[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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SB 882 Advisory Council on Improving Interactions between People with Intellectual and Developmental Disabilities and Law Enforcement Acknowledgements

Board Members

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 Director of the Arc of California, and United Cerebral Palsy California Collaboration. *Appointed by former Speaker of the Assembly Anthony Rendon.*

VICE-CHAIR ASTRID ZUNIGA, President of the United Domestic Workers of America (AFSCME Local 3930) Union. *Appointed by Governor Gavin Newsom.*

RICK BRAZIEL, Private Consultant and Adjunct Instructor, Cal Poly Humboldt. Member of the International Association of Chiefs of Police and Commissioner for the Commission on Peace Officer Standards and Training (POST). *Appointed by Governor Gavin Newsom.*

OLWYN BROWN, Board Vice President, California Policy Center for Intellectual and Developmental Disabilities. *Appointed by Governor Gavin Newsom.*

BETH BURT, Executive Director, Autism Society Inland Empire. *Appointed by Senate Rules Committee.*

DR. LAUREN LIBERO, Autism Specialist at the California Department of Developmental Services *Appointed by Governor Gavin Newsom.*

CHRISTINA PETTERUTO, General Counsel to the Regional Center of Orange County (RCOC). *Appointed by Governor Gavin Newsom.*

CLIFFORD PHILLIPS, Member of The Arc, San Francisco. *Council Member Emeritus. Appointed by the Senate Rules Committee.*

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

EMADA TINGIRIDES, Deputy Chief of the Community Safety Partnership Bureau, Los Angeles Police Department. *Appointed by former Speaker of the Assembly Anthony Rendon*.

[Other acknowledgements TBD]

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 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 individuals 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 of Justice) 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 12 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 as required by Penal Code section 13016 by April 15, 2026.

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" to mean:

> " . . . 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]

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

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

"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] 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. 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. 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. It will use "SB 882 population" to more neutrally indicate the full group of people included by the statute when references to the full population are appropriate. 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.

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 primarily 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 training discusses mental health generally but rarely focuses

[5] Pen. Code, § 13016, subd. (h)(1), (2).
[6] Pen. Code, § 13016, subd. (h)(5).
[7] Pen. Code, § 13016, subds. (h)(2), (4), (5).

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% of agencies responding by the February 2025 deadline from a mix of urban, suburban, and rural locations across California.

The survey provided the Council with invaluable information, such as trainings available 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 POST or third-party vendors) offer the trainings. The survey also provided the Council with insight regarding 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 Advisory 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 into its training courses to observe. [8]

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

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 critical aspects of the trainings they observed.[9] Department staff and 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, collaborated in developing the form.[10]

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 major areas of subject matter or presentation style that were well developed as well as those that 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 Advisory Council for their 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

[9] See Cal. Department of Justice, Office of the Attorney General, *SB 882 Advisory Meeting March 6, 2025: Meeting Minutes from January 17, 2025*, pg. 1 (*Roll Call Vote*), https://oag.ca.gov/system/files/media/sb882-030625-agenda-2.pdf.

[10] Further information regarding Dr. Randy Dupont's background and presentation to the Advisory Council can be found above Section 11, b. ii. 3: "Summary of witnesses who presented to the Council."

- Best and Emerging Practices
- Community / Non-Law Enforcement Recommendations

In October and November, subcommittees met multiple times to develop 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. [*More description of process to follow as it continues.*] The recommendations of the Council are described below.

Background

California law enforcement 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 people with mental health conditions and intellectual and developmental disabilities 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 officer knowledge of local services also can have an impact on outcomes. People with mental health disabilities 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] People with intellectual and developmental disabilities, on the other hand, are entitled to services coordinated through a

[11] Mental health care is usually accessed as part of an individual's regular health care provision, and thus, varies based on an individual's type of insurance and available clinical resources in an individual's area. *See, e.g.*, "Mental Health," Covered California (2026), https://www.coveredca.com/learning-center/using-your-plan/mental-health/ (discussing mental health care as part of a regular health care plan); "Mental Health By the Numbers," Nat'l Ass'n of Mental Illness (NAMI 2025), https://www.nami.org/about-mental-illness/mental-health-by-the-numbers/ (close to 10% 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; among U.S adults in nonmetropolitan areas, in 2020: 48% with a mental illness received treatment, 62% with a serious mental illness received treatment, and compared to suburban and urban residents, rural Americans: must travel 2x as far to their nearest hospital, are 2x as likely to lack broadband internet, limiting access to telehealth, and over 25 million rural Americans live in a Mental Health Professional Shortage Area, where there are too few providers to meet demand).

Regional Center.[12] However, gaps in these services make effective response after law enforcement interactions more difficult.[13]

How law enforcement became the primary responders to crises related to mental health or intellectual and developmental disability

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. 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. 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. Law enforcement 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 people 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 voluntary commitment process, and the

[12] *See, e.g.*, "Regional Center Eligibility & Services," CA Dep't of Developmental Servs., (2026), 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, Section 4512.

[13] *See, e.g.*, Cal. Policy Ctr. For Intellectual & Developmental Disabilities, "The Impact of the Direct Support Professional Workforce Shortage on Individuals and Families Served by the Regional Center System in California," (Jan. 2025), https://www.cpcidd.org/wp-content/uploads/2025/02/CPCIDD_Report_Jan2025.pdf.

[14] National Association of State Mental Health Program Directors Research Institute (NRI), "Transportation in Behavioral Health Crisis Services: 2022" (Apr. 2023), https://nri-inc.org/media/zjpgzgzm/transportation-in-bh-crisis-services-2022-update-4-3-23.pdf; Marvin S. Swartz &Megan Pruette, "Reducing Law Enforcement Custody and Transportation During Behavioral Health Crises," (Nov. 2024) 75 Psychiatric Servs. 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," Nat'l Ctr. For Missing & Exploited Children (Mar. 2025) at 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 special needs).

failure to adequately increase outpatient treatment capacity to meet the resulting need for care.[16]

The Deinstitutionalization of Mental Health Care 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 concerns or intellectual and developmental disabilities in locked psychiatric institutions, replaced by movement to increased community-based services. 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 disabilities 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 this combination of callousness and overmedication into the public eye.[18]

People with intellectual or developmental disabilities 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

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[16] E.g., H. Richard Lamb, Linda E. Weinberger & Walter J. Decuir, Jr., The Police and Mental Health, 53 Psychiatric Servs. 1266 (2002), pp. 1266–67; Watson, Amy, & El-Sabawi, Taleed, 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 Roles, 86 Law and Contemporary Problems 1 (2023), p. 2, ("Watson & El-Sabawi, *Expansion of the Police Role*") https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=5086&context=lcp; SB 882 Council Meeting (April 1, 2025) Testimony of Drs. Michael T. Compton and Amy C. Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.

[17] Nelson, Eric, Dorothea Dix's Liberation Movement and Why It Matters Today (2021), American Journal of Psychiatry Residents' Journal https://psychiatryonline.org/doi/full/10.1176/appi.ajp-rj.2021.170203; Racial and Identity Profiling Advisory Board, Annual Report (2021) ("2021 RIPA Report") pp. 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*, supra, p. 5

[18] Timothy W. Kneeland, Hurry Tomorrow 1975, 2010, https://emro.libraries.psu.edu/record/index.php?id=4142.

[19] History of Regional Centers and the Lanterman Act, Alta California Regional Center, https://www.altaregional.org/history-regional-centers (as of December 15, 2025).

[20] Id.

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 a variety of reasons. First, it is far less expensive to provide most people with mental health disabilities outpatient care in the community than it is to lock them in institutions.[22] Second, society began to recognize the dignity of people with mental health disabilities, the benefit to individuals of remaining in the community, and the right of individuals to freely access societal resources and opportunities unless restrictions were absolutely necessary due to danger to self or others.[23]

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 later.[26]

Conditions for people with intellectual and developmental disabilities were also addressed during this period through the development of the Regional Center system. 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 the Lanterman Developmental Disabilities Services Act (the Lanterman Act) in 1976.[27]

As a result, the proportion of people with mental health conditions receiving care in state psychiatric institutions significantly decreased by the end of the twentieth century. The number of people institutionalized in state psychiatric facilities in the United States dropped from more than 500,000 in the mid-1950s to 47,000 by 2003.[28]

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[21] Id.
[22] Id.
[23] Id.
[24] Watson & El-Sabawi, *Expansion of the Police Role*, supra, 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 California Regional Center, https://www.altaregional.org/history-regional-centers (as of December 15, 2025); Welf. & Inst. Code, §§ 4400 et seq, 4500 et seq, and 4900 et seq.; Gov't Code, §§ 95000-95029.5.
[28] Fuller, Doris 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, https://www.tac.org/wp-content/uploads/2023/11/Overlooked-in-the-Undercounted.pdf.

Unfortunately, despite this combination of closing institutions with public investment 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 struggle to staff positions due to competition with the private sector.[31] Many private practices do not accept insurance because of the billing requirements set 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 officers are often the first responders for a person suffering a mental health crisis.[33]

Moreover, law enforcement is authorized to initiate involuntary commitments. At least 25 states including California allow peace officers to start commitment proceedings, while 22 states include police 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]

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[29] National Mental Health Services Survey (N-MHSS): 2018, Data on Mental Health Treatment Facilities (2019) Department of Health and Human Services Substance Abuse & Mental Health Servs. Admin. https://www.samhsa.gov/data/report/national-mental-health-services-survey-n-mhss-2018-data-mental-health-treatment-facilities.

[30] See discussion in Key Elements of the System of Care, infra pp. XX.

[31] *Id*.

[32] Saunders, Heather, Guth, Madeline, and Eckart, Gina, A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs (2023), Kaiser Family 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, Jocelyn, Gavin Newsom signs law to 'overhaul' mental health system - CalMatters, Oct. 10, 2023, https://calmatters.org/health/2023/10/california-mental-health-involuntary-treatment-law/; Compton & Watson Testimony, supra https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.

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

[35] Treatment Advocacy Center Office of Research and Public Affairs, Prevention Over Punishment: Finding the Right Balance of Civil and Forensic State Psychiatric Hospital Beds (January 2024)

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.[36] 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.[37]

Disparities also appear when members of the SB 882 population interact with law enforcement as victim/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.[38]

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.[39] Since its creation, the Racial and Identity Profiling Advisory Board established by the Act has produced annual reports regarding these stops.[40] 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 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.[41] Officers reported taking more than three times more actions, on average, during a stop of someone with a perceived disability compared to someone without a perceived

https://www.tac.org/wp-content/uploads/2024/01/Prevention-Over-Punishment-Full-Report.pdf; as cited in *Mental health | Prison Policy Initiative*.

[36] Watson & E-Sabawi, *Expansion of the Police Role*, supra fn. 90.

[37] Compton & Watson Testimony, supra https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.

[38] Watson, Corrigan,& Ottati, Police Responses to Persons With Mental Illness: Does the Label Matter?, pg. 7-8 (2004) The Journal of the American Academy of Psychiatry and the Law https://jaapl.org/content/jaapl/32/4/378.full.pdf.

[39] Pen. Code § 13012.

[40] Pen. Code § 13519.2(j); RIPA Board reports are available online at at Cal. Department of Justice, Office of the Attorney General, RIPA Board Reports https://oag.ca.gov/ab953/board/reports.

[41] Racial and Identity Profiling Advisory Board, Annual Report (2025) 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.

disability.[42] People with perceived disabilities were arrested in 28% of all stops—more than twice as frequently as people without perceived disabilities.[43] While the above statistics include all types of disability, the RIPA Board found that perceived mental health disabilities accounted for nearly 65% of all reported perceived disabilities.[44]

Importantly, these data are based upon the 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."[45]

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.[46] These reports must indicate whether the officer observed signs of drug or alcohol impairment, erratic behavior, or "[m]ental, physical, or developmental disability."[47] In these encounters, officers discharged their firearms at 54.5% of those people with perceived mental health disabilities, with 43 in fact being shot.[48] By comparison, officers discharged their firearms at 22.5% of people showing signs of alcohol impairment, 30.8% of people showing signs of drug impairment, and 40.5% of people displaying other erratic behavior.[49] 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."[50]

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[42] Racial and Identity Profiling Advisory Board, Annual Report (2025), supra p. 30.
[43] Racial and Identity Profiling Advisory Board, Annual Report (2025), supra p. 33
[44] Racial and Identity Profiling Advisory Board, Annual Report (2025), supra p. 25. Officers reported perceiving a disability in only 1.1% of all stops.
[45] Racial and Identity Profiling Advisory Board, Annual Report (2025), supra p. 32.
[46] Government Code § 12525.2.
[47] Government Code § 12525.2(b)(12).
[48] Cal. Department of Justice, Criminal Justice Statistics Center, Use of Force Incident Reporting 2024, p. 40 tab. 19 (2024) https://data-openjustice.doj.ca.gov/sites/default/files/2025-07/USE%20OF%20FORCE%202024%20final.pdf.
[49] *Id*.
[50] 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

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.[51] The RIPA data also indicate that force is used disproportionately against youth of color, youth with disabilities, and gender minority youth.[52]

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.[53] Likewise, a higher percentage of youth perceived to have a disability experience force regardless of age groups, with a transition age youth (ages 18-24) experiencing force at a percentage five times higher than their peers without a perceived disability.[54] Youth with a perceived disability were more likely to be handcuffed during a stop than youths without a perceived disability.[55] Officers pointed a firearm at youths perceived to have disabilities in 67 stops in 2023, though none were reportedly discharged.[56]

Youth with disabilities are also dramatically overrepresented in the juvenile justice system. Data from Disability Rights California indicates sixty-five to seventy percent of the juvenile justice system is made up of youth with disabilities, which is three times the national average in the general population.[57]

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

people reported. See Cal. Department of Justice, Criminal Justice Statistics Center, Use of Force Incident Reporting 2024, supra note 44, at pp. 2, 39-40, tab. 18-19.

[51] Racial and Identity Profiling Advisory Board, Annual Report, supra p. 10.

[52] *Id*.

[53] 46.8 percent of youths with any perceived disability were searched, as compared to 12.2 percent of youths without any disability. See Racial and Identity Profiling Advisory Board, Annual Report, supra p. 10.

