

July 22, 2020

Attorney General Gordon MacDonald, Chair
Commission on Law Enforcement Accountability, Community and Transparency
107 North State Street
Concord, NH 03301

Dear General MacDonald and Commission Members,

Thank you for the opportunity to offer comments regarding law enforcement training. My comments today will focus on training relative to mental illness.

In addressing mental illness and specifically relative to police training, it is important to put it into a historical context. In 1957 NH's population was 750,000 and the census of adults at our state hospital was 2,700 adults. Today, 60 years later our population is about 1.3 million and the census at the state hospital is around 180 adults. While the transition to the community has gone well for many people, it has not gone well for others. With a mental health system that is chronically underfunded, police have become the front-line response system during a mental health crisis.

The most significant glaring negative impact of deinstitutionalization has been the resulting criminalization and incarceration of people with serious mental health conditions. Police are not the root cause of this, rather it is the long-standing discriminatory practices which people with mental illness have endured in access to health and mental health care, housing, education, and employment. For people of color with mental illness, the negative impact of these discriminatory practices is significantly worse.

It is also important to state unequivocally we can't train our way out of the systemic failures of our mental health system or of racism, discrimination, and issues of accountability and transparency. Specific to mental illness, the lack of inpatient capacity reflected by the 45 adults and 17 children in a mental health crisis being boarded in Emergency Departments in our state yesterday (7/14/20), demonstrates the inability of our current system of mental health services to provide appropriate and timely care to people in mental health crisis, and which unfortunately ends up often defaulting to police to respond to.

Families need other options than calling 911 or going to the Emergency Department when someone is in a mental health crisis. Like many individuals and families in NH, I have had to call police when a family member in a mental health crisis became unsafe at home. It is extremely stressful for all involved and unpredictable whether the presence of police will escalate or deescalate the situation. We need to look upstream and expand community mental health supports such as the establishment of a 3-digit national mental health crisis hotline number, combined with *statewide* mobile crisis response, to divert people in a mental health crisis away from contact with law enforcement. In Concord, Manchester and Nashua

we have seen how mobile crisis teams are successful in reducing hospitalization and incarceration and how they also have effectively partnered with law enforcement. We must also acknowledge that lack of affordable housing, resulting homelessness, and other social determinants of health are significant factors in increasing the likelihood of contact with law enforcement.

Director Scippa and others who have testified, have spoken of the importance of training being data and research driven. I agree; however, specific to mental illness, I am not aware of, and presume we don't have data needed to make informed decisions about the need or effectiveness of mental health training. This includes the number of calls for service for people with mental illness or what types of calls they are. Is the person disruptive in public, are they suicidal, is the individual or their family unsafe in their residence, did the call for service come from a family member or friend or member of the general public or school. Is there specific demographic data such as race and gender that can also inform us? Data is also lacking about the final disposition – such as, was the situation resolved, an arrest made, person taken into protective custody, or did it result in a compulsory mental status exam or involuntary emergency hospitalization?

About the only piece of real data I have is from a December 2019 InDepthNH story – <http://indepthnh.org/2019/12/01/nhs-police-involved-shootings-who-should-investigate/> about the NH Attorney General's report on the use of deadly force. Of the 56 officer involved shootings in NH during the past 30 years, 45% involved a person with a documented mental illness. This is considerably higher than the 25% of officer involved shootings nationally which involved a person with mental illness. I have personally sat with and spoken to three of the families of those victims and it is truly heartbreaking. I am sure it is also heartbreaking for the Officer and the impact was likely felt on some level by their family as well. Of those 56 shootings, 14 were not fatal and 52 were determined to be legally justified. No charges were brought in the other 4 cases.

I would not want to be in the situation of having to make a split-second decision regarding use of deadly force. But it is long overdue that as a state and a society we have a dialog about use of deadly force, accountability and transparency including how training or other measures may reduce the incidence of these tragedies.

Obviously, we want to invest in training that produces results. However, I caution that the results we are seeking are likely not available. Regarding the difficulty of evaluating police training, it should be noted that the 2016 International Association of Chiefs of Police Report: *An Evidence-Assessment of the Recommendations of the President's Task Force on 21st Century Policing — Implementation and Research Priorities* states: "Only limited research has examined the impact of any type of police training. The National Research Council's (NRC, 2004: 141-142) review of policing research concluded that "there is limited evidence available ... on the effects of training" and that "few studies evaluate the impact of training programs on actual performance on the job." Page 33 <https://www.theiacp.org/sites/default/files/all/ij/IACP%20GMU%20Evidence%20Assessment%20Report%20FINAL.pdf>. To be clear, this in no way lessens the importance of data driven training, it just explains in part why there is not necessarily research available to support the effects of training on law enforcement behavior. The report contains a wealth of information which may help inform our efforts and I will provide a copy of the report when I submit my remarks.

