[DRAFT] Report of the SB 882 Advisory Council on Improving Interactions between People with Intellectual and Development Disabilities and Law Enforcement

April 2026

Contents

Background

California law enforcement currently plays an integral role in interactions with people with behavioral health conditions. Since the deinstitutionalization movement from the 1950s to the 1970s, law enforcement officers are the frequently the first responders to calls regarding people experiencing a behavioral crisis. Data and research suggest high rates of contact between people with behavioral health conditions and law enforcement, often with worse outcomes. People with disabilities have legal rights during these interactions. Presently, people with mental health disabilities are offered varied services from an eclectic set of providers—people have access to different services depending on where they live, their income, and what insurance they have, among other variables. People with intellectual and developmental disabilities, on the other hand, are entitled to services coordinated through a regional center.

How law enforcement became the primary responders to behavioral health crises

Law enforcement are the primary responders to calls where such people may be a suspect, victim, or witness of a crime. Officers often respond to calls regarding a person being dangerous to themselves or others due to behaviors that stem from a disability. Law enforcement responds to missing people reports related to such people. Officers also transport people in crisis to an emergency room or psychiatric outpatient center, or as part of a 5150 hold. And officers encounter such people in their routine course of work, such as while on patrol. In most California jurisdictions, law enforcement is the default responder to people experiencing a behavioral health crisis.

Most academics agree that the de-institutionalization of mental health services and the failure to adequately increase outpatient treatment capacity are integral factors in law enforcement becoming the default responders to behavioral health crises.[1] But recent work expands on this understanding to include two more factors: procedural changes in the voluntary commitment process and changes in policing practices.[2]

The Deinstitutionalization of Mental Health Care and Increased Procedural Protections Against Involuntary Commitment

Beginning in the 1950s, there was a broad movement away from mental health care in locked psychiatric institutions and to community-based services. State-run psychiatric institutions were developed in the 1800s as a solution to the poor conditions people with mental health

[1] E.g., H. Richard Lamb, Linda E. Weinberger & Walter J. Decuir, Jr., The Police and Mental Health, 53 PSYCHIATRIC SERVS. 1266, 1266–67 (2002).

[2] 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," Law and Contemporary Problems, Vol. 86-1 ("Watson & El-Sabawi"), p. 2, https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=5086&context=lcp.

disabilities endured in jails or when hidden away in institutions by family members who did not want their existence known.[3]

But over time, those institutions became fraught with neglect and abuse of the very people the system was 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.[4] Moreover, funding 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.[5]

Community care was 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.[6] Second, society began to recognize the dignity of people with mental health disabilities and the importance of remaining in the community unless removal was absolutely necessary due to danger to self or others.[7]

During this same time—the 1950s to the 1970s—legislators and courts 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 also prohibited states from involuntarily committing patients who were not dangerous.[8] California codified these protections in 1967's Lanterman-Petris-Short Act, discussed later.[9]

As a result, the proportion of people with mental health conditions receiving care in state psychiatric institutions was significantly lower 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.[10]

Despite this combination of closing institutions with public investment community-based mental health services, a shortage of community health centers persists to this day.[11] The

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[3] Nelson, Eric, Dorothea Dix's Liberation Movement and Why It Matters Today,American Journal of Psychiatry Residents' Journal, Dec. 6, 2021, https://psychiatryonline.org/doi/full/10.1176/appi.ajp-rj.2021.170203; 2021 RIPA Report, p. 107, fn. 220; Watson & El-Sabawi, p. 5

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

[5] Watson & El-Sabawi, p. 7.

[6] Id.

[7] Id.

[8] Watson & El-Sabawi, p. 6.

[9] Welf. & Inst. Code, §§ 5001 et seq.

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

[11] Department of Health and Human Services Substance Abuse & Mental Health Servs. Admin., National Mental Health Services Survey (N-MHSS): 2018, Data on Mental Health Treatment Facilities, Oct. 2019,

investment in community-base services has not been sufficient to meet the need. There are insufficient mental health providers across multiple categories of professionals across California. County clinics can be sparse, especially in rural areas, and struggle to staff positions due to competition with the private sector. 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 implementation of Medicaid).

Changes in Policing

Over the last several decades, policing practices have changed in a direction that has tended to increase contacts between law enforcement and people with behavioral health conditions. For example, the President's 21st Century Task Force advocated a community policing approach, which meant increased interactions between law enforcement and members of the community.[12] Community policing employs organizational strategies and partnerships to proactively address crime and the fear of crime.[13] Community policing has become the predominant model of policing among California law enforcement agencies.

Following these shifts, law enforcement grew to play an integral role in mental health care. 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 law enforcement 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.[14]

Moreover, law enforcement has been tasked with initiating many involuntary commitments. At least 25 states including California allow law enforcement officers to start commitment proceedings, while 22 states include police officers as an "interested person" eligible to commence such a proceeding.[15] While the number of state hospital beds for adults with serious

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https://www.samhsa.gov/data/report/national-mental-health-services-survey-n-mhss-2018-data-mental-health-treatment-facilities.

[12] Created by President Obama, the 21st Century Policing Task Force was a national task force charged with developing strategies to strengthen community policing and improve trust between law enforcement officers and their communities. President's Task Force on 21st Century Policing. 2015. Final Report of the President's Task Force on 21st Century Policing. Washington, pg. 41, DC: Office of Community Oriented Policing Services, https://www.govinfo.gov/content/pkg/GOVPUB-J36-PURL-gpo64136/pdf/GOVPUB-J36-PURL-gpo64136.pdf.; Community Oriented Policing Services, U.S. DOJ, Community Policing Defined, 2014, . https://portal.cops.usdoj.gov/resourcecenter/content.ashx/cops-p157-pub.pdf.

[13] Id.

[14] Describe CA civil commitment process and SB 43. See for background: 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/.

[15] Watson & El-Sabawi, p. 17.

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.[16]

Statistics Regarding Law Enforcement Contact with People with Behavioral Health Conditions

Numerous studies have demonstrated that people with behavioral health conditions 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 are three times more likely to be arrested compared to the general population.[17]

Disparities also appear when people with behavioral health conditions interact with law enforcement as victim/survivors or witnesses. Research suggests that law enforcement officers are less likely to investigate and take action on reports that come from people with a perceived mental health or developmental disability.[18]

California required reporting on perceived disability as one of the elements to be reported about people stopped by law enforcement before SB 882. The data collection measures in SB 882 bolster those requirements by requiring that use-of-force incidents that result in serious injury include an officer's perception of whether the person has a mental disability.

California's Racial and Identity Profiling Act of 2015 (RIPA or the Act) requires that law enforcement officers record certain perceived demographic information, including mental disability, when they engage in vehicle and pedestrian stops.[19] Since its creation, the RIPA Board established by the Act has produced annual reports regarding these stops.[20] 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. 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."[21]

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[16] Treatment Advocacy Center Office of Research and Public Affairs, Prevention Over Punishment: Finding the Right Balance of Civil and Forensic State Psychiatric Hospital BedsTreatment Advocacy Center, January, 2024, https://www.tac.org/wp-content/uploads/2024/01/Prevention-Over-Punishment-Full-Report.pdf,; cited in Mental health | Prison Policy Initiative.

[17] Watson & E-Sabawi, fn. 90.

[18] Watson, Amy, Corrigan, Patrick, and Ottati, Victor, 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.

[19] Pen. Code § 13012.

[20] Pen. Code § 13519.2(j); RIPA Board reports are available online at https://oag.ca.gov/ab953/board/reports.

[21] Racial and Identity Profiling Advisory Board, 2025 Annual Report, pg. 32, Jan. 1, 2025, https://oag.ca.gov/system/files/media/ripa-board-report-2025.pdf.

That 2025 RIPA Report analyzed more than 4.7 million police and pedestrian stops conducted in 2023.[22] The RIPA Board found that officers reported perceiving a disability in only 1.1% of all stops, though perceived mental health disabilities accounted for nearly 65% of all reported perceived disabilities.[23] Nonetheless, 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 disability.[24] People with perceived disabilities were arrested in 28% of all stops—more than twice as frequently as people without perceived disabilities.[25]

California also requires law enforcement agencies to report use of force incidents that result in serious bodily injury or death or involved the discharge of a firearm.[26] These reports must indicate whether the officer observed signs of drug or alcohol impairment, erratic behavior, or "[m]ental, physical, or developmental disability."[27] For calendar year 2024, law enforcement agencies statewide reported a total of 581 such incidents that impacted 592 civilians.[28] Of those 592 civilians, officers perceived no impairment, erratic behavior, or disability in 322.[29] Officers perceived a mental health disability in 88 of the of the remaining 270 individuals and only one person with an intellectual or developmental disability.[30] In these encounters, officers discharged their firearms at 54.5% of those people with perceived mental health disabilities, with 43 in fact being shot.[31] 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.[32] The one person suspected of having an intellectual or developmental disability was subjected to an "[o]ther control hold/takedown."[33]

[22] Racial and Identity Profiling Advisory Board, 2025 Annual Report, pg. 32, Jan. 1, 2025, https://oag.ca.gov/system/files/media/ripa-board-report-2025.pdf.
[23] 2025 RIPA Report, p. 25.
[24] (2025 Report, p. 30.)
[25] 2025 RIPA Report, p. 33
[26] Government Code § 12525.2.
[27] Government Code § 12525.2(b)(12).
[28] California Dept. of Justice, Use of Force Incident Reporting 2024, p. 2, 2024, https://data-openjustice.doj.ca.gov/sites/default/files/2025-07/USE%20OF%20FORCE%202024%20final.pdf (*exec summary*)
[29] Use of Force Incident Reporting 2024, p. 39, tab. 18
[30] Use of Force Incident Reporting 2024, p. 39, tab. 18 (because officers can code more than one perceived impairment, the total number of coded impairments—688—is greater than the 592 individual people reported on).
[31] Use of Force Incident Reporting 2024, p. 40, tab. 19
[32] Use of Force Incident Reporting 2024, p. 40, tab. 19
[33] Use of Force Incident Reporting 2024, p. 40, tab. 19

Interactions between youth with behavioral health conditions and law enforcement can be particularly traumatizing. RIPA data shows that such encounters are more frequent for these youth than for youth without such disabilities.

