a Regional Center.[12] However, gaps in these services may make effective response after law enforcement interactions more difficult.[13]

[11] Mental health care is usually accessed as part of an individual's physical health care, and thus, varies based on an individual's resources, insurance coverage, and available professionals and settings in an individual's area. See, e.g., *Mental Health* (2026) Covered Cal., https://www.coveredca.com/learning-center/using-your-plan/mental-health/ (discussing mental health care as part of a physical health care plan); *Mental Health By the Numbers* (2025) Nat. Assn. of Mental Illness, https://www.nami.org/about-mental-illness/mental-health-by-the-numbers/ (close to 10 percent of adults with "mental illness" or "serious mental illness" had no insurance coverage in 2024; over 120 million people live in a designated Mental Health Professional Shortage Area, where there are too few providers to meet demand; and among U.S. adults in nonmetropolitan areas, in 2020 only 48 percent of people with a "mental illness," and only 62 percent of people with a "serious mental illness" received treatment).

[12] See, e.g., *Regional Center Eligibility & Services* (2026) Cal. Dept. of Developmental Services, https://www.dds.ca.gov/general/eligibility/ (discussing eligibility for services from regional centers for those with intellectual and developmental disabilities and the types of services available through the regional centers); Welf. & Inst. Code, § 4512.

[13] See, e.g., *The Impact of the Direct Support Professional Workforce Shortage on Individuals and Families Served by the Regional Center System in California* (Jan. 2025) Cal. Policy Ctr. For Intellectual & Developmental Disabilities, p. 4, https://www.cpcidd.org/wp-content/uploads/2025/01/CPCIDD_Report_Jan2025_FINAL.pdf (58 percent of surveyed family members reported not being able to access all of a person's regional center services because of a shortage of direct services personnel).

How law enforcement became the primary responders to crises related to mental health conditions or IDD

In most California jurisdictions, law enforcement is the default responder when people are experiencing a mental health crisis, or when caregivers or others are unable to manage behaviors related to intellectual or developmental disability. Peace officers respond to calls regarding a person being dangerous to themselves or others, which at times may be connected to the symptoms of a disability. Peace officers also transport people in crisis to an emergency room or psychiatric outpatient center.[14]

In addition to these crisis-focused interactions, peace officers encounter members of the SB 882 population in their routine course of work, such as while on patrol. Peace officers are the primary responders to calls where such people may be a suspect in, victim of, or witness to a crime. And law enforcement responds to missing person reports in which the person who is missing may have a disability covered by SB 882.[15]

A brief review of historical factors that have expanded the role of law enforcement in health care response follows to provide more context to the interactions that occur between law enforcement and the SB 882 population. These factors include the de-institutionalization of mental health services, procedural changes in the involuntary commitment process, and the failure to adequately increase outpatient treatment capacity to meet the resulting need for care.[16]

The Deinstitutionalization of Health Care for the SB 882 Population and Increased Procedural Protections Against Involuntary Commitment

Beginning in the 1950s, there was a broad movement away from centering care for people with mental health conditions or intellectual and developmental disabilities in locked psychiatric

[14] *Transportation in Behavioral Health Crisis Services: 2022* (Apr. 2023) Nat. Assn. of State Mental Health Program Directors Research Inst., https://nri-inc.org/media/zjpgzgzm/transportation-in-bh-crisis-services-2022-update-4-3-23.pdf; Swartz & Pruette, *Reducing Law Enforcement Custody and Transportation During Behavioral Health Crises* (Nov. 2024) Psychiatric Services 75, p.11, https://psychiatryonline.org/doi/full/10.1176/appi.ps.24075016.

[15] See, e.g., *Law Enforcement Policy and Procedures for Reports of Missing and Abducted Children* (Mar. 2025) Nat. Ctr. For Missing & Exploited Children, p. I, https://amberadvocate.org/wp-content/uploads/2024/04/law-enforcement-policy-and-procedures-for-reports-of-missing-and-abducted-children_March-2025.pdf (discussing how police response to missing people reports for children may need to include unique response protocols for children with disabilities).

[16] E.g., Lamb, et al., *The Police and Mental Health* (2002) Psychiatric Services 53, pp. 1266–67; Watson & El-Sabawi, *Expansion of the Police Role in Responding to Mental Health Crises Over the Past Fifty Years: Driving Factors, Race Inequities and the Need to Rebalance Role* (2023) Law and Contemporary Problems 86:1 (Watson & El-Sabawi, *Expansion of the Police Role*), p. 2, https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=5086&context=lcp; SB 882 Council Meeting (April 1, 2025) Testimony of Drs. Michael Compton and Amy Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.

institutions, and towards providing services in the community. While there were positive aspects to this well-intentioned shift, it also had the effect of increasing opportunity for contact between peace officers and this population.

State-run psychiatric institutions had been developed in the 1800s as a solution to the poor conditions people with mental health conditions endured in jails or when hidden away in institutions by family members who did not want their existence known.[17] But over time, those institutions became fraught with neglect and abuse of the very people they were designed to aid. Exposés like the Richard Cohen documentary *Hurry Tomorrow*—filmed on site at Metropolitan State Hospital in Los Angeles—brought the combination of callousness and overmedication into the public eye.[18]

People with IDD were increasingly placed in institutions in the early twentieth century, in part due to the influence of eugenics and a corresponding tendency to segregate this population from community life.[19] These individuals and their families began to organize in the 1950s and work together to provide alternative community support systems.[20] Families successfully advocated for the California Legislature to create a subcommittee to investigate conditions in institutions where members of this population were held, and found poor conditions delivered at great cost to the state.[21]

Deinstitutionalization and the provision of care in the community were preferable for both people with mental health conditions and those with IDD for a variety of reasons. First, it is far less expensive to provide outpatient care in the community than in institutions.[22] Second, society began to recognize the dignity of people in the SB 882 population, the benefit to individuals of remaining in the community, and the right of individuals to freely access societal resources and opportunities unless restrictions are absolutely necessary due to danger to self or others.[23]

[17] Nelson, *Dorothea Dix's Liberation Movement and Why It Matters Today* (Dec. 2021) American J. of Psychiatry Residents' J. 17:2, pp. 8-9, https://psychiatryonline.org/doi/full/10.1176/appi.ajp-rj.2021.170203; *Annual Report (2021)*, Racial and Identity Profiling Advisory Bd. (2021 RIPA Report) p. 107, fn. 220, https://oag.ca.gov/sites/all/files/agweb/pdfs/ripa/ripa-board-report-2021.pdf; Watson & El-Sabawi, *Expansion of the Police Role*, p. 5.

[18] Kneeland, *Hurry Tomorrow* (2010; originally published 1975) https://emro.libraries.psu.edu/record/index.php?id=4142.

[19] *History of Regional Centers and the Lanterman Act*, Alta Cal. Regional Center, https://www.altaregional.org/history-regional-centers~~*History of Regional Centers and the Lanterman Act*, Alta Cal. Regional Center,~~.

[20] Id.

[21] Id.

[22] Id.

[23] Id.

At the same time, funding and policy changes such as the Community Mental Health Act of 1963 and the introduction of Medicaid in 1965 incentivized states to invest less in institutional care and more in community care.[24] During this period—the 1950s to the 1970s—legislators and courts also increased the procedural protections for people at risk of being involuntarily committed. By the 1970s, the United States Supreme Court established procedural protections for patients and prohibited states from involuntarily committing patients who were not dangerous.[25] California codified these protections in 1967's Lanterman-Petris-Short Act, discussed in the California Protections section below.[26]

The development of the Regional Center system also addressed conditions for people with IDD during this period. Assemblyman Frank Lanterman was a driving force in the Legislature on this issue, first co-authoring legislation in 1966 creating a pilot project to explore the feasibility and efficacy of a regional center system, and ultimately authoring in 1969 the legislation that became the Lanterman Developmental Disabilities Services Act (the Lanterman Act) ~~in 1976~~.[27]

As a result of these changes, the proportion of people in the SB 882 population receiving care in state psychiatric institutions significantly decreased by the end of the twentieth century. The number of public psychiatric beds in the United States has dropped by more than 90% since the 1950s while the United States population has nearly doubled since that time.[28]

Unfortunately, despite this combination of closing institutions and increasing public investment in community-based mental health services, a shortage of community health centers and serious barriers to accessing care persist.[29] The investment in community-based services has not been sufficient to meet the need. There are insufficient mental health providers across multiple categories of professionals across California.[30] County clinics can be sparse, especially in rural areas, and can struggle to staff positions due to competition with the private sector.[31] Many

[24] Watson & El-Sabawi, *Expansion of the Police Role*, p. 7.
[25] Watson & El-Sabawi, *Expansion of the Police Role*, p. 6.
[26] Welf. & Inst. Code, §§ 5001 et seq.
[27] *History of Regional Centers and the Lanterman Act*, Alta Cal. Regional Center, https://www.altaregional.org/history-regional-centers~~;~~ (noting passage of legislation in 1969 and renaming in 1976); Welf. & Inst. Code, §§ 4400 et seq, 4500 et seq, 4900 et seq.; Gov. Code, §§ 95000-95029.5.
[28] Fuller, et al., *Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters* (2015) Treatment Advocacy Center Office of Research & Public Affairs (Fuller, *Overlooked*), p. 11, https://www.tac.org/wp-content/uploads/2023/11/Overlooked-in-the-Undercounted.pdf.
[29] *National Mental Health Services Survey (N-MHSS): 2018, Data on Mental Health Treatment Facilities* (2019) U.S. Dept. of Health and Human Services Substance Abuse & Mental Health Services Admin., https://www.samhsa.gov/data/report/national-mental-health-services-survey-n-mhss-2018-data-mental-health-treatment-facilities.
[30] See discussion in the Key Elements of the System of Care section.
[31] See id.

private practices do not accept insurance because of the billing requirements imposed on them by insurers; even fewer accept Medicare or Medi-Cal (California's Medicaid program).[32]

Expanded Role of Policing in the Mental Health Care System

Following these shifts in the availability of community care services, law enforcement's role in mental health care grew. With no hospital to accept patients, when family members or the public sought assistance in caring for a family member suffering a mental health crisis, the first recourse was often to call 911, where peace officers are the first responders. Law enforcement is often the first to the scene of a call for service and often are used to transport people for treatment to clinics and hospitals, which means that peace officers are often the first responders for a person suffering a mental health crisis.[33]

Moreover, law enforcement is authorized to initiate involuntary commitments. As of a 2016 study, at least 25 states including California allow peace officers to start commitment proceedings, while 22 overlapping states include peace officers as an "interested person" eligible to commence such a proceeding.[34] While the number of state hospital beds for adults with serious mental health conditions has reached a historic low of 10.8 beds per 100,000 people in 2023, 52% of the population occupying those beds were committed through the criminal legal system.[35]

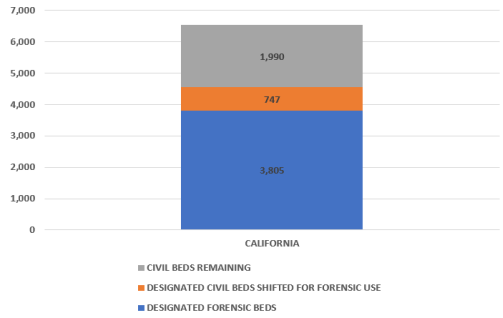
[32] Saunders, et al., *A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs* (2023) Kaiser Fam. Foundation, https://www.kff.org/mental-health/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs/.

[33] See Wiener, *Gavin Newsom signs law to 'overhaul' mental health system* (Oct. 10, 2023) CalMatters, https://calmatters.org/health/2023/10/california-mental-health-involuntary-treatment-law/; SB 882 Council Meeting (April 1, 2025) Testimony of Drs. Michael Compton and Amy Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be. A call for service is a communication that a member of the public makes to an emergency notification system or a first responder agency requesting assistance.

[34] Watson & El-Sabawi, *Expansion of the Police Role*, p. 17.

[35] Off, of Research & Public Affairs, *Prevention Over Punishment: Finding the Right Balance of Civil and Forensic State Psychiatric Hospital Beds* (Jan. 2024) Treatment Advocacy Center, https://www.tac.org/wp-content/uploads/2024/01/Prevention-Over-Punishment-Full-Report.pdf.

Figure X. Mental Health Bed Capacity in Psychiatric Institutions in California 2023[36]



Statistics Regarding Law Enforcement Contact with the SB 882 Population

Numerous studies have demonstrated that people who are part of the SB 882 population are more likely to encounter law enforcement. For example, one study found that one in four people with a serious mental illness report they have been arrested at least once in their lifetime, and such individuals are three times more likely to be arrested than the general population.[37] Individuals with a serious mental illness are most commonly arrested for minor misdemeanors, but such arrests still lead to interaction with the criminal justice system that can interfere with treatment and recovery.[38] Individuals with IDD are also overrepresented in criminal justice contacts. For example, one study indicated that 19.5% of youth with autism in the United States had been stopped by police by age 21, while another study indicated that comparatively, only 10% of the general population in the United States had experienced police contact in 2020.[39]

Disparities also appear when members of the SB 882 population interact with law enforcement as victims/survivors or witnesses. Research suggests that peace officers are less likely to investigate and act on reports that come from people with a perceived mental health or developmental disability.[40] Members of the SB 882 population have increased risk of victimization, and individuals dually diagnosed with both intellectual or developmental

[36] Id., p. 26. *(Note may change this to pie chart per recommendation from Member Libero.)*
[37] Watson & El-Sabawi, *Expansion of the Police Role*, p.17, fn. 90.
[38] SB 882 Council Meeting (April 1, 2025) Testimony of Drs. Michael Compton and Amy Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.
[39] Richardson, et al., *Law Enforcement Response to Persons with Intellectual and Developmental Disabilities* (2024) RAND Corp. (Richardson, *Law Enforcement Response*), p. 5, https://www.rand.org/content/dam/rand/pubs/research_reports/RRA100/RRA108-26/RAND_RRA108-26.pdf.
[40] Watson, et al., *Police Responses to Persons With Mental Illness: Does the Label Matter?* (2004) The J. of the Am. Academy of Psychiatry and the Law, pp. 7-8, https://jaapl.org/content/jaapl/32/4/378.full.pdf.

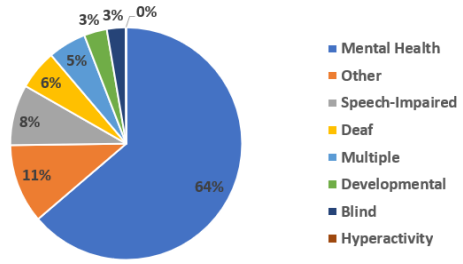
disability and a mental health condition are twice as likely to be involved in a crime either as a victim or a perpetrator.[41]

In recognition of these disparities, the California Legislature has developed reporting requirements to track how these trends might be present in California. The Racial and Identity Profiling Act of 2015 (RIPA or the Act) requires that peace officers record certain perceived demographic information, including mental disability, when they engage in stops and searches.[42] Since its creation, the Racial and Identity Profiling Advisory Board (RIPA Board) established by the Act has produced annual reports regarding these stops.[43] SB 882 also includes data collection measures requiring that use-of-force incidents that result in serious injury include an officer's perception of whether the person involved has a mental disability.

According to RIPA data published in 2025, people with disabilities in California experienced a higher frequency of law enforcement actions taken after being stopped, such as a citation, warning, or arrest.[44] Peace officers reported taking over three times more actions, on average, during a stop of someone with a perceived disability compared to someone without a perceived disability.[45] This disparity appeared reduced in RIPA data published in 2026, which indicated peace officers taking action over twice as often, on average, during a stop of someone with a perceived disability.[46] People with perceived disabilities were arrested in 28% of all stops—more than twice as frequently as people without perceived disabilities.[47] While the above statistics include all types of disability, the RIPA Board found that perceived mental health conditions accounted for nearly 65% of all reported perceived disabilities.[48] RIPA data published in 2026 contained similar findings, with mental health accounting for 58% of all perceived disabilities.[49]

[41] Richardson, *Law Enforcement Response*, p. 5.
[42] Pen. Code, § 13012.
[43] Pen. Code, § 13519.2, subd. (j); RIPA Board reports are available online at *RIPA Board Reports*, Cal. Dept. of Justice, https://oag.ca.gov/ab953/board/reports.
[44] *Annual Report (2025)*, RIPA Bd. (*2025 RIPA Report*), p. 35, https://oag.ca.gov/system/files/media/ripa-board-report-2025.pdf (the 2025 RIPA Report analyzed more than 4.7 million police and pedestrian stops conducted in 2023).
[45] Id., p. 30.
[46] *Annual Report (2026)*, RIPA Bd. (*2026 RIPA Report*), p.47, https://oag.ca.gov/system/files/media/ripa-board-report-2026.pdf (analyzing data from 2024).
[47] ~~Id.~~2025 RIPA Report, p. 33.
[48] Id., p. 25 (officers reported perceiving a disability in only 1.1 percent of all stops).
[49] *Annual Report (2026)*, RIPA Bd., p.47, https://oag.ca.gov/system/files/media/ripa-board-report-2026.pdf.

Figure X. Disabilities Perceived by Officers[50]



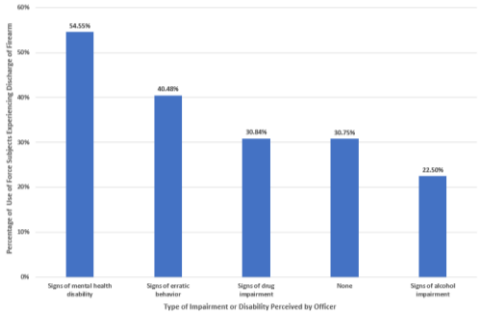
Importantly, these data are based upon the peace officer's perception; they are not self-reported by the people stopped or confirmed in any other way. Therefore, this data does not conclusively represent what happens to all people with disabilities during law enforcement stops, but rather demonstrates how outcomes change when peace officers interact with people that they think have disabilities. Indeed, the 2025 RIPA Report cautioned that at least some of its findings related to disability "should be interpreted with caution as more research is required to fully examine the intersection between disabilities, officer training, and other demographic variables."[51]

State data on uses of force also indicate increased uses of force and increased incidences of uses of firearms in interactions with people that officers observed to show signs of disability. California requires law enforcement agencies to report use of force incidents that result in serious bodily injury or death or involve the discharge of a firearm.[52] These reports must indicate whether the officer observed signs of drug or alcohol impairment, erratic behavior, or "[m]ental, physical, or developmental disability."[53] In these encounters, 43 individuals with perceived mental health conditions were shot by officers. Within the set of people involved in use of force incidents that required reporting, a greater percentage of those with perceived mental health conditions, as compared to those with other perceived conditions, had an officer discharge a firearm at them (54.5%).[54] By comparison, 22.5% of people experiencing one of these use of force incidents while showing signs of alcohol impairment had an officer discharge a firearm at them, while 30.8% of people showing signs of drug impairment during a use of force experienced this outcome, as did 40.5% of people displaying other erratic behavior.[55]

[50] 2025 RIPA Report, p. 25.
[51] Id., p. 32.
[52] Gov. Code, § 12525.2.
[53] Gov. Code, § 12525.2, subd. (b)(12).
[54] *Use of Force Incident Reporting 2024* (2024) Cal. Dept. of J., Crim. J. Statistics Center (*DOJ Use of Force 2024*), p. 40, tab. 19, https://data-openjustice.doj.ca.gov/sites/default/files/2025-07/USE%20OF%20FORCE%202024%20final.pdf .
[55] Id.

Among recorded incidents, there was one person officers suspected of having an intellectual or developmental disability, and that person was subjected to an "[o]ther control hold/takedown."[56]

Figure X. Use of Force Involving Discharge of Firearm Based on Officer Perception of Disability or Impairment[57]



In 2026 data, officers reported higher rates of use of any type of force in stops of an individual perceived to have a disability (43.27% of stops involving any use of force) as compared to individuals perceived as not having a disability (9.71% of stops involving any use of force).[58] People perceived to have a disability were also three to four times as likely to be detained, handcuffed, or searched and frisked as people perceived as not having a disability.[59]

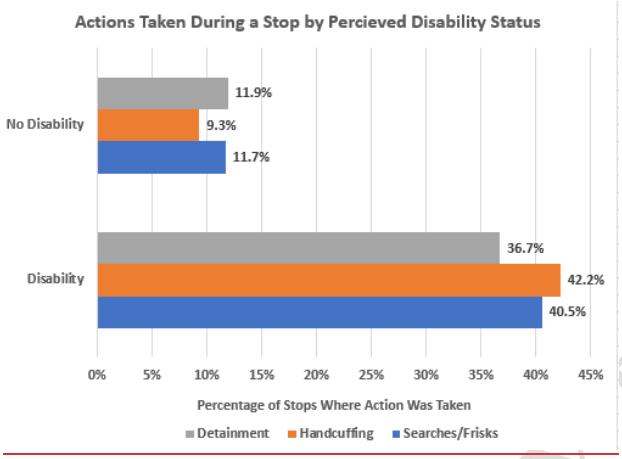
[56] For calendar year 2024, law enforcement agencies statewide reported a total of 581 such incidents that impacted 592 civilians. Officers perceived a mental health disability in 88 of these civilians and only one person with an intellectual or developmental disability. Because officers can code more than one perceived impairment, the total number of coded impairments—688—is greater than the 592 individual people reported. See Id., pp. 2, 39-40, tab. 18-19.

[57] Id.

[58] 2026 RIPA Report, pp. 47-48.

[59] Id., p. 48.

Figure X. Rates of Being Detained, Handcuffed, or Searched and Frisked, by Perceived Disability Status[60]



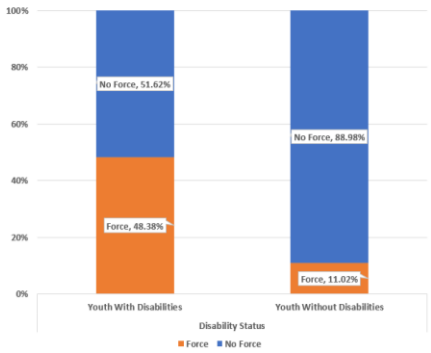
Interactions between youth members of the SB 882 population and law enforcement can be particularly traumatizing. RIPA data shows that such encounters are more frequent for youth in the SB 882 population than for youth without such disabilities. The RIPA Board's 2025 report found disability disparities in stops of youths ages 12-24 involving calls for service, and in the use of field interview cards for gathering information about the subject of a stop.[61] The RIPA data also indicate that force is used disproportionately against youth of color, youth with disabilities, and gender minority youth.[62]

Disparities were noted in the RIPA data for actions taken during a stop if the youth stopped was perceived to have a disability. For example, youth with a perceived disability were nearly four times more likely to be searched than youth without a perceived disability.[63] Likewise, a higher percentage of youth perceived to have a disability experienced force regardless of age groups, with transition-age youth (ages 18-24) experiencing force at a percentage five times higher than their peers without a perceived disability.[64] Youth with a perceived disability were more likely to be handcuffed during a stop than youths without a perceived disability.[65] Officers pointed a

[60] Id.
[61] *Annual Report (2025)*, RIPA Bd., p. 10.
[62] Id.
[63] 46.8 percent of youths with any perceived disability were searched, as compared to 12.2 percent of youths without any disability. See id., p. 10.
[64] Id., p. 60.
[65] Id., p. 61.

firearm at youths perceived to have disabilities in 67 stops in 2023, though none were reportedly discharged.[66]

Figure X. Use of Force Against Youth (Age 1-24) With and Without Disabilities[67]



Youth with disabilities are also dramatically overrepresented in the juvenile justice system. Data from Disability Rights California indicates 65-70% of the juvenile justice system is made up of youth with disabilities, which is three times the national average rate of disability in the general population.[68]

Disproportionate Incarceration of the SB 882 Population

The SB 882 population is also disproportionately represented in the country's penal institutions. This is particularly true for people of color with such disabilities. Given the scope of the Council's duties, this report does not cover incarcerated populations in depth but does offer a brief summary in order to highlight another venue through which the SB 882 population may have interactions with peace officers.