[54] Racial and Identity Profiling Advisory Board, Annual Report, supra p. 60.

[55] Racial and Identity Profiling Advisory Board, Annual Report, supra p. 61.

[56] *Id*.

[57] SB 882 Council Meeting (Sep. 18, 2025), Testimony of Megan Buckles, [link pending ###]; see also *Model Programs Guide Literature Review: Intersection between Mental Health and the Juvenile Justice System* (2017), Office of Juvenile Justice and Delinquency Prevention, https://ojjdp.ojp.gov/library/publications/model-programs-guide-literature-review-intersection-between-mental-health-and.

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 disability. Today, roughly 20% of all incarcerated people have a diagnosed mental health condition, but some facilities report that the number may be as high as half.[58] 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."[59] 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.[60] About 80% of people enrolled in the Developmental Disabilities program are also enrolled in the Mental Health Program.[61]

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 and 230% percent higher for people with mental health conditions, regardless of the diagnosis.[62]

Once incarcerated, people with mental health conditions 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 treatment since incarceration.[63] Reports on national data and information from throughout the country

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[58] Fuller, *Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters* (Dec. 2015) Treatment Advocacy Center Office of Research & Public Affairs, https://www.tac.org/wp-content/uploads/2023/11/Overlooked-in-the-Undercounted.pdf.

[59] Wolff, Fact Sheet: Incarceration and Mental Health (2017) Weill Cornell Medicine Psychiatry 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) American Journal of Public Health, 80(6), 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 Justice Center (2013) (cited in Prins, *Why Determine the Prevalence of Mental Illnesses in Jails and Prisons?* (2014) *Psychiatric Services*, 65(8), p. 1074.).

[60] SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Lee Lipsker, ###VIDEO LINK.

[61] *Id*.

[62] Wolff, *Fact Sheet: Incarceration and Mental Health* (May 30, 2017) https://spac.icjia-api.cloud/uploads/Fact%20Sheet%20Incarceration%20and%20Mental%20Health-20220608T19114846.pdf (citing Baillargeon et al, *Psychiatric disorders and repeat incarcerations: the revolving prison door* (2009) Am J Psychiatry 166(1): 103–109, https://psychiatryonline.org/doi/10.1176/appi.ajp.2008.08030416.

[63] *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-

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.[64] California does have limits on the use of restricted housing.[65]

Outcomes of Police Interactions with People with Mental Health Conditions and Intellectual and Developmental Disabilities

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.[66] For example, one study of police violence in Baltimore and New York found police contact to be associated with anxiety and trauma symptoms that increased with the number of police stops in a sample of predominantly people of color.[67] The study also noted an association between recent interaction with law enforcement and "psychotic experiences, suicide ideation, and suicide attempts."[68] 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.[69]

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 police use of force events occurring between 2011 and 2017, and found that people with serious mental illnesses were twelve times more likely to have force used and ten

access/#limitedhealthcareaccess. The study 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, *California Department of Corrections and Rehabilitation eliminates inmate copayments for health care services* (Feb. 21, 2019) https://www.cdcr.ca.gov/news/2019/02/21/california-department-of-corrections-and-rehabilitation-eliminates-inmate-copayments-for-health-care-services/.

[64] *Id.*

[65] California Department of Corrections and Rehabilitation, *Restricted Housing*, https://www.cdcr.ca.gov/adult-operations/restricted-housing/.

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

[67] Watson & El-Sabawi, *Expansion of the Police Role*, supra p. 18, citations to fns. 100-101 omitted.

[68] Watson & El-Sabawi, *Expansion of the Police Role*, supra p. 18, citations to fn. 102 omitted.

[69] Watson & El-Sabawi, *Expansion of the Police Role*, supra p. 18-19, citations to fn. 103 omitted.

times more likely to be injured than people without serious mental illnesses.[70] Analyzing these data, this study found that people with certain serious mental health conditions constitute 17 percent of use of force cases and 20 percent of suspects injured during law enforcement interactions despite constituting only one to three percent of the population.[71] Another study indicated that police may be more likely to use electronic control devices on people experiencing behavioral health crises than in cases that involve the arrest for a criminal offense, and also to use more shocks with members of this population.[72]

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 behavioral health condition, with estimates ranging from 25% to 50% of individuals killed by law enforcement having a mental health condition.[73] A 2015 "real-time" nationwide database of deadly police encounters operated by the Washington Post noted "signs of mental illness" in at least 25% of fatal incidents in a nine-month sample.[74] That same database indicated that 124 cases of officer shootings (27% of all officer shootings that year) nationwide involved a mental health crisis; in 36% of those cases, the officers had been explicitly called to help the person get medical treatment.[75] The Council also heard individual witness accounts of family members killed by peace officers in response to calls for assistance.[76]

Yet some sources suggest that 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

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[70] Laniyonu and Goff, *Measuring disparities in police use of force and injury among people with serious mental illness* (2021) *BMC Psychiatry* 21:500, p. https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-021-03510-w; see Wood and Watson, *Improving police interventions during mental health-related encounters: Past, present and future* (2016) Policing Soc. 2017 27: 289–299 https://pubmed.ncbi.nlm.nih.gov/29200799/ (finding people with behavioral conditions were twelve times more likely to experience use of force and ten times more likely to be injured).

[71] Laniyonu & Goff, *supra*.

[72] Watson & El-Sabawi, Expansion of the Police Role, supra fn. 95.

[73] E.g., 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 Institute p. 30, fns. 25, 27, and 30 https://www.vera.org/publications/crisis-response-services-for-people-with-mental-illnesses-or-intellectual-and-developmental-disabilities (hereafter "Vera Institute Report"); Compton & Watson Testimony, supra https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.

[74] Vera Institute Report, p. 30, fn. 24.

[75] Lowery, *Police shootings: Distraught people, deadly results*, The Washington Post (June 30, 2015) The Washington Post https://www.washingtonpost.com/sf/investigative/2015/06/30/distraught-people-deadly-results/.

[76] SB 882 Council Meeting (April 1, 2025) Testimony of Vincent Eng, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.

systematically sought to identify behavioral health in what it called "law enforcement homicide"—after an audit of the source found that the number of incidents was being undercounted by half because of incomplete or inconsistent source data.[77]

Interactions with people with mental health conditions and intellectual and developmental disabilities can impact peace officers as well, particularly when interactions lead to negative outcomes. Peace officers involved in negative encounters, particularly officer-involved shootings, may suffer negative emotions, including potentially a form a posttraumatic stress disorder that may include guilt and depression.[78] 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, anxiety, fear of legal or administrative problems, and sadness.[79] Thus, improved outcomes in interactions between peace officers and persons with mental illness or intellectual and developmental disability 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, or developmental disabilities.

Federal Protections

Federal law prohibits disability-based discrimination in many areas of everyday life, including in state and local government services.[80] 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.[81]

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[77] Note arrest-related deaths collected data only from 2002-2012. See Fuller et al., *Overlooking in the Undercounted* (2015); Scott, Arrest-Related Deaths (ARD) (2012) Bureau of Justice Statistics https://bjs.ojp.gov/data-collection/arrest-related-deaths-ard.

[78] National Institute of Justice, "Police Responses to Officer-Involved Shootings," Jan. 1, 2006, available at https://nij.ojp.gov/topics/articles/police-responses-officer-involved-shootings (as of Jan. 8, 2026); 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 (as of Aug. 19, 2025) (discussing impact of shooting of person with mental health disorder on individual officer).

[79] National Institute of Justice, "Police Responses to Officer-Involved Shootings," Jan. 1, 2006, available at https://nij.ojp.gov/topics/articles/police-responses-officer-involved-shootings (as of Jan. 8, 2026).

[80] 42 U.S.C. § 12101 et seq.; 29 U.S.C. § 794.

[81] Given the similarity between laws, courts often analyze ADA and Section 504 claims together. *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 one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. To be substantially

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.[82] This includes making reasonable modifications in their policies, practices, or procedures that are necessary to ensure accessibility for individuals with disabilities.[83] And the ADA requires officers to take appropriate steps to ensure that communication with people with disabilities are as effective as communications with others.[84]

Section 504 prohibits disability discrimination by any program or activity that receives federal financial assistance.[85] "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.[86]

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 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, medical conditions, and/or based on their genetic information.[87] And this protection includes people who are associated with people with disabilities, like caregivers, and people perceived as having disabilities.[88] The Government Code expressly incorporates the Title II of the ADA into California law.[89] 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."[90]

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

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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 CFR 35.108; 34 CFR 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.

[82] 42 U.S.C. § 12132; 28 C.F.R. § 35.130.

[83] 28 C.F.R. § 35.130.

[84] 28 CFR 35.160; *Commonly Asked Questions About the ADA and Law Enforcement* (2020) U.S. Department of Justice Civil Rights Division https://www.ada.gov/resources/commonly-asked-questions-law-enforcement/#resources.

[85] 29 U.S.C. § 794.

[86] *Id*.

[87] Gov't Code, § 11135, subd. (a).

[88] Gov't Code, § 11135, subd. (d).

[89] Gov't Code, § 11135, subd. (b).

[90] Cal. Code Regs. Tit. 2, § 14020, subd. (ii).

buildings."[91] The Act broadly guarantees access to all "places to which the general public is invited."[92] This act also incorporates the ADA into California law.[93] It also ensures that law enforcement officers traveling with a "search and rescue dog" are afforded the same protections.[94]

The Lanterman-Petris-Short Act (LPS Act) sets out rights and protections for people with mental health disabilities in commitment and conservatorship proceedings and provides a means for enforcing those rights.[95] 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."[96]

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 illness, 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 5150) and is one source of potential interactions between law enforcement and people experiencing mental health crisis.[97] 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.[98]

Individuals, even when 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.[99] The LPS Act also sets out procedural protections for people undergoing conservatorship.[100]

The Lanterman Act established rights for people with developmental disabilities and affords them the same legal rights guaranteed to all other individuals.[101] It also prohibits discrimination against people with developmental disabilities in programs and activities that receive public

[91] Civ. Code, § 54, subd. (a).
[92] Civ. Code, § 54.1, subd. (a)(1).
[93] Civ. Code, § 54, subd. (c); Civ. Code, § 54.1, subds. (a)(3) and (d).
[94] Civ. Code, § 54.25, subd. (a)(1).
[95] Welf. & Inst. Code, §§ 5150, 5250, 5350.
[96] Welf. & Inst. Code, § 5001.
[97] Welf. & Inst. Code, § 5150.
[98] Welf. & Inst. Code, §§ 5151-5152.
[99] Welf. & Inst. Code, §§ 5325-5325.1
[100] 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.")
[101] Welf. & Inst. Code, § 4502. The services offered under the LDSS Act are discussed further in section XXX below.

funds, which includes law enforcement agencies.[102] 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.[103]

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

To fully assess how to improve interactions between law enforcement and people with behavioral health conditions, 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 take 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 intellectual and developmental disabilities.

The Mental Health Care System

Demographics

Mental health conditions present in diverse ways across California. Overall, about 15.4% of adults in the state report experiencing some form of mental health disability, while 4.2% report a "serious mental illness" that impacts tasks of daily living.[104] There are regional variations in the prevalence of mental health conditions, with the highest rates occurring in San Joaquin Valley.[105] There is likewise racial and ethnic variation in rates of serious mental health disabilities, with white adults mirroring the 4.2% average for the state, while Native American rates are 6.6-7.0%, rates for Black Californians are 5.6-5.8%, and rates for the Asian and Pacific Islander population are below 3%.[106] Lack of socioeconomic resources also results in higher rates of serious mental health diagnosis. Mental health diagnoses decrease as income level increases. While 8.9% of people with incomes below the Federal Poverty Line (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

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[102] *Ibid.*
[103] *Ibid.*
[104] *Mental Health in California: For Too Many, Care Not There* (Mar. 2018) California Health Care Almanac, California Health Care Foundation https://www.chcf.org/wpcontent/uploads/2018/03/MentalHealthCalifornia2018.pdf.
[105] *Id.*
[106] *Id.*; Ramos-Yamamoto, *Californians and Mental Health: What We Know About Poverty and Race* (Mar. 2018) California Budget & Policy Center, March 2018, https://calbudgetcenter.org/resources/californians-and-mental-health-what-we-know-about-poverty-and-race/.

earning three times the FPL.[107] Nearly two-thirds of Californians reporting some level of mental health need also reported not getting treatment.[108]

California's rate of suicide is lower than the national average and was 10.0-10.5 per hundred thousand population level in 2011-2014.[109] However, the number of Californians who die by suicide has increased by more than 50% since 2001.[110] Here also there are racial, gender, and regional variations. Men are 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.[111] There is a large amount of regional variation, with a low of 7.7 per 100,000 in Los Angeles County and a high of 21.1 per 100,000 in the Northern and Sierra region.[112] Trinity County has an especially high rate of 34 per 100,000.[113]

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.[114] 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 impacts 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

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[107] See Ramos-Yamamoto, *Californians and Mental Health*, supra (Data from 2015, when the FPL was $11,700 for a single person and $24,250 for a family of four).
[108] *Id*.
[109] *Id.*
[110] Wiener, *Breakdown: California's mental health system, explained* (Updated Sept. 17, 2020) https://calmatters.org/explainers/breakdown-californias-mental-health-system-explained/.
[111] California Budget & Policy Center, Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding, March 2020, https://calbudgetcenter.org/app/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf; CHCF, https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf. 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. Valerie Callanan & Mark Davis, "Gender differences in suicide methods," 47 *Social Psychiatry + Psychiatric Epidemiology* (2012) 857–869 (2012), https://doi.org/10.1007/s00127-011-0393-5; Simina-Petra Simion & Harald Jung, "Gender disparities in suicide: a deeper look into the complexity of suicidal acts," 77 Legal Medicine (Sept. 2025), https://www.sciencedirect.com/science/article/abs/pii/S1344622325001130; "Suicide," Nat'l Inst. Of Mental Health (2026), https://www.nimh.nih.gov/health/statistics/suicide.
[112] CHCF, https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf.
[113] Wiener, https://calmatters.org/explainers/breakdown-californias-mental-health-system-explained/.
[114] *Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding* (March 2020) California Budget & Policy Center https://calbudgetcenter.org/app/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.

health services.[115] 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.[116]

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.[117] Any patient may access these services, subject to availability, and may pay for them using cash, private insurance, or Medi-Cal managed care and fee for service plans.[118] These services are likely to be higher cost than public services but allow for more attention to patients given the lower caseloads private practitioners carry. However, they are becoming less accessible as providers increasingly decide not to accept insurance.[119]

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.[120] Hospitals include Acute Psychiatric Hospitals, or psychiatric units in general hospitals, operated at the county level. 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.[121] Counties may offer residential treatment options including board and care facilities, mental health rehabilitation centers, or skilled nursing facilities.[122]

As described in section XX 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 decreased by 28%, leaving 25 mostly rural counties with none.[123] 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.[124] 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.[125]

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[115] *Id*.
[116] *Id*.
[117] *Id*.
[118] *Id*.
[119] Weiner, *Breakdown* (2020), supra.
[120] *Mental Health in California* (2020), supra.
[121] *Id*.
[122] *Id*.
[123] *Id*.
[124] Weiner, *Breakdown* (2020), supra.
[125] *Id*.

