SB 882 Advisory Council

Staff Notes Taken Live and Presented on Screen Regarding Agenda Item 9

October 14, 2025

1. Background both MH and IDD (Healthcare/service providers)
    a. *This subcommittee will discuss the background section of the report*.
    b. The IDD history needs to be fleshed out better.
    c. Explain differences in response related to MH v. IDD v. dual diagnosis/other—e.g. causation, psychiatric provider response.
    d. Page 17 of September 18 draft, Council of State DD uses the federal definition of IDD (vs. California Lanterman definition). Note both, how this impacts data, and that not everyone with IDD is an individual served by Regional Center.
2. Training Recommendations
    a. *This subcommittee will discuss recommendations related to training of law enforcement.*
    b. Any mandates require funding.
    c. Look to current POST mandates in and off these topics.
    d. Distinguish between urban and rural access to trainings.
    e. Circle back to identify gaps in trainings.
    f. Awareness, de-escalation, resource connection.
        i. Who are the role players?
        ii. How does that inform who are the trainers?
        iii. What is the experience of people with MHD/IDD, family members, and caregivers?
    g. Training before dispatch related to routing of emergency calls.
    h. How can existing resources like regional centers be leveraged?
    i. How to vet proposals to POST / ensure that trainings once approved are up to date and culturally appropriate?
        i. Needs a subject matter expert that is not part of the panel
    j. Intersection of other disabilities and conditions like sensory disabilities
    k. Hands-on or shadowing components for trainings e.g. how to use a communication card or sensory kit.
        i. Couple with (or separately) use real-life BWC footage of positive interactions that is then broken down by a SME
    l. Private security
3. Systems Intervention Recommendations (Crisis Response)
    a. *This subcommittee will discuss systemic recommendations in areas other than training for law enforcement such as crisis response models and dispatch systems.*
    b. Distinguish between urban and rural access to responses.
    c. What to do for families who are in the community and subjected to a third-party emergency call; does dispatch append these and are they being appropriately flagged?

        i. Does there need to be a backup plan if something is not flagged and for when family/caregiver cannot make the second call?
    d. Break out MHD/IDD/dual/other.
    e. P.24 (9/18) use of "delirium."
    f. Hospital beds—what happens once someone arrives at an emergency room, e.g. cycle of short hold and release or being turned away because of an IDD diagnosis.
    g. Dealing with recidivism from short-term support.
    h. Mental health crisis response teams—need more support for IDD population.
    i. Local departments of behavioral health: are program assignments appropriate? Too much one-size-fits all (similarly for people with sensory disabilities, e.g.)
    j. Coordination of connection between resources that should be linked (both for people with MHD/IDD and family/caregivers and also across resources)
    k. Group homes – information available to officers (getting repeated calls to a location, but just know that it's "a group home").
        i. All RC homes should have someone on-call 24 hours per day.
        ii. Special Incident Reports from RC service providers to RC; RC then reports to DDS
    l. Awareness of / connection with regional centers
    m. Consistency and accountability for RCs regarding responding to law enforcement
4. Data Recommendations
    a. *This subcommittee will discuss what data is needed to evaluate practices moving forward.*
    b. Missing some data from Arc's National Center for Justice and Disability (data pull).
    c. Need more disaggregation of data between MHD/IDD.
        i. Do any departments already do this? How does it work?
        ii. LAPD is able to leverage clinicians within the MEU through a shared agreement.
            1. Camp referral, e.g., for individuals with recidivism / extreme level. Through the database, the officers can access past data including prior interactions, holds, and length.
            2. How many calls for service to a specific residence and what were the results?
            3. If just an officer doing a 5150 hold, going to hospital not jail
            4. LA Twin Towers (if a crime was committed), they will be made aware
        iii. Does CA DOJ collect any of this information?
    d. Lack of consistency in data collection regarding categorization and definitions—makes it hard to look at big picture and make apples to apples comparisons.
    e. Big agencies have Computer Aided Dispatch (CAD) systems with premise histories. Can data be grabbed from those agencies that track it to determine whether there are high-incidence areas and use that information to inform public

education. Especially, if needed, working with training/partnerships by large corporations/big-box stores; who have resources to push this information out.

f. What data are/should be available from departments adopting these various practices?

5. Best / Emerging Practices
    a. *This subcommittee will discuss best and emerging practices.*
    b. Highlight options to reduce law enforcement interactions with people with MHD/IDD.
    c. P.49 (9/18) mention of an OT framework that is not funded
    d. LAPD mediator program at hospitals for processing emergency holds for victims and families. Could this be expanded to pre-intake?
        i. Hoag hospital in OC has a NAMI peer (?) person during regular business hours.
    e. Inland Regional Center forthcoming report on Blue Envelope Program
    f. Local registries
    g. Sensory kits that officers carry in cars (e.g. pop its) to help develop rapport/de-escalate
    h. Communication cards for interacting with non-speaking people
    i. Future recommendations for other first responders like EMS and Fire Departments
6. Community / Non-Law Enforcement Recommendations (K-12 Education, Regional Centers, e.g.)
    a. *This subcommittee will discuss recommendations regarding agencies other than law enforcement like educational agencies, local departments of behavioral health, and regional centers.*
    b. E.g.: RC of OC has a provider that provides safety training that includes training on what to expect during an encounter with law enforcement.
    c. Try to bring K-12(22) schools and school resource officers in for both training and interaction.
    d. LAPD in process of creating best practices brochure: Autism Resource Guide covering things like wandering issues, suicide crisis line, etc. that is for officers to keep on-hand and help them identify people with autism. Release date TBD.
    e. Encourage members of law enforcement who have family members with MHD/IDD who might be willing to share their experiences internally with fellow officers.
    f. Interactions with business sector.
    g. Private security.
    h. What information would be helpful for callers to provide during 911/988 calls? (This is in forthcoming LAPD Autism brochure, e.g.)
    i. What guidance can be given to people with MHD/IDD and families/caregivers in advance of contact? (Both before an actual call but also during non-emergent times)

j. Cal Applied Behavioral Analysis (ABA) will often incorporate this into safety plans but sometimes the guidance is just ~”call 911”; what education can be done for such agencies? (e.g. Board Certified Behavioral Analysts (BCBA))