In 1955, about 4% of the inmate population in U.S. prisons and jails had a mental health condition. Today, roughly 20% of all incarcerated people have a diagnosed mental health

[66] Id.
[67] Id., p. 60-61.
[68] SB 882 Council Meeting (Sep. 18, 2025) Testimony of Megan Buckles, https://www.youtube.com/watch?v=QSycCzGDhrI; see also *Model Programs Guide Literature Review: Intersection between Mental Health and the Juvenile Justice System*, Off. of Juvenile J. and Delinquency Prevention (2017) https://ojjdp.ojp.gov/library/publications/model-programs-guide-literature-review-intersection-between-mental-health-and.

condition, but some facilities report that the number may be as high as half.[69] One 2017 study notes that "[t]he rate of mental disorders in the incarcerated population is 3 to 12 times higher than that of the general community."[70] In California state prisons, more than a third of the current adult population is in the Mental Health Program, meaning they have a diagnosable mental health condition, and about 9% of the current adult population is enrolled in the Developmental Disabilities Program.[71] About 80% of people enrolled in the Developmental Disabilities Program are also enrolled in the Mental Health Program.[72]

In addition to being overrepresented in the carceral population, individuals with mental health conditions who were formerly incarcerated are more likely than the general population to be re-incarcerated, with rates of recidivism ranging between 50-230% higher for people with mental health conditions, regardless of the diagnosis.[73]

Once incarcerated, people with mental health conditions often face insufficient access to mental health services. According to one study examining national data from 2016, 33% of people in state prisons across the United States with "chronic mental illness" have not had any

[69] Fuller, *Overlooked*, p. 1; see also Wang, *Chronic Punishment: The Unmet Mental Health Needs of People in State Prisons* (2022) Prison Policy Initiative, https://www.prisonpolicy.org/reports/chronicpunishment.html#mentalhealth (indicating 56 percent of people in state prisons nationwide report history of mental health concerns and 43 percent have been diagnosed with a "mental disorder").

[70] Wolff, *Fact Sheet: Incarceration and Mental Health* (2017) Weill Cornell Medicine Psychiatry (Wolff, *Fact Sheet*), https://spac.icjia-api.cloud/uploads/Fact%20Sheet%20Incarceration%20and%20Mental%20Health-20220608T19114846.pdf (citing Teplin, *The prevalence of severe mental disorder among male urban jail detainees: comparison with the Epidemiologic Catchment Area Program* (1990) Am. J. of Public Health, 80:6, pp. 663–669); Cook County Sherriff Thomas Dart, quoted in Ford, *America's Largest Mental Hospital is a Jail* (2015) Atlantic Monthly; Council of State Governments J. Center (2013) (cited in Prins, *Why Determine the Prevalence of Mental Illnesses in Jails and Prisons?* (2014) Psychiatric Services 65:8, p. 1074.).

[71] SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Lee Lipsker, https://www.youtube.com/watch?v=a6uhhwrrhkU.

[72] Id.

[73] Wolff, *Fact Sheet* (citing Baillargeon et al, *Psychiatric disorders and repeat incarcerations: the revolving prison door* (2009) Am. J. Psychiatry 166:1, pp. 103–109, https://psychiatryonline.org/doi/10.1176/appi.ajp.2008.08030416?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed); see also Applegarth, *Examining the connection between mental illness and recidivism for persons on parole* (Dec. 2024) J. of Crim. J., https://www.sciencedirect.com/science/article/pii/S0047235224001648#bb0260; Magee et al., *Two-year prevalence rates of mental health and substance use disorder diagnoses among repeat arrestees* (2021) Health and J., https://pubmed.ncbi.nlm.nih.gov/33411067/.

treatment since incarceration.[74] However, treatment access in California compared favorably to that measured by other states in a 2025 study commissioned by the California Department of Corrections and Rehabilitation in connection with ongoing litigation related to its mental health services.[75] Reports on national data and information from throughout the country also indicate that incarcerated individuals who belong to the SB 882 population can be disproportionately represented in isolation units, which is concerning given harms that isolation can cause, particularly for individuals with intellectual or developmental disabilities or mental health conditions.[76] California has placed limits on the use of restricted housing in an attempt to address concerns about its impact.[77]

Outcomes of Law Enforcement Interactions with People with Mental Health Conditions and IDD

Increased law enforcement interactions result in three broad types of harm to community members: an increase in behaviors associated with the person's mental health condition or intellectual or developmental disability; increased experience of use of force; and an increased risk of death during an encounter with law enforcement.

First, during and after encounters with law enforcement, members of the SB 882 population can experience stresses, including fear for their lives or safety, humiliation, and stigma.[78] For example, one study of law enforcement violence in Baltimore and New York found law enforcement contact to be associated with anxiety and trauma symptoms that increased with the number of law enforcement stops in a sample of predominantly people of color.[79] The study also noted an association between recent interaction with law enforcement and

[74] *Mental Health*, Prison Policy Initiative, https://www.prisonpolicy.org/research/mental_health/ (citing Widra, *New research links medical copays to reduced healthcare access in prisons* (Aug. 2024) Prison Policy Initiative, https://www.prisonpolicy.org/blog/2024/08/29/fees-limit-healthcare-access/#limitedhealthcareaccess). The study of national data from 2016 found that the situation was exacerbated in facilities charging co-payments for medical visits, but California eliminated such copayments in 2019. *California Department of Corrections and Rehabilitation eliminates inmate copayments for health care services* (Feb. 21, 2019) Cal. Dept. of Corrections and Rehabilitation, https://www.cdcr.ca.gov/news/2019/02/21/california-department-of-corrections-and-rehabilitation-eliminates-inmate-copayments-for-health-care-services/.

[75] VRJS and Falcon, Inc., *California Department of Corrections and Rehabilitation (CDCR): Systemwide Mental Healthcare Study* (Sept. 19, 2025) https://www.cdcr.ca.gov/wp-content/uploads/2026/01/CDCR-Systemwid-Mental-Healthcare-Study.pdf. As of publication of this report, CDCR remains under a mental health receiver charged with implementing court-ordered remedies related to mental health services and staffing. *Coleman v. Newsom* (2025 E.D. Cal.) 2025 U.S. Dist. LEXIS 66385. See also Legislative Analyst's Office, *Addressing Chronic Vacancies in Prison Mental Health Care* (Feb. 23, 2026) https://lao.ca.gov/Publications/Report/5134.

[76] *Id.*

[77] *Restricted Housing*, Cal. Dept. of Corrections and Rehabilitation, https://www.cdcr.ca.gov/adult-operations/restricted-housing/.

[78] Watson & El-Sabawi, *Expansion of the Police Role*, p. 18, fns. 97-99, 101.

[79] Id., p. 18, citations to fns. 100-101 omitted.

"psychotic experiences, suicide ideation, and suicide attempts."[80] Another author, even while questioning the causal connection between law enforcement encounters and increased symptomology, conceded that "the stress of encounters with police is likely to be a very salient risk factor across the spectrum of psychotic experience, and may have severe consequences in people with" mental health conditions.[81]

Second, interactions between members of the SB 882 population and law enforcement result in higher rates of uses of force. For example, a 2021 study of nine cities across the United States analyzed 28,549 law enforcement use of force events occurring between 2011 and 2017, and found that people with serious mental illnesses were 12 times more likely to have force used and 10 times more likely to be injured than people without serious mental illnesses.[82] Analyzing these data, this study found that people with certain serious mental health conditions constitute 17% of use of force cases and 20% of suspects injured during law enforcement interactions despite constituting only 1% to 3% of the population.[83] Another study indicated that peace officers may be more likely to use electronic control devices on people experiencing mental health distress than in cases that involve the arrest for a criminal offense, and also tend to use more shocks with members of this population.[84]

Finally, encounters between law enforcement and members of the SB 882 population are also more likely to turn fatal. Multiple studies have found that individuals who are killed by law enforcement are disproportionately likely to have a serious mental illness, with at least one in four fatal police encounters ending the life of an individual with severe mental illness.[85] The Washington Post collected data on national police fatality shootings from 2015 – 2024.[86] In its reporting on preliminary data for the first half of 2015, the Washington Post reported that 124 cases of peace officer shootings (27% of all peace officer shootings that year) nationwide involved a mental health crisis; in 36% of those cases, the peace officers had been explicitly

[80] Id., p. 18, citations to fn. 102 omitted.
[81] Id., pp. 18-19, citations to fn. 103 omitted.
[82] Laniyonu & Goff, *Measuring disparities in police use of force and injury among people with serious mental illness* (2021) BMC Psychiatry 21:500 (Laniyonu & Goff, *Measuring disparities*), p. 4, https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-021-03510-w; see Wood & Watson, *Improving police interventions during mental health-related encounters: Past, present and future* (2016) Policing Soc. 2017:27 (Wood & Watson, *Improving police interventions*), pp. 289–299, https://pmc.ncbi.nlm.nih.gov/articles/PMC5705098/ (finding people with behavioral conditions were twelve times more likely to experience use of force and ten times more likely to be injured).
[83] Laniyonu & Goff, *Measuring disparities*, p. 1.
[84] Watson & El-Sabawi, *Expansion of the Police Role*, p. 17, fn. 95.
[85] E.g., Fuller, *Overlooked*, p. 1; SB 882 Council Meeting (April 1, 2025) Testimony of Drs. Michael Compton and Amy Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.
[86] *Fatal Force* (last updated December 31, 2024) The Washington Post (*Fatal Force*) https://www.washingtonpost.com/graphics/investigations/police-shootings-database/.

called to help the person get medical treatment.[87] Updated data for 2015 indicate that there were 261 peace officer fatalities involving mental illness (26% of all peace officer shootings that year).[88] The Council also heard individual witness accounts of family members killed by peace officers in response to calls for assistance.[89]

Yet some sources suggest that even these high numbers may be an undercount. The U.S. Bureau of Justice Statistics suspended its Arrest-Related Deaths Program—the only federal database that systematically sought to identify variables of mental health in civilian deaths—after an audit of the source found that the number of incidents was being undercounted by half because of incomplete or inconsistent source data.[90]

Interactions with people with mental health conditions and IDD can impact peace officers as well, particularly when interactions lead to negative outcomes. At the systems level, the demands of providing a public health function in addition to law enforcement functions place operational strain on law enforcement agencies, which were not designed or funded to provide health services.[91] These demands may be harder for smaller agencies with limited resources to absorb.[92] At the individual level, peace officers involved in negative encounters, particularly officer-involved shootings, may suffer negative emotions, including potentially a form of posttraumatic stress disorder that may include guilt and depression.[93] One study of peace officers following an incident where the officer shot someone found that officers had a range of reactions following the incident, including: trouble sleeping, fatigue, crying, recurrent thoughts,

[87] Lowery, *Police shootings: Distraught people, deadly results* (June 30, 2015) The Washington Post, https://www.washingtonpost.com/sf/investigative/2015/06/30/distraught-people-deadly-results/.
[88] *Fatal Force* (as of February 27, 2026).
[89] SB 882 Council Meeting (April 1, 2025) Testimony of Vincent Eng, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.
[90] Note arrest-related deaths collected data only from 2002-2012. See Fuller, *Overlooked*; Scott, *Arrest-Related Deaths (ARD)* (2012) Bur. of J. Statistics, https://bjs.ojp.gov/data-collection/arrest-related-deaths-ard.
[91] See, e.g., Jensen & Burke, *IACP@Work: The IACP Efforts to Help Support Public Health–Informed Policing*, IACP Police Chief (describing "Public Health Informed Policing" as a "new, emerging term," notwithstanding some longstanding practices, and describing limited grant funding for implementation) https://www.policechiefmagazine.org/iacpwork-the-iacp-efforts-to-help-support-public-health-informed-policing/?ref=8be4a95c09a8ca384cc26862dc675b54.
[92] E.g., *Evidence-Based Crime Reduction Strategies for Small, Rural, and Tribal Agencies* (2021) International Assn. of Chiefs of Police, p. 1 ("[s]mall, rural, and tribal [law enforcement] agencies often operate with limited financial and personnel resources that can make implementing" evidence-based best practices difficult) https://portal.cops.usdoj.gov/resourcecenter/content.ashx/cops-p454-pub.pdf.
[93] *Police Responses to Officer-Involved Shootings* (Jan. 1, 2006) National Institute of J. (*NIJ Police Responses 2006*), table 2, https://nij.ojp.gov/topics/articles/police-responses-officer-involved-shootings; see also SB 882 Council Meeting (Oct. 18, 2024) Testimony of Mark Stadler, Senior Program Administrator for Ventura County Sheriff's Office Crisis Intervention Team, https://www.youtube.com/watch?v=yWRnfEr33es (discussing impact of shooting of person with mental health condition on individual peace officer).

anxiety, fear of legal or administrative problems, and sadness.[94] Thus, improved outcomes in interactions between peace officers and the SB 882 population benefit peace officers as well.

The Rights of Individuals with Mental Health, Intellectual, and Developmental Disabilities

Both federal and California laws provide rights and protections for people with mental health, intellectual, and developmental disabilities.

Federal Protections

Federal law prohibits disability-based discrimination in many areas of everyday life, including in state and local government services.[95] The Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (Section 504) are the federal foundations for protections for individuals with disabilities.[96]

Title II of the ADA requires that public entities, including police and sheriff departments, provide people with disabilities an equal opportunity to benefit from all their programs, services, and activities.[97] This includes making reasonable modifications in their policies, practices, or procedures that are necessary to ensure accessibility for individuals with disabilities.[98] And the ADA requires peace officers to take appropriate steps to ensure that communication with people with disabilities are as effective as communications with others.[99]

Section 504 prohibits disability discrimination by any program or activity that receives federal financial assistance.[100] "Program or activity" includes the operations of a department, agency, or other instrumentality of a state or local government, such as police and sheriff departments that receive federal financial assistance.[101]

[94] *NIJ Police Responses 2006*, table 2.
[95] 42 U.S.C. §§ 12101 et seq.; 29 U.S.C. § 794.
[96] Given the similarity between laws, courts often analyze ADA and Section 504 claims together. See, e.g., *Sligh v. City of Conroe, Texas* (5th Cir. 2023) 87 F.4th 290, 304 n.4. Under both federal statutes, a person with a disability is an individual with a "physical or mental impairment that substantially limits one or more major life activities," and includes instances when an individual has a record of the disability or is perceived to have a disability. Major life activities include such things as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. To be substantially limited under federal law means that such activities are restricted in the manner, condition, or duration in which they are performed in comparison with most people. See 42 U.S.C. § 12102; 28 C.F.R. § 35.108; 34 C.F.R. § 104.3(j). A person with a disability may meet the definition under California law but lack the degree of impairment necessary to meet the federal definition.
[97] 42 U.S.C. § 12132; 28 C.F.R. § 35.130.
[98] 28 C.F.R. § 35.130.
[99] 28 CFR § 35.160; *Commonly Asked Questions About the ADA and Law Enforcement* (2020) U.S. Dept. of J. Civil Rights Division, https://www.ada.gov/resources/commonly-asked-questions-law-enforcement/#effective-communication.
[100] 29 U.S.C. § 794.
[101] Id.

California Protections

California law also protects individuals with disabilities. Government Code section 11135 and the Disabled Persons Act are key laws protecting people with disabilities from discrimination. The Lanterman-Petris-Short Act governs involuntary commitments, and the Lanterman Act sets forth a system of services for people with IDD.

Government Code section 11135 prohibits discrimination against people with a range of protected statuses, including disability, by any program or activity that receives state financial assistance. People with disabilities are protected as people with mental disabilities, physical disabilities, or medical conditions, and are protected from discrimination based on their genetic information.[102] This protection includes people who are associated with people with disabilities, like caregivers, and people perceived as having disabilities.[103] Government Code section 11135 expressly incorporates the Title II of the ADA into California law.[104] A "program or activity" is defined broadly and includes "all the operations of [a] covered entity ... even if only one part of the covered entity receives state support."[105]

The Disabled Persons Act guarantees people with disabilities "the same right as the general public" to use of public places including "streets, highways, sidewalks, walkways, [and] public buildings."[106] The Act broadly guarantees access to all "places to which the general public is invited."[107] The Act also incorporates the ADA into California law.[108] It also ensures that peace officers traveling with a "search and rescue dog" are afforded the same protections.[109]

The Lanterman-Petris-Short Act (LPS Act) sets out rights and protections in commitment and conservatorship proceedings and provides a means for enforcing those rights.[110] The LPS Act was passed to "end the inappropriate, indefinite, and involuntary commitment of people with mental health disorders, developmental disabilities, and chronic alcoholism," as well as to "provide services in the least restrictive setting appropriate to the needs of each person receiving services."[111]

Under the LPS Act, law enforcement personnel and certain mental health professionals can take an individual into custody if they believe that, because of a mental health condition, the individual is likely to cause or experience specific kinds of harm or danger. This process is often referred to as a "5150 hold" (because it is authorized by Welfare and Institutions Code section

[102] Gov. Code, § 11135, subd. (a).
[103] Gov. Code, § 11135, subd. (d).
[104] Gov. Code, § 11135, subd. (b).
[105] Cal. Code Regs. tit. 2, § 14020, subd. (ii).
[106] Civ. Code, § 54, subd. (a).
[107] Civ. Code, § 54.1, subd. (a)(1).
[108] Civ. Code, § 54, subd. (c); Civ. Code, § 54.1, subds. (a)(3) and (d).
[109] Civ. Code, § 54.25, subd. (a)(1).
[110] Welf. & Inst. Code, §§ 5150, 5250, 5350.
[111] Welf. & Inst. Code, § 5001.

5150) and is one source of potential interactions between law enforcement and people experiencing a mental health crisis.[112] A 5150 hold can last up to 72 hours, and during that period, mental health professionals will examine and determine whether the individual can be safely released, whether voluntary services would be appropriate, or whether additional treatment is needed.[113]

Individuals being detained for evaluation and treatment under the LPS Act have the same legal rights guaranteed to all individuals under federal and state laws. This includes, among others, the right to dignity, privacy, and humane care, the right to prompt medical care and treatment, and the right to social interaction and participation in community activities.[114] The LPS Act also sets out procedural protections for people undergoing conservatorship.[115]

The Lanterman Act established rights for people with developmental disabilities and affords them the same legal rights guaranteed to all other individuals.[116] It also prohibits discrimination against people with developmental disabilities in programs and activities that receive public funds, including law enforcement agencies.[117] Under the Lanterman Act, law enforcement agencies may not employ policies and practices regarding interactions with people with intellectual and developmental disabilities or mental health conditions that constitute discrimination against such individuals.[118]

The Current State of Care for People with Mental Health Conditions and IDD and Their Interactions with Law Enforcement

To fully assess how to improve interactions between law enforcement and the SB 882 population, it is important to have familiarity with the systems of care that such individuals can utilize to access treatment and related supportive services. The availability of services in a jurisdiction informs what resources peace officers can reasonably rely on when encountering a crisis because they can only refer or escort people to services that exist and have room to accept new clients. In some jurisdictions, the way services operate creates situations in which law enforcement encounters are more likely. For both these reasons, this report summarizes below key elements of the system of care for adults and youth with mental health conditions or IDD.

[112] Welf. & Inst. Code, § 5150.
[113] Welf. & Inst. Code, §§ 5151-5152.
[114] Welf. & Inst. Code, §§ 5325-5325.1.
[115] See e.g., Welf. & Inst. Code § 5350, subd. (d)(1) ("The person for whom conservatorship is sought shall have the right to demand a court or jury trial on the issue of whether the person is gravely disabled.")
[116] Welf. & Inst. Code, § 4502..
[117] Id.
[118] Id.

The Mental Health Care System

Demographics

Mental health conditions present in diverse ways across California. Overall, about 14.4% of adults in the state report experiencing some form of mental health condition, while 3.9% report a "serious mental illness" that impacts tasks of daily living.[119] There are regional variations in the prevalence of mental health conditions, with the highest rates occurring in San Joaquin Valley and the Northern and Sierra regions.[120] There is likewise racial and ethnic variation in rates of serious mental health conditions, with white and Latino adults showing rates closest to the 3.9% average for the state, while Native American rates are 6.8%, rates for Black Californians are 5.3%, and rates are below average for the Asian (1.5%) and Pacific Islander (2.1%) populations.[121] Lack of socioeconomic resources also results in higher rates of serious mental health diagnoses. Mental health diagnoses decrease as income level increases. While 8.9% of people with incomes below the Federal Poverty Level (FPL) have "serious mental health disorders," the rate decreases to 6.3% for people with incomes one to two times the FPL, 3.6% for those with incomes two to three times the FPL, and only 1.9% for individuals earning three times the FPL.[122] Nearly two-thirds of Californians reporting some level of mental health need also reported not getting treatment.[123]

California's rate of suicide is lower than the national average and was 10.3-10.9 per 100,000 population level in 2015-2019.[124] However, the number of Californians who die by suicide has increased by more than 50 percent since 2001.[125] Here also there are racial, gender, and regional variations. Men are over three times more likely to die by suicide than women, and rates are higher for people over 45 and for people who are Native American or white.[126]

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[119] *Mental Health in California: Waiting for Care* (Jul. 2022) Cal. Health Care Almanac, Cal. Health Care Foundation (*Mental Health in California: Waiting for Care*), p. 4, https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022.pdf.

[120] Id., p. 5.

[121] Id., p. 9; Ramos-Yamamoto, *Californians and Mental Health: What We Know About Poverty and Race* (March 2018) California Budget & Policy Center (Ramos-Yamamoto, *Californians and Mental Health*) https://calbudgetcenter.org/resources/californians-and-mental-health-what-we-know-about-poverty-and-race/.

[122] See Ramos-Yamamoto, *Californians and Mental Health* (Data from 2015, when the FPL was $11,700 for a single person and $24,250 for a family of four).

[123] *Mental Health in California: Waiting for Care*, p. 20.

[124] Id., p. 23.

[125] Wiener, *Breakdown: California's mental health system, explained* (Updated Sept. 17, 2020) CalMatters (Wiener, *Breakdown*) https://calmatters.org/explainers/breakdown-californias-mental-health-system-explained/.

[126] *Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding* (March 2020) Cal. Budget & Policy Center (*Mental Health in California: Understanding Prevalence*) https://calbudgetcenter.org/resources/mental-health-in-california/; *Mental Health in*

Notably the majority of California's IDD population is male.[127] There is a large amount of regional variation, with a low of 6.2 deaths from suicide per 100,000 population in Imperial County, and a high of 37.3 deaths from suicide per 100,000 population in Trinity County.[128] There is also consistent research showing disproportionate rates of suicidal ideation and attempts among people with autism.[129]

Key Elements of the System of Care

California's mental health system of care relies on multiple delivery structures and is influenced by federal, state, and local county policy.[130] Services may be public or private and include a range of inpatient, outpatient, and residential options. The quality and ease of access to these services impact the breadth of options first responders can employ to address mental health crisis calls in the community.

In the public mental health system, the federal and California state governments have a role in funding, governance, and oversight of public treatment settings, and set minimum standards of care, but otherwise give counties discretion in how to spend funds and operate county mental health services.[131] County-operated community clinics offer outpatient services geared toward people with more significant impairments, including crisis intervention, medication management, therapy, outpatient psychiatry, and case management.[132]

Services offered in private practice settings may include mental health evaluation and treatment including psychotherapy, psychological testing, outpatient medication monitoring, psychiatric consultation, lab tests, and medications.[133] Despite laws guaranteeing parity of coverage, many Californians with mental health conditions struggle to obtain in-network

California: Waiting for Care, pp. 25-26 (While the source does not address causation, it should be noted that men are more likely to die due to suicide attempts than women because they are more likely to choose more lethal methods.); Callanan & Davis, *Gender differences in suicide methods* (2012) Social Psychiatry and Psychiatric Epidemiology 47, pp. 857–869, https://doi.org/10.1007/s00127-011-0393-5; Simion & Jung, *Gender disparities in suicide: a deeper look into the complexity of suicidal acts* (Sept. 2025) Legal Medicine 77, https://www.sciencedirect.com/science/article/abs/pii/S1344622325001130; *Suicide* (2026), Nat. Inst. of Mental Health, https://www.nimh.nih.gov/health/statistics/suicide.

[127] See, e.g. Cal. Dept. of Developmental Svcs., Annual Report to the Legislature on Autism (Apr. 1, 2024) p. 6 https://www.dds.ca.gov/wp-content/uploads/2024/08/Annual_Report_Legislature_Autism.pdf (reporting 79% of statewide Lanterman-eligible autism caseload is male, and 21% female).