Suicide is the second leading cause of death in NH ages 10-34, third leading cause of death ages 35-44 and fourth leading cause of death ages 45-54. While mobile crisis response can handle many of these calls, there are calls involving someone who is armed and threatening with a firearm that may require police response. These situations can often be deadly for the individual and for law enforcement. As a result, some police departments across the US are no longer responding to individuals who are armed and threatening suicide. <https://www.latimes.com/california/story/2019-08-09/suicide-calls-california-cops-stopped-responding>. While fortunately this is not happening in NH, clearly, we need to rethink as a society how we respond to people experiencing suicidal intensity. This includes the use of SWAT teams in these situations and what type of mental health training SWAT teams receive.

Currently, NAMI NH provides 16 hours of the 24 hours of training of the mental health block for all police cadets attending the Police Academy. NAMI NH has been teaching at the NH Police Standards and Training Council (PSTC) for years and our training includes recognition of types of mental illness, how to communicate with someone with mental illness, co-occurring mental illness and substance use disorders, trauma and anxiety, de-escalation techniques and role plays. Our role plays involve trained speakers with their own personal lived experience with mental illness.

As you also heard presented from Colonel Noyes, NAMI NH has also been offering Crisis Intervention Team (CIT) Training to NH State Police and first responders under a 3-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). Other police departments in New Hampshire also provide CIT training. Also known as the Memphis Model, CIT is internationally recognized and often referred to as the “gold standard” for law enforcement in mental health training. CIT is specifically recommended in the May 2015 President’s Task Force on 21st Century Policing in Pillar 5: Training and Education.

- **5.6 RECOMMENDATION: POSTs (Peace Officer Training Standards) should make Crisis Intervention Training (CIT) a part of both basic recruit and in-service officer training.** *Crisis intervention training (CIT) was developed in Memphis, Tennessee, in 1988 and has been shown to improve police ability to recognize symptoms of a mental health crisis, enhance their confidence in addressing such an emergency, and reduce inaccurate beliefs about mental illness.*⁹⁸

It has been found that after completing CIT orientation, officers felt encouraged to interact with people suffering a mental health crisis and to delay their “rush to resolution.”⁹⁹ Dr. Randolph Dupont, Chair of the Department of Criminology and Criminal Justice at the University of Memphis, spoke to the task force about the effectiveness of the Memphis Crisis Intervention Team (CIT), which stresses verbal intervention and other de-escalation techniques.

Noting that empathy training is an important component, Dr. Dupont said the Memphis CIT includes personal interaction between officers and individuals with mental health problems. Officers who had contact with these individuals felt more comfortable with them, and hospital mental health staff who participated with the officers had more positive views of law enforcement. CIT also provides a unique opportunity to develop cross-disciplinary training and partnerships. (page 56)

- <https://noblenational.org/wp-content/uploads/2017/02/President-Barack-Obama-Task-Force-on-21st-Century-Policing-Implementation-Guide.pdf>

Over its 30-year history, It has been found to have an evidence base for officer-level cognitive and attitudinal outcomes. However, as noted earlier, determining an evidence base for other areas such as reducing violence or arrests has proved more elusive. Some departments have noted remarkable outcomes such as decreased arrests and increased engagement in treatment, reduction in use of SWAT teams, and reduction in injuries to law enforcement. More importantly, CIT trained officers and departments across the country are strongly endorsed by people with mental illness and their families who have had CIT trained officers respond to them. Many families indicate that when they are faced with a crisis and need to call law enforcement, they specifically ask for a CIT officer.

NAMI NH has a trained CIT Coordinator on our staff who organizes and leads our CIT Training. The training includes many hours spent practicing skills through role plays with the “actors” disclosing after the scenario that they were the ones locked in the bathroom cutting themselves and refusing to come out, or at a fast food restaurant who the manager called the police on because they were shouting at the voices in their head. The NH Department of Health and Human Services, Bureau of Mental Health Services is providing NAMI NH funds for an additional CIT Training this year for police from municipal departments. Having attended the Monday morning welcome and opening for CIT Trainings where I witnessed the initial hesitancy and reluctance to ask questions, and then contrasted that with the enthusiasm, confidence, engagement and camaraderie at Friday afternoon’s role plays and subsequent graduation ceremonies, I can wholeheartedly say CIT Training is transformational. We are hoping NH will sustain this grant when it ends in September 2021 and expand CIT Training in NH in the future.

NAMI NH also provides *Mental Health First Aid Training for Public Safety* which is an 8-hour internationally recognized evidenced-based training specifically designed for police to help them identify people in a mental health crisis and defuse the situation.

Like other fields, best practices in mental health are constantly evolving. Having 24 hours of training in mental health at the police academy should not be expected to carry an officer through what will hopefully be a 20+ year career in law enforcement. As was pointed out by Director Scippa, officers who have been around for a few years had shorter and a less comprehensive academy than what is offered today. Clearly, ongoing didactic and skill-based training is needed in mental health and other areas. It has been NAMI NH’s experience doing in-service training at the academy that those who choose to take a class in mental health as part of their 8-hour recertification requirement are often the ones who are already knowledgeable and interested in the topic of mental health. While some self-selection and specializing should be encouraged, there should be the ability for Police Standards and Training to mandate a specific training or topic as part of police annual recertification requirements.

