

S. HRG. 113-885

**LAW ENFORCEMENT RESPONSES
TO DISABLED AMERICANS: PROMISING
APPROACHES FOR PROTECTING PUBLIC SAFETY**

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CONSTITUTION,
CIVIL RIGHTS AND HUMAN RIGHTS

OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

APRIL 29, 2014

Serial No. J-113-57

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FOR PROTECTING PUBLIC SAFETY**

TUESDAY, APRIL 29, 2014

UNITED STATES SENATE,
SUBCOMMITTEE ON THE CONSTITUTION, CIVIL RIGHTS
AND HUMAN RIGHTS,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10 a.m., in Room SH-216, Hart Senate Office Building, Hon. Dick Durbin, Chairman of the Subcommittee, presiding.

Present: Senators Durbin, Franken, and Cruz.

**OPENING STATEMENT OF HON. DICK DURBIN,
A U.S. SENATOR FROM THE STATE OF ILLINOIS**

Chairman DURBIN. Good morning, and welcome to this hearing of the Subcommittee on the Constitution, Civil Rights and Human Rights. Today's hearing is entitled, "Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety." In a moment, I will be making an opening statement, then recognize my colleague Senator Cruz, the Subcommittee's Ranking Member, for an opening statement as well, and I want to thank Senator Cruz and his staff for their cooperation. We have agreed on today's witness panels on a bipartisan basis.

We are pleased to have a larger audience for today's hearing, demonstrating the importance of this issue. There was so much interest that we moved to a larger room. If anyone could not get a seat in this hearing room, we have an overflow room, 226 Dirksen.

Let me also thank those following the hearing on Facebook and Twitter using the hashtag #Ethanshearing. This is in honor of the late Ethan Saylor whose picture is to my right and who we will hear about during the later testimony today.

We are here to examine the growing role of law enforcement in responding to incidents involving persons with disabilities. State and local law enforcement have made great progress in combating violent crime and keeping communities safe. In recent years, law enforcement has been forced to shoulder a new challenge. Due to inadequate mental health and social services, police officers have many times become the first responders for disabled individuals in crisis. The deinstitutionalization movement has led to many disabled Americans' release from State and local institutions into the

community and a large reduction of available inpatient beds. It is estimated the country has lost 90 percent of its public psychiatric beds since the deinstitutionalization movement began.

The goal is certainly laudable. However, there has never been adequate funding to allow local service providers to care for the disabled Americans living in their communities, and in recent years, there have been draconian cuts in their meager budgets. As a result, police officers, sheriff's deputies, and troopers have been inundated with calls involving mentally ill persons, and with the reduction in inpatient bed space, our jails and prisons have become, sadly, our mental health institutions by default.

This Subcommittee considered this issue in a 2009 hearing on mental illness in prison and jails, more recently in two hearings on the use of solitary confinement. An estimated 56.2 percent of the inmates in State prison—56.2 percent—have mental illness, 44.8 percent of inmates in Federal prison.

Our focus today is the difficult challenge State and local law enforcement face in responding to incidents with individuals suffering from disabilities. This is a public safety issue. Numerous studies have found that at least half of the people shot and killed by police each year are mentally ill. And police officers are at risk as well. Many of us well remember the day in 1998 when a mentally ill man stormed the halls of this Capitol and fatally shot two Capitol Hill police officers who heroically confronted him and saved many lives in the process.

This is also a civil rights issue. The Americans with Disabilities Act requires law enforcement agencies to make reasonable modifications to ensure that disabled Americans are not subjected to discriminatory treatment. And just this month, the Justice Department's Civil Rights Division found a local police department was required to implement certain remedial measures to protect the constitutional rights of disabled Americans. As is so often the case, local governments are leading the way in crafting innovation solutions.

One promising approach we are going to hear about is the Crisis Intervention Team. It has two parts:

First, training officers to recognize the signs of disabilities and to de-escalate a crisis incident involving a disabled person;

Second, law enforcement building relationships with mental health and developmental disability communities. These relationships are critical to finding support and services for the disabled.

Today there are more than 2,700 CIT programs in 48 States. Nationwide, localities with CIT programs are experiencing a noticeable decline in officer injuries, injuries to disabled citizens, and reduced detention rates. I am proud to say Illinois is one of the Nation's leaders in this area. Forty-nine counties in my State out of 102 have a CIT program, and we will hear today from the Chicago Police Department's CIT program, which is considered a national model.

As local mental health and disability services become increasingly scarce, the burden on police officers is going to be even larger. It is incumbent on Congress and the executive branch to help local and State law enforcement shoulder this expanded role and develop practices that protect officers, disabled individuals, and the public.

Now, I might say at the outset that we have a series of votes on the floor at 11 o'clock this morning, six in a row, and then the mandatory lunches follow of the Democratic and Republican Caucuses. So we have a hard stop of 11:15. So we are going to do our best to give everyone a chance to testify and entertain questions and then proceed from that point.

Senator Cruz when he arrives will be given an opportunity for an opening statement when he does arrive.

Our first witness I would like to welcome is Denise O'Donnell, Director of the Justice Department's Bureau of Justice Assistance. The BJA provides grants and policy development services to local, State, and tribal criminal justice programs. Prior to her tenure with the BJA, Director O'Donnell was Deputy Secretary for Public Safety in New York and Commissioner of the New York State Division of Criminal Justice Services, and before that, U.S. Attorney for the Western District of New York.

Director O'Donnell, thank you for being here. We are going to give you 5 minutes for an opening statement, and your complete written statement will be made part of the record.

In keeping with the practice of the Subcommittee, please stand and raise your right hand to be sworn. Do you swear or affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

Ms. O'DONNELL. I do.

Chairman DURBIN. Thank you. Let the record reflect that the witness has answered in the affirmative, and, Ms. O'Donnell, please proceed.

**STATEMENT OF HON. DENISE E. O'DONNELL, DIRECTOR,
BUREAU OF JUSTICE ASSISTANCE, U.S. DEPARTMENT OF
JUSTICE, WASHINGTON, DC**

Ms. O'DONNELL. Chairman Durbin, Ranking Member Cruz, and distinguished Members of the Subcommittee, thank you for affording me an opportunity to speak to you today. As Senator Durbin noted, I am Denise O'Donnell. I am the Director of the Bureau of Justice Assistance within the Department's Office of Justice Programs.

BJA's mission is to provide policy leadership, guidance, and support to State, local, and tribal partners in implementing evidence-based and promising programs to promote safer communities. I am pleased to speak to you today about the strong commitment of the Department, and BJA specifically, to law enforcement in their growing role as first responders to crisis incidents involving people with mental illness and developmental disabilities.

It is important to begin by recognizing an often misleading perception that individuals with mental illness are violent. A person with a severe mental illness who has no history of substance abuse or violence has the same likelihood of being violent as any member of the general public. In fact, people with serious mental illnesses are estimated to be between 2.5 and nearly 12 times more likely to be victims rather than perpetrators of violence.

Yet persons with serious mental illness make up a significantly disproportionate number of people in our Nation's jails. According to a 2009 report, of people booked into U.S. jails, 14.5 percent of

men and 31 percent of women had a serious mental illness—rates in excess of 3 to 6 times those found in the general population.

Law enforcement are often the first responders to mental health crises that occur in the community, and we are grateful for the work of the Senate Judiciary Committee and this Subcommittee in raising awareness around this issue. We are also very grateful for your support of the Mentally Ill Offender Treatment and Crime Reduction Act—MIOTCRA—which has enabled BJA to take a leadership role in addressing the intersection of criminal justice and mental health.

Since 2006, this invaluable funding has enabled BJA to award 287 grants in 49 U.S. States, territories, and the District of Columbia. These grants support a broad range of activities, including Crisis Intervention Teams, mental health courts, treatment programs in prisons and jails, re-entry programs and cross-training of criminal justice and mental health professionals.

To expand the reach of effective justice mental health programs, BJA has used grant funds to establish a National Law Enforcement/Mental Health Learning Site program in which six geographically diverse police departments who are leaders in this field mentor and host visits from other jurisdictions to improve their responses to persons with mental illness.

The linchpin of BJA's efforts to build an effective law enforcement response nationwide has been through support of Crisis Intervention Teams, or CITs. CITs provide crisis intervention training to law enforcement and de-escalating situations involving persons with serious mental illness and a forum to partner with other organizations to coordinate diversion from jails to mental health services.

There are currently over 2,800 CIT programs nationwide. Many have begun to offer training to corrections officers, dispatchers, firefighters, school resource officers, and specialized training for youth and for veterans. In many communities, CITs have served as a springboard for a broader collaboration between the criminal justice and mental health systems.

I want to particularly recognize and thank Patti Saylor for participating in this hearing and for raising our awareness about the critical need for the justice system to develop sensitive and targeted responses to the special needs of individuals with intellectual or developmental disabilities.

In 2013, BJA awarded funds to The Arc to create the National Center on Criminal Justice and Disability. This is the first national effort of its kind to address both victim and offender issues involving persons with disabilities. When fully developed, the National Center on Criminal Justice and Disability will serve as a national clearinghouse and online resource, as well as provide training and technical assistance in this important area. Other DOJ partners such as the Office of Victims of Crime and the Civil Rights Division are also very focused on the particular needs and vulnerabilities of developmentally disabled persons, and we believe the National Center will be an important resource for all of us.

Mr. Chairman, Ranking Member Cruz, and Members of the Subcommittee, this concludes my testimony. I thank you for the oppor-

tunity to testify and would be glad to answer any questions that you have.

[The prepared statement of Ms. O'Donnell appears as a submission for the record.]

Chairman DURBIN. Thank you for your testimony, and thank you for prefacing the testimony with the most important fact to be said over and over again: People suffering from these disabilities are no more likely to be violent than the population at large and more likely to be victims of violence, which is something we should stress over and over again. Today we are focusing on those instances where law enforcement is called into action, and I think it is worthy of a reminder on the record here that the men and women who put those badges on every single day literally put their lives on the line every single day for us. Any moment can be a life-or-death situation, and they are faced with that tension and that reality, and we should be cognizant of it and sensitive to it.

So I guess two questions I would like to ask: What are we doing as a Government, at the Federal level and beyond, to make certain that they have the training to recognize the reality of these disabilities and how they are manifest? This is a challenge for many people with a great deal of experience in education to really perceive these things. And for those who are in law enforcement, faced with the tension of the moment, what are we doing to prepare them?

Ms. O'DONNELL. I agree, Senator, that it is so important that we provide training in this area, and that has been really a center focus of our efforts under the MIOTCRA-funded grant programs that we have, to fund programs that provide CIT training to look at the States that are providing leadership like Illinois to statewide take on the obligation to train law enforcement officers on these issues through CIT training, through more cross-disciplinary training with mental health professionals.

So we are committed to doing this. The law enforcement community is large and diverse and presents a challenge to be able to reach out to law enforcement all across the country. But we see a real interest in this training and are committed to providing the training.

Chairman DURBIN. Just to put in a plug for another bill, I have introduced the Smarter Sentencing Act, supported by the administration, on a bipartisan basis in Congress, to reduce the rates of incarceration in the hopes that the money saved there can be directed toward more productive ways of keeping this a safer Nation, and this is certainly one of them, to upgrade the skills and equipment and training of the men and women in law enforcement by not wasting as much time and money with people incarcerated for periods of time way beyond what is necessary.

There is another aspect of this which I find interesting in my State, and that is that we are starting to look at different court approaches. We have tried veterans courts, we have tried drug courts, and basically what we are saying is that certain criminal defendants should not be pushed right into the criminal justice system, but justice can be served, the safety of the community can be protected if we find alternatives for veterans, many times returning and struggling with substance abuse problems, with the stress and pressure of daily life, many times with PTSD. We have found that

putting them in jail is not the answer. In fact, there are much better and more efficient ways to treat them in a humane fashion, and we are doing that across our State.

The same thing is true when it comes to substance abuse. Rather than put the addict in jail with little or no treatment, we find ways to put them in programs that start to turn their lives around.

Can the same be said when it comes to mental health courts? Are we at a point now where we should be looking at this from a different perspective?

Ms. O'DONNELL. Well, I agree with you, Senator. We are very fortunate at BJA that you have all entrusted us with the responsibility to provide leadership in the drug court and the veteran court and in the mental health court area. We support mental health courts through our MIOTCRA funding. We provide training, we provide mentoring courts through other mental health courts, for mental health courts, to be able to meet the high standards of our other problem-solving courts. But we think that this is an important area for the country as a whole.

I personally have had a long-term relationship with Dr. Robert—or with Judge Robert Russell, who started the first veterans treatment court in my hometown, in Buffalo, New York. We have supported veterans courts now since they started in 2008. I think it is one of the most important things we can do as a Nation to pay the respect to our veterans who are returning from wars and are suffering from mental illness and PTSD to be able to provide a specialized court and work with the Veterans Administration to provide services to our veterans.

Chairman DURBIN. Before I hand it off to Senator Franken, I would urge, if possible, that your Division really focus more resources and more time, if you can, in the collection of data on law enforcement interaction with the disabled, particularly where force is used, so that we can understand this phenomenon and chart our progress, if we have some, in this area. So I hope you will consider that.

Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman, for this important hearing. I have been working on a reauthorization of MIOTCRA and expansion of it called the Justice and Mental Health Collaboration Act, as you know. And in researching this and in living with this issue for a while, I have seen some amazing things and some great things, including—I am not sure where in this hearing I will tell some of the stories, but both police who use crisis intervention training in a way that is very moving and very productive, and the same in our prison system.

I guess what I wanted to ask you about is sort of the cost-benefit analysis of this, because we have so many people languishing in our prisons who probably—well, who certainly are not benefiting by being there, and that we are not benefiting by being there. And what we have seen with the kind of programs that we are talking about is less recidivism, you know, all kinds of benefits from that.

Can you talk a little bit about the cost-benefit of crisis intervention training, of mental health courts, and other initiatives?

Ms. O'DONNELL. Yes, Senator. First of all, we think it is huge. We have two projects that I want to just focus on for a minute. One

is a project that the Council for State Governments is doing in New York City, in the Riker's Island facility, where they did probably one of the most comprehensive examinations of who is in that jail suffering from a severe mental illness and what is their length of stay. And they actually followed up on all of the records and determined that people with serious mental illness were staying in jail twice as long as other individuals in jail. That is a huge cost and certainly not contributing to their overall mental health.

And so New York City is fashioning a response to that where they are really developing centers in each of their courts in each of the boroughs, looking at how they can intervene quickly, identify those individuals, and get them out of jail, and provide the kind of services that they need. And they will be following the cost-effectiveness of that approach.

The second project that we have is under the Justice Reinvestment Initiative, which BJA supports, and it is a local JRI site in Texas. And that site is really doing a cost-benefit analysis looking at just 23 high users of the jails and the mental health and health services within that community, and taking those individuals from jail, putting them in supportive housing with wrap-around services, and projecting the cost savings from that approach. And I think that will help raise awareness of how we can manage individuals with mental illness in our jail system that are particularly non-violent offenders in a much more cost-effective way in the community and with better outcomes for the individuals involved.

Senator FRANKEN. I have had a number of roundtables on this. One, our sheriff in Hennepin County, Rich Stanek, wrote an op-ed piece in the Star Tribune saying about a third of the people in his jails had mental illness and that is why they were there. And we have seen that putting people in prison with mental illness makes them sicker, costs us money. We have—I guess 25 percent of the prisoners in the world are in our prisons, and we have 5 percent of the population. And a great deal of those are people with mental illness who are not benefiting, who, if our jails are overcrowded and costing us money, we are actually having to release people in States like California. But these people could do much better if they go to a mental health court, and a mental health court usually means that the prosecutor agrees to this—right?—the judge, the arresting officer, everybody agrees that this is the best place for this person, and see if they can get treatment instead of going to prison.

Ms. O'DONNELL. Yes.

Senator FRANKEN. We are going to have another panel who will be talking about some of the tragedies that have happened because our police officers have not gotten the right training, the crisis intervention training that has been so beneficial and is such a big part of this.

Thank you, and I guess we will move on to the next panel. I know we have some votes.

Chairman DURBIN. Ms. O'Donnell, thank you very much for your testimony. We appreciate it.

We will ask that the second panel now come to the witness table, and while they are coming, I am going to read the introductions. I am going to save one introduction for Senator Franken, but I

would like to introduce the others who are coming. Our first witness is Chicago Police Department First Deputy Superintendent Alfonza Wysinger. First Deputy Superintendent Wysinger is second in command of the Chicago Police Department, responsible for overseeing all its daily operations, served as an officer with the CPD for 28 years, many units, including patrol, narcotics, detectives, and the DEA task force, and we thank him for being here.

In addition to that, we have Sergeant A.D. Paul, Jr., a veteran of the Air Force, an officer in Plano, Texas, in the police department, for the past 28 years; received the department's Officer of the Year Award, Supervisor of the Year Award, and Meritorious Service Award. He currently is an instructor with the Dallas Police Department's Crisis Intervention Team Program and a coordinator for the Plano PD's CIT program.

I will let you introduce the next witness.

Senator FRANKEN. Okay. Well, it is my privilege to introduce the Honorable Judge Jay Quam of Minnesota. Judge Quam was appointed to the bench in 2006 following an 18-year career in civil litigation. He has served for more than 3 years as the presiding judge of his district's mental health court, and he has been actively involved in working with Minnesota's law enforcement community to improve collaboration between jails, courts, and mental health providers. Judge Quam offers valuable expertise and a unique perspective, which I have been the beneficiary of, and I am glad that he is able to join us today. Thank you for being here.

Chairman DURBIN. Thank you, Senator Franken.

Our next witness is Pete Earley, a former journalist and author of 13 books. In his book "Crazy," a Pulitzer Prize finalist, Mr. Earley wrote about his experience of trying to get his son out of the revolving door between hospitals and jails and getting the treatment that his son needed. He is a member of the National Alliance on Mental Illness and advocates for mental health reform.

Our next witness is Patti Saylor. Ms. Saylor is the mother of Ethan Saylor, a young man with Down syndrome who was tragically killed in Frederick, Maryland, on January 12, 2013. Ms. Saylor, a registered nurse, is an advocate for people with disabilities, developmental and intellectual disabilities. She founded F.R.I.E.N.D.S., the Family Resource, Information & Education Network for Down Syndrome, a parent support network in Frederick, Maryland, and an affiliate of the National Down Syndrome Society, served on the Maryland Developmental Disabilities Council, co-founded The Parent's Place of Western Maryland.

I would like to ask all the witnesses on the panel to please rise to be sworn in, as is the custom of the Committee. Do you solemnly swear that the testimony you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

Mr. WYSINGER. I do.

Sergeant PAUL. I do.

Judge QUAM. I do.

Mr. EARLEY. I do.

Ms. SAYLOR. I do.

Chairman DURBIN. Thank you. Let the record reflect that all the witnesses answered in the affirmative.

Mr. Wysinger, I am going to put your written statement in the record and ask you if you would give us a summary.

We would appreciate it very much.

STATEMENT OF ALFONZA WYSINGER, FIRST DEPUTY SUPER-INTENDENT, CHICAGO POLICE DEPARTMENT, CHICAGO, ILLINOIS

Mr. WYSINGER. Thank you. Good morning, Chairman and Ranking Member Franken.

Police in Chicago, as in many other metropolitan cities, have been receiving an increasing number of calls for service to respond to situations involving individuals with mental illness and co-occurring mental health and substance abuse disorders. The Chicago Police Department responds to a minimum of 63 pre-identified mental health-related calls per day, over 23,000 per year. Such calls bring police in contact with the veterans impacted by post-traumatic stress disorder and/or traumatic brain injury who face their own unique challenges in seeking treatment services for support.

Youth in desperately need de-escalation support and access to age-appropriate mental health and substance abuse services. All too often, these individuals lack the mental health care providers and non-treatment resources they need to lead healthy, law-abiding lives and to avoid becoming needlessly and inappropriately ensnared in the political and criminal justice systems. Thousands of calls for service are responded to annually by one of 1,800 Chicago patrol officers that have completed the 40-hour Chicago Police Department Crisis Intervention Training Program. These types of calls are responded to by officers who have not been CIT trained. If we are serious about jail diversion in crisis situations, law enforcement and mental health providers must work together to identify, analyze, understand, and solve gaps and weaknesses in the existing police-involved crisis intervention system. The Chicago Police Department and its award-winning CIT program and a network of strong mental health partners are uniquely qualified to do just that—improve the outcomes in Chicago and demonstrate strategies worth replication throughout the Nation.

Therefore, it is critical that mental health treatment services that officers direct people to are responsive and effective. This can only happen if funding is available for these services to continue. We cannot arrest our way out of this problem, nor can we put all of our energy into CIT as the saving grace for this crisis. A broad range of services and psychological services must be accessible. Without these services or with inadequate services, officers—CIT trained or not—eventually will become disillusioned and may stop making efforts to link people to services. Without properly funding services and resources, the volume of calls involving persons with mental illness will only increase, which means that the needs of the citizens are not being met effectively or humanely, resulting in an increase of arrests of persons with mental illness and an increase in injuries to both officers and citizens.

In Chicago, 50 percent of its community mental health centers closed in 2012, and one of three State facilities serving Chicago closed. That created a huge impact on public access, especially those with low income, to mental health services. While the closing

of community mental health centers may play one role in the steadily increasing number of mental health-related calls for police service, it is not the only contributing factor. In Chicago, for instance, the overwhelming majority of people with serious mental illness brought to hospitals by CPD officers are of low income, uninsured, on Medicaid, and unable to obtain their own access to needed services. This unfortunately is the reality, and currently the three largest providers of mental health services are jails in L.A. County, New York, and Cook County Jail in Chicago.

The Chicago Police Department recognizes that CIT programs are an effective tool. Data collected from federally funded sources of CIT Program found that, compared to their non-CIT-trained peers, CIT-trained Chicago police officers directed people to mental health services 18 percent more often. CIT-trained officers reported feeling better prepared to respond without needing to resort to the use of force and less force was used when the subject agitation increased.

No one chooses to be mentally ill. In order for CPD CIT or any CIT program to be successful, it must maintain strong partnerships. The Chicago Police Department's CIT Program is more than just training; it is a partnership with mental health service providers, advocacy organizations, individuals, and family members living with a mental illness.

Thank you.

[The prepared statement of Mr. Wysinger appears as a submission for the record.]

Chairman DURBIN. Thank you very much.

Sergeant Paul.

**STATEMENT OF AUBREY DALE "A.D." PAUL, JR.,
SERGEANT, PLANO POLICE DEPARTMENT, PLANO, TEXAS**

Sergeant PAUL. Thank you, Chairman Durbin, Ranking Member Cruz, and Members of the Committee for allowing me to testify here today. I am here to tell you about our CIT program. It is broken down into two major components: one is the training piece, and just as important is the collaboration or the partnership piece.

I want to describe briefly the training. We have an initial 40-hour class in which all first responders will have to complete, and then we have subsequent training after that. That 40-hour class is broken into day one and two where the officers are trained on the mental illnesses, developmental delays, traumatic brain injuries. They also receive de-escalation communication and active listening skills.

On days three and four, they have to go through reality-based training where they will answer a number of these calls involving anything from an Alzheimer's patient lost to a returning vet with PTSD. The officers must pass those scenarios to get to day five, and day five is probably the most exciting day of the training where we actually have consumers come in and interact with the officers. They tell about their encounters with law enforcement, and they also describe their road to recovery.

I think it is on that day that you can actually see the stigma start to leave from the police officers. Many, like me, come to the job with just a basic understanding of mental illness, and what

they get is from movies and TV and the news where they are often the villain in the script.

The second part of our program is the collaboration or the partnership piece. It is vitally important. We have experts that come into the classroom and give the officers skills on how to recognize mental illness and developmental delays. They are also imperative when we work on a difficult or complex case. We cannot do it alone, and usually the best results come from the back end of those relationships when they get the support that they need.

Also, the support from the advocacy and the provider community is tremendous. In law enforcement, we are going to make mistakes. And when we make those mistakes, it is imperative that those partners provide us with crisis. And if they know our hearts and our heads were in the right place, they will see us through those crises.

The National Alliance on Mental Illness, or NAMI, has been a great supporter of CIT. They were in the beginning with the Memphis model, and they support local training today. Our local NAMI Collin County is a great resource. The only issue I have is when they bring donuts the training. I have gained a few pounds.

CIT has been embraced by a number of law enforcement agencies. I think once administrators and sheriffs learn of the benefits, the empirical evidence, a lot of it gathered from the Memphis CIT Center at the University of Memphis, they will see the reduction in the number of injuries to officers, injuries to civilians. They will see the number of lawsuits and complaints on their department go down. So they are hungry for these programs. Unfortunately, only 2 percent of our local departments in our Nation have full CIT programs.

About 15 years ago, I was involved in a deadly shooting involving the death of Michael Clement, a young man on the autism spectrum. Today I have a 12-year-old son, Christopher Paul, who is also on the autism spectrum. I believe that CIT programs can improve the lives of millions of Americans living with disabilities. Your efforts to help make awareness and funding for CIT programs across our Nation are imperative.

Thank you very much.

[The prepared statement of Sergeant Paul appears as a submission for the record.]

Chairman DURBIN. Thanks, Sergeant.

Judge Quam.

STATEMENT OF HON. JAY M. QUAM, JUDGE, FOURTH JUDICIAL DISTRICT OF MINNESOTA, MINNEAPOLIS, MINNESOTA

Judge QUAM. Thank you, Senator Durbin and Ranking Member Cruz and Senator Franken. As Senator Franken said, my name is Jay Quam, and I have been a Hennepin County District Court judge for a little more than 7½ years. During that time, I have seen the disproportionate number of people with mental health conditions come into all areas of the court system. But the area of the court system where they come in with the greatest number and with the greatest tragedy and heartbreak is in the criminal justice system. And what that means is that people with mental health

conditions are too often brought to jail and then too often are left to languish there.

You know the statistics. You talked about some of them. But when I am in court, they are not statistics to me. They are people like Kevin Earley, Peter's son; or Jason Moore, who was an All-America wrestler with a promising future before schizophrenia led him to break his neck by smashing his head on a jail toilet; or Michael Schuler, who stabbed his eyes out with a pencil.

These are people to me, and they are people whose lives have been shattered by a disease they did not deserve, that they cannot control, and for which they are not able to receive adequate treatment.

This is obviously a very complex problem that is deeply embedded in all of our communities. There is no simple, there is no easy, and there is certainly no inexpensive solution. But what I would suggest is that the Justice and Mental Health Collaboration Act is an excellent step in the right direction. And it is an excellent step in the right direction because it starts with the premise that the best way to keep people from languishing in jail is to keep them from being brought there in the first place.

You already know about the CIT training. That initial point of contact can mean life or death. But it does not end there. The sad reality is that in most of our communities, when law enforcement encounters someone in mental health crisis, they have got three options:

One is to leave them there, which is typically not really an option.

A second is to bring them to the local emergency room, which, as you know, is an incredibly expensive option, but it very rarely leads to productive, successful outcomes.

That leave the jail. And as you have heard and as you have seen, the jail cannot provide adequate mental health treatment for people with mental health conditions.

The Justice and Mental Health Collaboration Act looks at a fourth option, and that option is a facility. I call it a "mental health hub," "crisis dropoff," "central receiving center." Those are the terms that you use for a facility where someone who is in law enforcement who has encountered someone in crisis can bring someone and then get back on the street and do what they do best, and that is, keep our streets safe. That hub, as what I call it, has mental health professionals who can stabilize a person when necessary, assess them to figure out what condition is going on; provide appropriate treatment of them; and when it is safe and appropriate to do so, place them in the community so they do not have to go to jail, and then follow them with the resources that they need to stay there. It is a concept that has great viability and, in fact, in Minnesota, there is legislation that is putting together a working group that is tasked with proposing a mental health center.

But it is not just successful in concept. There are some communities that have actually implemented this, including in Orange County, they have what is called a "central receiving center," and it has been in existence for over 10 years. And in that 10-year period, they have gathered statistics, and they are amazing. They have served 47,000 people. They have saved over 100,000 jail bed

days at a cost of somewhere of \$20 million or more. They have saved 22,000 emergency room bed days, saving, depending on how you calculate it, somewhere between \$17 and \$44 million, all while allowing law enforcement a dropoff time of 12 minutes or less. So I would say mental health hubs should be a central part of any solution going forward.

But, of course, some people are going to go to jail, and what you have already recognized, Senator Durbin, is that we need to be able to interact with those folks as soon as we can; and when we can safely and effectively divert them back to the community through mental health courts or veterans courts, we should do that. You have already expressed better than I can how effective they are, but what I can tell you is they are effective at giving people the lives that they deserve.

So I urge you to continue to look not just at the initial point of contact but at every point through the process where you can work with people, find appropriate alternatives, and get them into the community so they can have happy, successful, and meaningful lives.

Thank you.

[The prepared statement of Judge Quam appears as a submission for the record.]

Chairman DURBIN. Thanks, Judge.

Mr. Earley.

STATEMENT OF PETE EARLEY, AUTHOR, FAIRFAX, VIRGINIA

Mr. EARLEY. Thank you, Chairman Durbin and Ranking Member Cruz, for holding the hearing. Thank you, Senator Franken, for being here.

"How would you feel, Dad, if someone you loved killed himself?" My college-age son asked me that question when we were racing from New York City, Manhattan, to Fairfax County, Virginia, where I live. My son, Kevin, had been diagnosed with a mental illness, bipolar disorder, a year earlier but he had stopped taking his pills. When I picked him up in New York, he had been wandering across that city for 5 days. He had barely slept. He had not eaten. He was convinced God had him on some secret mission.

When we got to the emergency room, the nurse rolled her eyes because Kevin was talking about how God had him on his mission, and he said, "Pills are poison." We were taken into a room. We were being separated from everyone else. We sat there for 4 hours.

Finally, Kevin said, "Nothing is wrong with me. I am leaving." I went outside. I literally grabbed a doctor. I will never forget how he came in that room. He came in with his hands up as if he were surrendering. He said, "I am sorry, Mr. Earley. I cannot help your son." I said, "You have not even questioned him, investigated, asked him anything." It did not matter. Virginia law was very clear at the time. Unless you were in imminent danger, you could not be forced into any treatment. You could not be required to take any pills. And my son had said he thought pills were poison. The fact we had been sitting there for 4 hours meant there was no danger. So I was told, "Bring your son back after he tries to kill you or kill someone else."

I took my son home. Forty-eight hours later, I saw him sink deeper and deeper into a mental abyss. He slipped out of my house. He slipped out early, broke into a stranger's house. Luckily no one was there. It took five police officers to get him out, and an attack dog. He was charged with two felonies: breaking and entering, and destruction of property.

I was so frustrated. Virginia law had kept me from getting him help when he needed it, now wanted to punish him for a crime he committed when he was not thinking clearly.

I am a journalist. I decided to investigate this. I discovered this is not an aberration. As has been said before, right now as we are sitting here, there are 365,000 people with schizophrenia, major depression, and bipolar disorder in our jails and prisons. In 44 States, there are more people in jails and prisons than there are in State mental hospitals.

I spent 10 months in the Miami-Dade County jail following people through to see what happened to them if they had mental illness. Who are these prisoners? They are people like my son. They were not Hannibal Lecter serial killers. They were crowded into cells built for two prisoners. Beatings by guards were common. It was barbaric.

My son got 2 years of probation. He did great. As soon as his 2 years ended, he quit taking his medication. I could see he was slipping. I called the Fairfax County Crisis Response Team. They said, "Is he dangerous?" I said, "No." "Call us when he is dangerous."

The night he became violent, I called them. They said, "Oh, he is violent? We do not come if he is violent. Call the police."

The police came. They shot my son twice with a taser and hog-tied him and took him away and said, "Do you want to file charges?" I was so outraged.

The last time my son had a mental breakdown was a holiday. He was afraid I would call the police. He jumped in his car, he took off. He ran out of gas in North Carolina. He called me. He could not get out of that car because he was hearing voices that said if he got out, he would die.

I arranged for him to get gas. He drove, psychotic, up 95. He got home. We went to a safe house. He said, "I do not want to take pills. Just take me somewhere safe." He got up in the middle of the night. He took off all of his clothes because he thought that made him invisible.

But listen to what happened to him this time. This time, a CIT-trained police officer picked him up, and my son said, "Please do not handcuff me." The officer said, "I can use my discretion." He treated him with respect. He took him to the hospital, and I was told that when the doctor said, "Well, he is not really dangerous," the CIT officer said—and I do not recommend this—"Well, maybe I will take him to your front yard and let him loose." At that point my son was admitted. He got a case manager, Cynthia Anderson, who is sitting down here in the cowboy boots next to my son, Kevin. She said to him, "Why don't you take your meds?" She got him with a doctor who actually talked to my son. They found a medication that actually helped him, a low dose. She said, "Why don't you live with somebody besides your father?" She got him into housing with two people with schizophrenia.

She said, "What do you want to do with your life?" He said, "Well, I have a mental illness. What can I do?" She said, "Do not say that. Control the illness. Do not let it control you."

He became a peer-to-peer specialist, a person with mental illness who actually goes and helps other people with mental illness. He is part of our Fairfax Jail Diversion team right now. In fact, he holds two jobs. He works on weekends at a movie theater as an assistant manager. He lives in his own apartment, pays taxes, and has not had a relapse in 6 years.

My son is an example of what can happen when a person with a severe mental illness is given the tools that he needs to recover. Crisis Intervention Training literally saved his life. Jail diversion, mental health courts, re-entry programs, all of these help persons avoid costly and unnecessary jail and prison sentences. But we need more. We need social workers like Cynthia Anderson to get him supportive housing, meaningful treatment, jobs, and, most importantly, give them hope.

As a board member of the Corporation for Supportive Housing, I have seen hundreds of Kevins recover when they simply just get a safe place to live. There should be no shame in having a mental illness. There should only be shame in us not helping them. And, sadly, our Nation has much to be ashamed about.

Thank you.

[The prepared statement of Mr. Earley appears as a submission for the record.]

Chairman DURBIN. Ms. Saylor.

STATEMENT OF PATTI SAYLOR, FREDERICK, MARYLAND

Ms. SAYLOR. Thank you, Chairman Durbin and Ranking Member Cruz and Senator Franken. Thank you for being here to listen.

I am really excited that this Committee is interested in this subject matter that is so dear to my heart. I have a bit of a different story. As Ethan's mother—Ethan was not mentally ill. Ethan was born with Down syndrome, which is a completely different issue. He had limited cognitive ability.

I want to tell you that I am here as a grieving mother. It has been 14 months. I am not sure that it will ever stop. My family is here, Ethan's cousins, aunts, uncles. We are all still grieving very much for our Ethan.

I want to tell you a little bit about him if you have never met someone with Down syndrome before. Of course, everyone with Down syndrome is their individual person. No two people are alike, just as we are not alike. But Ethan was the most loving, compassionate person on the planet. No one ever met Ethan that did not walk away with a smile.

He had his challenges. He was frustrated a lot in life. Most of his challenges came from the world not understanding him, not valuing him, wanting things that other people had that he could not have—a wife, a college education, a driver's license. So he dealt with a lot of frustration.

He had quite a few passions in life. We have over 500 pictures on my computer right now that people have sent and I have looked at, and I have looked at everything from his lifetime. And his passions become very clear when you look at it. Law enforcement was

one of his passions. Ethan has an entire collection of law enforcement badges and hats and memorabilia that law enforcement officers would give to him.

Law enforcement was never called to respond to Ethan. Ethan called law enforcement on a daily basis because he wanted a job, he wanted to know if they had a dog, he wanted to see their gun, and mostly he just wanted to be friends with the law enforcement officer.

As he got older, that expanded to CSI, FBI, NCIS, Secret Service, and we have a million stories which we like to sit around talking about Ethan's stories because they bring us so much joy in our life.

We live in Frederick County, which is obviously where Camp David is. I worked as a camp nurse across the way at a camp for kids with special needs. And my family was there. Ethan, of course, being independent and strong-willed and lacking total judgment, decides he is going to go visit the President, the sitting President at the time, and I tried to explain to him that that would not be a good idea, that he could get hurt if he did that.

Well, he disappeared and kind of wandered away, and I knew right where he had gone. So, luckily, the Park Service brought him back. But when I had a conversation with Ethan, I said, "Honey, they are not going to know that it is you." He said, "But, Mommy, I am a good guy. I am a good guy. It is okay. I will not hurt the President." And that is what he thought. He did not realize what would happen to him or how people would perceive him.

On January 12, 2013, Ethan went to the movie theater. He went to the movies in our town all the time. He had supports. He benefited from a Medicaid waiver. He had private insurance, lots of family, lots of community support, and he had Government benefits as well. So he had a lot of support, and his support staff was with him, his support staff that was loving, kind, loved him, and he loved her. He had a great say in who he hired.

When he did not pay for the second ticket when he went back into the theater, the theater manager called security. Security were three off-duty sheriff's deputies. They went into the theater after his aide had told them that he had Down syndrome, that I was 5 minutes from the theater, I would help him transition to coming home, or help him stay, and that she could get him out if he needed to leave. They disregarded her and told her to stay out of the viewing area. They went in. The one officer approached him, nicely at first, but demanded that he leave. Ethan was trying to buy a ticket using his cell phone. He had no money. He did not drive for himself. He needed to depend on others to get the things he wanted in life, and he wanted to stay and watch the movie.

The officers proceeded to physically remove him from the theater, dragged him from his seat, tried to handcuff him. When that did not work while he was standing, they placed him on the ground, prone restraint, put handcuffs on, and my son died of asphyxiation on that floor of that movie theater for that \$10 movie ticket.

Ethan was not escalated. He was not threatening. He was not in crisis. He had a problem that needed solving. How do I stay and watch the movie when my aide is telling me it is time to go home? I would have solved that problem in literally absolutely 5 minutes.

Since then, we have done a lot of advocacy in Maryland. We are talking about training. The Governor of Maryland has written an executive order that established a commission to look at law enforcement policy, and we are really looking to change things in the State of Maryland, and you could be extremely helpful in the Federal level.

[The prepared statement of Ms. Saylor appears as a submission for the record.]

Chairman DURBIN. Thank you very much, Ms. Saylor.

The testimony from this panel has been so touching, and I am sure all the Senators feel moved by what you have had to tell us.

Mr. Wysinger, when you take a look at 1,100 or 1,800—I have forgotten the exact number—of the officers in the Chicago Police Department who have CIT training, it really raises a question about those that do not, those who are not new recruits and do not go through the 40-hour course.

Do you have any estimate of what it would cost your police department, our police department, to give training to all of those who come in contact with the public?

Mr. WYSINGER. No, Mr. Chair, I do not have an overall cost of what it would cost to train everyone. But in addition to the new officers, we do send some officers back for refresher courses. The new recruits coming through get 4 hours of training, and we also send officers that have taken the basic training to our advanced 40-hour course. So I would probably have to get back with you with a monetary answer to that, and that I will do, sir.

Chairman DURBIN. I wish you would.

[The information referred to appears as a submission for the record.]

Chairman DURBIN. Sergeant Paul, what a great testimony you gave us. You implemented a program where your police officers in Plano go to the homes of children with developmental disabilities and interact with the kids so that they can establish a comfort level between the police officers and those with disabilities. Can you explain this program and how you happened to bring it to Plano?

Sergeant PAUL. Yes, sir. We know that a lot of this population have a fight-or-flight response to police officers, just their presence and the uniform, the badge, the gun, the police car. So we thought that we had a program where we could be proactive, meet the child or even young adult at their place, communicate in the means in which they communicate, that we are here to help.

One of the issues in the autism world is wandering, and a lot of times we are looking for the child in our police cars with our PA systems, and we have got experience where the child stayed hunkered down. So we were looking for not only the fight-or-flight response when we make contact with them, but also to allow us to find them when they go wandering.

So it was just an effort on our part to bring a program, to be proactive so that that population will have more comfort with uniformed officers. Yes, sir.

Chairman DURBIN. Thank you.

Mr. Earley, when you observed the Miami-Dade criminal justice system, you concluded that 97 chronically mentally ill people in

that community accounted for 2,200 arrests, 27,000 days in jail, 13,000 days in crisis units, at a cost to the city of \$13 million over 5 years, demonstrating that an uncommonly small number of chronically mentally ill people were consuming a large amount of law enforcement resources.

What approaches have you seen that address this issue of repeat—if others who are not speaking would turn off their mics, maybe that will help. Thank you.

What approaches have you seen that successfully address the problem of repeat mentally ill offenders?

Mr. EARLEY. Thank you, Senator Durbin. Wrap-around services, intensive services, assertive community treatment, where the treatment team goes to the person who has a mental illness, instead of handing someone who has a mental illness, who probably does not even have a watch, if they are one of the hard-core homeless persons who are on the street, and telling, “Go here for this appointment,” and “Go here for this appointment,” they actually go in. That along with housing first are essential. The key is CIT, getting an intervention, then getting those persons into the right program that can actually help them.

I am glad you brought up the Miami jail. A hundred thousand dollars a day they are spending there. For one-third that, you could provide housing first, which takes a person whether they have addiction or mental illness and says, “We are going to give you a roof first. Then we will deal with your addiction,” and an ACT team, someone who can come in and say, “This is how we are going to help you. Why don’t you take medication? Have you thought about jobs?” Those are the most successful.

Chairman DURBIN. Ms. Saylor, one of the parts of the tragedy involving your son is a different aspect than what we have talked about so far. Admittedly, the three security officers that you referred to at the movie theater had some capacity in another part of their lives in law enforcement, but they were private security guards in this circumstance here.

What have you learned about their training before in their law enforcement capacity and whether they had any exposure to counseling or training in dealing with mentally ill people? And what can you say about those who are in the private sector security world?

Ms. SAYLOR. The three officers were sheriff county deputies working as security guards for the mall, and they had a short training in mental illness. But to our knowledge, they had no training in interacting with someone with an intellectual disability or a developmental disability such as Down syndrome. So we are not aware of any training that they had had.

Chairman DURBIN. That is an important distinction and one which I had not thought about and should, and I am glad that you brought that up as part of it.

Senator Cruz.

**OPENING STATEMENT OF HON. TED CRUZ,
A U.S. SENATOR FROM THE STATE OF TEXAS**

Senator CRUZ. Thank you, Mr. Chairman, and I want to thank each of the members of the panel for being here and for sharing

your testimony. In particular, Ms. Saylor, I want to thank you for sharing what I know is a heartbreaking experience as a mother, and let me say I am sorry for your loss.

Mental illness and mental disability are challenges we face in our society and face far too many. It has been reported about 6 percent of the population or 1 in 17 Americans suffer from a serious mental illness. About 200,000 of the mentally ill right now are homeless. About 125,000 are incarcerated in jails. And our resources to deal with that challenge are diminishing, and so I appreciate each of you highlighting the problem, highlighting the need for more attention to care for those with mental illness, to provide treatment, and to help those who are able to live to the maximum degree with independence and self-respect and dignity.

In my family, my grandmother suffered from Alzheimer's, and for over a decade we saw her faculties diminish to the point where they were altogether gone. So I have seen firsthand in my family how challenging it can be to deal with a person who no longer has the capacity to interact in a way to take care of herself, and that was a very challenging thing for my family.

I wanted to ask, Ms. Saylor, having gone through what you went through, looking forward what do you think law enforcement can do and should do to prevent future tragedies like the tragedy that happening to your son?

Ms. SAYLOR. Well, I have thought of that a lot, and I think two things.

I think, first of all, we need to build the capacity in the communities for relationship between law enforcement and people with intellectual and developmental disabilities. If we have a relationship, we are less likely to hurt each other, and there would be a greater understanding that a person with Down syndrome that may be refusing to get up out of their seat is really not questioning the officer's authority. Two different issues. So I think that we need to look at activities to build capacity relationship.

Second, obviously law enforcement needs to have training. But with that training, it needs to be dispelling some myths and assumptions, because there was an assumption that my son might be violent or harmful. It did not exist. That was not the issue. So getting rid of some assumptions and stereotypes along then with the training, like Senator Paul has talked about—I mean, Senator Paul? Officer Paul.

Senator CRUZ. Perhaps one day Sergeant Paul will join us as Senator Paul.

[Laughter.]

Sergeant PAUL. Thank you very much.

Senator CRUZ. Well, and let me take that opportunity to shift to Sergeant Paul. First of all, I just want to thank you for your years of service as a police officer in the great State of Texas.

Sergeant PAUL. Thank you.

Senator CRUZ. Before you became an instructor with the Dallas Police Department's Crisis Intervention Team and coordinator for the Plano Police Department's Crisis Intervention Team, what sort of training or protocols were given to police officers when interacting with an individual with mental disabilities or mental illness?

Sergeant PAUL. Throughout my career, we have had different pieces of active listening skills, verbal judo, these sort of things, and they kind of skirted the disability community and substance abuse.

I think one of the issues is from day one of the police academy, and rightfully so, officers have to be trained to control their environment. They have to use escalation of force to control their environment. That is what keeps them safe. And they are taught that throughout the whole academy and then in field training.

The issue comes, some of those same techniques that we are trained in the academy can aggravate someone in crisis. And so communications I think is one of the keys to this for our department. If we can communicate with our community, that we have CIT officers, that we do have the training, if you can get that information to us as quickly as you call in to the 911 dispatch or if the public suspects that there is mental illness, while that officer is still going to control his environment, he can shift into that CIT mode a lot quicker and start using some of those skills, giving some control back to the person so that we can start that de-escalation of that situation and then they can resolve the situation.

Senator CRUZ. Right now what percentage of officers would you say have some significant CIT training?

Sergeant PAUL. With about 2,800 police departments in our Nation with CIT programs—and you are talking about usually major police departments—that would seem like a high number. I think the issue, though, with 14,000 local police departments, we are missing a lot of those officers, a lot of those agencies.

In our department, we decided to train all of our first responders, our school resource officers, our hostage negotiators, our neighborhood police officers; anyone who might be the first responder on a scene of an incident, they are going to be required to go through the 40-hour training. I will get back with you on the number of officers.

Senator CRUZ. Mr. Wysinger, do you have anything to add from the perspective of Chicago on that same question?

Mr. WYSINGER. I would have to agree with Sergeant Paul's analogy. I think the more officers that we actually have trained and able to respond to situations makes for a better environment for public safety. We have implemented a process in Chicago where our dispatchers are actually trained, so they know which officers have gone through the CIT training and they can actually screen some of the calls to ensure that if a call is warranted of a CIT officer, the officer is immediately dispatched to try to help de-escalate the situation before it even rises to a level of use of force. So using that CIT training, being able to dispatch them to the scene first actually goes a long way with ensuring that the public is safe.

Senator CRUZ. Thank you very much.

Chairman DURBIN. Senator Franken.

Senator FRANKEN. I want to thank all the witnesses for being here today, especially Mr. Earley and Ms. Saylor. I know that the experiences you related are very difficult, especially for you, Ms. Saylor, and very difficult but a good outcome for Mr. Earley, which is inspiring. And I know your stories will help a lot of people know that they are not alone and hopefully will enable Congress to make

the reforms that we need, including more crisis intervention training.

Thank you for what you do, Sergeant Paul.

You know, I will just try to tell this as fast as possible. I went to the Columbia Heights Police Department, and it is a suburb in the Twin Cities, and they had had CIT training. And I asked, first of all, give me some idea of what the effect had been, and the sheriff was not there, but the county attorney was, and he apologized for the sheriff not being there. He had to do something. And he said, well, the day after he got the CIT training, he did not kill a guy he would have killed.

So I just turned to a police officer, a woman police officer, and said, "Could I get a more garden variety example?" You know, and she said, "Okay, garden variety." She was a policewoman. She said, "Garden variety. Okay. I do not know. About 3, 4 months ago I was out on the street, and I heard a woman screaming, and I thought it was some domestic violence thing. But she was just screaming, and then she went to this railing on a wall leading down to a playground, and I recognized what was going on, kind of." And she said, "By the way, CIT training is something I use every day. I will probably holster my gun once in my career, but it is something I use every day." And she said, "I was able to talk this woman, if she had dropped"—she had threatened to drop, to let go, and if she had done that, she would have gotten—I do not know if she would have gotten killed. She would have gotten very badly hurt. She talked her off. She said that she had been sexually abused as a child and that the abuser was back in her—had come back. He had left and had come back in her life. And then she said, "I told her, 'I think I can get you some help.'" She referred her to the community mental health services.

She said, "About 2 months later, I was working a community fair. A woman came up to me and said, 'Thank you. You saved my life.'" And I said, "Okay, that is the garden variety story." That is the garden variety story.

So thank you for—I really do believe that we need to have CIT training for every law enforcement official. I think it should be in the Justice and Mental Health Collaboration Act, which, thank you, Sergeant Paul, for endorsing and thank you all, Mr. Quam, for endorsing today in your testimonies. It would do that. It would give that in academies and other training for officers.

I have also heard from corrections officers what a difference it makes in, you know, the—I was in St. Cloud State Prison where they were talking about the different—I remember one officer saying, one of the corrections officers saying to me, "You know those things on TV on the weekend where they show these guys have to suit up because somebody is out of control, and they put on masks and they put on gear and go in there. Sometimes all you have to do is talk to the person, and it saves a lot of wear and tear."

But let us talk about after the crisis intervention training. Judge Quam, you run a mental health court, and what is the difference—what does that do in terms of outcomes, in terms of outcomes for them and for us, for everyone? What is the outcome of having that and hopefully veterans courts, et cetera?

Judge QUAM. Thank you, Senator Franken. There are two different mental health courts: one is a commitment court where there is civil commitment; the other is what more people know, and that is the—we call them “problem-solving mental health courts.” And the statistics nationwide, not just in Hennepin County, are phenomenal for the effectiveness of courts like mental health court and veterans courts. And they work because they provide what Mr. Earley suggested they need, and that is the services that someone needs in order to survive and thrive out in the community. That is one component.

The other component that makes it effective is intensive judicial supervision. So there are a lot of check-ins, there is a lot of monitoring, and there is always the threat of incarceration if the person is not following the path that they need.

When you combine those two components, the statistics are amazing. I cannot spout one off right now, but an incredibly high percent of veterans, people with mental illness, people with drug issues or dependencies can avoid reincarceration, have jobs, become the types of people that they had the potential to become before they became involved in a mental health or problem-solving court.

Senator FRANKEN. My time is up, and I know we have votes, but the costs-benefits in terms of not just actual dollars to the taxpayer but in terms of the lives, this is a more issue, too.

Mr. Chairman, can I ask Mr. Earley to speak to that?

Chairman DURBIN. Sure.

Senator FRANKEN. Or Judge, anyone on the panel, and then I am done.

Mr. EARLEY. Well, I went into jail, and I saw people who could have been my son, so it was very personal to me. And I also read the statistics, and one of the statistics you were after, 85 percent recidivism rate for persons with serious mental illness in jails and prisons—85 percent; 80-percent recovery rate for those same people if you give them—go through a mental health court, get into treatment, have wrap-around services.

The point that Senator Durbin was making earlier about the cost-benefit should be right on. We are spending that money. Senator Cruz talked about a lack of resources. We are already spending it. We are spending \$30,000—in Miami, \$35,000 a year to keep those frequent flyers going back and forth. We are not getting anything for it. Why not use that money for something that works?

Senator FRANKEN. Thank you all—or, Judge Quam?

Judge QUAM. If we have time, I have just got a short story that brought the humane point to me. I was presiding over a commitment case once, and I saw from the file it was a guy about my age. He came into court. It was a guy who looked maybe 80 years old, 75 years old, had schizophrenia beginning somewhere when he was in his 20s, spent most of his life on the streets or in jail or in homeless shelters. He could not talk very well. It was a very short hearing because of that. But he wanted to tell me something, and I told him, “Once we are done here, your lawyer will talk to you, make sure he knows what you said, and he will come and tell me.”

So a couple minutes later, the lawyer came in and said, “This does not make any sense, but what he said was, ‘I used to skateboard with you.’” And you know what he meant by that? He

actually used to skateboard with me. He was one of my high school friends who I had parted ways with, became schizophrenic, and had a completely different life than he deserved. And that was the point where it hit home to me that this can happen to anyone.

Chairman DURBIN. Thank you to this panel, and thanks to Ms. O'Donnell for being here earlier. We have left out a piece of this, which we could hold and probably will hold a separate hearing. Once incarcerated, what about the corrections officers? What happens in that setting?

Now, we have had hearings here about segregation in incarceration, which usually means once incarcerated for a crime, you commit another crime while incarcerated. It turns out that many mentally ill people are destined to be found guilty of violating some rules and conduct because of a lack of understanding on both sides, from the corrections officer as well as the prisoner. And many times it leads to segregation, which makes the mental illness even worse. And then they are released, just to show the ultimate futility and inhumanity of the current system. So thank you for helping to put a perspective on this and helping us to understand it.

We have so many organizations, over 100 organizations and individuals submitted statements for the record, and without objection, I will make them part of the record.

[The statements appear as submissions for the record.]

Chairman DURBIN. I want to give a special shout-out to an individual, Lucius Outlaw, on my staff, who has done a lot of work on this hearing. He is an attorney on a 1-year detail from the Federal Public Defender's Office to this Subcommittee, and his detail is ending soon. I want to thank him for his good work on this hearing and in many other areas.

We are going to keep the record open, and if there are questions from other Members, if you can respond to them in a timely fashion, I would appreciate that very much.

Thank you all for attending today.

[Whereupon, at 11:13 a.m., the Subcommittee was adjourned.]

[Additional material submitted for the record follows.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Witness List

Hearing before the
Senate Committee on the Judiciary
Subcommittee on the Constitution, Civil Rights and Human Rights

On

“Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting
Public Safety”

Tuesday, April 29, 2014
Dirksen Senate Office Building, Room 226
10:00 a.m.

Panel I

The Honorable Denise E. O'Donnell
Director, Bureau of Justice Assistance
United States Department of Justice
Washington, DC

Panel II

Alfonza Wysinger
First Deputy Superintendent
Chicago Police Department
Chicago, IL

A.D. Paul
Sergeant
Plano Police Department
Plano, TX

The Honorable Jay M. Quam
Judge
Fourth Judicial District of Minnesota
Minneapolis, MN

Pete Earley
Author
Fairfax, VA

Patti Saylor
Frederick, MD



Department of Justice

STATEMENT OF

DENISE E. O'DONNELL
DIRECTOR
BUREAU OF JUSTICE ASSISTANCE
OFFICE OF JUSTICE PROGRAMS

BEFORE THE

COMMITTEE ON THE JUDICIARY
SUBCOMMITTEE ON THE CONSTITUTION, CIVIL RIGHTS, AND
HUMAN RIGHTS
UNITED STATES SENATE

AT A HEARING ENTITLED

"LAW ENFORCEMENT RESPONSES TO DISABLED
AMERICANS: PROMISING APPROACHES FOR PROTECTING
PUBLIC SAFETY"

PRESENTED
APRIL 29, 2014

Denise E. O'Donnell
Director
Bureau of Justice Assistance
Office of Justice Programs
Statement Before the Senate Judiciary Subcommittee on the Constitution, Civil
Rights, and Human Rights
Washington, D.C.
April 29, 2014

Chairman Durbin, Ranking Member Cruz, and distinguished members of the Subcommittee, thank you for this opportunity to discuss the Department of Justice's support of state and local law enforcement responses to crisis incidents involving people with disabilities and untreated mental illnesses.

I am Denise E. O'Donnell, the Director of the Bureau of Justice Assistance (BJA), within the Department's Office of Justice Programs (OJP). BJA's mission is to provide policy leadership, guidance, and support to state, local, and tribal partners in implementing evidenced-based and promising programs and strategies to promote safer communities. I am pleased to speak to you today about the strong commitment the Department, and BJA specifically, has to law enforcement in their growing role as the first responders to crisis incidents involving people with mental illness and developmental disabilities.

The intersection of criminal justice and mental health has been a top priority in my career. In addition to being an attorney, I hold a Master's Degree in Social Work and worked as a social worker in a community mental health center. Prior to my confirmation, I served as the New York State Deputy Secretary for Public Safety, overseeing 11 homeland security and criminal justice agencies. In that capacity, I worked closely with state and local criminal justice and mental health agencies to address the growing mental health challenges in the criminal justice system. I also served as co-chair of the New York State/New York City Mental Health-Criminal Justice Panel, which

issued a report making a number of recommendations to improve the public safety response to persons with serious mental illness.

As the Director of BJA, one of my priorities is to invest in programs that improve justice system response to encounters involving people with mental illness and with developmental disabilities by utilizing and highlighting strategic and sustainable approaches that incorporate evidence-based prevention and intervention strategies.

It is important to recognize an often misleading perception in society that individuals with mental illness are violent. A person with a severe mental illness who has no history of substance abuse or violence has the same likelihood of being violent as any member of the general public. The risk of violence statistically attributable to serious mental illness is estimated to be 3 to 5 percent.ⁱ Because serious mental illness affects a small percentage of the population, it makes—at best—a very small impact on the overall level of violence in society. In fact, people with serious mental illnesses are anywhere from 2.5 times to nearly 12 times more likely to be the victims rather than the perpetrators of violence.

Despite these statistics about a lack of violent behavior, persons with serious mental illness make up a significantly disproportionate number of persons in our nations' jails. According to a 2009 report in *Psychiatric Services*, of people booked into U.S. jails, 14.5 percent of men and 31 percent of women had a serious mental illness—rates in excess of three to six times those found in the general population. Taken together, these numbers comprise 16.9 percent of jail bookings.ⁱⁱ A 2006 study from OJP's Bureau of Justice Statistics found that 64 percent of individuals incarcerated in jails had recently reported symptoms of a mental health disorder or were recently diagnosed with or treated for a mental disorder. About 24 percent of jail inmates reported symptoms of a psychotic disorder.ⁱⁱⁱ

Similarly, BJA recently funded a study, *Women's Pathways to Jail: Examining Mental Health, Trauma and Substance Abuse*^{iv}, which found that 32 percent of participants met

the criteria for a serious mental illness in the past year. Furthermore, the number of women meeting criteria for multiple lifetime and current disorders was high, and the prevalence of serious mental illness, Post Traumatic Stress Disorder, and substance use disorders- as well as high rates for co-occurring disorders- suggests that female offenders enter (or reenter) jail with substantial and often multiple mental health concerns and consequently have complex treatment needs. The report has been distributed widely and we hope that stakeholder groups of providers and policymakers in states and communities will use the report to make data-driven policy decisions concerning this population.

Several state and local jurisdictions have shared data that paints a picture of the challenges and successes that law enforcement faces around encounters with mentally ill individuals. The Tulsa Police Department has experienced a shortage of treatment services for individuals with mental disorders in need of crisis care, requiring officers to expend large amounts of time and resources transporting people to access treatment across the state. A 2012 report found that in one year, Tulsa officers made 180 such transports, with an average of 229 miles for each trip. In the first nine months of 2006, the Los Angeles (CA) Police Department made 46,129 contacts with people who displayed symptoms of mental disorders. The San Diego (CA) Police Department saw a 54percent increase in calls relating to mental health or suicide from 2008 to 2012. In a 2009 survey of the 100 sheriff's offices in North Carolina, the departments collectively reported more than 32,000 trips to transport individuals for involuntary commitments to psychiatric service providers. The median time for one transport was eight hours. In 2012, crisis intervention team officers from the Miami-Dade (FL) Police Department and City of Miami Police Department responded to nearly 10,000 mental-health related calls, resulting in over 2,100 diversions to crisis services and just 27 arrests.^y These statistics demonstrate both the need for increased community-based mental health services and the need for improved methods for police to interact with people with mental illness and local service providers.

We are grateful for the work of the Senate Judiciary Committee, and this Subcommittee in raising awareness of crisis incidents involving people with disabilities and untreated

mental illnesses. The Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA), signed into law in 2004, enabled BJA to take a leadership role in addressing the intersection of criminal justice and mental health. MIOTCRA enabled BJA to create the Justice and Mental Health Collaboration Program, which facilitates collaboration among the criminal justice, juvenile justice, and mental health and substance abuse treatment systems to improve access to effective treatment for people with mental disorders and to increase public safety.

Justice and Mental Health Collaboration Program

Since 2006, BJA has awarded 287 Justice and Mental Health Collaboration Program grants to sites that span 49 U.S. states and territories, tribal governments, and the District of Columbia. Grant recipients may use the grants for a broad range of activities, including crisis intervention teams and other specialized law-enforcement-based responses; mental health courts; mental health and substance abuse treatment for individuals who are incarcerated or involved in the criminal justice system; community reentry services; and cross-training of criminal justice and mental health personnel. Underscoring the collaborative nature of this program, all grants require a joint application from a mental health agency and unit of government responsible for criminal and/or juvenile justice activities.

The Justice and Mental Health Collaboration Program has helped BJA identify promising models to respond to this vulnerable population and approaches that are effectively support law enforcement and other components of the criminal justice system.

Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Correction Systems

For example the Justice and Mental Health Collaboration Program funds research that is put into direct action. In New York City, where even as crime has decreased and the jail population has declined, people with mental illness continue to represent an increasing percentage of the City's jail population (less than 25 percent of the average daily population in 2005 vs. about 33 percent in 2011).^{vi} In December 2012, BJA, through the

Justice and Mental Health Collaboration Program, funded the Council of State Governments Justice Center to analyze individuals with mental health needs booked into Rikers Island Correctional Facility. The Center developed the report *Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Correction Systems*.

The report found that inmates with mental illnesses stayed in jail nearly twice as long—an average of 112 days compared with 61 days—in part because people with mental illnesses were less likely to make bail and took longer to do so when they did. Based on the recommendations outlined in this report, in December 2013, New York City officials planned, funded, and are currently implementing “Court-based Intervention and Resource Teams” in each city borough. The teams will receive, collect, and quickly transmit accurate information about a defendant’s risk of flight, risk of re-offense and mental health and substance abuse treatment needs to inform pretrial, plea, and sentencing decision making and to facilitate timely connection to appropriate community-based supervision and treatment. The lessons learned from this initiative can serve as a model for other jurisdictions. This initiative also highlights the consequences of not having a specialized law enforcement response to divert individuals with mental illnesses as early as possible.

Since the inception of the Justice and Mental Health Collaboration Program, 74 grants (26 percent of the total 287 awards) have been awarded directly to a police or sheriff’s department as the criminal justice co-applicant. For example, the Los Angeles Police Department (LAPD) utilizes specially trained officers and clinicians from the Los Angeles County Department of Mental Health (LADMH). Together, these departments manage incidents involving people suffering from mental health crisis.

National Law Enforcement/Mental Health Learning Sites

In recognition of their innovative and effective program, BJA has selected the LAPD, along with five other jurisdictions -- Houston (TX) Police Department; Madison (WI) Police Department; Portland (ME) Police Department; Salt Lake City (UT) Police

Department; and University of Florida Police Department -- who have successfully implemented innovative strategies, to act as national law enforcement/mental health learning sites—agencies that will help other jurisdictions across the country improve their responses to people with mental illnesses. The six learning sites host site visits from interested colleagues and other local and state government officials, answer questions from the field, and work with the Council of State Governments Justice Center staff to develop materials for practitioners and their community partners. To date, over 584 jurisdictions across the country have requested to visit the learning sites.

Crisis Intervention Team Responses

BJA Justice and Mental Health Collaboration Program grants also support jurisdictions implementing Crisis Intervention Teams, an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships. There are over 2,800 Crisis Intervention Teams programs nationwide that are built on local partnerships between law enforcement agencies, mental health providers and advocates. They involve individuals living with mental illnesses and families at all levels of decision-making and planning. Crisis Intervention Teams provide law enforcement-based crisis intervention training on assisting individuals with mental illness and a forum for partner organizations to coordinate diversion from jails to mental health services.

In many communities, Crisis Intervention Teams (CIT) have served as a springboard for a broader collaboration between the criminal justice and mental health systems. These programs have included partners from the juvenile justice system, schools, courts, corrections, homeless services, children's mental health services, the Department of Veterans Affairs and others. Many CIT programs have begun to offer trainings to correctional officers, dispatchers, EMTs, firefighters, school resource officers, hospital safety officers and others. There are also CIT programs that offer specialized trainings focused on responding to youth and veterans.

One example of an innovative CIT program supported through the Justice and Mental Health Collaboration Program, is a partnership between the Allegheny County Office of

Behavioral Health and the Pittsburgh Police Department. As part of the CIT program, the County established a triage site, which serves as a resource for law enforcement officers who respond to people in mental health crisis. The Resolve Crisis Network (Resolve) provides round-the-clock, mental health crisis intervention and stabilization services. Relying on a staff of 150 crisis-trained psychiatrists, counselors, crisis nurses, crisis service coordinators, and peer support staff. Resolve provides multiple crisis services 24 hours a day, 365 days a year, including a telephone hotline, mobile dispatch unit, walk in services, and residential services for up to 72 hours.

Looking to support broader implementation of CITs across the country, BJA has partnered with the University of Memphis and the University of Illinois to create a national CIT standardized curriculum for a 40-hour, classroom-based in-person course for patrol officers and dispatch personnel. Training for officers will consist of didactics and lectures conveying specialized knowledge pertaining to mental illness, mental health patients, suicide prevention, and family/community perspectives. There will be on-site visits with mental health patients to help officers become more familiar with this constituency, and a range of scenario-based practical skills training elements. Dispatchers will receive training on proper receiving and dispatch of calls involving individuals in mental health crisis.

The Civil Rights Division at the Department of Justice supports the use of CIT and other de-escalation and collaborative methods as a means for law enforcement agencies to avoid civil rights violations and improper uses of force toward people with disabilities. The Civil Rights Division has included CIT as part of the remedy in civil rights settlements in various cities. These settlements are resulting in substantially improved outcomes in police interactions with people with disabilities.

Specialized policing responses for people with mental illnesses

In addition to local initiatives like CIT, BJA has also supported efforts on a statewide level to strategically implement coordinated initiatives tailored to the unique needs of the local community. The BJA-supported publication, *Statewide Law Enforcement/Mental Health Efforts: Strategies to Support and Sustain Local Initiatives*, highlights statewide initiatives for supporting local-level specialized policing responses for people with mental illnesses. Specialized policing responses are designed to help individuals in crisis connect to community-based treatment and supports, when appropriate, instead of becoming involved in the criminal justice system.

Law Enforcement–Mental Health Collection Data Practices for Specialized Policing Response (SPR) Programs

BJA has also funded efforts through the Council of State Governments Justice Center, in partnership with the Police Executive Research Forum (PERF) to support the “Law Enforcement-Mental Health Data Collection Practices for Specialized Policing Response Programs” project. Working with three police jurisdictions, Cambridge Police Department (MA), Delaware Police Department (OH) and Denver Police Department (CO), the Justice Center is identifying data collection obstacles and developing a tailored approach to improving the agencies’ data collection and use practices.

State Justice Assistance Grant funding supporting mental health efforts

In addition to this discretionary funding, some states use BJA administered JAG funding to improve criminal justice response to individuals with mental illness. Pennsylvania is using JAG funds to support the Mental Health and Justice Advisory Committee (MHJAC) and the Mental Health and Justice Center of Excellence. The Center of Excellence (whose work is overseen by MHJAC) promotes the use of evidence-based strategies for addressing the unique challenges associated with offenders with behavioral health disorders. The Center of Excellence provides resources, information, and technical assistance, and has conducted statewide and county specific systems-level mappings to help decision makers understand how those with significant behavioral health needs cycle through justice systems. This mapping process, known as the

Sequential Intercept Model, helps decision makers get a better understanding of where, within state and local justice systems, diversion or treatment alternatives may produce the highest return on investment and have a positive impact on public safety.

In addition to the work being performed at BJA, the Office of Community Oriented Policing Services (COPS) has long recognized the importance of ensuring that law enforcement has the requisite skills, knowledge, and sensitivity when encountering persons with mental illness. COPS has also recently partnered with the National Alliance on Mental Illness (NAMI) to develop a model for communities to address the mental health needs of law enforcement and other first responders in the aftermath of a mass casualty events, including school shootings. The project will address how law enforcement and other local government agencies can intervene to assist officers and other first responders who are experiencing PTSD symptoms. COPS and NAMI are working directly with the town of Newtown, CT, as one stakeholder to gain feedback on one community's response to a mass casualty event, and develop resources that enable other communities to address mental health needs of first responders in a timely and effective way.

The Arc's National Center on Criminal Justice and Disability (NCCJD)

Although BJA devotes significant resources and attention to individuals with mental illness who are involved with the criminal justice system, we also recognize that the justice system needs targeted and strategic responses to individuals with intellectual or developmental disabilities (I/DD). In 2013, BJA awarded funds to The Arc to create The National Center on Criminal Justice and Disability (NCCJD). This is the first national effort of its kind to bring together both victim and suspect/offender issues involving people with intellectual or developmental disabilities. When fully developed, the National Center on Criminal Justice and Disability will serve as a national clearinghouse and online resource, as well as provide training and technical assistance in this important area. Other DOJ partners such as the Office of Victims of Crime and the Division of Civil Rights are also focused on the particular needs and vulnerabilities of

developmentally disabled persons, and we believe the National Center will be an important resource for all.

Conclusion

In conclusion, I would like to emphasize that we are leveraging a number of other BJA funding resources that we have available to better serve persons with mental illness. These resources include veterans' treatment courts and other problem-solving courts, Second Chance Act reentry programs, specifically the Second Chance Act Reentry Program for Adult Offenders with Co-Occurring Substance Abuse and Mental Health Disorders. These programs help support individuals with mental illness remain in the community with supervision and access treatment when appropriate. They also improve the transition for people with mental illness out of incarceration and facilitate the successful return to their communities resulting in a reduction of recidivism. Along with this statement, we are also submitting for the record a compendium of BJA funded Justice and Mental Health Resources.

Mr. Chairman, Ranking Member Cruz, and Members of the Subcommittee, this concludes my testimony. Thank you for the opportunity to testify today and I would be glad to answer any questions you may have.

ⁱ Richard A. Friedman, "Violence and Mental Illness—How Strong is the Link?" *New England Journal of Medicine* 355 no. 20 (2006), 2064–2066.

ⁱⁱ Henry J. Steadman, Fred C. Osher, Pamela Clark Robbins, Brian Case, and Steven Samuels, "Prevalence of Serious Mental Illness among Jail Inmates," *Psychiatric Services* 60 (2009): 761–765.

ⁱⁱⁱ Doris J. James and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates* (Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice, 2006).

^{iv} Shannon M. Lynch, Dana D. DeHart, Joanne Belknap, and Bonnie L. Green, "Women's Pathways to Jail: The roles & intersections of serious mental illness & trauma" (Washington, DC: Bureau of Justice Assistance, U.S. Department of Justice, 2012).

^v Steven Leifman, witness testimony at Congressional hearing "Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage," March 26, 2014, available at <http://docs.house.gov/meetings/IF/IF02/20140326/101980/HHRG-113-IF02-Wstate-LeifmanS-20140326.pdf>.

^{vi} The Council of State Governments Justice Center, *Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Correction Systems*, (2012), available at http://csgjusticecenter.org/wp-content/uploads/2013/05/CTBNYC-Court-Jail_7-cc.pdf.

BJA-Funded Justice and Mental Health Resources**GRANT PROGRAMS****Justice and Mental Health Collaboration Program**

MIOTCRA was signed into law by President Bush in 2004 and authorized a \$50 million grant program to be administered by DOJ. This law created the Justice and Mental Health Collaboration Program (JMHCP) to help states and counties design and implement collaborative efforts between criminal justice and mental health systems.

In 2008, Congress reauthorized the MIOTCRA program for an additional five years. The reauthorization bill also expanded training for law enforcement to identify and respond appropriately to individuals with mental illnesses, and supported the development of law enforcement receiving centers as alternatives to jail booking, to assess individuals in custody for mental health and substance abuse treatment needs.

Funding History

\$5 million in fiscal years 2006 and 2007

\$6.5 million in fiscal year 2008

\$10 million in fiscal year 2009

\$12 million in fiscal year 2010

\$10,770,600 in fiscal year 2011

\$9 million in fiscal year 2012

\$9 million in fiscal year 2013

\$8,250,000 in fiscal year 2014

PUBLICATIONS/REPORTS**Women's pathways to jail: The roles & intersections of serious mental illness & trauma**

The rate of incarceration of women has increased substantially in recent decades, with a 31% increase between 2000 and 2011. Female offenders appear to have different risk factors for offending than do male offenders. In particular, female offenders report greater incidence of mental health problems and serious mental illness than do male offenders) and higher rates of substance dependence as well as greater incidence of past physical and sexual abuse. Other researchers also have noted elevated rates of experiences of interpersonal trauma, substance dependence, and associated symptoms of

BJA-Funded Justice and Mental Health Resources

posttraumatic stress disorder in female offenders. This BJA-funded multi-site study addresses critical gaps in the literature by assessing the prevalence of serious mental illness, posttraumatic stress disorder, and substance use disorders in women in jail and pathways to jail for women with and without serious mental illness. www.bja.gov/Publications/Women_Pathways_to_Jail.pdf

Intersection of the Criminal Justice and Mental Health Systems Publications

BJA has partnered with the Justice Center, and in many instances, other federal departments such as the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Labor (DOL), to publish and disseminate 15 publications related to the intersection of the criminal justice and mental health systems.

Publications can be found on the Justice Center's website [here](#)¹.

These publications are also listed below. Publications denoted with an asterisk (*) were also funded by partner federal agencies.

For Law Enforcement:

- Improving Responses to People with Mental Illnesses: Tailoring Law Enforcement Initiatives to Individual Jurisdictions
- Improving Responses to People with Mental Illnesses: The Essential Elements of a Specialized Law Enforcement-Based Program
- Improving Responses to People with Mental Illnesses: Strategies for Effective Law Enforcement Training

For Courts:

- A Guide to Collecting Mental Health Court Outcome Data
- A Guide to Mental Health Court Design and Implementation
- A Guide to the Role of Crime Victims in Mental Health Courts*
- Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court
- Navigating the Mental Health Maze: A Guide for Court Practitioners

For Corrections/Community Corrections:

- Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*
- Improving Outcomes for People with Mental Illness under Community Corrections Supervision: A Guide to Research-Informed Policy and Practice*

¹ http://consensusproject.org/jc_publication

BJA-Funded Justice and Mental Health Resources

- Improving Responses to People with Mental Illnesses: The Essential Elements of Specialized Probation Initiatives*

For Victim Advocates/Service Providers:

- Responding to People Who Have Been Victimized by Individuals with Mental Illnesses*
- Violence against Women with Mental Illness

For General Criminal Justice/Mental Health Professionals:

- Criminal Justice/Mental Health Consensus Project*
- Information Sharing in Criminal Justice/Mental Health Collaborations: Working with HIPAA and Other Privacy Laws

National Policy Summit on Building Safer Communities: Improving Police Response to Persons with Mental Illness.

In May 2009, the International Association of Chiefs of Police (IACP), in collaboration with BJA, JEHT Foundation, and the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services hosted a National Policy Summit on Building Safer Communities: Improving Police Response to Persons with Mental Illness. The goal of the summit was to begin a dialogue resulting in recommendations for local, state, federal, and tribal organizations that will improve the safety of community members and law enforcement officers when responding to crisis calls involving a person with mental illness. These recommendations are intended to reduce trauma, injury, or death during mental health crisis calls and to promote dialogue between law enforcement, community providers, and partners that will sustain short and long term improvement in crisis call response, treatment, and recovery around the United States. The final report is available at:

<http://www.theiacp.org/PublicationsGuides/NationalPolicySummits/BuildingSaferCommunities/tabid/664/Default.aspx>

WEBINARS

Since 2009, BJA, with additional support from other departments, has funded 30 webinars targeted at criminal justice and mental health system stakeholders around the topics of criminal justice and mental health. Webinars are unique in that they offer the ability to allow members of the field to interact with one another and experts in the field, while saving on the cost of traveling to meet in person. All webinars supported by BJA, as well as other federal partners, are open to the public and stored on the Justice Center's website for distance-learning opportunities.

BJA-Funded Justice and Mental Health Resources

Of particular note are the following webinars:

- Child Trauma and Juvenile Justice: Prevalence, Impact, and Treatment
- Improving Mental Health Court Response to Crime Victims
- Mental Illness and Violence

All Justice Center webinars can be found [here](#)².

CURRICULA

Developing a Mental Health Court: An Interdisciplinary Curriculum

BJA provided grant funds in 2010 to the Justice Center at the Council of State Governments to develop an interdisciplinary mental health court curriculum. This curriculum brings together interviews with experts from over 20 states into an accessible curriculum that includes both online and live elements. The curriculum can also be adapted for diverse learning needs, including introductions to behavioral health and criminal justice, discussion of the latest research from behavioral health and criminology, program design decisions, and tips for program management and sustainability. The curriculum will be online and available for use starting in January 2013 (<http://learning.justicecenter.csg.org/>). Technical assistance will be available from the Justice Center for states and localities that are interested in using or adapting the curriculum.

Law Enforcement Response to Special Populations:

- Community engagement, assessment, and implementation curriculum;
- Law enforcement response training curriculum; and
- Train the trainers curriculum.

The University of Memphis, in partnership with National Alliance On Mental Illness (NAMI), International Association of Chiefs of Police (IACP), and CIT International, has developed draft core elements curricula which includes not only law enforcement response training and train the trainers, but also a curriculum for community engagement, assessment, and implementation. The project includes a strategy for participants and trainers to evaluate the curriculum by creating a national template for curriculum evaluation using state and local programs to assist in identification of evaluation tools. The partner organizations will provide on-going technical assistance with the goal of creating programs that are permanent and self-sustaining. Please note that the curricula are still in development and not yet final, but the draft is accessible at: <http://cit.memphis.edu/bja.php>

² <http://consensusproject.org/technical-assistance/webinars>

BJA-Funded Justice and Mental Health Resources**RISK ASSESSMENT TOOL****RNR Simulation Tool**

This project is in the final stages of development of a RNR Simulation Tool that can assist local, state, and/or federal agencies to use the risk-need-responsivity approach in practice through defining the type and nature of correctional options available in their jurisdictions. This tool, which is still in development, will allow practitioners to assess the programs they already provide, based on intensity of liberty restrictions, treatment offered, content, and quality. BJA is also supporting the development of a tool that will allow practitioners to assess an individual's programming needs based on risk and criminogenic needs. The user will enter the individual's risk level and the number of criminogenic needs he/she has, then the tool will recommend programming for that individual. The tool is accessible at http://www.gmuace.org/research_rnr.html

Written Testimony of Alfonza Wysinger

First Deputy Superintendent, Chicago Police Department

Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights

“Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety Hearing”

April 29th, 2014

Thank you Chairman Durbin for convening today's hearing on *Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety* and inviting me to testify.

Police in Chicago, as in many other metropolitan cities, have been receiving increasing numbers of calls for service to respond to situations involving individuals with mental illness and co-occurring mental health and substance abuse disorders. All too often, these individuals lack the access to mental health care providers and non-treatment resources they need to lead healthy, law-abiding lives and to avoid becoming needlessly and inappropriately ensnared in the criminal justice system. Many such police-involved calls bring police into contact with veterans impacted by Post Traumatic Stress Disorder (PTSD) and/or Traumatic Brain Injury (TBI) who face their own unique challenges in seeking treatment services and support, and with youth in crisis in desperate need of de-escalation support and access to age-appropriate mental health and substance abuse services.

Because law enforcement officers are generally the first responders to crisis events, it is important to have individuals in law enforcement who can utilize effective strategies to ensure public safety. The Crisis Intervention Team Training provides officers with education about mental illness, as well as providing skills and tools for effectively and safely interacting with someone who is experiencing crisis.

CIT in Chicago

The Chicago Police Department's CIT Training is an in-depth 40-hour specialized course of study for patrol law enforcement officers who, in addition to their regular service calls, will be required to respond to crisis calls involving people with mental illness. These officers will use their knowledge and skills of mental illness and substance abuse to effectively handle any crisis and make the most appropriate disposition, which will best serve the individual and the community.

The key components of the CIT course are:

- Officers are exposed to the basic dynamics of common types of mental illness. This allows the officer to make quick decisions, utilizing options they have to resolve the crisis.
- Officers are exposed to the experiences, viewpoints, and concerns of people with mental illness (consumers). Officers meet with consumers in community settings in order to gain their perspective and learn from them.

- Officers receive instruction and demonstrations in basic listening and responding skills along with crisis intervention strategies. Real life scenarios on different types of mental illnesses are presented.

The Crisis Intervention Team (CIT) model is a dynamic collaboration of law enforcement and community organizations committed to ensuring that individuals with mental health treatment needs are referred for appropriate services and support rather than ending up in the criminal justice system. CIT programs have several essential components, including: training law enforcement as first responders to better understand individuals experiencing psychiatric crisis and how to respond effectively and safely to a crisis; designation of officers who have completed CIT training to respond to crisis situations; collaboration between law enforcement and adult or child serving systems to create effective linkages with mental health services instead of arrest and incarceration; and inclusion of people with mental illness and their families at every level of the program.¹

The Crisis Intervention Team model has been extensively implemented and evaluated over the country. Currently, there are over 2,700 CIT Programs nationally, according to the University of Memphis. Although each of these programs may have adopted strategies and information relevant to their jurisdiction's law enforcement structure and community needs, there are standard "Key Elements" or best practice components for CIT programs, including:

¹ National Alliance for the Mentally Ill. (2009). *Supporting Schools and Communities in Breaking the Prison Pipeline: A Guide to Emerging and Promising Crisis Intervention Programs for Youth*. Washington, DC. Located at: www.nami.org/caac.

- 1) Partnerships: Law Enforcement, Advocacy, Mental Health: bringing together a wide array of stakeholders in the community and professionally to identify core needs of the community.
- 2) Community Ownership: Planning, Implementation & Networking: Ensuring the partnership group is included in key decisions.
- 3) Policies and Procedures: Standardization of procedures for responding to a mental health crisis.
- 4) CIT: Officer, Dispatcher, Coordinator: A senior-level law enforcement official stewarding the development, implementation, and sustainability of the CIT program.
- 5) Curriculum: CIT Training: Standardized, with a core curriculum and expert presenters and teachers.
- 6) Mental Health Receiving Facility, Emergency Services: Identified partners who operate under shared principles and procedures.
- 7) Evaluation and Research: An external evaluator who can legitimize the training product and establish fidelity to the principles of the CIT model.
- 8) In-Service Training: Continuing education credits for officers who become certified.
- 9) Recognition and Honors: Commendation for officers who become certified and effectively implement CIT principles and techniques in a crisis situation.
- 10) Outreach: Developing CIT in Other Communities: Promoting the CIT principles and techniques in bordering cities/counties to build momentum for the project and to promote safe and healthy communities.²

To date, the Chicago CIT Program has trained over 2,200 police officers, 1,800 of which are still active CPD members. This training utilizes a unique specialized subject matter approach which relies upon the instructional expertise of mental health professionals and actual mental health consumers (in recovery). Each class is carefully introduced to the sensitive family issues brought on by a mental health crisis; each class is thoroughly briefed by service providers as to

the specific services they offer the actual consumer. The training program in Chicago uses an unprecedented blend of academic credentialed experts, law enforcement professionals, actual consumers, and field experienced experts to deliver a dynamic and powerful mental health training product.

Each one of 1,800 Chicago patrol officers who have completed the 40 hour Chicago Police Department (CPD) Crisis Intervention Team (CIT) program annually responds to thousands of such calls for service. These same type of calls are responded to by officers who have not been CIT trained. If we are serious about jail diversion in crisis situations, law enforcement and mental health professionals must work together to identify, analyze, understand, and solve gaps and weaknesses in the existing police-involved crisis intervention system. The Chicago Police Department and its award-winning Crisis Intervention Team (CIT) Program and a strong network of mental health partners are uniquely qualified to do just that - improve outcomes in Chicago to demonstrate strategies worthy of replication throughout the nation.

Chicago CIT Youth

This program is specifically designed to teach police officers how to recognize the signs and symptoms of children and adolescents in a mental health crisis, promote de-escalation skills when engaging juveniles in crisis, and develop specific intervention skills designed for child and adolescent mental health crisis situations. The Chicago CIT Youth was the first advanced 40 Hour training in the country focusing on mental health issues related to children and adolescents. This module was created based on officers requesting specialized training in

dealing with youth population. This proactive course of study is also effective when engaging youth who are in crisis. **This training course is only offered to officers who have already completed the Basic CIT certification.** Officers volunteering for this advanced training represent the uniformed district patrol personnel and officers assigned to the Chicago's Public School system.

Scope of the Issue

Nationwide, 1 in 4 adults struggle with mental illness³, while in Illinois alone, more than 700,000 adults struggle with severe mental illnesses at an annual cost to the state of more than \$2.6 billion in direct and indirect costs, including: reduced labor supply; public income support payments; reduced educational attainment; and costs associated with other consequences such as incarceration or homelessness. Yet, just in the last four years, according to the National Alliance on Mental Illness Illinois⁴, spending on mental health in Illinois has been cut by 32% and three major psychiatric hospitals have closed.

In Chicago, 50% of its community mental health centers closed in 2012, and 1 out of the 3 state facilities serving Chicago closed. This created a huge impact on public access (especially by those with low income) to mental health services. While the closure of community mental health centers may play one role in the steadily increasing number of mental health-related police calls for service, it is not the only contributing factor. In Chicago, for instance, the overwhelming majority of people with serious mental illness brought to hospitals by CPD officers are of low income, uninsured or on Medicaid, and unable on their own to access

³ National Alliance on Mental Illness (NAMI)

⁴ National Alliance on Mental Illness (NAMI)

needed services. The unfortunate reality is that currently the three largest providers of mental health services are jails- LA County, New York, and Cook County Jail, located in Chicago.

Chicago patrol officers frequently respond to calls for service involving: 1) citizens in crisis, 2) U.S. military veterans and 3) youth who are experiencing signs and symptoms of mental health or substance abuse disorders. Alarming, current statistics indicate that the U.S. prison population is increasing to post-Vietnam era levels, when veterans were 24% of the federal prison population, and 21% of the state population. This increase is attributed to the men and women returning home from Iraq and Afghanistan (Veterans & Justice, Justice Policy Institute⁵). According to Pentagon reports, suicides among soldiers and military veterans have reached epidemic proportions, with 154 suicides for active duty troops in the first 155 days of 2012. In addition, research shows that 70% of justice system-involved youth have one or more psychiatric disorders (National Center for Mental Health and Juvenile Justice. Blueprint for Change: 2006⁶). At least 20% of these youth have a serious mental illness, including those who are suicidal, struggling with psychotic disorders, and experiencing symptoms that significantly interfere with their day-to-day functioning (Blueprint for Change: 2006⁷). Youth violence in Chicago has become a topic of national concern, and officers responding to calls for service involving such juveniles face special risks – and opportunities – when interacting with them in crisis situations.

⁵ Hafemeister, T. L., & Stockey, N. A. (2010). Last Stand-The Criminal Responsibility of War Veterans Returning from Iraq and Afghanistan with Posttraumatic Stress Disorder. *Ind. LJ*, 85, 87.

⁶ Skowrya, K. R., & Cocozza, J. J. (2007). Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system. *Delmar: National Centre for Mental Health and Juvenile Justice*.

⁷ Skowrya, K. R., & Cocozza, J. J. (2007). Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system. *Delmar: National Centre for Mental Health and Juvenile Justice*.

We know from CPD data that Chicago police responded to over 2.2 million calls for service in 2012, and that a significant but underreported percentage of those calls for service (CPD CIT staff believe that the below reported "Z-coded" calls for service are but a fraction of the calls for service that should be so coded) are documented as involving individuals with histories of mental illness and/or who are experiencing current mental health or co-occurring mental health or substance abuse symptoms. Yet, because no more than 20% of our patrol officers are CIT-trained, less than a majority of mental health related calls were responded to by a CIT-trained officer. Thus, the outcomes of many thousands of mental health related calls were not benefited by interaction with an appropriately trained officer, and thereby adding unnecessary risk of physical altercation and bodily harm during those calls; missing opportunities to divert people from unnecessary jail; and reducing needed access to mental health and supportive services.

Several years ago, to improve the percentage of mental health-related calls for service responded to by a CIT-trained officer, the Chicago Office of Emergency Management and Communication (OEMC) trained its Call-Center dispatch personnel to 'code' such calls for service with an arbitrarily assigned "Z" and to request a response from a CIT-trained officer in proximity to the incident. CPD has a system in place that notifies OEMC of all CIT trained officers who are working during a particular shift in a dispatcher zone. Then, when a 911 call comes in, the call-taker asks questions from a drop-down menu to determine if a call has a mental health-related component. If the call is identified as "mental health-related," the call-taker makes every effort to dispatch the call to one of CPD's CIT trained officers. Recent

Z-coded calls for service data to date are revealing:

- 2010: 18,976 Z-coded calls, 4,862 responded to by a CIT-trained officer;
- 2011: 19,804 Z-coded calls, 5,460 responded to by a CIT-trained officer; and
- 2012: 20,073 Z-coded calls, 5,392 responded to by a CIT-trained officer

Thus, just over 25% of these calls over a three-year period were handled by CIT trained personnel. Of interest, approximately 56.5% (2,992) of the 5,392 CIT-trained responses in 2012 resulted in non-criminal diversions to hospital intake facilities and mental health evaluations.

It is evident that training more officers in the Basic and Advanced 40 hour CIT training programs designed specifically for juvenile and veteran populations will divert individuals from unnecessary justice system involvement and significantly link more citizens to needed mental health referrals. Because mental health-related calls for service can be particularly challenging, creating a larger pool of CIT-trained officers will decrease 'burnout' amongst the current pool of CIT trained personnel.

Research Concerning Chicago CIT

The Chicago Police Department's CIT program is more than just training. It is a partnership with mental health service provider organizations, advocacy organizations, individuals, and family members living with a mental illness. These partners assist by providing expertise for the delivery of the 40 hour CIT trainings for police officers. The dialogue between

officers and these partners identifies systemic problems and generates momentum and coalitions to work for system improvements.

Data collected from a federally funded study of the Chicago CIT Program⁸ found that compared to their non-CIT-trained peers, CIT-trained Chicago Police Officers directed people to mental health services 18% more often, reported feeling better prepared to respond without needing to resort to use of force, and used less force when subject agitation/resistance increases. That same research concluded that CPD CIT reduces injuries to officers and to persons experiencing a mental health crisis, reduces arrests, diverts more subjects from the criminal justice system, increases linkage to psychiatric services, and improves the knowledge, attitudes, and confidence of officers. As an evidence-informed practice, CPD CIT has become the most widely recognized and adopted best practice model of specialized police response in the nation.

National Institute of Mental Health funded research [NIMH R34MH081558], conducted by investigators from the University of Illinois at Chicago (UIC), on Chicago's Crisis Intervention team program examined mental health related police encounters handled by CIT, and non-CIT trained officers in four Chicago police districts. Findings indicate that CIT trained officers use less force with resistant subjects than their non-CIT trained peers. This suggests that CIT officers are better able to de-escalate crisis situations and reduce the risk of injury for all involved. Additionally, CIT officers were more likely to make efforts to transport or link persons with mental illnesses to appropriate psychiatric treatment.

⁸ Canada, K. Angell, B & Watson, AC (2010). Crisis Intervention Teams in Chicago: Success on the ground. *Journal of Police Crisis Negotiations*. 10 (1-2) 86-100.

Researchers from UIC are currently in the field on a subsequent NIMH funded study of CIT in all Chicago police districts [NIMH R01MH096744]. Preliminary findings from interviews and ride along observations of officers indicate that CIT trained officers recognize that intervening and providing linkage to services is an important part of their job. The training has allowed them to better recognize when a person is experiencing symptoms of mental illness, and has given them skills to effectively de-escalate mental health crisis situations and provide linkage to the appropriate mental health services, and be that transport for emergency evaluation or reconnection with a case manager in the community.⁹

Additional Research Findings:

CIT training improves officer knowledge and attitudes (Compton, et al 2006; 2014a)

CIT trained officers

- less likely to endorse use of force as effective response (Compton, et al 2011)
- use less force as resistant demeanor increases (Morabito, Kerr & Watson, 2012)
- more likely to transport or refer to mental health services (Watson et al 2011, Compton et al 2014b)
- less likely to arrest subjects with mental illnesses (Compton et al 2014b)

CIT implementation associated with:

- lower arrests rates than in jurisdictions with other models (Steadman, et al 2000)
- greater confidence in department's response (Borum, et al 1998)

⁹ Watson, AC, Fulambarker, A & Wood, J. (2014), CIT and Mental Health Service Accessibility in Police Encounters. Presented at the 22nd National Institute of Mental Health (NIMH) Conference on Mental Health Services Research (MHSR): Research in Pursuit of a Learning Mental Health Care System. Bethesda, Maryland.

- more mental disturbance calls identified (Teller, et al 2006)
- more transports to emergency psychiatric services (Teller et al 2006)
- more voluntary transports (Teller et al 2006)

Other Research Sources

- Morabito, MS, Kerr, AN, Watson, AC, Draine, J, Angell, B (2012). Crisis Intervention Teams and People with Mental Illness: Exploring the Factors that Influence the Use of Force. *Crime & Delinquency*, 58 (1) 57-77.
- Watson, A.C, Ottati, V.C., Morabito, M., Draine, J., Kerr, A.N., Angell, B. (2010). Outcomes of police contacts with persons with mental illness: The impact of CIT. *Administration and Policy in Mental Health and Mental Health Services Research*. Vol 37 (4) p302-317. DOI10.107/s10488-009-0236-9.
- Watson, A.C., Ottati, V.C., Draine, J.N., Morabito, M. (2011) CIT in context: The Impact of mental health resource availability and district saturation on call outcomes. *International Journal of Law and Psychiatry*, 34 (4) 287-294

Conclusion

No one chooses to be mentally ill! We cannot "lock-up" our way out of this problem, nor can we put all of our energy into CIT as the "saving grace" for this crisis. A broad range of services that support community inclusion such as housing, employment, medical and psychological services must be accessible. Without these services or with inadequate services, officers, (CIT trained or not) eventually may become disillusioned and may stop making efforts to link people. Without these services and resources, the volume of calls involving persons with mental illness will only increase, which means that these citizens' needs are not being met effectively or humanely. Without the services, resources, and proper funding, there will be an

increase in arrests of persons with mental illness, and an increase in injuries both to police and citizens.

In order for CPD CIT, or any agency's CIT program to be successful, it must maintain strong partnerships. The Chicago Police Department's CIT Program is more than just training; it is a partnership with mental health service providers, advocacy organizations, individuals, and family members living with a mental illness. If mental health treatment services are underfunded or not a priority, law enforcement involvement in mental health crisis will continue to rise and that increase may result in negative outcomes. We as a nation need to make certain that we are providing and making accessible the necessary resources for persons suffering with mental illness.

Testimony of Aubrey Dale Paul Jr.

**Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights,
and Human Rights**

**“Law Enforcement Responses to Disabled Americans: Promising Approaches
for Protecting Public Safety”**

April 29th, 2014

Thank you Chairman Durbin and Ranking Member Cruz for holding this hearing and inviting me to testify.

My name is Aubrey Dale (A.D.) Paul Jr., and I am from Frisco, Texas. I am the father of a twelve year old, Christopher Paul, who is on the autism spectrum. Christopher is a happy go lucky young man, but he does have the occasional melt-down. Many parents with special needs children have anxiety over issues such as education, development and finance, but I believe the last thing they should be concerned about is the safety of their children when encountering law enforcement. Part of my professional and personal life has been to lessen that fear.

For the last 28 years I've been a police officer with the Police Department in Plano Texas. In 1995, I was a young patrol sergeant when one of my officers shot 15 year-old Michael Clement, who was on the autism spectrum. I was one of the first responders that day and did CPR on Michael, who did not survive. The officer in that case was cleared of any criminal charges, but the impact on the families, the special needs community, and the department is still felt today.

I am currently the Crisis Intervention Team (CIT) Coordinator for my department and teach the lessons learned from the Michael Clement tragedy to law enforcement, parents, and civic groups. I teach this course from the perspective of both a first responder and a parent.

We started our CIT Program in 2009 after doing research and being invited by the then Dallas Police Chief, David Kunkle, to take part in a 40-hour CIT Class developed by the Dallas Police Department (DPD). I'm now an instructor for the DPD Class, which is still taught regionally in our area. We continue to invite area agencies to start programs and attend the training. We have trained a total of 232 employees, 213 of whom are sworn officers. We train jail staff and public safety personnel (non-sworn), as well as officers. The Plano Police Department has 499 employees with 348 sworn officers. Since the beginning of our CIT program we have seen a reduction of 24% in the number of Use of Force reports.

We have communicated to our officers that the CIT Program at its core is an “officer safety program.” In my opinion, once officers understand this, they buy into and use the communication and de-escalation techniques taught in the course. By keeping the officers safe, in turn we keep the community safe.

I am currently in the field using the skills taught in CIT training. In my experience, the best way to persuade law enforcement officers to adopt the CIT model is the successful use of CIT in the field. I've recently used CIT on a call involving an armed subject, who on my arrival, was surrounded by officers. He was demanding that the officers kill him after he threatened to kill his boss. While it took approximately two hours to talk him into surrendering, the rapport, patience and active listening skills learned in CIT training led to a successful nonviolent resolution. Another recent case involved a college student who had set up a "kill room." He had numerous writings describing his homicidal thoughts, and he had started doing surveillance on potential victims. Working with our team members, I was able to apprehend this young man, keep our community safe, and help this young man get the long term treatment that he will need.

The best way to explain the 40 hour CIT class is that it is part "hostage negotiator" training. It is also part psychology instruction with an emphasis on mental illness and cognitive disorders. It is also part anti-stigma training. During the class, citizens suffering from mental illness come and tell their stories of encounters with law enforcement and their road to recovery. Many officers get their knowledge of mental illness like the rest of our society - from movies and television where often people with mental illness are portrayed as the villains. By the end of a class you can see a change in the officer's perception of mental illness and those who suffer from it. You can see officers begin to empathize with those with mental illness.

CIT has also increased the collaboration between law enforcement agencies, mental health providers, advocates and families in our communities, hence the emphasis on "teams." We work closely with the National Alliance on Mental Illness (NAMI), who helps support our training. Agencies that forge these collaborations have the advantage of offering a holistic approach to tough mental health cases, including experts willing to teach officers, and support when something goes wrong during an incident.

In Plano, we work closely with our county criminal justice system because we have a lot of criminal cases involving persons with mental illness. Many of these offenders continue to commit minor offenses and never get treatment for their illness. Many court programs such as diversion and court ordered outpatient services have worked to slow down the number of repeat offenders. We also work with our county court system, where many of the Orders of Protective Custody are issued and typically served by local law enforcement.

According to the CIT Center at the University of Memphis (where the Memphis CIT Model got started) some 2800 agencies have started some form of CIT Program, but with almost 13,000 local agencies in the U.S., that is only approximately 2% of all local agencies. A number of agencies here in Texas have joined together to start the Texas CIT Association to help bring programs and training to more Texas agencies. Our association has mental health providers, advocacy groups and families as full members. With the help of NAMI Collin County we have also sent officers to CIT International Conferences where experts from around the world provide training and collaboration. I

have presented at the CIT International and the National Down Syndrome Congress concerning the Michael Clement shooting and our program.

We (Plano PD) do not have full time CIT Officers or Coordinator, but we follow the Memphis Model where we train first responders and supervisors. We have started two programs that have been very successful. The Take Me Home Program where persons who are non-verbal can be reunited with loved ones without delay or without having to be transported. And the CIT Home Visit Program where uniformed CIT officers will visit with persons with developmental delays to mitigate the "fight or flight" response. We hope to start a school program soon where our community CIT team will develop presentations on mental illness for secondary and college-aged students. We also hope to start an ad hoc committee to address cases of potential violence. We believe that we can lessen the stigma of mental illness, address undiagnosed illness, prevent violence and support families with limited resources. Two promising programs around the nation are in Phoenix and St. Louis where peers and local university interns assist individuals with their commitment by law enforcement. The peers and students assist these individuals with navigating follow-up care, housing, transportation, and other basic needs to mitigate future encounters with law enforcement.

We operate in the NorthSTAR funding system in our part of Texas. My limited understanding of the NorthSTAR system is that it provides a private/public partnership of managed care services. In our system, we have several psychiatric emergency facilities that have a "24 hour open door" for law enforcement, which allows our officers to drop apprehended persons and quickly return to our jurisdictions. NorthSTAR also funds a mobile crisis unit (Adapt) and a crisis hot line, both of which have benefitted our officers. My understanding is the issue of continual care after apprehension remains a big challenge in our and in many managed care systems around the nation.

I have personally seen life as a police officer in Plano before CIT and after. I can say as an officer and a member of the community with a son on the autism spectrum, that life in the community is better with CIT in it.

However, Plano and the other localities using CIT cannot do it alone. We could use assistance from the federal government if we are going to sustain our CIT programs over the long term, and spread CIT to other communities in need. Without any legislation, the Justice Department could direct more funding for state and local law enforcement toward CIT programs. Additionally, Congress should consider passing the bipartisan Justice and Mental Health Collaboration Act of 2013 cosponsored by Senator Franken and Senator Johanns, which would reauthorize federal funding for supporting CIT and similar programs. There are many police departments and communities of all sizes that want to implement CIT, but cannot afford to, or lack the resources to allow officers time away for the training. More federal funding would go far to allowing these police departments to bring CIT to their communities and help save and improve lives.

Again, thank you for the opportunity to testify, it has been a privilege.

Written Testimony of Judge Jay M. Quam
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INTRODUCTION

Good morning. My name is Jay Quam, and I have been a state district court judge in Minnesota's Fourth Judicial District located in Hennepin County, Minnesota, for more than seven years. I served three and one half of those years as the presiding judge of our mental health commitment court, where I estimate I presided over more than a thousand cases involving people with mental health disorders. Many of those cases involved people with mental health conditions coming from the jail. I now have rotated to a team that handles serious felony matters, an area that also involves a number of people with mental health conditions.

Before I begin my comments, I need to make clear that, while I am a judge of district court in Minnesota's Fourth Judicial District, I am neither testifying on behalf of, nor taking any positions for, the Fourth Judicial District or the Minnesota Judicial Branch. I am appearing solely in my personal capacity, which is informed by my service as the presiding judge of mental health court and by my other responsibilities.

Most people with mental health conditions don't belong in jail.

People with mental health conditions are brought into all areas of our justice system in disproportionate numbers, and they rarely fare well. But the area of the legal system where those with mental health conditions are brought most frequently, and with the most tragic and heartbreaking outcomes, is the criminal justice system. To put it bluntly, people with mental health conditions are brought to jail far too often, they too often languish there, and there is danger in keeping them there.

This point became graphic to me when the hospital room of Michael Schuler became my courtroom in 2012 as I presided over his civil commitment hearing. When I arrived I saw Mr. Schuler with large bandages over both eyes. The bandages were there because, while in jail and in a floridly psychotic state, Mr. Schuler had stabbed both eyes out with a pencil. During his 40 days in the local jail, Mr. Schuler told deputies he was the Prince of Wales. He stood naked in his own feces and talked to himself for hours. Mr. Schuler did not receive his medications while in jail, leading him to descend into his psychotic state. The county ended up paying Mr. Schuler \$1 million to compensate him for his injuries.

Michael Schuler was not an isolated incident. Five days after Mr. Schuler stabbed his eyes out, Tyondra Newton, twenty five and schizophrenic, hanged herself after spending thirty four days in her cell. A week later, Jason Moore, an All-America wrestler at a local liberal arts college before he succumbed to schizophrenia, broke his neck after repeatedly smashing his face into a cell toilet.

The danger within the jail is not confined to those with mental health conditions. The case of Sergeant Brad Berntson, a former Army Ranger and a deputy at our county jail, proved that to me. On Dec. 31, 2011, an inmate who was born HIV-positive and who had a dozen separate mental health diagnoses, complained that he didn't receive a spoon with his lunch tray. When Sgt. Berntson and two deputies began to search the inmate and his cell for the spoon, the inmate struggled with them. The inmate eventually bit Berntson on the right leg, clamping down for several seconds and breaking the skin through the pant leg. Sgt. Berntson took medications to avoid becoming infected, but he reacted poorly to them. He died several weeks later from complications. Whatever the exact cause of death, I strongly believe that Sgt. Bertson's death would not have occurred if he had not been bitten by the inmate who was in mental health crisis.

We need the Justice and Mental Health Collaboration Act.

There is no simple way to fix a problem that is so complex and so entrenched, but the Justice and Mental Health Collaboration Act is a critical

step in the right direction. It is a critical step in the right direction because it is based on three fundamental principles:

The best way to prevent people with mental health conditions from languishing in jail is to keep them from being brought there in the first place. Crisis Intervention Teams (CIT) and similar law enforcement training have been proven to be extremely effective in reducing risk and promoting positive outcomes when law enforcement officers come into contact with a person in mental health crisis. CIT teams reduce the number of people in mental health crisis brought to jail.

Further, law enforcement officers need somewhere to bring people in mental health crisis beside the emergency room or jail. Mental health hubs have proven to be an outstanding alternative by meeting the needs of those with mental health conditions and saving tens of millions of dollars. Later in my remarks I will describe an effective, cost-savings model in Florida that offers hope for a better way forward;

Secondly, in appropriate cases it is best to divert people with mental health conditions from jail as soon as it is possible and safe to do so. Mental Health Courts are efficient and effective at meeting the needs of those with mental health conditions; and

Thirdly, transitional services are essential in preventing people with mental health conditions from cycling back into jail. Transitional services have proven to have a high success rate in reducing recidivism and the use of emergency services.

There is no time to waste. I urge you to pass the Justice and Mental Health Collaboration so that we can continue to better meet the needs of those with mental health conditions.

BRIEF HISTORY

When we began closing our mental health institutions in the 1970s, we promised families and patients there would be resources within our

communities that would meet the needs of those with mental health conditions. We broke that promise, and the consequences reverberate daily through virtually every community in the form of overwhelmed support systems, devastated families, and shattered lives.

Our broken promise to those with mental health conditions manifests itself in tragic numbers in our criminal justice system. It has caused a dramatic influx of people with mental health conditions into our jails, our court systems, and our prisons. One often-cited statistic reveals the sad state of our current mental health care system, and how our jails and prisons have been forced to fill the void: more than 350,000 people with severe mental health conditions are currently locked up in jails and prisons, while only about 35,000 people with severe mental health conditions reside in state funded psychiatric beds.

JAIL OFTEN IS THE WRONG PLACE FOR THOSE WITH MENTAL HEALTH CONDITIONS

We should no longer ask whether people with mental health conditions should be allowed to languish in jail. Instead, we should ask how we can effectively help people with mental health conditions thrive in their communities when it is safe for them to do so.

The harms associated with keeping those with mental health conditions in jail show that:

- People with mental health conditions are usually kept in jail longer than others charged with similar crimes, sometimes dramatically so;
- People with mental health conditions frequently deteriorate in jail, sometimes irreversibly so;
- A disproportionate number of people with mental health conditions commit suicide or harm themselves or others while incarcerated;
- People with mental health conditions are held in solitary confinement far more often, and longer, than other inmates; and

--A disproportionate number of people with mental health conditions are harmed or abused by other inmates.

Judges Kerry Meyer, Peter Cahill, and others in Hennepin County District Court have done an excellent job streamlining our court processes for those with mental health conditions. And I have been working closely with our Sheriff's Office, Hennepin County Sheriff Rich Stanek, on speeding up other parts of the process for our inmate population who have mental health conditions. Even with the changes made to court practices and our state laws, however, we still have people with mental health conditions unnecessarily languishing in our jail for months at a time.

THE JUSTICE AND MENTAL HEALTH COLLABORATION ACT TAKES THE RIGHT APPROACH TO SOLVING THE PROBLEM

The JMHCA rightly takes the approach that we need to fund programs that divert people with mental health condition from jail at every stage of the criminal justice system when it is appropriate to do so. Each stage is discussed below.

The JMHCA recognizes we need to fund programs that properly train law enforcement.

The first point of contact a person with a mental health condition has with the criminal justice system is usually with a law enforcement officer. The nature of that contact, and the training that the officer has, determines whether or not it ends tragically.

Every state has an overarching, tragic story that epitomizes our failure to recognize the needs of people with mental health conditions. Minnesota has Barbara Schneider. Mrs. Schneider was about 50 years old, held two Masters degrees and was very active in the community. She also had a severe mental health disorder that began to appear when she was in college. On June 12, 2000, law enforcement responded to a noise complaint in Mrs. Schneider's home, and she was aggressive toward the

police officers as they approached her. Not understanding how to deal with someone in mental health crisis, the officers shot and killed Mrs. Schneider.

Following that shooting, the Minneapolis Police Department and individuals from the mental health community came together and agreed to do everything they could to prevent this type of confrontation from ever ending again. They worked together to bring the Crisis Intervention Training model (CIT) to Minneapolis, with that work expanding into many communities around Minnesota. The result is consistent with every community that has used CIT: many tragedies are avoided when law enforcement officers are trained to deal with people in mental health crisis.

The JMHCA reinforces the need to provide training for our law enforcement community so that they can better respond to people with mental health conditions. Without proper training for our law enforcement communities, we cannot meet the needs of those with mental health conditions-another reason why the passage of this act is so important.

We need mental health hubs as alternatives to jails and emergency room.

Better law enforcement training is only a first step. The JMHCA recognizes the unfortunate reality that exists in most of our communities today: no matter how well our law enforcement officers are trained, they generally only have three options when they encounter someone in mental health crisis. Those options are:

- 1) Leave them on the streets, which is generally a poor option and doesn't address the underlying problem;
- 2) Bring them to an emergency room, which rarely produces a good long term outcome and is always an expensive option; or
- 3) Book them into jail where jailers admit they cannot adequately care for them.

The JMHCA supports a fourth option, which is creating a facility that is a central point for accepting, assessing, and addressing the needs of

mentally ill people brought in by law enforcement. This type of facility can consolidate many of the existing resources and provide a continuum of care that could address the immediate, short-term, and long term care needs of individuals with mental health conditions who would otherwise languish in jail. Law enforcement supports the creation of this alternative option.

Based on the need to provide law enforcement officers with this fourth option, several state legislators in Minnesota are pushing a bill that would serve the entire state. Other communities are ahead of Minnesota, however, and have proven that mental health hubs work.

One of the best-established mental health hubs is in Orange County, Florida. The Orange County facility has existed for ten years, and has collected data on its results. That data is unequivocal: Not only do mental health hubs serve the needs of those with mental health conditions, but they save money. Some of the impressive data from the Orange County facility is that, over the past ten years, it has:

- served over 47,000 people;
- saved up to \$20 million in jail and correctional costs by avoiding over 100,000 jail bed days;
- saved between \$17-\$44 million by avoiding over 22,000 emergency room bed days;
- saved over \$4.2 million through care coordination; and
- saved over \$3.1 million in law enforcement costs by reducing law enforcement drop off time to about 12 minutes.

By supporting the creation of mental health hubs, the JMHCA is supporting a critical piece of what we must do to better meet the needs of those with mental health conditions who may otherwise languish in jail.

Mental health and veterans' courts are an important part of any solution.

It is inevitable that some people with mental health conditions will be brought to jail. The JMHCA recognizes that we can help many of them effectively manage their mental health conditions through mental health and veterans' courts.

Mental health and veterans' courts work on a simple principle: We can effectively divert many people with mental health conditions from jail by teaming our court professionals with assessment and support services. The focus is not on traditional notions of crime and punishment, but on solving the problems that cause involvement in the criminal justice system in the first place.

The success we have had in Hennepin County with mental health and veterans' courts is typical of mental health and veterans' courts around the country. Studies show that mental health and veterans' courts result in lower recidivism, less time spent in jail and prison, increased public safety, and people with mental health conditions better able to live meaningful and satisfying lives.

Transitional services are essential.

It is a recipe for failure to simply cut loose many people with mental health conditions without help in transitioning back to the community. The JMHCA recognizes this fact by supporting programs that help those with mental health conditions successfully transition back into the community.

Transitional programs work. As an example, a program in Orange County, Florida, called the A.N.C.H.O.R. program (short for Accessing New Choices for Housing Opportunities and Recovery) has provided transitional services for people with mental health conditions and substance abuse issues. The goal of the program is to assist its clients with developing the necessary skills to maintain permanent housing and assist in recovery.

The results have been impressive. Because of the transitional services available through the A.N.C.H.O.R. program, many clients successfully maintain their housing; they are successful in their treatment and recovery; they find employment; they no longer need the services of

the emergency room; and they are not brought back to jail. In short, they are able to lead productive, satisfying lives.

