



Advocacy Position Statement

Strengthening Relationships between Police and Persons with Intellectual Developmental Disability Co-occurring with Mental Illness: Family Perspectives and a Call for Action

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NADD is an international association for persons with intellectual/developmental disabilities and mental health needs. It comprises individuals, families, and support professionals dedicated to enhancing the understanding and treatment of people experiencing co-occurring intellectual/developmental diagnoses, including autism spectrum disorder, and mental health conditions or mental illness.

The national social and racial justice movement inspired the Family Voices Committee of NADD to examine police interactions with the people NADD represents.

DEFINITION OF TERMS

Developmental disabilities are a group of conditions due to an impairment in physical, learning, language, or behavior areas. These conditions begin during the developmental period, might impact day-to-day functioning, and usually last throughout a person's lifetime.¹

Intellectual disability is a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18.²

Mental illnesses are health conditions involving changes in emotion, thinking, or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work, or family activities.³

Dual Diagnosis, for the purposes of this paper, refers to a mental illness co-occurring with an intellectual/developmental disability.⁴

Autism spectrum disorder (ASD) is a developmental disability that can cause significant social, communication, and behavioral challenges. People with ASD may communicate, interact, behave, and learn in ways that are different from most other people.⁵

THE NEED FOR CHANGE

NADD's Family Voices Committee is gravely concerned about how often interactions between police and people with a dual diagnosis result in traumatic experiences, bodily injuries, and deaths.

We demand systemic change in the way law enforcement responds to persons who have dual diagnosis, in order to bring about positive outcomes for the person, their family, and the police.

There is a lack of reliable data that track interactions between police and persons with mental illness or persons with a disability, much less persons with a dual diagnosis. However, here is what research and news reporting suggest:

- Individuals with disabilities — including physical and cognitive — constitute one-third to one-half of all people killed by law enforcement officers. In fact, most fatal use-of-force cases that draw national attention involve people with disabilities.⁶
- What's more, people with disabilities are disproportionately incarcerated and are more likely to become victims of police violence.⁷
- 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.⁸
- Individuals with untreated mental illness are 16 times more likely than other civilians to be killed during an encounter with police.⁹
- Misunderstandings about mental health and disabilities have led to countless incidents in which people with mental health conditions have suffered brutality and violence at the hands of law enforcement.¹⁰
- People with mental or physical disabilities are 13 percent more likely to be arrested as juveniles or young adults than people without a disability, according to a report in the *American Journal of Public Health*. For African Americans, disability increases the chances of arrest by 17 percent. In fact, more than 55 percent of African Americans with disabilities are arrested by age 28.¹¹
- According to a U.S. Department of Justice Special Report, 30% of jail inmates report having a cognitive disability — far higher than among the general public, where less than 5% of people self-report a cognitive disability.¹²

OUR RECOMMENDATIONS

Having a well-trained police force, along with crisis intervention-trained professionals, increases the likelihood that officers can connect people to needed services, while also improving public safety, reducing unnecessary arrests, and saving vital agency resources. Studies have shown consistently that Crisis Intervention Team (CIT) training improves officers' knowledge of mental illness and reduces stigma that might affect their response to mental health crises.¹³

Accordingly, we strongly recommend:

- **Mandatory training for every police officer** to develop a foundational understanding of the characteristics of people with a dual diagnosis.
- **Strict standards for ongoing and follow-up training**, requiring officers to remain up to date in their knowledge and practices.
- **Robust crisis response systems** in which dispatchers are trained to identify the need for intervention teams and send the appropriate personnel, case by case. Caregivers and families should not bear sole responsibility for ensuring an incident is handled properly.
- **A collaborative planning team** in every community to develop a crisis intervention training model. It is imperative that the planning team consist of partners from the mental health system, intellectual/developmental disabilities system, impacted family members, law enforcement, and other relevant community allies.
- **CIT availability** as a rule, not an exception. Evidence shows that crisis intervention-trained professionals mitigate risk for all involved in an incident.