The 2025 RIPA Report, analyzing California stop data from 2023, provides a window into the disproportionate stops of youths—ages 12-24—with perceived disabilities, though it does not disaggregate behavioral health conditions from other disabilities. The RIPA Board found disability disparities in stops of individuals involving calls for service, and in the use of field interview cards.[34] "The RIPA data show officer interactions with youth frequently result in the use of force and that the use of force is directed disproportionately against youth of color, youth with disabilities, and gender minority youth."[35]

Disparities were noted for actions taken during a stop if the youth stopped was perceived to have a disability. For example, 12.2 percent of youths without a perceived disability were searched.[36] By contrast, 46.8 percent of youths with any perceived disability were searched.[37] Likewise, "youths who were perceived to have a disability experience force in a higher percentage than youth with no perceived disability, across all youth age groups."[38] That difference is largest for youth ages 18–24 where 52.07% of stops of youth perceived to have a disability involved the use of force compared to just 9.89 % of stops of youth perceived not to have a disability.[39] Youths with a perceived disability were more likely to be handcuffed during a stop than youths without a perceived disability.[40] Officers pointed a firearm at youths perceived to have disabilities in 67 stops in 2023, though none were reportedly discharged.[41]

Disproportionate Incarceration of People with Behavioral Health Conditions

People with behavioral health conditions are disproportionately represented in the country's penal institutions. This is particularly true for people of color with such disabilities.

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 behavioral health condition, but some facilities report that the number may be as high as half .[42] One 2017 study notes that "[t]he rate of mental disorders in the incarcerated population is 3 to 12 times higher

[34] 2025 RIPA Report, p. 10
[35] 2025 RIPA Report, p. 10
[36] 2025 RIPA Report, p. 33
[37] 2025 RIPA Report, p. 33
[38] 2025 RIPA Report, p. 60.
[39] 2025 RIPA Report, p. 61.
[40] 2025 RIPA Report, p. 61.
[41] 2025 RIPA Report, p. 61.
[42] Fuller, Doris et al., Overlooking in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters, Treatment Advocacy Center Office of Research & Public Affairs, Dec. 2015, https://www.tac.org/wp-content/uploads/2023/11/Overlooked-in-the-Undercounted.pdf.

than that of the general community."[43] Once incarcerated, people with mental health conditions also face insufficient access to mental health services. According to one study, 33% of people in state prisons with "chronic mental illness" have not had any treatment since incarceration.[44] Incarcerated individuals with behavioral health conditions are also 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].[45]

In addition to being overrepresented in the carceral population, individuals with behavioral 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 behavioral health conditions, regardless of the diagnosis.[46]

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

These increased law enforcement interactions result in three broad types of harm: an increase in symptoms of the person's behavioral health condition, 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, people with behavioral health conditions can experience stresses including fear for their lives or safety, humiliation, and stigma.[47] 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

[43] Wolff, "Fact Sheet: Incarceration and Mental Health," Weill Cornell Medicine Psychiatry (2017), available at Fact Sheet: Incarceration and Mental Health | Weill Cornell Medicine Psychiatry, citing Teplin, L. A. (1990). The prevalence of severe mental disorder among male urban jail detainees: comparison with the Epidemiologic Catchment Area Program. *American Journal of Public Health*, 80(6), 663–669; Cook County Sherriff Thomas Dart, quoted in Matt Ford, "America's Largest Mental Hospital is a Jail," *Atlantic Monthly,* June 8, 2015. and Council of State Governments Justice Center, 2013, cited in Prins, SJ, "Why Determine the Prevalence of Mental Illnesses in Jails and Prisons?" *Psychiatric Services*, 65(8), p. 1074.

[44] Prison Policy Initiative, Research on the prevalence and treatment of mental illness in the criminal legal system, n.d., https://www.prisonpolicy.org/research/mental_health/, citing Widra, Emily, New research links medical copays to reduced healthcare access in prisons, Aug. 29, 2024, https://www.prisonpolicy.org/blog/2024/08/29/fees-limit-healthcare-access/#limitedhealthcareaccess.

[45] Prison Policy Initiative, at 58.

[46] Wolff, "Fact Sheet: Incarceration and Mental Health," Weill Cornell Medicine Psychiatry (2017), available at Fact Sheet: Incarceration and Mental Health | Weill Cornell Medicine Psychiatry, citing Baillargeon J, Binswanger IA, Penn JV, Williams BA, Murray OJ. (2009), Psychiatric disorders and repeat incarcerations: the revolving prison door. *Am J Psychiatry*, 166(1): 103–109, https://psychiatryonline.org/doi/10.1176/appi.ajp.2008.08030416.

[47] Watson and El-Sabawi, p. 18, fn. 97-99, 101.

police stops in a sample of predominantly people of color.[48] The study noted as well an association between recent interaction with law enforcement and "psychotic experiences, suicide ideation, and suicide attempts."[49] 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" behavioral health conditions.[50]

Second, interactions between people with behavioral health conditions and law enforcement result in higher rates of uses of force than interactions with individuals who do not have a behavioral health condition. 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 times more likely to be injured than people without serious mental illnesses.[51] Analyzing these data, this study found that people with behavioral health conditions constitute 17 percent of use of force cases and 20 percent of suspects injured during law enforcement interactions.[52] Another study indicated that police may be more likely to use electronic control devices used on them and use more shocks on people experiencing behavioral health crises than in cases that involve the arrest for a criminal offense.[53]

Finally, encounters between law enforcement and people with behavioral health conditions 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.[54] A 2015 "real-time" nationwide database of deadly police encounters operated by the Washington Post found that "signs of mental illness" were noted in at least 25% of fatal

[48] Watson & El-Sabawi, p. 18, citations to fns. 100-101 omitted.
[49] Watson & El-Sabawi, p. 18, citations to fn. 102 omitted.
[50] Watson & El-Sabawi, p.. 18-19, citations to fn. 103 omitted, available at 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
[51] Laniyonu, A., Goff, P.A. Measuring disparities in police use of force and injury among people with serious mental illness. *BMC Psychiatry* 21, 500 (2021). https://doi.org/10.1186/s12888-021-03510-w, available at https://rdcu.be/eieqC, https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-021-03510-w; Wood, Jennifer, and Watson, Amy, "Improving police interventions during mental health-related encounters: Past, present and future," Policing Soc. 2017 ; 27: 289–299. doi:10.1080/10439463.2016.1219734 (people with behavioral conditions were twelve times more likely to experience use of force and ten times more likely to be injured than).
[52] Goff, *supra*.
[53] Watson & El-Sabawi, fn. 95.
[54] 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*, p. 30, fns. 25, 27, and 30, hereafter "Vera Institute Report".

incidents in a nine-month sample.[55] That same databases reported 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 were explicitly called to help the person get medical treatment, and shot them instead.[56]

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 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.[57]

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.[58] 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.[59] Under both, 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.[60] Major life activities include such things as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.[61] To be substantially limited means that such activities are restricted in the manner, condition, or duration in which they are performed in comparison with most people.[62]

[55] Vera Report, p. 30, fn. 24.
[56] Lowery, Westley et al., Police shootings: Distraught people, deadly results,The Washington Post, June 30, 2015, https://www.washingtonpost.com/sf/investigative/2015/06/30/distraught-people-deadly-results/
[57] Note arrest-related deaths collected data only from 2002-2012) Fuller et al, "Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters," Fuller et al (Dec. 2015) ("Fuller"), available at Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters - Treatment Advocacy Center; Scott, Kevin, Arrest-Related Deaths (ARD), Bureau of Justice Statistics, 2012, https://bjs.ojp.gov/data-collection/arrest-related-deaths-ard
[58] 42 U.S.C. § 12101 et seq.; 29 U.S. Code § 794
[59] 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
[60] 42 U.S.C. § 12102; 34 CFR 104.3(j)
[61] Ibid.
[62] 42 U.S.C. § 12102; 28 CFR 35.108

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.[63] This includes making reasonable modifications in their policies, practices, or procedures that are necessary to ensure accessibility for individuals with disabilities.[64] And the ADA requires officers to take appropriate steps to ensure that communication with people with disabilities are as effective as communications with others.[65]

Section 504 prohibits disability discrimination by any program or activity that receives federal financial assistance.[66] "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.[67]

California Protections

California law also protects individuals with disabilities. While various California laws protect individuals with disabilities with respect to interactions with law enforcement, this brief summary focuses on two: the Lanterman Petris Short Act and the Lanterman Developmental Services Disabilities Act.

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.[68] 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."[69]

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.[70] A 5150 hold can last up to 72 hours, and during that period, mental health

[63] 42 U.S.C. § 12132; 28 C.F.R. § 35.130.
[64] 28 C.F.R. § 35.130
[65] 28 CFR 35.160; *Commonly Asked Questions About the ADA and Law Enforcement*, U.S. Department of Justice Civil Rights Division (last updated Feb. 28, 2020), available at https://www.ada.gov/resources/commonly-asked-questions-law-enforcement/#resources
[66] 29 U.S.C. § 794
[67] Ibid.
[68] Welf. & Inst. Code, §§ 5150, 5250, 5350.
[69] Welf. & Inst. Code, § 5001.
[70] Welf. & Inst. Code, § 5150.

professionals will examine and determine whether the individual can be safely released, whether voluntary services would be appropriate, or whether additional treatment is needed.[71]

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.[72] The LPS Act also sets out procedural protections for people undergoing conservatorship.[73]

The Lanterman Developmental Disabilities Services Act (LDDS Act) established rights for people with developmental disabilities and affords them the same legal rights guaranteed to all other individuals.[74] It also prohibits discrimination against people with developmental disabilities in programs and activities that receive public funds, which includes law enforcement agencies.[75] Under the LDSS 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.[76]

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 law enforcement 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. And in some cases, 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 people with mental health conditions, for people with intellectual and developmental disabilities, and for youth.

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

[71] Welf. & Inst. Code, §§ 5151-5152.
[72] Welf. & Inst. Code, §§ 5325-5325.1
[73] See e.g. WIC § 5350(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.")
[74] Welf. & Inst. Code, § 4502. The services offered under the LDSS Act are discussed further in section XXX below.
[75] *Ibid.*
[76]

a "serious mental illness" that impacts tasks of daily living.[77] There are regional variations in the prevalence of mental health conditions, with the highest rates occurring in San Joaquin Valley.[78] 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%.[79] Lack of socioeconomic resources also results in higher rates of serious mental health diagnosis that 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 earning three times the FPL.[80] Nearly two-thirds of Californians reporting some level of mental health need also reported not getting treatment.[81]

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.[82] However, the number of Californians who die by suicide has increased more than 50% since 2001, during which time the state population only increased by 14%.[83] 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.[84] 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.[85] Trinity County has an especially high rate of 34 per 100,000.[86]

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[77] California Health Care Foundation (CHCF), Mental Health in California: For Too Many, Care Not There, California Health Care Almanac, March 2018, https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf.