Regional disparities also exist in adequacy of mental health staffing in counties across California. A 2018 snapshot of mental health providers in the state indicated California had 31,349 Marriage and Family Therapists (MFTs), 18,974 Licensed Clinical Social Workers (LCSWs), 16,683 psychologists, 5,806 psychiatrists, 1,207 counselors, and 306 psychiatric nurses.[126] Researchers 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.[127] This staff was not 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.[128]

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 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.[129]

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.[130] Set to be implemented from 2024 to 2026, as of May 2025 Prop 1 had awarded $3.3 billion in funds to create over 5,000 residential treatment beds and 21,000 outpatient treatment slots, and is in the process of evaluating applications for a second $800 million round of funding for treatment facilities and supportive housing that are anticipated to be awarded in Spring of 2026.[131] According to Prop 1, all counties are to implement new three-year comprehensive behavioral health services

[126] *Mental Health in California* (2018), supra.
[127] *Id*.
[128] See id. (Shortages included LCSWs in the Central Coast, Northern and Sierra, and Orange County regions; MFTs in Sacramento and San Diego; both psychologists and psychiatrists in the Northern and Sierra and Orange County regions, and psychologists in Sacramento.).
[129] *Mental Health in California* (2020), supra.
[130] See, e.g., *Accountability with results* (2025) State of California Mental Health for All https://www.mentalhealth.ca.gov/accountability.html.
[131] Id.; Office of Governor Gavin Newsom, *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) 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/ ; California Department of Health Care Services Proposition 1: Behavioral Health Infrastructure Bond Act of 2024: Behavioral Health Continuum Infrastructure Program Round 2: Unmet Needs (2025) Request for Applications, at 5, https://infrastructure.buildingcalhhs.com/wp-content/uploads/2025/06/Bond_R2_RFA_FINAL_06122025_508.pdf.

plans beginning in 2026.[132] It is therefore likely that county behavioral health systems are soon to see changes that may impact how they interface with law enforcement, and law enforcement agencies and those focusing on their training should monitor the changes that occur.

The System of Care for Individuals with Intellectual and Developmental Disabilities

Demographics

The State Council on Developmental Disabilities estimates that there are around 625,000 Californians with intellectual or developmental disabilities, or 1.58% of the total population.[133] Around 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 and one-third are women.[134] Approximately .24% of the California population are seniors with intellectual or developmental disabilities, while around .3% are youth with intellectual or developmental disabilities.[135]

Key Elements of the System of Care

In California, the Department of Developmental Services is the state agency responsible for providing and overseeing services for people with intellectual and developmental disabilities, which includes implementation of the Lanterman Act.[136] In addition to the protections the Lanterman Act enshrines as discussed above in section XXX, the Lanterman Act provides people with developmental disabilities the right to various services and supports needed to live independent, full, and productive lives.[137] 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.[138]

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[132] *Accountability with results* (2025), supra.

[133] About The California State Council on Developmental Disabilities, California State Council on Developmental Disabilities https://scdd.ca.gov/about/; *Some Snapshots of People with I/DD in California*, State Council on Developmental Disabilities https://scdd.ca.gov/wp-content/uploads/sites/33/2020/06/People-with-IDD-in-California-Snapshot-5.27.20-ACCESSIBLE.pdf.

[134] Individuals & Families, State of California Department 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*, supra.

[135] *Some Snapshots of People with I/DD in California*, supra.

[136] Cal. Dept. of Developmental Services, A Guide to California's Regional Center Services System (Feb. 2025) https://www.dds.ca.gov/wp-content/uploads/2025/02/Guide_to_Californias_Regional_Center_Services_System.pdf.

[137] Welf. & Inst. Code, § 4500 et seq.

[138] Welf. & Inst. Code, § 4502, subd. (b).

To ensure that the aforementioned services would be provided, the Lanterman Act created a system of 21 Regional Centers throughout California, which are the local agencies that assist people with developmental disabilities living in the center's area to get the services and supports they need.[139] Regional Centers do not offer services directly, but rather provide case management or other support to obtain needed services elsewhere.[140] The services themselves are generally funded by other sources, such as Medi-Cal, private insurance, or school district budgets, although the Regional Center can issue a Request for Proposal (RFP) or make other efforts to develop services that are unavailable.[141] Regional Centers serve clients for as long as they meet severity criteria, which for most people will mean they qualify for services throughout their lifetime.[142] However about 20% of people with intellectual or developmental disability do not qualify for Regional Center services.[143] Services are broad and include employment programs, adult day services, family homes, home health supports, independent living services, residential care homes, and other offerings.[144] Regional Centers offer services that respond to crisis, including residential crisis services and mobile crisis teams that respond to short-term crisis in the community.[145] Thus, Regional Center providers may encounter instances where law enforcement is also present when responding to a crisis involving a Regional Center client.

Case management available at Regional Centers assists clients to connect with the right level of services for them; it is a valuable resource for peace officers who are unsure how to respond to a person in crisis who also has an intellectual or developmental disability. 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.[146] The IPP must be tailored to the particular client and give the individual an opportunity to actively participate in the

[139] Welf. & Inst. Code, § 4620.
[140] Disability Rights California, *How does the regional center make sure I get the services and supports in my IPP, Rights under the Lanterman Act*, §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/.
[141] *Ibid.*
[142] Disability Rights California, *Can I lose my regional center eligibility? Rights under the Lanterman Act*, §2.24, https://rula.disabilityrightsca.org/rula-book/chapter-2-eligibility-for-regional-center-services/can-i-lose-my-regional-center-eligibility/.
[143] [###cite .]
[144] Cal. Dept. of Developmental Services, Regional Center Services and Descriptions (Aug. 1, 2018) https://www.dds.ca.gov/wp-content/uploads/2019/03/RC_ServicesDescriptionsEnglish_20190304.pdf.
[145] *Id*.
[146] Welf. & Inst. Code, § 4646; Cal. Dept. of Developmental Services, *A Guide to California's Regional Center Services System* (Feb. 2025), supra.

development of the plan.[147] 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 intellectual and developmental disabilities need, 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.[148]

Funding Considerations

In the last ten years, California spending on services for people with intellectual or developmental disabilities has more than tripled from approximately $6 billion in the 2015-2016 budget year to $19 billion in the 2025-2026 budget year.[149] Some of this increase is from a move to fully funded rate models that began in the 2024-2025 budget year.[150] The Legislative Analyst's Office estimates that a majority of the increase reflects growth in caseload and increases in the utilization of services.[151]

During the decade preceding this report, California general funds accounted for about 60% of this while the remaining 40% is primarily federal Medicaid funding.[152] California's 2025-2026 budget allocated $11.8 billion in state funds to the Department of Developmental Services.[153] 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.[154]

Systems of Care for Youth

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

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[147] Welf. & Inst. Code, § 4646; Cal. Dept. of Developmental Services, *A Guide to California's Regional Center Services System* (Feb. 2025), supra.

[148] Disability Rights California, *What other agencies provide services and supports? Rights under the Lanterman Act*, § 4.66, https://rula.disabilityrightsca.org/rula-book/chapter-1-the-lanterman-act/what-other-agencies-provide-services-and-supports/.

[149] Petek, *The 2025-26 Budget: Department of Developmental Services*, Fig. 1 (March 2025) Legislative Analyst's Office https://lao.ca.gov/Publications/Report/5008.

[150] Id.

[151] Id.

[152] Id.

[153] AB 102 (2025), Budget Act of 2025, Item 4300-101-0001 https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB102.

[154] Sergent, *If you live in these states, Trump's tax law will cut health care funds the most*, USA Today, (Aug. 22, 2025) https://www.usatoday.com/story/graphics/2025/08/20/trump-big-beautiful-bill-medicaid-cuts-where/85727000007/.

The behavioral health needs of youth have expanded in recent years, according to 2018 data showing 25% of youth reported needing mental health treatment, as compared to 13% in 2009, and 5.2 of every 1000 youth experienced a mental health hospitalization, as compared to 3.4 per 1000 in 2007.[155] In 2019, over half (54%) of court-involved youth placed in juvenile halls or camps, home supervision, or alternative confinement had an open mental health case, and 23% were prescribed psychotropic medication.[156] Young people's behavioral health is particularly impacted by poverty, with 10% of youth with family incomes below the FPL showing "serious emotional disturbance."[157]

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 would address or improve the child's behavioral health condition that would not be responsive to physical health treatment.[158] These less stringent standards may offer more referral options for first responders to youth in behavioral health crisis.

On the other hand, youth may receive services in locations that make them more susceptible to law enforcement contact and may even themselves refer youth to law enforcement. Youth may receive school-based behavioral health services, but schools refer students with disabilities to law enforcement two to three times more often than non-disabled students.[159] Foster youth also may receive mental health services in residential facilities such as group homes, transitional housing, or short term residential therapeutic program, where administrators also use law enforcement in this manner. One study found that children in these placements are 2.4 times more likely to be arrested than children with similar characteristics who are placed in foster homes.[160]

Guiding Principles and Process Recommendations

The California Legislature and local policymakers have a critical opportunity to strengthen and expand coordinated systems of care for individuals with mental health conditions and

[155] *Mental Health in California* (2020), supra.
[156] Id.
[157] *See* id. (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").
[158] *Id.*
[159] 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 https://civilrightsproject.ucla.edu/news/press-releases/2022-press-releases/new-report-stalled-pre-pandemic-progress-easily-escapes-attention/UCLA_Discipline_wDan2022-Press_Release-final.pdf.
[160] *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.

intellectual and developmental disabilities —including those experiencing crises. By building upon existing frameworks and championing the following priorities, lawmakers can deliver lasting benefits to Californians, improve public safety, and ensure the state leads the nation in compassionate, effective care. The following priorities will be essential to realizing these outcomes:

- **Prioritize person-centered planning** so individuals receive care tailored to their unique needs.
- **Consider the needs of people with multiple disabilities** in care systems and policy planning.
- **Ensure access to lifelong services** to reduce gaps that lead to instability and crisis.
- **Improve coordination across agencies** to ensure individuals consistently receive the right services at the right time.
- **Encourage innovative resources** that address complex needs and improve service delivery.
- **Reduce reliance on crisis law enforcement interventions** to improve outcomes and promote safety for individuals and communities.

By investing in these improvements, legislators will drive a more responsive, equitable, and effective system of care—one that delivers measurable health outcomes, strengthens families, enhances public safety, and reduces costly emergency interventions. These actions will demonstrate legislative leadership, fiscal responsibility, and a commitment to the well-being of all Californians.

The Council also developed recommendations related to training of law enforcement in informed by two “non-negotiable guiding principles”—stopping use of force/officer involved shootings and building trust and relationships with the community. The subcommittee also identified key challenges for law enforcement training. These include limited resources and tools tailored to encounters with the SB 882 population, the overwhelming volume of new policies without clear integration into existing training, lack of centralized, accessible guidance for officers in the field, insufficient inclusion of subject matter experts in curriculum development, need for more realistic, scenario-based training that reflects community needs, lack of trust and fear between law enforcement and the community which can heighten the response, and difficulty finding subject matter experts who also have the background both to relate to and to make materials relevant to law enforcement.

Finally, in addition to guiding principles and recommendations addressing the substance of the Council’s charge, the Council considered how to leverage data and research practices to continue expanding the knowledge base related to interactions between law enforcement and the SB 882 population. Included in this study would be methods of evaluating the success of programs intended to improve these interactions, including but not limited to any of the Council’s recommendations that are adopted and implemented.

[Data recommendations pending further discussion with CJIS]

Crisis Response Models and Other Systems Interventions

Overview of Crisis Intervention Models

Local agencies and community partners use many different approaches to structuring interactions between law enforcement and the SB 882 population to reduce negative outcomes. 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 strategies to respond to persons experiencing mental health crises. 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 with behavioral health conditions.

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 groups: (1) Crisis Intervention Teams (CIT), consisting of specially trained officers within law enforcement agencies; (2) co-responder teams that pair peace officers with behavioral 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 the jurisdiction's dispatch system.[161] The overview below includes a description of the basic elements of each category of model and analysis of the strengths and weaknesses of each type of intervention. The section also highlights features of successful programs that may be common to multiple categories of response model, such as the use of peer supports. The section concludes with recommendations from the Council regarding how crisis intervention models and other systems

[161] See, e.g., Congressional Research Service, *Issues in Law Enforcement Reform: Responding to Mental Health Crisis* (2022) https://www.congress.gov/crs-product/R47285?q=%7B%22search%22%3A%22r47285%22%7D&s=1&r=1; Wood & Watson, *Improving police interventions*, supra.

interventions in California can better address the needs of people with behavioral health conditions when they interact with law enforcement.