[128] *Mental Health in California: Waiting for Care*, p. 24.

[129] [Citations to be provided by Member Libero].

[130] *Mental Health in California: Understanding Prevalence*, pp. 46-50.

[131] Id., p. 42.

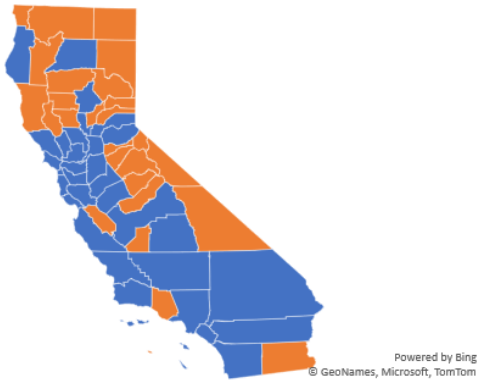
[132] Id., pp. 50 and 52.

[133] See id., p. 49 (describing services available under Medi-Cal Managed Care Plans).

care.[134] There are not enough providers in most areas.[135] And mental health services are becoming less accessible as providers increasingly decide not to accept insurance.[136]

A person needing more than outpatient intervention may access a continuum of services including hospitalization, residential treatment, or non-residential intensive treatment options such as day treatment or intensive case management.[137] Hospitals include acute psychiatric hospitals, or psychiatric units in general hospitals, operated at the county level.[138] California also has five state hospitals whose population comes mainly from the criminal legal system, with about 10% being placed through civil commitment, at times with involvement from law enforcement.[139] Counties may offer residential treatment options including board and care facilities, mental health rehabilitation centers, or skilled nursing facilities.[140]

Figure X. Adult Acute Psychiatric Beds in California[141]



As described in the *Expanded Role of Policing in the Mental Health Care System* section above, however, the available space in these types of facilities has steadily decreased, creating a challenge. From 1995 to 2017, the quantity of beds in mental health hospitals in the state

[134] Wiener, *Breakdown* (in 2015, privately insured Californians were seven times as likely to seek mental health treatment outside their provider network than physical health treatment).
[135] Id.
[136] Id. (reporting that only 55% of mental health care providers accept common insurance, compared to 89% of all health care professionals).
[137] *Mental Health in California: Understanding Prevalence*, p. 52.
[138] See id., p. 61.
[139] Id., p. 60.
[140] Id.
[141] Id., p. 63.

decreased by 28 percent, leaving 25 mostly rural counties with none.[142] Residential treatment beds have also reduced in number, leaving a gap in services for people who need more consistent treatment engagement via a higher level of care than outpatient care. For example, San Francisco lost more than a third of its board and care facilities between 2012 and 2019.[143] Over an overlapping time frame (2010-2015), emergency room visits that resulted in referral psychiatric inpatient care increased by 30%, putting additional pressure on the hospital system and emergency rooms.[144]

Regional disparities also exist in adequacy of mental health staffing in counties across California. A 202018 snapshot of mental health providers in the state indicated California had 31,34939,838 Marriage and Family Therapists (MFTs), 18,97426,055 Licensed Clinical Social Workers (LCSWs), 16,68317,452 psychologists, 5,8064,660 psychiatrists, 1,207and 1,985 professional clinical counselors, and 306 psychiatric nurses.[145] Nor was this staff proportionally distributed across California. San Joaquin Valley and Inland Empire had staffing levels below the state average in nearly all categories, while other regions had shortages of specific types of providers.[146] Additionally, in a similar 2018 snapshot, rResearchers noted that these professionals did "not reflect the racial and ethnic diversity of the state," which poses challenges for offering culturally salient care that improves chances of treatment success.[147] Workforce projections from the California Department of Health Care Access and Information

[142] Id., p. 63.
[143] Wiener, *Breakdown*.
[144] Id.
[145] *Mental Health in California: For Too Many, Care Not ThereWaiting for Care* (Mar. 2018) Cal. Health Foundation Cal. Health Care Almanac, p. 463, https://www.chcf.org/wp-content/uploads/2018/12/MentalHealthCA2018.pdf.
[146] See *Mental Health in California: Waiting for Care*, p. 47 (shortages included LCSWs in the Central Coast, Inland Empire, Northern and Sierra, Orange County, San Diego, and San Joaquin Valley regions; MFTs in Inland Empire, Northern and Sierra, Sacramento, San Diego, and San Joaquin Valley; both psychologists and psychiatrists in the Inland Empire, Northern and Sierra, Orange County, and San Joaquin Valley regions; psychiatrists in the Central Coast region, and psychologists in Sacramento). Regions listed include the following counties: Central Coast (Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Ventura), Greater Bay Area (Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma), Inland Empire (Riverside, San Bernardino), Los Angeles County (Los Angeles), Northern and Sierra (Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba), Orange County (Orange), Sacramento Area (El Dorado, Placer, Sacramento), San Diego Area (Imperial, San Diego), San Joaquin Valley (Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare).
[147] *Mental Health in California: For Too Many, Care Not There* (Mar. 2018) Cal. Health Foundation Cal. Health Care Almanac, p. 43, https://www.chcf.org/wp-content/uploads/2018/12/MentalHealthCA2018.pdf.Id.

indicate workforce shortages across all California counties in 2025-2026.[148] ~~Nor was this staff proportionally distributed across California. San Joaquin Valley and Inland Empire had staffing levels below the state average in all categories, while other regions had shortages of specific types of providers.[149]~~

Figure X. Licensed Mental Health Professionals by Region in California, 2020[150]

Region	Psychiatrists*	Clinical Social Workers	Marriage and Family Therapists	Professional Clinial Counselors	Psychologists	Psychiatric Technicians
Central Coast	11.6	61.8	144.4	5.2	47.1	52.6
Greater Bay Area	18.7	82.8	135.3	6.8	72.6	17.9
Inland Empire	8.2	39	60.8	3.7	15.9	40.9
Los Angeles County	12	81.1	106.2	4	48.7	8.8
Northern and Sierra	5.8	65.4	100.3	5.5	21.8	12.8
Orange County	7.9	56.8	106.3	5.6	40.1	15.2
Sacramento Area	12.3	72.6	98.4	5.7	37.6	12.4
San Diego Area	13.3	64.8	94.1	7.3	55	3.1
San Joaquin Valley	6.2	35.5	48.2	2.5	16.2	58.3
State Average	**11.8**	**65.9**	**100.8**	**5**	**44.2**	**22.7**

These rates are per 100,000 population for each region. The color scaling for each column references the state average for each profession. If a region's rate is above the state average, it is coded green. If the rate is close to the state average it is coded yellow. If the rate is below the state average, it is coded red.
***Psychiatrists include those who have completed residency training and are active in patient care at least 20 hours per week.**

Funding Considerations

Multiple funding streams support the mental health system of care and changes at the federal, state, and local levels continue to impact services. As noted above, private mental health services receive funds from patients' managed care and fee-for-service Medi-Cal plans, along with private insurance or other direct patient payment. County behavioral health systems

[148] Cal. Dep't. of Health Care Access and Information, *Supply and Demand Modeling for California's Behavioral Health Workforce* (2022) https://hcai.ca.gov/visualizations/supply-and-demand-modeling-for-californias-behavioral-health-workforce/#key-findings.

[149] ~~See id. *Mental Health in California: Waiting for Care*, p. 474 (shortages included LCSWs in the Central Coast, Inland Empire, Northern and Sierra, and Orange County, San Diego, and San Joaquin Valley regions; MFTs in Inland Empire, Northern and Sierra, Sacramento, and San Diego, and San Joaquin Valley; both psychologists and psychiatrists in the Inland Empire, Northern and Sierra, and Orange County, and San Joaquin Valley regions; psychiatrists in the Central Coast region, and psychologists in Sacramento). Regions listed include the following counties: Central Coast (Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Ventura), Greater Bay Area (Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma), Inland Empire (Riverside, San Bernardino), Los Angeles County (Los Angeles), Northern and Sierra (Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba), Orange County (Orange), Sacramento Area (El Dorado, Placer, Sacramento), San Diego Area (Imperial, San Diego), San Joaquin Valley (Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare).~~

[150] Id.

receive funds from Medi-Cal, Mental Health Services Act funds, and local safety net programs covering people who qualify for neither of these funding streams.[151]

State Proposition 1 (Prop 1), which passed in March 2024, instituted a number of reforms to the mental health system of care and set aside funding to support them, with an aim of addressing mental health generally and its overlap with housing concerns.[152] Set to be implemented from 2024 to 2026, ~~as of March 2026,~~ Prop 1 ~~had~~ awarded $3.3 billion in funds to create over 5,000 residential treatment beds and 21,000 outpatient treatment slots in its first round of funding in 2025~~, and is in the process of evaluating applications for a second $800 million round of funding for treatment facilities and supportive housing that is anticipated to be awarded in Spring of 2026~~.[153] In March 2026 California announced the second round of funding, covering 66 additional projects and bringing the two-round funding total to $4.17 billion.[154] Prop 1 required all counties to implement new three-year comprehensive behavioral health services plans beginning in 2026.[155] It is therefore likely that county behavioral health systems are soon to see changes that may impact how they interface with law enforcement agencies and officers and those focusing on law enforcement training should monitor the changes that occur.

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The System of Care for Individuals with IDD

Demographics

The State Council on Developmental Disabilities estimates that there are approximately 625,000 Californians with intellectual or developmental disabilities, or 1.58% of the total population.[156] Approximately 450,000 of these rely on the state's network of Regional Centers to connect them with direct services, and as of 2020, about two-thirds of these clients are men

[151] See *Mental Health in California: Understanding Prevalence*, p. 58.
[152] See, e.g., *Accountability with results* (2025) Cal. Mental Health for All (*Accountability with results*), https://www.mentalhealth.ca.gov/accountability.html.
[153] Id.; *Governor Newsom announces billions of dollars for behavioral health treatment facilities and services for seriously ill and homeless thanks to Prop 1* (May 12, 2025) Off. of Governor Gavin Newsom, https://www.gov.ca.gov/2025/05/12/governor-newsom-announces-billions-of-dollars-for-behavioral-health-treatment-facilities-and-services-for-seriously-ill-and-homeless-thanks-to-prop-1/; *Proposition 1: Behavioral Health Infrastructure Bond Act of 2024: Behavioral Health Continuum Infrastructure Program Round 2: Unmet Needs Request for Applications*(2025) Cal. Dept. of Health Care Services, p. 5, https://www.dhcs.ca.gov/BHT/Pages/BHCIP.aspx.
[154] Gov. Gavin Newsom, *Ahead of schedule: Governor Newsom's Prop 1 is exceeding goals to expand capacity and treatment statewide, helping 5M+ Californians* (Mar. 11, 2026) https://www.gov.ca.gov/2026/03/11/ahead-of-schedule-governor-newsoms-prop-1-is-exceeding-goals-to-expand-capacity-and-treatment-statewide-helping-5m-californians/.
[155] *Accountability with results.*
[156] *About The California State Council on Developmental Disabilities* Cal. State Council on Developmental Disabilities, https://scdd.ca.gov/about/; *Some Snapshots of People with I/DD in California* (May 2020) Cal. State Council on Developmental Disabilities (*Some Snapshots of People with I/DD in California*) https://scdd.ca.gov/wp-content/uploads/sites/33/2020/06/People-with-IDD-in-California-Snapshot-5.27.20-ACCESSIBLE.pdf.

and one-third are women.[157] Approximately .24% of the California population are seniors with IDD, while around .3% are youth with IDD.[158]

Key Elements of the System of Care

In California, the Department of Developmental Services (DDS) is the state agency responsible for providing and overseeing services for people with IDD, which includes implementation of the Lanterman Act.[159] In addition to the protections the Lanterman Act enshrines as discussed above in the *California Protections* section, the Lanterman Act provides people with developmental disabilities the right to various services and supports needed to live independent, full, and productive lives.[160] Rights the Lanterman Act guarantees include receiving services in the least restrictive environment, participating in social, educational, spiritual, and other community activities, being free from harm and abuse, and making choices about one's own life goals and circumstances.[161]

To ensure that these services would be provided, the Lanterman Act created a system of 21 Regional Centers throughout California, which are the local agencies that assist eligible ~~people~~ individuals with developmental disabilities who live in the center's area in getting the services and supports they need.[162] Regional Centers ~~do not offer services directly, but rather~~ assess individuals for eligibility for services and, if eligible, provide case management ~~or other support to obtain needed services elsewhere~~and coordination of purchased services.[163] While regional centers do purchase services directly from vendors, the regional centers are (by statute) considered the payor of last resort. So many services may be ~~The services themselves are generally~~ funded by other sources, such as Medi-Cal, private insurance, or school districts ~~budgets, although the Regional Center can issue a Request for Proposal (RFP) or make other efforts to develop services that are unavailable~~.[164] Regional Centers serve ~~clients~~ individuals for as long as they meet ~~severity~~ eligibility criteria, which for most people will mean they qualify for

[157] *Individuals & Families* Cal. Dept. of Developmental Services, https://www.dds.ca.gov/individuals-and-families/#:~:text=The%20Department%20supports%20over%20450%2C000%20individuals%20who,professionals%20who%20help%20them%20achieve%20their%20goals; *Some Snapshots of People with I/DD in California*.
[158] *Some Snapshots of People with I/DD in California*, p. 1.
[159] *A Guide to California's Regional Center Services System* (Feb. 2025) Cal. Dept. of Developmental Services (*A Guide to California's Regional Center Serv. System*), p. 8, https://www.dds.ca.gov/wp-content/uploads/2025/02/Guide_to_Californias_Regional_Center_Services_System.pdf.
[160] Welf. & Inst. Code, §§ 4500 et seq.
[161] Welf. & Inst. Code, § 4502, subd. (b).
[162] Welf. & Inst. Code, § 4620.
[163] See *How does the regional center make sure I get the services and supports in my IPP, Rights under the Lanterman Act* Disability Rights Cal., § 4.66, https://rula.disabilityrightsca.org/rula-book/chapter-4-individual-program-plans/4-66-how-does-the-regional-center-make-sure-i-get-the-services-and-supports-in-my-ipp/.
[164] See id.

services throughout their lifetime.[165] Services are broad and include employment programs, adult day services, ~~family homes,~~ home health supports, supported or independent living services, residential care homes, respite, and other offerings.[166]

Case management available at Regional Centers helps clients connect with the right level of services for them. The Lanterman Act requires Regional Centers to develop an Individual Program Plan (IPP) to specify the decisions made regarding the individuals' goals, objectives, services, and supports that the individual and the Regional Center agree a person needs and chooses.[167] The IPP must be tailored to the particular client and give the individual an opportunity to actively participate in the development of the plan.[168] Regional Center clients can use an IPP to achieve goals of different types of living arrangements, including living with family or finding alternative community living options.

Although Regional Centers coordinate many of the services that people with IDD need, not everyone diagnosed with IDD under the federal definition qualifies for Regional Center services. Regional Centers use the California-specific definition, which is narrower.[169] As a result, about 20% of people ~~with~~ who identify as having an IDD under the broader federal definition do not ~~qualify~~ meet eligibility criteria for Regional Center services under California law.[170] Individuals who do not qualify for Regional Center services may also receive services independently through other agencies such as school districts or In-Home Supportive Services.[171]

[165] See *Can I lose my regional center eligibility? Rights under the Lanterman Act* Disability Rights Cal., §2.24, https://rula.disabilityrightsca.org/rula-book/chapter-2-eligibility-for-regional-center-services/can-i-lose-my-regional-center-eligibility/.

[166] *Regional Center Services and Descriptions* (Aug. 1, 2018) Cal. Dept. of Developmental Services, https://www.dds.ca.gov/wp-content/uploads/2019/03/RC_ServicesDescriptionsEnglish_20190304.pdf.

[167] Welf. & Inst. Code, § 4646; *A Guide to California's Regional Center Serv. System*.

[168] Id.

[169] See Welf. & Inst. Code, § 4512.

[170] See *DDS Comprehensive Dashboard* Cal. Dept. of Developmental Services (487,615 Californians served by regional centers as of July 1, 2024) https://www.dds.ca.gov/transparency/facts-stats/dds-comprehensive-dashboard/; *Quick Facts California* United States Census Bureau, https://www.census.gov/quickfacts/fact/table/CA/PST045225 (estimating California's total population at 39,431,263 as of July 1, 2024); *State Profile for California* National Association of Councils on Developmental Disabilities, https://nacdd.org/state-profiles/california/ (using Center for Disease Control statistics to estimate that 5 percent of Californians—1,971,563 people based on the July 2024 Census estimate—have IDD under the federal definition).

[171] *What other agencies provide services and supports? Rights under the Lanterman Act,* Disability Rights Cal., § 4.66 https://rula.disabilityrightsca.org/rula-book/chapter-1-the-lanterman-act/what-other-agencies-provide-services-and-supports/. In-Home Supportive Services (IHSS) provides personal care and domestic services to persons who are aged, blind or disabled and who live in their own homes. IHSS is provided to those who otherwise might be placed in an out-of-home care facility but who can safely remain in their own home if IHSS services are received. *Support Services: Options for Regional Center*

Some gaps in available services remain. Services that appear sufficient on paper may in reality not be well- tailored to the individual circumstances of a particular client. Some elements of an IPP may not work in practice and there may not be adequate follow up to ensure an alternative. Services may have limited capacity and may therefore not be available when needed or may not be offered at the right time for other reasons. The Department of Developmental Services is developing a provider directory, but at present it is difficult to assess whether the services available in a given region are adequate for meeting the level of need for that geographic area.[172]

Regional Centers offer services that respond to a crisis, including residential crisis services and mobile crisis teams that respond to short-term crisis in the community.[173] Thus, Regional Center providers may encounter instances where law enforcement is also present when responding to a crisis involving a Regional Center client. However, there are some gaps in the Regional Center crisis service system. For example, not all regions have a crisis services provider and in ones that do, some Council members expressed concerns that families are not always informed that these services exist. Also, not all crisis services are offered 24/7 or with an immediate in-person response. And in most cases, the services must be preauthorized in an individual's IPP, meaning not all caregivers have access to the mobile crisis teams and are not able to receive a response during an individual's first crisis. Council members also noted that there is also the risk of missed opportunities for law enforcement and Regional Centers to connect to provide integrated services to a community member, either because Regional Centers may not tend to proactively reach out to law enforcement, or because Regional Center clients who are having an unexpected interaction with law enforcement do not always know to communicate to officers that they receive Regional Center services.

---Pop out boxes/colored separate page with anecdotes--

Jay,[174] now in his 30s, has autism with limited language and requires 24/7 care.
He once enjoyed art classes and regular community outings. But during the pandemic, his behavior began to deteriorate without warning and escalated dramatically—punching walls, pounding windows, and even attempting to jump from a moving car. Although Jay has medical insurance and Regional Center eligibility, his family cannot find local clinicians trained in complex autism with co-occurring medical issues. They drive over an hour and pay cash to see specialists out of their county. Jay received Applied Behavioral Analysis therapy but it did not

Consumers, Cal. Dept. of Developmental Services, https://www.dds.ca.gov/general/eligibility/support-services/.

[172] See *Provider Directory*, Cal. Dept. of Developmental Services, https://www.dds.ca.gov/initiatives/provider-directory/

[173] *Regional Center Services and Descriptions* (Aug. 1, 2018) Cal. Dept. of Developmental Services, https://www.dds.ca.gov/wp-content/uploads/2019/03/RC_ServicesDescriptionsEnglish_20190304.pdf.

[174] The following descriptions are based on actual situations, but names have been changed to protect privacy.

address his medical-behavioral complexity; sleep dysregulation worsened, and his parents now provide full-time care. His mother shares: "There are no local doctors who understand complex autism. We're paying out of pocket and still not getting help. We've been without services for four years. We are so worried that he will have an autism-related behavior in public and get arrested. That has almost happened once before."

Barbara's son, Ben, is 19 and autistic~~; his developmental functioning is closer to that of a young child~~with significant cognitive, behavioral, and adaptive disability.
During a period of extreme dysregulation, Ben injured his older brother. Police were called, and Ben was arrested and placed in the jail's general population while awaiting a hearing—despite his limited capacity to understand proceedings or advocate for himself. Barbara recalls: "I was desperate. My son couldn't speak for himself, and we were not allowed to speak for him." Ben was ultimately diverted to a residential setting, but Mom wonders why there weren't resources for him before this happened.

Adam is 15 years old and has autism along with co-occurring mental health conditions.
In the past 12 months, Adam has been placed on involuntary psychiatric holds 14 times. Each crisis feels more dangerous than the last. On one occasion, Adam broke a window, grabbed a shard of glass, and threatened his family—only to be released home three days later with no clear plan to break the cycle. Another time, Adam attempted suicide by walking toward a nearby freeway. When his mother called for help, requesting another 5150 hold, law enforcement refused to respond. She was told, "Suicide is not a crime, and we've already given you resources." Adam's family was left alone in a life-threatening situation, with no immediate intervention and no long-term solution. His mother shares: "We are terrified every day. There is no roadmap, no coordinated care, and no one to call when things spiral out of control. We've done everything they told us—therapy, medication, crisis lines—but nothing is working. We need help before something irreversible happens."

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Funding Considerations

In the last ten years, California spending on services for people with IDD has more than tripled from approximately $6 billion in the 2015-2016 budget year to $19 billion in the 2025-2026 budget year.[175] Some of this increase stems from a move to fully funded rate models that began in the 2024-2025 budget year.[176] The Legislative Analyst's Office estimates that a majority of the increase reflects growth in caseload and increases in the utilization of services.[177]

[175] Petek, *The 2025-26 Budget: Department of Developmental Services*, Legislative Analyst's Off. (March 2025), p. 3, figure 1, https://lao.ca.gov/Publications/Report/5008.
[176] Id., p. 2.
[177] Id., p. 2.

During the decade preceding this report, California general funds accounted for about 60 percent of this budget while the remaining 40% comes primarily from federal Medicaid funding.[178] California's 2025-2026 budget allocated $11.8 billion in state funds to the Department of Developmental Services.[179] It is unclear how 2025 federal cuts to the Medicaid program will impact this funding model, but one recent analysis suggests that California could lose an estimated $3,784 in Medicaid funding per resident.[180]

Systems of Care for Youth

Youth[181] can access services through many of the systems described above, but also receive services through other youth-specific programs.

The behavioral health needs of youth have expanded in recent years, according to 2018 data showing 25 percent of youth reported needing mental health treatment, as compared to 13 percent in 2009, and 5.2 of every 1000 youth experienced a mental health hospitalization, as compared to 3.4 per 1000 in 2007.[182] In 2019, over half (54 percent) of court-involved youth placed in juvenile halls or camps, home supervision, or alternative confinement had an open mental health case, and 23 percent were prescribed psychotropic medication.[183] Young people's behavioral health is particularly impacted by poverty, with 10 percent of youth with family incomes below the FPL showing "serious emotional disturbance."[184]

Systems of care sometimes apply broader eligibility criteria for youth to allow for early intervention before nascent conditions become severe. Youth are eligible for community mental health services when such services address or improve the child's behavioral health condition that is or would not be responsive to physical health treatment.[185] These less stringent standards may offer more referral options for first responders to youth in behavioral health crisis. Youth aged 6 and older can receive services from DDS' Systemic, Therapeutic, Assessment, Resources and Treatment (START) program, which provides case coordination,

[178] See id., p. 3, figure 1.
[179] Assem. Bill No. 102 (2025) Budget Act of 2025, (2025-2026 Reg. Sess.) https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB102.
[180] Sergent, *If you live in these states, Trump's tax law will cut health care funds the most* (Aug. 22, 2025) USA Today, https://www.usatoday.com/story/graphics/2025/08/20/trump-big-beautiful-bill-medicaid-cuts-where/85727000007/.
[181] Youth typically means individuals who are age 18 and younger, but may mean a different age span depending on the statute or program; for example, some of the material in this section specifies that transition age youth, ages 18-24, are included.
[182] *Mental Health in California: Understanding Prevalence*, p. 10.
[183] Id., p. 29.
[184] See id., p. 74 (defining serious emotional disturbance as applying to "youth age 17 and under who have, or during the past year have had, a diagnosable mental, behavioral, or emotional disorder resulting in functional impairment that substantially interferes with or limits functioning in family, school, or community activities").
[185] Id., p. 51.

holistic assessment services, and system linkages, although the START program has limited capacity and is not available in every county.[186]

On the other hand, youth may receive services in locations that make them more susceptible to law enforcement contact and some providers may even themselves refer youth to law enforcement. Youth may receive school-based mental health services, but schools refer students with disabilities to law enforcement two to three times more often than students without disabilities.[187] Foster youth also may receive mental health services in residential facilities such as group homes, transitional housing, or short-term residential therapeutic programs, where administrators also tend to refer youth with disabilities to law enforcement. One study found that children in these group home placements are 2.4 times more likely to be arrested than children with similar characteristics who are placed in foster homes.[188]

Child protective services agencies can also be involved in access to care, but the relationships with these service providers can be complicated. Some contact between law enforcement and the SB 882 population may occur because a child is experiencing abuse or neglect in the home. However, some families may also experience contacts because an unfamiliar observer incorrectly interpreted a child's symptoms as a sign of abuse or neglect. For some families, child protective services will provide appropriate linkage to needed services following such contacts. In other cases, social service agencies instruct families to follow a course of action that is not the appropriate response for a child with developmental disabilities and lacks flexibility to engage with the family to develop tailored interventions. And in yet other cases, parents may intend to follow the instructions of child protective services agencies but are unable to find services that accept patients with an intellectual or developmental disability.