**WE NEED TO ADDRESS MENAL HEALTH DISORDERS WITH THE
SERIOUSNESS WE ADDRESS CANCER BECAUSE THEY ARE SIMILAR.**

One of the most important things I have learned is that mental health conditions are analogous to cancer. Both strike the undeserving without regard to race, gender, background, or economic circumstances. Both are nonpartisan, striking without regard to where a person is on the political spectrum. And both devastate--even kill--their victims.

While mental health conditions and cancer have similarities, they are different in very important ways. People who are stricken with cancer are typically surrounded by treatment teams who provide the best cancer treatment available. Their co-workers understand, and their family and friends support them. They can even set up websites so that whole communities can help them through their difficult circumstances.

All of this is as it should be. It is what cancer victims need, and deserve, so they may have the chance to live healthy and productive lives.

But mental health conditions are different. Because of their nature and the enormous stigma that is still attached to them, together with our inadequate mental health system, people with mental health conditions are often isolated from friends and family. Too often, they are ostracized by the entire community.

I see this isolation every day. Most people with mental health conditions come into my courtroom alone. They leave my courtroom alone. And they are left to try to meet the challenges presented by their mental health condition, alone. We must do better.

CONCLUSION

Given that our country's three largest mental health care centers are the jails of Los Angeles, New York, and Cook County, there can be no doubt that we broke the promise we made over 50 years ago to those with mental health conditions, their families, and their communities. We have a duty as public servants to rectify the problems that were created when we broke that promise. Accordingly, I urge you to pass the Justice and Mental Health Collaboration Act as a first step toward making good on the promise we made to those with mental health condition so long ago.

Testimony of Pete Earley**Before the Senate Judiciary's Constitution, Civil Rights & Human Rights
Subcommittee****"Law Enforcement Responses to Disabled Americans: Promising Approaches
for Protecting Public Safety"****Senator Richard J. Durbin, Chairman****April 29th, 2014**

Good morning. Thank you Chairman Durbin and Ranking Member Cruz for holding this hearing and inviting me to testify.

My family's story begins with a frantic car ride and my son saying these words:

"How would you feel dad, if someone you loved killed himself?"

My college age son, Kevin, asked me this question while we were racing down Interstate 95 from Manhattan to an emergency room near my home in Fairfax County, Virginia. Kevin had been diagnosed a year earlier with a mental illness, bipolar disorder, but had stopped taking his medication. When I picked him up, he had been wandering around New York for five days. He hadn't eaten, had barely slept and was convinced God had him on a secret mission. I pleaded with him to take his medication but he screamed at me: "Pills are poison. Leave me alone."

At the emergency room, my son and I were taken into a separate waiting room because of his bizarre behavior. Four hours later, Kevin announced that he was

leaving. He yelled "There's nothing wrong with me!" I ran into the hallway and grabbed a doctor. I will never forget how he came into the room. He entered with his hands up as if he were surrendering.

"I'm sorry, I can't help your son," he said. The nurse had told the doctor that my son thought pills were poison, and under Virginia law, my son could not be forced to take medication or undergo treatment unless he posed an imminent danger to himself or others. The fact that we had been waiting four hours and no one had been hurt was proof there was no danger. I was told to bring my son back after he tried to harm himself or someone else.

During the next forty eight hours, I watched my son sink deeper into a mental abyss. At one point he had tin foil wrapped around his head to keep the CIA from reading his thoughts. He slipped out of the house early one morning and broke into a stranger's house. Luckily no one was home. He broke in to take a bubble bath. It took five officers and an attack dog to get him out. My son was charged with two felonies: breaking and entering and destruction of property.

I was so frustrated. Virginia laws had kept my son from getting help when he was not thinking clearly. Now Virginia laws wanted to punish him for a crime that he committed when he was not thinking clearly.

As a journalist, I decided to investigate and found my son's arrest was not some isolated event. There are more than 356,000 persons with serious mental illnesses, such as schizophrenia and bipolar disorders, currently in our jails and prisons.¹ Each year, roughly 2.2 million people experiencing serious mental illnesses requiring immediate treatment are arrested and booked into jails nationwide.² The largest public mental facilities in 44 of our 50 states are jails and prisons³, and the chance of you ending up in jail rather than getting help without incarceration if you have a mental breakdown such as my son are three to one nationally.⁴ In other words you are three times more likely to be put in jail. *This is a national scandal.*

Who are these prisoners? I spent ten months in the Miami Dade County jail to find out. I witnessed barbaric conditions in that jail. I routinely saw five to six men, completely naked, crowded into cells built for two prisoners. Beatings by guards were common.

I want to tell you about three prisoners who I followed through the Miami Dade Court system and whose stories I tell in my book.⁵ Alice Ann C. shoved an elderly woman at a bus stop who she thought was "stealing her thoughts." She faced a five year prison sentence as a habitual offender. Prosecutors sought the maximum because she had schizophrenia, was dangerous, and there was no place in the entire state of Florida to send her. No place. April H. was framed by her parents for car theft. They wanted her in jail because she was psychotic, homeless in South

Beach, and had been gang raped twice and beaten three times by teenagers on Friday nights. Her parents thought jail was safer for her. Freddie G. was so sick when I met him in jail, he could not speak. He stood naked in his cell where his keepers controlled him with sandwiches as if he were a dog performing for treats. He had been in and out of that jail a dozen times in a single year – charged with loitering but he never received help.

I learned that 97 chronically mentally ill prisoners in Miami-- people like Freddy -- who were diagnosed with mental illness and most of whom were homeless, accounted for 2,200 arrests, 27,000 days in jail, 13,000 days in crisis units and cost the city \$13 million in a five year period with no demonstrable return on investment in terms of reducing recidivism or promoting recovery.⁶

Fortunately, my son got two years of probation for breaking into a stranger's home. Medication helped him, but he stopped taking it the moment his probation ended. I called a Fairfax Crisis Response team but was told I had to wait for my son to become dangerous. When he became violent, they refused to come and called the police. Officers came, shot my son twice with a taser and asked if I wanted to file charges. I didn't.

My son's last breakdown happened once again after he stopped taking his medication. Afraid I would call the police, he took off in his car. He ran out of gas

in North Carolina and called me. Voices were telling him that if he stepped out of his car, he would die.

I arranged for him to get gas. He drove up Interstate 95 completely psychotic, twice going off the interstate. I took him to a mental health facility. That night, he took off all of his clothes because he thought it made him invisible and walked out.

But this time my son was picked up by a Fairfax County Police officer who had received Crisis Intervention Training. When Kevin asked him to not handcuff him, the officer used his discretion and treated my son with respect. He didn't handcuff him and took him to an emergency room where he persuaded the doctor to admit my son. It is thanks in part to the CIT program that my son is thriving today rather than being in jail.

This time, my son got a case manager, Cynthia Anderson. She got him to a psychiatrist who actually took time to listen to him. The psychiatrist found a medication with few side effects. Cynthia got him into an apartment with two men who had schizophrenia.

Equally important, Cynthia asked my son what he wanted to do with his life.

"I have a mental illness," he said. "What can I do?"

"You need to control your illness, not let it control you," she said.

She got him into a peer-to-peer program. Just like Alcoholics Anonymous has recovering alcoholics help other alcoholics, the program involves persons with mental illness helping each other. Today my son works for Fairfax County as a peer-to-peer specialist on a jail diversion team that helps mentally ill men and women get into treatment rather than languish untreated in jail.

Actually my son has two jobs. On weekends, he works at a movie theater as an assistant manager. He lives in his own apartment, pays taxes and has not had a relapse in six years. My son is a heroic example of what can happen when a person with a severe mental illness is given the tools that he needs to recover. Crisis Intervention Training by the police, jail diversion, mental health courts, re-entry programs –all of these help persons avoid costly and unnecessary jail and prison sentences. Along with supportive housing, jobs and, most importantly, hope, persons such as my son can and do recover to live successful and fulfilling lives. I've not only seen it happen with Kevin but with dozens of others as a board member of the Corporation for Supportive Housing, a national non-profit which provides technical assistance and grants to communities to build supportive housing and implement jail diversion and re-entry programs.

I want to emphasize the importance of Crisis Intervention Training for law enforcement officers because of the important role that a CIT trained officer played in helping my son. While I was doing my research in Miami for my book, I rode

with CIT officers and saw them defuse at least a dozen situations without making arrests. I also saw first-hand the difference CIT can make. At the time of my research, the larger Miami Dade County Police Department refused to adopt CIT while the smaller Miami City Police Department incorporated CIT training. During a six year period, five persons with mental illness were fatally shot by Miami Dade officers compared to no persons with mental illness shot by Miami police officers, a contrast that I believe was directly linked to CIT training. Thankfully, both jurisdictions now offer CIT training to their officers.

There should be no shame in having a mental illness, any more than there should be shame in catching a cold. The only shame should be in us not helping someone who is sick. And sadly, our nation has much to be ashamed about when it comes to how we are treating individuals whose only real crime is that they got sick.

Citations:

1. *In a September 6, 2006 report, the Bureau of Justice Statistics stated that there were 705,600 mentally ill adults in state prisons, 78,000 in federal prisons and 476,000 in local jails. (See <http://nicic.gov/mentalillness> or <http://www.bjs.gov/content/pub/press/mhppjipr.cfm>) However, this report was largely criticized because it used what critics claimed was an*

excessively wide definition of mental illness. The more commonly accepted figure used by the National Alliance on Mental Illness and more recently in a study by the Treatment Advocacy Center and National Sheriffs Association is 356,286 persons with mental illnesses in prisons and jails. (see <http://tacreports.org/treatment-behind-bars/executive-summary/226-summary-of-findings>)

2. *Statement Judge Steve Leifman, Chair, Supreme Court of Florida Task Force on Substance Abuse and Mental Health Issues in the Courts, before Subcommittee on Oversight and Investigations of the Energy and Commerce Committee of the U.S. House of Representatives. March 26, 2014, page 8. (See <http://docs.house.gov/meetings/IF/IF02/20140326/101980/HHRG-113-IF02-Wstate-LeifmanS-20140326.pdf>)*
3. *The Treatment of Persons With Mental Illness in Jails and Prisons: A State Survey, April 8, 2014 Treatment Advocacy Center and National Sheriff's Association (see <http://tacreports.org/treatment-behind-bars/executive-summary/226-summary-of-findings>)*
4. *More Mentally Ill Persons Are In Jails and Prisons Than Hospitals, May 2010, Treatment Advocacy Center and National Sheriff's Association. (see http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf)*

5. *Alice Ann C., April H. and Freddie G. are pseudonyms used to protect the privacy of prisoners with serious mental disorders.*

Ms. Patti Saylor, RN, MS

Testimony before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights

“Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety Hearing”

**Written Testimony
April 29th, 2014**

I want to thank Chairman Durbin and Ranking Member Cruz for convening today’s hearing on *Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety* before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights. I want to tell you firsthand that today’s hearing will save future lives.

Today, I am here as both a devoted mother and dedicated advocate for people with disabilities. I am the proud mother of three young adult children, Emma, Adam and the late Ethan Saylor. Growing up, I volunteered with Special Olympics Maryland, later earning a degree in Therapeutic Recreation from Shepherd College with an emphasis on working with people with intellectual and developmental disabilities (IDD). Little did I know, in 1987, I would be blessed with the birth of my son, Ethan, who had Down syndrome. Shortly after Ethan was born, I founded F.R.I.E.N.D.S, The Family Resource Information and Education Network for Down syndrome, a parent support network in Frederick, Maryland, now a National Down Syndrome Society (NDSS) affiliate. I later went on to become a registered nurse and earned a Master’s Degree in Special Education from Johns Hopkins University.

I served on the Maryland Developmental Disabilities Council, co-founded The Parent's Place of Western Maryland, and was instrumental in creating inclusive education opportunities for children with Down syndrome in Frederick County. I’ve served on numerous work groups, committees and boards, all in an effort to increase awareness and acceptance of individuals with intellectual and developmental disabilities. I am currently the owner of Health Link LLC, where I provide nursing case management for adults with disabilities who choose to live in their own homes and self-direct their own services with the support of the significant people in their lives. As you can see, I have always been an advocate for people with disabilities.

I want to share more about what brings me here before the Committee today. First, I want the Committee to understand who my son, Ethan, was as a person. Ethan was a 26 year old man. He was a brother and a son, and loved his family dearly. Ethan was the most loving individual, often responding to “I love you” with “I love you more” and leaving us long voicemails that he would sometimes sing to keep us all laughing. He was also strong willed, independent and had a tremendous sense of humor. For example, one time while taking a community college course, Ethan showed up to class with his backpack containing a laptop and a beer because he believed

that's what you did as a college student. Ethan also had his own apartment, and made his own hiring decisions for his support staff and the people he worked with. Ethan's support staff didn't have degrees in Down syndrome or disability, but I often say they had degrees in Ethan because he was a person first and foremost.

Ethan also had a passion for law enforcement. Since he was a young boy, Ethan was fascinated with police officers, people in uniforms, and people with authority. He watched NCIS on a regular basis, had a collection of officer badges and continuously would remind us "I am a good guy". He wanted nothing more than to get a job with our local police department. If Ethan were in the hearing room this morning, he'd want to be right up there sitting with the members of this Committee because that's where all the important people sit.

Today, our family now lives with a void in our hearts as we miss Ethan each day. On January 12th, 2013, our Ethan died in the hands of three, off-duty Frederick County Sheriff Deputies at our local Regal movie theater. Ethan's death was entirely unnecessary. It occurred when three Frederick County Sheriff Deputies sought to remove him from a movie theater for not purchasing a ticket to see the movie Zero Dark Thirty again. Before the Deputies approached Ethan, they were advised by Ethan's support staffer that Ethan had Down syndrome, was sensitive to being touched, and that his mother (me) was on her way to assist. The Deputies ignored the information provided by his support staff and proceeded to manhandle him out of his seat. When he resisted this rough treatment, they forced him into a prone position and handcuffed his hands behind his back with three sets of handcuffs.

While anyone, disability or not, could have been injured or killed in Ethan's situation that evening, our family also remains deeply concerned that Ethan's rights, as an individual with a disability, were violated. The autopsy showed that Ethan's larynx was crushed while being restrained by the officers. The manner in which Ethan was restrained that evening, with his hands behind his back and forced to lie face down on his stomach, has for years been considered excessive due to the chance of positional asphyxia.

Ethan never posed any immediate threat to the safety of the officers or others. The crime at issue was not severe, Ethan was sitting in a movie theater without a ticket and there were far less severe actions the officers could have taken. For example, they could have listened to advice from Ethan's support staffer, and allowed her to deescalate the situation by entering the theater to assist and support Ethan. We also feel there was no consideration, on the part of the Deputies, to the fact that Ethan had Down syndrome – a recognizable disability. We believe that the amount of force that was used on Ethan was not reasonable in light of the severity of the crime, the risk to the officers, the risk to Ethan, and the risk to others in the theater.

Since Ethan's death, we have been on our own advocacy journey to achieve justice for Ethan, while at the same time ensuring what happened to Ethan never happens to another member of the Down syndrome and disability community ever again. We have heard from advocates and parents all around the world that have been touched by our story, are fearful this may happen

to their son or daughter with a disability, and want to help advocate and ensure that something good comes out of our tragedy.

Right after Ethan's death, we began meeting with the US Department of Justice (DOJ) to share our story and pursue a civil rights investigation. From our understanding, the investigation is underway and we expect a report back from DOJ in the immediate future. Working with the National Down Syndrome Society and National Down Syndrome Congress, we activated the Down syndrome grassroots network to call on Governor Martin O'Malley of Maryland to pursue systemic change at the state level. My daughter and Ethan's little sister, Emma, authored a [change.org petition](#) calling for Governor O'Malley to commence a state investigation into Ethan's death as well as ensure law enforcement, first responders and other public officials all receive the very best training when it comes to their interaction with people with disabilities in the state. Emma's petition, to date, has received over 370,000 signatures, which we delivered directly to Governor O'Malley last September.

In September 2013, a few weeks after our meeting with Governor O'Malley, he issued an [Executive Order](#)¹, due in large part to the circumstances surrounding Ethan's death. The Governor's Executive Order established the [Maryland Commission for Effective Community Inclusion of Individuals with Intellectual and Developmental Disabilities \(the "Commission"\)](#). The Commission was tasked with (1) recommending statewide policies, guidance, or best practices regarding law enforcement and first responders' responses to situations involving individuals with IDD; and (2) developing a coordinated, collaborative, and comprehensive strategy to ensure enhanced responses to such situations, including consideration of expanding Crisis Intervention Teams and Mobile Crisis Teams for the state of Maryland. We also formed a coalition, Ethan's Law Workgroup, with disability organizations across the state, which is spearheading policy recommendations for the state of Maryland.

We are also proud to partner with The Arc's National Center on Criminal Justice and Disability (NCCJD), a national clearinghouse on criminal justice and disability issues founded by Bureau of Justice Assistance, U.S. Department of Justice with a two-year grant to develop a national center on criminal justice and disability, with a focus on intellectual and developmental disabilities (IDD) and to provide resources, information and referral, training, technical assistance and evaluation for criminal justice and disability professionals and programs.

Our advocacy journey had led us here, before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights. As we continue to advocate for justice for Ethan and systemic change at the federal, state, and local levels of government, I feel we have a real opportunity to ensure what happened to Ethan never happens to anyone with Down syndrome or another disability ever again.

¹Governor O'Malley's Executive Order for the *Commission for Effective Community Inclusion of Individuals with Intellectual and Developmental Disabilities*; Executive Order dated September 13, 2013

At the federal level, funding is needed to support training of law enforcement when it comes to interacting with individuals with IDD; and we must set standards to ensure that quality and meaningful training is the standard across all law enforcement departments and public sector agencies. At the state level, we have an opportunity to mandate and deploy the Crisis Intervention Team (CIT) model to law enforcement departments across states. We know CIT has a proven record of success, but it has to be mandated and appropriately deployed across law enforcement departments and agencies to make a real difference.

Lastly, I often say that the people and friends at our church didn't have training to work with Ethan, they knew him as a person. When you know someone with a disability and have a relationship with that person, it changes your whole being and perspective. At the local level, we have a real opportunity to build relationships with our local law enforcement and public sector officials, the ones that are on the frontlines serving our communities. We believe that local disability advocacy organizations and providers should build lasting relationships with their local law enforcement and public sector officials. It doesn't take an act of Congress, federal or state mandate, or even money to make you realize that relationships are everything.

In conclusion, we sincerely want to thank members of the Subcommittee, especially Chairman Durbin and Ranking Member Cruz, for their leadership and dedication to all people with disabilities. As I said at the onset, I know that today's hearing will help save future lives and we thank you for that. Rest assured, we are committed to be tireless advocates for our beloved Ethan and all people with Down syndrome and other disabilities; and we will work with members of this Subcommittee to ensure the necessary changes and policies are put in place to ensure what happened to Ethan never happens to another member of this community. We supported Ethan following his dreams and living the life he wanted, a life of love and acceptance. I wake up each day knowing that Ethan's legacy will live on and on through our collective advocacy and shared responsibility for all people with disabilities.

**Law Enforcement Responses to Disabled Americans:
Promising Approaches for Protecting Public Safety**
Hearing before the Senate Judiciary Subcommittee
on the Constitution, Civil Rights, and Human Rights
April 29, 2014

Statement by Curtis Ramsey-Lucas
Managing Director, Resource Development
American Baptist Home Mission Societies

I represent the American Baptist Home Mission Societies (ABHMS) on the steering committee of the Interfaith Disability Advocacy Coalition (IDAC). The mission of IDAC is to mobilize the religious community to take action on disability policy issues with Congress, the president and administration, and society at large. IDAC is a diverse, nonpartisan coalition of 33 national religious organizations, including representatives from the Christian, Jewish, Muslim, Hindu and Sikh traditions, whose core spiritual values affirm the rights and dignity of people with disabilities. IDAC is a program of the American Association of People with Disabilities (AAPD).

Although IDAC members come from a variety of faith traditions, they are united by a common commitment to honor all people, especially children and adults with disabilities. This means treating all people with dignity and respect—especially people on the margins of society. This means seeing someone with a psychiatric disability as a person first—someone with a name, someone with dreams and goals, someone who lives with but is not defined by their condition, and someone who requires specific community services and supports to achieve his or her potential and to contribute to the community. For IDAC, this means advocating for the services needed so that children and adults with long-term mental illness can live lives of meaning and hope.

In April 2013, AAPD published *Grounded in Faith: Resources on Mental Health and Gun Violence*. *Grounded in Faith* is a compendium of resources for congregational leaders, disability

advocates, and other concerned persons who wish to ensure that the on-going debate around gun violence does not further stigmatize people with mental illnesses which may discourage many from acknowledging their illness and seeking treatment. In preparing this report, IDAC learned that most violence is carried out by people who are not mentally ill and that persons with mental illness and other disabilities are much more likely to be the victims of violence than the perpetrators. In fact, demographic variables such as age, gender and socioeconomic status are more reliable predictors of violence than mental illness.

These findings are relevant to the work of the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights as it considers the matter of law enforcement responses to disabled Americans. Misconceptions about violence and mental illness can cause discrimination and unnecessarily hamper the recovery of the nearly 20 percent of all Americans who experience some form of mental illness each year. Moreover, misconceptions about violence and mental illness prevalent in society at large also shape law enforcement perceptions and approaches to persons with mental health conditions.

Given the inadequate mix of social and mental health services, law enforcement officers have increasingly become the first responders for people with mental illness or developmental disabilities who are in crisis. In these situations it is important that officers be adequately trained to respond effectively and properly to the needs of all concerned. Recent high-profile tragedies demonstrate the need for law enforcement officers to receive additional training to safely address crisis situations involving persons with mental health conditions. States and localities that have employed such innovative solutions such as Crisis Intervention Teams have seen fewer injuries and deaths among officers and people with mental illness or development disabilities, increased jail diversion rates, fewer

lawsuits following crisis incidents, and stronger ties with the mental health and disabilities communities. American Baptist Home Mission Societies commends the subcommittee for its attention to exploring how Congress and the Executive Branch can support and strengthen State and Local efforts in this area. While not exhaustive, we believe the following are important components of an effective response.

General Considerations for Law Enforcement

Training efforts should work to demystify mental illness and help officers overcome stereotypes and prejudices in order to respond properly and effectively to situations involving people with mental health conditions. Training materials that refer to situations involving people with developmental disabilities and mental illnesses as problems or generally violent predisposes the person and situation as adverse. Resources that describe the prevalence of mental health conditions and that use alternative language to describe individuals as “living with a mental health condition” as opposed to “mentally ill,” or that describe a person as “living with a disability” as opposed to “disabled” will help officers relate to the whole person rather than perceiving an individual as defined by their condition or disability. When confronting a situation that involves people with disabilities or mental health conditions, training that is rooted in such an approach may better prepare officers to adapt to the situation without negative judgment and to offer understanding rather than only trying to deescalate the situation.

General Considerations for an Effective Response Strategy

- *Train Police Offices in Mental Health:* Improving police officers’ awareness and understanding of mental illness will result in improved responses to incidents involving persons with mental health conditions.

- *Appoint Police Liaison Offices and Deploy Specialized Police Offices and Non-Police Officers:* Appointing police liaison officers and deploying specialized police officers and non-police officers, including police chaplains trained in crisis intervention techniques, improves police responses to situations involving mental illness and disability through the delivery of specialized knowledge, skills, and experience.
- *Alternative De-escalation:* Use of verbal engagement allows a collaborative relationship to be established and can deescalate a person out of an agitated state. Verbal engagement helps the person manage his or her emotions and distress and maintain or regain control of their behavior. When possible the use of restraint and/or the use of coercive interventions should be avoided as these may escalate agitation. When nonviolent alternatives have been exhausted, use of less-lethal weapons reduces the likelihood of serious injury or death. Officers should be trained to understand these weapons may affect a person in mental health crisis differently from those not in mental health crisis.
- *Working with the Mental Health Community:* The public mental health system and the criminal justice system must collaborate more effectively so that police officers have several alternatives, not just arrest or hospitalization, when responding to those with a mental illness in the community. Collaboration between police departments and mental health agencies and advocacy groups should focus on identifying and solving specific problems. Collaborating with the mental health community can result in more support, and can empower advocacy groups to increase their influence on legislation and funding decisions.

Beyond these more immediate concerns involving law enforcement, as a society we must do more to address the stigma associated with mental illness. It is estimated that almost half of all

Americans will experience symptoms of a mental health condition—mental illness or addiction—at some point in their lives. Yet, today, less than one in five children and adolescents with diagnosable mental health conditions receive the treatment they need.¹ Moreover, only 38 percent of adults with diagnosable mental health conditions—and only 11 percent of those with diagnosable substance use disorders—receive needed treatment.² When proper treatment and supportive services are not received, crisis situations can arise affecting individuals, families, schools, and communities—situations in which law enforcement officers too often find themselves to be the first responder. While we must do all we can to adequately train police officers to respond effectively in such situations, we must also do more to address the needs of individuals and families before they reach a point of crisis.

¹ Unmet Need for Mental Health Care Among U.S. Children: Variation by Ethnicity and Insurance Status. Sheryl H. Kataoka, M.D., M.S.H.S., Lily Zhang, M.S.; Kenneth B. Wells, M.D., M.P.H., *Am J Psychiatry* 2002; 159:1548-1555. 10.1176/aapa.aip.159.9.1548

² Substance Abuse and Mental Health Services Administration, *Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-45, HHS Publication No. (SMA) 12-4725. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.



Testimony of Alan L. Yatvin, Esq.
Legal Advocacy Subcommittee
American Diabetes Association

Before the
Subcommittee on the Constitution, Civil Rights, and Human Rights
Committee on the Judiciary
United States Senate

"Law Enforcement Responses to Disabled Americans:
Promising Approaches for Protecting Public Safety"

Tuesday April 29, 2014 — 10:00 a.m.

Contact: Katharine Gordon,
Director, Legal Advocate Program, American Diabetes Association
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The Association gratefully accepts gifts through your will.

**The Mission of the American
Diabetes Association** is to prevent and
cure diabetes and to improve the lives
of all people affected by diabetes.

Introduction

Thank you for the opportunity to submit testimony on behalf of the American Diabetes Association (Association) and on behalf of the nearly 26 million Americans who have diabetes. The Association is the largest, most prominent nongovernmental organization that deals with the treatment and impact of diabetes. It establishes and maintains the most authoritative and widely followed clinical practice recommendations, guidelines, and standards for the treatment of diabetes. This includes a medical statement on diabetes management in correctional institutions.

One of the Association's top priorities is giving voice to those denied their rights because of diabetes. We seek to ensure people with diabetes are free from discrimination in all areas of daily life, including by working to make sure people with diabetes are treated fairly by local law enforcement agencies.

I am the immediate past chair of the Association's Legal Advocacy Subcommittee and have worked closely with the Association to ensure law enforcement agencies have the tools necessary to fully serve and protect all people living with diabetes. I hope the Association's experience will be useful in developing collaborative strategies to ensure fair treatment of people with diabetes and all disabilities.

In my testimony I will focus on the following areas:

1. The scope of the problem of inappropriate law enforcement response to people with diabetes, including representative incidents.
2. The medicine and science of diabetes emergencies.
3. The Association's work with community partners, including law enforcement agencies, to provide quality diabetes training.

1. The Problem: Ignorance of Diabetes

The concern with regard to diabetes and law enforcement centers around the lack of adequate training on how to respond to diabetes emergencies. Individuals who experience severe hypoglycemia (low blood glucose) and hyperglycemia (high blood glucose) need immediate medical intervention, but too often, their medical needs are overlooked. Recent examples that have come to our attention include:

- A visibly pregnant woman with gestational diabetes had a low blood glucose emergency and local police officers, upon approaching her and seeing an insulin syringe, assumed she was a drug addict, despite her repeated explanations that she had diabetes and needed to eat her glucose tablets. She was taken from her vehicle and wrestled to the ground and then charged with resisting arrest, although charges were later dropped.
- An elderly man was found unresponsive by law enforcement officers inside his vehicle. The officers responding to the scene assumed that he was drunk and pulled him out of the vehicle and forced him to the ground. His hip was broken and a lung was bruised. He spent 21 days in the hospital as a result of how the officers responded to this medical emergency.

- A young man in police custody was denied access to insulin for more than 24 hours until he developed diabetic ketoacidosis and went into a coma. He now requires round-the-clock nursing care.
- A man with both schizophrenia and diabetes lingered in a jail cell for more than two months after a warrantless arrest. He received inadequate insulin and died.
- A man with schizoaffective disorder and diabetes was in prison on a parole violation. He was provided an injection of insulin in anticipation of an upcoming meal. However, when the meal did not come, he asked the guards for it because if insulin is given without food, severe hypoglycemia leading to seizure, unconsciousness, and death can occur. Instead of being given his meal, he was dragged from his cell and died after guards restrained him for several minutes using shock shields.

Each year, numerous individuals contact the Association alleging that they have been treated improperly by law enforcement on account of their diabetes. We believe that the reason for this mistreatment is due to ignorance rather than malice. However, as long as this ignorance continues, people with diabetes cannot be confident that they will be served and protected like other citizens, and families will fear for their loved ones.

2. The Medicine and Science of Diabetes Emergencies

In diabetes, insulin, a hormone produced by the pancreas, is either totally or partially lacking or the body cannot appropriately absorb insulin. Insulin is needed by the body to convert sugar, starches, and other food into energy needed to sustain life. Without insulin, life is not possible for long due to high glucose (hyperglycemia) and toxins that increase in the blood. On the other hand, too much insulin or some other medications causes low blood glucose (hypoglycemia) so much so that the brain and other organs cannot function.

Medical emergencies arise when individuals develop either severe hypoglycemia or hyperglycemia and immediate treatment is required. However, these conditions can be mistaken as intoxication, uncooperativeness, or belligerence. Training is required so that the law enforcement officers can distinguish between a person who is experiencing a medical emergency and a person who is choosing not to cooperate.

3. The Association's History of Educational Outreach and Cooperation

Philadelphia Police Department

Since 2001, the Association has worked to defend the rights of people with diabetes in the law enforcement context. In that year, I was lead counsel in a class action law suit against the Philadelphia Police Department (PPD) on behalf of detainees with diabetes who were denied access to appropriate food, medication and medical care while in police custody. The lead plaintiff was a businessman arrested for a minor liquor code violation who ended up in the hospital due to lack of access to medication and proper care while in police custody. The American Diabetes Association joined in this

suit. Settlement of the suit in 2003 included an agreement for the PPD and the ADA to jointly produce a training video and an informational poster, both aimed at helping police officers know how best to identify and respond to medical issues facing individuals with diabetes. These materials are geared towards when a police officer encounters a person with diabetes in the community needing help as well as when someone is being arrested or in custody.

Treating Diabetes Emergencies: What Police Officers Need to Know is a 20 minute training video designed to show law enforcement officers how to respond to people with diabetes in a variety of situations. Intended as a companion or stand-alone piece, *Diabetes is serious: It can be life threatening!* is a poster designed to help police officers understand diabetes and the signs and symptoms associated with diabetes emergencies. It also includes action steps to protect the safety of detainees with diabetes.

This was not the end of the cooperation between the PPD and the ADA however. In 2012, the PPD and the ADA agreed to work together to update and revise the PPD's key training and informational document. The result of our cooperative efforts was a much improved and updated police training tool, the 2013 diabetes Assist Officer. It has become a resource for other law enforcement agencies.

New York Police Department

In 2012, the Association began to meet with the New York Police Department in order to help it improve its officer training on diabetes. There had been several high profile incidents of individuals with diabetes being denied treatment while in NYPD custody. One incident involved the denial of insulin to an individual who subsequently experienced diabetic ketoacidosis and sustained serious brain damage requiring nursing care for the rest of his life. Through continued dialogue and cooperation, we have seen real change. The Association helped the NYPD to produce a compelling training video that is now shown to each officer. Earlier this year, one of the Association's medical experts and I were invited to present a program to 250 of the NYPD's training sergeants. As a result of the positive feedback, we have been invited to present annually.

Community Outreach

The work of the American Diabetes Association depends on our many volunteers in communities throughout the United States. To that end, in May 2013, we asked our volunteers to approach their local law enforcement agencies with our training materials and to offer to be resources for any agency that would like to begin a training program for their officers. Our volunteers have reached out to more than 400 local agencies in 31 states and the District of Columbia. However, even more hearteningly, law enforcement agencies have expressed their keen desire to receive training. They recognize the scope of the diabetes epidemic in their communities. Quite simply, they understand that their son, daughter, brother, sister, husband, wife, father, or mother could be in harm's way if law enforcement does not have the tools it needs to appropriately respond to people with diabetes.

Conclusion

We join our allies in the disability rights community to ask that the federal government develop concrete proposals to ensure that law enforcement officers across the country are given the tools, training, and resources to ensure that people with all disabilities can be confident they will be protected as well as any other citizen.

Thank you again for this opportunity to provide my testimony. The Association is ready and willing to work with the Senate Judiciary Committee and other legislative and executive groups to improve the treatment of people with diabetes by law enforcement officers.



Occupational Therapy:
Living Life To Its Fullest®

April 28, 2014

Submitted electronically to: Durbin_Testimony@Judiciary-dem.Senate.gov

Senator Richard Durbin, Chairman
U.S. Senate Committee on the Judiciary
224 Dirksen Senate Office Building
Washington, DC 20510

Senator Ted Cruz, Ranking Member
U.S. Senate Committee on the Judiciary
152 Dirksen Senate Office Building,
Washington, DC 20510

**Re: April 29, 2014 hearing, "Law Enforcement Responses to Disabled Americans:
Promising Approaches for Protecting Public Safety"**

Dear Chairman Durbin and Ranking Member Cruz:

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 140,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The practice of occupational therapy is science-driven, evidence-based, and enables people of all ages to live life to its fullest by promoting health and well-being while also minimizing the functional effects of illness, injury, disability, and other conditions.

AOTA appreciates the upcoming Senate Judiciary hearing, "Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety", and the opportunity to provide comments for the hearing. We would like to offer brief explanation of how occupational therapy practitioners can help to meet the public safety needs of people with disabilities and mental illness, and to offer ourselves as a resources as the committee moves forward with forming recommendations from the hearing.

Occupational Therapy practitioners work in multiple settings with clients across the lifespan. These settings include schools, early intervention programs, juvenile justice facilities, community mental health programs, mental health hospitals, forensic psychiatric units, and correctional facilities. Clients can include people with a developmental disability, an autism spectrum disorder (ASD), a mental health disorder, in addition to those with physical disabilities.

Occupational therapy practitioners are experts in understanding the complex interaction between a person, their activities, and their environment. It is imperative for law enforcement personnel to be prepared to interact with persons with disabilities. Because of occupational therapy's focus on activity participation and disability awareness, they offer a crucial role in preventing, promoting, and intervening to address both the physical and mental components inherent within interacting with individuals with disabilities in order to insure public safety. For example, for a person with a developmental delay, an ASD, or a mental health disorder, the



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physical environment can have a profound effect on behavior. How the physical or sensory environment is affecting a person, may not be readily apparent to law enforcement or other public safety officials.

Occupational therapy practitioners' understanding of this interaction can assist public safety officers in many ways including:

- 1) **Preventing wandering/elopement:** Someone with an ASD or mental health issue such as schizophrenia are more likely to wander or flee from a secure and safe environment, particularly during emergency responses. Occupational therapy practitioners can help to prevent wandering and fleeing by consulting with first responders and families. By helping to identify triggers for elopement (both positive and negative) as well as situations where elopement may occur (structured/unstructured, familiar/unfamiliar, etc.) occupational therapy practitioners can help reduce the occurrence of these behaviors as well as aid in search and rescue efforts.
- 2) **Helping to plan for emergency evacuations:** Emergency evacuations are an unstructured and stressful time. Changes to the routine and unpleasant sensory stimuli such as loud alarms could cause a person with certain disorders such as an ASD or mental illness to flee or to appear combative. Occupational therapy practitioners can help develop specific evacuation plans for individuals and help educate public safety personnel on common evacuation challenges. For example: occupational therapy practitioners can help to design cues such as color coded pathways to help patients with dementia who may become confused during times of stress; they can help to identify routes that require less direction-following for those with cognitive impairments; and they can help develop specific evacuation plans for individuals with physical limitations disabilities by identifying routes that are wheelchair accessible.
- 3) **Reducing the needs for restraints or seclusion in schools, forensic centers, juvenile justice centers etc.:** In the multiple settings in which they work, occupational therapy practitioners can serve on assessment and planning teams and help to identify client strengths and barriers to participation. Through environmental modifications, care-taker education and client-centered skills-training, practitioners can help reduce the need for the use of restraints and seclusion.
- 4) **Promoting Disability Awareness and a greater understanding of classic characteristics of specific disabilities:** Certain disabilities such as an autism spectrum disorder are associated with characteristics that could easily be misinterpreted by law-enforcement personnel. For example, a person with an ASD may not make eye-contact or may display echolalia (repeating another person's words). These characteristics are likely to increase during a time of stress, and could be easily misinterpreted by law-enforcement as the person being combative, noncompliant, or inebriated. Occupational therapy practitioners can help first responders recognize the classic signs of specific disabilities which prepares them in approaching those individuals in need during search and rescue missions. For example, a child with an ASD may apt to bolt when touched unexpectedly, thereby escalating an emergency response situation.

* * * *

The American Occupational Therapy Association greatly appreciates the Committee's focus on improving the public safety of Americans with a disability or mental illness. Occupational therapy practitioners are currently helping to meet this challenge in homes, schools, facilities and communities across the country. Thank you for the opportunity to provide comments on this issue. AOTA looks forward to providing additional information and assistance as needed. Please contact us at (240) 482-4147 or hparsons@aota.org if you have questions or need additional information.

Sincerely,

Heather Parsons
Director of Legislative Advocacy
The American Occupational Therapy Association, Inc.

Written Testimony to Support the Anchorage Crisis Intervention Team

The Anchorage Coordinated Resources Project (aka Mental Health Court), operated by the Alaska Court System strongly supports the local and statewide efforts the Anchorage Crisis Intervention Team (CIT) has provided for mentally ill individuals in Alaska. Under the leadership of Sgt. Wendi Shackleford of the Anchorage Police Department, Alaska's trained CIT officers have been instrumental in changing the face of how mentally ill offenders are handled by law enforcement in our local community, as well as our statewide community. Anchorage CIT has been at the forefront of system transformation for mentally ill individuals who interact with the criminal justice system for a number of years. An example of the strong partnerships that Anchorage CIT has is with the annual CIT training. Community partners, including the mental health court judge, provide training on their expertise in working with mentally ill individuals. The Anchorage CIT has helped to arrange trainers to cover topics on self-mutilation, mental illness recovery, excited delirium, officer self-care, and use of statistics to track CIT calls and outcomes of calls. This data helped to design a pro-active and preventative police response for responding to the mentally ill.

The Crisis Intervention Team (CIT) training model, a 40 hour training designed to assist law enforcement in responding appropriately and more sensitively to calls involving mentally ill individuals has been provided to over 300 members of law enforcement, corrections and community partners in Alaska. In Anchorage, there are over 70 officers and over 30 dispatchers who have attended the 40 hour Basic CIT training. CIT is now required training for new members of the Anchorage Police Department and CRU (Crisis Negotiator) teams.

Mentally ill offenders are a difficult and often forgotten population. Trained CIT Officers become competent in responding differently and humanely to mentally ill offenders. Now, instead of criminalizing the mentally ill, officers have the skills and resources to appropriately divert mentally ill individuals to the community (mental health court, community mental health agencies, psychiatric emergency rooms) and arrest is not the only option. When arrest is necessary, officers now communicate with partner agencies, such as the department of corrections mental health, the mental health court, community behavioral health agencies, consumer groups and family members to best meet the needs of the mentally ill individual.

Written Testimony to Support the Anchorage Crisis Intervention Team

The Anchorage Police Department's CIT was awarded the 2002 Downtown Partnership's *Heart of "our community" Community Partnership Honor Award for Best Neighbor*. In 2003, the CIT team was awarded the *Chuck Melick Memorial Award "For outstanding advocacy for individuals with disabilities. You make a difference."* presented by the mayor. On September 1, 2004, the CIT Team was honored by a local intellectual disability agency with the *Grace and Aram Wolf Memorial Award* "for the advancement of the rights and dignity of individuals who experience developmental disabilities". This award is presented to those who have demonstrated extraordinary championship in advocacy for equal rights, opportunity, and status for those who experience disabilities. The CIT team won the Governor's Award on 9-30-08—this award recognizes a civic organization that has done the most to improve the potential of people with disabilities. The CIT team was recognized for partnering with law enforcement and other community partners to educate their staff on how to best respond to people who experience mental health issues and are in crisis.

Anchorage Coordinated Resources Project (aka Mental Health Court) has a close working relationship with the Anchorage Police Department's CIT team. For example, CIT officers make referrals directly to the mental health court via phone or email. This close communication helps to swiftly identify mentally ill offenders and divert to the mental health court docket. Another example of collaboration is that APD CIT officers have been paired with or alerted to individuals with complex behavioral health issues in the community. Instead of arresting the individual, the officer is able to respond with an alternative approach, such as diverting to the psychiatric emergency room, calling the case manager, or the mental health court case coordinator. This helps to increase communication surrounding individuals with complex behaviors and reduce unnecessary arrest. Anchorage CIT is also a member of the Interagency Coordination Group, a multiagency group that meets monthly to identify high need consumers and problem-solve innovative interventions to best meet the needs of complex individuals with mental health needs.

**Appleton Police Department *Crisis Intervention Team (CIT)*
222 S Walnut Street, Appleton, WI 54911 920.832.5544**



***".....Fighting crime
.....Solving problems."***

April 28, 2014

U.S. Senator Dick Durbin
Senate's Assistant Majority Leader
Chairman of the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights
United States Congress
Washington DC

Regarding: **"Law Enforcement Responses to Disabled Americans"**
Promising Approaches for Protecting Public Safety." Because of inadequate social and mental health services, law enforcement officers have increasingly become the first responders for individuals with mental illness or developmental disabilities who are in crisis.

Dear Senator Durbin:

The Appleton Police Department adopted the "Memphis Model" of CIT (Crisis Intervention Team) in 2004 as a result of the declining services / budgetary investment in emergency mental health services in our community. Appleton has a population of nearly 75,000 people and would be considered middle class. We have a somewhat unique situation of sitting in three Counties. Each County has a varying degree of mental health services, especially emergency mental health. We saw at that time that while not a mental health services provider, we, law enforcement, are often called upon to be the "first responder to persons in crisis". We believed the mental health consumer was deserving of more and the mental health community owed it to the public at large to do more. The best way to achieve improved services and results was through the collaborative approach called CIT. CIT originated in 1988 in Memphis TN and was not in place anywhere in WI prior to our efforts to bring it to our community in 2003. Our primary partners were County Mental Health and our local National Alliance on Mental Health affiliate, NAMI Fox Valley.

Since inception we have achieved all of the known benefits of CIT:

- Reduced risk of injury to mental health consumers, the public or officers
- Reduced repeat calls for mental health and other services
- Improved working relationship between area providers and law enforcement first responders
- Increased involvement of the consumers family and friends

**Appleton Police Department *Crisis Intervention Team (CIT)*
222 S Walnut Street, Appleton, WI 54911 920.832.5544**

- Increased awareness of mental health services in the community to consumers and their support network
- All collaborators appreciate the value of early intervention as opposed to the emergency response. Early intervention is generally more successful and more cost effective.
- CIT places an emphasis on diversion to the civil mental health system of care as opposed to the Criminal Justice system which can be very unforgiving to persons in crisis.

Since 2004 we have seen our crisis calls to continue to increase in double digit percentages. At the same time we have successfully seen our actual Emergency Detention placements decline to pre-2003 levels. Most agencies that do not have CIT experience the exact opposite; increased Emergency Detentions. ED's can use a large amount of officer time and often result in overtime to the detaining agencies. CIT has reduced that impact at the Appleton Police Department and other agencies in WI.

The biggest hurdle to most law enforcement agencies is access to the training and being able to schedule it affordably. In many cases the CIT training is supported by community grants and is often at no cost to the attending law enforcement agencies. Most agencies have downsized over the last ten (10) years and being able to schedule officers is difficult to make happen and expensive so far as maintaining patrol coverage while the officers are away at the training. The training is forty (40) hours.

In closing let me say that two things should be considered:

- First, CIT should be recognized as a "best practice" nationwide by all law enforcement agencies or their guiding agencies (DOJ, etc.).
- Secondly, training dollars should be allocated nationally so that all law enforcement agencies, especially the smaller agencies, can afford to send officers to the CIT training. This incentive should stay in effect until such time that access to mental health services as well as the providing of mental health services improves on a national basis. This should not be law enforcements issue to deal with. Until such time that mental health services improve it will be.

Let us, the law enforcement community, embrace the need for this training so that we can truly protect and serve the community we work in. Countless persons with mental illness needlessly end up entangled in the criminal justice system. Too many mental health consumers and law enforcement first responders die in these conflicts involving our response to persons in crisis. Countless dollars are wasted on criminal court cases (James Holmes, Jared Loughner & Seung-Hui Seng, just to name a few) that could have been avoided had mental health services been easier to access and more readily available outside of crisis.

Thank you for allowing us to offer commentary on the importance of mental health training for law enforcement. CIT save lives and changes communities. This need for law enforcement training will always exist so long as there is mental illness.

Respectfully submitted

SSgt. John S. Wallischlaeger
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**INTERACTION OF INDIVIDUALS WITH AUTISM SPECTRUM DISORDERS
WITH THE JUSTICE SYSTEM IN PENNSYLVANIA**

The Bureau of Autism Services, PA Department of Public Welfare commissioned the Autism Services, Education, Resources, & Training Collaborative (ASERT) to conduct an update of the 2005 PA Autism Census. According to the 2014 PA Autism Census Update, there are 55,830 individuals with Autism Spectrum Disorders (ASD) in Pennsylvania receiving state services. Of that, 500 individuals with ASD in Pennsylvania who were receiving services had contact with the juvenile or criminal justice systems in 2011.

Frequency of Charges Committed by Individuals with ASD (2011)	
Charge Type	Frequency
Offense Against Person (e.g. assault, battery, sexual offenses)	1,171
Property Crimes (e.g. arson, theft, vandalism)	737
Offense Against Justice (e.g. drugs, weapons, fines)	525

Most Common Charges among Individuals with ASD in Pennsylvania (2011)	
1	Simple assault cause bodily injury
2	Theft
3	Harassment/strike, shove, kick, etc.
4	Disorderly conduct engage in fighting
5	Crime of violence intent to terrorize
6	Criminal mischief real or personal property
7	Indecent assault against person <13 years old
8	Burglary with person present
9	Unauthorized use of auto or other vehicle
10	Aggravated assault bodily injury to teacher

- ❖ Property offenses and physical crimes were the most common charge types among individuals with ASD who were in contact with the justice system in 2011.
- ❖ There is a dearth of existing literature on the interaction of individuals with ASD and the criminal or juvenile justice systems.
- ❖ There are many avenues to explore in training and systems preparations to meet the needs of the ASD population in the criminal and legal systems.
- ❖ It is necessary to collect more data and conduct more analysis to identify how to address the needs of individuals with ASD in the context of justice system interfaces.

The Autism Services, Resources, Education, & Training Collaborative (ASERT) Eastern Region would welcome the opportunity to present more on this topic area. Please contact Lindsay Shea (lj142@drexel.edu) for additional information.

To: The Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights
 Re: Crisis Intervention Training (CIT) [edited]
 From: Mary Neal, a/k/a MaryLovesJustice, director of Assistance to the Incarcerated Mentally Ill ("AIMI")

AIMI is an online mental health advocacy organization, founded in 2007, with roughly a thousand members at Care2, Facebook, and Google+, and over a million regular readers of our articles, emails, and posts in social media.

AIMI congratulates the U.S. Senate Judiciary Subcommittee for inviting input from stakeholders regarding crisis intervention training (CIT) for police officers who are the first responders regarding mentally ill Americans in crisis. People throughout the world are alarmed at the high death rate and the number of serious injuries our mentally challenged people face from arresting officers. AIMI supports additional training for police officers to enable safer arrests.

Be aware that in addition to mentally ill Americans being abused and killed during arrests, many persons with serious mental illnesses are raped, beaten, and killed while in custody in correctional institutions throughout the country. They are also overrepresented among inmates in solitary confinement torture. Physical health conditions the mentally ill inmates may have, such as hypertension, diabetes, and others, are frequently ignored, to their detriment. It appears necessary, therefore, to include correctional officers in crisis intervention training.

Presently, whenever police or correctional officers seriously injure and cause the deaths of mentally ill people, it is said to be due to lack of training regarding the safe capture or containment of the mentally ill. I submit to you that CIT training will address only part of the problem regarding police violence. Many of the deaths and injuries the mentally ill suffer from police and correctional officers are incurred despite the training that police and correctional officers have already received regarding the human and civil rights of the victims.

Even police officers who never received crisis intervention training know it is unlawful to beat a surrendered subject like Kelly Thomas to death. They should also know it is unlawful to secretly arrest a lifelong mentally ill heart patient, like Larry Neal, and lie to his family and social worker for 18 days, denying having Larry in custody, while he died without his vital heart drugs. Whether being Tasered or placed in restraint also contributed to Larry Neal's secret death in custody, his survivors cannot say. His kidnapping and murder are still treated like national secrets, even ten years later. Deaths in custody often result from abuses of power, and cover-ups are common. Therefore, the Senate Judiciary Committee should also recommend that police officers and correctional officers be held fully accountable for avoidable deaths and injuries to all Americans that occur during arrests and incarceration.

We understand that Memphis, Tennessee is the home of crisis intervention training. However, MPD continues to kill the mentally ill. A total of 23 people were killed by MPD during 2012 and 2013, including Christian Freeman, 19, a paranoid schizophrenic. He was shot to death June 12,

2012, about 1:40a.m. near Beale Street. Police claimed Freeman charged at two officers with a knife and they shot him to death. If he had lived, Freeman would have endured his second arrest for conduct caused by mental illness. He spent a month in a mental health ward after allegedly yelling and making obscene gestures at police officers in April 2012. The fact that people with serious mental illnesses are regularly killed in Memphis, the home of CIT, shows that instituting CIT for police officers around the country will not be sufficient to protect Americans with mental disabilities from police violence. Police accountability must be incorporated in the Senate's recommendations regarding reducing deaths and injuries to the mentally ill.

AIMI is not only concerned about the safe capture of the mentally ill and their safety while behind bars, but we also urge the U.S. Senate Judiciary Subcommittee to recommend passage of H.R.3717 - The Helping Families in Mental Health Crisis Act, which Representative Tim Murphy (R-PA) introduced in the U.S. House of Representatives in December 2013. The bill provides for CIT training for police and correctional officers. According to my understanding, it further provides for:

- Assisted outpatient treatment (AOT) programs, that offer subsistence assistance and mandated psychiatric treatment. AOT program participants in New York experienced over 85% decrease in rates of homelessness, arrests, and incarceration when compared to their rates from three years before entering the AOT programs.
- Relaxed HIPPA laws, so that close family members can be privy to their mentally ill relatives' medical and psychiatric information and better advocate for them.
- Resumption of Medicaid insurance to increase access to inpatient treatment facilities for people who financially qualify.

Thank you for this opportunity to share our opinions on CIT and the other provisions of H.R.3717, which would stop the revolving door to jails and prisons for our most vulnerable citizens.

Mary Neal



Director of
 Assistance to the Incarcerated Mentally Ill
<http://www.care2.com/c2c/group/aimi>
 Dog Justice for Mentally Ill
<http://dogjusticeformentallyill.blogspot.com>
 Website: Wrongful Death of Larry Neal
<http://wrongfuldeathoflarryneal.com>



Testimony Provided by Autism Speaks for the
Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights
On Law Enforcement Responses to Disabled Americans:
Promising Approaches for Protecting Public Safety

April 29, 2014

Chairman Durbin, Ranking Member Cruz, and members of the subcommittee, Autism Speaks thanks you for the opportunity to offer written testimony on the response of law enforcement officers to developmentally disabled individuals in crisis. Autism Speaks is the world's leading autism science and advocacy organization. Our goal is to change the future for all who struggle with autism spectrum disorders. We are dedicated to funding research into the causes, prevention, treatments and a possible cure for autism. We strive to raise public awareness about autism and its effects on individuals, families, and society, and we advocate for the needs of individuals with autism and their families. We have invested over \$400 million in this effort and we are committed to continuing our work.

Autism spectrum disorders (autism for short) are defined by deficits in very basic social and communication skills, differences in the way those skills are used in social interaction and

communication, and by a varied list of behaviors that share repetitive or restricted features. Autism can be associated with intellectual disability, difficulties in motor coordination and attention, and physical health issues. Autistic people may behave in unique and unexpected ways.

We now know that there is no one cause of autism or one type of autism. Most cases of autism appear to be caused by a combination of autism risk genes and environmental factors influencing early brain development. Autism occurs in all racial, ethnic, and socioeconomic groups, and is almost five times more common among boys than girls.

Many questions about autism remain to be answered, but we do know that autism is much more commonplace than once thought. According to recently released estimates from the Centers for Disease Control and Prevention, 1 in 68 children have autism. The new estimate is roughly 30% higher than the estimate from two years ago (1 in 88), roughly 60% higher than the estimate from four years ago (1 in 110), and roughly 120% higher than the estimate from six years ago (1 in 150). Improved diagnosis and identification explain only part of these dramatic increases.

The numbers mean more affected individuals and families will need services, whether routine or emergency. Nearly half of children with autism attempt to wander or bolt from a safe, supervised place. More than half of these wandering children go missing – often into dangerous situations. In 2014 Autism Speaks has had a total of **1,734** direct requests for wandering prevention and safety resources from individuals with autism, their families, and first responders. Since launching our partnership on January 23, 2014, Autism Speaks has worked

with the National Center for Missing and Exploited Children on **36 active autism wandering incidents**.

Law enforcement officers may be called upon to look for a missing child or adult, or may encounter people with autism in other crisis situations. Police are trained to respond with a certain protocol, but this protocol may not always be the best way to interact with individuals on the spectrum. Challenging law enforcement officers, not responding to their orders, or running away may not be acts of defiance by an individual with autism. Because police are usually the first to respond to an emergency, it is critical that officers have a working knowledge of autism and the wide variety of behaviors individuals on the spectrum can exhibit in emergency situations. Too often, we in the autism community hear of encounters between police and people on the spectrum, confrontations that result in death or serious injury and leave a family bereaved, and we are left to wonder whether different policing tactics could have avoided a tragedy.

On our [website](#) Autism Speaks has assembled these quick facts for law enforcement personnel:

- *Interacting with a child or adult who has autism will challenge your experience and training.*
- *You will hear terms such as low functioning/high-functioning autism and Asperger's Disorder to identify the level of their condition. In most cases, the person will have difficulties following verbal commands, reading your body language, and have deficits in social understanding.*
- *Law enforcement agencies should proactively train their sworn workforce, especially trainers, patrol supervisors, and school resource officers, to recognize the behavioral*

symptoms and characteristics of a child or adult who has autism, and learn basic response techniques.

- *A training program should be designed to allow officers to better protect and serve the public and make the best use of your valuable time, and avoid mistakes that can lead to lawsuits and negative media scrutiny, loss of confidence from the community, morale problems, and lifelong trauma for all involved.*
- *A good autism recognition and response workshop is designed to inform law enforcement professionals about the risks associated with autism, and offers suggestions and options about how to address those risks.*

In addition to information for enforcement personnel, Autism Speaks provides a dedicated safety portal broken down into sections to provide comprehensive and effective information on the following topics:

- [Safety in the Community](#)
- [Safety in the Home](#)
- [Recognizing and Preventing Abuse](#)
- [Recognizing and Preventing Sexual Abuse](#)
- [Information for First Responders](#)
- [National Safety Resources](#)

Our Autism Response Team is specially trained to connect people to information, tools, and resources. We can be reached at 888-288-4762 (en Español 888-772-9050) or familyservices@autismspeaks.org.

Autism Speaks has taken steps to facilitate collaboration between law enforcement and the autism community, but we need help from Congress and the Executive Branch. We look to

the federal government to work closely with first responders and local law enforcement on training to increase awareness of the special safety needs of people on the spectrum and to provide tools that will reduce the risk of harm to vulnerable individuals. Autism is and must be a national health priority, and the safety of individuals with autism in law enforcement situations must receive greater attention.



Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety

Submission for Senate Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights April 29, 2014

"On January 11, 2013 in a Maryland movie theater, a 26-year-old man with Down syndrome cried out for his mommy in the final moments of his life and started a movement. The death of Ethan Saylor at the hands of sheriff's deputies who were trying to evict him from the theater he entered without a ticket has become a significant event for people in the disability community who push for equality and inclusion as a civil rights issue. Ethan Saylor is their Emmett Till.

For me, the Saylor story is deeply troubling and personal. My 10-year-old daughter has Down syndrome. She is witty and sunny most of the time but there are moments when she is obstinate and difficult — much like any child. But the behaviors sometimes take extra effort to work around.

That kind of understanding and patience should have been afforded Ethan Saylor, who had an IQ of 40.

Instead, off-duty Frederick County Sheriff's deputies were summoned to oust Saylor when he wanted to watch "Zero Dark Thirty" a second time, without a ticket. As deputies went in, Saylor's aide pleaded for everyone to wait it out and allow her to deal with the situation. His mother was on the way. The aide warned that Saylor would "freak out" if touched.

Deputies dismissed her advice and told her to stay out of the theater. They went in, ordered Saylor to leave, then grabbed him when he refused and began swearing at them.

Deputies cuffed him, and Saylor struggled and cried, saying, "Mommy, mommy. It hurts." As officers wrestled with 294-pound Saylor, he fell to the ground with a deputy on his back. He soon stopped breathing and died. An autopsy later revealed his larynx was crushed."-Denver Post 1/11/14

Could this have ended differently if those officers had been trained in the proper way to interact with individuals with disabilities? Unfortunately, we will never know but Niagara University through the scale up and expansion of impact of its unique First Responder Disability Awareness Training (FR DAT) program intends to do everything possible to prevent this from happening to another family. The key is education and training that has staying power.

- **Everyone** needs disability awareness training; this is not unique to first responders. However, emergency personnel's presence at situations that call for a response to challenging behaviors, alleged

criminal conduct, physical and medical needs, assistance in a matter, or service and protection, are imperative to the well-being and quality of life for the vulnerable individual(s) in which they come into contact. The intent of any training should recognize that (most) individuals in law enforcement want to do the right thing; however, the unique, perplexing encounters that may call for split second decision-making can put an officer in a difficult spot. Our program exists so that all first responders, but especially police officers, are able to respond in a manner that allows for both parties to be safe and treated in the appropriate manner.

- “First Responders” is a term used to describe police, firefighters, emergency medical services (EMS), and 911 operators/dispatchers who are the first contact either via 911 or through arrival on the scene of medical or other emergencies.
- While **Ethan’s case** has garnered national attention, it is not the only instance where a first responder has inappropriately responded to an IWD and the result has been negative. However, to fault first responders would not be prudent. You can’t properly respond to an incident if you were never trained in how to do so, if your state’s criminal justice mandated training did not include a detailed section on disability awareness, if your Chief was never given the opportunity to send their personnel to a program. While some states include training for law enforcement in response to individuals with disabilities (IWDs), it is either not enough, buried within hundreds of hours of recruit training, doesn’t allow for on-going education, or is not delivered effectively. NU FR DAT’s **website (www.fr-dat.com)** has, under *Articles of Interest*, some 30 cases whereby law enforcement was challenged and may have responded in a manner that was not effective, resulting in injury to an IWD (both physical and mental), death of an IWD (across the disability spectrum), false arrest, civil lawsuits costing municipalities millions of dollars, officers losing their job and some even serving time.
- Society has many faults when it comes to proper response and interaction with IWDs which is manifested by misperception, misunderstanding, lack of awareness, viewing and IWD as a lesser person, sympathetic response as opposed to empathetic, fear of the unknown, and avoidance. However, for first responders to come into situations with these areas not being eradicated from their minds, the probability of an inappropriate interaction rises dramatically.
- IWDs may require response that would vary from everyday encounters. If emergency personnel are not comprehensively educated on this topic, results can be negative, some even catastrophic.
- Research shows that individuals with disabilities (IWDs) are **seven times more likely the victim of a crime** than other individuals while **50-80% of an officer’s day will be in contact with an individual with a disability**. Yet First Responders seldom have sufficient training to interact effectively with people with developmental disabilities.
- Historically, most individuals with developmental disabilities who required out of home placement resided in large institutional settings, some of which mirrored self-contained communities with emergency and other personnel available within the institution 24 hours a day, 7 days a week.
- **One of five Americans has a disability**, and it is on the rise. Current numbers include **1 in 68 children have autism, 3% of the population has an intellectual disability, one on 10 Americans will have a seizure, and 30 million people have ambulation challenges**, to name a few. That said many disabilities such as Tourette syndrome, traumatic brain injury, ADHD, and learning disability has a high incidence of encounters with law enforcement. All will present differently and have the potential to be challenging for an untrained officer.
- Today, most individuals with developmental disabilities live with their families, others in the community, or independently per their choice. Along with the rewards of community living, people with disabilities face increased risks of needing the assistance of First Responders.
- According to the US Bureau of Justice Statistics, an **estimated 1.3 million nonfatal violent crimes occurred against persons with disabilities in 2012** nationwide.
- **In 2012, the rate of violent crime against persons with disabilities was 34 per 1,000, compared to 23 per 1,000 for persons without disabilities**. Because persons with disabilities are generally much

older than those without, the age distribution differs considerably between these two groups, making direct comparisons misleading. To compare rates, each group was adjusted to have a similar age distribution, **making the age-adjusted rate of violent crime against persons with disabilities (60 per 1,000) nearly three times higher than the rate for persons without disabilities (22 per 1,000).** The age-adjusted rate of serious violent crime—rape or other sexual assault, robbery and aggravated assault against persons with disabilities (22 per 1,000) was nearly four times higher than that for persons without disabilities (6 per 1,000) in 2012.

- Among persons with disabilities, **those with cognitive disabilities had the highest unadjusted rate of violent victimization (63 per 1,000).** During 2012, about half (52 percent) of violent crime victims with disabilities had more than one disability. **Violent crime against persons with one disability type increased from 2011 (37 per 1,000) to 2012 (53 per 1,000),** while the rate among persons with multiple disability types remained stable during the same period.
- Other 2012 findings include: **Persons with disabilities experienced an estimated 233,000 robberies, 195,200 aggravated assaults, 838,600 simple assaults and 80,100 rapes or other sexual assaults;** Among persons with disabilities, whites were more likely than blacks to experience a violent crime; Hispanics with disabilities had a lower rate of violent victimization than non-Hispanics with disabilities; and, among persons ages 12-15, the unadjusted rate of violent victimization was three times higher for persons with disabilities than for persons without disabilities.
- Individuals with disabilities who are offenders will also have challenges in the judicial system, many of them at every level of it.
- Law enforcement will also be responding to IWDs when they are in need of assistance or in crisis. Individuals with autism and dementia may wander and first responders are called to find them. People who use wheelchairs may get stuck and need assistance, individuals with speech impairments will pose challenges, a need to be able to know basic sign language will be expected when interacting with a deaf person, etiquette and interaction skills with someone who is blind, to name a few.
- The **Americans with Disabilities Act (ADA)** already addresses some of these matters but often times officers are not kept abreast of how this impacts their responsibilities. The Department of Justice (DOJ) has some materials that assist in educating officers on how to be sure they both uphold the ADA and don't violate it.
- Still, incredibly, first responders, emergency managers, and municipal employees/elected officials receive no formal mandated training in proper response to IWDs.
- According to FEMA, **an average of an estimated 1,700 residential building fires involving individuals with mental disabilities are reported each year with an estimated 85 deaths and 250 injuries while an estimated 700 building fires involving individuals with physical disabilities are reported each year with an estimated 160 deaths and 200 injuries**
- This, in combination with the documented tragedies resulting from inappropriate first responder contacts with IWDs nationwide, indicates a clear need for expanded training for first responders and aligned emergency personnel.

In September 2010 Niagara University (NU) was awarded a three year \$550,000 grant from the NYS Developmental Disabilities Planning Council (DDPC) to address the lack of training and understanding of how to properly respond to IWDs with the intent to develop curriculum for the training of police officers, firefighters, EMS, and 911 operators in the State of New York. Although some states have versions of this program, no state has developed a fully comprehensive program. The program is a **Train the Trainer model**, which is the only way to reach first responders in mass. It incorporates a Trainer network that allows for FR to connect with IWDs to co-present on disability specific topics and sections. NYS DDPC researched and found no state to have comprehensive mandated training.

Consider that in **New York State** there are 588 police departments and sheriff's offices with more than 62,300 sworn full- and part-time officers, 45 law enforcement training academies, 2,135 fire departments and EMS agencies with more than 175,000 responder personnel statewide; thousands of 911 operators and hundreds of individuals responsible for emergency management of municipalities. The numbers and the training schedules that are utilized by firefighters (FF), law enforcement (LE), and EMS agencies are non-traditional. In essence, to train one police department (PD) of 100 officers will take a week, the schedule would be set by them, and there would be an expectation that this is offered at no charge. It is simply not practical. Couple this with the feeling that the best people to train FF and LE are themselves, and the odds are against any group to make a dent in their regions FR departments. Law enforcement receives two hours of mandated training on individuals with disabilities in the basic course (out of 639 hours). FR-DAT has reached (to date) over 800 representatives from 51 emergency management agencies, 70 law enforcement departments, and 75 FF/EMS departments through a combination of direct and train-the-trainer formats.

NU has also taken the measure to ensure some form of on-going education. They have done this through the following:

- The trainer manuals have additional materials on disabilities, the ADA, victimization/abuse, service animals as well as resources via websites per discipline.
- NU has developed a resource manual for every attendee that is a quick reference guide on everything disability related specific to first responders
- NU has developed an extensive website that allows for FR to continue educating themselves on everything relative to proper response. NU will develop state-specific links to adjust to the differences (i.e. laws, service providers, parent groups) across borders.
- NU maintains a relationship with all trainers, allowing for inquiries to be answered, new material to be shared, current trends and topics to be disseminated, and tracking of training conducted to be incorporated into the database. This ensures they are always connected to 'homebase' and their responsibilities are carried out.
- Working with the support of the **NYS Office of Persons with Developmental Disabilities (OPWDD)**, the end product includes, but not be limited to, class room training, a train the trainer program, on-line training, database of all departments and councils, extensive resources, comprehensive website, and regional disability contacts and information Research by DDPC staff indicated that there was no program or state in the country that addressed the complete issue eclectically.
- Through the Disability Awareness Training at NU, New York is the only state in the nation to have a comprehensive program that covers the disability spectrum and works with and through state offices and associations.

Firefighters, EMTs, paramedics, police and emergency room personnel are trained to handle emergencies but not necessarily an autism emergency. If not aware of the disability and the spectrum of the symptoms it encompasses then responders will not be adequately prepared to handle the emergency effectively.

Untrained or uneducated mistakes can result in the loss of a first responder or the individual with the disability - which is unacceptable given that we have training available. Individuals with autism are so unique in their actions and unpredictability, so it is in the name of safety for both the individuals and the first responder to have specific training.

Can you imagine going into a fire and reaching out to grab an individual in imminent danger only to find that the individual reacts in defense of being touched not in fear of the responder? There is not time in these situations to receive on the spot training. Responders need this training well in advance of this situation to know how to react.

As parents and advocates for this training, we believe that all firefighters, EMTs, paramedics, police and emergency room personnel should be required to have this specialized and critical training. They need to know how to recognize autism, learn communication and interaction strategies, learn how to lessen or eliminate dangerous behaviors and if warranted, how to restrain the individual in the safest way possible.

In an emergency situation, when every second can make a difference, this essential training will not only save lives, but continue to raise awareness in all communities, reducing myths and aiding those with autism to lead safe and productive lives. If our emergency first responders don't have this training, we can expect more loss of life and regret.

Respectfully submitted,

A handwritten signature in black ink that reads "Sarah Milko". The script is cursive and fluid.

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The Judge David L.

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Testimony submitted to the Senate Judiciary Subcommittee on
the Constitution, Civil Rights, and Human Rights

"Law Enforcement Responses to Disabled Americans:
Promising Approaches for Protecting Public Safety."

April 29, 2014

By the Bazelon Center for Mental Health Law

The Bazelon Center for Mental Health Law submits this statement for the record regarding the April 29, 2014 hearing on Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety. The Bazelon Center is a national nonprofit advocacy organization that represents individuals with psychiatric disabilities and advances their rights to live full and independent lives in their own homes and communities.

As the subcommittee has noted, individuals with psychiatric disabilities have disproportionate rates of involvement with the criminal justice system. Individuals with mental illness are much more likely to be arrested and studies have found that rates of arrest among public mental health service recipients are "roughly 4.5 times higher than those observed in the general population."¹ On average, 17 percent of people incarcerated in jails are estimated to have serious mental illnesses.²

¹ Bazelon Center for Mental Health Law, *The Role of Mental Health Courts in System Reform* 2 (2003) available at http://bazelon.org/LinkClick.aspx?fileticket=xQt5_1grKcl%3D&tabid=104; William H. Fisher, et. al., *Risk of Arrest Among Public Mental Health Services Recipients and the General Public*, 62 *Psychiatric Services* 62 (Jan. 2011).

² Alex M. Blandford & Fred C. Ocher, Council of State Governments Justice Center, *A Checklist for Implementing Evidence-Based Practices and Programs for Justice-Involved Adults with Behavioral Health Disorders* 1 (Aug. 2012). The most recent Bureau of Justice Statistics study estimated that the United States inmate population with mental health conditions was higher: 56 percent of inmates in state prisons and 45 percent of inmates in federal prisons. Doris James & Lauren Glaze, U.S. Dep't of Justice, *Mental Health Problems of Prison and Jail Inmates* 1 (Sept. 2006) available at <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>.

In Los Angeles, about 15 percent of the L.A. jail's 15,000 inmates, or about 2250 people, were classified as mentally ill.³ The Cook County Jail in Illinois screens all inmates for mental illnesses and reports that a third of the 10,000 inmates have a mental illness.⁴ These individuals are not imprisoned because of violent crimes, but because of minor offenses: "[p]olice have picked them up for small crimes like acting out in front of restaurants, sleeping in abandoned buildings or possessing drugs."⁵

These rates of justice involvement reflect the failure of our mental health systems to offer people the services they need to prevent law enforcement involvement. Providing these services to more individuals who need them would enable us to: (1) avoid many preventable deaths of individuals with psychiatric disabilities during encounters with law enforcement, (2) avoid spending costly sums on incarcerating individuals with psychiatric disabilities in jails and prisons where they are poorly served, and (3) prevent arrests and convictions that follow individuals for the rest of their lives, making it substantially more difficult for them to obtain housing and employment and reintegrate successfully into community life.

We have services that have demonstrated effectiveness in reducing law enforcement involvement—Assertive Community Treatment, mobile crisis services, and supportive housing. These services have demonstrated success in reducing recidivism, improving mental health outcomes, and lowering costs.⁶ These services may be covered by states under the Medicaid program. Moreover, states that have adopted the Medicaid expansion may cover these services at largely federal expense for numerous people who were previously uninsured and ineligible for Medicaid.⁷

³ Jack Leonard & Robert Faturechi, *L.A. county jailers more likely to use force on mentally ill inmates*, L.A. TIMES (Jan. 11, 2012) available at www.articles.latimes.com/2012/jan/11/local-la-me-sheriff-jails-20120111.

⁴ Laura Sullivan, *Mentally Ill Are Often Locked Up In Jails That Can't Help*, National Public Radio (January 20, 2014), available at <http://www.npr.org/2014/01/20/263461940/mentally-ill-inmates-often-locked-up-in-jails-that-cant-help>; Nicholas Kristof, *The New York Times*, *Inside a Mental Hospital Called Jail*, (Feb. 8, 2014) available at http://www.nytimes.com/2014/02/09/opinion/sunday/inside-a-mental-hospital-called-jail.html?_r=0.

⁵ Laura Sullivan, *Mentally Ill Are Often Locked Up In Jails That Can't Help*, National Public Radio (January 20, 2014), available at <http://www.npr.org/2014/01/20/263461940/mentally-ill-inmates-often-locked-up-in-jails-that-cant-help>.

⁶ Letter from Professor Kupers to County Supervisor Yaroslavsky, *supra* note __; see also H. Richard Lamb et al., *Treatment Prospects for People With Severe Mental Illness in an Urban County Jail*, 58(6) *Psychiatric Services*, 782-86 (2007); Jennifer S. Bard, *Re-Arranging Deck Chairs on the Titanic: Why the Incarceration of Individuals with Serious Mental Illness Violates Public Health, Ethical, and Constitutional Principles and Therefore Cannot Be Made Right by Piecemeal Changes to the Insanity Defense*, 5 *Hous. J. Health L. & Pol'y* 1 at 6 (2005); D. Lovell, et al., *Recidivism and use of services among people with mental illness after release from prison*, 53(10) *Psychiatric Services* 1290, 1296 (2002).

⁷ The Medicaid Expansion gives states an enhanced reimbursement rate (100 percent until 2016, after which a minimum 90 percent) for all newly eligible individuals, anyone whose annual income is less than 139 percent of the federal poverty level. States must create Medicaid expansion plans that cover, at a minimum, the mandatory traditional Medicaid services and the essential health benefits. States can also choose to align these expansion plans with the state's traditional Medicaid plan, simplifying administration. Regardless of what states cover in their Medicaid expansion plans, individuals with serious mental illness are among those considered "medically frail" and thus can choose to receive traditional Medicaid services. The state will still receive the increased reimbursement rate for the newly eligible. See THE JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW, WHEN OPPORTUNITY KNOCKS, HOW THE AFFORDABLE CARE ACT CAN HELP STATES DEVELOP SUPPORTED HOUSING FOR PEOPLE WITH

Assertive Community Treatment (ACT), an intensive set of services, helps people with the most significant mental health needs in navigating the day to day demands of community living. ACT is provided by a mobile team of professionals who coordinate and deliver comprehensive services that are flexible and individualized to meet each client's particular needs. ACT services are available on a 24/7 basis and may be increased or decreased as a person's needs change. ACT team members can help individuals not only in getting clinical needs addressed but in maintaining stable housing, securing and maintaining employment, engaging in community activities, skill building, managing health, and developing other recovery skills.

ACT has proved extremely effective in reducing justice involvement for individuals with serious mental illness. A 2005 study found an 83 percent decrease in jail days over the course of a year for participants in a local ACT program.⁸ In one year, Georgia experienced a net cost savings of \$1.114 million in associated reduced hospitalization, fewer arrests and decreased jail time.⁹

Mobile Crisis Services provide in-person psychiatric assistance to people in crisis situations. Mobile crisis teams are often used to divert individuals from inpatient hospitalization and into community programs. They meet individuals in the community at the time of crisis and include psychiatric nurses, social workers, and paraprofessionals. Rather than involve law enforcement, mobile teams can assess an individual and use a variety of interventions designed to de-escalate crises.

A national survey of mobile crisis services found that both consumers and law enforcement officials found mobile crisis intervention more effective than and preferable to law enforcement involvement (escorting an individual, for instance, to an emergency room for potential hospitalization).¹⁰ Mobile services prevented hospitalization 55 percent of the time compared to only 28 percent for regular police intervention. This national study also found mobile services to cost, on average, 23 percent less than police involvement and the subsequent higher rate of hospitalization.¹¹

Supportive Housing is another critical service that not only has substantial social and economic benefits, but furthers states' efforts to comply with the ADA and *Olmstead* by affording individuals with mental illness the chance to live in what is the most integrated setting appropriate for virtually all: their own apartments or homes. Supportive housing units are typically scattered in mainstream buildings throughout the community. Scattered site housing promotes greater integration than housing in developments exclusively or primarily designated

MENTAL ILLNESSES (2014) available at www.bazelon.org/portals/0/Where We Stand/Community Integration/Olmstead/When Opportunity Knocks. Bazelon Center for Mental Health Law.pdf

⁸ J. Steven Lamberti et al., Forensic Assertive Community Treatment: Preventing Incarceration of Adults with Severe Mental Illness, 55 *Psychiatric Services* 11, 1285-1293, 1289.

⁹ Georgia Rehabilitation Outreach, Inc., *Forensic Assertive Community Treatment: First Year in Review, July 1, 2004 - June 30, 2005* 3 (2006) available at <http://www.supporthousing.org/FACTrept1.pdf>.

¹⁰ Roger Scott, *Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction*, 51 *Psychiatric Services* 9, 1153-6 (Sept. 2000).

¹¹ *Id.*

for individuals with disabilities.¹² In addition, supportive housing provides the individual with a flexible array of services, such as case management, life skills training, homemaker services, substance abuse treatment, and employment supports. Supportive housing recipients can also receive ACT or other team-based services if they need them.

Studies have shown that supportive housing has substantial benefits: A large study in New York City of homeless individuals with SMI receiving supportive housing services demonstrated that these individuals experienced significant reductions in shelter use, hospitalizations, duration of hospital stays, and incarceration.¹³ A pilot project involving the Pathways to Housing program in Philadelphia, which provides supportive housing to formerly homeless individuals with serious mental illness and substance abuse disorders, found that the program reduced participants' prison system episodes by 50 percent.¹⁴

A number of jail diversion programs have used these services specifically to target individuals in the criminal justice system (including both pre- and post-booking), with great success. The Nathaniel Project¹⁵ uses ACT, supportive housing, and supportive employment to serve in the community adults with serious mental illness who have been convicted of non-violent and violent felonies, as an alternative to incarceration.¹⁶ The Project has demonstrated a "70 percent reduction in the mean number of arrests in the two years following program admission compared to the two years before,"¹⁷ and less than 3% of participants are arrested on violent charges once enrolled in the program.¹⁸

Pathways to Housing,¹⁹ a well-studied and widely emulated provider of ACT and supportive housing, has shown that its services yield dramatic reductions in contact with law enforcement

¹² See Substance Abuse and Mental Health Service Administration, *Permanent Supportive Housing Evidence-Based Practices (EBP) KIT* (2010) available at <http://store.samhsa.gov/shin/content/SMA10-4510/SMA10-4510-02-HowtoUseEBPKITS-PSH.pdf>; Department of Justice, Justice Department Obtains Comprehensive Agreement to Ensure New York City Adult Home Residents with Mental Illness Are Afforded Opportunities to Live in the Community (July 23, 2013) available at <http://www.justice.gov/opa/pr/2013/July/13-crt-830.html>; North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DOJ Settlement - Transition to Community Living Initiative (Aug. 23, 2012) available at <http://www.ncdhhs.gov/mhddsas/providers/dojsettlement/>.

¹³ Dennis P. Culhane et al., *Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing*, 13 Housing Policy Debate 107 (2002), available at http://repository.upenn.edu/cgi/viewcontent.cgi?article=1067&context=spp_papers.

¹⁴ Fairmount Ventures, Inc., *Evaluation of Pathways to Housing PA* (Jan. 2011), available at <http://pathwaystohousing.org/pa/wp-content/themes/pathways/assets/uploads/PTHPA-ProgramEvaluation.pdf>.

¹⁵ More information available at www.cases.org/programs/abh/act.php.

¹⁶ *Nathaniel ACT ATI Program: ACT or FACT?* www.cases.org/articles/ACTBrief051111.pdf.

¹⁷ *Nathaniel ACT ATI Program: ACT or FACT?* www.cases.org/articles/ACTBrief051111.pdf; see also Bradley Jacobs, Nathaniel Assertive Community Treatment, August 26, 2011, Presentation: The Mentally Ill Offender in the Criminal Justice System, www.cases.org/articles/APAPresentation08.26.11.ppt.

¹⁸ *Nathaniel ACT ATI Program: ACT or FACT?* www.cases.org/articles/ACTBrief051111.pdf.

¹⁹ More information available at pathwaystohousing.org.

and impressive improvements in mental health and personal stability.²⁰ Pathways offers immediate access to permanent independent apartments, and gives priority to people with a history of incarceration because it impedes access to other housing programs.²¹ Pathways' program has been shown to reduce prison episodes by 50 percent, as well as reducing shelter use by 88 percent, hospitalization episodes by 71 percent, and crisis response episodes by 71 percent.²²

Not only do these programs improve public safety and public health, but they are consistent with the purpose of the Americans with Disabilities Act and with the landmark decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), in which the U.S. Supreme Court affirmed that the ADA prohibits the needless institutionalization of people with mental disabilities. The U.S. Department of Justice (DOJ) has been actively promoting community-based services, especially ACT and supportive housing, as a means of preventing the needless institutionalization of people with mental illness in jails.²³

Despite the substantial benefits of these services, they are unavailable to thousands who need them. In 2012, state mental health authorities reported that only 2 percent of individuals served received ACT services and only 2.6 percent received supported housing services.²⁴ Increasing access to these services would drastically reduce the number of individuals with SMI who are involved in the Justice System.

The Subcommittee has noted that special law enforcement programs such as Crisis Intervention Teams (CIT) have proven effective in training state and local law enforcement personnel to more

²⁰ See generally, Tsemberis, S., et al. *Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities*, 51 *Psychiatric Services* 4 (April 2000); Gulcur, L., et al., *Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First Programmes*, *J. Community Appl. Soc. Psychol.*, 13: 171-186 (2003); Tsemberis, S., et al., *Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis*, 94 *American Journal of Public Health* 4, 651-656 (April 2004); Stefanic, A., et al., *Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: A Four-Year Study of Housing Access and Retention*, *The Journal of Primary Prevention* (June 2007).

²¹ Tsemberis, *Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals*, *supra* note 20 at 488.

²² Fairmont Ventures, Inc., *Evaluation of Pathways to Housing PA* (January 2011), pathwaystohousing.org/pa/wp-content/themes/pathways/assets/uploads/PTHPA-ProgramEvaluation.pdf; see also Tsemberis, *Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals*, *supra* note 20 at 487.

²³ See, e.g., *U.S. v. Georgia*, Civil Action No. 10-249 (N.D. Ga.) (DOJ entered into settlement agreement requiring Georgia, *inter alia*, to make available ACT, supportive housing and supportive employment to individuals with serious mental illness who are released from jails or prisons); *Amanda D., et al. v. Hassan, et al.*; *United States v. New Hampshire*, Civil Action No. 1:12-53 (D.N.H.) (DOJ entered into settlement agreement requiring New Hampshire, *inter alia*, to make available ACT, supportive housing and supportive employment to individuals who have had criminal justice involvement as a result of their mental illness); *U.S. v. Delaware*, Civil Action No. 11-591 (D. Del.) (DOJ entered into settlement agreement requiring Delaware, *inter alia*, to make available ACT, supportive housing and supportive employment to people with serious mental illness who have been arrested, incarcerated, or had other encounters with the criminal justice system due to conduct related to their serious mental illness).

²⁴ Substance Abuse and Mental Health Service Administration, *2012 CMHS Uniform Reporting System Output Tables* (2012) available at <http://www.samhsa.gov/dataoutcomes/urs/urs2012.aspx>.

effectively respond to individuals in mental health crisis. This specialized program teaches patrol officers about mental illness, reducing stigma, and about de-escalation techniques.²⁵ It also provides training on the local system of care and what resources are available for individuals with mental illnesses.²⁶ The goal of CIT is to connect individuals in mental health crisis with treatment services rather than introducing them to the criminal justice system.²⁷ It also reduces the chances that an individual in mental health crisis will be killed or injured.²⁸

CIT is a good beginning to address the immediate crisis of inappropriate law enforcement responses to individuals with psychiatric disabilities, but to effectively address the root of the problem, we should be focused primarily on interventions that occur earlier and not after the mental health system has failed people again and again, leading to crisis situations. This is the approach taken by DOJ in a recent settlement with the city of Portland, Oregon, regarding the Portland Police Department's treatment of individuals with mental illnesses.²⁹ The settlement invests additional resources into CIT training for the police and mobile crisis prevention teams—where a mental health worker accompanies a law enforcement officer responding to a crisis³⁰--but also requires the city to plan for the long term and develop ACT teams and other important services.³¹

This prevention focus would also reduce avoidable contact with the criminal justice system that can shatter individuals' lives. Once an individual has an arrest record or a criminal record, it becomes much harder for the individual to obtain basic necessities, such as housing and employment.³² Many individuals reentering the community following imprisonment are ineligible for housing subsidy programs despite their very limited financial resources, or are denied housing based on criminal background checks conducted by landlords. It is no surprise that "criminal justice officials say that finding housing for parolees is by far their biggest

²⁵ Randolph Dupont and Sam Cochran, The University of Memphis School of Urban Affairs and Public Policy, Department of Criminology and Criminal Justice, The Memphis Model CIT Program (2009) available at <http://www.cit.memphis.edu/aboutCIT.php?page=3>.

²⁶ Randolph Dupont and Sam Cochran, The University of Memphis School of Urban Affairs and Public Policy, Department of Criminology and Criminal Justice, The Memphis Model CIT Program (2009) available at <http://www.cit.memphis.edu/aboutCIT.php?page=3>.

²⁷ Randolph Dupont and Sam Cochran, The University of Memphis School of Urban Affairs and Public Policy, Department of Criminology and Criminal Justice, The Memphis Model CIT Program (2009) available at <http://www.cit.memphis.edu/aboutCIT.php?page=3>.

²⁸ See e.g., NBC News, *Family demanding answers after police fatally shoot mentally ill NC teenager* (Jan 6, 2014) available at <http://usnews.nbcnews.com/news/2014/01/06/22205826-family-demanding-answers-after-police-fatally-shoot-mentally-ill-nc-teenager>; Salon, *Dallas police shoot mentally ill man standing in the street* (Oct. 18, 2013) available at www.salon.com/2013/10/18/dallas_police_shoot_mentally_ill_man_standing_in_the_street/.

²⁹ *United States v. City of Portland*, Settlement Agreement, Case No. 3:12-cv-02265-SI (December 17, 2012).

³⁰ *United States v. City of Portland*, Settlement Agreement, Case No. 3:12-cv-02265-SI, 35-41 (December 17, 2012).

³¹ *United States v. City of Portland*, Settlement Agreement, Case No. 3:12-cv-02265-SI, 32-35 (December 17, 2012).

³² The Legal Action Center, *After Prison: Roadblocks to Reentry, 2009 Update* (2009) available at <http://www.lac.org/roadblocks-to-reentry/upload/lacreport/Roadblocks-to-Reentry--2009.pdf>

challenge.”³³ The stigma of having an arrest or conviction also impacts employment opportunities, making it much harder for justice-involved individuals to find jobs or even an interview.³⁴

These barriers could be avoided if individuals received services that have proven effective in reducing the need for police involvement. Expanding the use of ACT, mobile crisis services, and supportive housing would create a system that is less crisis-oriented and instead focused on affording individuals with mental illnesses access to the services they need.

³³ Caterina Gouvis Roman and Jeremy Travis, The Urban Institute, *Taking Stock: Housing, Homelessness, and Prisoner Reentry* (March 8, 2004) available at http://www.urban.org/UploadedPDF/411096_taking_stock.pdf.

³⁴ Michelle Natividad Rodriguez and Maurice Emsellem, The National Employment Law Project, *65 Million "Need Not Apply" -- The Case for Reforming Criminal Background Checks for Employment* (March 2011) available at http://nelp.3cdn.net/e9231d3aee1d058e9e_55im6wope.pdf. See also U.S. Equal Employment Opportunity Commission, *Pre-Employment Inquiries and Arrest & Conviction Guidance* (last visited April 28, 2014) available at http://www.eeoc.gov/laws/practices/inquiries_arrest_conviction.cfm (recognizing the disparate impact that employers' use of criminal background checks may have based on race; the EEOC has not issued guidance concerning the impact of such screens on people with disabilities, but given the disproportionate rates of individuals with mental illness and certain other disabilities in jails and prisons, these screens clearly have a disparate impact based on disability).

Sen. Durbin: I first want to acknowledge and thank you for conducting this needed and overdue testimony and hearing. I personally have been working steadily on this issue as it pertains to people with significant Intellectual and Developmental Disabilities (IDD) for over 32 years in Oregon (I also did my Master's thesis on this topic in 1980 when I was a graduate student at Portland State University). I have been an advocate and provider of direct services to people of all ages who have IDD in my work at The Arc of Multnomah/Clackamas in the Portland metro area. In my role here, I've directly worked with thousands (literally and uniquely) of people with IDD in this urban community. I have focused on serving those who have been considered as not served adequately or at all despite their significant disabilities. I have also worked with a great number of people with IDD who have other mental health/illness diagnoses (diagnoses of major schizophrenias and other debilitating mental health issues).

Throughout the years I've worked in this 'system' in Oregon, I have been well aware of the fact that our society—this and all states in this country—have not nearly supported and provided necessary services to the full realm of the population who have disabilities. We have NOT as a society been honest with ourselves about the complex and full needs of people with disabilities—all categories. Those 'leaders'—i.e. administrators—of social service and mental health programs throughout the country have not been honest with those making policy about our 'services' for people with disabilities in relation to their individual and collective needs. The majority of people with disabilities—including and especially those with mental health needs—are fundamentally underserved in our society. Some states do better (Oregon is not one of those states) but ALL states and the federal government have simply not addressed this issue in a coherent and comprehensive manner. The result of all this 'unmet need' with people who are disabled has resulted in the necessity of law enforcement to attempt to interact or 'engage' with individuals with disabilities as they grapple with our difficult and uncompassionate society and this process is thoroughly broken everywhere.

In Oregon—and specifically in Portland—that failure of law enforcement to have even the basic understanding of the needs of ALL the people in our community as meant that injustices have proliferated as law enforcement has directly harmed innocents who found themselves involved inappropriately with the police, the court systems and the jails. In Portland, the Police Bureau have been placed under the supervision of the courts and the federal Department of Justice for its egregious use of force against people with mental health and IDD issues. Our city government and the Police Bureau has not been able to satisfactorily address this oversight process with the DOJ and may be found in contempt of court or, more likely, nothing that would change and these injustices will occur now or in the future.

I write this with a great deal of sadness. I have been a part of a long-term advocacy effort focusing on the Portland Police Bureau for these 30 years—and especially in the last 20 years. Twenty years ago, we finally were able to have the PPB recognize our efforts and we started an Advisory Committee on Developmental Disabilities as an outcome of the then police chief (Chief Charles Moose—who later had some national notoriety) 'allowing' us to have this inroad through the burgeoning philosophy of 'Community Policing'. Through these efforts and with the successful acquiring of competitive grants (one from the DOJ), our efforts paid off in requirements for complete training of all law enforcement personnel in the PPB on issues of IDD and, concurrently on mental health issues and needs. These trainings were combined with two other seminal programs: here in Portland, the PPB developed a system for tracking and assisting people with very significant needs due to disability (most or people with complex diagnosis—including the major mental health issues effecting the population of elders—who are 'nonverbal') through the voluntary Disability Accommodation Registry. The DAR, though effective and certainly helpful, has only less than 400 individuals registered. Our advocacy efforts with the PPB also coalesced around the development of a comprehensive training curriculum for people with IDD called Safety Zone. The Safety Zone program is designed to help train adults with IDD in avoiding crime and effectively using law enforcement in an appropriate manner. This training has been

delivered to over a thousand adults with IDD in the Portland metro area. Finally our efforts led to the establishment of a mandatory Crisis Intervention Training with all law enforcement personnel in the PPB.

Despite these efforts, the situation in Portland has been met with only a slight improvement in the ability of law enforcement to engage with the population who have special needs due to disabilities (and in some analysis, no improvement that would mean a change in the 'culture' of the PPB). The result, again, is that the DOJ is undergoing a thorough process of overview of the PPB and do date, nothing of significant improvement or even change has occurred. This is truly a dismal indictment of a very broken social service system. In my conversations with many law enforcement personnel, they invoke a bitterness that they are the 'de facto' mental health system in our community. This is of course due to the fact that there is no adequate and comprehensive (i.e. effective) social services which exist in this region for people with disabilities. Law enforcement personnel constantly tell me that no amount of trainings will change that basic fact—that law enforcement can NOT be an alternative to effective services for people with disabilities. This needs to change.

What is not needed are competitively based 'granting' processes for local communities designed to pilot the society out of this morass. The federal government would do better to set standards and mandates for ALL localities designed to effectively address the needs of people with disabilities in all of our communities throughout the USA (a Civil Rights law pertaining to people with disabilities). We could do this with the appropriate leadership and comprehensive effort. We also need to do this as it would be not only compassionate but, again, necessary to head off a continuation of the inability of law enforcement to act as a 'screen' or intervention for people with disabilities. Most people with disabilities—by a huge difference—are victims of crime (than are suspects) and that is the crux and fundamental starting point in our redressing these social justice issues.

My hope is that the federal government can show leadership in this area. Thank you again for asking for our testimony on this critical and defining issue. Bill West, Arc.

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Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety

Hearing Before the Senate Judiciary Subcommittee on the

Constitution, Civil Rights, and Human Rights

Testimony of Witness, Brian A. Kelmar

There is an article written by Barbra Doyle, titled “ And justice for all... unless you have autism.” Instead of helping people with disabilities and training first responders we tend to make new laws that put people with disabilities at even higher risk of being caught up in the criminal justice system. This happened to my son. He got caught up in a very aggressive judicial system where no one had any training in autism. He was “swept under the bus” in a law which takes a broad stroke at supposedly catching the bad guys but has no room for allowing a judge to take into consideration the facts of the situation. Our result is we had to agree to a plea bargain to a felony that has destroyed any of his hopes and dreams that any of us would have. He will never get the chance to fulfill his dreams because of the way the law is written. This committee has great opportunity make a difference. We need a national program for training first responders and the judicial system in how to appropriately handle situations with people with disabilities. There also needs to be a centralized data base to track and categorize situations involving people with disabilities that are involved in the criminal justice system. This would help identify trends that need the most attention. Most importantly, we need a centralized organization like The Arc to proactively provide resources to people with disabilities and their families before , during and after crisis situations occur. Like many other Americans I have heart disease which resulted in open heart surgery, which costs hundreds of thousands of dollars and almost my life. Health care experts will tell you to minimize the risk, and that a more cost effective way would have been early diagnosis and a healthier life style to prevent this major surgery and health risk. People with intellectual and developmental disabilities just like people with heart disease need the same. They and their families need early intervention, support and education along with people in the educational and judicial systems that will come in contact with them.

No one in the judicial system in our son’s case had any training in autism. Had there been a program in place (like those in Maine and in New Jersey) in our state, things would not have escalated so fast. As one of the psychological experts in this field of criminal activity said when I asked him to be a witness at the sentencing hearing said to me “I can’t believe it went this far.” There needs to be national programs that educate law enforcement officers, prosecutors, and judges on handling cases with people with Autism. We tried to explain to the arresting officer and through our attorney to the prosecutor about his mental incapacity, but it was ignored. This was a situation which his autism was very relevant to the circumstances of which he had no idea of what was really happening during the incident. Like many children and adults with Autism, he has been bullied and taken advantage of his entire life. We never in our wildest imagination would

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have thought that the judicial system would have taken advantage of his disability and his civil rights in the way it has. This is a severe injustice and travesty for our son who will be scarred for life and ostracized by society forever. A law that was supposed to protect children ends up destroying them for life for any sexual encounter they may have as they are just beginning to mature and have no idea about sexuality, other than that what was taught in school or home. The education process in the schools is limited and does not even discuss appropriate and inappropriate behavior for teenagers and sex. A person who has Autism faces even greater risk, as they are easily manipulated. Mentally and socially they are at much lower development level than that of their peers. The laws do not take into account the individual situation, of mental incapacity. As the Judge said in this case: **“he clearly has diminished mental capacity but unfortunately the laws of Virginia do not take this in to account...”**

This was a one time incident in which a very sexually aggressive teenage girl, made aggressive sexual advances through lewd and explicit sexting text messages, and then aggressively sexually pursed him. As noted in the court appointed sexologist psychiatrist during the sentencing hearing “he has processing delays on thinking... on his feet” as part of his disabilities and also pointed out by the psychiatrist that “ he clearly has some kind of cognitive disorder which has a neurological basis and in my opinion it was relevant to the offense”. Due to the laws none of this would be allowed in a trial nor was it taken into account at the early stages of the judicial process. Although not known at the time of the incident, it was recently discovered that he has Intellectual Disability (ID)^(footnote i) specifically in the area of processing, specifically related to this case. Our son is now labeled as violent sexual offender for life. As stated by the court appointed psychiatrist and by the prosecuting attorney the alleged victim, was “clearly the sexual aggressor”. And yet, the prosecuting attorney refused to even to listen to experts on this situation. There was no force or violence in this incident. In fact one of the counts he was charged with was physically impossible due to sensory issues and documented fine motor skill deficiencies as is a typical trait with children on the Autism Spectrum Disorder.

Our attorney recommended we plea bargain to plead guilty to avoid jail. My son is now a felon who is listed as a violent sexual predator for life. He will not be able to receive any social services that help him with his disabilities. This situation will put him at an extremely high risk of being institutionalized. He will not be able to get services he will desperately need, to help him have a chance at life, but it will only be a matter of time until this very complicated process of being labeled a sexual predator will trip him up for even the most minor issue will put him in an institution for life. His name and face are all over the internet for the rest of his life. He must register every 90 days for the rest of his life, even when he is 90 years old or terminally ill. He will never be able to attend any of his children’s graduations, plays or sports events, not ever be able to take them to a park .His children will be ridiculed and ostracized as well. He will be limited in where

ⁱ ID; Intellectual disability (ID), once called mental retardation, is characterized by below-average intelligence or mental ability and a lack of skills necessary for day-to-day living. People with intellectual disabilities can and do learn new skills, but they learn them more slowly. There are varying degrees of intellectual disability, from mild to profound. Someone with intellectual disability has limitations in two areas. These areas are :**Intellectual functioning**. Also known as IQ, this refers to a person’s ability to learn, reason, make decisions, and solve problems. **Adaptive behaviors**. These are skills necessary for day-to-day life, such as being able to communicate effectively, interact with others, and take care of oneself. IQ (intelligence quotient) is measured by an IQ test. The average IQ is 100. A person is considered intellectually disabled if he or she has an IQ of less than 70 to 75. Studies show that somewhere between one (1) percent and three (3) percent of Americans have intellectual disabilities. Ref:

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he can ever live, will be looked down upon by his community forever and find it practically impossible of ever getting a meaningful job or any job for that matter. Every time he travels he will be limited to where he can go or where and how long he can stay. He will not be able to visit his grandparents or relatives in other states because of the numerous confusing rules for each state that he would travel through. All of this is because of a one time occurrence in a young developmentally delayed teenager with Autism and ID, who had no idea how to handle a situation with a very sexually aggressive female teenager. Our son has never been in any type of trouble, has never even been intimate with a girl or had any friends in his entire life, and now he will have his life destroyed forever.

There needs to be an education system in place for educators, first responders and people throughout the judicial process in working with people with autism. Judges need to be allowed to use their best judgment as they were meant to in our democratic process instead of law makers enacting laws that prevent them from doing this. Education, not laws, enables all people in the process to make better decisions. Ensuring a system that provides a standard of training to people in the judicial system would help to de-escalate situations like this. There are all ready some states that are doing this and some best practices from these states that could be used in a federal program.

A national data base needs to be set up to keep statistics on the incidence of people with ID and DD² disabilities having interaction with the criminal justice system. This would allow law makers, first responders and medical professionals' know where to focus their limited resources to help minimize risks to prevent incidents from escalating into major crisis. Here are some critical statistics to consider: The Centers for Disease Control and Prevention (CDC) recently released new data within the last month showing the prevalence of Autism Spectrum Disorder (ASD) continues to rise. The new rate of 1 in 68 reflects a 30% increase from two years ago when the CDC released data that 1 in 88 children has autism. Although there are no national statistics, research indicates that people with autism spectrum disorders and other developmental disabilities will have up to seven times more contacts with law enforcement during their lifetimes, than members of the general population³. While research studies by the UCE at the Shriver Center, a division of the University of Massachusetts Medical School, indicate there is no evidence to suggest that they will commit crime at a higher rate than the general population. People with Autism Spectrum Disorder are rapidly growing and we need to know where to focus resources to identify areas that need resources to help prevent situations from escalating.

Until the recent creation of The Arc's National Center on Criminal Justice and Disability, there has been no one place to go for people with autism, and other I/DDs to go to for help. A national center like this one is essential in providing a coordinated effort to address the complexity and broad range of issues this topic presents. . We

² DD: **developmental disability** which is a broader term that includes ASD (autism spectrum disorders), epilepsy, cerebral palsy, developmental delay, fetal alcohol syndrome (or FASD) and other disorders that occur during the developmental period (birth to age 18). The major differences are in the age of onset, the severity of limitations, and the fact that a person with a developmental disability definition may or may not have a low I.Q. While some people with intellectual disability will also meet the definition of developmental disability, it is estimated that at least half do not meet the requirements for the developmental disability definition. Ref: <http://www.thearc.org/page.aspx?pid=2543>

³<https://www.ahany.org/Debbaudt.htm>

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reached out to professionals and the education system on trying to find help for our son since he was born, but to no avail. It was not until we were able to find a professional trained in this area (through word of mouth) during my son's junior year in high school before he was even diagnosed with autism. Still we were not aware of organizations that could help us at that time. It was not until over a year after our son became involved with the criminal justice system that we became aware of organizations that could have helped earlier and throughout my son's life, and during his initial involvement with the judicial system. Again it was through a chance meeting that I learned of The Arc. They have been essential in providing our family guidance in working with state, federal and non profit organizations to find resources to help him with his disabilities. In my research since my son's incident with the law, I have found my son's situation is a lot more common than I had ever imagined. Many families like ours are not aware of what resources are out there. By keeping statistics and keeping medical and judicial professionals informed, a centralized national or federal organization needs to continually and proactively reach out to families. In cases of incidents involving people with I/DDs and the criminal justice system, it should be automatic that a centralized national organization gets involved from the very start. In cases where early diagnosis of mental disabilities, the national organization should be contacting families of what resources are available to them. We were not even aware of any of the state or federal programs that were available to my son until after we got involved with The Arc even though he was eligible for these resources years ago. Their National Center on Criminal Justice and Disability has been an invaluable resource for our family that needs ongoing federal and other support in order to help more families like ours. No one agency or family can do this alone, a national center like this one can bring all of our resources together in one place to create possible solutions.

"And Justice for all" really does mean justice for all even if you have an intellectual or developmental disability. This committee is to look at "Law enforcement responses to disabled Americans: Promising approaches to public safety". Safety and civil rights are what every American is entitled to, including people with I/DD. Being proactive in working with people with I/DD, is in the best interest of all Americans in preventing situations from escalating in to crisis.. Training educators, law enforcement and people in the legal and judicial system, through a national program, similar to what several states all ready have in place is essential to this prevention. The statistics to track and capture data on these situations enables lawmakers, health professionals and law enforcement to identify areas of risks and put the proper resources in place to address these issues. Most importantly by having a centralized national organization that proactively reaches out to the families, educators, health providers and people in the judicial system is critical in early intervention. All of these efforts combined will enable all Americans to have a more safe and productive America. People with I/DDs are Americans too and must have the same opportunities as citizens to equal access to the justice system, without discrimination, like all of us are entitled to. Hopefully by enacting these recommendations other families will not have to go through tragic situations similar or worse than our family has.

Thank you for your consideration of my testimony.

Witness Testimony of Brian A. Kelmar, April 28, 2014

Brian A. Kelmar

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Statement for the Record of
Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human
Rights

Hearing on Law Enforcement Responses to Disabled Americans: □

Promising Approaches for Protecting Public Safety

By Bruce and Pat Goodale

April 28, 2014

April 23, 2014

Congressman Paul Tonko
2463 Rayburn HOB
Washington, DC 20515
Congressman Paul Tonko

Dear Congressman Tonko:

We are writing to you urging your support of legislation currently under consideration that would make major changes to Federal mental health laws and policies (HR 3717).

We have reviewed the proposed changes in the legislation announced by Congressman Tim Murphy and feel they reflect an understanding of the current problems and propose reasonable changes. There is broad bi-partisan support for HR 3717 and we hope you will also add your support.

As parents of a son with Schizophrenia, we have been through been a draining and agonizing process in attempting to get treatment for our mentally ill son. The illness itself is bad enough. But, dealing with the current legal system governing mental health has in many respects been worse.

We particularly support the greater use of Assisted Outpatient Treatment (AOT). After enormous effort we were finally able to secure AOT for our son; the benefit has been almost miraculous. It transformed him from someone who was totally psychotic and a virtual street person into a functioning person again. We got our son back!

The main difficulty with the current legal system is that the courts are very reluctant to apply AOT unless the person is in imminent danger to himself or others. In practical terms the person must already have committed some act(s) of violence before the court will act. By then it is often too late. In our son's case he threatened his mother with a large chunk of broken glass. Fortunately he did not carry out his threat. The AOT law needs to be modified to allow earlier and easier intervention.

Another aspect of the problem is the current application of HIPAA law to people who are mentally ill. It is proper to give high legal weight to patient confidentiality to people who are mentally competent. However many mentally ill people like our son were not competent or rational and as a result refused treatment. In addition, the medical system effectively froze us as out as parents from medical information or input into the treatment process. Clearly, HIPAA needs to be modified to carve out exceptions to allow for family involvement in cases where the patient is not mentally competent to make rational decisions.

If you have any questions or seek information that might help the implementation of this legislation our contact information is (518) 584-0588 and goodale1966@earthlink.net

Sincerely,

Bruce & Pat Goodale

May 13, 2014

Dear Senator Durban;

I am writing because of the desperate need for your leadership to help our most seriously mentally ill and for the need of Assisted Outpatient Treatment in our country.

We live in Alameda County and have been advocating for the adoption of AB1421, an AOT, for over a year now. Our young, talented and very sweet son became ill with schizophrenia just after high school. In the next four + years, no matter what we did we could not get the help he needed given our current mental health system and laws. Our son did not believe he was ill and therefore would not seek help. Instead he was repeatedly hospitalized on very harmful 5150s our system relies on all too often. The 5150 holds are crisis driven and are not the sustained treatment needed for a person with severe mental illness. The repeated hospitalizations create much distrust and made us less able to help our son.

Without treatment, our son's paranoia and delusions increase until they disabled his life in all ways. Still, without an AOT in our county, it was impossible to get the sustained help he needed. Our son now sits at Napa State Hospital accused of the murder of an elderly gentleman. Another family has lost a grandfather, husband and father. Our family will never be the same and our young son has lost any quality of life. Our son **never** could have harmed anyone in his right mind but when a society leaves people to deteriorate to the point of extreme psychosis and when they are paranoid, delusional and hearing voices and afraid, some may try to protect themselves or someone else. There is nothing civil about letting a person deteriorate to such a state. If a person were hit by a car and unconscious, it would not be acceptable to wait for them to wake up to ask if we could help them. To treat our most severely mentally ill differently is unconscionable.

Not only is there great personal cost involved in these many tragedies but there is great financial cost to our system. Our son will now be in the system for the rest of his life. All because he was too ill to understand he was sick and needed help. This is inhumane and costly in all ways.

Our law enforcement, police, sheriffs, DAs and PDs spend much time dealing with persons who have severe mental illness instead of the criminals on our streets. Mentally ill need help from mental health professionals not police and they do not belong in our jails or prisons.

We can no longer abandon our most seriously ill and we must all advocate for the care needed to help them instead of our ill being criminalized.

Please advocate for change to our system and the adoption of Assisted Outpatient Treatment programs.

Most Sincerely,

Candy and Hans DeWitt

Carla Friedrich
 Sunday, April 27, 2014

“TESTIMONY FOR THE RECORD OF SENATE JUDICIARY APRIL 28”

It is my understanding that you are looking for letters concerning “Helping Families in Mental Health Crisis”. I am 65 years old and have lived through many of my family members having serious mental illness. I believe I can present a unique perspective from the point of view of having a mother, sister, brother, daughter & at least 2 nephews who suffer with serious mental illnesses.

When I was 5 years old, I remember my mother having problems with mental illness. I didn't know what to call it at the time, but I knew something was wrong. My mother thought water was poison, she couldn't wash vegetables or anything with water without thinking someone was trying to poison her. I would “always” have to reassure her that nothing was wrong and water was safe. My father had a business of his own, so he could not just leave and attend to my mother, her fears, unwarranted beliefs or her endless days of crying to sit with her just because she was afraid to be alone. All through grade school and into middle school I was called home to give my mother aspirin when she had a headache, because the medicine cabinet had to be locked and I had the only key. My mother's mental illness progressed; her believing water was poisoned expanded to taking aspirin or even vitamins. As my mother's illness continued, her paranoia and delusions got worse, her days of depression and crying lengthened.

This was 50 or more years ago, so my father feared that if “anyone” found out about my mother and how she was with water, medication or her days of crying (and NOT knowing why), they would put her in an institution and literally throw away at the key. My father from little on would tell me, “Carla, do not tell anyone about your mother, if you do they will put her in a horrible place and you will never see her again.” Honestly, the way things were 50 or so years ago, it may have not been far from the truth either. As I got older, I hated missing school, I hated being called home to give her aspirin and then having to reassure her over and over again that she only had 1 pill, it was not poisonous nor did she take a whole bottle ----when I had only given her one.

For me the blessing happened while visiting my Aunt Patty's (my mother's sister). While visiting my Aunts home my mother got a headache so I gave her an aspirin. Then of course it bothered her because she thought had her usual thoughts of poisoning and overdose, so she started the crying. By this time, my mother depended on me to be by her side while she cried, so even though my dad had first went to her—she insisted she wanted me. My Aunt Patty said, “this is not normal, what is wrong with my sister Shirley I am calling the ambulance and she is going to a hospital.” My dad fearing his worst fears thought they would institutionalize my mother, so he fought my Aunt Patty's suggestion all the way. Thankfully, my Aunt Patty won, she said it was “her sister, her house and she called the ambulance”. They put my mother in the Marshfield Hospital and ran a number of tests. After 3 days of testing, they told my father they would “only” release my mother from the hospital when she could prove she had a scheduled appointment at a psychiatrist. My father got on the phone, scheduled an appointment for her at a psychiatrist in Waukesha. The hospital released my mother to go home with us. There were

no miracle cures at the time or that many medications, but it did help my mother just having the psychiatrist to talk too, along with giving her whatever medication were available at the time. As time went on the medications got better and the treatment improved even more. Today my mother is in her 80's and delusion free and still living with my father.

I have seen both my sister (6 years younger) & brother (10 years younger) both hospitalized for serious mental illness. Not one of them has signed themselves in or realized they needed help at the time. It took family making the doctors aware of a problem and the doctors being able to follow through. There was a time that a person didn't necessarily have to agree to get help for their illness. A doctor or hospital could act, as like the case of what they did with my mother. They were not going to release a patient unless they continued with outpatient psychiatric treatment and there were psychiatric hospital rooms available for patients to get treatment until they got medications that actually helped.

Now it has totally changed, **I have personally found it impossible** to get ANY help for anyone with mental illness. My daughter left for Washington State after Art College. In 2008 while still in Washington she was diagnosed with schizophrenia. I tried everything imaginable to get help for her and have been told that unless she has a knife or gun in her hand when I call for a "good will" check, there is nothing they can do. She has been homeless several times through the winter, living in a tent because the birds told her she should leave her apartment. When I suggest to her about going to a hospital, she absolutely refuses because she believes the "voices" are absolutely "real". After, 10 long years of flying from WI. to WA. trying to find help for my daughter, she was facing homelessness again in 2013. I finally convinced her to come home and stay with us. I would pay for her train ticket and to have her stuff put in storage, on the condition she would see a therapist while here.

While living with us, the therapist & psychiatrist she was seeing suggested to my daughter that she needed medication and she refused. It was suggested we could try getting her help through going to court. We had 2 therapist reports from Washington, 2-3 psychiatrist & therapists reports from Waukesha and when we got to Court the Commissioner said, "She is not danger to herself or anyone else at that moment, so she can go free". She came back to our house after Court and packed her stuff and left back for Washington, because as she said, "She could not trust us to NOT call the police on her again". She took a train back to Washington State to be homeless again. I would read her Facebook page and she was living from one abandoned building to the next or putting her tent on construction sites and placing a tarp over the top (to make it look like part of the site).