Limitations of Data Regarding Crisis Response for Intellectual and Developmental Disabilities

Before engaging more deeply in the literature review, it is important to note that co-response and alternative response tend to focus broadly on mental health, not on intellectual or developmental disability (IDD).[162] Studies demonstrate that individuals with IDD tend to have an incidence of mental health issues 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.[163]

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 those 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.[164] 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 Pathways training to bring together the members of these different professions and facilitate long-term collaboration.[165] The program's pilot included an evaluation indicating participants were satisfied overall and the teams continued to meet post-training, but there is no published or empirical research on the program.[166]

Crisis Intervention Teams (CIT)

Key Elements of CIT

Law enforcement agencies seeking to improve their interactions with people with behavioral health conditions may choose to do so by focusing predominantly on the structural supports and training of their own officers. The Crisis Intervention Team (CIT) model is one such approach that is now in place in more than 2,700 law enforcement agencies and enjoys support from institutions such as CIT International that serve as a resource for implementing or learning about CIT.[167] 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

[162] Vera Institute Report, supra, p. 7; see also id. n. 52-88 (discussing literature and studies identified on comparison of response models, almost all of which focus on response to those in mental health crisis as at least a primary focus).
[163] Vera Institute Report, supra, p. 7.
[164] Id. at pp. 38-39.
[165] Id. at p. 38.
[166] Id. at pp. 38-39.
[167] Crisis Intervention Team Home Page https://www.citinternational.org/; see also CIT Center, University of Memphis Home Page http://cit.memphis.edu/.

suffering a mental health crisis.[168] 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."[169]

The CIT model involves training officers in 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.[170] 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.[171]

The traditional CIT model contains the following basic components:

Components of Traditional CIT Model

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

Volunteer Officers

One key component for the traditional CIT model is that officers volunteer to be part of the program, resulting in only a portion of the agency being CIT trained.[172] This approach rests on the assumption that officers whose personality traits and level of interest in handling mental health calls makes them more suited to the CIT method will be more effective in implementing

[168] Fuller et al., *Overlooking in the Undercounted* (2015), supra fn. 68-70; Watson & El-Sabawi, *Expansion of the Police Role*, supra fn. 105; Wood & Watson, *Improving police interventions*, supra pg. 5.
[169] Duff et al., *Issues in Law Enforcement Reform: Responding to Mental Health Crises*, Congressional Research Service (October 17, 2022) (CRS Report), fn. 28 https://www.congress.gov/crs-product/R47285?q=%7B%22search%22%3A%22r47285%22%7D&s=1&r=1.
[170] Wood & Watson, *Improving Police Interventions*, supra (citing Compton et al 2008).
[171] CRS Report, supra.
[172] Watson & Fulambarker, *The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners* (2012) 8 Best Pract. Mental Health 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 & the Law.).

the model.[173] Initially, the Memphis team envisioned that 20-25% of officers in a given agency would receive CIT training to ensure availability across shifts. [174] 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.[175]

Training

The traditional CIT model requires officers to undergo 40 hours of training that includes subjects such as recognizing the signs and symptoms of mental illnesses and co-occurring disorders, de-escalation techniques, and the availability of local resources.[176] 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 officers.[177] As discussed below, however, providing training to dispatchers can be challenging in jurisdictions with limited resources or if emergency dispatch services are distinct from the law enforcement agency.

CIT training involves role playing, where 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, their family members, law enforcement trainers, and mental health professionals.[178] For example, AASCEND, a Bay Area-based volunteer group of adults on the autism spectrum, participates in SF PD's CIT training through panels on autistic adults.[179] CIT training includes information on signs and symptoms of mental illnesses, including co-existing disorders and developmental disabilities, 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.[180] Many departments enhance CIT training by repeating it periodically or by including additional training related to interactions with youths, veterans, and

[173] Id. at p. ### (citing Dupont et al., *Crisis Intervention Team core elements* (2007) The University of Memphis School of Urban Affairs and Public Policy, Dept. of Criminology and Criminal Justice, CIT Center).
[174] Id. at p. ### (citing Dupont et al., *Crisis Intervention Team core elements*, supra).
[175] Id. at p. ### .
[176] Watson & El-Sabawi, *Expansion of the Police Role*, supra fn. 107; Watson & Fulambarker, *The Crisis Intervention Team Model* (2012), supra p. ### (citing Steadman et. al., 2001).
[177] CRS Report, n.31.
[178] Watson & El-Sabawi, *Expansion of the Police Role*, n. 108-109; Watson & Fulambarker, *The Crisis Intervention Team Model*.
[179] SB 882 Council Meeting (Jan. 17, 2025), Testimony of Michael Bernick https://www.youtube.com/watch?v=vAIndu5KVfM.
[180] Watson & Fulambarker, *The Crisis Intervention Team Model*, p. ### (citing Compton et al., *The Crisis Intervention Team (CIT) Model of collaboration between law enforcement and mental health* (2011) Faculty Bookshelf.

high-risk individuals with repeated contacts with law enforcement.[181] For more detailed discussion of CIT training, see section XX.

Common CIT Training Topics

- Information on signs and symptoms of mental illness
- Mental health treatment
- Co-occurring disorders
- Legal issues
- De-escalation technique
- Optional: 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 includes 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.[182] Officers also conduct site visits of community facilities where CIT-trained officers would typically refer civilians for treatment.[183]

Traditional CIT models typically designate a centralized drop-off emergency mental health care facility, which can accept individuals referred by CIT officers.[184] 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.[185]

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.

[181] Watson & Fulenaker, *The Crisis Intervention Team Model*, p. ### (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.
[182] CRS Report, n.31.
[183] CRS Report, n.29-30.
[184] CRS Report, n.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.
[185] Watson & Fulambarker, *The Crisis Intervention Team Model*.

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.[186] In the same region, the county's Mobile Crisis Response Teams (MCRT) operate around the clock with a clinician, case manager, and peer support specialist, offering a law enforcement-free response when there is no safety threat.[187] Sacramento's Mobile Crisis Support Team (MCST) builds on the co-response model by incorporating Peer Specialists—individuals with lived mental health experience—into the response model, providing post-crisis support and fostering trust between clients and systems.[188] 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.[189] 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.[190]

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.[191] 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 whilst integrating local school and housing systems.[192] 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

[186] *Mental Health*, City of San Diego Police, https://www.sandiego.gov/police/community/mental-health.
[187] *Mobile Crisis Response Teams*, San Diego County Behavioral Health Services, https://www.sandiegocounty.gov/content/sdc/mcrt.html.
[188] *Mobile Crisis Support Team*, Sacramento County Department of Health Services Behavioral Health Services, https://dhs.saccounty.gov/BHS/SiteAssets/Pages/GI-Provider-Resources-Forms/MCST%20Brochure%20-%20English.pdf.
[189] *Psychiatric Mobile Response Teams*, Los Angeles County Department of Mental Health, https://dmh.lacounty.gov/our-services/countywide-services/eotd/pmrt/.
[190] *Therapeutic Transportation Program*, Los Angeles County Department of Mental Health, https://dmh.lacounty.gov/our-services/countywide-services/eotd/ttp/.
[191] *Psychiatric Emergency Response Team*, San Mateo County Sheriff's Office and Behavioral Health and Recovery Services, https://www.smchealth.org/sites/main/files/file-attachments/pertbrochure.pdf?1556207937.
[192] Trujano, *Pleasanton receives award for police alternative response unit*, Pleasonton Weekly (Sep. 27, 2023), https://www.pleasantonweekly.com/news/2023/09/27/pleasanton-receives-award-for-police-alternative-response-unit/.

separately depending on the situation.[193] 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 assistance, Eureka's CARE has established a closed-loop crisis care continuum plan that best suits their population's needs.[194]

A recent report questions the premise of co-response teams, describing that in practice, law enforcement continues to be dominant in interactions when a co-responding mental health provider is present.[195] 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.[196]

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, 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 in general but not intellectual and developmental disability.

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 respond to calls triaged through 911 dispatch involving mental health, substance use, homelessness, or suicidal ideation. Crucially, CAHOOTS staff were unarmed and could not compel treatment or arrest individuals. They provided on-site crisis counseling, transportation to shelters, hospitals, or the White Bird Clinic, and connect clients with services like medical and dental care. As of 2020, CAHOOTS operated on a $2.1 million budget and handled approximately 17% of the Eugene Police Department's call volume.[197] Of the over 24,000 calls

[193] *Community Wellness and Crisis Response Team*, County of San Mateo, https://www.smcgov.org/ceo/community-wellness-and-crisis-response-team.
[194] *Crisis Alternative Response of Eureka Program*, City 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.
[195] Jany, *Report questions why APD 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.
[196] *Id*.
[197] *Public Resources*, City of Eugene, https://www.eugene-or.gov/5129/Public-Resources (finding that more recently, CAHOOTS has transitioned to operate through Lane County's Mobile Crisis Services to comply with new Oregon state mandates).

CAHOOTS responded to, less than one percent needed police assistance.[198] Because of changes in state law, the services formerly provided by the CAHOOTS program were transitioned to the County Department of Health and Human Services in 2025.[199]

In California, the Specialized Care Unit (SCU) in Berkeley exemplifies this structure, with a three-person response team that operates entirely outside the 911 system and conducts proactive outreach to high-need communities.[200] Oakland's MACRO program uses similar staffing but is embedded within the city's fire department for institutional support.[201] In Nevada County, a rural but innovative program dispatches behavioral health professionals 24/7 and operates a local Crisis Stabilization Unit for short-term psychiatric care.[202] Outside of California, Denver's STAR program pairs a clinician and paramedic to respond to low-acuity calls, while New York City's B-HEARD teams combine EMTs and mental health professionals to reduce emergency room admissions.[203] Albuquerque's Community Safety Department (ACS) has established 24/7 civilian-led response units that specialize in homelessness, substance use, and behavioral health.[204] 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 what types of specialized teams, such as a local or regional co-responder team, 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 at 51.3%, County/City co-responder teams at 45.5%, and agency-based co-responder teams at 25.0%. Some examples of other specialized teams or approaches used by a small number of agencies are phone-based support, 17.3%, or "blue envelope" or similar programs, 9.6%,. Agencies did not report using teams that specialized in working with individuals with intellectual and developmental disabilities, although a small number of agencies (less than 3%) reported having a response team focused on serving people with disabilities in general. One in

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

[199] See *Mobile Crisis Services of Lane County*, Lane Conuty Behavioral Health Division, https://www.lanecounty.org/government/county_departments/health_and_human_services/behavioral_health/mobile_crisis_services_of_lane_county.

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

[201] https://theappeal.org/oakland-macro-911-non-law-enforcement-emergency-response/.

[202] Crisis Care Services and Support | Nevada County, CA.

[203] Support Team Assisted Response (STAR) Program - City and County of Denver; https://mentalhealth.cityofnewyork.us/b-heard.

[204] Albuquerque Community Safety — City of Albuquerque.

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. Most agencies reported that their special teams meet between some (28.2%) and most of the needs (35.9%) in their community.

Other Elements of Crisis Response

There are also aspects of crisis response that are common to all types of system and for which quality improvements can result in better outcomes for people with behavioral health conditions. 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 seeking to close crisis interactions in a way that maximizes chances of people receiving needed care.

Dispatch Systems

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 SCU and MH First, operate entirely outside the 911 system with dedicated hotlines.[205] Others integrate clinical dispatchers to triage calls away from law enforcement. Durham's HEART program, for instance, includes a call diversion team that embeds clinicians in emergency communications to route mental health calls to civilian teams where appropriate.[206] 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.[207] 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.[208]

In California, an overhaul of the dispatch system is underway statewide pursuant to 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

[205] *Berkeley Launches Specialized Care Unit (SCU)*.
[206] Community Safety | Durham, NC.
[207] Support Team Assisted Response (STAR) Program - City and County of Denver; San Diego County Behavioral Health Services, Mobile Crisis Response Teams, https://www.sandiegocounty.gov/content/sdc/mcrt.html.
[208] See, e.g. SB 882 Council Meeting (April 1, 2025) Testimony of Vinny Eng, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.

mental health crisis.[209] The goal of AB 988 was to establish a 988 State Suicide and Behavioral Health Crisis Services Fund to support 988 Crisis Centers and related mobile crisis teams. The long-term goal was to establish a system in which individuals could 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 (CalHHS) with creating an implementation plan for the State's expanded 988 system. That plan, the Crisis Care Continuum Plan, was developed in consultation with stakeholder 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.[210] 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 more for mental health concerns than those related to intellectual and developmental disabilities, as the latter are not specifically highlighted or mentioned in the materials currently available about the system's development.

Implementation of AB 988 is still in its early stages, as the implementation plan was just released in January of 2025, so law enforcement agencies and officers throughout the state will 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. 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.[211] 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.[212] The Department continues to monitor the outcome of such

[209] *998 Lifeline Timeline*, SAMHSA Substance Abuse and Mental Health Services Administration, 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).

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

[211] Ibid. at p. 3.

[212] SB 882 Council Meeting (July 15, 2025) Testimony of Sacramento County Undersheriff Mike Ziegler, ### [video link pending].

calls, and thus far this process has connected hundreds of individuals to behavioral health services and has been connected to no adverse physical outcomes.[213]

California has taken other steps to build a comprehensive 988 crisis response system. The Substance Abuse and Mental Health Services Administration (SAMHSA) 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 2024, more than 450 Crisis Care Mobile Units—local crisis care units made possible by a recent increase in crisis care funding—were operating statewide. Additionally, under the Medi-Cal Mobile Crisis benefit, 48 counties were approved to provide mobile crisis services that would cover 98% of Medi-Cal recipients statewide.[214]

Integration of Peer Support

Another strategy for improving outcomes is integration of peer support to provide follow-up. 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. Olympia, Washington, through its Familiar Faces initiative, integrates peer workers who maintain long-term contact with individuals who frequently use emergency services. Peer-driven care is also central to MH First in Oakland and Sacramento, a grassroots alternative response project that emphasizes trauma-informed, socially conscious intervention over risk-based triage. 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.[215] It is not clear from available program descriptions whether any of the listed programs include a focus on intellectual and developmental disabilities, or employ peers who are members of these communities.

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 (SCRT) provide referrals, warm hand-offs to providers, and ongoing contact.[216] Durham's HEART program has a dedicated Care Navigation team to ensure that individuals

[213] Id.
[214] *Building California's Comprehensive 988-Crisis System*, p. 3.
[215] *Crisis Alternative Response of Eureka Program*.
[216] Community Wellness and Crisis Response Team | County of San Mateo, CA; https://www.sf.gov/street-crisis-response-team.

continue receiving services after the immediate crisis has passed.[217] 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.[218] These programs recognize that recovery and stability are long-term priorities. As above, while the listed programs do not appear to exclude individuals with intellectual and developmental disabilities, neither do services appear tailored for the needs of this population.