Thus, while services for youth are available, more tailoring is necessary to meet the needs of youth and families who belong to the SB 882 population.

Guiding Principles

[*Final text to be entered after March 16 & 19, 2026 meetings of the Council.*]

[186] *START Program*, Cal. Dept. of Developmental Services, https://www.dds.ca.gov/services/crisis-safety-net-services/start-program/.

[187] Losen et. al., *Unmasking School Discipline Disparities in California: What the 2019-2020 Data Can Tell Us about Problems and Progress* (July 26, 2022) The Civil Rights Project, p. 25, https://civilrightsproject.ucla.edu/reports/unmasking-school-discipline-disparities-in-california-what-the-2019-2020-data-can-tell-us-about-problems-and-progress/.

[188] Ryan et al., *Juvenile delinquency in child welfare: Investigating group home effects* (2008) Children and Youth Services Review 30, pp. 1088-1099 (cited in *Youth Arrests in Group Homes and Shelters* (July 6, 2018) Youth Law Center, https://www.ylc.org/wp-content/uploads/2018/11/YLC-Roundtable-Presentation-070618.pdf).

Data Recommendations

Lack of reliable data related the state of interactions between the SB 882 population and law enforcement, and what are the best ways to improve these interactions, was identified by a working group of experts in the field as among the biggest problems to address.[189] The Council has taken some steps to improve this knowledge base by completing its survey of law enforcement agencies and its evaluation of a collection of trainings offered in California, discussed below in the California Law Enforcement Agency Training Survey Results and the Training Review Results, respectively. The Council also makes the following recommendations to provide for ongoing efforts to improve the knowledge base and data reliability.

[*Final text to be entered after March 16 & 19, 2026 meetings of the Council.*]

[189] Richardson, *Law Enforcement Response*, pp. 7-9; see also SB 882 Council Meeting (Jan. 15, 2025) Testimony of PERF, https://www.youtube.com/watch?v=vAIndu5KVfM.

Crisis Response Models and Other Systems Interventions

Overview of Crisis Intervention Models

Within the last 30 years, several high-profile deadly encounters between peace officers and members of the community have prompted a concerted effort to find more effective and safer strategies to respond to persons experiencing crises. Local agencies and community partners use many different approaches to structuring interactions between law enforcement and the SB 882 population to reduce negative outcomes. Several of these programs integrate mental health professionals and mental health training of officers into agency response protocols, although it is rare for such programs to address intellectual and developmental disabilities separately from mental health. These programs include, for example, alternative dispatch systems like 988, crisis intervention teams, and co-response and alternative or community response models.

This section provides an overview of the crisis response models in common use generally and in California, drawing from a review of available literature, testimony of witnesses appearing before the Council, and findings of the Council's survey of law enforcement agencies across the state. This information both provides a context to understand the role of law enforcement training, which occurs against a backdrop of the existing response model an agency uses, and supports the Council's mandate pursuant to SB 882 to make recommendations related to training or other interventions impacting interactions between law enforcement and people in the SB 882 population.

While all crisis response systems differ in response to the needs and preferences of their jurisdictions, for the purposes of analysis this section divides response models into three main groups: (1) Crisis Intervention Teams (CIT), consisting of specially trained peace officers within law enforcement agencies based on a standardized curriculum and program; (2) co-responder models with teams that pair peace officers with health professionals to address crises together in the field; and (3) programs centered in non-law enforcement agencies, such as mobile crisis teams, that respond to crisis calls according to an agreement with law enforcement or integration into a jurisdiction's dispatch system.[190]

This section includes an explanation of the main elements of each category of model, along with examples of each category that have been implemented in California and around the country. In addition, this section includes information about other supportive elements that are integrated into crisis response programs and that may be common to multiple categories of response models. This includes research regarding dispatch systems generally and the

[190] See, e.g., *Issues in Law Enforcement Reform: Responding to Mental Health Crisis* (Oct. 2022) Congressional Research Service, p. 3 (Congressional Research Service Report) https://www.congress.gov/crs-product/R47285; Wood & Watson, *Improving police interventions*, pp. 4-6.

implementation of the 988 system in California, the importance of the integration of peer supports, and the importance of follow-up care.

Moreover, this section includes an overview of the existing research on the efficacies of each response model, and an analysis of the strengths and weaknesses of each type of intervention. This analysis includes a discussion of the obstacles to implementation surfaced by the research and Council witness testimony, including staffing and resource challenges and differences in model fidelity across communities. While there are limitations to the existing research, there are reasons to believe these response models can improve interactions between the SB 822 population and law enforcement, and outcomes in general for the SB 882 population.

The section concludes with recommendations from the Council regarding how crisis intervention models and other systems interventions in California can better address the needs of the SB 882 population when they interact with law enforcement.

Limitations of Data Regarding Crisis Response for People with Intellectual and Developmental Disabilities

Before engaging more deeply in the literature review, it is important to note that response models tend to focus broadly on mental health, not specifically on IDD.[191] Studies demonstrate that individuals with IDD tend to have an incidence of mental health conditions more than three times higher than the general population, but more intersectional research is needed that focuses on individuals with IDD and mental health conditions who interact with law enforcement.[192]

There is one IDD-specific model that has been created by the National Center on Criminal Justice and Disability at the Arc that provides an illustration of the way these response models can be structured to serve the needs of people with IDD. The program, Pathways to Justice, was designed to create Disability Response Teams that can better serve individuals with IDD who come into contact with the criminal justice system.[193] The program aims to include law enforcement, victim service providers, attorneys, self-advocates, and disability advocates in the Disability Response Teams, and consists of an eight-hour training to bring together the members of these different professions and facilitate long-term collaboration.[194] The program's pilot included an evaluation indicating that participants were satisfied overall and that the

[191] Watson, et al., *Crisis Response Services for People with Mental Illnesses or Intellectual and Developmental Disabilities: A Review of the Literature on Police-based and Other First Response Models* (2019) Vera Inst. (Watson, et al., *Crisis Response Services*) p. 7, https://vera-institute.files.svdcdn.com/production/downloads/publications/crisis-response-services-for-people-with-mental-illnesses-or-intellectual-and-developmental-disabilities.pdf?dm=1572461900.
[192] Id.
[193] Id., pp. 38-39.
[194] Id., p. 38.

teams continued to meet post-training, but there is no published or empirical research on the program.[195]

Crisis Intervention Teams (CIT)

Key Elements of CIT

Law enforcement agencies seeking to improve their interactions with people in the SB 882 population may choose to do so by focusing predominantly on the structural supports and training of their own peace officers. The Crisis Intervention Team (CIT) model is one such approach that is now in place in more than 8,000 law enforcement agencies and enjoys support from institutions such as CIT International that serve as a resource for implementing or learning about CIT.[196] Also known as the Memphis model, CIT came about in the wake of a 1988 deadly shooting in Memphis, Tennessee of a Black man diagnosed with schizophrenia who was suffering a mental health crisis.[197] The mission of the CIT model is to "reduce deaths that can occur during interactions between law enforcement and people experiencing a mental health crisis and to divert these individuals, when appropriate, away from the criminal justice system and into treatment."[198]

The CIT model involves training peace officers on how to respond to calls for service involving people experiencing mental health crises and how to link these individuals to mental health resources in the community to ensure they receive appropriate treatment. The CIT model relies upon significant coordination and collaboration with community resources and mental health professionals.[199] Peace officers trained in CIT respond to calls for service involving people experiencing mental health distress and liaise with mental health providers to increase the chances that the outcome of the interaction is that the person obtains the support they need.[200]

The traditional CIT model contains the following basic components:

[195] Id., pp. 38-39.
[196] *CIT International Improving Crisis Response Systems*, CIT International https://www.citinternational.org/; see also *CIT Center*, U. of Memphis, http://cit.memphis.edu/.
[197] Dupont & Cochran, *Police Response to Mental Health Emergencies: Barriers to Change* (2000), J. Am. Academy of Psychiatry and the Law 28 (Dupont & Cochran, *Police Response*), p. 338, https://jaapl.org/content/jaapl/28/3/338.full.pdf; Fuller, *Overlooked*, p. 11, fn. 68-70; Watson & El-Sabawi, *Expansion of the Police Role*, fn. 105; Wood & Watson, *Improving police interventions*, p. 5.
[198] Congressional Research Service Report, p. 4, fn. 28.
[199] Wood & Watson, *Improving police interventions* (citing Compton et al. *Crisis intervention team training: Changes in knowledge, attitudes, and stigma related to schizophrenia* (2008) Psychiatric Services 57:8, pp. 1199–1202).
[200] Congressional Research Service Report, pp. 4-5.

Components of Traditional CIT Model

- Peace officers volunteer for program
- 40 hours of specialized training
- Training of dispatch as well as patrol officers
- Drop-off sites for peace officers to bring persons experiencing mental health crisis
- Collaboration with community resources

Volunteer Officers

One key component of the traditional CIT model is that peace officers volunteer to be part of the program, resulting in only a portion of the agency being CIT trained.[201] This approach rests on the assumption that peace officers whose personality traits and level of interest in handling mental health calls make them more suited to the CIT method will be more effective in implementing the model.[202] Initially, the Memphis team envisioned that 20-25% of peace officers in a given agency would receive CIT training to ensure availability across shifts. [203] However, some agencies require 100% of their patrol officers to undergo this training, on the theory that all officers may encounter persons experiencing a mental health crisis.[204]

Leadership

A key component of the CIT Model is making major changes to law enforcement policy prior to training. This component includes a requirement that trained CIT officers oversee the crisis response, even when more senior patrol officers are present. This key element allows the officers with the most extensive training who have volunteered and have been vetted by an intensive selection process to take responsibility for the outcome.[205] Explicit internal policy support and commitment to adapting to the CIT model is a key determinant of the degree of program success.[206]

[201] Dupont & Cochran, *Police Response*, p. 339; Watson & Fulambarker, *The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners* (2012) Best Prac. Mental Health 8:2 (*Watson & Fulambarker, The Crisis Intervention Team Model*), p. 71, https://pmc.ncbi.nlm.nih.gov/articles/PMC3769782/#R21 (citing McGuire & Bond, *Critical Elements of the Crisis Intervention Team model of jail diversion: An expert survey* (2011) Behavioral Sciences and the Law (McGuire & Bond, *Critical Elements of the Crisis Intervention Team*)).

[202] Watson & Fulambarker, *The Crisis Intervention Team Model* (citing Dupont et al., *Crisis Intervention Team core elements* (2007) U. of Memphis School of Urban Affairs and Public Policy, Dept. of Criminology and Crim. J., CIT Center (Dupont et al., *Crisis Intervention Team core elements*).

[203] Watson & Fulambarker, *The Crisis Intervention Team Model* (citing Dupont et al., *Crisis Intervention Team core elements*).

[204] Id.

[205] Dr. Randy Dupont, correspondence on file with California Department of Justice.

[206] Id.

Training

The traditional CIT model requires peace officers to undergo 40 hours of training that includes subjects such as recognizing the signs and symptoms of mental health conditions and co-occurring disorders, de-escalation techniques, and the availability of local resources.[207] This training ideally extends to dispatchers who receive 911 calls, to train them to recognize calls for service that likely are mental health-related and to dispatch CIT-trained peace officers.[208] As discussed below, however, providing training to dispatchers can be challenging in jurisdictions with limited resources or if emergency dispatch services are part of an organization distinct from the law enforcement agency.

CIT training involves role playing, where peace officers simulate encounters with people experiencing a mental health crisis, and also includes presentations by people who have experienced mental health crises or have mental disabilities and/or IDD, their family members, law enforcement trainers, and mental health professionals.[209] For example, AASCEND, a Bay Area-based volunteer group of adults on the autism spectrum, participates in the San Francisco Police Department's CIT training through panels consisting of adults with autism.[210] CIT training includes information on signs and symptoms of mental health conditions , developmental disabilities, co-existing conditions, treatment for mental health-related crises and illnesses, and legal issues that may arise. The training may also include content on issues related to older adults and trauma.[211] Many departments enhance CIT training by repeating it periodically or by including additional training related to interactions with youths, veterans, and high-risk individuals with repeated contacts with law enforcement.[212] For more detailed discussion of CIT training, see the *Training on Interacting with the SB 882 Population* section below.

[207] Watson & El-Sabawi, *Expansion of the Police Role*, p. 19, fn. 107; Watson & Fulambarker, *The Crisis Intervention Team Model*, p. 3 (citing Steadman et. al., *The need for a specialized crisis response location for effective police-based diversion programs* (2001) Psychiatric Services 52, pp. 219-222).
[208] Congressional Research Service Report, p. 5, fn. 31.
[209] Watson & El-Sabawi, *Expansion of the Police Role*, p. 19, fn. 108-109.
[210] SB 882 Council Meeting (Jan. 17, 2025) Testimony of Michael Bernick, https://www.youtube.com/watch?v=vAIndu5KVfM.
[211] Watson & Fulambarker, *The Crisis Intervention Team Model*, p. 2 (citing Compton et al., *The Crisis Intervention Team (CIT) Model of collaboration between law enforcement and mental health* (2011) Faculty Bookshelf).
[212] Id., p. 4 (citing Rosenbaum, *Street-level psychiatry - A psychiatrist's role with the Albuquerque Police Department's Crisis Outreach and Support Team* (2010) Journal of Police Crisis Negotiations).

Common CIT Training Topics

- Information on signs and symptoms of mental health conditions
- Mental health treatment
- Co-occurring conditions
- Legal issues
- De-escalation techniques
- Developmental disabilities
- Older adult issues
- Trauma

Mental Health Partnerships Including with Centralized Drop-Off Psychiatric Emergency Mental Health Care Facilities

A key component of the CIT model is linking civilians with appropriate treatment and other mental health services. CIT programs thus require partnerships between law enforcement agencies, mental health services, mental health advocates, and other stakeholders.[213] Peace officers also conduct site visits of community facilities where CIT-trained peace officers would typically refer civilians for treatment.[214]

Traditional CIT models typically designate a centralized drop-off emergency mental health care facility, which can accept individuals referred by CIT peace officers.[215] As with other aspects of the CIT model, not all jurisdictions and communities can adopt this feature, either because of lack of resources or the size of the jurisdiction.[216]

Co-response Crisis Team Models

A co-response model generally pairs peace officers with behavioral health clinicians collaborating to respond to crisis calls. These teams are dispatched to mental health-related 911 calls to de-escalate crises on site and avoid unnecessary hospitalizations or arrests. As discussed in more detail below, these models often largely focus on incorporating general mental health specialists into law enforcement response rather than clinicians with specific experience with persons with IDD.

Several California jurisdictions have adopted this approach. In San Diego County, the Psychiatric Emergency Response Team (PERT) pairs licensed mental health clinicians with specially trained officers, and has invested in public education to help refine crisis intervention practices.[217] San Diego county also has Mobile Crisis Response Teams (MCRT) that operate around the clock with

[213] Congressional Research Service Report, p. 5, fn. 31.
[214] Id., p. 5, fns. 29-30.
[215] Id., p. 5, fn. 31; SB 882 Council Meeting (April 1, 2025) Testimony of Drs. Michael Compton and Amy Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.
[216] See Watson & Fulambarker, *The Crisis Intervention Team Model*, p. 3.
[217] *Mental Health*, City of San Diego Police, https://www.sandiego.gov/police/community/mental-health.

a clinician, case manager, and peer support specialist, offering a law enforcement-free response when there is no safety threat.[218] Sacramento's Mobile Crisis Support Team (MCST) builds on the co-response model by incorporating Peer Specialists—individuals with lived experience—into the response model, providing post-crisis support and fostering trust between clients and systems.[219] Similarly, Los Angeles County's Mental Evaluation Team (MET) handles high-risk cases and supplements immediate response with case management and ongoing law enforcement training. MET operates alongside the Psychiatric Mobile Response Teams (PMRT), which are composed entirely of clinicians and often serve as a non-law enforcement crisis option.[220] LA's Therapeutic Transportation Program (TTP) supports these efforts through unmarked vans staffed by clinical drivers and peer support specialists, providing trauma-informed transport to care centers.[221]

Other counties have adapted the co-response structure to meet their specific needs. In Santa Clara County, the PERT model deploys clinician-officer teams in plainclothes and unmarked cars during weekday hours, reducing the visibility of law enforcement and minimizing escalation.[222] The City of Pleasanton's Alternative Response Unit (ARU) adopts the same practice, utilizing non-uniformed officers and licensed clinicians to respond to behavioral health crises while integrating local school and housing systems.[223] San Mateo County's pilot program embeds mental health clinicians directly in four law enforcement departments, enabling a co-response model that is coordinated but flexible: clinicians and officers may respond together or separately depending on the situation.[224] Eureka's Crisis Alternative Response Eureka (CARE) program demonstrates how co-response can be implemented even in smaller jurisdictions. With partnerships across different social service entities, including hospitals and housing

[218] *Mobile Crisis Response Teams*, San Diego County Behavioral Health Services, https://www.sandiegocounty.gov/content/sdc/mcrt.html.
[219] *Mobile Crisis Support Team*, Sacramento County Dept. of Health Services Behavioral Health Services, https://dhs.saccounty.gov/BHS/Pages/BHS-Home.aspx.
[220] *Psychiatric Mobile Response Teams*, Los Angeles County Dept. of Mental Health, https://dmh.lacounty.gov/our-services/countywide-services/eotd/pmrt/.
[221] *Therapeutic Transportation Program*, Los Angeles County Dept. of Mental Health, https://dmh.lacounty.gov/our-services/countywide-services/eotd/ttp/.
[222] *Psychiatric Emergency Response Team*, San Mateo County Sheriff's Off. and Behavioral Health and Recovery Services, https://www.smchealth.org/sites/main/files/file-attachments/pertbrochure.pdf?1556207937.
[223] Trujano, *Pleasanton receives award for police alternative response unit* (Sep. 27, 2023) Pleasonton Weekly, https://www.pleasantonweekly.com/news/2023/09/27/pleasanton-receives-award-for-police-alternative-response-unit/.
[224] *Community Wellness and Crisis Response Team*, County of San Mateo, https://www.smcgov.org/ceo/community-wellness-and-crisis-response-team.

assistance, Eureka's CARE has established a closed-loop crisis care continuum plan that best suits their population's needs.[225]

While many jurisdictions are developing co-response team strategies, a recent report evaluating how teams have worked in Los Angeles County questions the premise of co-response teams. The report describes that in practice, law enforcement continues to be dominant in interactions when a co-responding mental health provider is present.[226] The report suggests this tendency may undercut the de-escalation expertise of the provider who is there for the purpose of providing this expertise, and maintains the risk of harm occurring in the initial moments of contact before the mental health provider has engaged with the individual.[227]

Alternative Response Civilian-Led Crisis Teams

Several jurisdictions have developed fully civilian-led crisis teams that operate independently of law enforcement. These programs deploy unarmed responders, typically a combination of mental health clinicians, peer support specialists, Emergency Medical Technicians (EMTs), and case managers, to calls involving behavioral health, substance use, or general distress. As with the programs described above, civilian-led crisis teams also tend to address mental health conditions in general but not to include specific focus on helping people with intellectual and developmental disabilities. Still, a non-law enforcement response to crisis situations may benefit both populations by reducing contacts with law enforcement officers and providing health care support.

One of the most established examples of this model was the CAHOOTS program (Crisis Assistance Helping Out On The Streets) in Eugene, Oregon, launched in 1989 by the White Bird Clinic. CAHOOTS teams were staffed by a medic and a crisis responder trained in behavioral health and responded to calls triaged through 911 dispatch involving mental health, substance use, homelessness, or suicidal ideation. Crucially, CAHOOTS staff were unarmed and did not have the powers of peace officers. They provided on-site crisis counseling, transportation to shelters, hospitals, or the White Bird Clinic, and connected clients with services like medical and dental care. As of 2020, CAHOOTS operated on a $2.1 million budget and handled approximately 5-8% of the Eugene Police Department's call volume.[228] Of the over 24,000 calls

[225] *Crisis Alternative Response of Eureka Program*, City of Eureka (*Crisis Alternative Response of Eureka)* https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.eurekaca.gov%2FDocumentCenter%2FView%2F3601%2FCARE-Program-Description&wdOrigin=BROWSELINK.

[226] Jany, *Report questions why LAPD mental health specialists must defer to armed officers* (Oct. 29, 2025) L.A. Times, https://www.latimes.com/california/story/2025-10-29/city-controller-lapd-mental-health-unit-report.

[227] *Id*.

[228] *Crisis Assistance Helping Out On The Streets, Media Guide* (2020), White Bird Clinic, Eugene Oregon, https://whitebirdclinic.org/wp-content/uploads/2020/07/CAHOOTS-Media.pdf; Eugene Police

CAHOOTS responded to, less than 1% needed police assistance.[229] Because of changes in state law and termination of Eugene City funding, the CAHOOTS program terminated and some services formerly provided by the CAHOOTS program were transitioned to the County Department of Health and Human Services in 2025.[230]

In California, the Specialized Care Unit in Berkeley exemplifies the civilian-led structure, with a three-person response team that operates entirely outside the 911 system and conducts proactive outreach to high-need communities.[231] Oakland's MACRO program uses similar staffing but is embedded within the city's fire department for institutional support.[232] In Nevada County, an innovative rural program dispatches behavioral health professionals 24/7 and operates a local Crisis Stabilization Unit for short-term psychiatric care.[233] Outside of California, Denver's STAR (Support Team Assisted Response) program pairs a clinician and paramedic to respond to low-acuity calls, while New York City's B-HEARD (Behavioral Health Emergency Assistance Response Division) teams combine EMTs and mental health professionals to reduce emergency room admissions.[234] Houston's Crisis Call Diversion Program is a collaboration between first responder agencies and the Harris Center for Mental Health &

Department Crime Analysis Unit, *CAHOOTS Program Analysis* (2020) https://www.eugene-or.gov/DocumentCenter/View/56717/CAHOOTS-Program-Analysis.

[229] *Case Study: CAHOOTS Eugene, Oregon*, Vera Inst. (Nov. 2020) https://www.vera.org/behavioral-health-crisis-alternatives/cahoots.

[230] See *Mobile Crisis Services of Lane County*, Lane County Behavioral Health Div., https://www.lanecounty.org/government/county_departments/health_and_human_services/behavioral_health/mobile_crisis_services_of_lane_county; Lewis, *When Reform Backfires: How the CAHOOTS Act Helped Dismantle Eugene's Mobile Crisis Program* (Nov. 10, 2025) KVAL CBS 13 News, https://kval.com/news/local/when-reform-backfires-how-the-cahoots-act-helped-dismantle-eugenes-mobile-crisis-program; Hansen-White & Lehman, *CAHOOTS service ending in Eugene, effective immediately* (Apr. 8, 2025) Oregon Public Broadcasting https://www.opb.org/article/2025/04/08/cahoots-service-ending-in-eugene-effective-immediately/.