[78] CHCF, https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf.

[79] CHCF, https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf; Ramos-Yamamoto, Adriana, Californians and Mental Health: What We Know About Poverty and Race, California Budget & Policy Center, March 2018, https://calbudgetcenter.org/resources/californians-and-mental-health-what-we-know-about-poverty-and-race/.

[80] Ramos-Yamamoto, https://calbudgetcenter.org/resources/californians-and-mental-health-what-we-know-about-poverty-and-race/ Data from 2015, when the FPL was $11,700 for a single person and $24,250 for a family of four.

[81] CHCF, https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf.

[82] CHCF, https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf.

[83] Wiener, Jocelyn, Breakdown: California's mental health system, explained, last updated Sept. 17, 2020, https://calmatters.org/explainers/breakdown-californias-mental-health-system-explained/.

[84] 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.

[85] CHCF, https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf.

[86] Wiener, https://calmatters.org/explainers/breakdown-californias-mental-health-system-explained/.

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.[87] 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.

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.[88] 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.[89] 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.[90]

In the public mental health system, federal and state governments have a role in funding, governance, and oversight of public treatment settings, and set minimum standards of care, but otherwise give counties discretion in how to spend funds and operate county mental health services.[91] 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.[92]

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.[93] Hospitals include Acute Psychiatric

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[87] 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.
[88] California Budget & Policy Center, *Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding* (2020) https://calbudgetcenter.org/app/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.
[89] Id.
[90] Weiner, https://calmatters.org/explainers/breakdown-californias-mental-health-system-explained/.
[91] California Budget & Policy Center, *Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding* (2020) https://calbudgetcenter.org/app/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.
[92] California Budget & Policy Center, *Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding* (2020) https://calbudgetcenter.org/app/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.
[93] California Budget & Policy Center, *Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding* (2020) https://calbudgetcenter.org/app/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.

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.[94] Counties may offer residential treatment options including board and care facilities, mental health rehabilitation centers, or skilled nursing facilities.[95]

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.[96] 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.[97] 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 in particular.[98]

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 .[99] 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.[100] 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.[101]

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[94] California Budget & Policy Center, *Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding* (2020) https://calbudgetcenter.org/app/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.

[95] California Budget & Policy Center, *Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding* (2020) https://calbudgetcenter.org/app/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.

[96] California Budget & Policy Center, *Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding* (2020) https://calbudgetcenter.org/app/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.

[97] Weiner, https://calmatters.org/explainers/breakdown-californias-mental-health-system-explained/.

[98] Weiner, https://calmatters.org/explainers/breakdown-californias-mental-health-system-explained/.

[99] CHCF, https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf.

[100] CHCF, https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf.

[101] CHCF, https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf. 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.

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.[102]

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.[103] Set to be implemented over the years 2024 to 2026, as of publication of this report Prop 1 had awarded $3.3 billion in funds to create over 5,000 residential treatment beds and 21,000 outpatient treatment slots, and was initiating a second round of funding for treatment facilities and supportive housing.[104] According to Prop 1, all counties are to implement new three-year comprehensive behavioral health services plans beginning in 2026.[105] 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.[106] Just under half of these (301,000) receive services from the State's network of regional centers, and of these clients, about two-thirds are men and one-third are women.[107] Approximately

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[102] California Budget & Policy Center, *Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding* (2020) https://calbudgetcenter.org/app/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.

[103] See, e.g., https://www.mentalhealth.ca.gov/accountability.html - implementation 2024-2026

[104] https://www.mentalhealth.ca.gov/accountability.html - implementation 2024-2026; 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*, 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/

[105] https://www.mentalhealth.ca.gov/accountability.html - implementation 2024-2026

[106] California State Council on Developmental Disabilities, https://scdd.ca.gov/about/; State Council on Developmental Disabilities (SCDD), Some Snapshots of People with I/DD in California, n.d., https://scdd.ca.gov/wp-content/uploads/sites/33/2020/06/People-with-IDD-in-California-Snapshot-5.27.20-ACCESSIBLE.pdf.

[107] SCDD, https://scdd.ca.gov/wp-content/uploads/sites/33/2020/06/People-with-IDD-in-California-Snapshot-5.27.20-ACCESSIBLE.pdf.

.24% of the California population are seniors with intellectual or developmental disabilities, while around .3% are youth with intellectual or developmental disabilities.[108]

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 Developmental Services Act (Lanterman Act).[109] The Lanterman Act defines "developmental disability" as a "disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual."[110] The term includes intellectual disability, cerebral palsy, epilepsy, and autism.[111] 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.[112] 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.[113]

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.[114] Regional centers offer direct services or case management support to obtain needed services elsewhere, and serve clients for as long as they meet severity criteria, which for most people will mean they qualify for services throughout their lifetime.[115] Services are broad and include employment programs, adult day services, family homes, home health supports, independent living services, residential care homes, and other offerings.[116] Regional

[108] SCDD, https://scdd.ca.gov/wp-content/uploads/sites/33/2020/06/People-with-IDD-in-California-Snapshot-5.27.20-ACCESSIBLE.pdf.
[109] Department 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.
[110] Welf. & Inst. Code, § 4512, subd. (a)(1).
[111] *Ibid.*
[112] Welf. & Inst. Code, § 4500 et seq.
[113] Welf. & Inst. Code, § 4502(b).
[114] Welf. & Inst. Code, § 4620.
[115] Disability Rights California, Can I lose my regional center eligibility?, Rights under the Lanterman Act, https://rula.disabilityrightsca.org/rula-book/chapter-2-eligibility-for-regional-center-services/can-i-lose-my-regional-center-eligibility/.
[116] California Department 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.

centers offer services that respond to crisis, including residential crisis services and mobile crisis teams that respond to short-term crisis in the community.[117] So regional center providers may encounter instances where law enforcement is also present when responding to a crisis involving a regional center client.

The case management available at regional centers assists clients to connect with the right level of services for them, and so is a valuable resource for law enforcement 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.[118] The IPP must be tailored to the particular client and give the individual an opportunity to actively participate in the development of the plan.[119] 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.[120]

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.[121] Some of this increase is from a move to fully funded rate models that began in the 2024-2025 budget year.[122] The Legislative Analyst's Office estimates that a majority of the increase reflects growth in caseload and increases in the utilization of services.[123]

[117] California Department of Developmental Services, Regional Center Services and Descriptions, https://www.dds.ca.gov/wp-content/uploads/2019/03/RC_ServicesDescriptionsEnglish_20190304.pdf.
[118] Welf. & Inst. Code, § 4646; Department of Developmental Services, A Guide to California's Regional Center Services System, https://www.dds.ca.gov/wp-content/uploads/2025/02/Guide_to_Californias_Regional_Center_Services_System.pdf.
[119] *Ibid.*
[120] Disability Rights California, *Rights Under the Lanterman Act, What other agencies provide services and supports?,* https://rula.disabilityrightsca.org/rula-book/chapter-1-the-lanterman-act/what-other-agencies-provide-services-and-supports/.
[121] Petek, Gabriel, The 2025-26 Budget: Department of Developmental Services, Legislative Analyst's Office, fig. 1, March 2025, https://lao.ca.gov/Publications/Report/5008
[122] Petek, https://lao.ca.gov/Publications/Report/5008.
[123] Id.

During the decade preceding this report, California general funds accounted for about 60% of this while the remaining 40% is primarily federal Medicaid funding.[124] California's 2025-2026 budget allocated $11.8 billion in state funds to the Department of Developmental Services.[125] 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.[126]

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.

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.[127] 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.[128] Young people's behavioral health is particularly impacted by poverty, with 10% of youth with family incomes below the FPL showing "serious emotional disturbance."[129]

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.[130] Likewise young

[124] Petek, https://lao.ca.gov/Publications/Report/5008, fig. 1.
[125] AB 102 (2025), Budget Act of 2025, Item 4300-101-0001 https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB102.
[126] Sergent, Jim, 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/.
[127] California Budget & Policy Center, *Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding* (2020) https://calbudgetcenter.org/app/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.
[128] California Budget & Policy Center, *Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding* (2020) https://calbudgetcenter.org/app/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.
[129] The California Budget Center defined 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" https://calbudgetcenter.org/resources/californians-and-mental-health-what-we-know-about-poverty-and-race/.
[130] California Budget & Policy Center, *Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding* (2020) https://calbudgetcenter.org/app/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.

children can qualify for regional center services based on a risk of being later-identified as having an intellectual or developmental disability or an existing set of symptoms that impact life activity.[131] 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.[132] 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.[133]

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 people with behavioral health conditions 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. These 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

[131] Disability Rights California, *Rights Under the Lanterman Act,* https://rula.disabilityrightsca.org/rula-book/chapter-2-eligibility-for-regional-center-services/2-2-can-someone-without-a-developmental-disability-apply-for-regional-center-services/; Disability Rights California, *Rights Under the Lanterman Act,* https://rula.disabilityrightsca.org/rula-book/chapter-2-eligibility-for-regional-center-services/2-5-what-is-provisional-eligibility/.

[132] McDonalds, John, UCLA Report: Unmasking School Discipline Disparities in California, The Center for Civil Rights Remedies, July 2022, 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.

[133] Youth Law Center, Youth Arrests in Group Homes and Shelters, https://www.ylc.org/wp-content/uploads/2018/11/YLC-Roundtable-Presentation-070618.pdf.

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 law enforcement 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.[134] 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 interventions in California can better address the needs of people with behavioral health conditions when they interact with law enforcement.

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.[135] Also known as the Memphis model, CIT came about in the wake of a 1988 deadly shooting in Memphis, Tennessee, of a Black man diagnosed with schizophrenia who was suffering a mental health crisis.[136] The mission of the CIT model is to "reduce deaths that can occur during interactions between law enforcement and people experiencing a mental health

[134] 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, Jennifer, Watson, Amy, "Improving police interventions during mental health-related encounters: Past, present and future," Policing Soc. 2017; 27: 289–299 (Wood), doi:10.1080/10439463.2016.1219734, available at Improving police interventions during mental health-related encounters: Past, present and future - PMC.

[135] https://www.citinternational.org/; see also University of Memphis' CIT Center (http://cit.memphis.edu/).