Across these models, certain shared features appear to contribute to their success: 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 illness or in a mental health crisis and for law enforcement personnel.[219] 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.[220] These programs, while still evolving, 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.

In its survey of law enforcement agencies in California, the Council asked about the community resources the 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 the time services are available, where services are located, and the number of available clinicians.

[217] Community Safety | Durham, NC.
[218] *Crisis Alternative Response of Eureka Program*.
[219] Kane et al, *Effectiveness of current policing-related mental health interventions: A systemic Review* (2018) Criminal Behaviour and Mental Health 28(2):108-119, at pp. 110, 114 (*Effectiveness of current policing*).
[220] Kane, *Effectiveness of current policing*, p. 114.

Review of Crisis Response Models

The variation among crisis response programs in operation, and the predominance of research focusing on CIT, present some obstacles to engaging in comparative evaluation among different types of 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.

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 feasible randomized controlled studies in this area.[221] Instead, studies have 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 officers, and surveyed or used qualitative methods to explore 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 are likely do a poor job of capturing accurate data on use of force, injury, arrest, and other commonly used benchmarks.

Studies do suggest that CIT programs are effective at improving officers' perceptions of and response to persons with mental health challenges.[222] Some studies indicate that CIT improves officers' knowledge about mental health, increases the extent to which officer beliefs about mental health reflect medical knowledge, and reduces stigma.[223] CIT also appears to reduce officer preference for using force, and increase preference for engaging in de-escalation, when interacting with people with behavioral health conditions.[224] Studies also suggest CIT increases officers' self-confidence in their and their departments' abilities to respond to people having a behavioral health crisis.[225] However, it is unclear whether and how these changes in peace officer mindset go on to change what happens in interactions with people with behavioral

[221] Amy Watson & Anjali Fulambarker, "The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners" Best Pract. Ment. Health (Dec. 2012) 8(2):71 ("Watson & Fulambarker"), available at nihms500811.pdf, pp. 3-5, citing McGure & Bond 2011; SB 882 Council Meeting (April 1, 2025) Testimony of Drs. Michael T. Compton and Amy C. Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.

[222] CRS Report, fn. 61-62.

[223] Vera Institute Report, p. 29; CRS Report, fn. 63.

[224] CRS Report, n. 63.

[225] Vera Institute Report, p. 29; CRS report, n. 63; Wells & Schafer, 2006; Borum, Deane, Steadman, & Morrissey, 1998.

health conditions.[226] 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.[227]

Other studies have shown that CIT training may improve an officer's responsiveness and de-escalation decisions.[228] For example, in one study CIT trained and non-CIT trained officers were given a series of vignettes describing a person with schizophrenia who was exhibiting escalating behavior. When compared to non-trained officers, CIT-trained officers perceived that force would be less effective and expressed a preference to use less force.[229] Another study found "significant and substantial differences" in de-escalation skills comparing CIT with non-CIT officers, when confronted with vignettes of persons who were suicidal or experiencing psychosis.[230] Some research indicates that these improvements do not dissipate after the training, especially for more experienced officers.[231]

However, studies are less clear that CIT training improves outcomes such as reducing uses of force or arrests of people in behavioral health crisis.[232] Some studies have shown a reduction in rates of arrest when officers are CIT-trained.[233] However, others, including a 2016 meta-analysis, do not show any effect of CIT on arrest rates.[234] One review comparing multiple crisis response models found limited evidence that these interventions reduced re-offending or improved mental health outcomes, and recommended further and more empirical research on these topics.[235] 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.[236]

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[226] CRS Report.
[227] SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Jack Glaser, Video Link.
[228] Watson & El-Sabawi, *Expansion of the Police Role*, n. 111; Wood, *Improving Police Interventions*, p. 5 (citing studies).
[229] Vera Institute Report, p. 30.
[230] Vera Institute Report p. 30.
[231] Watson & El-Sabawi, *Expansion of the Police Role*, n. 111; Wood, *Improving Police Interventions*, p. 5 (citing studies); Vera Institute Report, p. 30.
[232] Watson & El-Sabawi, *Expansion of the Police Role*, n. 112.
[233] Vera Institute Report, p. 28 (lower arrest rates for agency implementing CIT); Watson & Fulambarker, p. 4; Fuller, nn. 68-70.
[234] Taheri, *Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? A Systematic Review and Meta-Analysis* (2016) 27 Criminal Justice Policy Review 1:76, 85-86 (Taheri).
[235] Kane, pp. 114-115.
[236] 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 30:1665-1679, p. 1674 (Marcus & Stergiopoulos); Seo, et al., *Variation across police response models for handling encounters with people with mental illness: A systemic review and meta-analysis* (2021) Journal of Criminal Justice 72, p. 11 (Seo) ("[D]espite these interventions achieving success related to

Several studies do indicate that CIT-trained officers are less likely to express wanting to use force in response to difficult interactions with people with behavioral health conditions and are less likely to use such force.[237] The 2016 meta-analysis mentioned above shows no such effect, although the reasons for this are not clear.[238] Some studies also show reduced rates of injury to peace officers or civilians following these encounters, while others do not show this reduction.[239] 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.[240] Researchers are currently undertaking a randomized controlled trial of CIT response in seven sites, but data collection and analysis is not yet complete.[241] This trial may help address the dearth of research on the effectiveness of CIT models.

Studies do consistently show that people with behavioral health conditions who have interactions with peace officers who use the CIT model are more likely to be connected to care following the encounter.[242] One study examined the relationship between CIT practice and available community resources, and found that CIT 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.[243] Researchers have also identified jurisdictions in which law enforcement also directs people with behavioral health disorders toward less disruptive care, such as a crisis triage center or residential treatment, rather than to a jail or hospital.[244] A review comparing crisis response modalities concluded that the CIT intervention showed the most promise because it offers integrated services, combining the initial call for assistance with response triage and specially trained response officers with access to mental health professionals.[245]

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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)."); Vera Institute Report, 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").

[237] Fuller, nn. 68-70; Watson & Fulambarker, pp. 4-5 (discussing studies); SB 882 Council Meeting (April 1, 2025) Testimony of Drs. Michael T. Compton and Amy C. Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.

[238] Taheri, pp. 85-86.

[239] Watson & Fulambarker, pp. 4-5 (discussing studies).

[240] Watson & Fulambarker, p. 5.

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

[242] Fuller, nn. 68-70; Watson & El-Sabawi, *Expansion of the Police Role*, n 113.

[243] Watson, et al., *Improving Police Response to persons with mental illness: A multi-level conceptualization of CIT* (2008) 31 Int'l J. of Law and Psychiatry 359-368, p. 362.

[244] Wood, p. 5.

[245] Kane, p. 115.

CIT can also have cost benefits. For example, according to one comprehensive study of a CIT program in Louisville, Kentucky, CIT saved the city approximately $1 million annually. 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.

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 illness such as clinical training in mental health or social work, nursing, peers with lived experience, and specially-trained emergency medical technical 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.[246]

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. Police, as opposed to community partners and providers, also respond to incidents around-the-clock, so law enforcement will have some unavoidable contact with individuals with behavioral health conditions. [247] But, these alternative response models can minimize the contact between law enforcement and people with behavioral health conditions.[248] As set out below, while the research is still developing in this area, there are indications that this type of alternative response model is beneficial to those with behavioral health conditions and reduces the burden on law enforcement.

The data comparing law enforcement response to co-response or alternative response is generally sparse.[249] Many of these response models have only been in operation for a few years, there is huge variation in co-response and alternative response models, and controlled studies are difficult.[250] While current data is insufficient to draw strong conclusions, these

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[246] Legal Defense Fund, et al., *Community-Based Services for Black People with Mental Illness," Advancing An Alternative to Police* (Jan. 2023), p. 15, ("Legal Defense Fund") https://www.naacpldf.org/wp-content/uploads/2023-LDF-Bazelon-brief-Community-Based-Services-for-MH48.pdf.

[247] Balfour, et. al., *Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies* (Aug. 2020) National Association 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, [VIDEO LINK].

[248] Balfour, *Cops, Clinicians, or Both?*, pp. 4-5.

[249] See, e.g., James, et al. *Issues in Law Enforcement Reform: Responding to Mental Health Crises* (Oct. 2022) Congressional Research Servs. R47285 p. 10, (CRS Report) https://www.congress.gov/crs-product/R47285.

[250] See, e.g., Balfour, 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) https://doi.org/10.1016/j.socscimed.2024.116723; Vera Institute Report, p. 41.

models appear promising in certain areas. For example, co-responder models often receive higher community support than law enforcement-only response models.[251] One review determined co-responder programs decreased arrests and the amount of time officers spend handling mental health calls.[252] Another study that found no significant difference in arrest rates did find co-responder teams were significantly more likely to resolve calls without psychiatric hospitalization of the subject and had lower costs than calls handled by police alone.[253] In contrast, one randomized control 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.[254] 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 illness.[255] 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.[256]

Co-response models perform slightly better than CIT in some measures, but the differences are small.[257] Alternative/community response models appear to perform better than co-response models, but the data is unreliable.[258]

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.[259] 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

[251] Balfour, *Cops, Clinicians, or Both?*, p. 8; Vera Institute Report, pp. 14-16 (discussing studies).
[252] Balfour, *Cops, Clinicians, or Both?*, p. 8.
[253] Vera Institute Report, p. 16.
[254] Lowder, p. 1; SB 882 Council Meeting (April 1, 2025) Testimony of Drs. Michael T. Compton and Amy C. Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.
[255] Legal Defense Fund, p. 16, citing Taheri, p. 90; but see Seo, 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).
[256] Balfour, *Cops, Clinicians, or Both?*, p. 8;CRS Report, p. 10.
[257] Marcus & Stergiopoulos, pp. 1668-1672, 1674.
[258] See, e.g., *Ibid.*
[259] CRS Report, p. 9; Vera Institute Report, pp. 21, 24.

model to support the "development of alternative, evidence-based models that prioritise [sic] the lived experience of service users."[260]

In the United States, the most positive anecdotal evidence comes from CAHOOTS in Eugene, Oregon, which has been in operation for over 30 years and is described in the *Co-response and Alternative/Community Response Models* section above. The program reports savings to the city of $8.5 million in public safety costs and $14 million in ambulance and emergency room costs.[261] The most positive quantitative data comes from an evaluation of the STAR Program in Denver, likewise discussed above. The STAR Program reported that during its six-month pilot program in 2020, it resolved 748 mental health incidents (averaging six calls a day) that involved no force, arrests, or jail.[262] 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.[263] The study estimated that a community response model cost four times less than the direct costs of having law enforcement as first responders.[264] The researchers point out that successfully replicating the Program relies on factors such as successful recruitment and training of dispatchers and mental health field staff, along with coordination with law enforcement.[265]

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 received because officer involvement can retraumatize individuals due to their previous traumatic interactions with law enforcement.[266] One meta-analysis determined that most individuals with behavioral health conditions reported mixed, variable, or negative past experiences with law enforcement (both CIT and non-CIT), with nine studies describing individuals' interactions with law enforcement as "traumatic or extremely stigmatizing."[267] In

[260] Marcus & Stergiopoulos, p. 1674; see also Seo, 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.").
[261] Legal Defense Fund, , p. 15, citing Scottie 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/index.html.
[262] 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. (June 22, 2021) p. 4.
[263] 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).
[264] Dee & Pyne, p. 7.
[265] Dee & Pyne, p. 6.
[266] Legal Defense Fund, p. 8, citing Taleed El-Sabawi & Jennifer J. Carroll, *A Model for Defunding: An Evidence-Based Statute for Behavioral Health Crisis Response* (2021) 94 Temple L. Rev. 1, 13.
[267] Marcus & Stergiopoulos, p. 1673.

contrast, the analysis determined that individuals reported generally positive perceptions of services in co-responder models, and non-law enforcement models.[268]

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.[269] 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.[270] 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.[271]

Researchers caution that co-response or alternative response models are small components of a larger crisis system.[272] 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.[273] At all points along the continuum, which in this case includes co-location of crisis call center staff within 9-1-1, co-responder teams, and crisis facilities, easily accessible handoffs by law enforcement facilitates connection to treatment instead of arrest.[274]

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 published the 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care.[275] The Guidelines set out

[268] Marcus & Stergiopoulos, p. 1673.
[269] Balfour, et. al., *Crisis stabilization claims analysis: Technical report; Assessing the impact of crisis stabilization on utilization of healthcare services*, Wilder Research (April2013), p. 12,available at https://www.wilder.org/sites/default/files/imports/Crisis_stabilization_technical_report_4-13.pdf.
[270] Balfour, et. al., *The Tucson Mental Health Investigative Support Team (MHIST) Model: A prevention focused approach to crisis and public safety*. Psychiatry Serv (2017) 68(2):211–2, p. 5, available at http://www.gocit.org/uploads/3/0/5/5/30557023/tucson_mhst_model_full_version.pdf.
[271] Marcus & Stergiopoulos, at p. 1675; see also Vera Inst. Of Justice, at pp. 15-16.
[272] See, e.g., Balfour, *Cops, Clinicians, or Both?*, pp. 8, 10.
[273] Balfour, *Cops, Clinicians, or Both?*, p. 10.
[274] Balfour, *Cops, Clinicians, or Both?*, p. 10.
[275] Substance Abuse and Mental Health Administration, *2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care* (2025) HHS Publication No. PEP24-01-037, https://988crisissystemshelp.samhsa.gov/sites/default/files/2025-04/national-guidelines-crisis-care-

three foundational elements for an integrated crisis system of care, which generally include the categories of non-training interventions discussed above. The elements are: (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.[276] To support implementation of crisis systems of care, SAMHSA has also created Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services.[277] These resources provide extensive and detailed information to support the creation of crisis-related services throughout California.

Obstacles to Implementation

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 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 ten or fewer officers, which may limit availability for training and implementation of CIT.[278] Additionally, the collaboration needed to work with mental health resources and other agencies (for example, in creating a centralized drop-off emergency center, and 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 programs currently prepare people for positions in behavioral crisis response. To build a workforce of non-law

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pep24-01-037.pdf; SB 882 Council Meeting (April 1, 2025) Testimony of Drs. Michael T. Compton and Amy C. Watson, https://www.youtube.com/watch?v=TNfNQVlFvJc&feature=youtu.be.