[231] *Berkeley Launches Specialized Care Unit (SCU)*, City of Berkeley Health, Housing, and Community Services (*Berkeley Launches SCU)* https://berkeleyca.gov/sites/default/files/documents/SCU%20Brochure_ver1.1%5B28734%5D.pdf.

[232] Kamisher, *Oakland Takes First Steps Toward Directing Some 911 Calls To Community Responders* (Apr. 20, 2021) The Appeal, https://theappeal.org/oakland-macro-911-non-law-enforcement-emergency-response/.

[233] *Crisis Care Services and Support*, Nevada County, Cal., https://nevadacountyca.gov/470/Crisis-Care-Services-and-Support.

[234] *Support Team Assisted Response (STAR) Program*, City and County of Denver, Colo. (*Denver Star Program)* https://www.denvergov.org/Government/Agencies-Departments-Offices/Agencies-Departments-Offices-Directory/Public-Health-Environment/Community-Behavioral-Health/Behavioral-Health-Strategies/Support-Team-Assisted-Response-STAR-Program; *Re-imagining New York City's mental health emergency response*, New York City, https://mentalhealth.cityofnewyork.us/b-heard.

IDD that embeds a mental health crisis phone counselor within the city's 911 dispatch.[235] Albuquerque's Community Safety Department has established 24/7 civilian-led response units that specialize in homelessness, substance use, and behavioral health.[236] These programs show that cities of all sizes can implement robust, clinician-led alternatives to law enforcement response.

Crisis Response Models Used in California

The Council surveyed law enforcement agencies about the specialized teams or other specialized approaches the agency uses to respond to calls involving the SB 882 population, and about the efficacy of those specialized teams or approaches. Agencies were able to choose multiple selections to describe the types of specialized units they had. The three most common models reported were a Crisis Intervention Team (51.3% of responding agencies), County/City co-responder teams (45.5%), and agency-based co-responder teams (25.0%). Some examples of other specialized teams or approaches used by a small number of agencies are phone-based support (17.3%) and "Blue Envelope" or similar programs (9.6%). Blue Envelope programs are opt-in notification systems that allow an individual to display or present a Blue Envelope to first responders that can contain identification, contact information, or other important information.[237] Agencies did not report using teams that specialized in working with individuals with intellectual and developmental disabilities in particular, although a small number of agencies (less than 3%) reported having a response team focused on serving people with disabilities in general. One in ten agencies do not have any specialized team or approach. Even so, those agencies report partnerships or other approaches that aim to bridge the divide between law enforcement agencies and healthcare or other social services benefiting the SB 882 population. Most agencies reported that their special teams meet between some (28.2%) and most (35.9%) of the needs in their community.

Other Elements of Crisis Response

There are also aspects of crisis response that are common to all types of systems and for which quality improvements can result in better outcomes for people in the SB 882 population. One key element is dispatch, which is often the first site of decision-making that determines who responds to a crisis and how they approach it. Another element is the use of peer support, which can enhance response practices regardless of whether the first responders present are predominantly law enforcement, predominantly civilian or clinical, or a mix of both. Finally, the quality of follow-up care is an element that practitioners of all models need to consider while

[235] Houston Police Department, Mental Health Division, *Crisis Call Diversion Program (CCD)* https://www.houstoncit.org/ccd/; see also SB 882 Council Meeting (April 1, 2025) Testimony of Monica Porter Gilbert, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.
[236] *Albuquerque Community Safety*, City of Albuquerque, N.M., https://www.cabq.gov/acs.
[237] See, e.g., *Blue Envelope*, San Bernardino County Sheriff's Dept., https://wp.sbcounty.gov/sheriff/blue-envelope/.

seeking to address crisis interactions in a way that maximizes chances of people receiving needed care.

Dispatch Systems

Dispatch systems refer generally to the ways members of the community reach out for support in a crisis and how those calls are directed to responders, including law enforcement responders. The most common example is a call to 911 to request law enforcement assistance, but dispatch can cover a much wider variety of situations and responses. In addition to rethinking how dispatch teams respond to calls, many programs are also rethinking how calls for service or support are received and triaged. Some dispatch systems, like Berkeley's Specialized Care Unit, operate entirely outside the 911 system with dedicated hotlines.[238] Others integrate clinical dispatchers to triage calls away from law enforcement. Durham's HEART (Holistic Empathetic Assistance Response Teams) program, for instance, includes a call diversion team that embeds clinicians in emergency communications to route mental health calls to civilian teams where appropriate.[239] Denver's STAR and San Diego's MCRT also utilize alternative access lines (like 988 or regional crisis lines) that provide law enforcement-free response options.[240] These alternative access points are key to ensuring that individuals in crisis are not automatically routed into systems designed for criminal or medical emergencies. Council witnesses also spoke about the importance of working to reform dispatch systems to ensure that law enforcement is not the only crisis response available, in order to prevent the funneling of vulnerable individuals into avoidable harmful encounters.[241]

In California, an overhaul of the dispatch system is underway statewide pursuant to the implementation of 2022's Assembly Bill 988 (AB 988). AB 988, or the Miles Hall Lifeline and Suicide Prevention Act, was introduced after community member Miles Hall was killed by Walnut Creek law enforcement during a mental health crisis.[242] The goal of AB 988 was to establish a 988 State Suicide and Behavioral Health Crisis Services Fund to support 988 Crisis

[238] *Berkeley Launches SCU*.
[239] *Community Safety*, City of Durham, N.C. (*Durham Community Safety*), https://www.durhamnc.gov/4576/Community-Safety.
[240] *Denver Star Program*; *Mobile Crisis Response Teams*, San Diego County, Cal., https://www.sandiegocounty.gov/content/sdc/mcrt.html.
[241] See, e.g., SB 882 Council Meeting (April 1, 2025) Testimony of Vinny Eng, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be; SB 882 Council Meeting (April 1, 2025) Testimony of Monica Porter Gilbert, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.
[242] *998 Lifeline Timeline*, U.S. Dept. of Health and Human Services Substance Abuse & Mental Health Services Admin., https://www.samhsa.gov/mental-health/988/lifeline-timeline (finding that prior to 988's passage, the major crisis hotline for individuals to call when experiencing a mental health crisis was the National Suicide Prevention Lifeline, or 1-800-273-8255 (TALK); in 2020, the National Suicide Hotline Designation Act was instated and 988 was designated as the number for the national mental health crisis hotline, 988 Lifeline Timeline).

Centers and related mobile crisis teams. The long-term goal is to establish a system in which individuals can call, text, or chat with community-based providers and be connected to a full spectrum of crisis care services and other resources that would limit future crises.

AB 988 charged the California ~~Department of~~ Health and Human Services Agency with creating an implementation plan for the state's expanded 988 system. That plan, the Crisis Care Continuum Plan, was developed in consultation with stakeholders and outlines three strategic priorities: (1) build toward consistent access statewide; (2) enhance coordination across and outside the continuum; and (3) design and deliver a high quality and equitable system for all Californians.[243] AB 988 also created the 988 State Suicide and Behavioral Health Crisis Services Fund, which supports the operation of 988 mobile crisis teams and centers. Thus far the AB 988 system appears tailored for mental health conditions in general and does not appear to specifically target IDD.[244]

Implementation of AB 988 is still in its early stages; law enforcement agencies and peace officers throughout the state will thus need to remain aware of ongoing changes that may impact response to crisis calls. For example, AB 988 requires a continued effort to establish and maintain interoperability between the 911 and 988 systems, and includes goals of connecting 988 systems to more community based services.[245] Currently, calls to California's 911 system are answered by 450 locally-governed Public Safety Answering Points, meaning that the operations of the 911 system across jurisdictions are variable and there is no one solution for smoothly connecting 911 and 988 systems throughout California.[246] However, this interconnectivity can be a source of innovation in providing safer services to people with disabilities. For example, after investing in a technological upgrade improving connectivity between 911 and 988, the Sacramento Sheriff's Department has shifted away from responding to mental health calls that do not involve lawbreaking, diverting such calls to the 988 system unless there is a clear reason law enforcement needs to respond.[247] The Department continues to monitor the outcome of such calls, and thus far this process has connected hundreds of

[243] *Building California's Comprehensive 988-Crisis System: A Strategic Blueprint*, Cal. Health and Human Services (Dec. 31, 2024) (*Building CA's Comprehensive 988-Crisis System*), p. 13, https://www.chhs.ca.gov/wp-content/uploads/2025/01/AB-988-Five-Year-Implementation-Plan-Final-ADA-Compliant.pdf.

[244] See, e.g., id., p. 2 (Executive Summary focused on interventions for drug and alcohol abuse and "serious mental illness").

[245] SB 882 Council Meeting (April 1, 2025) Testimony of Dr. Ahn Thu Bui, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.

[246] Id., p. 3.

[247] SB 882 Council Meeting (July 15, 2025) Testimony of Mike Ziegler, https://www.youtube.com/watch?v=a6uhhwrrhkU~~-~~; see also Clayton, *Growing number of California sheriffs no longer respond to mental health calls* (Jan. 2, 2026) The Guardian, https://www.theguardian.com/us-news/2026/jan/02/california-police-cut-mental-health-calls.

individuals to behavioral health services and reported no adverse physical outcomes as of July 2025.[248]

California has taken other steps to build a comprehensive 988 crisis response system. The Substance Abuse and Mental Health Services Administration (SAMHSA), a subdivision of the United States Department of Health and Human Services, administers twelve 988 Crisis Centers across California. These centers provide free, confidential services to individuals experiencing a mental health crisis or emotional distress, answering calls, texts, and chats from those with a California area code. Communications are routed to the nearest 988 Crisis Center based on the help seeker's approximate physical location at the time of contact. As of December 2024, 48 counties were approved to provide mobile crisis services supported by the Medi-Cal Mobile Crisis benefit.[249]

Integration of Peer Support

Another strategy for improving outcomes is integrating peer support into law enforcement response to provide follow-up care. Peer Specialists, who have personal experience navigating mental health systems, are increasingly seen as critical to establishing rapport and ensuring continuity of care. For example, Sacramento's model incorporates peers into its follow-up process to sustain engagement after the crisis.[250] Olympia, Washington, through its Familiar Faces initiative, integrates peer workers who maintain long-term contact with individuals who frequently use emergency services.[251] In Eureka, California, the CARE program embeds peer support into its community outreach model, providing education, housing navigation, and linkage to mental health services in collaboration with local housing programs like UPLIFT.[252] It is not clear from available program descriptions whether any of the listed programs include a focus on IDD, or employ peers who are members of these communities.

Some communities, like Oakland, California, are attempting to implement peer support outside law enforcement response through programs like MH First, a grassroots alternative response project that emphasizes trauma-informed, socially conscious intervention over risk-based triage.[253]

[248] Id.
[249] *Building California's Comprehensive 988-Crisis System*, p. 3.
[250] SB 882 Council Meeting (July 15, 2025) Testimony of Mike Ziegler, https://www.youtube.com/watch?v=a6uhhwrrhkU.
[251] *Crisis Response and Familiar Faces*, City of Olympia, Wash., https://www.olympiawa.gov/services/police_department/crisis_response.php.
[252] *Crisis Alternative Response of Eureka*.
[253] E.g., *MH First Oakland*, Native Am. Health Center, https://www.nativehealth.org/resource/mh-first-oakland/.

Follow-up Care

Some models also integrate follow-up care and continuity of support. Rather than viewing crisis response as a one-time event, programs like San Mateo's PERT and San Francisco's Street Crisis Response Team provide referrals, warm hand-offs to providers, and ongoing contact.[254] Durham's HEART program has a dedicated Care Navigation team to ensure that individuals continue receiving services after the immediate crisis has passed.[255] In Eureka, CARE's case managers stay connected with at-risk residents, while New York's B-HEARD connects clients to outpatient care through specialized Health Engagement and Assessment Teams.[256] These programs recognize that recovery and stability are long-term priorities. As above, while the listed programs do not appear to exclude individuals with IDD, neither do services appear tailored for the needs of this population.

Certain shared features appear to contribute to the success of these models: reliance on trained clinical staff rather than law enforcement; strong community partnerships; mobile infrastructure for in-field care; a clear entry point for accessing services without law enforcement; and an emphasis on consent-based, trauma-informed intervention. The inclusion of peer support specialists, case managers, and follow-up teams also helps maintain relationships with individuals post-crisis, which is an aspect that traditional 911-based models often lack. One review comparing CIT, dispatch programs, co-responder teams, and diversion programs demonstrated positive impacts of these interventions both for those with mental health conditions or in a mental health crisis and for law enforcement personnel.[257] These positive impacts included decreased arrests, reduced jail time, and a path for accessing mental health treatment services. The study found that successful programs included two features: (1) a **psychiatric triage or drop-off center** where law enforcement can transport individuals in crisis; and (2) **community partnerships** so that law enforcement response is part of a wider response of relevant agencies.[258] These programs offer a blueprint for cities and counties seeking to rethink how they respond to behavioral health emergencies and their varying degrees of law enforcement involvement. Still, there is a need to expand the focus of such programs to include responses tailored to the needs of people with IDD in addition to those with mental health conditions.

These lessons align with the needs reported by California law enforcement agencies. In its survey of law enforcement agencies in California, the Council asked about the community

[254] *Community Wellness and Crisis Response Team*, County of San Mateo; *Street Crisis Response Team*, City and County of San Francisco, https://www.sf.gov/street-crisis-response-team.
[255] *Durham Community Safety*.
[256] *Crisis Alternative Response of Eureka*.
[257] Kane et al, *Effectiveness of current policing-related mental health interventions: A Systemic Review* (2018) Criminal Behaviour and Mental Health 28:2 (Kane et al., *Effectiveness of current policing*), pp. 110, 114.
[258] Id., p. 114.

resources that agencies utilize to respond to incidents and the desire for more community resources. Most agencies work with or rely on city or county agencies and mobile crisis units. About 41% of agencies reported that it would be helpful to have better access to in-patient mental health treatment for purposes other than 5150 holds. Agencies reported that it would also be helpful to have better access to substance use treatment centers, supportive housing resources, and mobile crisis units. Based on survey responses, access to and availability of resources are hampered by limits to when services are available, where services are located, and the number of available clinicians.

Figure X. Agency-Reported Needs for Improved Resource Access[259]

Review of Crisis Response Models

This section will review findings about the efficacy of CIT and of other programs, and some obstacles to implementing these response models. It will also present some of the limitations of the existing data, most notably, that CIT programs do not appear to specifically address interactions with people with intellectual and developmental disabilities. The variation among crisis response programs and the predominance of research focusing on CIT likewise present obstacles to engaging in comparative evaluation among different types of models.

CIT Efficacy

CIT programs are the most well-known and established of the mental health crisis response models that law enforcement agencies have implemented and thus are the most well-researched. However, efficacy research has been challenging to pursue given that agencies vary greatly in their implementation of the program, and that researchers have struggled to design

[259] Harmon, et al., *SB882 Survey of Law Enforcement Agencies*, Cal. Dept. of J. (Sep. 2025), Appendix D (Harmon, et al., *SB882 Survey*), p. 22.

feasible randomized controlled studies in this area.[260] Instead, studies have often examined attitudes and knowledge pre- and post-CIT training, compared call data before and after CIT implementation, compared calls handled by CIT and non-CIT trained peace officers, and surveyed or used qualitative methods to explore peace officer perceptions of CIT and its effectiveness. Many studies rely on officer self-reports or responses to hypotheticals, and some studies may effectively gauge attitudes and knowledge, but they likely do a poor job of capturing accurate data on use of force, injury, arrest, and other commonly used benchmarks that measure more concrete outcomes.

Studies do suggest that CIT programs are effective at improving peace officers' perceptions of and response to persons with mental health challenges.[261] Some studies indicate that CIT improves peace officers' knowledge about mental health, increases the extent to which peace officer beliefs about mental health reflect medical knowledge, and reduces stigma.[262] CIT also appears to reduce peace officer preference for using force, and increase preference for engaging in de-escalation, when interacting with people in the SB 882 population.[263] Studies also suggest CIT increases peace officers' self-confidence in their and their departments' abilities to respond to people experiencing a crisis.[264] However, it is unclear whether and how these changes in peace officer mindset go on to change what happens in interactions with people in the SB 882 population.[265] Indeed, research exploring the impact of implicit bias training on outcomes suggests that training can result in overconfidence which in turn results in worse outcomes.[266]

Other studies have shown that CIT training may improve a peace officer's responsiveness and de-escalation decisions.[267] For example, in one study CIT trained and non-CIT trained peace officers were given a series of vignettes describing a person with schizophrenia who was

[260] Watson & Fulambarker, *The Crisis Intervention Team Model*, pp. 3-5 (citing McGuire & Bond, *Critical Elements of the Crisis Intervention Team*); SB 882 Council Meeting (April 1, 2025) Testimony of Drs. Michael Compton and Amy Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.

[261] Congressional Research Service Report, p. 9, fn. 61-62.

[262] Watson, et al., *Crisis Response Services*, p. 5, p. 29; Congressional Research Service Report, p. 9, fn. 63.

[263] Congressional Research Service Report, p. 9, fn. 63.

[264] Watson, et al., *Crisis Response Services*, p. 5, p. 29; Congressional Research Service report, p. 9, fn. 63; Wells & Schafer, 2006.

[265] Congressional Research Service Report, p. 9.

[266] SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Jack Glaser, https://www.youtube.com/watch?v=a6uhhwrrhkU. Such trainings may be analogous to trainings related to interactions with the SB 882 population given that officer attitudes, perceptions, and biases about the population may be topics or targets of the training.

[267] Watson & El-Sabawi, *Expansion of the Police Role*, p. 20, fn. 111; Wood & Watson, *Improving police interventions*, p. 5 (citing studies).

exhibiting escalating behavior. When compared to non-trained peace officers, CIT-trained peace officers perceived that force would be less effective and expressed a preference to use less force.[268] Another study found "significant and substantial differences" between the de-escalation skills of CIT trained and non-CIT trained peace officers when confronted with vignettes of persons who were suicidal or experiencing psychosis.[269] Some research indicates that these improvements do not dissipate after the training, especially for more experienced peace officers.[270]

However, studies are less clear that CIT training improves outcomes such as reducing arrests of or uses of force against people in mental health crisis.[271] Some studies have shown a reduction in rates of arrest when peace officers are CIT-trained.[272] However, others, including a 2016 meta-analysis, do not show any effect of CIT on arrest rates.[273] One review comparing multiple crisis response models found limited evidence that these interventions reduced re-offending or improved mental health outcomes, and recommended further empirical research on these topics.[274] Similarly, evidence regarding whether CIT reduces use of force is inconclusive. One analysis determined that there is little evidence that, as compared to standard policing, CIT models averted arrests, impacted use of force, or impacted resolution of crisis calls on scene.[275] Several studies do indicate that CIT-trained peace officers are less likely to express wanting to use force in response to difficult interactions with people in the SB 882 population and are less

[268] Watson, et al., *Crisis Response Services*, p. 30.
[269] Id.
[270] Watson & El-Sabawi, *Expansion of the Police Role*, p. 20, fn. 111; Wood & Watson, *Improving police interventions*, p. 5 (citing studies); Watson, et al., *Crisis Response Services*, p. 30.
[271] Watson & El-Sabawi, *Expansion of the Police Role*, p. 20, fn. 112.
[272] Watson, et al., *Crisis Response Services*, p. 28 (lower arrest rates for agency implementing CIT); Watson & Fulambarker, *The Crisis Intervention Team Model*, p. 4; Fuller, *Overlooked*, pp. 10-11, fns. 68-70.
[273] Taheri, *Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? A Systematic Review and Meta-Analysis* (2016) Crim. J. Policy Review 27:1, pp. 85-86 (Taheri, *Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety?*).
[274] Kane et al., *Effectiveness of current policing,* pp. 114-115.
[275] Marcus & Stergiopoulos, *Re-examining mental health crisis intervention: A rapid review comparing outcomes across police, co-responder and non-police models* (2022) Health Soc. Care Community 30, p. 1674 (Marcus & Stergiopoulos, *Re-examining mental health crisis intervention*); Seo, et al., *Variation across police response models for handling encounters with people with mental illness: A systemic review and meta-analysis* (2021) 72 Journal of Criminal Justice, p. 11 (Seo, *Variation across police response models*) ("[D]espite these interventions achieving success related to mechanisms (i.e., increasing knowledge, decreasing desire for social distance, etc.) aimed at indirectly improving tangible 'observed' outcomes, they have little effect on 'observed' outcomes of greatest importance (i.e., arrests and use of force)."); *Watson, et al., Crisis Response Services*, pp. 30-31 (discussing studies finding both some small improvement and some finding no improvement, and stating "the findings can at best be considered inconclusive").

likely to use such force.[276] The 2016 meta-analysis mentioned above shows no such effect, although the reasons for this are not clear.[277] Some studies also show reduced rates of injury to peace officers or civilians following these encounters, while others do not show this reduction.[278] One study demonstrated an association between CIT implementation in Memphis and decreased use of high intensity police units such as Special Weapons and Tactics (SWAT) teams.[279] Researchers are currently undertaking a randomized controlled trial of CIT response in seven sites, but data collection and analysis are not yet complete.[280] This trial may help address the dearth of research on the effectiveness of CIT models.

Studies do consistently show that people in the SB 882 population who have interactions with peace officers who use the CIT model are more likely to be connected to care following the encounter.[281] One study examined the relationship between CIT practice and available community resources, and found that CIT peace officers in general were more likely to direct the people they encountered to mental health care, but that this impact was greatest in areas that had many mental health resources.[282] Researchers have also identified jurisdictions in which law enforcement also directs people toward less disruptive care, such as a crisis triage center or residential treatment, rather than to a jail or hospital.[283] A review comparing crisis response modalities concluded that CIT intervention showed the most promise because it offers integrated services, combining the initial call for assistance with response triage and specially trained response peace officers with access to mental health professionals.[284]

CIT can also lead to cost savings. For example, according to one comprehensive study of a CIT program in Louisville, Kentucky, CIT saved the city approximately $1 million annually.[285] That study did not calculate indirect costs like lost productivity, housing issues, or costs of supportive social services, and did not attempt to monetize non-economic benefits. Overall, there are

[276] Fuller, *Overlooked*, fn. 68-70; Watson & Fulambarker, *The Crisis Intervention Team Model,* pp. 4-5 (discussing studies); SB 882 Council Meeting (April 1, 2025) Testimony of Drs. Michael Compton and Amy Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.
[277] Taheri, *Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety?*, pp. 85-86.
[278] Watson & Fulambarker, *The Crisis Intervention Team Model,* pp. 4-5 (discussing studies).
[279] Id.
[280] SB 882 Council Meeting (April 1, 2025) Testimony of Drs. Michael Compton and Amy Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.
[281] Fuller, *Overlooked*, pp. 10-11, fns. 68-70; Watson & El-Sabawi, *Expansion of the Police Role*, p. 20, fn. 113.
[282] Watson, et al., *Improving Police Response to persons with mental illness: A multi-level conceptualization of CIT* (2008) Int'l J. of Law and Psychiatry 31, p. 362.
[283] Wood & Watson, *Improving police interventions*, p. 5.
[284] Kane et al., *Effectiveness of current policing*, p. 115.
[285] El-Mallakh, et al., *Costs and Savings Associated with Implementation of a Police Crisis Intervention Team* (June 2014) Southern Medical J. 107:6; see also Cowell, et al., *The Impact on Taxpayer Costs of a Model Jail Diversion Program for People with Mental Illness* (2013) Evaluation and Program Planning Vol. 41, pp. 31-37 (finding pre-booking component of CIT program saves costs).

indications that CIT can produce beneficial outcomes for law enforcement and SB 882 populations, but more research is needed to better understand impacts on outcomes like arrests and use of force.