My nephew was diagnosed with schizo-affective disorder in his late 20's after parking his car alongside a freeway and running cross country being found days later 2 Counties away. The sheriffs found him wondering around and they called my brother as they found his name in my nephew's wallet. My brother did take him directly to the psychiatrist he see's and he got started on medication. It took awhile but, finally at 32 years old my nephew was just starting to get back on his feet again, he had found an apartment he could afford on SSI, started doing a part-time job helping lay flooring. The apartment he got allowed pets so he had gone to the humane society and adopted a puppy, (at Christmas that is all my nephew could talk about, was his

puppy) and wanting to make sure he did not stay too long as he did not want to leave the puppy alone so long.

Then on a Friday night in April, a couple guys from work stopped over to see if my nephew would be able to help with a floor the next morning. Not knowing the puppy followed him out the door, while my nephew Jaren was talking to his co-workers his puppy ran out in the road and got hit by a car. My nephew picked up his puppy and took it to the humane society where they told him there was nothing they could do to save it. It all went down from there, that night my brother wanted Jaren to stay with him but he refused. Jaren went back to his apartment; the next day my brother got a text message from Jaren saying "demon's were chasing him". My brother, our entire family we all started calling everywhere we could think of for help. The following Friday (just 1 short week later), my nephew showed up at the Humane Society---this time demanding they give him his puppy back. He was positive they were using the dog for "dog fighting" and he was NOT going to allow anyone to use his dog for fighting. The Humane Society person on duty at the desk knew something wasn't right with Jaren and called the police. The police picked up Jaren and while in police custody my brother was called to pick him up. My brother refused and said, "Jaren is delusional and I want him evaluated at the hospital" While Jaren was still in police custody, my brother called the Sheriff's Department & the Waukesha Health & Human Services, begging them to hospitalize Jaren and do an evaluation on him. My nephew found a friend to pick him up at the police station and the police released him. My nephew being angry now at my brother for not picking him up at the police station, sent a text message saying, "Screw you" (this was the same day on Friday late afternoon). My brother over the weekend tried contacting Jaren several times over the weekend by text and phone but Jaren would not respond. Then late Sunday morning, Jaren appears at my brother's apartment door with blood on his shirt, still delusional saying he had to fight the demons. My brother went into the bathroom and called police, while my sister & brother-in-law distracted Jaren. Later we found out through news reports that Jaren had parked his truck, started stripping off his clothes, while running through woods & swam through 2 rivers, until he came to a deserted farm house. The rest is all history and well documented in the murder trial that followed. The trial had to be delayed several times because my nephew was so delusional the Judge felt he did not even understand the charges against him. My nephew now has life in a high security mental institution and is now being forced to take his medication. How ironic, he can be forced to take medication only now, after he has harmed someone.

Now please tell me what is more humane to a person who is ill??? Forcing them to get help and hospitalizing them BEFORE they become a danger to society or themselves or just letting them go until something serious happens?? My mother, sister & brother were all ill at a time when the family still could make a person get help before they got to the point of homelessness, being a danger or suicidal. With my daughter & nephew it is totally different, NO matter how we have tried or who we called the only answer we get from anyone is "they have to be a danger to themselves or others". So, even though just hours before my nephew used a "fire poker" to kill 3 people, the Health & Human Services people said he was not at danger at that time. **It is so frustrating** because, by the time Jaren left in his truck NO ONE knew where he was, NO ONE was with him when he saw the DEMON'S walk through that farm house door. There was NO ONE there to call the police, hospital or ambulance at the MOMENT my nephew

picked up that fire poker. We don't treat people with Alzheimer's as a nation this cruel. So why do people think it is okay to treat people with other serious mental illnesses this way. .

Believe me, I don't want to go back to the day when my father would say, "Carla, don't tell anyone about your mother and how she is, because they will put her in an institution and you will never see her again". I don't want anyone to go through that again, but then again---it is NOT working the way the laws are NOW. My mother, sister & brother were all (in around about way) forced by family to get help for their mental illnesses and they are all doing better today because of it. Not one of them has been homeless, harmed themselves or anyone else, because they are taking medication that has helped. They all were not at first happy to be made to take medication, but after being on the medication for awhile they realized it helped them lead happy productive lives. My nephew will spend his life incarcerated and my daughter (who once was making a living as a talented artist) now spends her life between homelessness and the delusional world she lives in, either talking to birds or writing on Facebook about how the government is after her.

I believe that one of the most important things that needs to happen is, **"a family needs to be able to have a say"!!** Had someone only listened to my brother when he asked that my nephew, his son be evaluated, 3 people would still be alive today. Jaren would have been in a hospital instead of in that farm house!!!! Family should not have to go to court just to see if someone needs medication; it ONLY makes things worse by having to go to court. Let medical doctors, therapist & psychiatrists evaluate people and determine whether they need help & medication and follow their directions. To me jail & homelessness is by far worse treatment of a sick person, than having AOT (Assisted Outpatient Treatment) or having the person hospitalized over a weekend.

Have hospital rooms available, so when the person needs the extra help there is a place to actually put them so they will be safe from harming themselves and the public will be safe from them.

Have community support available for those who do not require hospitalization, clubhouses, peer specialist, affordable housing or rooms in community type living areas where there are others who understand the illness. Once a person is released from the hospital have community support available to help keep the person on a path of recovery.

Have police, sheriff's and **family members** on mental health committee's and commissions. We are the people on the front lines, we see firsthand what NOT getting the proper care and treatment does to our loved ones.

I fully support aide for mental health issues, help and HR 3717. I have seen how NOT having help available can go so wrong not only for the person who is ill but for the entire family and the public at large.

Respectfully submitted,
Carla Friedrich

CRISIS INTERVENTION BETWEEN DEAF COMMUNITY AND LAW ENFORCEMENT OFFICERS.

My name is Carlton B. Strail and I am the Advocate for the Central New York Deaf Community.

There was a serious crisis happened in Town of DeWitt few years ago which we learned thru the local media outlet about the serious incident about the police officer noticed the stopped SUV in the public parking lot and knocked on the window and the driver began to yell and moved his arms to tell the officer that he was deaf. The officer assumed that the driver understood him thru lip-reading with his hand signal. The deaf driver got out of the SUV and officer pushed the driver down on the ground and held him here after the drier pushed officer's hands away until he backup officers came out to help him out. This incident caused the entire Deaf Community to get upset.

There was a big misunderstanding between the officer and driver due to lack of proper communications such as basic sign language, no written notes back and forth or getting sign language language interpreters.

This serious incident happened all over in the local Deaf community which caused them to be feared and get anger of knowing that the kind of reaction of police is to silence the Deaf communication because of them not knowing that hands are essential. There are several lawsuits against the law enforcement agencies in this country for not providing right communications or using basic sign language interpreters. This has happening almost everyday about them mishandling the deaf people all over this country.

The Deaf Advocacy Council of Central New York decided to meet with Town of DeWitt Police Department and discussed with their police chief regarding the serious incident and offered to conduct the in-service training classes to their officers in order to understand the Deaf community and their needs better with other agencies such as the Whole Me, Inc., a service agency for families and children, and the Aurora of CNY, a service agency for clients with vision and hearing problems. Chief Eugene Conway agreed to set up in-service training classes at the headquarters. The entire department members were trained on how to handle the Deaf people on the street and they were willing to learn more in order for them on how to communicate with them better. In town of DeWitt, the Deaf residents are knowing that the officers are well-trained to deal with them and are very comfortable with them.

Right now, the Deaf community still fears about the police being ignorant while dealing with them on the street whenever they face the officers without using proper communications. Right now, we have been getting more Deaf refugees coming in from Burma, Nepal, Sudan and other countries with their native sigh languages of their own which is different from American Sign Language. The refugees are very scared due to their bad experiences with the policemen in their native countries.

I beg that all of you not to **"label"** the Deaf people as **"mentally ill" or/crazy persons** because of their heightened emotions about not being able to communicate with their hands while being handcuffed. Also getting very upset if they don't understand what the police officer is talking to them about. Remember this it is only 30-35% of the English language is visible on the lips.

Show an example on how the person react and get upset and frustrated being handcuffed.

Our main goal is to get all of local police departments trained to learn how to communicate with the deaf community members. So far we have trained the Town of DeWitt twice, Towns of Geddes and Manlius plus 25 Central New York Police Chiefs.

Have a great day!

Carlton B. Strail
Syracuse, NY
irishman85carlton@aol.com



CHAUTAUQUA COUNTY DEPARTMENT OF LAW

VINCENT W. HERRIGAN
County Executive

STEPHEN M. ABDELLA
County Attorney

April 24, 2014

Hon. Dick Durbin, Chairman
U. S. Senate Judiciary Subcommittee
on the Constitution, Civil Rights and Human Rights
United States Senate Committee on the Judiciary
224 Dirksen Senate Office Building
Washington, D.C. 20510-6050

Via e-mail only to: DurbinTestimony@Judiciary-dem.Senate.gov

**Law Enforcement Responses to Disabled Americans: Promising Approaches
for Protecting Public Safety**

Submission for Senate Hearing Before the Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights April 29, 2014

"On January 11, 2013 in a Maryland movie theater, a 26-year-old man with Down syndrome cried out for his mommy in the final moments of his life and started a movement. The death of Ethan Saylor at the hands of sheriff's deputies who were trying to evict him from the theater he entered without a ticket has become a significant event for people in the disability community who push for equality and inclusion as a civil rights issue. Ethan Saylor is their Emmett Till.

For me, the Saylor story is deeply troubling and personal. My 10-year-old daughter has Down syndrome. She is witty and sunny most of the time but there are moments when she is obstinate and difficult — much like any child. But the behaviors sometimes take extra effort to work around.

That kind of understanding and patience should have been afforded Ethan Saylor, who had an IQ of 40.

Instead, off-duty Frederick County Sheriff's deputies were summoned to oust Saylor when he wanted to watch "Zero Dark Thirty" a second time, without a ticket. As deputies went in, Saylor's aide pleaded for everyone to wait it out and allow her to deal with the situation. His mother was on the way. The aide warned that Saylor would "freak out" if touched.

Deputies dismissed her advice and told her to stay out of the theater. They went in, ordered Saylor to leave, then grabbed him when he refused and began swearing at them.

Deputies cuffed him, and Saylor struggled and cried, saying, "Mommy, mommy. It hurts." As officers wrestled with 294-pound Saylor, he fell to the ground with a deputy on his back. He soon stopped breathing and died. An autopsy later revealed his larynx was crushed."-Denver Post 1/11/14

Could this have ended differently if those officers had been trained in the proper way to interact with individuals with disabilities? Unfortunately, we will never know but Niagara University through the scale up and expansion of impact of its unique First Responder Disability Awareness Training (FR DAT) program intends to do everything possible to prevent this from happening to another family. The key is education and training that has staying power.

- **Everyone** needs disability awareness training; this is not unique to first responders. However, emergency personnel's presence at situations that call for a response to challenging behaviors, alleged criminal conduct, physical and medical needs, assistance in a matter, or service and protection, are imperative to the well-being and quality of life for the vulnerable individual(s) in which they come into contact. The intent of any training should recognize that (most) individuals in law enforcement want to do the right thing; however, the unique, perplexing encounters that may call for split second decision-making can put an officer in a difficult spot. Our program exists so that all first responders, but especially police officers, are able to respond in a manner that allows for both parties to be safe and treated in the appropriate manner.
- "First Responders" is a term used to describe police, firefighters, emergency medical services (EMS), and 911 operators/dispatchers who are the first contact either via 911 or through arrival on the scene of medical or other emergencies.
- While **Ethan's case** has garnered national attention, it is not the only instance where a first responder has inappropriately responded to an IWD and the result has been negative. However, to fault first responders would not be prudent. You can't properly respond to an incident if you were never trained in how to do so, if your state's criminal justice mandated training did not include a detailed section on disability awareness, if your Chief was never given the opportunity to send their personnel to a program. While some states include training for law enforcement in response to individuals with disabilities (IWDs), it is either not enough, buried within hundreds of hours of recruit training, doesn't allow for on-going education, or is not delivered effectively. NU FR DAT's **website (www.fr-dat.com)** has, under *Articles of Interest*, some 30 cases whereby law enforcement was challenged and may have responded in a manner that was not effective, resulting in injury to an IWD (both physical and mental), death of an IWD (across the disability spectrum), false arrest, civil lawsuits costing municipalities millions of dollars, officers losing their job and some even serving time.
- Society has many faults when it comes to proper response and interaction with IWDs which is manifested by misperception, misunderstanding, lack of awareness, viewing and IWD as a lesser person, sympathetic response as opposed to empathetic, fear of the unknown, and avoidance. However, for first responders to come into situations with these areas not being eradicated from their minds, the probability of an inappropriate interaction rises dramatically.
- IWDs may require response that would vary from everyday encounters. If emergency personnel are not comprehensively educated on this topic, results can be negative, some even catastrophic.
- Research shows that individuals with disabilities (IWDs) are **seven times more likely the victim of a crime** than other individuals while **50-80% of an officer's day will be in contact with an individual with a disability**. Yet First Responders seldom have sufficient training to interact effectively with people with developmental disabilities.

- Historically, most individuals with developmental disabilities who required out of home placement resided in large institutional settings, some of which mirrored self-contained communities with emergency and other personnel available within the institution 24 hours a day, 7 days a week.
- **One of five Americans has a disability**, and it is on the rise. Current numbers include **1 in 68 children have autism, 3% of the population has an intellectual disability, one on 10 Americans will have a seizure, and 30 million people have ambulation challenges**, to name a few. That said many disabilities such as Tourette syndrome, traumatic brain injury, ADHD, and learning disability has a high incidence of encounters with law enforcement. All will present differently and have the potential to be challenging for an untrained officer.
- Today, most individuals with developmental disabilities live with their families, others in the community, or independently per their choice. Along with the rewards of community living, people with disabilities face increased risks of needing the assistance of First Responders.
- According to the US Bureau of Justice Statistics, an **estimated 1.3 million nonfatal violent crimes occurred against persons with disabilities in 2012 nationwide**.
- **In 2012, the rate of violent crime against persons with disabilities was 34 per 1,000, compared to 23 per 1,000 for persons without disabilities**. Because persons with disabilities are generally much older than those without, the age distribution differs considerably between these two groups, making direct comparisons misleading. To compare rates, each group was adjusted to have a similar age distribution, **making the age-adjusted rate of violent crime against persons with disabilities (60 per 1,000) nearly three times higher than the rate for persons without disabilities (22 per 1,000)**. The age-adjusted rate of serious violent crime—rape or other sexual assault, robbery and aggravated assault against persons with disabilities (22 per 1,000) was nearly four times higher than that for persons without disabilities (6 per 1,000) in 2012.
- Among persons with disabilities, **those with cognitive disabilities had the highest unadjusted rate of violent victimization (63 per 1,000)**. During 2012, about half (52 percent) of violent crime victims with disabilities had more than one disability. **Violent crime against persons with one disability type increased from 2011 (37 per 1,000) to 2012 (53 per 1,000)**, while the rate among persons with multiple disability types remained stable during the same period.
- Other 2012 findings include: **Persons with disabilities experienced an estimated 233,000 robberies, 195,200 aggravated assaults, 838,600 simple assaults and 80,100 rapes or other sexual assaults**; Among persons with disabilities, whites were more likely than blacks to experience a violent crime; Hispanics with disabilities had a lower rate of violent victimization than non-Hispanics with disabilities; and, among persons ages 12-15, the unadjusted rate of violent victimization was three times higher for persons with disabilities than for persons without disabilities.
- Individuals with disabilities who are offenders will also have challenges in the judicial system, many of them at every level of it.
- Law enforcement will also be responding to IWDs when they are in need of assistance or in crisis. Individuals with autism and dementia may wander and first responders are called to find them. People who use wheelchairs may get stuck and need assistance, individuals with speech impairments will pose challenges, a need to be able to know basic sign language will be expected when interacting with a deaf person, etiquette and interaction skills with someone who is blind, to name a few.

- The **Americans with Disabilities Act (ADA)** already addresses some of these matters but often times officers are not kept abreast of how this impacts their responsibilities. The Department of Justice (DOJ) has some materials that assist in educating officers on how to be sure they both uphold the ADA and don't violate it.
- Still, incredibly, first responders, emergency managers, and municipal employees/elected officials receive no formal mandated training in proper response to IWDs.
- According to FEMA, **an average of an estimated 1,700 residential building fires involving individuals with mental disabilities are reported each year with an estimated 85 deaths and 250 injuries while an estimated 700 building fires involving individuals with physical disabilities are reported each year with an estimated 160 deaths and 200 injuries**
- This, in combination with the documented tragedies resulting from inappropriate first responder contacts with IWDs nationwide, indicates a clear need for expanded training for first responders and aligned emergency personnel.

In September 2010 Niagara University (NU) was awarded a three year \$550,000 grant from the NYS Developmental Disabilities Planning Council (DDPC) to address the lack of training and understanding of how to properly respond to IWDs with the intent to develop curriculum for the training of police officers, firefighters, EMS, and 911 operators in the State of New York. Although some states have versions of this program, no state has developed a fully comprehensive program. The program is a **Train the Trainer model**, which is the only way to reach first responders in mass. It incorporates a Trainer network that allows for FR to connect with IWDs to co-present on disability specific topics and sections. NYS DDPC researched and found no state to have comprehensive mandated training.

Consider that in **New York State** there are 588 police departments and sheriff's offices with more than 62,300 sworn full- and part-time officers, 45 law enforcement training academies, 2,135 fire departments and EMS agencies with more than 175,000 responder personnel statewide; thousands of 911 operators and hundreds of individuals responsible for emergency management of municipalities. The numbers and the training schedules that are utilized by firefighters (FF), law enforcement (LE), and EMS agencies are non-traditional. In essence, to train one police department (PD) of 100 officers will take a week, the schedule would be set by them, and there would be an expectation that this is offered at no charge. It is simply not practical. Couple this with the feeling that the best people to train FF and LE are themselves, and the odds are against any group to make a dent in their regions FR departments. Law enforcement receives two hours of mandated training on individuals with disabilities in the basic course (out of 639 hours). FR-DAT has reached (to date) over 800 representatives from 51 emergency management agencies, 70 law enforcement departments, and 75 FF/EMS departments through a combination of direct and train-the-trainer formats.


NU has also taken the measure to ensure some form of on-going education. They have done this through the following;

- The trainer manuals have additional materials on disabilities, the ADA, victimization/abuse, service animals as well as resources via websites per discipline.
- NU has developed a resource manual for every attendee that is a quick reference guide on everything disability related specific to first responders

- NU has developed an extensive website that allows for FR to continue educating themselves on everything relative to proper response. NU will develop state-specific links to adjust to the differences (i.e. laws, service providers, parent groups) across borders.
- NU maintains a relationship with all trainers, allowing for inquiries to be answered, new material to be shared, current trends and topics to be disseminated, and tracking of training conducted to be incorporated into the database. This ensures they are always connected to 'homebase' and their responsibilities are carried out.
- Working with the support of the **NYS Office of Persons with Developmental Disabilities (OPWDD)**, the end product includes, but not be limited to, class room training, a train the trainer program, on-line training, database of all departments and councils, extensive resources, comprehensive website, and regional disability contacts and information Research by DDPC staff indicated that there was no program or state in the country that addressed the complete issue eclectically.
- Through the Disability Awareness Training at NU, New York is the only state in the nation to have a comprehensive program that covers the disability spectrum and works with and through state offices and associations.

The undersigned has spoken to numerous groups about the ADA and specifically Project Civic Access that is a program designed to assist municipalities in complying with the ADA. I also attended NU's Town Hall Training Program that provided essential information to interested community members about disability awareness and how we could all foster disability awareness through our own network of associates, family and friends. Chautauqua County has a high population of individuals with disabilities. NU's training program is accomplishing its mission and making a difference in western New York.

Respectfully submitted,



Kurt D. Gustafson
First Assistant County Attorney
gustafsk@co.chautauqua.ny.us

Honorable Senator Durbin,

As the Board Secretary for CIT International, (as well as an active police officer), I commend you for your leadership in presiding over the hearing "Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety". It should come as no surprise, that CIT International has been the trailblazing entity for spawning CIT Programs and advocating for Fidelity of these programs, throughout the United States and overseas. CIT International has held eight National/International conferences, focused exclusively on CIT Programs, over the past decade, with more than 6,500 attendees from nearly every state in the United States, as well as, individuals from Australia, Canada, Israel, Sweden, England and even Nigeria.

As we are the only national entity, exclusively focused on the promulgation and fidelity of CIT, I believe we are uniquely positioned to be of great value in your endeavor. In addition, our Board of Directors is made up of not only the originators of the CIT Program, but also leading national experts, researchers and coordinators of some of the largest CIT Programs in the Nation. I suspect that this insight could be invaluable in your efforts and help your committee avoid unanticipated potential pitfalls. Too many advocacy organizations, politicians, media outlets, etc., extol the virtues of CIT, which we of course appreciate, however, VERY few truly understand the complexity of what a CIT Program is. Most believe the CIT Programs are *Training* for Law-Enforcement and merely support or demand that police need this training. **Nothing could be more misleading... training is only ONE small part of a CIT Program**

Unfortunately, these well intentioned supporters unwittingly often can cause unintended negative consequences, if only the training component is enacted, without equal attention to the other components, which are needed to develop a complete and diverse collaborative Program. Hence, too many communities, which are just focused on the training of law-enforcement, are in reality, accomplishing very little outcomes. There may be some educated officers in their community, but frequently this knowledge is not put into practice as the other critical components are not present. This leads to little change in the day-to-day interactions by law-enforcement, and few opportunities to divert individuals with behavioral health needs into the Public Health System in lieu of the Criminal Justice System.

I have attached a 4-page document, that we believe helps to describe the critical components, complexity, and nuances of a vibrant CIT Program. Fidelity to these themes is indispensable if actually trying to create tangible positive outcomes, and not just good "public-relations opportunities" or "sound-bites."

Sadly, the largest obstacle to fidelity of a CIT Program, nearly always rests with a community's Public Health System. While nearly all communities have a behavioral health crisis system, the vast majority are sorely lacking in *accessibility* and *continuity*. Ironically, because of the accomplishments we have attained in my local community, I have just recently been invited to present at the largest Community Behavioral Health Conference, the National Council for Behavioral Health, in Washington, DC early this May, on just this topic – what behavioral health needs to understand about law-enforcement, to create a meaningful partnership and generate diversion opportunities. This is nearly a first for community behavioral health, and is an exciting opportunity. Besides increasing the opportunities for recovery and treatment while improving public safety, it also can maximize fiscal accountability. If communities can learn to address this phenomenon from a macro-level approach, focusing on system-level solutions, rather than perpetuating the traditional silo approach of Public Behavioral Health, it will have the added benefit of furthering CMS's "Triple Aim" goals of: Better health outcomes, Improved patient experience and Reduced costs.

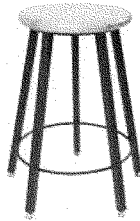
The possibilities are amazing, if community behavioral health crisis systems can embrace this tenet of accessibility. For example, officers in the Phoenix Metro area are handing-off a staggering 18,996 individuals a year (or about 56 times a day), directly to the region's community behavioral health crisis system. This has resulted in countless reductions in incarceration, improved linkages to critical long-term treatment opportunities and reduced need for re-hospitalization. Equally astonishing, police represent nearly 40% of ALL of the individuals who accessed community behavioral health crisis systems in our region! The transformation in the delivery of crisis services, combined with fidelity to the "Program" nature of CIT, is clearly the catalyst for our remarkable success.

I would like to offer our guidance and advice to provide some preparation assistance and/or participate in the actual hearings, if desired. Alternatively, since CIT International will already have a presence in Washington DC to present at the largest Community Behavioral Health Conference, just days after your hearing, I would be more than willing to meet off-line for an informal conversation. I suspect the substantive work will likely happen after the hearings, therefore, we would be happy to provide more ongoing, informal technical assistance.

Once again, we applaud you for your initiative and hope it instigates not only a much needed dialogue, but more importantly, puts a focus on fidelity and a paradigm shift in how community behavioral health crisis services can be made accessible.

Sincerely,

Nick Margiotta
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Chair – Public Awareness/Legislative Committee
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A Five-Legged Stool...A Model for CIT Program Success!!!

How A Crisis Intervention Team Program is More Than Just Training???

Introduction:

The Crisis Intervention Team (CIT) Program, based on the "Memphis Model", is an innovative Program designed to effectively assist individuals in their communities who are in crisis due to behavioral health or developmental disorders. While CIT is mistakenly viewed as Law-Enforcement "Training", in reality it is considerably more. It is a broad-reaching Program, which relies on strong community partnerships and a vibrant crisis system that understands and responds to the role and needs of law enforcement. The CIT Program encourages officers to access crisis facilities, when appropriate, to redirect individuals in crisis away from the criminal justice system. This fosters engagement into the behavioral health system for linkages to long term treatment and service which affects sustainable change in the community. The goals that are realized through implementation of CIT Programs include increased officer and consumer safety, diversion away from the criminal justice system and into the behavioral health system, hopefully leading to longer-term treatment and recovery. The CIT Model reduces both stigma and the need for further involvement within the criminal justice system.

CIT has existed for over twenty-five years and is built on 10 Core Elements. Despite the longevity of the program, there is still wide-spread confusion in many communities around what a healthy program really encompasses. This includes communities who have endorsed and implemented CIT training as well as communities who have yet to adopt the CIT Program. To help clarify, it may be useful to view CIT as a "5-Legged Stool." Our figurative "Stool" cannot function at all with only one leg (i.e. just training police), and really needs at least three legs to stand; and ideally needs all 5 legs to be strong, functional and enduring.

About the author: Nick Margiotta, MEd has been a Phoenix Police Officer for 18 years, and currently is the CIT Coordinator for the Phoenix Metro Region. He is the Board Secretary for CIT International and serves as a NAMI Arizona Advisory Board Member. He greatly acknowledges the assistance of CIT International Administrative staff, Erica Chestnut and Linda Smith, in development of this article. Margiotta.nick@gmail.com



1) Police Training

While the training of police officers is the most visible component of CIT programs, it is only one piece of a multi-level community collaborative effort. The importance of the effective training of police officers cannot be underestimated. These are the individuals to whom everyone in the community turns to in times of crisis. In most communities, the goal of law enforcement agencies should be to have 20-25% of their uniformed patrol officers CIT trained. The 40 hour advanced officer training is most effective when the officers in attendance have volunteered to complete the week-long training. Officers who volunteer to attend the program have shown initiative and interest and will generally be more amenable to applying the new tools they have learned upon returning to their units.

An important concept to emphasize to officers at the very beginning of the CIT week is that this training is not meant to replace anything they have learned as officers. Police officers are always officers first. CIT training is meant to give officers additional tools to use when they are in the field interacting with individuals who may be in crisis. This includes the opportunity, when appropriate, to utilize their discretion and divert the individual away from the criminal justice system and into the behavioral health system. CIT training helps officers evaluate when they might use their discretionary powers and gives them the information regarding available resources to effectively and successfully accomplish this diversion.

Much like a one-legged stool won't be able to stand, if a community only has this most "common" leg of a CIT Program, it really does not function and accomplishes little, if any, real tangible outcomes in a community.

2) Community Collaboration

It is vitally important that integral community partners are identified and utilized by the CIT development team. Community partners play an important role in the CIT process and it is important that Community ownership can be developed. This is accomplished by including Individuals and organizations within the community in all phases of developing and implementing the CIT program – from initial planning, training curriculum, and ongoing feedback and problem solving. Local professionals and agencies who dedicate their time, without charge, to assist in the training of patrol officers, helps to increase the sense of community ownership and networking for CIT. It is this broad-based grassroots community collaboration, that makes a CIT Program achievable and sustainable. In times of fiscal challenges, budgetary cuts, etc., the "in-kind" nature of a healthy CIT Program, helps it weather potential fiscal and political "storms" and permits the Program to endure, providing better outcomes for officers and those in crisis.

3) Vibrant and Accessible Crisis System

Training and collaboration throughout the community is imperative for CIT, but perhaps the most meaningful leg, in order to actually accomplish real outcomes, is having a robust Crisis System. Many communities "have" a system, however, it is more than just "having" a system. It requires that the system be responsive to the needs of police and community as a whole. Having quality services and providers is the first step, but if they are not responsive and easily accessible, then they will not be utilized by police. Thus, the CIT goal of reducing incarceration for those individuals who need behavioral health services, would not be achieved.

Accessibility is of paramount importance when it involves Police "hand-offs" to behavioral health services. These interactions need to be quick, efficient and guaranteed, regardless of capacity, funding sources, diagnosis, entitlement, etc. Triage must be kept to the minimum, to ensure that police officers are able to return to their police duties and behavioral health crises remain within the behavioral health system. A critical tenet to accessing Crisis Services is to ensure that community crisis services and "receiving centers" operate with a "no-wrong door" philosophy for law-enforcement. Despite an individual's diagnosis or presenting issue, the behavioral health crisis system needs to be prepared to respond to an individual referred by law enforcement. Police must have priority access to services for the people they bring and the behavioral health provider must not turn an individual away because they do not meet specific and narrow criteria. While this may create challenges to the behavioral health



provider, it is imperative that behavioral health entities collaborate within their own system in order to ensure an individual gets to the right door. Behavioral health entities should not expect Law-Enforcement to navigate their system, or even worse, prevent law-enforcement from handing off people to their facility. Rather than exercising utilization management techniques with police officers, the goal needs to be helping individuals in crisis. With that mindset, behavioral health can continue to partner with police in order to build stronger and healthier communities.

While Facility-based services operating with "No-Wrong Door" are critical to a CIT Program, an enhancement to consider to help build healthy communities is the ability to also access mobile behavioral crisis responses out in the community. For communities with mobile behavioral crisis services or for those communities seeking to create this level of care, it is important to consider how these services can meet the needs of law enforcement when they are dealing with a behavioral health crisis that can be handled out in the community. To make sure that the service has relevance to CIT, the key is for mobile community crisis response teams to always respond to a police request in a prioritized manner, and then free law-enforcement from the scene as quickly as possible. This level of responsiveness is needed to increase the likelihood that police will utilize mobile crisis services, thus increasing the opportunity to stabilize individuals safely at home, when appropriate.

The Behavioral Health Crisis System's guiding philosophy should be "Accessibility," with the goal to inculcate a culture in service providers which is focused on acceptance, rather than placing clinical barriers to accepting hand-offs. A consistent, prioritized and seamless process needs to be the expectation of the services provided by the behavioral health crisis system, in order to adequately meet the unique needs of the police. This consistency and commitment to meeting the needs of police helps build trust between law enforcement and behavioral health and increases the opportunity for therapeutic hand-offs.

4) Behavioral Health Staff Training

Training of behavioral health staff is critical in fostering positive working relationships between law enforcement and the mental health community. It is important that behavioral health staff have a clear understanding of the law enforcement officer's role in the behavioral health community. There is sometimes a tendency for behavioral health staff to incorrectly develop an impression that because an officer is CIT trained, they have somehow become a combination of both, a law enforcement officer and a social worker. A clear delineation of the two worlds should remain intact. Emphasize that the goal is collaboration, not integration. A social worker who gains an understanding of CIT does not become a law enforcement officer and behavioral health staff need to recognize that after a law enforcement officer receives some specialized training in behavioral health, that officer remains, first and foremost, a cop.

Because the world of law enforcement is somewhat misunderstood by those outside the law enforcement community, it will be key for behavioral staff to gain insight into what a law enforcement response looks like. To provide that insight, law enforcement agencies may want to identify some behavioral health staff members to participate in a ride-along with a CIT trained officer. Nothing will provide more clarity to a behavioral health worker than to witness on officer perform all of the functions and constraints typical in patrol. Behavioral health staff can appreciate the differences between the two cultures, and the image of the officer will no longer be seen as that of a behavioral health worker. This promotes the beginning of an understanding that CIT trained officers are, above all else, officers...who, by choice, have received specialized training in behavioral health topics.

In addition to ride-alongs, it can be helpful for law enforcement to provide training to front-line behavioral health workers. Just as it is important for police to learn about behavioral health issues, it is also important for behavioral health staff to understand and respect the law enforcement officer's role and practices. By highlighting what law enforcement practice looks like...and what it does NOT look like, behavioral health staff will become educated as to how best to coordinate, collaborate and cooperate with law enforcement officers. This has a two-fold benefit. It can lead to better interactions when law-enforcement is handing-off an individual, but also can help guide behavioral health staff on appropriate times to request law-enforcement involvement in a behavioral health incident. Training for ground-level behavioral health staff can be one of the most productive undertakings to advance community understanding and appreciation of the value that CIT training bring to their community.



5) Family/Consumers/Advocates Collaboration-Education

The final leg, family/consumers/advocates, is often the "forgotten" leg. Involvement of these stakeholders in CIT programs is truly critical to help entrench a CIT Program firmly in a community. In addition to having consumers participate in the actual training curriculum, the education and training of family/consumers/recipients helps to increase buy-in and "ownership" of the Program. This helps to support critical elements in the Program. There are two main ways this can benefit: Improved understanding of front-line level interactions involving law-enforcement and Advocacy for the Program needs. Supportive advocates of CIT processes and Program needs are important to help foster positive relationships between the police and their community, and improve the efficacy of the program. And who better to spread that positive word than those family members and friends whose loved ones have been helped by a CIT Trained Officer.

A CIT Program that helps to educate consumers/advocates on the resources that are available in their community, are able to be more engaged in the Program. The development of meaningful crisis plans, tips on how to improve face-to-face interactions when law-enforcement is responding to their loved-one, and increased understandings of law-enforcement's typical responses, limitations and procedures, go a long way to increasing the likelihood for successful outcomes. When both parties in the interaction are more informed and willing to respect each others' perspective, the opportunity for mutually beneficial results, increases exponentially. Families/advocates who are more informed, engaged in pre-crisis planning, and have reasonable expectations for the outcomes of crisis situations, greatly increase the likelihood of a positive outcome and typically are more supportive of the overall Program.

At the macro-level, this constituency can also be strategically helpful in advocating for the protection, expansion and accessibility of precious community behavioral health crisis services. For CIT to be effective in a tangible fashion, accessible crisis services are paramount. A CIT Program's ability to protect or acquire the needed behavioral health services to adequately support a true CIT Program is greatly improved when these community members actively advocate for this critical piece of a CIT Program. Since quality and accessibility to these services is generally a function of the funding provided by a region's behavioral health system and/or by the culture/vision of the agency providing these services, the consumers of the care can be an amazing ally.

Conclusion:

These five main "Legs" are the foundation of creating a strong CIT Program. Having three or four of the "Legs" is certainly an improvement over having none or just training for police. Having all five legs ensures that your community is on its way to having a strong and stable foundation that is systemically responsive to those individuals who are experiencing a mental health crisis. This solid foundation promotes a Program, which can be sustainable and weather the inevitable ups and downs that are certain to occur in a community over decades.

Central to the success of CIT is not only the training of the law enforcement officer, but also the education of those agencies and individuals within the behavioral health community who will be involved in the process. Successful diversion requires accessible crisis services. Only when law enforcement, behavioral health agencies and families/advocates, have a clear understanding and respect of each other's roles in a CIT Program, does true collaboration occur.



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**Law Enforcement Responses to Disabled Americans: Promising Approaches
 for Protecting Public Safety
 Senate Judiciary Subcommittee on the
 Constitution, Civil Rights, and Human Rights**

Submitted by: Council for Exceptional Children

April 29, 2014

The Council for Exceptional Children (CEC) is pleased to offer testimony for the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights hearing, *Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety*.

Members of CEC serve on the front lines as special education teachers, early interventionists and school administrators working in schools with children and youth with disabilities, or as higher education faculty who are preparing the next generation of educators. As a result, CEC members are professionally trained to understand the complexities of the more than 6 million children and youth with disabilities who receive early intervention and special education services in our nation's schools.

While outcomes for individuals with disabilities have improved since the Individuals with Disabilities Education Act was enacted in 1975, persistent gaps continue to exist between students with and without disabilities in key areas such as academic achievement, discipline occurrences, and incidences of the use of physical restraint and seclusion. In fact, in a new survey of every public school in the nation, representing 49 million students, the Office of Civil Rights within the U.S. Department of Education found that in 2011-2012:

- Students with disabilities represented a quarter of the students arrested and referred to law enforcement, even though they are only 12% of the overall student population¹.
- Students with disabilities are more than twice as likely to receive an out-of-school suspension than students without disabilities (13% vs. 6%)².
- One out of four boys of color with disabilities, and one out of five girls of color with disabilities receive an out-of-school suspension³.
- Students with disabilities represent 12% of the student population, but 58% of those students are placed in seclusion or involuntary confinement, and 75% of those students are physically restrained at school⁴.

¹ U.S. Department of Education Office for Civil Rights: *Civil Rights Data Collection: Data Snapshot (School Discipline)*. March 21, 2014.

² *Ibid.*

³ *Ibid.*

⁴ *Ibid.*

Given these statistics, it is easy to see that students with disabilities encounter experiences in school that could possibly involve law enforcement. CEC recognizes that there are instances when law enforcement officials may need to address situations within schools that involve students with disabilities.

Therefore, CEC's recommendations focus on two themes:

- 1) Increasing awareness and understanding of the various types of disabilities and appropriate responses.
- 2) Emphasizing prevention and de-escalation, to try and mitigate challenging situations from becoming instances when law enforcement is called.

CEC encourages Congress to pursue the following policy recommendations to ensure that the needs of children and youth with disabilities are adequately considered:

1. Law enforcement officials, particularly those who work regularly with schools, should have training, sensitivity and awareness to help ensure equitable treatment of individuals with disabilities⁵.
2. School safety policy proposals should use an interdisciplinary approach that reinforces a partnership between education, juvenile justice, mental health, social welfare and community engagement systems.
3. School safety policy proposals should require implementation of evidence-based practices that address prevention and response while ameliorating the stigma associated with disabilities and mental health challenges; such practices should be employed by law enforcement as well.
4. School safety policy proposals should confront and remedy the national shortage of special educators and specialized instructional support personnel who are trained to address the complex needs of students with disabilities and mental health challenges, and who are trained to work directly with law enforcement, if applicable.

The following is the rationale for our recommendations.

First, it is critical that law enforcement officials have an understanding of the broad range of disabilities, their characteristics and appropriate responses to enable effective communication and treatment of individuals with disabilities. To achieve this goal, law enforcement officials need access to high-quality training in their preparatory programs as well as their ongoing professional development.

Second, it is vital that policy proposals – whether at the federal, state, or local level – use an approach that reinforces interdisciplinary partnerships between education, juvenile justice, mental health, social welfare, and community engagement systems. This approach is necessary because “school violence is not a single problem amenable to a simple solution but, rather, involves a variety of problems and challenges.”⁶ While it is tempting to address single issues, such as installing metal detectors at entry points in school

⁵ U.S. Department of Justice, Office of Civil Rights. Commonly Asked Questions About The Americans With Disabilities Act and Law Enforcement. http://www.ada.gov/q%26a_law.pdf

⁶ Cornell, Dewey G., and Matthew J. Mayer. “Why Do School Order and Safety Matter?” *Educational Researcher*. 39.1 (2010): 7-15. Print.

buildings, research has demonstrated that it is necessary to address school safety using a comprehensive, coordinated approach

Third, in the wake of national tragedies, it has been common to see a knee-jerk response rather than the implementation of policies that are rooted in evidence and research. It is critical that we learn from past practices and look to research and evidence to determine successful practices and policies. Knowing that the best offense is a good defense, we have learned through research and practice about the importance of focusing on prevention.

In response to the events at Sandy Hook Elementary School, more than 100 national organizations representing more than 4 million professionals in education and allied fields, along with more than 100 prominent researchers and practitioners, supported a statement issued by the Interdisciplinary Group on Preventing School and Community Violence, which stated, "Preventing violence and protecting students includes a variety of efforts addressing physical safety, educational practices, and programs that support the social, emotional, and behavioral needs of students."⁷

A review of past school safety initiatives must help inform how to move forward. Policies such as *zero tolerance*, which the American Psychological Association found to be ineffective; *profiling*, for which the U.S. Secret Service and U.S. Department of Education revealed no accurate or useful demographic or social profile of school attackers⁸; and other simplistic solutions, have not had their intended effect.

Instead, school safety policies should encourage strategies that support prevention and are rooted in research, including:

- **Fostering Communication:** "Comprehensive analyses by the U.S. Secret Service, the FBI, and numerous researchers have concluded that the most effective way to prevent many acts of violence targeted at schools is by maintaining close communication and trust with students and others in the community."⁹

Practically, this means policies must (1) support professional development and training for school staff, including teachers, specialized instructional support personnel, and administrators, regarding effective communication strategies and initiatives; (2) employ a cadre of staff who are professionally trained to address the mental health needs of students; and (3) support changes to teacher preparation programs that reinforce the importance of communication.

- **Supporting a Positive School Climate and Connectedness:** School climate, which impacts school safety, teaching and learning, interpersonal relationships and institutional environment, according to researchers cited by the U.S. Department of Education, plays an integral role into the academic and social development of students. Research has demonstrated that a positive school climate helps create a culture of respect, understanding and caring among educators and students

⁷ Interdisciplinary Group on Preventing School and Community Violence. *Call for More Effective Prevention of Violence*. Dec. 19, 2012. Web. <<http://curry.virginia.edu/articles/sandyhookshooting>>.

⁸ Borum, Randy, Dewey G. Cornell, William Modzeleski, and Shane Jimerson. "What Can Be Done About School Shootings? A Review of the Evidence." *Educational Researcher*. 39.1 (2010): 27-37. Print.

⁹ Interdisciplinary Group on Preventing School and Community Violence. *Call for More Effective Prevention of Violence*. Dec. 19, 2012. Web. <<http://curry.virginia.edu/articles/sandyhookshooting>>.

where members of the school community feel physically and emotionally safe and secure, and facilitates an environment conducive to learning.

Practically, this means: (1) embracing whole school reforms that reinforce the important role of having a positive school climate, such as Positive Behavior Interventions and Supports; (2) supporting this shift in mindset with the tools and resources needed to foster its implementation, such as professional development and training, and (3) data collection and analysis tools to help schools study and respond to local school climate information.

- **Addressing Needs of Marginalized Students:** “Research indicates that those students most at risk for delinquency and violence are often those who are most alienated from the school community. Schools need to reach out to build positive connections to marginalized students, showing concern and fostering avenues for meaningful involvement.”

Practically, this means: We need to confront and address the persistent national shortage of special educators who are trained to address the complex needs of students with behavioral disorders and the shortage of specialized instructional support personnel such as school counselors, school social workers, and school psychologists who are underutilized and underemployed in schools. In 2011, the U.S. Department of Education reported a shortage of special educators in every state, continuing a decades-long trend.¹⁰

- **Increasing School Based Mental Health Services:** School based mental health services for purposes of screening, providing direct services, engaging and supporting families, and serving as a connection to community based supports, are critical to providing the prevention, response, and treatment that are so vital to students’ well-being. We must confront the stigma associated with mental health problems through multiple avenues, including making it an integral part of our educational system.

Practically, this means: In many schools, school-based mental health and student service providers carry a caseload that far exceeds the recommended ratios and far too often, no school-based mental health and student service providers are available to assist students in times of crisis, or at any other time. We need to address the national shortage of special educators and specialized instructional support personnel by reducing the recommended ratios of students to school counselors to 250:1, school social workers to 250:1, school psychologists to 1,000:1, school nurses to 750:1 and often increasing the number of other professionals who are specifically trained to address the mental health needs of students.

In closing, CEC stands ready to work with members of Congress to promote policies and meaningful actions not only to address violence in our nation’s schools and communities but to create solutions that are rooted in safety, prevention, and an interdisciplinary approach.

¹⁰ United States. Department of Education Office of Post Secondary Education. *Teacher Shortage Areas Nationwide Listing: 1990-1991 through 2012-2013*. 2012. Web.



CSH Statement for the Record
Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety

Hearing Before the Senate Judiciary Subcommittee on the
 Constitution, Civil Rights, and Human Rights
 April 29, 2014

Thank you Chairman Durbin and Ranking Member Cruz for hosting this important hearing about solutions that will improve the safety of law enforcement officials and address the needs of individuals with mental health or substance abuse issues. CSH is working with supportive housing, criminal justice and health service providers across the country to address the needs of this population in order to reduce involvement with the criminal justice system, address complex mental health or substance abuse issues and reduce homelessness.

CSH transforms how communities use housing solutions to improve the lives of the most vulnerable people. We offer capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends over 20 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions.

At CSH, it is our mission to advance housing solutions that deliver three powerful outcomes: 1) improved lives for the most vulnerable people 2) maximized public resources and 3) strong, healthy communities across the country. CSH is working to solve some of the most complex and costly social problems our country faces--like those related to homelessness. We envision a future in which high-quality supportive housing solutions are integrated into the way every community serves the men, women and children in most need.

All of CSH's housing solutions integrate supportive housing. Supportive housing is a proven intervention that uses housing as a platform for services that create opportunities for recovery, personal growth and life-long success. CSH blends our experience and dedication with a practical and entrepreneurial spirit. We uncover ways to move forward even in the most complex environments, so our partners can achieve stability, strength and success for the most vulnerable people in the communities where they live.

It's no secret that the United States incarcerates a higher proportion of its population than any other country in the world, with over 1.5 million people currently confined in U.S. prisons or jails. In 2013, the number of people in jail increased for the second straight year, with over 11.6 million admissions to U.S. jails over the year, with roughly 15% of inmates have experiencing homelessness in the year prior to their arrest. Much of this population has a history of substance abuse or mental illness; according to recent research, approximately 64% of jail inmates have a serious mental health problem, and 65% meet medical criteria for substance abuse addiction. Due to their unstable housing situations and struggles with mental illness and addiction, this population is at extremely high risk of returning to jail. They return to jail at a rate of 80 - 90% and in between stay on the street, at homeless shelters, psychiatric hospitals, detox and drug treatment programs, and other emergency systems at immense cost to the public, sometimes exceeding \$34,500 dollars per individual annually.



Since 2007, CSH has worked to advance replication of our signature initiative, Frequent Users Systems Engagement (FUSE). FUSE helps communities identify and engage high utilizers of public systems such as jails, shelters, and hospitals, and place them into supportive housing to break the cycle of repeated use of costly crisis services, and reduce recidivism rates to the criminal justice system. Since launching the first FUSE initiative in New York City in 2007, CSH has worked with more than 10 jurisdictions across the country to replicate and expand the model: Denver, King Co., WA, Chicago, IL, Connecticut, Rhode Island, Louisville, Mecklenburg Co., NC, Hennepin Co., MN, and Los Angeles are just some of communities that have taken on a FUSE initiative. Not only are several more locations in the planning stages, but some, such as Denver and Maricopa Co., AZ, are looking to “scale up” the intervention to maximize the budgetary and human impacts.

Targeting homeless frequent users of public systems provides a double win for communities, allowing public systems like jails and shelters to cut costs while improving outcomes for some of their most vulnerable community members. The model presents a *systemic* approach to social innovation and a radical departure from current practices in the re-entry field. FUSE increases housing stability and reduces recidivism and inappropriate crisis service use, resulting in public cost offsets. While CSH has helped several communities to adapt the FUSE model to suit unique local contexts and conditions, at the core of FUSE are three essential pillars:

1. **Data-Driven Problem-Solving** Data is used to identify a specific target population of high-cost, high need individuals who are shared clients of multiple systems (jails, shelters and ERs) and whose persistent cycling indicates the failure of traditional approaches. Data is also used to develop a new *shared* definition of success that takes into account both human and public costs, and focuses on system-wide cost reductions, as opposed to simply offloading clients from one agency to another.
2. **Policy and Systems Reform** Public systems and policymakers engage in a collective effort to address the needs of shared clients and to shift resources away from costly crisis services and towards a more cost-effective and humane solution: permanent housing and supportive services.
3. **Targeted Housing and Services** Supportive housing is enhanced with targeted and assertive recruitment through in-reach into jails, shelters, hospitals and other settings, to help clients attain housing stability, access to routine care to address their underlying issues, and avoid returns to crisis services and institutions.

Despite the incredible nationwide energy around FUSE, initiatives that focus on vulnerable individuals – often those with co-occurring disorders – need to be funded at higher levels in order to achieve savings beyond the pilot level. And we need multiple strategies to help solve the problem. Law enforcement is at the front lines of this issue, dealing first hand with frequent users on the street and in jails. Law enforcement agencies are increasingly recognizing the complex dimensions of offender reentry and the importance of partnerships in addressing these issues. Thus, front-line strategies, like Collaborative Case Management (CCM) training, for police, parole officers and social service providers is critical to addressing the multiple needs of returning offenders and ensuring a safe and successful path to re-integration.

However, of all the issues facing the frequent user population, none is more immediate than the need to secure housing. Without access to safe and affordable housing, people re-entering the community have little chance at success. In addition, to maintain housing and end the cycle of homelessness and incarceration, the target population requires a comprehensive, multi-sector service solution that involves coordination of services and funding streams across several, currently disparate, systems of care. FUSE is an enhanced supportive housing model that has emerged as a solution to this costly



and intractable problem. It combines permanent affordable housing with comprehensive support services, and hinges on interagency coordination.

Most importantly, the FUSE approach has been proven to work. Recently, Columbia University completed a rigorous evaluation of the NYC FUSE pilot, which housed over 200 individuals. The results are compelling:

- Psychiatric inpatient hospitalization days were dramatically lower for FUSE participants – comparison group members spent twice as many days in psychiatric inpatient centers as FUSE participants.
- Jail days were lower – over the 24 months after housing placement, FUSE participants averaged 29 jail days vs. 48 jail days for the matched comparison group.
- FUSE participants stayed housed – at 12 months, 90% remained in FUSE housing; at 24 months, 81% remained in FUSE housing and 86% had permanent housing of some type.
- Shelter use declined dramatically – FUSE participants averaged 15 days in shelters in the 24 months after housing placement, whereas a comparison group averaged 162 days in shelters in the same time.
- FUSE produced cost savings for crisis services – through reduced usage of jails, health services, and shelters, **each individual housed through FUSE generated \$15,000 annually in public savings**, paying for over two thirds of the intervention cost.

The initiative has demonstrated similar results in other jurisdictions. The Hennepin County, MN, FUSE initiative found dramatic reductions in shelter and arrests – 60% of FUSE participants experienced fewer arrests in the 22 months post-housing, and 45% had one or no arrests at all. There were 1,704 fewer shelter nights and 700 fewer nights in county jails. Connecticut's FUSE initiative, which houses 120 individuals, found that after the first year of housing, individuals experienced a 99% decrease in shelter days and a 73% decrease in jail episodes. The King County, WA, evaluation found a 45% reduction in jail/prison bookings, and a 38% reduction in jail days. The Denver FUSE initiative, headed by the Denver Sheriff's Department, recently shared findings that there has been a 90% decrease in annual jail days for FUSE consumers, translating into an estimated \$114,480 savings to the Department annually. Three other communities are in the first phases of measuring their FUSE initiative results including Louisville, KY, Mecklenburg County, NC, and Columbus, OH.

CSH believes that expanding supportive housing initiatives targeting high system utilizers will improve law enforcement and individual safety, as well as, save money at the local, state and federal levels. CSH supports the reauthorization of the Second Chance Act and the Mentally Ill Offender Treatment and Crime Reduction programs in the Justice and Mental Health Collaboration Act (S. 162) and urges Congress to act quickly to pass those important pieces of legislation. Together, they will enable communities and states across the country to expand or undertake community re-entry programs and cross-training for law enforcement, mental-health and criminal justice personnel.

Thank you for giving CSH an opportunity to submit this statement for the record. We look forward to working with you and your staff on continued efforts to help address the needs of America's most vulnerable populations. If you have any questions, please feel free to contact Hilary Swab Gawrilow (Hilary.gawrilow@csh.org), Director of Federal Policy at CSH.

Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety

Submission for Senate Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights April 29, 2014

First Responders Disability Awareness Training Niagara University

"On January 11, 2013 in a Maryland movie theater, a 26-year-old man with Down syndrome cried out for his mommy in the final moments of his life and started a movement. The death of Ethan Saylor at the hands of sheriff's deputies who were trying to evict him from the theater he entered without a ticket has become a significant event for people in the disability community who push for equality and inclusion as a civil rights issue. Ethan Saylor is their Emmett Till.

For me, the Saylor story is deeply troubling and personal. My 10-year-old daughter has Down syndrome. She is witty and sunny most of the time but there are moments when she is obstinate and difficult — much like any child. But the behaviors sometimes take extra effort to work around.

That kind of understanding and patience should have been afforded Ethan Saylor, who had an IQ of 40.

Instead, off-duty Frederick County Sheriff's deputies were summoned to oust Saylor when he wanted to watch "Zero Dark Thirty" a second time, without a ticket. As deputies went in, Saylor's aide pleaded for everyone to wait it out and allow her to deal with the situation. His mother was on the way. The aide warned that Saylor would "freak out" if touched.

Deputies dismissed her advice and told her to stay out of the theater. They went in, ordered Saylor to leave, then grabbed him when he refused and began swearing at them.

Deputies cuffed him, and Saylor struggled and cried, saying, "Mommy, mommy. It hurts." As officers wrestled with 294-pound Saylor, he fell to the ground with a deputy on his back. He soon stopped breathing and died. An autopsy later revealed his larynx was crushed."-Denver Post 1/11/14

Could this have ended differently if those officers had been trained in the proper way to interact with individuals with disabilities? Unfortunately, we will never know but Niagara University through the scale up and expansion of impact of its unique First Responder Disability Awareness Training (FR DAT) program intends to do everything possible to prevent this happening to another family. The key is education and training that has staying power.

Everyone needs disability awareness training; this is not unique to first responders. However, emergency personnel's presence at situations that call for a response to challenging behaviors, alleged criminal conduct, physical and medical needs, assistance in a matter, or service and protection, are imperative to the well-being and quality of life for the vulnerable individual(s) in which they come into contact. The intent of any training should recognize that (most) individuals in law enforcement want to do the right thing; however, the unique, perplexing encounters that may call for split second decision-making can put an officer in a difficult spot. Our program exists so that all first responders, but especially police officers, are able to respond in a manner that allows for both parties to be safe and treated in the appropriate manner.

- “First Responders” is a term used to describe police, firefighters, emergency medical services (EMS), and 911 operators/dispatchers who are the first contact either via 911 or through arrival on the scene of medical or other emergencies.
- While **Ethan’s case** has garnered national attention, it is not the only instance where a first responder has inappropriately responded to an IWD and the result has been negative. However, to fault first responders would not be prudent. You can’t properly respond to an incident if you were never trained in how to do so, if your state’s criminal justice mandated training did not include a detailed section on disability awareness, if your Chief was never given the opportunity to send their personnel to a program. While some states include training for law enforcement in response to individuals with disabilities (IWDs), it is either not enough, buried with hundreds of hours of recruit training, doesn’t allow for on-going education, or is not delivered effectively. NU FR DAT’s **website (www.fr-dat.com)** has, under *Articles of Interest*, some 30 cases whereby law enforcement was challenged and may have responded in a manner that was not effective, resulting in injury to an IWD (both physical and mental), death of an IWD (across the disability spectrum), false arrest, civil lawsuits costing municipalities millions of dollars, officers losing their job and some even serving time.
- Other cases that have garnered attention: Seattle shooting of deaf person, Oregon 11 year-old with autism tasered, San Diego county Sheriff’s Dept. beating of man with Down Syndrome, death of Suffolk county, NY individual with intellectual disability, dragging of person with physical disability/traumatic brain injury off bus in Syracuse, NY breaking his hip, DUI arrest of individual with cerebral palsy who wasn’t drinking, police shooting death of 15 year-old with autism in suburban Chicago, arrest of individual who was having a seizure. All of these cases (and more) can be found on our website as noted above.

Society has many faults when it comes to proper response and interaction with IWDs which is manifested by misperception, misunderstanding, lack of awareness, viewing and IWD as a lesser person, sympathetic response as opposed to empathetic, fear of the unknown, and avoidance. However, for first responders to come into situations with these areas not being eradicated from their minds, the probability of an inappropriate interaction rises dramatically. IWDs may require response that would vary from everyday encounters. If emergency personnel are not comprehensively educated on this topic, results can be negative, some even catastrophic. Consider the following statistics:

- Research shows that individuals with disabilities (IWDs) are **seven times more likely the victim of a crime** than other individuals while **50-80% of an officer’s day will be in contact with an individual with a disability**. Yet First Responders seldom have sufficient training to interact effectively with people with developmental disabilities.
- Historically, most individuals with developmental disabilities who required out of home placement resided in large institutional settings, some of which mirrored self-contained communities with emergency and other personnel available within the institution 24 hours a day, 7 days a week.
- **One of five Americans has a disability**, and it is on the rise. Current numbers include **1 in 68 children with autism**, **3% of the population has an intellectual disability**, **one on 10 Americans will have a seizure**, and **30 million people have ambulation challenges**, to name a few. That said, many disabilities such as Tourette syndrome, traumatic brain injury, ADHD, and learning disability

has a high incidence of encounters with law enforcement. All will present differently and have the potential to be challenging for an untrained officer.

- Today, most individuals with developmental disabilities live with their families, others in the community, or independently per their choice. Along with the rewards of community living, people with disabilities face increased risks of needing the assistance of First Responders.
- According to the US Bureau of Justice Statistics, an **estimated 1.3 million nonfatal violent crimes occurred against persons with disabilities in 2012** nationwide.
- **In 2012, the rate of violent crime against persons with disabilities was 34 per 1,000, compared to 23 per 1,000 for persons without disabilities.** Because persons with disabilities are generally much older than those without, the age distribution differs considerably between these two groups, making direct comparisons misleading. To compare rates, each group was adjusted to have a similar age distribution, **making the age-adjusted rate of violent crime against persons with disabilities (60 per 1,000) nearly three times higher than the rate for persons without disabilities (22 per 1,000).** The age-adjusted rate of serious violent crime—rape or other sexual assault, robbery and aggravated assault against persons with disabilities (22 per 1,000) was nearly four times higher than that for persons without disabilities (6 per 1,000) in 2012.
- Among persons with disabilities, **those with cognitive disabilities had the highest unadjusted rate of violent victimization (63 per 1,000).** During 2012, about half (52 percent) of violent crime victims with disabilities had more than one disability. **Violent crime against persons with one disability type increased from 2011 (37 per 1,000) to 2012 (53 per 1,000),** while the rate among persons with multiple disability types remained stable during the same period.
- Other 2012 findings include: **Persons with disabilities experienced an estimated 233,000 robberies, 195,200 aggravated assaults, 838,600 simple assaults and 80,100 rapes or other sexual assaults;** Among persons with disabilities, whites were more likely than blacks to experience a violent crime; Hispanics with disabilities had a lower rate of violent victimization than non-Hispanics with disabilities; and, among persons ages 12-15, the unadjusted rate of violent victimization was three times higher for persons with disabilities than for persons without disabilities.
- **72% of women with developmental disabilities and 32% of men will be sexually abused.**
- Individuals with disabilities who are offenders will also have challenges in the judicial system, many of them at every level of it.
- Law enforcement will also be responding to IWDs when they are in need of assistance or in crisis. Individuals with autism and dementia may wander and first responders are called to find them. People who use wheelchairs may get stuck and need assistance, individuals with speech impairments will pose challenges, a need to be able to know basic sign language will be expected when interacting with a deaf person, to name a few.
- The **Americans with Disabilities Act (ADA)** already addresses some of these matters but oftentimes officers are not kept abreast of how this impacts their responsibilities. The Department of Justice

(DOJ) has some materials that assist in educating officers on how to be sure they both uphold the ADA and don't violate it.

- Still, incredibly, first responders, emergency managers, and municipal employees/elected officials receive no formal mandated training in proper response to IWDs.
- According to FEMA, **an average of an estimated 1,700 residential building fires involving individuals with mental disabilities are reported each year with an estimated 85 deaths and 250 injuries while an estimated 700 building fires involving individuals with physical disabilities are reported each year with an estimated 160 deaths and 200 injuries**
- This, in combination with the documented tragedies resulting from inappropriate first responder contacts with IWDs nationwide, indicates a clear need for expanded training for first responders and aligned emergency personnel.

In September 2010, Niagara University (NU) was awarded a three year \$550,000 grant from the NYS Developmental Disabilities Planning Council (DDPC) to address the lack of training and understanding of how to properly respond to IWDs with the intent to develop curriculum for the training of police officers, firefighters, EMS, and 911 operators in the State of New York. Although some states have versions of this program, no state has developed a fully comprehensive program. The program is a **Train the Trainer model**, which is the only way to reach first responders in mass. It incorporates a Trainer network that allows for FR to connect with IWDs to co-present on disability specific topics and sections. NYS DDPC researched and found no state to have comprehensive mandated training.

Consider that in **New York State** there are 588 police departments and sheriff's offices with more than 62,300 sworn full- and part-time officers, 45 law enforcement training academies, 2,135 fire departments and EMS agencies with more than 175,000 responder personnel statewide; thousands of 911 operators and hundreds of individuals responsible for emergency management of municipalities. The numbers and the training schedules that are utilized by firefighters (FF), law enforcement (LE), and EMS agencies are non-traditional. In essence, to train one police department (PD) of 100 officers will take a week, the schedule would be set by them, and there would be an expectation that this is offered at no charge. It is simply not practical. Couple this with the feeling that the best people to train FF and LE are themselves, and the odds are against any group to make a dent in their regions FR departments. Law enforcement receives two hours of mandated training on individuals with disabilities in the basic course (out of 639 hours). FR-DAT has reached (to date) over 800 representatives from 51 emergency management agencies, 70 law enforcement departments, and 75 FF/EMS departments through a combination of direct and train-the-trainer formats.

NU has also taken the measure to ensure some form of on-going education. They have done this through the following:

- The trainer manuals have additional materials on disabilities, the ADA, victimization/abuse, service animals as well as resources via websites per discipline.
- NU has developed a resource manual for every attendee that is a quick reference guide on everything disability related specific to first responders
- NU has developed an extensive website that allows for FR to continue educating themselves on everything relative to proper response. NU will develop state-specific links to adjust to the differences (i.e. laws, service providers, parent groups) across borders.
- NU maintains a relationship with all trainers, allowing for inquiries to be answered, new material to be shared, current trends and topics to be disseminated, and tracking of training conducted to be

incorporated into the database. This ensures they are always connected to 'homebase' and their responsibilities are carried out.

- Through the Disability Awareness Training at NU, New York is the only state in the nation to have a comprehensive program that covers the disability spectrum and works with and through state offices and associations. Other states, including MD, VT, AK, TX, NJ, and MO have inquired.
- **Attached is the law enforcement training brief along with the evaluation summary from the 14 sessions conducted for law enforcement.**
- In fall 2014, NU will roll out the training for **911 operators/dispatchers**.

The overall mission of the First Responder Disability Awareness Training project is to develop and provide specific, customized training for law enforcement, firefighters, EMS and 911 operators/dispatchers that provides all First Responders with the knowledge necessary to best serve and respond to individuals with disabilities. The content of the training curriculum is specific to First Responder needs when interacting and responding to incidents, situations, and accidents that involve individuals with disabilities. Now in its fourth year of operation, the program is moving from providing a large percentage of direct trainings to individual participants, to a focus on capacity expansion and impact by: (1) increasing the number of train-the-trainer courses offered; (2) developing online versions of training for remote access; (3) creating a "master trainer" course to educate a network of individuals to teach the train-the-trainer courses on behalf of FR-DAT; and, (4) increase presence at state and national conferences to grow the market for the products offered

Highlights of program accomplishments include:

- 19 Firefighter/EMS direct trainings along with 9 train the trainer sessions with a total of 106 attendees. 3 more train the trainer sessions are scheduled.
- 11 law enforcement direct trainings along with 14 train the trainer sessions with a total of 116 attendees.
- In total, over 700 first responders have evaluated the FR DAT training after participation. Of those that responded, 99.6% said they would recommend the program. 96% of these respondents also gave the training a "good" or "excellent" rating, based on a five-point scale. Included among these respondents were approximately 200 fire fighters, 100 police officers, 50 EMS personnel, 60 emergency managers, and a number of probation officers, correctional officers, and municipal employees.

This is a collaborative effort with first responder entities. NU will provide the model necessary to ensure this program is imbedded into the FR community. States may also consider attempting to make this mandatory, however, this is a process and it is important to partner with FR, not alienate them. A direct push to mandatory training will not endear the program to FR and may make getting the program accepted difficult. NU has established a working relationship with state offices across all disciplines, all associations and councils that represent FR, and several groups that represent the disability community, who play an active role in direction per disability and topic of interest. Also imperative is the need for a statewide advisory council, which is charged with direct input representing law enforcement, fire fighters, EMS, emergency management, state offices, parent groups, service providers, and IWDs.

NU has been contacted by states and is outreaching to others and will look to partner with state entities, preferably institutes of higher education, who will be the recipient of funding and will sub-contract with

NU. In line with this hearing, NU believes in proactive approaches and minimizing the need to develop training that already exists. Within each state, the collaboration will focus on community resources and connecting with the disability community per region, customization per state, and state office and association working relationships.

I sincerely appreciate the time and effort your subcommittee is putting into this topic and applaud you for addressing it. Please feel free to reach out to us if we can help in any way.

Respectfully submitted,

David V. Whalen
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Law Enforcement Disability Awareness Training

Overview/Description:

1. *Major purpose/theme of workshop:* Disability awareness training has tailored a presentation for law enforcement. It brings together education on disabilities while enhancing sensitivity. The presentation includes the history of disabilities, definitions, etiquette and interaction skills, the disabled perspective, challenging behaviors, and current trends and topics, all relevant to police officers.
2. *How initiative relates directly to law enforcement and its impact on response:* The ability to respond appropriately to situations, whatever the magnitude, is essential in the initial interaction involving individuals. 50-80% of interactions by an officer involve an individual with a disability and they are most often the first to respond. High profile events have exposed the lack of training and preparedness in responding to this population. This training addresses every area of response and specific interaction skills in encountering individuals with disabilities including, but not limited to, characteristics of individuals with disabilities, challenges faced and how to overcome them, federal/state guidelines and supports provided, victimization, identifying and working with service providers, and the latest initiatives and programs. Attendees will also be provided with an in-depth explanation of why society discriminates against individuals with disabilities and the injustices that occur.
3. *Discuss the types of activities or teaching strategies that will be utilized:* Disability awareness incorporates sensitivity training so the audience can empathize with the injustices individuals with disabilities face. Videos, extensive materials and resources, federal guidelines, and current best practices will highlight the content and allow for attendees to best respond and interact with all citizens in their community.

Course Key Ideas/Content:

- Disabilities defined specific to law enforcement
- Victimization/abuse and the disabled
- Service provision and supports and how to develop a collaborative relationship
- Challenging behaviors and responsiveness
- Municipality role and responsibility

- Progressive approaches to addressing challenging situations
- Proper etiquette and interaction skills
- Alternative forms of communication (i.e. Speech Generating devices, ASL)
- Co-morbid/secondary, tertiary disabilities
- Durable Medical Equipment, Assistive technology
- Americans with Disabilities Act specific to Law enforcement
- Myths and misperceptions
- Incident review, identifying appropriate response
- NYS Justice Center

Learner Outcomes:

Attendees will learn about the disabilities that they will encounter and how to appropriately respond. Officers will be able to better understand the challenges they face and how to address them effectively. Video presentations specific to disabilities most frequently encountered with a breakdown and open discussion allow for all questions to be answered. Educated officers will ensure proactive response that is sensitive but appropriate to challenging situations. The ability to understand characteristics of individuals across all disability spectrums will be provided throughout the session.

David Whalen founded **Disability Awareness Training** in 2004. He specializes in training law enforcement, emergency responders, human service providers, public, private, and school transportation, corporations and businesses, places of worship and educators.

Mr. Whalen worked for 17 years serving adults with developmental disabilities before working with low-income, medically frail seniors in a Managed Long Term Care program. He served as President of the NYS Association of Day Service Providers. He also sat on the Developmental Disabilities Awareness Day committee for 18 years.

Dave is currently the Chair of the Town of Amherst's Committee on Disabilities, President of the Williamsville CSD Special Education Parent Teacher Students Association (SEPTSA), and CSE Parent representative for Williamsville CSD and the State of New York. He is past Chair of the Board of Directors of the Parent Network of WNY and an active member of the Diocese of Buffalo's Disability Action Team. In 2010, he was appointed by the Board of Regents to serve on the **NYS Independent Living Council (NYSILC)** and recently co-founded Access Buffalo. **In September 2010 he received, in collaboration with Niagara University, a NYS Developmental Disabilities Planning Council grant to develop disability awareness training for First Responders.** He currently sits on the **NYS Office of Emergency Management human services committee and chairs NYSILC's emergency preparedness committee.** He was appointed to the **Erie County Disability Advisory Board** and has served on it since 2010. On March 11, 2011, Dave accepted an invitation to the **White House for a historic signing between FEMA and the Disability Rights Network.** In January 2014, Dave accepted an invitation to join the advisory council of the **National Center on Criminal Justice and Disability.**

He has a BA in Psychology and an MS in Ed in Community Counseling from St. Bonaventure University, where he serves as the Buffalo Alumni chapter President.

David resides in Williamsville, NY with his wife Sandy and their 16 year-old twins, David and Rachel.

LAW ENFORCEMENT TRAIN THE TRAINER EVALUATIONS SUMMARY

Updated April 22, 2014

Law Enforcement Agencies Represented at TTT (14 sessions, 155 participants, 70 departments)

Number next to department indicates TOTAL officers in that department

1. Amherst Town PD – 153	25. Massena PD – 24	49. Poughkeepsie City PD – 101
2. Bethlehem PD – 35	26. Middletown City PD – 71	50. Poughkeepsie Town PD – 81
3. Binghamton PD – 127	27. Monroe Co. Probation – 180	51. Rochester PD – 760
4. Broome Co. Sheriffs – 58	28. Mount Pleasant PD – 42	52. Rockville Centre PD – 51
5. Buffalo PD – 813	29. New Castle Town PD – 37	53. Saranac Lake PD – 13
6. Cattaraugus Co. Sheriffs – 127	30. New Windsor PD – 40	54. Scarsdale PD – 45
7. Cayuga Co. Sheriffs – 41	31. NYC DEP Police – 185	55. Scotia PD – 15
8. Cheektowaga Town PD – 128	32. NYC HR Admin. Police – 100	56. Sea Gate PD – 35
9. Chenango Co. Sheriffs – 29	33. NYC Parks Police – 110	57. SUNY Buffalo
10. Clinton Co. Sheriffs – 27	34. NYS DARE Officers Assn	58. SUNY Otsego
11. Cortland PD – 43	35. NYS DEC – 330	59. SUNY Stonybrook
12. Dutchess Co. Sheriffs – 150	36. NYS ENCON – HQ LE – 446	60. Suffolk Co. PD – 3,004
13. East Aurora/Aurora Town PD – 16	37. NYS Justice Center	61. Syracuse University DPS – 80
14. Eden Town PD – 14	38. NYS Police	62. Tonawanda City PD – 28
15. Erie Co. LE Academy	39. NYS University Police – 600	63. Tonawanda Town PD – 102
16. Essex Co. Sheriffs – 21	40. Niagara Co. Probation – 29	64. Troy PD – 126
17. Fishkill Town PD – 42	41. Niagara Co. Sheriffs – 115	65. Vestal PD – 34
18. Genesee Co. Sheriffs – 49	42. Niagara Falls PD – 151	66. Watertown PD – 66
19. Hamburg Town PD – 60	43. Ocean Beach PD – 33	67. Westchester Co. DPS – 262
20. Hempstead PD – 117	44. Olean PD – 34	68. Westchester Co. Prob. - 160
21. Lewiston Town PD – 20	45. Oneida PD – 23	69. West Seneca PD – 66
22. Lockport PD – 49	46. Onondaga Co. Park Rangers – 20	70. Yorktown Town PD – 55
23. Livingston Co. Sheriffs – 74	47. Orchard Park PD – 28	
24. Manlius Town PD – 35	48. Plattsburgh PD – 46	

Total officers that can now receive FRDAT training: 9,956+

151 evaluations

Overall rating	Excellent – 69	Very good – 72	Good – 10	Fair – 0	Poor – 0
Content	Much too basic -1	Too basic – 0	<u>About right – 141</u>	A bit too complex – 9	Much too complex – 0

Length	Much too short – 0	Too short – 19	<u>About right – 126</u>	A bit too long – 17	Much too long – 2
Visual aids	Excellent – 63	Very good – 72	Good – 15	Fair – 1	Poor – 0
Handouts	Excellent – 67	Very good – 69	Good – 16	Fair – 0	Poor – 0
Presenter effectiveness	<u>Excellent – 99</u>	Very good – 48	Good – 3	Fair – 2	Poor – 0

*Some evaluations may have had missing responses

Comments about training in general:

- “Should be an in-service (mandatory) for all law enforcement”
- “This is very valuable and applicable training that can help officers in the field as well as in our personal lives.”
- “Extremely informative and educational. I will recommend it to other police officers.”
- “Very informative. Touched on many topics which I did not expect. Made me realize how much knowledge I lacked in regard to several disabilities.”
- “Opens up your eyes to certain situations you might be involved in.”
- “Well written and detailed. Best part was that it was written for police responders.”
- “Content was great and it breaks down the subject matter in a way I feel is perfect for teaching.”
- “Fulfilled a tremendous need that was overdue.”

Comments about training specifics:

- “The curriculum was organized very well. Very user-friendly. Shouldn’t have an issue when presenting this curriculum to the department.”
- “Trainer manual was excellent. Extremely easy to follow. One of the best I have ever used.”
- “I enjoyed watching the videos. The police examples helped with dealing with real situations and how I would respond when/if in those same situations.”
- “Videos are extremely useful and are more realistic to everyday life. Hearing real life situations are better than talking about ‘what could happen.’”
- “All training aids available contributed to presentations.”
- “Work guide is easy to use and look things up.”
- “Most handouts I get from other classes end up in the garbage. I know I am going to use these.”
- “Great examples. Will be very helpful for future department in-service trainings. The thumbdrive is a great resource.”
- “Great videos depicting actual people telling their stories, experiences, and knowledge.”

Testimony: “I really wasn’t too enthusiastic about attending this training. I thought, ‘how is disability training relevant to the police department?’ Soon after the training started I realized it’s very relevant to the police department and first responders. Whether a person with a disability is a victim or offender you need to realize why this person is responding or not responding in a certain way. Also it’s good to know how to communicate if you know what kind of disability they have. It’s very important to know

what to do and not to do especially for the victim's sake. This training is very relevant to police officers."

- Police officer, 27 years on the job

Statement of Testimony Regarding: "Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety
Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights"
Date: April 29, 2014

Dear Senators,

Thank you for holding this vital hearing. As the mother and guardian of an adult child with a serious mental illness known as schizoaffective disorder, I am speaking from over a decade of experience of watching the son that I love dearly succumb to a devastating and debilitating brain disorder. Nothing rivals this cruel disease, nothing that is, except the tragedy of our broken mental illness treatment system.

My son is incapacitated by his illness. He also has the clinical condition known as "anosognosia", he is not fully aware that he has a brain disorder which makes securing critical supports and treatment difficult. I cannot work outside of my home as advocating for him requires my full time attention. Thankfully my husband's employment provides for us and I live in a state that has good laws in place for involuntary treatment. My son is living currently in a residential/group home facility that is "temporary". The state wants him to live in an apartment type setting with less oversight and structure. Even though it is working for him, he is able to live outside of the state hospital and we can include him in outside activities, church, holidays, counseling, museums, trips to symphony, shopping etc. We have a good rapport with staff, my son has friends in his group home and he has consistent care with a psychiatrist that we have been able to stay with for the past 4 years. He has also been assigned to an ACT team which has 6 case mgrs. Involved with care.

Needless to say, including family and a church pastor, there are many eyes on his situation. This is what it takes to keep him stable and safe. We have had to fight tooth and nail to secure his support, my husband even quitting his job at one point due to his health. I share this because our story is a "good" one comparatively. From the beginning, the push has been for my son to live "independently". That may be good for a majority of disabled people, but for those with very serious mental illness it is not reality. In 2009, the Civil Rights Division launched an aggressive effort to enforce the Supreme Court's decision in *Olmstead v. L.C.*, a ruling that requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting *appropriate to their needs*.

I begin my testimony with this issue, the push for "independent" living, as one of the major factors being misinterpreted for some. For the small minority of individuals who, because of their brain not working properly, need more supportive, safe structure. I find the latter part of the decision above, "appropriate to their needs" being largely ignored in favor of "independence". Again, we are talking about the most critically disabled. To discuss law enforcement issues without this factor being at the forefront, is vanity.

Once law enforcement has been trained to handle the seriously mentally ill during a psychiatric crisis, where will these individuals go for treatment and supports?

The interaction we have had with the police in the city of Gilbert, Arizona has been good. My son's first psychotic episode happened when he was 18. In an extremely manic state, he ran through the neighborhood knocking on doors, jumped on top of cars, took off clothes, ran into a busy intersection away from police officers, even pushing one down. Thankfully the police were able to subdue him with a taser and took him to a hospital instead of jail. I will never be able to thank them enough for how they handled that situation that day.

This was our first introduction into the system. My son was then transferred to our county's psychiatric intake center in Phoenix. I had no idea that this place existed or that our state even had such a thing as "involuntary treatment". I immediately called the center, UPC (Urgent Psychiatric Center) to inquire about my son. The staff member I spoke with replied to me with the following statement: "Ma'am, your son is a psychopath. Give him the number to a homeless shelter and pack his bags". Needless to say, I was devastated and mortified!

In spite of that initial interaction, the center did not release him but transferred him to another hospital where he was placed on court ordered treatment. He did not respond to medications after several weeks and was sent to another hospital. Both hospitals would not share vital information about the medications they were giving him, nor did they inquire with us as to his medical history, etc. We had to initiate this we quickly learned and beg for any information. The hospitals hid behind the HIPPA law, even though my son could clearly not advocate for himself in his psychosis. A kind doctor called my husband and myself after work hours and discussed our son in detail with us (after much begging and fighting on our part). He told us he was not responsive to treatment and recommended he be placed on an ACT team.

Our son was stabilized enough to come home and was on court ordered treatment for a year with the ACT team providing support. When the year was over, they allowed him to go off of court ordered treatment. He quickly decompensated, we were able to help him go back into the hospital where they released him after only 4 days and with a totally new regime of medications. For almost a year he decompensated and was allowed to fall further into psychosis with 4 more hospitalization attempts (one involving us having to get help from our Governor) and subsequent releasing him on average of only a week of inpatient hospitalization. A revolving door in which we watched our son helplessly lose more and more of his capacity.

When we were finally able to get a hospital to keep him long enough for real stabilization, our son could no longer live with us as he had decompensated so badly that we were afraid for him and for ourselves. Since that time he has been in the "temporary" group home, but we have to fight every month for him to stay as the goal of the system seems to be independence over common sense and the best possible quality of life for our son.

Again, I write to tell you that so far our story is a fairly good one. I cannot imagine what other families lives' are like in states that have no laws for Assisted Outpatient Treatment as we have pushed the most vulnerable out of hospitals and into the streets, jails or even death...all in the name of "independence". Clearly, some individuals in our society need assistance and my son is one of them.

You cannot look simply at law enforcement for change, you must consider all of the factors. Where will the vulnerable mentally ill go once we have trained law enforcement to handle them in crisis?

Clearly we need a national standard for AOT that does not require violence, but a need for treatment statute. Our state has this and our son would not be alive without it. I do not exaggerate.

HIPPA laws must be clarified and states/hospitals held accountable when they abuse this or add extra layers of protections for themselves under the guise of privacy. How can you treat a patient in your hospital without information from parents or caregivers?

We must end the IMD exclusion. This is blatantly discriminatory.

We must provide reasonable, safe, long term housing or hospitalization with structure and needs according the individual.

We should consider using EMT for psychiatric calls, law enforcement should be supportive not on the front lines of care. Police are trained to enforce laws, they are not mental health workers.

Again, thank so much for holding this hearing and for considering my testimony.

Sincerely,

Deborah Geesling

Mesa, Arizona

Dear Senator Durbin,

I am writing as a constituent and also as the mother of an adult son with severe, persistent mental illness (SPMI). I believe Jean Morrow, President of NAMI Northern Illinois may have spoken with you in the past regarding my 2010-2012 attempt to get medical treatment for my son, who was in acute crisis. I am happy to see you representing us in Congress. Thank You.

I am a proponent of Representative Murphy's H.R.3717 for the following reasons:

On December 3, 2012, my son, Joshua, was arrested on violation of an order of protection. I had been trying to get help for Joshua for 3 years. Enclosed you will find a chart with dates correlating with police calls regarding my son. If you look closely enough at the chart, you can imagine during which months Joshua was involuntarily hospitalized. In each of **the eight (8) hospitalizations**, Joshua was discharged between 10 and 14 days. I did not realize then that the **IMD Exclusion**, which offered a monetary incentive to hospitals **if patients were discharged early without regard to his stability**, was the reason he continued to get sicker each time he was discharged. During those years of denied adequate medical treatment, Joshua continued to de compensate, exhibiting more aggressive symptoms such as destruction to property and, far worse, catatonia, with which he had never before presented.

The IMD Exclusion must be reformed so as to adequately get symptoms of SPMI into remission. When Winnebago County Judge, the Honorable Judge Randy Wilt ordered stabilization, it took 7 months!--a far cry from the previous 8 premature discharges.

AOT Illinois **passed** the AOT (Assisted Outpatient Treatment) Law in 2008, yet it remains **unfunded**. My son met every single strict criteria. This is not unusual for those with SPMI; however, the criteria is most certainly strict enough to avoid hospitalizing someone unjustifiably. Four to ten percent of persons with MI have SPMI, which almost always intense symptoms, including severe delusions (usually paranoid delusions), auditory hallucinations and lack of insight into their illness, (anosognosia), due to the progression of the disease. If psychosis is present, brain damage is in acute progress. **H.R. 3717 makes provisions for such unnecessary and harmful delays in treatment by offering immediate treatment options through AOTs.**

The existing AOT Programs, such as Laura's Law and Kendra's Law are certified DOJ programs that, across the board, reduce recidivism, repeat hospitalizations, damage to property, suicides, homicides, police interactions and non compliance with medication, each by over 70 percent! It saves both lives and money.

And finally, while considering H.R. 3717, remember that this bill pertains only to the 10% who become severely and dangerously symptomatic, not the 90% with 'serious' mental illness. There's an overwhelming difference in symptoms between serious mental illness (SMI) and severe, persistent mental illness (SPMI).

HIPPA Reform: While I appreciate the communicative manner in which I was received by Joshua's social worker while he was under court ordered treatment, Joshua spent two and one half months longer in psychotic de compensation because the psychiatrist was not inclined to take my twice weekly requests to add a mood stabilizer to my son's medical treatment. **In short, had the psychiatrists listened to me as well as making personal observations, Joshua would have begun the healing process of remission months earlier.**

In addition to this further delay of effective treatment, I believe there is likely information in my son's file that expresses concern for my physical safety upon Joshua's release based on communication with and observation of my son by his social worker, Angela Cowel. Her speech pattern suggested hesitation when she cautioned me: "Make sure you can protect yourself after he [Josh] gets out." She did her best. But she should have been able to do better. In psychiatric situations, critical information regarding safety concerns should not be concealed by informed psychiatric professionals. They should have the

freedom to share such information with parent/caretakers. The notion that it should automatically be up to the discretion of the attending psychiatrist as to whether or not to consult with family before even having met them is counter productive to both the efficacy and the efficiency of treatment provided. **H.R. 3717 relaxes the HIPPA Law in cases where a psychiatric patient lacks capacity to make informed decisions.**

SAMSHA/FERPA Reform- I want only for my son (and all persons diagnosed with a neuro biological disease) immediate medical care during acute crisis. However, the proposed probability of anyone in the 4-10% benefiting from an **alternative program that involves the avoidance of medication**, yoga, or meditation is irresponsible, erroneous and, in fact, most probably dangerous to people in SPMI crisis. And it only stands to reason that **non-evidence based programs** during acute crisis are not sensible options. Similarly, **the assertion that mental illness does not exist, made by many NCMHR/TAC leaders, is mere foolishness.** The processes by which emotion and thought are conducted in specific areas of the brain can be accessed and viewed scientifically. Changes in brain structure have long been observed by science, post mortem. This notion is worse than non scientific; it is anti-scientific, meaning it is anti-factual. It poses an almost certain danger for people with SPMI already compromised by lack of insight. **Government monies received by SAMHSA/FERPA should be used to further what we already know as science-based and effective medical treatment for those with SPMI, who now have zero programs.**

Also begging the question regarding the civil rights of people with SPMI, Joshua spent one month in **solitary confinement** while in the Winnebago County Jail (almost assuredly for his own protection), meaning, I don't suspect any abuses of power; yet Science has known for 200 years that solitary confinement exacerbates the symptoms of SPMI and that even those with no psychiatric diagnosis are at high risk of developing psychosis. **Our society's stage of scientific progress regarding the nature, causes and possible treatments--both medical and/or non-medical--of mental illnesses is evolution enough to make solitary confinement in jails and prisons a violation of the 8th amendment, which states that punishment for crime be reflective of the evolving society.**

Government and State funding should be allocated by The New Assistant Secretary of Mental Health so as to fund programs that speak to the obvious immediacy of treatment for the sub group currently being denied medical treatment, as well as programs that address coping mechanism for those with delusions or people who hear voices. We need programs that speak to the ability of the brain to recover significantly from programs that focus on brain plasticity and ways to enhance memory, reason and higher learning. We need EPIC (Early Psychotic Intervention Programs) available to every community to further decrease hospitalizations, incarcerations, etc.. We need programs that assist people after discharge from the hospital. **It seems to me that money currently being spent by PAIMI to lobby against treatment for people with SPMI is neither energy nor money spent wisely.** This funding, too, could be shifted to programs for people with SPMI, as there are currently no programs available, and jail should not be an option.

Finally, H.R. 3717's proposal to assign an Assistant Secretary for mental health only makes sense, given that funds are not being utilized to address the needs of the thousands upon thousands of this country's most seriously mentally ill.

Sir, common sense tells us that a person who is bizarrely and/or dangerously delusional cannot simultaneously have the wherewithal to make an informed decision regarding his or her best interest. It is therefore left either to loving family members who are most often a psychiatric patient's best advocate during crisis or the conscientious determination of a licensed psychiatric professional. It is shameful, Senator Durbin, that psychiatric abuses of professional power from those sworn to protect the citizens of the United States are practiced upon people who are already at the mercy of a mentally, emotionally and physically terrifying disease. We have need of a Zero Tolerance Level for abuses of power by or in any institution funded by state and government monies for the health and well-being for persons with mental illness; these institutions include but are not limited to jails and prisons.

Thanks, in large part, to **Senator Steve Stadelman**, who was instrumental in having my son transferred from a jail to a medical psychiatric center, my son's return to a state of mental health has now seen one year's progress. Significant thanks also to Winnebago County Judge, **The Honorable Randy Wilt** who, after hearing "sensitive information regarding Joshua's case" from Joshua's Public Defender, in his wisdom mandated 2 years of court supervision during which my son must report monthly with proof of med compliance. In essence, His Honor provides an immense service for my son. In fact, my son relies heavily on the structure provided by the Court.

I would like to thank you, as well, Senator Durbin. We have fought long and hard for a more humane response to people with SPMI, who should be met by paramedics instead of police. I feel confident that you will represent us well and inspire victory and much needed change through the adoption of Representative Murphy's **HELPING FAMILIES IN MENTAL HEALTH CRISIS ACT**.

My very best to you, Senator Durbin.

Very Truly Yours,

Donna Pitts
dpitts2011@aol.com

2010	2011	2012
Between 2002, when my son was first	January	January 16
diagnosed with bipolar disorder with	February 12, 19	February 14, 15, 22, 23, 25, 29
psychotic features, and May 8, he was	March	March 5, 14, 15, 19
hospitalized 9 times as a result of non-	April 21	April 19
compliance schools & inpatient, with	May	May 25
8 more hospitalizations from 2010-2013.	June 13, 14, 15, 16	June 3
July 26	July 8, 11	July
August	August	August 22
September 17	September 11	September 28, 29
October	October 26, 30, 31	October 12, 30
November 11, 29	November 17, 24, 27, 29	November 2
December	December 13, 14, 27, 28	December 3 arrest for OLP
This graph charts 3 years, during which I tried	to get effective medical care for my son.	Unfortunately, he was released early every
time he was hospitalized, without regard to	his emotional or mental deterioration and	despite my protestations that it was too soon.

Hearing before the Senate Committee on the Judiciary, Subcommittee on the Constitution, Civil Rights and Human Rights

Written Testimony of Dr. Janet Parker, DVM

Hearing before the Senate Committee on the Judiciary
Subcommittee on the Constitution, Civil Rights and Human Rights

"Law Enforcement Responses to Disabled Americans: Promising Approaches
for Protecting Public Safety"

Tuesday, April 29, 2014

Chairman Durbin, Ranking Member Cruz, and distinguished members of the
Subcommittee

I want to thank you all for this opportunity to supply written testimony and for
organizing this important hearing

Do You Know What a Dragon Looks Like?

Recently a friend suggested to me that I read a child's book called "Everyone Knows What a Dragon Looks Like" written by Jay Williams and illustrated by Mercer Mayer. Intrigued, I borrowed this richly illustrated and delightful child's book from the library and inside I found great wisdom. The story is simple and yet it reveals a deeper meaning. On the surface, it tells about a town on the border of China, threatened by the Wild Horsemen. The town elders need to decide how to defend themselves. After much discussion, they conclude that they do not have the resources to fight, they can not safely flee or safely surrender, and so they decide to do the only other option available to them - to

pray that the Cloud Dragon will come and protect them. But the following day, when small fat bald man leaning on a wooden staff, crippled with old age and disability arrives at the gate and tells them that he is the Cloud Dragon, they do not believe him. So on a deeper level this story is about how we judge people by how they look and often do not see the abilities and skills that may lie beneath the surfaces of appearances. The small elderly disabled man offers to help them, but they instead treat him disrespectfully and dismiss him. But a child listens to this disabled elderly man, who claims he is the Cloud Dragon.

Because the child is respectful and also responds to the elderly man's requests for food and water, the Cloud Dragon consents to save the town of Wu.

During a crisis, people act in haste and often not with adequate forethought. Good crisis management involves identifying possible scenarios and determining in advance what actions would be appropriate to take. Strategically planning involves identifying all the possible actions and determining which are the best options.

The town of Wu elders gather to discuss options to respond to the threat of the Wild Horsemen but they find that they had not planned for this contingency. Their army is not prepared to fight and they do not have a disaster evacuation plan.

Crisis management also involves accurate discernment of what is a dragon? Is the dragon friendly and likely to help save the town? Is the dragon angry and might destroy the town? Is this a real threat? Is this perhaps a friendly and capable protective dragon? What does a dragon look like?

What does the little boy do to get the Cloud Dragon to help them? He listens. He considers the basic human rights needs of the elderly disabled man. He offers the Cloud Dragon food and water and talks to him politely. These are the basic principles on how to deal with a dragon - whether friendly or unfriendly.

Utilizing human rights principles, we must listen first, respect for human dignity permits meaningful conversation to ensue. We must listen with discernment and be willing to question our own beliefs - maybe even deeply held beliefs. Everyone in the town had a deeply held belief about what a dragon looked like. Each believed that a dragon who was likely to save the town would of course

look like them. In reality the Cloud Dragon did not look like the savior they expected. Their discriminatory attitudes that dismissed the elderly disabled man, might have led to the destruction of the town, if it had not been for the willingness of a poor young lad to listen and to address the basic human needs of the Cloud Dragon.

So when faced with a crisis, one needs to apply these basic principles:

- ☐ Listen
- ☐ Address Basic Human Needs
- ☐ Act According to Human Rights Principles and in Compliance with Human Rights Law
- ☐ Involve and Empower Stakeholders

Listen

The city of Wu authorities were unwilling to listen to the old disabled man. They were angry at him for tracking dirt in onto their nice carpets and taking up their time. So they ignore him and send him away. If it weren't for the little boy, the Cloud Dragon would have departed and the town would not have been saved.

Dealing with persons with respect is essential. Listening to them. Sometimes this requires great skill to be able to discern from what they are saying - what a person may be trying to offer to do, what their skills and abilities really are. What do they really believe would be helpful? What can they really do?

If the disabled person is the one in crisis, then it is important to listen carefully so as to discern what is really wrong. Persons who are fearful, are in the moment of their distress often not able to accurately describe or articulate what the problem is. Thus the first responders must initially make the situation calmer, more controlled, less threatening to the person who is in crisis. Calling for authorities to come and coerce the person will lead to distrust and shut down meaningful communication. Ask them who they trust. Get a trusted person there to speak to them. Try to resolve the situation without using coercion or the

overt threat of harm. Unjustifiable pressures for compliance can occur when persons are in positions of authority over the disabled person or have commanding influence, this can thus secretly mask a hidden problem of medical fraud, abuse or neglect. Persons with diminished autonomy are entitled to protection.

Address Basic Human Needs

The child in this story shares food and drink with the little old man - satisfying his basic human needs. The child speaks to him politely, with respect for his human person, treating him with human dignity. This gives the old disabled man the opportunity to self report his identity as a Cloud Dragon and to reveal his hidden skills and abilities. The child learned he should not assume what the old disabled man could do. Unlike the city elders, the young lad is willing to let the old disabled man demonstrate his abilities.

Hostage negotiators similarly often will provide food or water to a hostage taker, because they understand that basic human needs must be met before meaningful negotiations can occur. A disabled person in crisis similarly needs their basic human needs met before they can meaningfully engage in the discussion of other more complicated needs and problems. In addition disabled persons who come forward to assist authorities also need to have a secure stable environment for themselves before they can assist another person or take on meaningful exchange about issues and situations.

Act According to Human Rights Principles and in Compliance with Human Rights Law

Law enforcement officers need to protect the person as well as preserve the safety of the society at large. Often authorities employ a substituted decision making process that denies the disabled a voice in their own lives. Atrocious human rights violations have taken place when people with disabilities are stripped of their rights through denial of "legal capacity." Under the existing legal system, being placed under guardianship is known as "legal death."

Thus when dealing with a person whose behavior has necessitated a crisis intervention, it is critically important to find out who that person trusts, if anyone. Constantly going back to persons who claim legal authority over the disabled person, but in whom the disabled person has no trust, may not improve the first responders assessment of what is really going on. A behavioral problem with a disabled person may be the first signal to the outside world that there is a serious situation of medical fraud, abuse or neglect. If you use a third party to act on the behalf of someone deemed incompetent - that person should be trusted by the disabled person and be someone most likely to understand the incompetent subject's situation and to be able act in that person's best interest.

Serious violations and discrimination against persons with disabilities may be masked as "good intentions" on the part of health professionals. What is being justified as beneficial "treatment" for people with disabilities can actually often be found to be psychologically damaging to them. Interventions that result in humiliation, isolation, injury and /or pain should not be considered appropriate.

Involve and Empower Stakeholders

In any crisis it is important to do a valid assessment of risks and also the benefits of a particular action. The term "risk" refers to a possibility that harm may occur. First responders need to resolve the situation quickly. Assessment of risk and benefit should involve input from the stakeholders - the disabled community themselves, not just social agency personnel or the substituted decision makers. Identifying alternative ways to address problems prior to an incident is also critical to speedy resolution of a crisis when it happens. Appropriate community supports and services are crucial to a resolution of a crisis situation and also important in the prevention of crisis. Greater attention should be paid to providing the services that are deemed by the disabled themselves to be most beneficial and effective. The lack of appropriate services for the disabled, however, is often a product of a lack of funding and planning – not because such alternatives are impossible to provide.

There has been an increasing reliance on drug therapy as opposed to non-drug therapies. There should be parity for persons wishing to use non-drug interventions and therapies and proper provision of community support and

resources that does not coerce pharmaceutical management of, and substituted decision making for, all disabled persons. Community resources and programs should support informed decision making regarding the use of medications. Not all problems and situations can be resolved, nor improved with drug intervention. Masking the symptoms without getting to the root of the problem can lead to greater incapacity and even mask abuse problems - such as drugging to silence an disabled person so as to discredit their complaints against an abuser.

We have learned as a society that abusers often use the governmental authorities and the legal system to silence those who would speak out against the abuse. There is often a huge differential in the exercise of power between the disabled and those who are trying to coerce and control them, and increasingly financially exploit them as well. This power imbalance includes societal beliefs, institutional bias, legal authority as well as physical and psychological threatening behavior. Persons committing medical fraud will similarly try to silence whistle-blowers and mandated reporters who report medical fraud, abuse and neglect in an effort to protect the vulnerable.

We have as a society often discriminated against certain classes of persons and used them for medical research based on their availability, their compromised position, or their ease of manipulation, or because of their financial vulnerability, age, racial or ethnic minority. The Nazi's during World War II also used the disabled without their consent for medical experimentation, from those human rights abuses, we learned valuable ethical lessons which are now delineated in The Common Rule and the Belmont Report.

Given the possibility that these essential human rights and ethical concerns might be being violated, a crisis presented by the disabled person may actually need law enforcement scrutiny for proper protection of the person as well as the safety of the public. Abusive physical treatment, as well as sexual, psychological, emotional abuse can lead to confusion, embarrassment, depression, abandonment, loneliness, sadness, loss of dignity, powerlessness, helplessness, despair, and acting delusional. Negative reactions to abusive therapies including restraints or seclusion may include the following: fear, loss of control, vulnerability, anger, anxiety, depression, humiliation, loss of dignity, powerlessness, abandonment and despair. Thus a person who is being mistreated and who is in crisis may present with any of these symptoms.

Sending the person back to the abusive situation is not an appropriate law enforcement response.

The US government has a "duty to protect" those who are most vulnerable and to provide equal access to treatment and community integration for all those with disabilities regardless of what that disability might be. The assessment of dangerousness must be cautiously done with full regard to human rights. It is also necessary to prevent private parties from interfering with the right to health, as well as affirmatively provide adequate mental health and physical health services in a community setting. It is inherent in the right to health that all disabled persons should receive adequate access to health services including treatment facilities and preventative health services.

It is important when planning how to deal with a crisis involving the disabled, that we involve the disabled themselves in the planning and the execution. Nothing about us, Without us. Persons with disabilities are often endowed with many skills and abilities which are underutilized because society discounts their contribution because of hidden discrimination. Those who are themselves disabled may have meaningful insights to how to respond to a crisis. Disabled persons who are in crisis can themselves describe how they feel and what they believe would help them. Disabled persons who are on the pathway to healing physically, emotionally and psychologically can help others by being mentors and role models.

Do we actually know what a dragon looks like? Or do we assume that the solution is just what we always have done? Or that a dragon looks just like us? Do we consider new or novel approaches in our crisis action plans? Do we adequately assess the skill sets of disabled persons and utilize their abilities to the fullest and fully include them in the decision making process? Do we ask them what will be helpful?

In the planning and development of such community resources and facilities, and crisis intervention strategies, persons with disabilities must be empowered to have a voice and to be consulted as to what kind and type of services and facilities are most helpful.

So I respectfully ask the US Congress

Do You Know What a Dragon Looks Like?

"Obviously, because of my disability, I need assistance.

But I have always tried to overcome the limitations of my condition and lead as full a life as possible. I have traveled the world, from the Antarctic to zero gravity."

Stephen Hawking

PREPARED STATEMENT OF EILEEN CARR

Implement CIT Model Policing Nationally

In any change model it is the leaders that are the catalyst. Leaders create and manage the environment, organizational culture, and strategies that encourage and sustain innovation, effectiveness, and success in the organization. Ladies and gentlemen of Congress and the Senate, you are in the seat of leadership. Implementation of crisis intervention team (CIT) model policing is a consideration you are contemplating today. I make this submission in hopes that you understand the urgent need for this model to be a national program.

If one were to observe the national news broadcasts over the past ten years it would be of notice that mass shootings are on the rise. These shootings are usually one person, opening fire upon a number of people. Particularly, the incidence of shootings in schools are included in that increase. What tragedy could be worse than innocent children being slaughtered? A knee-jerk reaction calls for gun control. Over the long run, the innovative, rational thought is to realize that society is changing. Therefore, an urgent need exists and the United States leadership identified the effort that will not change the US Constitution and has been proven to work. It is a collaborative effort from the US leadership that needs to make effort to implement the CIT model on a national level.

What exactly is CIT?

Let us unpack the meaning of each individual term or letter and then put it back together. The definition of the "C" in CIT is for crisis: "a psychological or social situation characterized by unusual instability caused by excessive stress and either endangering or felt to endanger the continuity of an individual or group" (Merriam-Webster, 2014). This is the definition that mental health and people from the community would be concerned with. Mental health personnel are concerned, because many times the person who is in psychological crisis either has been in treatment, or needs treatment for a mental health issue. The community is concerned with this definition, because from the community are the people who personally know the individual in psychological crisis. They are the neighbor who sees the deviant behavior, the mother who has a child with a disability, or the person on the street who is witness to a person in psychological crisis and calls the police.

Crisis: the dictionary meaning of crisis is "an unstable or crucial, time or state of affairs in which decisive change is impending" (Merriam-Webster, 2014). This would be the definition for law enforcement when they answer a call. Depending on the quality of information they receive, they may not know how unstable the situation is. The operative words are "decisive change". Law enforcement officers are not necessarily trained to use discretion. In situations that require instant decisions, they defer to their training, or what they know. If they respond to a call where the information is not good, or the situation has deteriorated unbeknownst to the officer during the drive to the location, decisions have to be made very quickly to change the situation to stable. This is where the "I" term in CIT, intervention, comes into play.

Law enforcement officers respond to emotionally disturbed person calls on a regular basis. More often they are the first responders to situations of crisis, putting them on the front line of intervening in the crisis situation. CIT model policing needs to be seen as a collaborative effort. "As first responders to crisis situations officers must be able to recognize and adapt to conflicts involving individuals with mental illnesses" (Compton, Hanafi, Bahora and Demir, 2008, p. 427). Law enforcement officers are the first responders, but the mental health professionals and the community all act as a team to de-escalate the situation. This collaboration tripod assists law enforcement in the best way to intervene. The law enforcement officers need to be

trained to collaborate with mental health and the community to assure proper intervention happens, which leads to the final letter in CIT, "T" for team.

When this writer started her thesis, a discussion was conducted between herself and Chief Botsford of the Onondaga County Sheriff's Office. Chief Botsford told a story of a man who entered a convenience market and hit a woman over the head with a hammer to steal her purse. The man was taken into custody and transported to CPEP (Comprehensive Psychiatric Emergency Program). Chief Botsford's way of looking at the situation was that the person in custody is a violent risk and flight risk. The Chief stepped up the guard for this man. Chief Botsford stated he was mad at the CPEP doctor because he had to take officers off the street to guard this man for nine days before the CPEP doctor released the patient. This writer has worked with people who have a mental illness for a number of years. This writer offered the other side of the story to Chief Botsford.

When the officers transported this man to CPEP the doctors were already familiar with the symptoms of this man, possibly he was under treatment and they were familiar with him. This education allowed the doctor to evaluate the patient/criminal and assess the necessary medication to get this man psychologically stable. The doctors knew that once the man was stable on medication all the Chief's fears about violence and flight would go away. The doctor also knew that Onondaga County Jail policy is no drugs for 24 hours. This writer told Chief Botsford that the CPEP doctor was actually assisting his jail deputies by getting enough medication in this man so he would remain stable after he was taken to the jail.

You see, without the other side of the story the different perspective cannot be understood. Chief Botsford assisted this writer in research for my thesis and knows my passion for CIT. With his new understanding he called this writer, voice trembling, and said, "Did you hear of the Binghamton shooting? We need to get CIT implemented like the day before yesterday." On April 1, 2014 an officer was shot to death while responding to a call (Borrelli, 2014). Chief Botsford, having assisted with and read the final copy of this writer's thesis (Carr, 2012), then asked, "What can we do to get this program implemented? I beg you to find a way." At that time it was this writer's dream for a national program to be started.

Last week this writer received an email from a father of a child who is autistic. He stated he read my thesis and requested a submission from me to assist the Senate Judiciary Subcommittee in understanding CIT model policing. Information was sent via email regarding the hearing before you on April 29, 2014, and this concerned father pleaded for me to help. How can I not do something? The civil rights act was written into law in 1964. The Americans with Disabilities Act followed in 1990. The time has come for all people in this country to be treated as equals.

As leaders of the United States, please do not take this lightly. "The primary objective of the police when responding to crisis intervention calls is to restore and preserve the peace and safety of all individuals involved in the disturbance, while protecting the community" (Olivia, 2010, p. 16). Due to this objective, law enforcement officers need training regarding situations involving emotionally disturbed persons to enhance their effectiveness in handling this type of call. CIT is an effort to stop relying on an old model to address the new issues in society today.

CIT programs have existed since 1988 and many programs have been developed since the inception of the model. A list of these programs can be found on the CIT International website (CIT, 2014). The website contains up and coming topics related to CIT. CIT (2014) is a good resource to explore research and happenings in the CIT International community. The literature states that strong community ties are

what make the CIT model successful. The community collaboration with law enforcement and mental health can create better outcomes for all.

I divert to the speakers who testify at the hearing. Please hold much weight in what they tell you. It is time that the most vulnerable populations in our country are elevated and understood.

Thank you.

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Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety

Hearing before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights:

Date of Hearing April 29 2014—Attention Senator Dick Durbin

May 6, 2014

To the Honorable Dick Durbin,

As a person with a mental health disability, my hope is that if the police are involved in a crisis that first responders (Police, EMS, Crisis Teams etc.) should receive sensitivity training and special care ought to be the norm. Every move ought to be thought provoking and calculated. Most often the patient needs empathy and a shoulder to cry on, even if the patient doesn't have family support and persons with Psychiatric illness are left to the mercy of first responders.

Sometimes, service starts abruptly, as with police intervention, and it ought to be a positive life affirming personal experience. I wish my past experience with law enforcement could have been more humane. Preparation and knowledge, in handling, would have been more advantageous in a delicate experience. Patients with suicidal tendencies need more support and empathy. Depression is a debilitating and painful illness and every negative interaction with others could potentially cause a tragedy. In conclusion, the actions of first responders can be the difference between wellness and chronic illness.

Thank you for your consideration of this testimony,

Sincerely,

Eileen Wall
Systems Advocacy Team—Westchester Independent Living Center



Stronger Together

8301 Professional Place, Landover, MD 20785-2353

Epilepsy Foundation of America**Written Testimony – Senate Judiciary Committee****Subcommittee on Constitution, Civil Rights, and Human Rights****Tuesday, April 29, 2014**

Thank you, Chairman Durbin and Ranking Member Cruz for allowing the Epilepsy Foundation to submit testimony on behalf of the more than 2.8 million Americans living with epilepsy and their families. We write specifically to support initiatives to train and educate law enforcement, to help them safely address issues regarding those with physical or mental disabilities. We partner with the Centers for Disease Control (CDC) to train law enforcement personnel, as well as first responders, teachers, and others, about epilepsy and seizures as well as how to best help someone experiencing a seizure. The CDC has been an invaluable resource in this challenging task, and with their help we have been able to train and educate hundreds of thousands of people throughout the United States.

The Epilepsy Foundation is the leading national voluntary health organization that speaks on behalf of the more than 2.8 million Americans with epilepsy. The Foundation fosters the well-being of children and adults affected by seizures through research programs, educational activities, advocacy, and direct services. We would like to share with the committee information about epilepsy so that you might better understand why our organization

supports training law enforcement personnel on how to address issues regarding those with disabilities.

Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions; it is also called a *seizure disorder*. A person is considered to have epilepsy if they have two or more seizures.¹ Epilepsy is a family of more than 40 syndromes² including Dravet syndrome, hypothalamic hamartomas (HH), and Lennox-Gastaut syndrome (LGS). Epilepsy affects more than 2.8 million Americans³ and 65 million people worldwide.⁴ This condition will develop in approximately one out of 26 people at some point in their lives,⁵ making it the fourth most common neurological disorder in the United States after Alzheimer's disease, stroke, and migraines.⁶ This year 200,000 people in the U.S. will be diagnosed with epilepsy⁷, with the very young and the very old being the most affected. Currently, 326,000 children under the age of fifteen have epilepsy, and more than 90,000 of them have severe seizures that cannot be adequately treated.⁸ Meanwhile, as the baby boomer generation approaches retirement age the number of cases in the elderly population is beginning to soar, with more than 570,000 adults age 65 and above living with epilepsy in the United States.⁹

Many people with epilepsy live with significant co-morbidities. Research has shown that 25.4 percent of people with autism have epilepsy, as well as 13 percent of those with cerebral palsy, 13.6 percent of those with Down syndrome, and 25.5 percent of those with intellectual

¹ Kobau R, Price P. Knowledge of epilepsy and familiarity with this disorder in the U.S. population: Results from the 2002 HealthStyles survey. *Epilepsia*. 2003;44(11):1449-1454.

² National Institute of Neurological Disorders and Stroke. Web site, <http://www.ninds.nih.gov/>

³ Projection based on Begley CE, et al. The cost of epilepsy in the United States: An estimate from population-based clinical and survey data. *Epilepsia*. 2000;41(5):342-351 and U.S. Census Bureau 2010 population estimate of 308,000,000.

⁴ Annual Report 2003: Global Campaign Against Epilepsy, p. 2. Published by World Health Organization, International Bureau for Epilepsy and International League Against Epilepsy.

⁵ M.J. England et al. / *Epilepsy & Behavior* 25 (2012) 266-276. Web site, <http://iom.edu/~media/Files/Report%20Files/2012/Epilepsy/epilepsyEBarticleFinal.pdf>

⁶ Hauser A. Epidemiology of seizures and epilepsy in the elderly. In: Rowan A, Ramsay R, eds. *Seizures and epilepsy in the elderly*. Boston: Butterworth-Heinemann, 1997:7-18.

⁷ See note 6 above

⁸ See note 6 above

⁹ See note 6 above

disabilities live with epilepsy. The percentage increases when you look at those who have both cerebral palsy and an intellectual disability, with 40 percent living with epilepsy.¹⁰

Those living with epilepsy also face serious barriers to proper care and first aid. A lack of knowledge about proper seizure first aid exposes affected individuals to injury from unnecessary restraint and from objects needlessly forced into their mouths.¹¹

While most law enforcement personnel do an outstanding job recognizing and handling individuals experiencing seizures, in limited cases they may respond with inappropriate force to those experiencing a seizure, especially a complex partial seizure. Complex partial seizures are the most common type of seizure and are non-convulsive seizures with altered awareness and automatic behavior. This type of seizure is also sometimes called a psychomotor or temporal lobe seizure, and can be difficult to recognize. The unusual behavior associated with complex partial seizures is often misinterpreted as stemming from intoxication or mental illness. It is this type of seizure that is also associated with symptoms that may be erroneously perceived as aggression. A lack of public understanding has resulted in people with complex partial seizures being unfairly arrested and sometimes seriously injured in the process.

During hearings on the Americans with Disabilities Act (ADA) held by the House Judiciary Committee, the Epilepsy Foundation brought the problem of inappropriate arrests of those with epilepsy to the attention of the Committee in 1990. In their final report the Committee stated:

¹⁰ McDermott S, Moran R. Prevalence of epilepsy in adults with mental retardation and related disabilities in primary care. *American Journal of Mental Retardation*. 2005;10(1):48-56

¹¹ Repeated surveys by the Epilepsy Foundation, the previously cited CDC report, and numerous other surveys have documented the low level of public knowledge about seizures and epilepsy, including persistent misconceptions about seizure first aid.

In order to comply with the non-discrimination mandate, it is often necessary to provide training to public employees about disability. For example, persons who have epilepsy, and a variety of other disabilities, are frequently inappropriately arrested and jailed because police officers have not received proper training in the recognition of and aid for seizures. Often, after being arrested, they are deprived of medications while in jail, resulting in further seizures. Such discriminatory treatment based on disability can be avoided by proper training.

The Epilepsy Foundation has been working to train law enforcement personnel on how to recognize a seizure and the proper steps to take to ensure everyone's safety. Our training strives to educate law enforcement personnel on signs that the person in question is, in fact, experiencing a seizure and not being aggressive or purposefully unresponsive. When an officer is called to a scene where a person may be experiencing a seizure, we encourage them to consult witnesses regarding the individual who was the subject of the call. It is important to identify if they have a history of epilepsy or seizures, if the unusual behavior was preceded by normal behavior, or if a cry or blank stare began the event. If any of these are true then it would be more likely the person in question is experiencing a seizure and should be treated as such. Furthermore, if the officer notices that the individual is unresponsive throughout the event, has a blank stare when asked a question, or if his or her body stiffens and begins to jerk as muscles contract and relax involuntarily, these could all be signs that they are in the midst of a seizure. After the event, if the officer notices epilepsy medication or medical identification that says "Epilepsy" or "Seizure Disorder" in the person's possession we encourage them to strongly consider the likelihood that the individual was experiencing a seizure.