[136] Fuller, Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters - Treatment Advocacy Center, fn. 68-70; Watson & El-Salawi, fn. 105; Wood, p. 5.

crisis and to divert these individuals, when appropriate, away from the criminal justice system and into treatment."[137]

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 program relies upon significant coordination and collaboration with community resources and mental health professionals.[138] 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.[139]

The traditional 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.[140] 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 the model.[141] Initially, the Memphis team envisioned that 20–25% of officers in a given agency would receive CIT training to ensure availability across shifts. [142] However, some agencies

[137] Duff, Jonathan et al., "Issues in Law Enforcement Reform: Responding to Mental Health Crises," Congressional Research Service (October 17, 2022) (CRS Report), fn. 28, available at https://www.congress.gov/crs-product/R47285?q=%7B%22search%22%3A%22r47285%22%7D&s=1&r=1.

[138] Wood, citing Compton et al 2008.

[139] Duff, "Issues in Law Enforcement Reform: Responding to Mental Health Crises," Congressional Research Service (October 17, 2022), hereafter "CRS Report," available at https://www.congress.gov/crs-product/R47285?q=%7B%22search%22%3A%22r47285%22%7D&s=1&r=1.

[140] Watson & Fulambarker, citing McGuire & Bond, 2011.

[141] Watson & Fulambarker, p. x, citing Dupont, Cochran & Pillsbury, 2007.

[142] Watson & Fulambarker, p. x, citing Dupont, Cochran & Pillsbury, 2007.

require 100% of their patrol officers to undergo this training, on the theory that all officers may encounter persons experiencing a mental health crisis.[143]

Training

The traditional CIT model requires officers – who, as noted above, traditionally have volunteered for the program - 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.[144] 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.[145] As discussed below, however, this element 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.[146] The 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.[147] Many departments enhance CIT training by repeating it periodically or by including additional training related to interactions with youths, veterans, and high-risk individuals with repeated contacts with law enforcement.[148] 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 and delirium

[143] Watson & Fulambarker, p. x.
[144] Wilson & el-Salawi, fn. 107; Watson & Fulambarker, p. x, citing Steadman et al 2001.
[145] Duff, "Issues in Law Enforcement Reform: Responding to Mental Health Crises," Congressional Research Service (October 17, 2022) (CRS Report, fn. 31 available at https://www.congress.gov/crs-product/R47285?q=%7B%22search%22%3A%22r47285%22%7D&s=1&r=1
[146] Wilson & el-Salawi, fn. 108-109; Watson & Fulambarker.
[147] Watson & Fulambarker, citing Compton et al., 2011.
[148] Watson & Fulenaker, citing Rosenbaum, 2010.

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 develop partnerships between law enforcement agencies, mental health services, mental health advocates, and other stakeholders.[149] Officers also conduct site visits of community facilities where CIT-trained officers would typically refer civilians for treatment.[150]

Traditional CIT models typically designate a centralized drop-off emergency mental health care facility, which can accept civilians referred by CIT officers.[151] 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. In Chicago, for example, having only one facility is not practical because of the city's size.[152]

Co-response Crisis Team Models

A co-response model generally pairs law enforcement 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. A number of California jurisdictions have adopted this approach. In San Diego County, the Psychiatric Emergency Response Team (PERT) has adopted this approach, investing in officer training, clinician staffing, and public education to refine crisis intervention practices. 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 law enforcement-free response when there is no safety threat. 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. 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. 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.

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.

[149] CRS Report, fn. 31.
[150] CRS Report, fn. 29-30.
[151] CRS Report, fn. 31.
[152] Watson & Fulambarker.

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. San Mateo County's pilot program embeds mental health clinicians directly in four law enforcement departments, enabling a co-response model that is coordinated but flexible—clinicians and officers may respond together or separately depending on the situation. Eureka's 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.[153]

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.

One of the most established examples of this model is the CAHOOTS program (Crisis Assistance Helping Out On The Streets) in Eugene, Oregon, launched in 1989 by the White Bird Clinic. CAHOOTS teams are 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 are unarmed and cannot compel treatment or arrest individuals. They provide 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.[154]

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. Oakland's MACRO program uses similar staffing but is embedded within the city's fire department for institutional support. 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. Additionally, 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. Albuquerque's Community Safety Department (ACS) has established 24/7 civilian-led response units that specialize in homelessness, substance use, and behavioral health. These programs

[153] Crisis Alternative Response of Eureka Program, HHAP 2022 RFP CARE Program Description.docx.
[154] CAHOOTS | Eugene, OR Website. More recently CAHOOTS has transitioned to operate through Lane County's Mobile Crisis Services to comply with new state mandates.

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 people with behavioral health conditions, and about the efficacy of those specialized teams or approaches. Agencies reported primarily utilizing crisis intervention teams and County/City co-responder teams. And about 25% of the agencies use agency co-responder teams, which was the next common specialized team or approach. Some examples of other specialized teams or approaches used by a small number of agencies are phone-based support, "blue envelope" or similar programs, and disability response teams. One in ten agencies do not have any specialized team or approach. Even so, those agencies report partnerships or other approaches that aim to bridge the divide. Most agencies reported that their special teams meet between some (28.2%) and most of the needs (35.9%) in their community.

Other Common Factors

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 teams respond, many programs are also rethinking how calls for service or support are received and responded to. Some, like Berkeley's SCU and MH First, operate entirely outside the 911 system with dedicated hotlines. 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. 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. These alternative access points are key to ensuring that individuals in crisis are not automatically routed into systems designed for criminal or medical emergencies.

In California broadly, 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 mental health crisis.[155] The goal of 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.[156] 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.

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 is variable and there is no one solution for smoothly connecting 911 and 988 systems throughout California.[157] 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.[158] The Department continues to monitor the outcome of such

[155] 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, SAMHSA, last updated Aug. 29, 2025, https://www.samhsa.gov/mental-health/988/lifeline-timeline.

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

[157] Ibid., p. 3

[158] Testimony of Undersheriff Mike Ziegler, July 28, 2025.

calls, and thus far this process has connected hundreds of individuals to behavioral health services and has been connected to no adverse physical outcomes.[159]

California has taken other steps to build a comprehensive 988-crisis 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 (CCMU) 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.[160]

Integration of Peer Support

One 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. 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.

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. Durham's HEART program has a dedicated Care Navigation team to ensure that individuals continue receiving services after the immediate crisis has passed. 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. These programs recognize that recovery and stability are long-term priorities.

[159] Id.

[160] California Health and Human Services, Building California's Comprehensive 988-Crisis System: A Strategic Blueprint, p. 3, Dec. 31, 2024, https://www.chhs.ca.gov/wp-content/uploads/2025/01/AB-988-Five-Year-Implementation-Plan-Final-ADA-Compliant.pdf

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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. 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. The least common resources agencies rely on are day centers and state agencies. About 41% of agencies reported that it would be helpful to have better access to in-patient mental health treatment, besides for the purpose of 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 available, where services are located, and the number of available clinicians.

Evaluation 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.

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.[161] 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.[162] The review 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.[163] However, the review found limited evidence that these interventions reduced re-offending or improved

[161] Kane, et al, Criminal Behaviour and Mental Health, 28(2), at pp. 110, 114.
[162] Kane, et al, Criminal Behaviour and Mental Health, 28(2), at p. 114.
[163] Kane, et al, Criminal Behaviour and Mental Health, 28(2), at p. 115.

mental health outcomes, and recommended further and more empirical research on these topics.[164]

This section will review findings about the efficacy of CIT and of other programs, some obstacles to implementing these response models, and the limitations of the existing data.

CIT Efficacy Research

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.[165] 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.[166] 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.[167] 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.[168] Studies also suggest CIT increases officers' self-confidence in their and their departments' abilities to respond to people having a behavioral health crisis.[169] However, it is unclear whether and how these changes in law enforcement officer mindset go on to change what happens in interactions with people with behavioral health conditions.[170] Indeed, research exploring the impact of implicit bias training

[164] Kane, et al, Criminal Behaviour and Mental Health, 28(2), at pp. 114-115.
[165] Watson, Amy (2010); Fulambarker, Anjali, "The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners" MSW (2012) ("Watson and Fulambarker"), available at nihms500811.pdf, pp. 3-5, citing McGure & Bond 2011.
[166] CRS Report, fn. 61-62.
[167] Vera Institute Report, p. 29; CRS Report, fn. 63.
[168] CRS Report, fn. 63.
[169] Vera Institute Report, p. 29; CRS report, fn. 63; Wells & Schafer, 2006; Borum, Deane, Steadman, & Morrissey, 1998.
[170] CRS Report.

on outcomes suggests that training can result in overconfidence which in turn results in worse outcomes.[171]

Other studies have shown that CIT training may improve an officer's responsiveness and de-escalation decisions.[172] 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 also expressed a preference to use less force. 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.[173] Some research indicates that these improvements do not dissipate after the training, especially for more experienced officers.[174]

However, studies are less clear that CIT training improves outcomes such as reducing uses of force or arrests of people in behavioral health crisis.[175] Some studies have shown a reduction in rates of arrest when officers are CIT-trained.[176] However, others, including a 2016 meta-analysis, do not show any effect of CIT on arrest rates.[177] 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.[178] 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, but the same

[171] Testimony of Dr. Jack Glaser, University of California – Berkeley, July 15, 2025.
[172] Watson & El-Shawali, fn. 111; Wood, p. 5, citing Compton, et al 2006, 2008, 2011, 2014; Ellis, 2014; Ritter et al, 2010; Wells & Shafer, 2006.
[173] Vera Institute Report p. 30.
[174] (Watson & El-Shawali, fn. 111; Wood, p. 5, citing Compton, et al 2006, 2008, 2011, 2014; Ellis, 2014; Ritter et al, 2010; Wells & Shafer, 2006.) ; Vera Institute Report, p. 30; Wood, p 5, citing Compton & Chien, 2008.
[175] Watson & El-Shawali, fn. 112.
[176] Vera Institute Report,,p. 28 (lower arrest rates for agency implementing CIT); Watson & Fulembarker, fn. 61-62; Fuller, Overlooked and Undercounted, fn. 68-70; Compton et al 2014b (in W&F); Franz & Borum, 2011 (in W&F); Steadman et al 2000 (in W&F); Dupont & Cochran, 2000 (in W&F).
[177] Teller, et al 2006 (in W&F); Watson et al 2010 (in W&F)
[178] Marcus & Stergiopoulos, Health Soc. Care Community 30:1665-1679, at p. 1674; Seo, et al., Journal of Criminal Justice 72, at p. 11 ("[D]espite interventions achieving success related to mechanisms (i.e., increasing knowledge, decreasing desire for social distance, etc.) aimed at indirectly improving tangible 'observed' outcomes, they have little effect on 'observed' outcomes of greatest importance (i.e., arrests and use of force)."); Watson, et al., Vera Inst. Of Justice, at 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").