Efficacy and Benefits of Co-response and Alternative Response Models

Alternative programs tend to have certain elements in common. This includes some combination of: (1) implementation by skilled personnel with a variety of backgrounds suited to aiding people with mental health conditions, such as mental health or social work clinicians, nurses, peers with lived experience, and specially-trained emergency medical technicians who are unarmed; (2) psychiatrists available "on call" as backup, potentially through telehealth; and (3) mobile crisis teams that are trained in de-escalation and connecting people with needed services.[286]

Comprehensive alternative responses do not eliminate the need for law enforcement training because non-law enforcement teams usually do not respond to calls that involve violence or weapons and call triage can be inaccurate. Peace officers, as opposed to community partners and providers, also respond to incidents around-the-clock, so law enforcement will have some unavoidable contact with individuals in the SB 882 population.[287] But, these alternative response models can minimize the contact between law enforcement and people in the SB 882 population.[288] As set out below, while the research is still developing in this area, there are some indications that co-response and alternative response models can be beneficial to members of the SB 882 population and reduce the burden on law enforcement. Like the research on CIT, there is little direct focus on people with intellectual and developmental disabilities rather than mental health conditions, and thus, more specific research in this area is also needed.

The data comparing traditional law enforcement response to co-response or alternative response models is generally sparse.[289] Many of these response models have only been in operation for a few years, there is huge variation in co-response and alternative response

[286] *Community-Based Services for Black People with Mental Illness, Advancing An Alternative to Police*, Legal Defense Fund and Bazelon Center for Mental Health Law (Jan. 2023), p. 15 (*Community-Based Services for Black People with Mental Illness*) https://www.naacpldf.org/wp-content/uploads/2023-LDF-Bazelon-brief-Community-Based-Services-for-MH48.pdf.
[287] Balfour, et. al., *Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies* (Aug. 2020) Nat. Assn. of State Mental Health Program Directors, pp. 4-5 (Balfour, *Cops, Clinicians, or Both?*); see also SB 882 Council Meeting (July 15, 2025) Testimony of Michelle Saunders, LCSW, https://www.youtube.com/watch?v=a6uhhwrrhkU.
[288] Balfour, *Cops, Clinicians, or Both?*, pp. 4-5.
[289] See, e.g., Congressional Research Service Report, p. 10.

models, and controlled studies are difficult.[290] While current data is insufficient to draw strong conclusions, these models appear promising in certain areas. For example, co-responder models often receive higher community support than law enforcement-only response models.[291] One review determined co-responder programs decreased arrests and the amount of time officers spend handling mental health calls.[292] Another study that found no significant difference in arrest rates did find that co-responder teams were significantly more likely to resolve calls without psychiatric hospitalization of the person, and the teams' calls had lower costs than calls handled by peace officers alone.[293] In contrast, one randomized controlled study comparing calls sent to a co-response team versus a law enforcement-as-usual response found no significant differences in event outcomes, including jail booking, outpatient encounters, and emergency department visits.[294] And one meta-analysis of currently implemented training programs and co-responder models did not find either reform to significantly reduce law enforcement use of force or arrests in encounters with people with mental health conditions.[295] In part, the lack of data and concrete impacts may be related to the fact that many co-response programs are limited in scope either in terms of hours of availability or geographic area, and can be hampered by a lack of mental health resources in the community.[296]

Co-response models perform slightly better than CIT in some measures, but the data sets are small and existing studies do not compare programs directly.[297] Alternative/community response models appear to perform better than co-response models, but the data is even more sparse for those.[298]

[290] See, e.g., Balfour, *Cops, Clinicians, or Both?*, p. 8; Lowder, at al., *Police-mental health co-response versus police-as-usual response to behavioral health emergencies: A pragmatic randomized effectiveness trial* (2024) Social Science & Medicine 345:116723, p. 2, (Lowder et al., *Police-mental health co-response*) https://doi.org/10.1016/j.socscimed.2024.116723; *Watson, et al., Crisis Response Services*, p. 41.
[291] Balfour, *Cops, Clinicians, or Both?*, p. 8; *Watson, et al., Crisis Response Services*, pp. 14-16 (discussing studies).
[292] Balfour, *Cops, Clinicians, or Both?*, p. 8.
[293] Watson, et al., *Crisis Response Services*, p. 16.
[294] Lowder et al., *Police-mental health co-response*, p. 1; SB 882 Council Meeting (April 1, 2025) Testimony of Drs. Michael Compton and Amy Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.
[295] *Community-Based Services for Black People with Mental Illness* p. 16, (citing Taheri, *Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety?*, p. 90); but see Seo, *Variation across police response models*, p. 10, (finding a "positive, moderate effect on nine 'self-reported officer perception' outcomes and small effect on five 'observed officer behavior' outcomes" for the CIT model).
[296] Balfour, *Cops, Clinicians, or Both?*, p. 8; Congressional Research Service Report, p. 10.
[297] Marcus & Stergiopoulos, *Re-examining mental health crisis intervention*, pp. 1668-1674 and Table 2 (among imperfect data sets, Co-Response models seemed to present lower arrest numbers and use of force rates than CIT models and lower rates of transportation to the emergency room).
[298] See, e.g., id.

Still, there is some data demonstrating that alternative response models appear to improve outcomes for individuals experiencing a mental health crisis and reduce both the number of people being taken into law enforcement custody and unnecessary emergency room visits.[299] Data from both co-response and alternative response models suggest that the addition of mental healthcare providers to the interaction with the individual adds to the quality and experience of services, leading one study to recommend a shift away from relying on the CIT model to support the "development of alternative, evidence-based models that prioritise [sic] the lived experience of service users."[300]

In the United States, positive anecdotal evidence comes from CAHOOTS in Eugene, Oregon, which operated for over 30 years and is described in the *Alternative Civilian-Led Crisis Teams* section above. At its peak the program reported savings to the city of $8.5 million in public safety costs and $14 million in ambulance and emergency room costs.[301] Strong quantitative data comes from an evaluation of the STAR Program in Denver, also discussed previously. The STAR Program reported that during its six-month pilot program in 2020, it resolved 748 mental health condition incidents (averaging six calls a day) that involved no force, arrests, or jail.[302] Researchers attempted to quantify the impact of the STAR Program on crime in the city and found that areas where the Program was active experienced up to 34% reductions in STAR-related crimes, but not in those crimes not directly related to STAR services.[303] The study estimated that a community response model cost four times less than the direct costs of having law enforcement as first responders.[304] The researchers point out that successfully replicating the STAR Program relies on factors such as successful recruitment and training of dispatchers and mental health field staff, along with coordination with law enforcement.[305]

Although missing key data to effectively compare response types, alternative responses may be better received (and more cost effective) than responses that involve law enforcement. For example, alternative response models that do not include law enforcement may be better

[299] Congressional Research Service Report, p. 9; Watson, et al., *Crisis Response Services*, pp. 21, 24.
[300] Marcus & Stergiopoulos, *Re-examining mental health crisis intervention*, p. 1674; see also Seo, *Variation across police response models*, p. 11 (findings indicate "collaborations between mental health professionals and law enforcement officers in co-response models may be more effective in handling police encounters with the mentally ill than providing training to frontline officers").
[301] *Community-Based Services for Black People with Mental Illness*, p. 15 (citing Andrew, *This Town of 170,000 Replaced Some Cops with Medics and Mental Health Workers. It's Worked for Over 30 Years* (July 5, 2020) CNN, https://www.cnn.com/2020/07/05/us/cahoots-replace-police-mental-health-trnd/).
[302] Butler & Sheriff, *How the American Rescue Plan Act will help cities replace police with trained crisis teams for mental health emergencies* (June 22, 2021) Brookings Inst., p. 4, https://www.brookings.edu/articles/how-the-american-rescue-plan-act-will-help-cities-replace-police-with-trained-crisis-teams-for-mental-health-emergencies/.
[303] Dee & Pyne, *A community response approach to mental health and substance abuse crises reduced crime* (June 2022) Science Advances 8:23, p. 3 (Dee & Pyne, *A community response approach*).
[304] Id., p. 7.
[305] Id., p. 6.

received because peace officer involvement can retraumatize individuals due to their previous traumatic interactions with law enforcement.[306] One meta-analysis determined that most individuals with mental health conditions reported mixed, variable, or negative past experiences with law enforcement (both CIT and non-CIT trained), with nine studies describing individuals' interactions with law enforcement as "traumatic or extremely stigmatizing."[307] In contrast, the analysis determined that individuals reported generally positive perceptions of services in co-responder models, and non-law enforcement models.[308]

These alternative response models can also have cost-savings benefits. For example, a claims analysis of crisis stabilization services estimated that for every dollar spent on crisis services, a locality had a return of $2.16, due to savings in inpatient, outpatient, and emergency department use.[309] Savings can accrue to law enforcement as well. For example, one study determined that by changing the response to suicidal patients "barricaded" in their homes to a system of care model, the Tucson Police Department reduced the number of SWAT deployments from 14 per year in 2012-2013 to 2.3 per year in 2014-2016, at a cost savings of $15,000 per incident.[310] And a meta-analysis determined there is evidence to suggest that co-responder and alternative response models are associated with cost savings from decreased use of law enforcement funds and justice system diversion.[311]

Researchers caution that co-response or alternative response models are small components of a larger crisis system.[312] Such responses are more likely to improve outcomes when different programs and services work together to achieve better outcomes as part of a coordinated system of care. For example, in Tucson, Arizona, a Regional Behavioral Health Authority (RBHA) contracts with multiple behavioral health agencies to create an array of services organized along a continuum of intensity, restrictiveness, and cost.[313] At all points along the continuum, which in this case includes co-location of crisis call center staff within 9-1-1, co-responder

[306] *Community-Based Services for Black People with Mental Illness*, p. 8, citing El-Sabawi & Carroll, *A Model for Defunding: An Evidence-Based Statute for Behavioral Health Crisis Response* (2021) 94 Temple L. Rev. 1, 13.
[307] Marcus & Stergiopoulos, *Re-examining mental health crisis intervention*, p. 1673.
[308] Id.
[309] Balfour, et. al., *Crisis stabilization claims analysis: Technical report; Crisis Stabilization Claims Analysis: Technical Report Assessing the Impact of Crisis Stabilization on Utilization of Healthcare Services* (April 2013) Wilder Research, p. 12, https://www.wilder.org/wilder_research/crisis-stabilization-claims-analysis-technical-report-assessing-the-impact-of-crisis-stabilization-on-utilization-of-healthcare-services/.
[310] Balfour, et. al., *The Tucson Mental Health Investigative Support Team (MHIST) Model: A prevention focused approach to crisis and public safety* (2017) Psychiatry Serv. 68:2, p. 5, http://www.gocit.org/uploads/3/0/5/5/30557023/tucson_mhst_model_full_version.pdf.
[311] Marcus & Stergiopoulos, *Re-examining mental health crisis intervention*, p. 1675; see also Watson, et al., *Crisis Response Services*, pp. 15-16.
[312] See, e.g., Balfour, *Cops, Clinicians, or Both?*, pp. 8, 10.
[313] Id., p. 10.

teams, and crisis facilities, easily accessible handoffs by law enforcement facilitates connection to treatment instead of arrest.[314]

The federal government has created extensive resources for designing and building out more robust crisis care systems, although the degree of availability of these resources may shift according to federal funding priorities. For example, SAMHSA's 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care set out three foundational elements for an integrated crisis system of care: (1) Someone to Contact: services like the 988 Lifeline and other behavioral health hotlines; (2) Someone to Respond: services like mobile crisis teams to deliver rapid, on-site interventions; and (3) A Safe Place for Help: emergency and crisis stabilization services that support on-demand crisis care and crisis-related supports in a variety of community settings.[315] To support implementation of crisis systems of care, SAMHSA has also created Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services.[316] These resources provide extensive and detailed information to support the creation of crisis-related services throughout California.

Obstacles to Implementation of CIT, Co-Response, and Alternative Response Models

Staffing and Resource Challenges

In response to the Council's survey of law enforcement agencies, agencies without specialized teams mostly cited budget and/or staffing limitations as the primary reason for not having a specialized team. CIT and alternative programs can be cost-intensive and may be difficult to support in smaller jurisdictions, even if they may ultimately lead to cost savings. Using CIT as an example, 40 hours of training for each CIT peace officer to be certified may be cost-prohibitive in smaller agencies, especially given the recommendation that 20-25% of patrol officers be CIT-certified to fully implement a CIT program. For smaller law enforcement agencies, extended training sessions and continuing education can pose significant burdens. Approximately 35% of California police departments employ 25 or fewer peace officers and about 10% employ 10 or fewer peace officers, which may limit availability for training and implementation of CIT.[317] Additionally, the collaboration needed to work with mental health resources and other

[314] Id.

[315] *2025 National Guidelines,* pp. 2-3. See also SB 882 Council Meeting (April 1, 2025) Testimony of Dr. Ahn Thu Bui, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be; SB 882 Council Meeting (April 1, 2025) Testimony of Monica Porter Gilbert, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.

[316] *Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services*, U.S. Dept. of Health and Human Services Substance Abuse & Mental Health Services Admin. (2025) HHS Publication No. PEP24-01-037 https://library.samhsa.gov/sites/default/files/model-definitions-pep24-01-037.pdf.

[317] *Agency Statistics*, Cal. Com. on Peace Officer Stds. and Training, https://post.ca.gov/Agency-Statistics; see also Congressional Research Service Report, p. 19, fn. 114 (presenting Bureau of Justice Statistics data indicating that three-quarters of law enforcement departments in 2016 employed 24 or fewer officers and about half employed nine or fewer officers).

agencies (for example, in creating a centralized drop-off emergency center, or conducting training of 911 dispatchers) may also be difficult to attain for smaller agencies.

Workforce considerations are also an issue for jurisdictions of all sizes. Few academic or vocational programs currently prepare people for positions in crisis response. To build a workforce of non-law enforcement responders, it is important to invest in creating educational, licensure, and recruitment pathways to becoming a crisis responder.

Model Fidelity

Program effectiveness also depends on how well the department implementing it understands the model and commits time and resources to supporting all the complexities of shifting policy.[318] For example, training is foundational to effective CIT, but training alone is not sufficient.[319] The model also calls for increased focus on dispatcher training, which does not always occur.[320] Beyond law enforcement, effective CIT implementation requires comprehensive community mental health services, designated psychiatric emergency receiving facilities, and interagency cooperation, which may not be present in any given jurisdiction.

Potential Promising Practices

[*Final text to be entered after March 16 & 19, 2026 meetings of the Council.*]

Recommendations

[*Final text to be entered after March 16 & 19, 2026 meetings of the Council.*]

[318] For an example of policy guidance, see *Interactions with Individuals with Intellectual and Developmental Disabilities: Model Policy, Concepts & Issues Paper*, IACP Law Enforcement Policy Center (Aug. 2017) pp. 1-3, https://www.theiacp.org/sites/default/files/2018-08/IntellectualDevelopmentalDisabledPaper.pdf.

[319] See, e.g., SB 882 Council Meeting (Jan. 15, 2025) Testimony of Dr. Randy Dupont, https://www.youtube.com/watch?v=vAIndu5KVfM (explaining the importance of systems integration alongside training for effective CIT); SB 882 Council Meeting (July 15, 2025) Testimony of Michele Saunders, LCSW, https://www.youtube.com/watch?v=a6uhhwrrhkU ("training has to be within the context of something larger than just training by itself").

[320] Congressional Research Service Report, p. 5.

Training

Training is a cornerstone of law enforcement preparedness. There is a broad universe of training that seeks to improve interactions between the SB 882 population and peace officers. Such training is critical to improving outcomes of such interactions, and to improving the experience of all persons in California, both peace officers and the SB 882 population alike.[321]

This section examines existing types of law enforcement training, and the research evaluating such trainings, to provide an overview of law enforcement training relating to interactions with the SB 882 population. This includes a review of the substantive training topics of training specifically designed to address interacting with the SB 882 population, de-escalation training, training specific to interactions with youth, training designed for the SB 882 population individuals themselves to improve safety in interactions with law enforcement, and lessons from implicit bias training research. It also discusses methods of delivering trainings, including role-play and simulation trainings, and the importance of repetition and refresher trainings. Finally, this section discusses findings from the survey of law enforcement agencies across California and the Council's review and evaluation of various trainings provided across the state.

Overview of Research on Efficacy of Trainings

Researchers have made attempts to synthesize existing findings on what substantive training subjects and methods of training in this field are most effective; however, it is difficult to draw firm conclusions because of the variety of types and quality of existing studies on law enforcement trainings focusing on the SB 882 population. The main takeaway from a review synthesizing existing research is that more research is needed, particularly with a focus on measuring concrete changes in peace officer behavior and increases in positive outcomes for the SB 882 population when they interact with law enforcement. Working to expand and support this type of research is critical for continuing to develop and support the most effective training models for law enforcement.

For example, in one review, researchers examined 19 different studies on various types of behavioral health training. These included trainings ranging from broad mental health awareness to more narrow trainings addressing a variety of specific mental health conditions.[322] The review found that while many of the training programs used evidence-based practices, strong and consistent evidence regarding outcomes was lacking. Some of the studies demonstrated short-term positive changes in behavior or attitudes for trainees, but longer-

[321] See SB 882 Council Meeting (Jan. 15, 2025) Testimony of Dr. Randy Dupont, https://www.youtube.com/watch?v=vAIndu5KVfM.

[322] Booth et al., *Mental health training programmes for non-mental health trained professionals coming into contact with people with mental ill health: a systematic review of effectiveness* (2017) BMC Psychiatry 17:196, pp. 2-3, 5-7 (Booth, *Mental health training*) https://doi.org/10.1186/s12888-017-1356-5.

term follow-up was needed for many of the studies.[323] Finally, and critically, no studies demonstrated clear links between the training results and concrete outcomes for the members of the public that the law enforcement trainees encountered.[324]

The current need for additional research to assess different training models~~-~~ is underscored by another systemic review on police training where the author was unable to identify enough studies that met the criteria and could not complete the review.[325] This review was broader in subject matter scope, looking at evaluations of any type of police training, rather than those focused solely on interactions with the SB 882 population.[326] The review was also more narrowly focused on results, attempting to review only studies that used empirical techniques to measure the effects of training on peace officer behavior, rather than descriptive-only studies or those that only measured attitudes from the training rather than the effects of the training itself.[327] Unfortunately, the review was unable to identify enough studies that met these criteria, and could not be completed, underscoring the need for further empirical research on which training methods provide improvement in concrete outcome measures.[328] The difficulty in identifying studies meeting stricter empirical criteria also may reflect limitations of using randomized controlled studies as the primary learning tool in this area; for example, interactions do not take place with the high frequency needed for a robust trial, crisis environments may preclude obtaining true informed consent to research, and ethical guidelines may prevent responding to legitimate crisis in an experimental manner. Case study or other qualitative research methods may provide alternate methods of learning in the field.

Existing Types of Law Enforcement Training

The Council considered various types of law enforcement trainings in developing their recommendations. The following describe the several types of trainings, including both the trainings' contents and methods of delivery and the efficacy of such trainings.

Trainings Required by Law

Peace officers in California are required to ~~meet~~ complete an introductory ~~minimum~~ training course ~~standards~~ as identified by law.[329] The Commission on Peace Officer Standards and Training (POST) sets the standards and training requirements for peace officers and dispatchers

[323] Id., pp. 10, 19-20, 22.
[324] Id., pp. 1, 20, 22.
[325] Huey, *What Do We Know About In-service Police Training? Results of a Failed Systematic Review* (2018) Sociology Publications 40 (Huey, *What Do We Know?*) https://uwo.scholaris.ca/items/31c811e6-209d-4e88-9bf4-38d7f76826ca.
[326] Id., p. 6.
[327] Id., p. 6.
[328] Id., pp. 13-15.
[329] Pen. Code, § 832; § 13510; see *About Post*, Cal. Com. on Peace Officer Stds. and Training (2025) https://post.ca.gov/about-us.

across the state and certifies trainings.[330] POST also has authority to certify peace officers, as well as to suspend and decertify peace officers for serious misconduct.[331] POST certifies courses that are offered at various points in peace officers' professional development.[332]

First, people hired as peace officers in California must complete 664 hours of basic training.[333] The basic training course certified by POST is divided into 42~~3~~ individual topics, called learning domains, that contain the minimum required foundational information on each topic.[334] One of these learning domains is training on people with disabilities.[335] The training must address issues related to stigma and be culturally relevant and appropriate.[336] It must also include topics such as recognizing indicators of mental health conditions and intellectual disability, conflict resolution and de-escalation techniques, and the perspective of individuals with lived experience.[337]

Second, in addition to basic training, every peace officer must complete field training before being assigned to perform general law enforcement uniformed patrol duties.[338] The field training must include a course relating to competency that addresses how to interact with people with mental health conditions or intellectual disability.[339] The course must include at least four hours of classroom instruction and instructor-led active learning, such as scenario-based training, must address issues related to stigma, and must be culturally relevant and appropriate.[340] Additionally, officers who provide instruction in the field training program must undergo at least eight hours of crisis intervention and behavioral health training to better train new peace officers on how to effectively interact with people with a mental health disability or intellectual disability.[341]

[330] *About Post*, Cal. Com. on Peace Officer Stds. and Training (2025), https://post.ca.gov/about-us.
[331] Id.
[332] Cal. Code Regs., tit. 11, § 1051; see *Training*, Cal. Com. on Peace Officer Stds. and Training (2025) https://post.ca.gov/training.

[333] Cal. Code Regs., tit. 11, § 1005, subd. (a); see *Peace Officer Basic Training*, Cal. Com. on Peace Officer Stds. and Training (2025) https://post.ca.gov/peace-officer-basic-training.
[334] *Regular Basic Course*, Cal. Com. on Peace Officer Stds. and Training (2025) https://post.ca.gov/regular-basic-course.
[335] *Regular Basic Course Training Specifications*, *LD 37 People with Disabilities*, Cal. Com. on Peace Officer Stds. and Training, https://post.ca.gov/regular-basic-course-training-specifications.
[336] Pen. Code, § 13515.26, subd. (c).
[337] Id.
[338] Cal. Code Regs., tit. 11, § 1005, subd. (a).
[339] Pen. Code § 13515.29.
[340] Id.
[341] Pen. Code, § 13515.28.

Third, certain peace officers and dispatcher personnel who are employed by POST-participating departments must satisfactorily complete continuing professional training.[342] The purpose of continuing professional training is to maintain, update, expand, and enhance an individual's knowledge and skills.[343] Available trainings must include a training course related to law enforcement interaction with people with mental and intellectual disabilities, although the governing statute does not specify whether that course should be required or at what frequency.[344] The training must utilize interactive methods to ensure that the training is as realistic as possible.[345] The training must also include instruction on conflict resolution, de-escalation techniques, appropriate language usage, and appropriate responses when interacting with a person with a disability.[346]

California state correctional officers must also complete required professional training. This training includes the Basic Correctional Officer Academy, where correctional officers receive six instructor-led modules totaling 13 hours on the topics of effective communication, the Developmental Disability Program, the Disability Placement Program, Dedurable Mmedical Eequipment, the Mental Health Services Delivery System, and Iinmate Ssuicide Pprevention.[347]

Training on Interacting with the SB 882 Population

Almost all law enforcement agencies currently provide some amount of training specific to the SB 882 population, and most appear to also have training specific to autism.[348] Many current law enforcement trainings relating to the SB 882 population include general education about mental health conditions and focus on addressing communication and social behavior differences and sensory and accommodation needs.[349]

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[342] Cal. Code Regs., tit. 11, § 1005, subd. (d).
[343] Id.
[344] Pen. Code, §§ 13515.25, 13515.27.
[345] Pen. Code, §§ 13515.25, 13515.27.
[346] Pen. Code, §§ 13515.25, 13515.27.
[347] SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Lee Lipsker, https://www.youtube.com/watch?v=a6uhhwrrhkU.
[348] Fiske, et al., *A National Survey of Police Mental Health Training* (2020) J. Police Crim Psychol. 36, p. 239, https://www.proquest.com/docview/2918766588?pq-origsite=gscholar&fromopenview=true&sourcetype=Scholarly%20Journals (noting 100 percent of agencies provided academy training for interacting with people with IDD and 93 percent provided training specifically related to autism).
[349] Holloway, et al., *A pilot study of co-produced autism training for policy custody staff: evaluating the impact on perceived knowledge change and behaviour intentions* (2021) Policing: An International Journal 45:3, p. 444, (Holloway, *A pilot study*) https://doi.org/10.1108/PIJPSM-11-2021-0159; Love, et al., *Measuring Police Officer Self-efficacy for Working with Individuals with Autism Spectrum Disorder*, (July 2020) Journal of Autism and Developmental Disorders 51, pp. 1342-1343, (Love, *Measuring Police Officer Self-efficacy*) https://doi.org/10.1007/s10803-020-04613-1~~;~~ ~~*Interactions with Individuals with Intellectual and Developmental Disabilities: Model Policy, Concepts & Issues Paper*, IACP Law~~

Materials that POST provided to the Council list available courses covering issues related to mental health and intellectual and developmental disabilities, and some trainings cover both topics.[350] The materials that POST provided to the Council for review included 186 unique trainings provided by law enforcement agencies, private agencies, and public and/or educational institutions that are available throughout the state.[351] Trainings ranged from two to 40 hours in length, with over 20 available to attend remotely, reflecting a wide variety of trainings offered at different points in a peace officer's professional development and at different levels of depth and focus.[352]

In California, peace officers learn about mental health conditions and IDD as part of the basic training academy in Learning Domain 37, which covers: disability laws; peace officer interactions with persons with disabilities; information regarding intellectual and developmental disabilities, specifically including autism and epilepsy; physical disabilities, including blindness and deafness or other hearing-related disabilities; mental illness; and the LPS Act.[353]

Many California law enforcement agencies offer CIT, or CIT-based-, training that often includes specific training on the SB 882 population, including information about types of disability, the kinds of behaviors that law enforcement might encounter, types of sensory impacts on members of the SB 882 population, and different ways sensory dysregulation may appear in an individual faced with a peace officer.[354] The training also includes actionable tips for crisis responders, including turning off flashing lights, reducing volume or offering ear plugs, providing sensory fidgets and avoiding unnecessary touch, and allowing movement and personal space.[355]

While there are a large number of available trainings, research demonstrates a lack of standardization in trainings.[356] Research also demonstrates a dearth of concrete evidence

~~Enforcement Policy Center (Aug. 2017) pp. 1-3, https://www.theiacp.org/sites/default/files/2018-08/IntellectualDevelopmentalDisabledPaper.pdf.~~

[350] SB 882 Council Meeting (Oct. 18, 2024) Agenda Item 7: Presentation by California Dept. of Justice Staff.