[276] Substance Abuse and Mental Health Administration, *2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care*, pp. 2-3.

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

[278] Commission on Peace Officer Standards and Training, *Agency Statistics* https://post.ca.gov/Agency-Statistics; see also CRS Report, n. 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).

enforcement responders, it is important to invest in creating educational, licensure, and recruitment pathways to becoming a behavioral health crisis responder.

Model Fidelity

Program effectiveness also depends on how well the department implementing it understands the model. For example, CIT is not only about training, but many of the departments that claim to implement it only focus on the training aspects. The model also calls for increased focus on dispatcher training, which does not always occur.[279] Beyond law enforcement, effective CIT implementation requires comprehensive community mental health services, designated psychiatric emergency receiving facilities, and interagency cooperation, some or all of which may or may not be present in any given jurisdiction. The Executive Director of CIT international highly encourages investing in community response teams that do not involve law enforcement, even in areas with CIT-trained officers.

Recommendations

Partnerships

- Law enforcement agencies should collaborate with community/non-law enforcement entities to allow for more natural, regular, non-emergency interactions between community members and law enforcement officers. Examples:
    - Host community events with law enforcement officers to build trust, reduce fear, and allow families to practice positive interactions in a safe environment. For example, agencies can have individuals with disabilities visit police stations and chat with law enforcement officers (e.g., "Meet the Police" days, sensory-friendly safety fairs) or have officers visit individuals with disabilities at various locations such as day programs, regional centers, regional center vendors.
    - Agencies, with community partners, can organize community events where natural conversations can occur, such as a community park, and officers and individuals do activities together (such as assigning buddies and playing games together).

- Law enforcement agencies should create programs or focus existing community outreach programs on community members with disabilities to encourage more natural, regular, non-emergency interactions.

- Foster law enforcement awareness of/connection with regional centers and county departments of behavioral health. Establish and maintain a library of sample

[279] CRS Report, p. 5.

memoranda of understanding between law enforcement, regional centers, and county departments of behavioral health.

Programs and Services

- Investigate and develop strategies to help address workforce shortages among law enforcement, regional centers, and county departments of behavioral health, and their vendors. Invest in creating educational, licensure, and recruitment pathways to becoming a behavioral health crisis responder.

- Address the statewide bed shortage for people in acute crisis, especially availability of beds for people with IDD who should never be denied services on the grounds of a co-occurring disability.

- Implement the Manny Alert Act per the recommendations of the November 2020 Manny Alert Act (AB 911) Feasibility Study of a Self-Registration Database for 911 Calls Final Report, including a funded voluntary statewide registry that is connected to all law enforcement agencies' and dispatchers' computerized systems.

    - Fund and require local law enforcement agencies and 911 dispatchers to utilize wireless emergency alerts to notify the public to be on the lookout for missing persons with IDD (including notice to check pools and bodies of water, or freeways). Such funding could come from a modest increase in the Emergency Telephone Users Surcharge from the State Emergency Telephone Number Account (SETNA) for wireless phone plans.

- Consider adopting Blue Envelope system or lanyard system (voluntary system where people with IDD can self-identify so officers know). Translate to common community languages.

- Encourage inclusion of people with MHD/IDD on civilian oversight boards regarding use of force.

- Systemically integrate calls for service with officer-initiated stops so that law enforcement is aware whether a given interaction was initiated by a family member who has called for help for a relative or whether an officer comes across the scene by other means. This typically occurs with Computer-Aided Dispatch (CAD) and the Council recommends promoting this benefit.

- Study response models that have been implemented by agencies that triage calls. For example, in Sacramento County Sheriff's Department response model, dispatchers determine which calls require a law enforcement response and which ones require a service-provider response (e.g., mental health provider) instead of law enforcement.

Dispatcher determines, for example, whether to call fire department, California Highway Patrol, local government (e.g., traffic light not working), mental health providers, etc.

Funding

- Advocate for funding opportunities for training to improve interactions between law enforcement and persons with MHD/IDD, for example, to allow officers to use virtual reality training and expand technology-based training opportunities.

- Evaluate and enact legislation to provide financial resources to schools, regional centers, and community groups so that students with disabilities, individuals who receive services from regional centers, and their family members or guardians can receive training and resources on how to safely interact with law enforcement officers. For example, individuals and family members can receive guidance on the difference between calling 911 or utilizing another resource and what information the caller should provide to help alert and notify of any disability-related needs.

- Provide special grants for each county to operate 24/7 mental health crisis teams to respond to non-crime related 911 and 988 calls.

    - Require IDD training for these county mental health crisis teams.
    - Require IDD as a topic in Medi-Cal Mobile Crisis Training and Technical Assistance Center (M-TAC) required core trainings.

- Consider the following funding streams to support these recommendations:
    - Priorities or special grants for smaller departments especially in rural areas.
    - An increase in the SETNA surcharge for wireless phone plans.
    - Proposition 63/Mental Health Services Act funds.

Training

Training is a cornerstone of law enforcement preparedness. There is a broad universe of training that seeks to improve interactions between persons with behavioral health conditions 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 those with behavioral health conditions alike.[280]

This section examines existing types of law enforcement training, and the research evaluating such training, to provide an overview of law enforcement training relating to interactions with individuals with the SB 882 population. This includes an overview of the current training requirements for peace officers in California, and the results of the survey that the Council

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

conducted of California law enforcement agencies focusing on their impressions of the training they receive. This section will also review the substantive training topics of de-escalation training, training specifically designed to address interacting with the SB 882 population, training designed for the SB 882 population themselves to improve safety in interactions with law enforcement, and lessons from implicit bias training research. It also includes an overview of research on methods of delivering trainings, including role-play and simulation trainings, and the importance of repetition and refresher trainings.

Researchers have made attempts to synthesize existing findings on what substantive training subjects and methods of training in this field are most effective, but the variety of types and quality of existing studies on law enforcement trainings focusing on behavioral health conditions makes drawing firm conclusions difficult. 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 people with behavioral health conditions 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. This included trainings ranging from broad mental health awareness training to more narrow trainings addressing a variety of specific mental health issues or conditions.[281] The review found that while many of the training programs used evidence-based practices, there lacked strong and consistent evidence regarding outcomes. Some of the studies demonstrated short term positive changes in behavior or attitudes for trainees, but longer term follow up was needed for many of the studies.[282] Finally, and critically, no studies demonstrated evidence of significant benefit for the members of the public that the law enforcement trainees encountered.[283]

The current need for additional research to assess different response and training model types 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.[284] This review was broader in subject matter scope, looking at evaluation of any type of police training, rather than those focused solely on interactions with the SB 882 population.[285] The review was also

[281] 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) 17 BMC Psychiatry 196, pp. 2-3, (Booth) https://doi.org/10.1186/s12888-017-1356-5.
[282] Booth, pp. 10, 19-20, 22.
[283] Booth, pp. 1, 20, 22.
[284] Huey, *What Do We Know About In-service Police Training? Results of a Failed Systematic Review* (2018) Sociology Publications 40, (Huey) https://uwo.scholaris.ca/items/31c811e6-209d-4e88-9bf4-38d7f76826ca.
[285] Huey, p. 6.

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.[286] 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.[287]

California Peace Officer Training Requirements

Peace officers in California are required to meet the minimum training standards as identified by law.[288]

First, people hired as peace officers who attend the regular basic course must complete 664 hours of basic training.[289] The basic training course is divided into 43 individual topics, called learning domains, that contain the minimum required foundational information on each topic.[290] One of these learning domains is training on people with disabilities.[291] The training must address issues related to stigma and be culturally relevant and appropriate.[292] It must also include topics such as recognizing indicators of mental illness and intellectual disability, conflict resolution and de-escalation techniques, and the perspective of individuals with lived experience.[293]

Second, in addition to basic training, every peace officer must complete field training before being assigned to perform general law enforcement uniformed patrol duties.[294] The field training must include a course relating to competency that addresses how to interact with people with mental illness or intellectual disability.[295] The course must be at least four hours of classroom instructions and instructor-led active learning, such as scenario-based training, and it also must address issues related to stigma and be culturally relevant and appropriate.[296] 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

[286] Huey, p. 6.
[287] Huey, pp. 13-15.
[288] Pen. Code, § 832.
[289] Cal. Code Regs., tit. 11, § 1005, subd. (a).
[290] Commission on Peace Officer Standards and Training, *Regular Basic Course* (2025) https://post.ca.gov/regular-basic-course.
[291] Commission on Peace Officer Standards and Training, *Regular Basic Course Training Specifications*, LD 37 People with Disabilities, https://post.ca.gov/regular-basic-course-training-specifications.
[292] Pen. Code, § 13515.26, subd. (c).
[293] Pen. Code, § 13515.26, subd. (c).
[294] Cal. Code Regs., tit. 11, § 1005, subd. (a).
[295] Pen. Code § 13515.29.
[296] Pen. Code, § 13515.29.

officers on how to effectively interact with people with a mental health disability or intellectual disability.[297]

Third, certain peace officers and dispatcher personnel who are employed by POST participating departments must satisfactorily complete continuing professional training.[298] The purpose of continuing professional training is to maintain, update, expand, and enhance an individual's knowledge and skills.[299] Available trainings must include a training course related to law enforcement interaction with people with mental disabilities and intellectual disabilities, although the statute does not specify whether that course should be required or at what frequency.[300] The training must utilize interactive training methods to ensure that the training is as realistic as possible.[301] The training must also include instruction on conflict resolution, de-escalation techniques, and appropriate language usage and appropriate responses when interacting with a person with a disability.[302]

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, durable medical equipment, the Mental Health Services Delivery System, and inmate suicide prevention.[303]

California Law Enforcement Agency Training Survey Results

As discussed in detail above, the Council approved 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. The survey of law enforcement agencies in California provided further information on the types of trainings that exist for peace officers in California.

The results of the Council survey reiterate the general findings that most law enforcement agencies receive some training regarding mental health conditions or intellectual and developmental disability, but that there is room for improvement. When asked about recommendations for improving law enforcement interactions, agencies' recommendations were most associated with training, including better quality training and increased frequency of training. Law enforcement agencies would benefit from more detailed and frequent trainings, and from more frequent trainings incorporating direct participation of members of the SB 882 population. Some experts note that hearing from those with lived experiences is often

[297] Pen. Code, § 13515.28.
[298] Cal. Code Regs., tit. 11, § 1005, subd. (d).
[299] Cal. Code Regs., tit. 11, § 1005, subd. (d).
[300] Pen. Code, §§ 13515.25, 13515.27.
[301] Pen. Code, §§ 13515.25, 13515.27.
[302] Pen. Code, §§ 13515.25, 13515.27.
[303] SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Lee Lipsker, VIDEO LINK.

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.[304] Moreover, a stronger focus on evaluation of training effectiveness could improve decisions about training and outcomes in law enforcement interactions in California. The lack of feedback mechanisms after training can negatively impact officer retention and application of the curriculum.[305]

In general, 9 out of 10 agencies reported that some type of training existed that related to people with IDD or mental health conditions. 64% of the agencies reported having trainings related to both people with IDD and/or mental health conditions. More than half (51.9%) of the agencies reported using exclusively trainings that are certified by POST, while another 44.9% reported that at least some of their trainings were POST certified. Survey responses indicated that their descriptions included trainings required by POST, Standards & Training for Corrections, or other trainings mandated by state legislation or standards. The agencies also described some online/video trainings, crisis intervention trainings, VR trainings, and de-escalation training.

Some agencies also identified some topics that were lacking in available trainings. These topics included handling call transfers between 911 and 988, running scenarios or other interactive elements that build skills and reinforce training content, and responding appropriately to people with mental health conditions or IDD in custody. About 10% of the responding agencies also noted not having anyone among the trainers for their agency with lived experience with IDD or with a disclosed mental health condition.

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. Agencies responded to questions on a three-point scale: no need for improvement, some need for improvement, and significant need for improvement. The agencies largely reported little to some need for improvement across all topics of training, but understanding mental health conditions and IDD and interacting with members of the public were the areas with the higher reported need for improvement.

With respect to the agencies' own evaluation of trainings, agencies reported using a range of methods to assess whether trainings delivered desired results. But about 1 in 5 agencies did not report evaluating their trainings. Just over half of the agencies reported using direct observation to evaluate their trainings. About 41% of the agencies examine their use of force,

[304] SB 882 Council Meeting (Sept. 18, 2025) Testimony of Marianne Halbert, VIDEO LINK.
[305] SB 882 Council Meeting (July 15, 2025) Testimony of Michele Saunders, LCSW, VIDEO LINK.

arrest, and stop data to evaluate trainings, about 34% of agencies evaluated their trainings using exams after training, and about 30% of agencies used surveys before and after training. Thus, while about 80% of agencies do something to evaluate their trainings, there is not a common approach.

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 for those with behavioral health conditions. 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."[306] 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.[307]

De-escalation training is provided in some form by many law enforcement agencies.[308] The general term, though, may cover a wide variety of training types, 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 discussed the importance of making sure peace officers realize de-escalation is not a "magic word," but rather is a process of using strategies and techniques.[309]

In California, de-escalation training is part of the law enforcement academy basic training and is available in various forms. 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.[310] These strategies may include: establishing contact with the individual in crisis,

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[306] Engel et al., *Does De-Escalation Training Work?: A Systematic Review and Call for Evidence in Police Use-of-Force Reform* (2020) 19 Criminology & Public Policy 721, 724, (Engel) https://onlinelibrary.wiley.com/doi/epdf/10.1111/1745-9133.12467; see also Alvarez, *Stop. Rewind. Replay.: Performance, police training and mental health crisis response* (2020) Performance Research, 25:8, 69-75, p. 70, (Alvarez) https://www.tandfonline.com/doi/full/10.1080/13528165.2020.1930783; see also SB 882 Council Meeting (Oct. 18, 2024) Testimony of Mark Stadler, https://www.youtube.com/watch?v=yWRnfEr33es; POST, *De-escalation: Strategies & Techniques for California Law Enforcement* (2020), ch. 2-1, https://dublin.ca.gov/DocumentCenter/View/25842/CA-POST-De-escalation-Strategies.

[307] Int'l Ass'n of Chiefs of Police, *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.