2016 meta-analysis shows no such effect.[179] Some studies also show reduced rates of injury to law enforcement officers or civilians following these encounters, while others do not show this reduction.[180] 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.[181]

Studies do consistently show that people with behavioral health conditions who have interactions with law enforcement officers who use the CIT model are more likely to be connected to care following the encounter.[182] 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.[183] 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.[184]

CIT can also have cost benefits. For example, according to one comprehensive study of a CIT program in Louisville, KY, 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

In general, and as illustrated in more detail above, 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.[185]

[179] Fuller, Overlooked and Undercounted, fn. 68-70; Compton et al 2011 (in W&F); Morabito and colleagues (2012) (in W&F); Skeem and Bibeau (2008) (in W&F)
[180] DuPont and Cochran (2000) (in W&F); Hanafi, Bahora, Demir & Compton, 2008 (in W&F); cf. Kerr, Morabito, & Watson, 2010 (in W&F).
[181] Dupont & Cochran (2000) (in W&F).
[182] Fuller, Overlooked and Undercounted, fn. 68-70; Teller, Munetz, Gil, & Ritter, 2006 (in Wood); Watson & El-Shawali, fn 113; Teller et al 2006; Watson et al 2010.
[183] Watson, Ottati, Draine, & Morabito, 2011 (in W&F).
[184] Wood, p. 5.
[185] Legal Defense Fund, et al., Community-Based Services for Black People with Mental Illness: Advancing An Alternative to Police (Jan. 2023), at p. 15, 2022.07.06-LDF-Bazelon-Brief-re-Alternative-to-Policing-Black-People-with-Mental-Illness.pdf.

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, so law enforcement will have some unavoidable contact with individuals with behavioral health conditions.[186] But, these alternative response models can minimize the contact between law enforcement and people with behavioral health conditions.[187] 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.[188] Many of these response models have only been in operation for a few years, there is huge variation in alternative response models, and controlled studies are difficult.[189] Co-responder models often receive higher community support than law enforcement-only response models, but studies looking at other outcomes have been mixed.[190] One review determined co-responder programs decreased arrests and the amount of time officers spend handling mental health calls, but there was limited evidence on other impacts.[191] One study randomized responses to calls to 911 over a set time period such that some callers received a co-response team (consisting of a CIT-trained officer and a mental health clinician) and others received a law enforcement-as-usual response. The study found no significant differences in event outcomes, including jail booking, outpatient encounters, and emergency department visits.[192] Moreover, many reviewed programs are limited in scope either in terms of hours of availability or geographic area, and programs can be hampered by a lack of mental health resources in the community.[193]

Most studies comparing law enforcement response (typically by CIT-trained law enforcement) to co-response find minimal differences in outcomes such as use of force and arrest.[194] For

[186] Balfour, et. Al., National Association of State Mental Health Program Directors, at pp. 4-5.
[187] Balfour, et. Al., National Association of State Mental Health Program Directors, at pp. 4-5.
[188] Balfour, et. Al., National Association of State Mental Health Program Directors, at p. 12.
[189] See, e.g., Balfour, et. Al., National Association of State Mental Health Program Directors, at 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, at p. 2, https://doi.org/10.1016/j.socscimed.2024.116723; Watson, et al., Vera Inst. Of Justice, at p. 41.
[190] Balfour, et. Al., National Association of State Mental Health Program Directors, at p. 8, citing Watson, et al., , Vera Inst. Of Justice; Lowder, at al., Social Science & Medicine 345, 116723, at p. 2.
[191] Balfour, et. Al., National Association of State Mental Health Program Directors, at p. 8; Legal Defense Fund, et al., Community-Based Services for Black People with Mental Illness: Advancing An Alternative to Police (Jan. 2023), at p. 8.
[192] Lowder, at al., Social Science & Medicine 345, 116723, at p. 1.
[193] Balfour, et. Al., National Association of State Mental Health Program Directors, at p. 8; Watson, et al., Vera Inst. Of Justice, at pp. 20, 44.
[194] See generally, James, et al., Issues in Law Enforcement Reform: Responding to Mental Health Crises, Congressional Research Service (Oct. 17, 2022) R47285, https://www.congress.gov/crs-product/R47285.

example, one meta-analysis of currently implemented training programs and co-responder models did not find either reform to significantly impact law enforcement encounters with people with mental illness in a positive manner.[195] Co-response models perform slightly better than CIT in some measures, but the differences are small.[196] Alternative/community response models appear to perform better than co-response models, but the data is unreliable.[197]

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.[198] 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 those individuals, leading one study to recommend a shift away from relying on the CIT model to support the "development of alternative, evidence-based models that prioritise [sic] the lived experience of service users."[199]

In the U.S., 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.[200] The most positive quantitative data comes from an evaluation of the STAR Program in

[195] Legal Defense Fund, et al., Community-Based Services for Black People with Mental Illness: Advancing An Alternative to Police (Jan. 2023), at p. 16, citing Taheri, Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? A Systematic Review and Meta-Analysis (2016) 27 CRIM. JUSTICE POL'Y REV. 76, 90, https://www.ojp.gov/library/publications/do-crisis-intervention-teams-reduce-arrests-and-improve-officer-safety#:~:text=This%20article%20discusses%20research%20findings%20of%20a%20systematic,and%20to%20train%20police%20officers%20about%20mental%20illness. ; El-Sabawi & Carroll, A Model for Defunding: An Evidence-Based Statute for Behavioral Health Crisis Response (2021) 94 TEMPLE L. REV. 1, 13, https://www.templelawreview.org/lawreview/assets/uploads/2021/12/1.-CarrollEl-Sabawi_FOR-PRINT.pdf; but see Seo, et al., Variation across police response models for handling encounters with people with mental illnesses: A systemic review and meta-analysis (2021) Journal of Criminal Justice 72, at p. 10, https://doi.org/10.1016/j.jcrimjus.2020.101752 (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).

[196] Marcus & Stergiopoulos, Health Soc. Care Community 30:1665-1679, at pp. 1668-1672, 1674.

[197] See, e.g., Marcus & Stergiopoulos, Health Soc. Care Community 30:1665-1679.

[198] James, et al., Congressional Research Service (Oct. 17, 2022) R47285, at p. 9; Watson, et al., Vera Inst. Of Justice, at pp. 21, 24.

[199] Marcus & Stergiopoulos, Health Soc. Care Community 30:1665-1679, at p. 1674; see also Seo, et al., Journal of Criminal Justice 72, at 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.").

[200] Legal Defense Fund, et al., Community-Based Services for Black People with Mental Illness: Advancing An Alternative to Police (Jan. 2023), at p. 15, citing Scottie Andrew, This Town of 170,000 Replaced Some

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.[201] 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.[202] The study estimated that a community response model cost four times less than the direct costs of having law enforcement as first responders.[203] 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.[204]

Although missing key data to effectively compare response types, alternative responses are 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.[205] 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."[206] In contrast, the analysis determined that individuals reported generally positive perceptions of services in co-responder models, and non-law enforcement models.[207]

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 saved $2.16, due to savings in inpatient, outpatient, and emergency department use.[208] 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

Cops with Medics and Mental Health Workers. It's Worked for Over 30 Years, CNN (July 5, 2020, 10:10 PM), https://www.cnn.com/2020/07/05/us/cahoots-replace- police-mental-health-trnd/index.html.

[201] Butler, et al., Brookings Inst., at p. 4.

[202] Dee & Pyne, Science Advances 8, at pp. 3, 6.

[203] Dee & Pyne, Science Advances 8, at p. 7.

[204] Dee & Pyne, Science Advances 8, at p. 6.

[205] Legal Defense Fund, et al., Community-Based Services for Black People with Mental Illness: Advancing An Alternative to Police (Jan. 2023), at p. 8, citing El-Sabawi & Carroll, 94 TEMPLE L. REV., at p. 17.

[206] Marcus & Stergiopoulos, Health Soc. Care Community 30:1665-1679, at p. 1673.

[207] Marcus & Stergiopoulos, Health Soc. Care Community 30:1665-1679, at p. 1673; Watson, et al., Vera Inst. Of Justice, at pp. 16, 20.

[208] Balfour, et. Al., National Association of State Mental Health Program Directors, at p. 12, citing Crisis stabilization claims analysis: Technical report [Internet]. Wilder Res. 2013; Available from: https://www.wilder.org/sites/default/files/imports/Crisis_stabilization_technical_report_4-13.pdf.

year to 2, at a cost savings of $15,000 each.[209] 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.[210]

Researchers caution that co-response or alternative response are small components of a larger crisis system.[211] Such responses are more likely to improve outcomes when different programs and services work together to achieve better outcomes as part of a coordinate 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.[212] 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.[213]

The federal government has created extensive resources for designing and building out more robust crisis care systems. For example, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) published the 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care.[214] The Guidelines set out 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.[215] To support implementation of crisis systems of

[209] Balfour, et. Al., National Association of State Mental Health Program Directors, at p. 12, citing 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, http://www.gocit.org/uploads/3/0/5/5/30557023/tucson_mhst_model_full_version.pdf.

[210] 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, at p. 1675; see also Watson, et al., Vera Inst. Of Justice, at p. 16.

[211] See, e.g., Balfour, M.E., Hahn Stephenson, A., Winsky, J., & Goldman, M.L. (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors, at pp. 8, 10; Legal Defense Fund, et al., Community-Based Services for Black People with Mental Illness: Advancing An Alternative to Police (Jan. 2023), at p. 15, 2022.07.06-LDF-Bazelon-Brief-re-Alternative-to-Policing-Black-People-with-Mental-Illness.pdf.

[212] Balfour, et. Al., National Association of State Mental Health Program Directors, at p. 10.

[213] Balfour, et. Al., National Association of State Mental Health Program Directors, at p. 10.

[214] 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.