[351] Id.

[352] Id.

[353] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Yolanda Cruz, https://www.youtube.com/watch?v=yWRnfEr33es.

[354] See, e.g., SB 882 Council Meeting (July 15, 2025) Testimony of Michele Saunders, LCSW, https://www.youtube.com/watch?v=a6uhhwrrhkU (explaining the integration of community partners and people with lived experience in creating CIT trainings).

[355] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Yolanda Cruz, https://www.youtube.com/watch?v=yWRnfEr33es.

[356] Richardson, et al., *Law Enforcement Response to Persons with Intellectual and Developmental Disabilities: Identifying High-Priority Needs to Improve Law Enforcement Strategies* (2024) RAND Corp.,

regarding the impact of such training on outcomes for members of the SB 882 population; much of the research concludes that additional and more outcome-oriented research would be beneficial.[357] Additionally, training evaluations have investigated whether the training has any impact on the rate at which law enforcement officers use force or on officers' knowledge, attitude, or competency, but without strong statistically significant results.[358] As noted earlier, this type of research is difficult to conduct in this area given the unexpected and varied environments in which crisis situations occur, and the need to treat all people equally during encounters with law enforcement.

Still, there are indications that existing training can increase peace officers' knowledge of mental health conditions and IDD and self-reported competency in interacting with members of the SB 882 population.[359] CIT training on mental health conditions and IDD may lead to increased officer knowledge and improved attitudes about responding to calls, and can increase linkages to care, such as transports to crisis centers, as well as community-based services.[360] More research specifically evaluating whether training directly impacts a law enforcement agency's rates of arrests or uses of force or whether encounters with members of the SB 882 population are more likely to be diverted to services rather than arrest after the training is still needed to ensure that resources are used most efficiently and with the greatest impact on individuals.[361]

De-escalation Training

De-escalation training for peace officers is often a central recommendation for improving law enforcement interactions with the public generally and specifically with the SB 882 population.

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p. 2, (Richardson, *Law Enforcement Response*) https://www.rand.org/content/dam/rand/pubs/research_reports/RRA100/RRA108-26/RAND_RRA108-26.pdf; Nguyen, *A Systematic Review of Evaluations of Law Enforcement Training Relating to Developmental and Intellectual Disabilities* (Dec. 2021) Sam Houston State Univ. (Nguyen, *A Systematic Review*), pp. iii, 48-49; Railey, et al., *A Systemic Review of Law enforcement Training Related to Autism Spectrum Disorder* (2020) Focus on Autism and Other Developmental Disabilities 35:4 (Railey, et al., *A Systemic Review*), pp. 230-231; Murphy, et al., *Autism awareness training for An Garda Siochana*, Letter to the Editor (July 2017; republished Dec. 2018) Irish Journal of Psychological Medicine (Murphy et al., *Autism awareness training*), p. 1, https://doi.org/10.1017/ipm.2017.31.

[357] Nguyen, *A Systematic Review*, pp. 20, 48, 54-55; Murphy, et al., *Autism awareness training*, p. 1; Holloway, *A pilot study*, p. 445; Railey et al., *A Systemic Review*, pp. 228-229.

[358] Nguyen, *A Systematic Review*, pp. 34, 55; Murphy et al., *Autism awareness training*, p. 1; Holloway, *A pilot study*, pp. 441, 443-444.

[359] Nguyen, *A Systematic Review*, pp. 51-52; Holloway, *A pilot study*, p. 444; Love, *Measuring Police Officer Self-efficacy*, p. 1342; Murphy et al., *Autism awareness training*, pp. 1-2.

[360] SB 882 Council Meeting (April 1, 2025) Testimony of Dr. Michael T. Compton & Amy C. Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.

[361] Nguyen, *A Systematic Review*, pp. 50-51; SB 882 Council Meeting (April 1, 2025) Testimony of Dr. Michael T. Compton & Amy C. Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.

De-escalation training is provided in some form by many law enforcement agencies.[362] De-escalation refers to a "process or tactics used to prevent, reduce, or manage behaviors associated with conflict, including verbal or physical agitation, aggression, violence, or similar behaviors."[363] De-escalation may involve verbal or non-verbal communication or other action used to reduce the immediacy of a potential threat and allow time and space for a non-force solution to be successful.[364]

De-escalation training may cover a wide variety of topics, such as strategies for the prevention and management of violence, early intervention, selection of appropriate responses, information regarding policies and legal guidance, and critical reviews of violent incidences. One instructor who appeared as a witness before the Council discussed the importance of making sure peace officers realize de-escalation is not a "magic word," but rather a process of using strategies and techniques.[365]

In California, de-escalation training is a required part of the law enforcement academy basic training and is presented across multiple learning domains. POST has created a stand-alone de-escalation training; and other training may use this same approach or incorporate de-escalation skills into trainings on other topics.[366] These strategies may include establishing contact with the individual in crisis, creating a visual connection, building rapport, and working to gain influence to decrease the intensity of the situation. [367] These can be taught in different ways. For example, in some CIT training, the instructor tackles de-escalation in four parts: (1) basics;

[362] Engel et al., *Does De-Escalation Training Work?: A Systematic Review and Call for Evidence in Police Use-of-Force Reform* (2020) Criminology & Public Policy 19 (Engel, *Does De-Escalation Training Work?*), p. 722, https://onlinelibrary.wiley.com/doi/epdf/10.1111/1745-9133.12467; Alvarez, *Stop. Rewind. Replay: Performance, police training and mental health crisis response* (2020) Performance Research 25:8 (*Alvarez, Stop. Rewind. Replay*), p. 70, https://www.tandfonline.com/doi/full/10.1080/13528165.2020.1930783.

[363] Engel et al., *Does De-Escalation Training Work?*, p. 724; see also Alvarez, *Stop. Rewind. Replay.*, p. 70; see also SB 882 Council Meeting (Oct. 18, 2024) Testimony of Mark Stadler, https://www.youtube.com/watch?v=yWRnfEr33es; De-escalation: Strategies & Techniques for California Law Enforcement, Cal. Com. on Peace Officer Stds. and Training (2020) ch. 2-1, https://dublin.ca.gov/DocumentCenter/View/25842/CA-POST-De-escalation-Strategies.

[364] *National Consensus Policy and Discussion Paper on Use of Force* (July 2020), p. 2, https://www.theiacp.org/sites/default/files/2020-07/National_Consensus_Policy_On_Use_Of_Force%2007102020%20v3.pdf.

[365] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Mark Stadler, https://www.youtube.com/watch?v=yWRnfEr33es.

[366] Engel, *Does De-Escalation Training Work?*, p. 724; SB 882 Council Meeting (Oct. 18, 2024) Testimony of Mark Stadler, https://www.youtube.com/watch?v=yWRnfEr33es; see also *Practical De-escalation & Tactical Conduct*, Cal. Com. on Peace Officer Stds. and Training (POST, *Practical De-escalation*), https://catalog.post.ca.gov/SearchResult.aspx?crs_no=20811&crs_title=PRACTICAL%20DE-ESCALATION%20%26%20TACTICAL%20CONDUCT&pageId=10&MAC=1bovcMfLxPQKAvHDYGE1NGw1jDk.

[367] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Mark Stadler, https://www.youtube.com/watch?v=yWRnfEr33es.

(2) active listening skills; (3) live-action role-playing scenarios where students implement active listening and other skills to attempt to avoid use of force; and (4) video scenarios and discussion.[368] In the POST de-escalation class, topics include, among other things: "practical, realistic and specific tactics to resolve common critical incidents including the mentally ill in crisis, subjects armed with knives and unconventional weapons, and criminal and non-criminal barricades in structures and vehicles."[369]

While studies have identified de-escalation training as a possibly promising practice, higher-quality research is needed to fully evaluate its efficacy. For example, one systematic review of existing research on de-escalation training identified 64 evaluations of de-escalation training across multiple professional fields over 40 years.[370] However, most of the trainings were from fields like nursing and psychiatry rather than policing.[371] The study found slight-to-moderate improvements at the individual and organizational levels (e.g., reduced aggression, improved communication), but also noted limitations in the quality of research.[372] Overall, the study determined that while de-escalation training seems promising and has few documented harms, there is a critical need for more rigorous evaluation in police settings.[373]

Still, the research provides some evidence-informed practices that can be implemented to improve the quality and efficacy of law enforcement de-escalation training.[374] One mixed-method study derived four categories of practice deemed likely to improve trainee's ability to learn and retain information in de-escalation training:

1. department commitment to the training, including organizational support, resources, and leadership buy-in;[375]
2. intentional development of the training itself, including focusing on relevant competencies like communication, decision-making, and stress management, providing realistic scenario-based training, and using appropriate instructional methods;[376]
3. implementation of the training on the ground, which includes focusing on engaging trainees, providing high-quality feedback, creating a positive learning environment, and ensuring trainer competency;[377] and

[368] Id.
[369] POST, *Practical De-escalation*.
[370] Engel, *Does De-Escalation Training Work?*, p. 721.
[371] Id., p. 729.
[372] Id., pp. 734-737.
[373] Id., pp. 737-738.
[374] Bennell et al., *Promising Practices for De-Escalation and Use-of-Force Training in the Police Setting: A Narrative Review* (2021) Policing: An International J. of Police Strategies and Management 44, p. 377, https://www.carleton.ca/policeresearchlab/wp-content/uploads/Promising-practices.pdf.
[375] Id., p. 380.
[376] Id., pp. 380-387.
[377] Id., pp. 387-392.

4. evaluation of training and ongoing assessment of skills and knowledge, which is related to monitoring training outcomes and continuously adapting curricula.[378]

While further research focused on police departments will provide more specific information about the most effective de-escalation training practices, the existing research and general experience provides important considerations for using and developing this training material.

Complete disengagement during an encounter is one strategy among others in a menu of strategies, and one that the Council strongly supports. While not part of its formal recommendation, the Council notes the importance of having de-escalation trainings include strategies and techniques for completely disengaging from an encounter when appropriate, and of studying agencies, such as the San Francisco Police Department,[379] that have adopted disengagement policies or procedures, in order to determine the impact of such procedures. The Council also notes that de-escalation trainings can benefit from information about how culture and local history and knowledge can impact tense situations and escalation, and that de-escalation strategies for people with mental health conditions will be different than de-escalation strategies for people with intellectual and/or developmental disabilities.

Training Specific to Interactions with Youth

Training specific to youth interactions represents an important component of law enforcement education. These interactions demand approaches grounded in the understanding that children and teens' reactions to stress, authority, and conflict differ significantly from those of adults. Yet, in a 2014 survey of police chiefs and school resource officers, responders expressed a general lack of training beyond basic security during youth encounters. There is, therefore, little evidence related to appropriate and effective training regarding youth with mental health conditions or intellectual and developmental disabilitiesy.

According to Gabrielle Celeste, the Policy Director for the Schubert Center for Child Studies, effective youth-interaction training incorporates lessons on adolescent brain development, trauma-informed practices, and communication strategies tailored to young people. It also emphasizes procedural justice to officers. Because teens are highly attuned to issues of fairness, fair and respectful treatment is shown to foster healthy moral development, ~~positive legal socialization, and~~ increased acknowledgement of ~~police legitimacy~~procedural justice, and an overall more positive experience as they develop attitudes and beliefs about law and legal institutions.[380] To sustain these gains, departments must go beyond training and establish comprehensive developmentally informed policies. The International Association of Chiefs of

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[378] Id., pp. 392-393.
[379] General Order 5.24, *Disengagement Procedures*, San Francisco Police Dept. (2023) https://www.sanfranciscopolice.org/sites/default/files/2023-06/SFPDDGO_5_24_20230606.pdf.
[380] SB 882 Council Meeting (Sept. 18, 2025) Testimony of Gabrielle Celeste, https://www.youtube.com/watch?v=QSycCzGDhrI.

Police (IACP) recommends training police to use developmentally appropriate responses, developing age-appropriate response protocols, and promoting collaborations with community partners.[381] The Cleveland Police Department's "Interactions with Youth" policy offers a model that provides age-appropriate guidance across all stages of contact, promotes diversion over arrest, and encourages trauma-informed police practices.[382]

Implicit Bias Training

Extensive research has been conducted on implicit bias in society and in policing, and on the impact of training for peace officers that attempts to address implicit bias. Given potential implicit biases against members of the SB 882 population, implicit bias training research also provides insight for future law enforcement training in the area of interactions with the SB 882 population.[383] Implicit bias refers to mental associations between social groups (such as racial or ethnic groups, or the community of people with mental health conditions and/or IDD) and characteristics (such as good, bad, aggressive) "that are stored in memory outside of conscious awareness and are activated automatically and consequently skew judgments and affect behaviors of individuals."[384]

Research demonstrates implicit biases exist in the general population, and can affect behavior, particularly real-world discriminatory behaviors.[385] For example, one study exploring implicit responses to images of armed and unarmed Black and white men found that law enforcement officers were more likely to select "shoot"—instead of "don't shoot"—when shown an image of an armed Black man.[386]

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[381] Id.

[382] Id.

[383] SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Jack Glaser, https://www.youtube.com/watch?v=a6uhhwrrhkU (beg. time stamp 2:40:37).

[384] Glaser, *Disrupting the Effects of Implicit Bias: The Case of Discretion & Policing* (Winter 2024) Dædalus, the J. of the Am. Academy of Arts & Sciences 153:1 (Glaser, *Disrupting the Effects of Implicit Bias*), pp. 152-153, https://www.amacad.org/sites/default/files/publication/downloads/Daedalus_Wi24_11_Glaser.pdf, citing Greenwald & Banaji, *Implicit Social Cognition: Attitudes, Self-Esteem, and Stereotypes* (1995) Psychological Review 102, p. 4.

[385] SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Jack Glaser, https://www.youtube.com/watch?v=a6uhhwrrhkU; (beg. time stamp 2:40:37); Glaser, *Disrupting the Effects of Implicit Bias*, p. 154; Greenwald, et al., *Statistically Small Effects of the Implicit Association Test Can Have Societally Large Effects* (2015) Journal of Personality and Social Psychology 108:4, pp. 553–561; Kang, *Little Things Matter a Lot: The Significance of Implicit Bias, Practically & Legally* (Winter 2024) Dædalus 153:1, pp. 193–212, https://direct.mit.edu/daed/article/153/1/193/119927/Little-Things-Matter-a-Lot-The-Significance-of.

[386] Correll, et al., *Across the Thin Blue Line: Police Officers and Racial Bias in the Decision to Shoot* (2007) J. of Personality and Social Psychology 92:6, pp. 1006–1023, https://www.apa.org/pubs/journals/releases/psp-9261006.pdf; Plant & Peruche, *The Consequences of*

Research also demonstrates that training and other methods to reduce implicit racial bias may result in only no or small reductions that do not last long.[387] For example, one study of the New York City Police Department found that while officers evaluated an implicit bias training positively, post-training rates of stop and frisk and use of force against Black residents actually increased.[388] Another study found that officers' use of strategies to manage bias was lower a month after the training than it was prior to receiving the training.[389]

But research also demonstrates that limiting discretion in areas where bias may appear can have a positive impact on outcomes.[390] For example, research has demonstrated that:

> across a range of law enforcement agencies, higher discretion in decisions to search was associated with greater disparities in search yield rates. Specifically, when discretion was high, White people who were searched were more likely to be found with contraband than were Black people or Latino people.[391]

In other words, allowing broader discretion allowed more room for taking action based on misjudgments that Black and Latino people possessed contraband when they did not. In one case, U.S. Customs greatly reduced the number of criteria that could trigger a search, reducing officer discretion to conduct searches. Comparing the full year before the policy change to the full year after the change demonstrated that the search yield rates became much less racially disparate, indicating "that the disparity was mostly due to differential standards of suspicion being applied when discretion was high – when there were a lot of criteria to choose from."[392]

This research presents takeaways that may impact both training and other attempts to improve interactions between law enforcement and members of the SB 882 population. As witnesses to the Council discussed, policing decisions are often made under considerably ambiguous circumstances, and situations with ambiguity, discretion, and potential bias can lead to

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Race for Police Officers' Responses to Criminal Suspects (2005) Psychological Science 16:3, pp. 180–183, https://doi.org/10.1111/j.0956-7976.2005.00800.x.

[387] SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Jack Glaser, https://www.youtube.com/watch?v=a6uhhwrrhkU. (beg. time stamp 2:40:37).

[388] Glaser, *Disrupting the Effects of Implicit Bias*, p. 159.

[389] Id., p. 159 (citing Lai & Lisnek, *The Impact of Implicit-Bias-Oriented Diversity Training on Police Officers' Beliefs, Motivations, and Actions* (2023) Psychological Science 34:4, pp. 424–434).

[390] SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Jack Glaser, https://www.youtube.com/watch?v=a6uhhwrrhkU. (beg. time stamp 2:40:37).

[391] Glaser, *Disrupting the Effects of Implicit Bias*, p. 161, discussing Charbonneau & Glaser, *Suspicion and Discretion in Policing: How Laws and Policies Contribute to Inequity* (2020) 11 UC Irvine Law Review 1327.

[392] Glaser, *Disrupting the Effects of Implicit Bias*, pp. 161-162; SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Jack Glaser, https://www.youtube.com/watch?v=a6uhhwrrhkU (beg. time stamp 2:40:37).

discrimination.[393] Thus, in addition to training, reducing discretion, and replacing it with "prescriptive guidance and systematic information (that is, valid criteria)" has been shown to have positive impacts on outcomes.[394] Other helpful actions include slowing tense situations down, which allows for higher order cognitive processing.[395] Likewise, when officers expect to be supervised and that their actions will be evaluated, this expectation can decrease reliance on bias and stereotypes.[396]

Role-Playing and Simulation

Interactive components of a training, such as role-playing and simulation, can be essential. Role-playing and simulation training often involve the live-action or virtual reality replay of a common type of interaction between law enforcement and a member of the public, which may be someone belonging to the SB 882 population. The training will often involve: (1) peace officers viewing a re-enactment of an encounter that ends in the use of force; (2) the opportunity to discuss the interaction; and (3) a replay of the situation, with the officer taking an active role and working to implement techniques that improve outcomes of such encounters in the future.

In California, some trainings and instructors use role-play and simulation to aid in peace officer learning. For example, one CIT instructor who presented to the Council discussed using four role-play scenarios, each with two actors and two evaluators, on the last day of the training to reiterate and apply the skills taught in the training.[397] The instructor had chosen this training structure in response to feedback from officers, who stated they wanted more role-play exercises and more opportunities to practice the skills they were learning.[398] Other witnesses who spoke to the Council also discussed the importance of hands-on training to acquiring skills, and that one major benefit of in-person training was the ability to role-play.[399] Additionally, witnesses discussed how role-play and simulation training allow the training to show the

[393] SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Jack Glaser, https://www.youtube.com/watch?v=a6uhhwrrhkU. (beg. time stamp 2:40:37).
[394] Glaser, *Disrupting the Effects of Implicit Bias*, p. 165; SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Jack Glaser, https://www.youtube.com/watch?v=a6uhhwrrhkU; (beg. time stamp 2:40:37). ~~Glaser, *Disrupting the Effects of Implicit Bias*, p. 165.~~
[395] Glaser, *Disrupting the Effects of Implicit Bias*, pp. 161-162.
[396] Id.
[397] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Mark Stadler, https://www.youtube.com/watch?v=yWRnfEr33es.
[398] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Mark Stadler, https://www.youtube.com/watch?v=yWRnfEr33es.
[399] SB 882 Council Meeting (July 25, 2024) Testimony of Teresa Anderson, https://www.youtube.com/watch?v=7Zf3bE-UkD4; SB 882 Council Meeting (Oct. 18, 2024) Testimony of Lieutenant Jonathan Larsen and Detective Elizabeth Reyes, https://www.youtube.com/watch?v=yWRnfEr33es; SB 882 Council Meeting (April 1, 2025) Testimony of Drs. Michael T. Compton & Amy C. Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.

officers *how* to do what the trainer wants to be done—they are able to see the skill in action, then practice the skills themselves, which is critical to increasing training efficacy and engagement.[400] This is most useful when role-play scenarios are highly realistic and based on actual events. Thus, role-play and simulation trainings likely play an important part in creating a robust training environment for law enforcement agencies going forward.

The ability for peace officers to personally take part in a live-action role-play of use of force encounters can impact officer behavior.[401] One study involved implementing and testing a form of scenario training where officers witnessed a live performance of a lethal force encounter with an individual in mental health crisis, and then were able to effectively hit the rewind button, stepping in to the scenario with the actors to try alternative crisis-resolution strategies.[402] This approach allows the officers in the training to rehearse ethical decision-making under stress and receive feedback from a multidisciplinary team of spectator-instructors. The intended purpose of the active role in the scenarios is that physically embodying different actions should work to ingrain new patterns of judgement and action in an officer's "muscle memory" and a repertoire of decision-making that can be drawn upon in future stressful encounters.[403] The study reports that among the 72 officers who had completed the study "all have shown marked improvements in de-escalation competencies according to a comparison of pre- and post-training measures."[404]

Specific training elements appear important to active and positive engagement by officers in this type of training. These included: (1) a realistic scenario that approximates a situation officers may very well encounter themselves, with officer choices that are believable and warranted; (2) framing the initial scenario in as neutral a manner as possible; (3) recommending officers draw on "tactical training" to engage their existing knowledge and responses to situations that may involve weapons or imminent risk; and (4) pausing the scene on repeated runs to allow officers to act out alternative methods of response.[405] The "high-fidelity simulation honours [sic] the uncertainty of 'real-life', high-stakes encounters while allowing [the trainers] to expand and contract the time pressure that, under 'real' circumstances, often precludes efforts to generate and evaluate options."[406] This allows officers to "regularize" the de-escalation tactics in their memory and expand their repertoire of available patterns of action in response to stressful situations.[407] This highlights the potential benefit of role-play and

[400] SB 882 Council Meeting (Jan. 15, 2025) Testimony of Dr. Randy Dupont, https://www.youtube.com/watch?v=vAIndu5KVfM.
[401] Alvarez, *Stop. Rewind. Replay*, pp. 69-75.
[402] Id., pp. 71-73.
[403] Id., pp. 70-71.
[404] Id., p. 74. The author does not provide any further detail about the evaluation methods used, and thus, the parameters, amount, or specific improvements that were shown are unclear.
[405] Id., pp. 71-73.
[406] Id., p. 73.
[407] Id., p. 73.

simulation training and provides several guideposts for determining whether such training will be as effective as possible.