NADD constituent families have vast experience — both positive and negative — with law enforcement in crisis situations. Their insights have helped inform our understanding that to properly address the needs of those with intellectual/developmental disabilities and/or mental health diagnoses, crisis intervention training for police and others must include the following components:

- **Positive communication practices with families and caretakers who can assist with a safe and effective outcome.**

A family's voice: “When police intervention was necessary, we would inform the dispatcher that we were calling for someone with an autism diagnosis. We had a script where we would ask for the police to arrive with no sirens and lights off once in front of our home. My son loves police cars, and we were always afraid that his behaviors would be increased by the lights and sirens. Once inside, I would immediately communicate with the officers to speak calmly and reassure Logan that he was safe in a quiet tone to help de-escalate the situation.”

- **Knowledge of tools and supports to accommodate individuals' different communication abilities, including understanding how behaviors can manifest in stressful situations such as a mental health crisis.**

A family's voice: "Our young adult son has autism, an intellectual disability, bipolar disorder, and he is non-verbal. Our first encounter with CIT officers brought a team of six or seven people. Our son's symptoms included severe aggression, property destruction, loud verbal outbursts, mania and psychosis, leading to a need for hospitalization. (The responders) were supportive and patient, offering to follow our lead. Our son was very combative, and the decision was made to use restraints as a last resort. It took seven people to hold him down. He broke the restraints and ended up handcuffed to the stretcher. Everyone, including the officers, was in tears. In subsequent visits by CIT officers ... (our son) recognizes officers who have returned more than once, which has helped with de-escalation. The officers bring a sense of safety and security because of the rapport they have developed and the patience with which they assist us."

A family's voice: "Once, when our adult daughter left our home while extremely manic and delusional, we located her in a neighborhood restaurant. She refused to come with us, so we requested police assistance in either getting her home or to the emergency room. We explained the situation, her dual diagnosis, and that we were her guardians. After interviewing her, we were told she was within her rights to be there as an adult. They agreed she seemed manic and said the best thing we could do was try to convince her to get in the car and then drive her to an ER. Then they left us on our own. We did eventually get her to the ER and she was hospitalized. We felt completely dismissed and abandoned in receiving much-needed crisis support while she was out in the community, unsafe. I wonder whether the officers understood what an intellectual disability is and why our guardianship was evidence of her vulnerability. Perhaps her dual diagnosis was overshadowed by their focus on whether she was displaying unsafe mental illness symptoms in the moment."

- **Understanding of physical, mental, or neurological disabilities that are not visible but can affect a person's behavior. Reactions should not be based on assumptions.**

A family's voice: "We've had officers respond to our daughter calling 911, expressing suicidal or delusional thoughts, only to have them leave after chatting with her a bit. Because she looks and acts much younger than she is, her intellectual disability is not obvious, and the seriousness of the situation is overlooked. Once, when she was ranting about having only 40 cents and that not being enough to go to college, an officer had her call one of us at work. We didn't know that a crisis had erupted. He provided us with information and reassured us she wasn't in trouble for calling 911 ... *this time*. Though we tried to explain her intellectual disability, the severity of her symptoms (that this actually was a sign of delusions), his course of action would not be changed and we could only scurry home to deal with it ourselves. Our daughter did end up hospitalized. These types of responses seem to come from a place of thinking developmental disabilities and mental illness only look a specific way. They don't."

- **Effective use of medical and behavioral health profile registries to guide appropriate crisis response by 911 operators, first responders, and crisis intervention staff.**

A family's voice: “In our area, we have enrolled our daughter’s profile in the RADAR program and SMART 911, promoted as ways to equip first responders with important details about your loved one with cognitive issues and/or mental illness in case you aren’t immediately available to fill them in. Through multiple emergency response situations, officers in the field have rarely utilized this profile information, despite our calling attention to it with 911 dispatchers and asking them to share. We’ve quizzed officers and received two responses: a.) they didn’t have time or didn’t think it was important to look up or b.) they couldn’t easily access it in the field on their equipment.”

- **Understanding of why restraint techniques should be a last resort to avoid physical harm and long-lasting trauma.**

A family's voice: “On one recent event, CIT officers assisted EMS in getting our son to the Emergency Department, but there was no bed, so we returned home. Later in the day, his symptoms worsened and we could no longer safely manage him at home, so 911 was called again. Five officers arrived. I explained the intent was to get him to the hospital and we provided detailed information about his disability (autism, intellectual disability, bipolar disorder). Our son made a small gesture toward an officer, not even a full swing. In less than a second, at least three of the officers had him pinned down, handcuffed, and in leg shackles. He was pulled through the house on his stomach, with one officer saying, “We’re gonna blow out his shoulder ...” I had failed to request CIT officers. Since then, almost daily, our son holds his hands behind his back, gesturing handcuffs, and says, ‘No woo woo (police siren)! No woo woo!’”