[215] 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, at pp. 2-3.

care, SAMHSA has also created a detailed Mobile Crisis Team Toolkit and Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services.[216] 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 responses to the Council's survey of law enforcement agencies, the agencies without specialized teams mostly cited budget and/or staffing limitations as the primary reason for not having a 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. Data from the Bureau of Justice Statistics indicates that three-quarters of law enforcement departments in 2016 employed 24 or fewer officers and about half employed nine or fewer officers.[217] 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 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.[218] Beyond law enforcement, effective CIT

[216] Substance Abuse and Mental Health Administration: Mobile Crisis Team Services: An Implementation Toolkit (2025) HHS Publication No. PEP24-01-037; 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.

[217] CRS Report, fn. 115.

[218] "Issues in Law Enforcement Reform: Responding to Mental Health Crises," Congressional Research Service (October 17, 2022) (CRS Report), fn. 31 available at https://www.congress.gov/crs-product/R47285?q=%7B%22search%22%3A%22r47285%22%7D&s=1&r=1

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.

Other Limitations of Data

Co-response and alternative response tend to focus broadly on mental health, not on intellectual or developmental disability (IDD).[219] 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.[220] 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.[221] 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.[222] The program's pilot included an evaluation indicating participants were satisfied overall and the teams continued to meet post-training, but there is not published or empirical research on the program.[223]

Recommendations

[*Advisory Council to develop winter 2025-26*]

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 law enforcement officers. Such training is critical to improving outcomes of such interactions, and to improving the experience of all persons in California, both law enforcement

[219] 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 (Oct. 2019) Vera Inst. Of Justice, at p. 7, crisis-response-services-for-people-with-mental-illnesses-or-intellectual-and-developmental-disabilities.pdf; see also, generally, notes 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 the primary focus.

[220] Watson, et al., Vera Inst. Of Justice, at p. 7.

[221] Watson, et al., Vera Inst. Of Justice, at pp. 38-39.

[222] Watson, et al., Vera Inst. Of Justice, at p. 38.

[223] Watson, et al., Vera Inst. Of Justice, at pp. 38-39.

officers and those with behavioral health conditions alike.[224] 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 behavioral health conditions.

This includes an overview of the current training requirements for law enforcement officers in California, the substantive training topics of de-escalation training, training specifically designed to address interacting with individuals with behavioral health conditions, and training designed for persons with behavioral health conditions themselves to improve safety in interactions with law enforcement. 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. Finally, the Council conducted a survey of California law enforcement agencies regarding training options and evaluations.

The results of the Council survey reiterate the general findings that most law enforcement agencies receive some training regarding behavioral health conditions, but that there is room for improvement. Law enforcement agencies would benefit from more detailed and frequent trainings, and frommore frequent trainings incorporating direct participation of those with behavioral health conditions. Moreover, a stronger focus on evaluation of training effectiveness, would improve decisions about training and outcomes in law enforcement interactions in California.

California Law Enforcement Officer Training Requirements

Law enforcement officers in California are required to meet the minimum training standards as identified by law.[225]

First, people hired as law enforcement officers must complete 664 hours of basic training.[226] The basic training course is divided into 43 individual topics, called learning domains, that contain the minimum required foundational information on each topic.[227] One of these learning domains is training on people with disabilities.[228] The training must address issues related to stigma, be culturally relevant and appropriate, and include topics such as recognizing indicators

[224] SB 882 Council Meeting (Jan. 15, 2025) Testimony of Dr. Randy Dupont, https://www.youtube.com/watch?v=vAIndu5KVfM (as of Aug. 20, 2025).
[225] Penal Code, § 832
[226] Cal. Code Regs. Tit. 11, § 1005, subd. (a)
[227] State of California, Commission of Law enforcement officer Standards and Training, Regular Basic Course, available at https://post.ca.gov/regular-basic-course (last visited on Aug. 19, 2025).
[228] State of California, Commission of Law enforcement officer Standards and Training, Regular Basic Course Training Specification, available at https://post.ca.gov/regular-basic-course-training-specifications (last visited Aug. 19, 2025)

of mental illness and intellectual disability, conflict resolution and de-escalation techniques, and the perspective of individuals with lived experience.[229]

Second, in addition to basic training, every law enforcement officer must complete field training before being assigned to perform general law enforcement uniformed patrol duties.[230] The field training must include a course relating to competency that addresses how to interact with people with mental illness or intellectual disability.[231] The course must be at least four hours of classroom instructions and instructor-led active learning, such as scenario-based training, and it must address issues related to stigma and be culturally relevant and appropriate.[232] 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 law enforcement officers on how to effectively interact with people with a mental illness or intellectual disability.[233]

Third, certain law enforcement officers and dispatcher personnel who are employed by POST participating departments must satisfactorily complete continuing professional training.[234] The purpose of continuing professional training is to maintain, update, expand, and/or enhance an individual's knowledge and/or skills.[235] The continuing professional training must include a training course related to law enforcement interaction with people with mental disabilities and intellectual disabilities.[236] The training must utilize interactive training methods to ensure that the training is as realistic as possible.[237] 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.[238]

De-escalation Training

De-escalation training for law enforcement officers is often a central recommendation to improving law enforcement interactions with the public generally and specifically for those with behavioral health conditions. De-escalation includes “taking action or communicating verbally or non-verbally during a potential force encounter in an attempt to stabilize the situation and reduce the immediacy of the threat so that more time, options, and resources can be called upon to resolve the situation without the use of force or with a reduction in the force

[229] Penal Code § 13515.26
[230] Cal. Code Regs. Tit. 11, § 1005, subd. (a)
[231] Penal Code § 13515.29
[232] Ibid.
[233] Penal Code § 13515.28
[234] Cal. Code Regs. Tit. 11, § 1005, subd. (d)
[235] Ibid.
[236] Penal Code §§ 13515.25; 13515.27
[237] Ibid.
[238] Ibid.

necessary."[239] More generally, de-escalation often 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, during an interaction between two or more individuals."[240]

De-escalation training is often a central policy recommendation for police training, and it is used in some form by many law enforcement agencies.[241] 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. Some training may be a stand-alone curriculum, "whereas others incorporate de-escalation tactics and skills within trainings on other substantive topics."[242]

In California, de-escalation training is part of the law enforcement academy basic training; POST has created a stand-alone de-escalation training; and other training may be available.[243] POST has defined de-escalation as "the process of using strategies and techniques intended to decrease the intensity of the situation."[244] One instructor discussed the importance of making sure law enforcement officers realize de-escalation is not a "magic word," but rather is a process of using strategies and techniques.[245] These strategies may include: establishing

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[239] Int'l Ass'n of Police Chiefs, National Consensus Policy and discussion paper on use of force (July 2020), 2, https://www.theiacp.org/sites/default/files/2020-07/National_Consensus_Policy_On_Use_Of_Force%2007102020%20v3.pdf

[240] 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, 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, at p. 70, DOI: 10.1080/13528165.2020.1930783.

[241] Engle et al., 19 Criminology & Public Policy 721, at p. 722; Alvarez, Performance Research, 25:8, at p. 70.

[242] Engel et al., 19 Criminology & Public Policy 721, at p. 724.

[243] 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); see also POST, "Practical De-escalation & Tactical Conduct," https://catalog.post.ca.gov/SearchResult.aspx?crs_no=20811&crs_title=PRACTICAL%20DE-ESCALATION%20%26%20TACTICAL%20CONDUCT&pageId=10&MAC=1bovcMfLxPQKAvHDYGE1NGw1jDk.

[244] 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); POST, "De-escalation: Strategies & Techniques for California Law Enforcement," (2020), at 2-1, https://dublin.ca.gov/DocumentCenter/View/25842/CA-POST-De-escalation-Strategies.

[245] 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).

contact with the individual in crisis, creating a visual connection, building rapport, and then working to gain influence to decrease the intensity of the situation. [246] 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.[247] 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."[248] Thus, de-escalation training is part of what is currently available to law enforcement officers in California in various forms.

De-escalation training is often part of a law enforcement approach to reducing use of force incidents, and 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.[249] However, most of the trainings were from fields like nursing and psychiatry rather than policing.[250] The study found slight-to-moderate improvements at the individual and organizational levels (e.g., reduced aggression, improved communication),[251] but also asserted that the quality of research was generally low.[252] 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.[253]

Still, the research provides some evidence-informed practices that can be implemented to improve the quality and efficacy of police de-escalation training.[254] These can be aggregated into four main categories, each of which have individual practices that can improve aspects of

[246] 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).
[247] 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).
[248] POST, "Practical De-escalation & Tactical Conduct," https://catalog.post.ca.gov/SearchResult.aspx?crs_no=20811&crs_title=PRACTICAL%20DE-ESCALATION%20%26%20TACTICAL%20CONDUCT&pageId=10&MAC=1bovcMfLxPQKAvHDYGE1NGw1jDk.
[249] Engel et al., 19 Criminology & Public Policy 721.
[250] Engel et al., 19 Criminology & Public Policy 721, at p. 729.
[251] Engel et al., 19 Criminology & Public Policy 721, at pp. 734-736.
[252] Engel et al., 19 Criminology & Public Policy 721, at p. 737.
[253] Engel et al., 19 Criminology & Public Policy 721, at pp. 737-738.
[254] 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, https://www.carleton.ca/policeresearchlab/wp-content/uploads/Promising-practices.pdf.

implementing de-escalation training. First, is department commitment to the training, which relates to organizational support, resources, and leadership buy-in.[255] Second, is development of the training itself, which incorporates focusing on relevant competencies like communication, decision-making, and stress management; providing realistic scenario-based training; and using appropriate instructional methods.[256] Third, is 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.[257] Fourth, is evaluation of training and ongoing assessment of skills and knowledge, which is related to monitoring training outcomes and continuously adapting curricula. [258]

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 Behavioral Health Conditions

In addition to de-escalation training, almost all law enforcement agencies currently provide some amount of training specific to behavioral health conditions, and most appear to also have training specific to autism.[259] For example, materials provided to the Council from the California Commission on Peace Officer Standards and Training (POST) regarding the trainings provided by POST to California law enforcement agencies demonstrate available courses covered training on issues related to mental health, intellectual and developmental disabilities, and some trainings covered both topics.[260] Materials covered 186 unique trainings provided by law enforcement agencies, private agencies, and public and/or educational institutions that are

[255] Bennell et al., 44 Policing: An International Journal of Police Strategies and Management 377, at p. 380.
[256] Bennell et al., 44 Policing: An International Journal of Police Strategies and Management 377, at pp. 380-387.
[257] Bennell et al., 44 Policing: An International Journal of Police Strategies and Management 377, at pp. 387-392.
[258] Bennell et al., 44 Policing: An International Journal of Police Strategies and Management 377, at pp. 392-393.
[259] Fiske, et al., "A National Survey of Police Mental Health Training," J. Police Crim Psychol. (2020) 36:236–242, at p. 239, 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).
[260] SB 882 Council Meeting (Oct. 18, 2024) Testimony of CA DOJ, https://oag.ca.gov/system/files/media/sb882-101824-agenda-7.pdf.