[308] Engel, p. 722; Alvarez, p. 70.

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

[310] Engel, p. 724; SB 882 Council Meeting (Oct. 18, 2024) Testimony of Mark Stadler, https://www.youtube.com/watch?v=yWRnfEr33es; see also POST, *Practical De-escalation & Tactical*

creating a visual connection, building rapport, and working to gain influence to decrease the intensity of the situation.[311] These can be taught in different ways. For example, in some CIT training, the instructor tackles de-escalation in four parts: (1) basics; (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; (4) video scenarios and discussion.[312] 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."[313]

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.[314] However, most of the trainings were from fields like nursing and psychiatry rather than policing.[315] The study found slight-to-moderate improvements at the individual and organizational levels (e.g., reduced aggression, improved communication), but also noted that the quality of research was generally low.[316] 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.[317]

Still, the research provides some evidence-informed practices that can be implemented to improve the quality and efficacy of law enforcement de-escalation training.[318] 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[319];

Conduct, https://catalog.post.ca.gov/SearchResult.aspx?crs_no=20811&crs_title=PRACTICAL%20DE-ESCALATION%20%26%20TACTICAL%20CONDUCT&pageId=10&MAC=1bovcMfLxPQKAvHDYGE1NGw1jDk.

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

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

[313] POST, *Practical De-escalation & Tactical Conduct*.

[314] Engel, p. 721.

[315] Engel, p. 729.

[316] Engel, pp. 734-737.

[317] Engel, pp. 737-738.

[318] Bennell et al., *Promising Practices for De-Escalation and Use-of-Force Training in the Police Setting: A Narrative Review* (2021) 44 Policing: An International Journal of Police Strategies and Management 377, (Bennell) https://www.carleton.ca/policeresearchlab/wp-content/uploads/Promising-practices.pdf.

[319] Bennell, p. 380.

2. 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[320];
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[321]; and
4. evaluation of training and ongoing assessment of skills and knowledge, which is related to monitoring training outcomes and continuously adapting curricula.[322]

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 the use and development of this training material. Focus on the critical training development of effective communication and decision-making, using the best methods of instruction, will have the greatest impact when supported by proper department commitment, implementation, and evaluation.

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 disability.

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 police legitimacy.[323] To sustain these gains, departments must go beyond training and establish comprehensive developmentally informed policies. The International Association of Chiefs of Police (IACP) recommends training police to use developmentally appropriate responses, developing age-appropriate response protocols, and promoting collaborations with community partners.[324] The Cleveland Police Department's "Interactions with Youth" policy officers a model that provides age-appropriate guidance across

[320] Bennell, pp. 380-387.
[321] Bennell, pp. 387-392.
[322] Bennell, pp. 392-393.
[323] SB 882 Council Meeting (Sept. 18, 2025) Testimony of Gabrielle Celeste, JD, VIDEO LINK.
[324] SB 882 Council Meeting (Sept. 18, 2025) Testimony of Gabrielle Celeste, JD, VIDEO LINK.

all stages of contact, promotes diversion over arrest, and encourages trauma-informed police practices.[325]

Training Specific to Behavioral Health Conditions

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.[326] For example, materials provided to the Council by POST regarding the trainings provided by POST to California law enforcement agencies demonstrate available courses covered issues related to mental health and intellectual and developmental disabilities; some trainings covered both topics.[327] The materials that POST provided to the Council for review came from 186 unique trainings provided by law enforcement agencies, private agencies, and public and/or educational institutions that are available throughout the State.[328] Trainings ranged from two to forty hours in length, with over twenty available to attend remotely.[329]

Many current law enforcement trainings relating to the SB 882 population include general education about mental health conditions and then focus on addressing communication and social behavior differences, and addressing sensory and accommodation needs.[330] In California, peace officers learn about mental health conditions and IDD as part of the basic training academy in Learning Domain 37 (LD 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

[325] SB 882 Council Meeting (Sept. 18, 2025) Testimony of Gabrielle Celeste, JD, VIDEO LINK.
[326] Fiske, et al., A National Survey of Police Mental Health Training, (2020) J. Police Crim Psychol. 36:236–242, p. 239, (Fiske) https://www.proquest.com/docview/2918766588?pq-origsite=gscholar&fromopenview=true&sourcetype=Scholarly%20Journals (noting 100% of agencies provided academy training for interacting with people with intellectual and/or developmental disabilities (IDD), and 93% provided training specifically related to autism).
[327] SB 882 Council Meeting (Oct. 18, 2024) Testimony of CA DOJ, https://oag.ca.gov/system/files/media/sb882-101824-agenda-7.pdf.
[328] SB 882 Council Meeting (Oct. 18, 2024) Testimony of CA DOJ, https://oag.ca.gov/system/files/media/sb882-101824-agenda-7.pdf.
[329] SB 882 Council Meeting (Oct. 18, 2024) Testimony of CA DOJ, https://oag.ca.gov/system/files/media/sb882-101824-agenda-7.pdf.
[330] 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), 434-447, p. 444, (Holloway) 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 51:1331-1345, pp. 1342-1343, (Love) https://doi.org/10.1007/s10803-020-04613-1; IACP Law Enforcement Policy Center, *Interactions with Individuals with Intellectual and Developmental Disabilities: Model Policy, Concepts & Issues Paper*, , (Aug. 2017), pp. 1-3, https://www.theiacp.org/sites/default/files/2018-08/IntellectualDevelopmentalDisabledPaper.pdf.

or hard of hearing; mental illness; and the LPS Act.[331] LD 37 training may also include training on common triggers and causes related to crisis calls, such as anxiety, sensory dysfunction, individuals who are non-verbal in a crisis, depression, schizophrenia, and how to react in such situations.[332]

CIT training also 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. 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, allowing movement, and allowing personal space.[333]

While there are a large number of available trainings, research demonstrates a lack of standardization in trainings.[334] Research also demonstrates a dearth of concrete evidence regarding the impact of such training on outcomes for members of the SB 882 population, and much of the research concludes that further, and more outcome-oriented research would be beneficial.[335] 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.[336]

Still, there are indications that existing training can increase peace officers' knowledge of mental health conditions and IDD and self-reported competency in dealing members of the SB

[331] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Yolanda Cruz, https://www.youtube.com/watch?v=yWRnfEr33es; https://oag.ca.gov/system/files/media/sb882-101824-agenda-10.pdf.
[332] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Yolanda Cruz, https://www.youtube.com/watch?v=yWRnfEr33es; https://oag.ca.gov/system/files/media/sb882-101824-agenda-10.pdf.
[333] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Yolanda Cruz, https://www.youtube.com/watch?v=yWRnfEr33es; https://oag.ca.gov/system/files/media/sb882-101824-agenda-10.pdf.
[334] 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., p. 2, (Richardson) 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., pp. iii, 48-49 (Nguyen); 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), 221-233, pp. 230-231.
[335] Nguyen, pp. 20, 48, 54-55; Murphy, et al., *Autism awareness training for An Garda Siochana, Letter to the Editor*, (July 2017) Irish Journal of Psychological Medicine, p. 1, (Murphy) DOI:10.1017/ipm.2017.31; Holloway, p. 445; Railey, pp. 228-229.
[336] Nguyen, pp. 34, 55; Murphy, p. 1; Holloway, pp. 441, 443-444.

882 population.[337] 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.[338] 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.[339]

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

As individuals with behavioral health conditions face elevated risks during interactions with peace officers, developing effective, evidence-based interventions for such individuals that enhance safety and communication is also a growing area of focus. While this training is *about*, rather than *for*, law enforcement, 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 spectrum disorder (ASD).[340] 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 ASD—are disproportionately at risk during police encounters.[341] Participants engaged in both video modeling and Behavioral Skills Training to improve police interaction skills.[342] Video modeling included watching four video clips with instruction related to police interaction or emergencies, such as self-disclosure of disability, and then participants worked with researchers to test responses to police interactions.[343] Behavioral Skills Training included: (1) participants receiving verbal instruction

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[337] Nguyen, pp. 51-52; Holloway p. 444; Love, p. 1342; Murphy, pp. 1-2.
[338] 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; https://oag.ca.gov/system/files/media/sb882-040125-agenda-5.pdf.
[339] Nguyen, pp. 5-51; 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; https://oag.ca.gov/system/files/media/sb882-040125-agenda-5.pdf.
[340] Davenport et al., *An Initial Development and Evaluation of a Culturally Responsive Police Interactions Training for Black Adolescents with Autism Spectrum Disorder* (2023) 53 Journal of Autism and Developmental Disorders 1375, (Davenport) https://doi.org/10.1007/s10803-021-05181-8.
[341] Davenport., pp. 1375-76.
[342] Davenport , pp. 1381-82.
[343] Davenport, pp. 1381-82.

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 rehearing 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.[344] Thus, participants were able to receive immediate instruction and feedback from peace officers, and the scenarios and skills were informed by qualitative feedback from caregivers and community stakeholders.[345]

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.[346] Both physiological (salivary cortisol, heart rate variability) and self-reported (qualitative survey questions) stress indicators showed generally favorable reductions after participants went through the training.[347] 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[348] The training was well-received, with caregivers reporting strong social validity and few side effects.[349] Thus, role-playing training with specific instructions and interactions focused on safety may be useful for larger community use as well as use with law enforcement agencies.

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 and peace officers.[350] This training approach is a key 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.[351]

While this study did not conduct empirical research on the efficacy of its model, it provided evidence-based rationale for its approaches, including the benefits of allowing individuals with behavioral health conditions to get to know members of law enforcement, helping individuals

[344] Davenport, p. 1382.
[345] Davenport, p. 1382.
[346] Davenport, p. 1383.
[347] Davenport, pp. 1383-85.
[348] Davenport , p. 1385.
[349] Davenport, p. 1385.
[350] Roberts & Satterelli, *Understanding Us: An Interactive Training Program for Members of Law Enforcement and Individuals with Disabilities* (2020) Occupational Therapy Capstones, (Roberts & Satterelli) https://commons.und.edu/ot-grad/456.
[351] Roberts & Satterelli, pp. 25-28, 36-40, 44-47.

with behavioral health conditions to develop positive attitudes toward law enforcement, and allowing individuals with behavioral health conditions to recognize their own attitudes and stigmas they potentially place on peace officers.[352] Thus, training that focuses on building positive interactions and understanding between individuals with behavioral health conditions and local law enforcement may provide benefits to both groups.

Implicit Bias Training

Extensive research has been conducted on both 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, this research provides insight for future law enforcement training in this area as well.[353] Implicit bias refers to mental associations between social groups (such as races, or people with behavioral health conditions) 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."[354]

Research demonstrates implicit biases exist in the general population, and can affect behavior, particularly real-world discriminatory behaviors.[355] For example, some research has demonstrated that an implicit association between Black people and weapons can be a predictor of the tendency to select "shoot" instead of "don't shoot" in police samples, when shown an image of an armed Black man, as opposed to a white man.[356]

Research also demonstrates that training and other methods to reduce implicit racial bias often have only no or small reductions that do not last long.[357] For example, one study of the New York City Police Department found that while officers evaluated an implicit bias training

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[352] Roberts & Satterelli, pp. 28, 40, 47.
[353] SB 882 Council Meeting (July 15, 2025), Testimony of Dr. Jack Glaser, VIDEO LINK.
[354] Glaser, *Disrupting the Effects of Implicit Bias: The Case of Discretion & Policing*, (Winter 2024) 153 Dædalus, the Journal of the American Academy of Arts & Sciences 1, pp. 152-153, (Glaser) 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*, Psychological Review 102 (1) (1995): 4.
[355] SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Jack Glaser, VIDEO LINK; Glaser, 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): 553–561; Kang, *Little Things Matter a Lot: The Significance of Implicit Bias, Practically & Legally*, (Winter 2024) 153 Dædalus (1):193–212, https://direct.mit.edu/daed/article/153/1/193/119927/Little-Things-Matter-a-Lot-The-Significance-of.
[356] Correll, et al., *Across the Thin Blue Line: Police Officers and Racial Bias in the Decision to Shoot*, (2007) 92 Journal of Personality and Social Psychology 6: 1006–1023, https://www.apa.org/pubs/journals/releases/psp-9261006.pdf; Plant & Peruche, *The Consequences of Race for Police Officers' Responses to Criminal Suspects*, (2005) 16 Psychological Science 3: 180–183, https://doi.org/10.1111/j.0956-7976.2005.00800.x.
[357] SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Jack Glaser, VIDEO LINK;

positively, comparisons between pre- and post-training rates of stop and frisk and use of force against Black residents did not decrease, and even increased.[358] Another study found that officers' use of strategies to manage bias was actually lower a month after the training than it was prior to receiving the training.[359]

But research also demonstrates that limiting discretion in areas where bias may appear can have a positive impact on outcomes.[360] 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 [w]hite people who were searched were more likely to be found with contraband than were Black people or Latino people."[361] 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."[362]

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 discrimination.[363] 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.[364] Other helpful actions can be slowing tense situations down, which allows for higher order cognitive processing, and expecting supervision and evaluation of activities, which can decrease reliance on bias and stereotypes.[365]

Role-play and Simulation Training

Role-playing and simulation can be essential parts of effective training for peace officers. 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 with a behavioral health condition. The training will often involve: (1) peace

[358] Glaser, p. 159.
[359] Glaser, p. 159, citing Lai & Lisnek, *The Impact of Implicit-Bias-Oriented Diversity Training on Police Officers' Beliefs, Motivations, and Actions*, (2023) 34 Psychological Science 4: 424–434.
[360] SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Jack Glaser, VIDEO LINK.
[361] Glaser, p. 161; Charbonneau & Glaser, *Suspicion and Discretion in Policing: How Laws and Policies Contribute to Inequity*, (2020) UC Irvine Law Review 11: 1327.
[362] Glaser, pp. 161-162; SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Jack Glaser, VIDEO LINK.
[363] SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Jack Glaser, VIDEO LINK.
[364] SB 882 Council Meeting (July 15, 2025) Testimony of Dr. Jack Glaser, VIDEO LINK; Glaser, p. 165.
[365] Glaser, pp. 161-162.