A family's voice: “Officers have walked into my home witnessing different scenarios — property destruction (broken windows, holes in the wall, shattered TVs, etc.), clothes shredded off me, my husband’s blood on the walls, my hair still wrapped in my young son’s hands ... Officers step into an environment of crisis, which at first glance can be hard to decipher. Not knowing the best approach, they often take an authoritative stance, raise their voice, and rapidly repeat demands, which only makes my son aggress harder toward us and eventually them. Their heightened approach escalated my teenage son’s behaviors, which led him to being handcuffed and taken to an adult crisis unit.”

- **Training and commitment to exercise trauma-informed care interventions and rely first on de-escalation techniques when responding to an individual in a mental health crisis.**

A family's voice: “Perhaps due to recent national events, the last time we called for assistance for our son, at least 12 officers responded, one ambulance, and a fire truck. The captain of the CIT program also arrived and stressed that every intervention would be taken to avoid traumatizing our son. Eventually a neighbor was allowed to bring her dog for assistance when other attempts at de-escalation failed. Our son agreed to walk the dog to the waiting ambulance, and then the dog and neighbor rode with us to the Emergency Department, the dog taking the gurney. Two officers accompanied us, providing support and reassurance.”

A family's voice: “The most effective officer who came into our home (multiple times) happened to be the spouse of one of my son’s therapists. He just got it — the approach came naturally to him. Maybe it was his life experiences and natural ‘training’ received by listening to his wife’s stories from work. This officer spoke with patience, calmness, and respect. In a time of crisis, he assured my son that he was safe and he took the time to de-escalate the situation in a way that worked for my son. We exhaled each time he would walk through the door.”

CONCLUDING STATEMENT

The basic human and civil rights of persons with intellectual/developmental disabilities and mental illness or mental health needs have been historically limited or denied based on social and cultural attitudes of devaluation and fear. These prejudices often fuel encounters of injustice and inequality.

It is through these commonalities with other marginalized groups that persons with a dual diagnosis and their families join the social and racial justice movement. They offer their experiences and approaches to facilitate change and move society toward progressive and proactive measures for positive interactions with law enforcement.

We at NADD stand ready to be part of the work to improve law enforcement’s interactions with those with a dual diagnosis.

RESOURCES

Tools exist for law enforcement to learn how to effectively interact with persons with intellectual/developmental disabilities or mental illness. These resources can help communities develop a comprehensive program for crisis intervention:

- [Model Policy, Interactions with Individuals with Intellectual and Developmental Disabilities from the International Association of Police Chiefs](#). Procedures listed here should be included in any training.
- [Pathways to Justice Training](#). This training from The Arc is part of its National Center on Criminal Justice and Disability.
- [Police Mental Health Collaboration Toolkit](#). This resource was created by the Bureau of Justice Assistance, a federal agency that works under the Department of Justice. Recommended by the National Alliance on Mental Illness (NAMI), the agency developed a forum for officials to learn from one another about how to adapt responses and connect citizens to needed services.
- [CIT International](#). The program includes community collaboration, creating an accessible crisis system, a 40-hour law enforcement training, behavioral health staff training, and the participation of families, consumers, and advocates. CIT International also has created [CIT International's Guide to Best Practices in Mental Health Crisis Response](#).
- [Serving Safely](#). This initiative of the Vera Institute of Justice is focused on improving interactions between police and people with dual diagnosis.
- [Crisis Intervention Team programs](#). NAMI promotes the expansion of CIT programs by providing information and support about [CIT implementation](#) to NAMI affiliates and state organizations, law enforcement, mental health providers, and community leaders.
- [Policy Brief: Law Enforcement Registries for Individuals with Disabilities](#). The Arc has outlined unintended consequences that law enforcement agencies and others must keep in mind when considering registry programs in their own communities, including violations of privacy and increased stigma toward people with disabilities.
- [The Academic Training to Enhance Police Engagement with People with Behavioral Health Issues and Developmental Disabilities](#). This project aims to increase access to training, technical assistance, and companion tools and resources to facilitate the adoption and implementation of multilayered approaches in police response for persons with behavioral health issues or developmental disabilities.

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