available throughout the State.[261] Trainings ranged from two to forty hours in length, with over twenty available to attend remotely.[262]

Many current law enforcement trainings relating to behavioral health conditions include general education about behavioral health conditions and then focus on addressing communication and social behavior differences, and addressing sensory and accommodation needs.[263] In California, law enforcement officers learn about behavioral health conditions as part of the basic training academy, Learning Domain 37 (LD 37), which covers: disability laws; intellectual and developmental disabilities, specifically including autism and epilepsy; physical disabilities, including blindness and deal or hard of hearing; mental illness; and the California Lanterman-Petris-Short Act.[264] One Council witness discussed how LD 37 would benefit from being expanded to explicitly include a "fifth category" of intellectual and developmental disability that encompasses "disabling conditions closely related to intellectual disability or requiring similar treatment," as this category covers a population that often has law enforcement encounters.[265] 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.[266]

CIT training also often includes specific training on behavioral health conditions, including information about types of disability, the kinds of behaviors that law enforcement might encounter, types of sensory impacts on individuals with behavioral health conditions, and different ways sensory dysregulation may appear in an individual faced with a law enforcement officer. The training also includes actionable tips for crisis responders, including turning off

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[261] *Ibid.*

[262] *Ibid.*

[263] 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, at p. 444, 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, at pp. 1342-1343, 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, Need to Know," (Aug. 2017), at pp. 1-3, https://www.theiacp.org/sites/default/files/2018-08/IntellectualDevelopmentalDisabledPaper.pdf.

[264] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Yolanda Cruz, https://www.youtube.com/watch?v=yWRnfEr33es (as of Aug. 19, 2025); https://oag.ca.gov/system/files/media/sb882-101824-agenda-10.pdf.

[265] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Yolanda Cruz, https://www.youtube.com/watch?v=yWRnfEr33es (as of Aug. 19, 2025); https://oag.ca.gov/system/files/media/sb882-101824-agenda-10.pdf.

[266] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Yolanda Cruz, https://www.youtube.com/watch?v=yWRnfEr33es (as of Aug. 19, 2025); https://oag.ca.gov/system/files/media/sb882-101824-agenda-10.pdf.

flashing lights, reducing volume or offering ear plugs, providing sensory fidgets and avoiding unnecessary touch, allowing movement, and allowing personal space.[267]

Model Training Content

Content from these types of trainings is reflected in the model policy guidelines issued by the International Association of Chiefs of Police (IACP) Law Enforcement Policy Center in collaboration with The Arc. The Model Policy includes recommendations for interacting and communicating with, and providing accommodations for, people with behavioral health conditions during initial encounters and the custody process.[268] For communication, law enforcement officers are recommended to use a calm voice, direct words, and allow for alternate communication such as ASL or communication icons.[269] Law enforcement officers are recommended to be mindful of individuals' sensory differences, and to allow for additional supports such as service animals, mobility devices, or support persons.[270] Moreover, law enforcement officers are recommended to use simple questions, avoid yes or no questions, deception, and false rapport to provide clarity, and to avoid leading a person with behavioral health conditions to potentially provide false information.

These recommendations are similar to those in POST's "A First Responder's Guide for Persons with Mental Illness or Developmental Disability, which Council witnesses described as an extremely useful resource for law enforcement training.[271] The Guide covers: calls for service, including law enforcement assessment and response to a scene and strategic communication factors; an overview of mental illness, including behavioral indicators, depression, bipolar disorder, and schizophrenia; other mental disorders, for example, Post-Traumatic Stress Disorder, Autism, and Intellectual Disability; physical disabilities, such as, neurological disorders, blindness, and deaf or hard of hearing; and finally documents tips.[272] These

[267] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Yolanda Cruz, https://www.youtube.com/watch?v=yWRnfEr33es (as of Aug. 19, 2025); https://oag.ca.gov/system/files/media/sb882-101824-agenda-10.pdf.
[268] IACP Law Enforcement Policy Center, at pp. 1-3.
[269] *Ibid.*
[270] *Ibid.*, see also Holloway, et al., Policing: An International Journal 45(3), 434-447, at p. 444; Love, et al., Journal of Autism and Developmental Disorders 51:1331-1345, at p. 1342;
[271] POST, "A First Responder's Guide For Persons with Mental Illness or Developmental Disability," (2023), https://oag.ca.gov/system/files/media/sb882-101824-agenda-13b.pdf; SB 882 Council Meeting (July 25, 2024) Testimony of Teresa Anderson, California Policy Center for Intellectual and Developmental Disabilities, https://www.youtube.com/watch?v=7Zf3bE-UkD4 (as of August 20, 2025); 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 (as of Aug. 19, 2025).
[272] POST, "A First Responder's Guide For Persons with Mental Illness or Developmental Disability," (2023), https://oag.ca.gov/system/files/media/sb882-101824-agenda-13b.pdf.

recommendations, based on research, provide important benchmarks for substantive topic areas in trainings relating specifically to behavioral health conditions.

Research

While there are a large number of available trainings, academic research demonstrates a lack of standardization in trainings, with coverage sometimes including how to accommodate individuals with behavioral health conditions in the law enforcement process, and general communication strategies during an initial stop or investigative interviews.[273] Research also demonstrates a dearth of concrete evidence regarding the impact of such training on outcomes for individuals with behavioral health conditions, and much of the research concludes that further, and more outcome-oriented research would be beneficial.[274] Training evaluations have investigated whether the training has any impact on the law enforcement officer's use of force incidents, law enforcement knowledge or attitude changes, and changes in competency, but without strong statistically significant results.[275]

Still, there are indications that existing training can increase law enforcement officers' knowledge of behavioral health conditions, and self-reported competency in dealing with individuals with behavioral health conditions.[276] CIT training on behavioral health conditions may lead to increased officer knowledge, improved attitudes about responding to calls, and can increase linkages to care, such as transports to crisis centers, as well as community-based services.[277] More research specifically evaluating whether training directly impacts a law enforcement agency's rates of arrests, use of force reports, or whether encounters with individuals with behavioral health conditions are more likely to be diverted to services rather

[273] Richardson, et al., "Law Enforcement Response to Persons with Intellectual and Developmental Disabilities: Identifying High-Priority Needs to Improve Law Enforcement Strategies," (2023) RAND Corp., at p. 2, https://www.rand.org/content/dam/rand/pubs/research_reports/RRA100/RRA108-26/RAND_RRA108-26.pdf; Nguyen, Jacqueline, "A Systematic Review of Evaluations of Law Enforcement Training Relating to Developmental and Intellectual Disabilities," (Dec. 2021) Sam Houston State Univ., at pp. iii, 48-49.; Railey, et al., "A Systemic Review of Law enforcement Training Related to Autism Spectrum Disorder," (2020) Focus on Autism and Other Developmental Disabilities 35(4), 221-233, pp. 230-231.

[274] Nguyen, Sam Houston State Univ., at pp. 20, 48, 54-55; Murphy, et al., 2017, "Autism awareness training for An Garda Siochana (Letter to the Editor," (July 2017) Irish Journal of Psychological Medicine, at p. 1, DOI:10.1017/ipm.2017.31; Holloway, et al., Policing: An International Journal 45(3), 434-447, at p. 445; Railey, et al., Focus on Autism and Other Developmental Disabilities 35(4), 221-233, at pp. 228-229.

[275] Nguyen, Sam Houston State Univ., at pp. 34, 55; Murphy, et al., 2017 Irish Journal of Psychological Medicine, at p. 1; Holloway, et al., Policing: An International Journal 45(3), 434-447, at pp. 441, 443-444.

[276] Nguyen, Sam Houston State Univ., at pp. 51-52; Holloway, et al., Policing: An International Journal 45(3), 434-447, at p. 444; Love, et al., Journal of Autism and Developmental Disorders 51:1331-1345, at p. 1342; Murphy, et al., Irish Journal of Psychological Medicine, at pp. 1-2.

[277] 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 (as of Aug. 20, 2025); https://oag.ca.gov/system/files/media/sb882-040125-agenda-5.pdf.

than arrest after the training is still needed to make sure that resources are used most efficiently and with the greatest impact on individuals.[278] However, the existing trainings provide useful information regarding current best practices, and areas where further research is most critical.

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

As individuals with behavioral health conditions face elevated risks during interactions with law enforcement officers, developing effective, evidence-based interventions for such individuals that enhance safety and communication is also 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 provide helpful information about effectiveness and best practices for a community approach. Moreover, such trainings often involve law enforcement officer participation as trainers, which can be an important part of a law enforcement agency's community engagement with the behavioral health community.

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).[279] 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.[280] Participants engaged in both video modeling and Behavioral Skills Training to improve police interaction skills.[281] 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.[282] Behavioral Skills Training included: (1) participants receiving verbal instruction on what to do to increase safety when interacting with a law enforcement officer, such as staying calm, remaining in place, and following directions; (2) the instructor modeling the responses required for safe interaction with a law enforcement officer; (3) each participant then rehearing the interaction skills with an assigned law enforcement officer a minimum of

[278] Nguyen, Sam Houston State Univ., at 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 (as of Aug. 20, 2025); https://oag.ca.gov/system/files/media/sb882-040125-agenda-5.pdf.

[279] 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, https://doi.org/10.1007/s10803-021-05181-8.

[280] Davenport et al., 53 Journal of Autism and Developmental Disorders, at pp. 1375-76,.

[281] Davenport et al., 53 Journal of Autism and Developmental Disorders, at pp. 1381-82.