If an officer suspects that someone is experiencing a seizure we encourage them to follow a few simple guidelines in order to help keep everyone involved safe. The most important step is to not restrain someone experiencing a seizure, unless it is essential for his or her personal safety or the safety of others. Restraint of persons during or soon after a seizure may exacerbate or precipitate combativeness – the opposite of the intended result. Furthermore, restraining someone face-down and/or with his or her arms restricted behind the back is especially dangerous. Additionally, we encourage officers to refrain from putting anything into an individual's mouth, as it can cause damage to the teeth and/or jaw. Furthermore, we also encourage officers to make sure someone is fully conscious before giving anything to drink or administering medications.

After a seizure, law enforcement personnel should help to slowly reorient an individual by asking simple questions and being a calming influence. The threat of arrest should not be mentioned until the seizure is over and the individual is fully conscious so that questioning can be conducted accordingly. Officers should also ensure that individuals receive the proper medication in order to help avoid further seizures.

There is more that law enforcement could do, and that is why we offer comprehensive online trainings as well as shorter videos that teach the basics. All of this can be found on our First Responder Training page at <http://www.epilepsy.com/get-help/services-and-support/training-programs/first-responder-training>. When we first developed our curriculum we distributed the information to 20,000 police departments nationwide, and have continued to train law enforcement personnel every year. Last year alone we trained 1,289 law enforcement personnel on seizure recognition and how to handle the situation.

Despite our trainings and distribution of materials, there are still far too many instances of individuals facing arrest, being subjected to excessive force, and even dying. In Michigan, “John” was out walking as part of rehabilitation following brain surgery to help his seizures. During this walk “John” experienced a seizure that left him in a state of semi-consciousness. A person noticed “John” acting erratically and called the police who showed up and took his involuntary movements and failure to respond as resistance. They didn’t recognize the obvious signs of a seizure and ignored the medical alert bracelet he was wearing. Instead, “John” was tasered, hit with a police baton, threatened at gunpoint, and handcuffed behind his back. As discussed earlier, restraining a person experiencing a seizure, especially with their arms behind their back, is extremely dangerous and can lead to an escalation of the situation. After his arrest, “John” was prosecuted for assaulting police officers and disorderly conduct, disregarding considerable evidence, including the state’s own mental health evaluation confirming that his actions were solely the product of a seizure. Due to a gap in Michigan law, “John” was forced to plead not guilty by reason of insanity and then spend the next three weeks in a psychiatric facility. This hardship could have been avoided if the officers were trained to properly recognize the symptoms of a seizure and how best to handle the situation so as to avoid any harm to themselves or “John”.

“Dan,” from Colorado, experienced a seizure and his fiancé called for help. When the police and EMTs arrived, “Dan” was in a post-ictal state of confusion, which caused him to walk away from the officers and EMTs. They then used force to restrain him, even though “Dan” had not made any violent gestures. “Dan” was repeatedly struck, then handcuffed, and put in custody. The incident aggravated “Dan’s” epilepsy and shoulder problem.

There was another case in California where “Mike” experienced a seizure and, due to confusion after the fact, wandered from his home and attempted to enter his neighbor’s

house. When police officers arrived, “Mike” was not responsive to their commands because of his impaired consciousness. To try to subdue “Mike,” officers struck him in the throat and attempted to wrestle him to the ground. When that failed, officers shot him with a taser several times and beat him. “Mike” then fell to the ground, face down, and was handcuffed behind the back with officers applying pressure to his back with their bodies. Shortly afterwards “Mike” stopped breathing and died. Due to a lack of training, the deputies assumed that “Mike” was intentionally combative and possibly high on illicit drugs.

In New Jersey, “Sam” experienced a seizure at a garment factory where he worked. The officers who arrived on the scene determined “Sam” was being combative, even though he was in a post-seizure state of confusion. The officers restrained him by placing pressure on his back and neck, despite his co-workers insisting that such force was unnecessary. “Sam” stopped breathing at one point during the incident, but started again before reaching the hospital, where he died. The cause of death was determined to be homicide by mechanical asphyxiation.

These are only some of the many cases where a lack of education and awareness has led to improper arrests, serious injury, and even death. These tragedies, as well as the immense hardship to the families, could have been avoided with proper seizure recognition and education training.

The Epilepsy Foundation strongly encourages Congress to work to train more law enforcement personnel on how to appropriately identify someone experiencing a seizure, and how best to respond in this situation. It is important for the safety of the epilepsy community as well as the safety of police officers. Our program with the CDC has helped to impact thousands of lives, as we continue to train first responders and other professionals who can

be so important to someone living with epilepsy. The training we have been able to provide due to the CDC's support is an example of how, with proper education and training, we can avoid unnecessary arrests, injuries, and deaths that have caused so much anguish in our community. We thank the Committee for considering our input on this important issue.



Crisis Intervention Teams in Florida
Testimony for Senator Durbin's Committee Hearing



**Law Enforcement Responses to Disabled Americans:
 Promising Approaches for Protecting Public Safety**
 April 29, 2014

Crisis Intervention Team (CIT) began in Memphis in the late 1980s and has been widely adopted around the country. CIT is an effective law enforcement response program designed for first responders who handle crisis calls involving people with mental illness including those with co-occurring substance use disorders as well as those with developmental disabilities. CIT emphasizes a partnership between law enforcement, the mental health and substance abuse treatment system, mental health advocacy groups, and consumers of mental health services and their families.

CIT is organized around key Core Elements that include strong community partnerships with law enforcement, mental health, individuals with mental illness and/or other disabilities, families and other stakeholders from the mental health and criminal justice system.

CIT was first introduced to Florida in 1998 in Pinellas County, FL. Since then there has been tremendous growth of this program throughout Florida through a coordinated and orchestrated effort by the Florida CIT Coalition. The Florida CIT Coalition is an informal group of communities throughout Florida that came together to advance the CIT program model to other communities, to support each other's efforts, to foster excellence in the delivery of CIT and to ensure the sustainability of such a life saving program and one that improves mental health systems of care.

Today, 40 counties out of 67 Florida counties are involved with CIT. The remaining counties are either sending officers to a nearby CIT training school, planning a regional CIT program or are yet to be fully engaged. The latter counties are mostly small and rural and face different challenges than larger urban areas. Most active CIT programs also include their corrections department staff.

More than 18,000 officers in Florida are now trained. There is also approximately 150 police departments involved with CIT as well as some Highway Patrol, Fire and Rescue, Probation and Hospital Security.

The Florida Department of Law Enforcement (Commission on Standards and Training) has certified the CIT 40-hour training as an advanced, post-academy training through its Specialized Goals and Objectives Handbook.

CIT has demonstrated many benefits to law enforcement officers, people living with mental illness who are in crisis, the law enforcement organizations, the mental health system and to families. Some of these benefits include:

- Increased officer/deputy safety
- Reduced officer/deputy injuries
- Reduced citizen injuries
- Increased jail diversion
- Increased chance for consumer to connect to mental health system
- Reduced unnecessary arrests or use of force
- Avoidance of costs to criminal justice system

A recent survey of over 20 CIT programs conducted by Dr. Larry Thompson, the Florida Mental Health Institute, in June 2012 supported the above listed benefits concluding that these programs overwhelming reported positive outcomes regarding reduction in officer and consumer injury, decreased use of SWAT and Negotiators, decreased liability and improved communication and relationships between criminal justice and the service system.

Another study conducted by a doctoral student at the University of Central Florida also resulted in positive outcomes as follows:

- On average, officers experienced a 24% increase in their knowledge of the mental health referral process and a 28% growth in their knowledge of mental health services in the community.
- Officers demonstrated an average 16% increase in their level of self-efficacy as well as their perceptions of mental health services and the mental health referral process.
- Officers' knowledge of mental illness increased by an average of 10% and their perceptions of verbal de-escalation improved by 6%.
- 72% of the law enforcement agency representatives responding to the survey reported a reduction in officer injury and a decline in the dispatch of SWAT/Hostage Negotiation Teams following the implementation of the CIT program in their agencies.
- 83% of law enforcement agency representatives responded in a manner that suggested their agencies have experienced a decline in the use of force employed and the incidence of injury to the subject in incidents involving persons with a mental illness since the adoption of the CIT model.

Overall, the CIT Program has been a very effective program in Florida for the past 16 years for improving the response by law enforcement officers who handle crisis calls involving a person with a mental illness, improving the relationships among the law enforcement and mental health

system for greater access to services, increasing access to needed community based treatment services and saving lives.

In Florida, CIT does not receive any funding from the State or local counties. Instead this program has been built from a grassroots approach through strong partnerships and with passionate champions who volunteer their time or are given time as a part of their duties within their agencies. All the trainers volunteer their time and the reproduction of materials is usually donated by agencies. In some cases there are small grants or other pots of money that help out.

The Florida CIT Coalition does believe that if there were dedicated funding streams to allow for each community to have a paid CIT Coordinator and funds to help the law enforcement agencies offset overtime when their officers are in training this would greatly increase the sustainability of CIT and ensure a robust and effective program that fosters excellence and stays true to the Core Elements of what makes CIT so successful.

On behalf of all the CIT Programs in Florida, I urge the Senate to consider funding streams to help local communities continue with this successful community program.

If you need further information please contact me at: msaunders416@comcast.net or 407/925-2462.

Sincerely,

A handwritten signature in black ink that reads "Michele M. Saunders, LCSW". The signature is written in a cursive, flowing style.

Michele Saunders, LCSW
Florida CIT Coalition Chairperson



Written Statement of the Family Resource, Information and
Education Network for Down Syndrome (FRIENDS) Before
the United States Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights

Hearing on

**Law Enforcement Responses to Disabled Americans: Promising
Approaches for Protecting Public Safety**

Tuesday, April 29, 2014

At 10:00 am

Dear Chairman Durbin, Ranking Member Cruz, and Members of the Subcommittee:

The Family Resource, Information and Education Network for Down Syndrome (FRIENDS) thank you for holding a hearing to discuss law enforcement responses to Americans with developmental or psychiatric disabilities.

FRIENDS was formed by a group of parents in June, 1999 in Frederick County, Maryland. In July 2007, FRIENDS became a federally identified 501 (c) 3 non-profit organization. The mission of FRIENDS is to promote and enhance the quality of life for persons living with Down syndrome and provide support for their families. FRIENDS provides a wide range of services, including increasing social awareness and acceptance through outreach programs, seminars and social events; advocating for equal consideration in the areas of education, workplace and everyday activities; serving as a resource for information and education for families, as well as throughout the medical, educational and local business communities.

The tragic death of Ethan Saylor has highlighted an important issue in our society today. It is the lack of training provided to law enforcement officers, and other first responders who, in carrying out their duties as protectors and caregivers in society, are often the first to interact with individuals with developmental or psychiatric disabilities.

FRIENDS recognizes that this type of specialized training is sporadic across the United States. Even more disturbing is that interactions with members of law enforcement disproportionately impacts already vulnerable and marginalized populations such as persons with disabilities. These vulnerable groups also disproportionately suffer the impact of interaction with law enforcement, particularly people with mental illness.

As an organization, FRIENDS is committed to drawing attention to the accomplishments and struggles of individuals with Down syndrome and their families. FRIENDS actively advocates to enhance the quality of life for these individuals. We have initiated a free educator's conference called Techniques for Success; this conference brings national experts in to teach the educators proven techniques and strategies to enhance their success in educating students who have Down syndrome.

A. Individuals with Down Syndrome Have Intellectual and Often Behavioral Issues

Down syndrome, or Trisomy 21, is a chromosomal condition that is associated with intellectual disability, a characteristic facial appearance, and weak muscle tone (hypotonia) in infancy. All affected individuals experience cognitive delays, but the intellectual disability is usually mild to moderate¹.

Delayed development and behavioral problems are often reported in children with Down syndrome. Affected individuals' speech and language develop later and more slowly than in children without Down syndrome, and affected individuals' speech may be more difficult to understand. Behavioral issues can include attention problems, obsessive/compulsive behavior, and stubbornness or tantrums. A small percentage of people with Down syndrome are also diagnosed with developmental conditions called autism spectrum disorders, which affect communication and social interaction.

1. Genetics Home Reference, National Library of Medicine, National Institutes of Health, <http://ghr.nlm.nih.gov/condition/down-syndrome>

People with Down syndrome often experience a gradual decline in thinking ability (cognition) as they age, usually starting around age 50. Down syndrome is also associated with an increased risk of developing Alzheimer disease, a brain disorder that results in a gradual loss of memory, judgment, and ability to function. Approximately half of adults with Down syndrome develop Alzheimer disease. Although Alzheimer disease is usually a disorder that occurs in older adults, people with Down syndrome usually develop this condition in their fifties or sixties².

Down syndrome occurs in approximately one in every 691 live births³. It affects people of all ages, races and economic levels and is the most frequently occurring chromosomal abnormality.

Down syndrome occurs when there are three copies, instead of the usual two, of the 21st chromosome in many (Mosaicism) or every cell of the body (Nondisjunction.) This results in a person with Down syndrome having cells with 47 chromosomes instead of the usual 46. It is this additional genetic material that alters the course of development and causes the characteristics associated with the syndrome.

Down syndrome affects approximately 400,000 people in the United States alone⁴. Recent advances in the understanding of Down syndrome have resulted in dramatic improvements in the life span and potential of those who are affected.

B. Federal Law Prohibits Discrimination Based Upon Having A Disability

Two federal laws, the Americans with Disabilities Act or 1990 (ADA)⁵ and Section 504⁶ of the Rehabilitation Act of 1973 prohibit discrimination on the basis of a disability. These laws define a person with a disability as someone with a physical or mental impairment that substantially limits one or more major life activities, who has a record of such impairment, or is regarded as having such impairment.

Both the ADA and Section 504 require law enforcement to offer to victims of crimes with disabilities an equal opportunity to benefit from, and to participate in, all programs and services provided by the law enforcement agency. Officers must also provide for equal communication with people with disabilities and must make reasonable modifications to policy, practice and procedure to accommodate crime victims with disabilities unless doing so would fundamentally alter the service or program.

C. Specialized Training Programs Are Already In Existence

As a result of previous tragedies involving law enforcement and persons with disabilities, a number of places have developed training for law enforcement in an effort to better equip officers with the knowledge they need to interact with individuals with disabilities. A few of these programs are:

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2. *Genetics Home Reference, National Library of Medicine, NIH, <http://ghr.nlm.nih.gov/condition/down-syndrome>*
 3. *National Down Syndrome Society - <https://www.ndss.org/Down-Syndrome/What-Is-Down-Syndrome/>*
 4. *Ibid*
 5. *<http://www.ada.gov/pubs/ada.htm>*
 6. *<http://www.dol.gov/oasam/reg/statutes/sec504.htm>*

1. First Responders Disability Awareness Training – Niagara University⁷

In September 2010 Niagara University was awarded a three year \$650,000 grant from the New York State Developmental Disabilities Planning Council (www.ddpc.ny.gov) to develop curriculum for the training of police officers, fire fighters, emergency medical services, and other first responders in the state of New York. Although some states have some versions of this program, no state has developed a fully comprehensive program.

Working with the support of the NYS Office of Persons with Developmental Disabilities (OPWDD), the end product is intended to include, but not be limited to, class room training, a train the trainer program, on-line training, database of all departments and councils, extensive resources, and regional disability contacts and information. Additionally, as suggested by some of their first responder partners, the use of podcasts and applications will also be explored.

2. Crisis Intervention Training developed in Memphis Tennessee⁸

The Memphis Crisis Intervention Team (CIT) is an innovative police based first responder program that has become nationally known as the "Memphis Model" of pre-arrest jail diversion for those in a mental illness crisis. This program provides law enforcement based crisis intervention training for helping those individuals with mental illness. Involvement in CIT is voluntary and based in the patrol division of the police department. In addition, CIT works in partnership with those in mental health care to provide a system of services that is friendly to the individuals with mental illness, family members, and the police officers.

In order to handle these specialized duties, CIT officers receive training in selected topics including mental health diagnoses, psychiatric medications, and issues of drug abuse and dependence. The officers are trained in mental health law and cross-cultural sensitivity. Officers spend time with individuals who experienced mental illness to learn first-hand of challenges of the illness. Most importantly, the officer receive intensive training in verbal de-escalation skills with consistent attention to officer safety throughout all components of the CIT training.

3. Assisting Victims and Witnesses with Disabilities in the Criminal Justice System: A Curriculum for Law Enforcement Officers (with Trainer's Guide)⁹ Institute on Disabilities, Temple University (2002), 98 pages

This is a training module providing law enforcement officers with a basic understanding of Intellectual disabilities and its impact on an individual's ability to interact with criminal justice personnel. The training is designed to enhance an officer's ability to respond more effectively to victims of crime, as well as witnesses and suspects, who have intellectual disabilities and other developmental disabilities. It includes both knowledge and skill components.

7. First Responders Disability Awareness Training, <http://www.fr-dat.com/>

8. University of Memphis CIT Center, <http://cit.memphis.edu/aboutCIT.php>

9. Institute on Disabilities, Temple University,
<http://disabilities.temple.edu/programs/justice/docs/CJproducts200809.pdf>

4. Law Enforcement Training By Individuals with Developmental Disabilities The ARC Maryland¹⁰

The Arc has a long history of advocacy for individuals with intellectual and developmental disabilities in the Criminal Justice System. They have numerous available resources for individuals, families, providers, and law enforcement professionals on this important topic.

In Sept 2013, The Arc (US) announced that it had been awarded a two-year grant for \$400,000 by the U.S. Department of Justice, Bureau of Justice Assistance (BJA) to develop a national center on justice and intellectual and developmental disabilities (I/DD). This is the first national effort of its kind to bring together both victim and offender issues involving people with I/DD under one roof. According to the National Crime Victim Survey of 2010 the victimization rate is twice as high for individuals with disabilities as compared to those without disabilities. And we don't have to look far for examples where law enforcement and people with I/DD could have benefited from this kind of work, including the tragic death of Robert Ethan Saylor in Frederick, Maryland, who died January 2013 after three off-duty deputies attempted to remove him from a movie theater over a misunderstanding over a ticket.

5. TEMPO (Training and Education about Mental illness for Police Organizations)¹¹

TEMPO is a multilevel learning strategy for Canadian police personnel. Learning objectives and key principles are articulated in order to ensure the model is applicable to a wide range of police agencies and individual jurisdictional needs. In addition to providing a firm basis of factual knowledge for police personnel, the resultant model embraces a human rights/anti-stigma philosophy, provides for a range of education appropriate to diverse police audiences, emphasizes a systems approach to police/mental health liaison activities and addresses issues related to the delivery and implementation of police education and training.

D. Training Makes Economic Sense

In today's times of economic uncertainty and the rising costs of health care, the adoption of practices which can increase safety and also decrease expenses can be invaluable. With the use of Crisis Intervention Training it has been seen that there is a:

1. Reduction in officer injuries sustained during responses to "mental disturbance" calls¹²
This should result in a reduced need for medical treatment and follow-up and consequently a reduction in insurance claims needing to be filed.

10. The ARC Maryland, <http://www.thearcmd.org/Programs>

11. Canadian Alliance on Mental Illness and Mental Health
<file:///C:/Users/rwaish/Downloads/Understanding%20Mental%20Illness%20-%20A%20Review%20and%20Recommendations%20for%20Police%20Education%20and%20Training%20in%20Canada%20-%202010.pdf>

12. CIT Toolkit, NAMI, http://www.nami.org/Content/ContentGroups/Policy/CIT/CIT_Facts_4.11.12.pdf

2. Reduction in the use of force.¹³

As a result of those, the following should reasonably be expected:

1. Reduced liability due to a reduction in "deliberate indifference"¹⁴ cases as well as injuries and deaths as a result of interactions between law enforcement and individuals with developmental or psychiatric disabilities.
2. Reduced insurance claims – for both law enforcement and victims/suspects.

E. The Need for a Legislative Solution

It is imperative that law enforcement professionals and other first responders receive appropriate training in disabilities awareness. Although there are training programs in existence they are not mandatory and therefore are not reaching all members of law enforcement who may find themselves in a situation involving individuals with developmental or intellectual disabilities as either a victim or suspect. Therefore, Congress should consider:

- Making Disability Awareness training mandatory for all law enforcement personnel. This training should also include basic de-escalation techniques to help law enforcement personnel be more prepared to interact with persons with developmental or intellectual disabilities;
- Providing funding (i.e. grants, etc.) for local law enforcement agencies to ensure the creation of Crisis Intervention Teams. Preference could go to those departments that partner with other local departments to obtain CIT training. Alternatively, funding could go to States to provide CIT training to their local law enforcement agencies;
- Requiring the development of Crisis Intervention Teams for all local jurisdictions;
- Requiring the creation of Crisis Intervention Teams for all Federal and State Law Enforcement Agencies;
- Requiring the creation of a National Database of data regarding "justifiable" and "unjustifiable" homicides by police. This database should also collect information on the deaths and/or injuries of individuals with developmental and intellectual disabilities by police;
- Requiring that law enforcement agencies create and maintain a contact list of mental health professionals and organizations in their jurisdiction where they can call for assistance and advice in situations where they don't have access to a CIT trained officer.

13. *Intervening at the Entry Point: Differences in How CIT Trained and Non-CIT Trained Officers Describe Responding to Mental Health-Related Calls*, Canada et al, *Community Mental Health Journal* (2012) 48:746-755

14. *Dutiful Minds – Dealing with Mental Illness* By Lt. Michael S. Woody, Ret.01/06/03
<http://www.citinternational.org/training-overview/129-dutiful-minds-dealing-with-mental-illness.html>

FRIENDS commends the Subcommittee for taking up this important issue of law enforcement responses to Americans with developmental or psychiatric disabilities, and we hope that this will mark the beginning of a permanent mechanism for providing law enforcement with the training and expertise they need when interacting with individuals who have developmental or psychiatric disabilities.



**Hindu American Foundation (HAF)
Written Statement for the Record**

Harsh Voruganti, Esq.
Associate Director of Public Policy

Samir Kalra, Esq.
Director/Senior Fellow for Human Rights

Suhag A. Shukla, Esq.
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Submitted to the United States Senate Committee on the Judiciary,
Subcommittee on the Constitution, Civil Rights, and Human Rights
April 29, 2014

"Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting
Public Safety"
216 Hart Senate Office Building
April 29, 2014



The Hindu American Foundation (HAF) is an advocacy organization providing a voice for over two million Hindu Americans. The Foundation interacts with and educates leaders in public policy, academia, media and the public at large about Hinduism and global issues concerning Hindus, such as religious liberty, the misportrayal of Hinduism, hate crimes, and human rights.

HAF is a member of the Interfaith Disability Advocacy Coalition (IDAC). IDAC seeks to mobilize the religious community to speak out on disability policy issues. As a member of IDAC, HAF has joined efforts supporting the Convention on the Rights of Persons with Disabilities (CRPD).

HAF commends Chairman Dick Durbin for calling this hearing. The ethical and humane treatment of individuals with disabilities and mental illness is a value shared by all Hindus. Hindu philosophy teaches that all individuals have an innate dignity and deserve to be treated with respect and understanding. Additionally, individuals with disabilities and mental illness have traditionally been under-represented and their interests have often been ignored by policymakers. Resources for mental illness services have faced significant and draconian cuts in recent years.

¹ As such, HAF fully supports this panel's efforts to help increase law enforcement capability in responding to Americans with mental illness and disabilities.

While there is no one solution to improving law enforcement response, a key factor is improved training and instruction. The Department of Justice and other law enforcement agencies have established training programs in conjunction with community groups such as HAF to improve the cultural competency of their responders. Similar trainings should be established to improve law enforcement understanding of mental illness and disabilities in their communities. The 40 hour Memphis Model of Crisis Intervention Team (CIT) training program is one such tool that should be studied and replicated.²

Additionally, the establishment of "Crisis Intervention Teams," "Specialized Police Response Models," and similar solutions are necessary to ensure that law enforcement responses to individuals with mental illness and disabilities are handled safely and appropriately. Similarly, the use of "screening checklists" can better help law enforcement evaluate how to respond to individuals with mental illness.³

Furthermore, it is essential that law enforcement agencies develop close partnerships with local disabilities rights and mental illness advocacy groups. HAF and other community partners have worked with law enforcement in establishing closer cultural understanding and improved community policing. Such efforts can and should be replicated in the disabilities and mental illness communities. These partnerships will not only assist law enforcement in understanding the communities they serve, they will also build trust of law enforcement among the affected

¹ Responding to Persons With Mental Illness (October 2011), Abigail S. Tucker, Psy.D., Vincent B. Van Hasselt, Ph.D., Gregory M. Vecchi, Ph.D., and Samuel L. Browning, M.S., <http://www.fbi.gov/stats-services/publications/law-enforcement-bulletin/october-2011/responding-to-persons-with-mental-illness>.

² *Id.*

³ Responding to Persons With Mental Illness: Can Screening Checklists Aid Law Enforcement (February 4, 2014), Christian Mason, Tod W. Burke, Ph.D., and Stephen S. Owen, Ph.D., <http://leb.fbi.gov/2014/february/responding-to-persons-with-mental-illness-can-screening-checklists-aid-law-enforcement>.



communities.

In conclusion, HAF commends the Chairman for his leadership on this issue. Ensuring consistent and appropriate law enforcement responses to Americans with disabilities and mental illness requires a sustained partnership between all the stakeholder groups. It is our hope that this hearing serves as a starting point for this discussion.

Senator Durbin – I am a person with a disability who is in favor of training people in law enforcement about disability issues so that they can better interact with individuals that they encounter who have disabilities. I believe that with appropriate training, law enforcement agencies will be able to have better techniques to assist them when they encounter individuals with disabilities, especially individuals with mental health disabilities. I know that I had a client who had a stroke in the street and law enforcement thought that he was just not attentive and injured that client further. It was a sad situation. Please do what you can to encourage training.

INSTITUTE FOR SAFETY AND PREPAREDNESS, LTD.

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The Recreation Safety Institute -- a leader in in the field of Recreation Safety for more than 25 years has merged with the Disaster/Emergency Preparedness Faculty Project and ASTM Homeland Security E 54 Committee Task Group Project to form the Institute for Safety and Preparedness.

STATEMENT FOR THE RECORD IN CONNECTION WITH THE
 HEARING BEFORE THE SENATE JUDICIARY SUBCOMMITTEE ON THE
 CONSTITUTION, CIVIL RIGHTS, AND HUMAN RIGHTS ON

LAW ENFORCEMENT RESPONSES TO DISABLED AMERICANS: PROMISING
 APPROACHES FOR PROTECTING PUBLIC SAFETY
 APRIL 29, 2014

We would like to thank the Chairman for holding this hearing on this very important and current topic. While the subject of this hearing includes potentially all interactions between first responders and people with disabilities, we would like to address the need for this Committee and Congress to consider the relationship of the law enforcement officers and first responders and disabled Americans during emergencies.

Public consciousness has been raised on this issue in the aftermath of Hurricane Katrina and has culminated in the recent Federal Court decision in *Brooklyn Center For Independence of The Disabled, Et Al V. Bloomberg And The City Of New York* which found that New York City violated both constitutional and statutory rights of the disabled in its emergency planning.

Pending a final decision and order in that case for specific requirements, we believe that local jurisdictions are compelled to address the needs of their disabled residents in emergency planning. An important component of that planning will be training their law enforcement members and first responders to be aware of the needs of their residents with disabilities and to develop the appropriate responses thereto.

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The failure to properly plan and equip law enforcement officers and first responders with the tools to correctly interact and assist disabled residents in times of emergencies and disasters could, and has, deprived these residents of their wellbeing, needs, functionality and ultimately their lives.

We have taken part in post Hurricane Sandy Stakeholders Meetings sponsored by FEMA Region II and have heard the experiences of disabled residents during the storm and its aftermath. There is no doubt that these resident's needs were not adequately met.

In order to anticipate and develop the means to satisfy these needs, local jurisdictions must open lines of communications with the various disabled communities. And, law enforcement officials and first responders must be included in those discussions. Only after these discussions will each locality be able to incorporate the needs of its disabled population in its emergency planning.

Accordingly, it is incumbent upon Congress to consider this issue and to determine the best way to provide the resources required by local governments to give their law enforcement officers and first responders the necessary training to aid and protect the disabled members of their communities during times of emergencies – both natural and manmade. We believe that further consideration must be given to this specific area of the broader topic of this hearing.

Respectfully submitted,
Gary F. Westfal,
Executive Director

Senate Judiciary Committee
Subcommittee on the Constitution, Civil Rights, and Human Rights

*Law Enforcement Responses to Disabled Americans:
Promising Approaches for Protecting Public Safety*

Statement of Robert "Joe" Bruce

10:00 a.m.
April 29, 2014

My name is Joe Bruce. I live in Caratunk, Maine.

The most promising approach for protecting the safety of Americans disabled by serious mental illness (SMI) and in some cases the public in general, is to ensure that individuals with SMI receive appropriate medical treatment, medication, and supportive community services to enable them to have successful lives. It is obvious that mental health crisis intervention training (CIT) for law enforcement is a necessary and good idea. However, CIT will never be more than a defensive response to an upstream problem. Without radical changes to our mental health system, societal problems caused by *untreated* SMI will continue to escalate and law enforcement will ultimately lose the battle. I will use the story of my family to illustrate some of the reasons why.

On February 6, 2006, my son William Bruce, age 24, was involuntarily committed to Riverview Psychiatric Center in Augusta, Maine. Prior to this time law enforcement had responded on two occasions to mental health crisis situations involving Will. The first time, in 2005, a Trooper from the Maine State police brought him to the emergency room for an evaluation after Will came close to shooting two people during a psychotic episode. The officer handled the situation gently and compassionately, in a model of extraordinary professionalism. On that occasion Will was sent to a psychiatric facility, but was released without being sent to a commitment hearing. The hospital had decided Will did not meet the criteria for involuntary commitment, despite my telling the doctor Will would "hurt or kill someone, in all likelihood his mother." On the second occasion, which this time resulted in the February 6th commitment, a Sargeant from the Somerset County Sheriff's Department responded after Will physically attacked me. Again, Will was treated by the Deputy in the same professional manner the State Trooper had.

On April 20, 2006, with help from federally funded patient rights advocates from the Disability Rights Center of Maine (DRCM), Will was discharged early from Riverview without the benefit of any medication.

As is most often the case with severely and persistently mentally ill persons across the country, Will returned home. Fears his mother and I had voiced to his doctors that Will would hurt or kill someone came true. On June 20, 2006 I returned home to find the body of my wife Amy. Will,

in a state of deep psychosis, had killed her with a hatchet. Unfortunately, the excellent work of these two officers turned out to be a waste of their time.

Will had been advised that without his consent, his parents had no right to participate in his treatment, or have access to his medical records. Will believed there was nothing wrong with him, that he was not mentally ill, a condition characteristic of many persons with severe bipolar disorder or paranoid schizophrenia, particularly of younger ages such as Will's. He would not consent to our involvement with his treatment, and because he was an adult, his mother and I were barred from all access to his treatment. The doctor's decision to release him, which resulted in such a tragic outcome, was made without the benefit of all of Will's history or any input from Amy and me.

After his commitment to Riverview by the criminal court, I applied to become his guardian. Will was agreeable to this until, incredibly, a patient advocate told him, "The guardianship is a bad idea. It would give your father complete power over you."

The attending physician (a new doctor), undoubtedly at the urging of DRCM, refused to provide the evaluation required in the guardianship application. He told me, "I could never participate in anything that would cause your son to be considered an incapacitated person." Bear in mind that at this point in time, Will had been placed in the hospital after being found incompetent to even stand trial!

Suffice it to say, I finally did become guardian, and I was able to participate in Will's treatment and to obtain the medical records of his prior treatments. Until then, I had not known the role the patient advocates had played in Will's premature and unmedicated release.

The medical records revealed exactly what the patient advocates had recklessly done and said to encourage Will to avoid the treatment he so desperately needed. His doctor had recorded verbatim what the patient advocates said to Will in the meetings from which Amy and I had been excluded.

- The patient advocate, a Trish Callahan, told the treating doctor that DRCM regarded Amy and me as a "negative force in Will's life." Amy and I had never met any of these people or even heard of Disability Rights Center of Maine.
- In the treatment meetings, she acted like a criminal defense lawyer. She openly coached Will on how to answer the doctor's questions so as to get Will the least treatment and the earliest release. She did this in the face of strongly contrary evidence of Will's unsuitability for unmedicated release.
- She repeatedly pressed for his early release despite knowing or recklessly disregarding that he was unsuited for it.

DRCM willfully neglected Will's need for treatment, and their pressure on the doctor to release Will led directly to Amy's death. But neither the patient advocates nor the DRCM has ever acknowledged they did anything wrong. They have not changed their procedures and Trish Callahan, the advocate who helped fuel Will's paranoid hostility towards his mother and contributed to her death, continued to work on the same unit at Riverview for years afterwards.

Lest anyone believe this is a local, isolated occurrence, the National Disability Rights Network, responding to a 2008 Wall Street Journal page one article concerning Will's case entitled "A Death in the Family", *defended* the actions of DRCM, and even prepared talking points to deflect criticism. The patient advocates can do this with impunity because they are literally accountable to no one. But my experience with the patient advocates did not end here.

I have come to know the stories of many other families, and their experiences with the advocates' surprising approach to these issues.

Beginning in 2007, I joined with other family members of some of the most severely mentally ill individuals in the State of Maine to seek legislative change to laws that had prevented our loved ones from receiving treatment. We took our concerns to the lawmakers in the Maine legislature.

To the shock of all of us we met with fierce lobbying opposition from Disability Rights Center of Maine. Nonetheless, we were successful in obtaining helpful legislation in 2007 providing for medication over objection in appropriate cases. Having failed in the legislature, the lawyers at DRCM filed a legal action challenging the law, which thankfully was unsuccessful.

At the time of Amy's death, the courts in Maine only had two options at a commitment hearing: to place someone in the hospital or to release them unconditionally. In 2008 and 2009 I and other Maine families worked to give the court a third option, that of releasing an individual into the community on the condition that he remain on medication. These types of laws are known as Assisted Outpatient Treatment laws and they have been opposed across the Nation by PAIMI organizations. Maine was no exception.

DRCM mounted a well-orchestrated lobbying attack on the proposed AOT law. It was joined in this effort by the Advocacy Initiative Network of Maine, another SAMHSA funded organization. Their campaign included proffering 20 or so consumer witnesses in opposition to the law, but these consumers were completely aware of their mental illness, stable on medication and successfully living in the community – the very goals that the proposed law was designed to achieve for *our* loved ones. DRCM had persuaded them to oppose the law by misrepresenting its essential provisions. This cynical opposition to the AOT law (which failed, because the law ultimately enacted) shocked me and the families. The incident illustrates the national policy of the PAIMI program to oppose any form of involuntary treatment.

The PAIMIs, like DRCM, are so concerned that one person may be inappropriately treated involuntarily that they seek to prevent *anyone* from being medicated. In Will's case, once I became his guardian, medication over his objection was his route to recovery.

As another example of DRCM's lobbying influence in this area, while the Maine families and I were busy working on the AOT law, DRCM was successful in getting a bill through the Maine legislature to make it *more difficult* for families to become guardians. Becoming a guardian is the only way families of adult patients can be involved in the treatment of their loved ones where the patients are unwilling or unable to consent. Why do PAIMIs want guardianship to be more difficult? Because a guardianship lifts HIPAA secrecy and allows the guardians into the treatment meetings.

* * *

The last time law enforcement was involved in a mental health crisis situation with Will was at the time of his arrest for the murder of his mother. This time the response was of a different nature. The police arrived in large numbers, heavily armed, in full tactical gear, and prepared to shoot to kill if necessary. It was the appropriate response, and just as professional as that of the Maine State Trooper and the Sheriff's Deputy. In the end, law enforcement was only there to clean up the mess. Where Congress needs to focus is on the problem upstream, the barriers to medical treatment for those with serious and persistent mental illness.

After almost eight years in Riverview Psychiatric Center, to which he was committed by the criminal court, Will has finally moved into a supervised group home. He has received, and continues to receive, the care he should have gotten before. Ironically and horribly, *Will was only able to get treatment by killing his mother*. We have found a medication that works. He is being successfully treated and he is doing extremely well. He works 20 hours a week at a part time job in the community. He now recognizes that if he had been treated his mother would still be alive today. He stated to the Wall Street Journal, "The advocates didn't protect me from myself. None of this would have happened if I had been medicated."

Tragedy visits families every day. That is a sad fact of life. But an unbearable aspect of Amy's death is that my own tax dollars helped make it possible. A retired nurse from Riverview may have summed it up best. She wrote: "Mr. Bruce . . . Your losses didn't happen for reasons other than your family's misfortune to become involved with the mental health system, when politics (now) override sound medical decisions."

Thank you for receiving my statement.



The Jonathan Carey Foundation
90 Delaware Ave. Delmar, N.Y. 12054
518-475-9100

April 24, 2014

Dear Chairman Durbin, Ranking Member Cruz and Members of the Sub-Committee,

The Jonathan Carey Foundation supports whole heartedly all efforts to better train and educate first responders in understanding and serving people with disabilities the very best possible. Sadly, my son Jonathan's testimony is one of where in many situations when Jonathan was injured and abused, 911 was never even called, therefore first responders could not respond to help him. Jonathan is now in heaven, but his life's testimony is extremely powerful and although he was non-verbal, his life and all that happened and did not happen to him, speaks loud and clear for what is right and for what needs to be changed.

My precious son Jonathan, whom our Foundation is obviously is named after, was developmentally disabled and had autism and was only 13 when he was killed within New York State's Mental Health Care System. If 911 were called and emergency first responders were contacted in previous incidents where Jonathan was injured Jonathan would probably still be alive today. At the same time I am fully aware, as Jonathan's father, that there were and continue to be great purposes for Jonathan's life and death, which is to help countless others with disabilities in desperate need of better protections and the assurance of their most basic of civil rights. The emergency 911 dispatch systems and emergency first responders are in place in all communities throughout our country to provide vital emergency assistance to everyone, the disabled cannot be bypassed. It appears that there is a great hole in the system and that people with disabilities and mental illnesses as well, can be treated far differently than the average citizen, even being denied emergency 911 first responder assistance. Training and education is vital, but all emergency situations must be required to be reported to 911 so that emergency first responders can be notified and able to respond. Jonathan suffered and endured much in his short life and I can see how many more significant changes for the better can happen on a national level because of Jonathan, because of Jonathan's testimony, as well as from all the insight we have gained. As Jonathan's father I am available to assist you and your staff in every way possible.

Numerous laws to date in New York State have been created or changed and signed into law including the most well known called Jonathan's Law, but tragically the rampant abuse and neglect continues in staggering scope and most cases are never reported to 911. Local emergency first responder medical and

police are rarely even notified and unable to assist and protect innocent and extremely vulnerable children and adults with disabilities. This severe problem is believed to be the case in many other States throughout our great nation as well and this must be changed swiftly. This is a civil rights issue, much like what Dr. Martin Luther King Jr. fought and gave his life for. If we value and treat everyone equally than we would never deny any group of people the emergency first responder help that they desperately need. These are our most vulnerable citizens and a very large number of people with disabilities are unable to call 911 themselves for many different reasons and so many like Jonathan are unable to speak. It is critical that at the same time each of you are looking at how first responders can be better trained in recognizing and assisting the disabled that you also look at this even greater problem. First responders have to be immediately notified of all injuries, above superficial ones, and all cases of physical and sexual abuse and deaths of people with disabilities.

Even the horrible night that Jonathan was suffocated to death and he had been dead for approximately an hour and a half before his lifeless body was brought back to the residential facility where he lived, 26 more minutes went by before 911 was even called. Two calls actually were then called into 911, one saying that Jonathan walked in on his own accord and fell down on the floor which was untrue and the other stating Jonathan was unresponsive in the van which was the truth. Why even then would 26 minutes go by before notifying 911? You are extremely bright individuals and you know the answer. I believe it is extremely important to share with each of you this systemic failure for you to see the much bigger picture. Hopefully as you move beyond this important hearing and actions taken to better equip emergency first responders you will also address this incredibly important basic civil right of required immediate 911 reporting. Emergency first responders can and must be in the position to properly assist and protect all of our disabled citizens in the first place.

It is critical that first responders are significantly trained to be much better equipped to recognize and serve those with disabilities with excellence. I fully support all efforts to better educate and train first responders, this is a vital step in another area to better not only people with disabilities, but our society as a whole. I have personally met with David Whalen of First Responders – Disabilities Awareness Training and was very impressed by what I heard and saw regarding their training methods.

Although this very important hearing is in regard to seeing how first responder, medical, police and fire emergency personnel can better serve our most vulnerable and most needy. The light must be shined on the major systemic problem of failing to require immediate reporting to 911. If the vast majority of injuries, above superficial ones, and incidents of physical and sexual abuse, as well as premature deaths are never called into 911 then the disabled are denied their equal rights and equal protections. Again, obviously first responders are unable to respond immediately to first protect millions of innocent children and adults properly. My hope is that all efforts to better train first responders is done with excellence and acted upon swiftly at this federal level. I also hope that the knowledge and insight that I have gained and shared with you regarding the critical importance of requiring immediate 911 reporting by all eye witnesses and mandated reporters would be addressed very soon as well at the federal level. Leaving such vital basic safety measures alone in the hands of each individual State simply is not working. People with disabilities must be valued appropriately and because of their disabilities and reliance on others they need minimally equal protections, but because of their extreme vulnerability they really need and deserve extra safety measures and protections.

It is important to mention that some of Jonathan's testimony was used in a GAO report, as well as in a video presentation in a Hearing in Washington on May 19, 2009 regarding the extreme dangers of restraints and seclusion- <http://autismschoolabuse.com/> (see short video clip). Since, I was able to get the New York Times to do a massive investigative reporting series titled "**Abused & Used**" which exposes a considerable amount of what I have discussed. This series was a runner up for a Pulitzer Prize. I have attached the link to this incredibly important series as well as links to a few recent pieces done by the New York Times and by AP News that are extremely important. I have also attached some important documents in a scanned in attachment. Please review, it will shock you of what continues to happen to our disabled behind closed doors. Thank you for caring for people with disabilities and your willingness to insure the very best of emergency care to millions of our most vulnerable citizens.

http://www.nytimes.com/interactive/nyregion/abused-and-used-series-page.html?_r=0

<http://www.nytimes.com/2013/08/09/nyregion/state-lagging-on-dismissals-in-abuse-cases.html>

<http://www.nytimes.com/2013/08/10/opinion/protecting-the-most-vulnerable.html>

<http://online.wsj.com/article/APf6309b71ca8545a4813fe4da866e66a0.html>

Sincerely,

Michael Carey – the proud father of Jonathan Michael Carey pictured above

		Allegations of Abuse and Serious Reportable Incidents, by Quarter																				
		1/1/2008 - 9/30/2012																				
		1Q08	2Q08	3Q08	4Q08	1Q09	2Q09	3Q09	4Q09	1Q10	2Q10	3Q10	4Q10	1Q11	2Q11	3Q11	4Q11	1Q12	2Q12	3Q12	Total	
Allegation of Abuse	Mistreatment	177	188	180	170	180	214	188	164	232	173	153	137	157	178	168	119	131	104	108	3,107	
	Neglect	948	1,123	1,162	881	1,082	1,148	1,126	1,012	1,225	1,114	1,024	738	829	924	821	757	747	689	671	18,221	
	Physical Abuse	874	989	887	841	1,005	847	879	882	878	1,002	897	860	881	1,086	871	889	821	829	885	17,733	
	Psychological Abuse	763	839	785	708	858	798	737	689	875	881	790	668	828	754	734	746	710	628	605	14,143	
	Seclusion	11	6	18	10	10	8	12	11	13	16	10	10	15	18	7	8	10	14	12	220	
	Sexual Abuse	396	384	378	301	303	313	285	306	350	388	354	277	320	335	323	285	303	288	307	6,146	
	Aversive conditioning	1	6	3	1	7	3	6	1	6	4	2	0	6	4	7	4	5	2	5	72	
	Restraint	24	25	23	24	13	22	21	22	17	27	18	14	18	15	29	17	17	19	19	383	
	Time-out	6	5	5	2	2	2	0	3	8	6	3	6	2	6	8	2	4	1	6	78	
	Civil rights	28	24	16	18	20	18	15	10	20	8	12	11	5	8	14	8	4	4	4	247	
	Total	3,161	3,570	3,433	3,141	3,464	3,460	3,267	3,108	3,712	3,608	3,228	2,698	2,857	3,326	3,182	2,830	2,837	2,657	2,606	60,113	
Serious Reportable	Death	217	186	208	217	233	184	188	251	224	172	170	146	162	119	109	94	88	80	85	3,162	
	Injury	131	123	123	162	174	134	137	145	188	147	147	133	146	158	163	141	130	149	159	2,769	
	Medication Error	4	8	14	11	7	11	13	13	10	13	15	11	8	8	4	9	7	6	8	182	
	Missing Person	70	140	142	108	97	145	111	90	84	139	114	90	90	115	119	125	96	120	124	2,127	
	Possible Criminal Act	308	392	403	311	370	367	330	303	366	382	321	287	328	509	421	350	343	353	404	8,854	
	Restraint	10	10	9	7	7	4	6	7	6	4	10	2	1	3	2	3	1	1	1	0	93
	Sensitive Situation	397	437	437	404	377	442	413	357	392	427	438	363	402	513	454	473	444	476	592	8,235	
Total	1,123	1,288	1,317	1,207	1,255	1,291	1,185	1,159	1,256	1,281	1,209	1,038	1,127	1,413	1,253	1,185	1,101	1,185	1,365	23,249		

Michael Carey

From: "OPWDD-FOIL Requests" <FOIL.Requests@opwdd.ny.gov>

To:

Sent: Friday, December 07, 2012 10:21 AM

Attach: MCarneyFOILASRbyQtr pdf pdf pdf.pdf

Subject: FOIL Request

Mr. Carey,

As requested and in follow up to your FOIL request 12-0055, we are providing you with a quarterly report of allegations of abuse dating back to January, 2008.



New York State Constitution

*As revised, including amendments
effective January 1, 2014*

ANDREW M. CUOMO
Governor

CESAR A. PERALES
Secretary of State

The Constitution of the State of New York

THE CONSTITUTION

¹[Preamble] WE THE PEOPLE of the State of New York, grateful to Almighty God for our Freedom, in order to secure its blessings, DO ESTABLISH THIS CONSTITUTION.

**ARTICLE I
BILL OF RIGHTS**

[Rights, privileges and franchise secured; power of legislature to dispense with primary elections in certain cases]
Section 1. No member of this state shall be disfranchised²; or deprived of any of the rights or privileges secured to any citizen thereof, unless by the law of the land, or the judgment of his or her peers, except that the legislature may provide that there shall be no primary election held to nominate candidates for public office or to elect persons to party positions for any political party or parties in any unit of representation of the state from which such candidates or persons are nominated or elected whenever there is no contest or contests for such nominations or election as may be prescribed by general law. (Amended by vote of the people November 3, 1959; November 6, 2001.)³

[Trial by jury; how waived]

§2. Trial by jury in all cases in which it has heretofore been guaranteed by constitutional provision shall remain inviolate forever; but a jury trial may be waived by the parties in all civil cases in the manner to be prescribed by law. The legislature may provide, however, by law, that a verdict may be rendered by not less than five-sixths of the jury in any civil case. A jury trial may be waived by the defendant in all criminal cases, except those in which the crime charged may be punishable by death, by a written instrument signed by the defendant in person in open court before and with the approval of a judge or justice of a court having jurisdiction to try the offense. The legislature may enact laws, not inconsistent herewith, governing the form, content, manner and time of presentation of the instrument effectuating such waiver. (Amended by Constitutional Convention of 1938 and approved by vote of the people November 8, 1938.)

[Freedom of worship; religious liberty]

§3. The free exercise and enjoyment of religious profession and worship, without discrimination or preference, shall forever be allowed in this state to all humankind; and no person shall be rendered incompetent to be a witness on account of his or her opinions on matters of religious belief; but the liberty of conscience hereby secured shall not be so construed as to excuse acts of licentiousness, or justify practices inconsistent with the peace or safety of this state. (Amended by vote of the people November 6, 2001.)

[Habeas corpus]

§4. The privilege of a writ or order of habeas corpus shall not be suspended, unless, in case of rebellion or invasion, the public safety requires it. (Amended by Constitutional Convention of 1938 and approved by vote of the people November 8, 1938.)

[Bail; fines; punishments; detention of witnesses]

§5. Excessive bail shall not be required nor excessive fines imposed, nor shall cruel and unusual punishments be inflicted, nor shall witnesses be unreasonably detained.

[Grand jury; protection of certain enumerated rights; duty of public officers to sign waiver of immunity and give testimony; penalty for refusal]

§6. No person shall be held to answer for a capital or otherwise infamous crime (except in cases of impeachment, and in cases of militia when in actual service, and the land, air and naval forces in time of war, or which this state may keep with the consent of congress in time of peace, and in cases of petit larceny under the regulation of the legislature), unless on indictment of a grand jury, except that a person held for the action of a grand jury upon a charge for such an offense, other than one punishable by death or life imprisonment, with the consent of the district attorney, may waive indictment by a grand jury and consent to be prosecuted on an information filed by the district attorney; such waiver shall be evidenced by written instrument signed by the defendant in open court in the presence of his or her counsel. In any trial in any court whatever the party accused shall be allowed to appear and defend in person and with counsel as in civil actions and shall be informed of the nature and cause of the accusation and be confronted with the witnesses against him or her. No person shall be subject to be twice put in jeopardy for the same offense; nor shall he or she be compelled in any criminal case to be a witness against himself or herself, providing, that any public officer who, upon being called before a grand jury to testify concerning the conduct of his or her present office or of any public office held by him or her within five years prior to such grand jury call to testify, or the performance of his or her official duties in any such present or prior offices, refuses to sign a waiver of immunity against subsequent criminal prosecution, or to answer any relevant question concerning such matters before such grand jury, shall by virtue of such refusal, be disqualified from holding any other public office or public employment for a period of five years from the date of such refusal to sign a waiver of immunity against subsequent prosecution, or to answer any relevant question concerning such matters before such grand jury, and shall be removed from his or her present office by the appropriate authority or shall forfeit his or her present office at the suit of the attorney-general.

The power of grand juries to inquire into the wilful misconduct in office of public officers, and to find indictments or to direct the filing of informations in connection with such inquiries, shall never be suspended or impaired by law. No person shall be deprived of life, liberty or property without due process of law. (Amended by Constitutional Convention of 1938 and approved by vote of the people November 8, 1938; further amended by vote of the people November 8, 1949; November 3, 1959; November 6, 1973; November 6, 2001.)

[Compensation for taking private property; private roads; drainage of agricultural lands]

§7. (a) Private property shall not be taken for public use without just compensation.

(c) Private roads may be opened in the manner to be prescribed by law; but in every case the necessity of the road and the amount of all damage to be sustained by the opening thereof shall be first determined by a jury of freeholders, and such amount, together with the expenses of the proceedings, shall be paid by the person to be benefitted.

(d) The use of property for the drainage of swamp or agricultural lands is declared to be a public use, and general laws may be passed permitting the owners or occupants of swamp or agricultural lands to construct and maintain for the drainage thereof, necessary drains, ditches and dykes upon the lands of others, under proper restrictions, on making just compensation, and such compensation together with the cost of such drainage may be assessed, wholly or partly, against any property benefitted thereby; but no special laws shall be enacted for such purposes. (Amended by Constitutional Convention of 1938 and approved by vote of the people November 8, 1938. Subdivision (c) repealed by vote of the people November 5, 1963. Subdivision (b) repealed by vote of the people November 3, 1964.)

[Freedom of speech and press; criminal prosecutions for libel]

§8. Every citizen may freely speak, write and publish his or her sentiments on all subjects, being responsible for the abuse of that right; and no law shall be passed to restrain or abridge the liberty of speech or of the press. In all criminal prosecutions or indictments for libels, the truth may be given in

¹ Section headings [enclosed in brackets], annotations and footnotes throughout this document are not in the official text.

² As so in original.

³ Except where otherwise indicated, each section hereafter was re-enacted without change by the Constitutional Convention of 1938 and re-adopted by vote of the people November 8, 1938.

The Constitution of the State of New York

evidence to the jury; and if it shall appear to the jury that the matter charged as libelous is true, and was published with good motives and for justifiable ends, the party shall be acquitted; and the jury shall have the right to determine the law and the fact. (Amended by vote of the people November 6, 2001.)

[Right to assemble and petition; divorce; lotteries; pool-selling and gambling; laws to prevent; pari-mutual betting on horse races permitted; games of chance, bingo or lotto authorized under certain restrictions]

§9. 1. No law shall be passed abridging the rights of the people peaceably to assemble and to petition the government, or any department thereof, nor shall any divorce be granted otherwise than by due judicial proceedings; except as hereinafter provided, no lottery or the sale of lottery tickets, pool-selling, book-making, or any other kind of gambling, except lotteries operated by the state and the sale of lottery tickets in connection therewith as may be authorized and prescribed by the legislature, the net proceeds of which shall be applied exclusively to or in aid or support of education in this state as the legislature may prescribe, except pari-mutual betting on horse races as may be prescribed by the legislature and from which the state shall derive a reasonable revenue for the support of government, and except casino gambling at no more than seven facilities as authorized and prescribed by the legislature shall hereafter be authorized or allowed within this state; and the legislature shall pass appropriate laws to prevent offenses against any of the provisions of this section. (Amendment approved by vote of the people November 3, 2013.)

2. Notwithstanding the foregoing provisions of this section, any city, town or village within the state may by an approving vote of the majority of the qualified electors in such municipality voting on a proposition therefor submitted at a general or special election authorize, subject to state legislative supervision and control, the conduct of one or both of the following categories of games of chance commonly known as: (a) bingo or lotto, in which prizes are awarded on the basis of designated numbers or symbols on a card conforming to numbers or symbols selected at random; (b) games in which prizes are awarded on the basis of a winning number or numbers, color or colors, or symbol or symbols determined by chance from among those previously selected or played, whether determined as the result of the spinning of a wheel, a drawing or otherwise by chance. If authorized, such games shall be subject to the following restrictions, among others which may be prescribed by the legislature: (1) only bona fide religious, charitable or non-profit organizations of veterans, volunteer firefighter and similar non-profit organizations shall be permitted to conduct such games; (2) the entire net proceeds of any game shall be exclusively devoted to the lawful purposes of such organizations; (3) no person except a bona fide member of any such organization shall participate in the management or operation of such game; and (4) no person shall receive any remuneration for participating in the management or operation of any such game. Unless otherwise provided by law, no single prize shall exceed two hundred fifty dollars, nor shall any series of prizes on one occasion aggregate more than one thousand dollars. The legislature shall pass appropriate laws to effectuate the purposes of this subdivision, ensure that such games are rigidly regulated to prevent commercialized gambling, prevent participation by criminal and other undesirable elements and the diversion of funds from the purposes authorized hereunder and establish a method by which a municipality which has authorized such games may rescind or revoke such authorization. Unless permitted by the legislature, no municipality shall have the power to pass local laws or ordinances relating to such games. Nothing in this section shall prevent the legislature from passing laws more restrictive than any of the provisions of this section. (Amendment approved by vote of the people November 7, 1939; further amended by vote of the people November 3, 1957; November 8, 1966; November 4, 1975; November 6, 1984; November 6, 2001.)

Section 10 which dealt with ownership of lands, yellowtail teatures and escheat was repealed by amendment approved by vote of the people November 6, 1962

[Equal protection of laws; discrimination in civil rights prohibited]

§11. No person shall be denied the equal protection of the laws of this state or any subdivision thereof. No person shall, because of race, color, creed or religion, be subjected to any discrimination in his or her civil rights by any other person or by any firm, corporation, or institution, or by the state or any agency or subdivision of the state. (New. Adopted by Constitutional Convention of 1938 and approved by vote of the people November 8, 1938; amended by vote of the people November 6, 2001.)

[Security against unreasonable searches, seizures and interceptions]

§12. The right of the people to be secure in their persons, houses, papers and effects, against unreasonable searches and seizures, shall not be violated, and no warrants shall issue, but upon probable cause, supported by oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.

The right of the people to be secure against unreasonable interception of telephone and telegraph communications shall not be violated, and ex parte orders or warrants shall issue only upon oath or affirmation that there is reasonable ground to believe that evidence of crime may be thus obtained, and identifying the particular means of communication, and particularly describing the person or persons whose communications are to be intercepted and the purpose thereof. (New. Adopted by Constitutional Convention of 1938 and approved by vote of the people November 8, 1938.)

Section 13 which dealt with purchase of lands of Indians was repealed by amendment approved by vote of the people November 6, 1962

[Common law and acts of the colonial and state legislatures]

§14. Such parts of the common law, and of the acts of the legislature of the colony of New York, as together did form the law of the said colony, on the nineteenth day of April, one thousand seven hundred seventy-five, and the resolutions of the congress of the said colony, and of the convention of the State of New York, in force on the twentieth day of April, one thousand seven hundred seventy-seven, which have not since expired, or been repealed or altered; and such acts of the legislature of this state as are now in force, shall be and continue the law of this state, subject to such alterations as the legislature shall make concerning the same. But all such parts of the common law, and such of the said acts, or parts thereof, as are repugnant to this constitution, are hereby abrogated. (Formerly §16. Renumbered and amended by Constitutional Convention of 1938 and approved by vote of the people November 8, 1938.)

Section 15 which dealt with certain grants of lands and of charters made by the king of Great Britain and the state and obligations and contracts not to be impaired was repealed by amendment approved by vote of the people November 6, 1962

[Damages for injuries causing death]

§16. The right of action now existing to recover damages for injuries resulting in death, shall never be abrogated; and the amount recoverable shall not be subject to any statutory limitation. (Formerly §18. Renumbered by Constitutional Convention of 1938 and approved by vote of the people November 8, 1938.)

[Labor not a commodity; hours and wages in public work; right to organize and bargain collectively]

§17. Labor of human beings is not a commodity nor an article of commerce and shall never be so considered or construed.

No laborer, worker or mechanic, in the employ of a contractor or subcontractor engaged in the performance of any public work, shall be permitted to work more than eight hours in any day or more than five days in any week, except in cases of extraordinary emergency; nor shall he or she be paid less than the rate of wages prevailing in the same trade or occupation in the locality within the state where such public work is to be situated, erected or used.

New York State Penal Law 260.25

Endangering the Welfare of an Incompetent or Physically Disabled Person

§ 260.25 Endangering the welfare of an incompetent or physically disabled person in the first degree.

A person is guilty of endangering the welfare of an incompetent or physically disabled person in the first degree when he knowingly acts in a manner likely to be injurious to the physical, mental or moral welfare of a person who is unable to care for himself or herself because of physical disability, mental disease or defect. Endangering the welfare of an incompetent or physically disabled person in the first degree is a class E felony.

THE WALL STREET JOURNAL
WSJ.com

Updated February 9, 2014, 12:50 p.m. ET

NY mum on thousands of reports of disabled abuse

Associated Press

"ALBANY, N.Y. — The agency established last year to protect the disabled in state-funded institutions has received nearly 25,000 reports of significant incidents, abuse, neglect and deaths in its first six months, though the public knows little about how many of those reports led to prosecutions, arrests and firings."

"Michael Carey, whose 13-year-old autistic son was killed in state care in 2007, said he believes the situation may even be worse now because caregivers believe they must report incidents to the Justice Center in suburban Albany instead of local police, keeping cases from being properly investigated."

<http://online.wsj.com/article/APf6309b71ca8545a4813fe4da866e66a0.html>

Most cases of abuse never go to 911 & are only internally investigated by providers

THE REPUBLIC

NY agency refuses to detail criminal cases from thousands of reports of disabled abuse

By MICHAEL VIRTANEN Associated Press
February 09, 2014 1:05 pm EST

THE NEW YORK TIMES

EDITORIAL

Protecting the Most Vulnerable

By THE EDITORIAL BOARD

Published: August 9, 2013

“Two-and-a-half years ago, The Times reported horrifying abuse of people with developmental disabilities or mental illnesses by state employees, who were rarely punished for it. Gov. Andrew Cuomo promised action. **But too little appears to have changed.**”

“Mr. Cuomo needs urgently to return to this issue, to use his political skills to get everyone in a room — state officials, patients’ advocates, the public workers’ unions — and figure out how to make lives safer for the thousands of people who cannot take care of themselves.

There is much the governor could do. He could require surveillance cameras in these facilities, just as prisons have them. He could make sure that the police get more involved.”

<http://www.nytimes.com/2013/08/10/opinion/protecting-the-most-vulnerable.html>

Breadcrumbs

[Home](#) [Recognizing Abuse as Violence](#)

Prevalence of Violence

Violence committed against persons with disabilities is a frequently unrecognized and underreported problem that has reached epidemic proportions in the United States as reflected in the following statistics:

- 54 million Americans with disabilities (U.S. Department of Justice, Office of Crime Victim Bulletin, 1998)
- According to one study in 2000, approximately five (5) million crimes were committed against persons with developmental disabilities in comparison to 1.4 million child abuse cases and one (1) million elder abuse cases. (From Joan Petersilia, Ph.D., When Justice Sleeps: Violence and Abuse Against the Developmentally Disabled.)
- More than ninety percent (90%) of people (both male and female) with developmental disabilities will experience sexual abuse at some point in their lives. Forty-nine percent (49%) will experience ten or more abuse incidents. (Valenti-Hein, D. & Schwartz, L. (1995). *The Sexual Abuse Interview for Those with Developmental Disabilities*. James Stanfield Company. Santa Barbara: California)
- A study of psychiatric inpatients found that eighty-one percent (81%) had been physically or sexually assaulted. (From Jacobson & Richardson, American Journal of Psychiatry, 1987)
- Sixty-two percent (62%) of women with physical disabilities reported experiencing emotional, physical or sexual abuse. (From Nussek & Howland, 1998)
- Only three percent (3%) of sexual abuse cases involving people with developmental disabilities will ever be reported. (From Valenti-Hein, D. & Schwartz, L. (1995), *The Sexual Abuse Interview for Those with Developmental Disabilities*. California: James Stanfield Company.)
- Adults with developmental disabilities are a risk of being physically or sexually assaulted at rates four to ten times greater than other adults. (From Sobsey, Dick (1994). *Violence and Abuse in the Lives of People with Disabilities The End of Silent Acceptance?* Maryland: Paul H. Brookes Publishing Company.)
- Sixty-eight (68) to eighty-three (83) percent of women with developmental disabilities will be sexually assaulted in their lifetime, which represents a 50 percent higher rate than the rest of the population (Pease & Fraaz 1994, Warwick, Jason (1997).
- The violence that women with disabilities experience includes verbal abuse, forced segregation, intimidation, abandonment and neglect, withholding of medications, transportation, equipment and personal assistance services and physical and sexual violence (Matuszka, 1996).
- Women with disabilities are raped, assaulted and abused at rates more than two times greater than women without disabilities.

Complementary Content

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Abused and Used: <i>Examining the treatment of the developmentally disabled in New Y... Page 1 of 5

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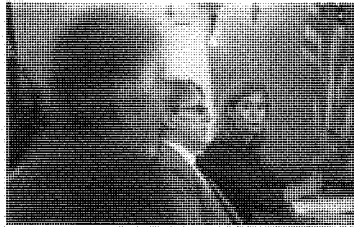
SERIES

Abused and Used: *Examining the treatment of the developmentally disabled in New York State*

Abused and Used

Articles in this series examine the treatment of the developmentally disabled in New York State and how money is spent on their care.

Update: April 23, 2012



Nathaniel Brooks for The New York Times

Courtesy Burke, right, commissioner of the Office for People With Developmental Disabilities, is held out of a State Senate-sponsored panel discussion on abuse after giving a brief state report.


State Ponders Relinquishing Its Oversight of Vulnerable

By DANNY HAKIM

The state agency charged with oversight of vulnerable populations in New York cannot sue on behalf of people with disabilities, or advocate independently for legislation.

Report on State Agency Oversight of Vulnerable

Update: March 22, 2012



Nathaniel Brooks for The New York Times


State Faults Care for the Disabled

By DANNY HAKIM

Nearly 300,000 disabled and mentally ill New Yorkers face a "needless risk of harm" because of conflicting regulations, a lack of oversight and even disagreements over what constitutes abuse, according to a draft state report obtained by The New York Times. The report was commissioned by Gov. Andrew M. Cuomo in response to this series.

New York State Draft Report on Abuse

December 23, 2011



Nathaniel Brooks for The New York Times

In Treating Disabled, Potent Drugs and Few Rules

By DANNY HAKIM

Abused and Used: <i>Examining the treatment of the developmentally disabled in New Y... Page 2 of 5

Tens of thousands of powerful pills created to treat serious mental illnesses like schizophrenia are given to developmentally disabled people in the care of New York State every day.

But a review by The Times of previously unreleased records, as well as interviews with state employees, clinicians, family members and outside experts, reveals that the psychotropic medications, which alter the brain's chemistry, are often dispensed sloppily, without rigorous or regular review, by general practitioners with little expertise in the area.

January 11, 2012

U.S. Report Criticizes New York on Monitoring Care of Developmentally Disabled

By DANNY HAKIM

ALBANY — The federal government sharply criticized New York's oversight of the developmentally disabled in a new report, saying the state agency charged with oversight lacks independence from the governor's office, failed to account for how it is spending public money and has broken several requirements of federal law.

Document: Federal Report on Disabled Care in New York State

December 28, 2011

An Operator of Group Homes Keeps State Aid Despite Faults

By RUSS BUETTNER

Bankruptcy filings and the prosecution of officials have not prevented the Federation of Multicultural Programs of Brooklyn from getting \$20 million a year to care for developmentally disabled people.

An analysis by The New York Times of state inspection data from 2004 to 2010 found that the federation had been cited 27 times; most providers of similar size were cited no more than twice.

March 12, 2011



Nathaniel Brooks for The New York Times

At State-Run Homes, Abuse and Impunity

By DANNY HAKIM

Decades after New York emptied its warehouses for the disabled, the current network of small group homes operates with scant oversight and few consequences for abusive employees.

Workers Keep Their Jobs, Even After Repeat Offenses

A Case History: Roger Macomber

Cuomo to Tighten Requirements for Workers in Homes for Disabled

By DANNY HAKIM

The first steps are unlikely to mollify advocates and aggrieved parents, long frustrated by widespread problems of brutality and neglect.

N.Y. Still Pursues Case Against Whistle-Blower

By DANNY HAKIM

Over the years, Jeffrey Monsour has filed many Freedom of Information requests examining the practices of the Office for People With Developmental Disabilities, and he sees the case being brought against him as his latest attempt at retribution.

June 6, 2011



Nathaniel Brooks for The New York Times

A Disabled Boy's Death, and a System in Disarray

By DANNY HAKIM

A seemingly inexplicable willingness by supervisors to tolerate abuse seems to pervade institutions that house residents with developmental disabilities, a New York Times investigation shows.

Records of Abuse

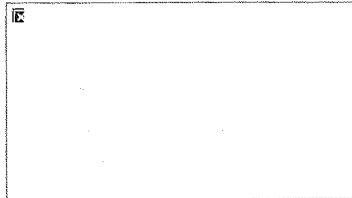
Q. & A. on Abuse in State-Run Homes



Video: A Failure to Protect

By ERIK OLSEN and DANNY HAKIM

A story of abuse and neglect in New York state's system of care for the developmentally disabled.

**Video: Witness to Abuse: The Worker's Story**

By NANCY DONALDSON, NATHANIEL BROOKS and DANNY HAKIM

Frustrated by the state's failure to respond to her reports that residents were being abused, a worker at O.D. Heck, Mary Maioriello, surreptitiously recorded a conversation with top agency officials.

Cuomo Vows Reforms at Residential Care Agencies

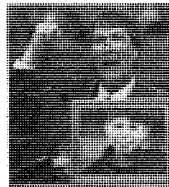
By DANNY HAKIM

The governor said mishandling abuse at institutions for the disabled was particularly problematic because "We are responsible for people's lives, literally."

New York Moves to Crack Down on Abuse of Disabled

By DANNY HAKIM

The Cuomo administration will establish guidelines for telling law enforcement about crimes against the developmentally disabled.



Nathaniel Brooks for The New York Times

Progress Claimed in Reporting Abuse at Group Homes

By DANNY HAKIM

Testimony during a hearing before the State Assembly underscored the challenges to improving the system for caring for the developmentally disabled.

November 5, 2011

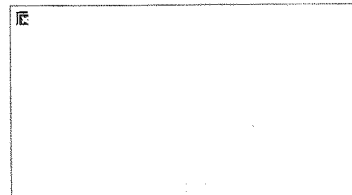


Steve Jassby/Times Union

In State Care, 1,200 Deaths and Few Answers

By DANNY HAKIM and RUSS BUETTNER

In New York, it is unusually common for developmentally disabled people in state care to die for reasons other than natural causes.

Deaths in Care: 16 Cases**The Death of James Taylor**

By DANNY HAKIM and ERIK OLSEN

The mother and sister of James Taylor, who died at age 41 while he was at a group home near Schoenectady, N.Y., share their story.

\$5 Million Payment to End Suits Over Death of 13-Year-Old Boy in State Care

By DANNY HAKIM

Testimony about the death of Jonathan Carey, 13, who was killed in 2007, highlighted widespread lapses in care at the state's disability agency.

August 2, 2011



Jonathan Carey for The New York Times

Reaping Millions in Nonprofit Care for Disabled

By RUSS BUETTNER

New York spends \$10 billion a year caring for the disabled, more than half of which goes to private providers, with little oversight on their spending.

14 Developmental Disabilities Inc.

Update: State Panel to Review Pay of Leaders at Nonprofits

State Seeks Data on Pay of Leaders at Nonprofits

By RUSS BUETTNER

A New York State task force takes a first step in response to reports of high executive pay and perquisites for nonprofits receiving state money.

December 14, 2011

Aiding Disabled, Nonprofits Rake in State Money

By RUSS BUETTNER

New York reimburses nonprofit providers for home care for the developmentally disabled at such beneficial rates that it has led to multimillion-dollar surpluses and eye-popping salaries.

November 12, 2011



Esther Miller for The New York Times

For Disabled Care Complaints, Vow of Anonymity Was False

By DANNY HAKIM

New York State has falsely assured its employees who care for the developmentally disabled that they could confidentially report concerns about the treatment of those in their care.

October 16, 2011

State Worker Recants Cattle Prod Story

By DANNY HAKIM

A state worker has recanted a story accusing a supervisor of using a cattle prod on a person with developmental disabilities, state officials said.

State Investigates Report That Cattle Prod Was Used on Disabled Man at Group Home

August 3, 2011

For Disabled Man Left in Van, Cause of Death Is Unclear

By RUSS BUETTNER

Alonzo Eason, 48, who was developmentally disabled, was found Tuesday slumped over in his seat; he was pronounced dead at the scene.

RESOURCES FOR FAMILIES

General Information

- Frequently Asked Questions about OPWDD
- What are Developmental Disabilities? (pdf)
- Map of Developmental Disabilities Services Offices
- Directory of Authorized Service Providers
- Who is Eligible for OPWDD Services?
- Testing and Assessment Centers
- Guide for Choosing a Residential Service Provider

Incidents and Abuse

- The Incident Review Process (pdf)
- Reportable Incidents and Abuse: A Handbook for all OPWDD Providers (pdf)
- Indicators of Inflicted Injury (pdf)
- Jonathan's Law

New York State O.P.W.D.D. Offices

The New York State Office for People with Developmental Disabilities (OPWDD) operates 13 offices that provide housing, employment, and family support services to individuals with developmental disabilities. The offices are located throughout the state.

Display Offices »



Andrew M. Cuomo, Governor
Jeff Wise, Executive Director

161 Delaware Avenue, Delmar, New York 12054
TEL: 518-549-0200

March 6, 2014

Mr. Michael Carey
90 Delaware Avenue
Delmar, NY 12054

Re: FOIL Appeal Decision (RA No. 466 and 468)

Dear Mr. Carey:

Your letter dated February 19, 2014 is an appeal under the Freedom of Information Law (FOIL), from the Justice Center Records Access Officer's determination of your FOIL requests dated November 18, 2013 (RA No. 466 and 468).

For the reasons that follow I affirm the determination of the Justice Center's Records Access Officer stated in her letters to you, dated January 30, 2014.

Your FOIL appeal challenges three aspects of the FOIL response. Each of those challenges is listed below and addressed in turn.

First, you assert that the statistical data provided to you is "inaccurate".

You asked for:

"The number of calls received by the Justice Center to date,"

and,

"The breakdown of those calls by categories by the Justice Center.... By every category used by the Justice Center."

In response to these two separate requests, two sets of data were provided to you. The first set of data [Call Center Report for the Week of 12/8/2013-12/14/2013] reflects the number of phone calls received by the Justice Center's call center from June 30, 2013 to December 14, 2013. The second set of data [Total Number of Reports to the VPCR by Type as of 12/11/2013] reflects the number of reports received by the Justice Center and their corresponding categorization as of December 11, 2013. The difference you note between the number of phone calls to the Justice Center call center (41,934 phone calls) and the number of reports to the Justice Center (36,196

reports) reflects that more than one call may be made with respect to a single report. The data provided reflects the fact that, under Social Services Law § 491, each mandated reporter who witnesses or becomes aware of a reportable incident has an obligation to make a report to the VPCR. In addition, the Call Center Report contains data for three days more than the VPCR Report by Type data.

Given that the data provided to you is accurate, the determination of this aspect of your FOIL request is upheld.

Second, in your appeal you assert that "calls reported by the Justice Center to 911...." is information which the "Justice Center obviously has record of."

Your FOIL request concerning 911 calls (RA #466) asked for:

"The number of calls taken in by the Justice Center and then reported by the Justice Center directly to 911,"

"The written Justice Center policy regarding when 911 is to be notified by the Justice Center,"

and,

"[a]ny and all other information the Justice Center has in its possession regarding 911 reporting, the requiring mandated reporters to report to 911 including what and when..."

In response to these aspects of your FOIL request, the Justice Center discretionarily provided you excerpts from the draft of the NYS Justice Center Intake Representative Procedure Manual regarding 911 reporting. You were also provided with the Justice Center Call Center Message Transcript and a link to a publically available power-point presentation issued by the Justice Center detailing mandated reporter responsibilities. Each of these records addresses how the Justice Center implements the obligation to call 911 if the mandated reporter or individual caller is witnessing or has knowledge of an emergency situation. As made clear in these records, the Justice Center does not call 911 directly, but instead directs call center staff to make appropriate inquiries to prompt callers to call 911 when it is believed that an emergency situation that may require immediate medical or law enforcement assistance exists.

In short, this procedural and policy information provided to you in response to your FOIL request regarding calls to 911, demonstrates, as a factual matter, how the Justice Center ensures that 911 is called. The records provided were responsive to your request and the Justice Center has no further documents that are responsive to your request. FOIL does not require an agency to prepare or create a record in response to a request. Public Officers Law §89(3). As a result, this aspect of the decision of the records access officer is also upheld, and your appeal is denied. The rationale for this decision is set forth in the Governing Law and Discussion sections below.

Third, you assert that "calls reported by the Justice Center to ..., the police and District Attorneys...." is information which the "Justice Center obviously has record of."

Your FOIL request asked for (emphasis added):

“The *number of calls and cases reported to County elected District Attorney’s* [sic] by the Justice Center” and,

“The written Justice Center *policy* regarding when County elected District Attorney’s [sic] are to be notified.”

The Justice Center’s Special Prosecutor has concurrent jurisdiction with all 62 District Attorneys in New York and therefore has no obligation to report or notify a local District Attorney when it is investigating a potential criminal case. The law only requires the Justice Center to consult with a local district attorney in connection with the timing of the Special Prosecutor’s appearance in County or Supreme Court, or before a grand jury, or with regard to prior notice of the application for a search warrant. Executive Law §552(2)(b) and (2)(c). Therefore, the Justice Center does not have an obligation to systematically compile the type of data you have requested and the Justice Center does not maintain such a record. As a result, your request does not elicit any responsive records. This aspect of your appeal is therefore denied based on the law set forth below.

A. Governing Law

Public Officers Law §89(3)(a) provides that when an agency has the ability to extract information contained in an electronic information system with reasonable effort, it is required to do so. However, an agency cannot extract such information when search terms are insufficient for purposes of locating or identifying records sought. *Konigsberg v. Coughlin*, 68 NY2d 245, 249 (1986). When the FOIL request is for data, and there is no combination of search terms that would yield the universe of responsive documents or data requested, the search will be fruitless. In those cases, because the search terms bear no rational relationship to the organization of agency records, the request is not reasonably described and a database search cannot yield any responsive records. See, e.g., *Asian Am. Legal Defense & Educ. Fund. v. New York City Police Dept.*, 41 Misc. 3d 471, 481 (Sup. Ct. NY County 2013) (Upholding denial of information pertaining to investigations of certain ethnic communities where “[r]espondents have sufficiently demonstrated in its papers that a database search ‘would be pointless, as there is no combination of search terms that would yield the universe of responsive documents,’ as the vast majority of its records are not organized along racial, religious, or ethnic classifications.”).

B. Discussion

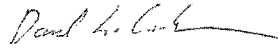
In this regard, please be advised that the Justice Center is a law enforcement agency with statewide concurrent jurisdiction with local law enforcement agencies, including local District Attorneys, to prosecute allegations of abuse and neglect committed against people with special needs in New York. In fulfilling these duties and responsibilities, the Justice Center works in close cooperation with local District Attorneys to pursue prosecutions in abuse and neglect cases that raise allegations of potential criminal wrongdoing committed against people with special needs. Indeed, one of the mandates of the Justice Center is to increase the capacity of local

district attorneys to prosecute cases involving special victims. In that regard, the support provided to police and local prosecutors is as significant whether the Justice Center Special Prosecutor or a local District Attorney appears in court on a criminal case, and it reflects the fluid nature of the relationship between the Special Prosecutor, local District Attorneys and other law enforcement agencies statewide. Given this fluid relationship, the complexity of the criminal justice process and its multiple stages, the search terms "calls and cases reported to local county elected district attorneys" or "the written ...policy when county elected district attorneys are to be notified," do not constitute a reasonable description of data or records in possession of the Justice Center, and thus do not yield any responsive documents or data.

For all of the above mentioned reasons, your appeal of the letter determination of your FOIL request, as detailed in your appeal letter, is denied.

Should you wish to appeal this decision, you have a right, pursuant to Public Officers Law §89 to commence a proceeding pursuant to Article 78 of the Civil Practice Law and Rules in the Supreme Court of the State of New York, for a review of this determination.

Sincerely,



David L Cochran
FOIL Appeals Officer

cc: Committee on Open Government

*The exact issue "dispute" oversight regarding "and" the only authority
 mentioning "dispute" is to protect the person's right to a fair trial.
 But regarding it the law says "dispute" not have the same meaning
 as "dispute" and "dispute" is simply state the facts and a Justice
 must decide if a dispute exists and then*

**NEW YORK STATE SUPREME COURT
 COUNTY OF ALBANY**

**In the Matter of the Application of
 ALBANY LAW SCHOOL and
 DISABILITY ADVOCATES, INC.,**

Petitioners and Plaintiffs

— against —

**NEW YORK STATE OFFICE of MENTAL RETARDATION
 and DEVELOPMENTAL DISABILITIES and DIANA JONES
 RITTER, in her Official Capacity as Commissioner of the Office
 of Mental Retardation and Developmental Disabilities,**

Respondents and Defendants,

For Judgment pursuant to CPLR Article 78.

AFFIDAVIT

In Support of Motion

Index No. 10371 - 08

STATE OF NEW YORK

COUNTY OF SCHENECTADY

ss.:—

JANE G. LYNCH, being duly sworn, deposes and states the following:

1. I am the Chief Operating Officer of the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (the "Commission") and I am fully knowledgeable concerning the facts asserted herein, except for those expressly stated upon the basis of information and belief.

2. I offer this Affidavit in support of Respondent-Defendants' motion to dismiss the Petition and Complaint herein, insofar as Petitioner-Plaintiffs have incorrectly asserted that relevant New York State and Federal laws effectively invest in them authority equivalent to that

least superfluous.

9. With its creation of the P&A system, Congress intended a balancing of legitimate interests among stakeholders, and so it designed tempered grant of authority which, while extraordinary, is nonetheless neither open nor on a par with the general oversight authority granted to the Commission under New York law. Moreover, to my knowledge, there is no indication in Congressional or New York legislative history relating to the P&A program that would suggest any design to create functioning duplicates of the Commission's role in the mental hygiene system, with concomitant authority to, e.g., command the production of records on a broad scale as the Petitioner-Plaintiffs suggest. The Federal law discussed in ¶7 sets out the conditions under which a P&A office may request and expect to compel disclosure of records and information pertaining to residents of a mental hygiene facility, and MHL §45.09(b) echoes that law, neither augmenting nor diminishing anything granted to the P&As under the Federal enabling legislation, also known as the Developmental Disabilities Assistance and Bill of Rights Act ("the DD Act").

10. There are foreseeable, adverse consequences of an interpretation favoring Petitioner-Plaintiffs' expansive reading of their authority; one is the risk of confusion across the jurisdictional spectrum of providers subject to MHL Article 45 oversight that necessarily includes hospitals, community residences, and many other entities functioning within the State-licensed mental hygiene system. It is fundamentally important to a coherent oversight scheme that licensed providers distinguish and understand the differences between the Commission and the P&A system in terms of function and method, for example. More

concomitantly, it is simply critical that, for example, administrators and staff of a residential care facility licensed by the Office of Mental Retardation and Developmental Disabilities ("OMRDD") understand that a request for information and records by the Commission does not carry with it an overlay of potential litigation concerns. One element of the Commission's effectiveness, historically, is a carefully cultivated understanding among providers that unbridled disclosure and candor where Commission functions are concerned with neither lead to nor become an exhibit in litigation brought against the entity or its personnel.

11. In the same vein, the history of this Commission's mandate reveals that it has always, and without exception, pursued its functions as intended by the Legislature, as an independent oversight agency. No aspect of its mandate has ever been delegated to other entities, including the P&A contract offices, which are themselves independently incorporated. Our activity within the mental hygiene system requires the dedication of appropriately qualified Commission staff whose authority under MHL Article 45 enables this agency to discover facts, receive information, make findings and issue reports on a range of matters that impact the lives of persons with mental disabilities. For their part, P&A offices within the system administered by the Commission are expected to engage in a range of activities that complement those of the Commission and further the expectations of Congress under the DD Act. These deliberate parallels in mission, design and function contribute to the robustness of the system, but as MHL §45.09(a) and (b) make clear, were never intended to suggest sameness of legal authority.

WHEREFORE, I respectfully submit that the Respondent-Defendant's motion to dismiss the Petition-Complaint be granted.

Jane G. Lynch

JANE G. LYNCH
Chief Operating Officer
Commission on Quality of Care and
Advocacy for Persons with Disabilities

Sworn to before me this
19th day of March, 2009.

Justine [Signature]
Notary Public

J. JUSTINE LYNCH
Notary Public, State of New York
No. 00000000000000000000
Commission Expires February 28, 2012

Juvenile Justice Initiative

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Evanston, Illinois 60201
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Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety

Realigning Justice Resources: Shifting Limited Resources from incarceration to Community Behavioral Healthcare

Hearing Before the Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights

Tuesday, April 29, 2014

We are grateful to Senator Durbin and the fellow members of the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights, for this opportunity to present written testimony on the need to shift limited justice resources away from incarceration of youth in detention centers, jails and prisons in the United States, in order to improve outcomes through enhanced funding of community level treatment of youth through individualized services including behavioral healthcare.

US shifting limited resources from incarceration to community based mental health and behavioral healthcare alternatives.

Within juvenile justice systems across the United States, research documenting the underlying behavioral healthcare needs of children caught up in the justice system is leading to a shift in limited resources away from incarceration to expand the focus on, and increase the availability of, innovative, individualized community behavioral health treatments.

A longitudinal study out of Northwestern University in Chicago, based on 1,829 youth who were detained in the Cook County Temporary Juvenile Detention Center between 1995 and 1998, established both that the mental health needs of children detained in the juvenile justice system are far greater than those in the general population, and that the mental health needs of children in detention are largely untreated. <http://www.ojdp.gov/pubs/234522.pdf> This large-scale longitudinal study of drug, alcohol and psychiatric disorders in a randomly selected group of juvenile detainees in Chicago documented the high levels of stress disorders and trauma, as well as the barriers for youth who need to receive mental health services. Among the most troubling findings was the fact that the study's participants had a mortality rate nearly four times that of the general population. The Office of Juvenile Justice and Delinquency Prevention noted that the study *provides much needed insight into the types of services and treatment that youth in the juvenile justice system most require.* For example, the study highlighted the surprisingly high levels of trauma of children in detention, clarifying the need for our communities to provide adequate trauma treatment within our schools and community centers. The study also highlighted the barriers to accessing mental health services as 85% of the children detained reported at least one perceived barrier to accessing services, including difficulty in locating help.

Incarceration is not the answer to these underserved behavioral healthcare issues. An article in the Bloomington, IL newspaper recently noted: *Jail is a Costly Place for Mental Health Care.* As the article states: *A shortage of psychiatric care for indigent people has contributed to the jail's dilemma.....data from the Center for Human Services [revealed] that three of every four people seeking psychiatric help are turned away by the provider.* http://www.pantagraph.com/news/local/jail-is-costly-place-for-mental-health-care/article_807a7afa-9cbb-5830-86c9-28589b9558ab.html

A Successful Model - Fiscal Reinvestment in Illinois shifts limited justice dollars from incarceration to community alternatives including behavioral healthcare:

The Redeploy Illinois program grants state dollars to participating counties in return for a pledge to reduce the commitments of youth to state juvenile prison by 25%. The participating counties design programs to suit the needs of their youth, but the majority of the youth served through Redeploy programs are assessed and found to have substance abuse issues and/or mental health/behavioral health issues. The Redeploy dollars allow participating counties to provide needed substance abuse and/or behavioral healthcare services to youth at risk of incarceration. As the Executive Summary outlines, the Redeploy programs are highly successful, ensuring that youth who are deep in the justice system receive individualized services in the community, thereby protecting public safety with lower repeat offending rates – while also saving tax dollars.

Evidence increasingly supports the conclusion that Redeploy Illinois provides a significant return on investment in terms of financial and human resources. The Redeploy Illinois Annual Report presents data, analysis, and findings substantiating this claim. Further, the report highlights efforts related to expansion in new counties and presents the program's activities and highlights during 2012 and 2013.

In financial terms, the average annual cost to serve a youth in the Redeploy program in 2013 was approximately 6% of the annual cost to house a youth in the Illinois Department of Juvenile Justice (IDJJ). In 2013 the average per capita cost to house a youth at IDJJ was a reported \$111,000. In 2013, 352 youth received full Redeploy Illinois program services with an appropriation of \$2,385,100. This equates to an annual Redeploy program cost per youth of \$6,776.

In 2012, 238 fewer youth were committed to IDJJ because of the Redeploy Illinois program, saving Illinois taxpayers nearly \$11.7 million in unnecessary incarceration costs for 2012.

In the first eight years of the program, participating counties sent 1,036 juveniles to IDJJ. This is a steep decline from the projected 2,268 youth that were likely to have been sent based on the previous three-year commitment trend; it represents a 54% reduction in IDJJ commitments over the life of the program. Through 2012, the Redeploy program diverted 1,232 youth saving the state a conservative \$60 Million in unnecessary incarceration costs.

From the human perspective, these 1,232 youth were provided with a second chance at becoming a contributing and law-abiding citizen of their respective communities. Beyond saving dollars, the program mends lives. A commissioned report by Illinois State University found that parents and youth believe the program significantly improved family relationships, youth attitudes, communications with youth, and offered opportunities for success. Youth coped with anger better, were more focused on positive goals, and committed substantially fewer crimes. Further, probation staff, service providers, and the judiciary exhibited strong support for Redeploy Illinois.

Read the recently released 2014 Redeploy Illinois Annual Report on activities FY12-FY13, here:
<http://www.dhs.state.il.us/page.aspx?item=70551>

We believe that public safety is most effectively maintained when youth in conflict with the law receive individualized services within the community, rather than incarceration.

Thank you for this opportunity to comment on your examination of the critical need for comprehensive continuums of care within our communities for children in conflict with the law. Please let us know if you need further information.

Respectfully submitted,

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Senator Durbin
224 Diverson Senate Office Bldg
Washington, D.C. 20510-6050

Dear Senator Durbin, April 28, 2014

Imagine in a blink of an eye you turn around and your five year old child is missing because he wandered off, panic sets in as you frantically call his name. You run around the house as a neighbor calls for help, you don't think to check the typical places that most parents do because your child is different, your child has special needs. A million thoughts begin to race through your mind "Oh no my son doesn't understand danger" so you run toward the street yelling his name

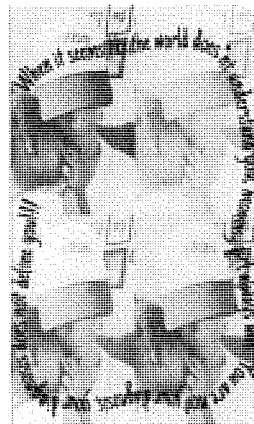
Your son also does not understand "stranger danger" which makes him an easy target, he has sensory needs so he likes to climb and jump from high places which can be dangerous, he has to have a one on one for just about everything he does. But what really scares you is that your son can not talk because he is 1 in 64 children on the Autism Spectrum, from a result of him being 1 in 200,000 that suffer from Landau-Kleffner Syndrome.

He can not yell "mom or dad" or tell a stranger "help me I'm lost" " he can not tell anyone his phone number" he is left vulnerable defenseless in a world that isn't always kind.

When an Amber Alert is called for this matter usually it entitles neuro-typical children, and even though it does not necessarily spell it out but children who are typically alike fit under one protocol. My child is hyposensitive, is easily overwhelmed, has a hard time adjusting to transition, has intense meltdowns, a sensory integration disorder and seeks constant input; does not understand danger can not speak and most of all may not want to be found because of fear of people, places even smells outside of his comfort zone. This child has a harder chance of being found under a typical protocol and that is why it is important for first responders to be privy to all the needs of people with a mental illness as well as intellectual disabilities. If this was your child that wandered away which is a common part of his disorder you would want to know that your child stands a fair chance of being found "safe and sound" just like any other child. We trust our first responders with our lives and we entrust them with our children's life, but not everyone is the same we all do not march to the beat of one drum so it is imperative that our first responders are equipped to do their job for a successful outcome.

I am a mother of a five year old and it brings me to tears to think of the above scenario happening to me let alone anyone; it was hard enough when my child climbed out the shopping cart and I could not find him for two minutes. I do not have any fancy degrees or large letters behind my name, but I do have incredible ideas that will help to make a difference, and most of all the Love, Courage, Will and Gumption to Protect my child in any way. So today I stand before you asking you to hear my plea, but not just mine but the plea of many. Thank you for your time. Respectfully Yours, Kie'lara V. Hallmon

"I'm just a Mom" (advocating for everyone to be found)
 "Safe and Sound"



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Senator Durbin
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Dear Senator Durbin, April 28,2012

Hello my name is Kie'lera Hallmon I just sent you a letter concerning my son and kids alike with safety. It is only right for me to come to you as a daughter of a mother with a mental illness. My mother has suffered from a mental illness since I was a child, I've seen every episode there was from it. However nothing could compare to the summer of 2007, my mother stopped taking her medications when all else failed we tried to get her help and petition the court, and we were told it was nothing we could do basically. We went to her doctors and ect at times even called the police but nothing could be done until my mothers behavior escalated to violence. My mother snatched a chair from underneath a neighbor sitting down out of rage causing her to fall it was then police was called and she was hit and cuffed and taken away to a hospital. My mother had to pay restitution and take anger management classes, she also stayed in the hospital for a week.

We had tried every thing but until my mother posed as a danger to her self or to anyone else nothing could be done about it. So my mother had to hurt someone in order for her to have gotten help. It is hard trusting someone with a mental illness to seek help on their own when they don't think anything is wrong with them, plus they can be very believable and convincing. I believe law enforcement should be privy to mental illness and a lot of the violence that happens as a result of not being equipped with the knowledge of it would in fact decrease.

Once my mother was in a well state of mind it was too late and she found herself paying restitution and going to anger management classes for something she had not remembered doing and felt awful about. I just don't think its fair for something to have to come to those extremes for one to get help. I hope that a new law will help to get individuals help and not handcuffs way before it escalates to that point. Thank you for hearing me as mom speak out and know me as a daughter speakout!

Respectfully Yours, Kie'lera Hallmon

Kie'lera V.Hallmon

To: Members of the Subcommittee on The Constitution, Civil Rights and Human Rights

Chair: Senator Durbin

Ranking Member: Senator Cruz

Members:

Senator Franken

Senator Coons

Senator Blumenthal

Senator Hirono

Senator Graham

Senator Cornyn

Senator Hatch

Re: April 29th Senate Hearing on "Law Enforcement Responses to Disabled Americans:
Promising Approaches for Protecting Public Safety"

April 28th, 2014

Written testimony for the record submitted by Andrew and Carolyn Gammicchia, President and
Executive Director of L.E.A.N. On Us.

Dear Chairman Durbin and members of the Subcommittee on The Constitution, Civil Rights, and
Human Rights Committee,

We are writing to you today to not only express our appreciation for holding this very
important hearing, but to also address our concerns on the topic of appropriate law enforcement
response to individuals with disabilities. We would like to express the importance of when
listening to the panels today that there is consideration of this issue from the standpoint of this
being a civil and human rights issue for individuals living with disabilities in our country who
are not having these rights provided daily by many within the public sector. There is a
realization that the focus of this hearing is on law enforcement professions and appropriate
response, however we feel there should also be a collaborative approach to this within all aspects
the criminal justice community to ensure that criminalization of any one disability does not take
place. Additionally since law enforcement professionals are members of the crime victim
services profession, we want to ensure this is a focus that is not lost within this conversation.

L.E.A.N On Us
P.O. Box 182338
Shelby Township, Michigan 48318-2338
www.leanonus.org 586-703-3866

We also feel important that you know why we are providing this testimony today. We are doing so as representatives of a non-profit organization, L.E.A.N. On Us, that we founded in 2002 to address these very issues. Our efforts started due to personal connections to this topic across many areas including the following:

- The Gammicchias both have been police officers in the field and actively responding to calls for both individuals in crisis situations as well as those who have been victims of crime that have a disability. Officer Andrew Gammicchia is still active in the field and have 26 years of experience in the field. Carolyn has 21 years experience and has been training first responders and advocating for individuals with disabilities since 1995.
- Officer Andrew Gammicchia was involved in a crisis situation where he recognized the subject was suffering from excited delirium, due to being appropriately trained and developing training to address this subject, and medical services were provided. He too was involved in a situation where there was death involving a crisis call, despite following appropriate response standard procedures, and addressed this during training sessions to provide insight into the trauma that is incurred in these situations.
- Carolyn's brother, Mark Coriaty, was a man who had live with epilepsy and had several encounters with police in public venues where he was arrested due to his seizures not being recognized by responding officers. Several times these encounters involved physical confrontations due to him not responding to verbal commands and officers using force to detain him. He incurred several injuries from these encounters, having not committed any crimes prior to them, and was criminally charged several times due to his resistance. He also died within a state facility, Walter Reuther Hospital, in Michigan due to restraint use and lack of appropriate medical care in 1999. Walter Reuther Hospital was the same facility where Carolyn's grandmother lived the last years of her life as an individual living with significant challenges from dementia and died in the facility in 1966.

- The Gammicchias have a son who has autism and significant expressive and receptive communication difficulties, who at one time had significant behavioral challenges, and who as a victim of crime was not initially provided appropriate victim services.
- Carolyn's father lived with dementia the last year of his life and member of Andrew have had this challenge as well. As care providers they have witnessed second hand the vulnerability one faces when living with a disability and how easily this vulnerability can be taken advantage of.
- The Gammicchias have worked on a variety of projects funded through the Department of Justice and the Office for Victims of Crime specifically to meet needs in this area by serving on committees or working directly with grants to develop training curriculums and materials in this area.
- Carolyn has worked as an advocate for fifteen years to ensure that victims of crime with disabilities are being provided appropriate services while also assisting in case review for individuals with disabilities accused of crimes. Both areas are still significantly lacking in complying with ADA requirements to provide access to individuals with disabilities.
- Carolyn is currently on the Professional Advisory Committee for the National Center on Criminal Justice and Disability to address this topic and to ensure that individuals with disabilities have access to appropriate interaction to those within the Criminal Justice system. <http://www.thearc.org/NCCJD>

There are many additional reasons why we felt it was necessary to provide this testimony as well due to not only our personal experiences, but due those we have experienced as professionals in law enforcements as advocates to ensure safety for all members of our communities. In doing so we are providing these concerns for your considerations:

- Currently there is no demographic within police reports to show that an individual has a disability if they are a victim of a crime or are accused of a crime. Ethan Saylor, whose

mother Patti Saylor will be testifying at the hearing, will being listed in the police report regarding his tragic death, however he will not be listed within the demographic information to show he at the was an individual with a disability. This is very vital and needs to be considered. We currently have no means to show how many of these encounters are taking place and their results without that demographic. If this is to be addressed within a national initiative to ensure appropriate responses during crisis situations where officers are called to assist, we need to have this demographic added to police reports. The only ability to do so currently on such reports is if a victim is the subject of a hate crime due to their disability and though we applaud this having been added recently, it still is not used accordingly due to lack of sufficient investigation of such crimes and individuals not being charge with hate crimes against individuals with disabilities. We as an agency feel this is actually a violation of an individual with a disability rights under ADA, who has been a victim of a crime or is accused of a crime, to not have this demographic on police reports. We feel this is the case because this is what generates appropriations for prevention programs as well as appropriate victim service programs. We have also discussed this with several administrators within the BJS, NIJ, DOJ, and the OVC to no avail unfortunately. These statistics also are used to show injuries or deaths to officers resulting from such encounters. Again, we do not have the demographic to show these encounters would involve someone with a disability. For more information on how these statistics are utilized please visit the FBI website at <http://www.fbi.gov/about-us/cjis/ucr/ucr>.

- There are numerous training programs across the country being offered on appropriate response to individuals living with a mental health disorder or developmental disability. Each differs significantly as well as their delivery to those within the law enforcement field. Many are mandated within states, but many only anything from watching a video for an hour to attending trainings lasting from two to forty hours. For crisis intervention, the CIT model has been lauded as the gold standard, however the 40 hour training is

something that has not been able to be realized by the majority of officers. So what we have are teams that may be available, but not often when the crisis may actually be occurring. Calling someone to a scene where there is an individual currently in crisis while family members or other officers stand by to assist isn't meeting the need set of the individuals within these situations, nor those involved. As officers in the field we were often given these calls due to our personal situations, even though our own departments may chosen not to train their officers in CIT, nor have team members available to respond.

- As we address mental health appropriately for members of the community we feel this needs to be done to address what transpires within crisis encounters for all of those individuals involved. There are no standard protocols for law enforcement officers involved in such incidents when a life is taken, either that of a fellow officer or of an individual with a disability. We feel that this is something that is vital to address since there will naturally be trauma incurred from these incidents. That holds true also for the individuals with disabilities involved in such incidents. Research has shown even one encounter with officers by an individual with a disability in crisis can result in Post Traumatic Stress Disorder, especially if the individual is not able to process what has transpired due to a heightened state of anxiety at the time of the encounter. Referrals for individuals involved also should be done as soon as possible and for law enforcement prior to returning to active duty when a death has resulted.
- There are seldom community trainings for members of families that have loved ones with a disability on how to contact law enforcement when a loved with a disability may be in crisis. When officers are trained across the country, these community 50/50 partnerships should be taking place so that families or individuals seeking assistance can participate by taking proactive measures to assist law enforcement to meet the needs of the individual they are responding to. There are many resources to allow for this to take

place, such as voluntary registries, identification to be worn by parties, self-disclosure protocols, as well as departmental community relations programs and communities by law enforcement to assist in this area.

- Many Jail Diversion programs are not being utilized pre-booking to assist in instances when encounters take place to allow for services to be accessed for individuals living with disabilities, such as mental health disorders or intellectual/developmental disabilities, to ensure their individual needs are being met. Often individuals are accused of crimes such as misdemeanor crimes such as Disorderly Conduct, Loitering, Larceny from a Building, etc. that are non-assaultive in nature and usually not committed with criminal intent. Many individuals too may be homeless or lack financial resources to meet even their basic needs. Criminalizing such actions, rather than supporting access to appropriate services, may not deter this activity in the future, but could lead to repeated and unnecessary contact with law enforcement.
- There are many programs that have been funded via Community Mental Health Block Grants and funding via that are not being utilized and have a variety of materials that are free or available for low cost. There is no central means of accessing this information and though the National Center on Criminal Justice for Disability has been provided funds to create a resource, the funds appropriated are limited and do not provide what we feel will be needed to provide assistance on a national level in this area. We feel this initiative needs to be recognized as a center that will provide a basis to ensure human and civil rights of those with disabilities are recognized as well as be the agency that works in collaboration with law enforcement and other criminal justice professionals to develop not only national training standards, but programs to meet the needs in this area. Doing so from what already exists too can prevent duplication, vent out programs that may be unsound, while also identifying gaps that need to be broach. Without such a national

agency we will continue to not meet the needs of individuals with disabilities in this very vital area.

- The reporting of violations through the Office of Civil Rights and the Department of Justice of situations where human rights and civil rights have been violated is often not accessible to individuals with disabilities or those acting on their behalf within the limited time frames that currently exist. Many encounters within crisis situations also result in litigation that freezes the process of full discovery of information related to such incidents, especially those that result in injury or the deaths of individuals with disabilities. We often find that full disclosure is not taking place within such incidents to limit liability. That we feel is unfortunate because it does not allow for preventive measures to take place to change what has unfortunately transpired. We'd like to ask that a commission be formed to address this issue and work together to ensure the safety of responding officers and those they are to properly serve and protect.
- Currently there is no national agency that addresses support specifically for individuals with a disability who have been accused of a crime. Funding is provided to state Protection and Advocacy organizations to assist individuals with disabilities in the majority of the fifty states via federal funds. However the majority of those agencies will not assist individuals with disabilities who have been accused of a crime. Many of those accused may be unable to access legal assistance due to being indigent or having limited financial means, not knowing their rights, or being denied the ability to such access while incarcerated. Often assigned public defenders do not have the experience within disability to properly represent individuals and they are often forced to plea to crimes they may not have committed due to the lack of appropriate representation. Many individuals who have contact with police during crisis calls are often charged with resisting an officer or another charge resulting from that encounter. Unfortunately in these majority of cases, individuals are referred to the criminal justice system as criminals

due to their disability and how that manifests during such encounters or they are subjected to involuntary mental health commitments. Again we stress that it is important that this type of criminalization does not occur because it may cause an individual with a disability to be denied access to appropriate health care, housing, employment, community supports, victim services, etc. when one incurs a criminal conviction and subsequent criminal history due to this process.

We have broached many subjects for you in this letter and want you to know that this is a very, very complex issue that is being faced across our country each and every day. It's not easy too to respond to these situations, often without knowing what is needed to assist those involved, and it is leading to unfortunate outcomes. It also is not easy for families to be able to pick up the phone to call 911 in these instances. However there are many programs meeting this need and with good results and those we feel can be celebrated and replicated. This process though has already taken much too long and we cannot continue to wait until more lives are lost. We need to address this in a way that will meet the needs of all involved and feel it's past the time to do so. This hearing is a start, and again we want to express appreciation to you for allowing this to take place and working toward eliminating unfortunate outcomes for all of those involved. We look forward to assisting in any way possible to make this a reality and please feel free to contact us.

Respectfully,

Andrew Gammicchia
President
L.E.A.N. On Us

Carolyn Gammicchia
Executive Director
L.E.A.N. On Us

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Shelby Township, Michigan 48318-2338
www.leanonus.org 586-703-3866

I'm writing in support of "Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety," testimony in my wildest dreams I never thought I'd be submitting. Yet here I am, reeling from recent events surrounding my son, Luke, who at twenty-two is non-verbal though cognitively not compromised. Gentle in nature, his nickname at birth was Lamb and remains with him to this day.

I am horrified and outraged by the lack of training and understanding with respect to Law Enforcement Agents as well as Agencies who purport to support adults with Developmental Disabilities: there but for the grace of God, I would be in Patti Saylor's shoes.

Approaching graduation from The Westchester Exceptional Children's School in North Salem NY - a magical oasis serving exceptional children from five through twenty-one, I was dismayed by the paltry choices available to Luke. He wanted what we all seek: a job with meaning and purpose, a social life and a home. Harnessing my cumulative Special Education and Business skills, I founded Cultivating Dreams, an entity designed to support individuals in the environment that is right for them without compromising their desire to lead an invigorated life.

Through a series of challenges presented by NY State, I agreed to launch under the auspices of CAREERS For People with Disabilities, located in Carmel and Valhalla NY who was looking to expand the numbers of adults it serves. It seemed expedient to join forces with an existing agency who supposedly shared my philosophy. Soon my vision was diluted when the State denied approval of my original dream, but agreed to support a Day-Hab Without Walls. Essentially this concept - now prevalent as a financially sound way to service adults with an emphasis on community integration - requires a nomadic life. Four or five young adults with a staff member(s) travel in a car or van all day, stopping at a variety of places, typically without rhyme or reason to the schedule. Not ideal by any measure - particularly for adults who like to be out and about but who, like Luke, sometimes find the stimuli of the community overwhelming.

Through repeated exposure to screams of little children, in combination with untrained staff, who despite input from Luke's former team at The Westchester Exceptional Children's School and me, refused to deviate or compromise to support Luke in the way he deserved. Instead they chose repeated punitive routes, resulting in the most distressing experience one can imagine.

My son is a gentle, compassionate, loving young man who disdains conflict of any kind, whose well-being is founded in the loving safety of those who care for him. This support is paramount in Luke's ability to navigate a world not meant for him.

The final act occurred when, once again, Luke was in the midst of community stimuli that unnerved him. Rather than comfort him, he was taken to the Carmel CAREERS office where he was asked by an unfamiliar staff member if he wanted to watch a video, color or read. He shook his head no. Exiled from his friends who left to play basketball - a sport he loves - with his lunch at hand, he was abandoned in unknown territory and realized he would not be re-joining his buddies. Luke's emotional balance is predicated upon explicitly understanding the sequence of events scheduled for him. Seated alone in a confined space without the benefit of any explanation, alone with no way to express himself, Luke stood up to look out the window and was confronted with a landscaper. Months earlier, Luke's intake process included relevant facts

regarding triggers that create discomfort for him. On the top of the list I highlighted little children and landscapers. Can you imagine how isolated and frightened he felt? Using the only communication tool available to him, he began to bang on the window. The staff proved they knew nothing of his needs and/or they were ill-trained in handling individuals with these types of concerns. When the response was for a job coach to grab him, the situation spiraled out of control. What would you do if a stranger grabbed you? As any of us would, Luke tried to defend himself, flailing in reaction to such an ineffective gesture.

Adding insult to injury, the first phone call I received was from Luke's former team who were informed by the CAREERS Executive Director that Luke had a concern and was being taken to the office. Apparently they were not concerned enough to inform me of the occurrence. Had I been aware of his exile I would have taken appropriate steps to prevent the situation from escalating. When in fact, the first call came over an hour later when CAREERS told me the police had been called.

Imploring her not to call the police, incredulous to even be in this situation (in twenty-two years Luke has never needed police intervention) knowing how frightening it would be for Luke, I raced to the office. I arrived to a horrific scene. Ignoring my initial dread at the haphazard placement of police vehicles, I ran up the stairs to witness six or seven police officers surrounding Luke who was on the floor, handcuffed. It was hard to grasp the fact that Luke was the cause of such a show of force by the Carmel police department. Nothing could have prepared me for what I witnessed: Luke was trembling as I've never seen him, not pale, but grey - ashen with fright. Knowing how crucial my response was to Luke's well being, I requested in a calm and controlled voice to please not continue in this manner. I was told to stay away from him and escorted out of the building. Instead of soliciting my support they removed from the premise. Luke and I are as close as any mother and son could be. His ultimate safety net, I was kept at bay by strangers who did not know him nor understand the damage they were inciting, when Luke needed me most.

Upon request, I explained to one officer my take on the situation, to which he responded his public concern. When I attempted to add in a composed manner, he pointed his finger at me and said, "Ma'am, I listened to you, now you listen to me." I knew enough to say no more, to keep my head down, my heart still so I could get to Luke. When the officer finished I walked away, to find myself barred from entering by a CAREERS employee who attempted to justify what happened, Luke's uneaten lunch in her hand. I gently took his lunch and moved around her so I could get to Luke, who remained my only concern.

When I returned, Luke was seated in a chair, hands cuffed behind his back, sweating but calm. Ignoring everyone in the room, I pulled a chair up to him whereupon he nuzzled me - our loving handle, a nose to nose caress - as I put my hand on his heart and said, "I know. I hear you. This is not your fault. I'm here. Everything will be ok." He folded into me as I kissed him, hugged him and loved him. Asking if he wanted to take off his sweatshirt, an officer said, "We can't because of the handcuffs."

Distracting energy from that directive toward my son who obviously was relaxed and importantly finally felt safe, I asked him if he wanted to go outside with me. As I learned, once a

911 call is made, the “subject” must then travel by ambulance to the hospital for an evaluation. Hard pressed to understand the logic, we were surrounded by too many law enforcement agents to count. By that time, in addition to the CAREERS employees several detectives were on the scene and not one law enforcement officer offered any introduction or desire to engage me in a practical and peaceful solution.

NOT ONE PERSON, NOBODY showed any concern toward Luke’s well-being, NEVER asking or obviously knowing what the caring approach should be, nor any mention of his medical needs (he’s on anti-seizure medication) and how this violent reaction would impact him. Not one person in that crowded room had any training or knowledge about supporting individuals with developmental disabilities; not one person comforted him or assured him he would be ok. The incredulity of that experience at every telling grows deeper as my gut is tied in knots at the memory of seeing my sweet son ON THE FLOOR, SURROUNDED BY SIX OR SEVEN POLICE PERSONNEL, HANDCUFFED, TREMBLING IN TERROR, ASHEN WITH FRIGHT.

Terrifying, horrifying, worse than any “Twilight Zone” episode I might imagine, I realized how close we came to having the outcome be far worse and fatal. Luke continues to have nightmares and is understandably timid about his future.

Desperate to have a qualified and comforting presence for Luke, I enlisted the help of the head of The Crisis Intervention Team at The Westchester Exceptional Children’s School. Though my brief time with Luke enabled him to gain some sense of safety I was not allowed to return to the building when Tim arrived. I could hear him greet Luke with loving warmth and was reassured when I heard a voice that spoke to Luke with respect and dignity. In that same tone, he turned to the officers and CAREERS staff and said: “I know you want Luke to walk down the stairs, and Luke wants to walk down the stairs. But in order to safely do so, he has to hold on to the railing so you’ll need to take off the handcuffs.” Surprisingly they did. Looking back on the events I am truly amazed at the calm yet forceful demeanor of Tim, who, despite being young in age, was treated as the expert to whom the police listened to without question.

As required by law, these kinds of circumstances require ambulance and hospital evaluation. Two points that must be acknowledged: the first came from an officer who witnessed the entire scene and accompanied us to the hospital. “I apologized to Luke and I apologize to you but when 911 is called a specific protocol must be followed.” The second came from the medical team who when hearing the full measure of what happened, replied, “He was cornered.” Yes, he was.

From beginning to end, not one law enforcement agent or CAREERS staff had any notion of how best to support Luke: IGNORANCE in full display which led to unnecessary force for a young NON VERBAL, gentle man who felt cornered, alone and frightened.

CAREERS has been quoted as saying, “People only know one side of the story.” My response: There is no other side to a story when you treat someone as inhumanely without dignity, respect or compassion as Luke was treated. Period.

How many more of us will experience this horrific and terrifying approach? How many of our children will suffer at the hands of law enforcement who, through ignorance, doesn't know the importance of lovingly supporting our children? How many more will suffer? How many families will grieve?

ENOUGH IS ENOUGH. At every turn, the community of those with Developmental Disabilities is discriminated in numbers that outdistance gender or ethnicity.