Many professions require ethics training as part of relicensing and perhaps the Police Standards and Training Council should develop a menu of training under the rubric of ethics that are required annually or periodically. This could include unconscious bias, bystander training, ethical policing and other similar topics There could also be a list of key training, including mental illness that must be part of recertification during a certain period of time such as every three to five years

NAMI NH is also very concerned about the mental health of law enforcement and our first responder community. Police are exposed daily to the worst of humanity and have higher rates of depression, trauma and suicide than the general population. Since 2008 we have included training at PSTC not only in suicide by cop, but suicide of police – a situation which has gone largely unnoticed in NH until the past year. In recent years, the increased national recognition that men and women of our military and uniformed services can have mental health issues has opened the door for law enforcement to address their own mental health and simultaneously increase their understanding and compassion toward people with mental illness. New Hampshire State Police and other departments have begun to train officers to provide confidential mental health peer support. We need to expand training and supports for law enforcement for addressing their own mental health.

Though not my area of expertise, I also think it is important to mention the importance of training in issues related to the LGBTQ population. Research points to police bias connected to sexual orientation. The previously mentioned IACP report, *Evidence-Assessment of the Recommendations of the President’s Task Force on 21st Century Policing —Implementation and Research Priorities* states: “Recent studies have found that police can be more intrusive, especially within the context of investigations and victimization experiences, when interacting with members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities (Wolff & Cokely, 2007; Dwyer, 2010; Stotzer, 2014). Specifically, officers are more likely to be dismissive and are more likely to engage in negative responses and behaviors during encounters with LBGQT citizens (Wolff & Cokely, 2007; Dwyer, 2011; Stotzer, 2014). Less is known about other forms of bias (e.g., disability, religion, etc.) in policing (page 15)

A member of the public pointed out to me that the PSTC website indicates that most, if not all of the instructors are male. I not aware whether there are people of color who are full-time instructors. I am aware that many adjunct faculty who participate in training at PSTC are more diverse. I don’t know if there is any data regarding the demographics of Field Training Officers throughout the state. However, having a more diverse training force is an important consideration.

I believe the issue of Police Department Accreditation is essential to insure there are some standards and oversight and that standard operating procedures are keeping up with best practices and emerging trends in policing. In looking at training needs, we should consider what training would be needed to assist local departments in going through an accreditation process.

Accountability requires goals and then determining what training will be needed to meet those goals and how we will measure them. While it is less true in NH, in too many areas law enforcement has become distanced or even estranged from the communities they serve. What training can be provided to assist police to connect with and engage in community goal setting? This should be done at a systemic level as well as at the individual community level. Are there success we can learn from where incidents of use of deadly force have decreased and where racial disparities in stops and arrests have been reduced or eliminated. How can they inform our efforts in New Hampshire regarding the role of training in accountability, transparency and community engagement?

I have been involved in the training of law enforcement in the area mental illness, off and on for over 35 years. During that time, I have seen increased understanding and compassion of law enforcement

toward people with mental illness, their willingness to partner with mental health organizations and positive steps to address their own mental health issues. There is much work still to be done and I believe specific to mental health, we need to continue to as expandi CIT training in NH, while at the same time, restructuring the mental health service delivery system to decrease police response to people with mental illness.

Last week, in an effort to promote “help rather than handcuffs,” NAMI National released a new report *Divert to What: Community Services that Enhance Diversion* <https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Divert-to-What-Community-Services-that-Enhance-Diversion/DiverttoWhat.pdf>. Some of the key findings of that report are contained in my remarks and I will include a link and attachment when I submit my written comments later today.

NAMI NH looks forward to recommendations this commission will make to inform training as we continue working with Police Standards and Training, NH State Police, municipal departments and other stakeholders to provide training and work toward reducing the use of force, and divert people with mental illness from the criminal justice system.

Respectfully submitted,


Kenneth Norton, LICSW

Regarding responses to questions from Commission members:

- Attached is a link to a report from the Department of Health and Human Services Bureau of Mental Health Services data regarding mobile crisis response teams and hospital and police diversion. The information is contained on pages 18, 19 and 20. Note the last 2 lines are Law Enforcement and Police Diversions
 - <https://www.dhhs.nh.gov/dcbcs/bbh/documents/qrtly-mar-2020.pdf>
- The Fusion Model is a 3 minute video about a crisis response model offered in many parts of the country where no one with mental illness (voluntary or involuntary) is denied admission and average drop of time for law enforcement is less than 5 minutes. There is a strong component of trained peers utilized in this model.
 - <https://www.youtube.com/watch?v=fGVuB1Z6xcU>
- Here is a similar 3 minute video regarding the future of crisis response for mental illness and substance use disorders.
 - <https://www.youtube.com/watch?v=M6BPxH09tqU&feature=youtu.be>