[282] Davenport et al., 53 Journal of Autism and Developmental Disorders, at pp. 1381-82.

three times, or more if needed, until the participant was able to demonstrate safe interactive skills in three consecutive sessions.[283] Thus, participants were able to receive immediate instruction and feedback from law enforcement officers, and the scenarios and skills were informed by qualitative feedback from caregivers and community stakeholders.[284]

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.[285] 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.[286] 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[287] The training was well-received, with caregivers reporting strong social validity and few side effects.[288] 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 law enforcement officers. For example, one study created a three-session, interactive workshop model involving both individuals with behavioral health conditions and law enforcement officers.[289] 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.[290]

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 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 law enforcement officers.[291] Thus, training that focuses on

[283] Davenport et al., 53 Journal of Autism and Developmental Disorders, at pp. 1382.
[284] Davenport et al., 53 Journal of Autism and Developmental Disorders, at p. 1382.
[285] Davenport et al., 53 Journal of Autism and Developmental Disorders, at p. 1383.
[286] Davenport et al., "53 Journal of Autism and Developmental Disorders, at pp. 1383-85.
[287] Davenport et al., 53 Journal of Autism and Developmental Disorders, at p. 1385.
[288] Davenport et al., 53 Journal of Autism and Developmental Disorders, at p. 1385.
[289] Roberts & Satterelli, "Understanding Us: An Interactive Training Program for Members of Law Enforcement and Individuals with Disabilities" (2020) Occupational Therapy Capstones, https://commons.und.edu/ot-grad/456
[290] Roberts & Satterelli, Occupational Therapy Capstones, at pp. 25-28, 36-40, 44-47.
[291] Roberts & Satterelli, Occupational Therapy Capstones, at pp. 28, 40, 47.

building positive interactions and understanding between individuals with behavioral health conditions and local law enforcement may provide benefits to both groups.

Role-play and Simulation Training

Role-playing and simulation can be essential parts of effective training for law enforcement 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) law enforcement 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, current trainings and instructors use role-play and simulation to aid in law enforcement officer learning. For example, one CIT instructor 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.[292] 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.[293] 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.[294] 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.[295] 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.

[292] 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).
[293] 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).
[294] SB 882 Council Meeting (July 25, 2024) Testimony of Teresa Anderson, California Policy Center for Intellectual and Developmental Disabilities, https://www.youtube.com/watch?v=7Zf3bE-UkD4 (as of August 20, 2025); 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 (as of Aug. 19, 2025); 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 (as of Aug. 20, 2025).
[295] SB 882 Council Meeting (Jan. 15, 2025) Testimony of Dr. Randy Dupont, https://www.youtube.com/watch?v=vAIndu5KVfM (as of Aug. 20, 2025).

The ability for law enforcement officers to personally take part in a live-action role-play of use of force encounters can impact officer behavior.[296] 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.[297] This approach allows the officers in the training to rehearse ethical decision-making under stress and receive feedback from a multidisciplinary team of spectator-instructors. The intended purpose of the active role in the scenarios is that physically embodying different actions should work to ingrain new patterns of judgement and action in an officer's "muscle memory" and repertoire of decision-making that can be drawn upon in future stressful encounters.[298] 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."[299]

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; (4) pausing the scene on repeated runs to allow officers to act out alternative methods of response.[300] 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."[301] 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.[302] 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.

[296] Alvarez, Stop. Rewind. Replay.: Performance, police training and mental health crisis response (2020) Performance Research, 25:8, 69-75, DOI: 10.1080/13528165.2020.1930783.
[297] Alvarez, Performance Research, 25:8, at pp. 71-73.
[298] Alvarez, Performance Research, 25:8, at pp. 70-71.
[299] Alvarez, Performance Research, 25:8, at 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.
[300] Alvarez, Performance Research, 25:8, at pp. 71-73
[301] Alvarez, Performance Research, 25:8, at p. 73.
[302] Alvarez, Performance Research, 25:8, at p. 73.

Other research demonstrates further potential for role-playing to impact real world law enforcement officer behaviors in interactions with people with behavioral health conditions.[303] 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.[304] The primary focus of feedback was increasing empathy and helping officers identify other approaches they could use to de-escalate the situation.[305] While the study determined the training did not change 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.[306] 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.[307]

This study suggests two interesting and important points. First, that changing stigma or understanding of mental illness is not necessary to change behavior.[308] Given that changes in behavior are what most impacts target populations, this is a critical point. Second, the study points to the potential power of role-playing scenarios that engage officers emotionally and give them specific tools that they can use in real life situations that are similar to the acted-out scenarios.[309] These results provide useful information for assessing and improving trainings going forward.

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.[310] In this context, virtual reality consists of an immersive, three-dimensional world that participants enter using a head-

[303] 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, https://doi.org/10.3389/fpsyt.2013.00009.

[304] Krameddine et al., 4 Frontiers in Psychiatry, at 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*.

[305] Krameddine et al., 4 Frontiers in Psychiatry, at p. 3.

[306] Krameddine et al., 4 Frontiers in Psychiatry, at p. 1.

[307] Krameddine et al., 4 Frontiers in Psychiatry, at pp. 5-8.

[308] Krameddine et al., 4 Frontiers in Psychiatry, at p. 8.

[309] Krameddine et al., 4 Frontiers in Psychiatry, at p. 8.

[310] Lavoie, et al., Training police to de-escalate mental health crisis situations; Comparing virtual reality and live-action scenario-based approaches, Policing: A Journal of Policy and Practice, 2023, 17, 1-12, https://doi.org/10.1093/police/paad069This study includes some of the researchers from the first study discussed in this section.

mounted display, where they can move freely while simultaneously interacting with objects and communicating with non-player characters.[311] 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) 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; and (4) are adaptable and can be modified to include content that feels more realist for individual police services.[312]

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 efficacy of the simulation training offered in virtual reality and live action compared to a control group in improving leaning outcomes.[313] 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.[314] 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.[315]

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.[316] 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.[317] 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.[318]

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.[319] Usability scores

[311] Lavoie, et al., Policing: A Journal of Policy and Practice, 2023, 17, at p. 2.
[312] Lavoie, et al., Policing: A Journal of Policy and Practice, 2023, 17, at p. 2.
[313] Lavoie, et al., Policing: A Journal of Policy and Practice, 2023, 17, at p. 3.
[314] Lavoie, et al., Policing: A Journal of Policy and Practice, 2023, 17, at pp. 7-10.
[315] Lavoie, et al., Policing: A Journal of Policy and Practice, 2023, 17, at p. 10.
[316] Joseph P. 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 1418, https://doi.org/10.1007/s10803-021-05181-8.
[317] McCleery et al., 13 Autism Research, at pp. 1419-20.
[318] McCleery et al., 13 Autism Research, at p. 1418.
[319] McCleery et al., 13 Autism Research, at pp. 1420-21.

were high, and 80 percent of participants expressed a desire to use the platform again.[320] 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.[321] 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.

The benefits of virtual reality training are supported by the use of this training method on the ground in California. The Los Angeles Police Department uses virtual reality training as part of its 40-hour Mental Health Intervention Training.[322] With virtual reality training "it actually feels that as if it's actually a real scenario, compared to other types of trainings that we've been on … Everything that happened is captured and we can have a frank conversation so they can get better when they come across something similar in the field."[323]

Repetition and Refresher Training

Repetition of material and skills learned in training can also be critical for a lasting positive impact on law enforcement 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.[324] Moreover, CIT may also recommend an 8-hour CIT refresher class. Ventura County started offering this 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.[325] 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,

[320] McCleery et al., 13 Autism Research, at pp. 1420-22.
[321] McCleery et al., (2020) 13 Autism Research, at p. 1419.
[322] 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 (as of Aug. 19, 2025).
[323] SB 882 Council Meeting (Oct. 18, 2024) Testimony of Detective III Elizabeth Reyes, https://www.youtube.com/watch?v=yWRnfEr33es (as of Aug. 19, 2025).
[324] 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).
[325] 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).

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."[326]

Comparing multiple training types

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 law enforcement 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.[327] 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.[328] Finally, and critically, no studies demonstrated evidence of significant benefit for the members of the public that the law enforcement trainees encountered.[329]

Another overview study examined published research and worked with an advisory committee to identify and review different models addressing interactions between police and persons with behavioral health conditions.[330] This study collected and reviewed existing research on several models to improve law enforcement response to target populations and provided recommendations for further research. Examined models included: mobile crisis teams, crisis intervention teams, co-responder teams, emergency services/ambulance-based responses, flagging systems, stand-alone training packages, case management/high-utilizer teams, and

[326] 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 (as of Aug. 19, 2025).
[327] 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, at pp. 2-3, https://doi.org/10.1186/s12888-017-1356-5.
[328] Booth et al., 17 BMC Psychiatry 196, at pp. 10, 19-20, 22.
[329] Booth et al., 17 BMC Psychiatry 196, at pp. 1, 20, 22.
[330] Compton & Watson, "Research to Improve Law Enforcement Responses to Persons with Mental Illnesses and Intellectual/Developmental Disabilities," Bureau of Justice Assistance, at pp. 5, 13, https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/Research_to_Improve_Law_Enforcement_Responses_to_Persons_with_Mental_Illnesses_and_Developmental_Disabilities.pdf.

behavioral health-specific models/strategies.[331] The study provides useful information about the state of research for each response model, but many models require further experimental research to determine impact on immediate and long-term outcomes for target populations, along with questions like cost effectiveness.[332]

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.[333] 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 those with behavioral health conditions, but was more narrowly focused on results, attempting to review only studies that used empirical techniques to measure the effects of training on law enforcement officer behavior, rather than descriptive-only studies or those that only measured attitudes from the training rather than the effects of the training itself.[334] 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.[335]

California Law Enforcement Agency Training Survey Results

As discussed in detail above, the Council approved the Department of Justice conducting a survey of law enforcement agencies across California to assess information on trainings relating to behavioral health conditions. The survey of law enforcement agencies in California provided further information on the types of trainings that exist for peace officers in California. 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.

In general, 9 out of 10 agencies reported that some type of training existed that were 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. All or at least some of the trainings are certified by POST. When asked to describe the trainings, responses 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.

[331] Compton & Watson, Bureau of Justice Assistance, at pp. 14-44.
[332] Compton & Watson, Bureau of Justice Assistance, at pp. 14-44.
[333] Huey, "What Do We Know About In-service Police Training? Results of a Failed Systematic Review" (2018) Sociology Publications 40, https://ir.lib.uwo.ca/sociologypub/40.
[334] Huey, Sociology Publications 40, at p. 6.
[335] Huey, Sociology Publications 40, at pp. 13-14.

Some agencies also identified some topics that were excluded from trainings. These topics included handling call transfers between 911 and 988, scenarios or other interactive elements that build skills and reinforce trainings content, and responding appropriately to people with mental health conditions or IDD in custody. About 10% of the responding agencies also noted the exclusion of a person with IDD or a person with a disclosed mental health condition among the trainers.

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 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, 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 to something to evaluate their trainings, there is not a common approach.

Recommendations

[Advisory Council to develop winter 2025-26]