Disability Rights Nebraska

Protection and Advocacy for People with Disabilities

Testimony on LB 663
Judiciary Committee
Nebraska Legislature

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Bradley A. Meurrens
Public Policy Director
Disability Rights Nebraska

Good morning Senator Lathrop and members of the Committee. For the record my name is Brad B-R-A-D Meurrens M-E-U-R-R-E-N-S and I am the Public Policy Director at Disability Rights Nebraska. Disability Rights Nebraska is the designated Protection and Advocacy organization for people with disabilities in Nebraska. I am here today in opposition to LB 663.

LB 663 presents serious concerns. The bill is stigmatizing and discriminatory. It imposes a permanent identifier on people with mental health histories based on the simplistic and wrongheaded assumption that people with mental illness are inherently and *permanently* dangerous; when people with mental illness are more often the victims of crime than the perpetrators. Just because a person has been committed, even once, should not automatically label them as deviant, which is exactly what this bill does—the statement of intent reads that the indicator should provide law enforcement a tool to "protect individuals who are in mental and behavioral health crisis" or "a tool to identify if an individual may be undergoing a known mental…health crisis". Only if we carry the assumption that people with a history of mental illness are *permanently* in crisis or dangerous would a "yes" on this indicator lead one to believe that the person is *currently* in crisis or that responders need to be warned. Moreover, the bill provides no qualifier for how long the arm of the Crime Commission will reach back to affix the mental health indicator—so a person's mental health commitment from *decades* prior would label them still dangerous after all these years.

The indicator is simply a yes or no—there is no contextual understanding of the individual, their current situation or any information other than they were or weren't committed. In conjunction with the presupposition of inherent and permanent illness and dangerousness, this indicator automatically applies these assumptions and creates tension for the responders even before they can assess the true nature of the emergency call. We note that there are no indicators suggested for other health or social conditions such as an incident of alcohol treatment/rehabilitation—only persons with a history, no matter how brief, of mental health commitment get the indicator (serving only to reapply and reinforce all the accompanying stigma and stereotype).

134 South 13th Street, Suite 600 Lincoln, NE 68508
1425 1st Avenue, Scottsbluff NE 69361
info@disabilityrightsnebraska.org
www.DisabilityRightsNebraska.org

Office: 402-474-3183
Fax: 402-474-3274
TTY Available: 1-800-422-6691

The bill is too intrusive and expansive, evaporating (and without consent) any realistic privacy right. Individuals who were recently, or in the distant past, subject to commitment did not consent for some or all of their private information (remember: any other information deemed necessary for identification) or even their mental health commitment history to be given out, let alone essentially without restriction, as this bill would do. Why does the Crime Commission need to gather information such as social security number, address, *"and any other information of the subject"* (p. 3, lines 10-11) to identify individuals who have been committed when the indicator is only designed to give a "yes" or "no" to a person's mental health commitment history? Furthermore, the number and types of people who could be granted access to this indicator is in effect, limitless: " *or other persons designated by the commission*" (p. 3, lines 19-20). This is not protecting privacy. In fact, we are concerned that the legislation actually runs afoul of established privacy rules[1].

LB 663 perpetuates an outdated model and dangerous framework about how law enforcement (and other first responders) should respond to emergencies involving people with mental illness. There are a variety of alternative models for police/first responders' interaction that offer a less threatening situational framing. I have attached examples including Crisis Intervention Training ("Memphis Model"), Co-Responder Models, and Oregon's "Crisis Assistance Helping Out on the Streets".

Disability Rights Nebraska recommends LB 663 not be advanced.

If you have any further questions, please contact me at your convenience: brad@drne.org or 402-474-3183.

[1] While health care providers are permitted to disclose information about a patient to law enforcement in some circumstances, those are limited to emergency situations where the provider "believes the patient presents a serious danger to himself or other people"; for example, if a mental health professional has a patient who has made a credible threat to inflict serious and imminent bodily harm on one or more persons. See United States Health and Human Services (2013), "Letter to the Nation's Healthcare Providers", available at: https://www.hhs.gov/sites/default/files/ocr/office/lettertonationhcp.pdf

Overview of Models

Crisis Intervention Training ("Memphis Model")

- Training a group of police officers in how to work with people with mental illness
- Goal is to improve law enforcement interactions with people living with mental illness with a goal of decreasing use of force, fostering connections with the mental health system, and raising the level of community policing

Co-Responder Models

- Pairing police officers with mental health professionals to respond to emergencies involving people identified as having a mental illness

Crisis Assistance Helping Out on the Streets

- Oregon: Responds to non-emergency calls involving substance use, suicide threats, mental health crises and welfare checks
- Two-person team: Emergency medical technician and a trained crisis worker