Ethan Saylor is one too many. The time for legislation is NOW before we're relaying yet another story. With a tsunami of a generation behind Luke's juxtaposed by national efforts toward more vigorous community interaction, it is incumbent upon those of us who love and care for these deserving and vulnerable individuals to push for justice. We MUST protect their civil rights by enforcing regulations and requirements for law enforcement and all agencies who engage with individuals with Developmental Disabilities to receive full and adequate training. If we don't, we fail the most vulnerable among us and we are better than that.

Laurie Cameron

Dear Senator Durbin:

As a retired NYS Teacher, I have first-hand experience assisting a developmentally disabled American for over 25 years. He has had many encounters with the police who have no clue on how to approach, speak and assist him even when presented with a written list of accommodations as protected under the ADA. This person has severe dyslexia, executive function difficulties, and an inability to express himself in writing or verbally, especially when confronted by threatening law enforcement. His facial features alarm law enforcers and further promotes aggressive actions.

He has endured harassment from college personnel and police officers for taking pictures on public lands whereby the photos assist him in remembering his surroundings. In effect, he has been handcuffed, arrested on trumped-up charges, restrained, made a prisoner in his own home, and excluded with inhuman treatment in violation of his civil rights for accommodations. This person is a law obeying citizen and not a criminal as the pre-conceived view by law officers.

I also had a woman trooper come to my house, unannounced, and query me on the activities and background of this individual so as to try to get information to provide some justification to the male officers for arresting him or denying him his driving privileges. He has been discriminated over and over based on his disability.

Law enforcement needs extensive training on how to approach, speak and handle persons with disabilities and not conspire to arrest these individuals who can't defend themselves.

Sincerely,

Linda J.Keeling

April 23, 2014

Testimony Regarding Law Enforcement Responses To Mentally Ill

By Lisa M. Ashley

Good Morning Mr. Chairman and members of the subcommittee. Thank you for inviting me here today to tell of my son's experience with Emergency Department (ED) and his experience with the police.

I am a Pediatric Nurse Practitioner with a Master's degree in pediatrics and have practiced for 38 years.

But I am not here to write in that capacity. I am here as a mother of an adult son who was diagnosed with Paranoid Schizophrenia 2 years ago. It is a long difficult and painful story like most.

My son was about 20-21 yrs. old when I knew something was wrong but it wasn't until he went homeless in LA and went missing for 3 weeks that I knew for sure. Of course he saw nothing wrong. When I was finally able to locate him, I brought him back to Sacramento. He was delusional, thinking the FBI was watching him, there were satellites in the sky that were monitoring his thoughts, having auditory hallucinations, could not hold a conversation, laughing to himself, not bathing or changing his clothes. Prior to this my son was extremely bright, received 740 out of 800 on his math SAT, was accepted to 7 Universities for mechanical engineering. His bizarre behavior went on for months. He refused to see a psychiatrist. He would see his primary medical doctor who was instrumental in having him 5150 (placed on a 72 hour hold) two years ago. I felt helpless and extremely frustrated. Even calling the police did not help since they did not believe he was harm to himself or others. They would just say they could not help and told me I should evict him from my home.

I am specifically going to tell his story regarding his stay in hospital emergency departments (ED), three times over a two year period. (We have no Psychiatric Hospital ED and the Sacramento County closed the Crisis Unit 3 years ago.) Each time I struggled with such pain and anguish, to see my beautiful son taken into

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custody and especially the first time, because he didn't know how sick he was and was very confused as to why he could not go home with me. I cried my heart out.

The first time was in May of 2012. He had been sick for almost over a year before I was able to get him evaluated. I told him I was taking him to the hospital to have some blood test done that his doctor ordered. With the help of his primary medical provider and his colleague who was the psychiatric ED physician, we were able to get my son admitted to the ED quickly, placed in a room and placed on a 72 hour hold. His stay the first time in the ED was for approximately 12 hours. I couldn't believe they had to hold him there for that long, not knowing that there was a shortage of psych beds in the County. He was then transferred to a local psych facility and remained 2 weeks, just as long as my insurance would allow. Although it was very difficult for me to have my son hospitalized, knowing he was in good hands relieved some of my anxiety. But still it was nothing like I had ever been through and having to trust a system that is so foreign to you is difficult as well. I worried every minute.

The second time was not quite as smooth. In January 2013, my son had asked voluntarily to be taken to the hospital because "he felt his head was on fire", he was very anxious and distressed. I dropped everything, knowing that if he was asking to go, he must have felt pretty bad. I brought him to the same ED that morning. When we reached the triage nurse, I identified myself as an employee and a nurse practitioner. **I explained my son was a paranoid schizophrenic and was in psychosis. I tried to remain calm as the triage nurses took his blood pressure and temp and then assigned him to a gurney in the hallway with at least 8 other patients which included children. All waiting to be seen by a doctor. It was not long before my son starting to get agitated and wanting to leave. The RN called the social worker to help intervene. She could not quiet him down. As he tried to approach the exit, an ED policeman tried to stop him by holding him back. His behavior then escalated. My son was screaming at him not to touch him (when schizophrenics are in psychosis they do not want to be touched). In front of all the children and adults waiting in the hallway, the police officer wrestled him to the ground and handcuffed him. I tell you this because I brought him to the hospital for medical treatment not for police**

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handcuffing him, and their intervention escalated his psychosis and made it worse. If he had been able to go to some kind of psych facility, he would of gotten him medical attention rather than police attention. Doctors would have known how to deal with him, calm him down and isolated him from others. The ED is not a quiet place and they are more trained to deal with physical illness and not mental illness.

They then placed him on a gurny, put him in 4 point restraints and then medicated him. He was screaming obscenities at me telling me this was my entire fault. I was taken to another part of the ED with social worker to help calm me down. To see all this happen to someone you love, especially your own child is devastating and heart wrenching. Later the officer came by and just wanted me to know he was not going to press charges.!! That was not helpful and it made me even more upset that he even considered pressing charges. !!!!! I should have been the one pressing charges. What he did was very inappropriate, especially in front of all those families watching in the hallway. !!!! He was not trained properly on how to approach psychotic patients and this was in a Level One Trauma ED where they get 6-8 psychotic patients a day!!

My son was admitted on Friday morning and was in the ED, that whole day, all day Saturday, all day Sunday until late Monday afternoon because they could not find an open psych bed anywhere. He stayed in a room, tied to his bed for those 4 days and was heavily medicated. Seeing him helpless tied to a bed for days was like a nightmare. This was my son, and I was helpless except to keep him company and to try to reassure him that things would be alright. I was angry that they could not place him somewhere. I wondered, "Really, does it take that long to find a psych bed?" Finally on Monday, I was told there was an opening at a hospital in San Francisco, 100 miles West of Sacramento. They took him later that day by ambulance. He stayed there another 2 weeks and because I work full time I was unable to see him except on the weekend and speak with him on the phone daily. I could not be a part of his treatment because he was so far away and that was extremely frustrating. Why did he need to go away so far from the family member who cared and loved him? By the way if I did not have him on my

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insurance plan he would have waited even longer in the ED because this facility did not take Medi-Cal (Medicaid).

I complained to the hospital about how he was treated in the ED. The head Physician of the ED agreed with me and said that if they had been able to place him in a quiet room, given him some additional antipsychotics, he may have not even needed to be hospitalized at all. He said they would make some policy changes so this did not happen again. He said people don't recognize the pain in mental illness is just as bad as the pain with a gun wound, you just don't see it.

The third time he was hospitalized was last November 2013. Once again "his head was burning and the voices were screaming at him". I took him back to the hospital ED, told the Triage nurse he was a Paranoid Schizophrenic having a psychotic episode and once again they placed him on a gurney in the hallway. Fortunately it was quiet with no others but staff there. I was very upset; I was silly enough to think they really did change the policy. I insisted that they place him in a quiet room and not leave him in the hallway like before, but I was told there were no rooms available and we would have to wait. Once again after a while he wanted to leave, this time 4 officers surrounded him but were able to talk him into staying and after several hours they then placed him in a room, tied him to the bed, sedated him. He was there for the entire day and most of the next. The only reason he was there for only 2 days that time is because in the months previous, I had made contact with a staff member at one of the local psych hospitals and, was able to call them and they made arrangements to transfer him there later that second day. He stayed another 3 days in the psych hospital. I was finally getting to know the system, but every time he becomes psychotic and I know I have no alternative but to bring him to the ED, knowing he will have a long stay, it upsets me, it shouldn't be so hard to get the right care you need at the right time in the right place.

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Because of these experiences, my son has told me he will never again go willingly to the ED. I only hope and pray that we will not need to return.

My son has been fairly stable since November not requiring any additional hospitalizations but attends regular psychiatrist visits and takes his medications regularly. I pray every day that he continues to stay in treatment.

Additionally, I attended a recent conference at this facility where they presented information about the effects on the ED as a result of the County closing beds (50 from 100 beds plus closure of the Crisis Unit). The staff stated that there was a 5 fold increase in the number of mentally ill patients admitted into the ED (1.3 to 4.4 patients per day) in 2012. In 2013 there were approximately 6.5 patients admitted per day and placed on holds with an average wait time of 40 hours before being placed in a psychiatric hospital somewhere in the State.

Thank for the opportunity to tell our story.

April 25, 2014

Dear Senators Durbin and Harkin,

I am writing one letter and sending it to both of you regarding the hearing on April 29-Law Enforcement Responses to Disabled Americans, and the Conventions on the Rights of People With Disabilities. My story is intertwined with both subjects making it impossible for me to separate them.

In May of 2004, my daughter and only child, was 19 years old. She was still living at home. She was working 30 hours a week as a file clerk and had taken a couple of courses in junior college. The Saturday before Mother's Day, she was home all day. That, by itself, was odd. Besides work, she was quite active with her friends and church. She had a car that we bought for her when she was 16 so getting around was no problem for her. She said she didn't feel well. She seemed unable to concentrate which was highlighted when she asked me if I had a tube of toothpaste while looking at a tube of toothpaste that was sitting on her sink counter.

The next morning, Mother's Day, began with her telling us things that shouldn't have made sense. But she had never given us any reason to think she would lie to us and we knew nothing about psychosis or delusions, so we listened to her concerns and tried to help her sort through them. She was distraught that the church we had attended where she had been in music ministry since she was 12 had, in her mind, suddenly become a cult. At one point, she asked permission to use the washing machine. I don't know if either of you have any 19 year old children still living with you, but asking permission for anything is rather odd. Sometime during that day she thought she was in trouble for leaving the house phone in her room. Again, at 19, she hadn't been "in trouble" in a number of years.

The evening began by her announcing she was going to try to attend church because as I stated earlier, she was in music ministry. She came downstairs somewhat past the time she should have left and said she couldn't go because people would follow her. By this time, we knew something was terribly wrong, but we had no clue what. My plan was to miss work the next day, insist that she miss work as well and take her to our family doctor. She was no longer on our insurance but I didn't care. All I knew was something was wrong. But again, not knowing what and having no reason to doubt that what she was telling us wasn't true...we discussed her fear of being followed with her. She said she would only be followed if she were in her car. In an effort to find out who was following her or to put her mind at ease, we got her to go for a ride with us in her car with her dad driving. We drove out of our quiet neighborhood up to the busy street whereby she laid down on the back seat so as not to be spotted by whoever was following her. There was nobody following us. My husband saw that her gas tank was almost empty, so we drove to the corner and filled up her tank. All the while she remained laying down on the back seat out of the view of whoever she was afraid of.

We drove back home and later went to bed. I hadn't been asleep long when she was knocking on our bedroom door. Again, I remind you, she was 19. I couldn't remember when the last time was that she had knocked on our bedroom door in the middle of the night. Naturally, I let her in. She laid down next to me. She was close enough to me that I could feel her heart racing. She said she really wanted to sleep. I suggested she go back to her room and try to relax. I told her I'd take her to the doctor the next morning and we'd find out why she was having a problem sleeping. She went back to her room.

It wasn't long before I was woken up by the phone ringing. It was a police officer asking me if I have a daughter named Toby. I said that I did. We spoke long enough for me to determine that she was at the corner gas station/mini mart, basically loitering and just being an unwanted nuisance. All she would tell

the officer was her name, her phone number and that she wanted her mom. My husband and I drove over there in our pajamas as we weren't about to take the time to get dressed. She was now convinced that her father was going to kill her. Weeks later, she told me that she ran through our neighborhood and crossed that busy street to the gas station with no clothes on which was probably why the clerk called the police. As she later recounted to me, she thought she would draw attention to herself which would then make the police wonder why she was walking around naked and thus, figure out that her dad was going to kill her and they would apprehend him. But that night, by sheer coincidence, someone who works on one of our crisis teams happened to be shopping at the gas station and gave her a shirt and some jeans. By the time we got there, she was wearing clothes that I knew weren't hers but at that time, she was unable to tell me where she got them.

The police knew she was on drugs. I knew she wasn't, but their attitude quickly told me that if I protest the obvious fact that she was on drugs, I looked like a stupid mom who either didn't know any better or was an over protective mother defending her obvious drug addicted child. The police called a crisis team who deals with folks on drugs who came to the gas station, talked with her and confirmed that she was indeed, on drugs.

The police told us to take her home even though she was terrified to get in our car with her dad. Somehow, I convinced her to come home with us. We all went back to bed. When my husband got up to go to work Monday morning, I checked her room. She wasn't in it. Shortly after my husband left for work, a police officer brought my daughter home. He was exceptionally kind. She didn't want to come in the house. He asked her if she'd like to go to the hospital. She said yes. So he took her to the closest hospital to my home which doesn't have a psychiatric ward, although at the time, I didn't know that's what she needed.

I called my husband. He left work and met me at our house. We got to the hospital as quickly as we could. We were there for 14 hours. She got a little bit of sleep due to feeling safe that her dad couldn't kill her while we were in the hospital and to an IV drip of Ativan and other fluids to treat dehydration. They ran drug a drug test which came back negative. They sent her blood work off for more comprehensive drug testing that would take 2 weeks for results. Those results also showed no drugs.

While at the time I didn't understand what the doctor was talking about, the ER physician knew she needed psychiatric care. He couldn't send her to one of our urgent psychiatric facilities for involuntary care because she wasn't an immediate threat to herself or others. In Arizona, we have a very well written law that also provides for involuntary treatment if the person is as disabled as my daughter was from her symptoms. The bad news is it's not considered an emergency. A petition has to be filed in person at the facility. I don't know if the ER physician was familiar with the process or not but it wouldn't have made much difference. It would have been her dad or I that would have had to do it and we were in no shape to understand the process or why we were doing it anyway. Plus, it could have taken up to a week for anyone to come get her which would have been far too long to wait. The doctor discharged her with the diagnosis that she had been slipped some acid which apparently doesn't show up on drug tests and told me to continue to be supportive.

We managed to get her in the car and began the short trip home. She threatened to jump out of the car if her dad was going to come home with us. So we dropped him off at a hotel that also wasn't far from our home. I was quite literally exhausted and hoped she was as well. I took her home. I suggested she take some Benadryl to help her sleep and again told her that the next day which was now Tuesday, that we'd go see our family practice doctor which was also recommended by the ER doctor. She wanted me to leave my bedroom door open and I did.

Once again, I was woken up by the phone ringing. This time it was a 911 operator asking if someone at my house was calling 911. I ran downstairs to find my daughter in the street with my cell phone in her hand talking to a 911 operator. I told the operator that I was speaking to that yes, my daughter was calling. I explained that I had no idea what was going on and added that we don't need the police. But they came anyway. They ushered my daughter into the house. She sat on the floor and explained to the officers that her father was going to kill her. I again explained that I didn't know what was going on, told him about the ER visit and that her dad wasn't even home. She said she was sure he was home and asked them to check the house. The male officer checked the house, confirmed that my husband wasn't in the house and told my daughter that if the police had to come to our house one more time on account of her, they would find a reason to arrest her. That's when I couldn't take anymore and while sobbing I told the officers that while I had no clue what was going, the one thing I was sure of was that she didn't belong in jail. The officers left.

I laid on the couch until the sun came up with all the phones, my purse and the keys to her car clutched in my hands in an effort to keep her from calling anyone or driving anywhere. When the sun came up, I realized I couldn't do this by myself. Since having my husband gone hadn't fixed anything for my daughter, I called him, told him we were missing another day of work and asked him to come home. Upon hearing that, my daughter hastily packed a suitcase, ran out of the house with the contents spilling out, walked around the corner, knocked on someone's door and asked if she could come in. Surprisingly, a lady whom we have never met, let her in. I found the house she was in by following the trail of clothes. The poor lady looked relieved that I had come to retrieve her. Thankfully, she came home with me, but then left again while I was showering. I went to look for her and found her when I saw police officers around the other corner. She was at another house, again occupied by people we don't know, asking if she could live there. When I got there, she was sitting on their front step. A police officer was trying to convince her to leave. She told me, again, weeks later, that she thought a member of her favorite band lived there and she wanted to move in with him. All of this had happened and it was still too early to call the doctor's office.

But I had stumbled across the behavioral health crisis line, so I called that number. They told me I could have the police take her to what I now know is one of our two psychiatric crisis facilities. The officers obliged. My husband came home and we went over there too. We talked to a woman who took all the information, then told us to be seated in the waiting room. A short while later, a man called me up to the counter and said they probably wouldn't be able to admit her. I didn't know what he was talking about. I didn't understand what type of facility we were in or exactly where she wasn't being admitted to. But I rejoined my family. My daughter had laid herself down on two empty chairs beside my husband and had her head in his lap. That was a good sign, or so I thought. Maybe this was over. We sat there a while longer. My daughter said she was tired. I asked her if we could go home and stop all this stuff now. She said we could. So we went home.

Things were quiet, albeit strange for a number of hours. She hadn't had much, if anything, to eat for the last couple of days. None of us had. At one point, she put all the makings for a sandwich on the counter, left them there and never made the sandwich. At another point she said she wanted something from Dairy Queen. She wanted me to take her. I said I was too tired to trust myself driving. She agreed to go to Dairy Queen with her dad. They went and got us all Blizzards without incident. While they were gone, I called the behavioral crisis line again. This time I was quite a bit more distraught, partly from exhaustion and partly from knowing that while things seemed calm for the moment, my gut told me this wasn't over. I had to know what to do. The lady who answered the phone was very helpful. She didn't think it was over either. She thought at some point my daughter would probably try to leave

again. She instructed me not to let her and to call the crisis line when it happened. She said they would send police who would keep her in the house until the crisis team arrived.

As she predicted, shortly after finishing her Blizzard, my daughter walked toward the front door. I asked her where she was going. She said she was going back to the last house where they had called the police on her. I explained to her they didn't want her there. She was going to go anyway. My husband got in between her and the door and told her she couldn't go. I called the crisis line while he tussled with her. The lady on the crisis line told us to restrain her if necessary. My husband did the vast majority of the restraining. At the time, she weighed 120 pounds, he weighed 200 pounds and is significantly stronger. He struggled to keep a hold of her on the floor even with most of his weight on top of her. Not a moment too soon, the police arrived, then the crisis team.

After their assessment, she was taken to our other emergency psychiatric facility by the police with the crisis team and us following behind. She was then taken through our involuntary treatment process. She was inpatient for a couple of weeks, then involuntarily treated as an outpatient for a year as our law allows. She wasn't diagnosed that first time with anything other than psychosis. After that first year she was allowed off treatment. After some months, symptoms returned, we went through a similar process to get her admitted again. This time she was given the diagnosis of Bipolar 1 Disorder with Psychotic Features. We repeated this process two more times as she had no insight, or anosognosia, simply meaning she was too sick to know she was sick. One doctor bluntly explained it to me by saying "she's too crazy to know she's crazy". Some people might think that's a cruel statement. I appreciated his honesty. While psychotic, she believed every single one of her delusions was the truth. The medicine did a good job at stopping the bizarre behavior and allowing her to sleep. But she could somehow always rationalize the irrational behavior that landed her in the hospital and forced the State of Arizona to provide the care she had no way to understand she needed.

Thankfully, after the psychosis cleared, she knew her dad was never going to harm her in any way. Their relationship is and always has been great. Even with no insight or understanding of her illness, she always regretted putting her dad through the heartbreak of being afraid of him. She hasn't been psychotic or hospitalized since January of 2010. In 2012, she gained insight and has been willingly taking medication since then. While that part of her story is an obvious success, it's not all good news. She went back to work after recovering from that first episode in 2004. After the second one in 2006, she went back to work as well, however, she had to work less hours. Two more psychotic episodes that also forced her to reach arbitrary guidelines set by law before she could get treatment, took their toll on her ability to function. I became her guardian to assist her in activities of daily living and to continue to advocate that she gets the best possible care available. Her dad, that man that she had those horrible delusions about, supports both of us, as he has for over 30 years, and she collects Social Security Disability.

While I now consider myself an expert in psychotic disorders and our system of care here in Arizona, I'm not an expert on civil rights. However, I know of no other illness where the patient is transported to the hospital, even when they aren't aware enough to give consent, by police car. I also know of no other illness where the symptoms so often require police intervention. I know the current thought by most advocates is to have all police officers CIT trained so they can recognize people with mental illnesses and be better able to handle them. I suppose it can't hurt. But I would rather we find ways for police officers to have less interaction with people who are sick and let them focus on protecting us from criminal activity that isn't due to the person having something wrong with their brain.

If police can be trained to recognize someone who is psychotic, shouldn't they be required to call the

professionals rather than being responsible for that person themselves? Perhaps they could call the local behavioral department or crisis team to assess the situation and then if the person needs medical care, the person is in the hands of the appropriate agency rather than being forced into the criminal justice system.

It would also make more sense and be far more compassionate to have someone be escorted in for an involuntary hold by EMTs as opposed to law enforcement. Not only was this practice demoralizing and humiliating for my daughter, it was confusing, which seems particularly cruel to do a person who is already confused and scared by unreal intrusive thoughts. She was handcuffed on two of her four trips to the urgent psychiatric location due to being rather disruptive. On the other hand, when her journey to one of her involuntary holds began with the EMTs due to an accidental overdose, she was put on a gurney, strapped down and escorted to the ER via fire truck. The EMTs explained they strap everyone down for safety reasons. So they not only have the ability but the requirement to restrain people. This was a far more humane way to be taken in for medical care. Ironically, she eventually had to be moved from that hospital and taken to the psychiatric facility. Since it was an involuntary pick up, a police officer came to the hospital and led her out in handcuffs. If that's not a civil rights violation, it should be.

Every state should have an involuntary treatment law that is as well written as Arizona's is, the text of which begins at ARS 36.520. Also, a well run behavioral health department staffed by medical personnel and technicians who understand the severity of these illnesses and really want to help meet the needs of people who suffer with them. Like many other states, including the Federal agency, SAMHSA, there are far too many advocates working in the system and far too few people who are actually able or willing to help the people, like my daughter, that suffer the most with these illnesses. The current trends are promoting the falsehoods that everyone can recover and illnesses like my daughter's or paranoid schizophrenia are caused by trauma.

One such bearer of false information is Tina Minkowitz, one of the proud drafters of the CRPD. The fact that she is a regular contributor on the Mad in America website, a site dedicated to bloggers who want us to believe that mental illness isn't real, the medicines that treat them are poison and psychiatry is bad, abusive and unnecessary, should disallow her from speaking about serious mental illness, much less being a part of drafting a treaty that could have the ability to drastically deny treatment to the sickest people. In a letter she wrote to Senator Harkin dated April 24 that she posted on Mad in America, she begins by describing her horrible and needless experience in 1977 when she was "taken from the street and locked up in psychiatry". She clearly feels this was unnecessary as she explains her parents precipitated it because they thought she was running away. However, here we are, almost 40 years later, and later in this letter to Senator Harkin, she refers to herself as a member of the disabled community, not by having a mental illness, but by psychiatric labeling.

I don't know what was happening in 1977, but as my daughter's case illuminates, even in a state with a rather liberal involuntary treatment law, people don't easily get picked up and taken anywhere. We are fortunate here in AZ because anyone can file a petition. But Ms. Minkowitz should be happy to know that if someone filed one simply due to an adult child "running away", that would be a crime. She also says she graduated from law school and as I mentioned, helped draft the CRPD. She is also the President of the Center for the Human Rights of Users and Survivors of Psychiatry. And yet, she is the one who should speak for people as sick as my daughter? How can she relate or have any idea of how sick my daughter is? What gives her the right to speak for my daughter or opine as to whether or not my daughter does or doesn't need, should or shouldn't have necessary medical care when the illness she suffers from precludes her from getting that care on her own? She also doesn't believe my daughter

should have a guardian. Again, I don't know if or how that relates to my daughter's civil rights, but it should. Someone who is as able minded as Ms. Minkowitz should not be allowed to speak out against medical care for those folks who so clearly would be unable to access it on their own. With that in mind, I respectfully ask that families of the folks that could be affected by Ms. Minkowitz's advocacy be spoken with before any further action is taken regarding people with serious mental illness and the CRPD.

Thank you for your time in reading and considering my story. I hope it can be included in the record.

Lois Earley

Statement to the Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights in response to:

Law Enforcement Responses to Disabled Americans: **Promising Approaches for Protecting Public Safety."**

BACKGROUND

As a 30-year career municipal law enforcement officer who is both crisis intervention team (CIT) trained and a CIT trainer, and who possesses a graduate degree in forensic psychology, I have extensive first hand experience observing, assessing, and working with law enforcement officers, mental health professionals, individuals in crisis, and those living with severe mental illness (SMI) and developmental disabilities (DD).

The movement in the 1960s toward deinstitutionalizing mentally ill individuals and providing locally-based community support options was well intended and absolutely the right thing to do for millions of Americans who live with intellectual and developmental disabilities. Sadly, the costs associated with funding local communities adequately to provide an effective support system for those living with SMI and gross developmental disabilities were vastly underestimated. A lack of funding priority, coupled with the efforts to balance the rights of the individual to comply with treatment and the need for public safety considerations has resulted in an over-representation of these populations in our jails, our homeless shelters, and often over-utilization of public safety resources. In effect, this population is once again institutionalized; this time with little or no treatment options available.

In the late 1980's, local law enforcement began to partner with mental health and social services to try and develop better ways to respond to the needs of SMI and DD individuals. The focus of this effort was to give police a greater awareness of SMI and DD, de-criminalize mental illness, divert SMI out of incarceration and into treatment, and reduce the number of violent confrontations between police and this population. Through these collaborative efforts, a 40-hour CIT training curriculum was born. Over the past 25 years several thousand state and local law enforcement officers have received CIT training and several studies have been published that indicate CIT does show a desired effect on reducing incarceration, reducing injuries to police and SMI / DD individuals, and promoting a greater awareness of the special needs of this population.

When Memphis PD created the first CIT program, they identified recommended core elements to be implemented:

Ongoing Elements

1. Partnerships: Law Enforcement, Advocacy, Mental Health
2. Community Ownership: Planning, Implementation & Networking
3. Policies and Procedures

Operational Elements

- 4. CIT: Officer, Dispatcher, Coordinator
- 5. Curriculum: CIT Training
- 6. Mental Health Receiving Facility: Emergency Services

Sustaining Elements

- 7. Evaluation and Research
- 8. In-Service Training
- 9. Recognition and Honors
- 10. Outreach: Developing CIT in Other Communities

While CIT training has proven to be a valuable resource for law enforcement, there exists a reluctance throughout agencies across the US toward “operationalizing” this training or fully adopting the core elements. To be fair, some agencies have recognized the value of adopting the CIT core elements and have been successful in adapting the organizational culture to embrace these concepts. However, budget constraints, cultural resistance, lack of administrative support, lack of community resources, and operational limitations all serve to impede an agency’s ability to view CIT training as much more than a training philosophy.

DISCUSSION

Evaluating the issues that diminish CIT adaptation requires understanding the realities of the 21st century police agency and officers, and the limitations that CIT training, as it currently exists, imposes on itself.

Few in law enforcement will argue that the police are the de facto liaison between those living with mental illness, the criminal justice system, and the mental health community. Yet, aside from CIT, remarkably little has been done on a global scale to seriously address this important functionality. While there may be several reasons for this lack of “buy-in” by law enforcement, one significant observation that frequently arises is the perception that CIT is an effort to teach police officers how to function as quasi-mental health professionals. Much of this perception is reinforced where local mental health departments have assumed a lead role in the development and presentation of CIT training curriculum to officers.

In several states, funding for CIT training is managed by the state or county Department of Behavioral Health Services and made available to train law enforcement. While collaboration is one key component of CIT training, an important misunderstanding arises when mental health professionals assume they can train law enforcement without fully understanding the existing role, philosophies, and practices of those in the audience. Unless the training is able to incorporate philosophies that are important to officer, such as officer safety, command presence, use of force, and time management, there is potential that the intended message will be missed or ignored. The prevailing attitude among the

majority of police officers is that those working in mental health have little credibility when it comes to understanding how to perform effectively in a “streets” environment. However, when the instructors are able to bridge this credibility gap, either by demonstrating firm understanding of police procedures, or being police officers themselves, the audience is more likely to embrace the training.

An officer’s first introduction into their role within the mental health system usually occurs in the basic police academy. There, s/he receives a limited (often only 4-8 hours) presentation on recognizing SMI and DD. It is here that the recruit officer learns about their authority to place an individual on an involuntary commitment for psychiatric evaluation and little more. With rare exception, little or no training is presented to understand communication techniques, crisis de-escalation, and use of force considerations. In fact, most academy officers receive substantially more training in how to use force than they do in how to avoid it.

After the basic academy, the officer usually enters a field training program gaining an in-field opportunity to put their academy knowledge into practical application with an agency field training officer (FTO). It is here that the new officer becomes indoctrinated into the prevailing operational culture of the agency. Often, the new officer will learn that the capabilities of the community mental health system are inadequate or non-responsive. The process of placing an individual on an involuntary hold may be cumbersome and perceived as a waste of valuable police time. If CIT is not a major focus for the agency, or the FTO is not trained in CIT, the new officer may have a diminished understanding of issues affecting SMI and DD individuals and potentially disastrous confrontations or incident dispositions may result.

For a majority of law enforcement agencies, in-service training budgets are tight and state mandated training may consume much of the time and budget allotted to their personnel. Many states require that certain training topics defined as “perishable skills” must be continually updated to assure competency. Usually these topics involve deadly force (ie: shooting and range qualifications), vehicle pursuits, domestic violence protocols, etc. Interaction with SMI and DD individuals is generally not a typical training consideration, nor a perishable skill and budgets may not be able accommodate ongoing training for this subject.

Because many agencies view CIT as simply specialized training, there is often little understanding regarding operationalizing a CIT program. No police administrator would consider sending officers to a specialized training such as SWAT or K9 without putting an operational program into place to best utilize the trained officer in a team or unit concept. Yet CIT has not received similar universal adaptation and often the expectation is that the CIT officer will simply bring added tools to prevailing field operations. Possibly this misuse of CIT results from inadequate understanding of the impact SMI and DD individuals pose to public safety services and the potential liability exposure represented by unsuccessful contacts with this clientele.

There has never been a definitive measure of the impact SMI and DD individuals have to public safety services because most law enforcement agencies classify their calls for service based on type of incident rather than by behavioral indicators. Thus, the tendency, upon call intake, is to identify an event by its criminality (ie: public disturbance, burglary), need for EMS response (ie: traffic accident) or general public contact (ie: civil standby, found property). Agencies trying to identify the impact of SMI and DD on their calls for service often under report their contacts because only those incidents initially classified or disposed out as an involuntary commitment are captured in dispatch records. Those agencies that have taken a more critical look at their calls for service soon discover that a few individuals are contacted with far greater frequency than the general population. Further exploration commonly reveals most of these individuals exhibit behaviors consistent with SMI or DD, yet few of these contacts ever identify SMI/DD as a factor in the dispatch log.

One emphasis of CIT as it currently exists is the requirement that only officers who voluntarily choose to receive the training be allowed to participate. This prerequisite seeks to maintain philosophical integrity by recognizing some officers have no interest in CIT and would not benefit from the training. However, this sends a mixed message regarding the commitment and support an agency has toward CIT and how officers interact with the SMI/DD clientele. In addition, since most agencies elect to set a goal of training between 10% - 25% of their staff in CIT, there is often a lack of available CIT trained officers on duty to respond when needed for a mental health crisis. Our position is that all officers should receive CIT related training to gain both a greater understanding of the clientele and the willingness to access available community resources as an option to incarceration. However, as the 40-hour course is a significant impact to training budgets and staffing limitations, and the depth of information offered in the course may not be necessary for every officer in an agency.

One approach that has proven successful in some agencies is to create a tiered response concept similar to how the fire service (see Seattle FD) integrated advanced life support capabilities into their medical responses. An operational Behavioral Health Unit model for law enforcement would involve a basic response tier, an advanced CIT intervention unit, and ongoing joint case management.

In such a concept, all officers receive an introductory course (8-16 hours) that is a distilled version of the 40-hour CIT course and relevant to in-field interactions. Because most agencies with CIT do not have the resources on call to provide 24/7 response capability for all incidents involving SMI/DD individuals in crisis, regular field officers tend to handle many of these events. The introductory course raises awareness to the demands the SMI/DD population places on public safety services and provides an overview of the more common interactions officers have with this population. The training involves less emphasis on identifying the causes of mental illness and developmental disabilities and more focus on the behaviors associated

with them. Diffusion techniques, intervention strategies, and enhanced assessment tools are presented that enable officers to seek better options when dealing with persons in crisis. This response tier would respond to all calls and conduct on site evaluations for individuals who exhibit behaviors consistent with SMI or who are acknowledged to be living with mental illness. When such an individual is identified, an interagency referral would be generated to the CIT Coordinator for follow up review. If documentation of crimes is indicated, these officers are able to investigate the mental health status of the defendant and provide valuable information that may be utilized when deciding to divert the individual to an emergency psychiatric facility or, if an arrest is made, referral to a behavioral health court.

Note: In 2008 the Sunnyvale (CA) Department of Public Safety developed a tiered CIT response program and provided an 8-hour introductory training course to all police and fire personnel. A 2012 study of the Sunnyvale program revealed that positive outcomes involving contacts with SMI/DD individuals and police did not significantly vary between contacts with CIT trained officers or introductory trained officers.

Cartwright, S. (2012). *Efficacy of Crisis Intervention Team Training Models: Reducing Repeat Contact between Police and Mentally Disordered Individuals* (doctoral dissertation). Alliant International University

The 40-hour CIT training is offered to a select group of officers who demonstrate a desire to work more closely with the SMI/DD population by gaining enhanced assessment skills and collaborating with the local behavioral health court, community mental health and social services, and allied agencies to find meaningful, relevant and long lasting solutions for those who over utilize the public safety systems. Similar to a SWAT team, the CIT unit would respond to the most severe incidents involving SMI/DD individuals. Besides response responsibilities, these CIT officers would review all referrals made by field officers and evaluate the need for additional intervention or linking them to needed community resources.

The final component of an operational law enforcement CIT program is case management. Once a SMI/DD individual comes to the attention of law enforcement, the CIT unit would monitor their disposition and any need for ongoing care. Since a main reason why SMI individuals fail to comply with treatment opportunities is the lack of a viable support network to help them stay on course, the CIT officer would be assigned to assess obstacles to treatment compliance and seek solutions to overcome them. Working closely with other community agencies and resources, the CIT officer would continue the process of bringing the client and the needed resources together as well as maintaining supportive contact. The CIT officer would participate in joint multi-disciplinary team committees to address individuals in greatest need of intervention as well as to maintain a regional awareness of individuals who are excessively impacting public safety and community resources.

RECOMMENDATIONS

Congress can assist local law enforcement agencies in responding to the needs of the SMI/DD population by seeking to create a standardization of best practices for CIT.

Adopting a tiered operational program model, as described herein, recognizes that the separation of roles between the criminal justice and social services systems has blurred, yet collaboration efforts have barely scratched the surface. CIT training, as designed in 1988, was a viable response to an immediate need resulting from a community demanding better response by police to incidents involving mentally ill and developmentally disabled individuals. Subsequent training over the past 25 years has resulted in thousands of officers receiving CIT training, yet countless contacts between SMI/DD individuals and police continue to result in tragic outcomes. Highly publicized mass public assaults appear almost daily in the news and all too often a common factor is the known, yet unreported or untreated, mental instability of the perpetrator.

We believe Congressional action can help to bring a sense of urgency and commitment toward expanding the role of CIT at the state and local levels. Through development of a standardized operational program model and supplying adequate funding opportunities to enable creation of these programs, law enforcement can move forward by becoming proactive rather than reactive to the needs of the SMI/DD population. We ask that Congress explore the following:

- Development of a standardized tiered CIT Program for all federal, state, and local law enforcement agencies (either individually or regionally)
- Actions to assist CIT collaboration efforts by removing or modifying obstacles that impede or restrict exchange of information between law enforcement, mental health, and social services

- Provide sufficient funding to enable all law enforcement personnel to receive introductory or advanced CIT training and for agencies to implement an operational CIT Program
- Urge individual state Police Standards and Training Commissions to require all basic police academy officers receive a minimum of 16 hours of training in introductory CIT awareness and intervention techniques

Respectfully submitted,

Lt. Charles Kirkham
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Testimony by
 Lt. Michael Woody (Ret)
 Akron Police Department
 Before the Senate Judiciary Subcommittee on the
 Constitution, Civil Rights, and Human Rights
 April 29, 2014

Chairman Durbin, and members of the Subcommittee, thank you for the opportunity to testify today on the positive impact that Crisis Intervention Team training has had in Ohio.

Ohio researched the “Memphis Model” of Crisis Intervention Teams (CIT) back in 1999. The county mental health board in one of our 88 counties (Summit) sent a two-person team including the Director of Training of the Akron Police Department and the clinical director of the county crisis center to Memphis. They actually went through the 40-hour course along with a mental health provider and brought back what they learned to share with the community. Our local National Alliance on Mental Illness (NAMI) organization immediately embraced the idea of starting a CIT Program. The first CIT Course was held in May of 2000 and gained not only local but statewide attention.

Then, Ohio Supreme Court Justice Evelyn Lundberg Stratton formed an ad-hoc committee called The Ohio Supreme Court Advisory Committee On Mentally Ill in the Courts (ACMIC). In short order this committee grew to over 70 people that included judges, magistrates, lawyers, law enforcement officers, mental health professionals, NAMI state officers, Ohio Department of Mental Health officials and other interested state agency heads. These members believed that persons suffering a mental illness would be better served in a hospital setting than a jail or prison setting. The creation of a CIT Program was the lynch pin that set this goal in motion. Simultaneously, the Ohio Department of Mental Health (ODMH) used a portion of its federal block grant dollars through the Substance Abuse and Mental Health Services Administration to establish Coordinating Centers of Excellence (CCoE’s).

One of those CCoE’s became “The Criminal Justice Coordinating Center of Excellence”. That Center is based out of The Northeast Ohio Medical University. Their immediate task was to spread CIT Programs throughout Ohio. It was a slow process at first but with the support of the National Alliance on Mental Health (NAMI) - Ohio, Ohio Supreme Court, the Ohio Attorney General’s Office, and all the stakeholders working together (hence why the “T” in CIT stands for TEAM) we are proud to say that over 7,000 sworn police officers in Ohio have gone through the course and proudly wear the CIT Pin. CIT Programs are in every county in Ohio except for two very rural ones. Over 500 law enforcement agencies have participated.

Also, over 500 Correction officers, 200 Police Dispatchers, 90 Park Rangers, 174 Hospital Security Officers, and 54 College/Universities have sent security officers to local courses.

We have even had 23 officers from other states and 3 officers from other countries come to Ohio to go through our CIT Courses. Why? Because we have the reputation of doing CIT the right way – 40-hours of intensive course work and presentations by many M.D.'s, Ph.D.'s, Judges, Magistrates, Law Enforcement CIT Coordinators, persons with a mental illness and their families, etc. that are from the community the class students are from. None of these instructors ask for remuneration. This is extremely important as it shows the students how much this course means to the community they serve.

It is also extremely important that the officers that wear the CIT Pin wear it proudly. Persons suffering a mental illness or other disability and their families look for that Pin on the officer's uniform. They know this officer has the heart because they volunteered and were vetted to be a CIT officer, and the knowledge of the illness so as to realize that they need help instead of a jail cell. That officer is part of a TEAM made up of other like-minded officers, judges, mental health providers, advocates and consumers who work together to solve a humanitarian problem. That problem is the criminalization of the mentally ill in our society.

The motto of CIT International is "CIT – It's More Than Just Training!" Here in Ohio we understand and embrace that. If it's just training then where does that leave the community stakeholders? If just any officer can become a CIT officer where is the pride of wearing the pin? Without a community partnership how do you solve seen and unforeseen problems? The phrase "It takes a village" definitely applies to such an undertaking – that is unless you just want to get minimum results without really fixing the overall problem.

Having a CIT Program in our state and in my community has opened many doors as that "lynch pin" referred to earlier. We now are working on solving the problem of the over crowded jails and prisons by diverting those with a mental illness into treatment. We are organizing community efforts to influence what happens to those with a mental illness that do enter the criminal justice system whether at the initial detention or the first appearance in court. We work on establishing mental health specialty courts, and re-entry to the community from jail or prison. We also are working to establish community housing, medication attainment, employment opportunities, etc. when individuals with a mental illness or other disability are released from incarceration. The goal, of course, is to try to insure they will not re-offend and end up back in the correctional system and will become productive citizens.



Law Enforcement Liaison – Ohio Criminal Justice Coordinating Center of Excellence
Board of Directors President – CIT International Inc.

Comments submitted to the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights, relative to the hearing entitled “Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety.”

Lydia Brown
May 2014

I am writing regarding the recent hearing that convened on April 29, 2014 to discuss issues concerning disabled people and law enforcement. I am an autistic advocate for people with disabilities presently serving on the Board of Directors of TASH¹ New England, as well as a current member of the District of Columbia Autism Task Force, and the Consumer Advisory Council for the Georgetown University Center for Excellence in Developmental Disabilities. TASH New England is the regional chapter of TASH National, an international association of people with disabilities, family members, and professionals devoted to equity, opportunity, and inclusion for people with the most significant disabilities and a founding coalition partner of the Alliance to Prevent Restraints, Aversive Interventions, and Seclusion (APRAIS). Previously I worked for the Autistic Self Advocacy Network² for over two years, and served on the Adult Services Subcommittee of the Massachusetts state autism commission. My work has primarily focused on issues of violence against people with disabilities, including police misconduct, police brutality, and prisoner abuse.

In 2009, I wrote legislation in my home state of Massachusetts that if passed would mandate training on autism and other developmental disabilities for all corrections and law enforcement officers, in both the basic training courses as well as in-service continued training. One of the most important elements in my proposed legislation requires that self-advocates—people who have developmental disabilities themselves—play a significant role in developing the curriculum as well as providing the actual in-classroom instruction for officers. However, it is critical to note that while appropriate and practical training for law enforcement can provide one tool for addressing issues that arise when law enforcement officers interact with disabled people, it is certainly not the only tool available either as even trained officers may engage in misconduct or outright brutality.

In recent years, there have been a number of incidents involving people with disabilities who have faced wrongful arrest, unnecessary use of force, coerced statements, and ultimately, death, at the hands of law enforcement officers. Increasingly, young children with disabilities are arrested and charged for acting in self-defense after being subjected to practices such as restraint by teachers and other staff at schools. In other incidents, such as those of Reginald “Neli” Latson and John Williams, people with disabilities face severe police brutality during routine encounters. In still other incidents, such as those of Mohamed Usman Chaudhry and Robert

¹ TASH was originally founded in 1975 as The American Association for the Education of the Severely and Profoundly Handicapped. In 1980, the name changed to The Association for the Severely Handicapped, and in 1983, to The Association for Persons with Severe Handicaps (TASH). In 1995, the Board of Directors discontinued the full name, but maintained the acronym. See TASH, ABOUT US, available at <http://tash.org/about>.

² The Autistic Self Advocacy Network is a 501(c)(3) nonprofit organization run by and for Autistic people. ASAN advocates for systems change and the inclusion of Autistic people in the policymaking process, while working to educate communities and improve public perceptions of autism.

Ethan Saylor, people with disabilities are unnecessarily killed by officers acting under the color of law.

The Committee must also consider the lack of meaningful access to equal opportunity, as well as the most basic rights protections, for people with disabilities in correctional settings. This includes d/Deaf prisoners, who face severe and urgent challenges to their most basic human rights in state and federal institutions across the country. Helping Educate to Advance the Rights of the Deaf (HEARD) has repeatedly publicized the silent crisis of violence against deaf inmates as well as the *de facto* denial of communications access to these inmates both with corrections staff and with their friends and families.

Finally, I urge the Committee to consider addressing the disparities in prosecutions of hate crimes targeting people with disabilities, including murders of disabled people by family members and caregivers. Severely underprosecuted under the Matthew Shepard and James Byrd, Jr. Hate Crimes Prevention Act, and likely severely underreported to the FBI's National Crime Information Center (NCIC), such crimes disproportionately target people with physical, psychiatric, intellectual, and developmental disabilities. Furthermore, law enforcement and prosecutors are not adequately educated to detect abuse and violence against people with disabilities committed by direct care staff, family members, or other caregivers—especially those who serve as legally appointed guardians for their wards.

It is critical to develop accurate means of collecting and maintaining data on crimes against people with disabilities, including those perpetrated by law enforcement officers and family members, in order to develop a framework for shifting funding to community-based projects and research to address the extreme disparities in access to justice for disabled people.

Lydia Brown
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Senator Durbin,

As the parent of a young man with autism and mental illness, I want to express my appreciation for the hearing you held earlier this week. Our family has had several encounters with first responders from the Fairfax (VA) County police department. I would like to offer the following comments from our personal experiences:

1. Each time that we were forced to engage the police department it was because of the utter lack of appropriate and comprehensive mental health services within one of the most affluent jurisdictions in the country.
2. Our police officers have been wonderful. Each time I commented to them that I appreciated the way things were handled, and that they obviously had some type of training.
3. There was one occasion where I felt I needed the assistance of the emergency mental health team, but I was told that they could not send someone out because my description wasn't desperate enough! Thankfully because of my professional background I was able to implement a safety plan for myself and my son; but I sure felt inadequate and most alone. Is this our government's definition of personal responsibility?

Some comments on the hearing:

1. Thank you for holding it.
2. It was clear from the people testifying that while CIT is very important for police officers and other emergency personnel, this cannot replace the need for adequate mental health services and supports for the person with mental illness/developmental disability/dually diagnosed AND their families. The people who live day in and day out with people with challenging behaviors need help.
3. It is clear that my tax dollars are already going to support the incarceration of people with mental illness. I thought we had "de-institutionalized" people

with mental illness over a generation ago. This area may not be under the jurisdiction of your particular committee, but please work with your senate colleagues to hold the appropriate hearing on a. the decriminalization of mental illness and b. transferring the money from prison budgets to mental health court and services budgets.

Thank you,

Marisa C. Brown

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Marisa C. Brown MSN, RN
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Join us for the 2014 Georgetown University Training Institutes on systems of care July 16 - 20, 2014 in Washington, DC! Check our website for up-to-date information <http://gucchdtacenter.georgetown.edu/traininginstitutes.html>

Mary Ann Bernard

(personal address omitted)

Sacramento, California

April 21, 2014

To the Senate Judiciary Committee:

My background qualifies me to offer a unique perspective on the problems of police confrontation with the severely mentally ill. A retired lawyer, I was eighteen years an Assistant Attorney General in Minnesota, and represented both police units and state mental hospitals during that time. I am well aware how workers were trained in both contexts, and how different that training was.

Sadly, I believe it needs to be. Mental hospital workers are trained to do no harm to berserk patients, even at the cost of injuries to themselves. They learn specific takedown methods that take advantage of large numbers of available staff, more controlled environments, and the fact that they rarely deal with anything other than *ad hoc* weapons. They employ "shows of force" or assign people to grab different limbs, or use mattresses as shields. Not techniques the police would ever think to use.

In contrast, police are our first protection against violent criminals. Their emergencies often involve people with concealed deadly weapons, in situations they approach with no backup and with little or no information. We want them to keep themselves safe, because we don't want the Bad Guys to win. Expecting them to make a split-second decision that someone is a mental patient rather than a violent gangbanger requires them to be more schizophrenic than the mental patients themselves. If they don't err on the side of protecting themselves, as they are now trained to do, Bad Guys will sometimes kill them and get away. So the *status quo* is the regrettable opposite: they assume the worst, do as they are trained, and wind up killing sick people who meant no harm. This is bad for everyone, including the police. It is every cop's nightmare.

We should therefore become a society that avoids making police the first responders in mental health crises wherever possible. A better approach, which the Committee should pursue, would be to fund specific pilot programs for mental health crisis units, staffed by first responders who are mental-health trained but who can call in specially-trained squads of police when the situation is too out of control for them to handle. Because these specially trained police units will not be first responders, they will not be approaching a crisis "cold" or without backup, and are less likely to treat the severely mentally ill as if they were violent criminals. And, they will be part of a team that has the necessary expertise and manpower to deal with an evolving crisis.

Mental health crisis units are now operating around the country, and are effective to varying degrees, depending on how they are structured. My understanding is that the "Memphis Model" has been the most studied, and looks to be the most promising. Whatever the case, money should go to funding pilot programs that build on the emerging data in this area, with the goal of taking ordinary cops out of the mental health arena entirely, and building a system that will contain and help the severely mentally ill without injuring anyone, including first responders.

Here are some data sources that may be helpful. I do not subscribe to, and consequently have not read, the "Advancing Research" article, only just published. Perhaps the authors would make good witnesses:

General information on mental health crisis units: <http://cit.memphis.edu>

An Agenda for Advancing Research on Crisis Intervention Teams for Mental Health Emergencies
Amanda Brown Cross, Ph.D.; Edward P. Mulvey, Ph.D.; Carol A. Schubert, M.P.H.; Patricia A. Griffin,
Ph.D.; Sarah Filone, M.A.; Katy Winckworth-Prejsnar; David DeMatteo, J.D., Ph.D.; Kirk Heilbrun, Ph.D.
Psychiatric Services 2014; doi: 10.1176/appi.ps.201200566

Thank you for your attention.

Sincerely,

Mary Ann Bernard

BA, Stanford University
JD, University of Chicago

Testimony to the Record

I would like to express a completely different approach and opinion to reforming our nation's mental health system.

Currently "mental illness" is managed by SAMHSA/behavioral health and "carved out" of physical health care utilizing the science of Behavioral Health. Behavioral science is the study of human behavior and a person's response to stress within their environment. (ie: substance abuse, smoking etc)
All of its policies and procedures originate from their philosophy of "personal responsibility" utilizing a voluntary health care system. Their staff is comprised of psychologists, lawyers, social workers, family therapists and consumers/peers. Psychiatry/MDs are mainly contracted for pharmaceutical services. First responders for "behavioral emergencies" are law enforcement. (Thus the high arrest rate for mental illness)

Current brain research clearly states that schizophrenia/psychotic disorders/bipolar are brain disorders. It has become very apparent>the behavioral sciences and professionals within cant appropriately manage ILLNESS. Physical illness is managed by Medicine. Its well out of the "scope of practice" for Behavioral health care to manage physical illness. They are essentially "practicing medicine without a license". Only professionals that hold a medical license can practice medicine-such as MDs/Psychiatrists, physician assistants, nurse practitioners, nurses, and paramedics; who are the first responders in physical health care.

Another major problem with our current mental health system is that the presenting symptoms are MEDICAL symptoms>psychosis, hallucination, delusion, confusion and agitation. These symptoms need to be assessed by medical professionals, who can render and order the proper care/services/diagnostic labs. Medicine also has liability to assess mental CAPACITY and a person's ability to understand/sign an "informed consent"-the pros and cons of treatment and the risks of refusing treatment. They have liability to follow EMTALA laws and the duty to stabilize patients.

There are two health care delivery systems (mental and physical health) with two different standards of care, liability and accountability. Behavioral health has zero liability and accountability for the health care provided. All responsibility is placed on the patient (personal responsibility) even when they lack capacity. Mental health laws have not properly addressed the medical symptom of capacity/competency-the laws are still interpreted on "behaviors" of "dangerousness" and grave disability". Unfortunately they have no uniform assessment standards, and assessments vary greatly according to the education, license, bias's and availability of in-patient psychiatric beds and local mental health resources.

1) We need to push the reclassification of schizophrenia/psychotic disorders, and bipolar under physical health/medicine.
Currently NIMH and the American Psychiatric Association (APA) are working on this, but this needs to be made a **very high priority**.

NIMH · DSM-5 and RDoC: Shared Interests

NIMH · DSM-5 and RDoC: Shared Interests

NIMH and APA have a shared interest in ensuring that patients and health providers have the best available tools and information today to identify and treat mental health issues, while we continue to invest in improving and advancing mental disorder diagnostic...

View on www.nimh.nih.gov

Preview
by
Yahoo

Reclassifying these ILLNESSES under Medicine would completely shift the responsibility providing the LIABILITY and ACCOUNTABILITY needed. Health care would be based on the NEED and RIGHT to treatment decided by qualified MD's, as we do every other physical illness when the patient is incapacitated/lacks capacity to understand/sign an "informed consent". It would stop the civil liberty debates on "involuntary treatment"/assisted outpatient treatment which are filled with opinions & philosophy (vs sound neuroscience) It would subsequently enforce the "dependent adult" mandates we already have in place and provide the necessary "after care" with housing and supervision we offer Alzheimer's and Autism patients. It would take the burden off law enforcement for those "too ill to save themselves", it would empty our jails, and promote the use of mental health courts/assertive community treatment for the high risk/difficult to treat patients.

2) We need to eliminate "carve outs" and the associated expensive administrations that accompany these segregated systems. Behavioral health should be a "service" (not a system) like occupational health and/or cardiac rehab. BHC runs over 30%, physical health is 5%. By creating ONE health care delivery SYSTEM this would close the gaps and provide a comprehensive patient care plan for Mind/Body, Brain/behavior.

3) We need to utilize our public health care system for in-home services, medication management, etc

4) We need to work with the judicial system to create mental health dockets for patients with schizophrenia/psychotic disorders by increasing the use of mental health courts, court ordered treatment and assertive community treatment/specialty probation.

Thank you for considering these points.
Sincerely,

Mary Palafox RN

Fedup-brain disease advocacy on face book
Fedup4brain on twitter

Senator Durbin,
Dirksen Senate Office Building
Room 226

4/18/2014

Testimonial in Memory of Keith Vidal

12/10/1995- 01/05/2014

www.keithvidal.com

Presented by Mary Wilsey
(Mother)

My name is Mary Wilsey. On January 5, 2014, my mentally ill son, Keith Vidal, was shot and killed by a Southport, NC police officer who has since been indicted on voluntary manslaughter charges.

Prior to his illness, Keith was a self-taught drummer and guitar player, demonstrating his perseverance and accomplishing his dream of being in a band and recording numerous videos/shows. He was a normal teenager enjoying soccer, basketball, swimming. He was a good student who worked hard. He hung out with his friends and had a loving girlfriend. Keith loved his dog Spike.

In August of 2012, Keith's whole life changed. He started to display symptoms of paranoia which led to depression, isolation and fear of the outside world. He had to be home schooled. This disorder caused Keith's socialization skills to plummet. He was no longer able to participate in all the things that he'd previously enjoyed. He became isolated and struggled to effectively communicate even with his own loving family. His only solace was found in his music, played alone in his room.

In March of 2013, Keith was diagnosed with schizoaffective disorder and started treatment with psychiatric approved medication. There was some improvement with some of the medications, but all of them caused him to sleep, gain excessive weight, and have a blunted effect; eventually each one stopped working. His bones ached continuously and uncontrollably.

About a month before Keith's death, he was put on Lutuda which proved to be a miracle drug. At that point he started communicating with his family and friends again and was becoming more of his 'old self'. All of the side effects from previous medications disappeared. On December 10, 2013 we celebrated Keith's eighteenth birthday. It was about this time that we noticed Keith's symptoms coming back, resulting in an increase in his medication by his psychiatrist.

On January 5, 2014, I realized that Keith's medication needed to be adjusted once again. Keith was having a bad day. His father and I were trying unsuccessfully to get him to go to the hospital. Medical professionals had instructed us to ask for assistance from Law Enforcement when he was unwilling to go for treatment. We had used this process successfully in the past. The other times when local law enforcement officers would talk to Keith, regardless of how long it

took, they were able to convince Keith to go willingly with me to the hospital. On two occasions Keith had to be involuntarily committed to a psychiatric facility.

On this day, Keith's father called 911 and informed the dispatcher that our son had schizoaffective disorder and assistance was needed to get him the medical treatment he so desperately required. Unfortunately, January 5, 2014 was not like the other times when we had called for help. This day there was an unexpected, totally preventable, tragic incident resulting in the death of my son Keith. We never imagined that a call for help, a call to those sworn to protect and serve, would result in the death of our son, Keith. There were two officers at my home speaking calmly to Keith. One of the officers continued to speak with dispatchers saying that there was a confrontation in the hallway, but everything was ok. This continued for about 15 minutes. Keith remained calm while in conversation with the two officers.

With the situation seemingly getting under control, a Southport NC police officer entered my home and immediately **escalated** the situation. Within 70 seconds (according to dispatch records) of the Southport officer's arrival, my son was tasered and fell on his back to the ground. The first two responding officers got on top of Keith and had him restrained. Then without warning, or regard for the safety of the other two officers, the Southport police officer stepped in, pulled his trigger and shot my son, Keith. I watched my mentally ill, 18 year old son bleed out all over my hallway floor.

At no time did the Southport officer make any attempt to communicate with Keith. I believe that if the Southport officer was CIT (Crisis Intervention Training) trained, Keith's death would have been prevented. In CIT training, officers are taught to deescalate, **NOT ESCALATE**, the situation. It is to my understanding this particular officer was on the Southport police force for approximately 9 years and because CIT training is not mandatory in the state of North Carolina, he was not CIT trained.

As a result of Keith's death, I have commissioned a proposal for a new law named, "Keith's Law" which would make CIT training mandatory for every police officer in the state of North Carolina. Also this law would require that CIT be implemented into the BLET Program (Basic Law Enforcement Training), or any and

all Police Academies. Frank Iler, NC House Representative, has been instrumental in assisting me to introduce this proposal before the 2015 NC legislative session.

As a child, I grew up with a Schizophrenic mother. There were many obstacles I had to overcome. I had to endure my mother's hospitalizations and often she was mentally and physically unable to raise her seven children. Unfortunately, often the older siblings had to step in and raise us younger kids. You can imagine how difficult this was for the older children as they had to give up their hopes and dreams in order to raise us. With great patience and love their dedication kept us all together as a family unit. Until my mother's death, it was her children's job, all of us, to take care of her when she was at home.

I remember the reaction from a very early age when telling people my mother was sick with Schizophrenia. They thought she was a crazy person. The stigma attached to mental illness forced our family to become isolated. Mental illness is not curable, but treatable, and it is a life long illness. So when Keith started to become sick with mental health issues, I had to become his advocate. I continued my battle to get Keith diagnosed correctly because in my heart I knew the symptoms he displayed were of schizophrenia.

Because my son Keith was never given the chance to gain insight into his illness and never had the opportunity to grow, achieve his goals, and succeed in his life, I have made it my life's goal to promote Mental Health awareness in support of the mentally ill as they seek treatment during their time of crisis. As part of this advocacy, the implementation of CIT training for all police officers has become my life's mission.

With great determination, I will continue to honor my son's memory by promoting "Keith's Law" in North Carolina and if passed, I will continue tirelessly to achieve "Keith's Law" legislation in each and every state. I will do everything in my power to prevent another family from suffering the inconceivable, senseless loss of their mentally ill loved one.

Mental Illness should never be a death sentence.



Maryland Center for Developmental Disabilities
at Kennedy Krieger Institute

Maximizing Potential. Creating Change.

**Hearing on Law Enforcement Responses to Disabled Americans: Promising Approaches for
Protecting Public Safety**

April 29, 2014

Senate Judiciary Subcommittee on the Constitution, Civil Rights and Human Rights
Hart Senate Building Office, Room 216
Washington, D.C.

The Maryland Center for Developmental Disabilities (MCDD) and Ethan's Law Work Group fully support Senator Durbin's efforts to examine state and local law enforcement efforts to develop policies and procedures and training for law enforcement officers. Increasingly, law enforcement officers have become the first responders for individuals with intellectual disabilities, developmental disabilities, or mental illness, who present in a crisis situation. The MCDD at Kennedy Krieger Institute (KKI) is one of a national network of University Centers for Excellence in Developmental Disabilities federally funded by the Administration on Intellectual and Developmental Disabilities. The MCDD envisions that all persons with intellectual and developmental disabilities lead fully inclusive and meaningful lives. This is accomplished through interdisciplinary pre-service training, exemplary community service, research and evaluation, technical assistance, and dissemination activities.

In March 2013, the MCDD's Associate Director, Maureen van Stone, Project Director, Diane Dressler, and the MCDD's 2013 legislative extern, Lauren Peterson, partnered with Maryland's self-advocacy organization called People On the Go, to attend a meeting with Ethan's mother, Patti Saylor, and other disability advocates throughout Maryland and the District of Columbia. At this first meeting, the group discussed the need for comprehensive and mandatory disability awareness training for police officers, firefighters, and other first-responders. Gail Godwin, the executive director of Shared Support Maryland, organized the first meeting and referred to the collective group as the "Ethan's Law Work Group." Ethan's Law Work Group has expanded to include additional advocates throughout Maryland, who engage with law enforcement and other first responders in a variety of meaningful ways. Initially, the goal was to conduct research and gain enough support to pass "Ethan's Law" through the Maryland General Assembly's 2014 session. Our hope was for legislation that required disability training for all first-responders in Maryland, including both new recruits and veteran members.

Maryland Center for Developmental Disabilities

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Christopher L. Smith, Director: smithchr@kennedykrieger.org

Maureen van Stone, Associate Director: Vanstone@kennedykrieger.org

While the work group was brainstorming, researching effective disability awareness trainings, and meeting with stakeholders during the spring and summer of 2013, Ethan's story continued to receive considerable press, locally and nationally. Maureen van Stone and Patti Saylor, along with other members of the work group, spoke at the National Down Syndrome Congress Annual Convention in Denver, Colorado. Furthermore, as we are all well aware, on September 17, 2013, Governor Martin O'Malley issued an executive order to create the Maryland Commission for Effective Community Inclusion of Individuals with Intellectual and Developmental Disabilities, the first of its kind in the nation. It is our understanding that the goal of the commission is to provide policy recommendations for law enforcement officials, paramedics, and first-responders to the Governor. The MCDD and members of Ethan's Law Work Group have engaged with the Commission by participating in their meetings, providing oral and written testimony at the listening forums, and meeting with the Commission's Executive Officer to discuss our work and how we can partner moving forward.

Leaders of the MCDD and Ethan's Law Work Group have been honored to work with the Commission members to effectuate change on a state level, however, we understand that first-responder training is not isolated to a single community or state; this is a national issue that needs to be addressed. We are encouraged by Senator Durbin's willingness to bring this important issue before this Subcommittee and fully support his efforts to develop training initiatives for first-responders to better serve all Americans.

We appreciate your time and consideration of this written testimony. The MCDD and Ethan's Law Work Group are both willing and able to assist with any future efforts to support this important work.

Maryland Center for Developmental Disabilities

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United States Senate
Committee on the Judiciary
Subcommittee on the Constitution, Civil Rights and Human Rights
Tuesday, April 29, 2014

**Law Enforcement Responses to Disabled Americans: Promising Approaches for
Protecting Public Safety**

Maryland Disability Law Center (MDLC), the Protection and Advocacy organization advancing the rights of Marylanders with all types of disabilities, appreciates this opportunity to provide information about law enforcement responses to people with disabilities and potential Congressional action.

MDLC strongly supports efforts to improve training for law enforcement personnel and the judicial system in interacting with people with disabilities. In addition, we recommend preventing behavioral health emergencies by increasing access to effective behavioral health services. We also recommend that, whenever possible, trained crisis intervention teams are the first responders to behavioral health issues.

MDLC is a participant on the Maryland Commission for Effective Community Inclusion of Individuals with Intellectual and Developmental Disabilities (Commission) that Governor Martin O'Malley convened in response to the death of Ethan Saylor. Mr. Saylor, who had Down syndrome, died while being removed from a movie theater by off-duty police officers when he wanted to watch a movie again but hadn't paid for a second ticket. The Commission is charged with developing training to improve first responders' interactions with individuals with intellectual and developmental disabilities (I/DD).

In other incidents in Maryland over the past year involving individuals with I/DD:

- After being confined in state institutions for many months after an arrest, an individual with autism and intellectual disability now has new regressed behaviors. His staff took him to a crowded public place when it was known that crowds make him anxious; he became agitated and struck a child. It was clear that the individual was incompetent to stand trial and was not dangerous with proper staff support. However, the state's attorney filed criminal charges and caused him to be removed from his familiar home and routine. Though he did finally return to his home, he is now incontinent and engaging in new behaviors he did not have before his arrest.
- Another individual with autism and intellectual disability was arrested when he began to engage in behaviors that a neighbor interpreted as threatening. The individual's staff was present but the police would not allow the staff to work with the man. Instead, the police confronted him and his behavior escalated to aggression, resulting in criminal charges. The man is not competent to stand trial and has returned safely to his home pending resolution of the charges.

The Governor's Commission for Effective Community Inclusion of Individuals with Intellectual and Developmental Disabilities is developing a multi-year strategy initially focused on first responders. Its report is expected soon. More info can be found here: <http://www.goccp.maryland.gov/iddc/index.php>.

Encounters with law enforcement would be greatly improved by training first responders on how to work with people with I/DD and psychiatric disabilities. MDLC clients have also reported respectful and compassionate responses from police officers and others in the judiciary who are familiar with and/or trained about people with disabilities.

Education and training are only part of the solution, however. Problematic responses from law enforcement personnel are inextricably linked to deficits in the service delivery systems for people with I/DD and psychiatric disabilities. People who are disengaged from behavioral health services may experience repeated emergency department visits and hospital admissions, homelessness and criminal arrests for status and nuisance crimes. Though MDLC strongly endorses efforts to train police officers and the judicial system in how to better respond to and work with people with disabilities, enhancing the service delivery systems would prevent many of these encounters or offer behavioral crisis teams instead of police officers in many instances. The use of crisis intervention treatment services can prevent the use of traumatic force and more immediately address the behavioral health concerns.

MDLC has called for an enhanced "evidence-based practice" model of service delivery to engage individuals who are at high risk for disruptions in continuity of care, including those who do not believe or acknowledge that they have a mental disorder.

When essential services are discontinued for individuals with disabilities, they experience negative outcomes, including emergency room admissions that are often facilitated by law enforcement, and involvement with the criminal justice system. In FY12 in Maryland, 588 Medicaid-eligible individuals, less than 1% of the total Public Mental Health System population, accounted for nearly one-quarter of all emergency department visits (each person had 6 or more during the year), and accounted for the highest 20% of all inpatient expenditures. Maryland's Mental Hygiene Administration (MHA) has identified this population as at "risk for challenges in care continuity."ⁱ MDLC has recommended building on the proven success of Assertive Community Treatment (ACT). ACT is an evidence-based practice and one of the most extensively researched models of community care for people with severe mental illness. Summarized outcomes from 25 randomized controlled studies of ACT show that it is highly successful in engaging clients in treatment who have been unwilling or unable to seek care in the past, substantially reduces psychiatric hospital use (between 50%-76%), lowers rates of substance use, increases housing stability, and improves symptoms and subjective quality of life.ⁱⁱ The literature also consistently shows an absence of negative outcomes and high client satisfaction.ⁱⁱⁱ

The ACT team provides for an array of services, including a comprehensive assessment; housing; substance-abuse treatment; illness management and recovery skills; individual supportive therapy; employment-support services; side-by-side assistance with activities of

daily living; intervention with support networks; medical care; benefits; transportation; case management; and medication prescription, administration, and monitoring. Clients are expected to be full partners in the creation and execution of a service plan. Substance-abuse treatment is a critical component, given that MHA data shows 74% of those at high-risk for treatment disruptions have a co-occurring substance use disorder.^{iv} These evidence based supports and services are effective in reducing client interactions with the police and criminal justice system.

MDLC strongly recommends improved access to voluntary behavioral health services in addition to better training for law enforcement and the judiciary on how to work with people with disabilities.

Respectfully submitted,

Nancy Pineles
Managing Attorney

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ⁱ Mental Hygiene Administration Data Shorts, Behavioral Health Data and Analysis, December 30, Vol.2, Issue 12.

ⁱⁱ Bond G., Assertive Community Treatment for People with Severe Mental Illness, 2002.

ⁱⁱⁱ Burns BJ, Santos AB, Assertive Community Treatment: an update of randomized trials. *Psychiatric Services* 46:669-675, 1995

^{iv} Mental Hygiene Administration Data Shorts, Behavioral Health Data and Analysis, January 14, Vol.3, Issue 1.

April 27, 2014

Statement to Senate Subcommittee on Law Enforcement Responses to Disabled Americans: Promising Approaches to Protecting Public Safety

As a proud parent of a young child who has Down syndrome, I support and commend this senate committee's efforts to address a growing need for improved public safety for disabled Americans. I urge you to take action and implement Crisis Intervention Teams and training nationally.

In our community in Central New York and across our country, generations of parents, advocates and people with disabilities continue to work hard and advance. More than ever, Americans with disabilities are achieving more, achieving independence and are productive and valued members of our families and communities. With increasing independence, equitable treatment by law enforcement is needed now.

Our community is very aware and concerned about nationally known tragedies such as Ethan Saylor, a young man with Down syndrome who died at the hands of Sherriff deputies in Maryland for an unpaid movie ticket in 2013 and local incidents such as Brad Hulett. Brad is man with a childhood brain injury who was tased and injured by Syracuse City police in 2013. The incident escalated when Brad wouldn't follow orders to sit down on a bus. Significant protests and a lawsuit by Brad continue to divide our community. These incidents and many others like it highlight the risks and diminish our hopes of achieving independence for those that we love and fight for.

As parents of children with disabilities, it's clear that any of our children could easily get into a situation like Brad or Ethan had. They force us to ask what could have been done differently and how will our legislators and law enforcement respond?

By account of those that have implemented it, strategies like Crisis Intervention Teams are addressing the problem by training officers and defining a model for responders. They serve both our special populations and law enforcement. I sincerely hope that these measures are put in place well before my child rides a public bus or goes to a movie with friends.

I thank this committee for exploring this important issue and urge you to implement the CIT model nationally.

Matthew Dwyer
Parent and Community Advocate
matthewdwyer@gmail.com
Syracuse, NY

References

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http://www.syracuse.com/news/index.ssf/2013/08/criminal_charges_dropped_against_disabled_man_tasered_by_syracuse_police.html



ALAN M. ARAKAWA
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GARY A. YABUTA
CHIEF OF POLICE

CLAYTON N.Y.W. TOM
DEPUTY CHIEF OF POLICE

April 28, 2014

The Honorable Dick Durbin
U.S. Senator
Assistant Majority Leader and
Chairman of the Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights
224 Dirksen Senate Office Building
Washington, D.C. 20510-6050

Hearing: Law Enforcement Responses to Disabled Americans: Promising
Approaches for Protecting Public Safety
Date: April 29, 2014
Time: 10:00 a.m.
Place: Dirksen Senate Office Building, Hart 216

Dear U.S. Senator Durbin:

My name is Gary A. Yabuta, Chief of Police of the Maui Police Department. I am submitting this testimony on behalf of the Crisis Intervention Team, which we strongly support, and would like to continue our efforts towards additional training for our officers in order to respond to crisis calls. By working in a joint effort between the police officers and our community, we will be able to pursue our common goals of safety, understanding and service to the mentally ill and their families.

The Maui Police Department started the Crisis Intervention Team (C.I.T.) Program in January 2013. We began networking with the State Maui Mental Health Center and met Dr. Dara Rampersad, Ph.D., LPC, NCC, Maui County Forensic Coordinator. With his expertise in working with various community agencies, he established a training program for the Police Officer to become a specialized trainer to respond to crisis calls. We have since completed three training sessions and have gained recognition through the media. Currently, the County of Maui is the first in the State of Hawaii to implement the C.I.T. Program. Our dedication and compassion for our people of this community will always be a priority which gives us the strength and courage to carry out our mission statement and leaving a legacy for the future generation.

The C.I.T. members handles incidents involving the mentally ill and those in crisis with care and expertise, ensuring that such persons receive a response which is appropriate to the needs of the individual involved. They are trained to interact with persons who are mentally ill or, are in an emotional crisis and to de-escalate crisis events and move them away from violent outcomes whenever possible.

By targeting the specific areas of the C.I.T. Program, the involvement of any violence decreases through pro-active measures by using techniques to de-escalate the situation. We have found a huge improvement since the implementation of the C.I.T. program. The benefits of the C.I.T. program are as follows:

The Honorable Dick Durbin
U.S. Senator
April 28, 2014
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- ▶ Crisis response is immediate by officers who can assess the situation.
- ▶ The C.I.T. Officers are better trained and educated in verbal de-escalation techniques.
- ▶ Individuals receive assistance sooner for mental health issues.
- ▶ Arrest and use of force have decreased.
- ▶ Fewer individuals are being transported to the hospital for medical treatment due to injuries from physical confrontations with police.
- ▶ The Officer's injuries during crisis events have declined.
- ▶ Police use various agencies to assist in servicing the mentally ill.
- ▶ Admittance time to the Emergency Room has been greatly reduced due to the collaboration between the C.I.T. officer and the Emergency Room Mental Health personnel.
- ▶ The court system is not burdened with individuals having mental health disorders.
- ▶ Police encounter less repeat offenders who now get mental health services instead of being released in the judicial system.
- ▶ Improved community awareness with police handling mental health issues.
- ▶ Overall cost savings.

I would like to highlight several areas that our department have found to be very beneficial in the reduction of time and expenses spent in these incidents:

In situations when the department receives a call for service involving someone who may be experiencing a mental health disorder, a "Disorderly Conduct - Mentally Ill" case is documented. During the 16 months prior to the C.I.T. training, 145 incidents were reported and 65 individuals were transported to the hospital (45%). After the C.I.T. training, 212 incidents were reported and 48 individuals were transported to the hospital (23%).

Prisoner expenses revealed a noticeable reduction. In 2012, the Maui Police Department spent \$122,507 for cleaning the holding cells, meals, and medical treatment for prisoners. In 2013, the cost decreased to \$58,129, a reduction by 52%.

There has been a decrease in Police Officers being injured while handling individuals with mental illness. In the 16 months prior to the implementation of the C.I.T. program, 104 officers were injured. Four cases were directly related to incidents handling the mentally ill. Since January 2013 to present, 108 officers were injured. Only two were related to mental health cases.

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U.S. Senator
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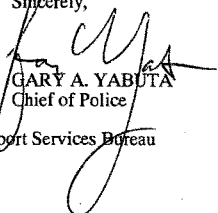
Another significant reduction was the Police Officer's time spent transporting and waiting with the mentally ill at the hospital. Prior to the C.I.T. Program, the officers would wait about three to four hours before the Emergency Room physician would meet with the individual. After the C.I.T. training, the waiting time is less than 30 minutes. This was due to the working relationship between the police and the mental health personnel.

In each of the above areas, there has been a 50% or more reduction - a significant amount. Although this may not be attributed entirely to the C.I.T. Program, the most common denominator is the C.I.T. Officer. The financial cost has been a huge factor in reducing medical expenses and the waiting time for the Police Officers at the hospital.

This program has proven to be a success. We love our community. The people we serve will always be our greatest reward.

Your consideration will be greatly appreciated. If you have any questions, please do not hesitate to contact me at (808) 244-6300, or e-mail at gyabuta@mpd.net.

Sincerely,


GARY A. YABUTA
Chief of Police

c: Dean Rickard, Assistant Chief, Support Services Bureau

MENTAL ILLNESS POLICY ORG.

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Statement for the Record of
Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights
Hearing on Law Enforcement Responses to Disabled Americans:
Promising Approaches for Protecting Public Safety
By DJ Jaffe Executive Director, Mental Illness Policy Org.
April 28, 2014

Police and sheriffs are being overwhelmed "dealing with the unintended consequences of a policy change that in effect removed the daily care of our nation's severely mentally ill population from the medical community and placed it with the criminal justice system." ... This policy change has caused a spike in the frequency of arrests of severely mentally ill persons, prison and jail population and the homeless population... (and) has become a major consumer of law enforcement resources nationwide." —Chief Michael Biasotti, Past President NYS Assoc. of Chiefs of Police¹

Data Points:

- 16% of individuals in federal prisons and 17% of those in jails have serious mental illness. (Osher, et al. 2012) There are 365,716 adults with serious mental illness in jails and prisons.² There are also 770,000 individuals with serious mental illness are under probation and parole.³
- Mental illness is not associated with violence, but untreated serious mental illness is. Studies that show no association between mental illness and violence are almost always of the treated mentally ill. They show that medications work, not that mental illness and violence aren't connected. Because the studies are typically done in the uninstitutionalized community, they exclude the violent who are involuntarily committed, incarcerated, hospitalized, or who have killed themselves.⁴
- All Americans can have their mental health improved. 20% have any mental illness. But only four percent of Americans have serious mental illness (i.e., schizophrenia, severe bipolar, severe major depression)⁵. It is the 4% who are most likely to become a police responsibility.
- Most community programs only serve voluntary patients, and often the highest functioning. Community programs do not generally accept the highly symptomatic.
- Up to 40% of the most seriously ill are so ill they do not know they are ill ("anosognosia"). Because they do not know they are ill (ex. they may think they are the Messiah), they may not accept voluntary services. John Hinckley "knew" the best way to get a date with Jodi Foster was to shoot President Reagan.
- Current civil commitment laws prevent people who refuse treatment from being treated until after they become 'danger to self or others' even if they have multiple previous incidents of violence or arrest. That's ludicrous. Laws should prevent violence, not require it.
- When people with untreated serious mental illness become violent, law enforcement is called in often putting the patient and the officer at risk.
- If officers want the mentally ill individual to receive treatment, they have to drive to a far away hospital only to find the patient is not admitted or is discharged before being stabilized.
- 10 times as many mentally ill are incarcerated as hospitalized
- **The best way prevent people with serious mental illness from becoming a police responsibility is to force the mental health system to prioritize them, rather than focus on all others. We have to replace mission creep, with mission-control. This will keep patients, public and police safer.**

Solutions to keep mentally ill in mental health, rather than criminal justice system

Fund Assisted Outpatient Treatment (AOT) Programs—The Department of Justice certified AOT as an "effective crime prevention program" for persons with serious mental illness.⁶ AOT is for a very tiny group of individuals. It is exclusively for those who have serious mental illness and a history of multiple arrests, violence, incarcerations or hospitalizations due to going off treatment. It allows judges to order this tiny group

into six months of mandated and monitored treatment and order the mental health system to provide the care. This ensures the most seriously ill go to the head of the line, rather than the end. AOT reduces homelessness, arrest, hospitalization and incarceration over 70% each⁷. It saves 50% by providing an off-ramp before more expensive and restrictive inpatient commitment or incarceration become needed. It is like putting a fence by the edge of a cliff, rather than an ambulance at bottom.

Ensure enough hospital beds for those who need them. Cook County Sheriff Tom Dart called his jail 'the new asylum' There is a direct correlation between cutting hospital beds and the need to build more jails and prisons. We are short 95,000 psychiatric hospital beds resulting in ten times more mentally ill being incarcerated as hospitalized.⁸ ⁹The lack of hospital causes police and sheriffs to have to book people they would prefer to hospitalize and treat. . Chief Michael Biasotti, Past President of the New York State Association of Chiefs of Police told Congress, "Community programs serve those who seek and accept treatment. Those who refuse, or are too sick to seek treatment voluntarily, become a law enforcement responsibility. ... (M)ental health officials seem unwilling to recognize or take responsibility for this second more symptomatic group. Ignoring them puts patients, the public and police at risk and costs more than keeping care within the mental health system."

- To increase the number of hospital beds available, delete the Institutes for Mental Disease Exclusion from Medicaid Law. The IMD Exclusion prevents states from receiving Medicaid reimbursement for the mentally ill who are so ill they need to be hospitalized for an extended period. So states kick the seriously mentally ill out of hospitals to make them Medicaid eligible. Many wind up incarcerated.

Parents of mentally ill can prevent their children from becoming a law enforcement responsibility if HIPAA and FERPA are reformed so they can be given information on what medications are needed and when appointments are. HIPAA and FERPA prevent parents from receiving information about mentally ill loved ones absent a specific waiver by the mentally ill individual. Neither James Holmes nor Jared Loughner gave the waiver, hence their parents did not know school authorities identified them as needing help. Parents need the information about their mentally ill loved ones so they can ensure they have prescriptions filled, transportation to appointments, and stay in treatment.

Give states an incentive to adopt 'need for treatment' and 'grave disability' standards to complement 'danger to self or other standards.'

Remove federal impediments to treatment by reforming SAMHSA and CMHS Reform- Congress created SAMHSA to "target ... mental health services to the people most in need". While accurate diagnosis is key to getting the right treatment, SAMHSA funds 20 Technical Assistance Centers (TAC) and the National Coalition for Mental Health Recovery (NCMHR) which joined the "Occupy Psychiatry" movement by declaring that "psychiatric labeling is a pseudoscientific practice of limited value in helping people recover." Many NCMHR/TAC leaders do not believe mental illness exists and conduct SAMHSA funded workshops to teach persons with mental illness how to go off treatment. It is very difficult to reform the mental health system so fewer go to jail when Congress is funding groups opposed to those reforms. SAMHSA uses block grant funds to coerce states to replace the medical model with SAMHSA's recovery model, which requires people self-direct their own care. The most seriously ill, who are psychotic and delusional can not self direct their own care. SAMHSA encourages states to spend on prevention, when there is no way to prevent schizophrenia, bipolar or the other serious mental illnesses. SAMHSA suggests everyone recovers, thereby ignoring those so ill they do not.

PAIMI Reform- PAIMI was founded with the noble purpose of helping to improve the quality of care received by the most seriously ill. It now focuses on 'freeing' them from treatment. Many become a police responsibility.

Create an Assistant Secretary to oversee mental health spending with a large contingent of criminal justice experts on the advisory board- An Assistant Secretary of Mental Illness could see that federal funds are spent on the most seriously ill, rather than all others. The Secretary could eliminate non-evidenced based practices, provide better coordination of federal resources, reduce duplication, require the prioritization of the seriously ill, and replace mission-creep with mission control. *The advisory board to the assistant secretary should include substantial criminal justice representation.* The "solutions" proposed by the mental health industry (ex. closing hospitals, making involuntary treatment more difficult) often increase incarceration. Having persons with criminal justice at the table will help prevent these bad ideas from becoming policy.

¹ As quoted in Management Of The Severely Mentally Ill And Its Effects On Homeland Security

² There were 1,504,150 in prisons and 735,601 in jail. (Glaze and Parks 2012) Therefore there were 240,664 seriously mentally ill in prisons and 125,052 seriously mentally ill in jails, or 365,716 adults with serious mental illness in jails and prisons.

³ There are also 4,814,200 individuals under probation or parole. (Glaze and Parks 2012) If the same 16% holds true then 770,000 individuals with serious mental illness are under probation and parole.

⁴ Violence studies also dilute their results by studying the 20% with any mental illness instead of the 4.1% with serious mental illness. Numerous studies show that untreated serious mental illness is a risk factor for violence. A meta-analysis of 204 studies of psychosis found it "was significantly associated with a 49%–68% increase in the odds of violence." A review of 22 studies concluded that "major mental disorders, per se, especially schizophrenia, even without alcohol or drug abuse, are indeed associated with higher risks for interpersonal violence."

⁵ See NIMH at http://www.nimh.nih.gov/Statistics/SMI_AASR.shtml

⁶ National Institute of Justice, Office of Justice Programs. Available at <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=228>

⁷ Research on NY available at <http://kendras-law.org/kendras-law/research/kendras-law-studies.html>. Research on California available at <http://kendras-law.org/states/california/lresultsin2counties.html>.

⁸ <http://mentalillnesspolicy.org/imd/shortage-hospital-beds.html>

⁹ Treatment Advocacy Center, "The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey" available at <http://www.tacreports.org/treatment-behind-bars>

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Program Profile

Assisted Outpatient Treatment (AOT)

Evidence Rating: **Effective - More than one study** 

Program Description

Program Goals

Assisted outpatient treatment (AOT), also known as outpatient commitment (OPC), is a civil legal procedure whereby a judge can order an individual with a serious mental illness to follow a court-ordered treatment plan in the community. AOT is intended for adults diagnosed with a serious mental illness who are unlikely to live safely in the community without supervision and treatment, and who also are unlikely to voluntarily participate in treatment. The goal of AOT is to improve access and adherence to intensive behavioral health services in order to avert relapse, repeated hospitalizations, arrest, incarceration, suicide, property destruction, and violent behavior.

Forty-four states have statutes permitting some form of OPC or AOT (Robbins et al. 2010). One example is New York State's "Kendra's Law." The law, passed in 1999, which was proposed by the New York State Attorney General, was named for a young woman who was killed after being pushed in front of a New York City subway by a man with a history of serious mental illness and hospitalizations. The intent of the law was not only to authorize court-ordered community treatment but also to require mental health authorities to provide resources and oversight necessary so that high-risk individuals with serious mental illness may experience fewer incidents and can live in a less restrictive alternative to incarceration or involuntary hospitalization.

Key Personnel

AOT is designed to ensure that service providers and county administrators deliver appropriate services to high-risk, high-needs individuals. Case managers, Assertive Community Treatment (ACT) team members, other clinical service providers, county personnel and attorneys, recipient advocates, and family members are among those who participate in AOT-related activities.

Under New York State's Kendra's Law, local AOT coordinators were created to monitor and oversee the implementation of AOT for each county and New York City. These local coordinators accept and investigate reports of individuals who may require AOT and arrange for the preparation of treatment plans and filing of petitions for AOT in local courts. Existing local programs are responsible for oversight and monitoring of clients by providing case management services. The case managers and ACT team members are in charge of directly monitoring an AOT recipient's level of compliance and delivery of services by other providers pursuant to the court order. Case managers and ACT team members report to local AOT coordinators on an individual's treatment status.

Target Population

Under New York's Kendra's Law, a person may be ordered to receive AOT if: the person is eighteen or older; suffers from a mental illness; has a history of lack of compliance with treatment that has at least twice within the last 36 months been a significant factor in necessitating hospitalization, or incarceration; or within the last 48 months, resulted in one or more acts or threats of serious violent behavior toward self or others and is unlikely to survive safely in the community without supervision. It must also be established that AOT is the least restrictive alternative. For some individuals, a voluntary service agreement may be signed in lieu of a formal court order. Individuals must agree to receive enhanced voluntary services, which usually include case management or ACT.

Program Components

Kendra's Law established mechanisms so that local mental health systems give individuals entering AOT priority access to case management and other mental health services that are essential to treating an individual's mental illness, avoiding relapse that would lead to arrest, incarceration, violence, self-harm, or rehospitalization, and helping the individual live in the community. Mandatory treatment plans are developed and implemented to ensure that comprehensive, community-based services are provided to AOT recipients by mental health officials. There is a wide range of services that can be included in the treatment plan, such as case management, medication management, individual or group therapy, day programs, substance abuse testing and services, housing or housing support services, and urine or blood toxicology (to ensure adherence to medication).

In many States, no court order goes into effect unless a treatment plan has been submitted to the court. The length of the court order can vary by individual. Court orders may not last longer than 6 months unless they are renewed by the court. When the court order expires, and it is not renewed, individuals continue receiving voluntary services. Noncompliance can lead to a temporary hold to evaluate for involuntary hospitalization.

Evaluation Outcomes

Program Basics

Age: 18 - 50

Gender: Both

Race/Ethnicity: Black, Asian/Pacific Islander, White, Other

Geography: Rural, Suburban, Urban

Setting (Delivery): Inpatient/Outpatient

Program Type: Cognitive Behavioral Treatment, Group Therapy, Individual Therapy, Wraparound/Case Management, Violence Prevention

Targeted Population: Mentally Ill Offenders

Current Program Status: Active

Training and TA Provider: D.J. Jaffe, Mental Illness Policy Org, 50 East 129th Street, PH 7, New York NY 10035

[Website](#)

[Email](#)

Training and TA Provider: Treatment Advocacy Center, 200 N. Giebe Road, Suite 730, Arlington VA 22203, Phone: 703.294.6001, Fax: 703.294.6010

[Website](#)

[Email](#)

Study 1**Arrest**

Gilbert and colleagues (2010) found that the odds of arrest in any given month for participants who were currently receiving Assisted Outpatient Treatment (AOT) were significantly lower than the odds for participants in the pre-AOT and prevoluntary agreement group (the reference group). The odds of arrest were nearly two thirds lower for participants currently receiving AOT, compared with the odds of arrest for the reference group.

However, there were no statistically significant differences in the odds of arrest between those with a current voluntary agreement and those in the reference group. The adjusted predicted probabilities of arrest in any given month were 3.7 percent for the reference group, 2.8 percent for individuals currently under a voluntary agreement and 1.9 percent for individuals currently on AOT.

Study 2**All Arrests**

Within-group analyses conducted by Link and colleagues (2011) showed that the risk of arrest was significantly higher for individuals during the period before Assisted Outpatient Treatment (AOT) than during the period of AOT. Though the risk of arrest went up slightly in the period after AOT was discontinued, this difference was not significant. For an individual who had ever received AOT, the risk of any arrest was 2.66 times greater before AOT as it was while receiving AOT.

The between-group results showed that the risk of arrest among individuals in the comparison group who were never assigned to AOT was significantly higher than the risk of arrest for the AOT group while they were assigned to AOT. Compared with individuals during and shortly after the period of assignment to AOT, the comparison group who never received AOT had nearly double the odds of arrest.

Arrests for Violent Offenses

Within-group analyses found that individuals receiving AOT were at significantly lower risk of arrest for a violent offense than they were before AOT. The risk of arrest for a violent offense was 8.81 times greater before AOT as it was while receiving AOT. However, because arrests for violent offenses were relatively rare, between-group analyses found there were no significant differences between the AOT and comparison groups on the odds of arrest for violent offenses.

Study 3**Violent Behavior**

An initial analysis performed by Swanson and colleagues (2000) found there was no significant difference in the rate of violence between the group randomly assigned to involuntary outpatient commitment (OPC) and the control group (32.3 percent in the OPC group versus 36.8 percent in the control group).

However, multivariate analysis showed that controlling for baseline history of violence and substance misuse, extended OPC was associated with significantly lower odds of any violent behavior during the year of the study. Treatment group members who received more than 180 days of OPC were only about one third as likely to commit a violent act during the year, compared with their control group counterparts. However, treatment group members receiving fewer than 180 days of OPC did not differ from the control group with respect to risk of violence.

Extended Outpatient Commitment

This initial analysis did not include the seriously violent group, nor was the length of exposure considered. When study participants with a history of serious violence were included in the analysis and the OPC intervention was defined as having received at least 6 months of court-ordered treatment, the treatment group had a significantly lower rate of violence during the year, compared with the control group (26.7 percent, versus 41.6 percent). This result should be viewed with caution, because the analysis included participants with a history of serious violent behavior who were not randomized to treatment.

Extended Outpatient Commitment Combined With Regular Community-Based Services

Additional analysis looked at whether OPC interacts with the provision of outpatient services to reduce the risk of violent behavior. An initial analysis found that OPC alone did not significantly reduce the risk of violent behavior. Similarly, receiving frequent outpatient services alone was not associated with less violence. However, a combination of both variables (at least 6 months of OPC with an average of three or more outpatient visits per month in the community) did significantly reduce the risk of violence. The predicted probability of any violent behavior was cut in half, from 48 percent to 24 percent, attributable to extended OPC and regular outpatient services. Again, this result should be viewed with caution, because the amount of time on OPC was neither random nor controlled for experimentally.

Evaluation Methodology**Study 1**

An evaluation of New York State's Assisted Outpatient Treatment (AOT) by Gilbert and colleagues (2010) examined whether individuals had lower arrest rates when receiving AOT or voluntary enhanced services than before initiating either one. Study participants were sampled from AOT program rosters of mental health service recipients in six New York counties. Based on structured interviews, 181 individuals who had either received court-mandated AOT (n=139) or had signed a voluntary service agreement (n=42) at some point during the study period were identified for the study. The sample was 60 percent male, with an average age of about 34. The sample was approximately 46 percent white, 35 percent African American, 11 percent Hispanic, and 7 percent Asian/Pacific Islander or other. There were no significant differences between the groups on age, gender, race or ethnicity, and education. Individuals with voluntary agreements were more likely to have a primary diagnosis of major depressive disorder (17 percent), compared with individuals who received AOT (4 percent), and were also more likely to reside in regions outside New York City (98 percent of the voluntary agreement group, compared with 60 percent of the AOT group).

The primary outcome of interest was arrest rates. Arrest records for the 181 participants from Nov. 1, 1999, to Feb. 28, 2008, were obtained from the New York State Division of Criminal Justice Services. Demographic information was collected during the interviews, and diagnostic data was extracted from matched Medicaid claims files. The primary diagnosis was classified into four categories: schizophrenia, bipolar disorder, major depressive disorder, and other.

A dummy variable was created to indicate whether the study participants had been arrested during any given month. Analytic comparison groups of person-month observations were constructed to reflect status in regard to AOT or a voluntary service agreement. A single category of observations (pre-AOT and prevoluntary service agreement) was used as the reference group.

for comparison. This category included all person-months before an individual either received AOT or signed a voluntary agreement. This created five groups of observations that were compared: 1) pre-AOT and prevoluntary agreement, 2) current AOT, 3) current voluntary agreement, 4) post-AOT, and 5) postvoluntary agreement.

The data was structured as one unit of observation per person, per month, over the 100-month study period. There were 9,229 person-months available for analysis: pre-AOT and prevoluntary agreement ($n=7,097$), current AOT ($n=1,094$), current voluntary agreement ($n=468$), post-AOT ($n=361$), and postvoluntary agreement ($n=208$).

Data was examined using estimated repeated-measures, multivariable logistic regression models to predict the odds of arrest by AOT and voluntary agreement status, with the models controlling for time and nonindependence of observations. The multivariate analysis also controlled for region, race and ethnicity, age, and sex.

Limitations of the study include a small sample size and nonrandomized study groups.

Study 2

The 2011 evaluation by Link and colleagues examined whether Assisted Outpatient Treatment (AOT) under New York's "Kendra's Law" was associated with reduced arrests for violent and nonviolent offenses. The study employed a quasi-experimental design that compared the arrest rates of 183 individuals—86 who were assigned to AOT at some point in their lives and a comparison group of 97 who were never assigned to AOT. Participants were recruited from outpatient clinics in the New York City boroughs of the Bronx and Queens. After a complete description of the current study, written informed consent was obtained from each participant to conduct searches of arrest records.

There were no significant differences between the groups, except that there were significantly more men in the AOT group than in the comparison group (67 percent versus 54 percent). The AOT group was 57 percent African American, 27 percent Hispanic, and 16 percent white or other, with an average age of 36%. The comparison group that never received AOT was 51 percent African American, 31 percent Hispanic, and 19 percent white or other, with an average age of 37%.

The outcome of interest was arrest rates. Official arrest data, including the date of each offense and the associated charge, was collected from the New York State Department of Criminal Justice Services for each participant from the date he or she turned 18 until Jan. 1, 2007. A data file was constructed indicating whether a study participant was arrested in each month of observation. In addition to analyzing arrests for any offense, arrests were categorized according to whether the charge was for a violent offense (including murder, nonnegligent manslaughter, forcible rape, robbery, and aggravated assault).

In addition, New York State Office of Mental Health records were used to accurately identify periods in which individuals were assigned to AOT. For individuals ever assigned to AOT, three time periods were constructed: before AOT, during and 6 months after AOT, and more than 6 months after AOT ended. Logistic regression estimated by generalized estimating equations (GEE) was used to examine the odds of arrest. Fixed-effects logistic regression analyses were also conducted, but only for all arrests combined because arrests for violent offenses were too rare to produce stable estimates. The study included a comparison of the estimates of the effect of AOT on arrests from the fixed-effects and GEE analyses to determine whether the conclusion about the effect of AOT was the same in these complementary analytic approaches.

Study 3

Swenson and colleagues (2000) employed a 1-year randomized trial to examine the effectiveness of involuntary outpatient commitment (OPC) combined with case management to reduce the incidence of violence among people with severe mental illness in North Carolina. Study participants were screened from a population of involuntarily hospitalized patients who had been court-ordered to undergo a period of OPC upon discharge.

Upon discharge from the hospital, 262 patients were randomly assigned to release or court-ordered treatment. Study participants in the experimental group received an initial period of OPC no longer than 90 days. After that, commitment orders could be renewed for up to 180 days if a psychiatrist and the court determined that the patient continued to meet the legal criteria for OPC. Participants in the control group received immunity from any OPC during the year of the study. All study participants received case management and other outpatient treatment at mental health programs in the area. An exception to the randomization procedures was made in cases where patients had a history of serious assault involving weapon use or physical injury to another person within the past year. This group (the seriously violent group) was required to undergo at least the initial period of OPC as ordered, but they were not randomly assigned to the group.

Of the 262 patients, 102 were randomly assigned to the OPC group, 114 were randomly assigned to the control group, and 46 were assigned to the seriously violent group. A little more than half of the study participants (53.4 percent) were male and 18–39 years old (52.7 percent). The majority of participants (66 percent) were African American, while the rest were non-Hispanic white (33 percent) or other (1 percent). Most of the sample had diagnoses of psychotic disorder (68 percent), 28 percent had bipolar disorder, and 4 percent had recurrent major depression. There were no significant differences between the groups on demographics and other characteristics.

Data was collected from structured interviews with study participants as well as family members, others who knew the participant well, and case managers. Data was also obtained from hospital records and outpatient service records. The outcome measures of interest included violence, psychiatric symptoms, functional impairment, insight, social support, substance use and misuse, medication adherence, and outpatient services utilization. Violent incidences included whether study participants had been picked up by police or arrested for physical assault on another person, had been in fights involving physical contact, or had threatened someone with a weapon.

Logistic regression was used to examine the relative impact of sustained OPC and outpatient services utilization on the incidence of violent behavior, controlling for baseline violence history and relevant covariates.

There were some limitations to the study. The study design deviated from a strict randomized controlled trial in two ways. First, the sample included a subgroup of study participants with a recent history of seriously violent behavior who could not be randomly assigned to the control group. Second, the amount of time on OPC was neither random nor controlled experimentally. The amount of time a study participant remained in OPC following the required 90 days of treatment varied depending on how the clinicians applied the legal criteria for renewal of OPC orders.

Cost

A recent examination of assisted outpatient treatment (AOT) implemented in the Nevada County, California looked at the cost savings that resulted from 17 individuals who were enrolled in AOT during the first 2½ years of program implementation (no comparison group was included). The results showed a total cost savings of over \$500,000, attributable to decreases in hospitalizations and in jail time of the 17 individuals. For every \$1.00 invested in AOT in Nevada County, \$1.81 was saved (Heggarty 2011).

Implementation Information

The Treatment Advocacy Center (TAC) provides an assortment of information on Assisted Outpatient Treatment (AOT). The organization created the TAC Model Law, which illustrates a type of AOT law that can be adapted and implemented in various jurisdictions. There also is a document that describes the civil commitment criteria for inpatient or outpatient psychiatric treatment currently in place in several States around the Nation. The information is available at the TAC Web site (links to the site are available under Additional References).

For law enforcement personnel, a problem-oriented policing guide from the U.S. Department of Justice's Office of Community-Oriented Policing provides police with information for responding to people with mental illness, including the option of initiating AOT (Cordner 2006, 28). A link to the document is also available under Additional References.

Evidence-Base (Studies Reviewed)

These sources were used in the development of the program profile:

Study 1

Gilbert, Allison R., Loma L. Moser, Richard A. Van Dorn, Jeffrey W. Swanson, Christine M. Wilder, Pamela Clark Robbins, Karl J. Keator, Henry J. Steadman, and Marvin S. Swartz. 2010. "Reductions in Arrest Under Assisted Outpatient Treatment in New York." *Psychiatric Services* 61(10):1–4.

Study 2

Link, Bruce G., Matthew W. Epperson, Brian E. Perron, Dorothy M. Castille, and Lawrence H. Yang. 2011. "Arrest Outcomes Associated With Outpatient Commitment in New York State." *Psychiatric Services* 62(5):504–08.

Study 3

Swanson, Jeffrey W., Marvin S. Swartz, Randy Borum, Virginia A. Hiday, H. Ryan Wagner, and Barbara J. Burns. 2000. "Involuntary Outpatient Commitment and Reduction of Violent Behavior in Persons With Severe Mental Illness." *British Journal of Psychiatry* 176:324–31.

Additional References

These sources were used in the development of the program profile:

Busch, Alisa B., Christine M. Wilder, Richard A. Van Dorn, Marvin S. Swartz, and Jeffrey W. Swanson. 2010. "Changes in Guideline-Recommended Medication Possession After Implementing Kendra's Law in New York." *Psychiatric Services* 61(10):1–6.

Cordner, Gary. 2006. "People With Mental Illness." *Problem-Oriented Guides for Police, Problem-Specific Guides Services, Guide No. 40*. Washington, D.C.: Office of Community-Oriented Policing Services, U.S. Department of Justice. <http://mentalillnesspolice.org/crimjust/communitypolice/mental40.pdf>.

Geller, Jeffrey L. 2006. "The Evolution of Outpatient Commitment in the USA: From Conundrum to Quagmire." *International Journal of Law and Psychiatry* 29:234–46.

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New York State Office of Mental Health. 2005. *Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment*. Albany, N.Y.: New York State Office of Mental Health.

Phelan, Jo C., Marilyn Sinkewicz, Dorothy M. Castille, Steve Huz, and Bruce G. Link. 2010. "Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State." *Psychiatric Services* 61(2):137–43.

Robbins, Pamela Clark, Karl J. Keator, Henry J. Steadman, Jeffrey W. Swanson, Christine M. Wilder, and Marvin S. Swartz. 2010. "Regional Differences in New York's Assisted Outpatient Treatment Program." *Psychiatric Services* 61(10):1–6.

Swanson, Jeffrey W., Richard A. Van Dorn, Marvin S. Swartz, Andrew M. Cisto, Christine M. Wilder, Loma L. Moser, Allison R. Gilbert, and Thomas G. McGuire. 2010. "Robbing Peter to Pay Paul: Did New York State's Outpatient Commitment Program Crowd Out Voluntary Service Recipients?" *Psychiatric Services* 61(10):1–8.

Swartz, Marvin S., Jeffrey W. Swanson, Henry J. Steadman, Pamela Clark Robbins, and John Monahan. 2009. *New York State Assisted Outpatient Treatment Program Evaluation*. Durham, N.C.: Duke University School of Medicine.

Swartz, Marvin S., Christine M. Wilder, Jeffrey W. Swanson, Richard A. Van Dorn, Pamela Clark Robbins, Henry J. Steadman, Loma L. Moser, Allison R. Gilbert, and John Monahan. 2010. "Assessing Outcomes for Consumers in New York's Assisted Outpatient Treatment Program." *Psychiatric Services* 61(10):1–6.

Telson, Howard, Richard Glickstein, and Manuel Trujillo. 1999. *Report of the Bellevue Hospital Center Outpatient Commitment Pilot Program*. New York, N.Y.: Department of Psychiatry.

Treatment Advocacy Center. 2011a. "Assisted Outpatient Treatment Laws." Arlington, Va.: Treatment Advocacy Center. <http://treatmentadvocacycenter.org/solution/assisted-outpatient-treatment-laws>.

—. 2011b. *State Standards for Assisted Treatment: Civil Commitment Criteria for Inpatient or Outpatient Psychiatric Treatment*. Arlington, Va.: Treatment Advocacy Center.

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http://treatmentadvocacycenter.org/storage/documents/Standards_-_The_Text_June_2011.pdf

———. 2011c. "Treatment Advocacy Center Model Law." Arlington, Va.:Treatment Advocacy Center.
<http://www.treatmentadvocacycenter.org/legal-resources/tac-model-law>

Assisted Outpatient Treatment Impact on District Attorneys

AOT has very strong support in the criminal justice community. AOT has been endorsed by the District Attorney's Association of the State of New York (DAASNY); National Sheriffs Association, Department of Justice ("effective crime prevention program"), New York State Chiefs of Police and numerous other law enforcement organizations.

It is estimated that 17% of those incarcerated have serious mental illness. District Attorneys were involved in all those cases. DA's are involved in many more cases that don't lead to incarceration. Assisted Outpatient Treatment is proven to reduce violence, homelessness, arrest and incarceration and therefore keeps patients and public safer and cuts court costs. A well-done study of New York's Kendra's Law found

"As AOT processes have matured, professionals from the two (mental health and court) systems have improved their working relationships, resulting in greater efficiencies, and ultimately, the conservation of judicial, clinical, and administrative resources."

AOT allows judges to order people into treatment and perhaps more importantly, order the mental health system to provide it. This causes the system to focus its resources on the most seriously ill who revolve through the system clogging court calendars. While Mental Health Courts do similar work, they are used *after* a crime has occurred and only for relatively low level crimes. AOT *prevents* crime and therefore DA involvement. (NYS's Kendra's Law was proposed by the State Attorney General, not the mental health commissioner).

Following is research on New York's Kendra's Law showing AOT reduces crime and violence and therefore preserves DA resources for other uses.

Independent Study	Findings
May 2011 Arrest Outcomes Associated With Outpatient Commitment in New York State Bruce G. Link, et al. Ph.D. Psychiatric Services	For those who received AOT, the odds of any arrest were 2.66 times greater ($p < .01$) and the odds of arrest for a violent offense 8.61 times greater ($p < .05$) before AOT than they were in the period during and shortly after AOT. The group never receiving AOT had nearly double the odds (1.91, $p < .05$) of arrest compared with the AOT group in the period during and shortly after assignment."
February 2010 Columbia University. Phelan, Sinkewicz, Castille and Link. Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State Psychiatric Services, Vol 61. No 2	Kendra's Law has lowered risk of violent behaviors, reduced thoughts about suicide and enhanced capacity to function despite problems with mental illness. <i>Patients given mandatory outpatient treatment - who were more violent to begin with - were nevertheless four times less likely than members of the control group to perpetrate serious violence</i> after undergoing treatment. Patients who underwent mandatory treatment reported higher social functioning and <i>slightly less stigma</i> , rebutting claims that mandatory outpatient care is a threat to self-esteem.
March 2005 N.Y. State Office of Mental Health "Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment."	Danger and Violence Reduced So Court Involvement Avoided <ul style="list-style-type: none"> • 55% fewer recipients engaged in suicide attempts or physical harm to self • 47% fewer physically harmed others • 46% fewer damaged or destroyed property • 43% fewer threatened physical harm to others. • 83% fewer experienced arrest • 87% fewer experienced incarceration. • 49% fewer abused alcohol • 48% fewer abused drugs • 74% fewer participants experienced homelessness • 77% fewer experienced psychiatric hospitalization • 56% reduction in length of hospitalization. •

	<p>Effect on court and mental illness system</p> <p>Improved Collaboration between Mental Health and Court Systems. As AOT processes have matured, professionals from the two systems have improved their working relationships, resulting in greater efficiencies, and ultimately, the conservation of judicial, clinical, and administrative resources.</p> <ul style="list-style-type: none"> o There is now an organized process to prioritize and monitor individuals with the greatest need; o AOT ensures greater access to services for individuals whom providers have previously been reluctant to serve; o Increased collaboration between inpatient and community-based providers <p>Improved Access to Services. AOT has been instrumental in increasing accountability at all system levels regarding delivery of services to high need individuals. Community awareness of AOT has resulted in increased outreach to individuals who had previously presented engagement challenges to mental health service providers.</p> <p>Improved Treatment Plan Development, Discharge Planning, and Coordination of Service Planning. Processes and structures developed for AOT have resulted in improvements to treatment plans that more appropriately match the needs of individuals who have had difficulty.</p> <p>Consumer participation and medication compliance improved</p> <ul style="list-style-type: none"> • Number of individuals exhibiting good adherence to meds increased 51%. • The number of individuals exhibiting good service engagement increased 103%.
<p>July 2013: The Cost of Assisted Outpatient Treatment. Can it Save States Money? American Journal of Psychiatry</p>	<ul style="list-style-type: none"> • In New York City net costs declined 50% in the first year after assisted outpatient treatment began and an additional 13% in the second year. In non NYC counties, costs declined 62% in the first year and an additional 27% in the second year. This was in spite of the fact that Psychotropic drug costs increased during the first year after initiation of assisted outpatient treatment, by 40% and 44% in the city and five-county samples, respectively. The increased community based mental health costs were more than offset by the reduction in inpatient and incarceration costs. Cost declines associated with assisted outpatient treatment were about twice as large as those seen for voluntary services
<p>October 2010: Changes in Guideline-Recommended Medication Possession After Implementing Kendra's Law in New York, Alisa B. Busch, M.D Psychiatric Services</p>	<p>(By increasing medication compliance, AOT reduces court involvement. –ed) In all three regions, for all three groups, the predicted probability of an M(edication) P(ossession) R(atio) $\geq 80\%$ improved over time (AOT improved by 31–40 percentage points, followed by enhanced services, which improved by 15–22 points, and "neither treatment," improving 8–19 points). Some regional differences in MPR trajectories were observed.</p>

U.S Senate
Statement for the Record
Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights
April 28, 2014
Submitted by
Chief Michael Biasotti
Immediate Past President New York State Association of Chiefs of Police
Author: *Management of the Severely Mentally Ill and its Effect on Homeland Security*
Chief of Police, New Windsor, NY

Priority # 1 Recommendations to ensure fewer persons with serious mental illness become involved with criminal justice

- ✓ Require federal mental health block grant funds to prioritize treatment of the most seriously ill (the 'round-trippers', 'frequent-flyers' who circle in and out of hospitals, jails and prisons as a result of lack of treatment) rather than all others.
- ✓ Eliminate or reform the IMD Exclusion in Medicaid to increase the number of hospital beds available to persons with serious mental illness.
- ✓ Encourage the use of Assisted Outpatient Treatment (AOT) to reduce suicide, homelessness, arrest, incarceration, and violence. It is extensively researched, proven to work, reduces the use of force, saves money and is certified by DOJ.
- ✓ Institute a 'need for treatment' civil commitment standard in each state
- ✓ Place more representatives from criminal justice on federal mental health boards and commissions so we can tell you how policies like closing hospitals, opposing AOT, and others cause criminalization.
- ✓ Increase community services (but only if targeted to delivering treatment to the most seriously ill)
- ✓ Reign in PAIMI/P&A lawyers that challenge states that want to implement policies to reduce incarceration of the mentally ill
- ✓ Allow parents who are caregiver's access to information we need to be good caregivers.

Priority # 2 Recommendations to help those who do become involved in the criminal justice system.

- ✓ Increase the use of Mental Health Courts. Mental Health Courts do after arrest, what AOT does before arrest.
- ✓ Criminal justice representatives in any mental health commissions, advisory boards, etc.
- ✓ Make mandated and monitored treatment an important component of parole and probation systems
- ✓ Increase police training (CIT)
- ✓ Support improved treatment for the incarcerated while incarcerated and post-discharge.

U.S Senate
Statement for the Record
Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights
April 22, 2014
Submitted by
Chief Michael Biasotti
Immediate Past President New York State Association of Chiefs of Police
Author: *Management of the Severely Mentally Ill and its Effect on Homeland Security*
Chief of Police, New Windsor, NY

I am the Immediate Past President of the New York State Association of Chiefs of Police, and Current Chief of Police, New Windsor N.Y. My wife, Barbara, who is a psychologist and I have a daughter with schizophrenia who has been involuntarily hospitalized in excess of 20 times. Barbara and I met when she, like many moms, turned to the police for help, when her, now our daughter became psychotic, disruptive and threatening. She was self-medicating, unemployed, and deteriorating despite my wife's heroic efforts to help her. Then she went into Assisted Outpatient Treatment and it saved her life.