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.[366] This was in response to feedback from officers, who stated they wanted more role-play exercises and more opportunities to practice the skills they were learning.[367] 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 do role-plays.[368] Additionally, witnesses discussed how role-play and simulation training allow the training to show the 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.[369] 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.[370] 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.[371] 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

[366] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Mark Stadler, https://www.youtube.com/watch?v=yWRnfEr33es.
[367] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Mark Stadler, https://www.youtube.com/watch?v=yWRnfEr33es.
[368] 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 II Jonathan Larsen and Detective III 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.
[369] SB 882 Council Meeting (Jan. 15, 2025) Testimony of Dr. Randy Dupont, https://www.youtube.com/watch?v=vAIndu5KVfM.
[370] Alvarez, pp. 69-75.
[371] Alvarez, pp. 71-73.

embodying different actions should work to ingrain new patterns of judgement and action in an officer's "muscle memory" and repertoire of decision-making that can be drawn upon in future stressful encounters.[372] The study reports that among the 72 officers that had completed the study "all have shown marked improvements in de-escalation competencies according to a comparison of pre- and post-training measures."[373]

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.[374] 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."[375] 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.[376] This highlights the potential benefit of role-play and 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 real world peace officer behaviors in interactions with people with behavioral health conditions.[377] This 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.[378] The primary focus of feedback was increasing empathy and helping officers identify other approaches they could use to de-escalate the situation.[379] While the study determined the training did not change

[372] Alvarez, pp. 70-71.
[373] Alvarez, p. 74. The authors do not provide any further detail about the evaluation methods used here, and thus, it is not clear the parameters, amount, or specific improvements that were shown.
[374] Alvarez, pp. 71-73
[375] Alvarez, p. 73.
[376] Alvarez, p. 73.
[377] Krameddine et al., *A novel training program for police officers that improves interactions with mentally ill individuals and is cost-effective* (2013) 4 Frontiers in Psychiatry 1, (Krameddine) https://doi.org/10.3389/fpsyt.2013.00009.
[378] Krameddine, 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." *Ibid.*
[379] Krameddine, p. 3.

attitudes of the police towards people with behavioral health conditions, it did demonstrate statistically significant improvements in directly measured behaviors and indirect measurements of behavior.[380] Specifically, there was a significant increase in the recognition of mental health issues as a reason for a call, improved efficiency in dealing with mental health issues, and a decrease in weapon or physical interactions with individuals with mental health needs.[381]

This study suggests two interesting and important points. First, changing stigma or understanding of mental illness is not necessary to change behavior.[382] 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 like the acted-out scenarios.[383]

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.[384] In this context, virtual reality consists of an immersive, three-dimensional world that participants enter using a head-mounted display, where they can move freely while simultaneously interacting with objects and communicating with non-player characters.[385] Virtual reality trainings can be advantageous because they: (1) provide a controlled environment to response 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.[386] 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 access.[387]

In one study, researchers used virtual reality to recreate live-action role-playing scenarios that had been used in a previous study, and thus, was able to specifically evaluate the comparative

[380] Krameddine, p. 1.
[381] Krameddine, pp. 5-8.
[382] Krameddine, p. 8.
[383] Krameddine, p. 8.
[384] Lavoie, et al., *Training police to de-escalate mental health crisis situations; Comparing virtual reality and live-action scenario-based approaches* (2023)17 Policing: A Journal of Policy and Practice, pp. 1-12, (Lavoie) https://doi.org/10.1093/police/paad069. This study includes some of the researchers from the first study discussed in this section.
[385] Lavoie, p. 2.
[386] Lavoie, p. 2.
[387] Alanis & Pyram, *From simulations to real-world operations: Virtual reality training for reducing racialized police violence* (2022) 15 Industrial and Organizational Psych. 4:621-625, https://doi.org/10.1017/iop.2022.80.

efficacy of the simulation training offered in virtual reality and live action compared to a control group in improving leaning outcomes.[388] 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.[389] 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.[390]

It also appears that it is possible to use virtual reality to deliver interactive trainings directly to individuals with behavioral health conditions, which can lower barriers and costs when such 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 ASD.[391] 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.[392] 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 ASD interventions.[393]

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.[394] Usability scores were high, and 80 percent of participants expressed a desire to use the platform again.[395] 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.[396] Though more research is needed, the availability of virtual reality to deliver training to those with behavioral health conditions may provide a helpful avenue to increase the resources available to this community.

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.[397] 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

[388] Lavoie, , p. 3.
[389] Lavoie, , pp. 7-10.
[390] Lavoie, , p. 10.
[391] 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) 13 Autism Research 8:1418-1424, (McCleery) https://doi.org/10.1002/aur.2352.
[392] McCleery, pp. 1419-1420.
[393] McCleery, p. 1418.
[394] McCleery, pp. 1420-1421.
[395] McCleery, pp. 1420-1422.
[396] McCleery, p. 1419.
[397] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Lieutenant II Jonathan Larsen and Detective III Elizabeth Reyes, https://www.youtube.com/watch?v=yWRnfEr33es.

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."[398]

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 behavioral health conditions. This can include repetition both during a single training, and follow-up and refresher training some amount of time after an initial training.

For example, one 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.[399] For example, the CIT in 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.[400] 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 where everybody can get continual training is key and paramount to the success of any of these programs, especially ours."[401] 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.[402] Training that mirrors the situations officers routinely face on the street not only reinforces retention but also increases the likelihood that officers will apply what they've learned in their day-to-day work.

Training Survey Results

As discussed in the introduction, the Council conducted a case study model review of trainings throughout the state and developed uniform review tool to record the Council members' impressions. Because of a turnover in Council membership during the middle of the review period, eight of the nine Council members attended and reviewed a total of 24 trainings between May and November 2025.

The Council was able to review a wide variety of trainings. The trainings that the Council reviewed targeted a mix of patrol officers, corrections officers, and dispatch staff. Targeted

[398] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Detective III Elizabeth Reyes, https://www.youtube.com/watch?v=yWRnfEr33es.
[399] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Mark Stadler, https://www.youtube.com/watch?v=yWRnfEr33es.
[400] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Mark Stadler, https://www.youtube.com/watch?v=yWRnfEr33es.
[401] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Lieutenant II Jonathan Larsen and Detective III Elizabeth Reyes, https://www.youtube.com/watch?v=yWRnfEr33es.
[402] SB 882 Council Meeting (July 15, 2025) Testimony of Michelle Saunders, LCSW, VIDEO LINK.

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, like Autism, for example, 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 training agencies included a mix of POST, 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 hours 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 with law enforcement professionals, most were developed with behavioral health personnel, and most were developed with community input.

Across trainings reviewed, the most commonly emphasized learning and resources 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 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 trainee, 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 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 such

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.

> [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, seeking understanding, etc." 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.

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.

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 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, information on disabilities was sometimes outdated including terminology. One training used “terms like "epidemic," "high functioning," "Aspergers," the focus on children, 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. 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, the Council witnessed many instances of effective and respectful trainings that offered opportunities to engage with the material through scenarios and role play, included passionate trainers, included trainers with lived experience and preferably 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 overlap of training coverage, over a longer period of time than the limited term of the Council, could be helpful.

Recommendations

Content of Training for Law Enforcement or Other Government Personnel

- Develop training for law enforcement on the spectrum of diagnoses including people with multiple conditions.

- Require POST to:
    - Update the content of Learning Domain 37 and in consultation with subject matter experts, including, but not limited to, the Department of Developmental Services, the Department of Health Care Services, organizations with expertise in

the SB 882 populations, and people with lived experience as a person in the SB 882 population or a family member or caregiver of such a person.
    - Increase required hours of training related to Learning Domain 20 from 16 to 20 hours, with the 4 additional hours focused on de-escalation techniques and principles specifically in the context of the SB 882 population.
    - Increase required hours of training related to Learning Domain 37 from 15 to 20 hours, with the 5 additional hours focused both on interacting with people with IDD and on practical exercises.
    - Require specific training for POST-certified trainers who provide Learning Domain 37 courses. Alternatively, provide DDS annual allocation to provide train-the-trainer courses for POST-certified trainers related to IDD and law enforcement. Allocation to DDS to include one full-time staff and funds for limited-term, intermittent consultants to serve as co-trainers/panelists to provide a lived-experience component.

- Advocate for policy and curriculum reform.
    - Recommend that POST formally integrate MHD/IDD considerations into de-escalation standards and include subject matter experts in curriculum review processes.
    - Initiate discussions with POST and academic partners to support curriculum updates and research.

- Require the California Office of Emergency Services to develop training for dispatch on handling third party calls that may involve a caregiver—what to screen for, prompts they can present, criteria for sending out law enforcement and how to code it. This guidance should be developed in consultation with subject matter experts, including, but not limited to, the Department of Developmental Services, the Department of Health Care Services, organizations with expertise in the SB 882 populations, and people with lived experience as a person in the SB 882 population or a family member or caregiver of such a person.

- Integrate MHD/IDD into de-escalation training. Embed MHD/IDD-specific scenarios and considerations into POST learning domains, emphasizing time, distance, and family involvement. Additionally, embed information and strategies for differentiating causation of certain behaviors requiring law enforcement response, and how different causations may impact intervention strategy, where helpful and appropriate. Trainings should include how to identify potential physical or mental conditions.

- Consider including in training options for decision-making that include complete disengagement. Study agencies that have adopted these policies, such as San Francisco

Police Department, which has a disengagement policy that establishes protocols for disengage from a barricaded/isolated subject. (See SFPDDGO_5_24_20230606.pdf

- Add Autism/IDD-specific modules to CIT training, focusing on differentiating autism meltdowns from psychiatric crises, strategies for de-escalation, and communication in both contexts.

- Train for different settings with potentially different responses, e.g., if CFS (call for service) is at a residence v. in the street. Responses may be different.

- Ensure trainings cover culture and local history of interactions and how those can lead to escalation. For example, having law enforcement officers share information on family members who are in the SB 882 Population to build trust and understanding among officers.

- Collaborate with subject matter experts, including professionals who work with people with MHD/IDD and community advocates, to co-develop training modules.

Law Enforcement Training Delivery and Process

- Develop field-ready resources and make them accessible via QR codes, mobile apps, and patrol vehicle desktops. For example, this could include: (1) training bulletins on black letter law; (2) best practices for different situations; (3) if/then guides; (4) relevant protocols.

- Create a centralized training hub/library.
    - Target audiences: law enforcement, medical professionals, non-profits, facilities like group homes and Regional Center vendors.
    - Library to include: trainings, recommendations, and sample policy language other agencies can access.
    - Access: Include mobile training units that can be "checked out" especially for smaller and rural agencies.

- POST Training Portal**:** Encourage all agencies to learn how to use the POST training portal for standardized access.
    - POST Training. Suggest POST continue to review third party trainings/products and link to POST training portal where appropriate.

- Micro-learning at briefings: Integrate short video reviews (e.g., YouTube body-cam footage) to discuss real scenarios, what went well, and what could be improved. (For

example, third-party videos, scenes on the news through third-party sources, in-house videos, or other agencies' incidents of community concern, other agencies posting of events.)

- Self-paced, interactive training modules featuring scenario-based decision trees, accessible through a secure online portal. Officers can complete these modules asynchronously, making it convenient for rural departments and those with varying schedules. To keep engagement high, the training should include realistic decision-tree scenarios where officers make choices and receive immediate feedback on outcomes. These branching pathways adapt to responses—providing extra resources for incorrect choices and unlocking advanced content for correct ones. Combined with interactive quizzes and knowledge checks, this approach ensures officers are actively engaged while reinforcing best practices through real-world decision-making. Consider hosting these on the POST portal for easy access.

- Leverage technology, including simulation technology.
    - Expand the use of virtual reality. Encourage/explore use of virtual reality to enhance training (e.g., goggles or participation in a video game simulated setting). Develop statewide mobile training units available to smaller agencies, and bodycam-based platforms like Pro-Forma to simulate real-world encounters involving individuals with MHD/IDD.
    - Virtual Reality (VR) Training: Provides immersive, scenario-based experiences that enhance decision-making and retention (Brown et al., 2023). While not yet standardized as a best practice, VR provides immersive, scenario-based experiences that enhance decision-making, de-escalation skills, and situational awareness. [Early research and pilot programs demonstrate improved engagement and knowledge retention among officers, particularly in high-stress or complex scenarios.]

Training for Community

- Develop and promote community training programs as the "flip side" of officer training, ensuring persons with IDD and their families learn how to respond effectively to stressful law enforcement interactions.
    - Ensure training includes lived experiences of people with MHD/BD.
    - Have law enforcement train people in the MHD/BD community how to interact with law enforcement. Develop and implement safety trainings for (1) youth/adults with behavioral health conditions and their families; and (2) direct support staff specific to interacting with law enforcement and emergency services.
    - Key Components:
        - Teach how to self-identify (e.g., Blue Envelope or lanyard systems).

        - Explain what to do during a traffic stop or police interaction. Emphasize safety steps, such as not automatically reaching into a wallet—instead, ask the officer when it's safe to move your hands.
        - Offer guidance on managing your own stress signals and staying calm during high-pressure situations.
        - Encourage role-play and scenario-based practice for individuals and families to build confidence.

- Provide a one-time special allocation to 21 regional centers to develop an ongoing service that provides safety training for individuals and direct support professionals specific to interacting with law enforcement and emergency services (including local law enforcement agencies where possible).

- Evaluate and enact legislation to integrate into the education system and curricula training and skills on how students can safely interact with law enforcement and interactions with law enforcement officers generally.
    - Any legislation should include positive and structured interactions with School Resource Officers so that students with disabilities can get used to interacting with officers and have continuity from school setting to other settings. For schools without School Resource Officers, interaction with officers can still be part of curriculum where officers and educators work together to teach students how to safely interact with officers.
    - Any legislation should consider requiring that experts be involved in developing the curricula. For example, a speech pathologist can develop a signal that helps individuals communicate non-verbally with law enforcement officers that they are experiencing a crisis. Once a signal is developed, educators can educate individuals and officers to utilize the signal.
    - Any legislation should consider requiring the integration into Individual Program Plans or Individual Education Plans skills and tips on how to interact with law enforcement (without necessarily having law enforcement come to plan meetings).

- Evaluate and enact legislation that requires the training of private security officers, especially those who are able to carry a firearm, in the same manner police officers are trained, during or after certification.