Other research demonstrates further potential for role-playing to impact peace officer behaviors in real-world interactions with members of the SB 882 population.[408] One study involved a one-day training program where officers would interact with actors to play out six defined scenarios, and then debrief to receive feedback on their response.[409] The primary focus of feedback was increasing empathy and helping officers identify other approaches they could use to de-escalate the situation.[410] While the study determined the training did not change attitudes of the police towards people with mental health conditions, it did demonstrate statistically significant improvements in directly measured behaviors and indirect measurements of behavior.[411] Specifically, there was a significant increase in the recognition of mental health conditions as a reason for a call, improved efficiency in dealing with mental health conditions, and a decrease in weapon or physical interactions with individuals with mental health conditions.[412]

This study suggests two interesting and important points. First, changing stigma or understanding of mental health conditions may not be necessary to change behavior.[413] Given that changes in behavior are what most impacts target populations, this is a critical point. Second, the study points to the potential power of role-playing scenarios that engage officers emotionally and give them specific tools that they can use in real life situations that are similar to the acted-out scenarios.[414]

Finally, such role-playing and simulation training may also be undertaken with the use of virtual reality without negating the positive benefits of the training.[415] In this context, virtual reality consists of an immersive, three-dimensional world that participants enter using a head-

[408] Krameddine, et al., *A novel training program for police officers that improves interactions with mentally ill individuals and is cost-effective* (2013) Frontiers in Psychiatry 4, p. 1, https://doi.org/10.3389/fpsyt.2013.00009.
[409] Id., p. 3. The six scenarios included: "a depressed individual who may have taken an overdose; a depressed individual who was very belligerent and potentially violent with a weapon nearby; a psychotic individual who was experiencing hallucinations; an individual with presumed alcohol dependence found collapsing on a public street; an individual with excitement acting strangely on a public street; and a couple who were arguing about the man's gambling addiction but which also represented other aspects of typical domestic disputes that police officers are called to."
[410] Id., p. 3.
[411] Id., p. 1.
[412] Id., pp. 5-8.
[413] Id., p. 8.
[414] Id., p. 8.
[415] Lavoie, et al., *Training police to de-escalate mental health crisis situations: Comparing virtual reality and live-action scenario-based approaches* (2023) Policing: A J. of Policy and Practice 17 (Lavoie, *Training police to de-escalate*), pp. 1-12, https://doi.org/10.1093/police/paad069.

mounted display, where they can move freely while simultaneously interacting with objects and communicating with non-player characters.[416] Virtual reality trainings can be advantageous because they: (1) provide a controlled environment to respond to scenarios that are complex, difficult to replicate, or involve working with vulnerable people; (2) allow participants to receive real-time feedback and guidance; (3) are adaptable and can be modified to include content that feels more realistic for individual police services; and (4) offer a cost-effective solution to scenario-based training because it can reduce costs associated with hiring actors and trainers, securing locations, and building sets and props.[417] However, the cost-effectiveness may be more difficult to realize for smaller jurisdictions, as a virtual reality training system likely requires upfront costs that may be harder to absorb.[418]

In one study, researchers used virtual reality to recreate live-action role-playing scenarios that had been used in a previous study, allowing them to evaluate the efficacy of the simulation training offered in virtual reality and live action compared to a control group in improving leaning outcomes.[419] The study found that the virtual reality format showed comparable effectiveness to the live action format in bringing about improved de-escalation skills through the scenario-based training. Moreover, the virtual reality format was not more cognitively demanding than the live action format.[420] This study demonstrates both the evidentiary support for scenario-based training to impact actions in the field, and the ability to use virtual reality to deliver such trainings at a potentially lower cost.[421]

Some jurisdictions in California are already employing this training method. The Los Angeles Police Department uses virtual reality training as part of its 40-hour Mental Health Intervention Training.[422] As a peace officer who had undergone this training shared with the Council, virtual reality training feels "as if it's actually a real scenario, compared to other types of trainings that we've been on … Everything that happened is captured and we can have a frank conversation so they can get better when they come across something similar in the field."[423]

It also appears possible to use virtual reality to deliver interactive trainings directly to individuals with mental health conditions or IDD, which can lower barriers and costs when such

[416] Id., p. 2.
[417] Id., p. 2.
[418] Alanis & Pyram, *From simulations to real-world operations: Virtual reality training for reducing racialized police violence* (2022) Industrial and Organizational Psych. 15:4, pp. 623~~1~~ ~~625~~, https://doi.org/10.1017/iop.2022.80.
[419] Lavoie, *Training police to de-escalate*, p. 3.
[420] Id., pp. 7-10.
[421] Id., p. 10.
[422] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Lieutenant Jonathan Larsen and Detective Elizabeth Reyes, https://www.youtube.com/watch?v=yWRnfEr33es.
[423] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Detective Elizabeth Reyes, https://www.youtube.com/watch?v=yWRnfEr33es.

equipment is available. For example, one study conducted a large-scale feasibility and safety trial of an immersive Virtual Reality (VR) program for adolescents and adults with autism.[424] The intervention simulates calm police interactions and allows users to practice safe responses in a controlled digital environment, guided by a clinician using an app interface.[425] The study was not designed to test efficacy in improving real-world police interactions, but rather to assess whether VR is a tolerable, scalable, and user-friendly platform for future autism interventions.[426]

The findings indicate virtual reality is safe and well-tolerated: no serious adverse events occurred, and mild side effects (e.g., nausea, dizziness) decreased over time.[427] Usability scores were high, and 80 percent of participants expressed a desire to use the platform again.[428] The study excluded individuals with known physiological risks (e.g., seizure history) and only included verbally fluent participants with IQ scores above 75, which limits generalizability to individuals with more significant intellectual disability.[429] Though more research is needed, the availability of virtual reality to deliver training to the SB 882 population may provide a helpful avenue to increase the resources available to this community.

Repetition and Refresher Training

Repetition of material and skills learned in training can also be critical for a lasting positive impact on peace officers and individuals with mental health conditions or IDD. This can include repetition both during a single training, and follow-up and refresher training after an initial training.

Multiple witnesses discussed the importance of repetition in their presentations to the Council. For example, one Ventura County CIT instructor described the importance of re-iterating the topic of de-escalation several times throughout the CIT training, and approaching the topic from both a lecture and role-play scenario approach.[430] Ventura County started offering an 8-hour CIT refresher class in 2022 after recognizing that skills are perishable, and now tries to get officers back in for a refresher class every two to three years.[431] The Los Angeles Police Department also spoke to the importance of repetition and continual training. In discussing the ongoing work of the Department, and challenges faced, one instructor stated, "[m]aking it to

[424] McCleery, et al., *Safety and Feasibility of an Immersive Virtual Reality Intervention Program for Teaching Police Interaction Skills to Adolescents and Adults with Autism* (2020) Autism Research 13, pp. 1418-1424, https://doi.org/10.1002/aur.2352.
[425] Id., pp. 1419-1420.
[426] Id., p. 1418.
[427] Id., pp. 1420-1421.
[428] Id., pp. 1420-1422.
[429] Id., p. 1419.
[430] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Mark Stadler, https://www.youtube.com/watch?v=yWRnfEr33es.
[431] Id.

where everybody can get continual training is key and paramount to the success of any of these programs, especially ours."[432] Furthermore, as CIT International Strategic Partnership Coordinator Michele Saunders noted, it is especially important that training be practical, relevant, and directly connected to the realities of policing because officers often receive limited follow-up instruction.[433] Training that mirrors the situations officers routinely face on the street not only improves retention but also increases the likelihood that officers will apply what they've learned in their day-to-day work.

Training for People with Disabilities on Safety and Interactions with Law Enforcement

As individuals that are members of the SB 882 population face elevated risks during interactions with peace officers, developing effective, evidence-based interventions for such individuals (and their family and support members) that enhance safety and communication is also a growing area of focus. While this training is *about*, rather than *for*, law enforcement, the Council recognizes that such trainings are an important part of the landscape that can complement training for law enforcement by helping families better prepare for potential interactions. Moreover, such trainings often involve peace officer participation as trainers, which can be an important part of a law enforcement agency's community engagement with the SB 882 population.

These trainings can incorporate different types of training methods, and target different populations, while providing important information on the efficacy of trainings more generally. For example, one study developed and evaluated an in-person police interaction training tailored for Black adolescents with autism.[434] This study aimed to fill a significant gap in the literature by addressing the intersectional vulnerabilities of race and disability, noting that Black youth—especially those with autism—are disproportionately at risk during police encounters.[435] Participants engaged in both video modeling and Behavioral Skills Training to improve police interaction skills.[436] Video modeling included watching four video clips with instruction related to police interaction or emergencies, such as self-disclosure of disability, and

[432] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Detective Elizabeth Reyes, https://www.youtube.com/watch?v=yWRnfEr33es.
[433] SB 882 Council Meeting (July 15, 2025) Testimony of Michelle Saunders, LCSW, https://www.youtube.com/watch?v=a6uhhwrrhkU.
[434] Davenport, et al., *An Initial Development and Evaluation of a Culturally Responsive Police Interactions Training for Black Adolescents with Autism Spectrum Disorder* (2021~~3~~) J. of Autism and Developmental Disorders 53, p. 1375~~,~~ https://doi.org/10.1007/s10803-021-05181-8.
[435] Id., pp. 1375-76. Black youth are also often misjudged as older than their chronological age, compounding this difficulty. See, e.g., Goff, et al., *The Essence of Innocence: Consequences of Dehumanizing Black Children* (2014) J. of Personality and Social Psych. 106, p. 526, https://www.apa.org/pubs/journals/releases/psp-a0035663.pdf.
[436] Davenport~~Id.~~, pp. 1381-82.

then participants worked with researchers to test responses to police interactions.[437] Behavioral Skills Training included: (1) participants receiving verbal instruction on what to do to increase safety when interacting with a peace officer, such as staying calm, remaining in place, and following directions; (2) the instructor modeling the responses required for safe interaction with a peace officer; and (3) each participant then rehearsing the interaction skills with an assigned peace officer a minimum of three times, or more if needed, until the participant was able to demonstrate safe interactive skills in three consecutive sessions.[438] Thus, participants were able to receive immediate instruction and feedback from peace officers. Further, the scenarios and skills were informed by qualitative feedback from caregivers and community stakeholders.[439]

The study found that Behavioral Skills Training was especially effective, with most participants able to model safe police interaction behaviors in the model scenarios only after such training, and not through video modeling alone.[440] Both physiological (salivary cortisol, heart rate variability) and self-reported (qualitative survey responses) stress indicators showed generally favorable reductions after participants went through the training.[441] Importantly, participants also demonstrated their ability to use the skills learned more generally in other situations, and some ability to continue using the skills as time passed after the end of the training.[442] The training was well-received, with caregivers reporting strong social validity and few side effects.[443]

Based on the study results, role-playing training with specific instructions and interactions focused on safety may be useful for the larger community in addition to law enforcement officers. For individuals with a developmental disability specifically, practicing interacting with officers, including implementing strategies on how to safely communicate to officers that they cannot communicate verbally, can be helpful in a potential interaction.[444]

It is also possible to use an occupational therapy framework to improve safety in interactions between individuals with behavioral health conditions and peace officers. For example, one study created a three-session, interactive workshop model involving both individuals with ~~behavioral health conditions~~disabilities and peace officers.[445] This training approach is a key

[437] Id., pp. 1381-82.
[438] Id., p. 1382.
[439] Id., p. 1382.
[440] Id., p. 1383.
[441] Id., pp. 1383-85.
[442] Id., pp. 1384-85.
[443] Id., pp. 1384-85.
[444] Id., p. 1385.
[445] Roberts & Satterelli, *Understanding Us: An Interactive Training Program for Members of Law Enforcement and Individuals with Disabilities* (2020) Occupational Therapy Capstones, pp. 2-3, 21 https://commons.und.edu/ot-grad/456.

innovation, as most interventions in this space target either police or individuals with disabilities, but rarely both. With an occupational therapy practitioner as the facilitator, the program employed role-play of real-life encounters, team-building activities, and structured dialogue to build mutual understanding between the two groups.[446]

While this study did not conduct empirical research on the efficacy of its model, it provided evidence-based rationales for its approaches, including the benefits of allowing members of the SB 882 population to get to know members of law enforcement, and of allowing individuals with mental health conditions and/or IDD to recognize their own attitudes and stigmas they potentially place on peace officers and work toward developing positive attitudes toward law enforcement.[447] Thus, training that focuses on building positive interactions and understanding between members of the SB 882 population and local law enforcement may provide benefits to both groups.

California Law Enforcement Agency Training Survey Results

As discussed in detail above, the Council approved and the Department of Justice conducted a survey of law enforcement agencies across California to assess information on trainings relating to mental health conditions and intellectual and developmental disabilities.[448] The survey of law enforcement agencies in California provided further information on the types of trainings that exist for peace officers in California.

Responses to the Council survey reflect that most law enforcement agencies receive some training regarding mental health conditions or intellectual and developmental disability, but that there is room for improvement.[449] Agencies' recommendations for improving interactions with the SB 882 population focused on training. Law enforcement agencies expressed that they would benefit from more detailed and frequent trainings, including more frequent trainings incorporating direct participation of members of the SB 882 population.[450] Some experts note that hearing from those with lived experiences is often identified as the most impactful part of training because it reminds peace officers of their motivations for service (or their "why"), increases empathy, and provides insight into system gaps.[451] Moreover, a stronger focus on evaluation of training effectiveness could improve decisions about training and outcomes in law

[446] Id., pp. 25-28, 36-420, 44-487.
[447] Id., pp. 28, 40, 47.
[448] *SB 882 Training and Police Survey Form*, Appendix C.
[449] ~~Harmon, et al., *SB882 Survey of Law Enforcement Agencies*, Cal. Dept. of J. (Sep. 2025), Appendix D (~~Harmon, et al., *SB882 Survey*~~)~~, p. 3.
[450] Id., pp. 3 and 5.
[451] SB 882 Council Meeting (Sept. 18, 2025) Testimony of Marianne Halbert, https://www.youtube.com/watch?v=QSycCzGDhrI.

enforcement interactions in California. The lack of feedback mechanisms after training can negatively impact officer retention and application of the curriculum.[452]

In response to the survey, nine ~~-~~out of 10 agencies reported that their agencies offer some type of training that related to people with IDD or mental health conditions.[453] Of responding agencies, 64% ~~percent~~ reported having trainings related to both people with IDD and/or mental health conditions.[454] More than half (51.9% ~~percent~~) of the agencies reported using exclusively trainings that are certified by POST, while another 44.9% ~~percent~~ reported that at least some of their trainings were POST certified.[455]

Some agencies also identified topics that were lacking in available trainings, including handling call transfers between 911 and 988 and responding appropriately to people with mental health conditions or IDD in custody.[456] Agencies also identified a need for more use of scenarios or other interactive elements that build skills and reinforce training content.[457] About 10~~8~~% ~~percent~~ of the responding agencies also noted ~~not having anyone~~the lack of individuals among the trainers for their agency with lived experience with IDD or with a disclosed mental health condition.[458]

In addition to receiving information about the types of law enforcement trainings that exist in California, the survey also asked about the efficacy of these trainings. The survey asked respondents to indicate the extent to which there is a need for improvement in four domains of training: (1) recognizing and understanding mental health conditions and IDD, (2) interacting with members of the public, (3) responding to incidents, and (4) including people with lived experience and effective training strategies.[459] Agencies responded to questions on a three-point scale: no need for improvement, some need for improvement, and significant need for improvement.[460] The agencies largely reported some need for improvement across all topics of training, but reported higher need for improvement as to understanding mental health conditions and IDD and interacting with members of the public.[461]

Agencies reported using a range of methods to assess whether trainings delivered desired results. Just over half of the agencies reported using direct observation to evaluate their

[452] SB 882 Council Meeting (July 15, 2025) Testimony of Michele Saunders, LCSW, https://www.youtube.com/watch?v=a6uhhwrrhkU.
[453] Harmon, et al., *SB882 Survey*, p. 3.
[454] Id., p. 10.
[455] Id., p. 11.
[456] Id., pp. 12-164.
[457] Id., p. 16
[458] Id., pp. 15-16~~, 11~~.
[459] *SB 882 Training and Police Survey Form*, Appendix C, pp. 6-12.
[460] Id.
[461] Harmon, et al., *SB882 Survey*, pp. 14-15.

trainings.[462] About 41 ~~percent~~% of the agencies examine their use of force, arrest, and stop data to evaluate trainings, about 34% ~~percent~~ of agencies evaluate their trainings using exams after training, and about 28~~30~~% ~~percent~~ of agencies use surveys before and after training.[463] But about one in five agencies did not report evaluating their trainings.[464] Thus, while about 80% ~~percent~~ of agencies do something to evaluate their trainings, there is not a common approach.

Training Review Results

As discussed in the Introduction, the Council conducted a case-study model review of trainings throughout the state and developed a uniform review tool to record the Council members' impressions.[465] Eight of the nine Council members attended and reviewed the trainings, reviewing a total of 24 trainings between May and November 2025.

The Council was able to review a wide variety of trainings targeting patrol officers, corrections officers, and dispatch staff. Targeted experience levels included basic academy courses, mandatory ongoing training, and specialized training. Some trainings specifically focused on one or more subpopulations of the SB 882 population, while others were more generally aimed at crisis intervention with discussions on interactions with the SB 882 population. About half of the trainings reviewed were online (either live or pre-recorded) while the other half were in-person. About three-fifths of the trainings reviewed were required at either a local or state level while the remainder were optional. Of the trainings where other trainees were observable, the average class size ranged from about 20 to about 40.

The trainers included a mix of POST trainers (that is, trainings offered by POST itself), local law enforcement agencies, colleges, and third-party trainers. The law enforcement agencies where the trainings occurred ranged in size from under 100 officers to several thousand; they served a mix of rural, suburban, and urban areas of the state. Trainings ranged from two to 40 hours, though Council members generally only attended one or two days of the longest trainings. Council members' impressions are that nearly all trainings were developed by or in partnership with law enforcement professionals and most were developed with input from behavioral health personnel and community members.

Across trainings reviewed, the most commonly emphasized topics were de-escalation followed by behavioral health resources and diversion. The most common learning strategies included question and answer sessions, facilitated discussion, visually interesting materials, and focus on participants' life experiences. Council members reported that trainees generally appeared very engaged throughout the trainings. One representative comment noted how an instructor "shared examples from his own experience as a crisis negotiator and talked through scenarios

[462] Id., pp. 17-18.
[463] Id., p. 18.
[464] Id., p. 17.
[465] *SB 882 Training Review Tool*, Appendix E.

with students," adding that this particular instructor was able to keep students engaged despite the added barrier of the training being virtual.

Many trainings involved some form of evaluation of the training, the trainer(s), or both. Evaluation methods that Council members observed included questionnaires, class participation requirements, demonstrations, group discussions, quizzes or trivia activities, and opportunities to provide digital feedback after the course. Some observers noted that some courses that used informal methods of assessing comprehension, such as using discussions, might benefit from adding measurable assessment tools to more clearly monitor whether material was being retained. Some observing Council members noted when courses used creative ways to assess attention and learning, such as a team-based Jeopardy game at the end of the course.

Council members identified several positive features across many of the trainings. First, every training reviewed provided the perspectives of one or more people with lived experience of a law enforcement interaction with a member of the SB 882 population. Almost all of the trainings presented members of the SB 882 population or their families and caregivers, and in some instances the main instructor was a member of the SB 882 population or a family member as well. One Council member was impressed with a training that was led solely by a diverse group of trainers with lived experience, which allowed the training to "make the point that autism does not always look the same" in a way that trainees could witness rather than just read about.[466]

> [Full quote for a text box: "The fact that the entire training was provided by individuals with autism and parents was very effective. The four individuals with autism who presented were also very different in terms of their functioning, which helped make the point that autism does not always look the same. I would love to see this training provided across the state."]

Council members perceived that trainings that included practical guidance for dispatchers and officers seemed most effective. For example, one training "emphasized important concepts such as de-escalation, empathy, gathering additional information, [and] seeking understanding." Another used real-life scenarios that helped make the content relatable and helped trainees develop relational skills, such as to ask open-ended prompts like "Tell me more about yourself." This Council observer remarked that this type of skill building "showed a human-centered approach that respects the individual's dignity." One observing member appreciated a training in which immediate feedback was available for trainees for their efforts taking a variety of practice calls during training scenarios.

[466] See also SB 882 Council Meeting (Dec. 10, 2025) Testimony of Kate Movius et al. [*video link forthcoming*] (presentation made to Council featuring group of trainers with mental health conditions and IDD and their families describing their peace officer training approach emphasizing population diversity and strengths).

Many trainings included information on specific community partnerships in the area served by the trainees. Though uncommon, a few trainings spent some time on officer wellbeing and self-care and sought to reduce the stigma associated with attending to one's own mental health needs. Several trainings emphasized using family and caregivers as a resource. The Council members also noted efforts to partner with various advocacy groups in developing trainings.

Council members also found it useful when trainings provided practical techniques for identifying members of the SB 882 population during dispatch and interactions. For example, one training "covered the step-by-step process officers should take before even entering a home. I appreciated the emphasis on collaboration—how officers discussed and agreed on their strategy beforehand to ensure a coordinated, respectful approach." Another training included review of key signs from American Sign Language. Council Members also had positive feedback on interactive strategies that included question and answer sessions, scenario practice (especially scenarios that were realistic and inclusive), and trainee feedback.

Council members also found that many of the trainers clearly cared about the subject matter and believed that trainers' own high level of interest in turn increased the engagement of their respective classes. One observing member appreciated one instructor's use of his own bodycam footage to show real scenarios.

Council members had mixed impressions of pre-recorded trainings. On one hand, such trainings provided "a good introductory to autism and ways to identify, communicate and/or address situations with individuals on the spectrum." However, these trainings were at times outdated, in one instance being over 15 years old, and were less hands-on and therefore felt less engaging to observing Council members. At least one observing member opined that pre-recorded material was best used "as a good introductory to a more broad training."

Council members identified gaps and areas for improvement. In particular, terminology and information on disabilities was sometimes outdated. One training used outdated "terms like 'epidemic,' 'high functioning,' 'Aspergers,' … outdated references (the movie *Rainman*), and outdated statistics." Other presenters used stigmatizing language (like "crazy") or shared other inaccurate information about the nature of mental health or developmental or intellectual disability diagnoses. Some trainings contained other factual inaccuracies such as referencing developmental centers that have been closed for years or sharing legally inaccurate statements about the operation of the relevant systems of care.

Council members noted that a few trainings lacked practical guidance and interactive components that assisted knowledge retention. Council members also reflected that, while it was important to provide some clinical background, some trainings, especially those on mental health, tried to cover too much information on diagnoses that could be at issue without enough grounding in practical effects on interactions.

Some trainings did not sufficiently incorporate the perspectives of people in the SB 882 population and their families, resulting in discussions feeling more abstract and removed from the real experiences of this population. In fact, one member observed that in one instance, "Officers commented that they would like to hear more stories from individuals [in the SB 882 population], and officer-involved success stories." Other trainings involved impacted community members but did not leverage them effectively to deliver practical content.

Overall, Council members' impressions of the trainings they reviewed were consistent with the literature reviewed for this report and with the testimony of subject matter experts that appeared before the Council. The Council witnessed many instances of effective and respectful trainings that offered opportunities to engage with the material through scenarios and role play, were led by passionate trainers, including trainers with lived experience and in some instance multiple trainers with diverse experiences, and stayed current as to community resources and evolving clinical and policy information needed to interact well with this population. However, members also observed trainings that were not well maintained and updated with current information, used language indicating less than full respect for the dignity of members of the SB 882 population, or made insufficient efforts to provide practical guidance regarding these potential interactions. Members felt that further qualitative reviews with more evaluators reviewing each training, over a longer period of time than the limited term of the Council, could be helpful.

Potential Promising Practices

[*Final text to be entered after March 16 & 19, 2026 meetings of the Council.*]

Recommendations

[*Final text to be entered after March 16 & 19, 2026 meetings of the Council.*]

List of Figures

[To be entered during publication]