In 2011, while attending the U.S. Naval Postgraduate School's Center for Homeland Defense and Security, I published a survey of over 2400 senior law enforcement officers nationwide, titled "*Management of the Severely Mentally Ill and its Effect on Homeland Security*."¹ The survey found that the mentally ill consume a disproportionate percentage of law enforcement resources. Many commit low level crimes.² 160,000 attempt suicide³, 3 million become crime victims⁴, and 164,000 are homeless each year⁵. While most mentally ill are not violent, that does not hold true for the untreated seriously mentally ill⁶. Ronald Reagan and Gabrielle Giffords were shot; and two guards in this very building were killed, the Navy Yard shootings, as well as many incidents nationwide, all were committed by persons with untreated severe mental illness.

The survey essentially found that we have two mental health systems today, serving two mutually exclusive populations: Community programs serve those who seek and accept treatment. Those who refuse, or are too sick to seek treatment voluntarily, become a law enforcement responsibility. We must acknowledge the second population exists. It is unjust to the most severely ill people. It puts them, the public and the police at risk and costs much more than if the mental health system would take responsibility for them. While fewer than 100,000 are in psychiatric hospitals⁷ over 300,000⁸ are in jails and prisons. It takes police officers, sheriffs, district attorneys, judges, prisons, jails and correction officers to manage each of them.⁹

Our primary recommendation is to prevent individuals from deteriorating to the point where law enforcement becomes involved.

There are four ways to do that:

#1. Focus federal funds on getting treatment to the most seriously ill.

We must acknowledge that some seriously mentally ill have histories of violence, crime, and arrest, because they refuse, or are too sick to understand that they need treatment. We must not continue to ignore this group. Block grants should prioritize treatment of the most seriously

ill. More representatives from criminal justice should be placed on federal mental health boards and commissions so we can voice our concerns on how policies like closing hospitals, opposing AOT, and others cause criminalization. Create a "need for care" standard to supplement the a "danger to self or others" standard. The goal should be to prevent violence, not require it.

#2. Preserve state hospitals

Reform the IMD Exclusion. Hospitals often can't admit new patients and they are forced to discharge the ones they have before fully stable to make room for the many who are waiting. Anyone who presents asking for help, is generally not sick enough to be admitted, so involuntary admission, that is, being a "danger to self or others" becomes the main pathway to treatment. Officers wait hours only to find the hospital refuses admission. The only solution left to our officers is to arrest people with serious mental illness for whatever minor violation exists, something we are loathe to do to sick people who need medical help, not incarceration.

#3. Implement Assisted Outpatient Treatment.

It is the most successful program to return care of the seriously ill to the mental health departments. It commits the individual to comply with treatment and the mental health system to provide it. DOJ found it reduces crime,¹⁰ it thereby reduces incarceration. The data shows that AOT reduces homelessness, suicide, incarceration, arrest and violence by over 70%. It cuts costs in half while reducing liberty-depriving incarcerations and involuntary inpatient commitments. 80% of those in AOT say it helps them get well and stay well.

#4. Help those who enter and leave the criminal justice system receive better treatment.

Fund Crisis Intervention Team training and encourage the use of Mental Health Courts. Support improved treatment for the mentally ill while incarcerated and provide mandated and monitored treatment post-discharge as part of parole and probation systems. Finally, allow parents who are caregiver's, like Barbara and I, access to information we need to help our loved ones by reforming both HIPAA and FERPA.

¹ Biasotti, Michael C., Management of the severely mentally ill and its effects on homeland security. Naval Postgraduate School, Monterey, CA, September, 2011. Key findings and quotes from officers surveyed attached as appendix. Full report available at <http://mentalillnesspolicy.org/crimjust/homelandsecuritymentalillness.pdf>. (Accessed 3/16/14.)

² Crime: A 1991 survey of 1,401 members of the National Alliance for the Mentally Ill (NAMI), an advocacy group for families of individuals with serious mental illnesses, reported that 40 percent of the mentally ill family members had been in jail at some point in their lives. Donald M. Steinwachs, Judith D. Kasper, Elizabeth A. Skinner, *Final Report: NAMI Family Survey* (Arlington, Va.: National Alliance for the Mentally Ill, 1992).

³ Suicide: There are 38,000 suicides a year. NIMH estimates 90% are mental illness related. We conservatively estimate that half of those are related to untreated serious mental illness (16,000). NIMH says (<http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics->

[and-prevention/index.shtml](#)) there are 11 attempts for every one suicide. They rely on Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS): www.cdc.gov/ncipc/wisqars

⁴ Victimization: Hiday, Virginia Aldigé, Ph.D.; Swartz, Marvin S., M.D.; Swanson, Jeffrey W., Ph.D.; Borum, Randy, H. Ryan, Psy.D., Criminal Victimization of Persons With Severe Mental Illness. Psychiatric Services. American Psychiatric Association. January 1, 1999, Vol 50. Issue 1.

⁵ Homelessness: Estimates of homeless mentally ill vary. In January 2012, the Annual Homeless Assessment Report determined 633,782 people were homeless on a single night in the United States. Sixty-two percent of them (390,155) were sheltered (living in emergency shelter or transitional housing) and thirty-eight percent (243,627) were unsheltered (living in places not meant for human habitation, such as the streets, abandoned buildings, vehicles, or parks. (Alvaro Cortes, et al. 2012) These estimates do not include homeless "couch-surfers" who camp out on the sofas of friends and families, move every few days and have no permanent address. Estimates of the percentage of homeless who have mental illness range from 25% to 46% (National Alliance to End Homelessness n.d.). Depending on the age group in question, and whether it includes all mental illness or just serious mental illness, the consensus estimate seems to be that at minimum 26% of homeless are seriously mentally ill. (U.S. Department of Housing and Urban Development 2010) Therefore, 164,783 seriously mentally ill are homeless at any given point in time as are 291,539 with any mental illness.

⁶ Violence: Most departments never have a mass tragedy like that that occurred in Representatives DeGette, Gardner's, or Griffiths' states. And most violence by persons with serious mental illness does not involve guns or lead to death. But all crime and violence does require a police response.

The evidence is clear that untreated serious mental illness is related to violence and that treatment can reduce that violence. As NIMH Director Dr. Thomas Insel told the Institute of Medicine earlier this month, "I'd like to say something which I think is unpopular many people in the mental health community. But the data I believe are fairly unambiguous.... An active psychotic illness is associated with irrational behavior--and violence can be part of that."

In a 1992 issue of *The American Psychologist*, John Monahan of the University of Virginia wrote: "The data that have recently become available, fairly read, suggest the one conclusion I did not want to reach: whether the sample is people who are selected for treatment as inmates or patients in institutions or people randomly chosen from the open community, and no matter how many social or demographic factors are statistically taken into account, there appears to be a relationship between mental disorder and violent behavior."

Following are some of the studies.

- The Epidemiological Catchment Area (ECA) surveys carried out 1980–1983 reported much higher rates of violent behavior among individuals with severe mental illness living in the community compared to other community residents. For example, individuals with schizophrenia were 21 times more likely to have used a weapon in a fight. Swanson JW, Hozer CD, Ganju VK et. al. Violence and psychiatric disorder in the community: evidence from the Epidemiologic Catchment Area surveys. *Hospital and Community Psychiatry* 1990;41:761–770.

- A review of 22 studies published between 1990 and 2004 "concluded that major mental disorders, per se, especially schizophrenia, even without alcohol or drug abuse, are indeed associated with higher risks for interpersonal violence." Major mental disorders were said to account for between 5 and 15 percent of community violence. Joyal CC, Dubreucq J-L, Gendron C et al. Major mental disorders and violence: a critical update. *Current Psychiatry Reviews* 2007;3:33–50.
- A study of 331 individuals with severe mental illness in the United States reported that 17.8 percent "had engaged in serious violent acts that involved weapons or caused injury." It also found that "substance abuse problems, medication noncompliance, and low insight into illness operate together to increase violence risk." Swartz MS, Swanson JW, Hiday VA et. al. Violence and severe mental illness: the effects of substance abuse and non-adherence to medication. *American Journal of Psychiatry* 1998;155:226–231.
- In a carefully controlled study comparing individuals with severe mental illness living in the community in New York with other community residents, the former group was found to be three times more likely to commit violent acts such as weapons use or "hurting someone badly." The sicker the individual, the more likely they were to have been violent. Link BG, Andrews H, Cullen FT. The violent and illegal behavior of mental patients reconsidered. *American Sociological Review* 1992; 57:275–292.

⁷ E. Fuller Torrey, M.D, The Shortage of Public Hospital Beds for Mentally Ill Persons: A Report of the Treatment Advocacy Center. Available at <http://mentalillnesspolicy.org/imd/shortage-hosp-beds.pdf>

⁸ More than 50% of those in jails and prisons have a mental health problem (James and Glaze 2006). However only about 16 or 17% of individuals in federal prisons and 17% of those in jails have serious mental illness. (Osher, et al. 2012) There were 1,504,150 in prisons and 735,601 in jail. (Glaze and Parks 2012) Therefore there were 240,664 seriously mentally ill in prisons and 125,052 seriously mentally ill in jails, or 365,716 adults with serious mental illness in jails and prisons.

⁹ Police were involved in arresting, processing paperwork, investigating and testifying at the trials of the 365,000 seriously mentally ill in jails and prisons, and the 770,000 under probation and parole. There are 4,814,200 individuals under probation or parole. (Glaze and Parks 2012) If the same 16% (Footnote 8) holds true then 770,000 individuals with serious mental illness are under probation and parole.

¹⁰ Department of Justice. Office of Justice Programs. Crime Solutions. Available at <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=228> (Accessed 3/19/14)

Excerpts from
Management of the Severely Mentally Ill and its Effect on Homeland Security:
A survey of 2400 senior law enforcement officials

By
 Chief Michael Biasotti
 Immediate Past President New York State Association of Chiefs of Police
 Chief of Police, New Windsor, NY
 U.S. Naval Postgraduate School's Center for Homeland Defense and Security
 September 2011

Selected Findings

Police and sheriffs are being overwhelmed "dealing with the unintended consequences of a policy change that in effect removed the daily care of our nation's severely mentally ill population from the medical community and placed it with the criminal justice system." "This policy change has caused a spike in the frequency of arrests of severely mentally ill persons, prison and jail population and the homeless population...(and) has become a major consumer of law enforcement resources nationwide."

84.28% (or 1,866) of respondents said there been an increase in the mentally ill population over the length of their career

63.03% (n=1,391) of respondents reported that the time spent on mental illness related calls has increased (during their career). An additional 17.72 percent reported that the time spent had substantially increased, totaling 70.7 percent (n=1,782) of respondents reporting an increase

When asked what the officers' attribute the increase in calls to, 56% said inability to refer mentally ill to treatment and 61% said more persons with mental illness are being released to the community,

The officers claimed that mental illness related calls take significantly longer than larceny, domestic dispute, traffic, and other calls.

When asked, "What obstacles affect the ability of law enforcement to make referrals for persons with mental illness", the inability to refer people unless they are danger to safe or others was cited by 77%; limited availability of services was cited by 57% and procedures required for mandated treatment were cited by 44% (Officers were allowed more than one response).

Selected Quotes from Senior Law Enforcement Officers

Problems Getting Admission to Hospitals

"The problems are not so much the obstacles but rather when we get them to the hospital we have to sit with them, depending on the incident that occurred, and we have a limited number of officers on duty. And once they are committed, it's only a matter of time before they are released and we end of dealing with them again in another situation."

"No support from the mental health doctors. You take them into the hospital and it takes four to six hours to admit to the ward if you are able to at all."

"In Nevada, the Sheriff is required to transport mentally ill subjects to the State hospitals. These trips can take five to eight hours one way due to the great distances we have to travel."

"The closest state mental health facility is approximately 300 miles from my jurisdiction. The closest private mental health facility is 100 miles. The private facility is quite difficult to work with."

"Our jurisdiction is extremely rural. If a person requires in-patient treatment, then it is a four-hour drive to the hospital, and our ambulance service will not transport. Given that most evaluations take two hours at a minimum that leaves an officer out of service for a minimum of ten hours. Because we have only eight officers including the Chief, it also means calling someone in on their days off to make the transport."

"The whole process is too long. It takes too long to have the patient evaluated. Takes too long to have the committal paper filed with the court. Takes too long to find a facility. Takes too long to have the paper obtained once a judge signs it. Then when the individual makes it to the next facility we get to go through the same thing and length of time on the other end. On average it takes approximately 10 hours. With a small department we have 2 or 3 people working. Basically one of my officers is tied up in this process and I have another officer at time working without backup."

"No mandate for mental health services to accept a person brought in by law enforcement unless they are willing to self-commit. To get a commitment there has to be a plan in place to harm themselves or others and the mental health officer has to work out a hold and make sure there is a bed free. There are far too many people who are off their medication for a number of reasons encounter by law enforcement and in need of assistance getting back on track."

"We refer them to facilities such as Emergency Mental Health (EMH) because they attempt to commit suicide and then for whatever reason are let out six to twelve hours later. I have questioned this as a Police Chief and have been told that it is difficult to predict if a person will actually ever commit suicide. What the hell do we bother bringing them to the hospital for then? I could say the same thing in their living room and save the trip to the hospital."

"After forming the Crisis Intervention Team local facilities found out we knew the regulations related to their responsibilities and they started working with us. There are still some obstacles related to some E.R. doctors, for those we that are not a danger to themselves. For others there are limited beds available and the state continues to cut funding to the support agencies."

Problems getting mental health departments to help the most seriously ill

"In the past, if an officer could articulate to the crisis counselor that a mental subject was a danger to him or others then they would respond and make arrangements for bed space. Now, they rarely come out unless it is an uncontrolled violent person. In some cases, a crisis counselor has asked to speak to the mental subject over the officer's cell phone and "diagnosed" the mental subject based on that short phone conversation. The problem here is

that the officer has made observations and noted the comments made by the mental subject. Most officers would not ever release a dangerous person despite whatever diagnosis is made over the phone. So, the mental subject either gets arrested or goes to a local hospital for evaluation. This wastes resources and takes more of the officer's time—all in the name of protecting one's self from liability."

"Police seem to be the only resource that is mandated to be trained and deal with these individuals in the field, usually because there is a disturbance that prompts the call for these individuals. However, EMS, local hospitals, etc., are not required the same level of participation in the de-escalation of a mental event as the police are."

"(Problem is) Catch and Release attitude of mental health professionals, i.e. anti-suicide contracts, promise not to do it again, etc."

"When subjects suffering from mental illness are confronted by law enforcement in the community if they have been abusing alcohol or illegal drugs most mental health practitioner will not assess these individuals regardless of behavior or symptoms until they are "sober." This requires prolonged periods of police officers and jails having to hold these individuals or protect them in medical facilities until mental health practitioners provide an assessment."

"Our system here requires a medical evaluation before acceptance, consequently its easier to arrest and put into jail since they don't need a medical / physical exam prior to acceptance."

"While no obstacles exist, referring to mental health services does little to protect the public safety. Mental health professional simply coaxed the client into taking their medications while at the facility and then sends them back home. Often times we will just have to deal with them again the next day."

Problems caused by lack of 'need for treatment' standard or "grave disability" standard

"We can get them to the psych unit, but the doctors let them go due to the "dangerous to self or others" criteria."

"The biggest problem does not lie with law enforcement. The problem is found when citizens can't get assistance due to the "danger" requirement. When they have nowhere else to turn they call the police to handle the issue. This takes a large amount of time to then pull strings to try and get help for the citizens."

"Although referrals are easily made, the voluntary involvement of the mental health patient is necessary. If they are not voluntary, and not a danger to themselves there is little that can be done with them."

"We are a small department and often only have one officer on duty at a time. This is VERY dangerous to have only one officer handle a mental health case. When possible, we have more officers' respond."

"We must call a mental health case worker, for OK to commit or county will not pay for it...they will listen to what we have to say...but it's their call if they find a bed for the person."

Attachment B: 10 Independent Kendra's Law (AOT) Studies Show it Works

(Researched by Mental Illness Policy Org. <http://mentalillnesspolicy.org>)

Independent Study	Findings
May 2011 Arrest Outcomes Associated With Outpatient Commitment in New York State Bruce G. Link, et al. Ph.D. Psychiatric Services	For those who received AOT, the odds of any arrest were 2.66 times greater ($p < .01$) and the odds of arrest for a violent offense 8.61 times greater ($p < .05$) before AOT than they were in the period during and shortly after AOT. The group never receiving AOT had nearly double the odds (1.91, $p < .05$) of arrest compared with the AOT group in the period during and shortly after assignment."
October 2010: Assessing Outcomes for Consumers in New York's Assisted Outpatient Treatment Program Marvin S. Swartz, M.D., Psychiatric Services	Consumers who received court orders for AOT appeared to experience a number of improved outcomes: reduced hospitalization and length of stay, increased receipt of psychotropic medication and intensive case management services, and greater engagement in outpatient services.
February 2010 Columbia University. Phelan, Sinkewicz, Castille and Link. Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State Psychiatric Services, Vol 61, No 2	Kendra's Law has lowered risk of violent behaviors, reduced thoughts about suicide and enhanced capacity to function despite problems with mental illness. <i>Patients given mandatory outpatient treatment - who were more violent to begin with - were nevertheless four times less likely than members of the control group to perpetrate serious violence after undergoing treatment.</i> Patients who underwent mandatory treatment reported higher social functioning and <i>slightly less stigma</i> , rebutting claims that mandatory outpatient care is a threat to self-esteem.
March 2005 N.Y. State Office of Mental Health "Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment."	<p>Danger and Violence Reduced</p> <ul style="list-style-type: none"> • 55% fewer recipients engaged in suicide attempts or physical harm to self • 47% fewer physically harmed others • 46% fewer damaged or destroyed property • 43% fewer threatened physical harm to others. • Overall, the average decrease in harmful behaviors was 44%. <p>Consumer Outcomes Improved</p> <ul style="list-style-type: none"> • 74% fewer participants experienced homelessness • 77% fewer experienced psychiatric hospitalization • 56% reduction in length of hospitalization. • 83% fewer experienced arrest • 87% fewer experienced incarceration. • 49% fewer abused alcohol • 48% fewer abused drugs <p>Consumer participation and medication compliance improved</p> <ul style="list-style-type: none"> • Number of individuals exhibiting good adherence to meds increased 51%. • The number of individuals exhibiting good service engagement increased 103%. <p>Consumer Perceptions Were Positive</p> <ul style="list-style-type: none"> • 75% reported that AOT helped them gain control over their lives • 81% said AOT helped them get and stay well • 90% said AOT made them more likely to keep appointments and take meds. • 87% of participants said they were confident in their case manager's ability. • 88% said they and case manager agreed on what is important to work on. <p>Effect on mental illness system</p> <ul style="list-style-type: none"> • Improved Access to Services. AOT has been instrumental in increasing accountability at all system levels regarding delivery of services to high need individuals. Community awareness of AOT has resulted in increased outreach to individuals who had previously presented engagement challenges to mental health service providers. • Improved Treatment Plan Development, Discharge Planning, and Coordination of Service Planning. Processes and structures developed for AOT have resulted in improvements to treatment plans that more appropriately match the needs of individuals who have had difficulties using services in the past. • Improved Collaboration between Mental Health and Court Systems. As AOT processes have matured, professionals from the two systems have improved their working relationships, resulting in greater efficiencies, and ultimately, the conservation of judicial, clinical, and administrative resources. • There is now an organized process to prioritize and monitor individuals with the greatest need;

	<ul style="list-style-type: none"> o AOT ensures greater access to services for individuals whom providers have previously been reluctant to serve; o Increased collaboration between inpatient and community-based providers.
February 2010 Columbia University, Phelan, Sinkewicz, Castille and Link. Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State Psychiatric Services, Vol 61, No 2	<ul style="list-style-type: none"> • Kendra's Law has lowered risk of violent behaviors, reduced thoughts about suicide and enhanced capacity to function despite problems with mental illness. • Patients given mandatory outpatient treatment - who were more violent to begin with - were nevertheless four times less likely than members of the control group to perpetrate serious violence after undergoing treatment. • Patients who underwent mandatory treatment reported higher social functioning and slightly less stigma, rebutting claims that mandatory outpatient care is a threat to self-esteem.
October 2010: Changes in Guideline-Recommended Medication Possession After Implementing Kendra's Law in New York, Alisa B. Busch, M.D. Psychiatric Services	In all three regions, for all three groups, the predicted probability of an M(edication) P(ossession) R(atio) $\geq 80\%$ improved over time (AOT improved by 31–40 percentage points, followed by enhanced services, which improved by 15–22 points, and "neither treatment," improving 8–19 points). Some regional differences in MPR trajectories were observed.
October 2010 Robbing Peter to Pay Paul: Did New York State's Outpatient Commitment Program Crowd Out Voluntary Service Recipients? Jeffrey Swanson, et al. Psychiatric Services	In tandem with New York's AOT program, enhanced services increased among involuntary recipients, whereas no corresponding increase was initially seen for voluntary recipients. In the long run, however, overall service capacity was increased, and the focus on enhanced services for AOT participants appears to have led to greater access to enhanced services for both voluntary and involuntary recipients.
June 2009 D Swartz, MS, Swanson, JW, Steadman, HJ, Robbins, PC and Monahan J. New York State Assisted Outpatient Treatment Program Evaluation. Duke University School of Medicine, Durham, NC, June, 2009	<p>We find that New York State's AOT Program improves a range of important outcomes for its recipients, apparently without feared negative consequences to recipients.</p> <ul style="list-style-type: none"> • Racial neutrality: We find no evidence that the AOT Program is disproportionately selecting African Americans for court orders, nor is there evidence of a disproportionate effect on other minority populations. Our interviews with key stakeholders across the state corroborate these findings. Court orders add value: The increased services available under AOT clearly improve recipient outcomes, however, the AOT court order, itself, and its monitoring do appear to offer additional benefits in improving outcomes. • Improves likelihood that providers will serve seriously mentally ill: It is also important to recognize that the AOT order exerts a critical effect on service providers stimulating their efforts to prioritize care for AOT recipients. • Improves service engagement: After 12 months or more on AOT, service engagement increased such that AOT recipients were judged to be more engaged than voluntary patients. This suggests that after 12 months or more, when combined with intensive services, AOT increases service engagement compared to voluntary treatment alone. • Consumers Approve: Despite being under a court order to participate in treatment, current AOT recipients feel neither more positive nor more negative about their treatment experiences than comparable individuals who are not under AOT.
1999 NYC Dept. of Mental Health, Mental Retardation and Alcoholism Services. H. Telson, R. Glickstein, M. Trujillo, Report of the Bellevue Hospital Center Outpatient Commitment Pilot	<ul style="list-style-type: none"> • Outpatient commitment orders often assist patients in complying with outpatient treatment. • Outpatient commitment orders are clinically helpful in addressing a number of manifestations of serious and persistent mental illness. • Approximately 20% of patients do, upon initial screening, express hesitation and opposition regarding the prospect of a court order. After discharge with a court order, the majority of patients express no reservations or complaints about orders. • Providers of both transitional and permanent housing generally report that outpatient commitment help clients abide by the rules of the residence. More importantly, they often indicate that the court order helps clients to take medication and accept psychiatric services. • Housing providers state that they value the leverage provided by the order and the access to the hospital it offers.
1998 Policy Research Associates, Study of the NYC involuntary outpatient commitment pilot program.	<ul style="list-style-type: none"> • Individuals who received court ordered treatment in addition to enhanced community services spent 57 percent less time in psychiatric hospitals.

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STATEMENT FOR THE RECORD

**Law Enforcement Responses to Disabled Americans:
Promising Approaches for Protecting Public Safety**

**Hearing before the Senate Judiciary Subcommittee on
the Constitution, Civil Rights, and Human Rights**

Chair: Senator Dick Durbin

Date: **April 29, 2014**

Time: **10:00 a.m.**

Location: **Dirksen Senate Office Building Room 226 (room location is tentative)**

Statement for the Record by:

Michael Sullivan

Michael Sullivan ADA Consulting, Specializing in Law Enforcement Issues

AUTHOR'S CREDENTIALS

I am a retired Sergeant with the San Francisco Police Department (SFPD) and served the City of San Francisco for 32 years, including 17 years as the SFPD's Americans with Disabilities Act Coordinator. While on duty at the age of 26, I was the victim of a violent crime and, as a result, am disabled. My disability provides me with the unique ability to see the ADA as it relates to law enforcement from both the perspective of a disabled person and the perspective of a law enforcement officer.

As the SFPD's ADA Coordinator, I was the department's liaison with San Francisco's disabled community and assured the department's compliance with Title I and II of the ADA, developing policies, procedures, and training regarding police officers' interactions with people with disabilities. I served in both training and advisory roles and developed and taught a model training course for peace officers regarding the requirements and responsibilities mandated by the ADA and the resulting Civil Rights implications—a course that has been attended by more than 2000 SF police officers as well as officers from other jurisdictions. I also investigated and responded to inquiries from the Equal Employment Opportunity Commission, the U.S. Department of Justice, and the SF Mayor's Grievance Committee.

In conjunction with San Francisco Community Mental Health Services, I developed and implemented Police Crisis Intervention Training, an intensive 40-hour course for San Francisco police officers that educated them about psychiatric disorders and developmental disabilities and provided them with intervention skills for effective interaction with persons with psychiatric disabilities. The course has been recognized and honored by San Francisco's Board of Supervisors, the California Assembly, and Congresswoman Nancy Pelosi.

I have served on the Executive Board of the President's Committee on the Employment of People with Disabilities and on the Joseph P. Kennedy Institute's Advisory Committee where I assisted with the development of training for the Washington, D.C. Police Department regarding interaction with persons with disabilities.

I was twice honored as San Francisco's ADA Coordinator of the Year, and was awarded San Francisco's Community Leadership Award by Mayor Gavin Newsom in conjunction with the Independent Living Resource Center of San Francisco for my efforts to build a more accessible San Francisco.

I conduct trainings for law enforcement and correctional agencies about the requirements of the ADA in law enforcement settings. The trainings emphasize the importance of law enforcement personnel knowing how to accommodate persons with disabilities in order to facilitate successful communication and interaction without compromising officer safety. And because disability-based behaviors can be misinterpreted, these trainings also emphasize how essential it is that officers have the ability to recognize disabilities and be able to differentiate characteristics and behaviors associated with them from criminal behaviors such as public intoxication and domestic violence. Awareness of community resources and how to access them as well as the need to have agency policies in place to facilitate that access are also covered in the trainings.

In addition to law enforcement agencies, I have made presentations for numerous non-profit organizations about the ADA and law enforcement issues and challenges. Among these

are the ADA National Network/Great Lakes ADA Center, Disability Rights California, Northern Florida Center for Independent Living Disability Resource Center, Open Doors, California Association of the Deaf, and the California Commission on Peace Officer Standards and Training. I have been a speaker or served on panels at regional and national conferences where topics included law enforcement issues related to specific communities of disabled persons including deaf/hard of hearing, autistic, mentally ill, as well as skilled nursing residents and veterans.

I have served as law enforcement consultant to the Center on Self-Determination/Oregon Institute on Disability and Development at Oregon Health Science University's School of Nursing and the Center for Research on Women with Disabilities at Baylor College of Medicine for these Centers' joint five year study, The Identification and Reporting of Violence by Persons with Disabilities Project.

I am currently a member of the Board of Directors of the National Association of ADA Coordinators (NAADAC) and participate in NAADAC's annual East Coast and West Coast national ADA conferences where I am a presenter and panelist in Title I (Employment) and Title II (State and Local Entities) of the ADA workshops as well as Law Enforcement and the ADA sessions.

I have a Bachelor of Arts degree in Health Science with an emphasis in Community Health Education from San Francisco State University and I am the principal consultant with Michael Sullivan ADA Consulting for Law Enforcement (michaelsullivanadaconsulting.com).

Attention Senator Dick Durbin and Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights:

The Americans with Disabilities Act (ADA), signed into law in 1990 by President George Bush, is landmark Civil Rights legislation that requires that state and local governments make their programs, services, and activities accessible to people with disabilities. The impact for law enforcement manifests in the need to have policies, procedures, and training in place to comply with the Act.

It is incumbent on law enforcement agencies to design training that will be practical, timely, and meaningful for its members. Law enforcement officers need to know how to effectively interact with a person with a disability, whether in a patrol, investigative, or correctional setting.

Officer safety is a priority and a fundamental principle of training. When approaching a person or being approached by a person in the field, an officer will instinctively conduct a threat assessment through observation and communication. The officer will determine if that person is the witness, suspect, victim, good guy or bad guy, and will note if the person is under the

influence, agitated, angry, violent, potentially violent, and/or exhibiting any number of other traits or behaviors.

This process will happen in seconds.

Officers use a “take charge” attitude as an essential technique to insure not only their own safety, but that of the general public. On the other hand, people with disabilities often lament that officers in these situations can be perceived as intimidating and controlling which may lead to communication breakdowns.

Effective law enforcement training can alleviate this communication problem.

As a starting point, law enforcement agencies should evaluate their existing training programs to determine to what extent, if any, disability-related training exists. Disability reaches across all socioeconomic groups. People with disabilities are in the workplace, living independently, utilizing public transportation, etc. as a result of progress and opportunities arising from implementation of the ADA. Our country is also seeing disabled veterans of the Iraq and Afghanistan wars, many with both visible and hidden disabilities, returning to our communities and reentering civilian life. Law enforcement personnel must be trained and prepared to accommodate all of these people in order to have successful interactions.

It cannot be assumed that a particular disability will affect all persons with it in the same way. Disability is personal and is therefore not subject to generalization. And when designing a training program, one must be aware of the differences between the “medical model” and the “people model.”

Much training in disability is based on the medical model. In the medical model, a disability is described in terms of its medical definition. For example, with regard to autism spectrum disorder, the DSM-IV describes “Autistic Disorder”¹ and lists the criteria necessary for diagnosis. A training program based on the medical model would use this information as the basis for discussing autism spectrum disorder. This is not to say that this information is not of value, but information about a disability needs to be presented in the context of use by law enforcement.

The particular pitfall of using a medical model training program to train law enforcement personnel is that the officer, armed with the medical knowledge about a disability, will be apt to “diagnose” the disability and form conclusions about the individual. Once the officer has concluded the person has a particular disability, as in the autism example, he or she will logically continue the contact based on expectations arrived at by the “diagnosis.” However, since the officer is not a trained diagnostician, the diagnosis may well be incorrect which can lead to an inappropriate response, lack of proper accommodation, and ultimately an unsuccessful interaction.

¹ The current usage is Autism Spectrum Disorder. This is a more accurate description of autism’s range. The revised DSM-V no longer includes Asperger’s as a separate diagnosis but includes as part of the spectrum.

In contrast, when using a people model of disability training, officers would be told to focus on behaviors. Earlier, a description of an officer's approach to an individual was provided. Officers need to be trained to recognize that if the person's behavior they are approaching does not fit any of their usual criteria, the person may have a disability.

Providing officers with essential information about disabilities will reduce the potential for misunderstanding in interactions. Specific disability-related topics should include but should not be limited to the Americans with Disabilities Act (and other related relevant State or local laws), intellectual disabilities, autism spectrum disorder, traumatic brain injury, mobility impairments, seizure disorder, deaf, hard of hearing, psychiatric disabilities, vision impairments, learning disabilities, how to provide accommodation, cerebral palsy and multiple chemical sensitivity. And training regarding disability is more practical if it is designed within a framework based on how people with disabilities often come into contact with law enforcement officers.

For several years, emphasis has been placed on the training of law enforcement personnel in the specific area of psychiatric disabilities. Commonly referred to as *Crisis Intervention Training*, a number of models for this training exist including Memphis Police, San Francisco Police, and San Jose Police.

In 2000, the California Legislature enacted Penal Code section 13535.25, which delineates the elements of a Crisis Intervention Training course.

At the conclusion of the Crisis Intervention Training, depending on the model utilized, the participating officers may be assigned the specific responsibility within their departments to handle calls for service involving people with psychiatric disabilities. These officers would respond to calls involving a person in crisis and use the techniques and training learned to resolve the incident.

Disability training can only be truly effective when the disabled community has input into the development of the training.

Including people with disabilities in the development of training allows for officers to hear first-hand what a disability means to a person and what people with disabilities want officers to know about them. Listening to a person who uses a wheelchair describe how he or she had to circumnavigate a block to get to an appointment because cars were parked illegally and blocked the path of travel on the sidewalk, or a person who is blind tell the story of shopping with a sighted friend and enduring the humiliation of having the salesperson speak only to the sighted person, or a person with a service animal being denied access to a facility because of no pet policies, or a person with a psychiatric disability describe the terror of being involuntarily committed by an officer who feels (legitimately) that he or she is helping the disabled person get treatment are powerful and enlightening stories.

When an officer is summoned to a situation involving a person with autism, having knowledge of the behaviors related to autism will assist him or her in reaching a successful conclusion. What law enforcement officers need to know about people with autism is that they may not be verbal, may display repetitive behaviors, and/or may not like to be touched. If an officer

determines it is necessary to remove a person with autism from harm, having the knowledge that a person with autism may not like to be touched and may resist is invaluable. It prevents the natural assumption that the person is resisting arrest, and instead allows the officer to consider that the person with autism is not resisting arrest or fighting the officer but is reacting to the sensory stimulation of being touched.

The character with autism portrayed by Dustin Hoffman in the movie *Rain Man* is someone who requires assistance with activities of daily living. Law enforcement contact with him would most likely be as a missing person.

Another form of training is "Awareness vs. Sensitivity Training." Sensitivity training exposes non-disabled participants to the effects of disabilities on daily living. Participants put cotton in their ears to simulate hearing loss, experience barriers while using wheelchairs, and wear blindfolds while navigating hallways. The non-disabled participants become frustrated with their newfound diminished abilities. When the role playing ends and they take out the ear plugs, take off the blindfolds, and get up from the wheelchairs, they do so with the deep understanding that people with disabilities cannot similarly walk away from those disabilities.

Training should also aim to eliminate stereotypes. People with disabilities have the same desires, hopes, and dreams as everyone else. Their disabilities are not indicators of intelligence nor are people with disabilities to be pitied.

This is awareness training. By raising their awareness of the concerns and issues of people with disabilities, law enforcement personnel will be educated and therefore better able to address the needs of people with disabilities.

Because they were provided with information about the characteristics of particular disabilities, officers will be better able to conduct interviews, distinguish criminal behavior from disability-related behavior, and understand how their presence may be the stressor. When in doubt, they will know to seek more information before proceeding.

In his book, *Fears of Your Life*, Michael Bernard Loggins, a person with an intellectual disability, lists his many fears. Among them, written in Mr. Loggins own words unedited are:

- 5. *Fear of going to jail as being punish for doing something very wrong and have to stay in for a long time.*
- 25. *Fear of being caught being with the person that steals.*
- 51. *Fear of sexually abused.*
- 60. *Fear of if I do something naughty I will cause something to happen to me and I will get in trouble.*
- 64. *Fear of Pirates.*
- 74. *Fear of Police.*

Officers who receive effective training will understand that a person with an intellectual disability may have the need to please, may act inappropriately in a situation, or may be embarrassed by the disability. Officers need to be trained as to how to successfully interact with

a disabled person, which is essential to obtaining a complete statement and/or having a good witness.

By writing and communicating effectively, Mr. Loggins challenges a stereotype about people with intellectual disabilities. He is able to communicate that he is afraid of police and pirates, and if law enforcement officers have contact with Mr. Loggins, it is important they understand that Mr. Loggins has those fears.

Such fears are real and not easily set aside. A person with an intellectual disability may have witnessed a crime. Asking open-ended questions about the incident or having the person stand where he or she was and tell what happened in a narrative form will reduce the chance of inaccurate “need to please” answers. As we see with Mr. Loggins’ fears, it may take time to build trust before beginning an interview.

Effective disability-related training provides law enforcement personnel with the tools to meet unique challenges to communication and understanding and to work successfully with people with disabilities.

Disability-related training is not the only extraordinary area of responsibility that law enforcement has to people with disabilities under the ADA. Since the ADA mandates that state and local governments make their programs, services, and activities accessible to people with disabilities, law enforcement must have policies and procedures in place to ensure equal access for people with disabilities. Some examples of policy, procedures, and training issues include, but are not limited to:

- *Providing ASL interpreters 24-7 for persons who are deaf. Training should include how to work with an interpreter, recognizing written language may be in non-standard English, what is effective communication, types of assistive listening devices, and making sure officers are aware that handcuffing a person who uses sign language prevents them from communicating.*
- *Transportation requirements for a person using a wheelchair.*
- *How to effectively search mobility devices and people using wheelchairs, and how to handcuff people with limited range of motion.*
- *Policy relating to housing of disabled prisoners, including preventing denial of program participation based on disability.*
- *Modifying a policy so that a person is allowed to verbally acknowledge a notice to appear if he or she is unable to sign the notice due to a disability.*
- *Developing a policy/procedure to obtain alternate format materials.*
- *Procedure for including disability information in a police report without disclosing the disability (unless it is an element of a crime), such as providing the email address or TTY number, contact times for a victim to be called, or the need for an accessible meeting location for a follow-up interview.*
- *Outreach to the disabled community through nonprofit service providers and community groups to develop training and encourage contact with law enforcement.*
- *Training service providers to recognize when a client is the victim of a crime and how to report to law enforcement.*

- *Training in awareness that individuals with intellectual disabilities and other disabilities may not respond to standard interview techniques along with training in alternate interview techniques.*

The passage of the 2008 ADA Amendments Act should have prompted law enforcement agencies to review their training, policies, and procedures with the goal of insuring that their personnel are properly prepared for successful interaction with people with disabilities and that access requirements for people with disabilities are met. By 2014, all agencies should have developed a self-evaluation and transition plan as required by the ADA.

However, the reality is that while many law enforcement agencies do conduct regular reviews of their policies and procedures related to the ADA and do train their officers in disability awareness, many more do not. The need for mandated across-the-board law enforcement training in all areas of disability is overdue. And one need only look at the news, case decisions, and settlement agreements to see that the need for training is not limited to one disability but to all disabilities. It should not be the goal of any training to encourage law enforcement officers to be diagnosticians. Instead, the goal should be to provide those officers with knowledge of disabilities so that people with them can be more easily recognized and then to provide those officers with policies and procedures that will help them successfully interact with persons with disabilities.

Let's mandate law enforcement training that will eliminate the potential for a negative encounter between an officer and a person with a disability caused by the officer's inability to recognize and understand the disability-based behavior.

Sincerely,

Michael Sullivan
Michael Sullivan ADA Consulting, Specializing in Law Enforcement Issues
Website: michaelsullivanadaconsulting.com

PREPARED STATEMENT OF MIKE ESTRADA

TESTIMONY FOR THE RECORD OF SENATE JUDICIARY April 28"

A contact/mental illness advocate told me that you're working on a bill re: the mentally ill. I listed some ideas below. I've been trying to get help for a severely mentally ill family member for close to six years. She has been homeless for most of the past three and has had repeated, frequent hospitalizations due to her deteriorating health. Along with not treating her mental illness at all, she does not adequately treat her diabetes. This is money being unnecessarily wasted by the hospitals who just stabilize her and then let her go. Then, weeks or months later, she is hospitalized again with high glucose or, in the most recent case, a minor stroke. Feel free to look at some background in a blog I posted a while back: <http://mentalillnessdespair.blogspot.com/>

Policy Ideas:

- Fund AOT and mandate or create strong financial incentives for states and counties to utilize it, otherwise many will not.
- For money for AOT, mandate money is not to be used for SAMHSA.
- Provide more funding for county psychiatric units so they are better able and willing to 51/50 individuals who so desperately need it.
- Require medicare and/or medicaid to fully compensate hospitals for involuntary hospitalization.
- Mandate and provide funding for the creation of state hospitals that provide medium term care for individuals who need the intensive care and support necessary to achieve functioning. County hospitals release people too early.
- Provide/require comprehensive cultural and holistic support and services for these same state hospitals. They should be rehabilitation/recovery centers, not hospitals per se.
- Provide funding, support services and more rights (e.g. time off of work) for families who are willing and able to help their ill family member recover, become functioning and maintain functioning.
- Mandate states like CA that legally require county hospitals to consider "past history" in their assessments to define what "past history" is more clearly. Right now, that requirement is toothless in CA, meaning hospitals and courts don't consider it at all. My ill family member has been involuntarily hospitalized multiple times and they refuse to consider this as evidence she is "gravely disabled."

MONTEREY COUNTY



DEPARTMENT OF HEALTH Ray Bullick, Director

ADMINISTRATION
ANIMAL SERVICES
BEHAVIORAL HEALTH

CLINIC SERVICES
COMMUNITY HEALTH
EMERGENCY MEDICAL SERVICES

ENVIRONMENTAL HEALTH
OFFICE OF THE HEALTH OFFICER
PUBLIC GUARDIAN

US Senator Dick Durbin
Assistant Majority Leader
Chairman of the Senate Judiciary Subcommittee on the Constitution, Civil Rights & Human Rights
Durbin_testimony@judiciary-dem.senate.gov

April 26th, 2014

RE: CIT

Chairman Durbin:

I am writing to tell you the history of CIT and how CIT has worked in Monterey County, CA. Crisis Intervention Teams (CITs) are innovative police-based first responder programs designed to prevent inappropriate incarceration of individuals with serious mental illness through immediate linkage with mental health services.

Since its development in 1988 in Memphis, Tennessee, CIT has been implemented by hundreds of localities across the country and the world. With the understanding that partnerships are key to their formation and support, the programs are the result of coalitions comprised of mental health providers, law enforcement agencies, family members of individuals with mental illnesses, and the individuals themselves, along with other stakeholders such as Judges, advocates and faith-based organizations. The coalition strategizes how to best address systems issues, such as how to transfer someone from law enforcement custody to mental health treatment; and includes the development of the curriculum which teaches law enforcement officers how to recognize and de-escalate a psychiatric crisis. With CIT, fewer people with severe mental illness enter the criminal justice system and people with mental illness can receive appropriate and effective treatment in the community. CIT has been proven to reduce the number of incidents involving use of force with people with mental illness by providing new tools for officers to de-escalate situations, resulting in fewer injuries to police and citizens.

CIT began in Monterey County as a result of a man with schizophrenia wielding a corkscrew and getting shot by law enforcement personnel. Today, we provide a 40 hour academy that officers attend to become part of the CIT team. Today, when calls come to County Communications regarding a person in crisis or a mentally ill person in crisis, a CIT trained officer is most likely to respond and de-escalate the situation. These officers work closely with CIT social workers in the County Emergency room to determine the best course of action. Often times, mentally ill individuals simply need support and proper linkage to deal with issues surrounding their mental illness.

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This course is not designed to make law enforcement officers social workers or psychiatrists, but to give law enforcement additional tools to use on the job. Traditional police methods, misinformation and lack of sensitivity can cause frustration for the mentally ill and their families as well as the police. Officers responding to calls involving the mentally ill are faced with a lack of knowledge about mental illness, resulting in a fear of the unknown, which increases the likelihood of physical confrontation. An increase in drug/alcohol abuse and the de-institutionalization of the mentally ill has caused many to be homeless potentially more violent and more involved with law enforcement. Approximately 40% of persons suffering from serious mental illness will be arrested at least once during their lifetimes. The CIT concept is to provide officers with a more in-depth understanding of the different types of mental illness and behavioral manifestations related to those illnesses. During this training, officers will receive information they can use more effectively to interact with mentally ill persons in crisis, as well as, other situations.

For those mentally ill individuals that do find themselves incarcerated in Monterey County, we also have a Mental Health treatment court called, Creating New Choices. Participants can volunteer to have their case(s) transferred to this court with the possibility of having their charges reduced or expunged upon completion of the program. Participants are closely monitored by a therapeutic probation officer, social worker and psychiatrist. They attend groups to learn skills to cope with their mental illness and substance abuse issues, and they have the opportunity to start a new life without the added stigma of charges on their record. Oftentimes, a participant's first chance to get connected with this program has to do with their initial interaction with a CIT officer who helped steer them in this direction.

Today, CIT has evolved into an international concept. CIT International is a non-profit membership organization whose primary purpose is to facilitate understanding, development and implementation of Crisis Intervention Team CIT programs throughout the United States and in other nations worldwide in order to promote and support collaborative efforts to create and sustain more effective interactions among law enforcement, mental health care providers, individuals with mental illness, their families and communities and also to reduce the stigma of mental illness. CIT International works to accomplish this purpose by raising public and stakeholder awareness through education and outreach, establishing and disseminating recommended standards for developing, implementing and sustaining crisis intervention programs, providing assistance to communities interested in developing CIT programs, supporting research, improving public health and safety, evaluation of CIT programs and partnering with CIT programs in various localities to hold annual International CIT Conferences.

The CIT International board of directors recognized the need to continued training throughout the world. Thus, it began having international conferences on an annual basis. This year, Monterey County is honored to host the 2014 CIT International conference. This will be the conference's first time on the West Coast. We anticipated between 800-1500 participants. Approximately 75% of the participants are law enforcement personnel. The other 25% is comprised of behavioral health personnel, consumers, family members and advocates in the mental health community. Approximately 90 workshops will be presented on topics from developing a CIT program to advanced CIT concepts. It is an exciting opportunity for people to come together once a year, share new and innovative ideas, and network with people who are passionate about improving interactions with the mentally ill.

Senator Durbin, there are many compelling stories about how CIT has actually saved the lives of individuals with mental illness. One example that I can share is that last year, I received an email from frantic parents about their mentally ill son. Officer Chris Johnson had responded to the residence a few times and had given these parents my contact information. I called Officer Johnson to get more information and he proceeded to tell me that this young man was wandering around at night, shouting

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and disturbing the residents. He believed that he was psychotic. He was frustrated because when he had taken the young man to a private hospital in Monterey, Ca. in the past, they discharged him rather quickly. We decided that the next time Officer Johnson responded to him, he would be brought to our county psychiatric hospital.

The young man eventually went missing and his parents were growing increasingly concerned. He was posting delusional rantings on Facebook and sending bizarre text messages to his parents. One message said, "I will either kill or be killed soon." Officer Johnson and I remained in constant contact discussing this young man and how to find him and bring him in for help.

The young man returned to Carmel after two months and immediately came into contact with Officer Johnson and his partner. By this time, he hardly recognized Officer Johnson and felt threatened by his partner, to which a fight ensued. Officer Johnson called me and transported the young man to NMC. Officer Johnson wanted to be sure that the young man felt safe before he had nurses attend to his own injuries. Officer Johnson also introduced the young man to me to establish a positive connection with mental health services.

This young man had also threatened Mr. Leon Panetta and his family, therefore, bringing himself into the limelight with the Secret Service. We were able to get him involved in our Creating New Choices program, which is our Mental Health Court here in Monterey County. He is a star! He has been med and program compliant and very successful. His parents emailed me last week to tell me that Officer Johnson's actions saved their son's life. Going above and beyond to help this family has meant the world to them. His collaboration and teamwork made this a wonderful success story and this young man is getting the treatment he deserves for his Schizophrenia.

It is important that progressive law enforcement agencies assume the responsibility of evaluating situations, recognizing mental illness and the need for treatment, and getting the mentally ill persons to the proper treatment resources. Until more resources are allocated to provide and care for persons with mental illness and until access to treatment is simplified, we must accept that in the foreseeable future mental health care providers, law enforcement and community stakeholders will share the responsibility for dealing with these problems.

Thank you for your time and consideration.

Sincerely,

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Detention of Disabled Persons
Testimony for the Record,
Hearing before the Senate Judiciary Subcommittee on the Constitution,
Civil Rights, and Human Rights
“Law Enforcement Responses to Disabled Americans:
Promising Approaches for Protecting Public Safety”

My name is Dr. Ron Manderscheid. I serve as the Executive Director of the National Association of County Behavioral Health and Developmental Disability Directors. Our Association represents county directors of mental health, substance use, and intellectual/developmental disabilities.

Many people with mental health, substance use, or intellectual/developmental disabilities become jail detainees inappropriately because of the lack of effective community services that would prevent their incarceration.

Needed local community services to prevent inappropriate detention must include appropriate treatment, care coordination, and peer support services and crisis intervention training for local police staff so that they know how to respond to situations involving persons with these disabilities. Most communities currently lack sufficient financial and staff resources to offer these services.

The Affordable Care Act provides much needed insurance coverage for these populations principally through the Medicaid Expansion, but also through the State Health Insurance Exchanges.

We request that the Subcommittee enact two simple changes which would make this insurance responsive to the needs just identified:

- Require that Medicaid pay insurance benefits for the health care of jail detainees rather than suspending benefits upon jail entry.
- Require that Qualified Health Plans pay for the health care of jail detainees and for their care upon release.

Both of these provisions would dramatically improve continuity of care between community and jail, as well as reduce recidivism.

Both also would protect the civil rights of persons who have been detained, frequently inappropriately, but who have not been adjudicated of any crime. In the United States, detained persons should be considered innocent unless proven guilty.



Statement of Laura Usher, CIT Program Manager and Ron Honberg, Director of Policy and Legal Affairs on behalf of NAMI (the National Alliance on Mental Illness) for the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights hearing on “Law Enforcement Response to Disabled Americans.”

April 29, 2014

Introduction

This statement is submitted on behalf of NAMI, the National Alliance on Mental Illness. NAMI is the nation’s largest grassroots mental health organization representing individuals living with mental illness and families. NAMI is dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raise awareness and build a community for hope for all of those in need. NAMI is the foundation for hundreds of NAMI State Organizations, NAMI Affiliates and volunteer leaders who work in local communities across the country to raise awareness and provide essential and free education, advocacy and support group programs.

NAMI Affiliate organizations have relationships with law enforcement and mental health agencies throughout the country. Since the late 1980’s, they have been deeply involved working to establish crisis intervention team (CIT) programs in their local communities. Today, there are 2800 local CIT programs around the country and NAMI Affiliates are key partners in many of them.

CIT programs are built on strong partnerships between stakeholders in communities, including NAMI Affiliates and other advocacy organizations, law enforcement agencies and mental health provider agencies. The goal of these programs is to improve police responses to people in mental health crisis situations and to connect people in crisis with mental health treatment instead of arrest and incarceration. For NAMI members, CIT programs are not just an opportunity to educate police; CIT saves lives, offers hope to desperate families and helps transform the way entire communities understand mental illness.

Two advocates from NAMI Memphis were the driving force behind the first CIT program. Ann Dino and Helen Adamo had both called police in a desperate attempt to get help when their adult children were in crisis. Outraged by the way their sons were treated, Dino and Adamo reached out to the Memphis Police and local leaders, proposing special training for police in responding to mental health crisis situations.

Soon after that, another family called the police, a mother desperate to get help for her grown son who was injuring himself in the midst of a psychiatric crisis. The community was outraged when Joseph Dewayne Robinson was shot and killed during this encounter.

In the aftermath of this tragedy, the Memphis Police Department, NAMI Memphis and the University of Tennessee Medical Center came together to form the first CIT program.

Spread of CIT Programs

Since the first CIT program started in Memphis, 2,800 communities nationwide have adopted CIT programs. CIT programs currently exist in 46 US States and the District of Columbia.ⁱ About a dozen states have well-coordinated statewide CIT efforts, usually initiated by a consortium of law enforcement agencies, criminal justice leaders, mental health providers and non-profit mental health advocacy organizations. Initially driven by the passion of NAMI members nationwide, CIT has taken on a life of its own, and many law enforcement officers, judges and other community leaders promote the program to their peers. NAMI is proud to count law enforcement leaders among our closest allies. In addition to NAMI, a handful of other organizations have been instrumental in promoting and supporting the spread of CIT nationwide: CIT International, the University of Memphis CIT Center, the International Association of Chiefs of Police, the Council of State Governments Justice Center and the Police Executive Research Forum.

CIT Training

The success of CIT is partly because of the innovative nature of the training program. CIT training is a 40-hour, intensive skills-based training for law enforcement officers.ⁱⁱ The training is developed at the local level and taught by a mix of local mental health professionals, law enforcement officers, individuals living with mental illness and family members. A typical training includes the signs and symptoms of common mental health conditions, including a simulation that allows officers to experience what it's like to have visual and auditory hallucinations. Officers also learn about local mental health services, including education and support offered by non-profit organizations like NAMI Affiliates, and how to connect individuals with those services. The training provides intensive scenario-based training on verbal de-escalation skills and how to talk someone down from a crisis situation without using physical force.

Finally, the training includes several hours of interacting directly with people living with mental illness and family members. For many law enforcement officers, CIT training may be the first time they interact with a person with serious mental illness who is doing well and managing the illness. Officers often have a huge shift in perspective, realizing that people living with mental illness are ordinary people with families, homes and jobs. Officers also come to understand that providing assistance to a person in crisis can be a turning point for that individual and set him or her on the road to recovery.

Partnerships are the Key to CIT's Success

Just as important as the training is the partnerships built around CIT. Training can prepare individual officers to respond to a crisis, but a network of local relationships and partnerships makes it possible for the law enforcement agency and the community to make a lasting change. The key partners are law enforcement agencies, mental health

provider agencies and advocacy organizations representing individuals living with mental illness and families. Historically, these agencies and groups often have built up resentment and misunderstanding, and the only way to resolve that is open dialogue, cross-training and an ongoing relationship.

CIT won't work if it is imposed from above. The commitment has to be rooted in the community, involving local government leaders, police and mental health professionals. This problem is not going away. Police will continue to be front-line responders to mental health crisis, until a more robust and coordinated mental health system makes it possible for people to get mental health services early and as often as needed.

To be effective, CIT officers need to be part of a coordinated system, so law enforcement agencies and mental health provider agencies typically come to an agreement about the best procedure for transferring custody of an individual to mental health services. Frequent conversation between these agencies' leaders allow for problem-solving and improvement.

Strong partnerships with mental health advocacy groups are also essential to help build the trust of the community they are serving and to educate the members of that community about what to do in a crisis. In return, advocates are the strongest boosters for CIT officers and the program, providing awards for good service, organizing community support and helping build local media attention.

CIT is unique because it brings together leaders and front-line staff from the criminal justice and mental health systems to talk about the challenges of people with mental illness in the justice system. This conversation often grows to include more initiatives for the community, for example specialized training to address the needs of veterans, youth, older adults or people with developmental and intellectual disabilities. CIT programs also frequently expand partnership and training opportunities to others in the community, including firefighters, emergency medical service, corrections officers, hospital security, campus police, school resource officers and others. Finally, CIT programs are often the impetus for local advocacy for better mental health services, especially crisis services, and for other criminal justice/mental health interventions, such as mental health courts and re-entry programs.

Outcomes of CIT Programs; Consequences of Doing Nothing

The goal of the first CIT program was to reduce injuries of officers and people with mental illness by training police in more humane tactics for responding to people in crisis. In this regard, the program has been very successful, with injuries to officers responding to mental health calls dropping 80% after the introduction of CIT.ⁱⁱⁱ The program also has numerous other benefits for police, individuals living with mental illness and communities. CIT officers report feeling better prepared to respond to mental health calls^{iv} and they do a better job of identifying people in mental health crisis.^v CIT officers are more likely to transport an individual for mental health services^{vi} and less likely to arrest.^{vii} CIT officers are less likely to use force in responding to mental health

calls and more likely to use verbal de-escalation skills to keep a situation from spiraling out of control.^{viii}

For individuals living with mental illness and their families, the presence of a CIT officer means a reduced risk of injury and arrest. Individuals and families also report feeling safer and more confident in calling the police; this is because CIT officers make a point of creating relationships in the community and often check in with individuals that they know may need mental health care. People who are diverted from jail by a CIT officer spend more time in their home and communities, get more medication and counseling, and spend less time in jail than people who interact with untrained officers.^{ix}

Engagement with mental health treatment is life-saving for people with serious mental illness. Without early identification and treatment, people with mental illness are high risk for suicide^x, dropping out of school^{xi}, involvement in the juvenile justice^{xii} and criminal justice system, becoming victims of violence^{xiii}, substance use and homelessness^{xiv}.

Equally important, involvement with the justice system often exacerbates a crisis for people living with mental illness. Most people with mental illness booked into jails are there because of non-violent crimes^{xv}, but once in the system are at high risk of cycling repeatedly through jails, emergency services and homeless services. In prison, people with mental illness stay longer than other inmates facing similar charges^{xvi}, are more likely to face sexual assault or other abuse, and are more likely to be placed in solitary confinement^{xvii} because corrections officers are not equipped to respond to psychiatric symptoms. People rarely get quality mental health services while in jail, and leave jails sicker and with fewer resources to be successful. Leaving jail, individuals often have lost access to Medicaid and Social Security, and face greater barriers to housing and employment because of their criminal record.

The involvement of people with mental illness in the justice system is a national crisis, because about 1 in 5 jail and prison inmates have a serious mental illness.^{xviii} Incarcerating these individuals when they have not committed serious crimes is ineffective and a waste of taxpayer money.

CIT programs, paired with strong crisis mental health services and supports for people with serious mental illness, are the first line of defense to prevent these tragic outcomes.

CIT in Jails and Prisons

Jails and prisons have tragically become de-facto “mental health treatment facilities” in many parts of the country. The Cook County jail, Twin Towers jail in Los Angeles, and Riker’s Island in New York City have been characterized as the largest “psychiatric hospitals” in the country. Characterizing these correctional settings as mental health treatment facilities is a misnomer, because they are generally ill equipped to provide quality psychiatric treatment. On the contrary, the stresses and dangers of correctional settings frequently exacerbate psychiatric crises and worsen symptoms. The response of

correctional officers is too frequently punitive, placement (sometimes for weeks, months or even years) of inmates with serious mental illness in solitary confinement or other forms of administrative segregation.

In an effort to create alternatives to solitary confinement and teach de-escalation techniques to correctional officers, CIT is now offered to correctional officers in many parts of the country. CIT training for corrections officers addresses conditions in the correctional facility.

An evaluation of CIT training for corrections officers in Maine showed that CIT trained officers were twice as likely to use verbal de-escalation than physical force in resolving mental health incidents.^{xix} This evaluation also stated that after CIT training, jail staff in Maine did a better job of identifying people in need of mental health services. Anecdotal evidence from CIT for corrections programs in Indiana suggests a dramatic drop in the use of force by corrections officers in dealing with mental health incidents.

While there are not a lot of published studies of the outcome of CIT in correctional settings, this is a promising practice with the potential to reduce use of force in correctional facilities and connect individuals with mental health services. There is a dire need to improve treatment of people with mental illness in jails and prisons, where people rarely receive adequate mental health services and are too frequently subjected to solitary confinement.^{xx}

Urgent Needs

Currently, most CIT programs operate with in-kind services from the partners agencies, or by cobbling together small amounts of state funding, foundation grants and the occasional federal grant. Many programs also receive technical assistance from non-profit agencies, including NAMI and NAMI State Organizations, The University of Memphis CIT Center and CIT International. In focus groups, CIT program leaders identified several areas where they need additional funding or technical assistance.

Technical Assistance

First, CIT programs need hands-on assistance and replicable models for building strong local partnerships, long-term planning, needs assessments and evaluation. National organizations provide technical assistance but that work has no sustainable source of funding, and most assistance is limited. CIT partnerships require constant nurturing and so it is vital for CIT leaders to have access to a community of their peers, through organizations like NAMI and CIT International. Several states have coordinated statewide efforts to promote and expand CIT. This approach provides local programs with structure and support, and support for statewide initiatives would help in many states.

Funding for CIT programs

CIT programs also identified a need for funding for training and operational costs. For training, the greatest funding need is to cover the costs of backfilling shifts while officers are in training. Programs also typically need a permanent CIT coordinator position, to support CIT officers and serve as a liaison between partner agencies.

The Justice and Mental Health Collaboration Program (JMHCP) grants, created by the Mentally Ill Offender Treatment and Crime Reduction Act, currently fund some CIT programs, along with other interventions in criminal justice/mental health, but no funds are specifically set aside for CIT. The JMHCP's emphasis on local cross-system collaboration is particularly relevant to CIT. Although this program is authorized to \$50 million a year, JMHCP has been funded at between \$9 million and \$12 million for the past several years.

Support for Needs Assessment and Evaluation

Even with leadership and a good faith effort by all partners, many programs simply do not have the expertise to collect data, conduct an evaluation or a needs assessment. Programs need this expertise to ensure they are successful and sustainable in the long term.

Funding for Mental Health Services

CIT program leaders also need further support for community mental health services. Many law enforcement agencies are doing everything they can to help people experiencing mental health crisis, but still find that there simply aren't crisis mental health services to assist people. Virginia has a promising model for addressing this concern: the state has created a competitive grant program that funds crisis assessment centers, designed to help people in crisis get an assessment and get connected to a confusing array of inpatient and outpatient services. Crisis assessment center work closely with law enforcement, but also accept walk-ins and voluntary admissions. Unfortunately, most states do have not adequate crisis services.

A Verbal De-escalation Training Curriculum

CIT programs typically develop training at the local level, which provides officers access to the experts and community leaders in their community. However, many programs would welcome a train-the-trainer program specific for the teaching of verbal de-escalation, to prepare local trainers to teach these complex skills.

Policy Recommendations:

Adopt CIT nationwide. CIT programs are proven effective at reducing arrests, injuries and other tragic outcomes of police responses to mental health crisis, but currently CIT is only available in 15% of law enforcement jurisdictions. Every law enforcement agency should engage in planning and partnership with mental health systems and advocates to address mental health crisis situations. Congress should support this expansion by providing funding incentives specifically for local jurisdictions to start CIT programs and supporting national or regional technical assistance centers to help programs get started. Congress should also pass S. 162/H.R. 401, the Justice and Mental Health Collaboration

Act of 2013 (JMHCA) which reauthorizes the Justice and Mental Health Collaboration grants. Congress should also pass provisions in HR 3717, the “Helping Families in Mental Health Crisis Act of 2013 which would allow the federal Edward R. Byrne Justice Assistance Grants (JAG) to be used for training to law enforcement and correctional officers on mental health and crisis intervention techniques. Similar provisions in HR 3717 allow the Staffing for Adequate Fire and Emergency Response Modifications (SAFER) program grants to be used for crisis intervention training to firefighters and other first responders.

Strengthen crisis mental health services. The mental health system in this country is broken. CIT can help address an immediate mental health crisis, but officers and families often have nowhere to go in the aftermath of crisis. Congress should support the creation of robust crisis mental health services in every community, including hotlines, psychiatric ERs or crisis assessment centers, crisis stabilization units, peer support services and crisis respite centers. Congress should also support intensive supports that are shown effective at serving people with mental illness who are high risk of arrest, such as Forensic Assertive Community Treatment (FACT) and supportive housing. No individual in crisis should have to sit in a crowded emergency room for days on end when the best possible outcome they can hope for is a stay in a hospital hundreds of miles from home.

Support data collection. National studies show that CIT is effective, but local CIT programs urgently need assistance in documenting the outcomes of their programs, to help improve programs and sustain community support. The U.S. Department of Justice should work with the research community, local law enforcement agencies, and others on developing a robust system for collecting data on law enforcement interactions with people living with mental illness. This should include data on deaths and serious injuries of people with mental illness and law enforcement officers responding to crises situations. This should also include national data on CIT programs and the outcomes of these programs over time in terms of disposition of cases, deaths, and serious injuries.

Conclusion

Police are often the first responders when a person is in psychiatric distress. Every community owes it to them to provide the knowledge and training to handle safely and compassionately mental health crisis situations. At the same time, people living with mental illness—through no fault of their own—deserve to be helped through appropriate understanding and de-escalation tactics. Ultimately, we should be promoting treatment rather than warehousing them in jails and prisons.

Crisis intervention teams are a proven model for improving interactions with law enforcement and people experiencing mental health crisis. The programs benefit law enforcement, individuals with mental illness and their families and mental health provider agencies by helping get people to needed mental health treatment as quickly as possible. CIT programs are local initiatives that require local leadership and partnership, but Congress should step up to promote their expansion nationwide.

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nami | Barrington
Area

National Alliance on Mental Illness

583 Cobblestone Lane
Buffalo Grove, Illinois 60089

04/25/2014

Honorable Senator Durbin:

The following are my public comments for the hearing regarding: Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights. I am President of the National Alliance on Mental Illness and my son with Asperger Syndrome is facing 55 years due to the Criminalization of Asperger Syndrome. I also sent written testimony to the National Institute of Mental Health NIH recently. Please contact me if you need additional information.

Joseph M. Jason, President NAMI BA
Board Member of Criminal Justice Advocacy for People with Mental Illness
Member/Director of CURE
(847)537-3009

The following is testimony presented to Washington.

04/04/2014

To: Ms. Lina Perez
Office of Autism Research Coordination
National Institutes of Mental Health, NIH
6001 Executive Boulevard, NSC
Room 6182A
Rockville, MD 20852
Phone: 301-443-6040
E-mail: IACCpublicinquiries@mail.nih.gov
To: kellie-tuttle@iowa-city.org
From: Joseph M. Jason-President of National Alliance on
Mental Illness-Barrington Area and CURE Illinois Board
Director

My son with Asperger Syndrome has undergone cruel and unusual punishment in the State of Iowa by the state and federal government since March of 2007. He has been incarcerated with the exception of four months in jails and prisons for non-violent crimes. Please read the following information from my petition that follows. I have done a radio interview and had articles written in the paper about the grave injustice happening to my son due to his Asperger Syndrome.

The crucifixion of Daniel S. Jason in Iowa City, Iowa Posted on September 28, 2013 by josephmjason Overzealous Prosecutors in Johnson County take care of the mentally ill problem by Joseph M. Jason-President NAMI BA Iowa prosecutors are intending to convict my son and send him to prison again for perhaps 55 years for non-violent crimes. The trial was going to commence October 22, 2013, but there had been a continuance. The trial took place on February 25, 2014 and lasted three days. The actions of the prosecution in Iowa City are indicative of the criminalization of Asperger Syndrome. My son was tried at this date for extortion and stalking. My son sent various emails and made two phone calls. These charges are a travesty. My wife and I met with the prosecutor in December of 2012 and explained Asperger Syndrome and mental illness. We explained that our son's behavior is childlike rather than criminal. We told them he needs treatment and not incarceration.

We gave them a forensic psychiatrist's report that demonstrates he is not violent. He is a nuisance. We told them that his behavior according to Dr. Mills is typical of one with Asperger Syndrome. We told them he has an organic brain disorder. His criminal behavior consists only of phone calls and emails. This meeting has made no difference. If the Iowa prosecutor's office was serious about avoiding an expensive trial, they would have offered a humane plea agreement. Instead they offered an agreement of ten years. During the trial Dr. Mills testified that Daniel has no history of violence. In fact people with Asperger Syndrome are more likely to be bullied. Daniel did not have intent and is not a stalker. His actions are part of having Asperger Syndrome and not a suitor stalker. His actions were flawed and ambivalent. He did not want to contact his ex-girlfriend so he chose a flawed way. He had her phone number and did not call it. He was blowing off steam. Daniel cannot connect the dots. There is a disconnect between

how we feel and how he feels. Daniel made reference to an embarrassing incident in the Johnson county auditor's office. This referred to an employee who defecated in their pants. He was given two counts of extortion for this by overzealous Johnson County prosecutors.

Perhaps the voters of Iowa should be told how much it has cost to prosecute and imprison Daniel in Iowa. The typical offender sitting in Johnson County right now has been charged with robbery, theft, murder, sexual abuse, domestic abuse assault, drug offenses etc. My son is not a thug, but yet will get the stiffest sentence out of all of them. It is the criminalization of Asperger Syndrome. A full one-third of the nation's states get a D or F grade for using mental health courts and crisis intervention teams (CIT) – diversion programs proven to reduce the criminalization of mental illness, the study found. Iowa received a well deserved F. "People with untreated psychiatric disease should be getting the treatment they need before law enforcement shows up at their door because of behaviors caused by their illness," said Doris A. Fuller, executive director. I had a deposition earlier this year recently and they tried to twist Dr. Mills' report. They not only want to lock him away for 55 years, but they extended the time period of the stalking to include the time he has been in jail. That is punishment fit for a major drug dealer and/or murderer. This case, as it always has, cries out for treatment and not incarceration. I have found a place for my son to live. It is called Trinity in Illinois and it is an excellent place for people with issues similar to my son. That is where he belongs. Daniel was living with us for the entire time and did not go to Iowa. This has not stopped the charges of stalking and extortion. This is not what our founding fathers envisioned that America should be. Daniel has already been in jail and prisons for most of the time since 2007. Dr. Mills has stated that Daniels's so called criminal conduct is caused by his Asperger Syndrome. "Mr. Jason cannot legitimately be considered morally responsible for his misconduct." Dr. Mills also states that "The lack of significant history of violence is important." As stated in the article, Forensic aspects of Asperger's Syndrome by Justin B. Barry-Walsh and Paul E. Mullen in the Journal of Forensic Psychiatry & Psychology, "It behooves us to draw to the court's attention the obvious: that patients with Asperger's Syndrome suffer from mental disorder and that their offending and subsequent disposition must be placed in this context. The core features of Asperger's Syndrome and how they determine what the individual knows and understand of the world should form a basis for sophisticated assessment of the issues of disability." NAMI National, Senator Durbin, and Senator Harkin have been apprised of this situation.. The Autism Society of America believes this to be the most egregious case in the United States. Even Drew Peterson and other murderers have received less of a sentence than my son is facing. Daniel has a brain disorder and needs mental health treatment not incarceration. National organizations such as NAMI and CURE are following this trial. This typifies everything that is wrong in the State of Iowa regarding the Criminalization of the Mentally Ill and Asperger Syndrome. This Criminalization of the Mentally ill must be confronted and stopped. I have seen and heard the overzealous prosecutors. It took courageous people to say no to slavery in our history. We must say no to the incarceration of our non-violent mentally ill. This is my mission in life. I have personally endorsed John Zimmerman for Johnson county Attorney. He gets it.

Finally here is an email sent to National NAMI-Ron Honberg on April 20, 2014

Ron:

My son is having another trial on Tuesday, April 22 for being a habitual offender. He is on the way of getting a potential 55 years. He was found guilty of stalking and extortion in his previous trial. This must be an issue addressed by National NAMI in the White House and all over the country. How can you charge a non-violent offender with this when they have an organic brain disorder that needs medication? I am appalled by the injustice in Iowa City and the Criminalization of Asperger Syndrome. They have a lynch mob mentality within Johnson County. The Judge did not allow Dr. Mill's testimony as the primary testimony. It was only allowed as a rebuttal. The Judge would not allow a continuance to have Daniel sign over his medical records. Thus the other Forensic Psychiatrist who spent very little time with Daniel and did not have his cooperation was the primary evidence in the trial. Also the Johnson County Board supervisor is stating that Daniel will kill his ex-girlfriend if he is released. I question whether the county is capable of having a fair trial.

They allowed evidence in the trial for which he was convicted of when he defended himself. This by itself is grounds for Appeal.

During the trial Dr. Mills testified that Daniel has no history of violence. In fact people with Asperger Syndrome are more likely to be bullied. Daniel did not have intent and is not a stalker. His actions are part of having Asperger Syndrome and not a suitor stalker. His actions were flawed and ambivalent. He did not want to contact his ex-girlfriend so he chose a flawed way. He had her phone number and did not call it. He was blowing off steam. Daniel cannot connect the dots. There is a disconnect between how we feel and how he feels. Daniel made reference to an embarrassing incident in the Johnson county auditor's office. This referred to an employee who defecated in their pants. He was given two counts of extortion for this by overzealous Johnson County prosecutors.

The bottom line is Daniel is non-violent based upon his history and this time never went to Iowa City. They could have contacted me without arresting him. I am personally trying to help the candidate running against this overzealous prosecutor. I have blogged all over the internet to get the truth out there. John Zimmerman is a progressive person who gets it.

This case has national consequences. We must do everything that we can do to stop this Criminalization of Asperger Syndrome and mental illness. There are many other cases out there where people also need help. Dr. Mills said this was in the top 2 or three for most egregious cases. He is appalled and upset by the convictions and he is an Asperger Syndrome expert.

We must save a life and save a world.

Joseph M. Jason, President NAMI BA

Board Member of Criminal Justice Advocacy for People with Mental Illness

Member/Director of CURE

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Crisis Intervention Team (CIT) Programs are “the greatest invention since sliced bread”. CIT training is officer safety training that decreases the potential for injury to officers and decreases the potential for injury to citizens who need officer assistance to cope with a crisis. The 40-hour CIT training curriculum teaches officers to recognize the signs and symptoms of serious mental illnesses, empowering them with skills to de-escalate crisis situations, and familiarizing them with mental health resources in the community thus encouraging officers to divert persons to treatment whenever possible.

CIT is more than just training. CIT programs, over time, are also transforming the mental health service delivery system.

CIT programs are built by a coalition of stakeholders including: mental health service providers, advocates, patients, family members, judicial and corrections representatives, as well as the local police department. CIT programs are built in the community where these stakeholders live, work and have a vested interest in good outcomes. This collaboration from the beginning stages of developing a CIT program produces buy-in to assist with ongoing training as well as the ongoing process of alleviating unnecessary delays in addressing the treatment needs of a person in crisis.

The Chicago Police Department initiated CIT training for its officers in the fall of 2014. The coalition of stakeholders began working on gaining approval to initiate CIT training five years before that launch date. In those five years, the stakeholders forged lasting relationships among the multitude of participants and crafted the 40-hour training curriculum still being used. Ten years later, more than 2,000 Chicago police officers have completed the basic 40-hour CIT training and more than 500 of these officers have completed the advanced 40-hours of Juvenile CIT training. Among other transformations, Chicago hospital and emergency rooms have revamped their procedures to expedite officer drop-offs. Some hospitals have even remodeled their physical structures to allow for drop-offs directly into the ER itself.

It is not possible to give you data on the potentially horrific events that have not happened because crises have been handled smoothly by CIT trained officers. Nor can I give you data on the cost of lawsuits that have not happened. Nor on the numbers of individuals in crisis who have not been arrested but diverted to treatment providers.

What I can tell you is that officers, patients and their loved ones all agree that CIT works.

Chicago is the largest urban city in the country to have CIT in place. Chicago was first in developing a 40-hour Advanced Juvenile CIT training. The Chicago Police Department has opened its CIT training to officers from the surrounding suburbs, university security officers, and visitors from countries across the globe. Chicago has shared its CIT training manuals with hundreds of police departments around the country and the globe.

Let's talk about funding for a moment. Chicago's CIT Program was built with hours donated by the coalition of stakeholders. It continues to be sustained by a patchwork of funding too meager to truly meet the need. Small grants from the State of Illinois and the Chicago Community Trust enabled the initiation of CIT training in 2004. A small amount of Recovery Act money has enabled the Advanced Juvenile CIT program to get up and running. The City of Chicago contributes the bulk of the funding supporting the ongoing training, but countless hours of volunteer effort are also contributed by the stakeholders including NAMI members who tell their personal stories, not to mention the hours donated by the officers who staff the CIT training unit.

CIT is too important a program to continually rely on the generosity of individuals to donate their time to this critically important effort.

CIT Programs need to exist in every community in the country, large and small, because mental health crises can and do happen anywhere. As long as persons living with these "no fault" brain illnesses, or their friends and loved ones on their behalf, are unable to speedily and affordably access needed medical treatment law enforcement officers will be on the front-lines to assist in managing crises in large numbers. As long as mental health treatment is under-funded, as it is in every community across this country, there will be an excessive number of crises that need law enforcement officers' response.

No one chooses to have a mental illness.

Suzanne M. Andriukaitis, M.A., LCSW, ACSW
NAMI Chicago

NAMI Illinois

National Alliance on Mental Illness

NAMI ILLINOIS AFFILIATES

Barrington Area

Champaign County

Chicago

Cook County North Suburban

DeKalb, Kane So. & Kendall Counties

DuPage County

Jackson County

Kane County North

Kankakee County

Lake County

Livingston/McLean Counties

McHenry County

Metrol Suburban

Metropolis-Southern Most Illinois

Mount Vernon

Northwestern Illinois / Rockford

Northwest Suburban

Sauk Area

Schaumburg Area

South Suburbs of Chicago

Southwest

Southwestern Illinois

Springfield

Stephenson County / Freeport

Trit County / Peoria

Will / Grundy Counties

April 29, 2014

Testimony for the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights hearing on "Law Enforcement Response to Disabled Americans."

Submitted by NAMI Illinois, the state organization chartered by NAMI

This statement is submitted on behalf of those individuals living with mental illnesses and their families as a tribute to all who are making Crisis Intervention Training (CIT) work in Illinois. Trained CIT officers, enlightened supervisors and law enforcement entities throughout Illinois who have embraced CIT have our heartfelt gratitude. They are making a tremendous difference in the lives of those living with mental illnesses, their families and communities throughout Illinois. Our hats are off to each of these officers who - are all too often unsung heroes - understand the need for a trained response to Illinois' mental health crisis.

NAMI Illinois is Illinois' largest grassroots mental health organization representing individuals living with mental illnesses and their families. We are dedicated to building better lives for the millions of Americans affected by mental illness. NAMI Illinois advocates for access to services, treatment, supports and we remain steadfast in our commitment to raise awareness and build a community for hope for all of those in need. NAMI Illinois and our 31 Affiliates work in local communities across Illinois to raise awareness and provide essential and free education, advocacy and support group programs.

Over the past several years, the face of first responders to mental health crises has taken on a whole new identity in Illinois. Today, for the most part, when there's a mental health crisis, the first person on the scene is a police officer. For the past several years, mental health budgets in Illinois have been slashed, leaving more individuals without support or treatment options. This has dramatically heightened the number of encounters between police officers and individuals living with mental illnesses.

Illinois' CIT program is a partnership endeavor between the Illinois Law Enforcement Training and Standards Board (ILETSB), NAMI Illinois, NAMI affiliates and other local mental health treatment and advocacy organizations. We have developed a united goal to improve police responses to people in mental health crisis situations. NAMI members understand that CIT programs are not just an opportunity to educate police; rather, we embrace the outcome of trained police

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officers. **Educated police officers save lives.** They offer hope to desperate families and often, they transform the way entire communities understand mental illness.

In communities where CIT has a significant presence, individuals and families alike feel safer when police intervention is needed. They know that they can rely on people who understand and will make the utmost effort to divert individuals from jails into treatment whenever possible. From anecdotal information, we know that CIT officers are more likely to transport an individual for services than arrest them, and they are much more likely to verbally de-escalate situations through communication rather than use of physical force. In essence, they see the individual – far beyond their illness – and engage individuals accordingly.

CIT trainings provide an opportunity for classes and individuals/families living with mental health challenges to talk, and educate each other. In Illinois the 40 hour class is traditionally held on a Monday through Friday schedule. On Thursday, community-based individuals and families visit the class to observe role-play scenarios and to engage over lunch with officers. For many offices, it's the first time they've had an informal opportunity to talk to individuals who are doing well in managing their illness. They utilize that opportunity to build relationships, ask questions and truly learn from individuals and families alike. This is a transformative moment for many, for all too often officers see people and engage only when they are sick or symptomatic. When engaging in an entirely different setting, they find individuals just like themselves, their families, their neighbors, etc. It's a unique educational opportunity to put a face on mental illness, and, it's an opportunity to observe and understand recovery. It provides a strong impetus to set others on a journey of recovery and lasting change. And for individuals and families? They see understanding of the illness, a desire to support individuals and families, and a vision of intervention that is broader than a jail cell. Their reluctance to involve police is swayed and fear is often dramatically reduced.

NAMI views the Illinois Law Enforcement Training and Standards Board as a key partner in our overall effectiveness of improving the lives of those who are living with mental illnesses. Over the past two years they have expanded officer trainings throughout Illinois; and we're hoping for even more regional trainings in the future. We also want to work closely with them on advocacy issues. Law enforcement officers did not sign up to be mental health first responders. They understand, however, far better than most, how a lack of investment in our mental health system – not only in Illinois but across our country - impacts every community. We hope to work with them to ensure that sooner, rather than later, they will have an improved system of community-based treatment options to access. Until we have robust crisis intervention services, supported by an array of appropriate treatment options, law enforcement will continue to be first responders. Through CIT programs, they are doing their part to step into the role, armed with information.

Investment in funding well-developed CIT programs would be an excellent starting point to support officers, law enforcement agencies, citizens (including those living with mental illnesses), and communities alike. It's a program with proven outcomes.

Thank you for this opportunity to comment.

For additional information, please contact:

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April 25, 2014

Introduction

NAMI Minnesota is a statewide grassroots advocacy organization dedicated to improving the lives of children and adults with mental illnesses and their families through education, support and advocacy. Our mission is to champion justice, dignity and respect for all Minnesotans impacted by mental illnesses.

For over seven years NAMI Minnesota has dedicated staff time and resources towards addressing the criminalization of mental illnesses, including advocating for alternatives to a police response and advocating for increased training of law enforcement and criminal justice staff. It is a very important issue and we have taken great steps to address it.

Alternative Responses

Mental illnesses should be treated as any other illness. Thus, when someone is having a mental health crisis, the appropriate responder should be a mental health professional. Unfortunately, all too often it is a police officer. To address this in Minnesota we have been increasing funding to develop mobile mental health crisis teams thus creating an appropriate response and an alternative to calling police. These teams have the preferred outcomes of preventing hospitalizations and connecting people with mental illnesses to treatment. Depending on the situation, police sometimes partner with the crisis teams to address a mental health crisis.

When there are alternatives to using police, fewer people are brought to jails. Most importantly people can be linked to mental health services and treatment sooner.

Training

In Minnesota there is a strong commitment to training of police and criminal justice staff. There is no doubt that police and criminal justice staff who have training on mental illnesses and how to deal with a crisis have better outcomes for themselves and the individuals with mental illnesses. Police often share their story of the first time they utilized what they had learned through CIT training and what a difference it made.

Several entities provide CIT training in Minnesota. Over 119 police forces have had at least one officer trained and over 600 police officers have been trained across the state. Even with this commitment we have reached less than 10% of all police officers in the state.

In rural areas it is difficult to access the CIT training due to the costs of the training and the costs of staffing a position while someone is at the training. NAMI Minnesota, through a grant from the National Council on Behavioral Health, will be offering a specialized Mental Health First Aid training to first responders this fall.

Over the past decade NAMI Minnesota has provided training to over 1000 staff who work in the criminal justice system, including staff who work in jails, parole officers, county attorneys,



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public defenders and others. In addition the Minnesota Department of Corrections has brought CIT training the prisons. One community college has developed an online course on mental illnesses for students studying law enforcement.

Recommendations

To address the issue of law enforcement responding to individuals having a mental health crisis Congress must first address the inadequate funding of mental health treatment and community supports. Focusing on police training is certainly beneficial but it does not address the underlying problem – lack of access to treatment and supports when and where they are needed. While it's important to have positive outcomes in terms of interactions with police, we need to move upstream and prevent people from ever coming into contact with the police in the first place.

While our national office has a list of items that could improve the mental health system, we would like to share some specific ideas that would benefit Minnesotans. We understand the controversy behind the IMD exclusion but at the very least a hospital (certified by JCAHO) that treats people with mental illnesses where the average length of stay is under 90 days should be exempted from the IMD status and be allowed to bill Medicaid. More funding should also be made available for affordable housing and supportive housing. Funding for evidence-based practices related to first episode, IDDT, IPS employment and others should be increased. Medicaid must be changed to make it easier to provide the in-home supports sorely needed by people with mental illnesses. Restricting access to those who need nursing facility level of care leaves many people with a serious mental illness without the necessary supports to live in the community.

Funding should be made available to fund CIT training and to use to fund temporary replacements for city police forces or county sheriff offices with few employees. Providing opportunities for greater partnerships for crisis teams would also be beneficial, including grant funding to pay for the time when staff are “on call” and not on a run. Additional funding is needed for the Justice and Mental Health Program grants to enable this to happen.

Thank you for the opportunity to provide input on this important topic.



April 22, 2014

Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights

NAMI South Carolina initiated CIT (Crisis Intervention Training) in 2004. This was implemented to help address the overwhelming use of force in detaining persons with Mental Illness. The training instructs law enforcement officers, first responders, and numerous other individuals in how to de-escalate a person in the throws of psychosis, mania, or paranoia. Any of these conditions can lead to fear and extreme anxiety. Our first and continuing task was/is to fund this operation. Our next task was to hire a CIT Director who would command the respect of other officers in training and then be able to relate through his own experience the necessity of this training. That is keeping the patient safe and keeping the officer safe. We were able to hire a retired Richland County Sheriff's Department Officer and then recruit a large volunteer staff that includes mental health professionals, probate judges, military personnel, family members, and persons living with a mental illness to name a few.

We have trained thousands of officers and we are still not able to keep up with all the requests for training. This need was exacerbated in August of 2010 when law enforcement was sent to the home of one of our NAMI members with mental illness to transport him to a facility for treatment (this was a non threatening court ordered transport). The individual did not wish to cooperate and the untrained law enforcement officers (3), proceeded to tase him repeatedly until he was dead. Since that time this law enforcement agency has become the premiere department in CIT training and has reduced their use of force from 51 incidents in 1 year to 1 incident in the following year. It is unfortunate that tragedy had to occur to invoke change.

Since 2011 NAMI SC has held 23, 40 hour CIT trainings, and numerous other 2 hour and 4 hour trainings. Since 2004 we have trained literally thousands of law enforcement and first responders and we have barely scratched the surface. Additionally, with the turnover in law enforcement, departments are in constant need of continuing training.

Moreover, since the deinstitutionalization of many of the state mental health hospitals and the decline in funding for treatment of those with mental illness, there has never been a greater need for CIT training. I urge you to spend the necessary resources to get people the treatment that they deserve, but to insure that they, the officers, and the public are presented with the opportunity to live in a safe community through CIT training.

A handwritten signature in cursive script, appearing to read "Bill Lindsey".

Bill Lindsey – Executive Director NAMI South Carolina

To: Senate Judiciary Subcommittee on the Constitution, Civil Rights and Human Rights

RE: Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety

April 29, 2014

This statement is submitted on behalf of NAMI Utah in support of Crisis Intervention Team Training.

Crisis Intervention Team Training (CIT) involves specially trained law enforcement officers who are educated about interventions to effectively de-escalate a situation involving a person experiencing a mental health crisis at academies lasting a full week. Between 15-17 Academies and 1-2 CIT Academy's for Youth are held each year throughout the state of Utah. There are currently 1475 sworn officers in Utah that are CIT certified. Additionally, there are 176 non sworn personnel or support staff trained.

The training is a partnership in which the mental health agency, the police agency, and other resources such as NAMI Utah come together to train both sworn and non-sworn personnel on how to respond to an individual living with serious mental illness during a crisis situation.

Utah has a nationally recognized CIT program that is administered statewide by the Salt Lake City Police Department. In fact in August 2013, the Treatment Advocacy Center studied the percentage of population served within each state by the diversion programs of CIT and Mental Health Courts. The only state in the nation to receive an "A+" rating was Utah. The study, *Mental Health Diversion Practices: A Survey of the States*, can be found online at tacreports.org/diversion-study. The Salt Lake Police Department has served for several years as one of six national law enforcement/mental health learning sites—acting as agencies that help other jurisdictions across the country improve their responses to people with mental illnesses.

We believe that a strong reason for the high rating Utah received in the TAC study is community ownership of the program. The community partnerships between law enforcement officers, criminal justice workers, healthcare professionals, mental healthcare providers, advocates, families and individuals living with serious mental illness have been the glue holding the CIT program together.

NAMI Utah has been an integral part of the training since its inception. Individuals and families who have been personally impacted by mental illness and have come into contact with law enforcement during a time of crisis are invited to serve as subject matter experts during the training. Each year, at our NAMI Utah State Conference, we recognize the work of the CIT program in general and award exemplary performance by individual officers as well.

Still, in spite of the fact that we have one of the best CIT programs in the nation, the availability of this program is still extremely limited throughout Utah. The program exists in 8 of the 11 mental health catchment areas of the state and within each catchment area, only a small fraction of officers are CIT-trained. We encourage the expansion of participation in CIT by both law enforcement agencies and mental health agencies.

CIT provides benefits for the individual in crisis, the family, the officers, and our communities as a whole. This training encourages more humane and appropriate treatment of the individual experiencing the mental health crisis, and improves the individual's ability to get *help* – to access necessary mental health treatment and services.

For families too, CIT officers are a lifeline. When a member of a family has a mental health crisis, the entire family is often in crisis and in need of help. CIT is profoundly beneficial to families who need assistance but are reluctant to call law enforcement, because their loved one has not broken any laws, but is *ill*. When families call and receive CIT assistance, they have the assurance that the responding CIT officers are trained to understand mental illness. These officers understand how the symptoms may be manifested and affect behavior, they are aware of the perspective of the person with the illness, and they recognize the needs of families in such a difficult situation.

Most people are unaware of the benefit CIT offers to our law enforcement community. Our law enforcement officers have an exceptionally difficult, dangerous job. They deserve to have the best tools and training at their disposal. CIT training actually improves *officer* safety and reduces *officer* injury. In addition, in a time of shrinking resources, CIT reduces many costs incurred by law enforcement agencies in responding to a person in a mental health crisis, and decreases the frequency of that individual's encounters with the criminal justice system - another significant cost-reduction measure.

Individuals with mental illness, their families, our law enforcement officers, our communities and taxpayers deserve to have CIT available in every corner of our State. Our communities—including our community mental health centers, law enforcement agencies, and local authorities—need to work together to make this happen.

Signed,

Rebecca Glathar
Executive Director, NAMI Utah

As a volunteer for the National Alliance on Mental Illness and the nonprofit, Open Our Hearts, I regularly talk to families in crisis with a loved one with severe mental illness. Often the relative could be helped but refuses treatment, and at times there is a threat of violence. Parents often fear for their own safety and/or the safety of the younger siblings of the ill adult child. (People with severe mental illness that is **untreated** are responsible for more violence than the general population.)

Some of these people go through a revolving door of ER visits, short hospitalizations, arrests and incarceration. But because of overly stringent protections against involuntary treatment of adults and a lack of psychiatric hospital beds, they are released, at a high cost to our economy and public safety. A number of parents have told me, "I fear my adult son will be the next Adam Lanza and there is nothing I can do about it."

And, as you know, police response to people with untreated mental illness who appear threatening is often brutal and sometimes fatal, to officers as well the ill individuals.

For these reasons, I urge that the approaches to protect public safety include:

1. **Court-ordered outpatient treatment (AOT).** Laura's Law programs in Nevada County, Calif., and Kendra's Law programs in New York have proven successful. These programs screen candidates carefully. They are NOT punitive and **involve no force**. They work because of the "black robe effect" (the authority) of a judge. They are highly effective in stabilizing people with severe mental illness and preventing crimes, arrests and incarceration.
2. **Changing the criteria for involuntary treatment** of people with severe mental illness to include need for treatment. Present standards are typically "danger to self or others or grave disability" *at the time of evaluation*. Individuals can have had repeated incidents in that category, but as long as they can feign stability when evaluated, they are released. The lack of hospital beds and fear of lawsuits for illegal holds places a premium on release. I have heard police officers lament having to repeatedly arrest the same ill individuals because they do not get treatment.
3. **Eliminating the Institutions for Mental Diseases exclusion** from Medicaid, which accounts for some of the scarcity of beds.
4. **Reauthorizing mental health courts.** A small and similar type of court in my county (Contra Costa, California) is a godsend for participants.

Thank you for your attention.

Sincerely,

Karen Cohen

TESTIMONY FOR THE RECORD OF SENATE JUDICIARY April 28

1. Fund Assisted Outpatient Treatment (AOL); Develop and monitor the policies or guidelines for adhering to the regulations.
2. Fund Mental Health Courts so that treatment can be offered as an alternative to incarceration.
3. Increase the number of psychiatric hospital beds and funding of psychiatric units within hospitals currently without psychiatric units. Adjust Medicaid rates so that they more accurately reflect costs of services provided.
4. Reform IMD – it is an archaic barrier to treatment and restricts housing opportunities that would provide social rehabilitation within the community for the SMI population. Distributive housing is not the best choice for many within the SMI population, and it is more costly.
5. Let families be more active in the treatment and recovery of the patients with Severe Mental Illness (SMI). This includes allowing access to medical records of SMI loved ones. (modify HIPAA/FERPA)
6. End SAMHSA funding of anti-psychiatry propaganda. Instead have SAMHSA promote the research results from NIMH and Evidence Based Best Practices in a positive way, consistent with medical science.
7. Fund community programs that will provide assertive mental health services for those with SMI transitioning out of the jails. If they can be successfully connected to community services (immediately), they are more likely to avoid future incarcerations.
8. Increase funding for education of mental health awareness in our schools and through public service announcements in our community.
9. Require that all School Resource Officers (SROs) have specialized training about mental illness and communication skills when working with youth with behavioral issues.
10. Fund pilot programs for community support activities for youth with SMI.
11. End PAIMI lobbying government to prevent treatment of the SMI.
12. Develop a uniform data system that will make it easier to follow the individual as he or she interacts with the various community services, including jails/prisons, mental health and medical service providers, schools, Emergency Rooms, Hospitals, etc. Just linking the mental and medical service providers would be a major step forward to addressing the total person's health.

Respectfully submitted,

Gerry Akland, President
NAMI Wake County (NC), Board of Directors



NATIONAL ASSOCIATION OF POLICE ORGANIZATIONS, INC.

Representing America's Finest

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WILLIAM J. JOHNSON
 Executive Director

April 25, 2014

The Honorable Dick Durbin
 Chair, Subcommittee on the Constitution,
 Civil Rights, & Human Rights
 Senate Judiciary Committee
 711 Hart Senate Office Building
 Washington, D.C. 20510

Dear Chairman Durbin:

On behalf of the National Association of Police Organizations (NAPO), I am writing to you to express appreciation for chairing a hearing of the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights to discuss law enforcement responses to Americans with developmental disabilities or mental illness.

NAPO is a coalition of police unions and associations from across the United States that serves to advance the interests of America's law enforcement through legislative and legal advocacy, political action, and education. Founded in 1978, NAPO now represents more than 1,000 police units and associations, 241,000 sworn law enforcement officers, and more than 100,000 citizens who share a common dedication to fair and effective crime control and law enforcement.

Public safety officers are routinely called upon to respond to situations that involve citizens with developmental disabilities or mental illness. It is vital that these officers receive the necessary training to appropriately identify and respond to these individuals. NAPO is a strong advocate for increasing training for public safety officers on how to respond to these citizens, which is critical for the safety of the officers involved and the individuals at the scene.

Moreover, individuals with mental illness are significantly overrepresented in our prison and jail populations. Providing public safety officers with training to assist those in crisis will help to ensure that these citizens receive the help they need as opposed to being placed in the criminal justice population.

Additionally, increased collaboration between mental health agencies and criminal justice agencies will yield public safety benefits. First responders are often ill-advised of those with serious mental health conditions when responding to calls to facilities that treat these individuals. Failure to properly identify such facilities for first responders leads to an increased risk of injury of both the first responder and the patient. It is imperative that public safety

officers be made aware of the potential to come into contact with a large group of individuals who may suffer from mental health conditions in order to appropriately respond and maintain public safety.

Law enforcement officers are called upon more frequently than ever to respond to individuals with mental illness or developmental disabilities who are in crisis. Public safety officers must be provided necessary training to respond to these individuals. An investment in training will assist with keeping officers and the communities they serve safe.

Thank you for taking action on this important issue. NAPO stands ready to assist with any efforts necessary as you explore how Congress and the Executive Branch can help support the law enforcement community with responding to individuals with mental health conditions and developmental disabilities.

If you have any questions, or if we can be of further assistance, please feel free to contact me at: (703) 549-0775. We look forward to working with you in the future.

Sincerely,

A handwritten signature in dark ink, appearing to read 'William J. Johnson', followed by a horizontal line.

William J. Johnson
Executive Director

**Statement of the National Association of the Deaf Regarding Law Enforcement
Interactions with Deaf and Hard of Hearing Individuals**

Interaction with law enforcement can in many situations be a nerve-wrecking experience for any individual. However, for millions of deaf and hard of hearing persons in the United States, the experience is often profoundly worse even though federal civil right statutes grant equal access and civil rights for persons with disabilities in the local and state government context. Communication barriers between deaf and hard of hearing individuals and law enforcement officers lead to misunderstandings, frustration, deprivation of Constitutional rights, and sometimes even serious or fatal bodily harm.

As the nation's premier civil rights organization of, by and for the deaf and hard of hearing individuals, the National Association of the Deaf ("NAD") has tirelessly advocated for the elimination of such communication barriers. Lack of effective communication between law enforcement and deaf and hard of hearing individuals is a widespread problem across the country. Many of the calls from deaf and hard of hearing consumers to the NAD offices are complaints against local and state law enforcement for failures to ensure effective communication with deaf and hard of hearing individuals. Indeed, this may rank as one of the top three issues of calls to the NAD.

The scope of law enforcement complaints is broad, including but not limited to: (1) interaction with the police; (2) routine traffic stops; (3) police investigations; (3) interrogations; (4) arrests; (5) booking and filing charges; and (6) detention. While the complexity of information and the exigency in each police encounter may vary, one thing remains the same: the legal obligation of all law enforcement to ensure effective communication with deaf and hard of hearing individuals.

Specifically, law enforcement are required to comply with Title II of the Americans with Disabilities Act ("ADA") ("Title II"). Title II of the ADA bans discrimination by public entities against qualified individuals with disabilities on the basis of disability. 42 U.S.C. § 12132. Similarly, law enforcement agencies that receive federal financial assistance are required to comply with Section 504 of the Rehabilitation Act of 1973 ("Section 504") and pursuant to this law may not discriminate against qualified individuals with disabilities based on their disabilities. 29 U.S.C. § 794.

The regulations implementing the ADA and Section 504 require public entities and recipients of federal financial assistance, respectively, to provide the auxiliary aids and services necessary to ensure that the entity's communication with deaf and hard of hearing individuals is "as effective as" its communication with others. *See* 28 C.F.R. § 35.160; 45 C.F.R. § 84.52. The ADA defines "auxiliary aids and services" to include "qualified interpreters" and the "exchange of written notes." 42 U.S.C. § 12103; 28 C.F.R. § 35.104. A "qualified" sign language interpreter must be "able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary." 28 C.F.R. § 35.104. According to Guidelines for Effective Communication published by the Department of Justice ("DOJ"), "covered entities may not rely on an accompanying adult to interpret when there is reason to doubt the person's impartiality or effectiveness. For example: . . . When responding to a call alleging spousal abuse, police should never rely on one spouse to interpret for the other spouse." DOJ, ADA Requirements: Effective Communication at 5; *see* 28 C.F.R. § 35.160(c)(2)(ii). The type of auxiliary aid or service necessary to ensure effective communication depends on several factors, including the communication method used by the individual with a disability, the nature, length, complexity and context of the communication. DOJ, ADA Requirements: Effective Communication at 1; *see* 28 C.F.R. § 35.160(b)(2).

Public entities are required to give "primary consideration" to the auxiliary aid or service that the individual with a disability chooses. 28 C.F.R. § 35.160(b)(2). Pursuant to the "primary consideration" requirement, a public entity "must honor the person's choice" of a particular auxiliary aid or service. DOJ, ADA Requirements: Effective Communication at 6. If it does not, the entity bears the burden of proving "that another equally effective means of communication is available, or that the use of the means chosen would result in a fundamental alteration or in an undue burden." DOJ, ADA Requirements: Effective Communication at 6.

Unfortunately, more often than not, law enforcement deny deaf and hard of hearing individuals their right to effective communication. The denial of effective communication can have disastrous consequences for all the parties involved. Just this month, the NAD filed an appeal on behalf of a deaf woman who was arrested after not

being afforded a meaningful opportunity to participate in police investigation when the police stopped interviewing her upon discovering she was deaf. Her two hearing companions, on the other side, were able to share their sides of the story to the police. As a result of talking only with the hearing companions, the police arrested the deaf woman. Such a practice renders deaf individuals as second class citizens who have no right to explain their version of events but are subject to the mercy of any hearing person who provides a contrary version.

Providing auxiliary aids and services, such as qualified interpreters, is particularly important during police interviews and interrogatories, as such interviews afford suspects “certain benefits, including the right to ask questions and tell [their] side of the story, which arguably [can] affect[] the charging decision.” *Bahl*, 695 F.3d at 788; *accord Seremeth*, 673 F.3d 333, 337 (4th Cir. 2012) (“The injury is the failure to make communication as effective as it would have been among deputies and persons without disabilities.”) (citing 28 C.F.R. § 35.160).

More common than complaints of inaccessibility during investigations and arrests are tales of not being able to communicate with the police during routine stops. During such stops, the police are understandably on alert regarding their own personal safety.

The deaf driver who is pulled over by a police car is in a delicate situation – they have the right to communicate, however there is an inherent difficulty in communicating with law enforcement during any stop. During such stops, deaf and hard of hearing drivers experience dread in anticipation of the difficulty in communicating with a police officer to accommodate their deafness. If a deaf or hard of hearing driver reaches for a paper and pen anywhere in the car, especially a glove compartment, this action may be misinterpreted as an act of aggression. When a deaf or hard of hearing driver indicates that s/he does not understand what the officer is saying, the officer often becomes frustrated and begins yelling angrily at the driver. If a deaf or hard of hearing person touches the officer as is often done in the deaf or hard of hearing community to get a person’s attention, the officer typically perceives this as a physical threat. Also, if a deaf person attempts to communicate using sign language at a time of heightened confrontation, an officer may view this as resisting arrest.

Such miscommunication during a routine stop or other police encounters too often leads to more stressful situations, including wrongful arrests, physical beatings, and deaths. For example, Jonathan Meister recently brought a lawsuit in California after the police tasered and beat him into unconsciousness. Meister, who is deaf, states that the police mistook his signs as manual aggression and responded by brutally beating him. In 2006, St. Paul Police maced Douglas Bahl, a deaf driver, just because the communication was not effective. In 2012, a deaf woman, Lashonn White called the Tacoma, Washington police to ask for assistance with a domestic violence situation with an abuser who would not leave her home. The police came only to use a taser on Ms. White and then jailed her for three days before the facts were cleared up on what had happened. Just this past January, the Oklahoma Highway Patrol pulled over 64-year-old Pearl Pearson and despite his having a placard indicating that he is deaf, the highway patrol officers proceeded to beat him up when he was not responsive to their commands. In 2010, Seattle police shot and killed a deaf man after he was non-responsive to an officer's command to stop.

It is not only the deaf suspects that are affected by the police's disregard of its Title II and section 504 obligations. Deaf family members, friends, victims, and witnesses often are faced with lack of effective communication with police officers. A deaf woman may not be able to tell a police officer about her violent husband's abuse, resulting in lack of probable cause for the police to arrest him. When police officers fail to communicate with a deaf person who is a victim or a witness, valuable information may not be obtained in time to arrest the right person.

Moreover, it is not just the deaf or hard of hearing individuals that suffer as a result of ineffective communication with the police. Hearing relatives and friends may be put in an impossible situation when the police refuse to communicate effectively with deaf or hard of hearing individuals. For example, a police officer responding to a domestic violence complaint at a deaf couple's home may attempt to use a young hearing child to interpret. This puts the child in an unfair and horrible emotional position.

Law enforcement agencies also need to ensure that effective communication is provided in terms of telecommunications within their facilities. Deaf and hard of hearing individuals who are at police stations or in the jails need to be able to make phone calls

on a functionally equivalent basis. Very few law enforcement facilities have videophones which are the primary means of telecommunication for deaf and hard of hearing individuals who use sign language as their primary mode of communication. Further, virtually no law enforcement facilities have captioned telephone services, and very few have amplified telephones.

These stories are examples of the worst incidents, but there are successes. For instance, the Washington, D.C. police department has a deaf unit. They have police vehicles equipped with videoconferencing equipment to allow police officers to connect to a video remote interpreter whenever necessary to communicate with deaf individuals. Many other police departments have had sensitivity training and/or dedicated units of police officers who are fluent in sign language. Therefore, it is indeed possible for the police to implement policies and procedures in place to effectively communicate with deaf individuals.

We urge that minimum standards be established for all law enforcement agencies and officers to create expectations for effective communication. Presently, the law mandates "effective communication" but clear guidelines need to be developed to assist law enforcement understand what the best practices are for dealing with deaf and hard of hearing individuals whether they be victims, witnesses, people seeking help, suspects, or arrestees. There should never again be battery against a deaf or hard of hearing person by any law enforcement officer; more training and strict standards can and must prevent such tragedies.



National Coalition for
Mental Health Recovery

Testimony submitted to

The Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights
“Law Enforcement Responses to Disabled Americans: Promising Approaches for
Protecting Public Safety”

April 29, 2014

By the National Coalition for Mental Health Recovery

The National Coalition for Mental Health Recovery is an organization of people in recovery from serious mental illnesses. Our Coalition, with member organizations in more than 30 states, is a national voice of people who have been most severely affected by mental health challenges and lack of adequate crisis response systems.

We share the concern of the Subcommittee that law enforcement personnel are increasingly called upon to respond to situations involving individuals in emotional crisis who may be hearing voices and/or diagnosed with serious mental health problems. We appreciate that these encounters are among the most challenging of all law enforcement interactions.

We support the efforts of state and local law enforcement agencies to develop innovative approaches to training, such as Crisis Intervention Teams (CIT) – which, in the words of the founding CIT coordinator, Major Sam Cochran (ret.), are “more than just training,” since they also involve the creation of elite volunteer units of officers who are vetted for their judgment and maturity. Every day, there are trained law enforcement heroes serving on Crisis Intervention Teams who help to prevent people from dying by suicide on our bridges, and sensitively and effectively respond to individuals in emotional crisis. However, our Coalition members working in our communities report that it is often the “luck of the draw” as to whether the responding officer in a given community has received the requisite training and skills to de-escalate crises and respond effectively to unusual behavior.

The following recommendations represent the Coalition’s vision for a comprehensive, innovative approach to preventing the kinds of tragic outcomes that we read about every day in the news, and instead fostering hope, recovery, and safety in our communities.

Recommendations

1. The Commission on Accreditation for Law Enforcement Agencies (CALEA) should collaborate with Bureau of Justice Assistance (BJA), CIT International, and all relevant

agencies/stakeholders to ensure the meaningful presence of individuals with lived experience of mental illnesses (also known as “consumers”) in all CIT 40-hour trainings via panels and presentations.

Officers in the City of San Francisco, where this is an established practice, report that the presentations by persons with lived experience of mental illness and recovery are among the most powerful components of the CIT training, and effectively help to reduce stigma. Some CIT trainings even include officers who share their own personal experiences of recovery. “The consumer panel helps officers to gain compassion and greater understanding of the needs of persons in crisis and their families,” said Commander Richard Correia of the San Francisco Police Department.

2. BJA and all relevant Federal agencies should provide technical assistance and training to help law enforcement establish direct linkages between 911/dispatch and CIT-trained officers when the call involves a person in emotional crisis, as well as to encourage ongoing data collection to ensure quality and to document outcomes.

This practice, which is being successfully implemented in San Francisco, is critical to ensuring that only appropriately trained officers respond to persons in crisis. Said Commander Correia, “It’s entirely possible to handle these situations without the use of force. Creating a citywide mechanism that facilitates the response of CIT-trained officers in appropriate situations improves outcomes for both the officer and the person in crisis. It is our aspiration to one day bring down use of force to zero.”

3. CIT International should look to other sources, such as the Emotional CPR (eCPR) curriculum, to complement the existing models.

The Emotional CPR curriculum has been endorsed by the International Association of Chiefs of Police (IACP) as a “way to enrich CIT curricula.” Emotional CPR (eCPR) (www.emotional-cpr.org) is a public health education program designed to teach people to assist others through an emotional crisis. eCPR was developed by people who have learned from their own experience how to recover from emotional crisis.

eCPR teaches law enforcement officers how to:

- Take their time and stay calm in the presence of a person in distress;
- Use new tools to assess the facts and circumstances surrounding these situations;
- Engage effectively and safely with individuals so they can resolve the immediate concern;
- Develop an awareness of available, accessible, community-based resources; and
- Interact with courtesy, professionalism and respect in challenging situations.

By practicing the tools and skills of eCPR, law enforcement can provide a life-saving service that helps someone survive great distress and pain, and regain a valued place in the community.

4. The Substance Abuse and Mental Health Services (SAMHSA), BJA, and all relevant Federal agencies should encourage the meaningful presence and participation of peer support specialists in jail diversion programs, mobile crisis teams, emergency rooms, and all crisis services.

One of the benefits of increasing the overall involvement of peers with experience in the behavioral health and criminal justice systems is that they have a clear understanding of the culture of incarceration and the challenges that involvement in the criminal justice system creates on such factors as eligibility for entitlements, housing, and employment. A model program in this regard is The Eleventh Judicial Circuit Criminal Mental Health Project (CMHP) Jail Diversion Program in Miami, Florida. This program utilizes peer support specialists to assist program participants with re-entry by providing access to housing and support services that reduce recidivism and promote recovery.

5. SAMHSA and the National Institute of Mental Health (NIMH) should develop, research, and promote innovative voluntary, recovery-oriented, trauma-informed alternatives to hospitalization and incarceration, such as peer-run respites, Open Dialogue, the Soteria model, and psychiatric advance directives.

The *peer-run respite* model is a promising practice offering community-based supports provided by persons with lived experience that foster recovery, wellness, and community integration. *Open Dialogue* is a family and social network approach to first episode psychosis care, and has garnered widespread attention for dramatically improving outcomes. Results consistently show that Open Dialogue leads to less recurrence of crisis when compared with psychosis treatment as usual. Similarly, studies of the *Soteria House* model indicate that most patients with schizophrenia can be as successfully treated as by standard hospital proceedings, avoiding re-traumatization, and at a much lower cost. Research is also needed to determine how *psychiatric advance directives* can be used to enable self-determined treatment for patients who lose decisional capacity, and thus reduce the need for coercive interventions such as police transport and involuntary commitment.

6. SAMHSA and all relevant Federal agencies should support easily accessible systems of crisis services and supports to decrease dependence on incarceration and unnecessary hospitalization.

A model program in this regard is the Parachute Program in New York City, which provides options for people having a psychiatric crisis. Parachute NYC offers rapid access (within 24 hours) to home-based treatment and crisis respite centers where people can stay in a calm, supportive environment that fosters recovery.

7. BJA, SAMHSA, the Department of Housing and Urban Development (HUD), and other relevant stakeholders should identify and promote funding and best practices to reduce and eliminate barriers to successful reentry for persons with mental illnesses and co-occurring disorders.

To reduce recidivism and achieve community integration, individuals should be able to easily access jail and hospital diversion programs, integrated health care, substance use

treatment, as well as critical community supports such as supported housing, supported education and vocational programs.

8. Congress and executive branch agencies responsible for administering Medicaid, Medicare and Social Security benefits should remove unnecessary obstacles to access to benefits for individuals reentering communities from jails, prisons, and other correctional facilities.

The current process for receiving benefits is unnecessarily daunting for persons exiting the criminal justice system, and individuals may give up applying for the benefits to which they are entitled, which can fuel crisis and recidivism.

9. BJA should work with HUD to encourage changes to public housing regulations to permit ex-offenders with mental illnesses to reside in public housing.

Increased access to safe, affordable housing will help to reduce recidivism and promote well being for persons with experience in criminal justice systems.

10. SAMHSA and HUD should encourage expansion of Housing First options for persons with mental illness who are diverted from or returning after incarceration in justice system facilities.

Housing First is an evidence-based program that will help to reduce recidivism and promote the recovery of persons with experience in criminal justice systems.

11. Federal agencies such as BJA and SAMHSA, and all stakeholders, should develop public awareness campaigns and strategies to decrease negative stereotypes of persons with mental illnesses and highlight the importance of decriminalizing mental illnesses.

Improving the outcomes of law enforcement responses to persons with mental illnesses depends on changing cultures, both within law enforcement agencies as well as communities at large. People who understand the challenges faced by those in emotional crisis, and understand that recovery is possible, are more likely to support recovery-oriented mental health care and other essential community services.

The National Coalition for Mental Health Recovery thanks you for your attention to this important public safety issue, and looks forward to opportunities for continued collaboration to make our communities safer, more recovery-oriented, and more resilient for all.

For more information, contact Leah Harris, NCMHR, leahharris2@gmail.com, 202-236-7747; or Raymond Bridge, Director of Public Policy, NCMHR, Raymond.bridge@ncmhr.org 703-883-7710.



Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety

Hearing Before the Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights

Comments submitted for the record by:

Linda Rosenberg, MSW
President and CEO
National Council for Behavioral Health

On behalf of the National Council for Behavioral Health, I am pleased to submit these comments for the record. The National Council for Behavioral Health (National Council) is the leading not-for-profit association representing 2,100 organizations that provide critical mental health and addiction services to more than 8 million adults, children, and families. Our member organizations stretch across 50 states and assist those in need from early stages of life through their elderly years. With a commitment to a proactive public policy agenda and success in preserving and enhancing mental health and addictions funding and support for critical treatment and support services, today's community behavioral healthcare providers continue to build healthy minds and strong communities — giving people with mental illness and addictions a chance to recover and lead productive lives.

Our members providing services and supports to persons living with substance use and mental illnesses also make us keenly aware of the need for this hearing and inform the two areas that we believe are of vital focus for your efforts:

- 1) Increasing community-based treatment capacity so as to reduce unnecessary contact between law enforcement and persons with mental illness and substance use disorders; and



- 2) Increasing access to training for law enforcement officers and other first responders so that they appropriately recognize the signs and symptoms of mental illness and substance use so that they know how intervene with these individuals.

The need for this hearing and a more informed response to individuals with mental and substance use conditions cannot be over-stated. An estimated 11.6 million persons are incarcerated in local jails every year.¹ The population is plagued with increased rates of homelessness, joblessness, former incarceration, hospitalization, and family instability.² As a whole, incarcerated individuals face serious physical and behavioral health problems. Eight out of ten men and nine out of ten women in prison have a chronic health condition requiring treatment or management, the incidence of mental illness is four times greater than the general public, and three-quarters of incarcerated persons meet the criteria for a substance use disorder; and even more disturbing is the fact that the majority of this population lacks health coverage upon re-entering their community.³ A seven year study performed by the Urban Institute showed that 68 percent of men and 58 percent of women lacked health insurance 8-10 months after their release.⁴

Lack of access to community treatment is a leading cause of contact with the criminal justice system for persons with mental illness and substance use disorders fueled by an under-investment in critical treatment capacity. Since the 1980s, states and localities have had responsibility for the provision of mental health and substance use treatment services, and the sad reality is that only four in ten⁵ persons with mental health conditions and 14 percent⁶ of persons with substance use conditions who are in need of treatment in any year receive it. The underfunding of the treatment system also means that the types of treatments available vary widely from county to county and state to state, so that there is no such thing as a standard of care for persons living with these complex illnesses.

Congress has recently taken steps to address both the under-funding of mental health and substance use services and to establish national standards of effective services that must be available to individuals with these illnesses through the passage of the Excellence in Mental Health Act. This legislation establishes criteria for Certified Community Behavioral Healthcare Centers, including the provision of such vital services as 24 hour crisis response, assertive community treatment and other intensive services designed to provide access to care for persons with serious mental and substance use illnesses. This legislation received widespread support from law enforcement organizations as they recognize the need for more intensive and available services as necessary to prevent law enforcement contact for this population.



The initial implementation of the Excellence in Mental Health Act will be an eight-state Medicaid demonstration, but the needs of communities around the country only continue to increase, and that is why the Excellence in Mental Health Act must be extended to every state. Congress must finish the work that it began with the initial passage of this important legislation by establishing national treatment and reimbursement standards through the expansion of this legislation as a Medicaid mandate.

The provision of timely and adequate mental health and substance use treatment is essential at all places along the criminal justice continuum – from diversion to re-entry. In fact, access to behavioral health treatment is key to ensuring a smooth and successful transition back to the community. Several studies have demonstrated that having healthcare upon reentry increases access to mental health care, utilization of behavioral health services, and results in fewer subsequent detentions.⁷ Currently, it is estimated that less than half of individuals with a reported mental health condition receive treatment 8-10 months post-release, one half of which receive treatment in emergency room or hospitalization settings.⁸ Certified Community Behavioral Healthcare Centers provide a means through which individuals returning to their communities can receive necessary treatment services, care management, care coordination, and patient and family support.

Police officers keep our communities safe and secure, and the pressures related to this have never been higher. It is also true that very few police officers entered the profession with the intention of becoming healthcare providers. And yet, because of the lack of adequate community-based treatments, this is often what happens. The volume of calls for police service associated with mental health increasingly demanded police intervention at levels estimated at 7-10 percent of calls handled during a single patrol officer's shift. Therefore, many police departments have begun to offer their officers training so that they understand the signs and symptoms of mental illness and substance use and how to respond accordingly. Once such training that has gained much traction within the law enforcement community is Mental Health First Aid (MHFA). This type of training is important so that a single police officer today can recognize and prevent a single depressed person from becoming tomorrow's armed barricaded subject. Public safety officers want to be of assistance to people who are experiencing mental health problems; however, they need to have the basic skills to aid them in recognizing the signs & symptoms of mental illness and to interact effectively individuals in crisis.

MHFA was introduced in the United States in 2006 and almost immediately was embraced by law enforcement to meet the local needs to make up for the lack of police training on the topic of mental illness response. Since this time, academies and localities have come to realize that the MHFA



course enables all potential first-responders to acquire basic knowledge and skills to respond to individuals in psychological distress.

The MHFA course has a module designed to accommodate law enforcement operational considerations and practices: custody factors, statutory mandates, safety precautions, etc. The experience in one state, Rhode Island, is illustrative of other parts of the country. The MHFA course has been taken by over seven hundred graduates that includes: Recruits, Patrol Officers, Police Supervisors, Field Training Officers, School Resource Officers, CIT Officers, Peer Support Team members, Dispatchers, Correctional Officers, Mental Health Clinicians, University Security, Sheriffs, Court staff, and Emergency Services Nurses.

To date, Mental Health First Aid for Public Safety remains highly regarded and in demand. The reputation of the course has extended. There is no denying the increase in communications between graduates, mental health practitioners, and Hospital ER staff since the training's inception. These improved relations have contributed to more reliable and efficient reporting of a first responder's or witness' observations of a mentally ill patient's earlier behavior. The relaying of this critical information has been greatly appreciated by clinical and medical staff in their efforts to properly assess and treat mental health intakes.

Public Safety Officers, regardless of rank or position, may find themselves confronted with a mental health crisis. Such was the case with Providence Police first-aid, Lieutenant Daniel Gannon, whose officers were confronted with a knife-wielding lunging youth. Although force intervention means were readily available to deploy, Lieutenant Gannon remained content with keeping the boy contained as he sought to calm him down and persuade him to drop the knife. When interviewed on scene by the press, Lieutenant Gannon credited the Mental Health First Aid training he received a few months earlier as a key factor in his ability to resolve this potentially violent incident.

All accredited police agencies throughout the country must comply with mandatory standards governing mental illness response which includes requirements for documented entry level and refresher training. Mental Health First Aid helps satisfy this professional policing standard.

Many officers and staff lack confidence in their ability to adequately respond to individuals in serious mental health crises. The more we learn the greater our chances of producing meaningful, productive and safe outcomes. The impact of education and training is greatest when public safety officers are able to identify situations involving mental illness, communicate and intervene effectively, so as to minimize the chances of violent incidents and maximizing access to care.



Congress enacted a \$15 million appropriation for Mental Health First Aid training in 2014, but this funding will be used primarily in state and local educational contexts to support teacher and staff training. To support and build upon the outstanding efforts of state and local police departments to improve their responses to people with mental illness and substance use conditions, Congress should enact the Mental Health First Aid Act. This bipartisan legislation provides \$20 million in funding for Mental Health First Aid training for a broad array of audiences, including law enforcement officers, correctional officers, family members, and community leaders.

¹ Conly, C. (2005). Helping Inmates Obtain Federal Disability. ABT Associates Inc.

² Ibid.

³ The Urban Institute. Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration. (2008). Retrieved from:

http://www.urban.org/UploadedPDF/411617_health_prisoner_reentry.pdf

⁴ The Urban Institute. Returning Home, Understanding the Challenges for Prisoners. (2010). Retrieved from:

<http://pweb1.rwif.org/reports/grr/051041.htm>

⁵ Substance Abuse and Mental Health Services Administration, Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-47, HHS Publication No. (SMA) 13-4805. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013

⁶ Substance Abuse and Mental Health Services Administration, Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

⁷ Substance Abuse and Mental Health Services Administration. (2010). Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions. HHS Publication No. (SMA) 10-4545. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

⁸ The Urban Institute. Returning Home, Understanding the Challenges for Prisoners. (2010). Retrieved from: <http://pweb1.rwif.org/reports/grr/051041.htm>



National Council on Disability

An independent federal agency making recommendations to the President and Congress to enhance the quality of life for all Americans with disabilities and their families.

Testimony of Rebecca Cokley

Executive Director, National Council on Disability

Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety

Hearing of the Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights

U.S. Senate

Tuesday, April 29, 2014
10:00 A.M.

Dirksen Senate Office Building Room 226

Chairman Durbin, Ranking Member Cruz, and Esteemed Members of the Senate Judiciary Subcommittee on The Constitution, Civil Rights and Human Rights:

Introduction

Thank you for the opportunity to provide brief written testimony on the important topic of today's hearing, "Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety." We commend the Subcommittee for shining a light on this topic by hosting a hearing and soliciting information from stakeholders, and we offer ourselves to the Committee as an ongoing resource as you examine this topic and consider appropriate legislative responses.

The National Council on Disability (NCD) is an independent federal agency that provides advice to the Administration, Congress, and other diverse stakeholders, and thoughtful, timely analysis and recommendations to inform policy development, revision, and enforcement. As a federal voice for 56 million Americans with disabilities, including those with psychiatric and intellectual and developmental disabilities (ID/DD), NCD is committed to advancing policy solutions that create a more inclusive country in which all Americans have equal opportunities to contribute to society.

NCD has written extensively over its 36-year history on the intersections of disability and the criminal justice system; dependency courts; crime victimization; child welfare, mental health systems; and education systems. In 2011, NCD hosted a regional policy forum in Portland, Oregon, during which we hosted panel discussions with leaders from state departments of corrections, mental health courts, and police departments on topics including law enforcement models and mental health courts; transitions back to the community following incarceration for people with psychiatric disabilities; and forging police/community advocacy relationships that assist in deescalating crisis moments and preventing tragedies. And in the wake of many of the recent mass shootings, NCD has offered advice to Congress, the Vice President, and the President as each has engaged related topics. We are grateful for the opportunity to bring the information we've learned and the advice we've offered to bear in our testimony today.

Facts and Myths about Disability and Crime

Misunderstandings, fears, and stereotypes about different types of disabilities have led to tragic outcomes throughout U.S. history. During the American Eugenics movement, pseudo-scientific "evidence" gave way to popular thought linking disability and criminality, and the inheritability of both.¹ The solutions advanced in the day were segregation and forcible sterilizations. As a result of these myths, for decades of U.S. history, people with disabilities were devalued, isolated from the rest of society, prevented from attending school, getting married, or being a part of their communities. Thankfully, people with disabilities now enjoy far greater civil rights that have come hard fought in the least fifty years. However, fears, myths, and stereotypes persist.

In the latest data released by the Bureau of Justice Statistics of the U.S. Department of Justice, people with disabilities were victims of violent crimes at nearly three times the rate of those without disabilities.² In 2012 alone, 1.3 million nonfatal violent crimes were perpetrated against people with disabilities ages 12 or older.³ And despite what some may conclude in light of recent tragedies, statistics bear out the fact that people with disabilities are far more likely to be the victims of crimes than the perpetrators of them, and therefore in need of supportive relationships and understanding with law enforcement, fears and assumptions about people with all types of disabilities have instead contributed to unfortunate and at times tragic consequences.

Public perceptions rooted in a history of stereotypes have given way to many instances in which people with disabilities receive disparate and inappropriate treatment by law enforcement. Presumptions of linkages between psychiatric disabilities and violence – not borne out in fact – have led to coerced treatments and commitments. Myths and misunderstandings about people with cerebral palsy, epilepsy, those who are deaf and hard of hearing, those living with AIDS / HIV, and a variety of intellectual and developmental (ID/DD) disabilities have led to wrongful arrests, overuse of force, deprivation of much needed medical attention, and even loss of life.

In the pages that follow, we offer findings and recommendations for the Subcommittee to consider , excerpted from our previous body of work. We suggest that progress will come as a result of improved cultural competence through law enforcement trainings; greater investment in a spectrum of mental health services; and involvement of and relationships with the disability community by law enforcement, as partners in progress.

Improved Cultural Competence through Law Enforcement Trainings

Unfortunately, when people with disabilities are victims of crimes or are experiencing an emergency, they often cannot rely upon law enforcement agencies to protect or serve them appropriately due to a lack of training and cultural competence about disability. Law enforcement officers are vital public servants and heroes of our communities. As first responders, the community relies upon them to address myriad situations of varying complexity and ensure the public safety. In order to execute this charge appropriately in instances involving people with disabilities, it is essential to develop law enforcement's cultural competence about disability in the same manner as a local police department would seek to develop cultural competence about an immigrant population with particular customs and language within its precinct.

NCD recommends:

- All law enforcement, criminal justice, and correctional personnel, including prison guards and probation officers, as well as people working in victim assistance programs, should submit to mandatory training that sensitizes these public servants to recognize certain disabilities; creates awareness of the unique needs of certain groups of people with disabilities; and informs about specific requirements of the Americans with Disabilities Act (ADA) and other laws that

protect the civil and human rights of people with disabilities.⁴

- People with a variety of disabilities and community organizations representing them should be included in the development and facilitation of such trainings as well as in all policy and program development at the local, state, and federal levels.⁵
- People with disabilities, particularly those with psychiatric disabilities or ID/DD should also receive training to learn about their rights when in situations involving law enforcement, and Congress should increase funding for such peer-managed support and training programs.⁶

Greater Investment in a Spectrum of Mental Health Services

There are many barriers to accessing mental health services in the United States, chief of which are stigma about seeking and receiving mental health treatment, and underfunding. As a result, jails are some of the largest mental health providers in the country,⁷ putting law enforcement and correctional personnel in roles they are often ill-suited to play. Over the years, NCD has consistently advised Congress and the Administration to pursue efforts to improve the quality, availability, and affordability of mental health services and supports to reverse this trend and eliminate the “warehousing” of people with disabilities in prisons and other institutions.

Community mental health programs can offer excellent, comprehensive services when sufficiently funded and supported. Unfortunately, the severe deficiency in current resources means that these services are often available only to people who are in immediate crisis and who have already endured multiple hospitalizations. Recently, pilot programs have been developed across the country to better meet the needs of people when they have their first psychotic episode. These programs are community-based and help to address critical unmet needs.

NCD recommends:

- Congress should allocate funds toward a spectrum of community-based mental health strategies across the lifespan, including peer-to-peer supports,⁸ which are being added to clinical services⁹ across the country.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) should invest in and award “system of care” expansion grants to improve the availability, quality, and affordability of community mental health services, mobile crisis services, housing, and peer supports for people with serious psychiatric disabilities, and to extend mental health preventative and maintenance care access and options for the general population.¹⁰
- Policymakers should look for ways to include the views of people with disabilities, particularly those with psychiatric and ID/DD, and their advocates when crafting

new laws and regulations. Excluding their insights and viewpoints will likely perpetuate flaws or oversights in policies of the past.¹¹

Community Reentry of Inmates with Disabilities

In 2005, 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates were people with mental health problems.¹² Approximately 74 percent of state prisoners and 76 percent of jail inmates with psychiatric disabilities also had substance dependence or abuse.¹³ Inmates with psychiatric and developmental disabilities are often placed with the general inmate population. They are a vulnerable group, subject to bullying and manipulation. Adjustment to prison life can be difficult, and they can find themselves in dangerous and threatening situations. These prison experiences often exacerbate their disabilities.

Youth with disabilities constitute a large portion of youth in the juvenile justice system, with some studies indicating as high as 85 percent of children in juvenile detention facilities have disabilities that make them eligible for special education services, and yet only 37 percent receive services while in school.¹⁴ Failing to adequately address the needs of students with disabilities, particularly at-risk students, creates what has been termed "the school-to-prison pipeline."¹⁵

Access to disability-related supports and services upon release from prison can make the difference for a person with a disability hoping to successfully reenter society. Many federal and state policies require that Supplemental Security Income (SSI) and Medicaid be terminated while a person is in prison. Leaving prison with a major mental or physical disability without health insurance and no funds for medication can only worsen these conditions. Transition planning for inmates with disabilities is of paramount importance for successfully addressing obstacles to successful reentry into the community.

Many of the difficulties faced by inmates returning to the community were addressed in The Second Chance Act of 2008 (SCA),¹⁶ which was designed to improve outcomes for people returning to communities from prisons and jails. This pioneering legislation authorizes federal grants to government agencies and nonprofit organizations to provide employment assistance, substance abuse treatment, housing, family programming, mentoring, victims support, and other services that can help reduce recidivism. However, programs under the SCA are funded through discretionary grants and therefore are subject to termination if the SCA is not reauthorized or funded by Congress. Transitioning inmates with disabilities need a consistent and reliable safety net to safeguard their access to disability-related supports and services when returning to the community.

NCD recommends:

- The U.S. Department of Justice should require correction facilities to create a prerelease assessment and individualized reentry plan for all inmates with disabilities, including a needs assessment and assistance in arranging for health care and medications, reinstitution of SSI and Medicaid benefits, special education services for those returning to school, vocational services, and accessible housing.¹⁷

Conclusion

NCD is grateful to the Subcommittee for elevating this important topic through today's hearing and is grateful to the men and women in law enforcement who strive to ensure public safety. Law enforcement and the disability community can be partners in improving the appropriateness of law enforcement's response to Americans with disabilities. We believe that demonstrable progress will come as a result of improved cultural competence through law enforcement trainings; greater investment in a spectrum of mental health; and involvement of and relationships with the disability community by law enforcement.

NCD stands ready to be of additional service to the Subcommittee as needed on this or any other topic implicating the rights of people with disabilities.

Thank you again for the opportunity to provide this written testimony.

¹ Edwin Black, *War Against the Weak* (2003), 16.

² Erika Harrell, Ph.D., "Crime Against Persons with Disabilities, 2009 – 2012 – Statistical Tables" (2014), at: <http://www.bjs.gov/index.cfm?ty=pbdetail&iid=4884>.

³ *Id.*

⁴ National Council on Disability, *From Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves* (2000) <http://www.ncd.gov/publications/2000/Jan202000>.

⁵ *Id.*

⁶ *Id.*; National Council on Disability, *Inclusive Livable Communities for People with Psychiatric Disabilities*, 8 (March 17, 2008) <http://www.ncd.gov/publications/2008/03172008> ("People who have recovered from mental illnesses and have first-hand knowledge and involvement with consumer/survivor-run self-help programs need to be included in designing future anti-stigma efforts.")

⁷ Bridget O'Shea, "Psychiatric Patients with No Place to Go but Jail," *The New York Times*, February 18, 2012, http://www.nytimes.com/2012/02/19/health/in-chicago-mental-health-patients-have-no-place-to-go.html?pagewanted=all&_r=0.

⁸ National Council on Disability, *Inclusive Livable Communities for People with Psychiatric Disabilities* (2008), at: <http://www.ncd.gov/publications/2008/03172008>.

⁹ Michelle P. Salyers Ph.D., Sam Tsemberis Ph.D., "ACT and Recovery: Integrating Evidence-Based Practice and Recovery Orientation on Assertive Community Treatment Teams," *Community Mental Health Journal* 43 (2007). <http://link.springer.com/article/10.1007%2Fs10597-007-9088-5>

¹⁰ National Council on Disability, *National Disability Policy: A Progress Report* (2013), at: http://www.ncd.gov/progress_reports/10312013.

¹¹ National Council on Disability, *From Privileges to Rights*, 72.

¹² Doris J. James and Lauren E. Glaze, *Bureau of Justice Statistics Special Report: Mental Health Problems of Prison and Jail Inmates* (Washington, DC: U.S. Department of Justice, 2006).

¹³ *Id.*

¹⁴ "SPLC Launches School to Prison Reform Project to Help At-Risk Children Get Special Education Services, Avoid Incarceration" (2007), Southern Poverty Law Center, <http://www.splcenter.org/get-informed/news/splc-launches-school-to-prison-reform-project-to-help-at-risk-children-get-special>.

¹⁵ *Id.*

¹⁶ Second Chance Act of 2007: Community Safety Through Recidivism Prevention, Pub. L. No. 110-199, 122 Stat. 657 (2007).

¹⁷ National Council on Disability, *National Disability Policy: A Progress Report* (2011), at: http://www.ncd.gov/progress_reports/Oct312011.

**Law Enforcement Responses to Disabled Americans:
Promising Approaches for Protecting Public Safety
Hearing**

**Testimony Submitted to the Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights; United States Senate;
April 29, 2014 at 10 a.m.**

The National Disability Rights Network (NDRN) would like to thank Senator Durbin and the Senate Committee on the Judiciary for focusing its attention on efforts to improve interactions between law enforcement and individuals with disabilities.

NDRN is the national membership organization for the Protection and Advocacy (P&A) System, the nationwide network of congressionally mandated, legally based disability rights agencies. A P&A and CAP agency exists in every U.S. state and territory. P&A agencies have the authority to provide legal representation and other advocacy services, under all federal and state laws, to all people with disabilities. The P&A network is the largest provider of legally-based services for people with disabilities in the country.

The P&As advocate on behalf of individuals with disabilities to ensure the provision of needed accommodations and services within all of the systems they encounter. In addition, P&As maintain a presence in facilities, including prisons, jails, and detention centers, where they monitor, investigate and attempt to remedy adverse conditions impacting individuals with disabilities.

Based on this work, NDRN has developed a comprehensive understanding of the needs of individuals with disabilities when they encounter law enforcement. We agree that law enforcement officers have increasingly become the first responders for individuals with mental illness, developmental or other disabilities who are in crisis, a fact that needs to be recognized and for which these officers must be properly prepared. We agree further that localities that have trained staff to use compassionate and research based approaches in times of crisis see fewer injuries to individuals in crisis and fewer negative interactions.

Below are brief summaries of some of the work P&As have done to help improve law enforcement interactions with individuals with disabilities.

Trainings by P&As

South Carolina

The South Carolina P&A (Protection & Advocacy for People with Disabilities, Inc.) staff teach police officers at a five-day training program several times per year. The training is based on the Crisis Intervention Training (CIT) model.

In addition to training on suicide and mental health related topics, the P&A staff also discuss other types of disability issues that the officers may encounter: including mobility issues (e.g. practical problems around the use of wheelchairs and service dogs); the effects of specific illnesses such as epilepsy, Traumatic Brain Injury, and diabetes that can be misinterpreted by law enforcement officers; and communication with individuals who are deaf or hard of hearing.

Wisconsin

The Wisconsin P&A (Disability Rights Wisconsin) has provided voluntary Crisis Intervention Training (CIT) in Milwaukee for interested law enforcement personnel for about 5 years. This project was a result of the work of the Milwaukee Mental Health Task Force, of which it is a founding member.

P&A Case work

P&As have investigated deaths of individuals with disabilities during incidents with police, with case outcomes that have resulted in specific training for officers. One area of especial concern involves police interactions with individuals who are deaf or hard of hearing.

The **Texas** P&A, Disability Rights Texas, filed two suits that alleged that the City of Houston Police Department and Harris County failed to meet their obligations under the Americans With Disabilities Act (ADA) to have effective communication policies for deaf arrestees upon booking and in court proceedings. One client was jailed for public intoxication when he failed a sobriety test because of a neurological condition. On another occasion, the same client was the victim of a crime and the police did not bring an interpreter to interview him even though they knew he was deaf. Another client who was arrested went before a judge three times without being provided an interpreter and in jail he had no access to a TTY (a device which provides access to the telephone). Later, he was asked to sign probation documents without an interpreter. The settlement requires the City to instruct and train police officers to appropriately interact with witnesses, victims and suspects and to obtain a qualified sign language interpreter when necessary for effective communication, including providing interpreters for individuals who are arrested, are given a sobriety test, or are suspected of a felony. The city jail and municipal court will advise people detained in jail and appearing in court of their right to interpreters and will maintain a list of qualified interpreters who are generally available on an hour's notice.

Similarly in **Louisiana**, the Advocacy Center filed a complaint alleging that Defendants held the Plaintiff, who is deaf, in New Orleans Parish Jail for 22 days without providing him with an interpreter, without providing him with an interpreter for his court date, or giving him access to TTY. The settlement in that case requires the Sheriff to provide interpreters and TTYs for deaf inmates and to inform the relevant courts of deaf inmates' need for interpreters when they go to court.

The **Minnesota** P&A (the Minnesota Disability Law Center) represented an deaf individual who alleged that a police officer beat and arrested him during a routine traffic stop when the man asked to communicate in writing. The police failed to provide an America Sign Language (ASL) interpreter after he was arrested (for communications concerning the reason for his arrest) and when the investigator interviewed him. After he was taken to jail, the County failed to provide an interpreter at any point during the three days that he was incarcerated. As a result, he was not informed about how to get out of jail, or about jail rules and procedures. In addition, the County did not provide an ASL interpreter for communications with jail nurses concerning treatment for his injuries. The County also did not provide a method for him to communicate with people outside the jail. The lawsuit includes claims by his current spouse, who also is deaf, that she was not able to communicate with him while he was in jail and as a result, she did not know where he was for two days.

NDRN and the P&A network are eager to work with the Senate Judiciary Committee to explore strategies to prevent the types of problems described above.

Contact:

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The National Down Syndrome Congress (NDSC) is a not-for-profit organization founded in 1973. The NDSC is governed by a twenty-two member Board of Directors composed of parents and family members of individuals with Down syndrome, self-advocates and other individuals involved with people with Down syndrome.

The purpose of the NDSC is to promote the interests of people with Down syndrome and their families through advocacy, public awareness, and information dissemination on all aspects of Down syndrome. Our affiliates, who are in 38 states, generally are people with Down syndrome and their advocates and family members.

The death of Ethan Robert Saylor in January, 2013 was a wake-up call for many families of people with intellectual and developmental disabilities and has begun to be a catalyst for change in First Responders training. Ethan was not the first person with a disability to have met with this horrific fate. However, many more have suffered and will continue to suffer if First Responders remain unaware and ill-trained dealing with people with disabilities. Many more will suffer people with disabilities are not valued and respected.

First responder training that centers on persons with disabilities has started in many jurisdictions. The Crisis Intervention Teams (CIT) are a pre-booking jail diversion program designed to improve the outcomes of police interactions with people with mental illnesses.

The first CIT was established in Memphis in 1988 after the tragic shooting where police officers shot and killed a man who was mentally ill and threatened others with a knife. The police department worked with the Memphis Chapter of the National Alliance on Mental Illness, local mental health providers, and two universities to develop a specialized unit to train officers on a more intelligent and safe approach.

The Memphis model has been adopted in many jurisdictions across the country.

However, few resources exist that specifically address first responder training addressed to individuals with intellectual/developmental disabilities such as Down syndrome. One example

of where training of people with intellectual/developmental disabilities has been incorporated into this (CIT) model is in Plano, Texas. In Plano, police incorporated the model after an incident in 1995 in which police shot and killed 18-year-old Michael Clement, who was autistic. Sgt. A. D. Paul was one of the responding officers and later became the department's chief CIT instructor. Sgt. Paul later became the parent of a person with autism.

Another innovative program is the First Responder Disability Awareness Training (FR-DAT) out of Niagra University in New York developed with funding from a grant from the New York State Developmental Disabilities Council. This statewide project for law enforcement, firefighters, Emergency Medical Services (EMS) and 911 operators/dispatchers provides a training curriculum that offers all First Responders the knowledge necessary to best serve and respond to individuals with disabilities. The content of the training curriculum is specific to First Responder needs when interacting and responding to incidents, situations, and accidents that involve individuals with intellectual/developmental disabilities.

Congress could play an important role in furthering efforts to ensure that First Responders have the information and training to protect the rights and the lives on individuals with disabilities in by ***Expanding the authority and the funding for the Department of Justice to carry out criminal justice initiatives and activities that affect individuals with disabilities, including those unique to individuals with intellectual/developmental disabilities by, in part by:***

- Training of all personnel in the criminal justice system about issues unique to our constituents, including identification of a disability;
- Developing and disseminating models of best practices; and,
- Preventing discrimination by the criminal justice system against victims, witnesses, and those accused of crimes on the basis of disability;



Testimony Submitted for the Record
On behalf of the
National Down Syndrome Society

before the

United States Senate
Committee on the Judiciary

Subcommittee on
The Constitution, Civil Rights and Human Rights

"Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public
Safety"

APRIL 28, 2014

Since we formed in 1979, the National Down Syndrome Society (NDSS) has strived to be the national advocate for the value, acceptance and inclusion of people with Down syndrome. We envision a world in which all people with Down syndrome have the opportunity to enhance their quality of life, realize their life aspirations and become valued members of their communities. NDSS is the largest nonprofit in the United States representing people with Down syndrome and their families.

We are pleased to offer written testimony to better protect individuals with Down syndrome across the country as we strive for full inclusion in all aspects of life. We are also honored to offer testimony and work with the Saylor family as we honor the late Ethan Saylor and his memory and legacy. Ethan had a passion for law enforcement. Since he was a young boy, Ethan was fascinated with police officers, people in uniforms, and people with authority. On January 12th, 2013, our Ethan died in the hands of three, off-duty Frederick County (MD) Sheriff Deputies at his local Regal movie theater.

Ethan's death could have been prevented. It occurred when the Frederick County Sheriff Deputies sought to remove him from a movie theater for not purchasing a ticket to see the movie Zero Dark Thirty again. Before the Deputies approached Ethan, they were advised by Ethan's support staffer that Ethan had Down syndrome, was sensitive to being touched and that his mother was on her way to assist. The Deputies ignored the information provided by his support staff and proceeded to manhandle him out of his seat. When he resisted this rough treatment, they forced him into a prone position and handcuffed his hands behind his back with three sets of handcuffs and he died right there in the movie theater.

Right after Ethan's death, our organization, NDSS, and the Saylor's began meeting with the US Department of Justice (DOJ) to share their story and pursue a civil rights investigation. From our understanding, the investigation is underway and we expect a report back from DOJ in the immediate future. Ethan's little sister, Emma, authored a [change.org petition calling for Governor O'Malley to commence a state investigation into Ethan's death as well as ensure law enforcement, first responders and other public officials all receive the very best training when it comes to their interaction with people with disabilities in the state](#). Emma's petition, to date, has received over 370,000 signatures, which we delivered directly to Governor O'Malley last September.

As a result, in September 2013, Maryland Governor Martin O'Malley established the Maryland Commission for Effective Community Inclusion of Individuals with Intellectual and Developmental Disabilities "Commission." NDSS Vice President of Advocacy and Affiliate Relations Sara Weir was appointed to be a part of the Commission. In creating the Commission, Governor O'Malley recognized that individuals with intellectual and developmental disabilities are three percent of the world's population, making it the world's largest disability group. We are now living in a time of greater inclusion in society of persons with intellectual and developmental disabilities. Despite some successes, we know that much more must be done to ensure that people with intellectual and developmental disabilities are fully included in all aspects of our communities.

The Commission's Vision Statement guides its work and is as follows:

The goals of justice, equality, and dignity remain unfulfilled for people with intellectual and developmental disabilities. The mission of the Commission on Effective Inclusion of Individuals with Intellectual and Developmental Disabilities is to bring to life accurate, effective and comprehensive attitudes, policies and supports that will guide first responders in their work with and care for individuals with intellectual and developmental disabilities. We hope to build on the goals of the Americans with Disabilities Act and its accomplishments by creating a more compassionate, knowledgeable and understanding society that respects the life-saving work of our public servants along-side the valuable contributions of our citizens with intellectual and developmental disabilities. We seek to reduce stigma, increase safety, and inspire relationships of acceptance and support for all Marylanders.

The Commission was tasked with (1) recommending statewide policies, guidance, or best practices regarding law enforcement and first responders' responses to situations involving individuals with IDD; and (2) developing a coordinated, collaborative, and comprehensive strategy to ensure enhanced responses to such situations, including consideration of expanding Crisis Intervention Teams and Mobile Crisis Teams for the state of Maryland. NDSS strongly believes that the work and outcomes of the Commission will and should serve as a model for other states. NDSS is also a part of the Ethan's Law Workgroup with disability organizations across the state of Maryland. Ethan's Law Workgroup is spearheading an effort to put forth policy recommendations for the state of Maryland. We envision in the next two to three years, we will have an Ethan's Law in every state.

We are also proud to partner with The Arc's National Center on Criminal Justice and Disability (NCCJD), a national clearinghouse on criminal justice and disability issues founded by Bureau of Justice Assistance, U.S. Department of Justice with a two-year grant to develop a national center on criminal justice and disability, with a focus on intellectual and developmental disabilities (IDD) and to provide resources,

information and referral, training, technical assistance and evaluation for criminal justice and disability professionals and programs.

At the federal level, we feel strongly that federal funding is needed to support training of law enforcement when it comes to interacting with individuals with IDD; and we must set standards to ensure that quality and meaningful training is the standard across all law enforcement departments and public sector agencies. At the state level, we have an opportunity to mandate and deploy the Crisis Intervention Team (CIT) model to law enforcement departments across states. We know CIT has a proven record of success, but it has to be mandated and appropriately deployed across law enforcement departments and agencies to make a real difference. At the local level, we must work to ensure local Down syndrome and disability organizations establish productive, meaningful relationships with law enforcement and first responders.

For additional questions or information, please contact NDSS Vice President of Advocacy & Affiliate Relations Sara Hart Weir, MS at sweir@ndss.org or 202-680-8867.

**Mental Health Policies That Will Help Avoid Individuals with Mental Illness
Being Turned over to the Police:**

1. In order to get to the bottom of the above issue you must look at how mental health services are delivered in the U.S. Most people with mental health conditions go to primary care, they will not go to specialty mental health settings, and they receive little or no mental health treatment in the primary care setting.
2. It is therefore on the re-design of primary care that we must focus in order to get early, early, effective mental health treatment and interventions to the majority of patients with mental health conditions including those most in need of it.
3. Over 80% of patients with behavioral health conditions go only, or primarily, to the primary or specialty medical setting. Of these, 60%-70% receive no treatment for the behavioral (mental health/substance use) conditions. Less than 1 in 9 of those who DO receive treatment in the medical setting, are exposed to a behavioral health intervention that is effective and evidence-based, i.e. expected to remove symptoms and return a person to psychological health.
4. The result is that there is a total mismatch of patients, providers and settings in the behavioral health field. The vast majority of BH patients go to the medical sector for help, but only 10% of the BH doctors/ professionals practice there. Meanwhile, 10%-20% of BH patients are seen in the specialty BH setting where 90% of the BH professionals are. So we have effectively abandoned 80% of persons with BH conditions in this country, many with serious mental illnesses.
5. The original idea of creating a standalone BH sector was to maximize delivery of evidence-based care to patients most in need of BH interventions in a setting designed for BH care. Unfortunately, few of those patients who need BH services *are willing to access treatment in independent BH service locations*. Therefore, the core issue to improving mental health treatment in the U.S. is to get evidence-based BH care interventions into the medical sector (as well as improve medical interventions for the seriously mentally ill in the BH sector). This requires a coordinated medical-behavioral health integration care delivery approach, of which there are many proven, effective models, particularly the collaborative care model.
6. No other medical specialty field, besides behavioral health, delivers services in such a different, segregated way, cut off from the rest of medicine. First, the BH sector is funded through segregated funding streams, that in effect don't allow BH practitioners to work and get paid in the medical sector. Second, clinicians who treat patients in the BH sector are part of networks of providers entirely independent from all other medical providers. Third, the BH sector

maintains independent record-keeping even when colleagues from other medical specialties, working for the same hospital and clinic system, also see the patients for whom they care. Fourth, communication among medical and BH practitioners is difficult and, in some cases, impossible. Also, independent record-keeping prevents analysis of “total” health outcomes for patients with both medical and BH care needs. Fifth, the BH sector is designed only for the delivery of BH care; likewise, the medical sector is designed only for delivery of medical care. However, many many high-use, high-cost patients have co-occurring medical and BH needs.

7. Thirty years ago, the segregation of BH services delivery made sense; not today with so many individuals, the ones most in need of care, having co-existing medical and BH needs. If the BH conditions are untreated in the medical sector, as the vast majority are, then you have situation where medical conditions do not improve, medical symptoms persist, chronic illness complications develop, there is greater impairment, more disability days, doubling of total healthcare costs, as compared to medical patients without BH co-occurrence. The cost of “co-morbidity” or co-existing medical and BH conditions in the same patients, as become too costly in this county, for it to continue. Thus, the subject of mental illness and law enforcement must be seen in this larger healthcare system context, for meaningful solutions to be arrived at.
8. Preventing the mentally ill from being turned over to the police is a matter of those individuals getting access to evidence-based effective mental health treatment early on in their illness. It is better for those patients overall medical + BH health, and it will save society a great deal of money. Early mental health intervention must occur in the medical (i.e. primary care) setting because that is the only place the majority of people with those needs will go for care. That in turns requires ending the segregation of behavioral health services delivery which has been happening in this country over past 30 years. It not only is no longer effective to get mental health care where it is needed, it has the exacerbating effect of worsening the patient’s medical conditions, and doubling or in some cases quadrupling total health care costs, in addition to not treating the mental health problem.
9. The goal which the healthcare system now has to work towards is providing access to coordinated medical and behavioral health care, in inpatient and outpatient hospitals and clinics, in both the medical and behavioral sectors.

For more information visit:

NHMH – No Health without Mental Health
www.nhmf.org

Statement for the Record of

Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights

Hearing on Law Enforcement Responses to Disabled Americans: □

Promising Approaches for Protecting Public Safety

By Patricia Goodale

18 Horizon Drive

Saratoga Springs, NY

April 28, 2014

Severe mental illness (schizophrenia, bipolar disorder) is not a partisan issue; it is an illness which can strike any young person just as they are beginning their career. Their brains are affected to the point where they cannot function in society without treatment. But the irony is that they oftentimes do not recognize the fact they are sick (lack of insight) and so avoid treatment.

We have lived this nightmare for 12 years through our son who was diagnosed as Schizo-Affective when he was 29 years old. For a few years he stayed on his meds but then decided he didn't need them. He was picked up by the police several times and hospitalized but after 72 hours was released as required by law. He did not keep mental health appointments, he destroyed his apartment, he begged for cigarettes and money on the streets, he walked the streets under-clothed and in bare feet in the winter; he couldn't shop or cook for himself. We tried to help him but our hands were tied as his medical team refused to talk with us because of HIPPA.

Not only is this population, whose brains are severely affected, not being served, but their actions can have a disastrous effect both for themselves and also for those around them as we have witnessed too many times. We listen to the news and hear about killings by someone who was mentally ill and not getting treatment. And this does not include the suicides by those who give up hope. Fortunately our son qualified for Assisted Outpatient Treatment (AOT) through a court order. He is able to function and care for himself as long as he stays on his meds. We feel that AOT was a life saver for him although he still resents the fact that the courts tell him he must comply with treatment. Our experience has convinced us that nationally, AOT is the best, most cost effective way to help those dealing with severe mental illness allowing them to lead a much more normal life than if they end up homeless or in jail. Yes, we've heard the cry "but what about their civil liberties?" My response is "tell me about their civil liberties when they're dead or in jail". We strongly encourage federal funding for AOT in all states to help treat those with severe mental illness.

Another overreaction has been to close mental health hospitals. Yes, they may have been torture chambers in the past, but now with more effective medications and new treatments they are needed to provide a safe place for the most vulnerable in our society.

Preventing families from being part of the team because of HIPPA has been extremely difficult for us. We have been excluded from all treatment planning and yet we are the ones who pick up the pieces when things go wrong. We have also been aware of some gross incompetents in the system, but these have been "hidden" behind the HIPPA. It is usually the family who remains closest to the patient, and yet we have no input in the treatment.

It is absurd to be using federal funds to support groups who are actively lobbying to oppose AOT treatment for those who are severely mentally ill. Are equal funds being given to groups supporting AOT laws?

And finally it is the law enforcers who are the first responders to calls for help. They are aware of many of the mentally ill in a community. We talked to several police officers about our son on several occasions and they were most concerned and helpful. They expressed frustration in taking someone to the mental health hospital only to have him released immediately. These law enforcers should be consulted when the mentally ill population in a community is affected. After all, they will be the ultimate care givers after all else fails.

April 16, 2014

Senator Dick Durbin, Chairman
Senate Judiciary Subcommittee on the Constitution, Civil Rights and Human Rights

Senator Durbin:

Thank you for the opportunity to provide a statement on the issue of law enforcement responses to disabled Americans. I, like many Americans, have followed with interest and horror the events that led to the death of Ethan Saylor. A death that could have, and more importantly should have, been avoided.

My Grandson, Jaxon, was born with Down Syndrome and just celebrated his eleventh birthday. The thought that what happened to Ethan could someday happen to Jaxon scares me to death. Jaxon has brought unbelievable joy to our lives, and all that know him experience his love and wonderment at the world. But we also see the challenges that dealing with a person with Down Syndrome can present. Challenges that can, and must, be handled with the right combination of patience and knowledge; patience and knowledge that appear to have been lacking in the officers that confronted Ethan in that movie theater.

Having served 22 years in the Fire Service, 20 of those years as a Paramedic, I worked closely with law enforcement on many occasions. I believe that those experiences and observations, in addition to the experience and knowledge gained from my time interacting with Jaxon, allows me to have some insight on the events, insight that can be summarized in three issues.

Firstly, there is the issue of knowledge regarding the handling of a person with Down Syndrome. By all accounts, it appears that Ethan was non-compliant with the Officers' requests, and probably defiant. This is not unusual, and indicative of the fact that Ethan wanted to watch the movie again. Just like Jaxon, I'm sure that when Ethan wanted something he wanted it then and reasoning was not going to change his mind, and more importantly, orders, and/or force, were going to have absolutely no positive effect.

Patience should have been the one, and only, tactic employed by the officers. Waiting it out was the best way to get Ethan to convert from his non-compliant state to acquiescence. The amount of time necessary would have been up to Ethan's state of mind at the time, but that time interval could have been shortened with the assistance of his aide, who was there with

him, or with the arrival of family, who were on the way. In any event, patience and time would have allowed this situation to resolve and Ethan would be with us today.

Secondly, there is the issue of knowledge regarding the anatomy and physiology of a person with Down Syndrome. Even though Ethan presented as a young adult, his physiology would be different. Typically, Ethan's bones and musco-skeletal structure would be more brittle and subject to fractures. In addition, even young adults often have an enlarged heart and other heart/lung issues that you would not typically see in others of the same age group.

This knowledge is crucial because the subsequent efforts to subdue Ethan obviously did not take into account the probable anatomy and physiology anomalies that may have been present. The physical exertion and the suffocating effect of the weight of the officers on top of Ethan could very easily have caused a cardiac event that led to Ethan's death.

Thirdly, there is the issue of why the Officers were there. I believe this is crucial and goes back to the issue of patience. These Officers were off-duty and were working part-time for the owners. I believe this altered their perception in determining the correct course of action. Their presence as agents for the property owner, instead of the Police Department, led them to take action to remove Ethan at the request of the movie theater manager, instead of waiting it out.

I firmly believe that had the Officers been on-duty, and responded to a call for assistance, they would have handled the situation from a much more non-confrontational position. They may have even taken the position that the theater manager was making too much over an \$8.00 ticket. In fact, they may have even given the manager the money, out of their own pockets, to allow Ethan to watch the movie again.

We can't ever know for sure that things would have been handled differently, but my observations of law enforcement tell me that there is a strong possibility that the mindset of the Officers, as agents for the property owners, contributed to the final outcome.

In the final analysis, there is only one thing that is certain, and that, unfortunately, is that Ethan is dead. Even though I believe there was no malice or intent on the part of the officers, I don't believe there is any doubt that their actions killed him. They took the position that Ethan must be removed and then used force to remove him, and those decisions and actions led directly to Ethan's death.

Unfortunately, I will not be able to be in attendance to support Patti Saylor when she testifies before the subcommittee. But she has my fervent support none the less. I am hopeful that the

subcommittee members will strongly consider her testimony and keep Ethan in their minds as they deliberate possible efforts at the Federal level. Hopefully, these efforts will prevent another "Ethan" from suffering a similar fate.

Thank you, again, for your consideration.

Sincerely,

Ray D. Buckler

PREPARED STATEMENT OF RICHARD JACKSON

I am speaking only for myself, however it has been my experience that law enforcement are good and kind to people with all kinds of disabilities. I was blessed with the opportunity to take part in acting crime scenarios at a police academy, to assist training of police recruits. It sometimes hurts when the press sensationalizes the tragedies, though, and I hope and pray for a more humane approach by the press.

***This is a personal message and doesn't necessarily reflect the views and opinions of NOAA, the National Weather Service or the Federal Government.

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Sincerely,

I am the mother/conservator/advocator of a 26-year-old daughter who was born with AICARDI SYNDROME. This syndrome has left our daughter ***completely dependent*** for all her needs. She lives at home with her father and me. To say we live a difficult because of this doesn't even touch the surface, however what is the alternative, put her in a home where we have not control how she will be treated. She cannot speak so she cannot tell us if someone was hurting her. I am sick and tired of law makers who have NO IDEA what it is like to care for a disabled adult to decide what families need or don't need. The bottom line is the senate or rather all of congress wants to make certain there is enough money for THEM and their families. Congress want s to make certain enough money is put aside for their retirement, healthcare and whatever else is given to them. In the meantime the middleclass is shrinking because we are paying for everyone else.

Give us the services we deserve to have, help out the middle class, and take a pay cut, live without for a change of pace, see out the rest of the united states is living, but leave the developmentally disabled and mentally disabled ALONE. This group of the population have no means to fight back and they should be protected not persecuted against. Shame on you for trying to take away from this group again.

Sandra M. Kanczuzewski

To: U.S. Senator Dick Durbin

From: Robert & Sharon Conrad - Guardians

RE: Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety

We would like to share our story regarding our 26 year old son who has an Intellectual Disability, is Bipolar, has ADHD, and Anxiety Disorder. Our son was awarded funding in Illinois from the Ligus Lawsuit. He was in the first group of people who was chosen from this lawsuit. We started looking for places for our son to live. We made a short stop in a house in Thornton. We knew this was going to be a stopping place until we could find a better place. Our son was then accepted in a new house in Shorewood through Cornerstone Services in Joliet. He was welcomed into a brand new house at the end of January. The next two weeks were heaven for our son and us. Then another group of guys moved in and this time a resident moved in who had worse behavior problems than our son. The two did not get along and tensions were always high in the house.

About a month ago we received a phone call at 1 a.m. from our son. He called from the back of an ambulance. Seems that he and the other client got into a yelling match, my son hit the staff member in the wrist and the other client came up and punched our son in the eye. He was taken to the hospital, had a C/T scan, and X-rays done. He had to have "glue" placed on the cut, which was deep. He should have had stitches but he would not allow it. We just got a copy of the police report from that incident, and even with my son being the one who called because he was hit and bleeding, he was written up at the "offender". The client that punched him and sent him to the hospital was listed as a "witness". On that call the police said they did not arrest our son on a battery charge "due to the mental capacity and required care of ***, we did not arrest him for battery".

One week later we get the call that all parents hate to hear, you son is sitting in the back of a squad car and is being transferred to the Will County Adult Detention Center. It seems that our son and another resident came out of their room and got into an argument with the resident that had punched our son. My son called him a racial name more than once. The

staff felt they had everything under control, but another resident got upset with the yelling and called 911. No one in the house knew that call had been made. When our son heard the police, he freaked out! He told the staff member "not to open the door for the police", and when she did he threatened her. Our son's usual MO is to threaten people so they will back off. In this case the police were let in. They tried to get our son to sit down at the table, which he wouldn't. He tried to get the officers to follow him down the hall to his friend's room. No one has a clue why he wanted them to come with him, but knowing our son it was to talk to them and also to give himself a little time to settle down. That didn't happen. When our son wouldn't stop walking an officer grabbed our son by his hoodie and pulled him toward him. When our son is angry or upset you CANNOT touch him. He hasn't hit anyone but he does bring up his fist. This time however he did bring up his fist and punched the officer in the jaw. When he did that, the officer "threw him to the floor and when he continued to resist arrest the officer threatened to tazer him", this information was from one of the staff members that was on duty. She said she tried to get our son to stop and listen, but by then he was probably in fight or flight mode. They finally got him handcuffed and pulled him up from the ground, in which they searched him for "drugs and any potential harmful articles". They then took him to Shorewood P.D. where the officer pressed charges for aggravated battery, "booked" him, read him his Miranda rights, where my son said he understood everything, and they had him sign them. They knew they were at a house where the residents had intellectual disabilities. This same officer was at the scene the week before and was outside with our son, the same scene where they said they didn't arrest him for battery because of his mental capacity. Did this officer think in a weeks time he suddenly had a rise in his IQ? So they took him to the detention center, where I called around 2 or 3 in the morning and talked to the Sargent on duty, this after our son kept trying to call us. I told the Sargent our son was MR and probably didn't know what was going on. I asked him if he could explain the phone system to him so he would stop calling and getting himself more and more anxious because he couldn't reach us. I also told the Sargent that he would need his medication, because the bond court wasn't until 1:30 the next day. He said "we will find out from him where his pharmacy is". I said "I'm sorry, I told you he was MR and he won't know that. He lives in a group home and they take care of all of that". The Sargent said he would look in to it. When we were finally able to bail him out and pick him up it was

almost 6 p.m. Our son was with out his morning medication, and his afternoon dose of anxiety medication. When I asked about it they said "he didn't know what pharmacy". I said exactly, I told your Sargent in the middle of the night!!! We went to court and they had nothing except that he hit a police officer. IHe was let out on a \$10,000 bond reduced from \$30,000 to our custody. The person who was behind us ended up being a Public Defender. She asked us to stay until she was done with her cases. A member from Cornerstone Services was with us during the court hearing. The three of us stayed behind and she told us who she was and said "I cannot believe we are here for this"! She explained what would happen next, and she personally asked for a certain Public Defender to be assigned to his case. After we left the courthouse we had to wait for our son to be released so we went back to Cornerstone to discuss moving our son out of the house he was living in to another home that is quieter and calmer to help keep our son calm, and to keep him and the one resident away from each other so nothing else would happen. The next day we took him to his psych. She raised his mood stabilizing medication. While we were there our son kept complaining about the pain in his ribs. He had been complaining to us earlier but we weren't sure about what had happened to him to have sore ribs. His psych check his rib area and said he was tender but that wasn't her area of expertise and told me to get him in to our family doctor. I was able to get him in to the nurse practitioner at the office. She said he was tender between his ribs, and also sent him for X-rays of his ribs. No ribs were broke, but the tenderness kept up. She had a medical term for what it was, and one of the descriptions for getting this is being thrown down. We did not know at this time what the staff member had said about him being thrown to the ground.

I realize a big push is on for the first responders to learn to deal with Autism, but the population that is being put in our communities because of the Ligus Lawsuit is a mixed population. Training should include strategies to work with all disabilities. I strongly feel that judges and lawyers should have a background in working with this population. Maybe they should be included having training in this area.

We, as a family strongly urge this committee to pass a law regarding First Responders, dispatchers, etc. to be trained in this area, for the safety of our loved ones, and for their own safety. The Ligus lawsuit is a wonderful thing

to get our loved ones in communities, but along with that comes a responsibility of the State to make sure our loved ones are cared for in a professional and caring way.

Thank you for taking on this subject. It is a VERY important one. If you would like to contact me at anytime, please feel free to do so. I'm sorry I couldn't make it in person, but I already had to take days off work to deal with all these happenings.

My contact information is:

Sharon K. Conrad

[REDACTED]
[REDACTED]
[REDACTED]

STATEMENT FOR THE RECORD

Donny Youngblood, Sheriff-Coroner, Kern County CA

**“Law Enforcement Responses to Disabled Americans: Promising Approaches
for Protecting Public Safety”**

Hearing Before the

Subcommittee on the Constitution, Civil Rights, and Human Rights

Committee on the Judiciary

United States Senate

April 29, 2014

My name is Donny Youngblood and I am the Sheriff of the Kern County Sheriff's Office in Kern County, California and current President of the Major County Sheriffs' Association. In recognition of the shared concern among California State Sheriffs related to better meeting the needs of the mentally ill within our communities, I offer the following written testimony to the Senate Judiciary Subcommittee of the Constitution, Civil Rights and Human Rights. This testimony serves to highlight the collaborative efforts in Kern County to educate and equip local law enforcement officers to handle mental health crisis situations as well as address the ongoing needs of the mentally ill within our communities.

As a large law enforcement agency serving a diverse county population of approximately 864,000 people, the Kern County Sheriff's Office is keenly aware of its critical role in responding to mental health crisis situations. As reflected by national trends, Kern County Law Enforcement officers are routinely the first to respond to calls involving mental health crisis situations. Reductions in mental health funding or services, returning veterans with PTSD, and the prevalence of those with co-occurring disorders have all contributed to the need for more training for law enforcement officers. The job of police work has evolved into a multi-faceted profession whose officers are required to have many specialized skills. Adding to the repertoire of training required of today's law enforcement officer to include active shooter, terrorism, cybercrimes and drug trafficking to name a few, the Kern County Sheriff's Office and other local stakeholders have recognized the critical need for increased mental health training for its officers. Law enforcement officers have become the default social workers in our communities. They are trained first responders who are better equipped to secure the scene and start the intervention process for people in a mental health crisis. Although there are excellent mental health crisis programs in Kern County, mental health staff are few and far between, and not

always available to respond as quickly as law enforcement. It seems logical that law enforcement should be trained to understand mental illness.

Due in part to a collaborative partnership with the Kern County Mental Health Department, the Kern County Sheriff's Office has been successful in creating a California Commission on Peace Officer Standards and Training (POST) certified, 40-hour Crisis Intervention Training (CIT) for Kern County law enforcement officers. First launched in April 2011, Kern's CIT course is based on a nationally recognized model, the Memphis Model, which is a mental illness training program designed for law enforcement first responders and dispatchers. The goal is to increase officer safety, de-escalate crisis situations involving mentally ill persons, reduce the need for the use of force and in many cases divert mentally ill persons from jail to the appropriate mental health resources. To date, 111 participants have completed Kern's CIT course with attendees including Kern County deputies and dispatchers as well as officers from several allied agencies. Because these intensive 40-hour CIT courses require the participation and coordination of several collaborative partners who serve as instructors for the various learning domains, the Kern County Sheriff's Office has been limited to hosting approximately 2 CIT courses per year. Notably, the Kern County Sheriff's Office and Kern County Mental Health have managed to build our CIT program with virtually no funding other than the costs associated with staff salaries.

The success thus far of Kern County's CIT program is a testament to the exceptional partnerships which have been developed locally among stakeholders who are equally dedicated to ensuring that local law enforcement officers have the knowledge, skills and resources to appropriately handle those crisis situations involving the mentally ill. Representatives from the Kern County Sheriff's Office, Kern County Mental Health, Aging and Adult Services, Veterans

Affairs and the National Alliance on Mental Illness (NAMI) are among those who have participated in the development and facilitation of Kern's CIT program. Understanding that no level of training can prepare an officer to peacefully resolve every scenario, the Kern County Sheriff's Office and its partners have remained committed to equip our law enforcement officers with the necessary tools to safely and effectively handle calls involving mentally ill persons, with an eye towards minimizing the risk of injury to officers and those encountered. Kern's CIT program has been well received by its participants and many have reported that they have successfully utilized skills learned to handle mental health crisis related calls.

One of the many challenges for the Kern County Sheriff's Office in serving a geographically diverse and vast county spanning over 8,131 square miles lies in the ability to respond to and serve the needs of the mentally ill within the community. When patrol staffing is limited, particularly in the rural areas of the county, and mental health resources are sparse or unavailable, deputies are often the sole responders to mental health crisis situations. These crisis calls can sometimes be unpredictable, rapidly evolving and challenging to handle. Many times, such calls involve non-criminal situations that may require the deputy to place a mental health hold (W&I 5150) on the individual when they pose a danger to themselves or others. Depending on the location of such calls, the deputy may be required to drive several miles outside of his or her patrol response area in order to transport an individual to the nearest county mental health facility. This often equates to deputies being tied up for extended periods of time and unavailable to respond to other priority calls. In the rural areas of the county, this can be especially problematic as patrol resources are often times extremely limited.

In 1998, Kern County Mental Health started a Mental Health Mobile Evaluation Team (MET), who's primary goal is to re-direct those persons in crisis away from unnecessary

hospitalizations and/or incarceration to appropriate crisis mental health services. This unique team is dispatched with law enforcement officers to those calls involving potential mental health crisis situations. MET personnel assist with the assessment of the mentally ill person and the facilitation of the appropriate disposition. The added benefit of this process for deputies is that they have the opportunity to observe the professional interaction of MET personnel with mentally ill persons in the field, and learn skills they can apply to similar types of mental health crisis related calls. The value of MET's co-response with deputies cannot be understated as this practice has further educated patrol deputies about the mentally ill and how to more effectively assess and interact with them during crisis related contacts. Ultimately, this partnership with MET has furthered the goal of diverting when appropriate, mentally ill persons away from the prospect of incarceration to the appropriate mental health services. Additionally, in those cases when a mental health hold is the appropriate disposition for the mentally ill person, MET personnel will in many cases handle the transport and transfer of the subject to the appropriate mental health facility. This is a significant time saver which frees deputies to handle other priority calls. The MET team also provides annual briefings for all Kern County Law Enforcement agencies as a way to provide ongoing education and updates related to MET operations and/or any pertinent changes within the mental health system which may impact law enforcement. Despite the limited staffing of MET team members who respond county wide, MET's assistance continues to be in great demand due to the steady frequency of mental health crisis related calls. For this reason, the availability of CIT trained deputies remains a critical component in our response to the mentally ill within the community.

Today, 15 law enforcement agencies in Kern County continue to receive ongoing support and training from County Mental Health staff. The Access to Care team for Kern County Mental

Health has recently begun to provide Suicide Prevention Training for every law enforcement agency in Kern County. The expectation for this training is to improve safety and minimize injury for people in crisis, as well as for officers and deputies who come into contact with persons who are suicidal. The training provides the deputies and officers basic knowledge, understanding and field strategies for reducing crisis and suicidal behavior. It is hoped that the skills acquired in this training will assist deputies and officers in diffusing and ultimately preventing loss of life to suicidal subjects, officers or others on scene.

The Kern County Sheriff's Office and its community partners have made considerable efforts to identify strategies which address the needs of the mentally ill inmates who are incarcerated in Kern County jail facilities. Currently, 51 percent of Kern's total inmate population is receiving mental health services. Specifically, our task has been to implement inmate programs which will better ensure the successful transition of mentally ill inmates from custody back into the community. Paramount to the success of such programs is the linkage to continued mental health services upon release. The goal is to ultimately prevent future mental health crisis situations involving these inmates and ideally, further contact with law enforcement.

In 2012, the Kern County Sheriff's Office partnered with Kern County Mental Health to provide a drug treatment/cognitive therapy program for incarcerated inmates called the Matrix program. This innovative program is the result of a collaborative partnership between the Kern County Sheriff's Office and Kern County Mental Health, to provide a comprehensive drug treatment program for those incarcerated inmates with a history of substance abuse. Facilitated by Mental Health staff, the onsite program provides an evidence based curriculum, Matrix Intensive Outpatient Substance Abuse treatment, for identified participants. Matrix teaches inmates how to

identify their “triggers” for using drugs and provides practical tools the inmate can use for avoiding and/or dealing with “triggers” without resorting to the use of illegal substances as a coping mechanism. Inmates also learn the importance of scheduling their time and are challenged to practice that skill daily. After 60 days of participation in this in custody program, the inmates receive a certificate of completion. Participants are then released on the Electronic Monitoring Program (EMP), and are scheduled for an appointment to enroll in outpatient treatment within a week of release. The final component of this program involves continued substance abuse treatment and random drug testing for an additional 4-6 months. To date, over 450 inmates have completed the Matrix program.

In 2013, the Kern County Sheriff’s Office received \$182,253 in grant funding from the Board of State and Community Corrections (BSCC) for Residential Substance Abuse Treatment (RSAT), to facilitate the expansion of Kern’s Matrix Program. The RSAT Matrix Program is an Intensive, 12 week Outpatient Substance Abuse Treatment program which requires participants to meet 5 days a week for 4 hours per day. The program requires the participant to be drug tested prior to program placement, 3 times during the program and also 30 days after release. The male participants of the program are housed together in a dedicated housing unit and receive weekly case management services to better prepare for re-entry into the community after release. These individuals are then released on EMP for continued monitoring. The first group of RSAT graduates in December 2013 reflected a 100% completion rate with all 41 inmates initially enrolled also completing the program. The initial success rate of this program is encouraging and it is hoped that that this will further translate into a reduction in drug related re-offenses among program graduates. To date, 126 inmates have participated in the RSAT program.

In March of 2014, the Sheriff's Office again partnered with Kern County Mental Health to provide additional evidenced based classes for Kern's inmates. Seeking Safety is an Evidenced Based, Cognitive Behavioral Therapy group for individuals designed to facilitate their insight/learning into the relationship between trauma and substance abuse. Research indicates that many individuals who have had traumatic experiences, or who have been diagnosed with Post Traumatic Stress Disorder (PTSD), have co-occurring substance related issues. Seeking Safety is designed to implement positive/productive coping skills as part of the individual's planning and stress management that will replace/avoid the negative, learned substance use. The ten week processing group, led by a Kern County Mental Health Therapist and co-facilitator, begins and ends every session with a "check-in" to assess current state of feelings, assess for use of positive coping skills (from list of 80 plus skills reviewed each session), and unsafe choices over the last week, as well as identifying a self-commitment to improve. Each weekly group focuses on a specific issue (Anger, PTSD, Honesty, Coping with Triggers, etc.) and members are encouraged to participate by commenting/sharing their thoughts, feelings and experiences on the topic. In addition to the weekly group, the Therapist or co-facilitator follows up with each individual weekly, to further process/explore the group material in an individual session. Currently two 10 week classes are underway, targeting the high risk to recidivate population. Thus far, this class has been well received by the inmate population. By the end of May 2014, the Seeking Safety class will be taught to a dedicated Veterans population.

In August 2012, the Kern County Sheriff's Office received a \$100 million dollar grant funding award via Assembly Bill 900 Local Jail Construction Phase II Financing Program, for the construction of a new 800 bed jail facility in Kern County. A major component of the new jail includes state of the art medical and mental health treatment facilities as well as program treatment

space designed to address the needs of the medically and mentally ill inmate population. The new jail will include a dedicated mental health unit which will be supported by around the clock mental health staffing. Upon its anticipated completion in late 2017, this new facility will provide for a safer and much improved environment for the management and treatment of the mentally ill inmate population.

The Kern County Sheriff's Office and its community mental health partners have made significant strides towards the goal of addressing the needs of the mentally ill population within the community. As a result of the law enforcement training opportunities developed through the cooperative working relationships between the Kern County Sheriff's Office and Kern County Mental Health, the two agencies have developed improved strategies and a solid support model that addresses the needs of the mentally ill within the community in a safer, faster and more efficient manner. With local programs such as CIT and MET, the Kern County Sheriff's Office and its partners are working towards minimizing the problem of repeat calls for the same mentally ill subjects and also equipping officers with the skills to independently respond to and refer people in crisis to the appropriate mental health services. As an unexpected by-product, law enforcement officers are becoming more educated and aware of their own mental health well-being. Additionally, the Kern County Sheriff's Office continues to make significant progress in addressing the mental health needs of its incarcerated population through the implementation of innovative inmate programs as well as the planned construction of a new jail facility. The Kern County Sheriff's Office and its mental health partners remain cognizant of the needs of the mentally ill population and are committed to providing the necessary training and resources for our local law enforcement officers to ensure these needs are met in a safe and effective manner.

STATEMENT FOR THE RECORD BY

SHERIFF RICH STANEK, HENNEPIN COUNTY, MN

Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety

Subcommittee on the Constitution, Civil Rights and Human Rights

Date: Tuesday, April 29, 2014, 10:00 AM

Presiding: Senator Durbin

Chairman Durbin, Ranking Member Cruz, and Members of the Subcommittee--I am submitting these comments in my capacity as Sheriff of Hennepin County, MN, located in the Minneapolis area. I am also the immediate past-president of the Major County Sheriffs' Association and I serve on the Executive Committee of the National Sheriffs' Association.

Hennepin County is among the largest counties in the U.S., with a population of approximately 1.3 million. The Hennepin County Sheriff's Office is a full-service law enforcement agency with approximately 850 employees. We operate the largest jail facility in Minnesota, the Hennepin County Public Safety Facility, where we book nearly 38,000 people every year. It is in this capacity, being responsible for the care and wellbeing of these 38,000 inmates while they are in our custody, that we encounter a great number of people with mental illness.

Of these 38,000 people booked in our jail each year, we estimate 25-30% of them are suffering with a mental illness. Our Jail staff must operate as front-line mental health workers and it is a challenge for them. We hear the same thing from my Sheriff counterparts nationwide. Jails have become our nation's largest mental health facilities.

Although the Hennepin County Sheriff's Office jail staff has won a national award for our treatment of inmates with mental illness, a jail is not the place for the mentally ill. Those suffering from mental illness need medical treatment rather than languishing in our jail for weeks and even months waiting for proper care.

In Hennepin County, our office has worked closely with members of the bench, mental health advocates and others to find solutions within the criminal justice system to move those with mental illness more efficiently through the system and reduce the time spent in our jail. Through this coalition, we have made changes to state law to improve the judicial process for a person who has mental illness.

We passed law in Minnesota mandating a 48 hour placement for court ordered mental health treatment. Prior to passing this law, we were having inmates waiting in our jail for up to 21 days after a court had ordered them committed for mental health treatment until a bed opened up in the state run mental health facility. All the while, the person's mental health is decompensating. Our legislature just sent another law to the Governor allowing for a more efficient process when an inmate is undergoing both an incompetency and civil commitment hearing.

Both of these changes in law impact the process after a person with mental illness has been arrested and brought to our jail. As a society, we need to look at solutions to deal with certain mentally ill offenders without bringing them to jail.

Currently, when law enforcement is called to a scene to deal with a person in crisis, they have three options: 1) Don't arrest them and allow them to continue the behavior that prompted the police call; 2) arrest and book them in jail; or 3) bring them to a hospital for a mental health hold. Although this last option sounds appealing, unfortunately, because of limited mental health treatment beds in local hospitals, many times the person is back on the street within a few short hours after talking to a doctor and failing to exhibit life threatening behavior. Local police officers have learned that if they want to keep this person off the street, they take them to jail because there is no other way for the person to receive care.

It is time to provide other options for how we help those suffering with mental illness. We have been working with Judge Jay Quam, 4th Judicial District of Minnesota, and others from the bench, the mental health advocates, and public health officials to determine the feasibility of establishing a mental health hub. Such a hub would allow for certain lower level offenders to receive the mental health treatment and support they need rather than being booked into a jail facility where their condition continues to worsen and they spend months cycling in and out of the jail, without ever getting help for their mental illness.

We welcome the conversation on this issue as we all recognize something more needs to be done for the treatment of the mentally ill in our society. The jails cannot be the holding place for the mentally ill.



Southern Tier Independence Center

Access your world.

April 17, 2014

Chairman Durbin and Members
Senate Judiciary Subcommittee on the Constitution,
Civil Rights and Human Rights
711 Hart Senate Office Building
Washington, D.C. 20510 -1304

Dear Chairman Durbin and Distinguished Members of the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights:

I am writing to thank you for holding a hearing on April 29, 2014, to address "Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety." I would like to offer a few comments.

I am the parent of a young adult with multiple disabilities. I also serve as the Advocacy Director for Southern Tier Independence Center located in Binghamton, NY. In addition I am honored to sit on two committees that work on emergency preparedness:

- the New York State Independent Living Council's Emergency Preparedness Committee and
- the Subcommittee for Health, Human and Animal Needs (a committee serving under the auspices of the Broome County Local Emergency Planning Committee).

I was pleased to hear about your hearing when contacted by Dave Whelan of the Disability Awareness - Training Program based at Niagara University in Western NY. We are very fortunate to have a comprehensive, statewide law enforcement and firefighter/EMS training program that reaches out to first responders with current and accurate information. Dave often partners with

Independent Living Centers to build networks of local support and information for law enforcement and firefighters/EMS workers. His efforts are greatly appreciated.

People, both those with and those without disabilities, have a wide range of experiences and needs, as you know. In crisis situations, we may all react with confusion, fear, pain, anxiety, or misunderstanding. I am sure your committee will hear about tragedies as well as innovative solutions to prevent those tragedies.

Everyone has a story and so do communities. Every individual, every town, village, city, county or region can experience emergencies. Foresight, vision, preparations and communication are absolutely essential. The kinds of emergencies that can occur can be vast and varied. In our community there has been a recognition that people with disabilities need to be at the emergency planning and training tables and for that, we are very thankful.

Our area of the country has experienced major floods (2006 and 2011), a tornado, and in April, 2009, a shooting at the American Civic Association that resulted in thirteen deaths. Ray Serowik, the EMS Coordinator for Broome County, told me, "Emergency Preparedness people dealt with nine different nationalities and cultures over the weeks and months that followed the shooting at the immigration support center. Relationships form when we work together during a crisis. You come to rely on those relationships when tested by fire."

During the flood of 2011 more than 24,000 people were evacuated and over 5500 were sheltered in Broome County, primarily at sites based at Binghamton University and the Johnson City School District. Our neighbors to the West in Tioga County (ground zero for the 2011 flood) opened their DSS site as public health and mental health staff manned their shelter for several days. Last year when I spoke with him, Tioga County DSS Commissioner Shawn Yetter said, "We didn't plan it, it happened. It was an intense problem solving experience and we have gotten better at planning out of necessity. In our county we have a group in leadership who do not have egos, we get along with each other and we work together; we get people to the table, set up tasks, and do what is needed. We work on communication and organization. Not every potential emergency is a flood disaster. We need to work together and we need to help each other." Over the last few

years we have witnessed emergency information being shared with audio, closed captioning, alternative formats, use of American Sign Language, and easy to understand information. This helps people with a wide range of different disabilities. These people are our neighbors, too.

As much as I acknowledge and appreciate the vision and framework of cooperation and communication in emergency planning, it is not happening in some other areas of county and state planning. Hence we are seeing serious problems that can lead to crises.

A few years ago in a county about an hour away, a young man with autism was arrested one night. He was non-verbal, scared, and bereft as he was pulled away from his mother's home. A neighbor had called emergency personnel when she heard noises coming from their apartment. The young man had a piece of a thin aluminum plate from a TV dinner in his hand. An emergency responder thought it was a knife. It took a group of parents who knew the family several hours to raise bail money to get this young man out of jail that night. A local law enforcement officer who knew the family did not prevent the arrest and detainment, despite the fact that he, too, had a family member with a disability. A local lawyer who was a parent of a disabled child also refused to intercede that night when contacted for help. Bad things can happen in a moment when law officers or emergency personnel do not recognize or respond with sensitivity to those who cannot process information or verbally communicate their fear and anxiety. We know more now about trauma induced behavior and sensory integration pain, but are we training people to recognize it and respond appropriately? How to defuse difficult and emotional situations can be taught.

Our area, like many others in the country, has lost state and local dollars for many of the community based service needs that would help people with disabilities to succeed. As services for people with dual diagnosis (both developmental and mental health needs) have been extremely difficult to find, we have seen more people with those dual needs end up in our local jail. Crisis Intervention Teams are a positive step, but lack of sufficient short term psychiatric crisis beds and lack of in home supports has created a serious need across the Southern Tier. Not meeting those needs has resulted in broken spirits, broken families, and broken services.

Advocates are hopeful that when NYS implements the Community First Choice Option, additional Medicaid dollars will be available to provide the

incidental supports that some people are not currently able to access. As a staff person at an Independent Living Center, I can tell you we have fought for thirty years for community services rather than institutionalization. NY is closing its developmental and psychiatric centers. Without adequate individual planning and sufficient supports, we have seen people enter the community and be hurt.

We have also witnessed a very negative stereotypical backlash against people with disabilities who have left institutional forensic units and prisons. One state legislator called for a new law that would rescind the habeas corpus rights of people with disabilities who are not convicted of crimes. In addition, NY currently houses more than 4000 prisoners in solitary confinement. Many of these people re-enter their communities with serious mental health issues brought on by the use of torture.

I hope and work for the same level of cooperation and communication to deal with the delivery of community based services that our area has been able to develop to handle floods. If we can shelter people from the storm, we can shelter people from other bad things that happen when we don't develop and maintain community based services. Of course some communities are having trouble planning supports to help people with disabilities in any kind of storm, personal or weather related.

Thank you, members of the committee, for shining a light on this most important issue and for giving people with disabilities a chance to come to the table. I hope your public hearing is able to highlight models that are working.

Sincerely,

Susan Ruff

Susan Ruff
Advocacy Director
Southern Tier Independence Center

STATE OF MARYLAND
OFFICE OF THE GOVERNOR



MARTIN O'MALLEY
GOVERNOR

April 28, 2014

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TTY USERS CALL VIA MD RELAY

The Honorable Dick Durbin
Chairman
Senate Judiciary Subcommittee on the Constitution, Civil
Rights, and Human Rights
SH-815
Washington, DC 20510

The Honorable R. Edward Cruz
Ranking Member
Senate Judiciary Subcommittee on the Constitution, Civil
Rights, and Human Rights
SH-229
Washington, DC 20510

Dear Chairman Durbin and Ranking Member Cruz:

I am pleased to submit the attached statement for the record from the Maryland Commission for Effective Community Inclusion of Individuals with Intellectual and Developmental Disabilities on the important and timely topic of *Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety*.

In September 2013, I established via Executive Order the *Commission for Effective Community Inclusion of Individuals with Intellectual and Developmental Disabilities*, in part as a response to the circumstances surrounding the death of Maryland resident Ethan Saylor. Through that tragedy, we recognized that many individuals in positions of authority, including law enforcement officials and other first responders, receive limited training about responding to situations involving individuals with intellectual and developmental disabilities. Ethan's mother, Patti Saylor, from whom the Subcommittee will receive testimony, is an inspiration to many parents and families across Maryland who have a family member with an intellectual or developmental disability.

The Commission is tasked with, among other things, making recommendations on improving training for law enforcement and first responders on how to address situations involving people with intellectual and developmental disabilities. In addition, it will also develop an overall strategy for inclusion across public sectors.

Dr. Timothy P. Shriver, Chairman and CEO of Special Olympics, chairs the Commission, and its membership includes state and local officials, disability advocates, and a self-advocate. Our state has been well-served by the Commission's dedication and resolve to develop thoughtful recommendations and policies designed to create a society where all Marylanders are fully included, whether by law enforcement and other first responders, schools, hospitals or additional public sectors.

I would like to offer that the Commission is available to work with you and your colleagues in Congress. A collaborative federal-state approach will ensure that best practices in one state are adopted and replicated in other states across the nation. We look forward to working with you in the months ahead to ensure the dignity of every individual is protected.

Sincerely,

Governor

cc: The Maryland Congressional Delegation

Testimony Submitted for the Record

**On behalf of the
Maryland Commission for Effective Community Inclusion of Individuals
With Intellectual and Developmental Disabilities**

before the

**United States Senate
Committee on the Judiciary**

**Subcommittee on
The Constitution, Civil Rights and Human Rights**

**“Law Enforcement Responses to Disabled Americans: Promising Approaches for
Protecting Public Safety”**

APRIL 29, 2014

Introduction

The Maryland Commission for Effective Community Inclusion of Individuals with Intellectual and Developmental Disabilities appreciates the opportunity to provide its views on law enforcement responses to individuals with intellectual and developmental disabilities.

In September 2013, Governor Martin O'Malley established the Maryland Commission for Effective Community Inclusion of Individuals with Intellectual and Developmental Disabilities "Commission." In creating the Commission, Governor O'Malley recognized that individuals with intellectual and developmental disabilities are three percent of the world's population, making it the world's largest disability group. We are now living in a time of greater inclusion in society of persons with intellectual and developmental disabilities. Despite some successes, we know that much more must be done to ensure that people with intellectual and developmental disabilities are fully included in all aspects of our communities.

The Commission's Vision Statement guides its work and is as follows:

The goals of justice, equality, and dignity remain unfulfilled for people with intellectual and developmental disabilities. The mission of the Commission for Effective Community Inclusion of Individuals with Intellectual and Developmental Disabilities is to bring to life accurate, effective and comprehensive attitudes, policies and supports that will guide first responders in their work with and care for individuals with intellectual and developmental disabilities. We hope to build on the goals of the Americans with Disabilities Act and its accomplishments by creating a more compassionate, knowledgeable and understanding society that respects the life-saving work of our public servants along-side the valuable contributions of our citizens with intellectual and developmental disabilities. We seek to reduce stigma, increase safety, and inspire relationships of acceptance and support for all Marylanders.

A National Review

The Commission looked at materials and approaches offered by various states, disability organizations and universities for training first responders, with a focus on training for law enforcement in the area of intellectual and developmental disabilities (there are also a variety of programs that emphasize one disability, such as Autism Spectrum Disorders, or center on mental illness, and those programs were not the focus of the Commission's review). States such as California, Delaware, New Jersey, Indiana, Louisiana, and New Mexico, have legislation requiring some or all first responders to receive training on how to interact with individuals with intellectual and developmental disabilities. Other states offer training without a legislative mandate, but it is not clear that every officer is receiving adequate training. Several universities and private organizations have also developed training curricula that are provided to police

departments and other first responders around the country, generally in the absence of a statewide mandate or a comprehensive statewide training program.

The Commission's Recommendations for Law Enforcement

The Commission has taken on the broad mandate of *community* inclusion and is looking at several public sector areas in which to develop recommendations for advancing full inclusion of individuals with intellectual and developmental disabilities. Its initial focus, however, is law enforcement and first responders. In addition to researching programs nationwide, the Commission: reviewed existing training programs in Maryland (including materials to meet a recent Maryland mandate to conduct in-service training on Autism Spectrum Disorder awareness for law enforcement); held a Listening Tour to solicit the public's input; and spoke to experts in the field.

Through its due diligence, the Commission concluded that attaining full inclusion will require that individuals feel safe, understood, and included throughout society. The Commission is in the process of developing training objectives and curriculum recommendations for law enforcement and first responders. The focus on safety includes not only teaching about de-escalation, "hidden" disabilities, and behavioral indicators, but also about the need for specialized responses that may require an officer to modify previously learned training material in order to ensure a safe outcome. To teach about understanding, the training objectives look at communication, both verbal and non-verbal, understanding the differences between mental illness and intellectual and developmental disabilities, as well as the role of family and staff support. The lesson of inclusion requires cross-cultural interactions (between law enforcement and people with intellectual and developmental disabilities) in settings outside a typical law enforcement interaction. Examples include school-based activities, ride-alongs, youth-led social activities and recreation.

The Commission believes strongly that establishing relationships between public sector officials and people with intellectual and developmental disabilities is a critical aspect to any training program. For law enforcement in Maryland, this relationship-building will begin in the classroom with trainers who are people with intellectual and developmental disabilities working along-side law enforcement trainers. The training will also include scenario-based learning and role playing, which are believed to be more effective training devices and will also include people with intellectual and developmental disabilities.

The Commission also heard from many Maryland citizens about the need to educate individuals with intellectual and developmental disabilities about what to expect from first responders. While this is often successfully done by parents or other family members, it needs to be more systemic so that all individuals with intellectual and developmental disabilities are receiving the same opportunities for such training. In addition, the Commission believes that we need to better educate the community about how first responders will be handling situations that involve people with intellectual and developmental disabilities in order to help increase understanding and acceptance.

The Need for Data

The significant number of people with intellectual and developmental disabilities alone tells us that there is a need to ensure that all of our law enforcement and first responders have adequate training in how best to address a myriad of situations that they will encounter with such individuals. As the Commission traveled throughout the State of Maryland on its Listening Tour, it heard several stories from family members, people with intellectual and developmental disabilities and disability organizations about the need for more training. Members of law enforcement also tell us there is a need. While the need has been clearly expressed, finding statistics to support that need has proven difficult. Data on the number of incidents between law enforcement and individuals with intellectual and developmental disabilities, as well as number of individuals with intellectual and developmental disabilities in the criminal justice system overall are elusive for the State.

Research into other parts of the country does not yield much better results. Data on people with intellectual and developmental disabilities in US prisons are widely divergent from state to state. Although we often hear that between 4 and 10%¹ of the prison population are people with intellectual and developmental disabilities, given the disparity in definitions from state to state, those numbers may not be accurate.

With regard to the number of encounters between the police and people with intellectual and developmental disabilities, there also is no uniformity. For example, in Maryland, there is no State Police clearance code for incidents involving targets with intellectual and developmental disabilities, as distinct from those with mental illness. While statistics suggest a high prevalence of mental illness among people with intellectual and developmental disabilities², it is not accurate to attribute all behavioral challenges seen by law enforcement in this community to a mental illness. Mental illness and intellectual and developmental disabilities are not the same and may require very different approaches; yet there is little data in regard to the number of contacts law enforcement officers have with people with intellectual and developmental disabilities.

The Federal Bureau of Investigations' Uniform Crime Reporting (UCR) requires data collection in the following areas:

- a. Violent crime
- b. Murder
- c. Rape
- d. Robbery
- e. Aggravated assault
- f. Property crime
- g. Burglary
- h. Larceny-theft
- i. Motor vehicle theft
- j. Arson

The FBI also utilizes the National Incident-Based Reporting System (NIBRS). A review of the NIBRS definitions further indicates that characteristics of offenders, victims, and witnesses are not collected in the data.

Based on the data we know to be collected at the Federal level and based on our research in Maryland and other states, the Commission believes that there is a need to develop baseline data in this area so that we can accurately determine the resources needed to address the problem, meaningfully measure training outcomes and adequately determine future training needs. This is an area where the federal government could be helpful and begin by including people with intellectual and developmental disabilities as a separate category in its various data collection methods. Having data will provide a much needed foundation for this discussion and ensure that scarce resources are used effectively today and in the future.

Community Inclusion

While law enforcement responds to people with intellectual and developmental disabilities are important, that is only one part of the larger community picture that needs to be addressed. More than a half century of laws, court decisions and public programs have led to greater numbers of persons with intellectual and developmental disabilities living independently in their communities, making their own choices, contributing to their own support and participating in active social lives. Yet stigma persists, and overcoming it is everyone's responsibility in the 21st century. Better educating our communities and first responders remains one of our unfinished tasks.

The Commission believes that now is the time to establish training priorities in many areas to best serve individuals with intellectual and developmental disabilities and ensure the same level of safety, understanding, and inclusiveness no matter what career or lifestyle they choose.

We are grateful that this Subcommittee has begun this important dialogue and hope it will continue and broaden so that the promises of community integration and inclusion are real and meaningful for all members of our society.

If you would like to reach any of the Commission members listed below or would like additional information, please contact: Alisa Macht, Executive Officer for the Commission for Effective Community Inclusion of Individuals with Intellectual and Developmental Disabilities at: amacht@goccp.state.gov.us

Commission Membership

Timothy P. Shriver
Chair
Special Olympics International

Colonel Marcus L. Brown, Superintendent
Maryland State Police

Officer Scott A Davis
Montgomery County Police Department

Lt Dwayne Embert
Queen Anne's County Sheriff's Office

Hon. Anne Colt Leites
State's Attorney for Anne Arundel County

Sam Abed, Secretary
Department of Juvenile Services
Represented by Joseph (Jay) Cleary

Gregg Hershberger, Secretary
Department of Public Safety and Correctional Services
Represented by Dr. James Holwager

Cathy Raggio, Secretary
Maryland Department of Disabilities

George Failla (as of 4/28/2014)
Maryland Department of Disabilities

Joshua M. Sharfstein, Secretary
Department of Health and Mental Hygiene
Represented by Dr. Lisa Hovermale

Maryland Institute for Emergency Medical Services
Represented by Rae Oliveria

Tammy Brown, Executive Director
Governor's Office of Crime Control and Prevention
Represented by James Hedrick

Charles Rapp
Police and Correctional Training Commissions

Brian T. Cox
Maryland Developmental Disabilities Council

Thomas Curtis
Maryland Department of Disabilities

Andrew J. Imparato
Association of University Centers on Disabilities

Joanna L. Pierson
The Arc of Frederick County Maryland

Theresa R. Sparks
Maryland Disability Law Center

Sara Hart Weir
National Down Syndrome Society

Erica Wheeler
Emeritus Assisted Living

The Hon. Michael E. Busch, Speaker
Maryland House of Delegates
Represented by Delegate Pete Hammen

The Hon. Thomas V. Mike Miller, Jr., President
Maryland Senate
Appointee

¹ Petersilia, J. (August 2000). Doing justice? Criminal offenders with developmental disabilities. CPRC Brief, 12 (4), California Policy Research Center, University of California.

² Hovermale, Lisa (2010). The Evaluation of People with Intellectual and Developmental Disabilities in the Acute Setting from Emergency Psychiatry, Edited by Arjun Chanmugam, Patrick Triplett, and Gabor Kelen.

Steven & Lourdes Fraser

April 23, 2014

The Honorable Dick Durbin
711 Hart Senate Bldg.
Washington, DC 20510

Dear Senator Durbin:

My name is Steven Fraser. My wife Lourdes and I reside at 9210 Oriole Pl, Gaithersburg, Maryland.

We are writing in regards to the upcoming hearing, "Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety."

First I would like to applaud you and your colleagues for holding such a hearing. My wife and I understand first hand the importance of addressing the need for first responders to be properly trained in handling calls involving those who suffer from a mental illness.

A very close personal friend of ours, Mary Wilsey and her family suffered a terrible tragedy on January 5, 2014. We strongly believe, that proper training for law enforcement officials responding to a call for help would have prevented the horrific events resulting in the death of her son Keith Vidal.

Unfortunately, the tragedy did not end with Mary and her family as the Police Officer who shot Keith was indicted by a North Carolina grand jury on charges of voluntary manslaughter.

As a result of Keith's death, a bill has been drafted and sent to North Carolina Rep. Frank Iler. The bill is called "Keith's Law". In short, Keith's Law calls for mandatory Crisis Intervention Team (CIT) training for all Law Enforcement officers in the State of North Carolina. We believe that CIT training should be a cornerstone of Law Enforcement training in North Carolina and nationwide.

We know from our involvement with the National Alliance of Mental Illness (NAMI) that the city of Memphis, Tennessee initiated a CIT program in 1988 and has been an example across the country for collaboration among Law Enforcement, Mental Health Services, and Medical Professionals on how to deal with this national crisis.

As a closing point, Mary Wilsey will be attending the hearing on Tuesday, April 29, 2014 and we respectfully urge you to consider listening to her testimony on this extremely important matter.

As a former Law Enforcement officer as well as “family” to the Wilsey-Vidal family, I can empathize with those who serve and those who are served.

Thank you again for your time and efforts to find a solution.

Sincerely,

Steven & Lourdes Fraser

I was told you were putting together a bill addressing Mental Illness. I wanted to share my experience and ideas on what I have seen firsthand that can help.

I am the mother of a 25 year old who was diagnosed with schizophrenia after a severe psychotic episode in late 2011. He was arrested for trespassing. He thought he was a holy man. He was not violent. The only thing that got him into the hospital was that the man that found him had him strip down to his underwear. You see, the next day when we went to ER, he said very robotically, I don't need to go when at the admission station. I had been concerned he was sexually abused and that was what got him in to be evaluated. He was out of his mind and admitted. The first time he was discharged he was looking for a high place to jump from but when I brought him to ER they were not going to admit him because he didn't have a "plan" for suicide. I was stubborn and he was admitted. The next time he was released he attempted suicide by cutting his wrists because he thought some random stranger on Craigslist was going to kill him. He was readmitted, pulled out his stitches and as he was being taken to get stitches fixed he tried to grab the security guard's gun. His total time inpatient was 3 months. This is how long it took to stabilize him on medication. He is better now, still not able to work, but better.

What I see as very important to improve helping the severely mentally ill are:

1. Assisted Outpatient Treatment funding. Although my son has thus far been compliant, I have learned of too many stories of parents whose mentally ill child is living with them watching their son/daughter deteriorate before their eyes, just waiting until they are sick enough to get them to the hospital. Sometimes that is in a catatonic state. When in the hospital, many times a hearing is held and medication is ordered. I know with my son how long it took him to climb out of the hole after his breakdown. To think he would ever have to get that sick again for help scares me. Each time it happens to these poor sick people it is harder to "come back". It seems so cruel to not help them earlier. It saves hospitalizations and keeps the mentally ill out of jail. Jails have become the asylums of yesterday in my view.
2. Please increase the number of psychiatric beds. My son was released too early because of lack of beds. He would not have the scars today if there was a place for him to stabilize. It is tragic that that congressman's son was sent home because of lack of beds and ended up dead.
3. We need police to have better training to deal with the mentally ill. They have such a difficult job and from where I sit I do not see any improvement in the number of homeless mentally ill. They need the tools to handle what I see as a situation that is only getting worse. We also need those on the front line involved in policy making.
4. Loosening up on HIPPA. My goodness, I cannot get any information to help my son. He writes very dark, scary stuff. Should I be concerned? Who knows? I have no one to ask because even though he signed all the paperwork, no one will talk to me. Should I bring up how upsetting his stuff is to him? Who knows? Who can help me do the right thing? Many parents struggle with the question of "what is the best thing I can do for my child?" Answer to me is, let me talk to his doctor.

It has been painful to experience my son's mental illness. What has added to the sadness is the lack of support for families. It is as if severe mental illness has been swept under the rug. My heart aches when I think about those with mental illness that have been incarcerated. That could have been my son if he didn't have me. He stole food, he trespassed. It seems the severely mentally ill are ignored, they need our help, they need our legislatures to enact laws that protect them and others from the few who do become violent when psychotic.

Susan Gallagher

Statement for the Record of
Sylvia Thompson, BA, CMC
Daughter of someone with serious mental illness
President, NAMI Westside Los Angeles
Care Manager/Client Advocate
to
Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights
April 28, 2014

My name is Sylvia Thompson and I am a professional client advocate and Care Manager as well as the President of the National Alliance on Mental Illness, Westside Los Angeles affiliate. But that is not why I am submitting a Statement for the Record.

I am my mother's daughter. I never knew anything other than a life surrounded by serious mental illness. My mother was severely mentally ill from as far back as I can remember. Growing up in our family was like living in a combat zone where my mother's serious mental illness terrorized every one of us. It never felt safe because you didn't know when the other boot was going to drop. The drastic mood changes, intense paranoia, grandiose ideas, impulsivity, delusions, depression, and inappropriate anger created a frightening environment for a child who depended on her. This led to emotional and physical neglect, as well as emotional, verbal, and, at times, physical abuse. And yet, I loved my mother. I watched as my father, and later my siblings and I, were powerless to help her.

My mother had zero insight into her illness. She did not believe she was ill. We call that anosognosia¹. It affects up to 40% of those with schizophrenia and bipolar disorder. Because she didn't believe she was ill, she would not stay in treatment and as a result could not take care of herself, let alone me. She had suicidal ideation, delusions I was possessed, multiple hospitalizations, and would disappear for spells of time...sometimes hours, sometimes weeks and we were powerless to do anything but watch her deteriorate.

I went to college and got a degree in Psychology, became a patient advocate for the most vulnerable population, and now President of NAMI Westside LA. I know what would have helped my mother and what would help the countless faces of serious mental illness I see day after day. Much of that is in HR 3717. It is the first bill to address the needs of the most seriously ill as opposed to the many bills that focus on helping the much higher functioning.

I believe in self-determination for those who are capable but **we must recognize** that there is a small group of people, like my mother, who are too ill to self-direct their own care. To take the extreme case, John Hinckley was self-directing his own care when he decided the best way to get a date with Jodi Foster was to shoot President Reagan. We can't pretend these people don't exist because by doing so, we marginalize them. They are our loved ones. These tragic stories in the news....they are not the face of mental illness. They are the face of **severe mental illness that is untreated**. Our helpline gets calls everyday from parents, children, siblings, and spouses of individuals who are so ill they can't acknowledge it and so refuse treatment. They cower in

their rooms believing the FBI planted a transmitter in their head. They refuse to eat for fear of being poisoned. They believe their young daughter is the child of the devil and will kill them in a great battle. The mental health system won't help them because they are not well enough to volunteer for treatment. The police can't help until after they become dangerous. Laws should prevent dangerous behavior not require it. How I wish everyone was well enough to take care of themselves and use voluntary services but some are not.

It can't be a recovery model OR a medical model. We must embrace both because **one size does not fit all!** Sometimes the Recovery Model works but sometimes AOT or involuntary hospitalization is initially necessary to GET someone on the Recovery path.

We need Assisted Outpatient Treatment. (AOT)

What would have helped my mother and would help some of those who call our helpline would be to have Assisted Outpatient Treatment as provided for in HR 3717. While some opponents cite old research on this (Appendix: Myths about Laura's Law) I have reviewed the recent research for New York and California (Appendix: Laura's Law Results in two counties) and the results are exceedingly clear: AOT reduces homelessness, incarceration, suicide, arrest, and yes, violence. It is for very few of the most seriously ill, only those with a past history of multiple incidents of arrest, violence or hospitalization caused by refusing to stay in treatment. By providing an off-ramp before involuntary commitment and incarceration it saves money and, more importantly, it saves lives.

We need enough hospital beds for the most seriously ill who need hospitalization.

We are in dire need of more hospital beds, something HR 3717 addresses. Our helpline is inundated with calls from parents wondering what they have to do to help get a loved one who needs hospital care into a hospital. California has only 5 state hospitals with less than 7,000 beds². 90% of those who get into California psychiatric hospitals do so through the criminal justice system not the mental health system³. That is criminalizing an illness. Admission, without becoming a danger to self or others, is virtually impossible. In California, individuals with serious mental illness are four times more likely to be incarcerated as hospitalized.⁴ Four times! Can you imagine that for Cancer or Alzheimer's Disease? Even if California had a perfect community based mental health system, we are still short over 10,000 hospital beds to help the seriously ill get stabilized well enough for release. Again, we can't pretend that hospitals are not needed by anyone. Some with a serious mental illness **do need** hospitalization to get stabilized.

We have to free family caretakers from HIPAA Handcuffs so they can provide care to loved ones.

HIPAA and FERPA prevent parents from getting information they need to provide care to seriously mentally ill loved ones. The information is readily available to programs that are paid to provide case management services or paid to provide housing for the mentally ill, but is withheld from parents who do it out of love. Again, to take an extreme case, while authorities identified both James Holmes and Jared Loughner as needing help, as a result of HIPAA and FERPA their parents were kept in the dark. How can a parent, or in my case a daughter, ensure

their loved one has transportation to an appointment if they don't know when the appointment is; or ensure they stay on medications if they are not told what the medicines are? We are given the responsibility to provide care for mentally ill loved ones, but not the information needed to do so and watch helplessly as our loved one spirals into madness while our hands are tied. HR 3717 writes limited exclusions into HIPAA law so family/caregivers get the same information paid caretakers would receive.

We have to have community services that will let the most seriously ill into them

We have to ensure that community services are in place to help the most seriously ill. Right now, the ability to get into a program is inversely related to severity of illness. The least seriously ill go to the front of the line while the most seriously ill are sent to jails, prisons, the streets, and morgues. HR 3717 creates a secretary of mental health who can help insure that when community services are introduced, they focus on the most seriously ill. SAMHSA provides guidance to states on how to use Mental Health Block Grants. That direction includes limiting care to those who can 'self-direct' their own care, leaving the most seriously ill unserved. It requires states to focus on 'prevention' when there is no way to prevent the most serious illnesses like schizophrenia and severe depression at this time. SAMHSA direction replaces the medical model with a recovery model that is based on aspirational vision rather than science...that excludes an entire population of people who need our help the most.

We have to stop funding non-evidence based programs and groups that impede care for the most seriously ill.

We have to ensure that programs are evidence based to improve a meaningful outcome in people with serious mental illness. Too many programs are measured by the claims of those who run them rather than independent investigators. Dr. Sally Satel testified that only four of the 288 programs in SAMHSA's National Registry of Evidence Based Practices focus on serious mental illness⁵. That's only 4 out of 288! Further, SAMHSA seems to focus on soft measures for people much higher functioning like 'hope' and 'empowerment'. Those are very important, but we should also be measuring drops in suicide, homelessness, incarceration and other harder outcomes. We also note that SAMHSA is funding groups in California that are working to prevent implementation of policies that help the most seriously ill. The SAMHSA funded groups oppose reforms of HIPAA, oppose implementation of Laura's Law, oppose preservation of adequate hospital beds. It is very hard for us to improve care for the most seriously ill in California when SAMHSA is providing funds to groups that oppose our efforts.

I urge you to pass HR 3717. I am not a politician nor am I a legislator. I am someone who has spent her life in the trenches, personally and now professionally. It is wonderful to want to improve the mental health of everyone but in the process, we cannot ignore the most severely ill. They are the **most vulnerable** and they need your help.

My mother struggled with delusional ideas, grandiose thinking, paranoia, anxiety, and depression. Before we gained guardianship, she was living in a state of squalor, surrounded by stacks of newspapers, rotten food, human feces, dead rodents...that was how she self-directed her care. **No one chooses that life.** She continued to alienate herself from us even though we

tried to do what was best for her. But you should also know she spoke 7 languages fluently, knew every opera libretto, and was a gifted pianist.....she was passionate, creative, and loving....she was someone's daughter, someone's sister, someone's wife...and mother to 6 amazing children who were desperate for her to be well.

My mother's inability to acknowledge her illness **was not a choice**. It was a symptom that robbed us of those amazing qualities...that robbed me of my mother. I am proud to be my mother's daughter. I inherited her passion, her creativity, her musicality, and her outside the box thinking.

As her daughter who loved her, it was never easy as we were abandoned by an inadequate mental health system. My mother was failed by this system, my family was failed by this system, I was failed by this system.

Thank you.

¹ Anosognosia is lack of awareness that an individual is ill. Anosognosia is the single largest reason why individuals with schizophrenia and bipolar disorder do not take their medications. It is caused by damage to specific parts of the brain, especially the right hemisphere. It affects approximately 50 percent of individuals with schizophrenia and 40 percent of individuals with bipolar disorder. The person believes that their delusions are real (e.g. the woman across the street really is being paid by the CIA to spy on him/her) and that their hallucinations are real (e.g. the voices really are instructions being sent by the President). Source: Dr. E. Fuller Torrey, Author, *Surviving Schizophrenia*. Studies on anosognosia at <http://mentalillnesspolicy.org/medical/anosognosia-studies.html>

² The Shortage of Public Hospital Beds for the Mentally Ill, Report of the Treatment Advocacy Center, Arlington, VA 2005. Available at <http://mentalillnesspolicy.org/imd/shortage-hosp-beds.pdf>

³ Governor Jerry Brown State Budget 2014. "The composition of the patients served by DSH has changed greatly over time, with over 90 percent currently coming from the criminal justice system. In addition, the class action lawsuit (Coleman v. Brown) involving mental health care in state prisons has increased referrals from the Department of Corrections and Rehabilitation to DSH for inpatient treatment. The inmates referred to DSH tend to have a more violent history." Available at <http://www.calnewsroom.com/wp-content/uploads/2014/01/FullBudgetSummary.pdf>

⁴ More Mentally Ill are in Jails and Prisons than Hospitals: A survey of the states. Treatment Advocacy Center. May 2010. Available at <http://mentalillnesspolicy.org/NGRI/jails-vs-hospitals.html>

⁵ Testimony to House Energy and Commerce Subcommittee on Oversight and Investigations. Available at <http://mentalillnesspolicy.org/samhsa/satel.5.22.13.samhsa.testimony.pdf>

**Reduction in harmful events when Laura's Law
implemented in Nevada County**

Key Indicator	Pre-AOT	Post-AOT	Improvement
Hospitalization	1404 days	748 days	46.7%
Incarceration	1824 days	637 days	65.1%
Homelessness	4224 days	1898 days	61.9%
Emergency Contacts	220 contacts	123 contacts	44.1%

**Reduction in costs when Laura's Law
implemented in Nevada County**

Key Indicator	Pre-AOT	Post-AOT	Improvement
Hospitalization	\$346,950	\$133,650	\$213,300
Incarceration	\$78,150	\$2,550	75,600

Summary: Nevada County gave individuals under court order access to services and found Laura's Law implementation saved \$1.81-\$2.52 for every dollar spent

**Reduction in harmful events when Laura's Law
implemented in Los Angeles County**

Key Indicator	Percentage Decrease
Incarceration	Reduced 78%
Hospitalization	Reduced 86%
Hospitalization after AOT ended	Reduced 77%
Milestones of Recovery Scores	Increased

**Reduction in costs when Laura's Law
implemented in Los Angeles County**

Laura's Law cut taxpayer costs 40 percent in Los Angeles.

Source for Nevada County Data: Michael Heggarty, Behavioral Health Director, Nevada County. "The Nevada County Experience," Nov. 15, 2011.

Source for Los Angeles County Data: County of Los Angeles. "Outpatient Treatment Program Outcomes Report" April 1, 2010 – December 31, 2010. Cost data from: Michael D. Antonovich, Los Angeles County Fifth District Supervisor, Los Angeles Daily News, December 12, 2011.

*Prepared by Mental Illness Policy Org.
3/2012 <http://lauras-law.org>*

MYTHS ABOUT LAURA'S LAW (AB1421)
Prepared by Mental Illness Policy Org
<http://mentalillnesspolicy.org>

MYTH: If there were more voluntary services, Laura's Law would not be needed.

REALITY: Voluntary programs and AOT currently serve two mutually exclusive populations. Voluntary programs serve those who 'voluntarily' accept services. Laura's Law by definition is for those won't accept voluntary services. Laura's Law does not preclude anyone from accepting voluntary services.

MYTH: Existing community programs serve the same people who would be served by Laura's Law

REALITY: Laura's Law is the *only* community program that serves people who refuse treatment.

MYTH: Laura's Law does not confer any benefits beyond those of LPS (\$150)

REALITY: LPS only allows for inpatient commitment. Laura's Law allows for court ordered outpatient treatment, a less restrictive, less expensive, more humane alternative.

MYTH: Court orders do not provide any benefit

REALITY: The 2009 study of NY's version of Laura's Law found "The increased services available under AOT clearly improve recipient outcomes, however, the AOT court order, itself, and its monitoring do appear to offer additional benefits in improving outcomes."

- ✓ The likelihood of a hospital admission over six months was "highly statistically significant" and lower among AOT recipients than among voluntary recipients.
- ✓ AOT patients were less likely to be arrested than their voluntary counterparts
- ✓ Persons receiving AOT for 12 months or more had a substantially higher level of personal engagement in treatment than those receiving services voluntarily.

MYTH: Laura's Law doesn't work.

REALITY: Nevada County's experience with Laura's Law found it works. Per Judge Anderson it saves people from severe mental health deterioration, increases voluntary participation in mental health care, increases stability, decreases crisis. Studies of the NYS version of Laura's Law show it

- ✓ Helps the mentally ill by reducing homelessness (74%); suicide attempts (55%); and substance abuse (48%)
- ✓ Keeps the public safer by reducing physical harm to others (47%) and property destruction (43%)
- ✓ Saves money by reducing hospitalization (77%); arrests (83%); and incarceration (87%).

MYTH: AOT will lead to a roundup of mentally ill individuals who will be forced into treatment.

REALITY: Laura's Law's narrowly-focused eligibility criteria, stringent multi-layer administrative requirements, independent judicial review and strong due process protections protect against misuse. Nevada County and Orange County estimate less than .003% of the population would be allowed into the program. This is consistent with NYS findings.

MYTH: AOT is unconstitutional and infringes on civil liberties.

REALITY: AOT has survived constitutional challenges in multiple states. A 2009 NYS study found:

"[I]t is now well settled that Kendra's Law is in all respects a constitutional exercise of the states police power, and its parens patriae power. Further, the removal provisions of the law have withstood constitutional scrutiny.

AOT also cuts the need for incarceration, restraints, and involuntary inpatient commitment, allowing individuals to retain more liberties.

MYTH: Laura's Law will frighten consumers away from seeking voluntary services

REALITY: A study in *Psychiatric News* of involuntarily treated discharged psychiatric patients found that 60 percent retrospectively favored having been treated against their will. A 2005 NYS study of consumers in their version of Laura's Law found:

- ✓ 75% reported that AOT helped them gain control over their lives;
- ✓ 81% said that AOT helped them to get and stay well;
- ✓ 90% said AOT made them more likely to keep appointments and take medication.

The 2009 independent study found:

"On the whole, AOT recipients and non-AOT recipients report remarkably similar attitudes and treatment experiences. That is, despite being under a court order to participate in treatment, current AOT recipients feel neither more positive nor more negative about their mental health treatment experiences than comparable individuals who are not under AOT."

MYTH: Assisted Outpatient Treatment is not racially neutral.

REALITY: A 2009 NYS study researched this issue and found:

"[N]o evidence that the AOT Program is disproportionately selecting African Americans for court orders, nor is there evidence of a disproportionate effect on other minority populations. Our interviews with key stakeholders across the state corroborate these findings."

MYTH: Assisted Treatment forces people to take medications.

REALITY: There is no provision for forced medication in Laura's Law.

MYTH: There is wide opposition to Laura's Law

REALITY: Laura's Law has wide support from constituencies as diverse as the National Alliance on Mental Illness, National Sheriff's Association, California Psychiatric Association, National Crime Prevention Council and consumers in AOT.

MYTH: Mental Health Commissioners support Laura's Law

REALITY: Many (not all) mental health commissioners oppose Laura's Law because they fear losing the ability to cherry-pick the easiest to treat for admission to their programs. Currently mental health policy is to send the most severely ill individuals to shelters and jails and use the 'savings' to fund services to a larger number of people ("mission-creep")

MYTH: Prop 53/Mental Health Services Act money can not be used to fund Laura's Law

REALITY: Both Los Angeles and Nevada County use MHSA money (plus Medicare, Medicaid, private insurance, and patient fees) to fund Laura's Law.

MYTH: Voluntary programs have to be cut to fund Laura's Law

REALITY: Per California Department of Mental Health, voluntary programs that provide services (ex., medication, case management, housing, CSS, etc.) may also serve individuals under court orders. There is no need to close these programs, merely open them up to people under court orders.

Myth: Laura's Law is expensive.

REALITY: Nevada County found they saved \$1.81 for every \$1.00 invested. The Mental Health Director found it decreases hospitalizations, length of hospitalizations, and use of 911, arrest, trial, incarceration and parole; and can be funded with existing sources.



Hearing Before the
Senate Judiciary Committee
Subcommittee on the Constitution, Civil Rights and Human Rights

Law Enforcement Responses to Disabled Americans:
Promising Approaches for Protecting Public Safety
April 29, 2014

Statement for the Record by Leigh Ann Davis, Program Manager
National Center on Criminal Justice and Disability,
The Arc of the United States

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**Senate Judiciary Committee, Subcommittee on the Constitution, Civil Rights and Human Rights
Hearing: Law Enforcement Responses to Disabled Americans: Promising Approaches for
Protecting Public Safety, April 29, 2014**

**STATEMENT FOR THE RECORD BY LEIGH ANN DAVIS ON BEHALF OF THE NATIONAL
CENTER ON CRIMINAL JUSTICE AND DISABILITY, THE ARC OF THE UNITED STATES**

Chairman Durbin, Ranking Member Cruz, and Members of the Subcommittee, thank you for the opportunity to provide testimony for this hearing concerning law enforcement responses to Americans with disabilities.

The Arc of the United States is the largest national community-based organization advocating for and serving people with intellectual and developmental disabilities (“I/DD”) and their families. The Arc has long recognized and responded to the need for law enforcement training on people with disabilities. In the 1970’s, one of The Arc’s local chapters in Florida developed a training key in collaboration with the International Association of Chiefs of Police (IACP), later developed into a full curriculum by The Arc’s national office in 1998. In 1996, The Arc testified to the U.S. Commission on Civil Rights regarding law enforcement use of Title II accommodations.² A number of The Arc’s nearly 700 chapters provide advocacy support and services to victims and suspects/offenders with I/DD and provide training to the criminal justice community, both at local and state levels.³ Currently, The Arc is operating the *National Center on Criminal Justice and Disability* (“NCCJD”), funded by the U.S. Department of Justice, Bureau of Justice Assistance. NCCJD is the first national effort to bring together both victim and suspect/offender issues involving people with I/DD in one comprehensive effort to educate criminal justice professionals. NCCJD partners with criminal justice professionals, including law enforcement and their respective national organizations,⁴ to create fact sheets, white papers and training materials, as well as provide information and referral and technical assistance to address public safety issues. NCCJD is accumulating a robust clearinghouse of information, and has already begun assessing promising practices regarding law enforcement training on disability issues from across the country.⁵

We commend the Subcommittee on their recognition of this burgeoning human rights issue at a time when increasing numbers of individuals with I/DD are transitioning from institutional to community living. NCCJD seeks to provide testimony on specific issues faced by the I/DD population and, to that end, submits this Statement for the Record.

I. Background

I/DD presents a unique set of issues and requires specific promising practice development to protect the safety of people with I/DD, the officers that serve them, and the community at large. To explain the selection of promising practices, NCCJD would like to first describe the current landscape for persons

¹ Intellectual disabilities and developmental disabilities are two distinct categories. Someone with a developmental disability (DD) like Cerebral Palsy may not have any cognitive problems. Someone with an intellectual disability (I/DD) may not have any developmental problems. Please read I/DD as intellectual and/or developmental disabilities.

² To learn more about The Arc’s history in criminal justice efforts, see: <http://www.thearc.org/NCCJD/timeline>

³ See a list of The Arc’s Criminal Justice Programs, available at <http://www.thearc.org/NCCJD/resources/general-resources/chapter-programs>.

⁴ International Association of Directors of Law Enforcement Standards and Trainings (IADLEST), The National Sheriff’s Association (NSA), Police Executive Research Forum (PERF), The Police Foundation, The Law Enforcement Awareness Network (LEAN), and First Responders Disability Awareness Training (FR-DAT). For a full list of partners, please see <http://www.thearc.org/NCCJD/partners>.

⁵ See NCCJD’s Model Programs and Promising Practices page, available at <http://www.thearc.org/NCCJD/resources/general-resources/model-programs>.

with I/DD as they come into contact with law enforcement. These facts highlight gaps in training, which can be eliminated with strong support for promising practices from Congress and the Executive Branch.

A. I/DD Generally

More than 54 million Americans have a disability, comprising the largest minority group in the country.⁶ Of those 54 million, roughly 2-3% have intellectual disability ("I/D").⁷ People with I/DD may have familiar diagnoses such as autism, Down Syndrome, or fetal alcohol spectrum disorder (FASD), or they may have no particular diagnosis associated with their disability.⁸

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) classifies intellectual disability as impaired mental ability impacting adaptive functioning in three domains: conceptual, social, and practical.⁹ People with I/D experience increased vulnerability in interactions with criminal justice professionals because of heightened suggestibility, gullibility, naiveté, desire to please, and desire to feign competence.¹⁰ While these vulnerabilities may be present in certain individuals with mental illness, they are pervasive and problematic across the population of persons with I/D. In addition, a high number—75-90%—while having a severe intellectual impairment are not necessarily recognized by outward appearance.¹¹

B. High Rates of Victimization

People with disabilities are especially vulnerable to victimization or manipulation by others, sometimes leading to criminal activity. In 2010, the age-adjusted violent victimization rate for persons with disabilities (28 violent victimizations per 1,000) was almost twice the rate of persons without disabilities (15 violent victimizations per 1,000). The age-adjusted rate of serious violent victimization (rape/sexual assault, robbery, and aggravated assault) was 16 per 1,000 persons with disabilities, compared to 5 per 1,000 for persons without disabilities.¹² *Among the disability types measured, persons with cognitive disabilities (I/D) had the highest rate of violent victimization (30 per 1,000).*¹³ People with cognitive disabilities such as I/D, and developmental disabilities such as cerebral palsy represented the largest group of victims.¹⁴ When police officers fail to handle emergency situations involving victims with I/DD appropriately, the chances of offenders remaining at large and reoffending greatly increase. To protect the public safety, law enforcement needs specialized training on effectively dealing with victims with I/DD.

⁶ Progress Report of the New Freedom Initiative, May 2002.

⁷ Daily DK, Ardinger HH, Holmes GE (February 2000). "Identification and evaluation of mental retardation". *Am Fam Physician* 61 (4): 1059-67, 1070. PMID 10706158.

⁸ CDC: Facts about Developmental Disabilities available at: <http://www.cdc.gov/nchddd/developmentaldisabilities/facts.html>

⁹ Intellectual Disability, AAIDD, available at <http://aaidd.org/intellectual-disability/definition#.U1a34vldW4J>.

¹⁰ Greenspan, S. (2006), Functional concepts in mental retardation; Finding the natural essence of an artificial category. *Exceptionality*, 14(4), 205-224; see p. 218 for a specific discussion of gullibility; available at <http://webcache.googleusercontent.com/search?q=cache:http://acdlonline.com/zoomdocs/presentations/Functional%2520aspects%2520of%2520MR%2520-%2520Greenspan.pdf>.

¹¹ Daily DK, Ardinger HH, Holmes GE (February 2000). "Identification and evaluation of mental retardation". *Am Fam Physician* 61 (4): 1059-67, 1070. PMID 10706158. (This means they are slower than average to learn new information or skills. With the right support, most will be able to live independently as adults. However, the nature of these types of hidden disabilities can lead to negative outcomes when such individuals become involved in the criminal justice system as victims, suspects, or offenders.).

¹² NCVS: Crime Against Persons with Disabilities, 2008-2010 - Statistical Tables (BJS), Oct 2011.

¹³ *Id.* at table 5.

¹⁴ *Id.*

C. Inconsistency in Training

Law enforcement training on disability is inconsistent, sometimes inaccurate, and may or may not be effective.¹⁵ For example, a recent 9th Circuit decision addressed whether the Americans with Disabilities Act (“ADA”) applies to police officers making an arrest in someone’s home and also addressed a 42 U.S.C. §1983 failure-to-train claim against a local law enforcement agency.¹⁶ While the failure to train argument ultimately failed, whether the outcome would be the same for someone with I/DD remains a question. In a world of limited resources for law enforcement, eliminating lawsuits by teaching compliance ultimately devotes more time and energy to public safety. Additionally, many law enforcement and other lay persons do not understand the difference between mental illness and I/DD, potentially leading to misapplied techniques and resulting officer and civilian endangerment.

D. Title II Accommodations

Other types of disabilities are often more straightforward to accommodate. Under Title II of the ADA, there are clear regulations for providing an interpreter for someone who is deaf¹⁷ or building a ramp for someone who uses a wheelchair.¹⁸ However, someone with I/DD may take up valuable police time and require patience and individualized effort. Take, for example, issues surrounding *Miranda*. It is a legal obligation for officers to recite the *Miranda* rights to every suspect before interrogation; that is, the suspect must be told that he or she has the right to remain silent and that anything said can be used against them in a court of law, and that he or she has the right to a lawyer, either appointed or hired by the individual. Providing the warning in writing to someone who is Deaf or hard of hearing or verbally to someone who is blind or low vision is relatively straightforward. However, someone with I/DD will not have the requisite seventh grade reading and listening skills to completely understand warnings provided in the *Miranda* rights.¹⁹ Intellectual functioning can affect one’s ability to even comprehend *Miranda* warnings, leading to waiver without true informed consent.²⁰ Moreover, it is common for people with I/DD to have “hidden disabilities” that can lead to miscommunications or even to feigning understanding in an effort to mask disability.²¹ Accommodating this need requires patience and individualized assessment, as well as officer awareness that waiver of those rights may not be knowing and intelligent.²² Ultimately, public safety suffers when this part of the system breaks down.

E. Disparity in training content

Considerably more law enforcement training is available on mental illness than I/DD. People with I/DD have distinct needs both as suspects/offenders and victims, different from persons with mental illness.

¹⁵ This includes training about I/DDs such as autism, FASD (Fetal Alcohol Spectrum Disorder), Down syndrome and similar disabilities.

¹⁶ *Sheehan v. City & County of San Francisco*, ___ F.3d ___, (9th Cir. Cause No. 11-16401 February 21, 2014); see Appendix B, “The Americans with Disabilities Act: Application of Title II to Police Officers Making an Arrest.”

¹⁷ See the United States Department of Justice, Civil Rights, Disability Rights Section’s resources, “Communicating with People Who Are Deaf or Hard of Hearing ADA Guide for Law Enforcement Officers,” available at <http://www.ada.gov/lawenfcmm.htm>; and “Model Policy for Law Enforcement on Communicating with People Who Are Deaf or Hard of Hearing,” available at <http://www.ada.gov/lawenfmodpolicy.htm>.

¹⁸ ADA Accessibility Survey Instructions: Curb Ramps, available at <http://www.ada.gov/pcatoolkit/app1curbramps.pdf>.

¹⁹ Petersilia, 2000.

²⁰ This, in turn, can lead to false confessions, inadmissible evidence, or other circumstances that ultimately cost the criminal justice system time and resources.

²¹ See Appendix A for The Arc and AAIDD’s position statement on Criminal Justice. It is a joint position statement currently undergoing update and review.

²² Section Review, *Miranda* warnings: The latest research and its implications, Eric Y. Drogin, available at <http://www.massbar.org/publications/section-review/2009/v11-n1/miranda-warnings> (An assessment of 107 defendants with mental disorders indicated that the 25 percent who were most impaired only understood about 24 percent of *Miranda* warnings, while the 25 percent who were least impaired could comprehend only about 66 percent of these warnings.); see Richard Rogers et al., *Knowing and Intelligent: A Study of Miranda Warnings in Mentally Disordered Defendants*, 31 Law & Hum. Behav. 401 (2007).

Crisis Intervention Teams (“CIT”): CIT programs²³ are proven to reduce both arrests and re-arrests of people with serious mental illness while simultaneously reducing officer stigma and prejudice towards this population. Upon learning to effectively identify persons in need of psychiatric care, CIT officers are 25% more likely to utilize psychiatric treatment facility options than other officers. Strikingly, “After the introduction of CIT in Memphis, officer injuries sustained during responses to “mental disturbance” calls **dropped 80%.**”²⁴

CITs, while a thoroughly effective effort to address mental illness, do not provide the focus necessary to train law enforcement for encounters with persons with I/DD. Referencing the National Curriculum provided by the University of Memphis CIT Center, approximately 2 hours of a 40 hour training are spent addressing I/DD issues.²⁵ Approximately 8.5 hours are spent addressing various types of mental illness.²⁶ I/DD is distinct from mental illness and requires a targeted collaborative training approach utilizing the strengths proven by CIT, but tailored to the specific needs of the I/DD population.

II. Promising Practices

A sustainable national training program is needed to ensure law enforcement professionals and first responders receive consistent and effective training about people with I/DD. Congress should continue to support federal funding for initiatives like NCCJD in an effort to remedy disparity in access to quality training, and support a comprehensive mandatory training program.

A. Focus on Inclusion: Community Policing

To foster relationships between persons with disabilities and law enforcement, effective training needs to focus on relationship building. Training must focus not on teaching law enforcement to diagnose disabilities, but on creating a greater awareness about people with disabilities, and assisting officers in creating an attitude of doing what it takes to ensure understanding of the citizen being served. Building principles of inclusion into the training, as well as how the training is incorporated into policing overall, can help remedy misperceptions from both the officer and the person with a disability. For instance, involving persons with disabilities in community policing through volunteer opportunities (such as neighborhood watch programs) will naturally create an increase in interaction with police on a regular basis, ultimately fostering healthy relationships in non-threatening situations on both sides.²⁷

England’s example of Disability Engagement Officers highlights officers who work to develop communication networks with people with disabilities, eventually improving trust and confidence in the Police Service. They also act as a liaison between the police and people with disabilities. Called “DEOs,” these police officers and police community support officers work as part of Neighborhood Policing Teams. They are provided with additional training to engage with, and offer support and advice to, people

²³ NAMI, Crisis Intervention Teams, available at “<https://www.nami.org/template.cfm?section=CIT2>” (“CIT (Crisis Intervention Team) programs are local initiatives designed to improve the way law enforcement and the community respond to people experiencing mental health crises. They are built on strong partnerships between law enforcement, mental health provider agencies and individuals and families affected by mental illness.”)

²⁴ National Alliance on Mental Illness (NAMI) CIT Toolkit: CIT Facts, available at http://www.nami.org/Content/ContentGroups/Policy/CIT/CIT_Facts_4.11.12.pdf, emphasis added.

²⁵ University of Memphis CIT Center, curriculum, available at <http://www.cit.memphis.edu/curriculum.php> (This 2 hours also covers Child & Youth issues, Adolescence, TBI (traumatic brain injury), Dementia, and Delirium.)

²⁶ Id. (Cognitive Disorders, Dementia, Delirium, TBI (9:00-10:00, Tuesday); Child & Youth, Adolescence, Autism, Dev. Disabilities (8:00-9:00, Wednesday); Severe, Persistent Mental Illness (9:00-11:00, Monday); Thought disorder, mood disorder (11:00-12:00, Monday); Substance Abuse Issues, Co-Occurring disorders (1:00-3:00, Monday); Special Focus Issues, Personality Disorder (8:00-9:00, Tuesday); Special Focus Issues, PTSD (8:00-9:00, Thursday); Special Focus Issues, Suicide (9:00-10:30, Thursday).

²⁷ Police Officers and Disability: Perceptions and Attitudes Scott J. Modell and Dave Cropp INTELLECTUAL AND DEVELOPMENTAL DISABILITIES VOLUME 45, NUMBER 1: 60–63 FEBRUARY 2007.

in the community who have a disability.²⁸

B. Communication Boards for First Responders

Law enforcement and other first responders should take communication boards when responding in preparation for dealing with non-verbal individuals. These boards, available in multiple languages, allow individuals with alternative means of communication a possible way to interact with first responders.²⁹

C. Evaluate past and current training strategies and related policies

Evaluation measures and evidence-based practices are key to identifying effective strategies for raising overall awareness and changing law enforcement attitudes about people with disabilities. Over the years, criminal justice and disability experts have debated possible strategies, but none have resulted in a strong, coordinated, national-level plan ensuring consistent, accurate, quality training throughout the states.

One approach includes disability awareness training in current mandatory police courses.³⁰ Secondly, police departments need policy from the federal level supporting their efforts to infuse effective practices into their training curricula.³¹ Knowledge sharing across professions and collaboration on core principals, policies, and positions is critical to impacting law enforcement nationally. In addition, while the Department of Justice has created a model policy for law enforcement on communicating with people who are deaf or hard of hearing,³² policies are needed on communicating with citizens with other types of disabilities; specifically I/DD where accommodations needed are not always physical in nature, but cognitive. DOJ should provide guidance on specific cognitive accommodations that law enforcement must use to promote both citizen and officer safety during either typical or highly dangerous encounters between law enforcement and persons with disabilities.

D. NCCJD's Multidisciplinary Teams ("MDTs"): An Evidence-based Approach

When an individual who has different needs or communicates differently becomes involved in a complex system with many moving parts, tapping the expertise of multiple parties facilitates the smoothest possible outcomes. Utilizing the promising practice seen across person centered planning in health care and also in the Office for Victims of Crime materials on assisting crime victims with disabilities,³³

²⁸ See [http://www.sussex.police.uk/help-centre/ask-us/disability-engagement-officers/what-are-disability-engagement-officers-\(deos\)](http://www.sussex.police.uk/help-centre/ask-us/disability-engagement-officers/what-are-disability-engagement-officers-(deos)).

²⁹ See <http://cdd.umn.edu/products/tips3rdedition.pdf>; <http://www.temple.edu/instituteondisabilities/aacvocabulary/e4all/EprepPictureAid.pdf>; (useful for many types of disabilities).

³⁰ See <http://ici.umn.edu/products/impact/133/prof4.html>. (In 2000, the Bureau of Justice Assistance funded a project to infuse disability terminology, information, and issues into existing mandatory training provided by the California Commission on Peace Officer Standards and Training (POST). The commission periodically revises core and crime-specific curricula, and worked with disability experts, advocates, and trainers to include disability throughout the curricula. General disability information, recognition of disability, and accommodation skills were infused in multiple courses including the Core Interview and Interrogation Course, crime specific curricula on sexual assault, and courses on child/adult abuse, robbery, and financial crimes. Disability was to be included in all institute courses by winter of 2001, along with practicals to test learned skills.)

³¹ See IACP's National Law Enforcement Policy Center Concepts and Issues Paper, March 2004, "Law Enforcement Encounters with Persons who are Developmentally Disabled" available at <http://www.cforjustice.org/wp-content/uploads/2008/08/encounters-w-persons-dev-disabled-paper.pdf> (Recently, NCCJD met with the International Association of Chiefs of Police (IACP) to discuss revising their model policy on "Encounters with the Developmentally Disabled," last revised March, 2004. Model policies are often developed into concepts and issues papers, informing training materials for officers nationwide. Once policy is collaboratively updated, it will be included in both IACP and NCCJD training materials, creating a consistent, content-rich foundation for effective training.)

³² See "Model Policy for Law Enforcement on Communicating with People who are Deaf or Hard of Hearing" available at <http://www.ada.gov/lawenfmopolicy.pdf>.

³³ See OVC Multidisciplinary Response to Crime Victims with Disabilities, available at <http://www.ovc.gov/pubs/victimswithdisabilities/index.html>.

NCCJD is supporting the evidence-based approach of training multidisciplinary teams (MDTs) to bring together criminal justice professionals (including law enforcement, legal professionals, and victim advocates), disability professionals, and people with I/DD and their family members to share expertise on behalf of people with I/DD. NCCJD's goal is to create a shared sense of ownership around the issue and spark innovative ideas that will lead to greater awareness of the challenges people with disabilities face when involved in the criminal justice system as victims or suspects/offenders. MDTs can take various forms, have specific goals for each particular community or state, and conduct a range of activities, such as offering joint training, developing memoranda of understanding and protocols, or forming interagency task forces. NCCJD believes that if criminal justice professionals can develop a personal understanding of and develop relationships with people with disabilities in their own communities, the resulting positive impact will reduce the number of miscommunications, needless arrests, overlooked victims, and possibly deaths of people with I/DD.

NCCJD's MDTs will consist of law enforcement, victim advocates, disability advocates, people with disabilities and/or family members, and prosecution and defense attorneys, who will then become the "go-to" source for knowledge about people with I/DD introduced into the criminal justice system—either as victims, or suspects /offenders. By accessing The Arc's broad Chapter network across the country, NCCJD's experts will utilize a "train the trainer" model to prepare The Arc's Chapters to recruit and train MDTs. While the training sessions themselves will be relatively short—only one - two days of in-person instruction—the MDTs will obtain continued support from NCCJD through the extensive state-by-state resource list, expert witness database, and technical assistance services.

III. Conclusion

To ultimately prioritize safety, there are promising practices all along the spectrum of interactions between law enforcement and persons with I/DD. The most obvious practices deal with the emergency itself—communication boards, identifying disability as a cause of behavior, community policing, and building relationships prior to the emergency—these and other practices must be implemented well before the emergency happens.

Beyond the emergency itself, however, there are other promising practices throughout law enforcement leading to safer outcomes. If officers know how to interact with victims with I/DD, they get perpetrators off the streets by effectively utilizing witnesses—regardless of witness communication style or ability. If officers know how to appropriately approach suspects/offenders with I/DD, they can prevent recidivism and target the truly responsible criminals in cases where vulnerabilities associated with I/DD were exploited.³⁴ Knowledge about this segment of the population, gained from training, interaction, and relationship building, leads to better policing and safer communities.

NCCJD asks this committee to consider these issues and take note of the work NCCJD has begun. With a small staff and limited resources, we are seeing hundreds of people sign on to our free monthly webinars; receiving Information and Referral and Technical Assistance requests from professionals and family members; and cataloging thousands of hits on our website. There is clearly an interest in and a need for a comprehensive national effort to address law enforcement interactions with Americans with disabilities. We thank you for acknowledging this need and hope to see strong steps towards broad implementation of promising practices.

³⁴ *Perske's List: False Confessions From 75 Persons With Intellectual Disability*, Intellectual and Developmental Disabilities: Vol. 49, No. 5, pp. 468–479, October 2011 available at: <http://www.robertperske.com/Articles/Perske's List False Confessions From 75 Persons With Intellectual Disability.pdf>. (Too many suspects have been "at the wrong place at the wrong time" and coerced into giving false confessions, some of whom have lost their lives by execution.).

Appendix A: The Arc and AAIDD's Position Statement on Criminal Justice

Criminal Justice

People with intellectual and/or developmental disabilities¹ who are victims, suspects or witnesses, like other residents of the United States, have the right to justice and fair treatment in all areas of the criminal justice system, including reasonable accommodations as necessary.

Issue

When individuals with intellectual and/or developmental disabilities become involved in the criminal justice system as suspects or victims, they often face fear, prejudice, and lack of understanding. Attorneys, judges, law enforcement personnel, forensic evaluators, victim advocates and jurors may lack the adequate and appropriate knowledge to apply standards of due process in a manner that provides justice for our constituents. Individuals with intellectual and/or developmental disabilities are:

- Four to ten times more likely to become victimized, yet are frequently devalued and ignored, and their cases rarely prosecuted;
- Subject to routine exclusion because of outdated and stereotyped views of their competence to testify or denial of their needs for supports and accommodations;
- Often denied due process and effective representation at each stage of the proceedings; and
- Abused, exploited, and excluded from habilitative programs when incarcerated.
- When individuals with intellectual and/or developmental disabilities come into contact with the criminal justice system, they find few organized resources for information, training, technical assistance, and referral. Moreover, people living with intellectual and/or developmental disabilities who enter the criminal justice system encounter problems in excess of their nondisabled peers, such as:
 - Failing to have their disability identified by authorities who lack the expertise to discern the presence of a disability (and often individuals with intellectual disabilities compensate very well so that the disability can be somewhat hidden);
 - Giving incriminating, but inaccurate "confessions" because the individual wants to please or is confused or misled by inappropriately used investigative techniques;
 - Being found incompetent to stand trial because the individual cannot understand the criminal justice proceeding;
 - Being found incompetent and being inappropriately placed in an institution for a long period of time in order to "regain competency;"
 - Being unable to assist their lawyer in their own defense;
 - Waiving rights unknowingly in the face of required warnings such as Miranda; and
 - Being denied their right to speak because their testimony is not deemed credible whether as a witness, victim or defendant.

While the Supreme Court ruled in *Atkins v. Virginia*² that it is a violation of the Eighth Amendment ban on cruel and unusual punishment to execute people with "mental retardation³," the states continue to play a major role in defining the term mental retardation and in deciding the process for consideration of the defendant's mental retardation. Laws vary from state to state on how a defendant can prove the presence of mental retardation. States also vary widely regarding whether it is the judge or jury who decides if the defendant has mental retardation. States may use non-clinicians who are not knowledgeable about mental retardation to make such determinations. As a result, defendants may not have their mental retardation identified because of states' unfair and inaccurate procedures.

Position

People with intellectual and/or developmental disabilities must have the same opportunities to experience

justice as victims, suspects or witnesses, similar to those without disabilities, when in contact with the criminal justice system.

- As victims, witnesses, or suspects they must:
- Have their right to justice and fair treatment assured;
- Receive assistance and accommodations to effectively participate in legal proceedings
- Have necessary supports and accommodations available so that their testimony is heard and fairly considered;
- Have access and the right to present expert evaluations and testimony by professionals with training and expertise in their disability;
- Be treated fairly by all personnel including judges, defense lawyers, prosecutors, court personnel, forensic evaluators, law enforcement personnel, victim assistance personnel, and criminal justice policymakers;
- Have the right to an advocate, in addition to their lawyer, who has specialized, disability-related expertise;
- Have their conversations with their advocate covered under, or treated similarly to, attorney-client privilege;
- Have available to them judges, lawyers, prosecutors, court personnel, and others who are educated about the effects of their disability;
- Have access to victim supports and compensation as appropriate;
- As a suspect, be protected from harm, self-incrimination, and exploitation at all stages of an investigation, including when they are questioned, detained, and incarcerated
- When sentenced they must:
- Have available reasonable and appropriate accommodations, treatment, and education, as well as alternatives to sentencing and incarceration that include community-based corrections;
- Have access to adequately trained probation and parole officers who will treat them fairly based on their individual disability and need for reasonable accommodations;
- Continue to be exempt from the death penalty because existing case-by-case determinations of competence to stand trial, criminal responsibility, and mitigating factors at sentencing have proved insufficient to protect the rights of individuals with mental retardation (or intellectual disabilities);
- Have access to expert witnesses and professionals who are experienced in mental retardation who can accurately determine the presence of mental retardation; and
- Have their mental retardation determined by state procedures that are accurate and fair. Those state definitions and procedures must ensure that people with mental retardation (or intellectual disability) are not executed as a consequence of falling through the cracks in the system.

Adopted:

Board of Directors, The Arc of the United States

August 4, 2008

Board of Directors, AAIDD

August 18, 2008

Congress of Delegates, The Arc of the United States

November 8, 2008

¹ "People with intellectual disabilities and/or developmental disabilities" refers to those defined by AAIDD classification and DSM IV. In everyday language they are frequently referred to as people with cognitive, intellectual and/or developmental disabilities although the professional and legal definitions of those terms both include others and exclude some defined by DSM IV.

² *Atkins v. Virginia*, 536 U.S. 304 (2002).

³ The term "mental retardation," though outdated, is still used in the legal and criminal justice system.

Appendix B: The ADA: Application of Title II to Police Officers Making an Arrest

In a recent three judge panel decision, the 9th Circuit again brought to the forefront the question of whether the Americans with Disabilities Act (ADA) applies to police officers when they make an arrest. *Sheehan v. City & County of San Francisco*, ___ F.3d ___ (9th Cir. CauseNo. 11-16401 February 21, 2014).

This opinion addressed 42 U.S.C. §1983, 4th Amendment, and ADA issues, the ADA issue is divisive among the Circuits. The opinion references United States Department of Justice ADA regulations stating:

A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity. 28 C.F.R. §35.130(b)(7).

The issue is unsettled across the country with various Circuits expressing different opinions.

- 4th Circuit: Considered a reasonable accommodation claim involving arrest, but held that “exigency is one circumstance that bears materially on the inquiry into reasonableness under the ADA.” *Waller ex rel. Estate of Hunt v. City of Danville*, 556 F. 3d 171, 175 (4th Cir. 2009).
- 5th Circuit: “Title II does not apply to an officer’s on-the-street responses to reported disturbances or other similar incidents, whether or not those calls involve subjects with mental disabilities, prior to the officer’s securing the scene and ensuring that there is no threat to human life.” *Hainze v. Richards*, 207 F.3d 795, 801 (5th Cir. 2000).
- 6th Circuit: Similar to the 4th circuit, discussing exigency as bearing materially into the reasonableness inquiry.
- 9th Circuit: “The ADA therefore applies to arrests, though we agree . . . that exigent circumstances inform the reasonableness analysis under the ADA, just as they inform the distinct reasonableness analysis under the Fourth Amendment.” *Sheehan v. City & County of San Francisco*,
- 10th Circuit: “a broad rule categorically excluding arrests from the scope of Title II . . . is not the law.” *Gohier v. Enright*, 186 F.3d 1216, 1221 (10th Cir. 1999).
- 11th Circuit: “the question is not so much one of the applicability of the ADA because Title II prohibits discrimination by a public entity by reason of [a person’s] disability. The exigent circumstances presented by criminal activity and the already onerous tasks of police on the scene go more to the reasonableness of the requested ADA modification than whether the ADA applies in the first instance. *Birrell v. Miami-Dade County*, 480 F.3d 1072, 1085 (11th Cir. 2007).

In addition to the ADA claim, Sheehan brought a 42 U.S.C. § 1983 claim under a “failure to train” theory. In this particular instance, Sheehan conceded that, “the department employed appropriate training materials to guide police officers’ responses to persons they knew to be suffering from mental illness.” Therefore, the city could prove that they were not “deliberately indifferent.” *Price v. Sery*, 513 F.3d 962, 973 (9th Cir. 2008) (quoting *City of Canton v. Harris*, 489 U.S. 378, 388 (1989)) (“The ‘inadequacy of police training may serve as the basis for §1983 liability only where the failure to train amounts to deliberate indifference to the rights of persons with whom the police come into contact.”).

The department avoided liability in this particular instance, but the lack of training surrounding I/DD in many departments *does* arguably approach the level of “deliberate indifference.” As this area of the law continues to evolve, perhaps persons with disabilities arrested by law enforcement may have recourse when officers fail to make reasonable accommodations—particularly if police departments have failed to train around I/DD issues.

Appendix C: Outline of NCCJD Training—currently in draft form**Phase One: A call to Chapters of The Arc**

NCCJD puts out a notice to the Chapter network³⁵ seeking host training sites. Chapter personnel are trained in the following areas: recruiting a multidisciplinary team (MDT)—who to talk to, which key players to contact, and which points to emphasize in describing why the training is important; basic Information and Referral services—even if this means simply referring MDT personnel to NCCJD; resource submission—each Chapter will be encouraged to submit applicable local criminal justice resources to be included on the state-by-state resource list compiled by NCCJD; recruiting self-advocates—one main goal of the training is to introduce criminal justice professionals to persons with disabilities that live in their area; and other support—for instance establishing criminal justice issues on the Chapter's website or identifying key national and local players in criminal justice in the Chapter's area.

Phase Two: Training the MDT

The training, still in the development stages, spans two days. Law enforcement, victim advocates, and legal professionals (both prosecuting and defense attorneys) are gathered for the in-person training. NCCJD staff host and administer the training along with local self-advocates recruited by Chapters of The Arc.

Day one: Issue Spotting9:00am—12:00pm: Disability Overview

Core Competency: Communicating with Persons with Disabilities I

This session serves as an introduction into why skills for dealing with persons with disabilities are increasingly important for criminal justice professionals. This section features discussions about various types of disabilities accompanied by stories of individuals with disabilities. Communication tips will be a core competency

1:00pm—4:00pm: Breakout Sessions**Law Enforcement**

Core Competency: Communicating with Persons with Disabilities II

Victim Advocates

Core Competency: Communicating with Persons with Disabilities II

Legal Professionals (Prosecution and Defense Attorneys)

Core Competencies: Communicating with Persons with Disabilities II; Competency to stand trial—legal and practical definition; Understanding Miranda and people with I/DD; Defenses, mitigation, and the plea deal

Day two: Building an MDT

Problem solving as an MDT. Various hypothetical situations are presented to the newly formed teams, and the skills learned day one are applied to real life situations. Where possible, scenarios are tailored to the particular locality where training is taking place and the people that actually had these experiences will talk about them.

³⁵ 684 Affiliated Chapters, updated 3/31/2014



Achieve with us.

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**"Law Enforcement Responses to Disabled Americans: Promising Approaches for
Protecting Public Safety"**

Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human
Rights

April 29, 2014

Jessica S. Oppenheim, Esq. Director, Criminal Justice Advocacy Program

The Arc of New Jersey

Dear Senator Durbin:

I would like to thank you and the Subcommittee for allowing us the opportunity to submit the
following testimony regarding an improved law enforcement response to individuals with
developmental disabilities and submit the following for your consideration:

I. What is the Problem?

It is a persistent and unresolved issue for professionals in the criminal justice system that
they all too often are faced with an individual who has an intellectual or developmental disability
(I/DD). It is generally agreed that persons with I/DD represent a disproportionate number of
offenders in both the juvenile and adult systems. Disabilities range from autism spectrum
disorders to intellectual disabilities such as Down syndrome, as well as cerebral palsy, traumatic
brain injury and in general neurological impairments covering a broad range of diagnoses.

- 2 to 3% of the general population can be identified as living with a developmental
disability, but at least 9% of the offender population has been identified as having a
developmental disability.
- A more recent study from Canada places those numbers as high as 40% of the individuals
currently imprisoned can be identified as a person with a developmental disability.

- Though the number of school age children identified as a person with a I/DD is around 9%, nonetheless, close to 32% of all juveniles in the juvenile justice system can be seen as having an I/DD.
- No matter which number best represents the percentage, individuals with developmental disabilities are grossly overrepresented in the criminal justice system
- There is a lack of identification and availability of services which seriously hampers the ability of people to return successfully to their communities. This causes untold suffering for individuals with I/DD and their families, who are often left with the responsibility of caring for someone with no assistance.

It is important to realize that the impact is felt all along the criminal justice system. First responders bear an enormous brunt of the responsibility of coping with individuals with I/DD when the initial emergency call goes out. Police and mental health workers face the daunting task first of identifying a person with a cognitive problem, then of determining whether the problem relates to a mental illness or a developmental disability and then locating often nonexistent resources and services to detour these individuals out of the criminal justice system.

Crisis intervention teams (CIT) are an effective and useful option, as is the 40 hour training that is required for certification as a CIT. In order to address the needs of individuals with mental illness, this multidisciplinary training is optimal. However, it is not a panacea. First, the CIT program is geared almost exclusively to working with people with mental illness; training about people with I/DD takes up only a small portion of the total 40 hour training. This is certainly better than no training, but does not fully address the needs of the disability community.

In addition, in New Jersey, we have approximately 40,000 sworn officers. Providing training at the 40 hour level can be an unrealistic goal. Rather, taking opportunities to provide in-service training and an updated mandatory module as part of recruit class training would afford an opportunity to reach officers early in their career.

The Arc of NJ is committed to increasing and improving training opportunities for law enforcement. In 2013, we produced a video specifically for law enforcement called *Effective Response to People with Developmental Disabilities: Law Enforcement Video*. This kind of training video is particularly geared toward helping officers de-escalate first responder scenarios, often family-related conflicts.

It is important to realize that law enforcement training is not a panacea. Resources are needed to assist individuals with I/DD who are involved in the criminal justice system. Law enforcement officers are often frustrated because they receive training, helping them to identify and understand people with I/DD, but then have no reasonable or available options but to arrest.

II. Who are Offenders with Developmental Disabilities (I/DD)?

People with intellectual and developmental disabilities (I/DD) commit offenses that are similar to those committed by the general offender population. We know now that it is false that I/DD offenders commit more sex offenses and other violent crimes. People with I/DD may commit actions due to a lack of knowledge or cognitive ability, which can result in criminal charges.

In addition, with less developed social skills, persons with I/DD may be more vulnerable to allegations of inappropriate or illegal sexual conduct. People with I/DD get involved with the criminal justice system for the same reasons other people do: youth, male gender, family history of offending, unemployment, history of "behavioral" problems, substance or alcohol abuse. One of the biggest problems facing the criminal justice system today is individuals with a co-existing mental health issue.

III. The Criminal Justice Advocacy Program: Our Experience with the Criminal Justice System for People with I/DD

Since the mid-80's, The Arc of NJ has supported a Criminal Justice Advocacy Program (CJAP). Funded by the New Jersey Division of Developmental Disabilities, this Program, formerly called the Developmentally Disabled Offenders Program, is the only program in New Jersey and one of only a handful of programs nationwide that advocates specifically for people with I/DD who have become involved in the criminal justice system. The program forges needed communication and coordination among agencies charged with assisting persons with I/DD and the criminal justice system professionals who are faced with these individuals. By providing information about offenders with I/DD to the criminal justice system, CJAP improves early identification and thus increases the likelihood of appropriate alternative disposition. By providing information to the service provider community, CJAP improves agency response and increases successful integration into the community. The goal is reducing recidivism and avoiding future incarceration, as well as contributing to the overall goal of helping people with I/DD live productive lives in their community.

Program Resource Coordinators work with approximately 100 clients statewide, with a caseload per manager of between 30 and 45. In this role, resource coordinators work directly with the Division of Developmental Disabilities case managers to identify appropriate services that address a client's issues, such as housing options, therapeutic services, drug or alcohol treatment and job training. Coordinators also provide information to the Courts, attorney and supervisory personnel such as parole and probation officers to ensure an understanding of an offender's limitations. Ultimately, services and supports are reduced to a Personalized Justice Plan, or PJP, which is provided to the court and the parties, delineating the plan in place to ensure a defendant's compliance with probation, or to assure the Court that dismissal or other alternate dispositions will be successful. The Plan is then carried out by the Resource

Coordinator, necessitating an ongoing relationship between the coordinator and the client, often over a period of years. The intent is that the PJP will address the needs of the Court and address accountability and responsibility on the part of the offender. Each PJP is individualized, addressing the needs of the particular offender and the circumstances of the case and will act as a preventive tool against future criminal involvement.

A review of our caseload reveals that approximately one-third of the clients have committed a sex offense. Though these numbers reflect a 10 year old study, we know that the percentages have remained essentially unchanged. A five year average from 2004 for criminal charges reflects the following:

- Assault 10%
- Arson 3.4%
- Narcotics 11.8%
- Homicide 1.6%
- Sex Offenses 36.2%
- Theft 11.6%
- Municipal Charges 15%
- Violation of Probation 3.4%
- Other 7% (includes weapons possession, bias crime, resisting arrest, violation of domestic violence restraining order)

These statistics are generally consistent with crime rates in the general population. The increasing sex offense convictions reflect the ongoing emphasis on sex crimes, including increased staffing and specialized training within Prosecutor's Offices. Also, since the mid-'90's, community awareness has increased, resulting in increased reporting. This has affected the I/DD population, taking into account increased integration into the community and more contact with family and non-family community members.

In order to address this, CJAP provides training for law enforcement, the defense bar and the courts to assist in the earlier identification and appropriate response to individuals with I/DD. In addition, the program works to increase communication between appropriate agencies and those with expertise in the area of sex offending to put services in place that address these concerns. Moreover, when proceedings result in conviction, the Program continues to work with clients, to ensure that they comply with registration obligations and with parole conditions. Additionally, the Program Coordinators advocate on behalf of our clients with parole, probation and the courts, to ensure that people with I/DD receive the same civil liberty protections as non-disabled offenders.

IV. Police Encounters and Particular Characteristics of People with I/DD

People who live in the community may encounter law enforcement on the streets, may have police officers called into their home in response to a 911 call, be approached in a public place by police officers or ultimately find themselves involved as a suspect or witness in possible criminal activities. As people with I/DD move into the community and take their place as contributing members of society, unencumbered by supervision and guardianship, the possibility of interaction with law enforcement increases. Also, the risk of involvement with criminally-minded individuals increases. This important component in improving the quality of life for persons with I/DD brings with it new responsibilities to understand and comply with the law as well as additional responsibilities for caregivers, family members, teachers and criminal justice system professionals to identify individuals with special needs and effectively address those issues.

Once people with I/DD have that initial contact with the criminal justice system there are characteristics which increase their vulnerability to more serious consequences than their counterparts who have no disability. Impaired cognitive abilities, poor coping mechanisms, limited impulse control, poor emotional control, and difficulties with logical and strategic thinking can all create obstacles for a person with an I/DD who is a suspect in or has been charged with a criminal offense. These characteristics directly impact the effectiveness with which they can communicate with law enforcement personnel, judges and their own attorneys.

Impaired cognitive abilities, seriously underdeveloped coping mechanisms and impulse control, along with limitations in logical and strategic thinking negatively affect the ability to interact successfully with law enforcement, defense counsel, prosecutors and the courts. First, simply failing to understand and respond appropriately and intelligently to the provision of standard Miranda warnings creates the first obstacle. It is challenging to exercise rights such as the right to remain silent, to access legal counsel and the warning that any statements can be used against you when language skills and abstract thinking are impaired.

Law enforcement officer interrogation techniques are intended to overcome a suspect's will and encourage confessions. This may confuse a person with I/DD, leading in fact to false confessions and inaccurate versions of events. The lack of knowledge and training on the part of officers with regard to these cognitive limitations can exacerbate the problem, causing serious communication issues which are hard to amend later in the process.

Persons with I/DD may, in addition to limitations in executive functioning, also have limited social skills and be highly suggestible. A desire to seek approval from authority figures results in statements of guilt which are not accurate. Also, the desire to be accepted by their peers and a simplistic understanding about complex concepts such as friendship and loyalty can lead a person with I/DD to accept blame for offenses and actions not their own. Family members and guardians may have emphasized that police officers are the person's friend and cooperation

should be given; distinguishing between situations in which law enforcement personnel is available to assist someone, as opposed to a situation in which the person with I/DD is a suspect and thus vulnerable can be difficult when cognitive ability is limited.

A strong desire to fit in and not be seen as lacking savvy or sophistication can result in persons with I/DD trying to hide their deficits when speaking to law enforcement officers. Certainly, it can be difficult and even embarrassing to a person to try to communicate that there is a difference which they can feel sets them apart from others. Consequently, a person with I/DD may become adept at mimicking language and actions and may “bluff” through a confrontation or interrogation. This creates a false impression about their competence and lead law enforcement to believe that the individual is cognizant of the situation and its ramifications.

Another potential characteristic of an individual with I/DD is impaired long or short-term memory. There may be limitations in orienting sufficiently to time and place so that remembering chronology of events can be impaired. In addition they may have a limited ability to tell time or to remember details which they believe are unimportant, but which may prove pertinent in light of later events. Their worldview can be skewed and based upon beliefs which are not generally held by the rest of the community. Their understanding of what has happened may not fit the full picture of an incident. In addition, their cognitive ability may be hampered by a short attention span and impulsivity, resulting in an utter inability to anticipate future consequences and react appropriately. Actions, too, may be reactive, rather than proactive with no regard to any long term implication of those actions.

In considering these common characteristics shared by persons with a wide array of developmental or intellectual disabilities, the result is often that people with I/DD are particularly vulnerable when attempting to navigate a system as complex as the criminal justice system. Persons with I/DD are more likely to give a statement against their interest, more likely to take responsibility for a criminal offense, more likely to provide a confession even when they are not the guilty party. If charged with a criminal offense, they are less able to effectively assist their attorney in their defense and less able to articulate remorse or demonstrate that they can change their behavior or respond affirmatively to treatment. They are more likely than their non-disabled counterparts to plead guilty and to plead guilty to the original more serious charges, resulting in longer periods of incarceration being imposed. Once sentenced, they are less able to comply with conditions imposed for a probation sentence and thus violate those conditions, resulting in further criminal prosecution. If incarcerated, they are less likely to understand prison disciplinary systems and thus have a higher incidence of disciplinary violation within the prison, resulting in longer sentences. They are, in addition, often victimized by other inmates. They are less able to take advantage of education and vocational opportunities in prison and so spend longer terms incarcerated rather than being granted parole, as parole requires that the individual have a plan in place for successful re-entry into the community.

The types of offenses committed by people with developmental disabilities are similar to those committed by the general offender population. Prior belief that sexual offenses and arson offenses were particularly high among the I/DD offender population has been proven false, though persons with I/DD may commit actions due to a lack of knowledge or cognitive ability, which can result in criminal charges. In addition, with less developed social skills, persons with I/DD may be more vulnerable to allegations of inappropriate or illegal sexual conduct. Generally speaking, factors shown to increase involvement with the criminal justice system are similar to those for the general population: youth, male gender, family history of offending, unemployment, history of "behavioral" problems, substance or alcohol abuse and possibly one of the biggest problems being faced by the criminal justice system today, a co-existing mental health issue.

One aspect which must receive particular attention is the commission of sex offenses. As noted above, persons with I/DD are not more likely to commit sexually-related offenses. However, there are instances where individuals with I/DD act improperly due to poor social skills, poor impulse control, a lack of formal sex education as well as a lack of opportunity to experiment sexually with peers. These deficits can result in criminal charges for sexual assault, sexual contact and endangering the welfare of a child. In every State, besides potential incarceration, such convictions now carry with them significant additional consequences under each State's Megan's Law statute. Each State has passed and upheld a statute requiring sex offenders to register their whereabouts and to update those registrations on a regular basis. In addition, all States have some level of community notification, including access for the public to an internet website with information about offenders. Finally, most States have some form of parole supervision for convicted offenders. Each of these obligations imposes responsibilities upon registrants which must be met over a long period of time. Individuals with I/DD often need assistance to understand and comply with these requirements or they face additional prosecution and other sanctions.

The need to identify and support people with I/DD involved in the criminal justice system is clear. At the same time, people with I/DD must, when appropriate, be held accountable for criminal acts and are entitled to respect as members of the community. Coordination among agencies, private and public, as well as family members, along with reliably funded, community-based, long-term services is critical. Incarceration for persons with I/DD needs to be an option of last resort for the criminal justice system, in part because of their increased risk of victimization in the corrections system but also because the incarceration of individuals who cannot comprehend the consequences of their actions and be appropriately punished and rehabilitated due to their mental capacity is not in keeping with the goals of a civilized criminal justice system.

Since the mid-80's, The Arc of NJ has supported a Criminal Justice Advocacy Program (CJAP). Funded by the New Jersey Division of Developmental Disabilities, this Program, formerly called the Developmentally Disabled Offenders Program, is the only program in New

Jersey and one of only a handful of programs nationwide that advocates specifically for people with I/DD who have become involved in the criminal justice system. The program works to forge needed communication and coordination among agencies charged with assisting persons with I/DD and the criminal justice system professionals who are faced with these individuals. By providing information about offenders with I/DD to the criminal justice system, CJAP improves early identification and thus increases the likelihood of appropriate alternative disposition. By providing information to the service provider community, CJAP improves agency response and increases successful integration into the community. The goal is reducing recidivism and avoiding future incarceration, as well as contributing to the overall goal of helping people with I/DD live productive lives in their community.

Conclusion

Crisis intervention teams and other forms of training are essential to provide needed knowledge to officers and mental health workers who are the first professionals on the scene. Increased training and understanding works to de-escalate already tense situations and improves safety for officers and for the community. However, increased resources for supervision, therapy, housing and employment are imperative for long-term reduction in recidivism. CJAP has been an ongoing program since 1985 and can demonstrate good outcomes with individual clients, particularly when there is good coordination with the state's Division of Developmental Disabilities and the support of the judiciary's probation system or the parole system. Where appropriate services can be afforded, along with stable housing and employment or day activities, the possibility of limiting reoffending improves. In light of the wide breadth of diagnoses for people receiving services, from low intellectual functioning to high-functioning individuals on the autism spectrum, as well as the high percentage of sex offenses, it is clear that sex offender specific treatment, therapy and social skills training can impact positively on future criminal behavior.

Prevention must be at the forefront of any discussion to reduce recidivism and increase safety for people with developmental disabilities and the community at large. Prevention strategies must include improved education about sex and healthy sexuality. Early identification of an individual's sexual issues is another vital aspect of prevention. Early identification along with availability of long-term therapeutic assistance can reduce the tide of recidivism. Finally, good, professional supervision by trained probation and parole officers can be a successful tool in limiting new offenses. No one strategy, standing alone, can be effective. Well-trained first response, along with early identification and more available resources are all needed to reduce crime and increase safety.



April 28, 2014

The Honorable Dick Durbin
Chairman

Judiciary Committee's Subcommittee on the Constitution, Civil Rights and Human Rights
711 Hart Senate Bldg
Washington, DC 20510

Dear Senator Durbin,

In response to the hearing, "Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety," the Autism Society would like to submit the following information on its Safe and Sound™ Campaign.

Since 2005, The Autism Society's Safe and Sound™ Campaign has provided much-needed resources on topics such as general safety, emergency preparedness and prevention, and risk management as these topics relate to those with autism spectrum disorders. The Safe and Sound™ Campaign works to develop information and strategies to benefit individuals on the autism spectrum, their families and the professionals who work with them. Another significant aspect of Safe and Sound™ is to provide information and training to first responders — those who are first on the scene in an emergency situation.

Safe and Sound™ helps parents and professionals identify potential public safety or criminal/juvenile justice situations and provide possible solutions so individuals with autism spectrum disorders and those who care for them can be prepared for, stay safe during and avoid these situations.

The Autism Society's Safe and Sound™ initiative began through a collaborative effort with several first response professionals including Bill Cannata, Jimmy Donohoe and Dennis Debbaudt, all parents of individuals on the autism spectrum. Captain William A. Cannata Jr. has been a member of the fire service for more than 30 years, and became a member of Massachusetts' Autism and Law Enforcement Education Coalition in November 2003. He is now statewide coordinator. Sergeant Jimmy Donohoe spearheaded the Take Me Home program for the Pensacola Police Department. Working with a local law enforcement software company, Officer Donohoe created a database where participants who are unable to speak or properly identify themselves to police officers register with a photo, physical description and contact information so first responders can provide special assistance that may be required when contact with a person with autism spectrum disorders occurs. Dennis Debbaudt is a law enforcement trainer with more than 15 years of experience presenting autism-related training sessions. His book, *Avoiding Unfortunate Situations*, was the first resource to address the interactions between law enforcement professionals and people on the autism spectrum, and his training materials are in use by law enforcement agencies around the world.

The Autism Society's Safe and Sound™ model for first responder training is to have a person who is close to someone on the autism spectrum (e.g. parent, sibling, uncle, etc.) who is also a professional in their field train their colleagues. Only a police officer can understand what another police officer faces in terms of rules and regulations so they can use that context to provide what they need to understand about autism. The same is true for firefighter to firefighter or EMT to

EMT. They understand the mandatory protocols that have to be followed and also the nuances of the profession, so they can truly teach with authority - they speak the language and provide real life examples.

As part of its Crime Victims with Autism Assistance, Education, and Training Program, a project funded by the Department of Justice Office for Victims of Crime, the Autism Society has created a series of fact sheets and brochures to assist crime victim assistance professionals, families, and individuals with autism. An Autism Society survey of individuals with autism spectrum disorders and their families revealed that 35 percent of individuals with autism spectrum disorders have been the victim of a crime and the Autism Society is taking steps to help communities and professionals provide crime victim assistance.

Our vision is to improve the quality of life of individuals with ASD by ensuring their awareness and preparedness related to risk and safety and creating community supports to keep them safe.

The following letter is from the Autism Society's Safe and Sound™ Campaign task force member, Sergeant James Donohoe:

I am a father of six children, one of which has autism. I am also a Sergeant with the Pensacola Florida Police Department. In 2004, I came up with an idea to create a software program that law enforcement could use to identify those individuals who may not be able to communicate to law enforcement. This would include all of those that are disabled. Because of the rate of children with autism that cannot speak, this program is popular when presented to law enforcement agencies. The Take Me Home program has been sent to approximately 350 different agencies across the United States. I am lucky to work for a Department that has allowed me to send this to any law enforcement agency that requests it, free of charge. We have had ten finds with the program in our city and realize the value.

Shortly after the development of the program, the Autism Society asked me to attend their national convention and present the program. Since then they have sent me to several cities to train first responders. During these trainings, I have talked with hundreds of first responders. Most state that they were unaware of the complications of dealing with those with disabilities. Others appreciate the training because they have a loved one with a disability.

Some of the issues that are presented in our 4 to 6 hour training seem to make an impact on those in attendance, especially when presented with reports such as: 91% of the children that drown in the United States under the age of 14 are children with autism spectrum disorders; when a rescue is performed in a fire or automobile crash how the person may run from them not knowing the dangers of the surrounding traffic; how they may run back into their home that is on fire, not knowing the dangers. We try to help them identify some things that would alert them to the fact that a person has autism. We discuss the need to be compassionate when they realize that they have encountered a person with a disability. We educate them on the fact that a few extra minutes dealing with these individuals could make it easier on everyone involved, both short term and long term.

We try to present some of the tools that would be helpful in locating those that wander away. In addition to the Take Me Home program, we show them "A Child is Missing" program, the "Project Lifesaver" program and the "Medic Alert" program. Although I see the value in each program, I feel that collectively these programs can make a difference in some of the tragedies that people with disabilities are suffering and that first responders experience frequently.

I am thankful for the Autism Society and their willingness to send me to these locations and allowing me the opportunity to educate those that are responding. Like most other programs of this nature, the funding is limited.

I travel and present with a retired firefighter out of Westwood Massachusetts, Captain Bill Cannata. We feel like we have been successful because we present in our uniforms and can relate to our audience because we have been in their shoes. We talk extensively to our audiences and discover the lack of training they have received on this topic. What we have

found is that most states do not have any training programs implemented to train first responders on dealing with persons with disabilities. Those that do have something have a very limited amount of time to address this growing issue. Education is the most crucial component to the problem and again, funding is the biggest obstacle to overcome.

Recently, I learned that a Senator suggested that ten million dollars would be available for law enforcement to address the wandering issue; however, the grant that he was referring to was issued some time ago and has been earmarked for other programs both now and in the future. I appreciate the fact that you are having this hearing. I hope that a plan can be developed to address the overwhelming need to train law enforcement in the realm of those who have disabilities.

The following letter is from the Autism Society's Safe and Sound™ Campaign task force member, Captain William A. Cannata Jr.:

Autism Spectrum Disorder (ASD) is the fastest growing neurobiological condition in the world. With prevalence numbers rising exponentially over the last six decades, more and more families are living with ASD than ever before. In the United States, one in every 68 American children will have ASD. Western Europe and Canada carry similar, if not higher numbers, and Latin America, Asia, the Middle East and Africa also face challenges due to their rising numbers and the increasing obstacles to accessing care.

Autism impairs a person's ability to communicate and relate to others. It is also associated with rigid routines and repetitive behaviors, such as obsessively arranging objects or following very specific routines. Symptoms can range from very mild to quite severe.

ALEC (Autism and Law Enforcement Education Coalition) began in 2003 as a collaborative effort of the South Norfolk County Arc Family Autism Center and former Norfolk County District Attorney/Current United States Senator William R. Keating. The ALEC Program currently receives funding through the Autism Spectrum Division of the Massachusetts Department of Developmental Disabilities. The goal of ALEC training is to foster a deeper understanding of ASD among public safety and law enforcement personnel. Basic EMTs, intermediate EMTs and paramedics earn 3 OEMS hours (continuing education hours) for ALEC training.

All trainers affiliated with the ALEC Program are First Responders/Professionals (Fire Fighters, Police Officers, EMTs, Lawyers) who are family members of an individual diagnosed with ASD. The audience hears from a colleague with an extraordinary investment in the program. This aspect of our training program is what makes ALEC like no other. The feedback we continually receive is that audiences are taken aback by the commitment of our trainers and the knowledge, both professional and personal, offered during our trainings.

The first key component of the ALEC curriculum is to work with First Responders to provide them with an overview of ASD, growth rates, theories, common characteristics, effective communication methods, behavioral symptoms, sensory issues, as well as some techniques in how to respond to an emergency involving a person with ASD. This is called our "Autism 101" Program and it is delivered at every training, whether it is for Fire, Police, Court Room Personnel, Medical staff or EMS Professionals.

From there, each model of the ALEC curriculum is tailored to the audience being trained. For example, the ALEC Program for Fire Fighters, along with the overview of ASD, is specific to instances that would be relevant to Fire Fighters. The Police curriculum also includes the "Autism 101" training, but goes into details that are relevant to Police interventions. We always provide information on how First Responders can recognize an individual with ASD, and discuss how actual incidents were handled. Incidents discussed include fire rescue, police intervention, wandering, rescue from heights, motor vehicle crashes, past and current court cases involving individuals with ASD and several EMS responses along with some practical skills on how to effectively interact with an individual diagnosed with ASD.

ALEC has partnered with the Autism Society to expand training in many regions of the country. We have trained first responders in New York, New Mexico, California and Louisiana. We have also trained first responders at the Autism Society National Conference in Pittsburgh, PA. Sergeant Jimmy Donahoe and I represent both ALEC and the Autism Society.

In order to continue with this much needed training, the Autism Society needs to secure funds to continue this program. I understand a hearing on this subject is about to take place. We would really appreciate that you support this training program through the Autism Society. The program is available and ready to be delivered.

Thank you for your time and consideration. If you would like more information on the Autism Society's Safe and Sound™ Campaign or from our task force members, please feel free to contact us.

Sincerely,

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"Empowering people
with disabilities to
lead self-directed,
independent, and
productive lives in a
barrier-free
community"

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THE FREEDOM CENTER, INC

The Center for Independent Living serving Carroll and Frederick Counties

April 28, 2014

United States Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights
224 Dirksen Senate Office Building
Washington, DC 20510-6050

Re: **Law Enforcement Responses to Disabled Americans:
Promising Approaches for Protecting Public Safety**

Dear Chairman Durbin, Ranking Member Cruz, and Other Members of
The Subcommittee:

I am the Executive Director of The Freedom Center in Frederick, MD. We are a center for independent living that serves all ages of people with disabilities who reside in Frederick and Carroll Counties. We offer supports and services to empower people with disabilities to lead self-directed, independent and productive lives in a barrier-free community. We provide four core services in individual and systems advocacy, information and referral, independent living skills training, and peer counseling. It is our goal to remove all physical and attitudinal barriers that people with disabilities face in their everyday lives within the community so they can have the same opportunities to live, work, and play in their own communities. We can provide services in an array of services that include nursing home transition, housing, employment, personal assistance services, education, assistive technology, accessibility, etc. Services are designed to provide resources, training, counseling, or other assistance of substantial benefit in enhancing the independence, productivity, and quality of life of individuals with disabilities because it is a necessary component of living independently. Community awareness programs will be available to enhance the understanding and integration of people with disabilities into the mainstream of life. Most importantly, this center includes other services that may be necessary to improve the ability of an individual with a significant disability to function, continue functioning, or move toward functioning independently in the his/her own home, in the family or community.

The philosophy of the Freedom Center is to promote equal access to independent living through consumer control, peer support, self-help,

self-determination, equal access, and individual as well as system advocacy. This philosophy will maximize leadership, empowerment, independence, and productivity of individuals with disabilities as well as promote and maximize the integration and full inclusion of individuals with disabilities into the mainstream of American society. People with disabilities are particularly vulnerable when physical and attitudinal barriers are limiting them to being labeled as “special” or being held captive in the segregated setting. There is the real need to remove these types of barriers and to promote and enhance the integration and full inclusion of people with disabilities in the mainstream of their communities. They need to be included in the fabric of American life.

I would like to advocate on behalf of people with disabilities in my community regarding finding ways to encourage disability awareness and sensitivity training for law enforcement officers so that their responses to Americans with disabilities are equitable and fair without misunderstandings or abuse. There have been incidents that have occurred in the last several years in which people with disabilities have been misunderstood and reasonable accommodations were not made, arrested when an explanation would have explained the harmless situation, beaten before asking questions, and yes, killed as a result of refusing to understand. It is crucial that the Senate Judiciary subcommittee consider guidance or legislation that will require law enforcement officers to have training that will teach them how to work with people with disabilities. They need to understand each and every disability whether it is physical or hidden. They need to understand the variations within disabilities. Not all people are the same. This type of disability awareness and sensitivity training needs to be a required part of the training protocol that a cadet in training should have prior to becoming a police officer regardless of whether it is for a local, state, or federal jurisdiction. The training needs to include information about all disabilities, not just intellectual or developmental disabilities. This training is sorely needed to avoid the situations that have happened over the years. The situation is so bad that it has the appearance of profiling against people with disabilities.

I know of incidents that would support this need and they are as follows:

- A Deaf man in another city went to visit his friends who lived in a high rise apartment. He rang their doorbell only to find that they would not answer. Not knowing they were not home and assuming they did not hear the doorbell, he climbed up the fire escape to knock on their window where they would see him. Another tenant saw him and called the police. The police arrested him for attempted burglary and put him in jail. They would not get him an interpreter. He stayed in jail for a couple of days before he could explain what happened. A simple explanation would have dropped the charges and he would not have had to spend any time in jail.
- An individual with a psychiatric disability was arrested and taken to jail in Frederick County a few years ago. We were called as well as another disability

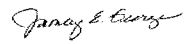
service provider to help him because they would not give him his medication. The other agency was a mental health agency and could supply him with his medication. They could not get the police to let them come with his medication.

- A person who had Diabetes in Frederick County had met his wife for dinner in another town. The person's sugar level had increased to dangerous levels and he was driving erratically. The police pulled him over and pulled him out of the car. They beat him very badly which required being transported to the hospital by ambulance. The police followed him to the hospital and pressed charges against him. There were stickers on the man's windshield as well as he was wearing a bracelet to indicate that he had Diabetes. Only after being in ICU and starting to heal, did the police understand what had happened and dropped the charges. Yes, the individual should have been pulled over. The appropriate behavior from the police should have been to seek the medical help the man needed.
- A person who worked for The Freedom Center had Panic Anxiety Disorder. She, along with a co-worker, was at an event in Frederick in which we had a display table set up on the sidewalks in Downtown Frederick. She brought her service dog, better known as a companion dog, to help her with her anxiety in being in public among 1,000's of people. Because no pets were allowed at this event, four police officers converged on her at one time. They told her that she was not allowed to have the dog there and she must leave. The Americans with Disabilities Act states that she is allowed to have a companion dog and in public places. There is no requirement for a service dog to be registered or certified to be a service dog. The ADA allows people to train their own dogs. Companion dogs are considered service dogs according to the ADA. The young girl was totally frightened and intimidated by the incident.
- The latest incident involved a young man going to the movies in Frederick. He had a developmental/intellectual disability. When the movie was over, his care provider went to get the car while he stayed inside because it was cold. He wanted to see the movie again not understanding that he had to pay again to see it. The management of the theatre called in off duty police officers who proceeded to drag him out of the theatre, forced him to the floor, and handcuffed him. He was dead by the time the care provider came back to get him. This man's death was ruled a homicide by the medical examiner but the Grand Jury did not agree. Three police officers are still working as police officers.

It is this particular incident that is bringing attention to the need for police officers to be properly training about all disabilities. They should also be trained by people with disabilities within their curriculum. They need to hear from people with disabilities to learn about various disabilities. It should not take a man's death to bring to your

attention. The appropriate laws and guidance in the United States will ensure that each state is requiring disability and sensitivity training, for all law enforcement officers whether it is for local, state, or federal jurisdictions. Thank you for consideration of this urgent and very serious matter.

Respectfully Yours,

A handwritten signature in cursive script, appearing to read "Jamey George".

Jamey George,
Executive Director



The Rural Institute: Center for Excellence
in Disability Education, Research, and Service
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STATEMENT FOR THE RECORD

**Law Enforcement Responses to Disabled Americans:
Promising Approaches for Protecting Public Safety**

**Hearing before the Senate Judiciary Subcommittee on
the Constitution, Civil Rights, and Human Rights**

Chair: Senator Dick Durbin

Date: **April 29, 2014**
Time: **10:00 a.m.**
Location: **Dirksen Senate Office Building**

Statement for the Record by:

Rosemary B. Hughes, Ph.D.

Representing:

**The Rural Institute: A University Center for Excellence
in Developmental Disabilities
The University of Montana
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I would like to thank Chair Durbin and other members of the Subcommittee for holding this important hearing. People with disabilities represent approximately 19% of the U.S. non-institutionalized civilian population (Brault, 2012). Crimes committed against this population constitute serious human rights violations, and measures must be taken to address this problem.

Due to multiple vulnerabilities for abuse¹⁴, people with disabilities experience violence at elevated and disproportionate rates when compared to people without disabilities. A literature review¹⁰ on the prevalence of interpersonal violence against people with diverse disabilities yielded lifetime rates ranging from 26 percent to 90 percent among women with disabilities and from 28.7 percent to 86.7 percent among men with disabilities. Another study¹⁹ reported more than 25 percent of individuals with severe mental illness had been crime victims, a rate eleven times greater than that estimated in the general population.

I invite the Subcommittee to consider the following priorities when addressing the response of law enforcement to Americans with disabilities:

Need for Specialized Officer Training

Evidence suggests that, as first responders¹², law enforcement officers need specialized disability-related training designed to improve their responses to people with mental illness and other disabilities⁷. Few departments provide adequate training^{7, 13, 15}. Although some police officers disagree on the need or time available for additional training⁹, there is substantial evidence that most officers acknowledge the importance of educational and training programs. For example, a survey of 125 police officers²¹ found that more than 90 percent agreed that mental health training was either fairly or very important. Officer training programs have been found to increase knowledge and reduce negative attitudes toward persons with mental illness⁴. Additionally, officers require training on responding to people with intellectual and developmental disabilities who may more readily provide confessions, accept blame, and have difficulty understanding compared to other people¹⁶.

Although evidence suggests that most law enforcement agencies provide some training on mental health issues, little is known about the nature and amount of the training⁷. According to a national study⁷ of 84 law enforcement agencies, the extent of training on mental health issues averaged 6.5 hours in academy training and one hour in-service training for police officers. More than a third did not provide post-academy training on disability issues⁷. A national survey¹⁵ found that only 56 of 133 departments provided disability awareness officer training at an average of 1.5 hours per year.

Providing police officers with basic information about disability and people with disabilities based on information generated with and by the disability community can reduce the possibility of misunderstandings between both parties and the incidences of police response based on disability-related myths and stereotypes. Evidence strongly suggests that crimes against people

with disabilities often go underreported. According to one study⁸, the majority of sexual victimization crimes against individuals with developmental disabilities did not get reported. The Protection and Advocacy, Inc.¹⁸ noted that approximately 71% of crimes against Californians with severe developmental disabilities went unreported. People with disabilities have identified barriers to reporting crime and expressed fears and concerns related to disability identification and disclosure, understanding the crime victim, credibility and victim blaming, communication challenges, and the provision of accommodations and supports³. These fears and concerns represent significant topics that should be addressed in officer training.

Need for Police Departments to Maintain Protocols for Responding to People with Disabilities

Title II of the Americans with Disabilities Act (ADA) is the Federal law that prohibits discrimination against people with disabilities in State and local governments including law enforcement agencies. This law requires police departments to make reasonable modifications to their policies, procedures, and practices to provide accommodations to crime victims with disabilities, unless the modifications would fundamentally change the service, program, or activity provided by the agency.

Research supports the need to create or improve the protocols for responding to people with mental illness and other disabilities. A recent study¹⁵ found that the majority of the 133 law enforcement departments surveyed lacked such protocols. Additionally, police departments may lack a formal policy or a specialized team in place for responding to individuals in mental health crises¹⁷. Findings from an earlier survey⁵ indicated that more than half of the 174 police departments had no specialized plan for responding to incidents involving persons with suspected mental health problems

Need for Improved Relations between Law Enforcement and the Disability Community

Strengthening the relationships between law enforcement and disability service providers and disability community non-profits could help inform and train both sides. Such relationships could foster collaborations that ultimately could benefit crime victims with disabilities and alleged offenders with disabilities as well as potentially enhance officer and citizen safety. Efficient, effective, and realistic strategies could evolve as people initiate and maintain relationships. Crime victims with disabilities have suggested that people with disabilities and police officers meet one other informally in the community rather than only when reporting a crime as well as the potential benefit of holding community events or a class where people from both communities could interact and learn from one another. The following quotation by a police officer⁹ illustrates the need for improved relations and training: "The person we're talking to is a victim of a crime, and maybe they don't feel comfortable communicating with us, or we don't have the skills to communicate with them."

According to an anecdotal report¹¹, a community task force comprised of disability organizations and services, law enforcement, and community organizations and members served as a forum for people to learn about one another and their respective organizations, and ways they could work together for the safety and well-being of the entire community. This community-based approach

provided shared ownership of decisions and products generated by the task force, expedited future problem solving, and mitigated the "us-them" relationship that can exist between the police and citizens in the community. Providing face-to-face social and educational opportunities for people with disabilities and law enforcement officials could also help reduce fear or negative attitudes of one another. Officers could use those opportunities to provide individuals with disabilities information aimed at lowering the risk of victimization, offer strategies to increase to enhance their personal safety, and provide information on how to ask for help or report a crime.

I urge the Committee to mandate adequate disability-sensitive training for police officers, require that police departments develop and maintain protocols for responding to people with disabilities, and recommend that law enforcement strengthen their relationships with the disability community.

Sincerely,

Rosemary B. Hughes, Ph.D.
The University of Montana

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Statement of University of Memphis CIT Center and CIT International for the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights hearing on "Law Enforcement Response to Disabled Americans"

April 29, 2014

On behalf of the University of Memphis CIT Center and CIT International we honorably join with other partnerships including mental health partners and advocates (NAMI and Mental Health of America) to express sincere heartfelt thanks for allowing voices (hearts of people) to be expressed and heard. Dr. Randolph Dupont and Major Sam Cochran (retired) are eager to express views and to join with others expressing the need and importance of this hearing process in discussing national issues and concerns: Community crisis issues and crisis response efforts relating to "Law Enforcement Response to Disable Americans."

A fitting starting point in my opinion is to acknowledge the harmful ways that are still very prevalent today. I speak of stigma directed to people (and family members) with mental illness and intellectual and developmental disabilities.

There is much talk (and articles) about the successful Crisis Intervention Team (CIT) model as an outstanding reflection of community partnerships - - community partners working together in effort to accomplish core elements making the CIT model a national success story. Although CIT was first introduced as a law enforcement first response to mental illness crisis events; success has opened other critical service roles. CIT is now incorporating specific training hours in service to needs of people who struggle and cope with intellectual and developmental disabilities.

The Past:

1987 is remembered by many as a time when NAMI Memphis voiced an outcry. Throughout that year, Memphis NAMI was asking: **"Why are you out there?"**

A 911 call came into Police Dispatch – a son was reported as having a mental illness, armed with a large knife, threatening family members and neighbors. Police were dispatched and after a brief encounter this 27 year old young man was fatally shot by officers. The National Alliance on Mental Illness (NAMI Memphis) had been advocating throughout 1987 promoting better ways and better services – their testimony was clear and to the point – police officers are not trained they said. Over-and-over their messages were introduced and reintroduced, but with no sense of urgent action (from the hearers) as though one was "yelling fire."

After the 1987 shooting event the urgency was captured by means of local news coverage. A "taskforce" was given political leverage and power to introduce and initiate change: a change that was intended to promote

safety for officers, family members and people who struggle and cope with mental illness. Safety was the common mission to that of assembling partnerships - law enforcement, mental health and advocacy – others too were included: University of Memphis, University of Tennessee Medical School, VA Hospital, and local and state hospitals.

During the Taskforce exploration to forge safety objectives to arrive at a specific proposal; a microscope review was undertaken to comprehend just how law enforcement training was applied to crisis events relating to mental illness. The examination findings were surprising to some – local law enforcement was actually receiving training from mental health professionals and training hours were reported more than many other law enforcement training sites. In brief: good training was being offered, but the shooting event remained troubling to many within the community.

The Taskforce Outcome/Recommendations – Crisis Intervention Team (CIT) 1988 Implementation:

- Formalizing a special Uniform Patrol response – CIT.
- Officers were given a chance to volunteer (CIT Officer) – selection process followed. CIT Officers remained in their current assignments and continued to respond to traditional calls for police services, but in addition, CIT officers were linked with Communication Dispatch to receive calls specific to mental illness crisis events – CIT Officers were the designated leader of all call events relating to mental illness.
- Leadership was essential (top down) to ensure CIT was successful in addressing and overcoming traditional and/or stigma bias mindsets.
- Other necessary components (CIT Core Elements) for CIT success were captured: partnerships, ownership, identity, change within policy and training. Specialization was recorded as a new way from other traditional ways of the past.

The Present:

This 26 year journey of introducing CIT as a law enforcement first crisis response mode (pre-jail) has been refreshing, exciting and thrilling. These words are a reflection of the many thousands of CIT champions who join others asking a demanding question: **“What are you doing out there?”**

One of the strong core elements of CIT is the passion surrounding and within the CIT partnerships and CIT training movement. Both features require specific attention from champions and the community or distractions are very likely to change the CIT model momentum to that of a “cookie-cutter” training program.

We have echoed the mantra calling: **CIT is more than just training.** There are many good intentions within our country as to “fixing” things. One traditional way of American life is to fix things by training. In almost all realms of concern I would agree – training to fix what is broke or not working well is the American way. But, traditional training ways are not enough – training without: ownership, identity, purpose, policy, resources, leadership, partnerships, and of course an active campaign fighting mental illness stigma is just that – “training.” The Question: **“What are you doing out there?”**

The empowering of CIT has much to do with protecting CIT from becoming a “cookie cutter” training program. CIT was never intended to be stifled within limitation of “good training.” Please don’t misunderstand – good training serves much to enhance performance, in fact, the more training the better. But, at what cost does “good training” minimize the attributes, skills and passion of CIT – more than just training. Again, The Question: **“What are you doing out there?”**

Specialized fields have unique status within our culture, but also, specialization is also recognized (revered) with qualities of honor – rightfully so in my opinion. Specialized fields of medicine, engineering and aviation are but three highly esteemed specialized fields. But also, specialization within traditional law enforcement has prestigious status too – SWAT is the who’s who of callout response when leadership and zeal are the preferred choice response regarding high profile call events. SWAT success is not by chance or happenstance – yes, excellent training, but also, core principles of the SWAT Team are embedded and understood within the officers and to their role. Such as: officer personal commitment, officer identity and ownership of SWAT, officer selection process, and the officer’s passion of unity and belonging to SWAT (specialization) and the community. It is here that CIT merges with the specialization as within SWAT – although a different specialty field (SWAT and CIT), but with similar core specialization attributes.

Which brings to topic discussions of training all officers to be CIT Officers? Again, I proposed CIT to be considered as a “specialist” as to a “generalist officer.” If good judgment, maturity and leadership are most needed qualities at a crisis scene, it is a personal belief crisis call events relating to mental illness would be best served having a specialist CIT officer assigned as responding officer (scene leader by policy). It is this specialization that reflects the best of attributes. Does an officer with less than one-year law enforcement experience likely to reflect the maturity, judgment, and leadership skills as that of a CIT Officer who is honored with experience, leadership skills and other outstanding attributes?

Countless stories from law enforcement, mental health partners and advocates, including people who live with mental illness have been noted within many CIT Award Programs throughout the country. Many testimonies have echoed the true meaning and purpose of CIT: Helping a special population of people who are deserving of special care and service – services to be given with dignity and respect. I speak of people who live and cope with mental illness.

CIT has successfully crossed many times over the traditional limitations of past efforts to bring change – CIT is not a law enforcement program: CIT is a COMMUNITY PROGRAM. Providing excellent training with no effort joining the community to review and address resource, system or infrastructure issues are erroneous and misguided at best.

A serious concern is within our midst: Officers receive excellent training only to be directed and/or encourage to use the criminal justice system (jail) because no accommodating system and/or infrastructure exists by which to best serve a timely service procedure. I am describing common choices of many communities; a directional outcome by which officers utilized the local county jails as a convenience of returning officers to other police duty assignments. Welcome to what is now within many communities – a new mental health system – your local county jail. **“What are you doing out there?”**

CIT works because it is a program that requires the community to act like a community. CIT works because of the passion of champions who understand the harm of stigma past and present. While researchers vigorously wrestle with data, as their calculators spin uncontrollable to solve the unsolvable: how do you prove something didn't happen – as in, CIT preventing a tragedy from happening? I would suggest a CIT officer's presence (leadership, experience, training and judgment – supported by policy making the CIT officer the scene officer in charge) would (as given in award testimonies) make a difference – live saving difference.

CIT works because the community is supporting a different message to the law enforcement officers: A CIT Message. In years past, the community called police to address community crisis issues, only police were not given training or community resources to adequately address the needs of the crisis (needs of the person or community). Law enforcement would see this as an indifference of the community – a mindset reflection many law enforcement came to own within their own thinking – “If the community doesn't care, then why should I care?”

As communities became engaged (real engagement) with CIT (more than just training); so also, became community awakenings of stigma, as a new campaign awareness of fighting mental illness stigma. It is CIT as a community program that supports a community message – a community spirit of caring for people – our people – our community. With this message, law enforcement embraces traditional of visualizing and performing CIT roles – that of helping people.

CIT works as a pre-jail diversion program, to more appropriately link people with mental illness and intellectual and developmental disabilities to appropriate care service – not jail. Again, CIT is platform by which to challenge communities to become a community of hope for all people – many of which struggle and cope with mental illness, intellectual and developmental disabilities – a community that offers and serves HOPE.

A word of caution as to duplicating outcome research studies as other previous studies. CIT is successful not solely on “training” principles alone – although training is critical, but also, the community awareness and engagement to ensure partnerships is critical. A common objective is not to create new and improved silos, but rather, community services addressing multiple service layers and/or corridors (houses, jobs, substance abuse treatment...). Is here the community envision and participates as a long-term commitment plan (strategies), rather than initiating a “Band-Aid” quick-fix effort. **“What are you doing out there?”**

When presenting CIT a thought provoking question is asked – “Do you know who was arrested 167 years ago?” With no response the following story is told:

On this day, July 23, in 1846, naturalist writer and philosopher Henry David Thoreau left his cabin at Walden Pond for a walk into Concord, Massachusetts, and ended up in jail for refusing to pay his \$1.00 poll tax. Behind the jail walls, Thoreau got the idea to write Civil Disobedience.

Thoreau came up with the term “civil disobedience” to describe his refusal to pay the \$1.00 poll tax because in part of his opposition to slavery.

As this story unfolds:

Longtime friend Ralph Waldo Emerson came by to visit Henry while he was in jail and said –

"Henry, What are you doing in there?"

With a more pointed return question, Henry asked -

"Waldo, the question is, What are you doing out there?"

Mental illness is a brain illness – yet, way too often our community treatment plans are that of local jails, due in many cases to lack of funding of resource support programs/systems. However, some critics will argue the case of state, county and local indifference is a much contributing factor.

It is not my intent to lash out at people and/or system issues, but rather to encourage a second look to that of focusing on some key service programs: CIT and local and/or regional crisis stabilization facilities (Crisis Assessment Centers). I am not suggesting one program is the cure all solution; but, if managed correctly the CIT platform (movement) coupled with programs similar to crisis assessment centers can be a "jumpstart" to getting the "team" back into the "ballgame." That is, addressing community issues within partnerships committed to both short and long term goals/purposes.

The Future:

"What are you doing out there" was the question from Henry to his friend Waldo; a question that I believe introduces an awareness of knowing the difference between what is right and what is wrong and what is kind and what is unkind.

Is not this "difference" what we are supposed to know?

My representation along with Dr. Randolph Dupont in service with The University of Memphis CIT Center and CIT International (chairmen) express our utmost sincere appreciation of your service and time to people who are deserving of honor. Service, real service is more than just training. The CIT program that we speak about is a process by which a change of heart occurs. A "heart" that is strong and committed to principles by which to engage and accomplish what is right and what is kind.

Respectfully,

Sam Cochran

Major Sam Cochran, retired
University of Memphis CIT Center, Coordinator
CIT International, Chairman



MUNROE-MEYER INSTITUTE
for Genetics and Rehabilitation

April 17, 2014

Administration

Senator Dick Durbin
Senate Chairman, "Constitution, Civil Rights and Human Rights"
Dirksen Senate Office Building Room 226
Washington, D.C. 20510

Attention: Owen Reilly

Senator Durbin and members of the Senate Judiciary Subcommittee,

RE: "Law Enforcement Responses to Disabled Americans: Promising Approaches for Protecting Public Safety"

For over eight years, the University of Nebraska's Munroe-Meyer Institute (Nebraska's federally designated University Center for Excellence in Developmental Disabilities-UCEDD) has been providing first responder training to police officers and others enrolled in a Crisis Intervention Class facilitated by the Community and Government Relations office from Alegen Creighton Health Behavioral Health in Omaha, Nebraska. The class is currently in its 22nd year and has a total of 586 graduates. Most of the focus of this week-long class is on mental/behavioral health. However, one hour is given to provide information about "Developmental Disabilities" (DD). In this hour, we provide an overview of DD, including the causes, incidence and resources to assist first responders, should they encounter someone with an intellectual or developmental disability. We also include statistics which show that typically, *individuals with DD are more likely victims of crimes rather than the perpetrators of crime*. Recently, we added a 30-minute "Parent Panel" to provide firsthand knowledge and 'lived experience' of disability and also experiences with law enforcement. This panel has been met with much enthusiasm and we have been encouraged by the facilitators and officers to continue the panel.

We have been told that officers are getting increased calls from parents having young children with autism- which only recently is covered under employer-sponsored insurance. This past year, our state legislature held a hearing looking at the services for individuals having 'dual-diagnosis.' State Senators reported they have been getting increased calls from their constituents about their inability to obtain services for their family member having a developmental disability and mental health condition. In addition, two of our panelists have adopted children who were exposed to alcohol and drugs in utero. Having these parents describe their child's strengths and also provide a background on why they might act-out has changed many of the first responder's perspectives. One parent panelist is a "frequent flyer" with calling law enforcement and is often recognized by the officers. Her take-away message to officers is that not every call that they respond to is a criminal call. Officers have visited with her after the session and have stated that they have a better understanding of her daughter's behaviors and are so grateful for having heard more about her medical condition and the steps that she has gone to advocate for her daughter. (Including losing her house to pay for her daughter's medicines.) Included are the comments from the parent panelists as well as the last round of satisfaction surveys from our session conducted on April 10, 2014.



MUNROE MEYER INSTITUTE
for Genetics and Rehabilitation

Administration

Providing this information to law enforcement, as well as incorporating the 'lived experience' of families who have tried to access these services, can give the first responders an entirely different perspective when they encounter a crisis situation. We have found this training to be very helpful and have gotten positive feedback of the past participants. However, we feel that this training needs to be expanded and incorporated across the state of Nebraska and in every state. We feel that enhancing the knowledge of first responders to recognize an individual with a DD and know how to adequately respond is very important. We encourage the committee to look toward organizations that have expertise in developmental disabilities including to the structure provided to each state from the Administration for Intellectual and Developmental Disabilities; specifically the network of University Centers for Excellence in Developmental Disabilities (UCEDD- one in every state).

If we can be of assistance, please do not hesitate to contact us.

Sincerely,

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A University Center for Excellence in Developmental Disabilities Education, Research and Service

Crisis Intervention Training

Comments from parents of children with developmental disabilities and special healthcare needs:

"One of my greatest fears as a parent of a child with special needs is being separated from them. In my instance, my son relies on an augmentative communication device to communicate his wants and needs. First responders are called in to help in emergency situations or when a child is lost or separated from their family. I rely on them to be able to identify and use their intuition to help when I am unable. So, if I can help first responders better know how to assist kids of all kinds of abilities, I feel better and I hope that I am helping not only my child but others' as well."

- Jenny

"Being the parent of a child with special needs I feel that I have to be a strong advocate for her. I want to simplify and make her life safe and as "normal" as possible. Participating in the Crisis Intervention Training allows me to voice what a parent goes through having a special needs child and the concerns and situations we often experience when individuals do not recognize our child's behaviors or lack of communication for what it truly is. The child's disability; specifically their lack of being able to adequately communicate or even understand the situation is not often understood. I feel the more educated people are in the community whether it be family, friends, professionals or co-workers it will allow my daughter to be safe, and participate in her community as she is capable."

I went away from participating in the CIT parent panel believing that the officers who participated in this training had a better understanding of why I might need assistance and that not every call that they go to is a criminal call. By informing the 911 communication dispatch center of my daughter's needs, the officers responding to the call are more prepared and are able to accommodate her and my needs. Participation on this panel made me feel like I advocated for not only my daughter but all individuals with disabilities who may encounter police or first responders."

- Mary

"I adopted my son, Tyler when he was five years old. I did not know that his mother had used both drugs and alcohol while she was pregnant until after the adoption was finalized. We realized that he most likely had an intellectual disability and global developmental delays. Once we got his medical records, we learned that he tested positive for cocaine at birth and that his birth mother had been giving him ADHD medications as early as 18 months old. Initially, his behavior was manageable and we could get assistance. However, after the birth of my twins-when the attention was not focused solely on him we started having more violent outbursts including aggression towards his siblings."

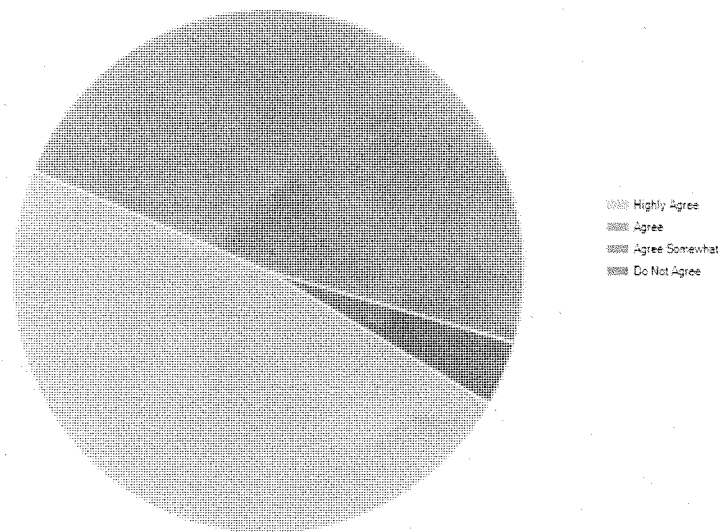
I have had to call the police in the past for assistance. Having the opportunity to educate police and first responders is very important to me. I want them to understand that I have tried to access various systems for support but have gotten doors shut because my son does not 'fit' into a specific system. He has a co-occurring disorder- an intellectual disability and mental health issues and because he does not 'fit' into one system he is restricted access to services. Sometimes a call to 911 during a crisis is necessary but from my experience police need to understand the context of the situation. Specifically, that sometimes we have to 'enter the system' (in this case through 911) simply to get the support we need."

- Tara

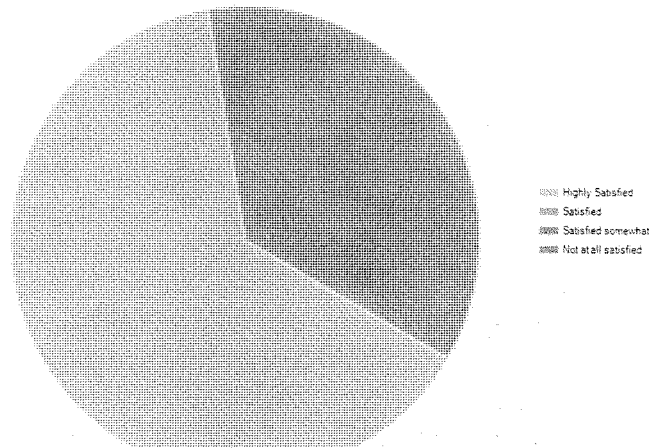
Crisis Intervention Training
Omaha, NE

Survey responses from 25 participants in April 10, 2014 C.I.T class:

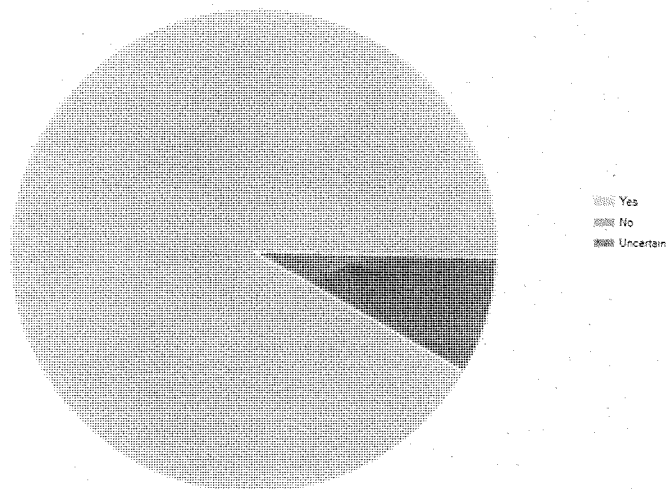
My understanding of developmental disabilities improved as a result of this presentation.



Overall, my satisfaction with this presentation was:



If I encountered someone with a developmental Disability or special healthcare needs, I would know how to respond.



**United States Committee on the Judiciary
Subcommittee on the Constitution, Civil Rights, and Human Rights
"Law Enforcement Responses to Disabled Americans: Promising Approaches
for Protecting Public Safety"**

**Written Testimony of Nicholas Turner
President and Director**

**Vera Institute of Justice
233 Broadway, 12th Floor
New York, NY 10279
April 29, 2014**

Thank you, Chairman Durbin, Ranking Member Cruz, and members of the Subcommittee, for the opportunity to submit written testimony for this hearing on law enforcement responses to Americans with disabilities.

The Vera Institute of Justice (Vera) is an independent, nonpartisan, nonprofit center for justice policy and practice, with offices in New York City, Washington, D.C., Los Angeles, and New Orleans. Since 1961, Vera has combined expertise in research, technical assistance, and demonstration projects to help develop justice systems that are fairer, more humane, and more effective for everyone.

A. Background on Disability Concerns in America

Equal opportunity for people with disabilities in the United States has commonly built upon the vision and language of the Civil Rights Act of 1964. There has been a perception of people with disabilities as a minority group with the same needs for protections of rights to equal opportunity as everyone else. Estimates of the number of people with disabilities in the United States vary for a variety of reasons: it is difficult to categorize, may not be a fixed condition and may not be acknowledged by the person. Estimates of the size of the population of people with disabilities in the U.S. include the 54 million that was used prevalently during the development and passage of the Americans with Disabilities Act (ADA) in 1990. That number is largely supported still by U.S. Census reports. In 2003, the Census Bureau released an analysis of 2000 census data that found 49.7 million people in the age group 5 years and over, non-institutionalized population, with at least one disability.¹

A small but persuasive body of research suggests that violence and abuse occur at epidemic rates among people with disabilities. It also suggests that people with specific kinds of disabilities are at a higher risk than others. Individuals with developmental disabilities, for example, are up to 10 times more likely to experience sexual assault than other adults. In one study, among adults who had a developmental disability, as many as

¹ U.S. Census Bureau (2003). Disability Status: 2000, Census 2000 Brief.

83 percent of females and 32 percent of the males are the victims of sexual assault.² Moreover, research and anecdotal evidence indicate that Deaf individuals and people with disabilities—regardless of their disability type—experience significant barriers to accessing and receiving services that provide support and safety for survivors of domestic and sexual violence.

In 2012, the age-adjusted rate of violent victimization for persons with disabilities (60 per 1,000 persons with disabilities) was nearly three times the rate among persons without disabilities (22 per 1,000 persons without disabilities). According to the most recent FBI statistics on hate crimes, 105 individuals were victims of a hate crime due to the offender's bias against a disability in 2012. People with disabilities are especially vulnerable to crime, and given the significant population of people living with disabilities in the United States, it is important to provide services to support them.³

B. Violence Against Americans with Disabilities

Though greater research is needed, the research and anecdotal evidence that does exist consistently suggests that people with particular disabilities are at a higher risk for victimization. Adults with disabilities, for example, are 3 times more likely to experience violent victimization.⁴ Children with disabilities are **almost 2 times** more likely to be neglected or abused.⁵ For example, children with disabilities are 2.9 times more likely than children without disabilities to be sexually abused and the rate is even higher (almost five times) for children with intellectual or mental health disabilities.⁶

People with specific kinds of disabilities are at higher risk than others. Individuals with cognitive or intellectual disabilities, for example, experience the highest rates of victimization. Additionally, individuals with multiple disabilities are more likely than those with one disability to be victimized.⁷

Individuals with disabilities are also more likely to experience certain crimes than others, with rates of sexual violence being alarmingly high. Both men and women reported markedly higher levels of lifetime and past-year sexual assault – from two to four times higher than individuals without disabilities.⁸ Some studies have found that individuals with developmental disabilities are up to ten times more likely to experience sexual assault than others. In one study, among adults who had a developmental disability, as many as 83 percent of females and 32 percent of the males are the victims of sexual

²D. Sobsey and S. Mansell. 1990. The prevention of sexual abuse and assault. Sexual exploitation of people with disabilities [Special Issue]. *Sexuality and Disability*, 9, 243-259.

³Crimes Against Persons with Disabilities. BJS, 2009-2012.

⁴Crimes Against Persons with Disabilities. BJS, 2009-2012.

⁵Sullivan, P. M. et al (1997) Maltreatment of children with disabilities: family risk factors and prevention implications. *Journal of Child Centred Practice*, 4(1): 33-46.

⁶Lund, Emily M., and Vaughn-Jensen, J. 2012. "Victimisation of Children with Disabilities." *The Lancet*, Volume 380 (Issue 9845), 867-869.

⁷Rand and Harrell. *Crime Against People with Disabilities*. 2007, 4.

⁸M. Mitra, V.E. Mouradian, and M. Diamond. 2011. Sexual Violence against men with disabilities. *American Journal of Preventive Medicine* 41(5) 494-7.

assault.⁹ While sexual assault is of particular concern to girls and women with disabilities, boys and men with disabilities experience high rates of sexual violence, as well. A recent prevalence study based on data from the Massachusetts Behavioral Risk Factor Surveillance System (n=25,756) found that men with disabilities were more likely to have experienced past-year sexual assault than men and women without disabilities, but less likely than women with disabilities.¹⁰

Compounding the problem of high incidence of victimization is that people with disabilities, compared to people without disabilities, are more likely to experience more severe victimization, experience it for a longer duration, be victims of multiple episodes of abuse, and be victims of a larger number of perpetrators.¹¹ People with disabilities are at an increased risk for experiencing violence in unique settings, including group homes, hospitals and institutions. Finally, while people with disabilities are victimized by many of the same people who victimize people without disabilities such as partners, family members, and acquaintances, they are also victimized by professionals connected to them through their disability such as personal care attendants, transportation providers, and health professionals.¹²

Despite high rates of victimization, crime victims with disabilities are underserved by victim services programs and the criminal justice system. Many of the traditional avenues of support for victims of crime are currently inadequate for people with disabilities. Unfortunately, when victims with disabilities seek help, they often find that their trusted disability providers are not equipped to support them in finding respite from the violence in their lives and victim services organizations, who they are often unaware of, are often inaccessible and not equipped to serve people with disabilities.¹³

The criminal justice system possesses barriers unique to its roles. Law enforcement personnel lack training on how to effectively interview survivors with disabilities, especially those with cognitive disabilities or other disabilities that impact speech. Prosecutors often question the credibility of survivors with cognitive or psychiatric disabilities, which often results in the dismissal of these cases. In addition, court and other personnel often lack knowledge about how to effectively provide accommodations, such as American Sign Language interpreters, resulting in flawed investigations and case dismissals. Moreover, a lack of cross-system collaboration prevents the sharing of

⁹ I Johnson, R. Sigler. 2000. Forced Sexual Intercourse Among Intimates. *Journal of Interpersonal Violence*. 15 (1). Available at <http://www.wcasa.org/info/factsheets/disabfact.htm> (accessed April 12, 2010).

¹⁰ Mitra, M., Mouradian, V. E., & Diamond, M. (2011). Sexual violence victimization against men with disabilities. *American Journal of Preventive Medicine*, 41(5), 494-497.

¹¹ J. Schaller and J.L. Fieberg, 1998. Issues of abuse for women with disabilities and implications for rehabilitation counseling. *Journal of Applied Rehabilitation Counseling*. 29(2), 9-17.

¹² J.P. Atkinson and K.M. Ward (2012) The Development of an assessment of interpersonal violence for individuals with intellectual and developmental disabilities. *Sexuality and Disability* 30(3) 301-309.

¹³ Office for Victims of Crime (OVC), Promising Practices in Serving Crime Victims with Disabilities. http://www.ovc.gov/publications/infores/ServingVictimsWithDisabilities_bulletin/crime.html#patterns (accessed February 27, 2014)

resources and knowledge to address the gaps within service delivery and criminal justice systems.

C. Substance Use and Mental Health

For decades in the U.S., individuals whose underlying problem is an illness or an addiction have been over-represented in the nation's criminal justice system. Mental illness is 2 to 6 times more prevalent in correctional facilities than in the general population, and more than 7 out of 10 prisoners with a mental illness also struggle with addiction.¹⁴ It is well documented that people with psychiatric needs do not fare well in correctional environments, where they are more likely to be victimized and placed in segregation that can lead to further decompensation.¹⁵

Recent research published in the *American Journal of Public Health* found that people with serious mental illness are 3.7 times as likely to self-harm for every day they are held in New York City jails are more than six times as likely to engage in potentially fatal self-harm compared with others in custody.¹⁶ Equally troubling, prison populations across the country have swelled due to long sentences for nonviolent drug offenses.¹⁷

Despite the high rates of need, the quality of health services available behind bars is generally poor and there is a lack of communication between criminal agencies and community treatment providers to help ensure that these individuals are linked to services as they transition between systems. This can result in what has been described as a "revolving door" where people with mental health needs needlessly and continuously cycle between the street and jail, while their psychiatric needs go largely unaddressed.

But this is beginning to change. Many policymakers and practitioners see these trends as costly and counterproductive, and are actively seeking alternatives. Several provisions of national health reform, including Medicaid expansions and parity, offers new opportunities for state and local jurisdictions to bolster the capacity of behavioral health services in the community and support collaborative approaches between health and justice agencies to abate the over-incarceration of people with serious mental illness.

Through Vera's research it has been particularly clear that more preventative measures are needed at the front-end of criminal justice systems that are designed to divert people whose contact with law enforcement is caused by an underlying mental health need away from incarceration and connect them with the community-based services. A growing body of research shows that diversion can effectively reduce recidivism, improve health,

¹⁴ Baillargeon, J., Binswanger, I., Penn, J., Williams, B., & Murray, O. (2009). Psychiatric disorders and repeat incarcerations: the revolving prison door. *American Journal of Psychiatry*, 166(1), 103-109; See also, Steadman, H., Osher, F., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60(6), 761-765.

¹⁵ Blitz, C. L., Wolff, N., & Shi, J. (2008). Physical victimization in prison: the role of mental illness. *International Journal of Law and Psychiatry*, 31(5), 385-393.

¹⁶ Kaba, F., Lewis, A., Glowa-Kollisch, S., Hadler, J., Lee, D., Alper, H., & Venters, H. (2014). "Solitary confinement and risk of self-harm among jail inmates". *American Journal of Public Health*, 104(3), 442-447. Chicago.

¹⁷ King, R. S., & Mauer, M. (2002). "Distorted priorities: Drug offenders in state prisons." Sentencing Project.

and yield cost savings.¹⁸ Having specially trained law enforcement units, such as Crisis Intervention Teams (CITs) is one essential diversionary tool. CITs are expert teams comprised of police officers and mental health professionals who are specially trained to peacefully deescalate situations where police are called to respond to a person who is in a state of emotional crisis or psychosis. As Jim Parsons, Vera's Vice President and Research Director, wrote recently:

*"Training police officers on how to respond appropriately to people with mental illness can prevent the tragic deaths that can result from these interactions, but the police are only one part of a coordinated approach that is needed to better serve the increasing number of people with serious mental illness who come into contact with the criminal justice system."*¹⁹

In New York City, panelists at a recent briefing convened by the Vera Institute of Justice also described initiatives to provide mental health interventions at various points in the criminal justice system.²⁰ These range from the initial encounter with a law enforcement officer, to programs that identify mental health needs when defendants first come into contact with the courts, to specialized mental health courts created as an alternative to incarceration for defendants with mental illness, to services designed to help people connect with treatment in the community upon their release from custody.

It is essential to grasp opportunities to connect people with the services and treatment needed to address their mental illness in community settings, rather than placement in jail and prison for noncriminal behavior. The disproportionate number of people with behavioral health disorders involved in the criminal justice system puts a tremendous strain on scarce public resources and has a huge impact on health care and criminal justice budgets. However, with appropriate treatment and access to community-based services, this population is less likely to be incarcerated and more likely to lead healthy, productive lives, resulting in substantial costs savings.²¹

D. The mental health of crime victims

Research on "secondary victimization" describes how contact with the criminal justice systems can have a detrimental impact on the mental health of victims, beyond the experience of the original crime.²² For example, the initial contact with law enforcement can leave victims feeling that their experiences are not taken seriously by the police or are treated purely as an administrative matter. In the courts, crime victims often report that the process for hearing cases is confusing and that the outcomes seem arbitrary. We need to do a better job of supporting victims if we are to avoid exacerbating the trauma of

¹⁸ David Cloud & Chelsea Davis. "Treatment Alternatives to Incarceration for People with Mental Health Needs in the Criminal Justice System: The Cost-Savings Implications." (Vera Institute of Justice, 2013).

¹⁹ Letter to the Editor, *New York Times*, April 11, 2014, located at:

http://www.nytimes.com/2014/04/12/opinion/mentally-ill-in-prison-and-outside.html?_r=1

²⁰ Panel can be seen at: <http://www.vera.org/videos/justice-transition-nyc-justice-system-mental-illness-trailer>

²¹ <http://www.vera.org/sites/default/files/resources/downloads/treatment-alternatives-to-incarceration.pdf>

²² Parsons, J., Bergin, T. (2010) The impact of criminal justice involvement on victims' mental health. *Journal of Traumatic Stress*, 23, 128.

violent crime. Studies of procedural justice have shown that victims report greater satisfaction with the outcome of their case and may experience improvements in their mental health if they feel that the police and courts acted in a way that was fair and equitable, that includes the perspective of all parties involved.^{23,24}

E. Vera's Work

Vera's Center on Victimization and Safety (CVS) works with communities around the country to fashion services that reach, appeal to, and benefit all victims. CVS's work includes initiatives focused on populations at elevated risk of harm who are often marginalized to ensure that these underserved victims of crime have equal access to services and criminal justice interventions. The Center combines research, technical assistance, and training to help policymakers and practitioners close gaps in systems and ensure that all survivors of violence have access to the services and support they need and want.

There is still much to learn about how individuals with disabilities experience crime and use victim services and the criminal justice system, as well as what services are most responsive to their needs and effective in the long run. To build the kind of knowledge that makes a real difference in the lives of victims, Vera is conducting empirical studies in the area and finding ways to better link practitioners to research findings. For example, with the support of the National Institute of Justice, Vera is currently studying how cases involving sexual assaults of people with disabilities are prosecuted. In the past, Vera has studied other areas such as the prevalence and nature of sexual abuse among children with disabilities and used our research to craft prevention strategies and inform the work of policy-makers and practitioners across the country.

In 2012, Vera partnered with the Ms. Foundation for Women to examine the prevalence of this abuse and existing responses and to recommend next steps for a national strategy to respond to this epidemic. Vera's brief, *Sexual Abuse of Children with Disabilities: A National Snapshot*, summarizes the study, its findings, and its recommendations.²⁵ The report finds that the higher incidence rate of sexual abuse of children with disabilities, coupled with the gaps in prevention efforts and barriers to getting help these children and their families face, warrant dedicating increased attention and resources to this issue. People and organizations charged with supporting children with disabilities and those addressing sexual abuse must strengthen their commitment and action to stop this epidemic and to assist the children who have been affected by it.

The complexities of the issues surrounding sexual abuse of children with disabilities require a unified and cohesive strategy. Because no such national strategy currently exists, the first and essential step is to create and, ultimately, implement one. Forums on the local, state, and national level can bring together people with disabilities, their family

²³ Orth, U. (2002). Secondary victimization of crime victims by criminal proceedings. *Social Justice Research*, 15, 313-325.

²⁴ Bell, M.E. (2007). Empowerment and disempowerment for victims of intimate partner violence: An overview of the effects of criminal justice system practices. In K. Kendall-Tackett, & S. Giacomoni (Eds.) *Intimate Partner Violence*.

²⁵ <http://www.vera.org/pubs/sexual-abuse-of-children-with-disabilities-national-snapshot>

members, and professionals from the areas of criminal justice, disability, health and medicine, schools, and victim services, among others.

Vera is also working nationally and with specific Department of Justice-funded communities – more than 50 communities in 21 states since 2006 – to create equal access to victim services and criminal justice options for victims with disabilities, especially those who are experiencing domestic and sexual violence. Vera is helping disability organizations develop and implement screening tools to identify people who have experienced domestic or sexual violence and implement procedures that ensure staff provide crisis interventions to victims. Vera is also helping victim services organizations design better outreach strategies to people with disabilities and to remove physical, attitudinal, and programmatic barriers that prevent people with disabilities from using their services. Moreover, by building collaborations between victim services and disability organizations and better sharing resources, Vera is helping these communities to enhance their existing infrastructure instead of creating new services for victims with disabilities.

Vera is sharing the lessons-learned and model policies and practices developed in these demonstration communities through a training academy. Since 2008, through in-person conferences and trainings, as well as webinars and video-conferences, Vera has trained more than **2000** law enforcement officers, victim service providers, disability advocates, and other professionals to respond more effectively to crime victims with disabilities. Vera has also offered specialized trainings to American Sign Language interpreters to increase their capacity for interpreting in contexts of domestic and sexual violence and is in the process of developing a training to help people with disabilities become more active in the movement to end violence in their lives.

Vera is also helping government and nonprofit organizations identify what works and what doesn't when it comes to effectively serving victims with disabilities. With support from the U.S. Department of Justice, Vera has developed practical system based on performance indicators organizations working to improve their services for victims with disabilities can use to track their progress. Currently, Vera is piloting this system in 10 communities across the country, with the hopes of expanding nationwide at the end of the year.

In addition, Vera's Substance Use and Mental Health Program (SUMH) is helping states and localities fashion evidence-based policies and practices that expand access to behavioral health care and promote greater collaboration between health and justice agencies to make the most effective use of public resources.

SUMH conducts applied research to help public officials and community organizations develop empirically driven responses to the substance use and mental health needs of people involved in justice systems. SUMH staff collect and analyze quantitative and qualitative data and evaluate existing programs to understand the experiences of those affected by psychiatric disorders or substance use and policies that prolong their involvement in the justice system.

SUMH's DC Forensic Health Project (DCFHP) uses data from several Washington, DC agencies to gauge rates of mental health problems among people arrested in the District and to assess the services they receive. Its aim is to provide government and community-based organizations with the information they need to improve the effectiveness and reach of mental health services.

Currently, SUMH has funding from the Bureau of Justice Assistance to conduct a follow-up study of this analysis that will include the Medicaid agency data with the goal of developing strategies related to Medicaid enrollment and care coordination. The Project, which is called "Bridging the Justice-Health Divide: Furthering Innovation through Information Sharing," began last year and it will be completed in 2016.

The project's main goals are to: 1) Create a multi-agency database to profile rates of mental health data, service engagement and Medicaid enrollment, using an innovative data matching and encryption technique; 2) support local agencies in efforts to use data to guide decision-making; and 3) provide practical guidance to a national audience of practitioners. We look forward to sharing findings from this work with the Committee as it continues to focus on this important topic.

The program also maintains a national online resource, *Justice and Health Connect*, which provides policymakers with practical guidance for increasing information sharing across health and justice systems to improve public safety and health outcomes, and make more efficient use of public resources.²⁶

SUMH team members are part of a pioneering Steering Committee comprised of John Jay College of Criminal Justice, Columbia University, and New York University called "From Punishment to Public Health" that is in part, exploring innovative ways for public health and law enforcement to develop collaborative solutions to address the over-representation of people with serious mental health needs in NYC's criminal justice system.

SUMH recently completed an in-depth analysis for the New York State Office of Mental Health and the New York City Department of Health and Mental Hygiene and provided recommendations to help improve forensic psychiatric services for individuals found incompetent to stand trial and committed to a state hospital for treatment. SUMH is currently working with a range of state and local stakeholders to develop plans for alternative competency restoration service models to improve the efficiency and effectiveness of New York's competency restoration treatment for an extremely vulnerable population.

Vera is also partnering with the Bureau of Correctional Health Services in New York City's Department of Health and Mental Hygiene to implement significant reforms to how ways that arrestees are screened for health problems in the city's central booking

²⁶ www.jhconnect.org.

facilities. SUMH has established a Steering Committee and coordinating efforts to increase the capacity of staff working in central booking to detect acute and chronic health conditions, and utilize health information technology to improve clinical decision-making and triage of care between providers working in community health and correctional settings.

F. Concluding Statement

In closing, I would like to thank the Chairman and Ranking Member for holding this important hearing, and for the opportunity to provide written testimony. Please do not hesitate to contact us if the Vera Institute of Justice can provide further assistance.



WASHINGTON STATE
CRIMINAL JUSTICE TRAINING COMMISSION

Susan L. Rahr, Executive Director

19010 1st Avenue South • Burien, WA 98148 • Phone: 206-835-7300 • www.cjtc.state.wa.us

April 28, 2014

Dick Durbin (D-IL), U.S. Senator and Chairman
Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights
U.S. Senate Assistant Majority Leader
U.S. Senate
Washington, DC

RE: Washington State Crisis Intervention Team Training & Programs Statement of Record to "Law Enforcement Responses to Disable Americans: Promising Approaches for Protecting Public Safety" Hearing, April 29, 2014

Chairman Durbin, et al,

The Washington State Criminal Justice Training Commission (WSCJTC) is the lead state agency for training for local law enforcement and corrections personnel. Per state law, RCW 43.101, all local municipalities are required to have basic law enforcement training within six months of hire, provided by the WSCJTC. The WSCJTC is also responsible to ensure 24-hours of annual in-service training is completed by every fully commissioned law enforcement officer.

Over the past six years, the WSCJTC has been mandated to provide Crisis Intervention Training for first responders to enable them to more effectively respond to persons in mental health crisis. We currently offer the following three programs:

- CIT-Statewide Training
- CIT-King County Program
- CIT-Basic Law Enforcement Academy (BLEA)

Additionally, in 2005, the Washington State Legislature created an option for counties to raise the local sales tax by 0.1 percent to augment state funding for mental health and chemical dependency services and therapeutic courts. More than a dozen counties in Washington have now implemented the sales tax increase to date.

CIT-Statewide Training

With 39 counties in Washington the WSCJTC has been provided legislated authority to provide training to law enforcement personnel to meet the needs of the communities in our state. As such, the WSCJTC set out in 2008 to create a "CIT Suggested Course Materials Manual" that is a "How-To" guide to set up and administer a CIT training for law enforcement personnel and is currently available online for download by any requesting agency from across the country.

Mission: The Washington State Criminal Justice Training Commission enhances public safety by establishing standards and providing education and training.

Values: Professionalism • Integrity • Accountability



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The WSCJTC also partnered with "The Arc" of Washington State (developmental disabilities advocacy group) to create a roll-call training CD called, "Interacting with Persons with Developmental Disabilities and Mental Illness." This CD is available to any requesting law enforcement personnel from across the country.

Due to budget shortfalls in 2010, the WSCJTC lost the statewide funding training, but still worked with local CIT coordinators to help provide resources and training opportunities. In 2013, due to public outcry after several negative incidents involving law enforcement responses to persons in mental health crisis, the Washington State Legislature reinstated funding for CIT training and the WSCJTC now provides a standardized CIT 40-hr training and hosts training at least five times a year in various locations across the state.

CIT-King CO Program

An extensive exploration of the possibility of utilizing the tax option in King County began with passage of a council motion, which yielded a three-part Mental Illness and Drug Dependency Action Plan completed in June 2007. The council accepted the action plan via motion in October 2008, and authorized the sales tax levy collection via an approved Council Ordinance on Nov. 13, 2007. In October 2010, the WSCJTC became the administrator of the CIT King County Mental Illness and Drug Dependency (MIDD) Plan funding under strategy #10(a) – Crisis Intervention Training Program for King County Sheriff, Police, Jail Staff, and Other First Responders."

For King County, the sales tax increase will yield approximately \$30 million in its first year and over \$50 million annually through 2016, when the sales tax levy is scheduled to end. Currently the MIDD Oversight Committee is looking to submit an action plan to extend the MIDD Plan by Council Ordinance beyond 2016.

Any law enforcement personnel taking the training that have overtime or backfill while at training receive reimbursement for attendance at \$55/hour per the program. The WSCJTC provides at least one CIT 40-hr training per month (using a school schedule), and offers additional CIT 8-hr trainings on the following subjects: in-service, advanced, force options, youth, Mental Health First Aid, and Justice Based Policing. Additionally, the WSCJTC has set up a partnership with Army OneSource to provide free 4-hr online training to all criminal justice personnel entitled, "Veterans-Treating the Invisible Wounds of War."

Statistics

CIT-King CO Program Passed Counts October 2010 – March 2014 (all criminal justice attendees)

Training Type	Adult Basic Attendee Count	Adult In-Service Attendee Count	Adult Force Options Attendee Count	SAFETY Youth Attendee Count	Other CIT Training Attendee Count*	Adult Justice Based Policing Attendee Count	Attendees Total
Total Passed Count	271	263	279	162	138	14	2027

*Other CIT Training Counts: (Mental Health First Aid, Advanced Training, Recruit Training, Train the Trainers, etc.)

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CIT-King CO Program Law Enforcement Only Passed Counts, October 2010 – March 2014

<i>CIT-KING CO Agency Completed Count LAW ENFORCEMENT ONLY</i>	<i>40-HR Basic</i>	<i>8-HR In-Service</i>	<i>CIT Other Training*</i>
<i>Total Passed Count</i>	<i>797</i>	<i>657</i>	<i>284</i>

*Other CIT Training Count: (Mental Health First Aid, Advanced Training, Executive Roundtables, Train the trainers, etc.)

CIT-Basic Law Enforcement Academy Training (CIT-BLEA)

In 2013, the Washington State Legislature allocated funding for crisis intervention team training during the basic law enforcement academy for all newly hired law enforcement personnel. The WSCJTC has set this training up as an introduction to de-escalation techniques and an opportunity for recruits to learn about mental health resources in their local jurisdictions. The training was implemented in March 2014, and looks extremely promising. Approximately 360 recruits per year will receive eight hours of mental health/CIT related training while funding is provided.


The basic academy recruits are also given the developmental disabilities training CD for their own additional training outside of the academy.

Wrap Up

The WSCJTC continues to enhance public safety with valuable training and to that end also holds an annual CIT Regional Conference that is open to any criminal justice personnel nationwide to attend. It is free, held every August, and is currently hosted in partnership by the WSCJTC, King County Mental Health, and the Marion County Crisis Outreach Response Team (Marion County, Oregon). The purpose of the training is to provide additional CIT training on current news topics, address training not covered in basic CIT training, and to address cultural competency needs regarding specific user populations. This August will mark the fourth CIT Regional Conference.

For more information on the WSCJTC CIT training visit: www.cithappens.com.

Sincerely,


Sue Rahr, Executive Director
Jeff Myers, Commission Chair
Debbie Mealy, Deputy Director
CIT Training Program Staff, et al

Mission: The Washington State Criminal Justice Training Commission enhances public safety by establishing standards and providing education and training.

Values: Professionalism • Integrity • Accountability



Insurance Authority

April 28, 2014

P.O. Box 88030

Tukwila, WA 98138

Phone: 206-575-6046

Dear Senator Durbin,

Fax: 206-575-7426

Thank you for your interest in this important and growing problem in our Communities. The Washington State Criminal Justice Training Center's (WSCJTC) Crisis Intervention Training (CIT) is a critical state resource for local police agencies.

We have seen diminishing State and Federal resources devoted to meeting the medical needs of mentally ill citizens. Small changes that curtail an individual's ability to meet the daily needs of medication, appointments or timely available hospital beds in times of crisis has huge impacts to Law Enforcement responses. The WSCJTC is our State's leading resource for ongoing training to our State's Police agencies on dealing with the mentally ill. We believe in their training of Officer's so much so that we budget funds for Speakers and Trainers to speak to our Police Agencies. The need is greater than local and state law enforcement can bear.

When medical resources are unavailable, the mentally ill will engage the Community in less healthy interactions. Many times the mentally ill are victimized by street level crime and seek law enforcements help in reporting the crimes. Unfortunately their medical needs, many times, leaves them less able to constructively assist the Police in developing an investigation or if leads are developed that lead to criminal charging against the offenders since the mentally ill can be hard to locate for prosecution many months later. The criminals know this and continue to victimize the vulnerable mentally ill population that lives in our area and are our mom's, dad's, brothers, sisters and children.

The other side of dealing with the mentally ill is when an Officer is confronted by a person in crisis. An Officer will be dispatched to a disturbance call and then be face to face with urgent issues of safety to the mentally ill person, to other members of the public and to the Officer herself. The Officer many times will perceive a level of mental illness but will have no reliable history of what the illness is or what approach may best work in the situation. The WSCJTC provides some general information to greatly assist the Officers on some approaches that may assist in handling the dynamic, dangerous and many times escalating environment. Thankfully, many great women and men serve our Communities as Police Officers and most interactions are resolved well, for the mentally ill citizen and for the public. Occasionally use of force is required and a result no one would have wished for is obtained.

Unwanted outcomes have devastating personal consequences for families and communities. They also regularly result in litigation against Officers. Juries today are requiring more and more of government services. The jurors assume adequate medical services, even when those services are woefully lacking. When jurors are informed of present mental health issues, we have seen a shift in their expectations of Police Officers. The jurors expect Police Officers to handle the situation with therapeutic responses to the mentally ill citizen. The jurors are less likely to allow the Officers to use traditional law enforcement use of force procedures. If the dynamic situation develops suddenly to a use of force situation, the plaintiff attorney will fault the Officer's for not responding in a medically responsible way prior to using

force. It is a tough situation for our Officers and a dilemma for local government. As traditional sources for governmental medical services are eroded, the legal liability exposure to local police agencies rises. This is a poor formula for local resources or for communities committed to caring for our most vulnerable community members.

The WSCJTC is the backbone of our State and local law enforcements response to this growing crisis. It is the last line of governmental response for the Civil Rights of the mentally ill. The WSCJTC's efforts to train local police on how to deal with the mentally ill is important and vital work. Until we fully fund the medical needs of this vulnerable and difficult Community, we will continue to lean greatly on the WSCJTC and its efforts with Crisis Intervention Training. It is the last line of help for Officers and the Mentally Ill and is deserving of your recognition, support and funding for expansion.

Sincerely,



Patti Crane, Member Services Manager
Washington Cities Insurance Authority